DOI: 10.1590/1413-812320212612.14112021

Vulnerability of access to health services for informal workers in Mexico in the face of the SARS-CoV-2 pandemic

Oswaldo Sinoe Medina-Gómez (https://orcid.org/0000-0003-1286-7317) [1]

Abstract *This critical-reflective essay problematizes the labor dynamics in the framework of informality considered as a determinant for access to the health system in Mexico and discusses the vulnerability of workers to the pandemic caused by the SARS-CoV-2 virus. This analysis aims to contribute to the construction of proposals aimed at improving the lives of male and female workers by guaranteeing their right to health.*

Key words *COVID-19, Informal workers, Access to Health Services, Mexico*

[1] Unidad de investigación en epidemiología clínica, HGR 1, Instituto Mexicano del Seguro Social, México. Av. Paseo de la Reforma 476 Juárez, Cuauhtémoc. 06600 Ciudad de México CDMX México. epired@gmail.com

Introduction

A regime of opening and deregulation of the markets for goods and services was promoted during the implementation of the neoliberal model in Mexico. It was necessary to subordinate the world of work extremely and simultaneously dismantle the existing welfare system[1,2]. Justified as mechanisms to increase productivity and competitiveness, the deregulation and flexibilization of the labor market implied a cheaper workforce while physical and emotional exhaustion increased vulnerability to cause harm to health associated with the activities performed[3-5].

The current contractual relationships between workers and employers are geared to productive work and new forms of volatile labor relationships, characterized by the flexibilization of the labor market and the increased social insecurity, economy through subcontracting or outsourcing schemes[4-6] as in the case of the provision of services between individuals and with the intermediation of business consortiums through electronic platforms, whose economic gains are derived from this intermediation.

Entrepreneurship was promoted before the advance of the digital economy, which is nothing more than a form of self-employment under an apparent belonging to the business class. The advancement of new digital platforms has promoted a form of work called "microtasks", where the apparent freedom from work is accompanied by precariousness and lack of labor rights and regulatory framework. The non-recognition of the labor relationship builds new identities towards working people, such as being called "partners" and creating the idea of being part of the company among working people[7].

Health policies as part of social policies are an expression of the specific characteristics underlying the State. From the viewpoint of classical liberalism, the State should not intervene in the economy to adjust social inequalities and, thus, its intervention through social policies should be minimal, since the best mechanism for the distribution of goods for satisfaction needs occurs through the "free market".

The objectives of the health systems' reforms have been reoriented towards a market logic, not necessarily under a total and direct privatization of health services, but some services with some degree of profitability. Otherwise, these services are refunctionalized or abandoned[8,9] if this is not achieved.

By reducing the role of the State, in the best of cases, to a simple mediator between the market and society, health policies are reflecting this new role in determining the access and supply of health services and actions, which is a health inequality element.

The dimension of informal work in Mexico

Labor market transformation is reflected in the distribution of formal and informal work through measurement based on the *Measuring Informality: a new statistical manual on the informal sector and informal employment*[10] and the work carried out by the Delhi group. Two dimensions can be identified: the nature or type of the economic unit and the employment perspective. The first dimension identifies the sector in which the work activity is performed, while the second one addresses employment's legal or institutional framework. All employment carried out without social or labor protection, in formal companies or not, is considered informal employment, while all employment linked to informal economic units is employment in the informal sector. The information that makes up both dimensions is the Hussmanns matrix.

In Mexico, according to data available by the National Institute of Geography and Statistics (INEGI), the employment rate in the informal sector was 27.5% of the employed population (men 26.4% and women 29.1%) in the fourth quarter of 2019, while the seasonally adjusted labor informality rate was 56.2% of the population aged 15 years and over[11].

The Labor Informality Rate (LIT) showed values of 56.24% in the last quarter of 2019. The states with the highest rates of labor informality were Oaxaca (80.5%), Guerrero (79.3%), and Hidalgo (75.0%), while Coahuila recorded the lowest rate in the country (34.8%).

It is worth mentioning that the LIT was higher among women (57.64) than men (55.31) during this period. In the last quarter of 2019, the population employed in the informal sector in Mexico amounted to 15,281,473 people, of which 41.9% were women (Table 1). Approximately 41.47% of the people with informal employment were between 25 and 44 years old. The fact that 77.69% of working older adults were in the informal sector[11] is striking.

An important relationship is observed concerning the level of education and the type of occupation, where 56.6% of the population with formal employment have high school and higher education, contrasting with the informal sector where 38.75% of workers have high school education and 37.96% only have elementary school

level. Specifically, among informal workers in the formal sector, 36.93% have completed high school, and 25.97% have completed high school and higher education[11].

The structure of Hussmanns' matrix identifying the sector and the status of formal and informal work by gender is shown in Tables 2 and 3.

Barriers to access to health services

Unequal access to public health services determined by people's employment conditions is observed due to the characteristics of the Mexican health system, and it is difficult to identify the possible existence of organizations and initiatives of informal workers that favor or promote access to health services due to the secrecy of some activities to provide information that allows knowing the dynamics and working conditions, mainly among informal workers who carry out itinerant commercial activity[12].

In 2004, the *Seguro Popular* (Popular Insurance) came into force to provide medical care to a population without affiliation to social security systems. Since its inception, its implementation was considered in three stages: universal association; universal coverage, and subsequently achieving effective universal coverage, which ensures equally to all the highest achievable level of health outcomes from a high-quality service package that also avoids financial crises by reducing out-of-pocket expenses[13].

However, out-of-pocket spending, which is made up of household spending and recovery fees (copayments), mainly of people without social security affiliation, has shown a slight decline in recent years. In contrast, household expenditure for acquiring health goods and services indicates a significant increase (Graph 1). In the total household expenditure, 51.2% is used to purchase medicines and 17.0% for medical visits or medical care[13].

Before 2020, the only option of workers outside the formal labor market was private care services according to their ability to pay, self-care, self-medication, or affiliation to the *Seguro Popular*. The universal coverage of health services had been limited to people's affiliation under severe infrastructure and human resources issues, restricting the concept of universal coverage to regular access to a package of health services for those enrolled in the program[8].

The *Seguro Popular* has presented abnormalities in the financial management, including the lack of evidence of the full use of the assigned re-

Table 1, Distribution of formality condition by type of employing unit in the employed population aged 15 years and over in Mexico, October-December 2019,

Employing economic unit type	Position in the occupation and informality condition												Total
	Subordinate and paid workers				Employers		Freelancers		Unpaid workers		Subtotal by perspective of the economic and/or labor unit		
	Employees		Non-salary earnings										
	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	
Informal sector	4,153,178		761,381		1,045,728		8,283,288		1,037,898		15,281,473		15,281,473
Paid domestic work	2,319,923	79,550	16,595	0							2,336,518	79,550	2,416,068
Companies, Government, and Institutions	6,152,119	20,163,002	929,639	210,467		1,164,900		1,829,386	626,577		7,708,335	23,367,755	31,076,090
Agricultural sector	2,556,892	446,161	170,550	12,545		463,190	2,398,438		862,043		5,987,923	921,896	6,909,819
Subtotal	15,182,112	20,688,713	1,878,165	223,012	1,045,728	1,628,090	10,681,726	1,829,386	2,526,518		31,314,249	24,369,201	
Total		35,870,825		2,101,177		2,673,818		12,511,112		2,526,518			55,683,450

Source: INEGI, 2019 National Occupation and Employment Survey. Available from: https://www.inegi.org.mx/programas/enoe/15ymas/default.html#Tabulados.

Table 2. Distribution of formality status by type of employing unit in the employed male population aged 15 years and over in Mexico. October-December 2019.

Employing economic unit type	Position in the occupation and informality condition												Total
	Subordinate and paid workers				Employers		Freelancers		Unpaid workers		Subtotal by perspective of the economic and/or labor unit		
	Asalariados		Con percepciones no salariales										
	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	
Sector informal	3,132,189		668,099		810,019		3,975,115		300,370		8,885,792		8,885,792
Trabajo doméstico remunerado	209,571	32,260	2,108	0							211,679	32,260	243,939
Empresas. Gobierno e Instituciones	3,406,174	12,018,196	655,138	170,332		880,010		1,144,844	193,334		4,254,646	14,213,382	18,468,028
Ámbito agropecuario	2,312,752	349,038	139,541	9,577		432,994	2,254,314		555,220		5,261,827	791,609	6,053,436
Subtotal	9,060,686	12,399,494	1,464,886	179,909	810,019	1,313,004	6,229,429	1,144,844	1,048,924		18,613,944	15,037,251	
Total		21,460,180		1,644,795		2,123,023		7,374,273		1,048,924			33,651,195

Source: INEGI, 2019 National Occupation and Employment Survey. Available at: https://www.inegi.org.mx/programas/enoe/15ymas/default.html#Tabulados

Table 3. Distribution of formality status by type of employing unit in the employed female population aged 15 years and over in Mexico. October-December 2019.

Employing economic unit type	Position in the occupation and informality condition												Total
	Subordinate and paid workers				Employers		Freelancers		Unpaid workers		Subtotal by perspective of the economic and/or labor unit		
	Employees		Non-salary earnings										
	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	
Informal sector	1,020,989		93,282		235,709		4,308,173		737,528		6,395,681		6,395,681
Paid domestic work	2,110,352	47,290	14,487	0							2,124,839	47,290	2,172,129
Companies, Government, and Institutions	2,745,945	8,144,806	274,501	40,135		284,890		684,542	433,243		3,453,689	9,154,373	12,608,062
Agricultural sector	244,140	97,123	31,009	2,968		30,196	144,124		306,823		726,096	130,287	856,383
Subtotal	6,121,426	8,289,219	413,279	43,103	235,709	315,086	4,452,297	684,542	1,477,594		12,700,305	9,331,950	
Total		14,410,645		456,382		550,795		5,136,839		1,477,594			22,032,255

Source: INEGI, 2019 National Occupation and Employment Survey. Available at: https://www.inegi.org.mx/programas/enoe/15ymas/default.html#Tabulados

Ciência & Saúde Coletiva, 26(12):5897-5904, 2021

sources and observations by the Auditor General of the Federation on the lack of accreditation of the existence of the contracted staff, irregularities in the acquisition of medicines and services, transfers of resources to other bank accounts, among others[10] that affected the health infrastructure and the lack of resources to provide care and respond to contingencies and health emergencies.

The Health Institute for Well-being (INSABI) was established when the *Seguro Popular* disappeared in 2020. It aims to provide free public health services, medicines, and associated supplies to the population without access to social security when requesting care[15].

The foregoing aims to ensure medical care to the most socially and economically disadvantaged people, mainly due to their employment status, and which is based on the perspective of the right to health, moving away from the limited vision of the right to access to health, defined according to people's working conditions, also stopping efforts to market public health services.

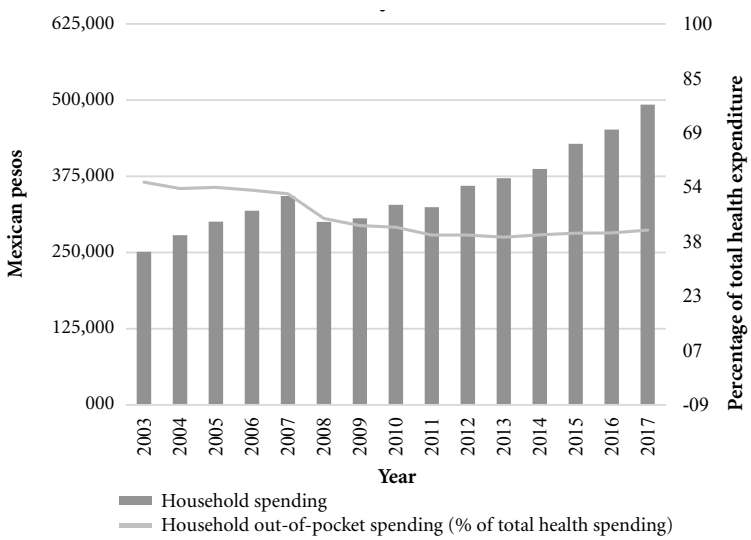
The setting in the face of the SARS-CoV-2 pandemic

In 2019, a new virus appeared in Wuhan, China, identified as COVID-19, which causes an acute and severe respiratory syndrome called SARS-CoV-2 and whose expansion throughout the world has reached pandemic status[16]. One of the most effective measures to control the pandemic is the restricted social mobility, home confinement, and the closure of commercial, non-essential establishments and work centers, all of which disrupt the disease's transmission chain, albeit with different results between countries[17].

Undoubtedly, the pandemic has adverse effects on the national economies despite the actions taken[18], including its impact on employment. Specifically, the informal workers in the formal sector are vulnerable to dismissal or termination of their employment relationship. In contrast, workers in the informal sector find it practically impossible to comply with the measures of confinement and physical distancing given that their subsistence income depends on the daily income earned, which resulted in the loss of 346,878 jobs in Mexico during the contingency derived from the pandemic[19].

Undoubtedly, the response capacity of the health services is essential to face the pandemic; However, countries that in recent years decreased financing for public health services or promoted reforms to move from a public to a private system[20-22] currently face the effects of the pandemic with greater intensity, increasing the inequality gap among the most vulnerable groups[5,23].

Health systems based on the free market show appalling effects on the population. Millions of people are without health insurance in



Graph 1. Health expenditure of Mexican households, 2003-2017.

Source: Health Secretariat. General Directorate of Health Information. Health expenditure. Indicators, Mexico 2020.

the U.S. Thus, the impediment of carrying out a diagnostic test and obtaining timely medical attention affects morbidity and mortality due to the pandemic and consequently indirectly impacts the economy. As a result, it is imperative to discuss health reforms[24] that guarantee universal access to health services.

In Mexico, the publicly available data that provide information at the national level regarding cases and deaths from COVID-19 do not present the employment status of the cases. However, an approximation to the dimension of the problem can be found by analyzing the information available for Mexico City, where the highest number of cases and deaths from the disease has occurred.

Although the available data have limitations regarding the specific activity of the sick person, mainly because any person who performs an economic activity is usually identified as an employee, merchants in fixed or itinerant markets represented 4.8% of the COVID-19 confirmed cases in Mexico City. In comparison, 2.4% were transport workers, 12.8% were in the category of others, and the unemployed represented 3.5%.

Undoubtedly, the lack of information regarding the employment condition of people who fall ill and die from COVID-19 is not minor; it makes invisible the unsafe conditions in which they live and access health services, which is why it is necessary to know in the immediate future the effect of the pandemic on the morbimortality of workers, exploring issues about access to health services, lethality, and excess mortality, coupled with the analysis of the work setting including changes in unemployment and formal and informal work.

Final considerations

Arguing that it is urgent to start the economy and, thus, expose workers to the new virus, acquire and spread the disease, presents a false dilemma between prioritizing the market and labor activity concerning confinement measures and reduced mobility[26-28] given the evidence that establishes the need for social distancing measures to reduce the transmission of the disease[29].

The limited labor activity will have significant economic consequences. However, the lives of people weigh on the economy, which the market has differentiated and polarized. As an example of the above, we can consider the inequality gaps regarding the distribution of the national wealth. Mexico has a significant discrepancy: while the poorest decile has an approximate quarterly income of US$ 457 (9,113 pesos, US$ 5/day), the wealthiest decile has an income of 58,496 USD, which shows the inequality gap among the Mexican population[30].

Undoubtedly, the success of actions to reduce population mobility depends on the participation of the population. However, like many countries in the Americas, one should not forget that most of Mexico's population lives in conditions of poverty, and the predominant labor market is located in informality. People who are in the informal sector do not have a choice[29]. They often expose themselves without the proper safety measures and with the high probability of being infected by the SARS-CoV-2 virus or carrying the disease to their family core and community to ensure the survival of their families.

Various support mechanisms have been established at the federal and state levels to confront and mitigate the effects of the pandemic. Specifically, in the workplace, economic support has been implemented for small and medium-sized enterprises (SMEs) and monetary transfers to the unemployed and informal workers who have small businesses. Unemployment benefits have been implemented, and food has been distributed, mainly to highly marginalized households, to mitigate the people's loss of economic income[32-34].

As a short-term counting measure, we propose establishing a universal pension as a mechanism to reduce the gap of social inequalities in Mexico. Such action, in turn, requires a profound transformation of the type of labor market to curb the high levels of informality and transforms outsourced services into stable and formal labor relations. As a result, workers achieve the benefits of social security in terms of medical care and the enjoyment of social and economic benefits, including a decent pension system, better distribution of wealth, and equitable tax collection. These changes will tend to reinforce the leading role of the Ministry of Health and encourage the strengthening of infrastructure, resources, and coverage of social security systems.

After overcoming the pandemic caused by the new virus, it will be necessary to reactivate the economies of the countries, but also reconsider the continuation of a neoliberal model, in which, paradoxically, the State has been considered a ballast for the free market and now calls out for rescuing large capitals.

Finally, new welfare state models should be considered and developed where health results from the full enjoyment of individual and collec-

tive rights that allow us to face this pandemic and the future health challenges.

References

1. De la Garza E. Neoliberalismo y Estado. In: Laurell A. *Estado y Políticas Sociales en el Neoliberalismo*. México: UAMX; 1994. p. 59-73.
2. Vite MA. Estado, globalización y exclusión social. *Polit Cult* 2006; 25:9-26.
3. Medina-Gómez O. Prevalencia de mobbing en trabajadores y factores de riesgo asociados. *GacMedMex* 2016; 125(4):452-456.
4. Cuevas H. Precariedad, Precariado y Precarización: Un comentario crítico desde América Latina a The-Precariat. The New DangerousClass de Guy Standing. *Polis* 2015; 14(40):313-329.
5. Medina-Gómez O, López-Arellano O. Informalidad laboral y derecho a la salud en México, un análisis crítico. *Cien Saude Colet* 2019; 24(7):2583-2592.
6. Ibarra Cisneros MA, González Torres LA. La flexibilidad laboral como estrategia de competitividad y sus efectos sobre la economía, la empresa y el mercado de trabajo. *Contaduría y administración* 2010 ;231:33-52.
7. Berg J, Furrer M, Harmon E, Rani U, M, Silberman S. *Las plataformas digitales y el futuro del trabajo. Cómo fomentar el trabajo decente en el mundo digital*. Ginebra: OIT; 2019.
8. Laurell AC. Las reformas de salud en América Latina: procesos y resultados. *Cuadernos de Relaciones Laborales* 2016; 32(4):293-314.
9. Laurell AC, Ronquillo JH. La segunda reforma de salud: aseguramiento y compra-venta de servicios. *Salud Colect* 2010; 6(2):137-148.
10. International Labour Organization (ILO). *Measuring informality: A statistical manual on the informal sector and informal employment*. Ginebra: International Labour Office; 2013.
11. Instituto Nacional de Geografía y Estadistica (INEGI). *Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH*). *2018 Nueva*serie Tabulados.[acceso 2020 Abr 05].[página en Internet]. Disponible en: https://www.inegi.org.mx/programas/enigh/nc/2018/default.html#.
12. Montarcé I, Hernández J, Garabito G, Feregrino A, Olivo MA, Ruiz S, Gayosso JL, León C, Pogliaghi L, Martínez C. Condiciones de trabajo y organización en algunas ocupaciones "atípicas": Call centers, Walmart, Macdonald' s, extras de televisión, ambulantes del centro histórico, vagoneros, tianguistas, microbuseros, taxistas, metrobuseros. En: De la Garza E, editor. *La situación del trabajo en México 2012, el trabajo en la crisis. La situación del trabajo en México 2012, el trabajo en la crisis.* México: Plaza y Valdéz-UAM-I; 2012. p. 345-94.
13. Knaul FM, González-Pier E, Gómez-Dantés O, García-Junco D, Arreola-Ornelas H, Barraza-Lloréns M, Sandoval R, Caballero F,Hernández-Avila M,Juan M, Kershenobich D, Nigenda G, Ruelas E,Sepúlveda J,Tapia R, Soberón G, Chertorivski S, Frenk J. Thequestfor universal healthcoverage: achieving social protectionforall in Mexico. *Lancet* 2012; 380(9849):1259-1279.
14. Instituto Nacional de Geografía y Estadística (INEGI). *Salud México* [página en Internet]. [acceso 2020 Abr 05]. Disponible en: https://www.inegi.org.mx/temas/saludsat/

15. Decreto por el que se reforman, adicionan y derogan diversas disposiciones de la Ley General de Salud y de la Ley de los Institutos Nacionales de Salud. México: *Diario Oficial de la Federación Secretaría de Salud;* nov 2019. [acceso 2020 Abr 15). Disponible en: https://www.dof.gob.mx/nota_detalle.php?codigo=5580430&fecha=29/11/2019.
16. Paules CI, Marston HD, Fauci AS. Coronavirus Infections - More Than Just the Common Cold. *JAMA* 2020; 323(8):707-708.
17. Remuzzi A, Remuzzi G. COVID-19 and Italy: what next? *Lancet* 2020; 395(10231):1225-1228.
18. McKibbin W, Roshen F. The Global Macroeconomic Impacts of COVID-19: Seven Scenarios. *CAMA WorkingPaper* 2020; 2(19):1-43.
19. Gobierno de México. *Versión estenográfica de la conferencia de prensa matutina del presidente Andrés Manuel López Obrador 08 Abr 2020*. [acceso 2020 Abr 17]. Disponible en: https://presidente.gob.mx/08-04-20-version-estenografica-de-la-conferencia-de-prensa-matutina-del-presidente-andres-manuel-lopez-obrador/
20. Sánchez-Martínez FI, Abellán-Perpiñán JM, Oliva-Moreno J. La privatización de la gestión sanitaria: efecto secundario de la crisis y síntoma de mal gobierno. Informe SESPAS 2014. *Gacet Sanit* 2014; 28 (Supl. 1):75-80.
21. García-Aguado J. La crisis de la sanidad: gestión pública versus gestión privada. *Rev Pediatr Aten Primaria* 2013; 15(Supl. 23):43-47.
22. Armocida B, Formenti B, Ussai S, Palestra F, Missoni E. The Italian health system and the COVID-19 challenge. *Lancet Public Health* 2020; 5(5):e253.
23. Rodríguez-Feijoó S, Rodríguez-Caro A. El copago farmacéutico en España tras la reforma del año 2012 desde la perspectiva del usuario. ¿Evidencias de inequidad? *Gacet Sanit* 2020; DOI: 10.1016/j.gaceta.2019.09.009.
24. King JS. Covid-19 and the Need for Health Care Reform. *N Engl J Medicine* 2020; 382 (26):e104.
25. Secretaría de Salud de la Ciudad de México. COVID 19 CDMX. [Internet]. [acceso 7 Jul 2021]. Disponible en: https://covid19.cdmx.gob.mx/
26. Hilsenrath PE. Ethics and Economic Growth in the Age of COVID 19: What Is a Just Society to Do? *J Rural Health* 2021; 37(1):146-147.
27. Londoño E, Andreoni M, Casado L. Bolsonaro, aislado y desafiante, subestima la amenaza del coronavirus en Brasil. *The New York Times*. [acceso 2020 Abr 11]. Disponible en: https://www.nytimes.com/es/2020/04/02/espanol/america-latina/bolsonaro-coronavirus-brasil.html.
28. Zurcher A. Coronavirus: President Trump defends tweets against US states' lockdowns. *BBC News.* 18 April 2020; Sect. US & Canada. [acceso 2020 Abr 19]. Disponible en: https://www.bbc.com/news/world-us-canada-52330531.
29. Dalton C, Corbett S, Katelaris A. Pre-emptive low cost social distancing and enhanced hygiene implemented before local COVID-19 transmission could decrease the number and severity of cases. *Med J Aust* 2020; 212(10):443-446.
30. Instituto Nacional de Estadística y Geografía (INEGI). *El inegi da a conocer los resultados de la encuesta nacional de ingresos y gastos de los hogares (ENIGH) 2018 serie* [página en Internet]. [acceso 2020 Abr 19]. Disponible en: https://www.inegi.org.mx/contenidos/saladeprensa/boletines/2019/EstSociodemo/enigh2019_07.pdf.
31. Paredes R. Coronavirus "El confinamiento es un concepto burgués": cómo el aislamiento afecta a las distintas clases sociales. *BBC News Mundo.* [acceso 2020 Abr 12]. Disponible en: https://www.bbc.com/mundo/noticias-internacional-52216492.
32. Gobierno de México. *Versión estenográfica. Informe del presidente de la República al pueblo de México.* Acto encabezado por el presidente Andrés Manuel López Obrador desde Palacio Nacional, Ciudad de México. [acceso 2020 Abr 19]. Disponible en: https://www.gob.mx/presidencia/es/articulos/version-estenografica-informe-del-presidente-de-la-republica-al-pueblo-de-mexico?idiom=es.
33. Gobierno de la Ciudad de México. *Ampliación de apoyos a la economía familiar Ciudad de México*; México. [acceso 2020 Abr 19]. Disponible en: https://www.cdmx.gob.mx/portal/articulo/ampliacion-de-apoyos-a-la-economia-familiar-por-covid-19.
34. Gobierno de Yucatán. *Casa por casa el Gobierno del Estado continúa con la distribución de ayudas alimentarias a 450,000 hogares yucatecos Yucatán, México: 2020*. [acceso 2020 Abr 20]. Disponible en: http://www.yucatan.gob.mx/saladeprensa/ver_nota.php?id=2713.

Article submitted 19/05/2020
Approved 16/07/2021
Final version submitted 18/07/2021

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva