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Sergio Meneses Navarro

The Health Care System in Mexico

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Content

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1. Country overview

Source: https://ontheworldmap.com/mexico/ (Accessed March 13, 2025)

- Sub-Region: North America
- Capital: Mexico City
- Official Language: Spanish
- Population size: 129,739,759 in 2023
- Share of rural population: 18.4% in 2023
- GDP: 1.79 trillion in 2023
- Income group: Upper-middle-income
- Gini Index: 43.5 in 2022
- Colonial period: Mexico was a Spanish colony between 1535 and 1821. In September 27th, 1821 Mexico became an independent nation.

Source: World Bank, 2023

2. Selected health indicators

Indicator	Mexico	Global Average
Life expectancy (years)	74.8 (2022)	72 (2022)
Male life expectancy (years)	71.5 (2022)	69.6 (2022)
Female life expectancy (years)	78.2 (2022)	74.5 (2022)
Under-5 mortality rate (per 100,000 live births)	12.8 (2022)	37.1 (2022)
Maternal mortality rate (per 100,000 live births)	59 (2020)	223 (2020)
HIV prevalence (%ages 15-24)	0.2% (2022)	0.25% (2022)
Tuberculosis prevalence (per 100,000 people)	28 (2022)	134 (2022)

Source: World Bank, 2023

3. Legal Beginning of the System

Name and type of legal act	Social Security Act
Date the law was passed	January 19, 1943
Date of *de jure* implementation	January 1, 1944
Brief summary of content	The Mexican Social Security Institute (Instituto Mexicano del Seguro Social or IMSS) is a social security institution for the protection of salaried employees, which includes health and maternity insurance, as well as other benefits such as child daycare, retirement savings, disability and death benefits, and other social services. Based on the principle of solidarity, is financed on a tripartite basis with the participation of the federal government, the employer, and the employee. The basis for eligibility for IMSS is to be a salaried employee in the formal sector of the private sector economy (González-Block 2018).
Socio-political context of introduction	At the time of the creation of the IMSS, several of the developed countries of the world were immersed in the Second World War, so Mexico assumed a preponderant role in the production of raw materials for these countries. Thus, the country underwent an accelerated process of industrialization and economic growth based on an economic policy called "import substitution". In addition, less than three decades had passed since the Mexican Revolution, which had raised social demands aimed at protecting workers and their families, their wages, and productive capacity. Thus, these aspirations for social justice were combined with economic conditions that favoured the establishment of social security for salaried workers in the industrial sector (González-Block 2018).

Name and type of legal act	Decree establishing the Secretariat of Health and Assistance.
Date the law was passed	October 15, 1943
Date of *de jure* implementation	October 15, 1943
Brief summary of content	There is a consensus that 1943 was the birth year of the modern Mexican health system. In that year, the first Social Security Institute (IMSS) was created, as well as the Secretaría de Salubridad y Asistencia -Secretariat of Health and Assistance- (SSA), to provide medical services to those excluded from social security, who were most Mexicans at that time. However, the basis of eligibility of the beneficiaries of the services of the SSA was the condition of exclusion from social security under a welfare system and not based on rights. The SSA was a highly centralized federal government institution that provided both general health and medical care to the population in need. It had a meager infrastructure, concentrated mainly in the republic's major cities. The SSA was financed by general taxes; the allocation of expenditures between public health and medical care activities was highly discretionary (Bustamante 1983; Frenk & Gómez-Dantés 2008).
Socio-political context of introduction	In January of that year, the Mexican Social Security Institute (IMSS) was created to provide health care to the growing salaried working class. Since 1917, however, the post-revolutionary Mexican state had taken a leading role in providing medical care to the most vulnerable through social assistance. With the birth of the IMSS, the population excluded from social security could not be left unattended, and the SSA was created to oversee this important sector (Frenk & Gómez-Dantés 2008).

4. Characteristics of the system at introduction

a. Organisational structure

Initially, in 1943, the health system was centralized through the IMSS and the SSA, with the federal government in charge of directing, financing, and providing services to different social groups. However, the republic states also participated in certain health activities, mainly sanitation (Frenk & Gómez-Dantés 2008).

Originally, the IMSS covered only the working population of the formal private-sector economy. A little more than a decade later, in 1959, public sector workers were included in the social security system through the Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE). The workers covered by social security represented a small percentage of the population (initially less than 10%), and the benefits covered were medical coverage for basic health services, hospital care, and other social benefits such as pensions and insurance for accidents and occupational hazards (Frenk & González Block 1992).

The SSA served the informal population, which had no access to social security. This sector received only basic medical care and some hospital care in a limited network of public hospitals located in the country's major cities, particularly Mexico City (Frenk & Gómez-Dantés 2008; Gómez-Dantés et al. 2011). We do not have quantitative data on the population covered by the SSA because services were provided through an assistance program and there was no membership mechanism. However, in 1943, the availability of resources to provide medical services was initially very limited. The health system was fragmented and lacked an organized structure to ensure universal access. Public hospitals and clinics provided most medical care, but these were scarce and could not adequately meet the needs of the population, especially in rural areas. Medical care tended to be concentrated in the upper classes, and most of the population lacked health insurance and access to basic health services.

Percentage of population covered by government schemes	Indeterminate because we do not have registration systems for SSA beneficiaries and IMSS records are not public, although its coverage began with the population of the first industrial organizations in the country.
Percentage of population covered by social insurance schemes	
Percentage of population covered by private schemes	Negligible
Percentage of population uncovered	There were no explicit coverage criteria for the uninsured population. The sector covered by the uninsured was insignificant.

b. Coverage

Since the birth of the modern health care system, two eligibility criteria have been established for access to health care institutions. Firstly, it was required to be a salaried worker in the formal sector of the economy, for whom medical care was established through social security institutions such as the IMSS (for workers in the private sector) or the ISSSTE (for workers in the public sector). These people were called "derechohabientes" and were entitled to care only as long as they maintained their status as wage earners or retired. On the other hand, for people who did not have a salaried job (e.g., the self-employed, the unemployed, farmers, housewives, students, etc.), health services were created, administered by the Secretariat of Health and Assistance (SSA), and provided under a welfare logic, not as a right. However, access to health services was very limited and concentrated mainly among the urban population and the higher social classes. The majority of the rural population, especially indigenous communities, did not have access to public health services (Meneses Navarro et al. 2022) (Serván-Mori et al. 2025).

c. Provision

In the early days of Mexico's health system, the number of doctors, nurses, and hospital beds was quite limited compared to the population's needs. In the late 1940s, there were approximately 60 physicians per 100,000 people, 25 to 30 nurses per 100,000, and 2.5 hospital beds per 100,000. This number of health resources was lower than in other Latin American countries. It was clearly insufficient to meet the population's needs, especially in rural, indigenous, and marginalized areas (Gómez-Dantés et al. 2025).

The benefits package was also limited. The IMSS provided general medical care for its members to treat common diseases. Specialized care was under development and not readily available outside the country's major cities. The IMSS also provided surgical services, but its capacity was very limited. The most common surgeries were emergency or work-related. Care for pregnant women and children was a priority area for IMSS and SSA. IMSS began to provide maternity services, but initially only in urban areas and at the main hospitals. These services included antenatal care, delivery, and postnatal care. Rehabilitation services were incipient, especially for conditions related to work-related injuries or accidents (Gómez-Dantés et al. 2025).

d. Financing

In the early years of the IMSS, in the 1940s, health spending was less than 2% of GDP. By the 1960s, total health spending was around 3-4% of GDP. Most of the resources were concentrated in the social security institutions (IMSS and ISSSTE), and their financing was tripartite, based on contributions from employers, workers, and the federal government.

e. Regulation

In the early days of the Mexican health system, the main institutions responsible for managing the health system and regulating the provision of services were the Secretaría de Salubridad y Asistencia (SSA) and the IMSS. The SSA was responsible for establishing public health policy. However, it was in charge of general and public health services at the national level, in addition to regulating the medical care provided to the population excluded from social security in the SSA's health facilities. The IMSS was primarily responsible for regulating the medical care provided by its member organizations. However, regulations for health care providers were limited because they were still in the process of being developed (Gómez-Dantés et al. 2025; Frenk & Gómez-Dantés 2008).

In 1943, the Public Health Law was enacted to comprehensively regulate public health and medical services throughout the country and ensure they were provided with quality standards. This law outlined the initial basis for supervising public and private hospitals and clinics. In those early years, the SSA and the *Consejo de Salubridad General* (General Health Board, created by presidential initiative in 1891) were also responsible for regulating physicians and other health professionals. In 1938, the Law of Professions was enacted, stipulating that all persons practicing the health professions in Mexico must hold an official degree from a legally recognized educational institution and meet the requirements to practice their profession. This law also regulated the supervision of professional activities and compliance with ethical standards (Frenk & Gómez-Dantés 2008; Gómez-Dantés et al. 2025; 2011).

5. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Decree amending and supplementing the General Health Law for the creation of the Social Health Protection System (Fox-Quezada 2003)
Date the law was passed	May 15, 2003
Date of de jure implementation	Jan 1, 2004
Brief summary of content	The Social Health Protection System and its operative arm, the Seguro Popular -Popular Health Insurance- (SP), is a health insurance scheme with predominantly public financing and a tripartite financial structure similar to that of the IMSS and ISSSTE and is aimed at people whose employment status excludes them from conventional social security. Its purpose was to provide public health insurance coverage to the Mexican population excluded from conventional social security as a necessary step towards universal health coverage through a public insurance scheme with the same level of financing and the same package of interventions for the entire population (Knaul & Frenk 2005; Knaul, Frenk, & Horton 2007; Knaul, Frenk, & Gómez-Dantés 2004; Frenk et al., n.d.).

Population coverage	As of November 2018, Seguro Popular covered more than 55 million Mexicans, just over 40% of the national population. Among them, it covered the unemployed, indigenous populations, and social groups in greater conditions of vulnerability (CONEVAL 2018).
Type of benefits	Seguro Popular covered a package of essential services, defined according to explicit cost-effectiveness and social acceptability criteria, contained in the Unified Catalogue of Health Services (CAUSES). In 2004, there were 105 interventions - representing about 90% of the reasons for care - financed by the Personal Health Services Contribution Fund and provided in a decentralized manner in SESA and IMSS-B health centers and second-level hospitals. As of 2018, CAUSES included 294 health interventions and 670 medicines and consumables. The Catastrophic Expense Protection Fund was defined for high-cost and more serious but less frequent diseases, and it was also based on cost-effectiveness, epidemiological profile, and technological development criteria. It was managed directly by the federal government through tertiary care hospitals. Until 2018, it covered 65 interventions, including the treatment of various forms of childhood and adult cancer - such as leukemia, colon, cervical, and breast cancer -, acute myocardial infarction, neonatal intensive care, the treatment of congenital or acquired malformations, the treatment of HIV/AIDS and the transplantation of various organs - cornea, kidney, heart, liver, etc. - as well as the treatment of cancer and other diseases (Meneses-Navarro 2020).
Socio-political context of introduction	Seguro Popular was born in a political context of democratic transition. For the first time in more than 70 years, Mexico's federal government was occupied by a party other than the one that had been hegemonic since the end of the Revolution. Although the federal government did not have a legislative majority, the decree creating the Social Health Protection System and the Seguro Popular was approved by a broad majority of all political parties in both chambers of the Mexican Congress and was ratified by all the states of the republic (Ortíz 2006).

b. Major reform II

Name and type of legal act	Decree creating the Descentralizied Public Entity called the Health Services of the Mexican Institute of Social Security for Welfare (IMSS-Bienestar) (*Diario Oficial de La Federación* 2022)
Date the law was passed	August 31, 2022
Date of *de jure* implementation	January 1, 2023
Brief summary of content	The IMSS-Bienestar aimed to provide medical services to the population excluded from social security, approximately 80 million Mexicans, through a process of recentralization of health services. In this way, through the IMSS-Bienestar, the federal government is responsible for providing, financing, and coordinating health services throughout the country. Until November 2024, only 24 states had handed over their state health systems to the IMSS-Bienestar; 8 federal entities continued to retain ownership and operation of their health systems.
Population coverage	According to data from the National Council for the Evaluation of Social Policy (CONEVAL), with the disappearance of the Popular Health Insurance, more than 33 million Mexicans considered that they did not have access to health services. No new metric for affiliation to health services has been created since the implementation of the IMSS-Bienestar (CONEVAL 2021).
Available benefits	IMSS-Bienestar provides a limited package of primary health care services as well as basic hospitalization. It does not provide specialty health services or third-level care.

Socio-political context of introduction	The IMSS-Bienestar was created in the political context of constructing a new partisan hegemony in Mexico, represented by the National Regeneration Movement (MoReNa), which claims to identify itself with the political left. This movement is headed by the historical leader of the partisan opposition of the last three decades, Andrés Manuel López Obrador. The party MoReNa controls both chambers of Congress, the federal government for the second consecutive administration, and most state and municipal governments.

6. Description of current health care system

From the beginning, the health system was segmented between the social security institutions that covered salaried workers and their families - represented by the IMSS, the ISSSTE, and the social security systems of sectors such as the workers of Petróleos Mexicanos (the Mexican government's oil company or PEMEX), the military, the navy, electricians, and others. Similarly, there are the institutions responsible for providing health services to the population not covered by social security (the self-employed, independent workers, non-salaried peasants, among others), a sector that has been wrongly nicknamed "ineligible" - that is, without the right to health services - or "open population" (Frenk & Gómez-Dantés 2008; Meneses Navarro et al. 2022).This health subsystem, which serves the population without social security, has had different institutions involved. From 1943 to 1983 it was the Ministry of Health and Assistance (SSA), which was later renamed the Ministry of Health (keeping the same acronym); in 1979, the IMSS added the presidential program called General Coordination of the National Plan for Disadvantaged Areas and Marginalized Groups, known as IMSS Coplamar, to the care of people without social security in rural areas; this program changed its name with the beginning of each new presidential administration. It was called IMSS-Solidaridad from 1988 to 1994, IMSS Progresa from 1944 to 2000, IMSS Oportunidades from 2000 to 2012, and IMSS Prospera from 2012 to 2018; In 1985, the health system was decentralized and the states began to provide health services through their State Health Secretariats (SESA); From 2003 to 2020, the Seguro Popular de Salud (SP) was responsible for financing health care for this sector of the population; from 2019 to 2023, the Instituto de Salud para el Bienestar (INSABI) was responsible; and from 2023 to the present, the Decentralized Public Organism IMSS-Bienestar has been responsible for financing and providing health care for this sector, now under a recentralization logic (Knaul et al. 2023).

This segmentation responded to a constitutional legal basis, since Article 123 establishes the responsibility of employers to provide health services to their workers as a benefit of employment, considering the risks inherent in the activities associated with the job (González-Block 2018). Surely, the original objective in establishing this structure of the system was not to segment the population on the basis of health care but rather that the economic and industrial development of the country would grow in such a way that all citizens would have a salaried job - or be part of a household with a salaried head of household - that would allow them to have social security and, therefore, health insurance for health protection (López-Cervantes et al. 2011). Thus, the medical assistance provided by the SSA to sectors without social security would play a lesser role, while economic expansion would lead to an increase in social security coverage. However, the country's economic development did not follow the expected path. Instead, it led to the emergence of a large sector of the population working on their own account in the formal or informal economy, in addition to a variable group of unemployed and people outside the labor market. For these citizens, financial and operational mechanisms had to be defined to guarantee the protection of their health as a constitutional right of citizenship, over and above the benefits of work (Meneses Navarro et al. 2022).

a. Organisational structure

The Mexican health system is broadly composed of two sectors: the public sector, which refers to government institutions, and the private sector. The public sector includes social security institutions such as IMSS, ISSSTE, medical services for PEMEX, military and navy personnel, as well as the services of the federal (SSA) and state (SESA) health secretariats and IMSS-Bienestar for the population without social security. The private sector includes private insurers, hospitals, clinics, and private medical service providers, whether allopathic or alternative.

These sectors have different funding sources, which are aggregated into different funds with specific providers and different beneficiaries (Meneses Navarro et al. 2022).

Thus, there is a duplication of functions among the various health system institutions. Social security institutions have their own rules for medical care, sources of funding, and ways of financing, as well as infrastructure for providing services, while the institutions that provide services to the population without social security have different rules, sources of funding, and infrastructure. This duplication leads to higher costs and consequent inefficiency of the system and creates inequalities by treating citizens with and without social security differently, who experience different conditions of access, service packages, and quality of services.

On the other hand, the private sector consists of a wide variety of providers with different medical rationales and costs: from individual providers in small pharmacies, laboratories or allopathic medical practices, other health specialties or alternative therapies, to highly specialized private hospitals. Costs in the private sector are very heterogeneous, ranging from low to very high. However, these services are generally for-profit, and users pay for them directly at the time of use, which is known as out-of-pocket spending (Serván-Mori et al. 2023).

In 2020, 44.95% of the population had social security. The rest of the population depended on the services of the SSA and the SESAs based on a criterion of access on the basis of welfare (INEGI 2020). Thus, they did not have an explicit package in a policy specifying what services they were entitled to (Knaul, Frenk, and Horton 2007), and *per capita* funding was two to ten times less than that of those with social security (from US$51 *per capita* for the population without social security to between US$224 and US$542 per capita for those with social security) (Meneses Navarro et al. 2022). The population with social security has access to first, second, and third-level health services (i.e., highly specialized services), although they do not have a service policy with an explicit catalog of coverage (i.e., with covered diseases and interventions). On the other hand, the IMSS-Bienestar, which serves the population without social security, has only first and second-level services (with the basic specialties of general surgery, gynecology-obstetrics, pediatrics, and internal medicine) but no high specialty services. For the population without social security to have access to high specialty services, the SSA has tertiary-level hospitals. However, most of them are in Mexico City with a limited installed capacity that does not allow the attention of potential users from all over the country.

Percentage of population covered by government schemes	70.95%
Percentage of population covered by social insurance schemes	44.13%
Percentage of population covered by private schemes	2.08%
Percentage of population uncovered	26.52%

Source: Population and Housing Census, 2020, National Institute of Statistics and Geography (INEGI 2020).

b. Coverage

Table 1. Coverage of public health institutions, 2020

Population Type	Finance subsystem	Provider Institution	Population covered	Percentage of country
Without Social Security	Federal Funding/ Health for Wellness Fund	SSA SESA IMSS-Bienestar	33,801,552	26.82%
Social security	IMSS	IMSS	47,245,909	37.49%
	ISSSTE	ISSSTE	7,165,164	5.69%
	PEMEX SEDENA SEMAR	PEMEX SEDENA SEMAR	1,192,255	0.95%
	Subtotal		89,404,880	70.95%
Unmet population			33,431,212	26.52%
Private Insurance	Several private companies		2,615,213	2.08%

Source: Population and Housing Census, 2020, National Institute of Statistics and Geography (INEGI 2020).

c. Provision

Mexico's healthcare system has experienced significant growth in the number of healthcare professionals and hospital infrastructure. In 2021, Mexico will have approximately 324,290 registered physicians working in public or private institutions, or 251.4 physicians per 100,000 inhabitants. In 2023, the number of nurses in the country was 310,000, or 240.3 per 100,000 inhabitants. The public sector had about 90,000 census beds in 1,400 hospitals, or 69.8 per 100,000 people. The private sector has 2,874 hospitals, and its census bed capacity represents 34% of the hospital system.

Public institutions do not have an explicit package of intervention coverage. Social security institutions theoretically provide care for all health needs. In some cases, however, their resources are limited, so that waiting times for care are too extensive, effectively excluding some people from receiving services. This is the case, for example, for most organ transplants, care for some types of cancer, or services such as hemodialysis.

Similarly, the public institutions that serve the population without social security do not have an explicit package of services. This omission is intentional since the party in power in the Mexican government since 2018 considers that defining a package of services is "neoliberal" and "immoral" since it is a measure that inherently excludes certain interventions. Thus, in its propaganda, the government points out that the health system provides all services for the needs of people without social security. However, the services it offers are limited to first and second-level care, with a limited supply of highly specialized services (Knaul et al. 2023).

d. Financing

Health expenditure in Mexico is 6% of the Gross Domestic Product, but public spending represents only 2.8% of GDP. The public sector of the health system has two main forms of financing: that of the social security institutions and that of the population without social security. The financing of social security has a tripartite structure: the national government participates with an equal social contribution for each member of these institutions -which corresponds to half of the total cost-, and the employer and the affiliated worker cover the rest of the insurance costs. In the case of the IMSS, the employer is a private company, and in the case of the ISSSTE, the employer is also the government, whether federal or state. In 2003, the SPS established a financial mechanism like that of the IMSS and the ISSSTE, including the same social contribution (paid by the federal government), a solidarity contribution paid by the federal and state governments, and finally a family contribution based on income deciles, with the possibility of exemption for the first two deciles. Thus, one of the objectives of the 2003 reform was to unify the financial architecture of the social security system and the SPS (tripartite structure) to reduce inequalities in financing. This would be an essential step in the process of integrating a universal health system. However, as mentioned above, this policy was repealed in 2020, abandoning the path of integrating the financing and delivery functions between the different health subsystems so that they would operate as a single coordinated system. Currently, institutions serving the uninsured population are mainly financed by federal public funds, although SESA also uses state public funds to varying degrees. The private sector, on the other hand, is financed mainly by out-of-pocket payments by users at the time-of-service use and, to a lesser extent, by private health insurance.

e. Regulation of dominant system

Stewardship is the main function of the SSA, and it involves the participation of the General Health Council, professional associations and civil organizations. However, with the creation of the IMSS-Bienestar in 2023, this institution has *de facto* taken over the attributions of the steering role.

However, in the fragmented context of the Mexican health system, the steering role of the SSA faces difficulties and challenges (Meneses Navarro et al. 2022). Each institution in the health system - be it IMSS, ISSSTE, SESA, or IMSS-Bienestar - has some authority to define and implement its policies and programs, decide on financial management or establish coordination mechanisms, i.e., to exercise steering functions within its organization. For example, each institution has its own health programs, which are not always aligned with the action programs defined by the SSA. Thus, the steering role of the SSA faces the enormous challenge of integrating a coherent and efficient response among the institutions that make up the health system, one that is congruent with - and effective in the face of - the needs of the population. To meet this challenge, the SSA has established various inter-

institutional coordination mechanisms to provide an integrated response to specific problems. In the same sense, each institution defines the services it will provide, although clinical practice guidelines are developed with the participation of inter-institutional technical teams.

Another difficulty in the governance role is the regulation of medical care to ensure a minimum level of quality in the provision of services. Regulatory activities include the certification of doctors and nurses, as well as the accreditation and certification of health units. The certification of these units refers to the evaluation to ensure that they have the necessary infrastructure, equipment, and supplies to provide quality care. However, the certification process is optional - not mandatory - for the facilities of any institution. This process is carried out by the General Health Council, not the SSA. Accreditation, on the other hand, is carried out by the SSA, SESA, and IMSS-Bienestar. It is an obligatory evaluation for health units that aims to guarantee the quality and safety of the care they provide, according to established standards.

7. Co-existing systems

In addition to the public sector, Mexico's healthcare system comprises the private sector, both for-profit and not-for-profit (Gómez-Dantés et al. 2025). The private sector includes private hospitals, clinics, doctor's offices, and laboratories. Financing comes mainly from patient co-payments, either through health insurance or out-of-pocket payments. The latter is the predominant form of payment in the private sector (Serván-Mori et al. 2023; 2022; Knaul et al. 2022).

Since the beginning of the 21st century, doctor's offices adjacent to pharmacies, which offer low-cost outpatient general medical services, have gained importance (Pérez-Cuevas et al. 2014). By 2023, there were more than 18,000 doctor's offices adjacent to pharmacies, and their use for outpatient consultations exceeded the use of public health services at the first level of care(Bautista-Arredondo, Vargas-Flores, and Colchero 2024). According to the 2023 National Health and Nutrition Survey, 66% of people without social security who needed outpatient medical care sought private services, mainly in doctor's offices adjacent to pharmacies; among IMSS members, 39% sought care in private services, while among ISSSTE members, the percentage was 49% (Shama Levy 2024).

There are some non-governmental organizations (NGOs) and community health initiatives that provide services, especially in rural, highly marginalized areas and in crisis contexts (e.g., the migration crisis affecting large parts of the country) (Orozco-Núñez et al., n.d.; Guerra et al., n.d.). These services are not-for-profit; their funding comes mainly from donations, international sub-grants, and private funds. Their infrastructure is usually modest, but they are in areas that are poorly served by public or private for-profit services. Their human resources are often volunteers or general medical staff with limited experience due to funding constraints. The focus of these organizations is highly localized in vulnerable and highly marginalized communities.

8. Role of global actors

Some global actors are or have been involved in the financing and delivery of health services. International organizations such as the World Health Organization and the Pan American Health Organization mainly provide technical assistance to promote public health policies and programs and to strengthen health systems. However, their involvement is modest ("Healthcare in Latin America: History, Society, Culture" 2022).

The World Bank and especially the Inter-American Development Bank have financed initiatives to improve the infrastructure and sustainability of the health system, especially in the states with the greatest poverty and marginalization, as well as those with the greatest social backwardness and the worst health indicators. One example is the Mesoamerica Project, which has been operating since 2008 in the state of Chiapas and the countries of Central America and the Caribbean (Sacks et al. 2022).

Other global actors that finance and provide health services through initiatives targeted at vulnerable populations or specific problems include the United States Agency for International Development (USAID), the Bill and Melinda Gates Foundation, Médecins Sans Frontières, and Médecins Du Monde. However, the Mexican government is not financially or technically dependent on these organizations (Guerra et al., n.d.).

Finally, in some rural and highly marginalized localities, especially in Indigenous regions, some Catholic Churches and other Christian denominations have medical clinics, dispensaries, and small hospitals that provide healthcare services to these populations within the framework of religious philanthropy and charity (Frenk & Gómez-Dantés 2008).

9. List of additional relevant legal acts

The main regulatory documents of the Mexican health system are:

- Political Constitution of the United Mexican States. Article 4 establishes the right to health protection. Article 132 establishes the right of workers to social security.
- General Health Law. This is the main regulatory framework of the health system. It regulates all aspects related to the protection of the health of Mexicans, the organization and delivery of health services, health promotion, disease prevention, and the responsibilities of health service providers. It establishes the bases for medical care and access to services; regulates the education and training of health professionals; establishes sanitary norms and public health protocols; and defines the responsibilities and functions of the country's various health institutions (SSA, IMSS, ISSSTE, among others).
- Mexican Social Security Institute Act (Ley del IMSS). Regulates the functioning of the IMSS. Establishes the insurance system for private sector employees and their families. Regulates the coverage of medical, hospital and pharmaceutical services. Establishes the basis for the financing of the IMSS.
- Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE) Law. Regulates the functioning of the ISSSTE. Establishes the basis for health care coverage for state employees and their families. Regulates the provision of medical and social services, as well as the rights and obligations of beneficiaries.
- National Health Program. It is the set of strategies and actions of the Mexican federal government to address the main public health needs of the country. This program changes with each new federal government administration.
- Mexican Official Standards (Normas Oficiales Mexicanas or NOM's). These are normative documents issued by the Ministry of Health that establish technical and operational criteria for the provision of health services. NOMs are applied nationwide and are fundamental to the quality of medical care.

References

Bautista-Arredondo, Sergio A., Adriana Vargas-Flores, and M. Arantxa Colchero. 2024. "Medical Care Seeking Behavior and Healthcare Utilization at the First Level of Care, 2006-2023." Salud Pública de México 66 (4): 589–97. https://doi.org/10.21149/16215.

Bustamante, Miguel. 1983. "Hechos Sobresalientes en la Historia de la Secretaría de Salubridad y Asistencia." Salud Pública de México 25 (5): 465–82.

CONEVAL. 2018. "Sistema de Protección Social en Salud: Seguro Popular y Seguro Médico Siglo XXI Antecedentes." https://www.coneval.org.mx/EvaluacionDS/PP/CEIPP/IEPSM/Documents/Seguro_Popular_Seguro_Medico_Siglo_XXI.pdf.

CONEVAL. 2021. "Nota Técnica sobre la Carencia por Acceso a los Servicios de Salud." México.

Consejo Nacional de Población. 2024. "Conciliación Demográfica de 1950 a 2019 y Proyecciones de La Población de México y de Las Entidades Federativas 2020 a 2070." https://www.gob.mx/conapo/documentos/bases-de-datos-de-la-conciliacion-demografica-1950-a-2019-y-proyecciones-de-la-poblacion-de-mexico-2020-a-2070.

Diario Oficial de La Federación. 2022. "Decreto Por El Que Se Crea El Organismo Público Descentralizado Denominado Servicios de Salud Del Instituto Mexicano Del Seguro Social Para El Bienestar (IMSS-BIENESTAR)," August 31, 2022.

Fox-Quezada, Vicente. 2003. Decreto Por El Que Se Reforma y Adiciona La Ley General de Salud. Ciudad de México: Congreso de la Unión.

Frenk, J., E. González-Pier, and O. Gómez-Dantés. 2007. "Reforma Integral Para Mejorar El Desempeño Del Sistema de Salud En México." Salud Pública de México. Accessed January 31, 2023. https://www.scielo.org.mx/scielo.php?pid=S0036-36342007000700007&script=sci_arttext.

Frenk, Julio, and Octavio Gómez-Dantés. 2008. Para Entender El Sistema de Salud de México. México, D.F.: Nostra Ediciones.

Frenk, Julio, and Miguel A. González Block. 1992. "Corporatism and Health Care: A Comparison of Sweden and Mexico." Health Policy 21 (2): 167 80. https://doi.org/10.1016/0168-8510(92)90016-5.

Gómez-Dantés, Octavio, Edson Serván-Mori, Diego Cerecero, Laura Flamand, and Alejandro Mohar. 2025. "Mexico's Health System, 2023." Salud Pública de México 67 (1): 91–105. https://doi.org/10.21149/15802.

Gómez-Dantés, Octavio, Sergio Sesma, Victor M. Becerril, Felicia M. Knaul, Héctor Arreola, and Julio Frenk. 2011. "Sistema de Salud de México." Salud Pública de México. https://www.scielosp.org/pdf/spm/v53s2/17.pdf.

González-Block, Miguel Ángel. 2018. El Seguro Social: Evolución Histórica, Crisis y Perspectivas de Reforma.Universidad Anáhuac.

Guerra, Germán, Emanuel Orozco, Paulina Jiménez, Arne Ruckert, Ronald Labonté, and Nelly Salgado De Snyder. n.d. "Global Health Diplomacy in Mexico: Insights from Key Actors in the Field." Accessed March 4, 2025. https://doi.org/10.1186/s12992-021-00789-y.

"Healthcare in Latin America: History, Society, Culture." 2022. Healthcare in Latin America, August. https://doi.org/10.5744/FLORIDA/9781683402619.001.0001.

Hernández-Bringas, Héctor H., and José Narro-Robles. 2019. "Infant Mortality in México: Achievements and Challenges." Papeles de Población 25 (101): 17–49. https://www.researchgate.net/publication/345765101_Infant_mortality_in_Mexico_achievements_and_challenges.

INEGI. 2020. "Censo de Población y Vivienda 2020." Censo de Población y Vivienda 2020. https://www.inegi.org.mx/programas/ccpv/2020/.

Knaul, Felicia, Julio Frenk, and Octavio Gómez-Dantés. 2004. "Financiamiento Justo y Protección Social Universal: La Reforma Estructural Del Sistema De Salud En México." Health Policy 27 (1): 19–34. https://doi.org/10.1016/0168-8510(94)90155-4.

Knaul, Felicia Marie, Hector Arreola-Ornelas, Michael Touchton, Tim McDonald, Merike Blofield, Leticia Avila Burgos, Octavio Gómez-Dantés, et al. 2023. "Setbacks in the Quest for Universal Health Coverage in Mexico: Polarised Politics, Policy Upheaval, and Pandemic Disruption." The Lancet. Elsevier B.V. https://doi.org/10.1016/S0140-6736(23)00777-8.

Knaul, Felicia Marie, and Julio Frenk. 2005. "Health Insurance in Mexico: Achieving Universal Coverage through Structural Reform." Health Affairs 24 (6): 1467–76. https://doi.org/10.1377/hlthaff.24.6.1467.

Knaul, Felicia Marie, Julio Frenk, and Richard Horton. 2007. "La Reforma del Sistema de Salud Mexicano." Salud Pública de México 48 (supl. 1): S1–4.

López-Cervantes, Malaquías, Juan Luis, Durán Arenas, and Marcia Villanueva Lozano. 2011. "La Necesidad de Transformar El Sistema de Salud En México." Academia.edu. https://www.anmm.org.mx/GMM/2011/n6/26_GMM_Vol_147_-_6_2011.pdf.

Meneses Navarro, Sergio, Blanca Estela Pelcastre-Villafuerte, Victor Becerril-Montekio, and Edson Serván-Mori. 2022. "Overcoming the Health Systems' Segmentation to Achieve Universal Health Coverage in Mexico." International Journal of Health Planning and Management 37 (6): 3357–64. https://doi.org/10.1002/HPM.3538.

Meneses-Navarro, Sergio. 2020. "¿Qué Es y Cómo Funciona El Seguro Popular de Salud?" In Contribuciones Desde La Antropología Médica y La Salud Pública Para Personal de Salud En Regiones Indígenas y Rurales, edited by Sergio Meneses-Navarro and María Graciela Freyermuth-Enciso, 72–81. México: Centro de Investigaciones y Estudios Superiores en Antropología Social; Instituto Nacional de Salud Pública.

Instituto Nacional de Salud Pública. n.d. "Síntesis Sobre Políticas de Salud: Panorama del Problema."

Orozco-Núñez, Emanuel, Enai Ojeda-Arroyo, Nadia Cerecer-Ortiz, Carlos M. Guerrero-López, Beatriz M. Ramírez-Pérez, Ileana Heredia-Pi, Betania Allen-Leigh, Emma Feeny, and Edson Serván-Mori. n.d. "Gender and Non-Communicable Diseases in Mexico: A Political Mapping and Stakeholder Analysis." Accessed March 4, 2025. https://doi.org/10.1186/s12961-024-01125-7.

Ortíz, Mauricio. 2006. El Seguro Popular: Una Crónica de La Democracia Mexicana. México: Fondo de Cultura Económica, Secretaría de Salud.

Pérez-Cuevas, Ricardo, Svetlana V. Doubova, Veronika J. Wirtz, Edson Serván-Mori, Anahí Dreser, and Mauricio Hernández-Ávila. 2014. "Effects of the Expansion of Doctors' Offices Adjacent to Private Pharmacies in Mexico: Secondary Data Analysis of a National Survey." BMJ Open 4: 4669. https://doi.org/10.1136/bmjopen-2013-004669.

Sacks, Emma, Montserrat Mendez Alvarez, Pilar Bancalari, and Juan Carlos Alegre. 2022. "Traditions and Trust: A Qualitative Study of Barriers to Facility-Based Obstetric and Immediate Neonatal Care in Chiapas, Mexico." Women & Health 62 (6): 522–31. https://doi.org/10.1080/03630242.2022.2089442.

Secretaría de Salud. 2024. "Información Relevante Muertes Maternas."

Serván-Mori, Edson, Octavio Gómez-Dantés, David Contreras-Loya, Laura Flamand, Diego Cerecero-García, Héctor Arreola-Ornelas, and Felicia M. Knaul. 2022. "Changes in Health Care Coverage, and Catastrophic and Impoverishing Health Expenditures in Mexico Associated to the Dissolution of Seguro Popular." Under review in Lancet Global Health. https://doi.org/10.2139/ssrn.4252674.

Serván-Mori, Edson, Sergio Meneses-Navarro, Rocío García-Díaz, Diego Cerecero-García, David Contreras-Loya, Octavio Gómez-Dantés, and Arachu Castro. 2025. "Ethnic and Racial Discrimination in Maternal Health Care in Mexico: A Neglected Challenge in the Search for Universal Health Coverage." International Journal for Equity in Health 24 (1): 10. https://doi.org/10.1186/s12939-024-02374-2.

Serván-Mori, Edson, Sergio Meneses-Navarro, Rocío García-Díaz, Laura Flamand, Octavio Gómez-Dantés, and Rafael Lozano. 2023. "Inequitable Financial Protection in Health for Indigenous Populations: The Mexican Case." Journal of Racial and Ethnic. Health Disparities, October. https://doi.org/10.1007/s40615-023-01770-8.

Levy, Teresa Shama. 2024. "Encuesta Nacional de Salud y Nutrición Continua 2023." Instituto Nacional de Salud Pública. Accessed 2024. https://ensanut.insp.mx/encuestas/ensanutcontinua2023/index.php.

World Bank. Mexico. 2023. Accessed March 14, 2025. https://data.worldbank.org/country/mexico.