

UHC HIGH - LEVEL FORUM 2025

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NATIONAL HEALTH COMPACT Republic of Mexico



#InvestinHealth

Declaration of Commitment by the Government of Mexico

The Government of Mexico pledges universal access to quality healthcare for all people, without financial hardship or discrimination. This Compact represents a historic and collective effort by the Government to guarantee the constitutional right to health for all, building a fairer, more cohesive, and resilient national health system by 2030.

Mexico's progress toward universal health coverage has long been constrained by institutional fragmentation, persistent inequality, and limited fiscal space. The decentralization of health services that began in the 1980s resulted in 32 state-operated systems with varying capacities and performance levels, reflecting the country's deep regional inequalities. The 2003 Seguro Popular reform, while intended to expand protection for the uninsured, exacerbated these disparities by reinforcing the decentralized model without addressing its structural weaknesses. Its financing scheme linked federal transfers to the number of affiliates rather than to improvements in service quality or health outcomes, which incentivized enrollment expansion over system strengthening. As a result, states with stronger administrative and fiscal capacity and with stronger constituencies benefited more, while poorer states lagged behind, further entrenching inequalities in access, quality, and health results. These systemic weaknesses became even more evident during the COVID-19 pandemic, which exposed the limited resilience and coordination capacity of the fragmented model and underscored the urgent need for comprehensive transformation.

Recognizing these lessons, the Government of Mexico has embarked on a structural reform aligned with the National Development Plan (PND) 2025–2030 and the Health Sectoral Program (PROSESA) 2025–2030. Both instruments place health at the center of the country's development agenda and establish clear objectives: to guarantee the right to health protection, to ensure financial protection against illness, and to consolidate a modern, integrated, and equitable health system capable of serving all people, regardless of employment or social security status.

This Compact embodies the shared vision of the Government to achieve Universal Health Coverage through a two-phase reform process that integrates institutions, aligns financing, and strengthens stewardship. The first phase, launched in 2022, advances the federalization of service delivery by consolidating IMSS-BIENESTAR as the main provider for the uninsured population. By transferring facilities, personnel, and budgets from state health systems to federal management, this phase establishes a uniform framework for quality and governance. Its priorities include the standardization of care protocols, the equitable distribution of resources, the modernization of infrastructure, and the creation of interoperable health information systems. Throughout the network of services now operated by IMSS-BIENESTAR across the states. Through these measures, the Government seeks to eliminate state-level fragmentation, ensure free services at the point of care, and lay the foundation for integration, which is expected to strengthen equity and continuity of care by addressing the coordination and resource disparities that emerged under the previous system.

The second phase, beginning in 2026, will establish a unified national network of public healthcare providers (hereinafter referred to as Public Health Service or PHS) that integrates the main institutions covering insured and uninsured populations – IMSS, ISSSTE, and IMSS-BIENESTAR – under a single operational framework. The PHS is not conceived as a new institution, but as an integrated, people-centered network of healthcare services with the mission of ensuring universal, timely and free access to quality care for the entire population. Its mission will be to harmonize financing, quality standards, and service delivery to guarantee that every person in Mexico can access essential and quality health care services regardless of income, geography, or institutional affiliation. By 2030, this integration will represent a historic milestone in Mexico’s transition toward a universal public health system.

This reform is anchored in the principles of equity, efficiency, and solidarity. It also reflects Mexico’s alignment with the Sustainable Development Goals, particularly SDG 3 — ensuring healthy lives and promoting well-being for all. The Compact defines measurable national targets for 2027 and 2030, including reductions in maternal and child mortality, preventable deaths from chronic diseases, and out-of-pocket spending, as well as improvements in vaccination coverage and public service utilization. These indicators will guide implementation and ensure accountability across all levels of government.

Signed on behalf of the Government of Mexico

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Technical Context and Implementation Framework

I. COMPACT OBJECTIVES, TARGETS AND INDICATORS FOR 2027 AND 2030

The Universal Health Coverage (UHC) Compact sets out a results-oriented framework to translate reform commitments into measurable progress by 2027 and 2030. The targets reflect the Government of Mexico’s priorities to improve population health, expand access to quality care, and strengthen financial protection in line with the National Development Plan (PND) and Health Sector Program (PROSESA) 2025–2030.

Key Objectives of the Compact

- **Enhanced Population Health:** Strive to improve health outcomes for all Mexicans, with emphasis on reducing preventable mortality, including maternal, child, and tackling key risk factors to reduce NCD-related deaths, and addressing persistent regional and socioeconomic disparities.
- **Universal Access to Quality Health Services:** Expand access to high-quality, integrated care for all individuals—

regardless of location, income, or social security status— ensuring continuity and dignity in the provision of services throughout the life cycle, and maintaining service provision in the face of natural and climate shocks and stressors.

- **Financial Protection:** Strengthen public financing and service delivery to reduce out-of-pocket spending, guarantee free access to essential medicines and supplies, and protect households from catastrophic health expenditures.

Key Targets of the Compact

The following table summarizes the core targets of this Compact, with baseline values and the desired outcomes for 2027 and 2030. These national targets will be complemented by annual monitoring milestones to ensure effective intersectoral coordination and sustained fiscal commitment.

OBJECTIVE	INDICATORS	BASELINE	TARGET 2027	TARGET 2030
Improve population health	Maternal Mortality Ratio	34.1 per 100,000 live births (2024)	30.0 per 100,000 live births	25.0 per 100,000 live births
	Under-five mortality ratio	16.06 per 1,000 live births (2023)	13.0 per 1,000 live births	10.0 per 1,000 live births
Improve health outcomes/ Universal access to quality of care	Mortality rate between the ages of 30 and 70 from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.	15.05% 2023	12.0%	8.0%

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OBJECTIVE	INDICATORS	BASELINE	TARGET 2027	TARGET 2030
Universal access to health care	Percentage of the population without access to health care services.	39.09% (2022)	25.0%	10.0%
	Percentage of the population aged one year who have completed the vaccination schedule during period.	66.8% (2024)	90.0%	95.0%
Financial protection in case of illness	Percentage of the population that received care in the public sector and had out-of-pocket health expenses.	17.8% (2022)	12.0% (2028)	5.0%

II. COUNTRY AND SECTOR OVERVIEW

Mexico, a nation of approximately 130 million people organized as a federal republic of 32 states, stands at a historic turning point in its pursuit of Universal Health Coverage (UHC). As an upper-middle-income country and member of the Organization for Economic Co-operation and Development (OECD), Mexico has achieved notable progress in health over the past decades but continues to face deep inequalities in health outcomes and access across regions and population groups.

Life expectancy in Mexico has increased significantly over recent decades, reaching approximately 75.5 years, yet it remains nearly five years below the OECD average.³

The country has made notable progress in the reduction of child stunting and undernutrition, which has contributed to reductions in infant and child mortality and eliminated many infectious diseases through sustained vaccination efforts. However, Mexico now faces a major public health challenge: the growing burden of non-communicable diseases (NCDs) — including cardiovascular disease, diabetes, and cancer — which have become the leading causes of death and disability. The high prevalence of key risk factors such as high obesity rates (about 36% of adults) and persistent socioeconomic and regional disparities continue to undermine progress toward equitable health outcomes.³

Historically, Mexico's health sector has been highly fragmented. Multiple public institutions were created to serve different population groups in parallel:

- *IMSS for private-sector workers and their families;*
- *ISSSTE for public-sector employees;*
- *PEMEX and the armed forces for their respective personnel; and*
- *The Ministry of Health (Secretaría de Salud, SSA) and state health services for the uninsured population.*

This structure led to inefficiencies, duplication, and unequal resource allocation across institutions. Per capita spending, service availability, and quality of care varied widely—favoring formal workers and wealthier states while poorer regions and those without social security coverage lagged behind.

In 2003, the creation of Seguro Popular was a landmark effort to expand health insurance coverage for the uninsured. While its objectives were ambitious, the reform did not address the structural inequalities inherited from the earlier decentralization of health services and instead exacerbated fragmentation. The decentralization process that began in the 1980s had already produced 32 state-operated systems with uneven capacity and performance, reflecting Mexico's deep regional disparities. Seguro Popular's financing model linked federal transfers to the number of affiliates rather than to improvements in service quality or health outcomes, prioritizing enrollment expansion over system strengthening. Combined with limited investment in infrastructure, equipment, and human resources, this approach resulted in dispersed resources, variable performance, and incomplete coverage across states.

Moreover, the financial protection achieved under Seguro Popular was largely concentrated among higher-income households. The program's Catastrophic Health Expenditures Fund covered costly conditions such as cancer, leukemia, and other complex diseases that

required third-level hospital care. However, these specialized facilities were mostly located in urban areas, particularly within the National Institutes of Health in Mexico City. As a result, households with higher incomes, living closer to these facilities, were better able to access and benefit from coverage, while poorer families in remote regions faced geographic barriers, limited service availability, and high indirect costs, leaving many still exposed to catastrophic health expenditures or, more likely, lack of access to treatment.

At the same time, the federal government's stewardship role weakened further, lacking effective mechanisms to monitor performance, ensure accountability, or articulate a unified vision for the national health system. The result was a divided and increasingly unequal health architecture that limited Mexico's ability to guarantee the constitutional right to health.

By 2018—the last full year of operation of the Seguro Popular, which was formally eliminated at the end of 2019—it was evident that Mexico's health outcomes lagged behind comparable countries. For instance:

- *The maternal mortality ratio remained high (around 55 deaths per 100,000 live births in 2020), well above OECD levels.⁹*
- *There was a 4.7-year life expectancy gap between wealthier states (e.g., Nuevo León) and poorer states (e.g., Chiapas).^{4,5}*
- *Access to medicines and diagnostic services was inconsistent, particularly in rural and marginalized areas.*

Recognizing these challenges, the new administration elected in 2018 launched a major reform to strengthen federal stewardship. The Institute of Health for Welfare (INSABI), established in 2020 to replace Seguro Popular, aimed

to provide free healthcare for the uninsured and to standardize benefits and eliminate user fees. However, the simultaneous onset of the COVID-19 pandemic, occurring just months after INSABI's creation, severely

disrupted its implementation and prevented the consolidation of this effort. The pandemic severely tested the health system, exposing its limited resilience and capacity to respond to large-scale shocks. Hospitals were overwhelmed, routine services were disrupted, and essential health indicators—such as vaccination coverage and life expectancy—deteriorated significantly during this period.

These events reaffirmed the urgent need for a coherent, integrated, and resilient public health system capable of providing continuous care, financial protection, and equitable access nationwide.

In 2022, learning from prior experiences on fragmentation and weakened federal stewardship, the Government took decisive steps to correct course by expanding and transforming IMSS-Bienestar—originally a rural care program—into the central operational arm for uninsured populations. Through formal agreements with state governments, facilities,

personnel, and budgets were transferred to federal management, marking the beginning of systematic federalization of health services.

By 2024, with a new administration under President Claudia Sheinbaum, health was reaffirmed as a national priority and central pillar of the social agenda. The Government announced its commitment to achieve Universal Health Coverage by 2030, through the progressive integration of all public health institutions into a unified PHS.

The Universal Health Coverage Compact arises from this context—leveraging past lessons and current momentum to align the health sector around a shared national goal:

Guaranteeing the right to health protection for every person in Mexico through an integrated, equitable, and sustainable public system by 2030.

III. CURRENT STATUS, OPPORTUNITIES, AND CHALLENGES

Current Status

As of 2025, Mexico's health system is undergoing an active and transformative reform process. Approximately 87% of the population is currently covered, primarily through IMSS, ISSSTE, the expanding IMSS-BIENESTAR network, and other social security institutions.^{5,6} The remaining 13% of the population—mainly those in informal employment, rural areas, and marginalized communities—are still served by state health services in the states that have not yet signed integration agreements with IMSS-BIENESTAR. These populations, therefore, remain under fragmented and heterogeneous delivery models, reflecting the unfinished agenda toward universality.

Private spending is about 48% of total health expenditure, with out-of-pocket spending representing about 41% and private health insurance plans 7% of total health expenditure.

Out-of-pocket spending remains a key obstacle in financial protection and one of the highest shares among OECD countries—pushing families into poverty and discouraging timely care-seeking. Total health spending in Mexico represents roughly 6% of GDP, but public spending accounts for only 3%, significantly below the OECD average. Chronic underinvestment in public health has resulted in shortages of personnel, medicines, and infrastructure, especially in the most disadvantaged regions.⁷

For instance:

- *Mexico counts 2.7 doctors and 3.0 nurses per 1,000 inhabitants, compared to OECD averages of 3.9 and 9.2, respectively.³*
- *The country has 1 hospital bed per 1,000 population, compared to OECD averages of 4.2 beds per 1,000, reflecting limited inpatient capacity.³*

These constraints translate into overcrowded facilities, long waiting times, and disparities in service quality across states.

Health outcomes reflect both long-term progress and recent setbacks. Infant and under-five mortality rates have fallen steadily, yet preventable mortality remains high—418 per 100,000 population, around twofold the OECD average.³ Maternal mortality, which had improved through the 2010s, rose to 55 per 100,000 live births in 2020 due to pandemic disruptions. Life expectancy, now around 75 years, has just recovered from the decline during COVID-19.⁹

Geographic inequities persist: in southern states such as Chiapas, Guerrero, and Oaxaca, mortality and malnutrition rates are significantly higher, and access to services is lower than in wealthier states like Nuevo León or Mexico City. A child born in Chiapas can still expect to live several years less than one born in the north. These differences highlight that equity remains the central challenge for universal coverage.

The quality of care also varies widely. Some tertiary hospitals and national institutes provide world-class treatment, yet primary care facilities, particularly in rural or indigenous areas, often lack diagnostic capacity or functioning equipment. Preventive services have weakened: vaccination coverage dropped during the pandemic (DTP3 coverage around 78%, measles coverage lower), and screening for chronic diseases and cancers remains insufficient. Only 20% of women aged 40–69 report having had a mammogram in the last two years—less than half the OECD average.³

Recurrent medicine shortages have eroded public confidence in the system for decades. In recent years, supply interruptions for cancer drugs and other critical medicines prompted emergency measures, including centralized purchasing and international procurement. Additionally, the Government is now implementing long-term supply chain reforms and promoting domestic pharmaceutical production to ensure consistent availability.

The regulatory environment is improving, but gaps remain. COFEPRIS continues to strengthen its oversight and streamline approval processes, yet delays and administrative bottlenecks still hinder timely access to innovative medicines and medical devices.

Mexico's health system faces a dual reality: it possesses strong institutional foundations and valuable experience, yet continues to struggle with inequalities in access, service quality, and financial protection. Achieving universal coverage requires addressing these structural divides while consolidating recent advances in federalization, financing, and governance.

Climate change further amplifies these challenges, with rising temperatures, floods, and droughts disrupting service delivery and threatening infrastructure—particularly in areas served by IMSS-BIENESTAR. Building climate resilience into health reform—through stronger infrastructure, digital systems, and cross-sector coordination—will be critical to safeguard continuity of care and protect the most vulnerable populations.

Opportunities

Despite persistent challenges, Mexico has a unique opportunity to achieve UHC in this decade, supported by strong political commitment, institutional capacity, and reform momentum.

- **Strong Political Commitment:** The current administration has placed health at the center of the national agenda. Under the leadership of President Claudia Sheinbaum, the Government has prioritized health reform, backed by joint action from the Ministries of Health and Finance. This high-level alignment ensures sustained political will, policy coherence, and intersectoral coordination.
- **Ongoing Health Sector Transformation:** The integration of services under IMSS-BIENESTAR and the planned creation of the PHS offer a historic opportunity to overcome

fragmentation and achieve systemwide efficiency and equity. This reform will enable standardized quality, pooled financing, and service delivery under a unified provider network, translating into better health outcomes and stronger public trust.

- **Institutional Strengths:** Mexico's major health institutions—IMSS, ISSSTE, COFEPRIS, and the National Institutes of Health—provide a robust platform for reform. Their technical expertise, infrastructure, and human capital are key enablers for system integration and modernization, and design of evidence-based programming.
- **Health Workforce Pipeline:** Expanded training, fair remuneration, and digital support systems (e.g., tele-education and teleconsultation) will increase the availability of health workers in underserved regions. This strategy supports the Government's commitment to universal primary healthcare coverage and equitable workforce distribution, and is a fundamental component for improved quality of care for preventive service delivery, like nutrition counseling and behavior change.
- **Digital Transformation:** The national digital health strategy, including the rollout of a unified electronic health record (EHR), telemedicine expansion, and connected health information system, is at the center of service integration, and will improve coordination, data-driven decision-making, and service efficiency—especially for remote communities.
- **Domestic Pharmaceutical and Vaccine Production:** The Government's emphasis on health sovereignty—expanding local manufacturing capacity for medicines and vaccines—will enhance supply chain resilience and reduce dependence on imports. This initiative also supports economic development through public-private partnerships and technology transfer. Mexico's vibrant pharmaceutical

sector, which includes a dynamic network of national producers and multinational firms, plays a central role in ensuring sustainable access to affordable, high-quality medicines and vaccines. Encouraging local production, research and development, and technology transfer through public-private collaboration will be key to achieving the Government's objectives.

- **Climate-Resilient Universal Health Coverage:** Integrating climate resilience into the pursuit of universal health coverage offers a strategic opportunity to strengthen service continuity, protect access for vulnerable populations, and ensure equity in times of crisis. By designing IMSS-BIENESTAR and other public networks to withstand climate shocks, Mexico can build a more inclusive and sustainable health system that guarantees essential care for all—even under changing environmental conditions.

Challenges

Achieving Universal Health Coverage by 2030 requires overcoming several persistent challenges that have historically constrained Mexico's progress:

- **Insufficient and Inequitable Financing:** Public health spending ($\approx 3\%$ of GDP) remains well below the OECD average³, constraining infrastructure and human resources. Reaching UHC will require more equitable resource allocation and strict efficiency and transparency mechanisms to ensure that investments reach frontline services.
- **Human Resource Shortages and Distribution:** Mexico faces specialist shortages and urban-rural imbalances in workforce deployment. Addressing these gaps will require expanded training capacity, equitable remuneration, and career incentives (such as recognition and formalization of certain cadres) for service in priority areas. As well as expanded access to telemedicine services across the country.

- **Infrastructure and Supply Gaps:** Many secondary-level hospitals and clinics are outdated or incomplete. The reform requires that new infrastructure projects are sufficiently staffed, with the right professional profile to respond to population needs, well-equipped, and maintained to guarantee sustainable service capacity.
- **System Integration and Transition Management:** The ongoing federalization and institutional convergence of IMSS, ISSSTE, and IMSS-BIENESTAR entails complex administrative transitions. Ensuring continuity of care, interoperability of systems, and effective communication with the public will be critical.
- **Quality and Standardization of Care:** Establishing uniform clinical standards and a national quality monitoring system remains a priority. This will require a national strategy to define and implement standardized treatment protocols (PRONAM) and robust performance indicators.
- **Burden of Disease and Prevention Gaps:** The high prevalence of obesity (36%), diabetes (14%), and hypertension continue to strain the system.³ Without stronger prevention and early detection programs throughout the life cycle, and multisectoral coordination, the financial and service burden from malnutrition and the associated growth of NCDs will overwhelm the health system.
- **Geographic and Socio-Cultural Barriers:** Serving rural and indigenous populations, including 68 recognized language groups, demands culturally sensitive approaches, mobile health services, and bilingual health workers.
- **Regulatory and Procurement Bottlenecks:** Persistent procurement delays and drug approval backlogs undermine timely service delivery. Strengthening COFEPRIS' capacity and streamlining centralized purchasing are necessary for a stable medicine supply.
- **Data and Monitoring Systems:** Effective reform requires reliable, interoperable, and transparent health data. The integration of digital systems must include staff training, data privacy safeguards, and analytics for continuous improvement.
- **Climate Change Vulnerability and Resilience:** Rising temperatures, floods, and droughts are increasingly disrupting service delivery and damaging health infrastructure—particularly in regions served by IMSS-BIENESTAR. By 2050, up to 12% of facilities could face flood exposure under a high-emissions scenario estimated by the World Bank,⁸ compounding existing inequities. Strengthening climate resilience requires investment in robust infrastructure, early-warning systems, and cross-sector coordination to ensure service continuity and protect the most vulnerable populations.

IV. SCOPE AND VISION OF THE REFORM

The central strategy to reach UHC by 2030 is the creation of a unified Public Health Service (PHS) conceived not as a new bureaucracy but as a service-oriented, interoperable network that integrates the capacity of existing federal institutions (IMSS, ISSSTE, and IMSS-BIENESTAR). This network will offer free care at the point of service with uniform quality standards nationwide, eliminating financial barriers and improving equitable access to quality care. The Health Reform defines two sequential phases of implementation that will transform the current fragmented model into a unified public health service. Each phase combines structural, institutional, and operational measures to advance toward universal health coverage by 2030. To ensure sustainability, a fiscal roadmap and legal framework for pooled public health financing will be developed by 2026.

First Phase of Health Reform — Establishment and Consolidation of IMSS-BIENESTAR

This first phase—already under implementation since 2022—integrates state-level health systems. It is central to the Compact and represents a decisive shift toward federalized, equitable service delivery. It addresses the historical fragmentation resulting from decentralization reforms in the 1980s and 2000s, which created 32 distinct state systems (SESA) and uneven service quality.

The federalization of public health services transfers facilities, staff, and budgets to IMSS-BIENESTAR, establishing a single national operational model for the uninsured population. This transition is designed to strengthen primary health care (PHC) as the foundation for an integrated service network, by:

- *Guarantee patient-centered free services at the point of care;*
- *Promote equitable allocation of financial, human, and physical resources, prioritizing underserved regions to reduce territorial and social inequalities;*

- *Standardize quality and operational procedures across IMSS-BIENESTAR states;*
- *Modernize infrastructure and accelerate digital transformation, including interoperable health information systems and telemedicine; and*
- *Reinforce the stewardship role of the Ministry of Health in planning, regulation, and oversight.*

As of 2025, 23 of 32 states have signed collaboration agreements for integration under IMSS-BIENESTAR.

Key initiatives under this phase include:

- **Governance:** Clearly define and strengthen the mandates of IMSS-BIENESTAR as a public healthcare provider for the uninsured and the state health authorities responsible for public health functions such as disease prevention and health promotion.
- **Financing:** Implement an efficient and transparent financing model, pooling and maximizing availability of resources at the federal level, including through increased and better-targeted investments to meet new service and infrastructure needs. Advance the federalization of the health workforce payroll, eliminate precarious employment, and ensure equitable distribution of funds based on population health needs.
- **Organization and Service Delivery:** Strengthen operational capacity to guarantee free, comprehensive, and timely access to quality services, essential medicines, and diagnostic tests across all IMSS-BIENESTAR facilities by organizing Integrated Service Networks, prioritizing the strengthening of infrastructure and essential equipment provision, and developing a comprehensive Human Talent Strategy to ensure staff availability and competency.

- **Infrastructure and technology:** Expand and modernize IMSS-BIENESTAR's physical and technological infrastructure. Prioritize the completion of pending projects and the upgrade of medical equipment through coordinated budget oversight at the federal level.
- **Integration of Health Delivery Networks:** Develop and adopt a national strategy and roadmap for the integration of IMSS, IMSS-BIENESTAR, and ISSSTE networks. This integration, which includes establishing interoperable health information systems, will lay the essential foundation for the subsequent implementation of Phase 2 of the reform and the creation of the PHS.
- **Digital Health Strategy:** Launch a national digital health platform linking all public hospitals and clinics through a unified Electronic Health Record (EHR) system. This will enable telemedicine, improve efficiency, and reduce errors, ensuring that specialist consultations are accessible to every community by 2030.

The goal of Phase I is to eliminate fragmentation in service delivery for the uninsured, ensure equitable access to quality care, reduce out-of-pocket expenditure, and build the institutional and financial foundation for the unified PHS.

Second Phase of Health Reform — Creation of the Public Health Service

The second phase, beginning in 2027, will integrate public healthcare providers. In this phase, the Ministry of Health will establish the PHS—a fully integrated national network that coordinates IMSS, ISSSTE, IMSS-BIENESTAR, and other public providers under a single operational and governance framework.

Rather than creating a new institution, the PHS will link existing systems through a new legal framework, shared financing mechanisms, interoperable information systems and unified service standards. By aligning governance,

financing, and service delivery across institutions, the PHS seeks to reduce duplication, expand access to underserved populations, and ensure greater continuity and quality of care. It will serve as the mechanism to guarantee universal, timely, and free health care for the entire population.

Key priorities under this phase include:

- *Define an initial set of services covered by integrated service network and create financial mechanisms to facilitate reimbursement of services across institutions;*
- *Ensuring universal access to essential medicines and diagnostics;*
- *Coordinating service networks to guarantee continuity of care;*
- *Expanding digital health interoperability to achieve full nationwide integration of medical records; and*
- *Institutionalizing quality standards and accountability frameworks across the entire PHS*

This integration will deliver tangible benefits directly experienced by patients, including universal access, regardless of employment or affiliation, to:

- *Emergency care at any public provider;*
- *Continuity of care for chronic and severe conditions;*
- *Diagnostics and essential medicines; and*
- *Higher-quality, dignified, and patient-centered care.*

The establishment of the PHS marks a decisive milestone in Mexico's historic health reform, completing the transition from a fragmented system to a truly universal public service. By 2030, the PHS aims to ensure that all people in Mexico enjoy the same standard of care, free at the point of use, and that no family faces impoverishment due to health expenses.

V. ENDNOTES

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