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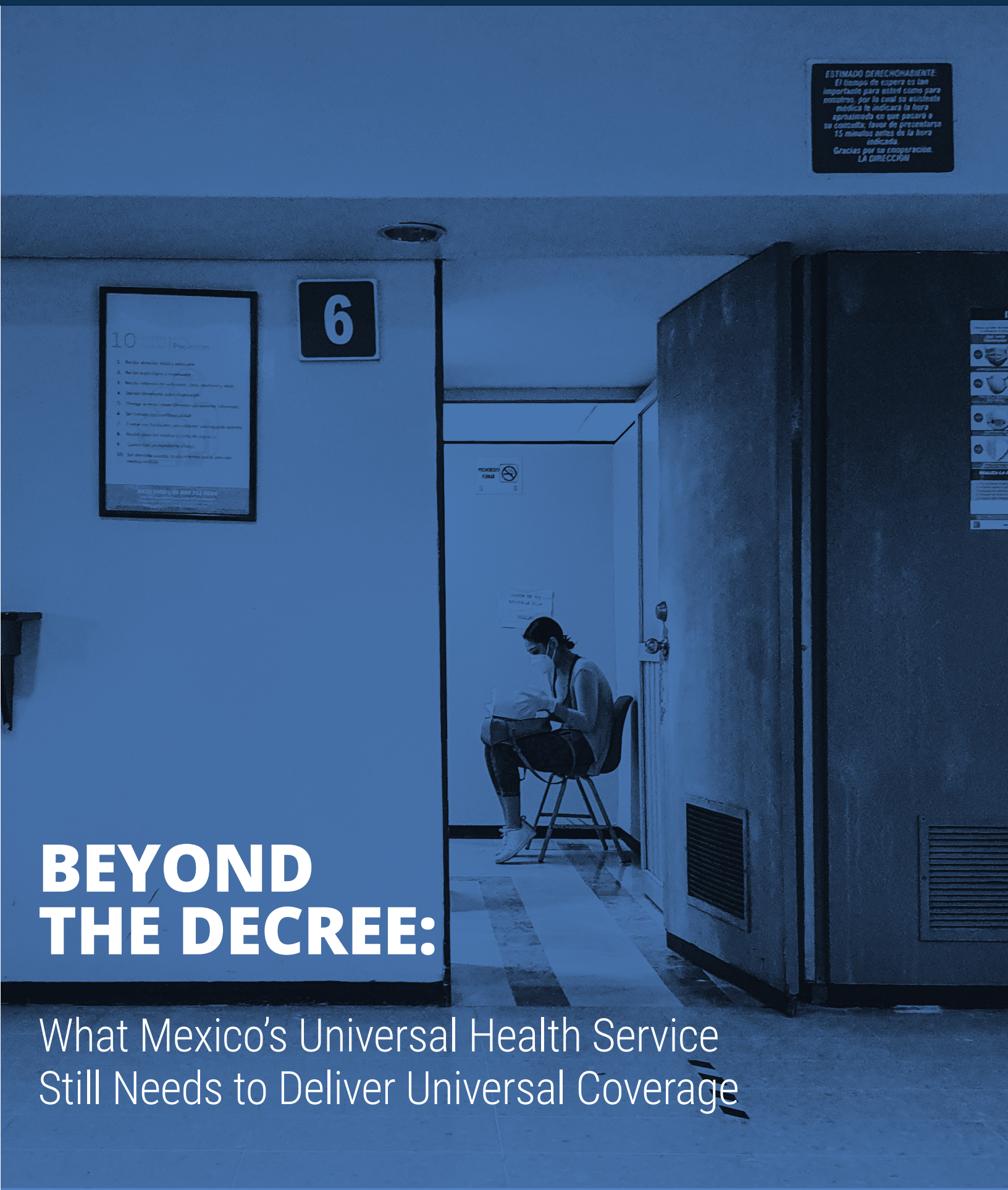

BEYOND THE DECREE:

What Mexico's Universal Health Service Still Needs to Deliver Universal Coverage

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Foreword

On April 17, 2026, the Mexican government published a Presidential Decree (the Decree) creating the Universal Health Service (Servicio Universal de Salud, or SUS) — the most ambitious attempt in a generation to integrate the country's fragmented public health subsystems. Beyond its domestic significance, the Decree raises a question relevant well past Mexico's borders: can executive action alone integrate a health system whose fragmentation is written into the Constitution, statutes, financing, and the labor market?

Our answer is no.

A System Split by Who You Work For

Mexico's health system was never one system. It is a set of parallel subsystems, financed, governed, and operated separately according to employment status. Salaried private-sector workers go to the Mexican Social Security Institute (IMSS) and public employees to the Institute for Social Security and Services for State Workers (ISSSTE). Everyone else, informal workers (54.8% of Mexico's employed population in early 2026), self-employed, the unemployed, goes to services now grouped under IMSS-Bienestar, alongside state-level services and a large, loosely regulated private sector. This fragmentation is usually described as a problem of "access." Following Mexico's own poverty-measurement definitions, as INEGI, Mexico's national statistics institute, currently measures them, the more accurate word is coverage, meaning affiliation that is supposed to guarantee care without *out-of-pocket payment.*[5] Most Mexicans can get care somewhere; what they often cannot do is get it without paying for it themselves, which is exactly the financial protection that coverage, properly defined, is meant to deliver. Additionally, Mexicans receive different quality of care depending on the subsystem that provides them care.[6]

Two decades of reform have not closed that gap. Seguro Popular, launched in 2003, expanded coverage for the uninsured and improved financial protection — but it was eliminated in 2019 amid corruption allegations and a breakdown in coordination between the federal government and the states. That breakdown, per the evaluation by CONEVAL, Mexico's social-policy evaluation agency, intensified during the transition to its successor amid the COVID-19 emergency, compounded by confusion among officials and the public over the new no-affiliation-required scheme. Its replacement, INSABI (the Institute of Health for Well-Being, which briefly replaced Seguro Popular), coincided with a near-tripling of uninsurance among older adults and a marked shift toward private care before being folded into IMSS-Bienestar in under four years. IMSS-Bienestar itself was created that same year as a decentralized public body (organismo público descentralizado) to take over INSABI's functions. The numbers tell the story: the population with no public or private coverage more than doubled, from 20.1 million in 2018 to 44.5 million in 2024, or 34.2% of the country, while households' out-of-pocket health spending rose 41% in real terms.

In December 2025, the government marked a pivot by signing the National Health Compact — a unilateral commitment by the Government of Mexico, presented at the UHC High-Level Forum 2025 in Tokyo, to narrow fragmentation and inequality gaps by 2030. The April 2026 Decree is its first concrete move, echoing integration language used earlier under Calderón (2007) and Peña Nieto (2013).

A Service, Not a System

The SUS does not merge institutions. It is a service: a way to pool operational capacity across subsystems for a phased set of interventions. The first phase, starting in January 2027, covers universal emergency care, high-risk pregnancy, Código Infarto (a heart-attack fast-track), Código Cerebro (a stroke fast-track), continuity of ambulatory treatment, universal vaccination and primary-care consultations. A second phase, from July 2027, adds specialized diagnostics and radiotherapy. Measured against the World Health Organization's health system building blocks, the Decree makes real progress on some fronts and leaves others conspicuously open. The most conspicuous omission is the private sector, which the Decree does not mention once even though it treats roughly half the country.

WHO health system building block	SUS conceptualization (2026 Decree)	Identified gap
Leadership and governance	Inter-institutional coordination led by the Ministry of Health through specialized committees that define interventions, access rules, and further regulation needed for implementation.	Committees have no legally binding authority over the statutorily autonomous social security institutes, and the Decree creates no state- or health-district-level *(jurisdicción sanitaria*) governance structure for implementation.
Health financing	Cross-institutional compensation based on voluntary legal instruments signed between healthcare providers and a budgetary compensation scheme.	Participation is subordinated to each institution's "budgetary availability" and financial regime; no mandatory tariffs — the July 2026 rules still leave them as a proposal, not an obligation.
Health information systems	Promotion of digital health and electronic health records through a unique personal identifier.	Cross-subsystem interoperability—attempted by five consecutive administrations—remains undelivered.
Service delivery	Phased integration: emergencies, vaccination, and continuous care (January 2027); specialized diagnostics and radiotherapy (July 2027).	No mechanism to observe or modulate the differential demand the SUS itself will generate across subsystems.
Health workforce	Relies on existing subsystem personnel and encourages telemedicine to optimize human resources.	No legal protection for personnel treating out-of-network patients. E.g., an IMSS clinician treating an ISSSTE-affiliated patient during a demand spike has no clear liability shield under either institution's rules if something goes wrong.
Medical products, vaccines, and technologies	Guarantees continuity of ambulatory treatment for chronic kidney disease, cancer, transplant care, HIV, or hemophilia at the same institution where a patient started treatment, even after losing social-security affiliation, plus universal vaccination.	Continuity of treatment depends on the same voluntary compensation scheme.

Table. The SUS mapped against WHO's health system building blocks, and the gaps the 2026 Decree leaves open.

The Design Gap

Presidential decrees cannot override the statutory autonomy of the social security institutes. IMSS and ISSSTE are governed by their own laws, the Social Security Law (Ley del Seguro Social) and the ISSSTE Law (Ley del ISSSTE), with their own tripartite financing (contributions split between worker, employer, and the state) and reserve regimes. The Decree itself acknowledges as much: it makes cross-institutional compensation depend on voluntary legal instruments, bilateral agreements (convenios) that institutions are free to sign or not, and conditions cross-institutional care on each provider's "budgetary availability" and financial regime. In practice, this lets any institution restrict participation exactly when a demand crisis hits — which is precisely when a universal service matters most. As Mexico's COVID-19 pandemic showed, when demand for intensive care and diagnostic testing spiked unevenly across institutions even though the shared tariff catalog already priced ventilator days and SARS-CoV-2 testing (Anexo 1, Intercambio de Servicios).

None of this is new, in fact. Cross-institutional exchange already existed before the Decree — earlier catalogs go back to at least 2022, through a narrow, pre-agreed catalog of 789 interventions with maximum reference tariffs, requiring bilateral agreements between specific institutions and states rather than a general obligation. The SUS does not expand that catalog; it changes who can invoke it. Before, only patients already covered by a specific bilateral *convenio* between two named institutions could draw on it. Under Article 77 bis 8 of the General Health Law (Ley General de Salud, or LGS), any person, affiliated or not, can now invoke it based on their condition, geographic accessibility, or medical urgency, with the receiving institution billing the person's institution of origin. That is exactly why broader, effective collaboration across subsectors, and not merely a longer list of interventions, has been flagged as a priority for improving how Mexico's health system performs. It matters most in the time-critical cases the Decree itself prioritizes for its first implementation stage: universal emergency care, high-risk pregnancy and obstetric emergencies, and time-sensitive protocols such as Código Infarto and Código Cerebro (Third Transitory Article).

The design gap is made worse by a predictable behavior the Decree does not address. Once affiliation stops being a barrier at the point of care,[7] patients will gravitate toward whichever subsystem they perceive as strongest. In practice, that means IMSS. Without a way to observe and manage that flow, the SUS risks congesting its best-resourced provider while capacity sits idle elsewhere.

The Decree already flags this for surgical care, which it folds into the SUS but leaves for future guidelines to schedule. How much that flow is actually managed will likely vary a great deal by state and depend on the specific terms each *convenio* sets. Hypothetically, an institution could respond by capping how many partner-institution patients it accepts rather than expanding capacity. Which institution holds the advantage could also flip from state to state, since specialized infrastructure such as radiotherapy or intensive-care capacity is not evenly distributed: a small number of states concentrate most specialized hospitals and equipment while others remain underserved. Mexico's marked regional disparities in specialized infrastructure make this a real risk to watch as those agreements are negotiated.

The information block matters more than a footnote suggests. The Decree's unique personal identifier, a health credential tied to the unique population registry code (Clave Única de Registro de Población, or CURP), and the Electronic Health Record (Expediente Clínico Electrónico) are preconditions for managing demand.[8]

Managing demand means routing patients to available capacity across subsystems in real time, sometimes called digital triage, and it works only if that routing sends people to wherever they can be treated soonest rather than back to their own institution. Even then, digital tools do not by themselves guarantee inclusion where connectivity, territorial inequality, or language barriers persist.

The same information is a precondition for financing. No compensation scheme can reimburse care on a per-case basis unless it can trace that care to a specific patient and provider.

A January 2026 amendment to the General Health Law made digitization compulsory, building on the digital-inclusion mandate the 2013 telecommunications reform wrote into Article 6 of the Constitution. Interoperability has eluded five consecutive administrations — from Fox's early exchange pilots through Calderón's 2007 ISSSTE reform, Peña Nieto's 2013 "universality" push, and López Obrador's INSABI/IMSS-Bienestar consolidation, to Sheinbaum's SUS today.

Fox's IMSS built a unified clinical record across its primary-care clinics from 2001 to 2003, though it never reached second- and third-level hospitals; Calderón's ISSSTE launched its own digital record starting in 2007 — both single-institution efforts that were never extended across subsystems.

Doing it now, with real ARCO data rights (access, rectification, cancellation, and objection) and genuine portability would finally convert a recurring promise into the SUS's operational backbone. That depends on the interoperable Electronic Health Record described above actually circulating between subsystems rather than remaining siloed in whichever institution first captured it.[9]

Fixing the Fine Print

For the design gap to close, the secondary regulation must deliver on three fronts — and, again, at least the first two of these cannot be achieved through regulation alone. They require, among other things, amending the underlying laws of IMSS and ISSSTE, and, in parallel, the 2022 decree that created IMSS-Bienestar as a decentralized public body, since that statute defines its population and mandate independently of the SUS framework. That legislative package should also close a gap the Decree leaves untouched and shield clinicians who treat a patient from another institution, since no SUS instrument creates that protection. Running underneath all three fronts is interoperable information. It is the precondition the others depend on. Without it no clinician can consult a patient's record across institutions, and no compensation scheme can trace what it owes.

First, binding governance, at every level where the SUS will actually operate. At the federal level, the interinstitutional committees the Decree creates should have legally binding authority over the statutorily autonomous institutes for the interventions the SUS covers. The July 2026 rules confirm as much since they task a legal committee with drafting the reforms needed to give the SUS a sound legal basis (article 13.I), an implicit admission that it still lacks one. The committee was installed in June 2026.[10] The rules themselves describe the committees' work as "deliberative processes oriented toward building consensus" (article 18), language that underscores their lack of any power to bind the autonomous institutes they coordinate. Federal committees alone, however, cannot govern a service that is delivered state by state. The convenios will be negotiated and executed at the state level, so each state needs a mirror coordination structure with the same binding character, seating IMSS, ISSSTE, IMSS-Bienestar, and the state health services at one table.

And below that, Mexico's health districts (jurisdicciones sanitarias) are the operational units where patients are actually routed between facilities. They need explicit authority, information, and resources to apply SUS access rules day to day; no federal committee can decide whether a given clinic accepts a partner institution's patient on a given morning. Binding rules should also govern how the SUS communicates with the public as a matter of the right to health information, since people need to know exactly which services they can actually get outside their home institution, so the legal promise and the sign on the clinic door do not diverge.

A more radical route would be folding providers together entirely, as recently happened between IMSS-Bienestar and IMSS's ordinary regime (two different entities share that name.)[11] That is simpler on paper but politically and fiscally out of reach for IMSS and ISSSTE as a whole.

The populations, financing, and benefit packages are simply not comparable. Per-capita spending for IMSS-Bienestar (formerly INSABI) has run at roughly $3,058–3,641 pesos (about US$152–181), against $6,921–7,311 pesos (about US$344–363)[12] for IMSS, a gap that persists after recent budget increases — on top of differences in staffing and intervention packages. Unifying access without closing these gaps is a real risk of entrenching disadvantage for people without prior social-security ties (no derechohabientes), one worth watching closely as the SUS is implemented. The country carries steep structural inequality and a documented inequity in how public health funding is allocated between the population with and without social security, and the Decree itself subordinates the exchange to not diminishing care for each institution's own target population. Binding authority over a defined package of interventions is the realistic middle path and one that runs through Congress, not just through a new bylaw, still less through a presidential decree. That the July 2026 rules go on to create a coordinating body the Decree never provided for (articles 22–28) shows how far the framework is being built by administrative means.[13]

Second, mandatory compensation through a shared clearinghouse, a "Cámara de Compensación," that replaces bilateral deals with mandatory tariffs.

These would be per case for acute care and per capita for chronic disease management, with medical costs kept separate from supply costs, since separating the two keeps swings in drug and supply prices from distorting what providers are actually paid for care. Even the July 2026 rules keep tariffs as a proposal, not a binding price (article 9.I).

Other countries have shown that fragmented pools of money can be knitted together financially without merging the institutions themselves. Germany's risk-structure equalization scheme redistributes resources across more than a hundred "sickness funds" under mandatory federal rules. The Netherlands runs compulsory risk equalization across competing private insurers. Colombia centralized pooling and payment[14] for its contributory and subsidized health regimes in a single administrative entity, the Solidarity and Guarantee Fund (FOSYGA), renamed in 2017 the Administrator of Health System Resources (ADRES). Where countries instead merged their funds outright, as in South Korea in 2000, and Turkey under its "Health Transformation Programme", financial unification came first and service integration followed.

Three lessons apply to Mexico. Korea centralized claims review and payment, and equalized the benefit package across schemes, years before it merged them. That is a sequence the SUS could follow without touching the institutes' autonomy. If the institutions stay separate, Germany shows that the redistributive work is done by a single reallocation pool and a morbidity-adjusted formula, not by bilateral netting between providers. And Turkey's transformation rested on a legal mandate enacted by its legislature, the element the Decree still lacks. Mexico's clearinghouse will have to solve a problem all of these systems faced: IMSS and IMSS-Bienestar grew up on different budget logics, tripartite contributions and their own unit-cost tables on one side, a federal subsidy with no equivalent costing system on the other. The same procedure has rarely been costed the same way twice, so mandatory tariffs require standardized cost accounting. That accounting depends on the information system described above, which is a further reason it needs to be built first.

Who runs the clearinghouse deserves real scrutiny. Handing tariff-setting to the Ministry of Finance (Secretaría de Hacienda) invites a fair objection since transferring consolidated drug procurement to Hacienda in 2019–2020 did not go well. Shortage reports rose 118% from 2019 to 2020 (1,175 to 2,556 cases across institutions) and drove a wave of amparo lawsuits over missing cancer and chronic-disease medicines. The distinction matters, since Hacienda's expertise is in enforcing budgetary transfers, not in running logistics. Tariffs should be built on technical costing produced by the health sector itself, with Hacienda enforcing settlement, not setting prices. That is the division the Decree itself lays out: Article Fifth tasks the Secretaría de Salud and the participating institutions with defining the compensation mechanism, subject only to Hacienda's approval. If that division of labor cannot be guaranteed, the better design is an autonomous technical body modeled on ADRES, Colombia's clearinghouse, an entity that only pools and pays claims, with no other budget to protect and no stake in health financing beyond making the settlement work.

Third, the private sector, which the Decree does not mention at all. It absorbs roughly half of Mexico's total health spending[15] and drives the region's highest out-of-pocket burden, at 41.2% of current health expenditure, more than any other major Latin American economy. It also delivers care to most of the uninsured, since 66% of Mexicans without social-security coverage saw a private doctor or a pharmacy-adjacent doctor's office (consultorio) in 2021. A universal service that ignores the sector treating most of the country is not really universal. Expanding public clinics may bring some of these patients back over time, but it cannot replace the private sector quickly or completely, which is why the reform must engage that sector, not just try to compete with it. Regulating prices, quality, and information in the private market must be part of the same reform — starting with the doctors' offices attached to pharmacies, which grew from 239 to more than 6,500 nationwide between 2011 and 2018 with no quality oversight of their own.

The Structural Ceiling

Even a perfectly designed SUS runs into a fiscal wall. Public health spending sits at 2.6–3.0% of GDP, well below the 3.7%-of-GDP average Latin American governments managed in 2023, far short of the 6% target the region's own governments committed to in the Pan American Health Organization's (PAHO) 2014 Universal Health Strategy, and 4.1% lower in real terms than a year earlier. That already-thin budget is not shared evenly either. In 2022, Ministry of Health hospitals serving people without social security had 5.84 hospital beds per 10,000 people — 20.1% fewer than the 7.31 available inside the social-security institutions, a gap a 23-year analysis of national administrative records shows has not closed despite repeated reforms.

No clearinghouse can compensate for money the system simply does not have. And as long as affiliation, and the funding that follows it, is still determined by whether and how someone works, integrated care will keep coexisting with segmented entitlements. The logical endpoint of this reform path, in Mexico as in South Korea and Turkey before it, points toward decoupling health financing from employment altogether. Korea's own experience suggests the same. Where income is hard to assess and contributions hard to collect, a mix of taxes and contributions works better than payroll alone. Doing that cleanly is not a regulatory tweak, since it would require a reform of constitutional and fiscal scope, not merely administrative. This means a new understanding of how Article 4's health guarantee is funded and how federal-state revenue-sharing absorbs the cost currently carried by payroll contributions. We leave the specific mechanism open here; the destination is clear, even if reaching it will take exactly that kind of structural change.

Not Yet a System

The 2026 Decree is a real and welcome step forward after the long, uneven succession of Seguro Popular, INSABI, and IMSS-Bienestar. None resolved the system's underlying fragmentation despite six years of drift in search of a durable alternative. But the Decree will only succeed if binding committee authority and mandatory compensation are written into the laws that govern IMSS and ISSSTE, alongside interoperable information systems and real rules for the private sector. And even with all of that, how far the SUS can reach will still be limited by the size of public financing and by the fact that affiliation remains tied to employment.

The first task is a matter of drafting regulation over the coming months. The second is a matter of constitutional, fiscal, and legislative reform that this Decree, by itself, cannot deliver. Nevertheless, its own success will make it impossible to keep postponing. And even a fully integrated public system would still leave untouched and unregulated the private market, a sector that treats roughly half the country and that this reform has not yet approached.

Mexico's experience offers a precise lesson. Coverage gains are reversible, and integration by decree, without money and without a legal mandate behind it, is only a promise. Mexico's neighbors have reason to pay attention. The question the Decree poses, how far executive action can reach before it needs the legislature, is not relevant to Mexico alone. It arises wherever coverage is still tied to employment, financing is under strain, and barriers to portability persist. How Mexico answers it is worth watching.[16] It is not yet a system.

ENDNOTES

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5 Out-of-pocket health spending refers to direct payments made by individuals when receiving any type of service — preventive, curative, rehabilitative, palliative, or long-term — provided by any provider, and excludes any reimbursement by a third party such as the government, a health insurance fund, or a private insurance company. Judith Senyacen Méndez Méndez, Gasto de bolsillo en salud: Resultados de la ENIGH 2024 [Out-of-pocket health spending: Results of the 2024 ENIGH] (Mexico City: Centro de Investigación Económica y Presupuestaria, August 5, 2025).

6 González Block et al., "Mexico: Health System Review," 184. Thirty-day mortality after acute myocardial infarction is reported at 28 per 100 discharges nationally, close to four times the OECD average, against 3.1 per 100 discharges in private hospitals with more than 100 beds.

7 For now this is a first-level-of-care dynamic. The app-based routing the Decree envisions operates at the primary-care visit, while hospital admissions and specialty referrals still follow each institution's own gatekeeping rules.

8 The CURP is a field for which IMSS runs a formal correction procedure covering cases of duplicate, homonymous, or invaded NSS records. Instituto Mexicano del Seguro Social (IMSS), "Corrige tu CURP ante el IMSS" [Correct your CURP with IMSS], (accessed July 29, 2026).

9 Interoperability is being built agreement by agreement rather than as a statutory obligation. In August 2026 the Ministry of Health, through its National Institutes of Health and High-Specialty Hospitals Coordinating Commission (Comisión Coordinadora de Institutos Nacionales de Salud y Hospitales de Alta Especialidad, or CCINSHAE), signed a collaboration agreement with IMSS that binds only those two parties and does not include ISSSTE or IMSS-Bienestar. "Secretaría de Salud e IMSS firman convenio para impulsar el expediente clínico electrónico" [Ministry of Health and IMSS sign an agreement to advance the electronic health record], Secretaría de Salud, press release 213, August 7, 2026.

10 The ISSSTE director general described its purpose as proposing and drafting "las reformas legales que otorguen el sustento jurídico que requiere el SUS para su implementación" (the legal reforms the SUS requires for its implementation). "Instalan Secretaría de Salud e ISSSTE Comité Legal del nuevo Servicio Universal de Salud" [Ministry of Health and ISSSTE install the Legal Committee of the new Universal Health Service], Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, press release, June 25, 2026.

11 The name IMSS-Bienestar refers to two different things. The first is Programa IMSS-Bienestar, a scheme IMSS itself has run since the 1970s to serve people without social security, under Articles 214–217 of the Ley del Seguro Social, renamed several times as IMSS-COPLAMAR, IMSS-Solidaridad, IMSS-Oportunidades, IMSS-Prospera and, since 2018, Programa IMSS-Bienestar. The second is the IMSS-Bienestar decentralized public body, created by decree in 2022 to absorb INSABI. They are separate entities. In 2025 the Programa was incorporated into IMSS's ordinary regime. Its hospitals and rural medical units, which the Institute already operated under the solidaridad-social scheme, became part of the ordinary regime. This was an internal reorganization of IMSS, not a merger of two institutions, which is why it says little about what merging IMSS with ISSSTE would involve. Ley del Seguro Social [Social Security Law], arts. 214–217; "Decreto IMSS-Bienestar."

12 Converted at the Banco de México average interbank exchange rate for 2022, 20.12 pesos per U.S. dollar; the underlying figures are expressed in constant 2022 pesos.

13 "Secretaría de Salud instala Grupo Estratégico para la Implementación del Servicio Universal de Salud" [Ministry of Health installs the Strategic Group for the Implementation of the Universal Health Service], Secretaría de Salud, press release 143, June 10, 2026. Chaired by the Minister of Health, with the Deputy Minister for Sectoral Integration as technical secretary, it created the seven specialized committees.

14 Organisation for Economic Co-operation and Development, OECD Reviews of Health Systems: Colombia 2016 (Paris: OECD Publishing, 2016). FOSYGA is the Fondo de Solidaridad y Garantía; ADRES is the Administradora de los Recursos del Sistema General de Seguridad Social en Salud.

15 Centro de Investigación Económica y Presupuestaria (CIEP), "Cobertura universal en salud: Avances en acceso, retos en afiliación y financiamiento" [Universal health coverage: Progress in access, challenges in affiliation and financing], April 7, 2026. Total health spending is a broader measure of who ultimately pays than the narrower out-of-

pocket share cited next.

16 Michael R. Reich, "Mexico's New Health Reform: El Servicio Universal de Salud," Health Systems & Reform 12, no. 1 (2026): 2688285. On April 9, 2026, President Claudia Sheinbaum announced that Mexicans living abroad may obtain the SUS health credential and receive care in Mexico, while acknowledging that the scheme had not yet been developed. The Decree makes no provision for registration from abroad, and Article Seventh ties registration to the CURP. Article 77 bis 1 of the General Health Law, which the Decree invokes, extends the right to persons in the country regardless of nationality, a territorial condition that care received in Mexico would satisfy. What the SUS would add is the ability to register in advance, and the operational questions, starting with where care is delivered, remain open. Alma E. Muñoz and Alonso Urrutia, "Mexicanos en el extranjero podrán acceder al Servicio Universal de Salud: Sheinbaum" [Mexicans abroad will be able to access the Universal Health Service], La Jornada, April 9, 2026.

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