
Misaligned Reforms: Mexico's Experience with Health Financing Recentralization and Procurement Reform

A Case Study Using the CGD/ARC Integrated
Financing of the Healthcare Supply Chain Framework

Content

Executive summary 2

1. Introduction 3

2. Context 3

3. Reforms 6

4. Implications for the supply chain 9

5. Results 18

6. Conclusions and lessons for countries 24

Executive summary

When governments pursue major health system reforms simultaneously, how those reforms interact often matters as much as their content. Mexico's recent experience offers a clear — and costly — illustration of what happens when this alignment is absent, and why countries considering concurrent changes to health financing and supply-chain governance should pay close attention.

Between 2019 and 2022, Mexico dismantled Seguro Popular — a publicly funded health scheme covering roughly half the population through decentralized State Health Authorities — and re-centralized financing and service delivery to the federal government. At the same time, it overhauled public procurement of medicines and medical goods, replacing a well-functioning consolidated tendering system and a formal interinstitutional price-negotiation mechanism with new arrangements managed subsequently by different agencies, and separating procurement from distribution and delivery.

The CGD/ARC integrated framework for the financing of healthcare supply chains provides the analytical lens for this case study. A core insight of the framework is that how health systems finance their supply chains — who pools resources, on what terms, and with what rules — shapes every downstream function: how products are planned, budgeted, tendered, delivered, and monitored. These financing decisions are often treated as an afterthought to "big" policy choices about coverage and benefits. Mexico's case shows why this is a costly mistake, and the framework makes the causal chain visible: reform uncertainties generated planning failures; weak budget execution produced arrears; separating procurement from distribution created last-mile failures; and weak monitoring undermined course correction.

Neither reform was designed with the other in mind. Recentralizing health financing stripped states of the budgetary autonomy they had relied on to adapt procurement to local needs and absorb supply disruptions — at the very moment the procurement overhaul was creating those disruptions. Dismantling coordination mechanisms — consolidated tendering, sector-wide price negotiations, integrated procurement-and-delivery contracts — before workable replacements existed compounded the damage. States transitioning to the new system remained accountable to their populations but had lost the tools to meet that responsibility.

Mexico's experience is not simply a story of centralization gone wrong. It illustrates a broader tension many countries face: centralization pursued for greater control and accountability can inadvertently erode the local flexibility and managerial capacity that supply chains depend on to function. More fundamentally, it is a case of misaligned reforms — where old coordination mechanisms were dismantled before functioning replacements were in place. The CGD/ARC framework, by tracing how high-level financing decisions reverberate through planning, procurement, delivery, and monitoring, offers countries a practical tool to anticipate these interactions and design reforms that reinforce, rather than undermine, one another.

1. Introduction

Mexico, an upper-middle-income country in Latin America, recently underwent two major reforms at the same time: the recentralization of financing and service delivery for the population without social security, and a far-reaching overhaul of public procurement for medicines and other health commodities.¹ Seguro Popular, which since 2004 had financed state-level services for roughly half the population through decentralized arrangements and explicit funding rules, was dismantled in 2020. In parallel, procurement responsibilities were subsequently reassigned across multiple agencies, some outside the health sector; tendering was separated from distribution; and the formal mechanism for negotiating single-source medicine prices was discontinued. These reforms were not designed or sequenced together, and insufficient attention was given to preserving functioning supply-chain financing during the transition. The result was substantial disruption in procurement, delivery, and product availability across public institutions.

This case study examines Mexico's experience to draw key lessons for countries seeking better alignment between health financing reforms and supply chain financing. Although the reforms affected a broad range of health commodities, the analysis focuses on medicines because they provide the clearest evidence on their effect.

Using the CGD/ARC's framework on integrated financing of the healthcare supply chain, these reforms are described and assessed in terms of their effects on the governance, planning (pooling/revenue raising, prioritization, budgeting, market shaping), procurement (centralized direct procurement, indirect facility procurement, purchasing rules, budget execution), delivery, and monitoring.² This helps better understand the operational implications of high-level reforms.

The case study is structured as follows: section 2 summarizes the health system context. Section 3 describes the financing and procurement reforms. Section 4 analyzes their implications for the financing of the supply chain using the CGD/ARC's framework. Section 5 presents results based on the analysis of procurement data, and section 6 concludes with lessons for other countries.

2. Context

Like many other countries, Mexico's health system is fragmented into various financing and service delivery schemes. It comprises three main sub-systems: i) employment-based social security schemes for salaried workers and their families; ii) publicly funded services for the population without access to social security (uninsured); and iii) a private sector that operates largely on an out-

¹ In 2025 Mexico had a population of 131 million and per capita health spending of 761 USD. World Bank. World Development Indicators. <https://data.worldbank.org/> [Accessed 25/02/2026].

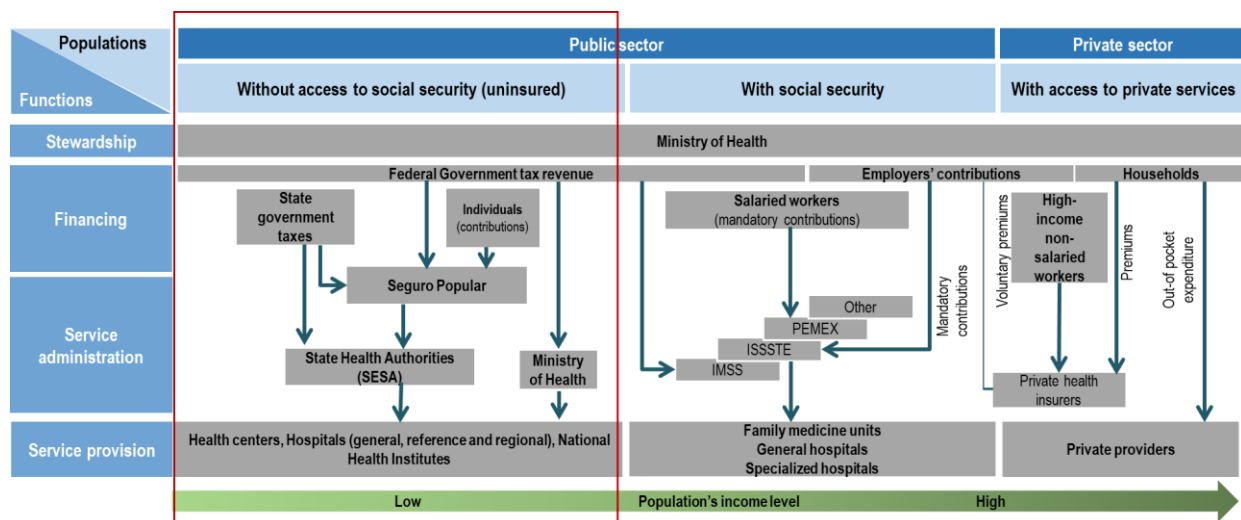
² Center for Global Development (CGD)/ Africa's Public Health Supply Chain Institution (ARC) (2025) Financing of Healthcare Supply Chains in Low- and Middle-Income Countries. A Novel Conceptual Framework. Policy paper 362. September 2025.

of-pocket basis to anyone demanding care with capacity to pay, with a more limited role for private health insurance.

Total health spending in Mexico remains low relative to OECD levels, at 6% of GDP in 2023. Public expenditure — covering both government contributions to social security schemes and services for the uninsured— represented 2.9% of GDP – well below the WHO benchmark of 5–6%. Limited public financing has therefore been accompanied by high private spending, which reached 3.1% of GDP and has been largely driven by household out-of-pocket payments (OOP) to compensate for underfunded public services.³

Figure 1 shows Mexico’s health system structure in 2018, before the reforms were implemented, organized by health system function and subsystem. This case study primarily focuses on the healthcare services subsystem for the population without access to social security (red rectangle).

Figure 1. Mexico’s health system structure in 2018 – pre-reforms



Note: Leading social security institutions benefiting salaried workers: Mexican Institute of Social Security (IMSS), Institute for Social Security and Services for State Workers (ISSSTE) and Mexican Oil Company’s social security scheme (PEMEX).

Source: Own elaboration.

Before the reforms, services for the population without social security were provided by 32 decentralized State Health Authorities (SESA) funded through Seguro Popular, a publicly funded scheme. States were responsible for delivering an explicit health benefits package and budget allocations followed legally defined funding rules. State governments also supplemented federal resources with local revenues. States were responsible for service delivery, budget execution, and

³ WHO. Global Health Expenditure Database. <https://www.oecd.org/en/data/datasets/oecd-health-statistics.html> [Accessed on 20/01/2026].

procurement of health commodities through their own provider networks, including primary care facilities and secondary-level hospitals.^{4,5}

Federally run hospitals, including national institutes of health and other tertiary or high-specialty facilities, also served this population. In addition to their regular federal supply-side funding, they could receive Seguro Popular resources from a catastrophic fund for selected high-cost or high-specialty interventions. After Seguro Popular was dismantled, these hospitals continued to execute their own budget and procure their own health commodities.

In such a fragmented system, public institutions have always operated in parallel, with limited coordination, each governed by its own rules, target populations, budgets, benefit packages, and infrastructure. However, one key area in which there had been increasing coordination since the late 2000s was the procurement of health commodities through a consolidated process and sector-wide price negotiation.

Before 2019, Mexico's consolidated procurement model functioned as a coordinated, sector-wide mechanism led by the Mexican Institute of Social Security (IMSS). IMSS served as the central procurer because, as the country's largest public provider covering about 54% of the total population, it developed greater procurement scale, technical capacity, and institutional experience than any other public entity. IMSS consolidated annual supply requirements from participating institutions—including the 32 State Health Authorities (SESA), national institutes of health, other federal hospitals, and other social security institutions—into a single tender for multiple-source medicines and other health commodities.⁶ In parallel, an inter-institutional commission involving IMSS, the Institute for Social Security and Services for State Workers (ISSSTE), the Ministry of Health (which represented SESA, national institutes, and other federal hospitals), the Ministry of Finance and the Ministry of Economy, negotiated prices for single-source medicines, securing uniform prices and terms for all public purchasers.⁷ Once contracts were awarded, however, each institution remained responsible for signing, managing, and paying its own contracts, meaning that financing of procurement stayed facility-led, even though tendering was centralized (see Box for more details about this commission).

⁴ Frenk J, Lozano R, González-Pier E, et al. (2006) Comprehensive reform to improve health system performance in Mexico. *The Lancet* 368:1524–1534.

⁵ There is also a separate special federally funded program (IMSS-Bienestar) providing basic community and primary care services to marginalized populations in some states. This is run by IMSS through their own facilities, financially and organizationally separately from the regular provision of care for social security affiliates. This program covered about 10% of the total population.

⁶ Multiple-source health commodities refer to those available from more than one manufacturer or supplier once patent protection or market exclusivity has expired.

⁷ Secretaría de Salud. Acuerdo por el que se crea la Comisión Coordinadora para la Negociación de Precios de Medicamentos y otros Insumos para la Salud. *Diario Oficial de la Federación*. 27 sep 2008.

Box. Price negotiation of single-source medicines in Mexico

The *Comisión Coordinadora para la Negociación de Precios de Medicamentos y otros Insumos para la Salud* (Coordinating Commission for the Negotiation of Prices of Medicines and Other Health Commodities) was established in 2008 through a presidential decree. Its creation responded to the need for a unified, transparent mechanism to negotiate prices for patented, single-source, and usually high-cost medicines purchased by public health institutions. Prior to its establishment, each institution purchased these products independently and often without any price negotiation, resulting in fragmented purchasing, heterogeneous prices, and limited bargaining power across the public sector.

The Commission's main objective was to negotiate prices for medicines and other health technologies included in a national formulary applicable to public health care providers, with patent protection or only one supplier. By consolidating demand from major public purchasers, the Commission sought to improve efficiency, equity and value for money in pharmaceutical procurement. It also aimed to strengthen transparency and reduce price variation across institutions that otherwise procure independently.

The Commission was composed of senior representatives from the Ministry of Health, Ministry of Finance, Ministry of Economy, leading social security institutions (IMSS and ISSSTE), with the Ministry of Public Administration and the Federal Competition Commission participating as permanent advisors. It operated through regular sessions in which clinical, economic, and market evidence was reviewed; institutional demand was consolidated; and structured negotiations with suppliers were conducted. The outcomes of these negotiations established reference prices that public institutions were expected to apply in their procurement processes.

The Commission was dismantled as part of the procurement overhaul undertaken since 2019 onward. However, during its 10 years of existence, the Commission had a significant impact on public pharmaceutical spending. Centralized negotiation has contributed to lower prices, greater price uniformity, and enhanced transparency in the acquisition of single-source high-cost medicines. At the time of its dismantlement, challenges remained —such as ensuring consistent adoption of negotiated prices across decentralized purchasers and continuing its institutionalization and the professionalization of supporting technical cadres. However, the Commission became a key instrument in Mexico's strategy to strengthen purchasing efficiency and improve access to strategic health technologies.

Secretaría de Salud. Acuerdo por el que se crea la Comisión Coordinadora para la Negociación de Precios de Medicamentos y otros Insumos para la Salud. Diario Oficial de la Federación. 27 sep 2008.

Secretaría de Salud. Comisión Coordinadora para la Negociación de Precios de Medicamentos y otros Insumos para la Salud.

<https://www.gob.mx/salud/acciones-y-programas/comision-coordinadora-para-la-negociacion-de-precios-de-medicamentos-e-insumos-para-la-salud-91422>

3. Reforms

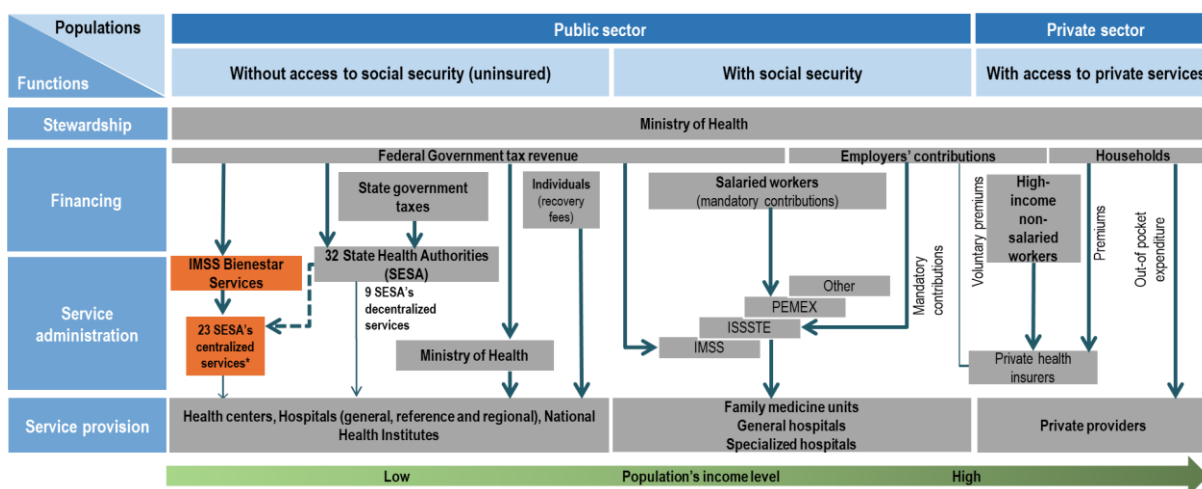
From 2019 onward, Mexico undertook two concurrent reform processes: the recentralization of financing and service delivery for the uninsured population, and the redesign of public procurement for health commodities across the public sector. Both reforms were presented politically as ways to strengthen control and reduce corruption. The main health financing reform has been the recentralization of financing and services for the uninsured population.

The financing reform sought to transfer budgets, assets, and service responsibilities for the uninsured population back to the federal level, but its implementation was neither straightforward nor immediate. The first phase took place through the National Institute of Health for Wellbeing (INSABI), which replaced Seguro Popular's national commission. INSABI inherited responsibility for channeling funds, coordinating with SESA, and financing high-cost interventions on a per-case basis through a catastrophic fund. However, the transition relied heavily on ad hoc negotiations with individual states and lacked a stable legal, budgetary, and operational design with clear criteria for roles and responsibilities. A more formal phase followed in 2023, when legal reforms created IMSS-

Bienestar Services as a new federal entity with control over recently re-centralized resources and direct responsibility for financing and delivering services for the uninsured.⁸

Recentralization was voluntary and therefore uneven. States joined through successive rounds of negotiations and legal agreements, at different times and under different conditions. Not all were willing to transfer their budgets, infrastructure and personnel. By the time of writing, 23 of 32 states had done so. This staggered process created prolonged uncertainty over financing rules and over the respective roles of the federal government and the states. Figure 2 shows the current health system structure.

Figure 2. Mexico's current health system structure



Source: Own elaboration.

* Yucatán state is in the process of centralizing state services into IMSS-Bienestar Services, but for the purposes of this analysis, it is considered a decentralized state.

In parallel, the main procurement reforms have been: i) the overhaul of the previously established procurement process, whereby supply chain phases (from planning to monitoring) were subsequently taken over by different entities at the federal level: the Ministry of Finance (2019), the United Nations Office for Project Services (UNOPS) in collaboration with the INSABI who liaised with SESA and other federal health care providers (2020-2022), INSABI (2022 and early 2023), IMSS

⁸ Note that this new entity is separate from and unrelated to IMSS. Its name is inherited from the name of a federally funded program targeting marginalized populations which is operated by IMSS, but through a special office and in separate facilities, not mixed with social security service delivery. The reason for this is that at some point between 2021-2022, it was considered that services for the uninsured could be integrated into IMSS through this special program platform. While this ended up not being the case, nevertheless the name remained.

Bienestar Services and Birmex⁹ (2023 and 2024); and ii) the separation of the procurement of health commodities from logistics and delivery, which had been previously integrated.

Figure 3. Health financing and procurement reforms

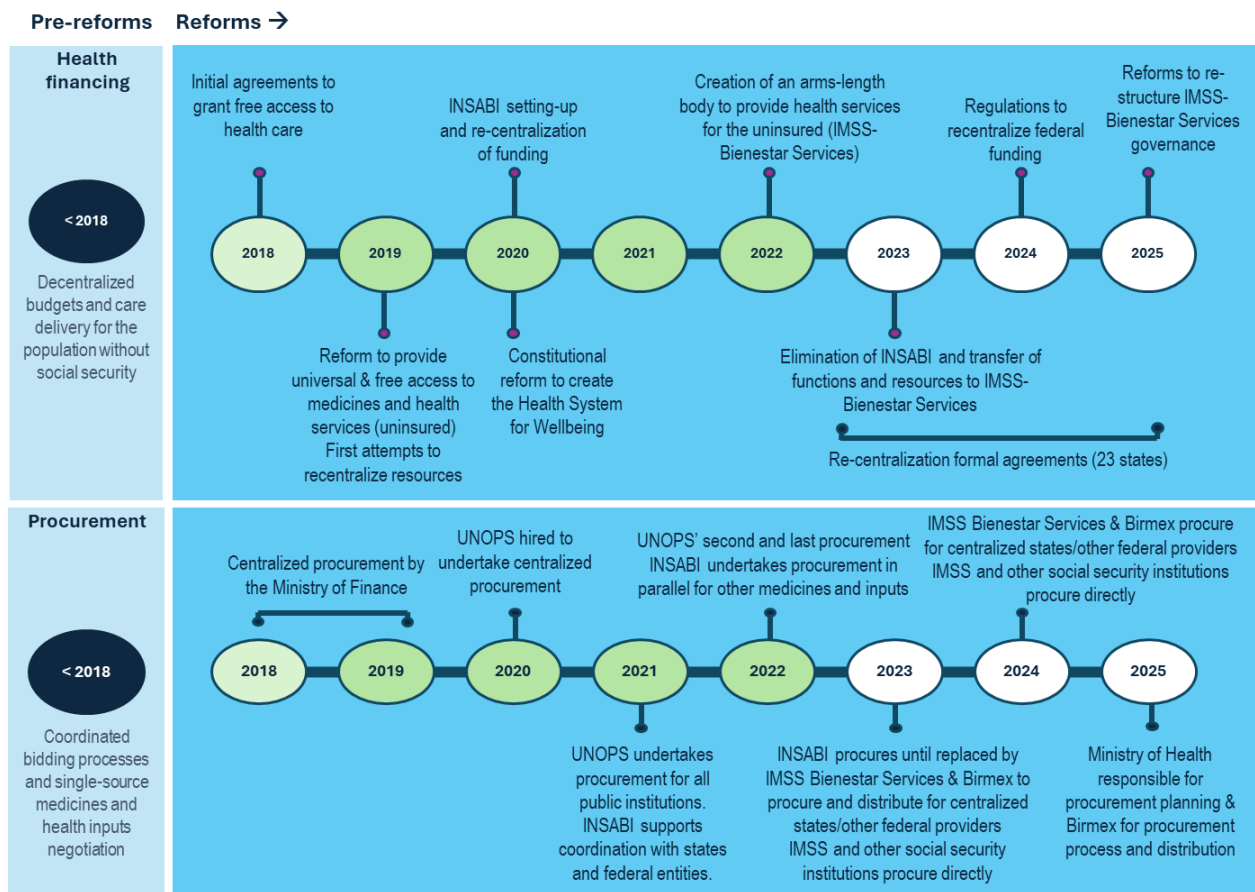


Figure 3 presents a dual-track timeline of Mexico's health financing and procurement reforms from 2018 to 2025, with a pre-reform column showing the baseline arrangements before 2018. The upper track shows the recentralization of financing and delivery for the insured population, while the lower track covers procurement.

On the health financing track, the pre-reform baseline was a decentralized model in which SESA held their own budgets and were responsible for care delivery to the population without social security. The reform sequence began in 2018 with initial agreements to grant free access to health care, followed in 2019 by efforts to provide universal and free access to medicines and health services and first attempts to re-centralize resources. A constitutional reform to create the Health System for Wellbeing was enacted in 2020, dismantling Seguro Popular and setting up INSABI, and the re-

⁹ BIRMEX (Laboratorios de Biológicos y Reactivos de México) is a state-owned company. Historically, it was dedicated to vaccine production, but during these reforms its focus moved toward the distribution of medical goods and more recently to procurement.

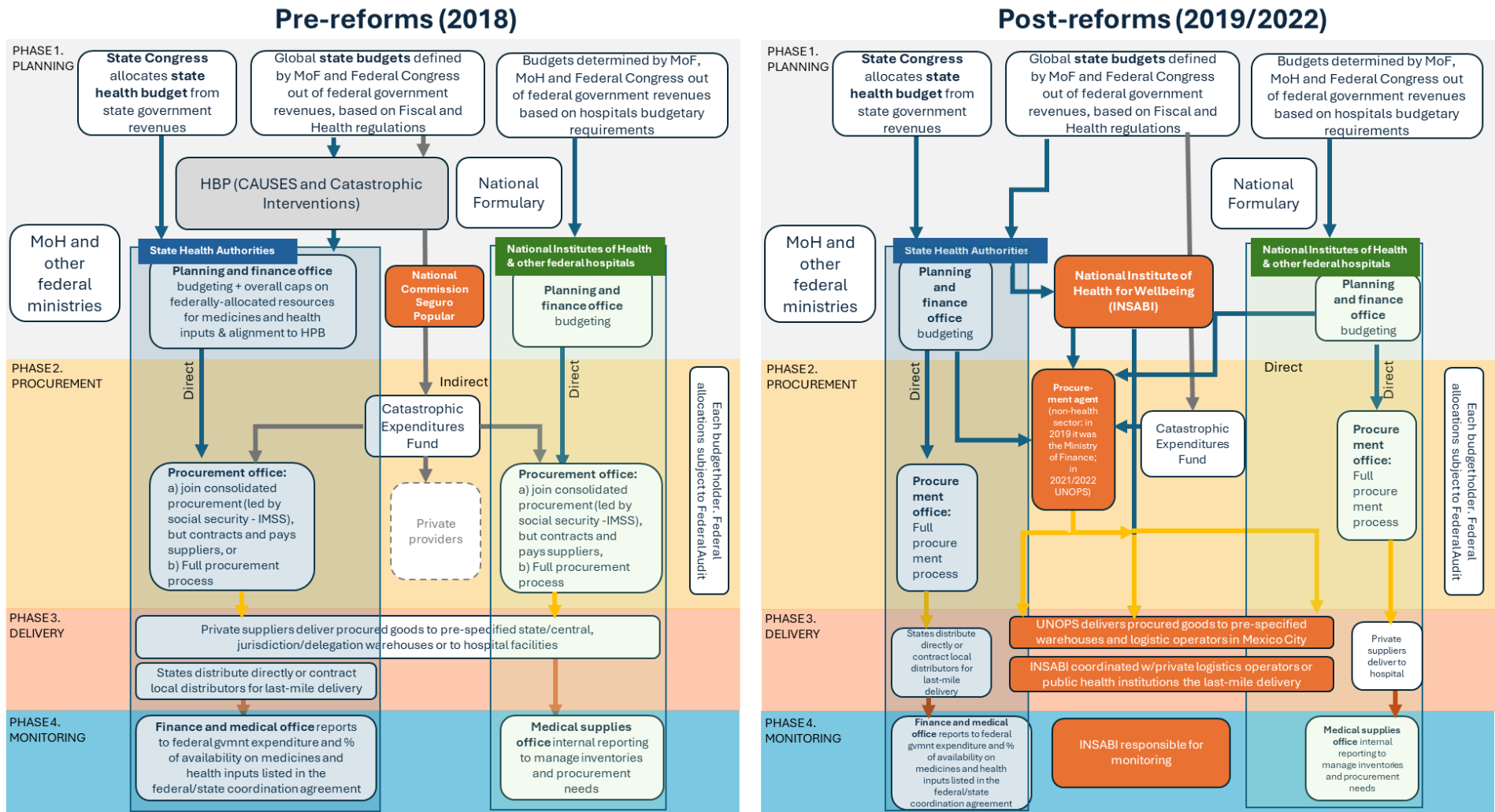
centralization of funding began. By 2022, an arms-length body — IMSS-Bienestar Services — was created to provide health services for the uninsured, and formal re-centralization agreements with states followed in 2023 (covering 23 states). INSABI was eliminated in 2023 with its functions transferred to IMSS-Bienestar Services, and subsequent milestones in 2024 and 2025 involved regulations to re-centralize federal funding and reforms to restructure IMSS-Bienestar Services governance.

On the procurement side, the pre-reform baseline consisted of consolidated tenders led by IMSS for all public health care providers and centralized price negotiation for single-source medicines. From late 2018 onward, these arrangements were repeatedly altered. First, centralized procurement was moved to the Ministry of Finance, then from 2020, UNOPS was hired to undertake centralized procurement. Initially, UNOPS undertook procurement for all public institutions with INSABI coordinating states and federal entities, and subsequently UNOPS ran its second and last procurement in parallel with INSABI procuring other medicines and health commodities. By 2022–2023, INSABI procured until it was replaced jointly by IMSS-Bienestar Services and Birmex, which took on procurement and distribution arrangements for centralized states and other federal providers, while IMSS and other social security institutions continued to procure directly. From 2024 onward, IMSS-Bienestar Services and Birmex procure for centralized states and other federal providers, and the Ministry of Health assumed responsibility for procurement planning and distribution. The sequence did not reflect a stable target model; rather, it reflected repeated attempts to address implementation problems as they emerged. The following sections describe the implications and findings of the reform period 2019-2022.

4. Implications for the supply chain

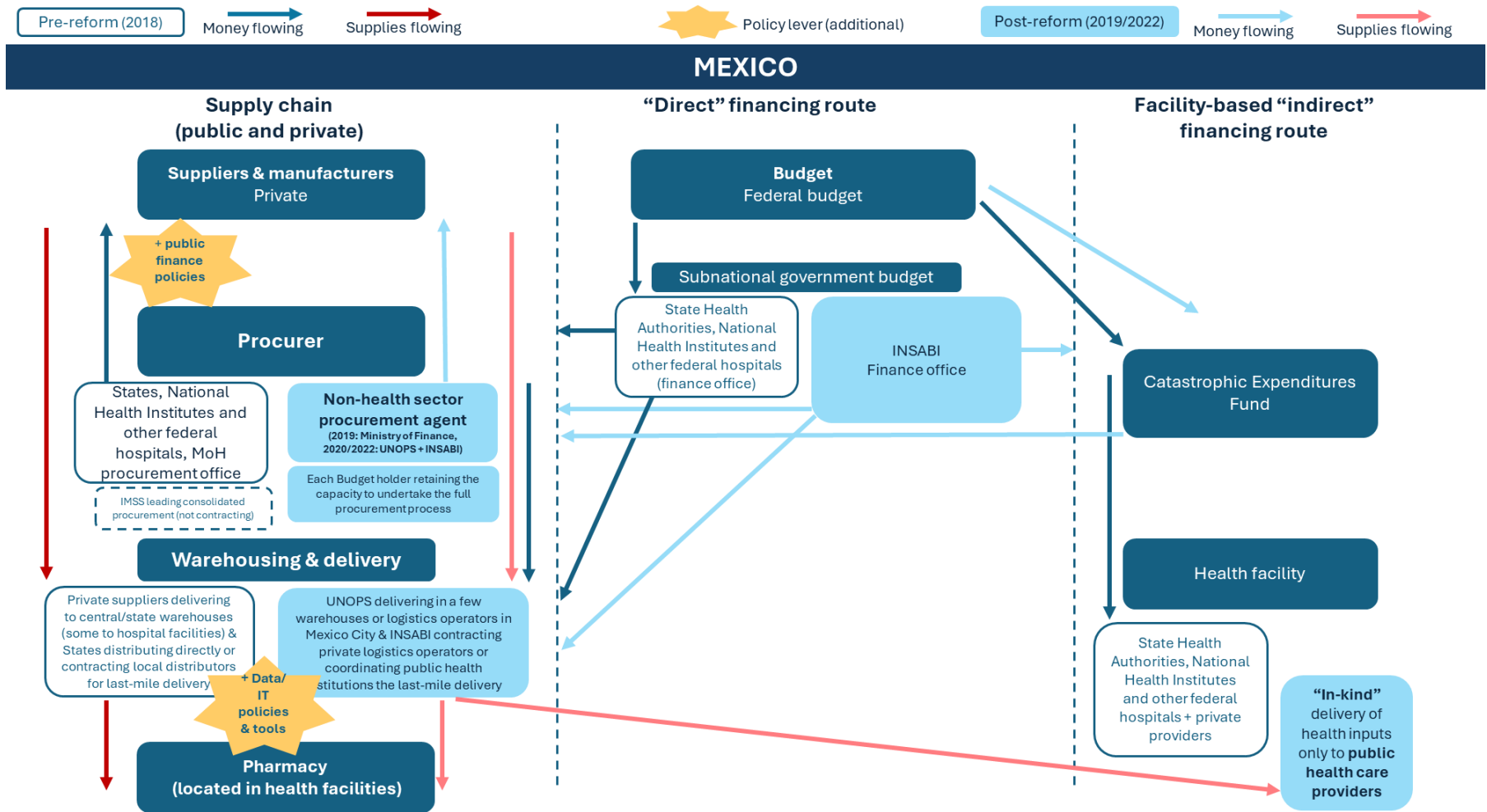
The analysis below applies the CGD/ARC framework to two periods: the pre-reform arrangement up to 2018, and the main disruption period from 2019 to 2022. Later developments are referenced only where they help assess whether observed problems appear transitional or persistent. Figures 4 and 5 summarize the financing of the supply chain architecture and the main commodity and financial flows across these two periods. The discussion is organized around integrated governance, planning, procurement, delivery, and monitoring.

Figure 4. Financing of supply chains



Note: State Health Authorities (SESA) deliver care through their own health facilities (primary care, general hospitals and some regional hospitals). Patients obtain their prescribed medicines in pharmacies located in these health facilities. Blue arrows correspond to direct procurement. Grey arrows correspond to indirect procurement. Source: Own elaboration based on CGD/ARC framework.

Figure 5. Major flows of commodities and finances in supply chains



Note: Colors indicate the corresponding period for each flow and key instance (pre-reform and post-reform).
 Source: Own elaboration based on CGD/ARC framework.

4.1 Pre-reform period (up to 2018)

Integrated governance

Before the reforms, each SESA and each federal public provider—including national institutes of health and other federal hospitals—remained responsible for procuring medicines and other health commodities for the populations they served. Within that fragmented architecture, however, consolidated tendering for multiple-source products and price negotiation for single-source products had become increasingly important sector-wide governance mechanisms. These arrangements reflected more than a decade of coordination across health and other federal authorities to improve transparency, competition, and purchasing efficiency.

Planning

Revenue raising and pooling

In 2018, Seguro Popular financed two broad health benefits packages through explicit legal rules. One covered primary and hospital care delivered through the 32 decentralized SESA (direct financing of procurement, see blue arrows in figure 4). The other financed selected high cost/high specialty interventions through the Catastrophic Expenditures Fund, which paid certified providers (public and private) on a per case basis. And operated by the Seguro Popular National Commission (indirect financing of procurement, see grey arrows in figure 4).

Prioritization

Healthcare providers retained discretion to determine which health commodities to procure within their available budgets and clinical practices, but explicit benefit packages and clinical rules helped align procurement with stated service priorities.

Budgeting

Budgeting was largely bottom-up. Facilities and providers informed forecasts, procurement lists, and budget requests, allowing expenditure plans to remain linked to service priorities and expected demand.

Market shaping and regulation

Market shaping relied on two complementary mechanisms. For single-source medicines, the inter-institutional commission negotiated prices and terms on behalf of public purchasers, thereby reducing price dispersion and strengthening bargaining power. For multiple-source products, consolidated tenders generated market intelligence and reinforced more coherent procurement strategies across the public sector. Information shared across both processes supported better procurement strategies for the public sector.

Procurement

Direct centralized procurement

Consolidated procurement aggregated demand from multiple public providers into a single tendering process designed to secure better prices and conditions for the government as a whole. IMSS coordinated this process and contributed the technical expertise needed to run it in an orderly and predictable way, thus benefiting states or institutions with less experience and knowledge in procurement. Once a bid was awarded, however, each participating institution still signed, managed, and paid its own contracts. Similarly, under the price negotiation process for single-source products, once prices were negotiated, they applied to purchases made by all public providers.

SESA, national institutes of health and other federal hospitals maintained the possibility to undertake their own procurement, but their participation in consolidated procurement had increased over time.

Indirect facility-led procurement via purchasing of services

Through the catastrophic fund, interventions were funded on a fee-for-service basis and delivered by a set of certified providers, including both private and public providers. Public providers receiving funding from the catastrophic fund could join the consolidated procurement or price negotiation to procure medicines necessary to deliver the funded interventions, for example certain cancer drugs and other high-cost medicines, although they could also undertake their own procurement. Interventions funded through the catastrophic fund were subject to clinical protocols, therefore indirect facility-led procurement was somewhat aligned to priority-setting and health needs.

Purchasing rules

A defining feature of the pre-reform model was that procurement contracts typically included delivery. The purchasing of products and the logistics needed to place them at agreed delivery points were not treated as separate functions. For competitive tendering processes, it was mainly distributors who participated in the bidding, representing the industry and offering product delivery on sites included in the tender call. For single-source products, contracts were signed directly with the industry, but delivery was also included as part of the contracted price and contract terms.

Budget execution

Budget execution remained institutional. Each provider or state authority formalized and managed its own contracts and paid suppliers directly. Therefore, the financing of procurement remained at the state level (or facility level in the case of the National Institutes of Health and other federal hospitals). That arrangement preserved local autonomy and created room for emergency purchases when needs changed unexpectedly

Delivery

Private suppliers (mostly distributors in the case of tender processes for multiple-source products) agreed to deliver the procured goods to pre-specified state, central, jurisdiction or delegation warehouses, or hospital facilities, depending on the healthcare provider. In the case of SESA, the

local government could then directly distribute the items to their health facilities or contract local distributors for last-mile delivery.

Distributors were the responsible instances to deliver the product and since they handled products from multiple manufacturers, they could secure the requested product volumes, manage inventories, and reduce the risk of non-delivery.

Monitoring

Monitoring was uneven across institutions but functional. Larger entities such as IMSS had long-standing information systems to track contracts and inform future procurement. In non-social-security institutions, information systems were weaker, but participation in consolidated procurement created incentives to improve visibility over contract performance and demand.

Overall, the pre-reform model had two major strengths: consolidated tendering for multiple-source products and inter-institutional price negotiation for single-source medicines. Both still had room for further institutionalization, professionalization, and digitalization, and not all states or providers participated fully. Even so, they had succeeded in bringing much of the public sector into more coordinated purchasing arrangements with better prices and clearer terms. Procurement corruption was not absent, but available evidence does not suggest a system characterized by generalized corruption. On the contrary, the model had gradually reduced room for abuse through standardized procedures, federal procurement rules, an electronic procurement platform, reverse auctions, and closer scrutiny of bid rigging and other anticompetitive practices. In practical terms, the system functioned and medicine availability was generally maintained, with gradual improvement over time, especially during 2010–2018.

4.2 Post-reform (2019-2022)

Integrated governance

In line with presidential instructions, in January 2020, Seguro Popular was fully repealed by Congress. The Seguro Popular National Commission, responsible for coordinating the scheme with the SESA and operating the Catastrophic Fund, was replaced by the INSABI.

As a result, in these states, INSABI became directly involved in the financing of procurement, as well as in delivery and monitoring. However, without new, clear financing rules in place, this process led to rising uncertainty on roles and responsibilities for those SESA willing to pass on their resources to the federal government, for those unwilling to join the re-centralization process, and for those who accepted a so-called “partial” transfer of resources.

In parallel, as part of a presidential instruction to overhaul pre-existing procurement arrangements under the political banner of anti-corruption, the responsibility to collect and determine medical goods requirements, plan and undertake the procurement process, and sign, pay and monitor contracts was repeatedly shifted among the Ministry of Finance, UNOPS, INSABI, and later other federal actors. These changes did not follow a sequenced transition toward a clearly defined model.

Rather, they were successive responses to implementation failures, and they introduced ambiguity over who planned demand, who procured, who paid, and who ensured delivery.

Planning

Revenue raising and pooling

The repeal of Seguro Popular eliminated per capita funding rules for SESA and health benefit packages and resulted in a re-centralization of budgets, infrastructure, and human resources through voluntary agreements signed between INSABI and state governments. The lengthy and chaotic process over the course of five years resulted in a high degree of uncertainty about financing rules, and the roles and responsibilities of the federal government and the states.

Prioritization

The removal of explicit benefits-linked financing rules was not replaced by new, clear rules. This left the system with a more discretionary and uneven approach to prioritization, where in principle the health system should provide all services to those in need thus leading to implicit rationing and lack of tools to guide the procurement of medicines.

Budgeting

Recentralizing resources also meant adjusting budgets, subjecting the execution of resources to federal treasury rules, payment calendars, and retention mechanisms that affected supplier behavior and delivery timelines. Reorganizing budgets and calendars took time and was subject to the federal public financial management (PFM) cycle involving the Ministry of Finance as well as annual budget authorizations by Congress. Payments to suppliers were now made centrally with retained resources previously allocated to the states. Anecdotal evidence indicates that the industry did not receive payment until products were effectively delivered, even if delivery was not a responsibility they shared with distributors anymore. Delayed or missing payments affected the willingness of the industry to participate in public procurement.

Taken together, the loss of explicit funding rules, the uncertainty over responsibilities, and the disruption to budget execution weakened planning discipline across the first three CGD/ARC functions: revenue pooling, prioritization, and budgeting.

Market shaping and regulation

The interinstitutional commission for single-source price negotiation, which had been a pre-reform strength, was removed as part of the procurement overhaul. The responsibilities for planning demand, tendering and contracting, and payment were separated across different institutions and periods, reducing clarity on who plans demand, who tenders and contracts, and who pays. The reforms coincided with the layoff of technical cadres in public institutions and the incorporation of new teams with little experience and knowledge in procurement, thus wasting long-standing efforts to develop technical capacities and robust market intelligence.

Procurement

Direct centralized procurement

A central authority different to IMSS—whether the Ministry of Finance, UNOPS or later INSABI—was now responsible for the tendering of products and the distribution of medical goods. Procurement processes were intended to cover in principle all public health care providers.

For those states that had not joined the recentralization process (i.e. the decentralized states), the option was to participate at least with a few requirements in the consolidated, centrally led processes while in parallel using their resources (federal and often local) to undertake their own procurement process, in order to secure the timely availability of products in their medical facilities.

When undertaking direct centralized procurement, a recurrent operational issue was demand planning, including the identification of products and volumes required by each provider to consolidate requirements across the sector, and how to monitor awards, contracts, delivery and payment. As simple as it may be, the integration of lists of products and volumes was done without necessarily considering past volumes and local requirements. Anecdotal evidence suggests that much of past information and information systems were either disregarded, unknown or had to be collected from scratch, resulting in products and volumes procured that were not in line with actual needs and market product specifications. This was aggravated by the layoff of technical cadres and the migration of procurement responsibilities from IMSS to the Ministry of Finance first and then to UNOPS and was reflected on bidding suppliers who did not fulfil technical criteria or the award for inadequate products or quantities.

Indirect facility procurement

Financing for high-cost interventions through the catastrophic expenditures fund was interrupted. Although the fund itself formally remained in existence, its accumulated resources were redirected to other uses. When those resources were later used for medicines, procurement was managed directly by INSABI rather than through the previous service-purchasing arrangements.

Purchasing rules

The main procedural change was the separation of product procurement from distribution. Manufacturers or suppliers delivered products to the logistics operator selected by UNOPS or INSABI, but payment could still depend on final delivery. This weakened the risk-sharing arrangement that had previously linked distributors, suppliers, and purchasers. Decentralized states, by contrast, often continued procuring through integrated contracts that included distribution.

Budget execution

Centralized payment processes added new validation steps, including confirmation of product receipt from states before payment could be completed. Delays and administrative bottlenecks varied across states, reflecting wide differences in geography, infrastructure, and implementation capacity.

Delivery

One of the central implications of these reforms was the disruption of timely and correct delivery of medical goods. In the past, distributors participating in tenders secured the availability of medicines in agreed locations throughout the country. There were about 15-20 distributors (each representing between 10-12 laboratories who had three roles: i) manage distribution centers (large warehouses regionally distributed) to ensure the delivery of products, ii) consolidation/aggregation of the supply of various providers to cover the demand, iii) financial buffer: they paid laboratories on time while waiting for public sector payments. Intended to eliminate corruption and market power abuse by large national and regional distributors, splitting the procurement from the distribution of the good eliminated a mechanism that enabled manufacturers and distributors to share risk while securing the delivery to purchasers, and opened the door to new incumbents, many of which had no experience nor the necessary qualifications, operations scale or infrastructure to adequately maintain and transport medical goods.

When awarding contracts for the distribution of medical goods, these were delivered in a more limited set of central locations agreed by INSABI without consideration of local needs. From these locations, medical goods still had to be distributed either to regional or state warehouses and then to medical facilities through additional tendering and contracting processes.

Adding additional steps in the distribution created a greater margin of error in terms of what was delivered and left the states with little or no margin to accommodate local needs and circumstances for the delivery of products. States were only passive recipients of the goods, without a say in terms of quantities, type of product, timing, or location for receipt.

Monitoring

INSABI became responsible for monitoring, especially for centralized states. However, the chaotic implementation of reforms complicated monitoring, resulting in less transparency and accountability. In the end, the financial reform changed institutions faster than it changed information systems, leaving weak visibility over orders, deliveries, payment status, and stock availability.

5. Results

Misalignment of reforms has distorted the financing of the health supply chain, resulting in a lack of supplies and inefficient procurement, ultimately affecting the availability of medicines in public institutions. While it may be argued that some of the resulting effects could have been transient, further reforms following 2022 and to date, both in centralization arrangements and procurement, indicate this may not be entirely the case. Moreover, even if transient, the resulting economic and social cost of supply shortages and reduced access to medicines for the population in need could have been avoided through more informed reform planning and implementation.

Medicines shortage became a major public concern in Mexico between 2019 and 2022. Civil society tracking documented repeated peaks in media reports of shortages and more than 24,000 complaints in 2019-2020 alone, with a notable concentration in institutions serving the population without social security.¹⁰ At the same time, average quarterly out-of-pocket household spending on medicines (both prescription and over-the-counter) and wound-care supplies rose by 43% in real terms, increasing from 20 USD to 28 USD between 2018 and 2022.¹¹

The COVID-19 pandemic was an important system-wide shock and undoubtedly contributed to supply disruption, service instability, and procurement stress. However, the broader pattern observed in Mexico cannot be explained by the pandemic alone. Trends in spending, procurement modality, bidding failure, and delivery problems indicate that the reforms themselves also had structural effects on supply-chain performance.

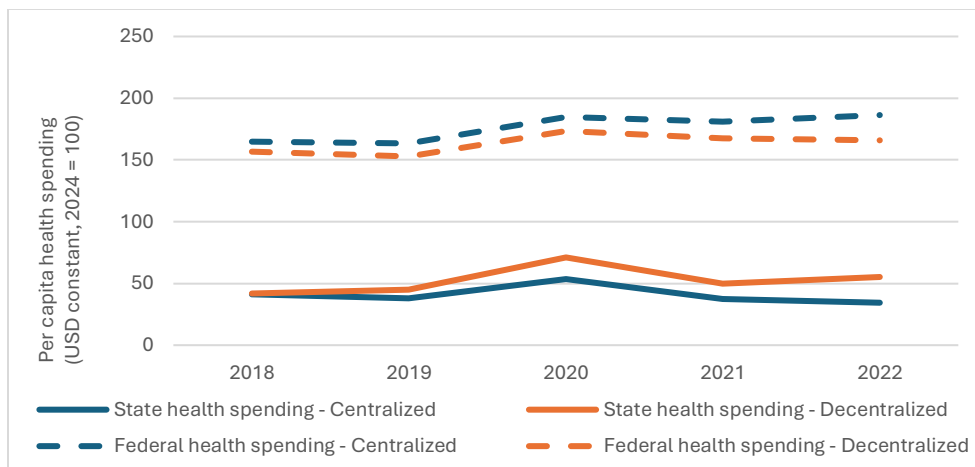
State-level services for the uninsured population are funded through federal and state resources, and the state contribution varies with local economic development, fiscal capacity, and political priorities. Between 2018 and 2022, re-centralized states (labelled throughout the rest of this section as ‘centralized’ as opposed to those who did not join the re-centralization process who will be labelled as ‘decentralized’) had, on average, increasingly higher federal per capita allocations compared to those states that remained decentralized. During this period, the average federal per capita allocation for centralized states increased 13% in real terms, while federal allocations for decentralized states increased only 6%. Although in all states both federal and state allocations increased in 2020 during the pandemic, decentralized states seem to have compensated for restrictions on federal funding by increasing state health spending. During this period, on average, per capita state health spending in decentralized states increased by 32% in real terms, whereas it decreased by 17% in centralized states (see Figure 6). Additional state allocations in decentralized states may have helped them meet procurement needs either through their own procurement or alternative schemes. For example, one state (Guanajuato) maintained a pay-per-dispensed

¹⁰ Nosotrxs-Cero Desabasto (2021) Mapeo del Desabasto de Medicamentos en México. Informe de Transparencia en Salud 2019-2020. Available at: <https://cdn-yeeko.s3.amazonaws.com/assets/Informe+de+Transparencia+en+Salud+2019-2020.pdf>

¹¹ Own calculations based on National Income-Expenditure Household Surveys 2018 and 2022.

prescription- outsourcing model, ensuring high fill rates by shifting inventory risks to private vendors.¹²

Figure 6. Average per capita health spending by source in centralized and decentralized states, 2018-2022



Source: Own elaboration based on data from Secretaría de Salud/Dirección General de Información en Salud. Sistema de Cuentas en Salud a Nivel Federal y Estatal (SICUENTAS), México 2024.

Efficient procurement combines competition, predictable processes, and sufficient purchasing power to secure the best feasible prices for equivalent commodities and delivery terms. In fragmented systems, efficiency also depends on the ability to aggregate demand across institutions. Supplier participation, in turn, depends on timely tenders, legal certainty, transparent procedures, accurate information on products and volumes, clear delivery requirements, and prompt payment. Mexican procurement law, as in many countries, favors competitive processes for multiple-source products while allowing direct purchasing for single-source products and for exceptional circumstances. Direct awards are therefore not inherently problematic. However, when they expand sharply because competitive tenders fail, they become a signal of underlying dysfunction in planning, tendering, or supplier confidence. Conversely, adding single-source medical goods to formal tendering processes creates an unnecessary administrative burden.

The evolution of procurement activity considering all public health care institutions between 2018 and 2022 shows increased activity in terms of the number of procurement processes¹³ but overall lower purchased volumes and values suggesting an overall less efficient procurement process (Figure 7). The total number of procurement processes considering all public health care institutions increased 19%, from 12,780 to 15,233. Processes involving direct awards increased 1.5 times between 2018 and 2022 (from 6,952 to 10,380 processes), perhaps because of the unpreparedness following the reform. The noticeable large increase observed in 2020 and 2021 may have been partly

¹² Call for the international open public tender, in-person, for the procurement of medicines, medical supplies, and the service of management and dispensing of these in the modality of stock, pharmacy, and unit-dose service for the medical units of the Public Health Institute of the state of Guanajuato Available at: https://transparencia.guanajuato.gob.mx/transparencia/informacion_publica_licitaciones.php

¹³ Process refers to purchasing procedures or awards.

driven by the pandemic. At the same time the number of competitive tenders reduced 38% (from 2,985 in 2018 to 1,846 in 2022) and their relative share in terms of total volume and total value purchased per year diminished significantly in 2020-2022.

Figure 7. Public procurement of medicines in the Mexican health system, 2018-2022



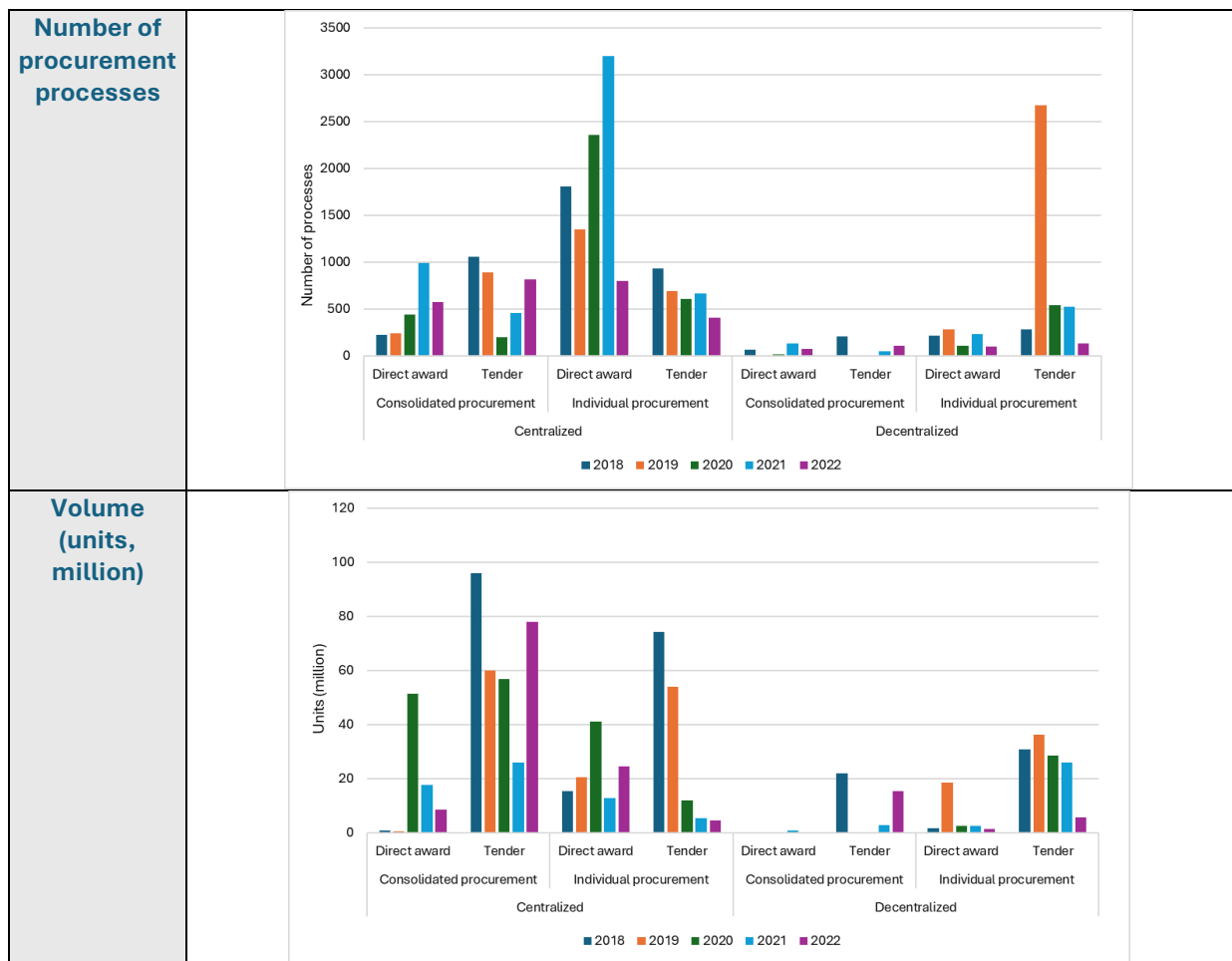
* Category 'Other' mainly includes unspecified processes, as well as a small number of invitations to at least three suppliers and awards resulting from market research.

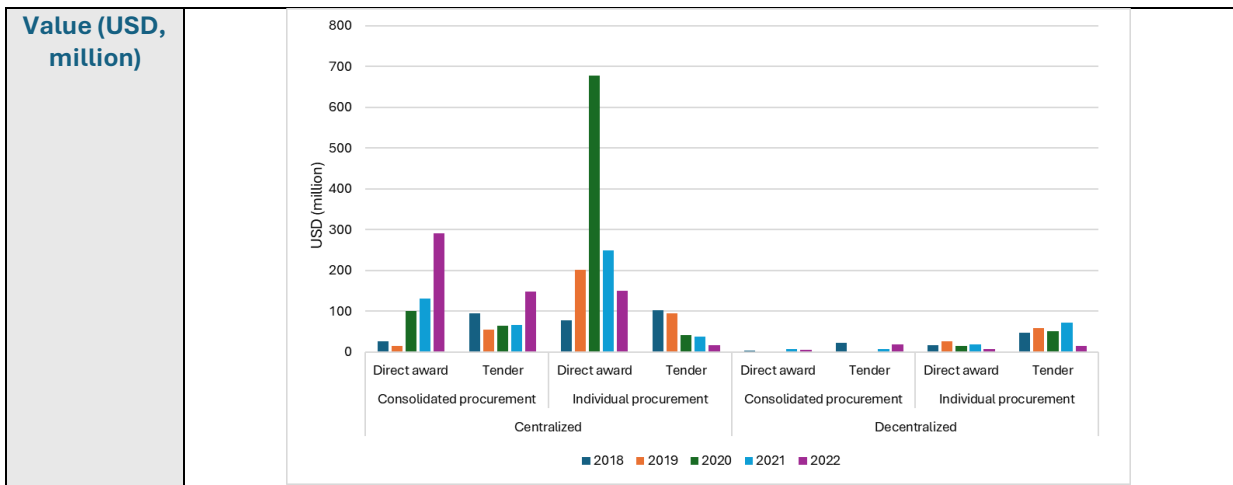
Source: Own elaboration based on data from Instituto Farmacéutico (INEFAM).

States that remained decentralized continued procuring through individual processes using their own resources and those federal resources agreed with the Federal government in continuation of decentralized care provision. They also had the option to join consolidated procurement, and a few did so for some medical goods. In these states, tendering processes seemed to prevail (Figure 8).

Centralized (i.e. re-centralized) states were expected to rely on consolidated procurement, and these processes accounted for large shares of procured volume. Yet they also resorted increasingly to individual procurement, including direct awards at relatively low volumes and high values. This pattern suggests that centrally led tenders did not function reliably enough to remain the dominant procurement platform. Some of this behavior may reflect emergency responses during the pandemic, but it is also consistent with repeated breakdowns in consolidated purchasing.

Figure 8. Procurement platform and procurement type in centralized and decentralized public purchasers, 2018-2022

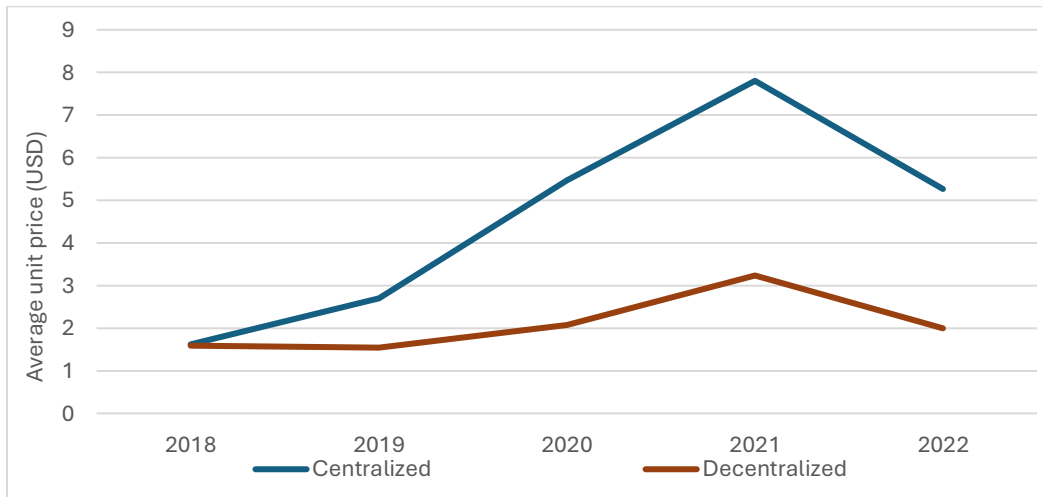




Note: Category 'Other' is excluded from this analysis.
 Source: Own elaboration based on data from Instituto Farmacéutico (INEFAM).

If consolidated procurement had been working effectively, one would expect it to generate lower average unit prices than procurement in decentralized states. The opposite pattern appears in the data (Figure 9). Although the underlying product mix is not identical across providers, centralized entities purchased medicines at increasingly higher average unit prices. At 1.6 USD per item on average, unit prices were the same for centralized and decentralized providers. By 2022, the gap had increased 2.6-fold.

Figure 9. Average unit price for procured medicines 2018-2022: centralized and decentralized public purchasers

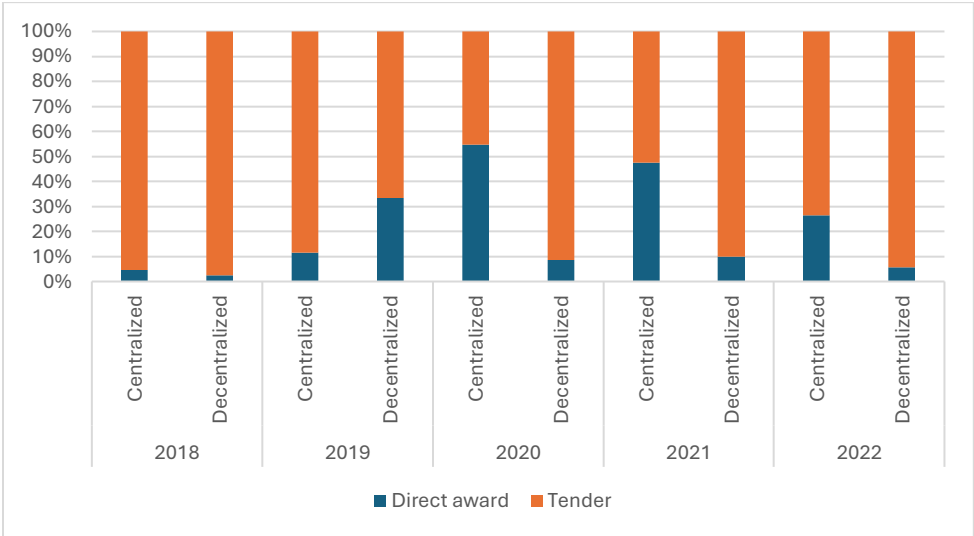


Source: Own elaboration based on data from Instituto Farmacéutico (INEFAM).

Competitive bidding is not expected for every pharmaceutical product, but it should remain the standard route for most multiple-source generic medicines. On that measure, procurement performance deteriorated sharply: the number of competitive processes for generic products fell by more than half between 2018 and 2022, and the decline continued through 2024.

Figure 10 shows a marked shift away from competitive procurement for multiple-source or generic products in centralized states during the main reform years. In decentralized states, by contrast, tendering remained much more prevalent. The contrast suggests that procurement disruption was concentrated in the part of the system most exposed to central restructuring. In 2018, 95% of all single-source medicines in centralized states were procured through tendering. By 2020 and 2021, this share had declined to 45% and 48%, respectively, and in 2022 it rose again to above 70%. In contrast, in decentralized states this share has remained above 90% since 2018, except in 2019 when it dropped to 67%, possibly in response to failed tenders during that year.

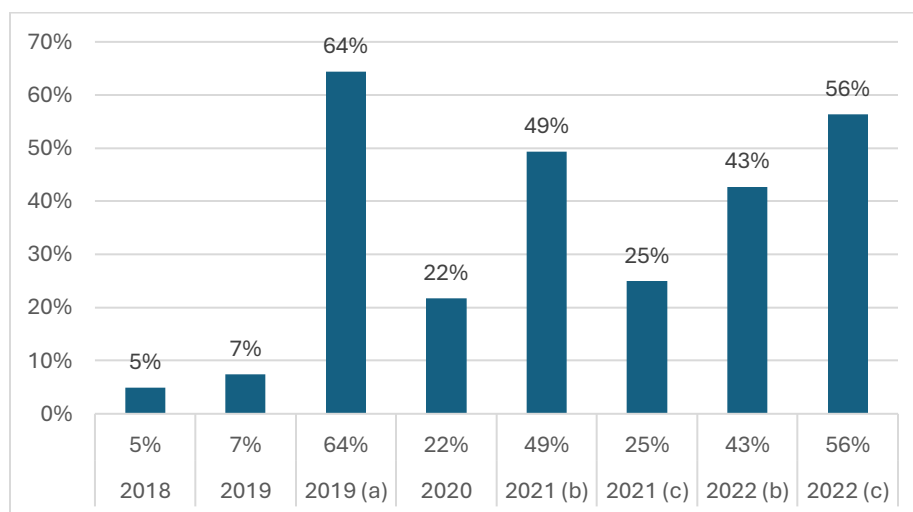
Figure 10. Single-source products by type of procurement and type of purchaser, 2018-2022



Source: Own elaboration based on data from Instituto Farmacéutico (INEFAM).

A final indicator of weak consolidated procurement is the high share of products for which no bids were received. Before the reforms, the average share of products left without bids in consolidated tenders was about 10 percent (Figure 11). After the reforms, that figure rose to 43 percent, and in some processes exceeded 50 percent. Such outcomes point to failures in demand planning, specification design, process credibility, supplier incentives or deficiencies in supplier suppliers or offered goods, especially when these do not meet technical specifications —or to some combination of all five.

Figure 11. Percentage of deserted (no bid) products in consolidated tendering processes, 2018-2022



(a) Complementary consolidated tender process; (b) Consolidated processes led by INSABI; (c) Consolidated process led by UNOPS.

Source: Own elaboration based on data from Instituto Farmacéutico (INEFAM).

6. Conclusions and lessons for countries

Mexico's experience illustrates the risks of pursuing major health financing and procurement reforms simultaneously without a shared implementation strategy. The two reform streams were not designed to be mutually reinforcing and they were not sequenced in a way that protected critical supply-chain functions during transition.

Recentralization removed the budgetary autonomy and managerial flexibility that states had previously used to respond to shortages and adapt procurement to local needs. When shortages arose, states that had transferred their budgets and resources to the federal level lacked the means to timely procure alternative supplies or otherwise compensate for gaps at the central level, yet the evidence shows they ended up using resources (either local or from other federal budget lines) to procure medicines, albeit more inefficiently. At the same time, procurement reform dismantled established coordination mechanisms—consolidated tendering, single-source institutional price negotiation, and integrated procurement-and-delivery contracts—before credible replacements were operating. The interaction of these reforms amplified disruption beyond what either reform would likely have produced on its own. Several lessons emerge for countries considering concurrent reforms in health financing and supply-chain governance.

1) Fragmented financing structures undermine equity and efficiency

Mexico's long-standing separation between social security schemes and services for the uninsured shows how parallel financing pools create unequal entitlements, variable service quality, and inefficiencies in resource allocation and procurement. Even where fragmentation cannot be eliminated, countries can still improve performance through coordinated procurement arrangements that pool demand across schemes.

2) Centralized or consolidated procurement can generate major savings when institutional capacity exists

Mexico's pre-2019 consolidated procurement, led by IMSS, demonstrates that a technically strong central buyer can secure lower prices and better contract terms for the entire public sector while maintaining facility-led procurement financing. The lesson relevant for other countries is that centralization works best when the leading institution has professionalized procurement capacity, stable processes, and clear mandates. IMSS's role as the largest public provider gave it the scale, expertise, and institutional memory to lead procurement. Countries do not need to replicate IMSS as such, but they do need an institutional anchor with the credibility and capacity to manage procurement consistently over time. They can leverage their own large purchasers—social insurance funds, national hospitals, or central medical stores—as reform anchors.

3) Inter-institutional coordination mechanisms are critical for price negotiation

Mexico's former commission for single-source price negotiation illustrates the value of a formal multi-agency mechanism for high-cost products that cannot be competitively tendered. Such mechanisms can reduce price dispersion, strengthen bargaining power, and improve transparency across fragmented public purchasers.

4) Abrupt structural changes can disrupt service delivery

Mexico's post-2019 reforms show that dismantling established procurement or financing arrangements without transitional planning can create supply disruptions and weaken institutional capacity. Countries should prioritize sequenced reforms, risk mitigation, and continuity of essential functions. Reform sequencing would imply first, defining and agreeing on the roles and responsibilities of the federal government and the states under a new distribution of responsibilities between levels of government, and undertaking the financial changes necessary to reflect those roles and responsibilities in federal and state budget allocations, financial calendars, and mechanisms to include states in budget planning or monitoring. Procurement reforms may follow once it is clear who will be responsible for planning and budget execution, including payment to providers.

5) Reliable information and data systems are essential for planning, purchasing and monitoring delivery and contracts/payment

Basic information and standards for compiling and validating evidence-based planning, budgeting, and purchasing, especially when multiple health care providers are involved. Mexico's challenges in having accurate and complete information on products and volumes required, as well as robust market intelligence, at the time of the reforms, highlight how the lack of this information risks inadequate procurement.

6) Procurement reforms must consider the entire supply-chain—not only purchasing

Procurement reform must be designed across the full supply chain, not only around the purchasing act. Mexico's reforms separated procurement from distribution and delivery without a clear understanding of how the supply chain worked and how states managed their contracts and the delivery with distributors. This introduced new coordination failures and weakened last-mile

delivery. Countries should therefore assess reforms across planning, tendering, distribution, and monitoring as an integrated system.

7) Public finance rules can make or break procurement performance

Public financial management rules can materially affect procurement outcomes. Treasury controls, payment calendars, retention mechanisms, and receipt-validation procedures shape supplier behavior and delivery timelines. These constraints should be examined explicitly whenever countries redesign supply-chain financing.