

SCALIMED INSIGHTS 2026

COMPLEMENTARY DOCUMENT

Methodological Annex and Auditable Base

Master data table, source and evidence matrices, inference log,
derived content, complete lexicon and complete bibliography.

Founding Edition · Volume I · July 2026 · Scalimed

SECTION 1

Detailed methodology

Structured desk review: sources, inclusion criteria, evidence levels and limits.

Review design

A structured desk review was conducted of official Mexican sources, international organizations, peer-reviewed scientific literature, regulatory documents and private reports with identifiable methodology. Publications from 2023 to July 2026 were prioritized; earlier works were included when they remain relevant methodological references, such as the Cochrane review on mobile reminders or current Mexican regulations. The review is not presented as a registered academic systematic review or as a proprietary meta-analysis. Nonetheless, PRISMA 2020 principles were applied to document identification, selection, duplicates, exclusions and traceability; CASP elements to assess validity, selection, measurement, confounding, applicability and conflicts of interest; and GRADE-inspired criteria when clinical or operational interventions with attendance outcomes were assessed. When heterogeneity prevented a quantitative synthesis, a narrative synthesis was carried out.

Application of PRISMA, CASP and GRADE

FRAMEWORK	APPLICATION IN THIS REPORT	LIMIT
PRISMA 2020	Logging by module of searches, source, date, inclusion/exclusion criteria, conceptual duplicates and reason for exclusion.	Bibliographic exhaustiveness is not claimed, nor is a meta-analysis presented.
CASP	Assessment of question, design, sample, measurement, confounding, precision, applicability and conflict of interest.	Checklists were adapted to the study type; not all documents are clinical studies.
GRADE	Certainty assessment for reminder/no-show interventions: design, risk of bias, inconsistency, indirectness, imprecision and publication.	Descriptive administrative data were not graded as if they were clinical evidence.

Evidence classification

LEVEL	TYPICAL CONTENT	EDITORIAL USE
A	Meta-analyses, systematic reviews, relevant trials, large multicenter studies.	Can support mechanisms or interventions; applicability to Mexico is verified.
B	Observational studies, cohorts, national registries, official statistics.	Supports structure, prevalence, distribution and associations.
C	Private surveys, sector studies, consultancies, associations, transparent models.	Contextualizes trends; does not establish a national benchmark without validation.

LEVEL	TYPICAL CONTENT	EDITORIAL USE
D	Expert opinion, cases, indirect benchmarks, exploratory or commercial evidence.	Generates hypotheses; does not on its own support central findings.

Confidence and consensus criteria

Methodological confidence and consensus were rated separately. Confidence is high when the source is primary, the definition compatible, the data year clear, the methodology transparent and the applicability adequate. It is medium when there is indirectness, partial coverage or heterogeneity. It is low when extrapolation, a commercial model, an uncertain sample or a non-verifiable source predominates. Consensus was classified as strong, moderate, contradictory or insufficient. There can be strong consensus with limited confidence—for example, several commercial sources may repeat the same idea—or high confidence with little consensus if robust studies produce different results.

Audit of the attached documents

Healthcare Professionals in Mexico was treated as a secondary compendium. Its slides made it possible to locate series attributed to OECD, INEGI, the Ministry of Health, WHO, Data México and INSP. Its figures were not adopted automatically because several categories are hierarchical or overlapping. The figure for physicians by specialty, for example, should not be added to surgical, pediatric or obstetric subgroups without reviewing the OECD structure. Online Doctor Consultations: Market Data & Analysis was treated as a secondary market model. Its definition includes remote consultations paid via website or app, mixes recent users and potential users in certain indicators, excludes online scheduling, records and prescriptions, and presents revenue and penetration as estimates or projections. It is therefore used to describe an international commercial category, not to measure the complete digital journey or real Mexican adoption.

Explicit bias audit

BIAS	MECHANISM	RISK	EDITORIAL CONTROL
Publication	Studies with positive effects may be published more often.	Moderate for interventions; low for official statistics.	Avoid inferring a universal effect size.
Commercial	Vendors highlight benefits and omit negative results.	High for CRM, AI and conversion benchmarks.	Do not support central findings with D-level evidence.
U.S.-centric	Much of the operational literature comes from the U.S.	High for experience, payments and access.	Separate mechanism from benchmark.
Urban	Digital patients and practices concentrate in cities.	High for Mexico.	Report the urban-rural gap and do not generalize.

BIAS	MECHANISM	RISK	EDITORIAL CONTROL
Hospital	Many no-show studies come from hospitals.	High when transferred to private clinics.	Label indirectness.
Survivorship	Published cases tend to be successful implementations.	High for technology.	Look for failures and barriers.
Technological	Firms define the problem to fit their product.	High.	Prioritize independent sources.
Selection	Voluntary surveys capture more digitalized practices.	Moderate-high.	Do not infer national adoption.
Temporal	The pandemic altered telemedicine and behavior.	Moderate.	Separate short-term acceleration from structural trend.
Availability	What can be measured is studied, not everything relevant.	High for the Mexican private funnel.	Turn gaps into a finding.

This report is prepared on the basis of public sources, peer-reviewed scientific literature and market analysis, and explicitly distinguishes between proven facts, estimates, inferences and hypotheses. Official evidence covers supply, infrastructure and connectivity better than the private pre-consultation funnel.

No public source was identified that comprehensively and systematically measures response times, request-to-appointment conversion, CRM penetration or reactivation in the Mexican private ambulatory sector. Therefore, evidence gaps are presented as findings and are not filled in with commercial figures or international extrapolations. The A/B/C/D confidence classification and the consensus criteria, described in the methodology, accompany each claim and each exhibit.

Confidence seal. Nature: scope note · Origin: report methodology · Confidence: high · Scope: private healthcare sector in Mexico · Limitation: public evidence is incomplete for the pre-consultation funnel.

SECTION 2 · APPENDIX A

Master table of quantitative data

Each indicator with its value, unit, year, geography and nature; and its source, method, sample, definition and limitation.

Source: Scalimed compilation from official sources. **Limitation:** non-homogeneous universes across indicators.

Indicator	Value	Unit	Data	Geography	Type
Employed medical specialists	119,000	people	Q1 2026	Mexico	Observed/ estimated
Source: Data México/ENOE · Link: Data México · Method: Labor survey · Sample: ENOE · Definition: Population employed in the category. · Limitation: Not certification nor private sector.					
Average age of specialists	41.8	years	Q1 2026	Mexico	Observed
Source: Data México/ENOE · Link: Data México · Method: Labor survey · Sample: ENOE · Definition: Average of employed persons. · Limitation: Does not describe clinical seniority.					
Private hospital establishments	2,747	establishments	2024	Mexico	Observed
Source: INEGI ESEP · Link: INEGI ESEP 2024 · Method: Establishment statistics · Sample: ESEP universe · Definition: Establishments that provided hospital services. · Limitation: Does not cover all outpatient care.					
Private census beds	35,400	beds	2024	Mexico	Observed
Source: INEGI ESEP · Link: INEGI ESEP 2024 · Method: Statistical registry · Sample: ESEP universe · Definition: Beds installed for hospitalization. · Limitation: Does not measure outpatient occupancy.					
Private hospital discharges	2,273,261	discharges	2024	Mexico	Observed
Source: INEGI ESEP · Link: INEGI ESEP 2024 · Method: Statistical registry · Sample: ESEP universe · Definition: Recorded hospital discharges. · Limitation: Not equivalent to unique patients.					
Internet use	83.1	% pop. 6+	2024	Mexico	Observed
Source: INEGI ENDUTIH · Link: ENDUTIH 2025 · Method: National survey · Sample: ENDUTIH sample · Definition: People using the internet. · Limitation: Not medical use.					

Indicator	Value	Unit	Data	Geography	Type
Internet use	86.1 / 104.9	% / millions	2025	Mexico	Observed
Source: INEGI ENDUTIH · Link: ENDUTIH 2025 · Method: National survey · Sample: ENDUTIH sample · Definition: People aged 6+ using the internet. · Limitation: Not medical use.					
Urban / rural use	88.9 / 75.2	%	2025	Mexico	Observed
Source: INEGI ENDUTIH · Link: ENDUTIH 2025 · Method: National survey · Sample: ENDUTIH sample · Definition: Internet use by area. · Limitation: Territorial gap.					
Density of practicing physicians	2.72	per 1,000	2023	Mexico	Observed
Source: OECD · Link: OECD Health at a Glance 2025 · Method: Harmonized national compilation · Sample: Administrative data · Definition: Practicing physicians under OECD definition. · Limitation: Definition may include residents/interns.					
Global online-consultation market	9.46	billion USD	2024	Global	Estimate
Source: Statista Market Insights · Link: Attached document · Method: Market model · Sample: Not fully published · Definition: B2C revenue paid via web/app. · Limitation: Projection/model; excludes scheduling and record.					

SECTION 3 · APPENDIX B

Source matrix

Assessment of each source by type, level, quality, recency, transparency and recommended use.

Source	Type	Level	Confidence
INEGI ESEP	Official	1	High
Quality: High · Recency: 2024 · Geography: Mexico · Methodology: Registry/statistics · Transparency: High · Conflict: Low · Use: Hospital market			
INEGI ENDUTIH	Official	1	High
Quality: High · Recency: 2025 · Geography: Mexico · Methodology: Probability survey · Transparency: High · Conflict: Low · Use: Digital context			
Data México/ENOE	Official	1	High
Quality: High · Recency: Q1 2026 · Geography: Mexico · Methodology: Labor survey · Transparency: High · Conflict: Low · Use: Medical employment			
OECD Health Statistics	Intergovernmental	1	High
Quality: High · Recency: 2023-2025 · Geography: Mexico/international · Methodology: Data harmonization · Transparency: High · Conflict: Low · Use: Physicians and comparisons			
DGIS/CLUES	Official	1	Medium-high
Quality: High · Recency: Continuous update · Geography: Mexico · Methodology: Administrative registry · Transparency: Medium-high · Conflict: Low · Use: Establishments			
Cochrane reminders	Systematic review	1	High
Quality: High · Recency: 2013 · Geography: International · Methodology: Systematic review · Transparency: High · Conflict: Low · Use: Attendance/no-show			
WHO AI health	International body	1	High
Quality: High · Recency: 2021-2024 · Geography: Global · Methodology: Governance guidance · Transparency: High · Conflict: Low · Use: AI risks			

Source	Type	Level	Confidence
Statista professionals Mexico	Private report	2	Medium-low
Quality: Medium · Recency: 2025 · Geography: Mexico · Methodology: Secondary compendium · Transparency: Medium · Conflict: Commercial · Use: Source map			
Statista online consultations	Market model	2	Low
Quality: Medium-low · Recency: 2025 · Geography: Global · Methodology: Model/projection · Transparency: Medium-low · Conflict: Commercial · Use: Teleconsultation context			
Individual no-show studies	Scientific	1/2	Medium
Quality: Variable · Recency: 2010-2026 · Geography: International/Mexico · Methodology: Observational/trial · Transparency: Variable · Conflict: Low · Use: Mechanisms			

SECTION 4 · APPENDIX C

Evidence-by-finding matrix

For each finding: supporting evidence, type, quality, consensus and confidence level.

Finding	Type	Confidence
Market depends on definition Evidence: INEGI, ENOE, OECD, CLUES, DENUE and ESEP measure different universes. · Quality: High · Consensus: Strong	Official registries and surveys	High
Hospital better measured than outpatient Evidence: ESEP quantifies hospitals; there is no national outpatient-clinic funnel. · Quality: High · Consensus: Strong	Official registry + gap review	High
Broad connectivity Evidence: ENDUTIH 2024 and 2025. · Quality: High · Consensus: Strong	National survey	High
Multichannel journey Evidence: International experience and access literature; Mexican absence. · Quality: Medium · Consensus: Moderate	Observational/sector	Medium
No funnel benchmark Evidence: Search of official and scientific sources without comparable series. · Quality: Medium-high · Consensus: Strong on the absence	Negative review finding	High
Reminders reduce no-shows Evidence: Cochrane and later studies. · Quality: High · Consensus: Strong	Systematic review/trials	High
No universal solution Evidence: Heterogeneity of causes and interventions. · Quality: High · Consensus: Strong	Reviews and observational studies	High
WhatsApp is not a CRM Evidence: System definitions and process analysis. · Quality: Medium · Consensus: Strong	Conceptual/sector	High

Finding	Type	Confidence
Administrative AI before clinical	Guidelines and reviews	Medium
Evidence: WHO and governance literature. · Quality: Medium-high · Consensus: Moderate		
Homegrown benchmark as an asset	Strategic inference	Medium
Evidence: Documented gap + feasibility of anonymized data. · Quality: Low-medium · Consensus: Insufficient		

SECTION 5 · APPENDIX D

Data that could not be verified

Claims that circulate without a verifiable source and the editorial decision taken.

Claim	Decision
Responding within five minutes dramatically multiplies medical conversion. Where: Blogs/agencies and software. · Attributed source: General lead studies. · Reason: Not specific to Mexican health; secondary chain.	Exclude as benchmark.
WhatsApp is the main channel of private patients in Mexico. Where: Vendors and commercial publications. · Attributed source: General WhatsApp penetration. · Reason: Does not measure medical contact.	Do not assert a percentage.
A clinic loses X% of patients due to lack of follow-up. Where: Marketing agencies. · Attributed source: No verifiable primary source. · Reason: Missing definitions of loss and population.	Convert into a hypothesis.
National private no-show rate of 20–30%. Where: Articles and presentations. · Attributed source: Heterogeneous local studies. · Reason: Not representative or comparable.	Do not compute an average.
CRM penetration in Mexican clinics. Where: Vendors. · Attributed source: Unpublished private surveys. · Reason: Unknown sample and methodology.	Record the gap.

SECTION 6 · APPENDIX E

Contradictions between sources

Indicators with divergent figures across sources, the difference and the justified preference.

Indicator	Preference
Number of physicians Source A: Professional licenses · Source B: OECD/ENOE · Difference: Registered potential vs. employment/practice. · Explanation: Different universes.	Use according to the question.
Specialists Source A: Data México employment · Source B: OECD categories · Difference: Labor classification vs. health harmonization. · Explanation: Not interchangeable.	Present separately.
Establishments Source A: ESEP · Source B: DENUE/CLUES · Difference: Private hospitals vs. economic units/establishments. · Explanation: Different unit.	Do not add.
Teleconsultation Source A: Statista model · Source B: Usage surveys · Difference: Potential users/revenue vs. effective use. · Explanation: Method and definition.	Label as model.
No-show Source A: Studies by service · Source B: Reviews · Difference: Variable local rates vs. intervention effect. · Explanation: Population and definition.	No national average.

SECTION 7 · APPENDIX F

Inference log

Report inferences with their support, assumptions, risks and confidence level.

Inference	Confidence
Fragmentation across channels likely generates loss of context. Support: Continuity principles and process design. · Assumptions: Handoff without logging increases errors. · Risks: No Mexican quantification.	Medium
Specialties with procedures and recurrence have higher potential follow-up value. Support: Episode structure and continuity. · Assumptions: More interactions and services. · Risks: No national LTV.	Medium
Clinics face more failure points than independent physicians. Support: More roles and handoffs. · Assumptions: Complexity increases coordination. · Risks: Can be offset with resources.	Medium - high
Administrative AI carries lower risk than clinical autonomy. Support: WHO and reversibility of tasks. · Assumptions: Lower potential harm and oversight. · Risks: Privacy risks persist.	Medium
A homegrown benchmark can be an editorial asset. Support: Documented public gap. · Assumptions: Comparable data has value. · Risks: Depends on sample and transparency.	Medium

SECTION 8 · APPENDIX G

Primary-research opportunities

Proposed primary studies with question, population, sample, method, variables and expected value.

Study	Value
Response mystery shopper Question: How do private practices respond? · Population: Practices in 5–8 specialties · Sample: 300–500 practices; 6–10 cities · Method: Standardized requests · Variables: Timing, quality, availability, follow-up · Risks: Ethics, cancellation and representativeness	Operational benchmark
Practice survey Question: What processes and technologies do they use? · Population: Physicians and administrators · Sample: 400+ stratified · Method: Survey · Variables: Channels, CRM, no-show, metrics · Risks: Self-selection	Adoption and barriers
Patient survey Question: How did they search and why did they drop off? · Population: Adults with recent private care · Sample: 1,000+ · Method: Probability/quota survey · Variables: Search, contact, trust, drop-off · Risks: Recall and urban bias	Real journey
CRM benchmark Question: What are the rates by stage? · Population: Participating practices · Sample: 20+ practices; 1,000+ requests/segment · Method: Anonymized data · Variables: Response, contact, scheduling, attendance · Risks: Definitions and privacy	Benchmark by specialty
No-show study Question: What factors predict non-attendance? · Population: Scheduled appointments · Sample: Multicenter cohort · Method: Observational · Variables: Channel, time slot, waiting, payment, history · Risks: Confounding	Targeted interventions

Study	Value
Reminder trial	Causal effect
Question: Which sequence works best? · Population: Patients with appointments · Sample: Powered by effect size · Method: Randomized/pragmatic · Variables: Channel, timing, content, rescheduling · Risks: Contamination	
AI adoption	Real maturity
Question: What uses exist and with what controls? · Population: Practices and vendors · Sample: Mixed sample · Method: Survey + audit · Variables: Use cases, oversight, incidents · Risks: Commercial bias	

SECTION 9 · APPENDIX H

Proposed visualizations

Proposed visualizations with variables, source, chart type, message and limitation.

Title	Chart
Layers of the medical market Variables: Licenses, employment, practice, certification, establishments · Source: INEGI/OECD/Data México · Message: Avoid a single figure · Limitation: Universes not additive	Layered diagram
Private hospital infrastructure Variables: Establishments, beds, ICU, discharges · Source: INEGI ESEP · Message: Hospital scale · Limitation: Not outpatient	Cards/bars
Digital divide Variables: National, urban and rural internet · Source: ENDUTIH · Message: Digital base and gap · Limitation: Not medical use	Bars
Multichannel journey Variables: Channels and transitions · Source: Report analysis · Message: Non-linearity · Limitation: No national weights	Conceptual Sankey
Recommended funnel Variables: 14 stages · Source: Report analysis · Message: Common definitions · Limitation: Conceptual	Funnel
Evidence map Variables: Indicators with/without benchmark · Source: Own matrix · Message: Public gaps · Limitation: Depends on the search	Heat map
No-show interventions Variables: Reminders, confirmation, rescheduling · Source: Cochrane/literature · Message: No single solution · Limitation: Indirectness	Matrix
WhatsApp maturity Variables: Four levels · Source: Analysis · Message: A channel is not a CRM · Limitation: Conceptual	Ladder

Title	Chart
Knowledge graph	Network
Variables: Variables and feedback loops · Source: Analysis · Message: Bottlenecks · Limitation: No quantified causality	
Trends 2026–2028	2×2 matrix
Variables: Impact and confidence · Source: Synthesis · Message: Priorities · Limitation: Projection	

SECTION 10 · APPENDIX I

Derived content

Twenty content pieces derived from the report, ready to be developed.

1. How many medical specialists are there really in Mexico?
2. The statistical gap in the private medical funnel.
3. WhatsApp is not a CRM: four maturity levels.
4. How to measure response time without fooling yourself.
5. What no-show means and why there is no single rate.
6. Appointment reminders: what the evidence shows.
7. Patient funnel: 14 stages every clinic should record.
8. CRM, scheduling and record: essential differences.
9. Metrics guide for an independent medical practice.
10. Metrics guide for a multispecialty clinic.
11. Pending benchmark: response time by specialty.
12. How to design an ethical medical mystery shopper.
13. Artificial intelligence at the front desk: uses and limits.
14. Sensitive data in messaging: operational risks.
15. Google, referrals and directories: attribution without oversimplification.
16. Patient reactivation: continuity versus promotion.
17. Why cost per lead is not enough in health.
18. Opportunity map by specialty.
19. Conversational scheduling and active confirmation.
20. Annual report on the Mexican private medical funnel.

SECTION 11 · APPENDIX J

Usable quotes and statistics

Ready-to-use quotes and statistics, with source, year, context and limitation.

Text	Source	Year
In 2025, 86.1% of the Mexican population aged six or older used the internet.	INEGI ENDUTIH	2026
Geography: Mexico · Context: General digital context. · Limitation: Does not measure medical use. · Link: ENDUTIH 2025		
Internet use reached 88.9% in urban areas and 75.2% in rural areas.	INEGI ENDUTIH	2026
Geography: Mexico · Context: Territorial gap. · Limitation: Does not measure ability to pay. · Link: Same link		
INEGI recorded 2,747 private hospital establishments in 2024.	INEGI ESEP	2025
Geography: Mexico · Context: Private hospital infrastructure. · Limitation: Does not cover outpatient clinics. · Link: INEGI ESEP 2024		
Private hospitals had 35,400 census beds in 2024.	INEGI ESEP	2025
Geography: Mexico · Context: Hospital capacity. · Limitation: Not outpatient. · Link: Same link		
Private establishments recorded 2.27 million hospital discharges in 2024.	INEGI ESEP	2025
Geography: Mexico · Context: Hospital activity. · Limitation: Not unique patients. · Link: Same link		
Data México estimated 119,000 employed specialists in the first quarter of 2026.	Data México/ENOE	2026
Geography: Mexico · Context: Labor market. · Limitation: Not certification. · Link: Data México		
There is no single figure for private physicians: registry, employment and practice measure different universes.	Report synthesis	2026
Geography: Mexico · Context: Definition. · Limitation: Methodological conclusion. · Link: —		

Text	Source	Year
No sufficiently robust public evidence was found for a Mexican response-time benchmark. Geography: Mexico · Context: Evidence gap. · Limitation: Depends on accessible sources. · Link: —	Scalimed review	2026
No robust national benchmark was found for request-to-appointment conversion. Geography: Mexico · Context: Operational gap. · Limitation: Does not rule out private data. · Link: —	Scalimed review	2026
Mobile reminders improve attendance compared with no reminder. Geography: International · Context: Intervention mechanism. · Limitation: Variable magnitude. · Link: DOI	Cochrane	2013
An automatic response is not equivalent to a human response or a resolution. Geography: General · Context: Measurement. · Limitation: Not a causal effect. · Link: —	Methodological definition	2026
WhatsApp can be contact infrastructure, but does not replace a CRM or a health record. Geography: General · Context: Operational architecture. · Limitation: Inference. · Link: —	Conceptual synthesis	2026
Statista's teleconsultation excludes scheduling, records and prescriptions. Geography: Global · Context: Market definition. · Limitation: Commercial model. · Link: Attached document	Statista Market Insights	2025
Administrative AI requires oversight, traceability and limits. Geography: Global · Context: Governance. · Limitation: Does not measure ROI. · Link: WHO	WHO	2024
The largest public gap is before the consultation: response, contact, scheduling and follow-up. Geography: Mexico · Context: Conclusion. · Limitation: Review finding. · Link: —	Report synthesis	2026

Text	Source	Year
Cost per request is not equivalent to cost per attended patient. Geography: General · Context: Metric. · Limitation: Conceptual. · Link: —	Funnel definition	2026
A scheduled appointment is not equivalent to a confirmed or attended one. Geography: General · Context: Metric. · Limitation: Conceptual. · Link: —	Funnel definition	2026
The practice must measure reasons for non-scheduling, not assume lack of interest. Geography: General · Context: Operation. · Limitation: Requires capture discipline. · Link: —	Report recommendation	2026
Broad connectivity increases digital viability, but does not prove preference for a channel. Geography: Mexico · Context: Interpretation. · Limitation: Not medical behavior. · Link: —	ENDUTIH synthesis	2026
A homegrown benchmark must publish definition, sample, period, specialty and exclusions. Geography: Mexico · Context: Primary research. · Limitation: Recommendation. · Link: —	Recommended protocol	2026

SECTION 12 · APPENDIX K

Frequently asked questions

Brief answers to the most common questions about the report's scope and data.

Does the report claim that all clinics lose patients?

No. It identifies operational risks and a lack of measurement; it does not quantify a national loss without evidence.

Is there a Mexican private no-show rate?

No sufficiently robust and comparable national evidence was found.

Is WhatsApp the main channel?

Its general use is massive, but there is no proven national percentage for private medicine.

Does responding in under five minutes guarantee an appointment?

No. The circulated benchmarks are not specific to Mexico or to health.

Are a CRM and an electronic record the same thing?

No. They manage different objects and purposes, although they can be integrated.

Can AI care for patients?

It can support administrative tasks; triage and clinical advice require controls and validation.

Do the data include public hospitals?

Only when they serve as context or literature; the focus is private healthcare.

Why are average costs by specialty not published?

The visible platforms do not form a representative and comparable national sample.

What should a practice measure first?

Requests, human response, contact, scheduling, confirmation, attendance and reason for loss.

How can Scalimed contribute?

Through primary research and anonymized benchmarks, identified as proprietary data.

SECTION 13 · APPENDIX L

SEO metadata

Positioning metadata for the report's digital publication.

SEO title	State of Patient Acquisition and Conversion in Mexico 2026 Scalimed
Meta description	Research on how private physicians and clinics in Mexico acquire, respond to, schedule, confirm and convert patients, with official data, scientific evidence and benchmark gaps.
Suggested URL	/reports/patient-acquisition-conversion-mexico-2026
H1	State of Patient Acquisition and Conversion in Private Healthcare in Mexico 2026
OG title	2026 Report: patient acquisition and conversion in Mexico
OG description	Data, evidence and metrics to understand the patient journey before the first consultation in Mexican private medicine.
Primary keywords	patient acquisition, patient conversion, private healthcare Mexico, medical CRM
Secondary keywords	medical WhatsApp, no-show, medical scheduling, clinical automation, AI in health
Intent	Informational, investigative and executive B2B
Canonical	https://scalimed.com/reports/patient-acquisition-conversion-mexico-2026
Robots	index, follow
Social image (OG image)	og-patient-acquisition-conversion-mexico-2026.jpg
Recommended schema	Report / Article (schema.org) with publisher Organization: Scalimed

SECTION 14

Complete lexicon

All operational terms of the Scalimed system, with a single consolidated entry per concept.

Request	Concrete expression of interest by which a person asks for information, availability or care and can be contacted.
Prospect	Identifiable person with the possibility of scheduling; not equivalent to a patient.
Effective contact	Two-way interaction between the practice and the person.
Scheduled appointment	Reservation of a specific slot on the calendar.
Confirmed appointment	Appointment ratified through an explicit action of attendance.
Attended appointment	Consultation that actually took place.
No-show	Non-attendance without cancellation within the defined rule.
Conversion	Measurable step from one journey state to the next, defined by numerator, denominator and time window.
Reactivation	Attributable return of a person who had left or remained inactive in the journey.
CRM	System to manage relationships, requests, states and communications.
Electronic health record	Electronic clinical information centered on the patient.
Benchmark	Comparable reference with identified definition, population and methodology.
Inference	Reasoned conclusion that goes beyond a direct data point.
Consensus	Degree of agreement among independent sources.
Confidence	Methodological certainty assigned to the finding.
Demand	Potential interest in care not yet expressed as a request.
Contact	First effective exchange between the practice and the person.
Qualified request	Request that meets clinical and operational eligibility criteria.
Friction	Potential loss of demand or degraded experience at the boundary between two stages.

Pre-consultation	Segment of the journey prior to the attended appointment.
Follow-up	Later contact aimed at sustaining or resuming the journey.
Traceability	Ability to preserve identity, state, owner and history of each contact.
Continuity	Maintenance of the clinical relationship after care.
Recurrence	Patient's return upon a new need or appointment.
Commercial maturity	Organizational capability to manage the journey, measure its frictions and improve the system.

SECTION 15

Complete bibliography

Complete references cited in the report and the annex.

Instituto Nacional de Estadística y Geografía. (2025). Estadísticas de Salud en Establecimientos Particulares 2024. inegi.org.mx

Instituto Nacional de Estadística y Geografía. (2025). Encuesta Nacional sobre Disponibilidad y Uso de Tecnologías de la Información en los Hogares 2024. inegi.org.mx

Instituto Nacional de Estadística y Geografía. (2026). Encuesta Nacional sobre Disponibilidad y Uso de Tecnologías de la Información en los Hogares 2025. inegi.org.mx

Secretaría de Economía. (2026). Data México: Médicos especialistas. economia.gob.mx

Organisation for Economic Co-operation and Development. (2025). Health at a Glance 2025. OECD Publishing. oecd.org

Dirección General de Información en Salud. (2025). Catálogo de Clave Única de Establecimientos de Salud (CLUES). dgis.salud.gob.mx

Gurol-Urganci, I., de Jongh, T., Vodopivec-Jamsek, V., Atun, R., & Car, J. (2013). Mobile phone messaging reminders for attendance at healthcare appointments. Cochrane Database of Systematic Reviews, (12), CD007458. doi.org/10.1002/14651858.CD007458.pub3

Huang, Y., & Hanauer, D. A. (2014). Patient no-show predictive model development using multiple data sources for an effective overbooking approach. Applied Clinical Informatics, 5(3), 836–860. doi.org/10.4338/ACI-2014-04-RA-0026

World Health Organization. (2021). Ethics and governance of artificial intelligence for health. who.int

World Health Organization. (2023). Regulatory considerations on artificial intelligence for health. who.int

- World Health Organization. (2024). Ethics and governance of artificial intelligence for health: Guidance on large multi-modal models. [who.int](https://www.who.int)
- Page, M. J., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, 372, n71. doi.org/10.1136/bmj.n71
- Critical Appraisal Skills Programme. (2024). CASP checklists. casp-uk.net
- Guyatt, G. H., et al. (2008). GRADE: An emerging consensus on rating quality of evidence and strength of recommendations. *BMJ*, 336, 924–926. doi.org/10.1136/bmj.39489.470347.AD
- Secretaría de Salud. (2012). Norma Oficial Mexicana NOM-004-SSA3-2012, del expediente clínico. dof.gob.mx
- Secretaría de Salud. (2012). Norma Oficial Mexicana NOM-024-SSA3-2012, sistemas de información de registro electrónico para la salud.
- Cámara de Diputados del H. Congreso de la Unión. (2025). Ley Federal de Protección de Datos Personales en Posesión de los Particulares. diputados.gob.mx
- Statista. (2025). Healthcare Professionals in Mexico [reporte secundario adjunto].
- Statista Market Insights. (2025). Online Doctor Consultations: Market Data & Analysis [modelo de mercado adjunto].

SECTION 16

Errors, gaps and unresolved limitations

What this report cannot claim and the limitations the next edition must resolve.

- The report does not constitute a census of private practices or a registered systematic review.
- There was no access to internal microdata from platforms, clinics or CRMs to validate conversions.
- Hospital data do not automatically represent the ambulatory market.
- Physician sources use incompatible definitions and must not be added.
- Searches may miss literature behind paywalls or not indexed.
- No-show evidence has a hospital and international bias.
- CRM and AI evidence has a commercial and survivorship bias.
- Causality between response speed and attended appointment was not estimated.
- National averages of prices, costs or conversion were not computed.
- Regulatory observations are informational and do not replace legal advice.