SCALIMED INSIGHTS

ANNUAL RESEARCH SERIES · PRIVATE HEALTHCARE IN MEXICO

State of Patient Acquisition and Conversion in Private Healthcare in Mexico 2026

How specialist physicians and private clinics are acquiring, responding to, following up, scheduling and converting.

FOUNDING EDITION · VOLUME I

July 2026 · Editor and sponsor: Scalimed

Report prepared based on public sources, scientific literature and market analysis.

CREDITS AND EDITORIAL DATA

Scalimed Insights 2026

PUBLICATION

State of Patient Acquisition and Conversion in Private Healthcare in Mexico 2026. Founding Edition · Volume I · July 2026.

EDITOR AND SPONSOR

Scalimed · Scalimed Digital Health LLC.

NATURE

Report prepared based on public sources, peer-reviewed scientific literature and market analysis. It explicitly distinguishes between proven facts, estimates, inferences and hypotheses.

SERIES

Scalimed Insights is Scalimed's annual research series on patient acquisition and conversion in private healthcare in Mexico. This Founding Edition inaugurates the series and sets the methodological framework, the definitions and the measurement architecture on which the following editions will be built.

DOCUMENTS

This publication is accompanied by the Methodological Annex and Auditable Base, which preserves the master data table, the source and evidence matrices, and the complete technical material.

EDITOR'S LETTER

A journey problem, not a scarcity problem

Mexican private medicine operates in a paradoxical environment. The population is intensely connected, information search and digital messaging are part of everyday life, and patients can compare alternatives in minutes. Yet public information on the sector remains concentrated on human resources, establishments, beds, discharges and spending. There is far less visibility into what happens between the first search and the appointment actually attended. This report examines that operational space. It does not start from the premise that every practice needs more advertising, nor that technology replaces clinical judgment. It starts from a more basic question: what happens to the demand that already exists when a person calls, writes, fills out a form, requests a price, asks about availability, tries to reschedule or leaves a conversation unfinished? The research explicitly distinguishes between proven facts, estimates, inferences, hypotheses and recommendations. Scalimed appears as editor and sponsor; external figures correspond to the cited sources. When there is no sufficiently robust public evidence to establish a Mexican benchmark, the gap is presented as a finding and is not filled in with commercial figures or international extrapolations.

CONTENTS

Contents

HOW TO READ THIS REPORT

How to read this report

This report is organized as a three-layer architecture —Journey, Frictions and Capabilities— read in sequence.

LAYER 1	LAYER 2	LAYER 3
Journey	**Frictions**	**Capabilities**
Eight stages, from discovery to post-care continuity.	Six pre-consultation boundaries where demand is lost.	The operational maturity that sustains the journey.

- Demand does not convert on its own. In private healthcare, competitive advantage arises from the ability to sustain it from the first search to care.
- Between the first search and the attended appointment, part of the demand is lost to pre-consultation frictions that available public evidence does not measure comprehensively and systematically. The advantage does not depend solely on generating more demand or adding more technology, but on developing the operational maturity needed to manage the complete patient journey.
- The report's architecture: Journey → Frictions → Capabilities
- Scalimed Map of the Patient Journey. It reappears in miniature at the start of each Part.
- How each chapter is built
- — Guiding question: each chapter opens with the question it answers and closes with «What this sets up», which links to the next.
- — Confidence seals: they indicate nature, origin, confidence level, scope and limitation; they follow the A/B/C/D classification of the methodology.
- — «What this means» boxes: they translate an exhibit or a dense block into a decision, a risk or a capability.

CORE THESIS

Demand does not convert on its own. In private healthcare, competitive advantage arises from the ability to sustain it from the first search to care.

Between the first search and the attended appointment, part of the demand is lost to pre-consultation frictions that available public evidence does not measure comprehensively and systematically. The advantage does not depend solely on generating more demand or adding more technology, but on developing the operational maturity needed to manage the complete patient journey.

EXECUTIVE SUMMARY · 1 OF 5 — THESIS AND CORE FIGURES

Demand exists. The capacity to sustain it does not always.

CORE THESIS

Demand does not convert on its own. In private healthcare, competitive advantage arises from the ability to sustain it from the first search to care.

2,747
private establishments with hospital services (INEGI, 2024); 35,400 beds and 2.27 million discharges.

119K
people employed as medical specialists (Data México/ENOE, Q1 2026).

86.1%
of people aged 6+ used the internet: 104.9 million (ENDUTIH 2025).

The Mexican private medical market is broad, heterogeneous and hard to summarize in a single figure. Records of licenses, employed population, practicing physicians, certified specialists, economic units and health establishments measure different universes. This difference is not a technical detail: it determines whether a figure describes potential capacity, effective employment, clinical practice or infrastructure.

Official evidence quantifies the hospital component better than the ambulatory one. INEGI reported 2,747 private establishments that provided hospital services in 2024, with 35,400 census beds and 2.27 million discharges. These data do not represent the complete universe of clinics, ambulatory practices, medical groups or independent practices. Data México, based on ENOE, estimated 119,000 people employed as medical specialists in the first quarter of 2026; it is a labor indicator, not a census of certified specialists or private physicians.

EXECUTIVE SUMMARY · 2 OF 5 — ARCHITECTURE OF THE PROBLEM

Journey, Frictions and Capabilities

The population's digital infrastructure is no longer the main structural constraint. ENDUTIH 2025 reported that 86.1% of people aged six or older used the internet, equivalent to 104.9 million people, with a still-relevant urban-rural gap. Instant messaging is a mass behavior, but there is no robust national evidence to state what percentage of private doctor-patient relationships begin through WhatsApp, Google, directories, social networks or referral.

LAYER 1 · JOURNEY	LAYER 2 · FRICTIONS	LAYER 3 · CAPABILITIES
Eight stages	**Six boundaries**	**Operational maturity**
From discovery to post-care continuity; hybrid and non-linear.	Pre-consultation points where demand is lost before the appointment.	Definitions, speed, follow-up, traceability and governance.

The patient journey is hybrid and non-linear. A referral can trigger a Google search; reviews can validate trust; a conversation can start on WhatsApp and end by phone; an appointment can be rescheduled from another channel. Last-click attribution and fragmented systems hide this sequence. To measure it, a practice must record concrete events: request, acknowledgment, human response, effective contact, qualification, scheduled appointment, confirmation, attendance, treatment, recurrence, reactivation and reason for loss.

EXECUTIVE SUMMARY · 3 OF 5 — TWELVE KEY FINDINGS (1–6)

Twelve key findings

01

Market size depends on the unit observed.

Licenses, employment, practice, certification and establishments are not equivalent.

Level A | Strong consensus | Confidence High

02

The private hospital component is better measured than the ambulatory one.

ESEP offers national coverage of private hospitals; there is no equivalent for the outpatient-clinic funnel.

Level B | Strong consensus | Confidence High

03

Digital connectivity is broad, but territorial and age gaps persist.

ENDUTIH 2025: 86.1% internet use; the figure does not prove digital-health use.

Level B | Strong consensus | Confidence High

04

The patient journey is multichannel and non-linear.

Evidence on digital experience and access agrees that discovery, validation, contact and scheduling can occur in different channels.

Level C | Moderate consensus | Confidence Medium

05

The Mexican private pre-consultation funnel is statistically invisible.

There are no comparable public national benchmarks for response, contact, scheduling and conversion.

Level C | Strong consensus on the gap | Confidence High

06

Response-speed benchmarks are usually transferred without external validity.

Most come from general sales, software or non-healthcare samples.

Level D | Moderate consensus | Confidence High

EXECUTIVE SUMMARY · 4 OF 5 — TWELVE KEY FINDINGS (7–12)

07

Reminders reduce no-shows compared with no reminder.

Systematic reviews and trials support mobile messaging, although the effect varies.

Level A | Strong consensus | Confidence High

08

There is no single universal intervention against no-shows.

Causes, populations, specialties and costs differ; adapted combinations are required.

Level A/B | Strong consensus | Confidence High

09

WhatsApp is a channel; CRM, scheduling and the health record are distinct systems.

Each system manages different objects, risks and purposes.

Level C | Strong conceptual consensus | Confidence High

10

Administrative AI has a more prudent basis for adoption than clinical autonomy.

The WHO recommends governance, oversight and evaluation for generative models in health.

Level C | Moderate consensus | Confidence Medium

11

The main barrier is not only technological, but one of processes and data.

Without definitions, owners and data quality, automation reproduces fragmentation.

Level C | Moderate consensus | Confidence Medium-high

12

The next sector asset will be a transparent, homegrown Mexican benchmark.

The absence of comparable data opens an opportunity for primary research.

Level D | Insufficient evidence; strategic hypothesis | Confidence Medium

EXECUTIVE SUMMARY · 5 OF 5 — GAPS AND IMPLICATIONS

Evidence gaps and implications

No sufficiently robust public evidence was found to establish a national Mexican benchmark for response time, contact rate, scheduling rate, request-to-appointment conversion, cost per attended appointment, CRM penetration, reactivation or patient lifetime value in the private ambulatory sector. The percentages circulating in marketing usually come from B2B sales, software vendors or non-comparable private samples. Repeating them does not turn them into Mexican evidence.

International literature does offer useful evidence on mechanisms. Systematic reviews show that mobile-phone reminders improve attendance compared with no reminder, although the magnitude varies by population, channel, design and service. Evidence on deposits, overbooking, waitlists and no-show prediction is more heterogeneous and context-dependent. The robust recommendation is not a universal tactic, but a combined system of confirmation, easy rescheduling, risk-adapted reminders and cause measurement.

WhatsApp can function as contact infrastructure, but it does not replace a CRM or a clinical record. A messaging channel resolves communication; a CRM manages states, owners, follow-up and attribution; a record concentrates clinical information. Integrating them can improve continuity, but mixing them without controls increases risks of privacy, duplication and improper access.

Artificial intelligence has a more defensible adoption path in delimited administrative tasks than in clinical autonomy. Request classification, conversation summarization, data extraction, draft generation, prioritization, reminders, rescheduling and call analysis are plausible uses when there is human oversight, traceability, access limits and escalation protocols. Evidence of specific economic returns in Mexican private clinics is still insufficient.

The strategic conclusion is sober: digital demand is growing faster than the public capacity to measure how it converts. Practices that define events, responsibilities and comparable metrics will be able to improve with greater discipline. For Scalimed, the most valuable institutional opportunity is to build Mexican primary evidence through mystery-shopper studies, patient and practice surveys, and anonymized CRM benchmarks by specialty, city and organization type.

> Digital demand is growing faster than the public capacity to measure how it converts.

The **Scalimed Map of the Patient Journey** develops this architecture on page **50**.

METHODOLOGY IN BRIEF

How this report was built

Structured desk review of official sources, scientific literature and market analysis.

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.
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.
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.

SCOPE AND LIMITATIONS

Scope and limitations

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.

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

PART I

The context: a large and poorly measured market

How much private medicine exists, how it is measured and how digital demand behaves today.

Every conversation about acquisition and conversion begins with a question that seems trivial and is not: how big is the market? The answer depends entirely on what one decides to count. Professional licenses, employed population, practicing physicians, certified specialists, economic units and hospital establishments measure different universes, and adding them produces inflated, meaningless figures. This part sets the ground on which the rest of the report rests. First it delimits the real size of the market and its composition, distinguishing potential capacity, effective employment, clinical practice and infrastructure. Then it describes how demand behaves in an intensely connected population, where search, validation and first contact rarely occur in a single channel or in a straight line. The goal is not to add more data, but to order what exists and pinpoint, precisely, where public evidence allows a claim and where it does not yet. Without that framing, any subsequent recommendation would rest on a mistaken basis.

WHAT THIS PART RESOLVES

1. Market size depends on what one decides to count
2. The patient journey is hybrid and non-linear

PART I · CHAPTER 1

Market size depends on what one decides to count

THIS CHAPTER'S QUESTION

How big is the private market and what are we really counting when we measure it?

Mexican private medicine is not a homogeneous block. It includes physicians who practice on their own, offices attached to pharmacies, specialized clinics, diagnostic centers, low-capacity hospitals, hospital groups and networks of physicians with shared infrastructure. A single professional may combine public employment, private practice and academic activity, so the public-private separation cannot be inferred from employment alone. Data México, based on ENOE, estimated 119,000 people employed as medical specialists during the first quarter of 2026, with an average age of around 41.8 years. The indicator describes labor employment under a statistical classification; it is not equivalent to certified specialists, valid licenses or physicians with a private office. OECD, for its part, reports practicing physicians and professional categories under international definitions. The figures are useful, but they answer different questions. The private hospital component is more clearly measured. INEGI recorded 2,747 private establishments that provided hospital services during 2024, 35,400 census beds and 2,273,261 discharges. These establishments do not represent all offices or all health economic units. DENUE records economic units; CLUES records system establishments; ESEP observes private hospital establishments. Adding them would produce double counting.

EXHIBIT 1

The Five Lenses of the Market — The real composition of the Mexican private medical market

Indicator	Value	Data year	Detalle
Employed medical specialists	119,000 people	Q1 2026	
Geography: Mexico · **Nature:** Observed/estimated ENOE · **Limitation:** Not certification nor private sector.			
Private hospital establishments	2,747	2024	
Geography: Mexico · **Nature:** INEGI statistical registry · **Limitation:** Does not cover all outpatient care.			
Private census beds	35,400	2024	
Geography: Mexico · **Nature:** INEGI statistical registry · **Limitation:** Hospital capacity.			
Private hospital discharges	2,273,261	2024	
Geography: Mexico · **Nature:** INEGI statistical registry · **Limitation:** Does not measure requests or consultations.			
Internet use	86.1% / 104.9 million	2025	
Geography: Mexico, population 6+ · **Nature:** National survey · **Limitation:** Not equivalent to digital medical use.			
Urban/rural internet use	88.9% / 75.2%	2025	
Geography: Mexico · **Nature:** National survey · **Limitation:** Territorial gap.			

Reading — Five universes (license, employment, practice, certification and infrastructure) measure different things and must not be added.

The error this chapter avoids

Adding licenses, employment, practice, certification and establishments produces an inflated, meaningless number. The useful question is not how many physicians there are, but how much clinical capacity is actually available for new private demand.

WHAT THIS SETS UP With the real market size defined, the next question is how demand behaves today: where the patient comes in.

PART I · CHAPTER 2

The patient journey is hybrid and non-linear

THIS CHAPTER'S QUESTION

Where and how does the patient reach a consultation today?

The patient journey is neither exclusively digital nor linear. A person may identify a symptom, ask for a referral, search for the physician's name, check reviews, compare location and availability, write on WhatsApp, call later and end up scheduling with another practice. In that process, discovery, validation, contact and scheduling may belong to different channels. Broad connectivity makes this behavior possible, but does not quantify it on its own. ENDUTIH 2025 reported 86.1% internet use among people aged six or older. For urban private medicine, the digital base is extensive; even so, it cannot be inferred that the patient always prefers a digital channel, trusts a remote consultation or that online search replaces personal referral. The system must distinguish discovery source, first-contact channel and closing channel. The practice that only records "WhatsApp" loses the difference between a patient who arrived by referral and wrote on WhatsApp, another who arrived via Google Maps and another who responded to a campaign. Last-contact attribution underestimates the role of reputation, referrals and search.

EXHIBIT 2

The patient journey, stage by stage

Stage	Question	Observable events
Discovery	How did they learn the practice existed?	Referral, Google, Maps, directory, social network, hospital, insurer.
Validation	What did they check before contacting?	Reviews, profile, credentials, content, location, price, availability.
Contact	Through which channel did they seek care?	WhatsApp, call, form, chat, email, scheduling.
Resolution	What did they need to obtain?	Availability, administrative guidance, cost, eligibility, coverage.
Scheduling	How did they book?	Front desk, link, self-service, transfer.
Attendance	What happened with the appointment?	Confirmed, attended, canceled, rescheduled, no-show.
Continuity	What happened afterward?	Treatment, procedure, follow-up, recurrence, reactivation.

Reading — Discovery, contact and closing can occur in different channels; recording them separately is the basis of all measurement.

CHAPTER SYNTHESIS

Implication for measurement

Recording only «WhatsApp» erases the difference between someone who arrived by referral, via Google Maps or through a campaign.

> ***The system must separate discovery source, first-contact channel and closing channel.***

Last-click attribution underestimates reputation and referral.

WHAT THIS SETS UP If the journey is hybrid, it helps to see where demand starts to be lost; the next chapter opens the leaks.

PART II

The patient journey and its leaks

Where demand is lost between the first search and the attended appointment.

Between the moment a person identifies a need and the moment they take a slot on the calendar, there is a sequence of events where demand filters out. This part traces that sequence point by point: how demand is generated and why the most visible channel is not always the one that builds trust; what happens when the response arrives late or resolves little; how a conversation becomes —or does not become— an appointment; what distinguishes good follow-up from commercial pressure; and why no-shows are, above all, a system-design problem. Each leak has its own mechanism and, therefore, a different intervention. Treating them as a single problem —\"few patients arrive\"— makes it impossible to diagnose where the loss really is. The common thread is the separation of events: discovery, contact, qualification, scheduling, confirmation and attendance are not the same, and confusing them allows favorable metrics to be reported while capacity is lost. International evidence illuminates the mechanisms; the absence of Mexican benchmarks makes it necessary to measure one's own distribution before comparing.

WHAT THIS PART RESOLVES

1. The most visible channel is not the one that builds trust
2. Speed without resolution does not convert
3. A high conversion can hide lost capacity

PART II · CHAPTER 1

The most visible channel is not the one that builds trust

THIS CHAPTER'S QUESTION

Which channel generates demand and which builds the trust that converts it?

Demand can originate from personal or medical referral, organic search, maps, directories, advertising, content, insurers, hospitals, partnerships and former patients. No comparable Mexican public evidence was found to rank these channels by effectiveness across private specialties. Platforms usually publish internal metrics without sufficient methodology to represent the market. The most visible channel is not necessarily the one that builds trust. A referral may start the journey and Google serve to validate. A campaign may generate first exposure, while reviews and availability determine the decision. That is why the analysis must separate acquisition, attendance and revenue. Cost per request without contact rate and attended appointment may reward low-quality volume. Comparison by specialty requires caution. Fertility, plastic surgery, bariatrics and specialized dentistry tend to have long cycles, a high comparison component and greater value per procedure. Pediatrics, psychiatry and chronic care have more recurrence. Oncology and emergencies should not be treated as standard commercial acquisition, because navigation, appropriateness and clinical coordination dominate the decision.

What to watch

Cost per request, without contact rate or attended appointment, rewards low-quality volume. Before comparing channels it helps to separate acquisition, attendance and revenue, and to treat oncology and emergencies outside the logic of commercial acquisition.

WHAT THIS SETS UP With the trust-building channel recognized, what remains is to measure what happens when the response arrives late.

PART II · CHAPTER 2

Speed without resolution does not convert

THIS CHAPTER'S QUESTION

What matters more in the response: speed or resolution?

Response speed matters because a request may be simultaneous: the person compares availability, price, location, reputation, coverage and treatment. However, commercial claims promising dramatic multipliers for responding within five minutes usually come from B2B sales, web forms or software vendors. It is not valid to turn them into a Mexican private-health rate. Correct measurement must distinguish automatic acknowledgment, first human response, first attempt, two-way contact and resolution. An instant response that only confirms receipt may be worth less than a later response that resolves availability and next steps. Speed without precision can also cause errors, false expectations or clinical risks. No sufficiently robust public evidence was found to establish a national Mexican benchmark for response time in private offices and clinics. The recommendation is to measure one's own distribution —median, 75th and 90th percentiles— by time slot, channel, specialty and owner, and then test operational changes.

EXHIBIT 3

The speed metrics that do matter

Metric	Recommended definition	Risk
Time to acknowledgment	Request to receipt confirmation.	May be automatic and not resolve.
Time to human response	Request to a person's intervention.	Must exclude bots and scheduled messages.
Time to effective contact	Request to two-way interaction.	Depends on the patient's availability.
Time to resolution	Request to scheduling, guidance, referral or closure.	Requires structured states.
After-hours coverage	Share of requests without immediate human attention.	Needed for shifts and automation.
Abandonment without response	Requests with no verifiable response.	Requires central logging and a closure criterion.

Reading — An automatic acknowledgment is not a response; measuring one's own distribution is worth more than an imported benchmark.

The distinction that changes the conversation

An instant acknowledgment is not equivalent to a response that resolves availability and next steps. Without a Mexican benchmark, the defensible action is to measure one's own distribution —median, 75th and 90th percentile— by time slot, channel, specialty and owner, before promising times.

WHAT THIS SETS UP With the response resolved, demand must convert into an appointment: that is where capacity is lost without being seen.

PART II · CHAPTER 3

A high conversion can hide lost capacity

THIS CHAPTER'S QUESTION

When does a good conversion actually hide a loss of capacity?

Converting a request into an appointment depends on clinical appropriateness, availability, location, price, coverage, reputation, clarity, ease of payment and trust. Persuasion is only one part. A mature practice records reasons for non-scheduling: ineligible, no availability, economic barrier, incompatible insurer, location, preference for another provider, no contact or deferred decision. The opportunity and appointment stages must not be mixed. A request may be qualified without having an appointment; an appointment may be scheduled without being confirmed; a confirmed appointment may be canceled or not attended. Without this separation, a clinic may report a high "conversion" and still lose capacity to no-shows.

EXHIBIT 4

The funnel leaks, from request to treatment

Stage	Numerator	Denominator	Interpretation
Contact rate	Requests with two-way interaction	Valid requests	Ability to establish a conversation.
Qualification rate	Eligible requests	Effective contacts	Clinical/operational relevance.
Scheduling rate	Scheduled appointments	Qualified requests	Ability to close a booking.
Confirmation rate	Confirmed appointments	Scheduled appointments	Explicit commitment.
Attendance rate	Attended appointments	Eligible scheduled appointments	Real use of capacity.
Conversion to treatment	Treatments started	Eligible attended consultations	Clinical and patient decision.

Reading — Each boundary (contact, qualification, scheduling, confirmation, attendance) is a leak measurable separately.

The hidden risk

Mixing opportunity and appointment allows reporting a high «conversion» while no-shows consume capacity. A qualified request is not an appointment; a scheduled appointment is not a confirmed one; a confirmed one may not be attended. Each boundary is measured separately.

WHAT THIS SETS UP If an attended appointment does not guarantee continuity, follow-up is the next boundary.

Scalimed Pre-consultation Friction Model

The journey from a request to an attended appointment crosses six pre-consultation boundaries; at each one demand can be lost. The model uses the same nomenclature as the Map and ends at the attended appointment (Attendance); the Attendance → Continuity or treatment transition is post-consultation continuity.

Boundary	Entry event	Exit event	Detalle
1 · Discovery → First contact	**Need detected / request**	First contact established	
Possible leak: Not contacted / unable to reach · **Indicator:** Generation and speed of first contact · **Capability required:** Presence, capture and rapid response			
2 · First contact → Response	**First contact**	Two-way interaction	
Possible leak: Acknowledgment without resolution · **Indicator:** Contact rate · **Capability required:** Response that resolves availability and next steps			
3 · Response → Qualification	**Conversation established**	Qualified request	
Possible leak: Incomplete data / no criteria · **Indicator:** Qualification rate · **Capability required:** Criteria and eligibility recording			
4 · Qualification → Scheduling	**Qualified request**	Appointment scheduled	
Possible leak: No booking offered or omitted · **Indicator:** Scheduling rate · **Capability required:** Booking close; visible availability			
5 · Scheduling → Confirmation	**Appointment scheduled**	Appointment confirmed	
Possible leak: No explicit commitment · **Indicator:** Confirmation rate · **Capability required:** Active confirmation; reminders			
6 · Confirmation → Attendance	**Appointment confirmed**	Appointment attended	
Possible leak: No-show / cancellation · **Indicator:** Attendance rate · **Capability required:** Easy rescheduling; staggered reminders			

Definition · Scalimed Lexicon Qualified request, scheduled appointment, confirmed appointment and attended appointment are distinct states, not synonyms.

Nature: conceptual measurement model · Origin: this chapter · Confidence: medium · Scope: national (mechanism) · Limitation: no public source was identified that measures these rates comprehensively and systematically.

PART II · CHAPTER 4

Follow-up adds when it helps decide, not when it pressures

> **THIS CHAPTER'S QUESTION**
> *What distinguishes follow-up that helps from follow-up that pressures?*

Not every request is ready to schedule in the first interaction. Some people compare options, wait for results, check with their insurer, coordinate with family or need to resolve a scheduling barrier. Follow-up must distinguish reasonable delay, lack of response, disinterest, ineligibility and incomplete request. No robust Mexican evidence was found to establish a universal number of follow-ups. Rigid sequences can be annoying or inappropriate, especially in sensitive health. The design must consider consent, channel, urgency, stage, content and exit mechanism. Automation is more defensible for administrative reminders and resuming conversations than for indiscriminate promotional insistence. Demand recovery must be measured as attributable return after a defined action, with a time window and an eligible population. Reactivating does not mean sending mass messages; it means identifying a legitimate pending need, having applicable legal basis and consent, offering a useful action and recording the outcome.

Design principle

There is no Mexican evidence of an optimal number of follow-ups. The robust rule is to adapt cadence, channel and content to the contact's state and its clinical sensitivity, with a clear exit mechanism. Reactivating is identifying a legitimate pending need, not sending mass messages.

WHAT THIS SETS UP From follow-up arises the question of attendance: why the patient confirms and does not show up.

PART II · CHAPTER 5

There is no single intervention against no-shows

THIS CHAPTER'S QUESTION

Why is a no-show a system problem and not a single-tactic one?

A no-show is not a single event. It can result from forgetting, cost, transport, resolved symptoms, fear, poor communication, waiting times, work conflict, dependent care, ease of booking without commitment or difficulty canceling. Rates vary by specialty, population, payment system and definition. The highest-quality evidence supports mobile-phone reminders versus no reminder. The Cochrane review by Gurol-Urganci and colleagues found that mobile messages improve attendance, although the evidence comes from diverse contexts and periods. Later studies on personalization, prediction and digital channels expand the options, but do not justify a single effect size for Mexico. The operational strategy must combine active confirmation, easy rescheduling, staggered reminders, waitlist, cause analysis and, when proportionate, deposits or cancellation policies. Overbooking can increase utilization, but also waiting times and poor experience; it requires risk models and limits.

EXHIBIT 5

What works against no-shows —and with what caveat

Intervention	Evidence	Applicability	Caveat
SMS/mobile reminders	Level A; improves attendance vs. no reminder.	High as a general mechanism.	Variable magnitude; international evidence.
Active confirmation	Level B/C.	High.	Must offer real rescheduling.
Deposits	Level C/D.	Contextual.	May create access barriers.
Waitlist	Level C.	High for in-demand calendars.	Requires rapid communication.
Overbooking	Level B/C.	Selective.	May raise waiting and saturation.
Risk prediction	Level B/C.	Emerging.	Bias, data quality and transparency.

Reading — The evidence supports a combined system, not a universal tactic.

What the evidence says —and does not say—

The highest-quality evidence supports that mobile reminders improve attendance versus no reminder, but does not set a single magnitude for Mexico. The answer is not an isolated tactic, but a system: active confirmation, easy rescheduling, staggered reminders and cause analysis.

WHAT THIS SETS UP With the main path closed, it is time for the infrastructure that sustains it; it starts with the most-used channel.

PART III

Channels, data and systems

The infrastructure that sustains the journey —and why confusing its pieces is the risk.

The patient journey rests on an infrastructure of channels and systems that, too often, are confused with one another. A messaging channel resolves communication; a CRM manages states, owners and attribution; a record concentrates clinical information. They are complementary pieces, not equivalents, and mixing them without controls is the most common source of operational and privacy risk. This part examines that infrastructure in layers. It analyzes WhatsApp as contact infrastructure and the conditions under which it stops being messaging and becomes traceability. It reviews the value —and the risks— of historical patient databases, where data quality and consent determine whether a campaign is an asset or a liability. It places the CRM not as a warehouse, but as the ability to produce organizational memory. And it situates artificial intelligence within a risk hierarchy, separating reversible administrative tasks from uses that touch the clinical realm. The principle running through the part is simple: the availability of a technology does not, on its own, resolve either compliance or accountability.

WHAT THIS PART RESOLVES

1. WhatsApp resolves communication, not traceability
2. A historical database is worth something only with quality and consent
3. A CRM without definitions is just another inbox

PART III · CHAPTER 1

WhatsApp resolves communication, not traceability

Infrastructure Taxonomy by Function Three layers that must not be confused: Communication (messaging), Traceability (CRM) and Clinical record (health record). A messaging channel resolves communication; a CRM manages states, owners and attribution; a health record concentrates clinical information. Confusing them is the most common source of operational and privacy risk.

THIS CHAPTER'S QUESTION

What does —and does not— using WhatsApp as infrastructure resolve?

Instant messaging is massive in Mexico, but general penetration is not equivalent to medical use. No sufficiently robust national figure was found on the percentage of private requests that arrive via WhatsApp. The channel is attractive for familiarity, asynchrony and multimedia capability; it also creates risks when it depends on personal numbers, single devices or unstructured conversations. A maturity in four levels can be described: individual use without logging; multi-user use with rules; integration with scheduling and CRM; and governed operation with automation, consent, audit and escalation. The value is not in “having WhatsApp”, but in preserving context, assigning owners, responding consistently and protecting data. Health data are sensitive personal data. The practice must limit the information requested before the consultation, avoid improvised diagnoses in administrative channels, control access, document purpose, review vendors and separate care messages from marketing. The technical availability of an API resolves neither compliance nor accountability.

The essential distinction

Being «on a single app» is not centralization. Without contact identity, history, owner, state and a link to scheduling, the practice has messaging, not traceability. And because health data are sensitive, having an API resolves neither compliance nor accountability.

WHAT THIS SETS UP If WhatsApp does not provide traceability, what role does the historical patient database play?

PART III · CHAPTER 2

A historical database is worth something only with quality and consent

THIS CHAPTER'S QUESTION

When is a patient database an asset and when a risk?

Historical databases may contain inactive patients, pending follow-ups, periodic reviews and unfinished treatments. Their value depends on quality, currency, consent, segmentation and clinical relevance. Duplicates, shared phones, incomplete records and obsolete states can turn a useful campaign into a risk. Reactivation must distinguish care continuity, preventive reminder, clinical follow-up and promotion. Each category has different purposes and sensitivities. The central metric is not messages sent, but eligible patients contacted, responses, attended appointments and outcomes, with complaint and opt-out rates.

Before launching a campaign

Duplicates, shared phones, incomplete records and obsolete states turn a useful database into a risk. The metric is not messages sent, but eligible patients contacted, responses, attended appointments and outcomes, with complaint and opt-out rates in plain view.

WHAT THIS SETS UP A valuable database needs a system that preserves state and context: the CRM.

PART III · CHAPTER 3

A CRM without definitions is just another inbox

THIS CHAPTER'S QUESTION

What turns a CRM into organizational memory and not just another inbox?

A CRM manages relationships, requests, owners, stages, communications and attribution. A calendar manages availability and bookings. An electronic health record manages care information. They can be integrated, but they are not equivalent. Confusing them produces incorrect expectations and access risks. Centralization makes it possible to answer basic questions: how many requests came in, which channel originated them, who responded, how long it took, what reason prevented scheduling, which appointments were attended and which patients returned. Without event definitions and capture discipline, the CRM becomes just another inbox. The main barriers are ambiguous processes, staff resistance, duplication, lack of integration, incomplete data, excessive permissions and activity-centered measurement. Implementation must begin with a data dictionary, owners, states, closure criteria and quality audits.

Why implementations fail

The CRM produces organizational memory only with defined fields, consistent capture and review routines. If recording a closure reason is harder than abandoning the contact unclassified, the data degrade and the dashboard shows vanity metrics. Start with a data dictionary, not with a tool.

WHAT THIS SETS UP With definitions and memory, the question arises of how far to delegate to AI.

PART III · CHAPTER 4

AI is adopted by risk layers, not by enthusiasm

THIS CHAPTER'S QUESTION

How is AI adopted without overexposing the relationship with the patient?

Artificial intelligence can support request classification, data extraction, summarization, drafts, prioritization, documentation, reminders, scheduling, rescheduling and call analysis. These uses are administrative and must have clear limits. The system must know when to escalate to a person, how to handle sensitive data and what actions it cannot perform. The WHO has warned about biases, hallucinations, opacity, privacy, security and uncritical automation in generative models applied to health. Evidence of commercial effectiveness in Mexican private offices is still limited. Vendor demonstrations do not replace comparative studies. Prudent adoption must follow a hierarchy: first repetitive and reversible tasks; then administrative decisions with oversight; lastly, only with robust governance, uses that could affect access, triage or clinical advice. Every output with health implications needs human review and emergency protocols.

EXHIBIT 6

AI Risk Ladder — Administrative AI, by risk layers

Use case	Risk	Minimum control	Confidence
Conversation summary	Medium	Human review, minimization and traceability.	Medium
Administrative classification	Medium	Closed categories and escalation.	Medium
Scheduling/rescheduling	Low-medium	Availability and confirmation rules.	Medium
Administrative voice agent	Medium	Disclosure, regulated recording, transfer.	Low-medium
Request prioritization	Medium-high	Bias audit and human review.	Low-medium
Clinical triage or advice	High	Clinical validation, governance and accountability.	Low

Reading — Risk, not enthusiasm, defines what is automated and with what minimum control.

How to adopt it without overexposure

The defensible sequence advances by risk layers: first repetitive and reversible tasks; then administrative actions with closed rules; and only with robust governance, uses that touch triage or clinical advice. Human oversight must specify who reviews, at what threshold it escalates and how the incident is recorded.

WHAT THIS SETS UP With infrastructure closed, the diagnosis forks: physician and clinic do not fail the same way.

PART IV

From diagnosis to action

What to measure, where the opportunities are and what to decide before buying technology.

A diagnosis is only valuable if it translates into decisions. This part turns the evidence from previous chapters into a concrete management system. It begins by recognizing that the independent physician and the clinic do not face the same failure points, and that their solutions differ accordingly. From there it proposes the operational scaffolding: a fourteen-stage funnel that orders the journey, a minimum set of indicators that makes it measurable without overloading capture, and an opportunity map that recognizes that acquisition does not work the same in every specialty. It then raises its gaze toward the trends that will define the 2026–2028 period and toward the seven decisions an organization should make before buying any tool. The underlying message is that sustainable competitive advantage will not come from adopting more technology, but from turning technology into organizational capability: common definitions, coverage, continuity, quality data and governance. Action, here, does not mean speed; it means discipline.

WHAT THIS PART RESOLVES

1. The physician and the clinic do not fail at the same points
2. Fourteen stages turn scattered conversations into information
3. The minimum indicators that make the journey measurable

PART IV · CHAPTER 1

The physician and the clinic do not fail at the same points

THIS CHAPTER'S QUESTION

How do the failure points of the independent physician and the clinic differ?

EXHIBIT 7

Physician–Clinic Matrix — Independent physician and clinic: two risk architectures

Dimension	Independent physician	Clinic
Volume	Lower; high dependence on the physician.	Higher; multiple professionals and services.
Staff	Limited or shared front desk.	Teams, shifts and specialization.
Handoffs	Few, but fragile.	More numerous; risk of losing context.
Technology	Limited budget and capacity.	More integration and greater complexity.
Decision	Centralized in the physician.	Distributed across management, administration and physicians.
Metrics	Can operate with a simple funnel.	Requires cohorts, sites, specialties and owners.
Risk	Dependence on one person/number.	Fragmentation, permissions and consistency.

Reading — The physician risks dependence on one person; the clinic, fragmentation among many.

The independent physician can improve with a minimum system: a central inbox, simple states, integrated scheduling and defined follow-up. The clinic additionally needs assignment, service levels, escalation, specialty rules, access control and analytics by site. Complexity does not justify capturing more data indiscriminately; it requires capturing the right events.

Two distinct problems

The independent physician risks dependence on one person or number, and improves with a well-run minimum system. The clinic risks fragmentation and permissions, and needs assignment, service levels, escalation and analytics by site. Complexity does not call for capturing more data, but for capturing the right events.

WHAT THIS SETS UP With both distinguished, a common language is needed to record the journey: the funnel.

PART IV · CHAPTER 2

Fourteen stages turn scattered conversations into information

THIS CHAPTER'S QUESTION

What funnel allows recording the journey in a comparable way?

EXHIBIT 8

The recommended commercial funnel: fourteen stages

Stage	Definition
1. Exposure	The person sees a referral, ad or digital presence.
2. Visit	Accesses a profile, site, map or directory.
3. Request	Asks for information, availability or care.
4. Conversation started	There is an identifiable thread or call.
5. Effective contact	Two-way interaction.
6. Qualified request	Meets clinical and operational-administrative criteria.
7. Appointment scheduled	Confirmed reservation on the calendar.
8. Appointment confirmed	Active ratification.
9. Appointment attended	Consultation carried out.
10. Patient converted	A defined care relationship begins.
11. Treatment/procedure	Eligible plan is executed.
12. Recurrence	Expected return or follow-up.
13. Reactivation	Return after inactivity and an attributable action.
14. Accumulated value	Revenue or care value accrued under a definition.

Reading — Each rate must declare numerator, denominator, time window and exclusions.

Each rate must declare numerator, denominator, time window, exclusions and unit of analysis. One person may generate several requests and several appointments; mixing people with events distorts conversion. For financial analysis, billing, collections and margin must be separated.

WHAT THIS SETS UP With the funnel defined, which minimum indicators make it measurable without overloading?

PART IV · CHAPTER 3

The minimum indicators that make the journey measurable

THIS CHAPTER'S QUESTION

What is the minimum set of indicators that makes the journey measurable?

EXHIBIT 9

The minimum indicators of a practice

Indicator	Minimum definition
Valid requests	Number of requests excluding tests, spam and duplicates.
Time to first human response	Median and percentiles by time slot/channel.
Contact rate	Effective contacts / valid requests.
Qualification rate	Eligible requests / contacts.
Scheduling rate	Scheduled appointments / qualified requests.
Confirmation rate	Confirmed appointments / scheduled appointments.
Attendance rate	Attended appointments / eligible scheduled appointments.
No-show	No-shows without cancellation / eligible scheduled appointments.
Cancellation	Cancellations / scheduled appointments.
Rescheduling	Rescheduled appointments / scheduled appointments.
Conversion to treatment	Treatments / eligible consultations.
Reactivation	Attributable returns / eligible contacted patients.
Cost per attended appointment	Attributable spend / attributable attended appointments.
Value per patient	Revenue or margin per patient in a defined window.
Capacity utilization	Time attended / available clinical time.

Reading — A small, well-defined core makes the journey measurable without overloading capture.

WHAT THIS SETS UP With the indicators defined, it helps to delimit what the evidence allows one to claim today.

PART IV · CHAPTER 4

What public evidence allows one to claim —and what it does not yet

THIS CHAPTER'S QUESTION

What does public evidence allow one to claim and what remains unmeasured?

EXHIBIT 10

What we know and what we still do not know

There is no national public benchmark in Mexico for response time, request-to-appointment conversion, CRM penetration or reactivation. Official evidence covers supply, infrastructure and connectivity; the pre-consultation funnel remains statistically invisible.

There is reasonable public evidence for professional supply, hospital infrastructure, connectivity, regulations and some reminder mechanisms. No sufficiently robust public evidence was found to establish the following Mexican benchmarks:

- First-response time in private ambulatory medicine.
- Contact, qualification and scheduling rates.
- Conversion from scheduled appointment to attended appointment by specialty.
- Comparable national private no-show by specialty.
- Cost per request, attended appointment and patient.
- Comparable share of Google, Maps, social networks, directories, WhatsApp and referrals.
- CRM and automation penetration in offices.
- Reactivation rate and incremental value.
- Patient lifetime value by specialty.
- Causal impact of automation or AI on conversion.

WHAT THIS SETS UP With the limit of the evidence recognized, acquisition is specified by specialty.

PART IV · CHAPTER 5

Acquisition does not work the same in every specialty

THIS CHAPTER'S QUESTION

Why does acquisition not work the same in every specialty?

EXHIBIT 11

Opportunities by specialty

Specialty	Decision complexity	Recurrence	Procedures	Note
Gynecology	Medium-high	High	High	Reputation, continuity and sensitive episodes.
Trauma and orthopedics	High	Medium	High	Pain, imaging, rehabilitation and surgery.
Ophthalmology	High	Medium	High	Schedulable procedures and reputation.
Fertility	Very high	High	High	Long cycle, high value and emotional load.
Plastic and aesthetic surgery	Very high	Medium	Very high	Intense comparison and prolonged follow-up.
Bariatrics	Very high	High	Very high	Multidisciplinary process.
Cardiology	High	High	Medium-high	Variable urgency and continuity.
Pediatrics	Medium	Very high	Low-medium	Recurrence and role of referral.
Psychiatry/psychology	High	Very high	Low	Privacy and continuity.
Specialized dentistry	High	High	Very high	Should be analyzed separately from medicine.
Oncology	Very high	Very high	Very high	Clinical navigation; not standard acquisition.

Reading — Decision complexity, recurrence and procedure weight change the equation in each specialty.

WHAT THIS SETS UP From specialties to the view of the future: which trends will define 2026–2028.

PART IV · CHAPTER 6

Toward 2028, the advantage will be organizational before technological

THIS CHAPTER'S QUESTION

What will define competitive advantage toward 2028?

EXHIBIT 12

Toward 2028: trends by impact and confidence

Trend	Type	Impact	Confidence	Description
Hybrid human-AI front desk	Projection	High	Medium	AI for repetitive tasks; humans for exceptions.
Conversational scheduling	Projection	High	Medium	Booking and rescheduling within the channel.
No-show prediction	Trend	Medium	Medium	Risk to target reminders and lists.
Omnichannel centralization	Trend	High	Medium-high	Conversations and states in a single view.
Traceability to attended appointment	Trend	High	Medium-high	Pressure to link spend with real care.
Sensitive-data governance	Trend	High	High	Permissions, audit, minimization and vendors.
AI-mediated search	Scenario	Medium-high	Medium	Changes in discovery and reputation.
Voice agents	Projection	Medium	Low-medium	Coverage of repetitive calls with transfer.
Event-based interoperability	Trend	Medium	Medium	CRM, scheduling and record share states.
Homegrown benchmarks	Hypothesis	High	Medium	Networks and platforms publish aggregates by specialty.

Reading — The highest-impact trends are organizational and governance-related, not product-related.

WHAT THIS SETS UP With the trends seen, the journey reads as a system of interdependent events.

PART IV · CHAPTER 7

The journey is a chain of events with feedback

THIS CHAPTER'S QUESTION

How do the journey stages connect as a system?

The system can be represented as a chain of events with feedback loops. Demand activates search and referral; search leads to validation; the contact channel and availability influence the conversation; time, quality and resolution determine contact and scheduling; confirmation and ease of rescheduling affect attendance; experience and outcome influence recurrence, reputation and new demand. Data quality, process, staff, price, capacity and regulation run through the entire chain.

EXHIBIT 13

The patient journey as a system of events

Node	Main relationships	Bottleneck	Data needed
Demand	Need, referral, campaigns, recurrence.	Non-relevant demand.	Reason and source.
Search/ validation	Google, Maps, reviews, directories, referrals.	Inconsistent information.	Discovery source.
Contact	WhatsApp, call, form, scheduling.	Fragmented channels.	Channel and timestamp.
Response	Acknowledgment, human, resolution.	Delay or empty response.	Timing and content.
Follow-up	Sequence and maturation.	Absence or pushiness.	Attempts and outcome.
Scheduling	Availability and booking.	Friction or no slots.	Supply and choice.
Confirmation	Commitment and rescheduling.	Forgetting or barrier.	State and cause.
Attendance	Consultation carried out.	No-show/cancellation.	Appointment outcome.
Treatment	Plan and execution.	Drop-off.	Eligibility and start.
Recurrence	Follow-up and return.	Loss of continuity.	Window and reason.
Reactivation	Return after action.	Outdated database.	Eligible and response.
Value	Revenue, margin, health and reputation.	Partial measurement.	Cohort and period.

Reading — Each node has a bottleneck and a data point that makes it visible.

WHAT THIS SETS UP With the system understood, what remains are the decisions prior to any technology purchase.

PART IV · CHAPTER 8

Seven decisions before buying technology

THIS CHAPTER'S QUESTION

What should an organization decide before buying technology?

1. Define events before buying technology. Without definitions, platforms produce activity without learning.
2. Measure speed together with resolution and quality. An automatic response is not equivalent to a solution.
3. Separate channel, system and purpose. WhatsApp, CRM, scheduling and record are not substitutes.
4. Build data governance as an operational capability, not as a legal appendix.
5. Adopt AI by risk: reversible and administrative tasks first; clinical uses only with robust controls.
6. Compare by specialty and practice type, not with universal averages.
7. Publish your own evidence with methodology, anonymization and stable definitions.

WHAT THIS SETS UP From the decisions to the synthesis: what all this implies for the sector.

SYNTHESIS

Conclusions

The architecture, in one sentence Journey → Frictions → Capabilities: the Map shows where the journey happens, the Friction Model where it can break, and the Scorecard how prepared the organization is to manage it.

Mexican private healthcare already operates within an intensely connected society, but measurement of the patient journey lags behind. Official statistics allow knowing professionals, establishments, beds, discharges and connectivity; they do not allow knowing precisely how many requests are lost before the consultation or why. The available evidence does not justify absolute headlines about percentages of lost patients, universal response times or national conversion rates. The institutional value of this report lies in distinguishing the proven from the inferred and in turning the absence of data into a research agenda. The recommended minimum standard is to record source, request, owner, response, contact, qualification, scheduling, confirmation, attendance, reason for loss, treatment, recurrence and reactivation. This sequence turns scattered conversations into operational information. The next frontier of knowledge must be Mexican primary research. An annual program of mystery shopping, surveys and anonymized data can establish real benchmarks by specialty, city and practice type. That evidence would have greater value for the sector than repeating international figures without comparability.

PART V

Strategic perspectives

Systemic relationships, contradictory evidence and the pending research agenda.

The previous parts describe the journey and its leaks. This one delves into the relationships that connect them and into the evidence that contradicts simplistic readings. It is the report's analytical engine room, aimed at the operator who wants to understand the complete system before intervening in it. Here it examines why a large market does not imply available capacity; why response speed is a plausible but unquantified mechanism; why no-shows are a design problem more than a patient's responsibility; and why full automation clashes with exceptions that require human judgment. The section also introduces two instruments that elevate the report from the descriptive to the institutional: a five-level operational maturity model and an annual primary-research agenda. It does not repeat the previous chapters: it stresses them, deliberately seeking the negative results and the omitted relationships that a commercial narrative would tend to ignore. Its editorial function is explicit: whoever only needs conclusions can stop earlier; whoever must defend investment or operational decisions will find here the reasoning that supports them.

WHAT THIS PART RESOLVES

1. What systemic relationships connect the journey layers?
2. What instruments allow assessing and improving operational maturity?
3. What research agenda underpins the future benchmark?

PART V · SYSTEMIC RELATIONSHIPS

Systemic relationships of the journey

1. From market size to actually available capacity

The existence of a large number of physicians, offices or establishments does not imply that all that capacity is available for new private demand. Effective capacity depends on consultation hours, public-private mix, vacations, administrative time, operating rooms, support staff, insurer restrictions and the physician's own decision to grow. Two practices with the same number of professionals may have completely different commercial capacities. Therefore, a useful market estimate must separate theoretical capacity, published capacity, bookable capacity and attended capacity.

The most useful operational unit is not the number of physicians, but the number of eligible clinical slots per period and the proportion that remains unused. A clinic may have abundant demand and, at the same time, idle capacity if the schedule does not correctly distribute time slots, sites or specialties. It may also have high apparent occupancy through overbooking and generate waiting times that degrade the experience. The utilization indicator must combine available schedule, blocked time, scheduled appointments, attended appointments and actual duration.

The evidence that contradicts a purely expansionary reading of the market is important: a practice may not need more requests. It may need better selection, fewer no-shows, a clearer scheduling policy or a different set of time slots. Acquisition ceases to be the bottleneck when clinical capacity, coordination or later follow-up is the dominant constraint.

2. Patient behavior: convenience, trust and perceived risk

Digitalization does not eliminate the information asymmetry inherent to health. The patient can compare profiles, reviews and availability, but still finds it difficult to assess clinical quality before receiving care. Consequently, seemingly administrative variables —clarity, tone, response time, ease of getting an appointment and context continuity— function as signals of organizational competence. They do not prove clinical quality, but they influence initial trust.

The search for convenience also does not mean the patient always chooses the fastest option. In situations of high perceived risk, costly procedures or complex diagnoses, reputation, referral and explanation can dominate over immediacy. In recurring services or those of lower administrative complexity, ease of scheduling may carry more weight. This heterogeneity contradicts commercial models that apply a single script and the same response window to all specialties.

The practice must record what question the person is trying to resolve: availability, price, insurer, appropriateness, location, second opinion, urgency, procedure or follow-up. Response quality is assessed against that need. A system that responds quickly but does not identify the purpose may increase activity without improving conversion or experience.

3. Response speed: plausible mechanism, unquantified effect

There is a plausible logic for responding quickly: intent can cool, the person may contact several options and uncertainty can increase. However, the relationship between minutes and attended

appointment cannot be assumed linear. Real availability, response quality, time slot, request type and level of urgency can confound any observed association.

Contradictory evidence must be considered. In some contexts, an overly automated response can reduce trust; in others, an immediate acknowledgment prevents abandonment. A bot that asks too many questions can add friction, while a brief confirmation with a clear expectation can improve continuity. The correct intervention depends on designing an explicit transition between automation and person.

The recommended causal study is pragmatic: randomly assign different coverages or sequences within ethical limits, keep the same staff and availability, and measure contact, scheduling, attendance and satisfaction. Without that control, an improvement observed after installing technology may be due to training, campaign changes, greater availability or seasonality.

4. Follow-up: useful persistence versus commercial pressure

Follow-up has value when it helps complete a pending decision, not when it turns the patient's vulnerability into pressure. The content must be administrative, relevant and proportionate. Highly sensitive requests, mental health, fertility, oncology or invasive procedures require special care in language, privacy and frequency.

Public evidence does not allow establishing that a fixed number of attempts maximizes conversion in Mexico. A more defensible rule is to adapt follow-up to the state: incomplete request, uncontacted person, person who asked for time, unconfirmed appointment, cancellation or pending clinical follow-up. Each state needs its own purpose, channel, cadence and closure criterion.

The outcome must be measured over an eligible cohort. If old contacts without a valid number, people who asked not to be contacted or irrelevant requests are included, the reactivation rate loses meaning. Negative consequences must also be recorded: blocks, complaints, opt-outs and wrong contacts.

5. No-shows as a system-design problem

Treating no-shows solely as patient irresponsibility hides modifiable factors. Long windows between request and appointment, difficulty canceling, confusing instructions, lack of transport, unexpected costs and incompatible schedules can contribute. The analysis must separate causes attributable to the patient, to the practice and to the context.

Reminder evidence is consistent, but does not mean all messages are equivalent. Timing, channel, the possibility of replying, content and ease of rescheduling modify the effect. A one-way reminder can reduce forgetting; a two-way confirmation additionally frees capacity. The practice must measure both outcomes.

Deposit policies can reduce low-intent bookings, but also exclude patients with liquidity constraints. Overbooking can offset expected absences, but increases waiting when everyone attends. These interventions involve trade-offs and must be assessed with equity, experience and utilization metrics, not only revenue.

6. From the messaging channel to operational continuity

The WhatsApp conversation may seem centralized because it is in a single app, but it remains fragmented if it depends on several phones, inconsistent labels or staff memory. Real

centralization requires contact identity, history, owner, state and a relationship to scheduling. Without those elements, the practice has messaging, not traceability.

The use of templates and automation improves consistency, but can introduce errors at scale. An incorrect time, a wrong site or an outdated insurer rule is replicated across all conversations. Governance must include content ownership, periodic review, version control and an incident-reporting mechanism.

The relationship between messaging and privacy demands minimization. Before a consultation, the practice normally needs less data than it usually requests. Collecting detailed symptoms, documents or photographs without a clear purpose and controls increases exposure. The recommended architecture separates administrative, clinical and marketing data, with differentiated access and retention.

7. CRM: a learning capability, not mere storage

The value of a CRM lies in producing organizational memory. It allows comparing cohorts, identifying causes of loss and observing variation across time slots, channels, sites or owners. Storage on its own does not produce learning: defined fields, consistent capture and review routines are needed.

An implementation can fail even if the technology works. If staff perceive that the system duplicates work, data are captured late or too many states are created, quality falls. Incentives must align with the process: recording a closure reason must be easier than abandoning the contact unclassified. Dashboards must show decisions, not vanity metrics.

The evidence that contradicts the full-automation narrative is relevant. Some exceptions require tacit knowledge, schedule negotiation or human sensitivity. The goal is not to eliminate the front desk, but to reserve its time for tasks that require judgment, while the system sustains memory, follow-up and control.

8. Artificial intelligence: adoption by risk layers

Generative AI can reduce reading and documentation work, but its performance depends on context, instructions and data. A plausible summary may omit an important condition; a classification may reproduce biases; a voice agent may fail to recognize an emergency. Human oversight must not be a generic phrase: it must specify who reviews, at what moment, what threshold triggers escalation and how the incident is recorded.

The lowest-risk use cases are reversible and administrative: classifying intent, summarizing a conversation for review, suggesting a reply, extracting availability or detecting that a data point is missing. Medium-risk cases execute actions, such as booking or rescheduling, and require closed rules. High-risk cases affect clinical priority, diagnosis or treatment and must not be adopted with the same commercial logic.

Return measurement must include errors avoided or introduced, human time, satisfaction, transfer rate, abandonment and adverse events. A cost reduction that increases wrong contacts or compromises privacy does not represent net value.

9. Omitted relationships that modify the funnel

- Availability: can dominate conversion even when response and follow-up are excellent.

- Price and payment method: influence differently by specialty, urgency and insurance.
- Reputation and reviews: can mediate between acquisition and trust, but are subject to selection bias.
- Time to appointment: differs from response time and may be the real bottleneck.
- Prior experience: recurring patients do not follow the same funnel as new patients.
- Dependents: pediatrics, geriatrics and disability involve third-party decisions and contacts.
- Referral capacity: a response that guides appropriately can be successful even if it produces no appointment.
- Seasonality: vacations, epidemics, school cycles and fiscal closings alter demand and attendance.
- Language and accessibility: can exclude patients even when the channel is available.
- Perceived clinical quality: built before and after the consultation and feeding back into reputation.

PART V · MATURITY FRAMEWORK

EXHIBIT 14

Operational maturity of a medical practice

From reactive to governed, in five levels: maturity is measured by questions the practice can answer and risks it can control, not by the number of installed tools.

Maturity can be assessed in five levels. At the reactive level, conversations live on phones and the calendar is the only record. At the coordinated level, requests are centralized and assigned. At the systematized level, there are events, times and reasons for loss. At the optimized level, the practice experiments, segments and manages capacity. At the governed level, it integrates privacy, quality, audit, supervised AI and responsible publication of benchmarks.

Progress must not be measured by the number of tools, but by the ability to answer questions and control risks. A small practice can reach high maturity with a simple, disciplined process; a large clinic can remain reactive despite multiple systems.

Source: Scalimed conceptual framework. **Reading:** maturity is assessed by journey coverage, not by number of tools. **Limitation:** qualitative instrument; not a validated index in this edition.

PART V · SYNTHESIS AND IMPLICATIONS

Narrative synthesis and implications

12. Narrative synthesis

The story that emerges is not that of a market that automatically needs more advertising. It is that of a system where demand becomes digital and multichannel, while the capacity for response, scheduling and measurement remains fragmented. Leaks can originate before contact, during the conversation, between scheduling and attendance or after the consultation. Each leak has different mechanisms and solutions.

> The sustainable advantage will not be adopting more technology, but turning it into organizational capability.

The best-performing practices between 2026 and 2028 will not necessarily be those that adopt more technology, but those that turn technology into organizational capability: common definitions, coverage, continuity, quality data, experimentation and governance. The sustainable advantage will be learning from the complete journey without sacrificing trust, privacy or clinical judgment.

13. Implications for management, operations and measurement

For management, the first change is to stop managing the patient journey through isolated impressions. The question “are patients arriving?” must be broken into verifiable questions: how many valid requests came in, what proportion made contact, how many were eligible, how many booked, how many attended and what capacity remained unused. This decomposition avoids attributing all results to marketing and allows distinguishing problems of demand, care, scheduling and continuity.

For operations, the priority is to design exceptions. Most systems work in the ideal case; problems appear when the patient requests another site, needs an invoice, uses insurance, needs to speak with a family member, changes the time, reports an urgency or asks about a condition the practice does not treat. Each exception must have an owner, an escalation rule and a recordable outcome. Automating without resolving exceptions displaces the work and can hide the risk.

For marketing, the useful metric does not end at the request. The quality of a source must be assessed through to contact, attended appointment and, where legitimate, treatment or recurrence. A source with a high cost per request may generate more relevant patients; another with cheap volume may saturate the front desk and produce few appointments. Attribution must preserve the discovery source and the contact channel so as not to confuse reputation, search and messaging.

For finance, the cost of acquisition must be separated from the operational cost of conversion. Staff, software, calls, commissions, reminders and physician time consumed in gaps or delays are part of the system. Return must be calculated by cohorts and with margin, not only with billing. In long-cycle specialties, the observation window must be sufficient to capture procedures and recurrence without attributing revenue that does not correspond to the analyzed action.

For quality and compliance, every optimization must incorporate data minimization, access control, consent recording where applicable, retention, vendor review and incident response. The same event may have commercial and clinical dimensions; for example, a request may turn into a care communication. Permissions and automation must change when the purpose changes.

For research, publishing benchmarks requires preserving heterogeneity. A multispecialty clinic must not be mixed with an individual practice, nor an elective-surgery request with a recurring consultation. The sample must be stratified and results must include distribution, not only average. When size does not allow comparison, the correct decision is to declare insufficiency and accumulate evidence for a later edition.

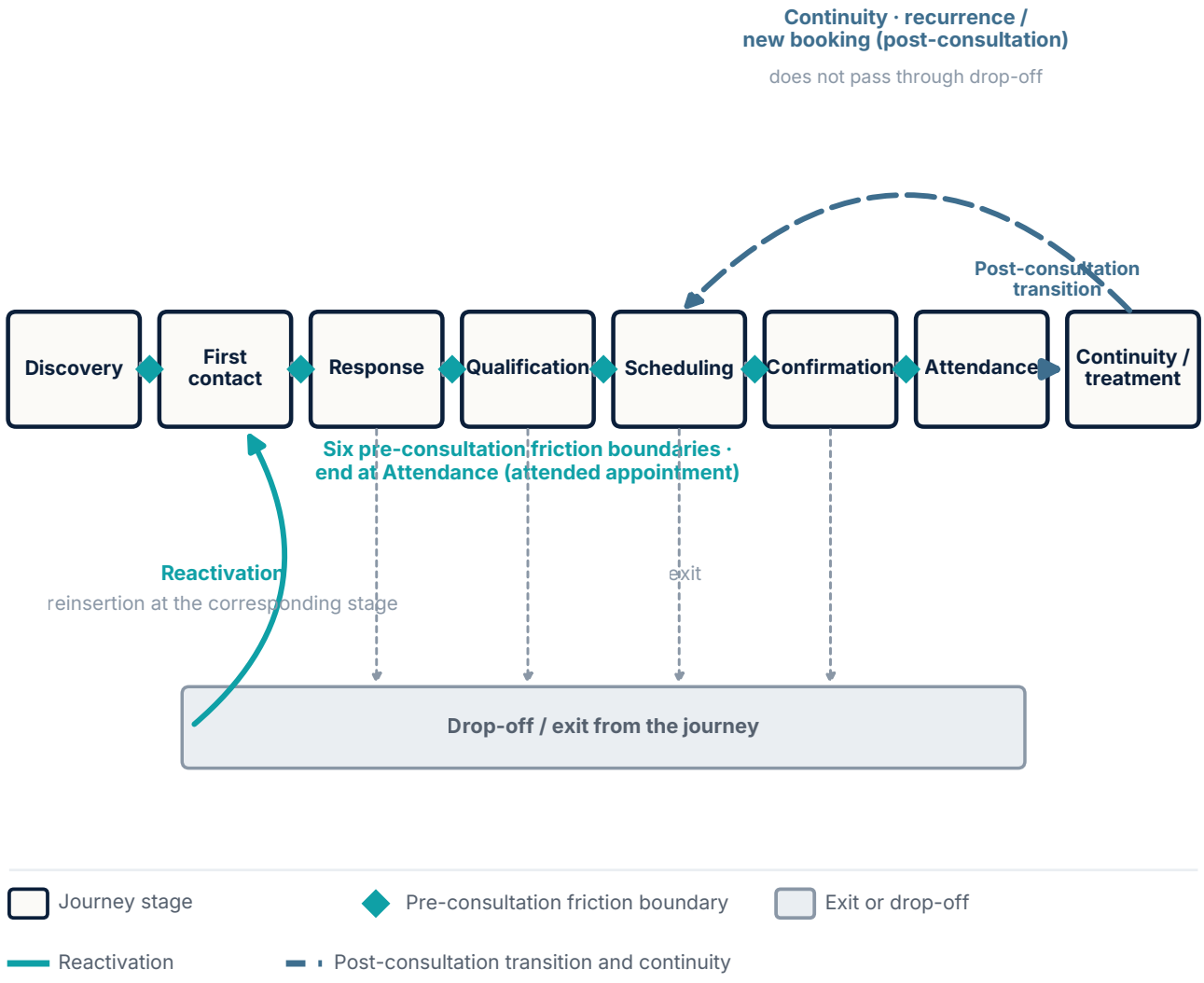
Taken together, these implications turn the funnel into a management system. Its purpose is not to commercialize medicine aggressively, but to reduce friction, improve administrative access, use capacity responsibly and produce information that enables learning. Methodological discipline is part of the value proposition: without it, any apparent improvement may be the result of changing definitions, seasonality or favorable case selection.

MAIN FRAMEWORK · EXHIBIT A

Scalimed Map of the Patient Journey

From the first search to post-care continuity: eight stages, six pre-consultation friction boundaries and the exit, reactivation and post-consultation continuity circuits.

Source: Scalimed conceptual framework · editorial framework. **Limitation:** it is not an empirical measurement of the journey in this edition.



HOW TO READ THIS MAP

1. The main path represents the journey, from the first search to the attended appointment.
2. The turquoise diamonds mark six pre-consultation friction boundaries.
3. The circuits show reactivation from drop-off and post-consultation continuity.

METHODOLOGICAL NOTE

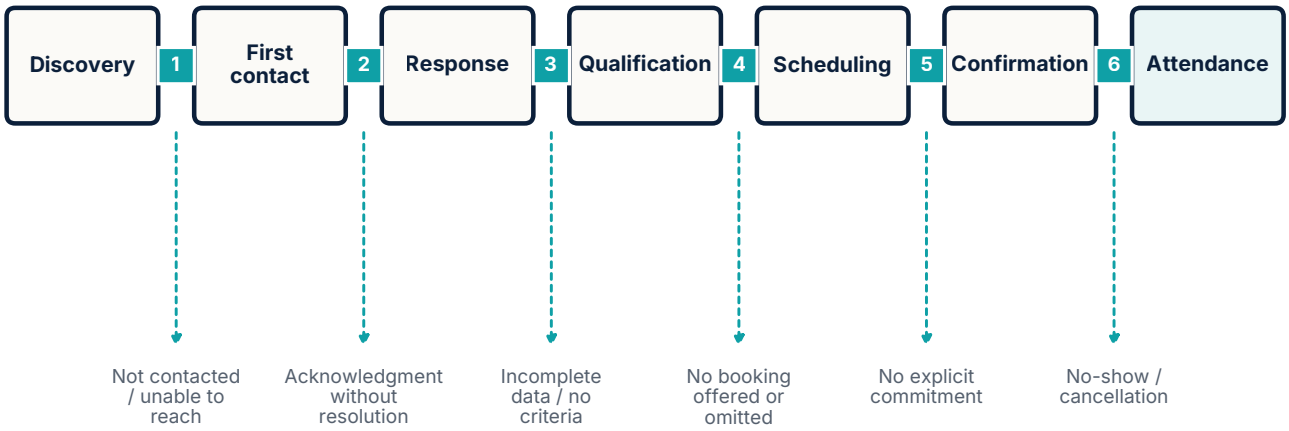
It is a conceptual framework to order the journey and locate frictions. It is not an empirical measurement or a benchmark: its function is analytical and editorial.

MAIN FRAMEWORK · EXHIBIT B

Scalimed Pre-consultation Friction Model

Six friction boundaries between discovery and attendance: each is a point where demand can be lost before the attended appointment.

Source: Scalimed conceptual framework · editorial framework. **Limitation:** the boundaries are analytical; their magnitude is not measured empirically in this edition.



Six pre-consultation friction boundaries · all end at Attendance (attended appointment)

■ Friction boundary (point of possible leak)

HOW TO READ THIS MODEL

1. The numbered diamonds mark the six pre-consultation boundaries, from discovery to attendance.
2. Each boundary has an entry and an exit event; between them a leak can occur.
3. The table on the next page details the six boundaries with their indicator and required capability.

METHODOLOGICAL NOTE

The six boundaries are an analytical framework to locate where demand is lost. They do not constitute an empirical measurement in this edition.

SCALIMED PRE-CONSULTATION FRICTION MODEL · DETAIL

The six pre-consultation boundaries

For each boundary: entry event, exit event, possible leak, indicator and required capability.

1 · Discovery → First contact — Not contacted / unable to reach

Entry: Need detected / request · **Exit:** First contact established · **Indicator:** Generation and speed of first contact · **Capability:** Presence, capture and rapid response

2 · First contact → Response — Acknowledgment without resolution

Entry: First contact · **Exit:** Two-way interaction · **Indicator:** Contact rate · **Capability:** Response that resolves availability and next steps

3 · Response → Qualification — Incomplete data / no criteria

Entry: Conversation established · **Exit:** Qualified request · **Indicator:** Qualification rate · **Capability:** Criteria and eligibility recording

4 · Qualification → Scheduling — No booking offered or omitted

Entry: Qualified request · **Exit:** Appointment scheduled · **Indicator:** Scheduling rate · **Capability:** Booking close; visible availability

5 · Scheduling → Confirmation — No explicit commitment

Entry: Appointment scheduled · **Exit:** Appointment confirmed · **Indicator:** Confirmation rate · **Capability:** Active confirmation; reminders

6 · Confirmation → Attendance — No-show / cancellation

Entry: Appointment confirmed · **Exit:** Appointment attended · **Indicator:** Attendance rate · **Capability:** Easy rescheduling; staggered reminders

Source: Scalimed conceptual framework. **Limitation:** analytical framework; the magnitude of each leak is not measured empirically in this edition.

SCALIMED COMMERCIAL MATURITY SCORECARD · 1 OF 4

Five dimensions of operational maturity

The scorecard describes journey maturity across five dimensions. The result is presented as a profile, not a single score: the predominant level, the limiting dimension and the critical exceptions are reported.

DIMENSION 1

Definitions and measurement

Whether the journey states —qualified request, scheduled, confirmed and attended appointment— are defined and recorded consistently.

DIMENSION 2

Response speed and quality

Whether the response resolves availability and next steps, and whether the practice measures its own distribution instead of importing a benchmark.

DIMENSION 3

Follow-up and reactivation

Whether follow-up helps decide and reactivation distinguishes clinical continuity from promotion.

DIMENSION 4

Infrastructure and traceability

Whether channel, CRM, scheduling and record serve distinct functions and journey traceability is complete.

DIMENSION 5

Data and AI governance

Whether AI adoption follows risk layers, with oversight, access limits and escalation protocols.

HOW TO READ IT

Profile, not a grade

Each dimension is placed in one of five levels: Reactive, Coordinated, Systematized, Optimized and Governed.

SCALIMED COMMERCIAL MATURITY SCORECARD · 2 OF 4

Level rubric by dimension

From reactive to governed: observable indicators by level.

Dimension	1 · Reactive	2 · Coordinated	3 · Systematized	4 · Optimized	5 · Governed
Definitions and measurement	No definitions; case by case	Each area measures differently	Events and rates defined and captured	Acts on the distribution, not the average	Auditable dictionary; continuous improvement
Response speed and quality	No control of timing	Responds, without measuring	Time and resolution measured	Managed by percentiles and time slots	Governed and reviewed SLAs
Follow-up and reactivation	No follow-up	Manual and irregular	Cadence defined by state	Segmented reactivation with exit	Auditable policies and consent
Infrastructure and traceability	Messaging only	Unintegrated tools	CRM with state and owner	Channels, scheduling and CRM integrated	Complete, governed traceability
Data and AI governance	No controls	Informal rules	Basic access and consent	Human oversight and escalation	Formal, auditable governance

SCALIMED COMMERCIAL MATURITY SCORECARD · 3 OF 4

Self-assessment sheet

One row per dimension: observable evidence, current level, next level, gap and action.

Dimension	Observable evidence	Current level	Next level	Main gap	Priority action
1. Definitions and measurement	Is there a dictionary of events and rates?	(1–5)	(current + 1)	(to complete)	Define events and rates with numerator, denominator and window
2. Response speed and quality	Is the distribution measured, not just the average?	(1–5)	(current + 1)	(to complete)	Measure median, p75 and p90 by channel and time slot
3. Follow-up and reactivation	Is there cadence by state with an exit mechanism?	(1–5)	(current + 1)	(to complete)	Define cadence by state and record reasons
4. Infrastructure and traceability	Are communication, CRM and record separated?	(1–5)	(current + 1)	(to complete)	Assign state and owner; integrate scheduling and CRM
5. Data and AI governance	Is there consent, access control and oversight?	(1–5)	(current + 1)	(to complete)	Establish data governance and AI oversight

SCALIMED COMMERCIAL MATURITY SCORECARD · 4 OF 4

Interpretation rule and warning

PROFILE INTERPRETATION RULE

The result is presented as a five-dimension maturity profile. No single overall level is computed. When an executive summary is required, the predominant level, the limiting dimension and the critical exceptions are reported.

METHODOLOGICAL WARNING

This scorecard is an indicative self-assessment tool. It is not a validated index and does not allow national comparisons in this edition.

FUTURE ASSET · RESEARCH

National Patient Journey Benchmark Agenda

Presented only as future methodological architecture, not as results.

The first edition of a benchmark must prioritize a few robust metrics. A viable core includes valid requests, time to human response, effective contact, scheduled appointment, attended appointment and reason for loss. Later editions may add cost, treatment, recurrence, satisfaction and value. Expansion should occur only when the basic definitions are stable.

Annual publication must keep a methodological sheet: period, practices, specialties, cities, volume, exclusions, size distribution, process changes and suppression of small cells. Results must be presented as distributions —median and percentiles— and not only averages, because operational variation tends to be asymmetric.

The program must include a deliberate search for negative results. If an automation does not improve attendance, if a sequence increases opt-outs or if a clinic with a slower response keeps high conversion through reputation and availability, those results are essential to avoid simplistic recommendations.

Nature: methodological agenda (design). It contains no series or benchmarks in this edition.

PLATFORM UNDER CONSTRUCTION

Scalimed Patient Journey Observatory

The Scalimed Patient Journey Observatory is the editorial architecture and umbrella brand of the series' future publications. It is an editorial platform under construction: in this edition it does not yet have historical series, a national sample, its own database, longitudinal indicators or external institutional validation.

Nature: umbrella brand and platform under construction. It has no historical series, own sample or external validation in this edition.

ESSENTIAL OPERATIONAL LEXICON

Essential operational lexicon

The core journey terms, with a single definition per term. The complete lexicon is in the Methodological Annex.

Request	Concrete expression of interest by which a person asks for information, availability or care and can be contacted.
Qualified request	Request that meets clinical and operational eligibility criteria.
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.
Friction	Potential loss of demand or degraded experience at the boundary between two stages.
Traceability	Ability to preserve identity, state, owner and history of each contact.
Commercial maturity	Organizational capability to manage the journey, measure its frictions and improve the system.

REFERENCES

Selected bibliography

Sources cited in the main report. The complete bibliography is in the Methodological Annex.

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

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

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

Dirección General de Información en Salud. (2025). Catálogo de Clave Única de Establecimientos de Salud (CLUES). www.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: 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:10.4338/ACI-2014-04-RA-0026

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

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

World Health Organization. (2024). Ethics and governance of artificial intelligence for health: Guidance on large multi-modal models. www.who.int

Page, M. J., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ, 372, n71. doi:10.1136/bmj.n71

Critical Appraisal Skills Programme. (2024). CASP checklists. casp-uk.net/casp-tools-checklists

Guyatt, G. H., et al. (2008). GRADE: An emerging consensus on rating quality of evidence and strength of recommendations. BMJ, 336, 924–926. doi: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. www.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].

Methodological Annex and Auditable Base

All the technical evidence of this report —master table of quantitative data, source matrix, evidence-by-finding matrix, unverifiable data, contradictions between sources, inference log, primary-research opportunities, proposed visualizations, derived content, usable quotes, frequently asked questions, SEO metadata, complete lexicon, complete bibliography and unresolved errors— is preserved in the complementary document:

Scalimed Insights 2026 — Methodological Annex and Auditable Base

The annex uses landscape orientation and the two-level record system to preserve each indicator with its source, method, sample, definition and limitation, without compressing the typography.