Territorial Health Groups as a Structuring Lever of the Moroccan National Health System to Reduce Inequalities in Access to Healthcare

LAHDAB Lahbib[1], RAHMOUNI Ahmed Fath-Allah[2], EL BARNOUSSI Nadia[3], AMENSOUR Mahassine[4] and EL YOUNOUSSI Laila[5]

[1,2] ENCG of Tangier – Morocco

[3, 4,5] ISPITS of Laayoune – Morocco

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ABSTRACT

The Moroccan health sector continues to face significant inequalities in access to healthcare, despite sustained national efforts since independence to improve the population's health. These efforts have recently resulted in a major structural reform of the national health system with the promulgation of Framework Law No. 06-22 and Law No. 08-22. These legislative texts establish Territorial Health Groups (GST) as autonomous public institutions primarily responsible for strengthening governance and management of the health system at the regional level.

This paper aims to identify the mechanisms through which Territorial Health Groups can reduce inequalities in access to healthcare. The central research question is formulated as follows: How do Territorial Health Groups contribute to reducing inequalities in access to healthcare for all Moroccan citizens?

A qualitative approach based on a comprehensive literature review was adopted. Documents were selected and analyzed according to their relevance to the key concepts of the study: decentralization, public governance, integration of care, and health equity.

The results highlight four main mechanisms by which the GST can act: Strengthening territorial governance, Integration and coordination of patient care pathways, equitable territorial planning, improvement of operational efficiency and service quality.

In conclusion, the Territorial Health Groups represent a promising and innovative lever for advancing toward Universal Health Coverage (UHC) in Morocco. Their successful implementation will determine the health system's ability to guarantee equitable, high-quality, and financially accessible healthcare for the entire Moroccan population, regardless of geographic location or socio-economic status.

Keywords: National health system, Territorial Health Groups (GST), Inequalities in access to healthcare, Territorial governance, Universal Health Coverage (UHC).

INTRODUCTION

The Moroccan health system is evolving in a context marked by persistent inequalities in access to healthcare. These disparities concern the territorial distribution of infrastructure, financial accessibility, and the quality of services (Ministry of Health and Social Protection, 2023). Despite the progress made in extending medical coverage, particularly with the generalization of Mandatory Health Insurance (AMO), recent data reveal an overall negative perception by the population regarding these three dimensions. This observation, confirmed by the 2025 Afrobarometer surveys, highlights a significant gap between formal advances in coverage and the reality experienced by citizens.

These inequalities are expressed particularly through a marked divide between urban and rural areas, as well as between socio-economic groups. The structural analyses of the High Commission for Planning (2024) highlight significant gaps in the supply of care, waiting times, and costs borne by households. Peripheral regions and vulnerable populations often remain faced with limited access, both geographical and financial, which compromises overall health equity. The concentration of human and material resources on the Kenitra-Rabat-Casablanca axis perfectly illustrates this imbalance that affects our national health system (Boutayeb, 2006).

To overcome these dysfunctions, an ambitious reform has been undertaken by the Moroccan State through Framework Law No. 06-22 on the national health system and Law No. 08-22 creating territorial health groups (GST). This overhaul represents a major turning point insofar as these new public entities aim to strengthen inter-establishment coordination, improve management efficiency, and adapt the supply of care to regional specificities and needs. The GSTs, endowed with legal personality and financial autonomy, group together all public health establishments at the regional level, from the primary health center to the University Hospital Center (CHU).

Therefore, our research problem revolves around the effective contribution of these territorial health groups to reducing inequalities in access to healthcare in Morocco. Thus, the question adopted in the context of this paper can be formulated as follows:

How do territorial health groups contribute to reducing inequalities in access to healthcare for the benefit of all Moroccan citizens?

The objective of this study is therefore to determine the mechanisms through which territorial health groups participate in reducing inequalities in access to healthcare in a context where public governance is often crossed by tensions between local autonomy and central control (Maquart & Lethielleux, 2024).

LITERATURE REVIEW

The literature on health systems in developing countries, and particularly in Africa, highlights the central role of territorial and socio-economic inequalities in access to healthcare. Numerous studies emphasize that the concentration of resources in urban areas accentuates disparities, particularly in contexts of incomplete or poorly funded decentralization. Health equity is not limited to equal access, but implies an allocation of resources proportional to the needs of populations (Asante et al., 2016).

In Morocco, the evolution of key health indicators over the last decade has been marked by an increase in life expectancy and a decrease in infant mortality. However, these national measures mask deep regional disparities.

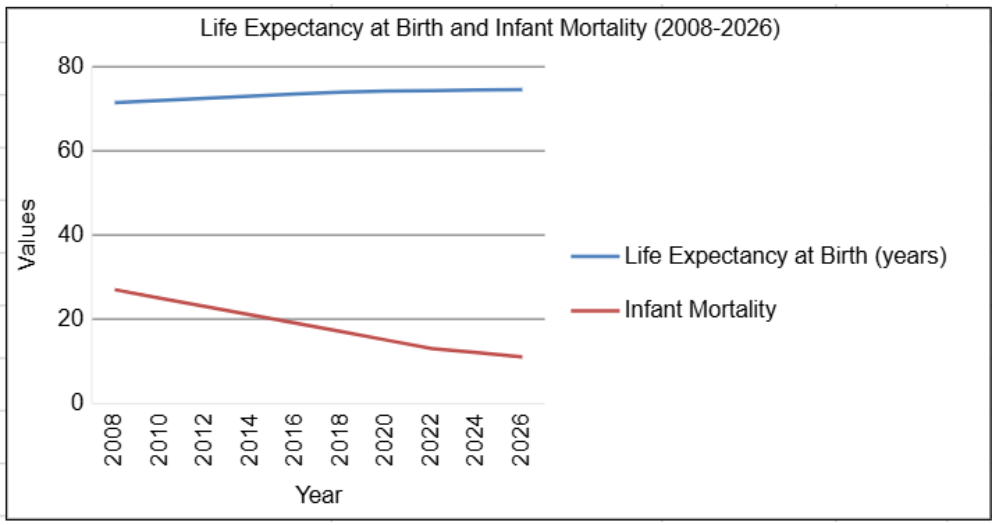

Figure 1: Evolution of key health indicators in Morocco (2010-2024)

Source: HCP Morocco and World Bank

In the context of health decentralization, the work of Sapkota et al. (2023) indicates that the transfer of skills to the local level can improve responsiveness to population needs, provided that clear mechanisms for accountability and central regulation are maintained. Decentralization cannot be a universal solution in itself; it requires strong local institutional capacities so as not to exacerbate existing inequalities between rich and poor regions.

In the same perspective, Ridde (2021) insists that territorial health governance must be analyzed through the prism of equity. According to this author, simple administrative deconcentration is not enough; true decentralization accompanied by adequate resources is necessary to reduce inequalities, particularly in sub-Saharan Africa where reforms inspired by New Public Management have often shown their limits.

Furthermore, African and Latin American experiences show that the integration of care levels (primary, secondary, and tertiary) constitutes a major lever for streamlining patient pathways and eliminating bottlenecks in the process of their care (Holcman, 2019). Integration makes it possible to overcome the fragmentation of health systems, often characterized by hospitals operating in silos and primary health centers that are under-equipped and bypassed by patients (Giri & Din, 2025). Therefore, territorial health planning is essential as a central operational instrument.

Indeed, this mechanism makes it possible to correct historical imbalances in the allocation of human and material resources when it is based on geolocated data and equity indicators. The establishment of the regional health map by the general management of a GST constitutes a fundamental tool of this planning.

The World Health Organization (2023) places the efficiency and quality of services at the heart of universal health coverage (UHC). The pooling of resources at the territorial level appears as a means of optimizing expenditure while improving the availability of care. UHC is based on three dimensions: the proportion of the population covered, the range of services offered, and the share of costs covered (World Health Organization, 2015).

Moroccan institutional analyses, notably those of the High Commission for Planning (2024), confirm the persistence of an urban-rural gradient in access to infrastructure and health professionals. The deficit in qualified human resources, estimated at several tens of thousands of doctors and nurses, disproportionately affects rural and isolated areas as shown in the following figure:

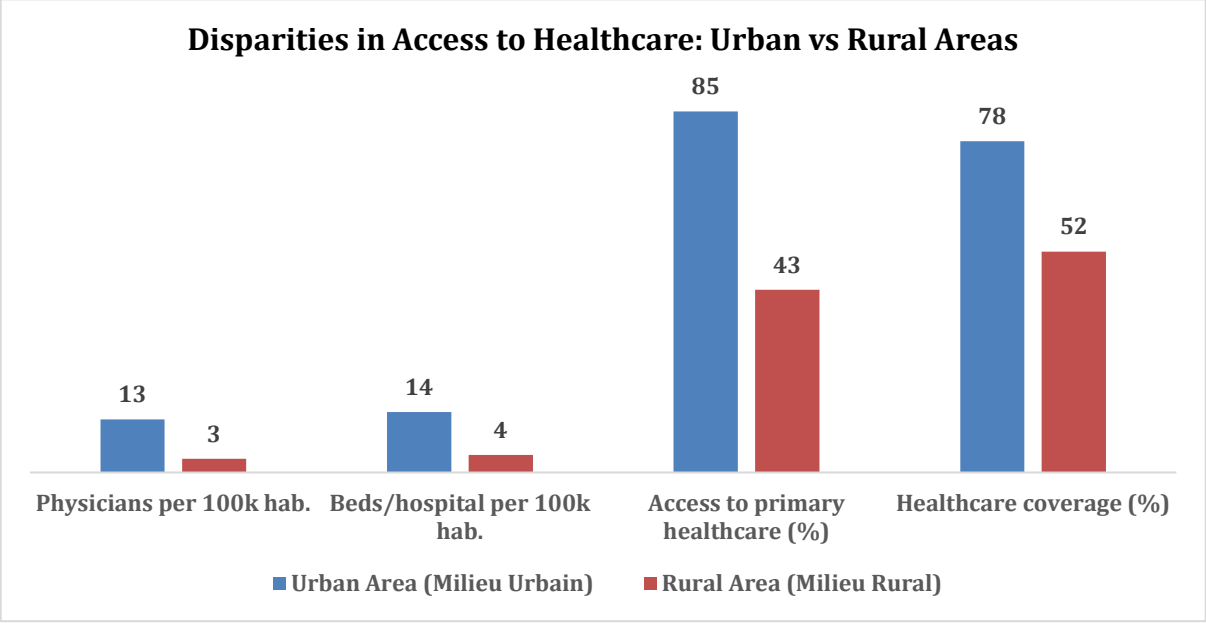

Figure 2: Disparities in access to healthcare between urban and rural areas in Morocco

Source: Ministry of Health and Social Protection and HCP Morocco

A work on public governance (Charreaux, 2010) warns against tensions between local autonomy and central control, tensions particularly visible in health decentralization reforms. Hospital governance must strike a balance between management imperatives (efficiency) and public service missions (equity and access for all) (Maquart & Lethielleux, 2024).

International comparative studies (Chol, 2018) emphasize that the impact of decentralization depends heavily on local institutional capacities, the level of funding, and the quality of national strategic steering. Without a strategic State capable of equalization between territories, decentralization can lead to a balkanization of the health system.

Finally, the literature insists on the determining role of solidarity financing. Organizational reforms risk having only a limited impact on real equity (World Health Organization, 2024; Cashin & Dossou, 2021). Health financing in Africa remains a major challenge for achieving UHC (Karamagi et al., 2023) due to the importance of out-of-pocket household payments in health expenditure, including in Morocco. As a reminder, this rate stood at 38% in 2022 against 45.60% in 2018 (National Health Accounts, 2022).

METHODOLOGY

The approach taken is based on a qualitative literature review allowing for an in-depth exploration of the theoretical and empirical mechanisms linking territorial governance, institutional reforms, and the reduction of health inequalities, relying on evidence.

Data Collection

The mobilized sources include a diversity of documents to ensure a relevant analysis:

- Moroccan institutional reports;
- Publications of the High Commission for Planning (HCP) and the Ministry of Health and Social Protection;
- Normative and legal documents: Framework Law No. 06-22 on the national health system and Law No. 08-22 creating territorial health groups;
- Academic work: National and international scientific articles on health decentralization, hospital governance, and health equity in Africa and middle-income countries;
- Publications of international organizations: Reports from the World Health Organization (WHO), the World Bank, and the International Monetary Fund.

Inclusion and Exclusion Criteria

The selection of documents was based on their analytical relevance to the key concepts of the study: decentralization, public governance, integration of care, and health equity. To ensure the topicality of the data and reflect recent developments in health systems, only sources subsequent to 2015 were favored, with particular attention paid to publications from the 2020-2025 period.

Data Analysis

The analysis adopts a thematic and conceptual approach. It identifies and groups the action levers of territorial health groups by confronting them with the recognized determinants of inequalities in access to healthcare (geographical, financial, and organizational).

This method makes it possible to structure the results around explanatory mechanisms validated by international literature, while contextualizing their application to the specific case of Morocco. The cross-analysis of Moroccan legal texts and theoretical frameworks of public governance makes it possible to evaluate the transformative potential of the GST reform.

RESULTS

The results of the analysis highlight four main mechanisms through which territorial health groups (GST) can contribute to reducing inequalities in access to healthcare in Morocco. These mechanisms revolve around governance, integration, planning, and efficiency.

Strengthening Territorial Governance

The first mechanism lies in strengthening territorial governance. The GSTs introduce a real decentralization of decision-making at the regional level, breaking with the centralizing tradition of the Moroccan health system. Endowed with legal personality and financial autonomy, the GSTs have a board of directors and a general manager with expanded prerogatives.

This decision-making proximity allows for a better match between specific local needs and the health policies implemented. Regional decision-makers are better placed to identify areas of vulnerability and allocate resources accordingly. In this sense, decentralization promotes efficiency when responsibilities are clearly defined and accompanied by mechanisms for regulation and accountability.

Table 1: Evolution of health governance in Morocco

Dimension	Before the reform (Centralized system)	After the reform (GST Model)	Expected impact on equity and equality of access
Decision-making	Centralized at the Ministry (Rabat)	Decentralized at the regional level (GST)	Better responsiveness to specific local needs
Human resources management	State civil service status	Specific status for GST health professionals	Retention of staff in peripheral regions
Budget	Vertical allocation by establishment	Regionalized global budget	Possibility of inter-regional equalization
Coordination	Autonomous or siloed establishments	Grouping under a single authority	Reduction of fragmented care pathways

Source: Elaborated by the authors

Integration and Coordination of Care Pathways

The second mechanism concerns the integration and coordination of care pathways. Historically, the Moroccan health system suffered from strong fragmentation between primary health care (health centers), provincial/regional hospitals, and University Hospital Centers (CHU). The GSTs aim to reduce this fragmentation by placing all of these structures under the same management authority.

They thus ensure a more fluid continuity between primary, secondary, and tertiary levels of care within the same territory. This integration limits breaks in patient pathways, reduces redundant examinations, and improves effective access to specialized care, particularly for rural patients who were often lost in the maze of the referral system. The general practitioner of the primary health center regains their role as a pivot and guide.

Equitable Territorial Planning

The third mechanism relates to equitable territorial planning. Territorial health groups facilitate a more balanced allocation of human and material resources. The law provides for the development of Regional Medical

Programs (PMR) which implement the national health policy at the regional level.

The GSTs rely on precise territorial indicators and an opposable regional health map to correct historical imbalances between provinces of the same region and between urban and rural areas (High Commission for Planning, 2024). For example, the deployment of mobile medical units or the creation of local centers can be decided more quickly by the GST to cover health blind spots.

Improvement of Efficiency and Quality of Services

The fourth mechanism concerns the improvement of efficiency and quality of services. The pooling of resources (group purchasing, shared technical platforms, unified information systems) within the GSTs strengthens operational efficiency. The economies of scale achieved can be reinvested in improving the supply of care.

Furthermore, governance closer to users and professionals promotes continuous improvement in the quality of services. The implementation of an integrated information system at the regional level allows for better epidemiological monitoring and more rigorous evaluation of the performance of establishments.

Overall, these four dimensions (Governance, integration, planning, and efficiency) constitute essential pillars of universal health coverage as promoted by the World Health Organization (2023).

DISCUSSION

The results of this analysis confirm that territorial health groups (GST) are part of a logic of systemic and profound transformation of the Moroccan health system. They do not constitute a simple administrative arrangement, but a redesign of the public health management paradigm.

The effectiveness of the GSTs relies on a successful articulation between operational decentralization (at the regional level) and the maintenance of national strategic governance (at the level of the Ministry and the High Authority of Health). However, this articulation remains complex. Work on public governance highlights the existence of persistent tensions between the desire for local autonomy of managers and the State's desire for central control (Charreaux, 2010; Maquart & Lethielleux, 2024).

International experiences demonstrate that decentralization does not automatically produce positive effects on equity. If poorly prepared, it can even aggravate disparities between regions with strong management capacities and those lacking them. Its impact depends closely on regional institutional capacities, the level of available funding, and the quality of strategic steering (Chol, 2018; Ridde, 2021). Thus, the success of the GSTs in Morocco requires sustained support in terms of training senior executives, strengthening skills in public management, and establishing robust evaluation and monitoring mechanisms.

The issue of financing remains a major challenge for this reform. Indeed, equal access to care presupposes a solidarity-based and progressive financing system capable of significantly limiting out-of-pocket payments by households. In Morocco, despite the extension of the AMO, these direct payments remain high, constituting a major financial barrier for vulnerable populations (Cashin & Dossou, 2021).

Organizational and territorial reforms risk having only a marginal impact on the real reduction of inequalities without a parallel and profound restructuring of health financing guaranteeing perennial and sufficient resources to the GSTs (World Health Organization, 2024; Karamagi et al., 2023). The GSTs must have global budgets calculated on the basis of the real needs of the population of their territory (activity-based pricing adjusted, population allocations) and not on the simple renewal of historical budgets.

Morocco suffers from a shortage and instability of human resources in the health sector. The GSTs must therefore encourage the installation and retention of professionals in under-endowed areas, otherwise the current imbalances that compromise the principle of equity and equal access to care will be reproduced.

The success of the reform will also depend on the ability of the GSTs to open up to their environment. They will have to closely associate local actors (territorial communities, regional councils, civil society, private sector) in defining health policies. Health not being only the business of the care system, a 'health in all policies' approach at the regional level is essential to act on the social determinants of health.

Finally, the integration of digital dimensions (telemedicine, shared medical records) will also be a powerful lever for the GSTs to compensate for the lack of specialists in remote areas and ensure the continuity of care (Giri & Din, 2025).

CONCLUSION

Territorial health groups (GST) constitute a structuring, innovative, and promising lever for reducing inequalities in access to healthcare in Morocco. By breaking with centralized and fragmented management, this institutional reform attacks the organizational roots of health disparities.

Their potential contribution rests on three fundamental pillars: the territorialization of governance which brings decision-making closer to the field, the integration of health services which streamlines the patient's pathway, and a more equitable planning of resources at the regional level based on real needs.

The reform undertaken opens a perspective of profound transformation of the Moroccan health system. It is part of a broader desire to build a more equitable, resilient, and citizen-centered social model. The central challenge for the coming years remains the establishment of a health system capable of guaranteeing effective, quality, and financially accessible access to care for the entire Moroccan population, regardless of their place of residence or socio-economic level. The GSTs are the tool of this ambition; their implementation will determine whether Morocco succeeds in its bet on universal health coverage.

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