

TERRITORIAL HEALTH GOVERNANCE MODELS AND ORGANIZATIONAL INNOVATION: A SYSTEMATIC SCOPING REVIEW AND ANALYTICAL INSIGHTS FOR MOROCCO'S GST REFORM.

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Abstract

Fragmented care, coordination failures across levels, and uneven territorial performance have long shaped debates in health systems, with territorial governance arrangements emerging as an important institutional response across contexts. Yet the academic literature remains dispersed, with no shared framework for comparing how governance models are designed, adapted, or evaluated across contexts. This study maps the main territorial health governance models identified in the international literature and examines the institutional factors shaping their trajectories. A systematic scoping review was conducted following PRISMA-ScR guidelines, covering 28 peer-reviewed studies published between 2000 and 2025 and indexed in Scopus database. The synthesis identifies four reform directions: decentralization and equity, territorial integration, participatory governance, and hybrid accountability. These reflect distinct forms of organizational innovation, involving changes in coordination mechanisms, authority distribution, and accountability arrangements. The findings suggest that territorial governance is best understood as a context-specific process of institution building, which limits the direct transferability of models across settings. In Morocco, the ongoing implementation of the Groupements Sanitaires Territoriaux points to the importance of context-sensitive adaptation in the design and delivery of territorial health reforms.

Keywords: territorial health governance; organizational innovation; decentralization; health system reform; scoping review.

Introduction

Health systems around the globe have experienced significant structural and organizational transformations over the past two decades. These changes have been influenced by demographic change, increasing burden of chronic disease, ongoing fiscal constraints and growing societal pressures for equity and quality (OECD, 2019; World Health Organization, 2018). Collectively, these movements have increasingly laid bare the limits of fragmented and hierarchically ordered modes of health services provision. Accordingly, many countries have begun to adopt territorially integrated approaches designed to enhance efficiency, accountability and population responsiveness (Bossert & Mitchell, 2011; Saltman et al., 2007).

The COVID-19 pandemic only further highlighted these structural failings. In addition, to its immediate repercussions from a health perspective, the crisis showed how inadequate care coordination across levels of care leaves the system vulnerable, especially in low-resource environments. In numerous settings, the pandemic served as a trigger to revisit governance design and coordination mechanisms to enable a more integrated and adaptive health system (Kluge et al., 2020). In this context, decentralization and territorial governance structures have increasingly been seen as potential levers to enhance system performance through better coordination across hospitals, primary healthcare and social services.

However, the literature suggests that decentralization is not merely an administrative adjustment, but rather a broader institutional transformation. It is often referred to as a strategy of governance and organizational innovation which involves devolving authority and financial responsibility to subnational governments with the aim of enhancing effectiveness, equity and accountability in the delivery of public services (Ahmad et al., 2008). Evidence from a variety of settings indicates that decentralization may lead to greater efficiency and effectiveness in allocating resources and coordinating services when it is part of coherent national frameworks, supported by effective intergovernmental arrangements (Bossert et al., 2003). At the same time, a number of studies warn that the realization of these outcomes is by no means inevitable and depend largely on institutional capacity and governance environment.

Experiences in high income countries offer specific examples of territorially anchored organizational reforms. In France, the 2016 law on modernization of the health system created Groupements Hospitaliers de Territoire (GHT) in order to facilitate hospital cooperation through joint medical projects, co-governance structures and shared support functions (HCSP, 2017). In Québec, the establishment of Centres intégrés de santé et de services sociaux

(CISSS/CIUSSS) aimed to integrate hospitals, primary care and social services into integrated regional structures with a focus on improving coordination, governance capacity and population-based planning (Demers, 2013). Similar initiatives have also appeared in Singapore and Ireland that adopted territorially accountable governance models to respond to fragmentation of care; however, those were associated with mixed consequences of institutional burden and financial constraint (Burke et al., 2014; Ong et al., 2018; Schulmann et al., 2024).

Outside the OECD, territorial governance reform has become more prevalent, especially in low- and middle-income countries (LMICs). In all these contexts, decentralization has commonly been advocated as a solution to the need for health systems strengthening, local accountability and continued inequity. For example, impact studies from sub-Saharan Africa and Latin America indicate the potential and limitations of such reforms in place: positive effects largely depend upon factors including local institutional capacity, fiscal autonomy and political stability (Arredondo et al., 2018; Binagwaho & Scott, 2015; Bossert et al., 2022; Tsofa et al., 2017). The literature is also increasingly acknowledging that reform outcomes are influenced by context-specific governance dynamics, undermining the transferability potential of territorial governance models across settings (Abimbola et al., 2019; Bossert & Mitchell, 2011).

While there is significant heterogeneity in the design and implementation of these reforms, they seem to coalesce around a common goal: promoting integration by territorializing relations between hospitals, primary care and social services, linking them up within coherent regional networks (Goodwin, 2016). Despite this emerging convergence, comparative literature on territorial health governance is still fragmented. Many of the current studies are limited to one country or levels of care and tend to explore isolated aspects of reforms instead of how governance structures, financing systems, and performance outcomes interact with one another (Priedeman Skiles et al., 2013; Soeters et al., 2006). Cross-national syntheses currently available indicate that effective reform of territorial governance is likely to depend on a clear role differentiation between central and peripheral powers, strong accountability mechanisms and learning capacities on the local level (Jalilvand et al., 2024; Oliveira et al., 2023).

Recent contributions further emphasize that governance arrangements play a decisive role in shaping reform outcomes, particularly in contexts characterized by institutional complexity and multi-level coordination challenges (Greer et al., 2016; Jalilvand et al., 2024; Exworthy & Powell, 2004).

In North Africa, Morocco recently implemented sweeping health sector reform with the enactment of Law 08-22 that established Groupements Sanitaires Territoriaux (GST). This reform has brought about a major organizational and governance rearrangement to promote territorial integration of care and overall system performance. However, very little evidence has been synthesized that can inform the design and the implementation process of territorial governance models in reforming health systems like that of Morocco.

Notwithstanding this wealth of literature, territorial governance and organizational innovation are often studied separately, as streams of research seldom intersect. Very little research has systematically pooled international experiences in order to investigate the relationship between multi-level governance arrangements and organizational integration in shaping reform paths and results, including in developing and middle-income countries. This gap is particularly relevant in the case of Morocco, where successful implementation of GST is arguably based on a nuanced and evidence-informed understanding of territorial governance as a driver for organizational innovation, equity, and sustainability.

Thus, this study seeks to address the following research question: **What models of territorial health governance and organizational innovation have been described within the international literature and what institutional and contextual factors are indicated as conditioning their design, implementation, and eventual transferability to emerging settings such as Morocco?**

To explore the issue, the study adopts a scoping review design based on the PRISMA-ScR framework. This method is well suited for mapping of heterogeneous bodies of literature, disentangling central concepts and processes, and reveal dominant reform pathways across complex health systems. Based on an overview of international experiences, this review aims to establish conceptual and analytical findings may be relevant for reflections related to the ongoing implementation of Morocco's Groupements Sanitaires Territoriaux (GST), focusing in particular on governance coherence, institutional capacity and contextual congruence.

This article aims to systematically map and analyze the main models of territorial health governance and organizational innovation identified in the international literature, with particular attention to the institutional and contextual factors shaping their implementation. In doing so, it seeks to contribute to a more integrated understanding of how governance arrangements and organizational transformations interact within complex health systems.

This study contributes to the literature in three main ways. First, it provides a structured synthesis of territorial health governance models by explicitly integrating organizational innovation perspectives, which are often examined separately. Second, it identifies four dominant reform trajectories that help clarify the diversity of governance configurations observed across contexts. Third, it offers analytical insights relevant to emerging health systems, particularly Morocco, where empirical and comparative evidence on territorial reforms remains limited.

The remainder of this article is structured as follows. The next section presents the methodological approach adopted for the scoping review. The third section reports the main results, including the descriptive characteristics of the included studies and the thematic synthesis. The fourth section discusses the findings in light of international experiences and their implications for Morocco's ongoing GST reform. Finally, the conclusion summarizes the key insights and outlines avenues for future research.

1. Materials and Methods

1.1. Research design and methodology

This research is grounded in an interpretive and exploratory epistemological stance, consistent with the objective of understanding how territorial health governance models are conceptualized and implemented across diverse institutional contexts. Rather than testing predefined hypotheses, the study adopts an inductive reasoning approach, allowing patterns, reform trajectories, and contextual determinants to emerge progressively from the literature.

Such a positioning is particularly relevant given the complexity and heterogeneity of territorial health governance, which involves multiple actors, institutional arrangements, and context-dependent dynamics. This approach is aligned with recommendations in health systems research emphasizing the need for flexible and theory-generating methodologies when addressing complex policy and organizational phenomena (Greenhalgh & Papoutsi, 2018; Peters et al., 2020).

This study adopts a systematic scoping review design to map and analyze how territorial health governance and organizational innovation have been addressed in the international literature. The use of a scoping review is relevant for clarifying concepts, models and theories, as well as identifying the main sources and types of available evidence and highlighting gaps in this knowledge base where research remains limited or underdeveloped. It is more frequently used

in the field of health systems and policy research when the literature crosses various disciplines, methodological traditions, and geographical locations (Arksey & O'Malley, 2005; Levac et al., 2010; Peters MDJ et al., 2020).

Unlike systematic reviews whose questions are often narrow, and which prioritize critical appraisal and effect estimates, scoping reviews offer a more flexible and exploratory approach to synthesizing evidence. This methodological choice is justified by the conceptual diversity and contextual variability characterizing research on territorial health governance and organizational innovation in multi-level health systems (Munn et al., 2018; Peters MDJ et al., 2020). Instead of seeking relationships, the study aims to provide a structured overview of reform approaches, interpretations and comparisons in context.

The review adhered to the PRISMA-ScR guidelines ensuring a standardized approach that improves transparency, methodological quality and replicability (Tricco et al., 2018) . The process is based on the methodological phases originally proposed by Arksey and O'Malley (2005) and developed by Levac et al. (2010) that consisted of identifying the research question, searching for literature, article selection, charting data and synthesizing study results. These stages were used to enable refinements as the review team became more knowledgeable about the literature.

1.2. Data collection procedure

Data collection was conducted in the Scopus database because of its comprehensive inclusion of the peer-reviewed literature in health policy, public health, management and social science topics and is appropriate for interdisciplinary scoping reviews (Falagas et al., 2008) . There is no single source that can be described as exhaustive but Scopus was considered broad enough and would give full or relevant international coverage for the purpose of this study.

The search strategy sought to achieve a balanced approach between breadth and relevance. It was intentionally broad to capture the diversity of approaches in the literature and was followed by a multi-stage screening process. The search was conducted in the Scopus database using combinations of keywords related to territorial governance, decentralization, health system reform, organizational innovation, integrated care, and regional health systems, combined using Boolean operators (AND, OR). Searches were limited to peer-reviewed journal articles published between 2000 and 2025 in English or French, a period during which territorial governance reforms have been increasingly recognized as important to health systems globally.

1.3. Criteria for considering studies and selection process

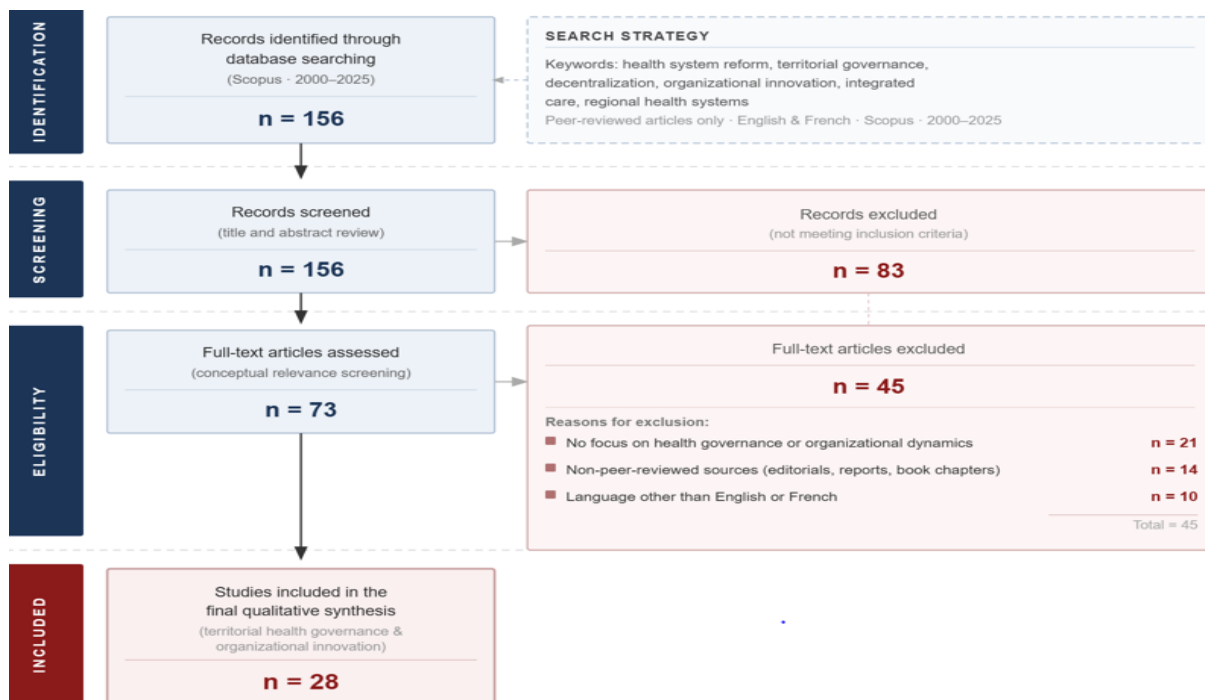
Study selection followed three eligibility criteria. Articles had to be peer-reviewed and published in English or French. Their subject matter had to fall within health systems, health policy, management, or related social science disciplines. Most importantly, each study had to engage directly, whether empirically or conceptually, with territorial governance of health systems, decentralization processes, organizational innovation, or integrated care delivery.

Studies were excluded if they did not concern governance or organizational dynamics in health, had its focus in an area that was not healthcare per se, or were non-peer-reviewed (editorials, commentaries, conference proceedings, reports and book chapters). Articles not written in English or French were also removed. These criteria were used consistently across the review to retain thematic relevance and the broad scope of the scoping review.

The initial search identified 156 records. Upon title and abstract screening, a total of 73 articles were included for full-text assessment. Further screening for conceptual relevance (territorial health governance and organizational innovation) resulted in 28 studies in the final sample. Documentation of each step of identification, screening, eligibility and inclusion processes was guided by PRISMA-ScR guidelines and reported in Figure 1 following the PRISMA-ScR format.

Given the exploratory nature of this scoping review, the study does not rely on predefined hypotheses or operational variables. Instead, it follows an open analytical framework in which themes and conceptual categories are derived inductively from the literature, in line with established methodological guidance for scoping reviews (Arksey & O'Malley, 2005; Munn et al., 2018).

Figure N°1: PRISMA flow diagram



Source: Authors' elaboration

Figure 1 illustrates the identification, screening, eligibility, and inclusion phases of the scoping review in accordance with the PRISMA-ScR guidelines. A total of 156 records were identified through the Scopus database; 73 articles were retained after screening, and 28 studies were included in the final qualitative synthesis.

2. Results

2.1. Description of included studies

The final database included 28 peer-reviewed articles published between 2000 and 2025, which represented more than two decades of academic and policy-related discussions in territorial health governance and organizational innovation. The included studies were conducted in diverse geographical settings. Cases range from countries representing high-income (France, Canada, Singapore and Italy) to low- and middle-income settings: Rwanda, Kenya, Mexico, Chile, Indonesia and multi-country analyses. The reviewed studies originate from quite diverse national contexts, suggesting that territorial reform strategies are discussed well beyond a single geographical area. At the same time, their practical meaning appears to vary considerably depending on institutional and political conditions. The literature also spans different academic traditions such as health policy, public administration, management, and public health, which

reflects the fact that territorial governance does not fit neatly within one disciplinary boundary. Methodologically, the majority of studies included qualitative or mixed-methods designs: comparative case studies; institutional analyses; policy evaluations and narrative and realist synthesis. Although used in some cases, quantitative methods remain rare and tend to be applied to issues of governance or performance frameworks, with little attention given to causal impact estimation. This methodological orientation is consistent with the exploratory nature of qualitative research. Most research takes a macro- or meso-level approach to reform processes at the national, regional or local levels. Less is known, however, about the impact of these policies on micro-level organizational and front-line service delivery. This pattern of distribution indicates that the literature has largely focused on governance mechanisms, coordination methods, and institutional configurations rather than operational processes at point-of-care.

The key features and attributes of the included studies (geographic setting, methodological approach, analytical level, dominant governance orientation) are summarized in Table 1.

Table N°1: Key characteristics of the included studies

Author(s), Year	Country / Region	Income Setting	Study Aim / Focus	Study Design / Methodology	Level of Analysis	Governance Reform Type	Main Insights	Scoping Theme
Bossert et al., 2003	Colombia; Chile	LMIC	Examine the effects of health sector decentralization on equity in resource allocation	Comparative quantitative and policy analysis	Macro / Meso (Multi-level governance arrangements)	Decentralization (Fiscal and administrative)	Decentralization can improve equity in resource allocation when accompanied by redistributive financing mechanisms and strong central stewardship	Decentralization & equity
Bossert & Mitchell, 2011	Multi-country	Mixed	Decentralization and equity	Comparative policy analysis	Macro / Meso (Multi-level governance arrangements)	Decentralization	Equity gains depend on institutional and fiscal capacity	Decentralization & equity
Bixi et al., 2013	China	LMIC	Sub-national governance and health equity	Policy and governance analysis (Case-based)	Macro / Meso (Inter-governmental and territorial governance)	Decentralization	Decentralized financing without aligned accountability exacerbates territorial inequities	Decentralization & equity
Bossert et al., 2022	Latin America	Mixed	Sustainability of equity-oriented decentralization	Conceptual / comparative analysis	Macro / Meso (Multi-level governance arrangements)	Decentralization	Long-term equity requires sustained institutional support	Decentralization & equity
Mohammed et al., 2016	Fiji	LMIC	Decentralization of health services and decision space	Qualitative case study (Decision space analysis)	Meso-level (Subnational / territorial governance)	Decentralization	Decentralization outcomes are strongly shaped by the actual decision space available to subnational actors, constrained by limited managerial capacity and central oversight	Decentralization & equity
Tsofa et al., 2017	Kenya (Kilifi)	LMIC	Devolution impacts on HR and commodities	Qualitative study	Meso-level (Regional / territorial governance)	Decentralization	Capacity gaps challenge early decentralization	Decentralization & equity
Kristiansen & Santoso, 2006	Indonesia	LMIC	Regional autonomy impacts	Case study	Meso-level (Regional / territorial governance)	Decentralization	Weak local capacity undermines reforms	Decentralization & equity
Mosca, 2006	Italy / Spain / Norway	HIC	Limits of decentralization	Comparative policy analysis	Macro / Meso (Multi-level governance arrangements)	Decentralization	Decentralization is context-dependent	Decentralization & equity
Oyaya & Rifkin, 2003	Kenya	LMIC	District-level planning reforms	Policy analysis	Meso-level (Regional / territorial governance)	Decentralization	Planning capacity shapes outcomes	Decentralization & equity
Priedeman Skiles et al., 2013	Rwanda	LMIC	Role of local organizations	Qualitative case study	Meso-level (Regional / territorial governance)	Decentralization	Local institutions mediate reforms	Decentralization & equity
Soeters et al., 2006	Sub-Saharan Africa	LMIC	Decentralization in fragile settings	Comparative analysis	Macro / Meso (Multi-level governance arrangements)	Decentralization	Fragility affects implementation	Decentralization & equity
Root et al., 2020	Honduras	LMIC	Organizational mediation of decentralization	Qualitative governance study	Meso-level (Regional / territorial governance)	Decentralization	Local conditions shape decentralization	Decentralization & equity
Denis et al., 2001	Canada (Québec)	HIC	Regional integration governance	Qualitative case study	Meso-level (Regional / territorial governance)	Territorial integration	Integration requires clear governance and leadership	Territorial integration
Greer et al., 2016	Europe	Mixed	Integrated regional governance	Comparative qualitative	Meso-level (Regional / territorial governance)	Territorial integration	Integration is an adaptive governance process	Territorial integration

Decentralization & equity
 Territorial integration
 Participatory co-governance
 Hybrid accountability

HIC = High-income Country, LMIC = Low- and Middle-income Country, N/A = Not applicable

Author(s), Year	Country / Region	Income Setting	Study Aim / Focus	Study Design / Methodology	Level of Analysis	Governance Reform Type	Main Insights	Scoping Theme
Burke et al., 2014	Ireland	HIC	Regional health governance reform	Qualitative case study	Macro / Meso (Multi-level governance arrangements)	Territorial integration	Clear roles support regionalization	Territorial integration
Özçelik et al., 2021	Brazil / Turkey	Mixed	PHC organization and equity	Comparative case study	Macro / Meso (Multi-level governance arrangements)	Territorial integration	Organization influences equity	Territorial integration
Massuda et al., 2018	Latin America	LMIC	Governance principles, participation, and equity in primary health care reforms inspired by Alma-Ata	Qualitative and historical policy analysis	Macro / Meso (Health system and territorial governance)	Participatory co-governance	The central role of community participation and shared governance values in shaping equitable primary health care reforms	Participatory co-governance
Ansell & Gash, 2008	Multi-context	N/A (Conceptual)	Collaborative governance framework	Conceptual / theoretical analysis	Macro / Meso (Multi-level governance arrangements)	Participatory co-governance	Institutionalized participation can enhance legitimacy and collaborative capacity	Participatory co-governance
McIntyre et al., 2017	Canada	HIC	Deliberative primary care reform	Deliberative synthesis	Meso-level (Regional / territorial governance)	Participatory co-governance	Participation strengthens ownership	Participatory co-governance
Arredondo et al., 2018	Mexico	LMIC	Governance trends after reforms	Qualitative analysis	Macro / Meso (Multi-level governance arrangements)	Participatory co-governance	Participation uneven across regions	Participatory co-governance
Iedema et al., 2017	Australia	Mixed	Deliberative governance networks	Qualitative / conceptual analysis	Macro / Meso (Multi-level governance arrangements)	Participatory co-governance	Networks support collective learning	Participatory co-governance
Atun et al., 2015	Multi-country	LMIC	Participatory management implementation	Political / qualitative analysis	Meso-level (Regional / territorial governance)	Participatory co-governance	Participation constrained by power relations	Participatory co-governance
Tediosi et al., 2009	Italy	HIC	Decentralization under fiscal constraints	Policy analysis	Macro / Meso (Multi-level governance arrangements)	Hybrid accountability	Hybrid models balance autonomy and control	Hybrid accountability
Binagwaho & Scott, 2015	Rwanda	LMIC	Post-reform governance	Policy analysis	Macro / Meso (Multi-level governance arrangements)	Hybrid accountability	Hybrid governance supports rebuilding	Hybrid accountability
Ong et al., 2018	Singapore	HIC	Stakeholder views of reform	Qualitative study	Macro-level (National policy and governance)	Hybrid accountability	Strong steering reduces fragmentation	Hybrid accountability
Chansa et al., 2019	Zambia	LMIC	Performance-based contracting	Mixed-methods	Macro / Meso (Multi-level governance arrangements)	Hybrid accountability	Accountability tools shape equity	Hybrid accountability
Jafari et al., 2018	Iran	LMIC	Hospital governance reform barriers	Qualitative content analysis	Macro / Meso (Organizational / managerial level)	Hybrid accountability	Governance capacity limits reform	Hybrid accountability
Chol et al., 2018	Sub-Saharan Africa	LMIC	Post-conflict reforms	Literature review	Macro / Meso (Multi-level governance arrangements)	Hybrid accountability	Adaptive governance needed	Hybrid accountability

Decentralization & equity
 Territorial integration
 Participatory co-governance
 Hybrid accountability

HIC = High-income Country; LMIC = Low- and Middle-income Country; N/A = Not applicable

Source: Authors' elaboration

Based on these descriptive characteristics, the following section synthesizes the included studies thematically to identify the main trajectories of territorial health governance and organizational innovation.

2.2. Thematic map around models of territorial health governance

The synthesis of the selected studies provides a structured understanding of the literature on territorial health governance and organizational innovation.

Four main analytical clusters can be identified, reflecting different but interconnected reform trajectories.

To provide a clearer and more structured overview of these reform trajectories, Table 2 summarizes the main characteristics, key drivers, and potential risks associated with each identified cluster.

Table N°2: Analytical synthesis of territorial health governance reform trajectories

CLUSTER CORE LOGIC	ORGANIZATIONAL INNOVATION DIMENSION	KEY ENABLING CONDITIONS	IMPLEMENTATION CHALLENGES	STRUCTURAL PREREQUISITES
C1 DECENTRALIZATION & EQUITY	<i>Redistribution of authority across governance levels</i>	Reconfiguration of decision-making processes and resource allocation	Risk of fragmentation; territorial inequalities; weak local capacity	<ul style="list-style-type: none"> Institutional capacity Fiscal decentralization Regulatory coherence
C2 TERRITORIAL INTEGRATION	<i>Coordination across healthcare and social services within defined territories</i>	Development of integrated organizational structures and shared management practices	Professional resistance; governance complexity; system incompatibility	<ul style="list-style-type: none"> Interoperable IS Leadership alignment Coordination mechanisms
C3 PARTICIPATORY GOVERNANCE	<i>Inclusion of multiple stakeholders in decision-making processes</i>	Transformation of governance practices toward collaborative and inclusive models	Symbolic participation; limited decision power; resource constraints	<ul style="list-style-type: none"> Legal frameworks Stakeholder engagement Transparency mechanisms
C4 HYBRID ACCOUNTABILITY	<i>Combination of centralized oversight and decentralized implementation</i>	Emergence of mixed governance models balancing autonomy and control	Role ambiguity; coordination costs; accountability tensions	<ul style="list-style-type: none"> Clear role definition Performance monitoring Inter-level trust

Source: Authors' elaboration

Building on this synthesis, the following sections examine each cluster in greater detail.

The first cluster, decentralization and equity, focuses on the transfer of authority, resources and decision-making power from central to regional or local levels by governments. Studies within this cluster often characterize decentralization as a means to enhance equity, responsiveness and align with local health needs. However, several studies suggest that decentralization may lead to fragmentation when institutional capacity and redistributive funding mechanisms are insufficient.

The second cluster focuses on territorial integration and includes research examining reforms aimed at linking hospitals, primary care, and social service providers within defined territories. A second body of work documents the emergence of system-wide organizational arrangements, such as health regions, hospital territories, and similar structures, designed to support integrated planning and coordinated service delivery. Efficiency gains and improved governance are frequently reported, yet recurring tensions around leadership diversity, information system compatibility, and professional autonomy persist across contexts.

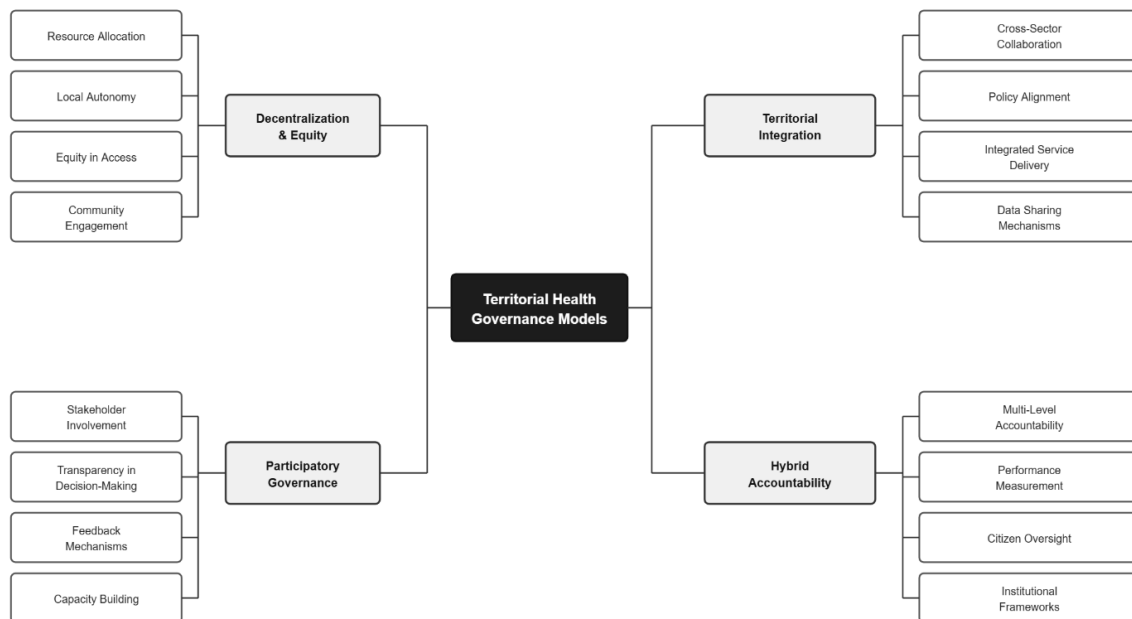
Participatory co-governance constitutes a third strand in the literature. Here, the involvement of healthcare professionals, local authorities, and community actors in territorial decision-making is increasingly framed not as an optional addition, but as a condition for legitimacy, transparency, and social accountability. That said, several studies warn that participation risks

becoming symbolic or simply sporadic when formal mandates, adequate resourcing, and genuine decision-making authority are absent.

A fourth cluster brings together work on hybrid accountability arrangements, where centralized oversight and local operational autonomy coexist. These governance configurations are widely described as better suited to the complexity of contemporary health systems than either purely centralized or purely decentralized models. Evidence suggests, however, that their performance depends heavily on how clearly roles are defined and how consistently outcomes are monitored.

Figure 2 presents a thematic framework for understanding regional health governance systems based on patterns observed in existing literature. This framework illustrates how territorial governance models emerge from the interaction between decentralization dynamics, integration processes, participatory mechanisms, and accountability structures.

Figure N°2: Thematic map of territorial health governance models identified in the literature



Source: Authors' elaboration

2.3. Patterns across and enabling conditions

Building on these thematic clusters, several cross-cutting patterns emerge from the literature regarding the conditions that shape territorial governance reforms and their outcomes.

First, institutional capacity at the territorial level appears as a critical factor. Reforms are depicted more positively where regional or local authorities benefit from managerial capacity, administrative continuity and analytic capacity into operational improvements. Conversely, limited institutional capacity typically constraints in implementation regardless of the governance model implemented.

Second, financial arrangements and mechanisms play a central role in all these contexts. The literature consistently suggests that territorial autonomy, when not supported by effective fiscal coordination and redistributive mechanisms, carries a significant risk of reinforcing territorial disparities, particularly in resource-constrained settings. This dynamic reflects the uneven capacity of territories to mobilize financial and organizational resources, which can ultimately affect service delivery and equity outcomes.

In addition, several studies highlight the importance of enabling investments, particularly in information systems that support interoperability and performance monitoring. Digital infrastructures are often described as facilitating coordination across organizations, strengthening accountability mechanisms, and supporting evidence-based decision-making at a broader scale.

Collectively, these findings suggest that territorial health governance appears to be better understood as a dynamic and context-sensitive process, shaped by the interaction between institutional arrangements, organizational practices, and local capacities rather than as a fixed or standardized model.

3. Discussion

This scoping review gathers a disparate set of international literature around territorial health governance and organizational innovation, which converge on four prevalent and intersecting trajectories: decentralization for equity, territorial integration, participatory co-governance, and hybrid accountability. Considered together, these trajectories suggest that territorial health reforms cannot be viewed as isolated policy instruments; rather, they form part of a broader reconfiguration of health system governance aimed at addressing fragmentation, enhance coordination and increase system resilience within an increasingly complex institutional context.

Decentralization is approached as fundamental to territorial and organizational innovation in the reviewed literature. Instead, it appears to involve deeper institutional and managerial

transformations that reshape how responsibilities are distributed across governance levels. Decentralization seems to constitute more profound managerial, institutional and even cultural changes within health systems. It is believed, by some, to enhance geographical equity and local responsibility particularly as it can be achieved within a coherent national policy framework, supported by compensatory fiscal mechanisms (Bossert & Mitchell, 2011) . Experiences in Latin America, for instance, have shown that fiscal and administrative devolution has facilitated planning according to territorial proximity with more context-appropriate distribution of primary care resources, particularly in maternal and child health. Meanwhile, evidence from countries like Kenya and Indonesia suggests that decentralized processes introduced in the absence of managerial capacity, institutional maturity, and predictable funding tend to weaken service delivery and that for some services may even increase fragmentation (Kristiansen & Santoso, 2006; Tsofa et al., 2017) . In combination, these results indicate that decentralization should be conceived as a phased and responsive process rather than a one-off devolution.

A second key insight relates to territorial integration as a response to chronic fragmentation between levels of care. Several studies included describe integration initiatives aimed at linking hospitals, primary care and social services in governance structures based on territoriality with a view to better coordination, continuity of care and population-based planning (Greer et al., 2016). In both literature and policy, reforms such as France's GHTs or Québec's CISSS/CIUSSS are frequently highlighted as examples of innovative shared governance arrangements and integrated management structures that promote cooperation while maintaining institutional diversity (Breton et al., 2013; J.-L. Denis et al., 2001). These models can be interpreted as forms of organizational innovation, as they redefine coordination mechanisms and managerial practices across healthcare organizations. However, the literature also makes reference to persistent barriers to implementation such as inconsistent leadership, limited information systems interoperability and cultural tensions related to professional independence. From this perspective, territorial integration appears less as a stable organizational structure and more as a process that juxtaposes autonomy with coordination.

A third trajectory identified in the review is the rise of participatory co-governance. Participatory structures are also frequently referred to as tools that give health providers, local government officials, and community actors a seat at the table in decision-making in order to increase legitimacy, transparency, and social accountability (Ansell & Gash, 2008). Institutionalized participation may contribute to trust-building and adaptive governance in

contexts ranging from Ireland and Canada to Rwanda where participatory mechanisms are formally embedded into governance systems, as well as tied to transparent performance-monitoring tools (Jean-Louis Denis et al., 2001; McIntyre et al., 2017). In contrast, some studies in LMICs warn that participation is at risk of becoming symbolic and limited if there are not mandates enforced by the law or increased access to information, skills development. These findings support the perspective that co-governance is not a superficial consultation exercise, but rather requires an institutional change of power relationships which needs ongoing resources and infrastructure.

Hybrid modes of governance can be understood as practical responses to the inherent tensions within territorial health reforms. These approaches typically combine central strategic steering with decentralized implementation, aiming to preserve national coherence and equity while allowing some degree of regional flexibility (Saltman et al., 2007).

Evidence from countries such as Italy, England, and Rwanda suggests that performance-based models, shared budgeting mechanisms, and monitoring systems may strengthen accountability while still leaving room for local decision-making (Greer et al., 2016). However, the literature also indicates that such hybrid arrangements remain fragile and highly context-dependent. Their effectiveness appears to rely less on formal institutional design than on factors such as clarity of roles, transparent financial rules, and a minimum level of trust between governance levels.

Several enabling conditions are consistently highlighted across studies. These include institutional capacity at the territorial level, fiscal arrangements that balance autonomy and redistribution, interoperable information systems, and professional cultures that support collaborative learning (Bossert & Mitchell, 2011; Greer et al., 2016; Sbai & Belaroussi, 2023).

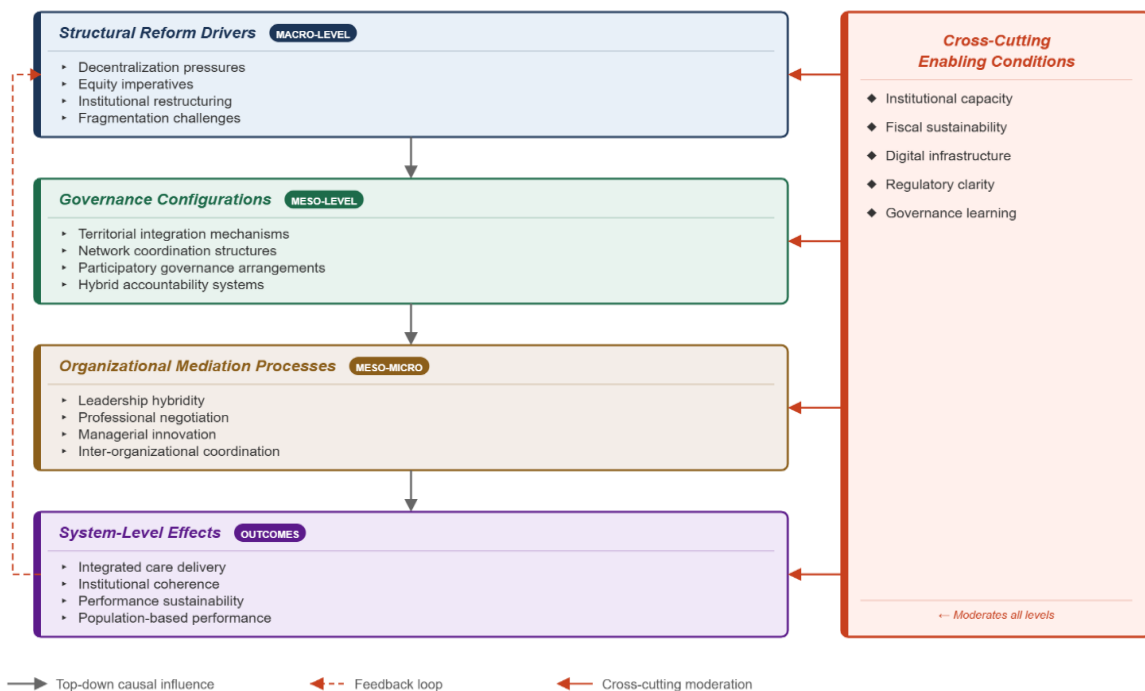
Overall, the synthesis suggests that coherence in governance arrangements often matters more than their formal structure, and that similar models may produce different outcomes depending on contextual factors. In the Moroccan context, these findings provide useful insights for understanding the ongoing implementation of the Groupements Sanitaires Territoriaux. Rather than being viewed as a direct replication of international models, this reform can be interpreted as a process of contextual adaptation shaped by local institutional conditions. If managed appropriately, such as with calibrated degrees of decentralization, combined with territorially anchored organization, mechanisms for participation and hybrid accountability tools, GSTs may be able to serve as platforms for organizational learning and innovation. As the

international literature also implies, the main challenge is to preserve national strategic consistency by allowing territorial actors to transform reforms according to local needs.

More broadly, Morocco’s experience could also enrich the global conversation on territorialized health systems on how emerging contexts may address decentralization and solidarity, integration and professional autonomy, innovation and accountability. It would be valuable for future research building on this scoping review to empirically examine how these governance trajectories intersect in practice and how territorial reforms develop over time.

Building on the thematic clustering identified across the 28 included studies, Figure 3 provides an integrative conceptual framework synthesizing the dominant reform trajectories and cross-cutting enabling conditions observed in the literature.

Figure N°3: Conceptual Framework: Territorial Health Governance and Organizational Innovation



Source: Authors’ elaboration

Conclusion

This scoping review set out to map and synthesize international evidence on territorial health governance and organizational innovation, with the aim of identifying the main reform trajectories discussed in the literature and the institutional conditions that appear to shape their implementation across different health system contexts. Based on 28 peer-reviewed studies published between 2000 and 2025, the review highlights four interrelated trajectories: decentralization and equity, territorial integration, participatory co-governance, and hybrid accountability, which structure much of the contemporary debate on territorialized health system reforms. Overall, the literature does not portray territorial health governance as a standardized or readily transferable model. Instead, territorialization is more often described as a context-dependent process, shaped by institutional arrangements, governance capacities, and broader socio-political environments. Across settings, reform trajectories seem to be influenced less by formal institutional design alone than by the coherence of governance configurations and the ability to align authority, resources, and accountability across different levels of the health system.

In this respect, three enabling conditions recur throughout the reviewed studies: a clear delineation of roles between central and territorial authorities, sufficient managerial and financial capacity at the meso-level, and fiscal mechanisms capable of balancing territorial autonomy with national solidarity and equity. From a comparative standpoint, the reviewed studies suggest that territorial governance reforms follow different logics depending on context.

In high-income countries, such reforms are often framed as managerial and organizational innovations aimed at improving coordination, accountability, and system integration within already complex service delivery environments. In contrast, in low- and middle-income countries, territorial governance is more frequently discussed as a pathway toward equity, resilience, and responsiveness to local health needs, while also revealing vulnerabilities linked to limited institutional capacity, uneven decentralization processes, and fragile financing arrangements. These differences point to the importance of institutional learning, gradual reform sequencing, and context-sensitive policy adaptation.

With regard to Morocco, the ongoing implementation of the Groupements Sanitaires Territoriaux can be interpreted in light of these international experiences as a process of contextual adaptation rather than direct model replication. The synthesis presented in this review suggests that particular attention may need to be paid to governance coherence, regional

managerial capacity, clarity of institutional responsibilities, interoperable information systems, and participatory arrangements; dimensions that recur in the literature as shaping territorial reform trajectories.

Several limitations of this review should be acknowledged. The analysis was restricted to peer-reviewed literature indexed in Scopus and did not include grey literature, policy documents, or detailed implementation reports, which may capture informal governance dynamics and operational challenges more directly. In addition, as a scoping review, this study does not assess the effectiveness of specific reforms, but rather maps concepts, models, and patterns discussed in the existing literature.

Future research could build on these findings by examining empirically how territorial health governance reforms unfold over time, particularly in low- and middle-income contexts. Longitudinal and comparative studies focusing on the interaction between decentralization, organizational innovation, participation, and governance arrangements may help to deepen understanding of reform dynamics and inform more adaptive policy design.

Taken together, this scoping review suggests that territorial health governance and organizational innovation are discussed in the literature not merely as technical adjustments, but as processes that reshape relationships between institutions, professionals, and territories. When supported by coherent governance arrangements, learning-oriented organizational cultures, and equitable financing mechanisms, territorialized health systems appear to hold potential for improving coordination, accountability, and system resilience. In this sense, Morocco's GST reform may also contribute to the broader international discussion on how health systems attempt to reconcile decentralization with solidarity, innovation with accountability, and territorial autonomy with collective cohesion.

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