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RESEARCH ARTICLE

COVID-19 and Public-Private Partnerships: Strategic Issues for the Resilience of the Moroccan Health System

ABSTRACT

This article examines how public-private partnerships (PPPs) were mobilized within Morocco's health system during the COVID-19 pandemic, and how these hybrid arrangements shaped organizational and territorial resilience, as well as social tensions around equity and access. Building on a qualitative research design combining (i) documentary analysis of PPP-related agreements and regulatory texts (2020–2023), (ii) fifteen semi-structured interviews with institutional, medical, private-sector and civil-society stakeholders, and (iii) a systematic review of peer-reviewed and grey literature, the study mobilizes a dual analytical lens: collaborative governance (Ansell & Gash, 2008) and systemic crisis management/resilience (Boin, 't Hart, Stern, & Sundelius, 2016). Findings suggest that PPPs contributed to rapid surge capacity and operational coordination, particularly through temporary pooling of intensive care resources, yet their benefits remained territorially uneven and insufficiently regulated from an equity perspective. Across the analyzed PPP initiatives, equity safeguards such as explicit social pricing clauses or access conditions were frequently absent, contributing to perceptions of a two-speed health system. The article argues that, beyond emergency pragmatism, PPPs can only become levers for inclusive resilience if embedded in robust regulatory frameworks, transparent monitoring and territorially grounded governance mechanisms, in alignment with Morocco's broader health reform agenda toward universal health coverage.

KEYWORDS Public-Private Partnerships · COVID-19 · Health System · Resilience · Equity · Morocco

AUTHOR

Oumaima Omari Harake
Assistant Professor and Researcher, Université de Poitiers, CEREGE (UR 13564)- France
oomari01@poitiers.iae-france.fr

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1. Introduction

The COVID-19 pandemic acted as a stress test for health systems worldwide. In Morocco, the crisis revealed long-standing structural constraints, limited hospital bed capacity, uneven distribution of resources between metropolitan and peripheral areas, and persistent gaps in financial protection. Pre-crisis indicators pointed to comparatively low inpatient capacity relative to high-income benchmarks: WHO/World Bank series report values below or around one hospital bed per 1,000 population in recent years, while OECD averages exceed four beds per 1,000 (Figure 2). During the first waves of SARS-CoV-2 transmission (2020), Morocco responded through a mix of public measures (emergency procurement, conversion of facilities, mobilization of military

health capacities) and negotiated collaborations with private providers. These collaborations often framed as PPPs or emergency public-private arrangements sought to secure additional care capacity, reduce bottlenecks in intensive care, and maintain continuity for non-COVID services.

PPPs are not new in Morocco. The country has progressively consolidated a legal framework for public-private partnership contracts, notably through Law No. 86-12 and its amendment by Law No. 46-18, aiming to clarify procedures and governance for PPP projects. Yet the pandemic accelerated the political and operational reliance on private sector capacities, raising a key question: were these collaborations simply ad hoc crisis instruments, or do they signal a structural rebalancing of Morocco's public-private mix in health?

This article addresses that question by analyzing how PPPs were designed, implemented and experienced during the crisis, with a focus on two intertwined dimensions: (i) resilience (surge capacity, adaptive coordination, learning) and (ii) equity (affordability, territorial access, and social accountability).

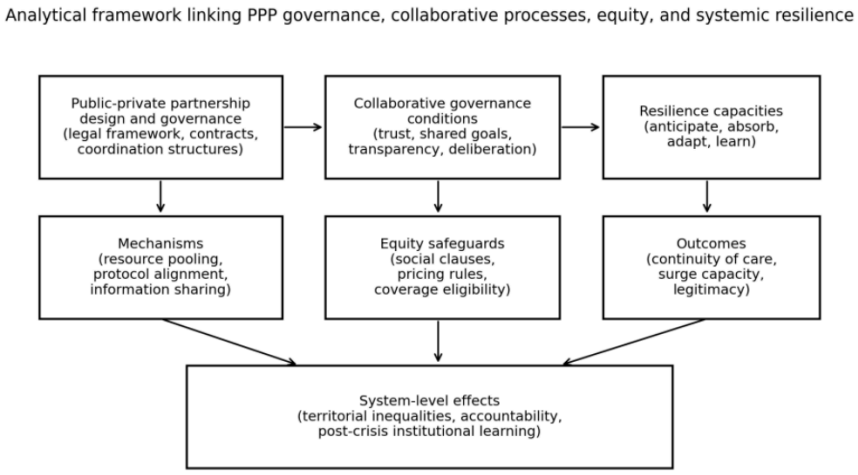


Figure 1. Analytical framework linking PPP governance, collaborative processes, equity, and systemic resilience.

2. Context: The Moroccan Health System and the COVID-19 Shock

Before COVID-19, Morocco's health system faced a dual challenge: expanding coverage while addressing geographic and socioeconomic disparities. International sources consistently highlight that bed density and human resources remain lower than many comparators. For instance, the World Bank reported that at the beginning of the pandemic Morocco had about 1.1 hospital beds per 1,000 people, placing the country among the lower-capacity systems in its income group. Meanwhile, Morocco's reform agenda toward universal social protection and the generalization of mandatory health coverage gained political momentum during the pandemic years, with several initiatives aiming to expand coverage to previously uninsured groups.

In parallel, Morocco displays a growing public-private divide: public services remain the primary provider of care delivery, but private provision and out-of-pocket spending are substantial. Recent international briefings emphasize the weight of private spending and the perceived quality gap between public and private services. These structural features shaped the political feasibility and the operational logic of PPP mobilization during COVID-19: private clinics and laboratories represented a reserve of beds, equipment and specialized staff that could be rapidly integrated into the national response provided that governance and payment rules were agreed upon.

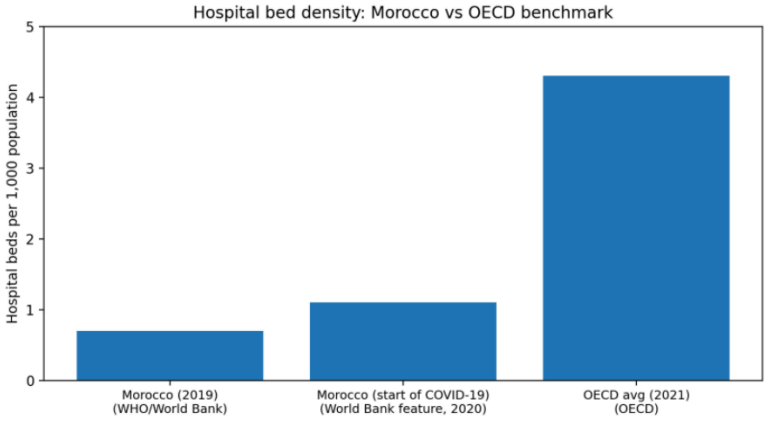


Figure 2. Hospital bed density benchmarks (selected years). Sources: World Bank/WHO indicator series; World Bank (2020) COVID-19 feature; OECD Health at a Glance (2023).

3. Literature Review

3.1. PPPs as Instruments of Modernization and Organizational Efficiency

Pro-PPP arguments emphasize responsiveness, resource mobilization and managerial efficiency. In health systems characterized by fiscal constraints or infrastructure gaps, public-private collaboration can facilitate accelerated investment, access to specialized expertise, and more flexible procurement. In crisis settings, PPPs may also enable rapid surge capacity through contractual reallocation of resources (beds, oxygen, ventilators) and the integration of private diagnostic and treatment capacities.

This instrumental perspective aligns with collaborative governance scholarship, which conceptualizes cross-sector cooperation as a structured process of shared decision-making among public agencies and non-state actors. Ansell and Gash (2008) highlight the importance of face-to-face dialogue, trust-building, and shared understanding to generate collaborative outputs. Within pandemic governance, these conditions translate into the ability to harmonize clinical protocols, coordinate triage criteria and negotiate payment mechanisms that reduce friction between sectors.

3.2. Critical Perspectives: Privatization, Fragmentation and Inequality

Critical scholarship warns that PPPs may entrench market logics in essential public services and contribute to the segmentation of access. Concerns include “creeping privatization”, regulatory capture, the creation of dual tracks of quality (for solvent vs non-solvent users), and accountability gaps when private entities perform quasi-public missions without commensurate transparency obligations.

Beyond normative debates, health system research stresses that fragmentation in funding flows and service delivery can erode equity and weaken system-wide performance. Recent work on health financing fragmentation in low- and middle-income countries (LMICs) highlights how under-resourcing, rigid payment streams and weak alignment of incentives can undermine people-centred primary care, public trust and distributional justice. While this literature often focuses on financing, it is directly relevant to PPP governance: contractual design and payment rules may either reduce fragmentation (through interoperability and coherent purchasing) or deepen it (through parallel pathways).

In Morocco, public discussions during and after the pandemic increasingly reflected these tensions, including perceptions that private expansion could weaken public hospitals by attracting staff and concentrating investment in metropolitan areas.

3.3. Territorialization, Regulation and the Question of Inclusive Resilience

A third strand of literature argues for moving beyond a binary "PPPs: good or bad" framing and instead examining how regulatory design, territorial governance and social accountability shape outcomes. From this perspective, partnerships may support resilience only if coupled with enforceable equity safeguards (social clauses, transparent pricing rules, eligibility conditions), and if decisions are anchored in territorial needs rather than exclusively centralized technocratic logics.

Morocco's broader health reforms including efforts toward territorial governance innovations and the redesign of institutional arrangements create an evolving backdrop for PPP debates. However, the pandemic experience suggests that emergency-driven contracts may circumvent longer-term governance reforms unless monitoring and learning mechanisms are institutionalized.

4. Theoretical Framework

This study combines two complementary analytical perspectives. First, collaborative governance (Ansell & Gash, 2008) focuses on the process conditions under which public and private actors cooperate in consensus-oriented forums. Key dimensions include starting conditions (power/resource asymmetries), institutional design (rules of engagement, inclusiveness), facilitative leadership, and an iterative collaborative process (dialogue, trust, commitment, shared understanding). Applied to pandemic PPPs, this lens helps interrogate how protocols were negotiated, how disputes were managed, and how coordination structures affected the speed and legitimacy of decisions.

Second, systemic crisis management and resilience (Boin et al., 2016) emphasizes a system's capacity to absorb shocks while maintaining essential functions and to learn and adapt in ways that reduce future vulnerability. Resilience is not merely "bouncing back"; it also entails adaptive reconfiguration, institutional learning and legitimacy maintenance under high uncertainty. Within this perspective, PPPs may be interpreted as adaptive instruments that expand capacity and flexibility, but also as potential sources of new dependencies and legitimacy risks if equity and accountability are undermined.

The integration of these frameworks enables an assessment of PPPs as both coordination processes and institutional choices with distributive consequences (Figure 1).

5. Methodology

The research design is qualitative and interpretive, aiming to capture the institutional logics, governance mechanisms and equity tensions embedded in PPP arrangements during COVID-19.

5.1. Datasources

Three complementary data sources were triangulated:

- Documentary analysis of 12 PPP-related agreements and regulatory texts produced between 2020 and 2023 (including the PPP legal framework and sectoral guidance);
- Fifteen semi-structured interviews with key stakeholders (public officials, private clinic managers, physicians, civil society representatives and health policy experts);

- A systematic review of 43 scientific and technical publications (peer-reviewed articles and grey literature) using PRISMA-inspired screening principles.

5.2. Analyticalstrategy

Materials were coded thematically using a hybrid strategy combining deductive categories derived from the theoretical framework (coordination, trust, accountability, resilience capacities, equity safeguards) and inductive coding to capture context-specific themes (territorial asymmetries, contractual ambiguity, informal selection practices). Following Braun and Clarke's (2006) approach, themes were iteratively refined to ensure internal coherence and analytical distinctiveness.

Table 1. Empirical corpus and data sources

Data source	Scope	Contribution
Documents	12 agreements/texts (2020–2023) + institutional reports	Contract rules; governance design; equity clauses
Interviews	n=15 (public officials, private managers, clinicians, civil society, experts)	Implementation dynamics; perceived fairness; legitimacy
Systematic review	n=43 (peer-reviewed + grey literature)	Context and triangulation (indicators, comparisons, concepts)

6. Findings

6.1. Crisis Governance Under Construction: Rapid Coordination, Weak Institutionalization

Interviewees described the early pandemic period as a phase of "improvised coordination" in which the urgency of rising cases outweighed routine administrative procedures. Public actors reported that negotiated agreements with private providers facilitated rapid access to beds, oxygen supplies and specialized staff in urban centers. Private clinic managers emphasized that collaboration was enabled when clinical protocols and payment rules were clarified quickly. However, the collaborative process remained fragile. Stakeholders highlighted (i) unclear lines of authority between central and regional levels, (ii) limited transparency regarding selection of partner facilities, and (iii) insufficient mechanisms to monitor performance and compliance. From a collaborative governance perspective, the process relied heavily on informal trust and crisis leadership, but lacked durable institutional design features that would support sustained collaboration beyond the emergency.

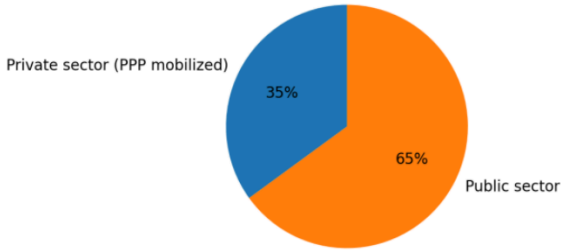


Figure 3. Illustrative share of ICU capacity mobilized through private providers during the first wave (35%) as reported in secondary literature.

6.2. Uneven Territorial Resilience: Metropolitan Gains, Peripheral Strain

PPPs did not deliver uniform resilience across territories. In Casablanca, Rabat and other major cities, respondents described tangible operational gains: faster admission pathways for severe cases, temporary relief of public hospitals, and improved coordination of referrals. By contrast, interviewees from peripheral and rural regions emphasized that PPP benefits were limited by (i) the geographic concentration of private clinics, (ii) transport and referral barriers, and (iii) weaker regional governance capacity. This territorial polarization reflects starting conditions emphasized by Ansell and Gash (2008): resource asymmetries structure what collaboration can achieve. In regions with few private facilities, PPPs could not substitute for structural public investment. Several stakeholders also noted indirect effects, such as disruption of chronic care pathways and reduced preventive services, which may have longer-term health impacts.

6.3. Hidden Social Costs: Equity Gaps and the Risk of a Two-Speed System

While many stakeholders recognized the short-term usefulness of PPPs, the most contentious issue concerned affordability and fairness. Civil society representatives and some clinicians reported that access to private facilities under PPP arrangements was often perceived as opaque, and that vulnerable groups (low-income households, persons with disabilities, rural residents) faced barriers linked to upfront payments, administrative complexity, or informal selection practices. From a contractual standpoint, the documentary analysis suggested that many PPP arrangements contained limited explicit equity safeguards. A recurrent concern was the lack of enforceable social pricing mechanisms or standardized coverage rules. Figure 4 synthesizes this issue using the study's contract-screening results (illustrative summary): a large share of analyzed PPP initiatives did not include explicit social pricing clauses.

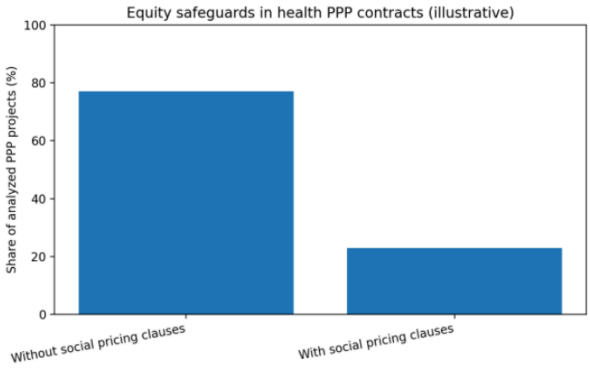


Figure 4. Equity safeguards in analyzed health PPP contracts (illustrative summary from the study's contract screening)

7. Discussion

The Moroccan case illustrates a common pandemic pattern: PPPs can operate as rapid adaptation instruments that expand surge capacity and provide short-term operational flexibility, yet they do not automatically translate into inclusive, system-wide resilience.

7.1. PPPs as "shock absorbers" rather than transformative reforms

Using Boin et al.'s (2016) lens, PPPs helped the system absorb the initial shock by mobilizing additional beds and coordination channels. However, interviewees suggested that learning and institutionalization remained limited: emergency contracts were often time-bound, evaluation tools were scarce, and responsibility for monitoring was fragmented. Without systematic feedback loops, the resilience gain risks being temporary.

7.2. Collaborative governance under asymmetry

Collaborative governance theory highlights how starting conditions shape processes and outcomes. The Moroccan partnerships operated under asymmetric conditions: private actors controlled critical resources in metropolitan areas, while public authorities retained regulatory authority but faced time pressure and informational constraints. Such asymmetry can accelerate cooperation when interests align (crisis response), but it can also reduce transparency and weaken equity-oriented bargaining when public purchasers lack standardized purchasing and monitoring tools.

7.3. Equity as a core dimension of resilience

The findings support the argument that equity is not an "add-on" to resilience. A response that increases capacity while deepening exclusion undermines legitimacy and can generate post-crisis distrust. In this sense, PPP governance should be evaluated not only on throughput indicators (beds mobilized, admissions processed) but also on distributional outcomes (who benefits, where, under what conditions). Morocco's ongoing efforts to expand health coverage and redesign governance structures provide an opportunity to re-embed PPPs within a coherent purchasing strategy aligned with universal health coverage principles.

8. Policy Recommendations

Based on the findings and theoretical implications, the following measures can strengthen the inclusive resilience potential of health PPPs in Morocco:

- Create independent regional observatories (or evaluation units) tasked with monitoring PPP performance, equity outcomes and contract compliance.
- Mandate the inclusion of equity safeguards in PPP contracts (social pricing clauses, explicit eligibility rules, accessibility requirements, grievance mechanisms).
- Strengthen public sector capabilities in contract engineering and strategic purchasing (costing, risk allocation, performance indicators, auditing).
- Promote interoperability between public and private information systems to enable real-time capacity monitoring and reduce administrative barriers.
- Ensure territorially grounded governance by aligning partnership design with regional needs assessments and reinforcing the decision-making role of regional health authorities.

9. Conclusion

Public-private partnerships in Morocco's COVID-19 response reveal a paradox. They enabled rapid operational coordination and temporary reinforcement of care capacity in a period of acute uncertainty. At the same time, their benefits were territorially concentrated and frequently insufficiently structured to protect equity, contributing to social tensions and perceptions of a two-speed system.

PPPs can become levers of systemic resilience only if they are governed as instruments of public value: contractually explicit about equity, monitored transparently, and embedded within territorially grounded governance and learning mechanisms. Future research could deepen the analysis by quantifying distributional effects (by region, insurance status and socioeconomic group) and by comparing Morocco's experience with other middle-income health systems that relied on private surge capacity during the pandemic.

References

Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. Journal of Public Administration Research and Theory, 18(4), 543–571. https://doi.org/10.1093/jopart/mum032

Boin, A., 't Hart, P., Stern, E., & Sundelius, B. (2016). The politics of crisis management: Public leadership under pressure (2nd ed.). Cambridge University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

European Investment Bank. (2020, December 2). COVID-19 threatened Morocco's health system until it didn't. https://www.eib.org/en/stories/morocco-health-system-covid-19

Expertise France. (2022, August 4). Project to support the generalisation of mandatory health insurance in Morocco. https://www.expertisefrance.fr/en/projects/project-maroc-support

Gatome-Munyua, A., et al. (2025). Reducing fragmentation of primary healthcare financing for more equitable people-centred primary healthcare. BMJ Global Health, 10, e015088. https://gh.bmj.com/content/10/1/e015088

Japan International Cooperation Agency. (2025). Data collection survey on health care services delivery and related systems (selected indicators for Morocco). https://openjicareport.jica.go.jp/pdf/12388989.pdf

Ministry of Economy and Finance, Morocco. (2020, January 14). La loi n°46-18 relative aux contrats de partenariat public-prive . https://www.finances.gov.ma/fr/Pages/detail-actualite.aspx?fiche=4689

Organisation for Economic Co-operation and Development. (2023). Health at a glance 2023: OECD indicators (Hospital beds and occupancy). https://www.oecd.org/en/publications/2023/11/health-at-a-glance-2023_e04f8239/full-report/hospital-beds-and-occupancy_10add5df.html

World Bank. (2020, June 16). Morocco: Stepping up to the COVID-19 pandemic outbreak. https://www.worldbank.org/en/news/feature/2020/06/16/morocco-stepping-up-to-the-covid-19-pandemic-outbreak

World Bank. (2023). Morocco Health Reform Program (P179014): Program appraisal and related documents. https://documents.worldbank.org/

World Bank. (2023, June 19). New program in Morocco supports improved access to quality healthcare for all. https://www.worldbank.org/en/news/press-release/2023/06/19/new-program-in-morocco-supports-improved-access-to-quality-healthcare-for-all

World Bank. (n.d.). Hospital beds (per 1,000 people) – Morocco (SH.MED.BEDS.ZS). Retrieved

December 16, 2025, from https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?locations=MA

World Bank PPP Resource Center. (2020). PPP laws / concession laws – Morocco (Law No. 46-18 amending Law No. 86-12). https://ppp.worldbank.org/library/ppp-laws-concession-laws-morocco