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FROM WAR TO RECOVERY: STRENGTHENING UKRAINE'S HEALTHCARE FOR A RESILIENT FUTURE

ABSTRACT

The availability and effectiveness of healthcare infrastructure are critical for both immediate humanitarian response and long-term societal recovery, especially in a country embroiled in war. The Russian full-scale invasion has placed immense strain on Ukraine's already fragile healthcare system, exacerbating pre-existing challenges such as underfunding, limited capacity, and workforce shortages. This situation underscores the need for targeted reforms and resource allocation to ensure accessibility and resilience. Rebuilding efforts must address systemic fragmentation, integrating diverse stakeholders like international donors, civil society, and unions, while prioritizing long-term self-reliance through financial sustainability and institutional development. A successful recovery requires inclusive policy-making, anti-corruption measures, and investments in infrastructure and workforce capacity to meet Ukraine's future healthcare needs. Drawing from expert interviews and qualitative research, this policy brief highlights the complexities of Ukraine's healthcare reform in the context of crises like war and the COVID-19 pandemic, offering insights into the challenges and opportunities for sustainable recovery.

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Introduction and methodology

The availability and effective functioning of healthcare infrastructure plays a substantial role in both an immediate humanitarian response and long-term societal recovery, in particular considering the context of a country in the midst of a brutal war. The impact of the latter – public health infrastructure being put under unprecedented strain – demands comprehensive, long-term recovery efforts. A strong healthcare sector will not only provide critical support for the current war effort, including care for soldiers and war victims, but also foster resilience against future challenges, ensuring that the Ukrainian nation can not only heal from unimaginable trauma and pain, but also prosper on its path to becoming an EU member.

Ukraine's healthcare system, predominantly shaped by austerity-driven reforms and modernisation efforts, has been deeply strained by the Russian full-scale invasion. Pre-existing challenges, including underfunding and limited capacity, have been exacerbated. The latter leads to severe gaps in personnel; infrastructure and the ability to meet emerging needs, such as mental health, palliative care and rehabilitation services. These deficiencies, coupled with the ongoing reliance on international aid, highlight systemic vulnerabilities and underscore the pressing need for targeted reforms and resource allocation. Both are key to ensuring accessibility and resilience in healthcare provision.

Efforts to rebuild the healthcare sector must navigate the fragmented landscape, which includes international donors, civil society and private actors, simultaneously addressing exclusion dynamics between government structures and key stakeholders like unions and grassroots movements. Future-oriented strategies should balance immediate post-war needs with long-term goals, prioritising self-reliance through financial sustainability, institutional development and equitable resource distribution. Successfully overcoming these challenges will require a progressive agenda – inclusive policy making, robust anti-corruption mechanisms, and investments in infrastructure and workforce development to create a healthcare system capable of meeting Ukraine's current and future demands.

The following analysis is based primarily on the author's own research work[1] – 13 expert interviews conducted in two waves to analyse Ukraine's healthcare reform. This data was supplemented by available secondary sources. The first round of interviews was conducted after the start of the full-scale invasion, from October 2022 until February 2023; the second one – for the purpose of preparing this policy brief – took place at the end of 2023 and beginning of 2024. A qualitative methodology was chosen due to the complexity of the subject and the limited availability of comprehensive quantitative data. Expert interviews provided valuable insights into the motivations, design and implementation of the reform, especially in the context of crises like the COVID-19 pandemic and the war. The selection of interviewees aimed to cover a broad spectrum of perspectives, including primary care providers, medical specialists, researchers, civil society representatives and former government officials.

The author has chosen semi-structured interviews, allowing for flexibility and a focus on the specific expertise of respondents. Data was analysed using grounded theory, ensuring a systematic interpretation of qualitative data through iterative coding and refinement of categories. This methodology facilitated the identification of central themes, such as funding, corruption and crisis impacts, and linked subjective experiences of stakeholders to theoretical insights. The research in question adhered to rigorous qualitative standards to ensure reliability and depth in its findings. Any reference to expert interviews in this policy brief is linked to the original analysis mentioned above, unless stipulated otherwise.

Mapping the context: 2017 healthcare reform

After gaining independence in 1991, the Ukrainian healthcare system inherited Soviet infrastructure and an organisational architecture that was based on centralised government and public funding. Since 2017, it has been undergoing its first extensive reform.

The reform concentrated on four aspects:

- **the introduction of family medicine to strengthen primary care;**
- **financing based on the number of services provided rather than the capacity of a hospital;**
- **the introduction of "service packages" that define bundles of services which can be provided in hospitals in various fields; and**
- **the introduction of international standards to the system.**

The aim of the reform was to innovate the inherited and redundant Semashko system developed and operational in the USSR. The system was oriented on the stationary treatment of patients, leading to very broad infrastructure and in-patient capacity of healthcare facilities. Many facilities have been closed and workers laid off since 2017. Positives of the reform include digitalisation of the system, centralisation of the budget in the hands of one institution (National Healthcare Service of Ukraine (NHSU), somewhat analogous to the British NHS). This allowed more transparency in tracking the allocation of resources, for example, through online boards of the NHSU.

The decentralisation of responsibilities gave local authorities and hospitals more leverage over their resources, which, on one hand, allowed for more flexibility and faster reactions to crises. For example, a former head of the NHSU used to argue that the new system allowed a more efficient approach to deal with the pandemic, because hospitals could autonomously decide how to allocate their budgets, which eliminated the need to wait for centralised approval. On the other hand, this system often encourages worker exploitation and corruption at the hospital level. As the leader of the nurses' union pointed out in an interview, this autonomy led to an unfair allocation of resources that didn't prioritise wages, leading to delays in payments for medical workers for up to months. This is especially the case, as currently no unified monitoring tools have been developed in the system. One aspect of the reform that gained a lot of praise was the introduction of an "accessible medicines" program, which allows patients with certain chronic illnesses to get medication free of charge. Currently, the program mostly targets diseases such as diabetes and cardiovascular disease, but many others are also included. More costly treatments are not always available though, meaning patients make use of help from civil society organisations that specialise in their illnesses to get medication or pay out-of-pocket. This is very often the case for rare diseases and complex illnesses that require expensive modern treatments (e.g., autoimmune diseases, rare genetic disorders and sometimes cancer treatments). Many examples can be seen through organisations such as the charitable foundation "Orphan Titmouse", the organisation "Orphan Diseases of Ukraine" and "Athena. Women against Cancer", who post many singular cases as well as organise crowdfunding, and describe their partnerships with various public and private actors to secure the availability of medicines.

Another positive aspect was the prioritisation of primary care, which was marginalised in the old system. Currently, the first physician patients encounter in the healthcare system, in most cases, is supposed to be their family doctor, with whom they have a contract. Family doctors have the role of gatekeepers and issue referrals for patients that need specialist care. In the old system, many patients used the possibility of consulting specialists directly, leading to an inadequate

allocation of resources in the system. This led to the absence of a gatekeeping mechanism, which is usually carried out by primary healthcare, for the treatment of simpler issues (such as seasonal infectious disease cases without complications) by specialists, and thus, took capacity away from patients with chronic, severe and/or complex cases. In most OECD healthcare systems, gatekeeping mechanisms are implemented to regulate access to secondary and specialised care. Countries such as the UK, Sweden and the Netherlands have well-established gatekeeping systems, where primary care physicians play a pivotal role in controlling access to secondary services. In the case of Ukraine, primary healthcare was severely neglected prior to reform, primary care doctors were underpaid more than others and had less prestige than specialists. Patients can now choose their own family doctor, while previously they were assigned to hospitals and doctors based on their place of residence.

Common criticisms were the inability of reform to deal with the lack of resources and low salaries in the medical field. Financing remained at the level of 2-3% of GDP, which was drastically lower than in EU countries.[2] This led to the proliferation of existing petty corruption and exploitation of workers, such as delays of payments. The restructuring of the system was achieved through the closure and mergers of hospitals based on a strict number of patients that hospitals actually treated. This was a departure from capacity-based governmental financing of the old system. This, however, led to numerous layoffs of medical workers that often were not properly communicated. One of the respondents, the leader of the nurses' union, told multiple stories about local incumbents arriving at hospitals that were to be closed or merged and telling the staff that no layoffs would be happening, only to fire the workers months or even weeks later.

Others have to actively fight local governments to prevent their workplaces from being closed down, which often leads to downright harassment (e.g., cutting off of heating and electricity). The laid-off workers are to be assigned other workplaces, equivalent to their original ones. However, according to the same respondent, many are offered workplaces tens of kilometres away from their homes, meaning that the costs of commutes are too high for their wages to make new workplaces a reasonable alternative. Some relevant groups were not sufficiently included in the development of the concept and implementation of the reform (e.g., various unions of medical workers). The issue of poor communication between governmental structures and the medical community remains one of the biggest problems in Ukrainian healthcare, hindering reasonable development of the healthcare sector, which can be remedied through proper institutionalisation and functioning of social dialogue processes.

Another problem was the dismantling of the epidemiologic-sanitary service in 2014.[3] No alternative was planned and the criticism became especially salient during the COVID-19 pandemic. In general, reform is oriented towards cost savings and the allocation of available scarce budgets to the most immediate issues, for example, diseases that cause the highest mortality. Ukrainian healthcare services are currently financed through hospitals signing contracts with NHSU for specific services packages (provided they fulfil the general criteria) or from local budgets. Many services are also financed through specific international programs, which continues to deepen Ukraine's dependence on international aid and foreign partners.

Healthcare under pressure: Response to war and other crises

The COVID-19 pandemic burdened Ukrainian healthcare and delayed the implementation of the reform. The "first link", meaning primary care, had just moved to the new system, so family doctors were supposed to be the first contact point for patients with COVID-19 symptoms. This burdened them, considering many transitions were still happening. As encouragement and compensation, special payments were introduced for medical workers who suffered from COVID-19 (not limited to primary care); however, they were difficult to receive, as doctors were heavily scrutinised, which led to widespread criticism from the medical community. The measures to limit the spread of

the virus were not popular and not timely, as they were implemented at the same time as in Western European countries, while the first significant wave of infection in Ukraine happened months later. Closures of specialised infectious disease hospitals due to reform and the policy of shrinking the infrastructure were highly unpopular and stalled for the period of the pandemic. The acquisition of vaccines in Ukraine also happened later than in Western European countries and the USA. In some professional settings, vaccine mandates were implemented but were very unpopular. Furthermore, it could be argued that COVID-19 vaccination rates have remained relatively low, with various available data indicating that they have not surpassed 50%.

Currently, medical districts are being formed in Ukraine. These are districts that are supposed to encapsulate a certain number of secondary and tertiary facilities. Districts[4] are formed according to the population that has to be treated. Such a system will avoid redundancies in secondary and tertiary care. The aim is to avoid excess facilities that don't treat enough patients and to concentrate highly specialised care in populated and easily accessible areas. This, in turn, is another measure to save costs.

The protocols for various diseases are updated continuously, and in 2023, the deadline for the old centrally approved protocol by the ministry passed. New protocols are being arranged with the consideration of international standards. The introduction of international standards is one of the goals of the reform; it includes many aspects besides protocols, such as "updating the material and technical base, providing information and human resources to healthcare facilities at all levels of medical care in accordance with international standards", according to the Ministry of Health. Concerning the protocols, a decision was passed in 2020 to declare around 100 protocols invalid and replace them with updated versions that consider international evidence-based practices within a year, meaning in 2021. This deadline shifted and protocols are still being replaced.

A series of anti-labour laws have been passed since the beginning of the war.[5] Recently, a law allowing the reduction of the salaries of medical personnel to a minimum wage was passed.[6] Especially with the beginning of the war, the exploitation of medical workers, especially nurses, became commonplace. Countless reports on this can be observed in the public communication channels of unions, first and foremost among those newly formed ones like the nurses' trade union "Be like Nina". Because of the intersectional exploitative nature of such conflicts, there is no systematic data about the scope of labour abuses in the healthcare system. Many nurses are working much more in reality than their contracts state or the law permits, aren't paid for the real amount of work performed, and often suffer from wage arrears – one of the reasons Be like Nina emerged as a movement in the first place.[7] In general, women are overrepresented in non-leading positions in healthcare, yet in Ukrainian society, as in most societies, women also do most of the unpaid reproductive labour in households, which is confirmed through data. Considering that full-scale invasion added further responsibilities and made the situation more stressful, many female workers are likely experiencing not double but triple the burden.

Considering that, according to the Ukrainian Healthcare Center (UHC), the workforce in healthcare shrank by around 14% since the beginning of the full-scale invasion (meaning the loss of 89,000 medical professionals in one year[8]), there could be war-induced migration of healthcare workers.[9] There is no conclusive data about how many healthcare workers moved and to which countries, but it is known that there were around 522,000 healthcare workers in Ukraine in 2022,[10] and there are currently 2,300 doctors of Ukrainian origin and thousands of Ukrainian care workers in Poland (according to the Poland's Minister of Healthcare). In Germany, there were only a few reports of Ukrainian doctors who got their degrees acknowledged to be able to work in Germany, but as the process is very bureaucratic and complicated (e.g., candidates need to work under supervision for two years in a clinic they have to find themselves) and many qualified doctors lack sufficient language skills, it could be the case in the next years that more Ukrainian doctors will start working in Germany. The situation with care workers is similar in Germany; although it is

easier to get degree acknowledgement (it takes six months, unlike in the case of doctors), the problem of language competence is similar.

Concerning patients, a program of simplified transfers of critically ill patients and people with disabilities was established between Ukraine and EU countries in April 2024, meaning that patients who require costly and/or complex treatments are being taken care of outside of the Ukrainian system. Additionally, as of December 2023, there were 6,343,000 Ukrainian refugees globally, 5,939,400 of whom were in EU countries, most residing in Germany and Poland (1.1 million and 1.6 million refugees, respectively).[11] In both countries, Ukrainians have direct access to the healthcare system.

The system also suffers from infrastructural damage caused by Russian bombings. In November 2023, on the Ukrainian government portal, it was stated that more than 1,500 medical facilities had been damaged or destroyed, of which 186 were fully destroyed and 700 have been partially or fully restored. Mykhailo Radytskyi, Chairperson of the Committee of the Verkhovna Rada of Ukraine on National Health, Medical Care and Health Insurance, stated that additionally 755 pharmacies were damaged. Citing the World Bank, he states that the estimated cost of restoring healthcare infrastructure is around $2.5 billion, and the system in general will need around $16 billion in the next decade (both estimates are likely higher due to the unknown situation in the currently occupied territories). As a temporary solution, mobile treatment centers are operating in deoccupied territories, where infrastructure was damaged, to ensure access to healthcare services.

Concerning the pharma sector, according to a UHC report, it suffered a lot due to a large war-induced GDP loss in 2022:

> *The pharmaceutical market size decreased by 23% in USD spent (and by 10% in UAH58), while the average price per pack increased by 15% from 100.6 UAH in 2021 to 115.8 UAH in 2022. […] these changes put pressure on already stretched household budgets. Over-the-counter (OTC) drugs constituted a share of 62.2% of all packs sold in 2022, which represented 42.2% of total USD sales in the same year. Prescription drugs constituted 37.8% of all packs and 57.8% of total USD sales, respectively. The pharmaceutical market has been experiencing a dramatic drop in packs sold and USD sales since March 2022. It had not recovered to the pre-war level by the end of 2022, which indicated a growing financial barrier to medications.*[12]

Resource allocation in healthcare: In search of optimisation

Ukrainian legislation stipulates that healthcare has to remain at a level of 5% of GDP.[13] Yet, Ukraine has never achieved this level since independence – governmental financing of healthcare was always around 3% of GDP, while GDP itself has never reached that of the 1991 level again in real terms. Due to the reallocation of resources because of war efforts, healthcare received less financing than planned in 2022. Many aspects of healthcare are dependent on foreign aid of different types (specific programmes for healthcare from the World Health Organization (WHO), the UN, the United States Agency for International Development (USAID) etc.; financial aid from international partners; donations from grassroot organisations etc.), a precise estimation of these resources is unlikely. In the interviews conducted at the end of 2022, the head of NHSU, one of the leaders of a big patient's rights organisation and a member of a medics association all argued that, due to big waves of migration abroad due to war, the current amount of available resources were adequate for the system, also considering that many hospitals were actively being closed down and merged and that many workers had been laid off.

The planned healthcare budget for 2023 was around $5.5 billion, which was around 670 million more than in the previous year. This is about 6.1% of all budget expenditures for 2024 (total expenditure is ca. $91 billion). The expenditures include:

- the accessible medicines program – $4.8 billion;
- the development of rehabilitation services – around $165 million;
- mental health – $146 million;
- medical equipment – $68.5 million;
- medical staff investment – about $55 million; and
- free reproductive services for families of war veterans – about $44 million.

The planned budget further shows that the dependence on international institutions will persist and that even though the government is trying to react to new needs (such as increased demand for rehabilitation), it will likely be hindered by a lack of resources as well as a lack of infrastructure and personnel. The latter are issues that can't be solved in the short term, even if resources were available. It is likely that these issues will once again place the responsibility for rehabilitation on civil society and will contribute to the privatisation of rehabilitation programs.

Key needs and policy recommendations for Ukraine's healthcare system

To update the primary evidence collected earlier by the author (see the Introduction),[14] further input from experts was obtained in 2024 for the purpose of preparing this policy brief. The updated data once again underscored a number of challenges facing Ukraine's healthcare system, some of which were already indicated by experts in earlier interviews and throughout the available secondary sources. While the list is not exhaustive, and some challenges tend to change over time, a decision has been made to underscore several points in the following sections.

1. Challenges in nursing and small hospital sustainability

A major challenge within Ukraine's healthcare system is the inadequate recognition and support for nursing professionals. Nurses' contributions are often overlooked, and the compensation for their services remains insufficient, failing to meet the operational costs of healthcare facilities. This issue is particularly pronounced in smaller regional hospitals, especially those in areas impacted by internal migration, where financial instability is more acute. These hospitals largely rely on funding based on the number of patients they treat, a model that is unsustainable for smaller, less populated institutions. Without a fundamental shift in how healthcare funds are allocated and improved financial support for these hospitals, many smaller city hospitals face an uncertain future. The ongoing war has further intensified these challenges, placing additional strain on both healthcare facilities and their staff, exacerbating existing vulnerabilities in the system.

2. Governance issues

The reform of the system was marked both by centralisation of a big part of funds in the hands of NHSU and decentralisation of responsibilities. The former is generally a positive process, solving the problem of scattered funds. The latter, however, has raised a number of issues – firstly, local governments have authority over financing hospitals as a second pillar alongside NHSU, and simultaneously, the hospitals themselves (meaning hospital administrations) have been given authority over the allocation of finances. Hospital administrations often neglect salaries, especially of nurses and care workers, often citing debt. Considering that hospital administrations often have informal ties to local authorities, and NHSU and the Ministry of Health don't see themselves as being responsible because of decentralisation, medics have no one to protect their rights. Similar problems occur when hospitals are being closed or merged and layoffs happen. There are tensions between NHSU and hospital administrations too, largely because

NHSU is responsible for contracting, funding and monitoring. Currently, the system is unbalanced in multiple aspects.

There is a clear lack of independent regulatory bodies that could ensure greater transparency and accountability in areas like medical service pricing and the management of health data. This has led to many critical issues being neglected. Additionally, the current healthcare information systems face major limitations. These systems are unable to accurately collect health data, effectively track patient care or support the growing need for interoperability across various medical platforms. Without comprehensive structural reforms and the establishment of independent oversight, these inefficiencies and resource mismanagement will continue to undermine the healthcare system's effectiveness.

3. Key areas for strategic development

Looking ahead, Ukraine's healthcare system must focus on strategic development in several key areas. The biggest issues are underfunding and a general policy move towards austerity. In essence, the system adjusts needs to resources, when it must be the opposite way round. Austerity is happening at the cost of adequate salaries and neglecting the labour rights of medics, as well as the wellbeing of patients, who are burdened with out-of-pocket payments. The first priority must be the development of an adaptive funding[15] system that takes the problems of medics seriously and proactively aims to improve working conditions. Unions or other forms of organisations capable of representing workers must be encouraged and taken into account.

Firstly, a well-elaborated educational policy and appropriate employment conditions for those who graduate are key for modernisation to drive innovation in medical education, research and clinical practices. By applying such an approach, Ukraine can develop a highly skilled healthcare workforce and strengthen its connections with the global medical community. Finally, to improve the governance of the healthcare system, developing expertise in independent audits and decision-making frameworks is essential. This will ensure more effective healthcare policies, better resource allocation and transparency in the future.

These recommendations underscore the need for comprehensive reforms in Ukraine's healthcare system to promote recovery from the ongoing war and to prepare for future rebuilding and modernisation efforts. Addressing these challenges requires concerted action to modernise both the infrastructure and governance mechanisms within the sector, alongside sustained investment in workforce development and the integration of cutting-edge technology.

4. Resources allocation and accessibility of services

An increase of public financing of healthcare to at least 5% of GDP from sustainable sources must be achieved. This threshold is codified in Ukrainian law, as mentioned before, and there is data-based evidence that this is a minimal optimal level of expenditure. It was also confirmed to be a long-term goal in interviews with experts such as the former head of NHSU, who generally sees the reform very positively. It would still lie below the average healthcare spending of OECD countries but would be a tangible goal that could also lessen Ukraine's dependence on international aid.

5. War-induced needs and rehabilitation

A rather big investment in rehabilitation services indicates a reaction to the needs of veterans. The allocation of budget indicates that the priorities of the healthcare system remain similar, meaning to target widespread diseases that cause mortality. The benefit of investment in rehabilitation services will depend not only on the monetary resources allocated directly to such services, but also on infrastructure available and medical workers who can adequately work in the field.

6. International aid and partnerships

Ukraine works with many international organisations in the healthcare sector. Multiple programs concerning the implementation of the reform and other topics are being carried out with organisations such as USAID, the World Bank and the UN.

USAID's strategy for Ukraine, as indicated in the Ukraine Country Development Cooperation Strategy 2019-2024, focuses on addressing pervasive corruption while pursuing meaningful structural reforms. The strategy aims to improve the efficiency of government resources, remove health-related barriers for citizens and engage the private sector in modernising the healthcare system. Key activities include decentralising healthcare services, ensuring the stable supply of essential drugs at fair prices and advocating for a greater role of private healthcare providers. By reforming the Ministry of Health and creating a more transparent system, these efforts will increase the impact of state resources, free up public funds for other priorities and support Ukraine's long-term goal of self-reliance in healthcare.

Decentralisation was praised by some experts, such as the former head of NHSU, allegedly giving an opportunity to tackle the pandemic more efficiently. It can, however, localise abuse of workers and make resistance to it and the broader mobilisation of workers and unions harder. A nurse, for example, described in the interview how it leads to a "blame game" when local authorities refer unions and workers to the ministry or NHSU, but the latter refer them back to local authorities citing decentralisation. Decentralisation should be preserved but also be accompanied by encouragement from unions and local oversight boards. Clear pathways for the prevention of impunity of hospital management should be developed.

USAID, however, focuses on competition and market forces instead, without describing how the employers-workers conflict and lack of adequate pay and prestige in healthcare can be tackled. It underscores that, as Ukraine's economy recovers from the 2014-2015 fiscal crisis, there is potential for sustainable, market-driven growth, especially within the agriculture sector. This growth, alongside improved public health initiatives and the introduction of market forces in healthcare, can strengthen human capital and boost financial inclusion through innovative digital financial services. By addressing infectious diseases and fostering competition and informed choice in healthcare, Ukraine could accelerate economic development. Furthermore, implementing health-financing reforms would increase private sector investment and competition, supporting the country's shift toward greater self-reliance in healthcare.

USAID specifically targets combating infectious and preventable diseases, but still cites privatisation and austerity as key solutions. Other international organisations have similar strategies. Considering that Ukraine still has quite a high out-of-pocket payment ratio and that medical workers cite low salaries among the main reasons for corruption and leaving the profession, it is not clear how further austerity can positively influence the development of healthcare in Ukraine and achieve self-reliance, as the USAID report claims. It is therefore necessary to counteract these tendencies and take into account the existing negative impact of resource scarcity.

In general, support from international partners goes beyond actual support and is needed to guarantee the availability of resources and institutional stability of NHSU, as mentioned in their report from 2022.[16]

In their article about access to medicines in Ukraine, Olga Grintsova and Zaheer-ud-din Babar stated that in 2015 over 99% of all spending on medicines came from patients.[17] They see a positive impact of the reform, specifically the accessible medicines program. In 2017, Ukraine introduced the *Affordable Medicines Program* to improve access to essential medications for patients with chronic conditions, such as cardiovascular diseases, type 2 diabetes (excluding insulin) and bronchial asthma. This program provided 23 internationally recognised medicines (international nonproprietary names, INN) free of charge, significantly enhancing accessibility. By 2017, over 8 million Ukrainians benefited, with the majority suffering from cardiovascular diseases, followed by those with type 2 diabetes and asthma.

The initiative has had a measurable impact on medicine prices, with costs remaining stable or even decreasing for reimbursed medications.

Additionally, the government implemented a special insulin reimbursement program in 2016 for patients with diabetes, ensuring insulin access either free of charge or with a co-payment. The introduction of a national registry for diabetes patients has improved the planning and allocation of resources for better coverage. By 2019, the Ukrainian government planned to fully reimburse the cost of insulin, further expanding patient access and reducing financial barriers across the country.

Recently, the range of available medicines in the program was expanded, the full list of medicines eligible for reimbursement can be found on the website of the Ministry of Health, and the list of medicines with fixed prices can be found in the national list of essential medicines. According to a NHSU report in 2022, during the war, the number of reimbursed medicines was expanded from 401 to 435.[18] According to the UHC report, the program's performance deteriorated due to the war's impact:

> *Under the AMP, a total of 26 million packs of medications were subjected to full or partial reimbursement in 2021. In 2022, however, this number fell by 23.4%, comprising a total of 21.8 million packs being delivered to the population through the AMP reimbursement mechanism. Monthly data from the AMP evidences a serious crisis in the program's performance in March-April 2022, with a drop of over 50% from pre-war figures. Since May 2022, the numbers have stabilised and even slightly increased by the end of the year, reaching the level of sales of January-February 2022.*[19]

Future development of healthcare policy has to continue expanding the range of the program and include more expensive treatments. Currently, as mentioned earlier, some of the more expensive treatments are available through local funding, but it is often inconsistent. It is beneficial to include more costly treatments for chronic illnesses in the program.

Still, according to the UHC, which references World Health Organization (WHO) and International Organization for Migration (IOM), one in five Ukrainians could not afford to buy medication, while per data after the start of full-scale invasion almost a third of Ukrainians could not buy medicines in late 2022.[20] This is especially significant considering that out-of-pocket payments are very high in Ukraine compared to OECD countries and amounted to 47% of current healthcare expenditure in 2020.[21]

One of the less discussed aspects is preventive healthcare – pivotal as part of the old Semashko system and particularly important in the context of the war and for (post)war reconstruction.[22] In 2016, the sanitary-epidemic service, which was an all-encompassing institution for the issues of prevention, sanitation and infectious diseases, was abolished. It was argued that it was obsolete because its activities could be carried out by other institutions. A clear alternative has not been worked out nor financed; currently, there is a body within the Ministry of Health – Directorate of Public Health and Disease Prevention of the Ministry of Health of Ukraine – which, according to the description, partially assumes the tasks of the sanitary-epidemic service. In 2020, the question therefore arose as to how the pandemic should be managed and the then Deputy Minister for Health Viktor Lyashko (current minister) became the Chief State Sanitary Doctor of Ukraine (2019-2021), whose tasks included coordinating the fight against the pandemic. Currently, there are a few regional centres that deal with prevention and treatment of infectious diseases, and the concept of mobile brigades[23] that deliver medicines and services to heavily destroyed and newly liberated territories is being implemented. The latter solution was praised by some experts in the interviews;

however, it is unclear if this solution is scalable and reasonable from a long-term perspective.

Lastly, considering that there is and will be an increase in demand for psychological help, the Ukrainian Veterans Ministry announced three levels of access to mental health services for veterans and their families: (1) social workers and trained professionals provide basic social and psychological support; (2) psychological assistance is offered by certified providers, including individual entrepreneurs; and (3) comprehensive medical and psychological care is provided by licensed institutions with multidisciplinary teams. This tiered approach ensures that individuals receive appropriate care at each stage.

This program, however, only covers veterans and their families. Earlier, the Minister of Health estimated about 15 million Ukrainians may need psychological support, of which about 3-4 million need to be prescribed medication. The creation of respective capacities is once again managed by civil society – organisations such as UA Mental Help and various others offer free counselling. Such initiatives, however commendable and helpful, cannot be treated as a sustainable supplement, let alone substitute for the integrated services of a state healthcare system. Charity care is fragile, as it depends on donation streams for financing and volunteers, while public oversight and universality of provision cannot be secured.

7. Workers' rights in the sector

Workers' rights protection and extensions in workers' safety and security inspections can be assessed as a mixed picture at best. Since the beginning of the war, several laws that restrict labour rights have been passed.[24] Currently, a new labour laws code is being prepared that would be implemented in 2025 and will have a significant negative impact on workers' rights in Ukraine if enacted. The code is planned to allow workers to be fired more easily, legalise 12-hour work shifts, allow employers to disrupt their employees' vacations and remove a number of restrictions on labour that 14 year olds can legally perform.

Ensuring that hospitals can pay salaries on time and allocating sufficient resources to healthcare facilities is crucial for reducing corruption and resource mismanagement. Addressing systemic issues, such as the hoarding of resources by hospital administrators and inequitable distribution of funds, is key to creating a more transparent and efficient system. To fully address these challenges, further in-depth research is needed to better understand the extent and impact of marginalisation within the healthcare system, particularly among underrepresented groups. As an example, the author's interviews with representatives of a nurses' union suggests that the existence of unlawful practices, such as shadow (out-of-pocket) payments and practices of bribing medical personnel, deeply affect their (professional) situation.

Concluding remarks

Ukrainian healthcare has been undergoing reforms that were simultaneously negative in their austerity and positive in adapting to current circumstances and facilitating necessary modernisation of the system for some aspects, while selling it short for the rest. Ukrainian healthcare is, however, financed by the residual principle, not as a priority. The Russian full-scale invasion exacerbated these issues, therefore deepening the dependence on international aid. The main problems lie in resource scarcity, possible personnel scarcity and a general lack of self-reliance of the Ukrainian system, mostly due to political and economic instability. Even with the most positive turn of events, the system will need time to adapt to newly emerging needs caused by the war (such as accessible and wide-ranging mental health services and physical rehabilitation for affected soldiers and civilians).

Currently, considering the limitations of the state budget, a substantial part of streams of resources, including those for healthcare, are tied to international aid and cooperation among institutions, private donors, small activist groups and so forth.

The development of future healthcare policy in the context of rebuilding has to take into account the fragmentation of these resource streams and the general fragmentation of Ukrainian civil society. This constellation is the result of years of societal adaptation to scarce resources and unresponsive governmental structures. The consequence is that a policy has to have a clear strategy of either integration of fragmented actors into governmental structures or the systematic inclusion of them and an adequate, coordinated, reliable form of financing. Considering that the Ukrainian government tends to prefer decentralisation (see the respective reform, including devolution of responsibilities for securing and allocating the financing of healthcare), the latter scenario is more viable. Any aid provision for Ukraine needs to be done through coordinated stakeholder dialogue, which must consider that there are many actors involved in every single sector of healthcare. It should specifically seek to include different actors, considering the existing exclusion dynamic between governmental structures and certain experts, labour rights' activists and so forth. It has to consider the overwhelming domination of efficiency and austerity narratives in Ukrainian policy making and the poor efficacy of both in the delivery of a quality healthcare service, as evidenced by Ukraine's own experience and numerous similar experiences globally.[25] It is important to consider self-reliance (via financial, institutional and infrastructural capacity building) as a long-term goal of aid and reconstruction in the healthcare sector. Although it is unlikely that Ukraine will reduce its dependency on foreign aid in the near future, the structures and practises for a self-sufficient and balanced system have to be organised right now. This involves, first and foremost, the inclusion of workers and/or workers' unions – as well as, in general, those who have opposing views to the governmental structures and incumbents – in the social dialogue; the development of monitoring tools to prevent and trace corruption; and defining the needs of healthcare more precisely, and in this context, the decoupling and various functions that are currently concentrated in NHSU. Secondly, wage-led growth and self-financing fiscal expansion in healthcare instead of austerity must be considered.[26] The long-term problems in healthcare, such as scarce resources and the aforementioned exclusive strategy development, have to be considered and substituted for capacity building, in addition to paying attention to actors involved in reconstruction to achieve the best results.

Appendix

A comparison of selected indicators of the healthcare system setup and performance for the following five clusters of countries is given in Table 1:[27]

- Cluster 1: Australia; Austria; Belgium; Czech Republic; France; Germany; Luxembourg; Ireland; Iceland; Slovenia.
- Cluster 2: Finland; Japan; Republic of Korea; Norway; New Zealand; Portugal; Sweden.
- Cluster 3: Canada; Denmark; Spain; Italy; Netherlands; UK.
- Cluster 4: Estonia; Poland; Hungary; and Slovakia.
- Cluster 5: USA and Switzerland.

Indicator	Ukraine	Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5
Health expenditure per capita	907.16	4,262.51	3,782.84	3,964.92	**1,651.78**	7,466.73
General practitioners (GPs) per 1,000 people	0.46	1.33	0.84	0.85	**0.40**	0.70
Government expenditure on health as % of current health expenditure	49.29	78.6	82.79	75.7	74.4	**46.2**
% of private co-payments in total healthcare expenditure	51.12	14.10	15.38	13.96	**22.83**	19.26
Payment of medical specialists (according to expenditure (fee-for-service – 0) or according to salary (1))	0	**0**	1	1	**0**	**0**
Regulation of access (0=none, 3=maximum)	2	0.5	**2**	3	3	0
Cost sharing for GP visits (0=none, 1=maximum)	0	1	1	**0**	**0**	1
Selection restrictions (0=none, 1=maximum)	0	**0**	1	1	0.5	1
Expenditure on primary healthcare as % of current healthcare expenditure	38.43	36.17	45.04	**37.50**	41.86	39.75 (Switzerland only)
Ratio between GPs and specialists	0.24	0.63	0.50	0.42	**0.19**	0.31
Percentage of smokers in the population over 15 years of age	16.5	19.5	**16.5**	19.4	23.48	17.15
Alcohol consumption in litres per person over 15 years of age	8.34	11.15	**8.93**	9.20	10.74	9.33
Probability of dying from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases between the ages of 30 and 70	26.06	10.7	8.95	10.08	**17.01**	10.86

Table 1 shows Ukraine's similarity to the cluster of other Central and Eastern European countries, which have a low performance and low resources in comparison to other clusters of OECD countries.

Endnotes

1 Slobodyan, O. (2023) "The healthcare system of Ukraine in reform – an attempt at classification". Master's thesis. Humboldt University, Faculty of Humanities and Social Sciences.

2 EU countries spend an average of 10.9% of GDP on healthcare, while in Ukraine this figure was less than 3% in 2024.

3 Organised public health system responsible for monitoring, preventing and controlling the spread of diseases within a population. See more: Slobodyan, O. (2023) "The healthcare system of Ukraine in reform – an attempt at classification".

4 The author did not come across of examples of mapping (visualisation) of the districts.

5 "Labor reform is becoming even more dangerous". Social Movement, 30 June 2022.

6 "Some issues of remuneration of employees of state and communal health care institutions". Cabinet of Ministers of Ukraine Decree, 13 January 2023.

7 Editor's note: the need to unionise bottom-up when a trade union for health workers already exists highlights the complexity Ukraine's workers face in other sectors too, i.e., not all unions lobby for the interests and rights of the workers effectively. This and other problems with Ukraine's trade union movement is addressed in this project by Yuliya Yurchenko's contribution.

8 Ukrainian Health Centre Analytics (https://uhc.org.ua/en/category/analytics/)

9 Ukrainian Health Centre Analytics (https://uhc.org.ua/en/category/analytics/); Khlyudzinskyi, V. (2024) "Ukraine is facing a global shortage of doctors - the head of the Ministry of Health". Ukrainian Independent News Agency, 28 June, although one has to note the lack of comprehensive statistical data on the phenomenon at the time this analysis was prepared.

10 Ukrainian Health Centre Analytics (https://uhc.org.ua/en/category/analytics/)

11 Slobodyan, O. (2024) "Ukrainian fashions in the EU – between war and integration". SD Platform, 26 November.

12 Ukrainian Health Centre Analytics (https://uhc.org.ua/en/category/analytics/).

13 "On State Financial Guarantees for Medical Care of the Population". Law of Ukraine 2018.

14 Slobodyan, O. (2023) "The healthcare system of Ukraine in reform – an attempt at classification"; Slobodian, L. (2023) "Challenges of healthcare reform in Ukraine: On workers' perspectives and struggles". Gyvenimas per Brangus, 9 October.

15 More about the importance of adaptive funding models in middle- and low-income countries that have a grey economy and taxation issues can be found in Domapielle, M. K., J. Sumankuuro and F. Der Bebelleh (2022) "Revisiting the debate on health financing in low and middle-income countries: An integrative review of selected models". *The International Journal of Health Planning and Management*, 6(37): 3061-3074.

16 National Health Service Data Portal (https://edata.e-health.gov.ua/e-data).

17 Grintsova, O, & Babar, Z. (2020). Access and Use of Medicines in Ukraine. In Z-U-D. Babar (Ed.), *Global Pharmaceutical Policy* (1st ed., pp. 247-260). Springer Singapore

18 National Health Service Data Portal (https://edata.e-health.gov.ua/e-data.

19 Ukrainian Health Centre Analytics (https://uhc.org.ua/en/category/analytics/)

20 "Accessing health care in Ukraine after 8 months of war: The health system remains resilient, but key health services and medicine are increasingly unaffordable". WHO, 24 October 2022; IOM 2022.

21 "Out-of-pocket expenditure (% of current health expenditure) - Ukraine". World Bank Group, 15 April 2024.

22 A more detailed context is elaborated on in Slobodyan, O. (2023) "The healthcare system of Ukraine in reform – an attempt at classification". Master's thesis. Humboldt University, Faculty of Humanities and Social Sciences.

23 Mobile brigades should be understood as specialised, flexible teams designed to travel and provide essential services wherever they are needed, particularly in challenging or crisis-affected environments.

24 More information on the issue is available in the *Progressive Ukraine* analytical series published by the Foundation for European Progressive Studies, in particular the analysis of Yurchenko, Nazarenko and Lomonosova.

25 For a more detailed overview please see research conducted by Public Services International Research Unit at the University of Greenwich.

26 A more comprehensive view on the matter has been provided, among others, by Dr. Yuliya Yurchenko in the framework of "Progressive Ukraine" analytical series published by FEPS.

27 Ukraine and OECD countries, approximation of indicators based on the author's original research, Slobodyan, O. (2023) "The healthcare system of Ukraine in reform – an attempt at classification". Master's thesis. Humboldt University, Faculty of Humanities and Social Sciences.

About the author

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Olena Slobodian is a sociologist. She studied political science and sociology at the LMU in Munich and did her Masters at the Humboldt University in Berlin. Her thesis was on health care reform in Ukraine, and she has since written several analytical articles on this and related topics. She has worked on issues such as science communication, migration and discrimination.

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Kalevi Sorsa Foundation is a social democratic think tank established in 2005 and based in Helsinki, Finland. The foundation's objective is to promote public debate on equality and democracy and to produce research and publications.

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