ZDOROVI

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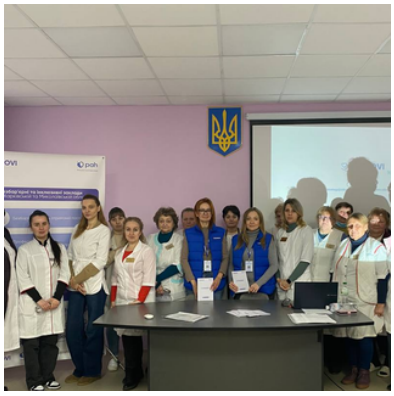
BAROMETER

assessment of current challenges and needs in the development/recovery of the healthcare system in Ukraine.


8TH WAVE OF THE RESEARCH

IV quarter of 2025 – I quarter of 2026

2025-2026

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Project's goal

The charitable organization "CHARITABLE FOUNDATION 'NATIONAL AGENCY FOR HUMANITARIAN AID 'ZDOROVI'" launched the **BAROMETER** project in **2022** with the aim of studying and assessing the dynamics of changes in the healthcare sector, as well as the level of provision of medical institutions and their ability to provide high-quality medical services under the impact of war consequences — from the crisis state to post-war recovery.

The results of the survey will allow all stakeholders to obtain an objective assessment from industry experts and field specialists in order to jointly **increase the effectiveness** of management of the public, private, and civil sectors aimed at **solving** current problems and creating a modern healthcare system in the post-war period. The updated study focuses on surveying **two target groups**: heads of healthcare institutions and patients, in order to provide the most comprehensive and objective assessment of the state of healthcare provision and the quality of services provided.

Project Initiator

ZDOROVI was founded in July 2013 as an organization that creates educational and research projects in the healthcare sector closely related to medical reform. ZDOROVI has implemented innovative projects jointly with UNICEF, WHO, USAID, GIZ, Renaissance Foundation, Global Giving, International Rescue, Americares, the EBRD and others, carried out on behalf of Ukrainian government institutions: the Ministry of Health of Ukraine, the Ministry of Veterans Affairs, the Ministry of Digital Transformation of Ukraine, and the National Health Service of Ukraine.

Today, **ZDOROVI** is one of the leaders in the verification of needs and procurement for medical support of hospitals, in conducting integrity monitoring, developing the post-crisis medical system, mental support programs for medical workers, organizing advocacy initiatives and management internships for Ukrainian medical professionals abroad, and acts as a provider of behavioral change in the healthcare sector in Ukraine.

ZDOROVI partners

Ministry of Health of Ukraine and more than 75 international partners and donors, including UNICEF, Global Giving, International Rescue Committee, AMERICARES, Polish Humanitarian Action, GIZ, SWECARE, ISAR Ednannia, and the East Europe Foundation.

Research Methodology

The report presents the results of the eighth wave of the updated survey, the **aim** of which is to assess the dynamics of changes in the healthcare sector, as well as the level of provision of medical institutions and their ability to provide high-quality medical services under the impact of the consequences of war — from a crisis state to post-war recovery. The study is also aimed at identifying current needs in the professional development of medical staff, management effectiveness, the level of system transparency, implementation of services and assessment of reform effectiveness, as well as readiness to implement energy-efficient solutions and European integration processes. Special attention is paid to the analysis of staff mental health and interaction between medical institutions at the regional level.

The collected data make it possible to form an up-to-date picture of the challenges faced by medical teams and to outline directions for supporting and restoring the healthcare system in Ukraine.

Reseach method: online survey through self-completion of the questionnaire by respondents using the KoboToolbox platform.

In this wave of the study, a questionnaire was used that was developed with the involvement of medical field experts, heads of healthcare institutions, and taking into account the experience of crisis response of the Charitable Organization “Charitable Foundation ‘National Agency for Humanitarian Aid ‘ZDOROVI’”.

A total of 114 senior-level doctors from healthcare institutions took part in the study — including directors or their deputies, heads of departments, directors of nursing, as well as senior nurses.

Study Limitations: the survey used an internal panel of medical institutions that had previously cooperated with the National Agency for Humanitarian Aid ZDOROVI. This means that the sample is not representative of the entire healthcare system of Ukraine, and the results reflect the experiences and opinions of those institutions that were already involved in cooperation with non-governmental organizations. However, given the wide geography and typology of institutions, the obtained data can be a valuable source for analyzing the current state, challenges, and trends faced by the healthcare system.

The field stage of the study was conducted from December 8, 2025 to January 23, 2026.

BLOCK S: SOCIO-DEMOGRAPHIC

Distribution of respondents by gender

The study included **76 female** representatives of senior management of institutions and **38 male** representatives, which in the total sample constituted two thirds and one third of respondents, respectively.

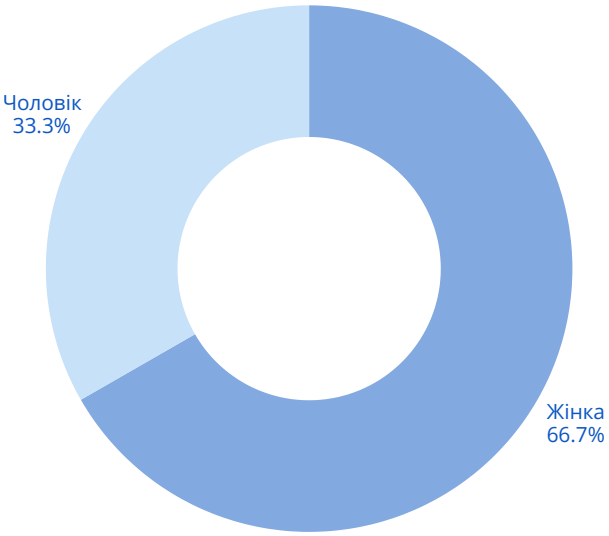


Figure 1: Gender of respondents
s3. Please indicate your gender (Single answer).
[% of responses among all respondents].

Distribution of respondents by position

Senior-level physicians of healthcare institutions participated in the study. This selection of respondents makes it possible to obtain a comprehensive assessment of the functioning of medical institutions — from the provision of equipment, medicines, and finances to staffing needs, service level, staff mental health, inclusivity, safety, fundraising activity, and readiness to implement changes and digital solutions. In addition, heads of institutions have a holistic understanding of organizational structure, human resources potential, as well as the specifics of internal management and clinical processes. This makes it possible to identify both local and systemic needs in the functioning of healthcare institutions at different levels.

The distribution of respondents by position was as follows:

- **Director or Deputy Director — 90.4% (84.6% in the 7th wave):**
- **Head of Department — 6.2% (11.5% in the 7th wave);**
- **Director of Nursing, Chief or Senior Nurse — 3.5% (3.8% in the 7th wave).**

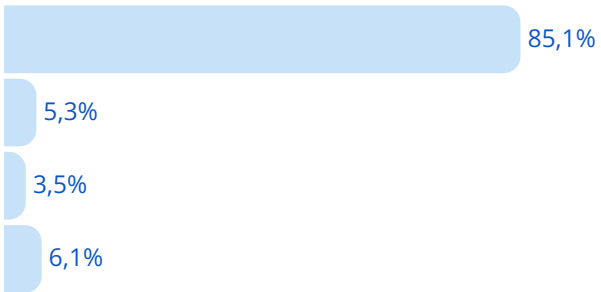


Figure 2:
Distribution of respondents in the study by position
S6 Please indicate the position you hold in this medical institution (Single answer).
[% of responses among all respondents]].

Regional distribution of medical institutions

The medical institutions represented in the study belong to three macro-regions:

- **Western region:** Khmelnytskyi, Volyn, Rivne, Ternopil, Ivano-Frankivsk, Chernivtsi, Lviv, Zakarpattia **— 23.7% of institutions (26.2% in the 7th wave)**;
- **Central-Northern region:** *Kyiv, Zhytomyr, Chernihiv, Kirovohrad, Poltava, Sumy, Kharkiv, Cherkasy, Vinnytsia* ***— 51.7% of institutions (48.5% in the 7th wave)***;
- **Southern-Eastern region:** *Donetsk, Luhansk, Zaporizhzhia, Kherson, Mykolaiv, Dnipropetrovsk, Odesa* ***— 23.7% of institutions (25.4% in the 7th wave)***.

Figure 3: Region of location of medical institutions
S7. Please indicate the region in which this medical institution is located (Single answer).
[% of responses among all respondents].

Location of institutions by territory status

The medical institutions represented in the study are predominantly located in **territories that have never been occupied — 86.8%**. Only **13.2% of medical institutions are located in de-occupied territories**. Compared to the previous wave, there were virtually no changes.

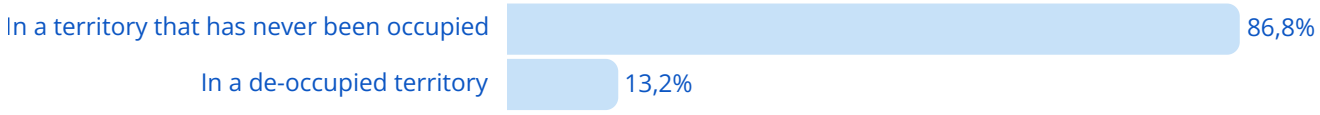


Figure 4: Location of institutions by territory status
S8. The institution is located in: (Single answer).
[% of responses among all respondents].

Type and form of ownership of medical institutions

By type of medical care provision, most institutions represented in the study **(45.5%)** belong to **general healthcare institutions**. An equal share of institutions are **supercluster and cluster healthcare institutions (10.5% each)**. **30.7% of institutions belong to other types** than those described above. **2.6%** of respondents were **unable to classify the medical institution by type**. Compared to the previous wave, the share of general institutions noticeably **decreased from 60% to 45.6%**.

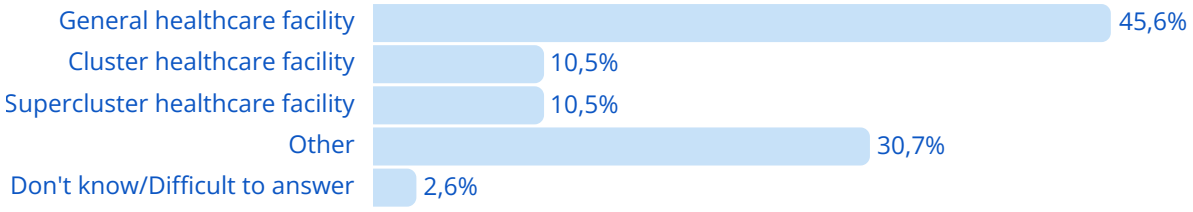
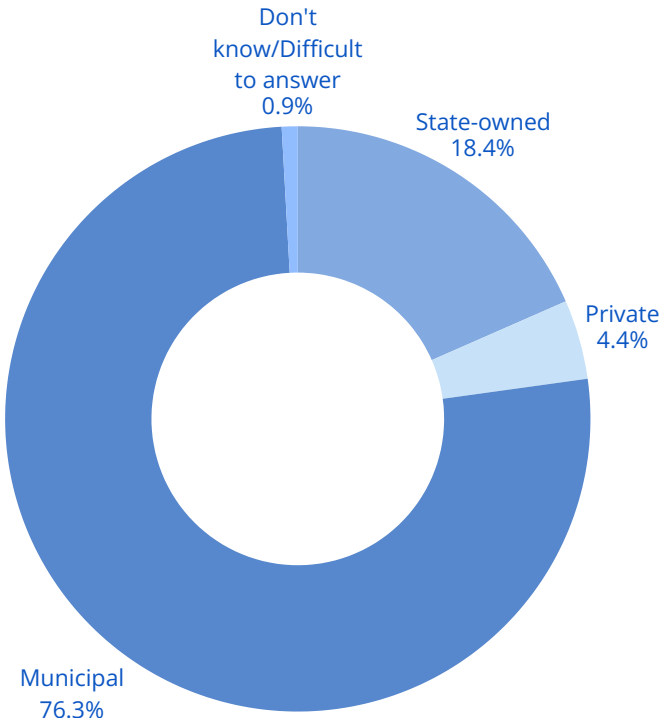


Figure 5: Type of medical institution
S9. Which type does this medical institution belong to? (Single answer).
[% of responses among all respondents].

By form of ownership, the majority of medical institutions represented in the study are **municipally owned (76.3%)**, while **18.4% of institutions are state-owned and 4.4% are private**. About 1% of respondents were unable to answer the question.

Figure 6: Form of ownership of medical institutions
S10. Please indicate the form of ownership of this medical institution (Single answer) .
[% of responses among all respondents].



BLOCK M: MANAGEMENT / SERVICE

Implementation of electronic services

The heads of institutions were asked to assess the level of implementation of electronic services on a five-point scale from “Very high” to “Very low”, as well as to select the greatest obstacles to their effective implementation.

The level of implementation of electronic services in medical institutions is most often assessed as average: this was the response of **49.1%** of managers. Another **35.1% characterize it as high**, **10.5%** indicate a low level, while the same number of respondents — **2.6%** — noted very high and very low. In general, this means that electronic services are already present in most institutions and operate at a basic or sufficient level, but not everywhere reaches a fully “high” standard of implementation, and some institutions have not yet implemented electronic services.

Figure 15: Implementation of electronic services

m1. Assess the level of implementation of electronic services in your medical facility (online appointment, electronic queue, patient access to their own medical record online, etc.):
(Single answer). [% of responses among all respondents].

Among institutions that rated the level of implementation of electronic services as “average” or lower, **the biggest obstacles are the lack of qualified IT specialists (57.8%) and insufficient funding (52.1%)**. The shares of responses about the low level of digital literacy of patients (**45.1%**) and the lack of technical resources for digitalization (**43.7%**) are also high.

Overall, the results show that the key barriers are primarily **resource and capacity-related** — personnel, financial, technical, and related to digital skills — while **bureaucratic constraints** play a **secondary** role.

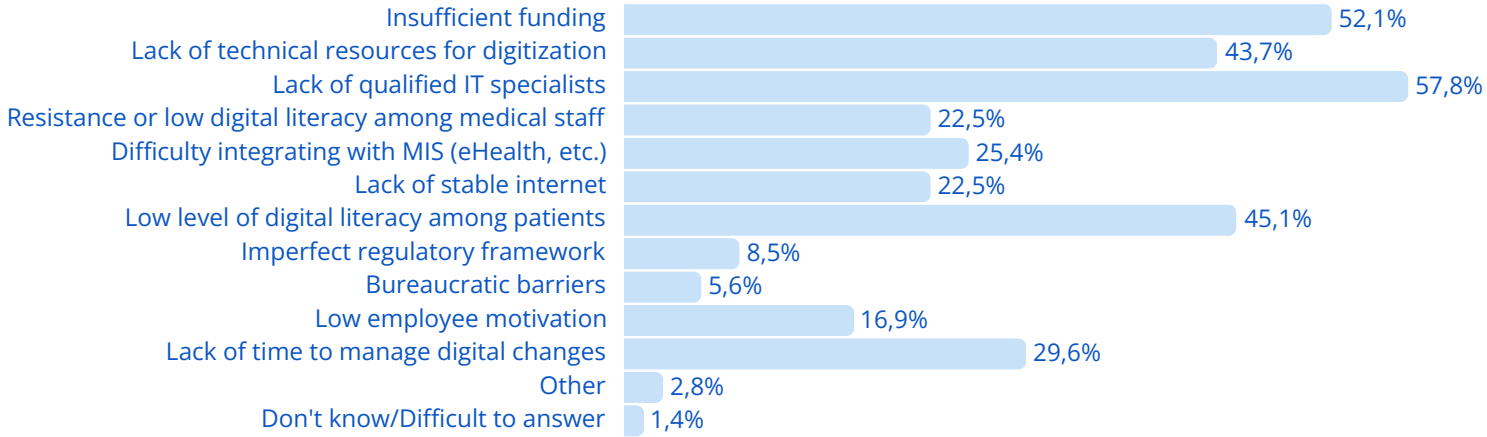


Figure 16: Obstacles to the implementation of electronic services

m1.1. What do you think is the biggest obstacle to implementing electronic services in your medical facility (online registration, electronic queue, patient access to their own medical record online, etc.)
(Multiple answers possible). [% of responses among respondents who rated the level of service implementation as “average” or lower in m1(n=71)].

Preventing unofficial monetary or other “gratuities” to employees in medical institutions

In order to determine the most effective methods of preventing manifestations of domestic corruption in medical institutions, respondents were asked which mechanisms are the most effective for this.

The most effective mechanisms for preventing unofficial monetary or other "gratitudes" to employees are most often named by managers as **a transparent system of personnel payments and bonuses — 67.5%**. Also, more than half of the respondents indicate the importance of **clear standards of communication with patients regarding the freeness of services and channels of official payments (56.1%)**. Internal organization and culture tools are mentioned noticeably less often.

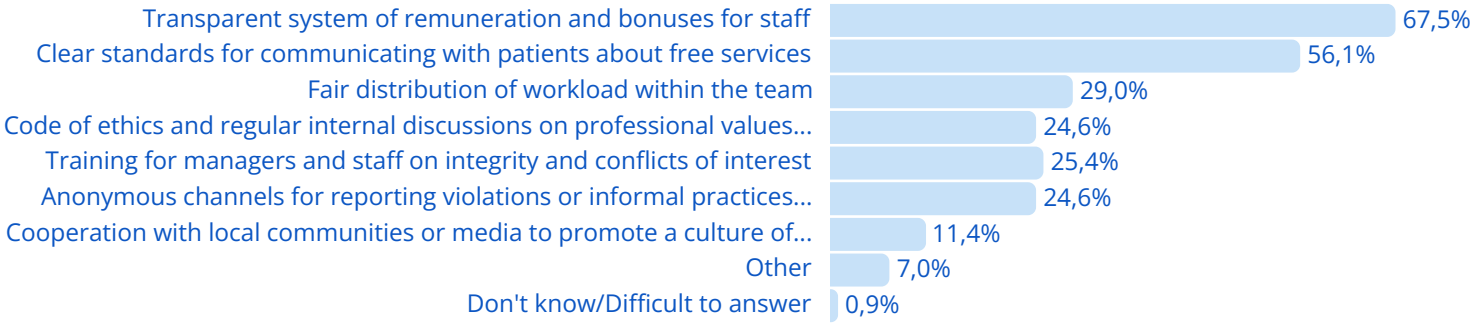


Figure 17: Mechanisms to prevent unofficial monetary or other “gratitudes” to employees:
m2. What mechanisms are most effective for preventing informal monetary or other “gratuities” to healthcare workers? (Multiple answers possible)
[% of responses among all respondents]

That is, respondents consider systemic financial and communication solutions to be the key levers for countering informal "gratitudes," while ethics, training, and feedback tools are viewed more as additional.

Energy efficiency and economy

To assess the energy efficiency of institutions, managers were asked questions about the level of energy efficiency and about conducting an energy audit.

The energy efficiency was assessed on a five-point scale from “Very high” to “Very low.”

- **Very high:** the institution systematically applies modern methods of reducing energy consumption and regularly updates approaches.
- **High:** most basic energy efficiency measures have been implemented, but the institution still has potential for improvement.
- **Medium:** the institution has some energy-efficient solutions, but a significant part of the processes needs modernization.
- **Low:** some measures have been implemented, but they are not systematic and do not have a tangible effect.
- **Very low:** the institution practically does not apply energy efficiency measures; equipment and infrastructure are outdated.

Overall, dominates the perception of an **“average” state- 53.5%** of responses, but a significant proportion of institutions already see the problem of energy efficiency as a weak point, while there are few examples of a truly high level.

A high level is noted by 21.1% of managers, while a very high level is noted by only **2.6%**. In contrast, **14.9% assess energy efficiency as low**, and **5.3% as very low**.

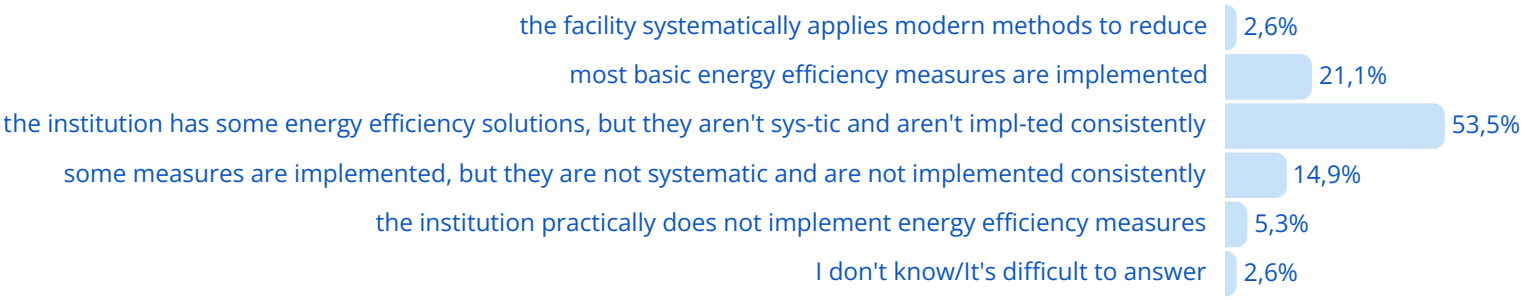


Figure 18: Energy efficiency assessment of institutions
m3. Rate how energy efficient your healthcare facility is currently (Single answer)
[% of responses among all respondents].

An energy audit or other actions aimed at increasing energy efficiency were carried out in only **21.9%** of medical institutions in 2025. More often, respondents report that an audit was not carried out: **33.3% note that it was never carried out**, and **30.7% — that it was carried out before, but not in 2025**. Another **14.0%** could not answer. This may indicate that a systematic approach to energy efficiency is not yet a regular management practice for most institutions, and a significant part either does not have such experience at all, or does not maintain its relevance with annual actions.

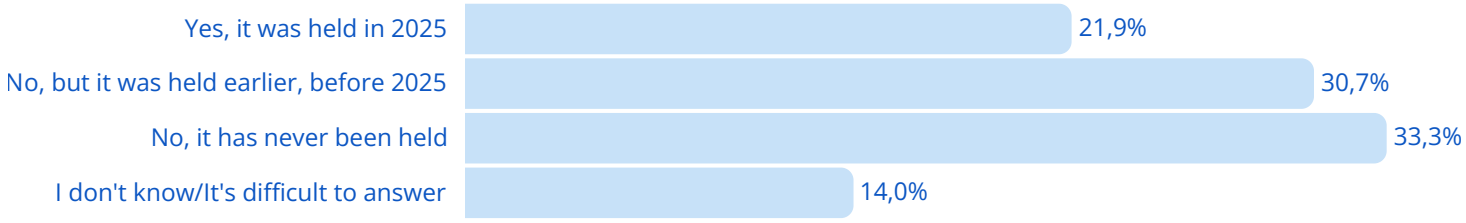


Figure 19: Conducting an energy audit
m4. Has your healthcare facility conducted an energy audit or other energy efficiency improvement actions during 2025? (Single answer)
[% of responses among all respondents].

To assess the most effective cost-saving measures that will be implemented or have already been implemented, managers were offered a list of measures from which they could choose up to five answers.

Most often, among the measures already implemented to save money on utilities, managers mention **educational activities for personnel on the economical use of resources (58.8%), thermal insulation of buildings (55.3%) and the transition to energy-saving lighting - LED, motion sensors, automatic shutdown (54.4%)**. They mention noticeably less often the use of alternative energy sources, in particular solar panels or heat pumps (**36.8%**), as well as optimization of equipment operating schedules (**32.5%**).

Other steps that require greater technical modernization or system monitoring appear much less often - **modernization of heating and ventilation systems (21.1%), optimization of water consumption (18.4%) and centralized energy management/monitoring of energy consumption (18.4%)**; cooperation with energy service companies within the framework of energy efficiency programs was noted by **5.3%**.

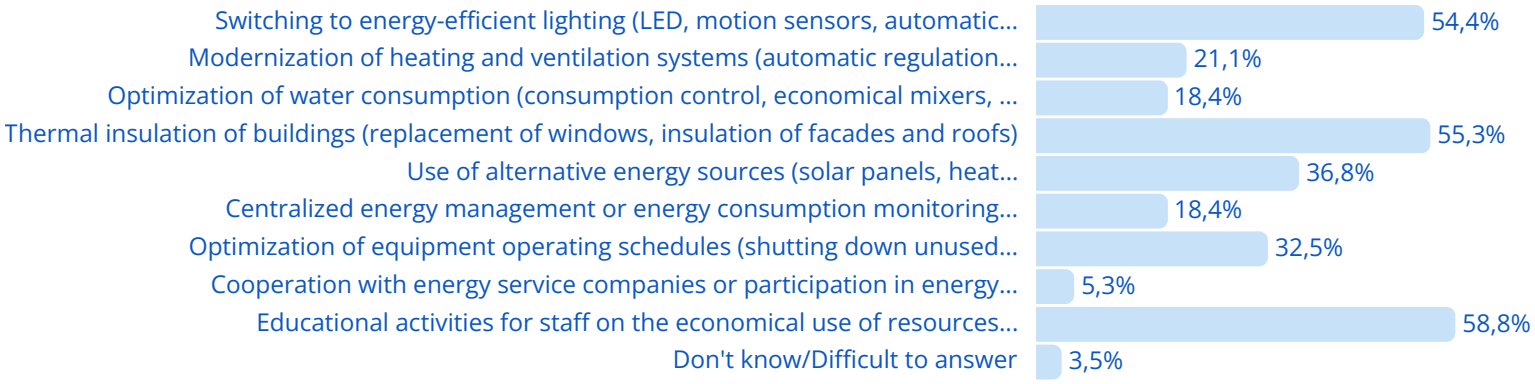


Figure 20: Implemented cost-saving measures

m5. What are the most effective measures to save money on utilities that are already implemented in your medical facility? (Multiple answers possible). [% of responses among all respondents].

This shows that institutions primarily implement relatively affordable and quick measures (behavioral and basic technical solutions), while complex investment modernizations and management systems are implemented significantly less frequently.

As for planned measures, the most frequently mentioned is the use of **alternative energy sources (solar panels, heat pumps, biofuel generators) — 47.4%**. Next in popularity is **thermal insulation of buildings (39.5%)**, while **educational measures for personnel on the economical use of resources are planned by 25.4%**. The next group of responses concerns more technical and managerial solutions: the transition to energy-saving lighting and modernization of heating/ventilation are mentioned by **22.8%** each, and centralized energy management or monitoring of energy consumption and optimization of equipment operating schedules — by **20.2%**. Cooperation with energy service companies within the framework of energy efficiency programs (**17.5%**) and optimization of water consumption (**14.9%**) are less often planned; the share of those who find it difficult to answer is **13.2%**. This indicates a shift in focus from relatively simple "quick" solutions to more capital-intensive modernizations and systemic energy management, which require resources and planning.

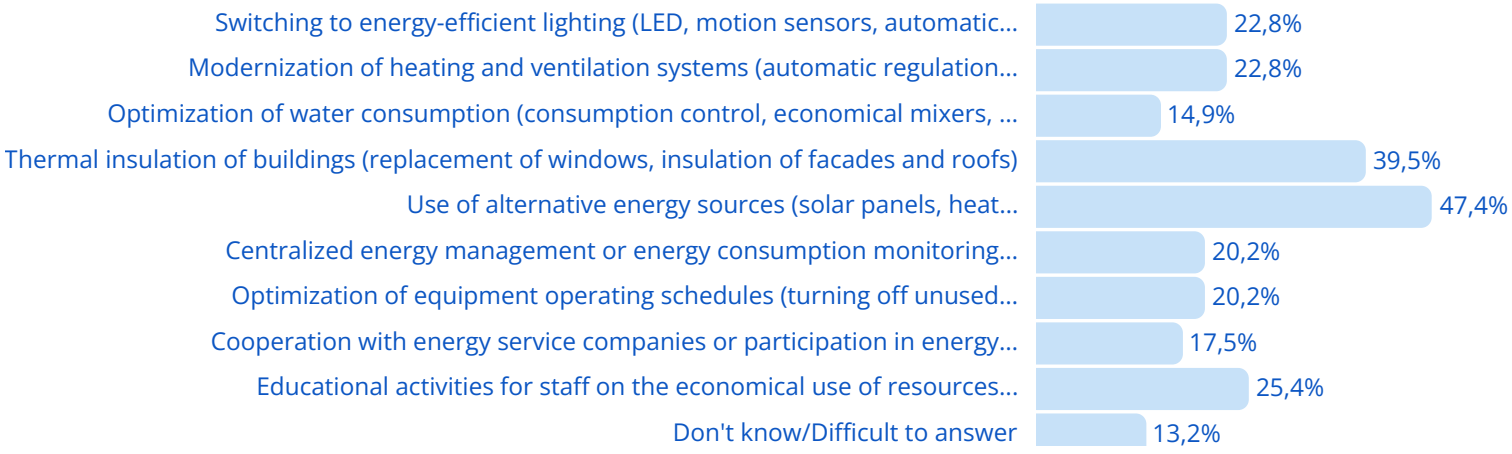


Figure 21: Planned cost-saving measures

m5. What are the most effective measures to save money on utilities already implemented in your medical facility? (Multiple answers possible). [% of responses among all respondents].

Conclusions for block M:

- The level of implementation of **electronic services** in most institutions is assessed as **average** (49.1%) or **high** (35.1%); the share of "very high" assessments is minimal (2.6%), and the low/very low level is recorded at 13.1%.
- Among institutions with a “medium or lower” level of digitalization, the **key barriers** are **resource-related**: primarily **a lack of IT specialists** (57.8%) and **insufficient funding** (52.1%), as well as **a shortage of technical resources and digital skills**, especially **among patients** (45.1%) and some staff; regulatory and bureaucratic factors are mentioned much less frequently.
- To **prevent unofficial "gratitudes"**, managers most often rely on **a transparent payment and bonus system** (67.5%) and **clear standards of communication with patients regarding free services and official payments** (56.1%), while internal organization and ethics tools are mentioned noticeably less often.
- The **energy efficiency** of institutions is most often assessed as **average** (53.5%); high/very high scores are given by 23.7%, while low/very low scores are noted by 20.2%.
- **Energy audit** practice in 2025 is **uneven**: 21.9% conducted an audit in 2025, while 64.0% either did not do it this year or had never done it; another 14.0% could not answer, which may indicate a lack of consistency/accounting in this area.
- Already implemented **measures to save costs on utilities** mostly belong to “quick” solutions: **working with personnel behavior** (58.8%), **thermal insulation** (55.3%), and **energy-saving lighting** (54.4%). In contrast, more complex energy management tools and partnership mechanisms are used much less frequently.
- The focus in the **plans** is shifting towards more expensive modernizations, primarily **alternative energy** (47.4%) and **thermal insulation** (39.5%).
- **Recommended:**
  1. To **combat unofficial payments**, it is worth developing two mechanisms that managers themselves rely on the most: **transparent payment/bonus rules** and **standardized communication with patients about the free nature of services and official payment channels**
  2. In **energy efficiency**, it is worth establishing the regularity of the management cycle: audit/assessment → action plan → budgeting → monitoring of results; this is especially relevant given that in most institutions, audits were not conducted in 2025 or are not a permanent practice.
  3. **Establish an IT function** (staff/outsourcing), ensure financing and updating of the technical base, as well as stable internet as a critical condition for the operation of electronic services.

BLOCK N: NEEDS

As part of the needs assessment, facility managers were asked to identify general needs to improve the functioning of the facility, and the specific types of equipment or technology, as well as types of humanitarian assistance.

The gretest needs for ensuring effective work and high-quality service provision are most often identified by managers as **diagnostic equipment (57.9%) and IT infrastructure — computers, servers, network equipment, medical information systems (57.0%)** (multiple options could be selected). **Medical consumables (38.6%)** follow with a significant margin. At the same time, a significant proportion of responses concern the basic material and technical support of the institution — medical furniture (**34.2%**), medical equipment (**33.3%**) and vehicle fleet/sanitary transport and logistics **(31.6%**). Separately, a quarter of respondents note the need for critically important medicines (**25.4%**), while rehabilitation equipment (**18.4%**) and resuscitation and intensive care equipment (**11.4%**) are mentioned less frequently.

This indicates that the priorities of the institutions are primarily focused on diagnostics and digital infrastructure, as well as on supporting “day-to-day” operational capacity through consumables, equipment, and logistics.

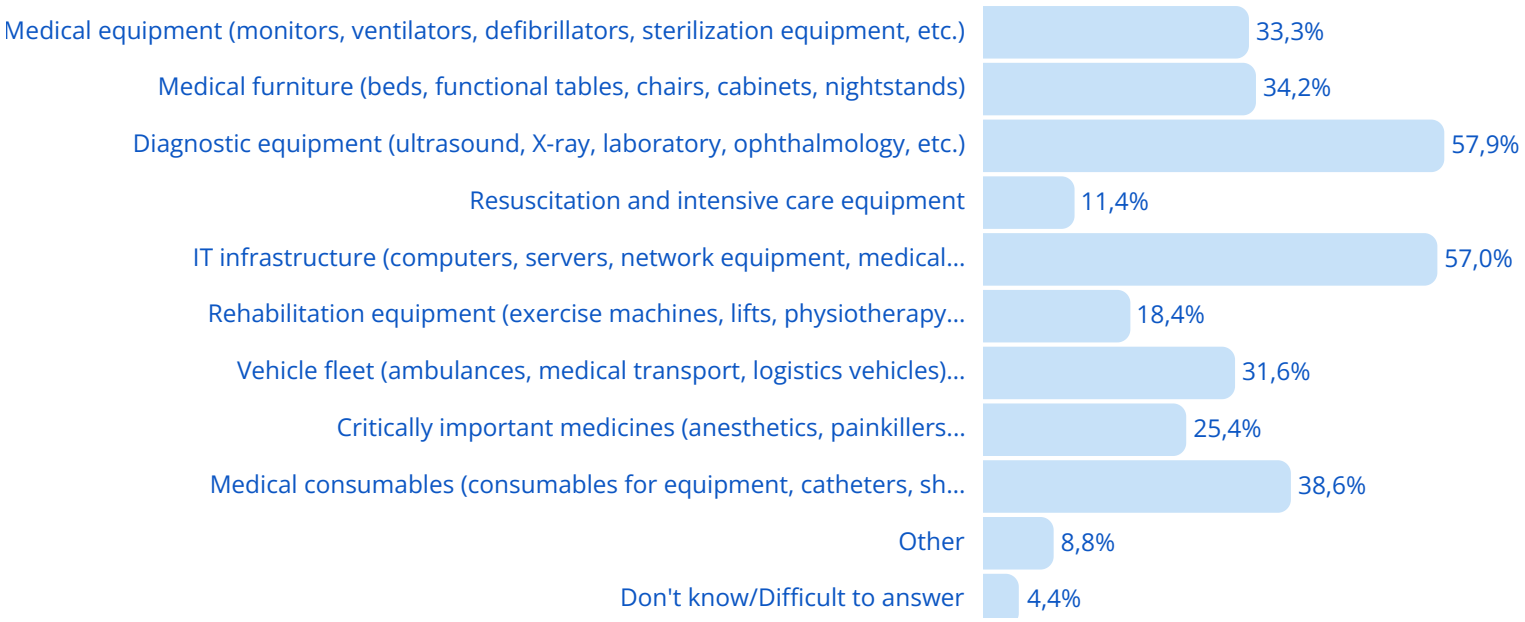


Figure 22: Types of greatest needs

n1. What are the greatest needs of your medical institution to ensure efficient operation and quality provision of medical services? (Multiple answers possible). [% of responses among all respondents].

When it comes to types of equipment or technology, managers most often mention **laboratory analyzers — 36.0%**. In second place — **laptops or computers (25.4%)**.

Next, sterilizers are mentioned by a **significant margin (13.2%)**, while patient monitors (**2.6%**) and defibrillators (**1.8%**) are chosen individually. The share of “other” responses is **14.9%**.

This indicates that the most urgent need for institutions is to strengthen diagnostic capabilities and basic digital capabilities, while equipment for critical conditions is more often not perceived as a top priority in the format of “one most important” acquisition.

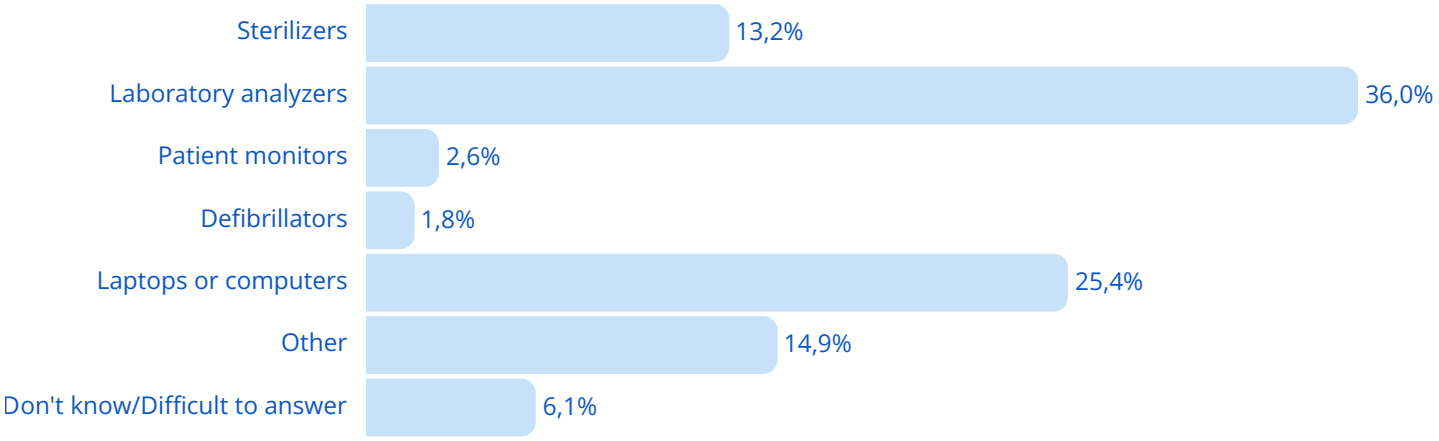
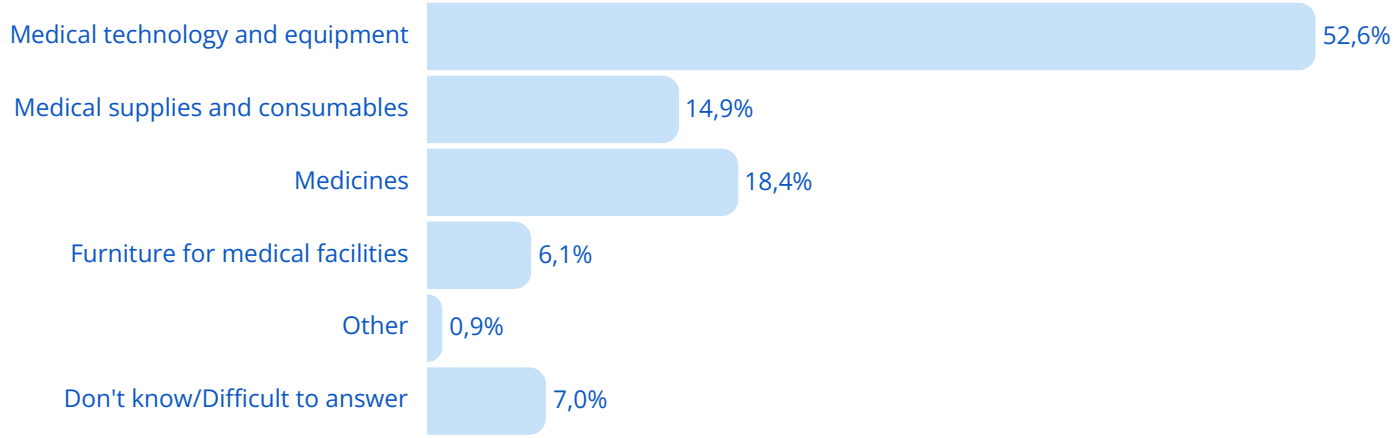


Figure 23: Types of equipment or technology

n2. What one type of equipment or technology do you think would most enhance the efficiency and quality of healthcare services in your facility if you could get it right now? (Only one answer)
[% of responses among all respondents].

The most useful type of humanitarian aid for the daily activities of the institution is most often named by respondents as **medical equipment and supplies — 52.6%**. **Medicines (18.4%) and medical supplies and consumables (14.9%)** are much less often noted as the most useful.

Furniture for medical institutions is mentioned only once — **6.1%**. This shows that the greatest practical value for institutions is aid that directly strengthens their technical capacity to provide services, while the supply of medicines and consumables is more often perceived as important, but secondary compared to equipment.



Figures 24: Types of humanitarian aid

n3. What type of humanitarian assistance received by your medical facility has been most useful in the daily operations of the facility? (Single answer). [% of responses among all respondents].

Conclusions for block N:

- The **greatest needs** of medical institutions for effective work are centered around **diagnostics and digital capabilities**: diagnostic equipment (57.9%) and IT infrastructure (57.0%) confidently lead among all requests (several options could be selected).

- When it comes to "**one priority right now**" **laboratory analyzers** (36.0%) and **laptops/computers** (25.4%) are most often cited, further confirming the focus on diagnostics and basic digital infrastructure as the most bottlenecks.

- **The most useful type of humanitarian aid** for the daily operations of institutions was **medical technologies and equipment** (52.6%), while medicines (18.4%) and consumables (14.9%) were much less frequently identified as "most useful."

- **Recomended:**
  1. **Prioritize support** for **diagnostic equipment and laboratory capacity** (including analyzers) as the most frequent request and critical driver of service quality, as well as for IT infrastructure.
  2. For **humanitarian programs**, focus on the **supply of machinery and equipment**.

BLOCK E: EDUCATION

Need for education

The vast majority of managers note the **need for medical institution employees to improve their skills and expand their professional knowledge right now — 78.1%**. Another **20.2% believe that there is currently no such need, but it may arise in the future**. Responses about the lack of need generally occur only occasionally (**0.9%**). This demonstrates a very high demand for training from institutions.

Compared to the previous wave, the need for training increased by 6.6 percentage points, and the number of responses "do not need at all" also decreased slightly. It can be assumed that there has been an increase in the need, or an increase in the awareness of the need for staff training over the past year.

However, all differences are not statistically significant, so they express a certain trend rather than a serious shift in need.

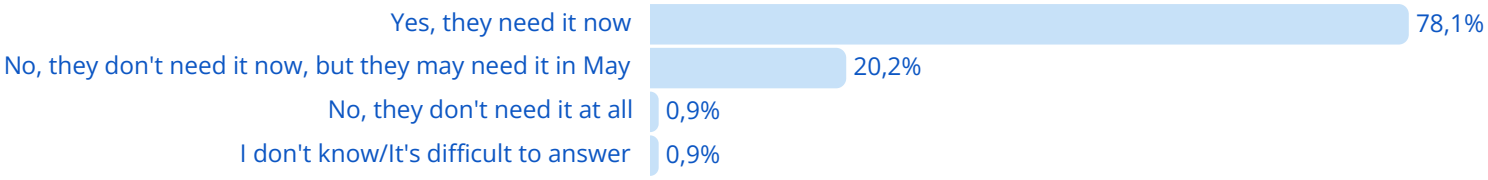


Figure 25: Training needs assessment

ee1. Do the employees of your medical institution need to improve their qualifications and expand their professional knowledge? (Single answer). Comparison of the 7th and 8th waves of the study.
(the results of the 7th wave are highlighted in a lighter shade of color). [% of responses among all respondents].

Skills that will be relevant in the future

To determine the skills that will be most critical in the future (over the next five years), managers were asked to select or name the following skills separately for doctors and separately for nurses.

Among the skills that may become the most critical for a doctor over the next five years, **work with digital systems (AI, clinical decision support, telemedicine, etc.) is the leader by a significant margin — 73.2%**. In second place is **communication with the patient and a patient-centered approach (55.4%)**. This is followed by **critical thinking and working with data (38.4%)**. Other skills are mentioned significantly less often: leadership and team interaction (**28.6%**), ethics and corporate culture **(22.3%)** and building a doctor's reputation and personal brand **(20.5%)**, as well as interaction with the community and public role **(17.0%)** and intersectoral interaction **(9.8%)**

Figure 26: Critical skills for doctors in the future

e1.1. What skills, other than purely professional (clinical), do you think will be the most critical for a physician in the next five years? (Choose up to three options). [% of responses among respondents who believe that their staff needs or will need training in e1. (n=112)].

This shows that in the minds of managers, the “doctor of the future” must first of all be digitally competent and strong in communication, as well as be able to work with data for decision-making, while managerial and social-communication roles are seen as additional.

For nurses in the next five years, the most critical skills most often mentioned are **digital literacy (57.9%) and communication with patients and their families (49.1%)**. Next in prevalence is **working with modern equipment and monitoring technologies (40.4%)**. A significant proportion of responses also concern the “team” and psychological block - team interaction (**36.0%**) and emotional stability and self-regulation (**34.2%**). Compliance with ethical standards and confidentiality (**28.1%**) and basic proficiency in English or necessary terminology (**18.4%**) are mentioned less often.

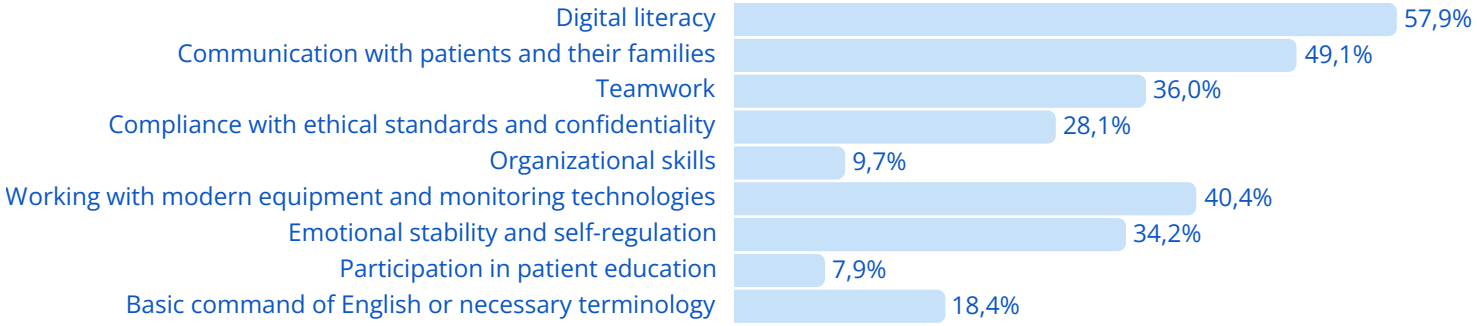


Figure 27: Critical skills for future nurses

e3. What skills, other than purely professional (clinical), do you think will be the most critical for nurses over the next five years? (Choose up to three options)
[% of responses among all respondents].

That is, the most critical skills for both doctors and nurses in the future, managers see in digital and communication skills.

Readiness of the education system to create new personnel and treat nurses as equal to doctors

The system of training doctors in Ukraine, according to the leaders, is rather not ready to form the "doctor of the future": **50.9%** choose the option **"rather not ready"**, another **9.7% - "not ready at all"**. Positive assessments are less common - **36.0% believe that the system is "rather ready"**, and only **1.8%** - that it is "completely ready". The share of uncertain answers is minimal.

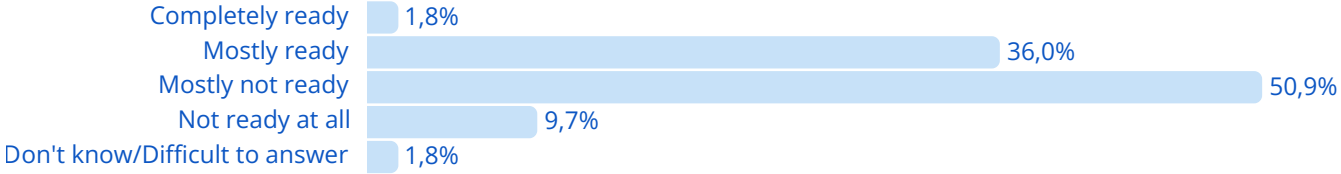


Figure 28: Evaluation of the doctor training system

e2. In your opinion, is the current system of training doctors in Ukraine ready to form the “doctor of the future” — a specialist who not only follows protocols, but also thinks systematically, works with data, has digital tools and effective communication with the patient? (Single answer)
[% of answers among all respondents].

This may indicate that, from the point of view of the heads of institutions, the future of human resources in Ukraine is problematic, since it is the skills related to digital literacy and communication that they singled out as the most critical over the next five years.

The readiness of the hospital education and management system to perceive nurses as equal members of the team is also assessed rather critically by respondents. **46.5% believe that the system is "rather not ready"**, another **7.0% — that it is "not ready at all"**. Positive assessments are less common: **39.5% choose the option "rather ready"**, and **5.3%** — "completely ready".

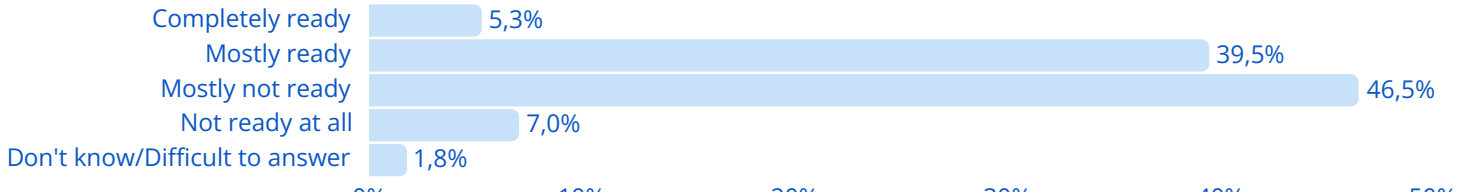


Figure 29: Assessment of the perception of nurses as equal members of the team

e4. In your opinion, is the education system and hospital management in Ukraine ready to perceive nursesr not as "doctor's assistants", but as equal members of the team who have a real impact on the quality of treatment, communication with patients and the efficiency of the institution? (Single answer)
[% of answers among all respondents].

Training formats and topics

The most convenient and effective format for improving the skills of personnel are often identified to be **training and simulation training by respondents — 74.6%** (up to three options could be chosen). This is followed by **offline workshops and practical groups (43.9%)** and **online webinars and courses (40.4%)**. Also quite common are the exchange of experience with Ukrainian colleagues (**39.5%**) and a combined format (**38.6%**). Internships abroad are chosen less often — **23.7%**.

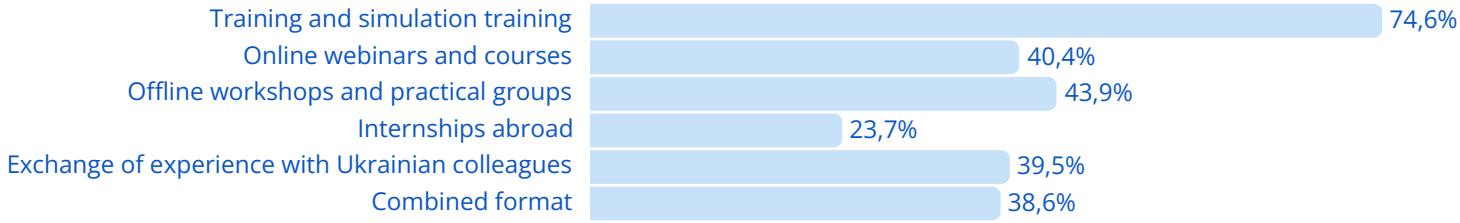


Figure 30: The most convenient formats for advanced training

e5. What format of advanced training is the most convenient and effective for the staff of your medical institution to acquire knowledge and further apply it in their work? (Choose up to three options). [% of responses among all respondents].

This demonstrates a clear advantage of practice-oriented formats with skills development, while online learning and blended approaches are perceived as an important addition rather than the main tool.

Respondents were also asked to choose the most relevant topics for training of employees of institutions at different levels - managers, doctors and middle management.

Among the entire list of topics for training management, five areas are most often chosen: **effective management (43.0%), financial budget planning (41.2%), donor funding (40.4%)**, risk management and quality indicators (**36.9%**) and strategic management in conditions of instability (**36.0%**).

That is, the request of managers primarily concerns practical management competencies - how to better organize the work of the institution, plan and maintain financial sustainability, find additional resources, as well as build quality and risk management systems in conditions of constant change.

Figure 31: The most relevant training topics for managers

e6. In your opinion, which of the following topics are most relevant for training management staff in your healthcare facility? (Choose up to five options). [% of responses among all respondents].

Among the topics of training for doctors, the most relevant is named **team ethics in medicine - a culture of mutual respect, trust and partnership (60.5%)**. Next in frequency of choice are **conflict management (51.8%)** and the topic of **combining standards with humanity - how to work with protocols, empathy and patient feedback (48.3%)**. Also, a significant request concerns communication in a military context: communication with veterans is noted by **40.4%**, and communication with families who have lost a loved one at the front or as a result of shelling - **39.5%**. In contrast, the "art of a difficult conversation" about delivering bad news is chosen less often (**24.6%**).

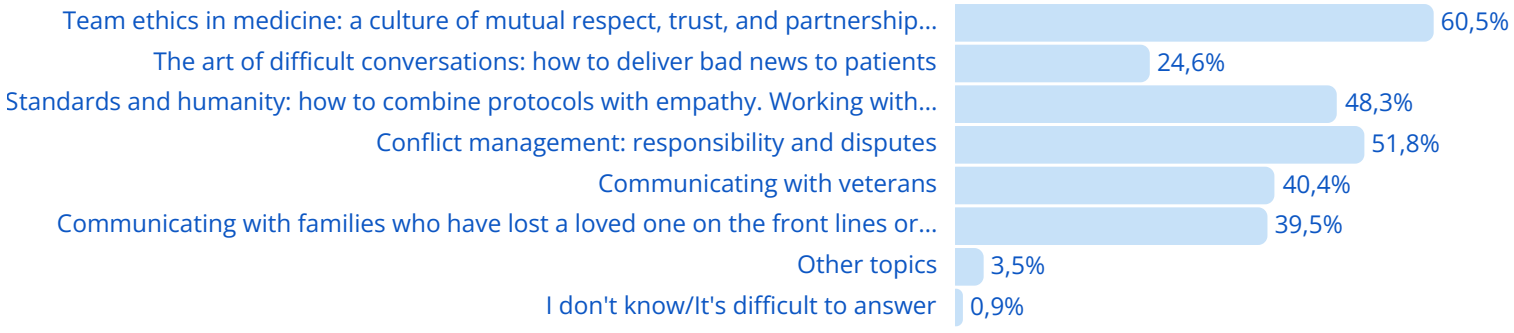


Figure 32: The most relevant training topics for doctors

e7. In your opinion, which of the following topics are the most relevant for training for doctors at your medical institution? (Choose up to three options) [% of responses among all respondents].

This indicates that the priority of doctors is the skills of interaction in a team and with patients, as well as the management of conflict situations and sensitive communication, in particular with groups that have been particularly affected by the war.

For mid-level employees, the most relevant topic of training by a large margin is **communication in a multidisciplinary team and the role of the nurse in modern medicine — 82.5%**.

In second place is a **new service approach in the institution to involve patients, families and staff (65.8%)**. This is followed by topics **related to communication in a military context: communication with veterans (45.6%) and communication with families who have lost a loved one (40.4%)**. Improving the patient experience to build loyalty is chosen less often (**30.7%**). This shows that, according to managers, team interaction skills are key for mid-level medical staff.

Figure 33: The most relevant training topics for middle-level employees

e8. In your opinion, which of the following topics are the most relevant for training for paramedical staff in your medical facility?
(Choose up to three options)
[% of responses among all respondents].

Conclusions for block E:

- The need for **advanced training** is almost **universal**: 78.1% of managers note that employees need training now, another 20.2% say that the need may arise in the future; the option "not needed at all" occurs only occasionally (0.9%).

- For doctors and nurses, the **critical skills** of the next five years are clearly **focused on digitalization and communication**: working with digital systems and communicating with the patient are the most frequent priorities.

- The **assessment of the readiness of the education system** to form the "doctor of the future" is **mostly critical**: 50.9% believe that it is "rather not ready", another 9.7% - "not ready at all", while positive assessments (36.0% "rather ready" and 1.8% "completely ready") are less common. Similarly, **skepticism** prevails regarding the **perception of nurses as equal members** of the team: 46.5% choose "rather not ready", 7.0% - "not ready at all", although at the same time 39.5% consider the system "rather ready".

- The most convenient and effective training format is practice-oriented: **training and simulation training** (74.6%) significantly outperforms other formats.

- The top 5 topics for management focused on **governance and financial sustainability** (43.0%), **budget planning** (41.2%), **donor fundraising** (40.4%), **risk management and quality indicators** (36.9%), and **strategic management in times of instability** (36.0%).

- For **doctors**, the most popular topics about interacting with people and the team are: **team ethics** (60.5%), **conflict management** (51.8%), **combining standards with empathy and working with feedback** (48.3%).

- For **middle-level staff**, the priorities, according to managers, are even more pronounced: **communication in a multidisciplinary team and the role of a nurse** (82.5%) and **a new service approach in the institution** (65.8%) are the undisputed leaders.

- **Recommended:**
  1. Given the high demand for training, it is advisable to consider advanced training as a **regular management process**.
  2. Build **training programs** around two cross-cutting skills for all staff categories: **digital tools/data** and **patient communication**, complementing them with team interaction, ethics and resilience depending on the role.
  3. Focus on **practical formats** for conducting training.
  4. For **management**, focus training on "**management skills**": management, budgeting, resource mobilization, quality and risk management, and strategizing in instability — these are the topics that are most anticipated.

BLOCK D: ROUTING AND SPECIALIZED ASSISTANCE

Assessment of interaction between institutions in the region during complex situations

Heads of institutions were asked to assess the extent to which their region has established coordination and interaction between healthcare institutions when referring patients for specialized or emergency care, interaction between the perinatal center, maternity hospital, and emergency medical care for transporting premature babies, and interaction between family doctors, psychiatrists, neurologists, inpatient and outpatient facilities in the context of providing neurological and psychiatric care on a four-point scale.

- **Fully established** – there are clear patient routes, coordinated actions between specialists, and effective communication (explanation only for question d3 on neurological and psychiatric care);
- **Rather established** – interaction between levels of care exists, but without unified protocols and coordination (explanation only for question d3 on neurological and psychiatric care);
- **Rather not established** – referral is made by personal agreement or at the doctor's initiative (explanation only for question d3 about neurological and psychiatric care);
- **Not established** – patients are often left without proper accompaniment or transferred between services without a route (explanation only for question d3 on neurological and psychiatric care).

Coordination and interaction between healthcare institutions when referring patients for specialized or emergency care is assessed positively in most cases. **62.3% of managers believe that it is rather well-established, another 7.0% — that it is fully established**. At the same time, **25.4% note that interaction is rather not well-established**, and **5.3%** — that it is not established aty all. This means that basic coordination in the regions is generally working, but almost a third of the assessments signal significant problems in routing and coordination between institutions.

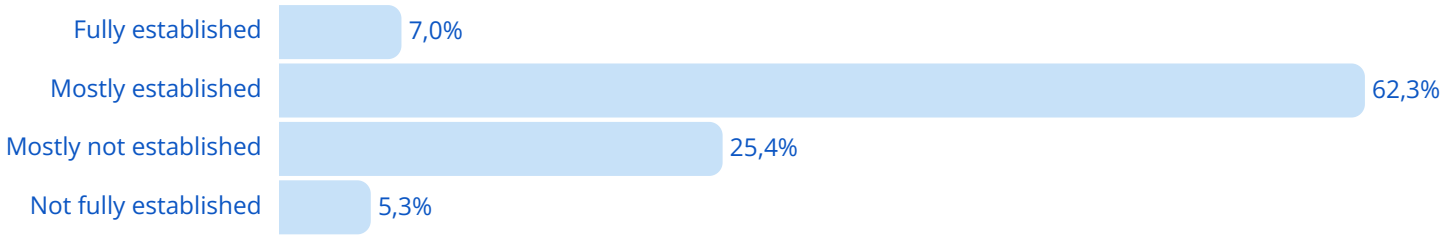


Figure 34: Interaction regarding emergency care

d1.To what extent is there coordination and interaction between healthcare institutions in your region when referring patients for specialized or emergency care?
(Single answer)
[% of responses among all respondents].

The interaction between the perinatal center, the maternity hospital, and emergency medical care for transporting premature babies is also most often assessed positively. **44.7% of managers believe that it is rather well-established, and another 25.4% believe that it is completely well-established**. Negative assessments are much less common: 7.9% note that the interaction is rather poorly established, and the proportion of responses about complete disorganization is minimal. At the same time, there is a noticeable degree of **uncertainty - 21.1%** of respondents could not assess the situation.

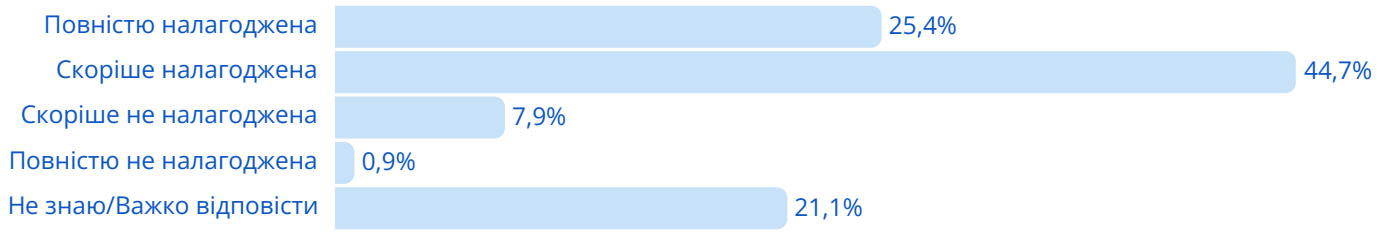


Figure 35: Interaction regarding the transportation of premature babies

d2. To what extent is the interaction between the perinatal center, maternity hospital, and emergency medical care for the transportation of premature babies established in your region? (Single answer). [% of answers among all respondents].

Among those who indicated that cooperation regarding the transportation of premature babies in the region is not established (n=10), the most common barrier is the **lack of clear transportation routes or agreed protocols — 50.0%.** Other reasons are mentioned much less frequently and without clear dominance. However, the rather small number of responses does not allow for sufficiently substantiated generalizations regarding these problems.

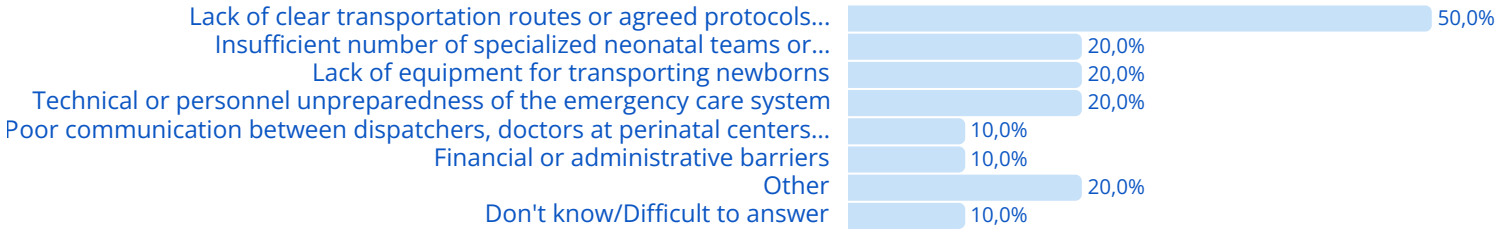


Figure 36: Barriers to interaction regarding the transport of premature infants

d2.1. What are the main barriers in your region that prevent effective interaction between the perinatal center, maternity hospital, and emergency medical care for transporting premature babies? (Select multiple answers)
[% of respondents who said that interaction is not established in d2 (n=10)].

The state of interaction in the system of providing neurological and psychiatric care (between family doctors, psychiatrists, neurologists, inpatient and outpatient facilities) is also most often assessed as **rather well-established — 43.0%**. Another **13.2% believe that the system is completely well-established**. At the same time, the share of critical assessments is significant: **29.0% note that interaction is rather poorly established**, and **8.8%** — that it is completely not established. Another **6.1%** could not answer.

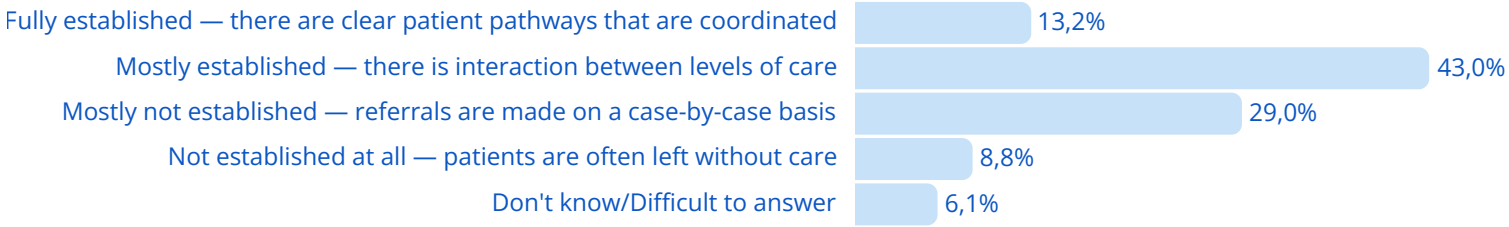


Figure 37: Interaction regarding the provision of neurological and psychiatric care

d3. To what extent is the system for providing neurological and psychiatric care in your region well-established, including interaction between family doctors, psychiatrists, neurologists, inpatient and outpatient facilities? (Single answer)
[% of responses among all respondents].

To summarize, we can say that the interaction of various medical institutions regarding solving transportation and treatment problems in difficult situations, according to the management of the institutions, is often somewhat well-established.

Assessment of the level of training of primary care physicians in working with patients with mental health disorders and the process of prescribing neuroleptics

A four-point scale was used to assess the training of primary care physicians in working with patients with mental health disorders:

- **Sufficient** - primary care physicians are able to independently identify, consult and support such patients;
- **Partially sufficient** - basic knowledge is available, but practical experience and a supervision system are lacking;
- **Partially insufficient** - most physicians do not have the skills to manage such patients and are often limited to prescribing medications;
- **Insufficient** - formal training, lack of control and coordination with psychiatrists.

The level of training of primary care physicians to work with patients with mental health disorders is most often assessed as **partially sufficient — 49.1%**. Another **12.3% consider the training sufficient**. On the other hand, **13.2% note that it is partially insufficient**, and **4.4%** — insufficient. At the same time, the share of answers **"don't know/difficult to answer" is quite large — 21.1%.**

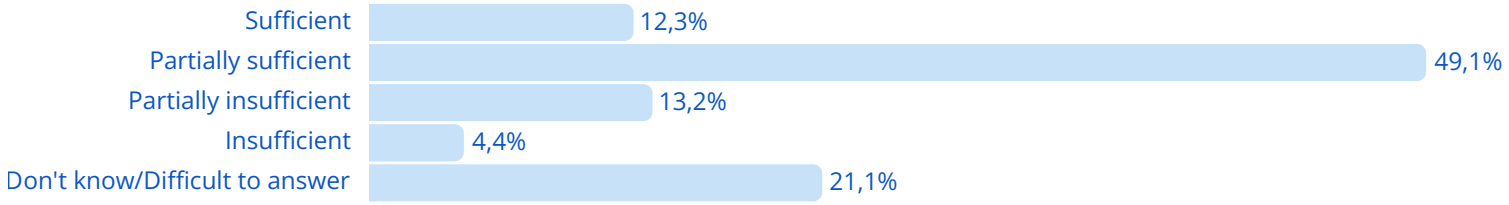


Figure 38: Assessment of the level of training of primary care physicians

d4. How would you rate the level of training of primary care physicians at your medical facility to work with patients with mental health disorders (depression, anxiety, PTSD, etc.)? (Single answer). [% of responses among all respondents].

That is, in general, primary care physicians training is more often assessed as rather good, but a significant part of managers does not have a clear idea of its level, which may indicate either a lack of systematic assessment and clear criteria within institutions.

The frequency of cases when antidepressants or neuroleptics are prescribed by primary care physicians without further referral or monitoring by a psychiatrist, according to managers' estimates, varies. **10.5%** note that such situations occur often, another **27.2% — sometimes**. At the same time, **21.9% answer that it happens rarely**, and **14.0%** — indicate never. The share of uncertainty is also **quite noticeable — 26.3%** "don't know/hard to answer."

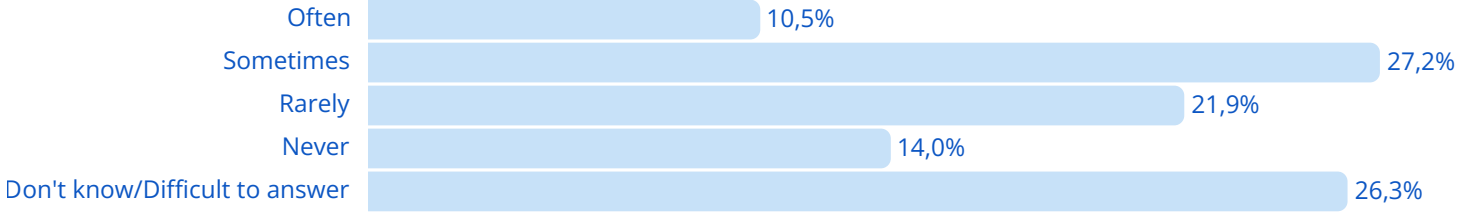


Figure 39: Frequency of inappropriate prescribing of neuroleptics and antidepressants

d5. How often have you observed cases where antidepressants or neuroleprics are prescribed by primary care physicians without further referral or monitoring by a psychiatrist? (Single answer)
[% of responses among all respondents].

This may mean that the problem of improper assignment exists for at least some institutions, but at the same time, control and tracking of such cases are not systematic enough, which may explain why a significant proportion of managers cannot confidently assess the situation.

Most often, managers note that when **prescribing neuroleptics, the patient receives complete information about the drug, risks, possible side effects and alternatives — 35.1%**. Also, **32.5%** respond that in case of side effects there is a mechanism for reviewing the prescription or referring to a specialist. The presence of a clear protocol or internal instructions for **prescribing neuroleptics is noted by 19.3%**. At the same time, 10.5% indicate that the prescription is made individually by each doctor without a single procedure. **The share of uncertain answers is 18.4%**.

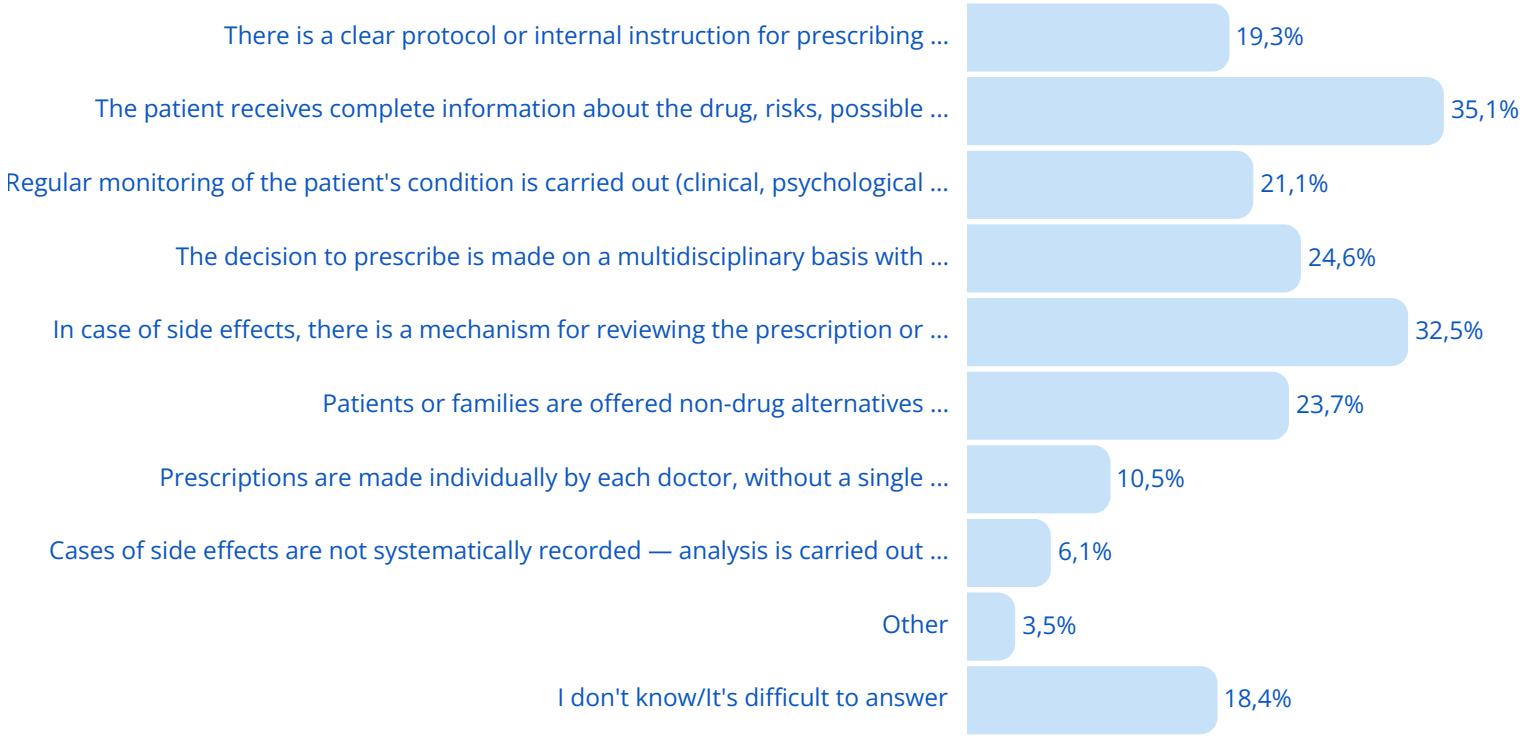


Figure 40: The process of prescribing neuroleptics

d6. How is the process of prescribing neuroleptics organized in your healthcare facility, including monitoring side effects, informing patients, and considering therapeutic alternatives? (Select multiple answers) [% of responses among all respondents].

This may indicate that the basic elements of informing and responding to side effects are present in many institutions, but process standardization and systematic monitoring are not implemented everywhere, and some managers do not have sufficient awareness of how this practice is organized at the institution level.

Conclusions for block D:

- **Coordination between institutions** when referring patients for specialized or emergency care is generally assessed **quite positively**: most respondents consider it well-established.
- **Interaction regarding the transportation of premature babies** is also more often perceived as **well-established**, however, for a significant part of managers this topic remains “out of sight” (high proportion of responses “don’t know/difficult to answer” (21.1%).
- **The system of providing neurological and psychiatric care** is assessed **less unambiguously**: along with positive assessments, there is a larger share of critical ones.
- **The level of training of primary care physicians** to work with patients with mental health disorders is more often assessed as **at least acceptable** (predominantly "partially sufficient - 61.4%"), but **the large proportion of "don't know" responses (21.1%)** may indicate **the lack of clear assessment criteria**.
- **The issue of prescribing psychotropic drugs** appears problematic from a transparency perspective: **some respondents record cases** when antidepressants/neuroleptics can be prescribed without referral or monitoring by a psychiatrist, and **a significant proportion cannot confidently assess the frequency** of such situations.
- **The process of prescribing neuroleptics** in institutions is often **described through individual elements** (patient information, review mechanism for side effects, multidisciplinary approach, monitoring), but at the same time, **the proportion of unclear answers and the presence of answers about the lack of a unified procedure** indicate that for some managers this **process is not sufficiently clear and not always standardized**.
- **Recommended:**
  1. A separate management direction should be made **transparency in the prescription of psychotropic drugs**. Given that 26.3% cannot estimate the frequency of inappropriate prescriptions, and 18.4% cannot answer about the process of prescribing neuroleptics, it is worth introducing minimal accounting and control mechanisms that will give management a better idea of such practices.

BLOCK P. MENTAL HEALTH

Psycho-emotional conditions of patients: algorithm for identifying stress, information about support, impact of conditions on treatment.

More than half of respondents report the presence of a specific algorithm: **35.1% indicate that the institution has an internal procedure or recommendations approved at the institution level, and 20.2% - that an officially approved algorithm or protocol** is in place. At the same time, about a third of the responses describe the absence of a formalized algorithm: **14.9% indicate an informal approach, when the doctor or nurse independently determines further actions**, another **14.0%** - that patients are referred to the institution's psychologist or psychiatrist without a separate algorithm. In addition, **7.0%** report that there is currently no algorithm, but they plan to implement it; **3.5%** refer patients to external specialists or organizations, Only **1.8%** note that there is no algorithm and it is not planned.

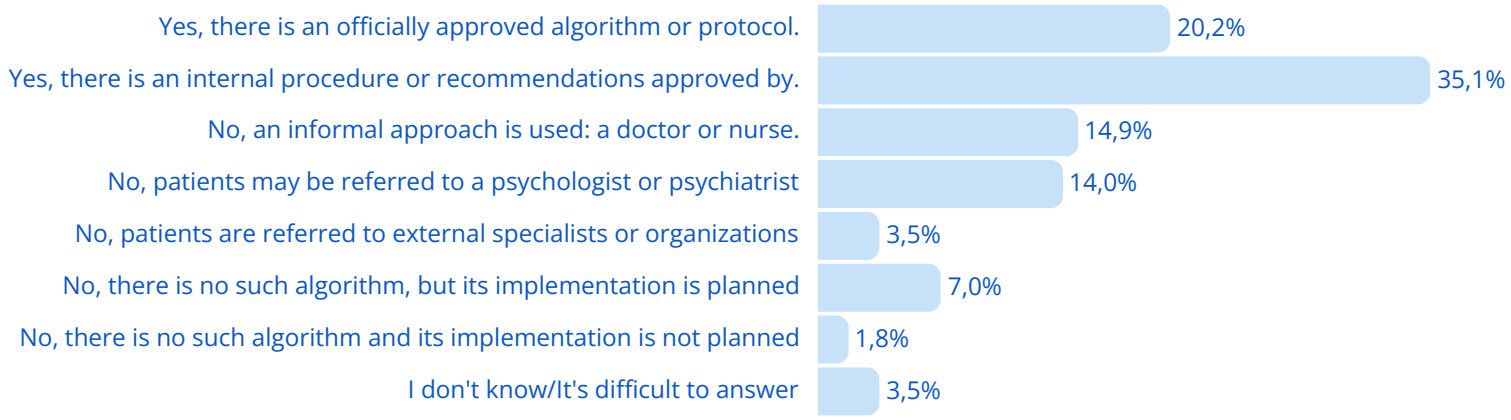


Figure 7: Presence of initial detection of signs of psychological stress

p1. Does your healthcare facility have an algorithm for early detection of signs of psychological distress in patients and referral of individuals with disorders (e.g., anxiety, depression) for further care? (Single answer).
[% of responses among all respondents].

Overall, the results indicate that in most institutions certain approaches to the initial detection of stress have already been defined, but in a significant proportion they remain informal or are replaced by situational decisions and referrals.

As for informing patients about the possibilities of seeking psychosocial support, if they do not make a direct visit to a doctor, patients in institutions are most often informed about the possibilities of psychosocial support during contacts with medical staff: **60.5% of respondents note that information is provided by family doctors or nurses during other consultations**. Almost as widespread are the communication channels of the institution itself - **59.7% indicate the official website or social networks, and 57.9% - information materials directly in the institution (posters, booklets, stands)**.

The share of responses that patients are mostly not informed about the possibilities of mental help is small (**3.5%**).

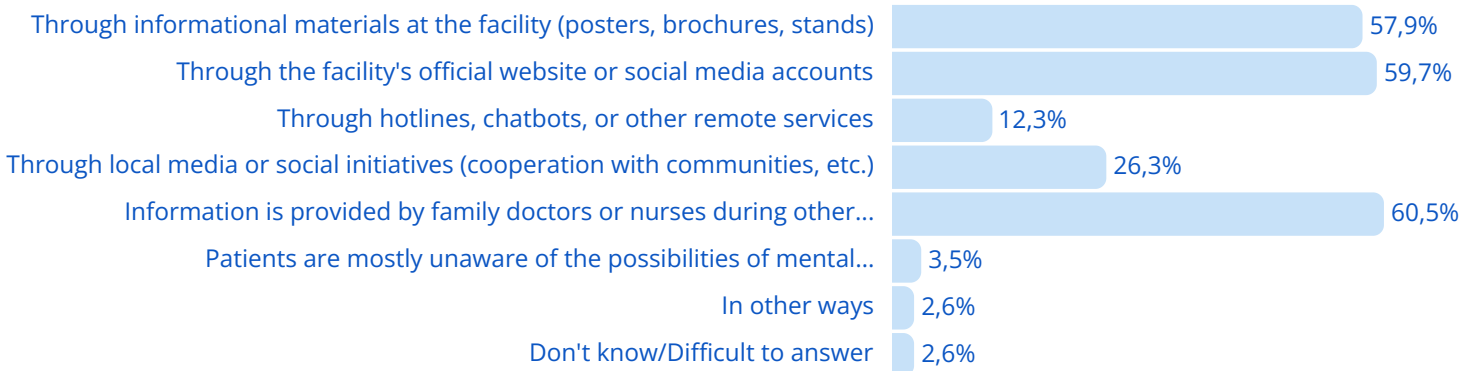


Figure 8: Informing patients about psychosocial support options

p4. How do patients in your facility receive basic information about psychosocial support options if they do not visit a doctor in person? (Multiple choices are possible). [% of responses among all respondents]

The results show that basic information is mostly disseminated through the institution's staff and communication channels, while specialized remote tools and partner media channels are used significantly less frequently.

The impact of patients' psycho-emotional states on the quality and effectiveness of treatment was assessed on a 4-point scale:

- **Has a significant impact** - patients with high anxiety/stress recover more slowly, are more likely to violate recommendations
- **Has a moderate impact** - sometimes makes it difficult to adhere to treatment
- **Has a small impact** - but some difficulties still arise
- **No impact** - treatment is the same for everyone

The vast majority of managers believe that the patient's psycho-emotional state affects the quality and effectiveness of treatment: **75.4% assess this impact as significant, another 18.4% as moderate**. Only **4.4% indicate a slight impact**, and the proportion of responses that actually deny the impact is minimal (**about 1%**).

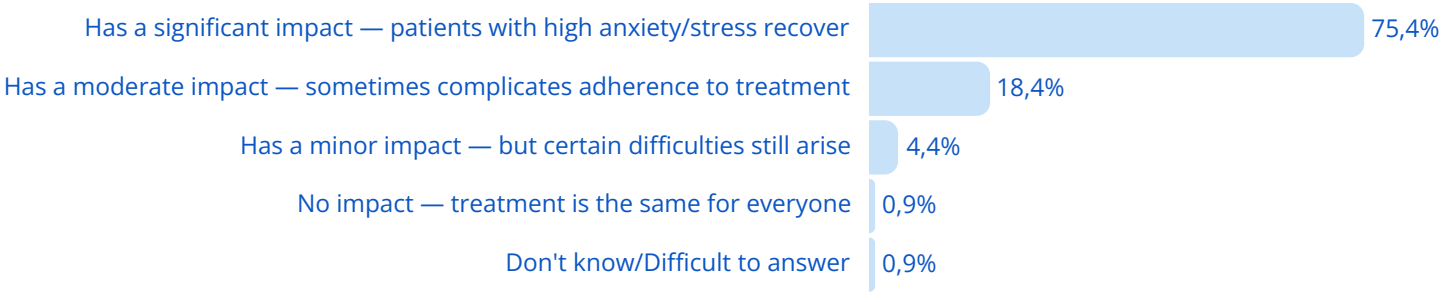


Figure 9: The impact of patients' psycho-emotional states on the quality and effectiveness of treatment

p5.How do you think the psycho-emotional state of the patient affects the quality and effectiveness of treatment? (Single answer). [% of responses among all respondents].

This may demonstrate an almost consensus position: for most institutions, the psycho-emotional state of patients is perceived as a critical factor in the effectiveness of treatment, and therefore requires systematic attention in the practice of providing care.

Assessment of staff competence level and improvement of their qualifications

Respondents assessed the level of staff in terms of work and management of patients with mental disorders in accordance with modern approaches, based on a 5-point scale from lack of competence to high level (the scale is reversed in the question):

- **High level** - staff has modern skills and approaches.
- **Sufficient level** - basic competencies are available, but need updating.
- **Average level** - some staff have competencies, some need additional training.
- **Low level** - significant deficit of knowledge and skills.
- **Lack of competencies** - staff do not have the necessary training.

Assessments of staff competencies are most often concentrated in the average and sufficient zone: **39.5% of respondents characterize the level as average, and 36.0% as sufficient**. A high level is noted by **7.9%** of respondents. At the same time, **11.4% assess competencies as low**, and 4**.4%** indicate the absence of necessary competencies. In general, this may mean that the majority of managers see at least some of the staff as having basic or acceptable training, but for a significant part of institutions, the need for additional training and advanced training remains relevant.

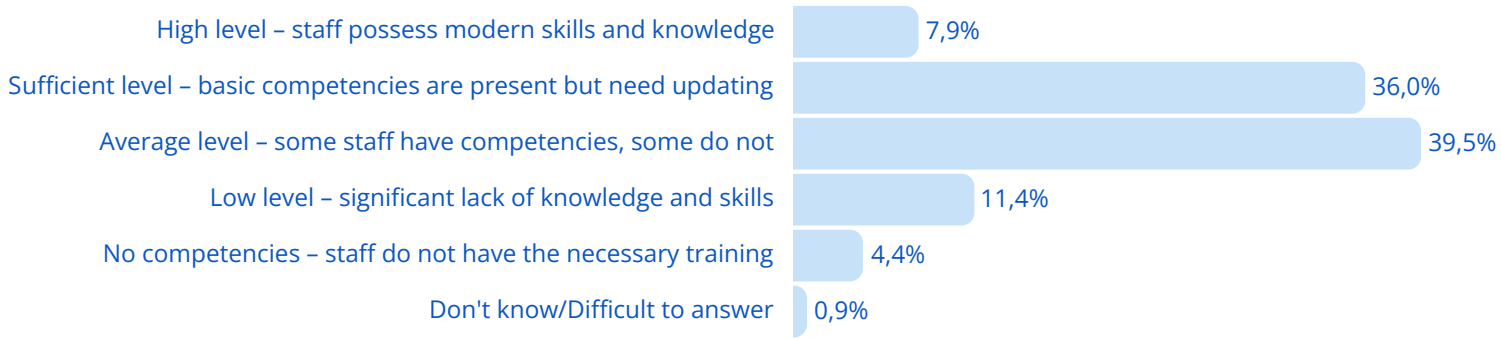


Figure 10: Level of staff competence

p2. How would you rate the level of competence of your staff in working with and managing patients with mental disorders according to modern approaches? (Single answer). [% of responses among all respondents].

When it comes to staff development, most often healthcare facilities provide **mental health training through publicly available materials and online courses — this was the response of 50.0%** of respondents. Another **18.4% indicate that they refer staff to partner organizations** for training, and **14.0%** talk about partially providing opportunities depending on available options and external resources. At the same time, only **8.8%** report that they organize internal training and education. A small proportion of facilities do not provide training: **4.4%** do not do so and do not plan to, and **3.5%** do not yet provide it, but plan to.

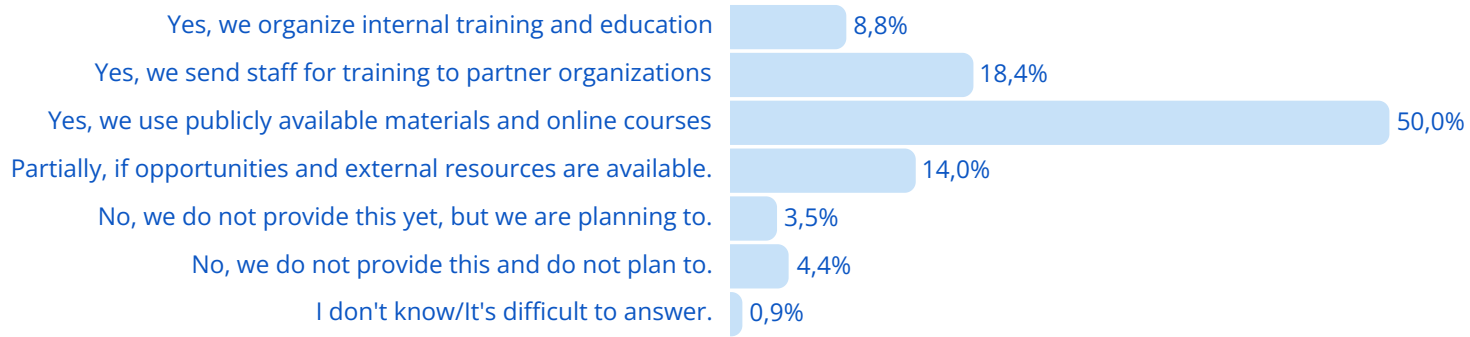


Figure 11: Recommended mental health programs among those who have taken part

p3. Does your health care facility provide opportunities for mental health professional development? (SIngle answer) [% of responses among all respondents].

Overall, the results show that learning opportunities mostly exist, but the format of self-education and external resources prevails, while systemic internal programs are much less common.

Supporting the psychological health of the employees

Practices to support employees' mental health are available only in some medical institutions. 1**7.5% of managers note that such practices exist and are regularly used, another 28.1% say that they exist, but are used irregularly**. At the same time, the most common answer is the absence of practices with the intention to introduce them: **39.5% report that there are currently no such practices, but their implementation is planned**. Another **12.3%** indicate that there are no practices and they do not plan to introduce them.

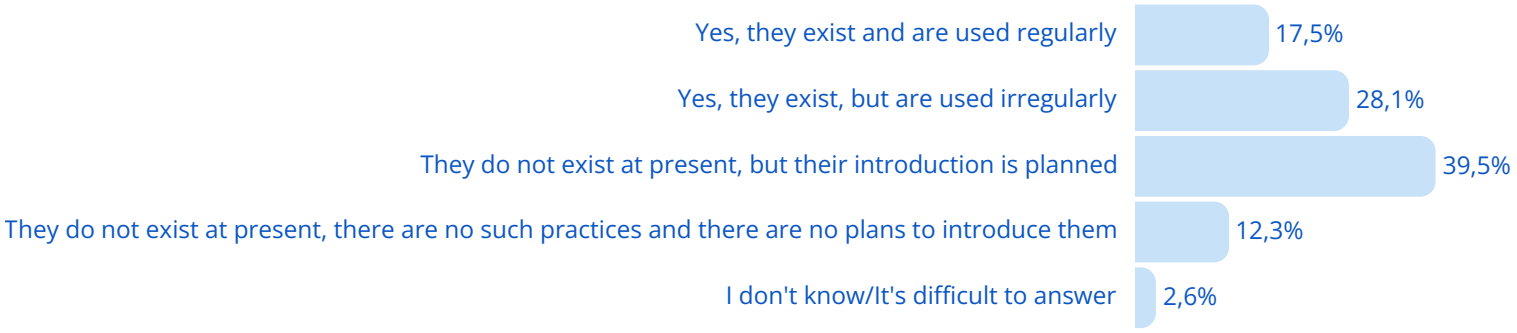


Figure 12: Practices to support employees mental health

p6. Does your healthcare facility have practices to support the mental health of employees after difficult shifts, crisis situations, or manifestations of professional burnout? (Single answer). [% of responses among all respondents].

Staff support as an institutional practice has not yet become standard for most institutions: a significant proportion is at the planning stage, and regular use of such approaches remains the exception rather than the norm.

Among institutions that reported the presence of practices to support the mental health of employees, the most common forms are **access to a staff psychologist or psychotherapist of the institution (53.9%) and support from colleagues and mentoring within the team (50.0%)**. Also quite often mentioned are **education and training in stress management, emotional resilience and self-regulation (40.4%)**, as well as participation in joint projects with charitable or public organizations in the field of mental health (**34.6%**).

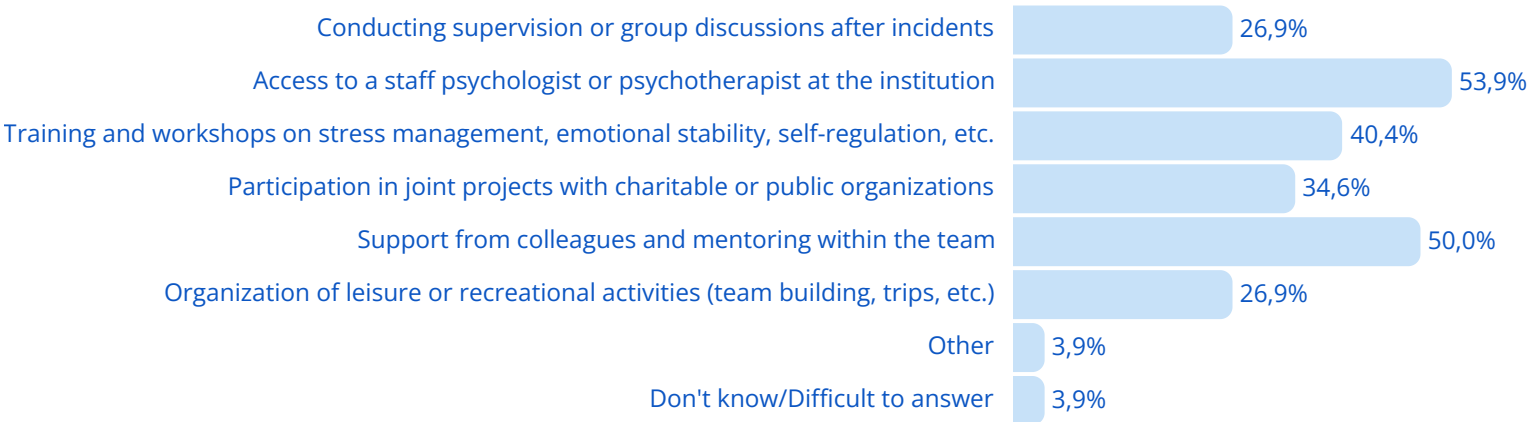


Figure 13: Types of practices to support employees mental health

p6.1. How does your medical institution support the mental health of employees after difficult shifts, crisis situations, or in conditions of professional burnout? (You can select multiple options).
[% of responses among respondents who noted the presence of practices to support the mental health of employees in p6 (N=52)].

The structure of the responses shows that staff support is most often implemented through a combination of internal resources (specialist on staff, mutual team support) and training activities, while post-incident systemic reflection practices and recovery measures are implemented significantly less frequently.

According to managers, responsibility for the mental state of employees **should be shared by all institutions and actors listed in the question: 39.5%** chose this option. At the same time, a significant share assigns a key role to the **medical institutions themselves - 31.6%** indicate them as the main responsible ones. Authorities are mentioned much less often: **12.3% indicate local authorities and local self-government bodies**, and **10.5%** - central authorities (MoH, NHSU). Other actors are almost not considered responsible:

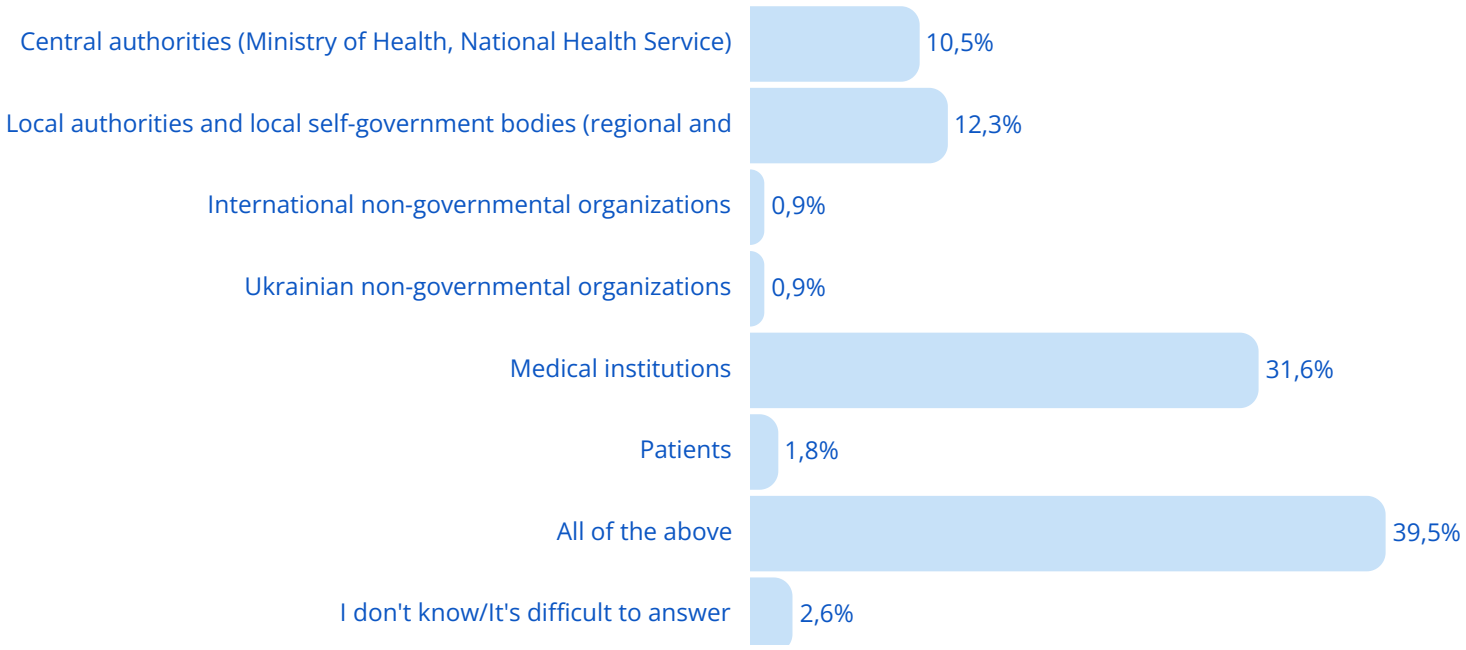


Figure 14: Practices to support employees mental health

p7. Who do you think should have the primary responsibility for supporting the mental health of healthcare workers? (Single answer)
[% of responses among all respondents].

Conclusions for block P:

- **The psycho-emotional state of patients** is perceived as a **critically important factor in treatment**: 75.4% of managers believe that it has a significant impact on the quality and effectiveness of treatment, another 18.4% believe it has a moderate impact.
- Most institutions have at least **basic approaches to the initial detection of signs of psychological stress**: 35.1% have an internal procedure/recommendations, 20.2% have an officially approved algorithm or protocol.
- **The level of staff competence** in working with mental disorders is most often assessed **as average or sufficient** (39.5% and 36.0%, respectively), which emphasizes the need for systematic professional development.
- **Mental health training** is most often provided through **self-education and external resources**: 50.0% use publicly available materials and online courses, 18.4% refer staff to partner organizations for training, while only 8.8% conduct internal training.
- **Informing patients about psychosocial support opportunities** mostly occurs through the **institution's staff and channels**: 60.5% - through family doctors/nurses during consultations, 59.7% - through the website or social networks, 57.9% - through information materials in the institution.
- **Practices to support the mental health of employees** are not yet standard: 17.5% of institutions have such practices and use them regularly, 28.1% use them irregularly, while the largest share (39.5%) reports the **absence of practices**, but **plans to implement them**.
- Among institutions where staff support practices are available, the most common concerns are access to a **full-time psychologist/psychotherapist** (53.9%) and mutual support and mentoring within the team (50.0%).
- **The responsibility for supporting the mental health of healthcare workers** is most often seen as **shared** (39.5%), but with a clear emphasis on the role of **healthcare institutions** themselves (31.6%).
- **Recommended:**
  1. Strengthen staff competencies through **systematic training**;
  2. Shift the emphasis from self-education to organized **internal programs**;
  3. **Institutionalize support for employee mental health**

BLOCK G: REFORM AND SYSTEM EFFICIENCY

Tangible results of reform and decentralization

Most often, among the results of medical reform and decentralization, managers **note the ability to directly conclude contracts with the National Health Service and receive payment for services — 52.6%. This is followed by improved financial autonomy of the institution (independence in managing funds, transparency of finances) — 43.9%, as well as increased management responsibility and opportunities for strategic management — 36.0%**. A significant share of respondents also connects the reform with improved service quality through competition and patient orientation (**30.7%**). At the same time, more "material" or external effects are mentioned less often: development of the material and technical base (**23.7%**) and improved accessibility of medical services (**23.7%**), while more effective interaction with local authorities is noted by **14.0%**. Only **9.7%** do not observe any changes, and the share of "don't know/hard to answer" responses is small (**3.5%**).

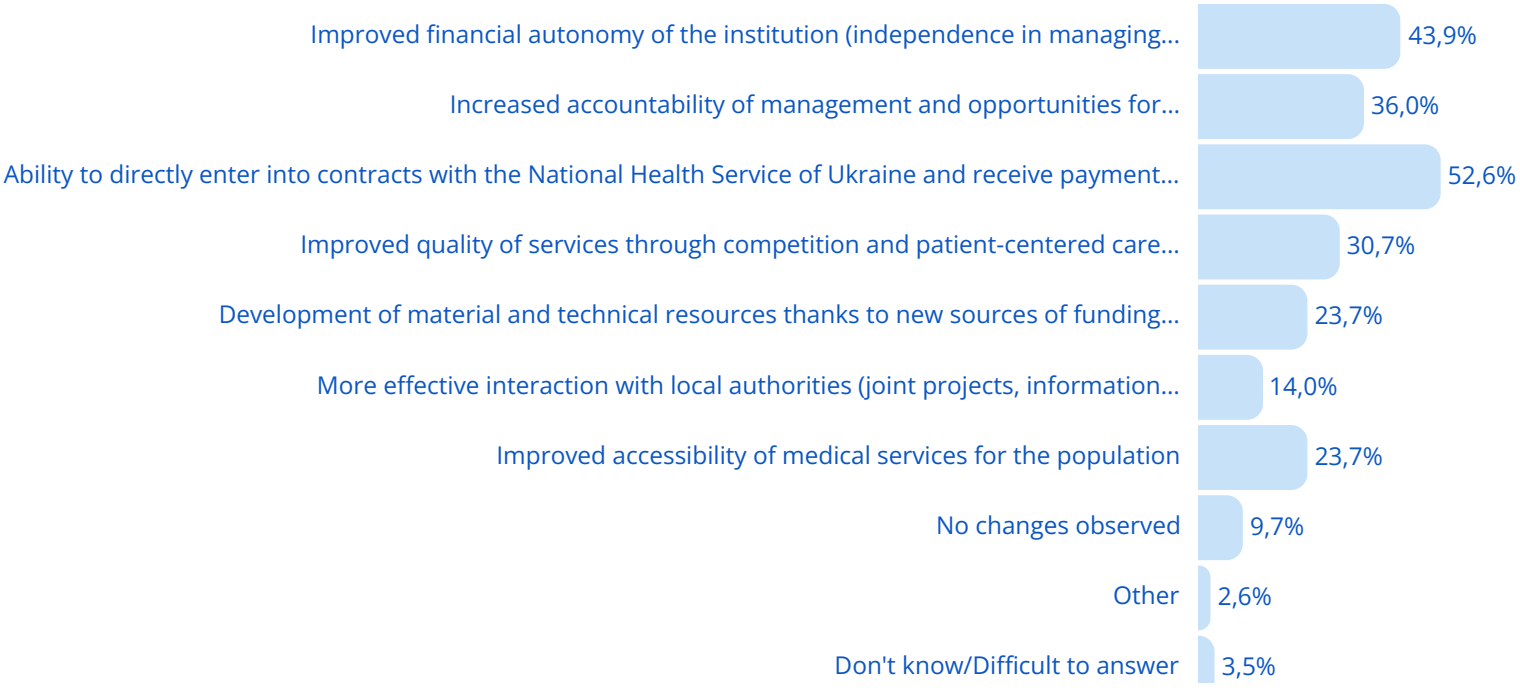


Figure 41: Results of medical reform and decentralization

g1. What results of the healthcare reform and decentralization process have you already observed in the work of your healthcare facility? (Select multiple answers). [% of responses among all respondents].

This shows that reforms are most pronounced for institutions through financial and organizational mechanisms (contracts with the National Health Insurance Fund, autonomy, managerial role of management), while changes in interaction with local authorities and infrastructural changes are felt to a lesser extent.

Compliance with state policy and NHSU requirements

Most managers report that medical institutions face difficulties in fulfilling the requirements of state policy, standards, or conditions of the National Health Insurance Fund. **44.7% note that this happens often**, another **42.1% - sometimes**. At the same time, **7.9% answer that difficulties arise rarely**, and **3.5%** - never.

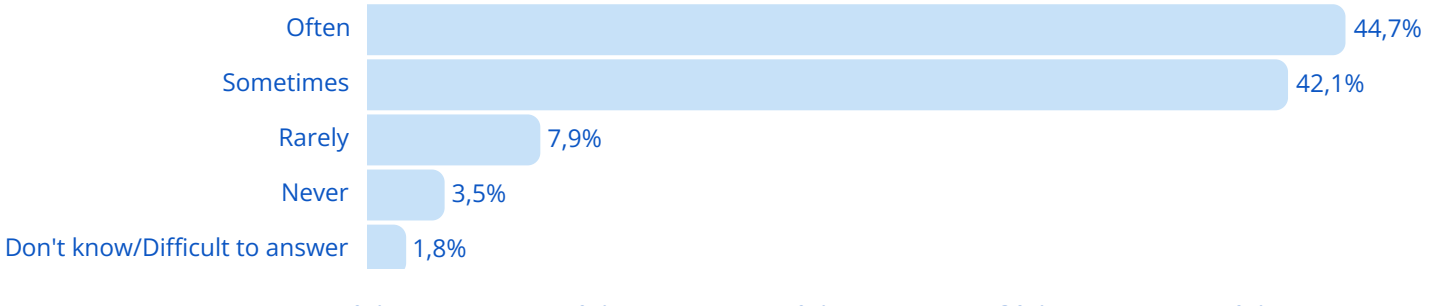


Figure 42: Difficulties in meeting institutional requirements

g2. Does your medical facility often face difficulties in fulfilling the requirements of state policy, standards, or conditions of the National Health Service? (Single answer). [% of responses among all respondents].

That is, for the vast majority of institutions, compliance with requirements is accompanied by obstacles at least from time to time, and for a significant part - it is a systemic, recurring problem.

Among respondents who at least sometimes face difficulties in implementing state policy, standards or conditions of the NHSU (g2, n=108), the most common problem is the **inadequate cost of NHSU packages, when funding does not cover the actual costs of providing services - 74.1%**. This is followed by **a shortage of personnel, in particular in administrative and middle medical personnel - 45.4%, as well as conflicting requirements between the Ministry of Health, NHSU and local administrations - 42.6%**. Administrative and organizational factors are also noticeable: low motivation of staff due to unequal pay and non-recognition of the role of specialists (**38.9%**) and excessive bureaucracy - paper reporting, duplication of processes, excessive inspections (**36.1%**).

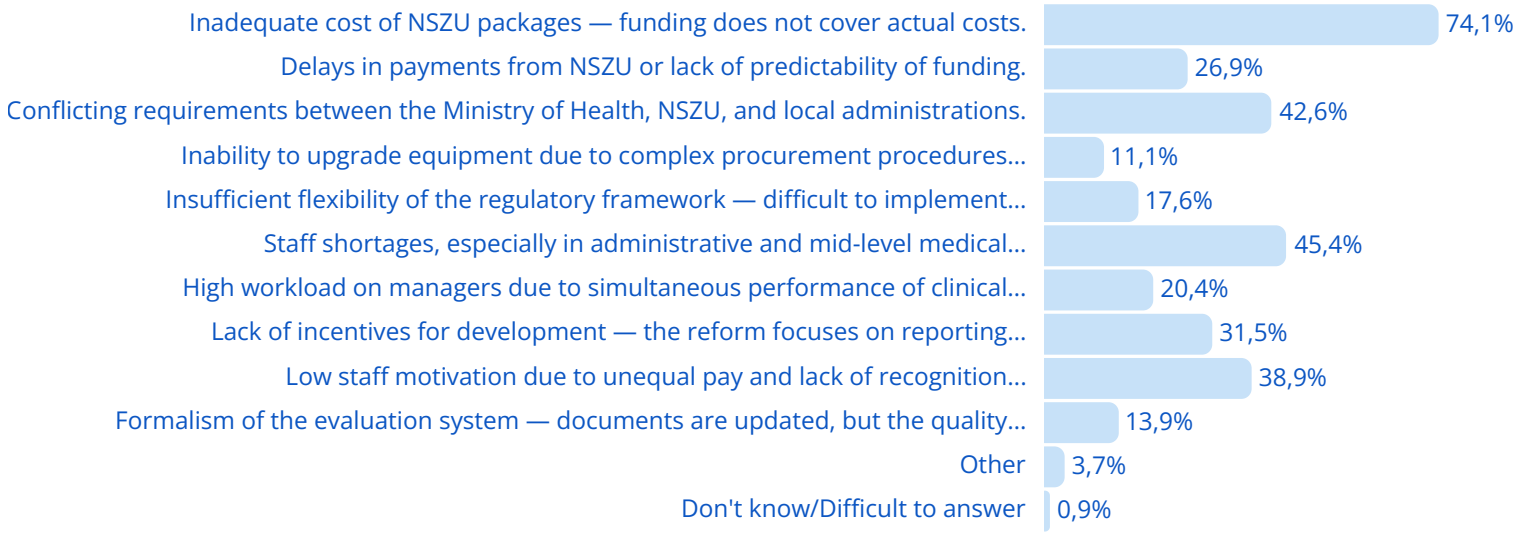


Figure 43: Difficulties in implementing public policy

g2.1. What are the biggest challenges your medical facility faces in implementing state policies, regulations, or NHSU requirements? (Select multiple answers)
[% of responses among respondents who at least sometimes encountered difficulties in g2(n=108)].

As a result, the greatest pressure on institutions is created by financial constraints and staff shortages, exacerbated by conflicting requirements and bureaucratic burdens.

The readiness of medical institutions to implement the updated guaranteed package of services is most often assessed as positive. **70.2% of managers believe that their institution is rather ready, another 14.0% - that it is completely ready**. At the same time, **11.4% note that the institution is rather not ready**, but no institutions were recorded that were not ready at all.

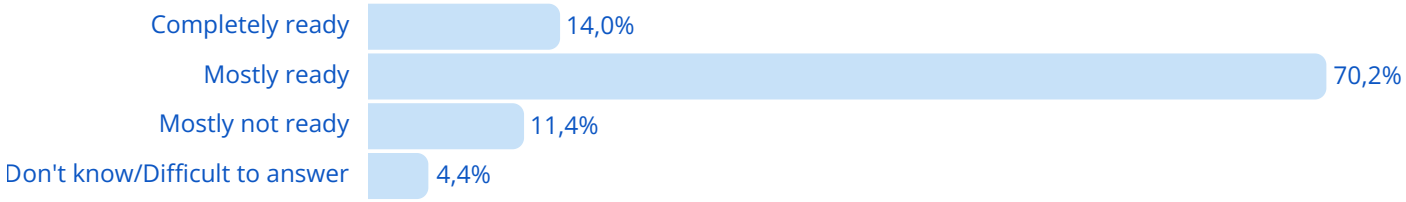


Figure 44: Readiness to implement the updated guaranteed service package

g3. Assess the degree of readiness of your medical institution to implement the updated guaranteed package of services, taking into account personnel, technical, managerial and financial aspects (Single answer). [% of responses among all respondents].

This indicates that the vast majority of institutions declare at least a basic readiness for change.

Attrition of staff and patients

Respondents assessed the level of staff and patient attrition to private medical institutions. Respondents who assessed staff attrition as insignificant further reported what exactly helps them avoid significant attrition, and all managers reported what could prevent patient attrition.

Assessments of staff attrition to private medical institutions mostly indicate that for the majority this is not a critical problem. **53.5% of managers note that the attrition is insignificant, and 23.7% — that there is no attrition**. At the same time, **20.2% consider the attrition to be significant**, and only **1.8%** — very significant.

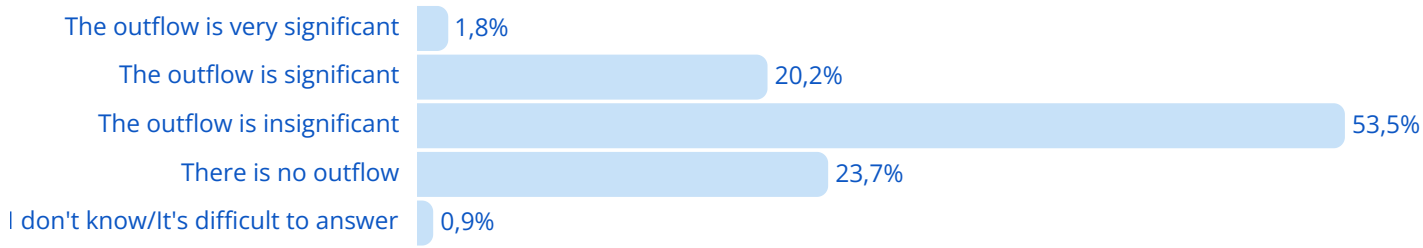


Рисунок 45: Assessment of staff attrition

g4. How significant is the attrition of staff from your medical facility to private medical facilities? (Single answer) [% of responses among all respondents].

That is, in most institutions, the attrition is either absent or not large-scale, but about a fifth still experience it.

Among respondents who noted a slight attrition of personnel (n=61), the combination of the professional capacity of the team and the management quality of the institution are most often mentioned as "retention" factors. In the first positions are **a high level of professionalism of the medical staff (32.8%) and an experienced administrative team/effective management (32.8%)**, almost as often the availability of **free or partially compensated services is mentioned (31.2%)**.

Figure 46: Factors preventing staff attrition

g4.1. In your opinion, what helps your medical facility avoid staff attrition to private medical facilities? (Select multiple answers) [% of responses among respondents experiencing minor attrition (n=61)].

This shows that the lower risk of churn is not associated with one factor, but with a combination: a strong team, adequate management, and a clear value of the institution for patients and the community.

As for patient churn, it is also assessed as small in most cases. **58.8% of managers note that the churn is insignificant, and 15.8% — that there is no churn**. At the same time, **20.2% consider the churn to be significant**. That is, the overall picture is rather stable (more than three quarters do not see significant churn), but for approximately one fifth of institutions, competition with the private sector for patients is already felt as a noticeable problem.

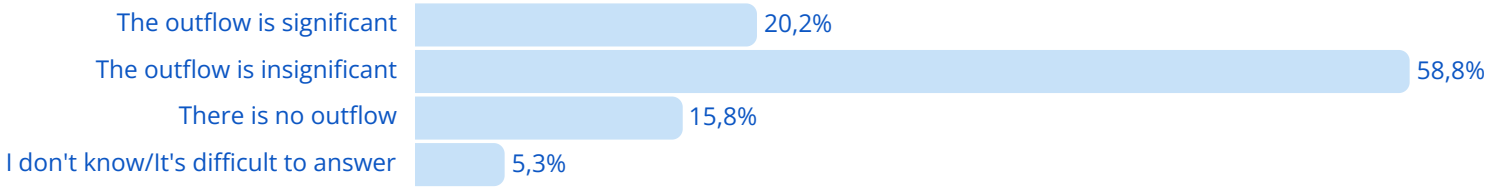


Рисунок 47: Assessing patient churn

g5. How significant is the outflow of patients from your medical facility to private medical facilities? (Single answer). [% of responses among all respondents].

That is, the overall picture is rather stable (more than three quarters do not see a significant outflow), but for approximately **16% of institutions, competition with the private sector for patients is already noticeable**.

Among the possible steps that could help institutions prevent the outflow of patients and specialists to other medical institutions, financial and material factors are most often mentioned. In first place is an **increase in the cost of NHSU tariffs or adequate financing of services (59.7%)**, almost as often is an **increase in salaries or bonus motivation for staff (57.9%)**. The third most frequent priority is **updating equipment and infrastructure (42.1%)**. This is followed by a group of management and personnel decisions with noticeably lower shares: investments in training, internships and development of managers and doctors (**28.1%**) and improving working conditions and comfort for medical staff (**27.2%**). Comparatively less frequently, improvements in communication and the reputational presence of the institution (**19.3%**) and reduction of bureaucratic burden/greater autonomy in management (**16.7%**) are mentioned.

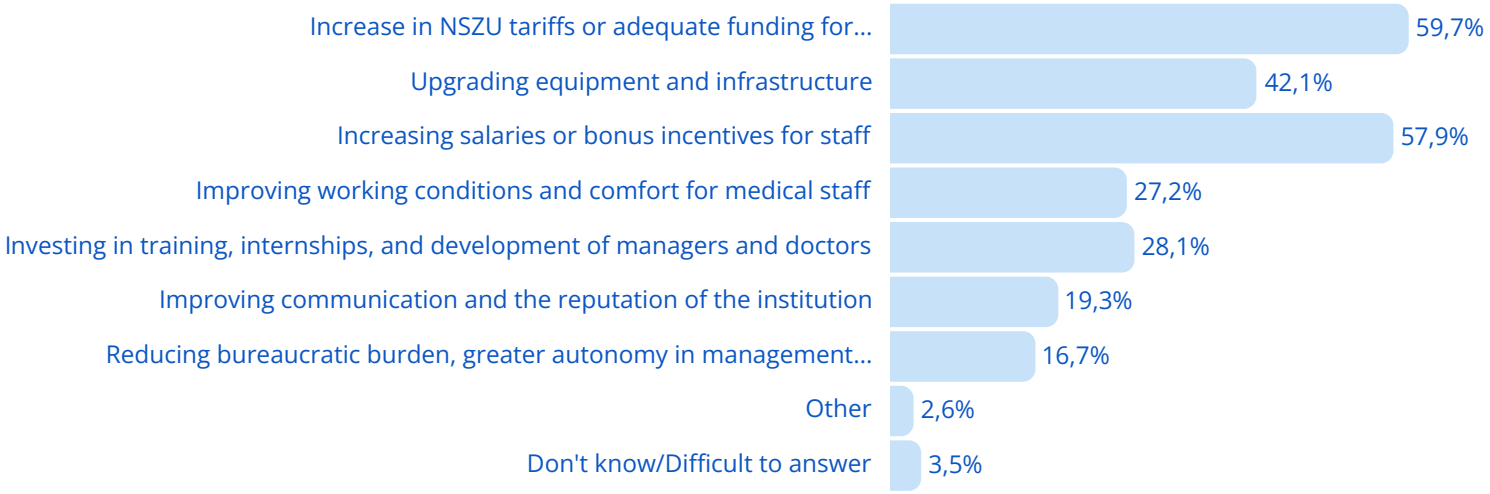


Figure 48: Factors that may prevent patient churn

gg6. What do you think could help your healthcare facility prevent the outflow of patients and professionals to other healthcare facilities? (Select multiple answers). [% of responses among all respondents].

As a result, respondents primarily associate patient and staff retention with resources and pay, while “soft” tools such as communications or managerial autonomy are perceived as supporting but less of a priority.

Compliance of reform policies with the real conditions of institutions

Respondents were asked to assess the compliance of the reform policy with the real conditions of the institutions on a four-point scale:

- **Completely corresponds:** the reform policy is consistent, resources and standards are sufficient for its implementation.
- **Rather corresponds:** the direction is correct, but the tools, financing and pace of implementation are not consistent with reality.
- **Rather does not correspond:** most requirements are formed without taking into account the capabilities of the institutions, especially at the regional level.
- **Completely does not correspond:** the reform policy creates more administrative burden than real improvements and widens the gap between the public and private sectors.

Assessments of the compliance of the state reform policy with the real conditions and capabilities of medical institutions are quite polarized, but with a slight predominance of a negative view. **43.9% of managers believe that the policy is rather consistent with the capabilities of institutions**, and only **4.4%** — that it fully complies. At the same time, **41.2% note that it is rather inconsistent**, and **9.7%** — that it is completely inconsistent. Thus, in total, **48.3%** give a positive assessment, and **50.9% give a negative one**.

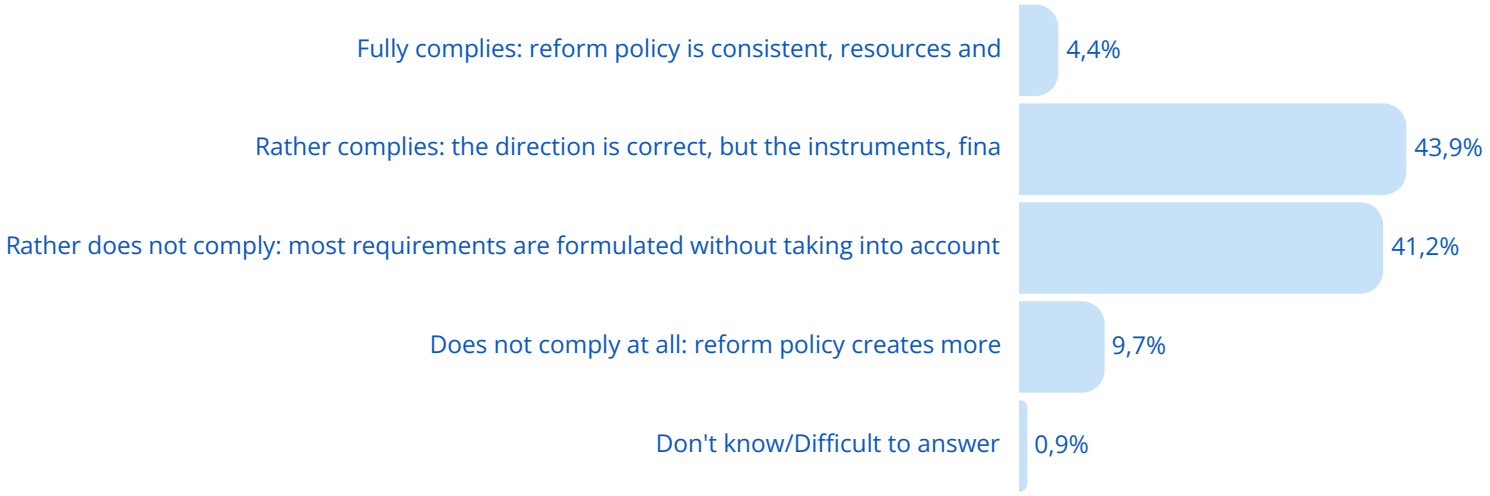


Figure 49: Assessment of compliance of state policy with the real conditions of medical institutions
g7. To what extent, in your opinion, does the state policy of reforming the healthcare system correspond to the real conditions and capabilities of medical institutions?
(Single answer)
[% of responses among all respondents].

This indicates a fairly polar attitude towards state policy among the management of medical institutions.

Conclusions for block G:

- Reform and decentralization are most often manifested for institutions through financial and organizational mechanisms: the **ability to directly conclude contracts with the National Health Service** (52.6%), **financial autonomy** (43.9%), and strengthening the managerial role of management (36.0%). At the same time, **changes in infrastructure/accessibility** are mentioned less often (23.7% each), and i**mproved interaction with local authorities** is mentioned even less often (14.0%).

- Despite the noticeable improvements, **fulfilling the requirements of state policy and conditions of the NHSU** is problematic for the majority: 44.7% encounter difficulties often, 42.1% sometimes. The most acute barrier is the **NHSU tariffs** (74.1%), followed by **staff shortages** (45.4%) and **contradictory requirements between the Ministry of Health/NHSU/local administrations** (42.6%); **staff demotivation** (38.9%) and **bureaucracy** (36.1%) are also significant.

- **Readiness for the updated guaranteed package** is mostly assessed **positively** (70.2% “rather ready”, 14.0% “completely ready”).

- **Staff and patient turnover** in most facilities is described as **insignificant/absent** (staff: 53.5% + 23.7%; patients: 58.8% + 15.8%), but about a fifth already experience it as significant (20.2% for staff and patients each). **Staff retention factors** are most often associated with the **quality of the team and management** (32.8% each) and the **availability of free services (31.2%)**.

- Respondents consider resource solutions to be the most effective **steps to prevent patient outflow: adequate funding/tariffs of the National Health Service** (59.7%), **increasing salaries and bonus motivation** (57.9%), **updating equipment and infrastructure** (42.1%); **training and development** (28.1%) and **working conditions** (27.2%) are important, but secondary in terms of frequency of mention.

- The assessment of how well state policy meets real conditions is almost **equally** divided: 48.3% are inclined to say “it meets”, 50.9% to say “it does not meet”.

- **Recommended:**
  1. **Review the NHSU tariffs** and bring funding closer to the **actual cost of services** (because this causes the greatest difficulties — 74.1% — and at the same time is the most frequent request as a solution to patient outflow — 59.7%).

BLOCK F: EUROPEAN INTEGRATION

Respondents were asked about the difficulties of implementing European Union standards, as well as the European Union's Green Deal - difficulties and advantages

Difficulties in the implementation of European Union standards

The managers assessed how difficult the process of implementing the standards is and named the main difficulties of the process.

When implementing European Union standards in the healthcare sector, most institutions do face difficulties of varying magnitude. 57.0% of managers indicate that they have minor difficulties, and another 18.4% say that the difficulties are significant. At the same time, 7.9% answer that they have no difficulties at all.

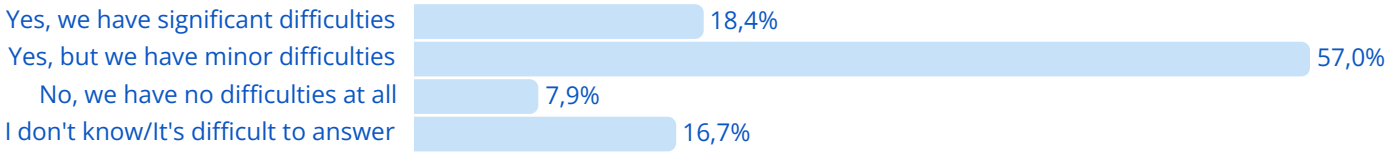


Figure 50: Assessment of the process of implementing European Union standards

f1. Does your healthcare facility face difficulties in implementing European Union standards in the healthcare sector? (Single answer) [% of responses among all respondents].

That is, the overall picture shows that the process of European integration changes in medicine is perceived as complex, but mostly "manageable" (more often they talk about minor difficulties), but a sufficient percentage of answers "I don't know/Difficult to answer" may indicate insufficient awareness of the real requirements and the progress of their implementation.

Among respondents who noted the presence of significant or minor difficulties with the implementation of European Union standards, the biggest problem is **ensuring the financial capacity of the institution (60.5%) and modernization of technical equipment and compliance with technical standards (55.8%)**. Next in frequency of mention is the **transition to European clinical protocols and patient routes (33.7%)**. The next group of barriers is more of a "systemic and organizational" nature: the implementation of quality standards for medical services (**25.6%**) and harmonization of documentation and document flow (**25.6%**), as well as the lack of institutional support or methodological recommendations at the national level (**24.4%**). Human capital development issues are mentioned less frequently: staff training (**18.6%**), and resistance to change/complexity of transforming management practices — **14.0%**.

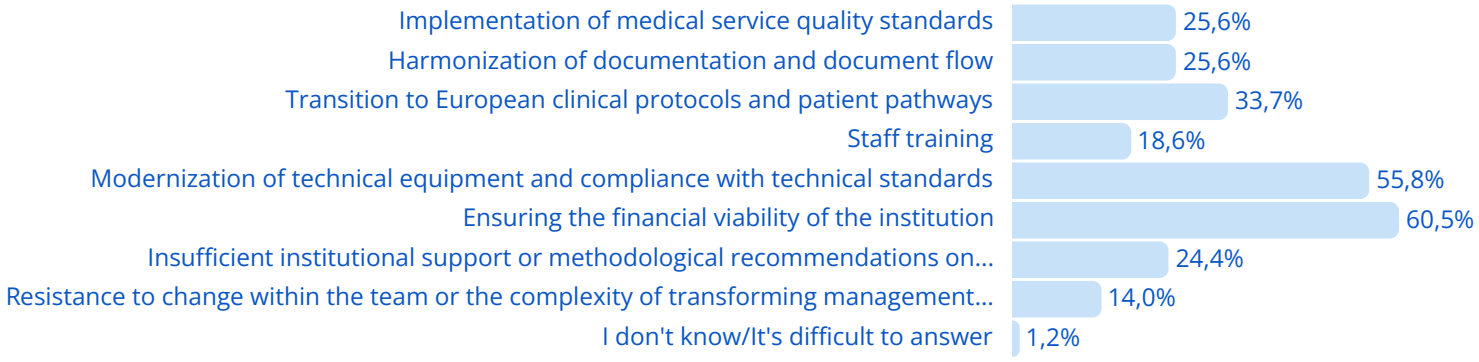


Figure 51: The biggest difficulties in implementing European Union standards

f1.1. What are the biggest challenges your healthcare facility faces in implementing European Union healthcare standards? (Select multiple answers). [% of respondents who indicated significant or minor difficulties in f1(n=86)].

European Union Green Deal

It is worth noting that only **11 managers** said that the requirements of the European Union Green Deal for Healthcare had been implemented in their medical institution, so the results of the assessment of their opinions on the deal should be treated with caution, avoiding overly broad generalizations.

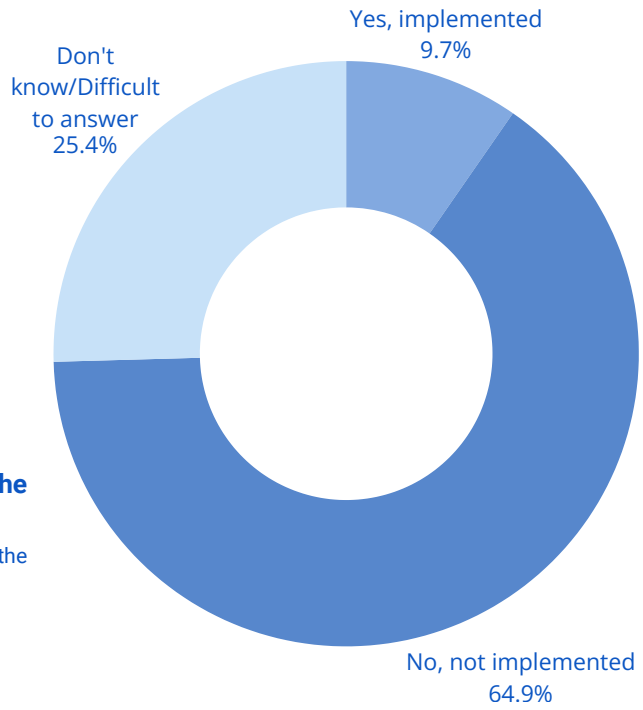


Figure 52: Implementation of the requirements of the European Union's Green Deal
f.2. Has your healthcare facility implemented the requirements of the EU Green Deal for Healthcare? (Single answer).
[% of responses among all respondents].

Among respondents whose institutions have already implemented the requirements of the Green Deal (n=11), the answers tend to be that it has provided more opportunities than restrictions. Almost half noted that there **have been more opportunities than restrictions (45.5%)**, and another **9.1%** — that there have been significantly more opportunities. At the same time, **27.3% believe that there have been more restrictions than opportunities, and 18.2% have not noticed any changes in the work of the institution**.

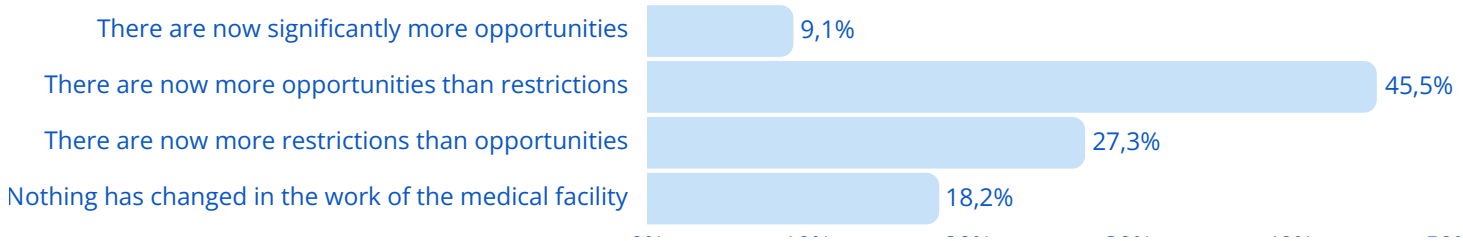


Figure 53: Possibilities or limitations of implementing the Green Deal requirements
f2.1. Has your healthcare facility experienced more restrictions or opportunities due to the implementation of the EU Green Deal in Healthcare requirements? (Single answer)
[% of responses among respondents who indicated that their facility implemented the Green Deal requirements in f2(n=11)].

However, it is worth considering that due to the very small sample, any conclusions here are tentative: the results reflect the experience of individual institutions rather than a stable trend for the entire population.

Among respondents who feel that there have been more restrictions (n=3), the main obstacles were financial restrictions - they were mentioned by all three respondents, while restrictions on energy efficiency and staff resistance / low motivation to environmental changes were also mentioned quite often - they were mentioned by two respondents. One respondent each indicated technical restrictions and difficulties associated with the disposal of medical waste

The same subsample asked respondents to indicate in which areas of Green Deal implementation their medical institution has the greatest difficulties or systemic limitations. All respondents mentioned energy efficiency, which is consistent with the previous question. Next in frequency of mention were the reduction in the use of plastic and disposable materials and the lack of funding/compensation mechanisms for environmental measures (two respondents each). Problems with waste sorting and the lack of awareness/culture of "green thinking" among staff were separately mentioned (one respondent each).

The majority of respondents generally tend to believe that the implementation of the EU Green Deal requirements in Ukraine could change the approach to managing medical institutions. **16.7% completely agree with this statement, another 36.0% tend to agree**. At the same time, **13.2% tend to disagree,** and **1.8%** disagree.

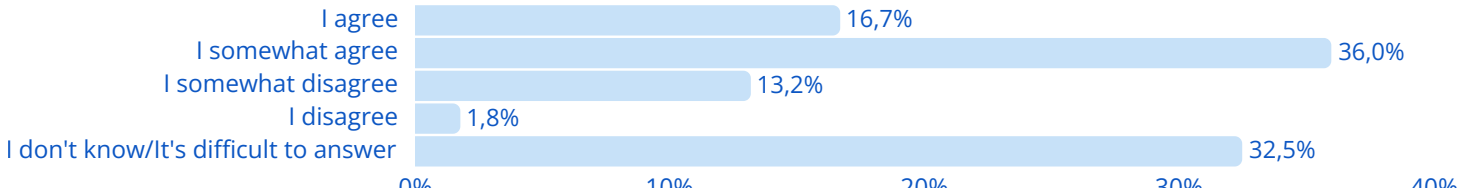


Figure 54: Assessing the impact of the Green Deal on the approach to healthcare governance

f3. Do you agree with the statement that the implementation of the EU Green Deal requirements in the healthcare sector in Ukraine will change the approach to the management of medical institutions? (Single answer). [% of responses among all respondents].

There is a noticeable degree of uncertainty: almost a third of respondents could not decide (**32.5% "don't know/hard to answer"**). This may indicate that a significant portion of managers lack the information/experience to assess the potential managerial effect of the Green Deal.

Conclusions for block F:

- **The implementation of European Union standards** is accompanied by difficulties for most institutions. 57.0% report minor difficulties, another 18.4% - significant; only 7.9% indicate that there are no difficulties, and 16.7% hesitate to answer.
- Key barriers are **resources and technical modernization**. Among those who have difficulties, the most frequently noted are financial capacity (60.5%) and equipment modernization/compliance with technical standards (55.8%).
- **The Green Deal has a low level of practical experience.** Only one in ten institutions reports implementing the Green Deal requirements; among those who have had such experience (n=11), the impact is more often perceived as opportunities (45.5% — "more opportunities than limitations", 9.1% — "much more opportunities"), but there is also a share that sees mainly limitations (27.3%), and 18.2% did not notice any changes.
- There is a **significant level of uncertainty** about the **management impact of the Green Deal**. While 52.7% generally agree that it will change the approach to management (16.7% "agree" + 36.0% "tend to agree"), almost a third do not know/are undecided (32.5%), reinforcing the conclusion of lack of awareness.
- **Recommended**:
  1. **Raise awareness of European Union standards** and **Green Deal requirements** among healthcare management.
  2. Assist with **funding and modernization** for better implementation of the above standards.

GENERAL CONCLUSIONS

If we speak about the study as a whole, a fairly coherent picture emerges of the existing needs of institutions in the field of education: managers see directions for development (digitalization, communication, training, mental health), but run up against practical constraints — money, people (staff), and the technical base.

In several sections, the same logic is repeated: where infrastructure and systemic investments are required, progress is perceived as slower. This is evident in digital services (the level is rather medium/high, but the main barriers are the lack of IT staff, finances, and technical resources), in energy efficiency (quick solutions prevail, whereas systemic energy management and partnership mechanisms are encountered less often), and in European integration standards (key difficulties again lie in resources and equipment modernization).

The needs of institutions are very “practical” and are concentrated around diagnostics and digital capacity. The same logic is reflected in the assessment of humanitarian aid: what proves most valuable for daily work is precisely equipment/technology rather than consumable items.

At the management level, a shift toward transparency of rules and service-oriented communication is noticeable: on the issue of informal “gratitude” payments, managers most often rely on clear financial rules (payment/bonuses) and standards of communication with patients about the free-of-charge nature of services and official channels. This may be explained by pragmatism: when the salary and financial base is limited and the system is complex, simple and transparent rules and clear communication become key tools for maintaining trust and reducing everyday corruption.

Human capital is also seen as a priority for managers. The demand for training is almost universal, while managers see future critical skills not only as purely clinical: the digital use of tools/data and communication with patients cut across all roles (doctors, nurses, administrators). Training formats, in turn, are seen as needing to be as practice-oriented as possible, rather than limited to lectures or purely online options. At the same time, there is skepticism about the extent to which the current education system manages to form the “doctor/team of the future” and about how ready management is to see mid-level staff as an equal part of the team — that is, training is perceived as a compensatory mechanism for systemic gaps.

GENERAL CONCLUSIONS

The sections on mental health and patient routing highlight another important point: certain processes in institutions exist but are not always “visible” at the management level. On the one hand, the psycho-emotional state of the patient is almost unanimously recognized as important for treatment outcomes, and basic approaches and information channels exist. On the other hand, support for employees’ mental health has not yet become a standard, and professional development often relies on self-education and external resources, meaning it is less controlled and less uniform. In patient routing, the overall assessment of interaction is rather positive, but in certain areas a noticeable “zone of uncertainty” appears (some managers cannot confidently assess the state/frequency of certain practices). The same is evident in the issue of prescribing psychotropic drugs: not so much as evidence of a problem, but as a signal that the process is not standardized everywhere and is not fully transparent for managerial oversight, which means that risks may remain unnoticed.

The systemic context (reform/the National Health Service of Ukraine and European integration) appears two-layered. Managers most often see the advantages of the reform in financial and organizational aspects (direct contracts, autonomy, strengthening the role of management), while the obstacles lie in meeting requirements and regulations: this places noticeable strain on institutions, and the main reasons are again related to resources and management (tariffs, contradictory requirements). Importantly, readiness for the updated service package is assessed rather positively — that is, motivation and willingness to move forward exist, but managers often perceive the cost of entry as too high. In European integration, the situation is similar: EU standards exert significant pressure due to financial and technical compliance requirements, while the topic of the Green Deal currently has low practical penetration (it has actually been implemented by a small share of institutions), and therefore the level of certainty/understanding of its consequences is lower.

In summary, the study provides an understanding of a system that sees prospects and is developing: in many areas there is noticeable movement (services, readiness for change, understanding of important issues), but stable progress most often requires three elements that recur across different sections: resources (finances/equipment), people (staff and training), and systemic organization (transparent procedures, record-keeping, monitoring, and regular management cycles).

THANK YOU FOR YOUR ATTENTION!

About ZDOROVI

As providers of change in the healthcare sector, **ZDOROVI** has assembled a team of healthcare professionals who, from the very first days of the full-scale invasion by the Russian Federation, demonstrated their civic stance by setting aside their main areas of activity and directing their efforts toward helping those affected by the military action.

ZDOROVI was founded in July 2013 as an organization that creates educational and research projects in the field of healthcare, which were closely linked to reform. ZDOROVI has implemented innovative projects in partnership with UNICEF, USAID, GIZ, Deloitte, and the EBRD, commissioned by Ukrainian government agencies: the Ministry of Health of Ukraine, the Ministry of Digital Transformation of Ukraine, and the National Health Service of Ukraine.

However, starting on February 24, 2022, the **ZDOROVI** team reorganized itself with the aim of creating an effective system for providing humanitarian medical assistance throughout Ukraine: **ZDOROVI** focused its efforts on helping war victims and continues to implement global educational projects, mental health support measures, and projects to support medical system reform.

Today, **ZDOROVI** is one of the leaders in providing medical humanitarian aid and a driver of behavioral change in the healthcare sector in Ukraine.

You can find more information about our activities on the website: **https://www.zdorovi.help**

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