World Health Organization

European Region

Unlocking investment for the transformation of Ukraine's health-care network

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Abstract

Significant national and international financial resources are available to support capital investment in Ukraine's health system. This provides a window of opportunity for Ukraine to transform its health-care infrastructure in line with long-standing objectives – including the consolidation of hospitals, and the expansion and integration of outpatient, community and primary care. In this context, ensuring strong governance of the capital investment programme is a strategic imperative for the Ministry of Health and other health authorities. This report provides an assessment of the strengths and limitations of current approaches to the planning, coordination and appraisal of investments, and based on this assessment, offers recommendations for improved governance. The Ministry of Health needs to take urgent action to: establish a strategic framework for capital planning and investment; ensure that this framework is fully reflected in prioritization criteria; draw on the framework and criteria to define a sectoral portfolio that reflects the health system's actual needs; and build strong capacity at all levels for project development, appraisal, implementation, audit and monitoring.

Keywords

HEALTH FINANCING; INVESTMENTS; UKRAINE; HEALTH CARE SYSTEMS; DELIVERY OF HEALTH CARE

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Abbreviations

CEB	Council of Europe Development Bank
CMU	Cabinet of Ministers of Ukraine
DREAM	Digital Restoration Ecosystem for Accountable Management
EBRD	European Bank for Reconstruction and Development
EHIF	Estonian Health Insurance Fund
EIB	European Investment Bank
ERDF	European Regional Development Fund
EU	European Union
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HNDP	Hospital Network Development Plan
H-SWG	Health Sectoral Working Group
IFC	International Financial Corporation
IFI	international financial institution
IOWISZ	Instrument Oceny Wniosków Inwestycyjnych w Sektorze Zdrowia (assessment tool)
KNP	komunalne nekomertsiine pidpryemstvo (communal non-profit enterprise)
MoE	Ministry of Economy of Ukraine
MoF	Ministry of Finance of Ukraine
MoH	Ministry of Health of Ukraine
MoI	Ministry of Infrastructure of Ukraine
MoSA	Ministry of Social Affairs of Estonia
MRI	magnetic resonance imaging
NHF	National Health Fund (Poland)
NHSU	National Health Service of Ukraine
PHC	primary health care
PMG	Programme of Medical Guarantees
PPP	public–private partnership
SIC	Strategic Investment Council
SPP	Single Project Pipeline

Executive summary

Introduction

Significant national and international financial resources are available to support capital investments in Ukraine's health system. The scale of support available provides a window of opportunity for the country's health-care infrastructure to be reconfigured in line with long-standing objectives, including the consolidation of hospitals, and the expansion and integration of outpatient, community and primary care. To realize this, however, stronger governance of the capital investment process – by the Ministry of Health (MoH) and other health authorities – will be required. Efforts to strengthen governance should include a focus on establishing: a strategic framework that defines the key goals to be pursued by capital investments; a set of prioritization criteria (to be applied across all projects, independent of applicant or donor) set to reflect the principles and objectives defined by the framework; and, by ensuring universal application of these criteria, a sectoral portfolio of projects that reflects the health system's real priorities, and can be presented to national and international funders accordingly.

Conversely, in the absence of these attributes, the health system's access to national and international financial support will be curtailed (as donors prioritize other sectors in the allocation of capital), and the opportunity to use capital investments to strengthen service delivery missed. In the context of fiscal constraints created by the war, such an outcome threatens the health system's ability to provide effective coverage.

Against this background, this report draws on a comprehensive review of documents, semi-structured interviews and case studies of recent European experience to:

- assess the strengths and limitations of current approaches to the governance (planning, coordination and appraisal) of capital investments in Ukraine's health system; and
- define key principles, reform directions and specific actions for strengthening these elements of governance.

Situation analysis

Ownership of Ukraine's public health-care infrastructure is mostly held by local governments, which creates challenges for system-wide planning, coordination and appraisal of investments. Capital planning and investment decisions are primarily taken at the local government level, and often reflect owner-specific priorities rather than system-level needs. Currently, there is no centrally defined strategic framework for capital investments, and thus, no defined basis for developing criteria for the prioritization of projects. In turn, these limitations make it difficult for the MoH to define a portfolio of prioritized projects aligned to reconfiguration goals.

The governance of public investment in Ukraine is changing, which creates an opportunity for stronger governance in the health sector. In August 2024, Ukraine's Cabinet of Ministers began to implement a new approach to the governance of public investment. This focuses on establishing a more effective system for capital investment planning, prioritization and implementation – at both the sectoral and cross-government levels. A Strategic Investment Council (SIC) has been established to coordinate this process. An important goal is to produce sectoral portfolios of projects, which, in combination, form the Single Project Pipeline (SPP) – the list of projects prioritized for central government and/or external support. These regulations provide a stimulus for the MoH to strengthen governance, and to work with regional and local government owners in defining a multi-year sectoral portfolio of investments. Currently, however, there is no strategic framework; approaches to the prioritization of capital investments are informal, qualitative and pragmatic, and the sectoral portfolio is misaligned with reconfiguration goals. Thus, there is more work to do in responding to the new regulations.

The "capable network" concept provides a logical basis for a more strategic approach to capital investment decisions. However, the infrastructure requirements of capable networks need to be more fully elaborated. For example, in primary care, the infrastructure required to deliver the "organizationally integrated set of providers capable of providing high-quality, comprehensive, continuous and patient-oriented primary care"[1] (called for by the capable network concept) has not been defined. In the hospital sector, the development of "cluster networks" is a central goal of capital planning, and is reflected in (transitional) prioritization criteria – but these do not define what kinds of investments are required. Investment principles should, for example, lead to the prioritization of projects that: (i) enhance "in-network" hospitals' competence to deliver a full range of acute care services; (ii) build upon all existing capacity in the local health system, regardless of the ownership of that capacity; and (iii) enable the reprofiling of "out-of-network" facilities to address currently unmet needs, or address them in more efficient, effective ways.

Given fiscal constraints, external sources of capital are required to address Ukraine's capital needs. The capital budgets of central, regional and local governments are limited relative to demand. Most "owners" of facilities are unable to borrow from commercial banks, but they can receive funds from international financial institutions (IFIs) and other donors. Access to such funds generally depends, in part, on a strong public interest rationale. For example, in the case of the European Investment Bank's operations in health, lending criteria include the strength of the business case in terms of the project's contribution to defined

health policy/systems objectives, as well as the extent of MoH support. Indeed, most IFIs and other donors are looking to the MoH to provide strategic direction and guidance on the health system's actual needs and priorities. In this context, effective MoH leadership in developing a credible portfolio of health sector projects will support access to external funds.

There is a lack of cross-owner/cross-donor coordination of capital planning and investment. In general, owners have incentives to maintain or extend the capacity of their networks, independent of local health system-level needs. Many owners have submitted "their" projects on the SIC's Digital Restoration Ecosystem for Accountable Management (DREAM) website (which hosts the projects in the SPP) without MoH or regional (oblast)-level oversight. Many donors wish to align their support with health system priorities, but they are impeded from doing so due to the lack of a credible health sector portfolio within the SPP. It is also unclear how donors are expected to coordinate in responding to the SPP – to avoid, for example, wasted time and effort as different donors work on approvals for the same project.

Policy guidance

Develop a strategic framework to underpin capital planning and investment decisions. The cross-government reforms to public investment in Ukraine require the MoH to have a comprehensive strategic framework in place by the end of 2025. To ensure coherence, this should draw on the Health Care System Development Strategy for the period until 2030.[2] However, it needs to provide further clarity on the infrastructure reconfiguration implications of the Strategy, and thus, the strategic principles that will underpin capital planning and investment up to 2030 and beyond.

Define prioritization criteria according to this strategic framework. Clear, strategically informed prioritization criteria should determine the selection of projects included in the sectoral portfolio. Capable networks should be incorporated into the criteria – but this will require further work on capital planning implications (i.e. what facilities – and thus, what investments – are required to establish them). For example, the criteria should reflect the fact that investments are required for both in-network and (some) out-of-network facilities, and – in both cases – should be aligned with (i.e. sufficient to achieve, but not exceed) regulated and/or National Health Service of Ukraine (NHSU)-defined service standards and requirements for each type of provider. The criteria should also discourage projects resulting in excessive or duplicative capacity at the local system level.

Establish central oversight of, and accountability for, the capital investment programme. Proposals for investment will continue to be generated by local governments. As noted, these should be appraised and prioritized according to strategic objectives. The MoH (alongside other central government bodies) should be involved in the scoring of each project, and thus, in the composition of the sectoral portfolio within the SPP. It is also important that the MoH and the NHSU ensure that projects in the portfolio are affordable, good value for money and technically feasible. In addition, for larger projects that will generate long-term recurrent costs (e.g. public–private partnerships (PPPs) with a capital value of over €2 million), scrutiny by the State Audit Office is also desirable.

Conclusions

Action is required to strengthen governance of the capital investment process in Ukraine's health sector. Such action includes: developing a strategic framework to underpin capital planning and investment decisions; defining prioritization criteria according to defined strategic principles; and establishing MoH oversight of, and accountability for, capital investment. All three will require additional technical capacity; building this is a strategic priority for central government and international agencies.

1 Наказ МОЗ України, Міністерства регіонального розвитку, будівництва та житлово-комунального господарства України 06.02.2018 № 178/24 "Про затвердження Порядку формування спроможних мереж надання первинної медичної допомоги" [Order of the Ministry of Health and Ministry of Regional Development, Construction and Housing and Utilities of Ukraine dated 6 February 2018, No. 178/24 "On the approval of the procedure for the formation of capable networks of providing primary medical care"]. Kyiv: Ministry of Health of Ukraine; 2018 (https://zakon.rada.gov.ua/laws/show/z0215-18#Text) (in Ukrainian).

2 Кабінет Міністрів України Розпорядження від 17 січня 2025 р. № 34-р Про схвалення Стратегії розвитку системи охорони здоров'я на період до 2030 року та затвердження операційного плану заходів з її реалізації у 2025—2027 роках [Cabinet of Ministers of Ukraine Order from 17 January 2025, No. 34. On the approval of the Health Care System Development Strategy for the period until 2030 and the approval of the operational plan of measures for its implementation in 2025–2027]. Cabinet of Ministers of Ukraine; 2025 (https://www.kmu.gov.ua/npas/pro-skhvalennia-stratehii-rozvytku-systemy-okhorony-zdorovia-na-period-do-2030-roku-ta-zatverdzhennia-operatsiinoho-planu-zakhodiv-z-ii-realizatsii-u-20252027-rokakh-34r-170125) (in Ukrainian).

1. Introduction

1.1 Background

The health system is operating amidst the Russian Federation's war on Ukraine, with WHO confirming 2214 attacks on health care as of 22 January 2025 *(1).* Total recovery and reconstruction needs are estimated at US$ 19.4 billion over the next 10 years *(2)*. In addition, there is an urgent need to invest in the comprehensive reconfiguration of health-care infrastructure in the country, in order to tackle long-standing inefficiencies, including:

- the fragmentation of infrastructure and services across local government "owner" networks
- excess capacity in acute inpatient services
- the lack of resources in, and of integration between, outpatient, community and primary care *(3)*.

The war has mobilized significant national and international financial support for strengthening the country's health system. The country's intention to pursue European Union (EU) membership has also created additional opportunities in this regard – including a €50 billion EU Ukraine Facility, which includes a component specifically earmarked for capital investment.

To maximize the health system's access to funds, while ensuring these are used to deliver both urgent reconstruction and longer-term reconfiguration goals, strong governance of the capital investment process is essential. This must include:

- development of a strategic framework that links to existing strategic documents for health system reform and recovery, but provides further guidance on key objectives to be pursued by capital planning and investment decisions;
- refinement of prioritization criteria, ensuring these fully reflect the strategic principles and policy objectives for capital planning and investment outlined in the framework; and
- ensuring unified application of the criteria by all owners, so as to create a programme of projects – a sectoral portfolio – that credibly reflects the health system's real priorities, and can be presented to national and international funders accordingly.[1]

In taking forward this agenda, there are important lessons to learn from several existing EU member states that have, in recent decades, utilized EU funds to modernize and reconfigure their health-care networks. Conversely, without such actions, it is probable that access to national and international funds will be curtailed (as donors choose to deploy their capital in other sectors), and the scope for reconstruction and reconfiguration will be constrained. In this case, long-standing health system weaknesses *(4)* are likely to remain unaddressed,

1 The focus of this report is the strategic level. This does not, however, diminish the importance of ensuring robust implementation of projects (which requires modern planning, construction and equipment guidelines, and in turn, specialist human resources, such as architects, engineers and medical planners, among others), alongside robust audit and monitoring of project outcomes.

and may even be exacerbated (especially if capital projects are undertaken that entrench existing inefficiencies) *(5)*. In the context of fiscal constraints created by the war *(6)*, such an outcome threatens the sustainability of public health spending and the effective coverage it provides.

Against this background, the objectives of this report are to:

- assess the strengths and limitations of current approaches to the governance (planning, coordination and appraisal) of capital investments in Ukraine's health system (Section 2); and
- define key principles, reform directions and specific actions for strengthening these elements of governance (Section 3).

1.2 Methods

The research underpinning this report included a comprehensive review of documents and 65 semi-structured key informant interviews, covering stakeholders from:

- the Government of Ukraine (Ministry of Health (MoH), Ministry of Finance (MoF), regional (oblast) departments of health; the National Health Service of Ukraine (NHSU) and NHSU interregional offices);
- health facilities (managers, senior doctors, other health professionals);
- civil society organizations;
- the European Commission;
- international financial institutions (IFIs) (World Bank, European Bank for Reconstruction and Development (EBRD), European Investment Bank (EIB), Council of Europe Development Bank (CEB));
- overseas development agencies (Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Enabel, Expertise France, United States Agency for International Development);
- current and former government officials/experts from EU member states with long-standing experience of managing capital investment programmes in the health sector.

Interviews were conducted in-person in Ukraine (in Dnipro, Kyiv, Mykolaiv, Odesa, Poltava, Zaporizhzhia), and virtually (on Microsoft Teams or Zoom) during May–October 2024, and were recorded and transcribed. In addition, a policy dialogue was held in Kyiv on 3 December 2024, with representatives from the MoH, MoH Recovery Office, NHSU, Delegation of the European Union to Ukraine, IFIs, bilateral donors, and individual experts from neighbouring EU member states with direct experience of leading capital investment programmes for health sector transformation.

2. Situation analysis

2.1 Capital investment in Ukraine's health infrastructure

In the public health-care sector, capital investment comprises expenditures in:

- construction of hospitals and other health facilities
- purchasing of diagnostic and treatment technologies
- upgrades to information and communication technology platforms *(7)*.

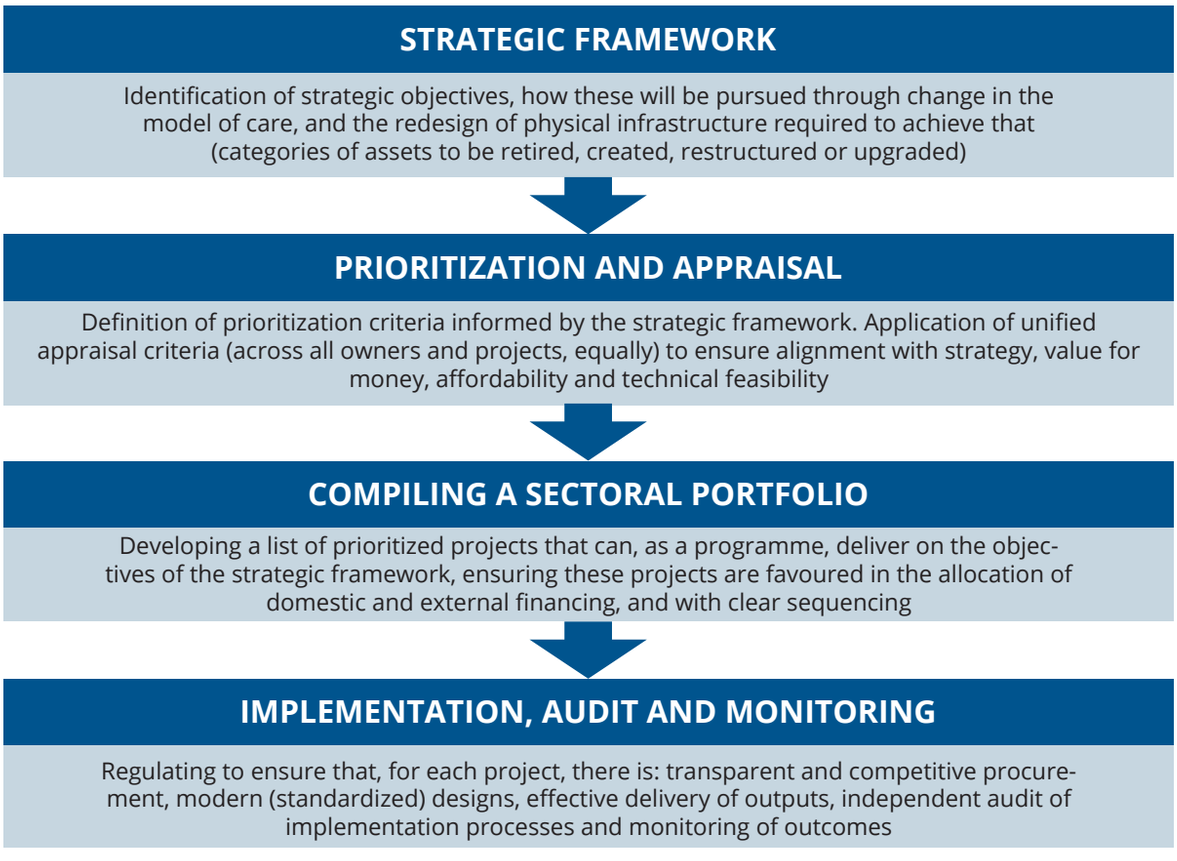
From a financing perspective, capital investments in this sector involve: capital costs (i.e. the costs of building/equipping a health facility) and recurrent costs (e.g. the costs of maintenance over the lifecycle of the assets, and for some categories of commercial or development funds the repayment of principal and interest).

Most of Ukraine's public health-care infrastructure is owned by regional and local governments – especially rural municipalities (hromada) and districts (rayons), city councils and oblast authorities. For example, of the public facilities contracted by the NHSU in 2024, more than half are owned by city councils. Accordingly, planning for and implementation of capital investment projects are, primarily, the responsibility of regional and local governments; these entities provide most of the capital funding, and have considerable discretion over investment decisions (without central government oversight). Financing for capital costs can, however, be provided by central government and/or external funders (as highlighted in Table 1). Currently, such funding is rarely tied to explicit conditionalities (e.g. the degree of alignment with the government's service delivery or model of care vision). This set-up impedes the establishment of an effective capital planning and investment process for the public health-care sector (see Fig. 1), resulting in a lack of:

- strategic planning of investments at the state or regional levels
- clear procedures for the coordination, appraisal and selection of capital projects.

In turn, these limitations make it difficult for the MoH to lead the process of defining a portfolio of prioritized projects in line with strategic needs. This is a particular concern given the lack of capacity at local government level to develop, appraise, implement, audit and monitor projects.

Fig. 1. Stages in investment planning and implementation



Source: authors.

Key points from section 2.1

- Ownership of Ukraine's public health-care infrastructure is mostly held by local governments, which creates challenges for system-wide planning, coordination and appraisal of investments. Capital planning and investment decisions are primarily taken at the local government level, and often reflect owner-specific priorities rather than system-level needs. Currently, there is no centrally defined strategic framework for capital investments, and thus, no defined basis for developing criteria for the prioritization of projects. In turn, these limitations make it difficult for the MoH to define a portfolio of prioritized projects aligned to reconfiguration goals.

2.2 Government reforms to the governance of public investment

In August 2024, the Cabinet of Ministers of Ukraine (CMU) began to implement a new approach to the governance of public investment across all sectors. This is focused on establishing a more effective system for the planning, prioritization and implementation of public investments, reflecting the phases of the investment cycle summarized in Fig. 1.

Defined in CMU Resolution 903 *(Some issues of preparation, submission, evaluation and criteria for prioritization of concepts of public investment projects for 2025) (8)*, this reform is intended to:

- establish a strategic approach to public investment within and across sectors;
- create a unified approach to the prioritization criteria applied to projects, including sector-specific elements reflecting defined principles and objectives (with legal enforcement of this by the second quarter of 2025); and
- integrate public investment decisions with medium- and long-term budgeting.

The Strategic Investment Council (SIC) has been established to coordinate this process. In addition, a website with a list of capital investment projects – the Digital Restoration Ecosystem for Accountable Management (DREAM) – has been launched *(9)*. This system represents a promising response to the weaknesses of public investment management alluded to above, as well as a means of improving public accountability and transparency. However, at the time of writing, DREAM remains in a transitional phase.

There is no central coordination or oversight of the projects listed on the site. A wide range of project "sponsors" (central, regional and local government owners of health facilities, and individual health facilities themselves) can upload information about the projects they wish to pursue. DREAM's contribution to transparency is also limited at the time of writing. The information that project sponsors should enter into the system is not fully defined, and there is no independent (e.g. MoH) assessment of the accuracy of the information included on the website.

Under current arrangements, the SIC has approved, from the list of projects uploaded to DREAM, a "Single Public Investment Projects Portfolio" (in some cases, this is called the Single Project Pipeline (SPP)), which forms part of the 2025 state budget process. The SPP is comprised of multiple sectoral portfolios – including one for the health sector. In turn, this portfolio is divided into two categories:

- projects that require direct financing from the state budget
- projects that require financing from (undefined) "other" sources.

In the first category, there are 24 projects. These are to receive state budget support in 2025 of (Ukrainian hryvnia) ₴5.64 billion (US$ 134.9 million) (see Table 1).

Table 1. Investment programme categories and projects approved for state budget support, 2025

Investment programme category and project title	State budget support for 2025 (million hryvnia)	State budget support for 2025 (US$ million)
Investment Programme Category 1. Development of capacity of MoH/other centrally owned facilities		
1. Cyclotrons – construction of facilities in Kyiv, Lviv & Kryvyi Rih	866.7	20.9
2. Reconstruction of the building of the Ukrainian Scientific and Practical Center for Endocrine Surgery, Transplantation of Endocrine Organs and Tissues of the MoH	390	9.4
3. Creation of a modern clinical base for the treatment of oncological diseases at the National Cancer Institute	300	7.2
4. The National Children's Specialized Hospital "Okhmatdyt" of the MoH	300	7.2
5. Ukrainian State Medical and Social Center for War Veterans	100	2.4
6. Scientific and Practical Medical Center for Paediatric Cardiology and Cardiac Surgery of the MoH	404	9.8
7. Amosov National Institute of Cardiovascular Surgery	350	8.4
8. State Institution "National Scientific Center of Surgery and Transplantation Named After O.O. Shalimov"	20.6	0.5
Subtotal	*2 731.3*	*65.9*

Investment Programme Category 2. Development of medical education		
9. Kryvyi Rih City Clinical Hospital No. 2 of Dnipropetrovsk Regional Council	520	12.6
Subtotal	*520*	*12.6*
Investment Programme Category 3. Rehabilitation in the health-care sector		
10. Rehabilitation Center in Chernihiv (based in the former Cardiology Center)	100	2.4
11. Ivano-Frankivsk Regional Clinical Hospital	100	2.4
12. Mykolaiv Veterans' Hospital	50	1.2
13. Dubno City Hospital of the Dubno City Council	200	4.8
14. Rivne Regional Veterans' Hospital of the Rivne Oblast Council (Klevan)	700	16.9
Subtotal	*1 150*	*27.8*
Investment Programme Category 4. Mental health and psychosocial support		
15. Lviv Regional Clinical Psychiatric Hospital	200	4.8
16. Health Recovery Center in Taranske Village, Konotop District, Sumy Oblast	100	2.4
Subtotal	*300*	*7.2*
Investment Programme Category 5. Development of health-care facilities of the capable network		
17. Slavutych City Hospital	200	4.8
18. Kharkiv Regional Clinical Hospital (Project: Underground Hospital "Ark")	80.5	1.9
19. Chernivtsi Regional Infectious Disease Hospital	67.8	1.6
20. Mykolaiv Regional Children's Hospital	100	2.4
21. Kherson Regional Children's Hospital	60	1.4
22. Novohrad-Volynskyi Territorial Medical Association (Zviahel)	100	2.4
23. Kharkiv Regional Clinical Oncology Center	50	1.2
Subtotal	*658.3*	*15.9*
Investment Programme Category 6. Centralized procurement of medical equipment		
24. X-ray, PET-CT and MRI equipment; endoscopes; defibrillators; ventilators; ultrasound equipment, etc.	283.3	6.8
Total State Budget Support 2025	**5 642.9**	**136.2**

Source: Ministry of Finance (2024) *(10)*.

Note: PET-CT = positron emission tomography–computed tomography; MRI = magnetic resonance imaging

As Table 1 shows, almost exactly half of the total amount of state budget support for 2025 has been allocated to capital investment projects for health facilities that are owned by the MoH or other central government entities. This allocation stands in contrast to the distribution of health facilities across government owners, which, as noted, is strongly weighted towards regional and local governments. For example, 80% of public hospitals are owned by oblasts or city councils, with rayon and hromada-level facilities making up most of the balance – while national facilities account for less than 1% of the total.

According to data shared by the NHSU,[2] total capital expenditures across facilities equalled ₴33.96 billion (US$ 800 million) in 2024, of which: 42% came from central or local government; 33.5% was from charitable donations; 20% was from NHSU payments under the Programme of Medical Guarantees (PMG); and 4.5% was from other sources. Most owners have very limited capacity to finance large-scale capital investments, such as a hospital reconstruction. As a result, the viability of many capital projects is dependent on there being a substantial increase in the availability of external sources, for example from the EU's Ukraine Facility, IFIs and other donors *(11)*. Reflecting this, in the current health sector portfolio within the SPP, most projects have been placed in the category that requires financing from such external sources. These projects have a total estimated cost of ₴143.5 billion (US$ 3.47 billion), and an estimated 2025 financing requirement of ₴85.8 billion (US$ 2.1 billion) *(10)*.

2 The NHSU collects data on sources and uses of funds from providers through the 1NS form.

It is recognized that the current health sector portfolio has been defined on the basis of relatively informal, qualitative and pragmatic criteria, with a principal focus on project maturity and technical feasibility *(12).* Currently, a more accurate prioritization process is impeded by what an MoF respondent described as a lack of up-to-date sectoral strategic documents, and of ministerial capacity to carry out evaluation and prioritization of projects in their respective areas. As such, the current portfolio designated for external financing support is lacking in credibility, and of limited value to IFIs and other donors as a guide to the health sector's actual priorities.

In 2025, as the public investment reforms transition from the pilot stage to full implementation, the DREAM system will increasingly be used to assess projects on the basis of formal criteria and scoring designed to capture the extent of alignment with national and sectoral strategies (assessed by the Ministry of Economy (MoE)); financial feasibility (assessed by the MoF); and technical feasibility, focusing on capacity to implement (assessed by the Ministry of Infrastructure (MoI)[3]) *(12)*. For the health sector specifically, according to CMU Resolution 903 *(8)*, prioritization is assessed according to the extent to which a project is:

- needed to restore facilities damaged by war
- needed to develop a "capable network" of health facilities *(13)*
- aimed at providing medical care, rehabilitation or psychological support for military veterans.

In principle, these criteria, alongside other cross-sectoral elements, result in an aggregate score for each project, which is in turn used by the MoE, MoF and MoI, but not the MoH or other sectoral ministries, to determine a project's degree of priority. However, as outlined below, these transitional criteria fail to provide an adequate guide to prioritization, and further refinement in accordance with defined strategic objectives will be required. For example, to ensure that investments support the development of capable networks, there needs to be a clear strategic framework for infrastructure reconfiguration that links capital investments to that outcome (see section 2.3).

Over the course of 2025–2026, a more formal approach to the definition of sectoral strategies and prioritization is planned, under the leadership of the MoE. This will include:

- new general procedures for the formation of sector-specific pipelines (by February 2025);
- updated sectoral criteria for the preparation, assessment and prioritization of projects (by May 2025);
- updated sectoral strategies, containing the main goals and priorities of investments in the relevant sector (by December 2025); and
- ongoing updates to the sectoral pipelines defined in accordance with sectoral strategic priorities.

These new regulations can provide an important stimulus for the MoH to improve governance of capital investments – albeit, and as discussed in sections below, the MoH will likely require additional regulatory authority to exercise effective leadership in this regard. A well-defined strategic framework, underpinned by explicit objectives, and linked to assessed needs, the intended model of care and an understanding of how this can be advanced through capital planning and investment, are required. In turn, this framework should be reflected

3 The Ministry of Infrastructure was renamed the Ministry for Development of Communities and Territories of Ukraine in September 2024 (https://www.kmu.gov.ua/npas/pro-pereimenuvannia-ministerstva-kultury-ta-informatsiinoi-polityky-ukrainy-i-ministerstva-rozvytku-hromad-terytorii-ta-infrastruktury-ukrainy-1028-060924)

in well-defined prioritization criteria. This will create stronger foundations for a multi-year sectoral portfolio of investments that reflects justified priorities – and thereby encourages access to financial support from both central government and external sources.

Key points from section 2.2

- Current (transitional) approaches to investment prioritization in the health sector are relatively informal, qualitative and pragmatic, while state budget support is heavily weighted towards the small fraction of health-care infrastructure owned by the MoH. New structures for the governance of public investments will increasingly require the MoH (and other sectoral authorities) to define a robust strategic framework (setting out the strategic principles and policy objectives to be pursued through investments) and prioritization criteria defined by these principles and objectives.
- Going forward, the sectors that effectively respond to these requirements are likely to be advantaged in accessing capital financing (from both central government and, especially, external sources) relative to those that do not.

2.3 An important input into a strategic approach to capital investments in the health sector – the concept of the capable network

Over the last decade, several legislative initiatives have been in place to better align health infrastructure with needs, and build optimal patient pathways. The current focus is on the establishment of capable networks *(13)*. Full realization of this concept has the potential to accelerate the intended reconfiguration of the public health-care estate (i.e. the consolidation of capacity in inpatient care, integration of services across owner networks and redistribution of resources to outpatient, community and primary care settings). This provides a logical focus for a strategic framework needed to underpin capital investment planning in the coming decade. Formal institutionalization of capable networks through regulation is needed to form a stable basis for capital investment planning, and for the NHSU to align its contracting approach to the network concept. In addition, the infrastructure requirements of capable networks need to be more fully elaborated for this concept to properly inform prioritization criteria. Not all investments for an in-network facility are equal – some have (or should have) a higher level of priority than others, while some may entrench existing inefficiencies, impeding the intended reorganization of care. Integral to the capable network concept, then, is the need to specify and justify the intended "model of care" at the local health system and individual facility levels.

Primary care networks

For the primary health care (PHC) level, the capable network is defined in legislation as "an organizationally integrated set of providers capable of providing high-quality, comprehensive, continuous and patient-oriented PHC in accordance with the sociodemographic characteristics of the population and local peculiarities" *(14)*. Local authorities are expected to define PHC networks as a list of providers with service locations, considering factors such as provider capacity, population coverage, collaboration with other service providers, transportation accessibility and financial stability. They are required to define a list of providers meeting the access requirements and map the service locations.

However, implementation of the PHC network concept has been variable across localities. While in a small minority, such networks have been defined, there is no effective enforcement of the legislation, in part due to a lack of capacity at the hromada level. The network concept is not linked to NHSU contracting arrangements. There is no mapping of the PHC network at national or oblast level, and in this is lacking in most hromada. As a result, there is no information available that would allow investment needs for PHC (e.g. identifying low coverage areas that require additional physical infrastructure) to be identified in a credible manner. Many PHC facilities have been damaged or destroyed due to the war, while many others require upgrading or expansion to enable the intended redistribution of resources and services from hospital to primary care settings *(15)*. However, investment in facilities, equipment and repairs at this level is at the discretion of hromada, and is focused on re-establishing what has been damaged or destroyed during the war. The lack of a more comprehensive framework for identifying needed investments in PHC networks is reflected in the fact that no primary care project has been included in the state budget programme for 2025 (see Table 1).

Hospital networks

As noted above, the hospital network in Ukraine is characterized by significant excess capacity. In 2021, the number of hospital beds per 10 000 population in Ukraine was 62.6, compared to the EU average of 51.8 *(16)*, and this ratio is likely to have increased in the last three years due to loss of population as a result of the war *(17)*. The network is also fragmented across multiple owners, which have incentives to maintain the number of revenue-generating hospitals. As komunalne nekomertsiine pidpryemstvo (KNPs), which are communal non-profit enterprises with substantial financial and operational autonomy, hospital provider organizations have strong incentives to maximize revenues, and thus to maintain or expand the range of NHSU packages they take on and the service volumes they provide. These incentives impede efforts to moderate the provision of care in high-cost inpatient settings, and redirect services to lower-cost outpatient settings *(18)*.

CMU Resolution No. 174 *(13)* sets out the procedure for creating capable hospital networks (sometimes called "cluster networks", although in this report we use the original terminology),[4] which is the current legislative attempt to "right-size" the hospital network. In response, regional administrations in most oblasts have defined hospital networks, and development plans for each included hospital, for 2024–2027. This group does not include the "frontline" oblasts of Donetsk, Kherson, Luhansk, Mykolaiv and Zaporizhzhia, which are exempted from the Resolution until after the end of Martial Law. The networks and development plans for the participating oblasts were subsequently approved by MoH working groups. For these oblasts, hospitals have been categorized into three groups:

- above-cluster hospitals (135 in total), to provide 28 categories of sophisticated specialized care for the oblast (1–2 million people);
- cluster hospitals (166 in total), to provide 18 categories of specialized care for a catchment population of 120–150 000; and
- general hospitals (282 in total), to provide six categories of specialized care for a catchment population of 50–80 000.

The CMU Resolution requires capable network decisions to be agreed between oblast and local government owners. However, this does not define procedures for obtaining

4 There have been numerous iterations of the capable network concept, the latest of which was established in 2023 – focused on the concept of hospital clusters.

agreement, principles for the inclusion of hospitals, or criteria for the designation of included facilities into the above-cluster, cluster and general categories. In practice, the basis for decision-making has been variable and non-transparent, and the definition of the networks remains controversial in some oblasts. While at the oblast level (including in oblasts close to the frontline), there is widespread support for the network concept, this may not always be shared at the rayon and hromada level, which have stronger democratic accountability to local communities, as well as stronger powers under Ukraine's constitution and laws. This, alongside the high degree of financial and operational autonomy afforded to KNPs, means full implementation of capable networks can only happen with local government and KNP support. In reality, many local authorities continue to maintain hospitals outside of the capable network, and are seeking to invest in them as inpatient care facilities, and engaging in fundraising activities accordingly.

The political incentive to maintain such facilities is strong, not least because the long-term future of out-of-network facilities is unclear. While it is assumed that many hospitals will be reprofiled (e.g. as outpatient specialist and/or nursing care facilities, which are under-strength in the country), or be merged with capable hospitals, there is no nationally defined plan for achieving this. In addition, the pressure on local governments to push for reprofiling or mergers is limited, due the NHSU's largely "passive" approach to purchasing, under which contracts for most service packages (excluding treatment for stroke and acute myocardial infarction, and perinatal care) can be awarded to both in- and out-of-network hospitals.[5]

As noted in section 2.2, the capable hospital network provides a useful basis for capital planning and investment, just as similar concepts have done in neighbouring EU countries (see Box 1). Indeed, in Ukraine, further development of capable hospital networks has been identified by the MoH as an investment priority, and this is reflected in transitional prioritization criteria as per CMU Resolution 903 *(8)*. However, it is not yet clear whether this criterion is having much impact on prioritization decisions; for example, as Table 1 highlights, state budget support for investments in local government-owned hospitals is, in 2025, very limited – and, of the investments to be supported at that level, most are for facilities in oblasts where no capable network formally exists. There is, therefore, a need to clarify what kinds of projects are required to realize the capable network concept. Two points are of critical importance:

- Planning should ensure that in-network facilities are prioritized for restoration, modernization and/or upgrading of equipment, so that they are able to deliver the specified range of services according to regulated standards and NHSU contractual requirements.
- However, planning should also ensure that viable out-of-network facilities are supported to transition out of the inpatient care domain, and towards currently under-provided services (e.g. outpatient care, palliative care or long-term care) *(19)* or merge with in-network facilities.

On the former point, it should be recognized that an in-network hospital that does not currently meet licensing/NHSU requirements in a specific service domain may operate in close proximity to one that does. In such cases, a merger will often be a more efficient option than, or an important precursor to, a capital investment project, especially if that project will result in further duplication of capacity (an example of this would be an investment in an magnetic resonance imaging scanner when one exists in a neighbouring hospital). This

5 NHSU processes are changing, however. For example, in November 2024, the NHSU began contracting above-cluster and cluster hospitals (alongside PHC and emergency medical services providers) under 3-year agreements, whereas general and out-of-network hospitals continue to be contracted on an annual basis.

is independent of whether the two hospitals have the same owner or, indeed, whether the latter hospital has "in-" or "out-of-network" status. The problem arises because, in the existing lists of capable hospitals, some hospitals have been designated "general", "cluster" or "above-cluster" status, even though they lack the required service capacity, while other geographically adjacent providers that have those capacities have been excluded from the capable network. If the in-network hospitals seek to meet NHSU requirements by investing in new capacities, this may lead to duplication (rather than consolidation) of services at the oblast level. Accordingly, it is important that the strategic framework signals the requirement for mergers, both within and across owners' hospital networks, and that this requirement is reflected in revised prioritization criteria.

Going forward, therefore, investment appraisals should consider the extent to which a proposed project:

- enhances in-network hospitals' competence to perform their functions in alignment with regulated and contractually defined standards (both of which need to be strengthened in accordance with modern standards of care);
- enables the reprofiling of out-of-network facilities to address currently unmet needs or address needs in more efficient and effective ways; and
- is determined by an oblast-wide, and not merely owner-specific, plan for optimizing, reshaping and where necessary extending service capacity – again, in alignment with regulated and contractually defined standards as these are introduced and/or improved.

As the MoH and other health authorities continue to strengthen procedures for investment prioritization and appraisal, central government and external funders can also take a more proactive approach in this regard – ensuring that their grants and loans are allocated towards projects that clearly align with, and help to advance, network optimization goals (i.e. reflect one or more of the bullet points above).

Key points from section 2.3

- The capable network concept provides a potentially strong foundation for efficient capital planning across service levels (primary care and hospitals). However, realizing this potential will require further refinement of sectoral strategies and prioritization criteria to reflect:
  - the need to strengthen primary care provision – providing the assets required to meet unmet needs in areas of low coverage, and support consolidation of small practices, integration of appropriate diagnostics and the creation of a multidisciplinary primary care approach;
  - the need to bring many in-network hospitals up to regulated and NHSU contractual standards for the full range of services they provide;
  - the requirement to support the reprofiling of viable out-of-network facilities (reducing the political costs and risks for local governments of retiring inpatient care capacity within their localities); and
  - the potential for integration and mergers both within and across owners' networks, which:

- will often be a more cost-effective means of meeting service delivery objectives than an investment project (e.g. where this will result in duplicate capacity at the oblast level); and
- may provide a logical focus for such a project (e.g. if, to be effective, the merger requires investments in new buildings or equipment).

- As the MoH and other health authorities continue to define a strong strategic framework and related prioritization criteria, central government and external funders can take responsibility to ensure alignment of investment decisions with network optimization goals – ensuring that grants and loans are allocated only to projects that have a business case clearly informed by the capable network concept.

Box 1. Building capital planning mechanisms for hospitals in Poland

In Poland, regulatory changes in 2016/2017 introduced a range of measures which collectively strengthened the governance of investments in the hospital sector. These measures comprised:

1. comprehensive mapping of health needs in each region;
2. introduction of a new tool for appraisal of capital investment applications; and
3. regulations and amendments to purchasing arrangements to support full implementation of hospital networks (analogous to Ukraine's capable hospital networks).

Below, each of these is examined in turn.

1. Health-care needs maps

The stated rationale for the maps is to support services distribution in accordance with present and forecasted patient health needs; and to support evidence-based policy-making. The maps consist of four elements: demographic and epidemiological situation analysis; description of available health-care resources; prognosis of the future health needs; and anticipated resource needs for the health system. The maps are based on data from the state purchaser, the National Health Fund (NHF), as well as the Public Health Centre. They are updated every four years using data from these sources and are placed online. The maps are used as key reference documents for: defining regional priorities, including in relation to financing for hospital investments – limiting, for example, duplication of investment in the same geographical area; and developing plans for the services to be contracted by the regional branches of the NHF. Since their initial implementation in 2015, the maps have been constantly updated and upgraded. Currently they function as an interactive online platform, allowing for cross-regional comparisons, while the data are also available down to county (middle local government) level *(20)*.

2. The assessment tool

The stated rationale for the Instrument Oceny Wniosków Inwestycyjnych w Sektorze Zdrowia (IOWISZ) assessment tool is "...to stop chaotic and short-sighted investments in the health sector and improve efficiency of public spending" *(21)*. The IOWISZ tool functions as follows:

- Proposals for all new investments with costs higher than (Polish złoty) zł2 million (US$ 492 000) are obliged to undergo formal assessment using the IOWISZ tool.
- The assessment procedure is based on a standardized electronic form consisting of a list of 30 questions, with scoring based on a predefined algorithm determining the level of priority for each project application *(21)*.

Since 2018, there have been two versions of the questionnaire: for "replacement/modernization investments", which do not result in a change in the scope of the health-care services provided, and other (so-called "developmental") investments, the purpose of which is to change the scope of the health-care services provided, and thus the organization of care in the relevant locality. The questions are related to the four following areas:

- the extent to which the investment is consistent with the priorities of regional health policy and meets actual, identified health needs, as well as forecast needs (in accordance with the regionally defined "health care needs map");
- the extent to which the investment will provide improvements in the organization of service delivery within the relevant locality;
- the extent to which the investment will improve efficiency in use of existing resources;
- the extent to which the investment is innovative and consistent with contemporary, evidence-based medical standards.

The questionnaire is completed by the applicant (i.e. the owner); however, feedback is also provided by the NHF. Achieving a minimum score is a prerequisite to be considered for approval. An opinion (positive or negative) is issued by the central government representative to the region (for capital investments of zł2–50 million), or by an entity called the Commission for the Assessment of Investment Applications in the Health Sector of the Ministry of Health (for investments with a capital value in excess of zł50 million (US$ 12.3 million)). A positive opinion is a prerequisite for state support for the investment, and receipt of NHF support for the recurrent costs of the investment (e.g. interest rates on any loans taken for cofinancing, asset maintenance and running costs). Most applications submitted in 2016–2023 were approved – demonstrating a high level of preparation of the planned investments evaluated in the IOWISZ system, and reflecting the incremental development of administrative structures and human capital (know-how) since the pre-accession period.

3. The hospital network

The stated rationale for the hospital network is to improve the organization and coordination of services delivered by hospitals (both inpatient and outpatient); to improve access to services; to optimize the number of specialist wards; and to improve hospitals' management. The hospital network plan closely resembles, in both objective and content, Ukraine's capable network concept. Regulations on the hospital network in 2017 introduced:

- division of hospitals into six categories depending on the scope of services provided;
- assignment of entities to the categories, valid for four years, and undertaken by the directors of regional NHF branches based on published criteria;
- guaranteed access to NHF financing for all in-network hospitals; and
- selective contracting only for some service domains/out-of-network facilities in accordance with unmet needs *(22)*.

Implementation of the first two instruments (the health maps and the IOWOSZ tool) was stimulated by criteria and conditionalities related to EU funds – specifically, the European Regional Development Fund (ERDF) and the European Social Fund in the 2014–2020 EU financial perspective. Introduction of these measures was associated with a significant increase in both the number and value of projects cofinanced by EU funds *(23)*.

Key learning points for Ukraine

- **Needs-based capital planning:** in Poland, this incorporates both a situation analysis and prognosis of health needs and related resource requirements, and is based on systematic integration of data from the NHF and the Public Health Centre. The resulting maps are placed in the public domain in a format accessible to health system stakeholders, academics, the media and the public. In contrast, in Ukraine, mapping processes that underpin the definition of capable hospital networks have not been transparent, and do not included the systematic integration of data from the NHSU or the Public Health Centre (whose data on the health status of the population is in need of updating in the context of extensive population displacement), such that the results of these processes lack credibility among stakeholders.
- **Central government influence on project appraisal, and oversight of investments:** in Poland, investment appraisal is guided by a single instrument, regardless of applicant or funding source. This instrument includes a focus on the extent to which a given proposal aligns with the priorities of regional health policies in accordance with regionally defined mapping. This contrasts with the current situation in Ukraine. While the reforms to public investment in Ukraine may replicate some elements of the Polish approach, this does not obviate the need for a health sector-specific tool and detailed prioritization criteria, linked to an MoH-defined

strategic framework. In addition, the NHF's systematic involvement in project appraisals is instructive. In Ukraine, the equivalent agency, the NHSU, has no such role – such that its understanding of the pattern of need, the likely impact of investments on service delivery, and the long-term recurrent costs associated with investments are not utilized in decision-making. Notably, in Poland, receiving approval from a special commission of the MoH is a prerequisite for both state support for the investment and receiving NHF support for related recurrent costs.

- **Full implementation of the hospital network:** in many respects, the hospital network in Poland resembles the capable network in Ukraine; however, the impact on capital planning and investment in Poland is far greater. One important reason is that, in Poland, only hospitals in the network have "automatic" access to NHF financing *(24)*, unlike the "any qualified provider" model applied in Ukraine.

Note: NHF = National Health Fund; IOWISZ = Oceny Wniosków Inwestycyjnych w Sektorze Zdrowia, ERDF = European Regional Development Fund

2.4 Sources of funds for capital investments in the health sector

As indicated in section 2.1, the central government's budget for capital investment in the health sector is limited relative to investment needs. More than half of state budget support in 2025 is allocated to the MoH and other central government-owned facilities, which own less than 1% of facilities in the public health sector network. Funding for investment in the rest of the health sector can, in principle, come from a variety of alternative sources, as set out below.

Public sector sources

As noted above, the primary responsibility to meet capital costs is held by local government owners, and thus the NHSU's financing of services through the PMG (e.g. capitation at the primary care level, and a mix of global budgets and case-based payments at the hospital level) is not set to cover the cost of capital. As autonomous entities, KNPs can allocate any surpluses generated from NHSU payments to meet operational costs (e.g. payments for maintenance over the lifecycle of the assets) and financing costs (e.g. repayment of capital and interest rates). They can also, in principle, use surpluses to finance capital investments directly; however, there is no explicit "margin" to meet such costs within NHSU payments. NHSU payments are intended to pay for salaries, medicines and other expenses, while local governments are responsible for covering capital and utilities costs. Thus, the budgets of central, regional and local governments provide the largest share of capital funds (at 42%, with 33.5% coming from charitable donations, just 20% from the PMG and 4.5% from undefined "other" sources) *(25)*. Domestic capital funding is, however, limited relative to need – a long-standing challenge, and one likely to be exacerbated in the coming years due to the economic and fiscal effects of the war *(26)*.

Non-government sources

Most oblast/local government owners are prohibited from accessing sources of commercial financing, such as bank loans, as the right to engage in direct borrowing is restricted to the city councils of Kyiv and some of the larger oblast capitals *(27).* PPPs – transactions in which private capital is used to finance public investments – provide one option for circumventing this constraint, but present a number of serious practical challenges and risks (see Box 2). Conversely, oblast/local government owners have access to loans from IFIs (e.g. from the EIB, EBRD, CEB, the World Bank, the International Financial Corporation (IFC), Kreditanstalt für Wiederaufbau, GIZ and several other development banks).[6] Pillar II of the European Commission's Ukraine Facility (2024–2027) provides an indicative amount of €2.75 billion (US$ 2.94 billion) in budgetary guarantees and blended finance grants. The Commission works with IFIs to increase borrowers' access to commercial or development bank loans for recovery and reconstruction *(28)*. For local governments and other owners of health facilities, the level of access to IFIs' funds will generally depend on non-commercial criteria. For example, in the case of the EIB's current operations in the health sector, the lending criteria include:

- the strength of the strategic context and rationale for investment and general feasibility;
- the project's contribution to social welfare, including in comparison with alternative options for achieving intended outcomes;
- the contribution of the investment to health policy/systems objectives (in particular, achieving universal health coverage, the Sustainable Development Goals and EU strategic objectives) *(29)*.

In addition, the EIB will in general not lend to a project in the absence of a letter of support from the relevant central executive authority (i.e. the MoH for health sector projects) that confirms that the project is aligned with system-level goals.

This emphasis on strategic investment is reflected in the approach of the EU more generally – which is relevant for Ukraine, both in terms of the Ukraine Facility and additional funds that will become available through the accession process. For instance, under the EU "Recovery and Resilience" facility, the "enabling conditions" for investments in the health sector include a requirement to have a national strategic policy framework in place that contains:

- mapping of health needs
- definition of the infrastructure required to meet these
- an articulation of the coordinated set of investments needed to deliver this.

In turn, disbursement of funds is dependent on the enabling conditions being met in practice *(30)*.

As the EU accession process advances, and new EU funding sources become available, Ukraine will have an opportunity to learn from the many former (now current) EU member states that have used EU structural funds to modernize and reconfigure their health systems (see Boxes 1 and 3 for examples).

6 In the case of both commercial and non-commercial loans, the Budget Code of Ukraine specifies that the costs of debt servicing cannot exceed 10% of the total spending of the relevant owner per year.

Conversely, there have been several occasions in recent years when IFIs have received applications to support health sector projects in Ukraine that they have been unable to support – often due to the absence of a clear strategic framework, weak or outdated business cases, and poor coordination and communication between levels of government. In our interviews for this report, and in a related policy dialogue event, IFIs expressed a desire to receive clearer guidance from the MoH on how they can support sectoral priorities, including capable networks.

In contrast to IFIs, which usually provide loans, other donors may provide grants for the provision of capital assets, or, in some cases, provide the assets directly. In such cases, there are no ongoing financing costs; however, such assets are not "free goods", as they generate costs in relation to installation, maintenance, energy and staffing (among other thigs), and so it remains important to ensure that their allocation is in accordance with system needs. Many donors, like their IFI counterparts, are keen to ensure that their investment activities are coordinated with central authorities. For example, they are aware of the capable network concept, and are keen to align their activities with it, but require clearer guidance on what this means in practical terms.

Key points from section 2.4

- Given constrained public sector budgets, external sources of capital are required to address Ukraine's capital needs. Access to these sources of funds is currently limited by the absence of a robust strategic framework and comprehensive prioritization criteria.
- IFIs and other donors are increasingly looking for strategic direction, including from the MoH and other health authorities, about the health system's actual priorities, so that they can allocate capital accordingly.

Box 2. The role of PPPs in capital investments for the health sector

Pillar II of the European Commission's Ukraine Facility consists of a "Ukraine investment framework", designed to attract and mobilize public and private investments for recovery and reconstruction. The Implementation Plan for the Ukraine Facility has a strong emphasis on the role of PPPs – transactions in which private capital is used to finance public investments *(31)*. It states:

> Under health facility PPPs, private investors can finance, design, build, equip, and maintain new multidisciplinary hospitals that would replace existing outdated public hospitals under a national strategic consolidation program... [In addition] diagnostic services PPPs can be used to have private investors finance, equip, maintain, and operate networks of radiology and laboratory diagnostic centres that would replace current centres.

Several IFIs – including the EIB, EBRD and the IFC – have supported the use of PPPs in the health sector, and may do so in Ukraine. For example, the IFC is providing advisory services to the Zhytomyr City Council for the procurement of a new multidisciplinary hospital under PPP arrangements *(32)*. This method of procurement can enhance

the efficiency of capital procurement with an emphasis on establishing certainty of public sector costs over the lifecycle of the assets.

In terms of technical efficiency, the case for PPPs rests on their potential to deliver outputs on time, to budget and to defined standards. This potential is primarily due to risk transfer (i.e. that the payment to the private operator is "capped", such that post-contractual cost overruns should not be borne by the public sector, while penalties or deductions may also be made if the private operator fails to meet contract specifications) *(33)*. However, PPPs also generate several risks, outlined as follows.

- **Complexity.** PPPs can be complex, and require careful management across the full period of the contract (which can run to many years – even decades). The government of Ukraine has established a central PPP agency under the MoE, to support the implementation of PPP contracts, but this is at a very early stage of development. There is no specialist PPP unit within the MoH, which would be needed to coordinate the selection, procurement and implementation of PPPs (for instance, ensuring that the PPPs taken forward are aligned with strategic planning objectives, including the effective realization of capable networks) *(34)*.
- **Transparency.** PPPs can create challenges to budgetary transparency and long-term financial sustainability. The use of private capital – sourced by a private "special purpose vehicle" acting as intermediary – means that related liabilities are not necessarily recognized in government or other owners' accounts. This can lead to over-investment (i.e. investment of a magnitude that threatens future financial sustainability, as financing and maintenance costs fall due).
- **Feasibility.** Despite recent legal reforms, which have clarified the right of state authorities to commit to long-term budgetary liabilities under PPPs, the legal and institutional environment for PPPs in Ukraine remains weak (as acknowledged in the Implementation Plan) *(35)*, and use of PPPs at scale may not be feasible for several years. Therefore, it is important that alternative procurement modalities are available to the MoH and local authorities to take forward prioritized investments.

Overall, the possibility that PPPs may play a role in capital investments for the health sector reinforces the need for:

- a clear strategic framework, and clear selection criteria, for investments;
- a competent and well-resourced MoH and oblast departments of health, including PPP-specific expertise; and
- transparent budgeting processes, with State Audit Office scrutiny of all projects of above €5 million in capital value.

Having these things in place can diminish – but not eliminate – the risk that a (largely) fixed and sizeable proportion of future resources is committed to health-care infrastructure and service areas that would not otherwise be prioritized, at the cost to the long-term financial sustainability of the health sector network, and thus the ability of health authorities to sustain effective coverage *(36)*.

A fuller description of the costs, benefits and risks of PPPs is provided in Annex 1.

2.5 The importance of vertical and horizontal coordination mechanisms

In the context of local government and KNP autonomy, demand for capital financing in Ukraine's health sector is heavily fragmented. Owners and providers have incentives to maintain or extend service capacity, and many are engaging in fundraising initiatives accordingly. Hundreds of owners/KNPs have submitted "their" projects on the DREAM website, without central or regional oversight. According to our interviews, owners tend to present a common list of projects to IFIs and donors – leading to wasted time and effort when several different funders work on approvals for the same project. On the supply side, the Health Sectoral Working Group (H-SWG) has the potential to coordinate donors' activities in this sector. Yet, inevitably, donors maintain their own programmatic interests, and have considerable discretion over which local governments and which projects they support. This can undermine strategic coherence, and exacerbate geographical inequities (if for example, localities close to the frontline, where health needs are often greatest, are disadvantaged in accessing funds).

Currently, the MoH Recovery Office performs some coordinating functions. It monitors war-related damage and engages with donors on priorities for reconstruction (including via its role as the secretariat of the H-SWG). However, its influence is less than that of equivalent bodies in some other European countries (e.g. Poland's Commission for the Assessment of Investment Applications in the Health Sector, which is part of the MoH). Indeed, in Ukraine, the MoH often lacks access to even basic information on investment activity. For example, it does not have a comprehensive view of funding applications made in the health sector. Given Ukraine's decentralized governance, the MoH could do more to work with oblasts to ensure capital planning and investment is coordinated across owners, in alignment with the MoH-defined strategic framework as this is applied to regional health system needs.

In addition, the NHSU is not consulted in investment decisions or appraisals (though NHSU data may in some cases be sought by regional administrations to inform such decisions). The NHSU is a legitimate stakeholder in investment decisions because:

- investments generate ongoing cost commitments (e.g. for maintenance) that will be met, in large part, by the NHSU;
- the NHSU has a strong stake in ensuring the efficiency of the network (ensuring that there is limited duplication in providers' capacity) – especially given that, under current arrangements, all providers that meet NHSU contractual requirements in each service domain are eligible to receive a contract for the related service package; and
- investments may support or undermine the financial viability of the network in each oblast that is underpinned by NHSU funds and, thus, the ability of the NHSU to sustain effective coverage.

For these reasons, there is a strong case for introducing arrangements to enable the MoH to have more oversight of investment decisions, especially in relation to the identity of projects included in the SPP, and enable the NHSU to play a role in provision of data, thereby informing the focus and prioritization of investments.

Key points from section 2.5

- The MoH could strengthen its role in setting the strategic framework for capital investments. In turn, oblasts could strengthen their role in ensuring capital planning and investment is coordinated in alignment with the strategy. Capacity to undertake related tasks is, however, limited, and needs to be built over time. On the financing side, IFIs and donors have a responsibility to respond to, and support, a coordinated approach.
- There is unrealized potential for the NHSU to be involved, over time and as its capacity develops, in provision of data to inform projects, reinforcing coordination, supporting value for money, and safeguarding effective coverage and financial sustainability in the context of fiscal constraints.

3. Policy guidance on strengthening the health system through capital investments

Significant national and international support for Ukraine's recovery has created a historic opportunity. The capital funds being made available can be used to restore needed facilities damaged by the war – but also support a transition to a more efficient, integrated, people-centred health-care network. With a well-defined strategic framework, reflected in clearly specified prioritization criteria, and effective coordination across all owners, a multi-year programme of projects can be identified that will realize this transition. Such a programme will command strong support from providers of capital financing – including the MoF, EU, IFIs and other donors. Conversely, in the absence of a robust strategic framework, and without prioritization of projects aligned to that framework, decision-making may be influenced more by owners' fundraising initiatives, donor interests and political considerations than actual health system needs. In the context of acute fiscal constraints, this outcome will threaten the system's ability to sustain effective service coverage.

Considering these opportunities and risks, this section provides guidance on the further development of capital planning and investment management for Ukraine's health system. This guidance is aligned with the public investment management reforms to which all central executive agencies, including the MoH, must respond. In brief, it is recommended that:

- the MoH should define a strategic framework for capital planning and investment;
- the MoH should define a set of prioritization criteria that reflect the principles and objectives outlined in the strategic framework, and regulate to ensure these are applied in a unified manner to each project proposal (regardless of owner and/or financing source); and
- the MoH should, by applying the above, define a programme of prioritized health sector projects (the sectoral portfolio) for inclusion in the government-wide SPP, and present this to potential funders for support; while, in turn, donors should ensure that their support is coordinated and aligned with the identified priorities.

Further detail on these recommendations is provided below.

3.1 Develop a strategic framework to underpin capital planning and investment decision-making

Under reforms to public investment management, the MoH is expected to have a comprehensive strategic framework in place by the end of 2025. This should be informed by the government of Ukraine's current health strategy – *the Health Care System Development Strategy for the period until 2030 (37)*, but should provide further clarity on the main principles and objectives for capital planning and investment specifically. In particular, the framework should specify the changes in the model of care required to meet strategic objectives. This should respond to long-standing imperatives, including: the needs to consolidate inpatient care, concentrate outpatient specialist care and integrate this with (expanded) primary care capacity. In this regard, Ukraine can learn from the Estonian experience of using EU funds to transition from a hospital-centric to a more integrated care system (see Box 3).

As emphasized in earlier sections of this report, the capable networks concept, for primary care and hospitals, can provide an important foundation for strategic planning and prioritization. This concept has broad support at the central and oblast levels, and has analogues in many EU countries, including Poland. However, as detailed application of the concept continues to evolve, it is important that future analytical work includes mapping of:

- health needs (with incorporation of data from the Public Health Centre)
- the availability and distribution of resources to meet needs (with input from the NHSU).

This strategic framework should inform – alongside mapping of health needs and current resources (across all owners) – oblast-level capital planning and investment activities. In addition, the framework should provide the necessary foundation for the specification of clear prioritization criteria.

Box 3. Leveraging access to EU structural funds for health system transformation – Estonia

In Estonia, EU funding has played a pivotal role in facilitating a two-decade process of health sector transformation. Estonia joined the EU in 2004. Prior to this, in 2002, the Hospital Network Development Plan 2015 (HNDP) was published. This set out a plan for: (i) consolidating acute care services in 19 large hospitals, with hospital locations determined based on demographics, service area size and resources, to ensure geographical accessibility within a 70 km radius (about a 60-minute drive) from any point in the country; and (ii) reprofiling other hospitals into nursing care facilities, thereby addressing the country's nursing bed shortages, and supporting this with increased training of personnel, under the Nursing Care Network Development Plan 2004–2015 (which required each county to have 10 long-term care beds per 1000 people aged 65 and over.) These plans were underpinned by legislative provisions that ensured the strategic hospitals plan had a clear basis in law.

It was recognized that the state budget was insufficient to deliver the HNDP in full. In addition, the structure of Estonian Health Insurance Fund (EHIF) tariffs would be inadequate to fund the repayment and interest costs of commercial loans for investments of the scale envisaged. Therefore, upon Estonia's accession to the EU in 2004, grant funds were sought under the ERDF to implement the HNDP.

To secure access to these funds, Estonia's Ministry of Social Affairs (MoSA) led the development of a comprehensive application strategy, incorporating three critical components:

- a comprehensive assessment of regional health care needs;
- development of a national strategic framework that defined key priorities for reconfiguration and modernization of the network; and
- detailed plans for adapting existing infrastructure to meet evolving needs.

Each individual HNDP hospital was required to adopt a functional development plan, to serve as a guide for the infrastructure investments required, encompassing: (i) analyses of health needs within the hospital service area; (ii) care projections by clinical specialties, demographics, space requirements and technology needs; and (iii) service delivery plans. Subsequently, these plans were evaluated by a commission led by the MoSA and the EHIF (with the final approval decision resting with the MoSA). In addition, during project appraisal, the EHIF evaluated the plans' long-term financial implications within the context of projected budget constraints.

This approach was effective in convincing both the Estonian Ministry of Finance and the European Commission to support ERDF co-financing of health sector transformation.[a] The national strategy was pursued during separate phases of funding. During the first phase of ERDF funding (2004–2006), priority was given to improving the capacity of two regional hospitals (Tartu University Hospital and North Estonia Medical Center). The main objective was to consolidate and modernize inpatient and outpatient specialized care within these facilities. In the second phase (during EU financial perspective 2007–2013), additional objectives were pursued, including: (i) incentivizing the establishment of hospital networks, whereby regional hospitals formed networks with general hospitals in their catchment areas; and (ii) encouraging general hospitals to apply for funding to reorganize parts of their acute care infrastructure for nursing care.

Subsequently, from 2014, reforms launched under the Health System Development Plan 2020 focused on an expansion of PHC capacity. To access ERDF funding, the MoSA established eligibility criteria based on the analysis of regional PHC investment needs. According to these criteria, groups of at least three family doctors in rural areas, or six family doctors in urban areas, could apply for EU grants to build or renovate PHC centers. The MoSA also specified the geographic locations of these centers based on population density and use of PHC services. By the end of 2023, a total of 54 PHC centers and one merged center of Hiiumaa hospital and PHC center were refurbished and/or built with ERDF funding. In addition, in this phase, funding was allocated to investments in digital infrastructure, enhancing the information system for PHC providers and developing a unified health portal.

Key learning points for Ukraine

- Estonia is one of several former EU accession (now member) states that drew on EU funds to transform their health-care networks. Estonia's ability to access, at large scale, EU structural funds depended on the strength of its strategic framework, with investments prioritized according to defined structural reform objectives. This included: (i) clear needs-based plans for consolidation, modernization and upgrading of inpatient care services, and (ii) use of EU funds to encourage the reprofiling of smaller acute hospitals into the nursing care domain, in which capacity was inadequate to meet the needs of an ageing population.

Source: adapted from Habicht et al. (in press) *(38)*.

a Most EU-supported projects also require co-financing, ranging from 0% to 50% of capital investment values. In Estonia's case, providers had to raise capital from their own retained earnings or bank loans, while, in some cases, additional support also came from state or local government budgets. This can create a budgetary constraint, in some cases leading to delays.

3.2 Define prioritization criteria that reflect the principles and objectives of the strategic framework

Under the public investment management reforms, the MoH is obligated to define updated criteria for the preparation, assessment and prioritization of projects. The Oceny Wniosków Inwestycyjnych w Sektorze Zdrowia (IOWISZ) assessment tool used in Poland (see Box 1), which focuses on 30 questions covering the extent to which the project is aligned with defined priorities and will lead to improvements in the organization of care, provides a useful model for this.

In Ukraine's case, central and oblast authorities report that capable networks are merely "taken into account" when promoting capital investment projects to potential donors. This is not strong enough. Under CMU Resolution 903 *(8)*, a project may be prioritized if it is needed to develop a capable network of health facilities. This is not a clear enough guide for decision-making. Thus, refined criteria should reflect:

- the fact that investments for both in- and (some) out-of-network facilities are required for a capable network that meets local health needs to be established and sustained;
- that, in both cases, investments should be aligned with (i.e. sufficient to achieve, but not exceed) regulated and/or NHSU-defined service standards and requirements for each type of provider; and
- that all available resources should be deployed to ensure optimization, and that capital projects result in additional, rather than duplicative, capacity.

3.3 Establish central oversight of and accountability for the investment programme

While proposals for investment can continue to be generated on a bottom-up basis, from the oblast or local government levels, the MoH needs to establish a strong oversight role – ensuring that its strategic framework and prioritization criteria are accurately reflected in all applications for large-scale funding, regardless of applicant or financing source. It should have the final, evidence-based say on scoring of individual projects, and thus, on the make-up of the sectoral portfolio – as the health sector component within the SPP.

In addition, as the capacity to bear the recurrent costs associated with investment is limited, the MoH should ensure that MoF-defined appraisal criteria are applied, and that the projects taken forward are:

- affordable (considering the full costs borne over the lifecycle of the facility);
- value for money (considering the strategic context, all costs and benefits, and how these compare with other options for achieving intended improvements in service delivery); and
- technically feasible (considering the available capacity for project implementation).

As noted, the NHSU can play a role in assessment of affordability. In addition, all appraisals should be subject to independent scrutiny, including, for larger schemes (e.g. those with a capital value above €2 million), reporting by the State Audit Office. This is especially critical for projects, such as PPPs, that generate long-term operational and financing costs.

In this way, a single programme of projects – to be included in the SPP and hosted on the DREAM website – can be assembled at the national level that reflects the health system's actual priorities, is affordable and can be implemented. This will give central government and sources of external funding – including the community of IFIs and other donors – clear information on where they should be deploying their funds.

For the MoH to play this role, a strong investment unit within the Ministry will be needed – to define strategies, prioritization criteria and, based on these elements, the sectoral pipeline. Technical assistance to strengthen skills and knowledge within the MoH and at local levels may be available under Pillar III of the Ukraine Facility or donor programmes. However, it is also important that the authority of the MoH in capital investment policy is clarified in legislation, not least so that it has greater ability to obtain the budget needed to perform these functions.

The investment unit will also have an important role to play in providing technical assistance to regional/local decision-makers in, for example:

- working with health authorities such as the Public Health Centre and NHSU to map health needs and resources;
- responding to MoH-defined strategic principles and objectives in the specification of projects; and
- strengthening local government's capacities to develop feasibility studies, run competitive procurements and manage the implementation of projects.

4. Conclusions

The war has had a devastating impact on health care in Ukraine. But the international financial support mobilized in response creates a window of opportunity – one that can enable large-scale transformation of the health system, ensuring its sustainability for the long-term. This means consolidating the existing capacity in acute inpatient care; expanding resources in outpatient, community and primary care; and reducing fragmentation of services across owner networks. Making the most of this opportunity will not be easy, but as the experience of Ukraine's EU neighbours highlights, it can be done. Concrete action on an urgent timeframe is required to:

- establish a strategic framework for capital investment planning;
- improve systems for prioritizing, coordinating and appraising projects;
- draw on the above to define a credible portfolio of projects – for inclusion in the SPP, and to be presented to domestic and external funders – that reflects real health system needs; and
- build strong capacity at all levels for project development, appraisal, implementation, audit and monitoring.

The challenge is huge, with billions of euros and the welfare of Ukrainians at stake. With stronger governance of the process – from setting strategy to monitoring of outcomes – capital investments can help to sustain effective coverage and improve health outcomes for the long-term.

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Annex 1. The role of public–private partnerships in the health sector

This annex provides a summary of key points concerning the use of public–private partnerships (PPPs) for capital investments in Ukraine's health sector. Though there are different models of PPP, the focus here is on the Design, Build, Finance and Operate (DBFO) model, which is frequently used to develop multiprofile hospitals. Under this form of PPP, a private sector consortium assumes the responsibilities of:

- financing the capital expenditure required to design, build and equip the hospital
- ensuring that the infrastructure, once completed, is maintained to required standards.

In return, the public authority pays to the consortium an "availability charge", which is: (i) structured as a performance-adjusted global budget; and (ii) set to cover the consortium's operating costs (as estimated at the time of contracts being signed) and capital costs (i.e. repayment of capital, interest on loans and returns on equity).

The efficiency case for the PPP model rests on the incentives it generates for the consortium to deliver outputs on time, to budget and to defined standards, as failure may result in financial losses. Because financing of capital expenditure is the responsibility of the consortium, this expenditure may not (depending on accounting rules) register immediately on the public authority's budget. However, this apparent relaxation of the budget is superficial, because capital costs, along with estimated operating costs, must eventually be paid (or repaid) by the authority – with periodic payments that last many years or even decades.

PPPs of this form are very complex, and they generate several risks and challenges, as set out below.

Complexity. For a public authority to realize efficiency gains from PPPs, it must be capable of: (i) running competitive procurements; (ii) defining required outputs and standards over the multidecade period of the contract in a legally enforceable and operationally relevant manner; and (iii) monitoring and verifying performance. While the Government of Ukraine has established a central PPP agency under the Ministry of Economy, this is at a very early stage of development. There is no specialist PPP unit within the Ministry of Health (MoH). There is no technical capacity to undertake PPPs at the regional or local levels.

Financial sustainability. Availability charges will be paid over an extended time period – usually 15–30 years. The assessment of affordability must encompass this entire period. Public authorities find this assessment challenging, and assessments may be subject to technical error, optimism bias and even misrepresentation. For this reason, the assessment of affordability must be subject to detailed, independent scrutiny. For larger schemes such as multiprofile hospitals (the capital costs of which usually exceed US$ 100 million, with availability charges of more than US$ 20 million a year), scrutiny should be undertaken by the supreme audit institution, and both the MoH and the National Health Service of Ukraine should be involved in approvals.

Assessment of the costs to government should include both actual and contingent costs. Because PPPs are privately financed, and last for many years, the costs to government vary according to macroeconomic circumstances – including changes in inflation and exchange rates. The impacts of such variation can make a major difference to the costs. For example, in Türkiye's case, unanticipated changes in exchange rates (lira versus United States dollar) materially undermined the affordability of PPP contracts for multiprofile hospitals, and led to the government's decision, in 2021, to discontinue this method of financing (see Box A1).

Feasibility. The attitudes of investors (commercial banks, development banks, investment banks) have important implications for the feasibility of PPP projects and programmes. Investors need to be confident in the legal and public policy framework underpinning the use of PPPs, and that solutions to specific issues, such as how disputes will be adjudicated, are clear. Currently, these institutions are not in place in Ukraine, and thus, implementation of PPPs at scale may not be feasible for several years. Therefore, it is important that alternative procurement options are available to public authorities in Ukraine to take forward prioritized investments.

Box A1. The realization of macroeconomic risks in Türkiye's health sector PPP programme

Over the last two decades, health authorities in Türkiye have been among the most enthusiastic commissioners of PPP projects, and as such, they have become a source of inspiration for other middle-income countries. In 2021, however, the Ministry of Health announced that there would be no further PPPs in the country, and that all future hospital construction projects would be financed from the government capital budget. The decision was taken after it emerged that payments for 10 of the operational hospital PPPs had come to account for some 27.8% of the MoH budget. The large capital values of projects, and the scale, therefore, of the recurrent expenditures committed, were implicated in this problem; however, this was exacerbated by the structure of the financial terms, in which unitary payments had been linked to the value of the US dollar. This decision may have seemed to make good financial sense at the time, as by reducing the amount of exchange risk borne by private investors, decision-makers were able to exert downward pressure on capital costs, and thus the initial contract price. However, as the Turkish lira depreciated significantly against the US dollar, the real cost of unitary payments increased proportionally and the fraction of the MoH budget (denominated in lira) allocated to paying these reached unsustainable levels.

More information on PPPs for health sector capital investments is available in two WHO reports:

- Public–private partnerships for health care infrastructure and services: considerations for policy makers in Ukraine. Copenhagen: WHO Regional Office for Europe; 2022 (https://iris.who.int/handle/10665/359561). License: CC BY-NC-SA 3.0 IGO

- Public–private partnerships for health care infrastructure and services: policy considerations for middle-income countries in Europe. WHO Regional Office for Europe; 2023 (https://iris.who.int/handle/10665/365603). License: CC BY-NC-SA 3.0 IGO

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