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## INTEGRATED CARE FOR OLDER PEOPLE IN UKRAINE: GOVERNANCE, SYSTEM READINESS, AND STRATEGIC PATHWAYS FOR IMPLEMENTATION IN A WARTIME AND RECOVERY CONTEXT

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### Abstract

Ukraine is undergoing accelerated population ageing under conditions of full-scale war, displacement, and systemic pressure on public institutions. These dynamics have exposed structural limitations of fragmented health and social care systems and intensified the need for integrated, person-centred approaches to supporting older people. This article analyses Ukraine's systemic readiness to implement the World Health Organization's Integrated Care for Older People (ICOPE) framework, with a particular focus on governance, financing, workforce policy, and administrative coordination.

The study is based on a national mixed-methods readiness assessment conducted in 2025–2026 across two regions of Ukraine. Using the WHO ICOPE Implementation Scorecard as an analytical framework, the research evaluates macro-level (system) and meso-level (service delivery) capacities for integrated care implementation. Findings indicate that Ukraine demonstrates partial and uneven readiness, corresponding to an early implementation stage. While important enabling factors exist – including primary health care reform, decentralised social service networks, and high professional motivation – critical systemic enablers remain underdeveloped. These include interministerial governance mechanisms, integrated financing models, workforce coordination structures, and interoperable information systems.

A structured SWOT analysis suggests that Ukraine's challenge lies not only in limited system capacity but in the misalignment of institutional, financial, and governance arrangements. Workforce shortages and resource constraints remain significant, yet existing elements of integrated care operate largely in parallel rather than as a coordinated system, reducing their effectiveness and sustainability. At the same time, post-war recovery, digitalisation, and ongoing public administration reforms create a window of opportunity to align these capacities and institutionalise integrated care as a core component of national ageing policy.

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The article argues that ICOPE implementation in Ukraine should be understood not as the introduction of a new service model but as a strategic instrument for systemic integration of existing health and social care structures. A phased, governance-led approach is proposed, combining pilot implementation with institutional reform and equity-focused financing mechanisms. Embedding integrated care into Ukraine's recovery and European integration trajectory could transform current fragmentation into a resilient, person-centred system for ageing populations.

**Keywords:** integrated care, ICOPE, ageing policy, health and social care integration, governance reform, Ukraine, post-war recovery

## Introduction

Population ageing in Ukraine has transitioned from a long-term demographic trend into an acute policy and humanitarian challenge. Even prior to the full-scale invasion of 2022, approximately one-fifth of the population was aged 60 years or older, with a high prevalence of chronic disease, disability, and poverty. The war has significantly intensified these vulnerabilities. Large-scale displacement, infrastructure destruction, loss of family support networks, and disruption of services have disproportionately affected older people, many of whom now experience overlapping medical, functional, social, and economic risks.

These developments have revealed structural limitations of Ukraine's traditionally fragmented care model. Health and social services for older people operate largely in parallel institutional and administrative systems. Medical care is primarily organised through the Ministry of Health and financed via the National Health Service of Ukraine (NHSU), while social support and long-term care services fall under the Ministry of Social Policy and local self-government bodies. Coordination between these sectors is not institutionalised and typically depends on informal professional relationships or project-based initiatives. As a result, older people and their families must navigate complex and disconnected service pathways.

In the context of war and demographic ageing, such fragmentation has become increasingly unsustainable. Older persons who are displaced or living alone often lose access not only to health care but also to informal caregiver support and community networks. Under these conditions, integrated care is not merely a matter of service efficiency but of survival and dignity. A coordinated system capable of addressing medical, functional, and social needs simultaneously is essential for maintaining functional ability and quality of life.

The World Health Organization's Integrated Care for Older People (ICOPE) framework provides a comprehensive model for such coordination. Rather than focusing solely on disease treatment, ICOPE emphasises maintaining intrinsic capacity and functional ability through person-centred, multidisciplinary, and community-based approaches. Core components include early identification of functional decline, comprehensive assessment, coordinated care planning, support for caregivers, and enabling governance and financing structures. Implementation of ICOPE requires alignment across health and social sectors, shared information systems, and policy frameworks that support intersectoral collaboration.

Ukraine presents a complex environment for ICOPE implementation. On one hand, ongoing primary health care reform, decentralisation of social services, digitalisation initiatives, and strong civil society engagement create favourable preconditions. On the other hand, structural fragmentation, workforce shortages, and fiscal constraints limit the system's capacity for coordinated action. The wartime context further intensifies these challenges while simultaneously creating a window for systemic transformation during reconstruction.

This article examines Ukraine's readiness to implement the ICOPE approach from a governance and administrative perspective. Rather than reassessing the clinical effectiveness of ICOPE – which has been established through WHO guidance and international evidence – the paper focuses on institutional capacity to operationalise integrated care at scale within the Ukrainian context. Drawing on findings from a national readiness assessment, it explores systemic strengths and weaknesses, identifies strategic opportunities and risks, and outlines pathways for embedding integrated care into Ukraine's recovery and ageing policy framework.

The central argument advanced here is that integrated care in Ukraine should be understood not as a new programme or pilot intervention but as a strategic mechanism for aligning existing reforms in health care, social services, decentralisation, and digital governance. Whether ICOPE becomes a collection of local experiments or the foundation of a new system architecture will depend on policy choices made in the coming years.

## Methodology

This article is based on findings from a national readiness assessment of the feasibility and systemic capacity for implementing the World Health Organization's Integrated Care for Older People (ICOPE) approach in Ukraine. The assessment was conducted in 2025–2026 using a mixed-methods design and focused explicitly on system, governance, and service-delivery readiness rather than clinical outcomes.

## Study Design and Analytical Framework

The study employed a cross-sectional mixed-methods approach combining qualitative and quantitative data sources. The analytical framework was derived from the WHO ICOPE Implementation Scorecard, which evaluates readiness across key system domains required for integrated care implementation. These domains include governance and accountability, workforce capacity, financing mechanisms, information systems, and coordination of service delivery.

The scorecard framework was adapted to the Ukrainian context and used qualitatively to determine the stage of readiness across domains, ranging from initial awareness to structured implementation and scale-up. Rather than assigning purely numerical scores, the analysis emphasised structural alignment, institutional capacity, and feasibility of operationalisation.

The research design allowed for triangulation across macro-level (policy and system), meso-level (service delivery and institutional practices), and micro-level (experience of providers, caregivers, and older people) perspectives. This multi-level approach enabled the identification of both systemic constraints and operational realities affecting integrated care implementation.

## Data Collection

Data collection was conducted across two Ukrainian regions selected to reflect diverse administrative and service-delivery contexts, including both urban and rural communities and varying levels of war-related disruption. Selection criteria included relative functionality of health and social infrastructure, accessibility for research teams, and presence of both governmental and non-governmental service providers.

The following data sources were used:

- structured desk review of national legislation, policy documents, reform strategies, and financing mechanisms related to health care, social services, ageing policy, and decentralisation;
- key informant interviews with national and regional policymakers, representatives of ministries, local authorities, service managers, and civil society organisations;
- focus group discussions with older people and informal caregivers;
- structured surveys of caregivers and social workers, older people.
- facility-level checklists assessing organisational capacity for coordination and integrated service delivery.

The combined sample included approximately 240 older persons and 60 informal caregivers, alongside a purposive sample of service providers and institutional stakeholders from primary health care, specialised medical services, social protection institutions, local authorities, and non-governmental organisations. Sampling aimed to reflect the diversity of service contexts and administrative levels across the study regions. Data collection tools were designed to capture both structural conditions and experiential insights regarding service fragmentation, coordination practices, and perceived feasibility of integrated care. A detailed methodological description and full stakeholder breakdown are presented in the underlying assessment report.

## Data Analysis

Qualitative data from interviews and focus groups were analysed using thematic analysis, with coding structured around key health system and governance dimensions reflected in the ICOPE readiness scorecard, alongside emergent cross-cutting themes. Quantitative survey data were analysed descriptively to identify patterns in service access, coordination practices, and workforce capacity. Findings were triangulated across data sources to ensure consistency and reliability.

Particular attention was paid to identifying systemic barriers and enabling factors affecting integrated care implementation. These included governance arrangements, financing flows, workforce availability and competencies, information-system interoperability, and the role of informal caregivers.

The SWOT (Strengths, Weaknesses, Opportunities, Threats) analytical framework was applied as a complementary strategic tool to synthesise findings and identify structural conditions influencing

implementation trajectories. This approach enabled integration of empirical data with policy-oriented analysis and facilitated the formulation of strategic recommendations.

Validation of findings was conducted through consultations with selected national stakeholders and experts involved in ageing, health, and social policy. Feedback was incorporated to ensure that interpretations accurately reflected institutional realities and policy constraints.

## **Results: System Readiness for Integrated Care Implementation**

### **Overall readiness level**

The assessment indicates that Ukraine demonstrates partial and uneven readiness for the implementation of integrated care for older people. Overall system readiness corresponds to an early implementation stage. While important enabling elements are present, they remain insufficiently aligned to support systematic, coordinated, and person-centred service delivery at scale.

Across all data sources, respondents consistently described a system in which health and social services operate in parallel rather than as components of a unified continuum of care. Coordination between sectors occurs primarily through informal professional relationships rather than institutionalised mechanisms. As a result, continuity of care depends heavily on individual initiative and local context.

The current configuration can be characterised as a system in which integrated care exists in fragments but not as an organised model. Informal coordination practices demonstrate professional commitment and adaptive capacity, yet they remain vulnerable to disruption and cannot be reliably replicated across regions.

### **Governance and Institutional Alignment**

At the governance level, the most significant constraint is the absence of a national regulatory or organisational model for integrated care. Health and social protection systems operate under separate ministerial mandates, financing structures, and accountability frameworks. No interministerial body or formal mechanism exists to coordinate policy development or implementation of integrated care.

This institutional separation extends to regional and local levels. While decentralisation has granted communities substantial authority over social service provision, coordination with health-care providers is not structurally embedded. Local initiatives often depend on personal relationships between family doctors, social workers, and community administrators rather than formal protocols or shared planning processes.

The absence of defined roles for care coordination further complicates integration. No nationally recognised position of care coordinator or case manager exists to facilitate communication between sectors and ensure continuity of support for older persons with complex needs.

### **Financing and Resource Allocation**

Financing arrangements represent another major barrier. Health care is financed primarily through national-level contracting by the NHSU, whereas social services rely on local community budgets supplemented by targeted state subventions and donor funding. These funding streams are not designed for joint planning or integrated service delivery.

As a result, even when local authorities and service providers recognise the need for coordinated care, they lack mechanisms to finance multidisciplinary teams, case management functions, or joint service packages. Budgetary fragmentation reinforces sectoral boundaries and limits the scalability of integrated models.

Resource disparities between communities further exacerbate inequalities. Wealthier or more stable regions may pilot integrated initiatives with donor support, while resource-constrained or war-affected communities struggle to maintain basic services. Without equalisation mechanisms or dedicated funding for integration, territorial disparities are likely to widen.

### **Workforce Capacity**

Workforce constraints significantly affect readiness for integrated care. Both health and social sectors report shortages of qualified personnel, high workloads, and limited opportunities for specialised training in geriatric and multidisciplinary care. The war has intensified these challenges through displacement, mobilisation, and burnout among professionals.

Social workers are often overburdened with administrative and household-support tasks, limiting their capacity to engage in case management or coordination activities. Informal caregivers – typically family

members – carry a substantial share of care responsibilities but remain largely invisible within formal service structures. They receive minimal training, support, or respite services, despite functioning as de facto coordinators of care.

### **Information Systems and Data Integration**

Digital infrastructure has developed unevenly across sectors. The health system has established eHealth platforms for clinical documentation and service contracting, while the social sector maintains separate registries and information systems. However, these systems are not interoperable, and secure data-sharing mechanisms are largely absent.

Consequently, providers often work in information isolation. Health professionals rarely have access to social assessments, and social workers cannot easily obtain the medical information necessary for comprehensive support planning. The absence of a shared data architecture limits continuity of care, monitoring of functional ability, and evaluation of outcomes.

### **Impact of War and Decentralisation**

The wartime context has both intensified the need for integrated care and constrained its implementation. Destruction of infrastructure, displacement of populations, and loss of family support networks have increased demand for coordinated services. At the same time, fiscal pressures and workforce depletion have reduced system capacity.

Decentralisation reforms create opportunities for locally adapted models but also introduce risks of uneven development. Without strong central coordination and support, integrated care may emerge only in selected communities with sufficient resources and leadership.

Overall, the findings suggest that Ukraine possesses significant latent capacity for integrated care but lacks the structural alignment necessary for system-wide implementation. The following section presents a structured SWOT analysis synthesising these conditions and identifying strategic implications for policy and practice.

### **Systemic SWOT Analysis of ICOPE Implementation in Ukraine**

To synthesise structural conditions influencing implementation of integrated care for older people, a structured SWOT analysis was conducted based directly on the national readiness assessment. The analysis focuses on governance, administrative, and system-level factors affecting the feasibility and scalability of the ICOPE approach in Ukraine.

#### **Analytical Interpretation**

The SWOT profile indicates that Ukraine's readiness for integrated care implementation should be understood as transitional rather than initial. The system already possesses many of the core elements required for integrated care – primary health care reform, decentralised social service infrastructure, motivated professionals, and active civil society engagement. However, these elements exist as parallel subsystems that interact situationally rather than structurally.

#### **Strengths: Latent Integration Capacity**

The principal strength of the Ukrainian system lies in its human and institutional capital. Integrated practices already occur informally: family doctors communicate with social workers in complex cases, social workers address the multidimensional needs of clients, and caregivers perform essential coordination functions. This demonstrates that the conceptual and practical foundations for integrated care are present.

Importantly, integrated care does not need to be constructed from the ground up. Instead, existing practices require formalisation, institutional support, and financing. The decentralised governance framework provides flexibility for local innovation, while the presence of non-governmental and international organisations enables pilot implementation and methodological development.

#### **Weaknesses: Systemic Architecture Gaps**

Weaknesses are structural rather than operational. The system lacks the institutional “engine” necessary to sustain coordination: there is no unified governance mandate, no integrated financing mechanisms, no defined coordination roles, and no shared data infrastructure. These gaps prevent existing practices from evolving into a coherent model of care.

Table 1

**SWOT Analysis of ICOPE Implementation in Ukraine**

<p><b>Strengths</b></p> <p>Primary health care reform provides a platform for continuous follow-up of older people</p> <p>Established network of social services and territorial centres</p> <p>High level of awareness of ageing challenges among professionals</p> <p>Motivation of health and social workers toward person-centred models</p> <p>Active NGO and international sector capable of piloting models</p> <p>Decentralisation enables local pilot implementation</p> <p>Existing eHealth infrastructure in the health sector</p> <p>Presence of social workers at the community level</p> <p>Strong resource of informal caregivers</p> <p>Experience of pilot and project-based integration</p>	<p><b>Weaknesses</b></p> <p>Absence of a national regulatory model for integrated care and interministerial governance</p> <p>Institutional separation between the health and social sectors</p> <p>Coordination exists mainly informally and is person-dependent</p> <p>No formal care coordinator or case manager role</p> <p>Workforce shortages exacerbated by war and migration</p> <p>Fragmented financing and inability to jointly fund multidisciplinary teams</p> <p>Lack of interoperability between eHealth and social service systems</p> <p>Social workers limited to administrative and household functions</p> <p>Caregivers remain unsupported and institutionally invisible</p> <p>Services remain institution-centred rather than person-centred</p>
<p><b>Opportunities</b></p> <p>WHO ICOPE as a legitimate framework for intersectoral alignment</p> <p>Pilot projects as a foundation for a national integrated model</p> <p>Integration of ICOPE elements into NHSU financing packages</p> <p>Post-war recovery as an opportunity for systemic transformation</p> <p>Development of joint SOPs and care pathways</p> <p>Formalisation of care coordinator roles</p> <p>Creation of a secure shared data architecture</p> <p>Integration of caregiver support into a formal system</p> <p>Donor interest in long-term care reform</p>	<p><b>Threats</b></p> <p>Prolonged war and infrastructure destruction</p> <p>Risk of permanent pilots without policy decisions</p> <p>Exhaustion of local community budgets</p> <p>Growing regional inequality between communities</p> <p>Professional burnout and workforce erosion</p> <p>Legal and data-sharing risks</p> <p>Institutionalisation of fragmentation</p> <p>Demographic pressure of population ageing</p> <p>Shifts in political priorities</p>

The institutional separation between health and social protection sectors remains a central barrier. Different mandates, budgets, and accountability systems create parallel administrative logics that rarely intersect. Budgetary fragmentation further limits the possibility of funding multidisciplinary teams or coordinated service packages.

Workforce shortages and burnout represent additional structural constraints. The absence of formal recognition and support for informal caregivers reinforces inequities and places unsustainable pressure on families.

### **Opportunities: ICOPE As an Instrument of System Integration**

The SWOT analysis highlights that ICOPE can function not only as a service model but as an instrument for broader intersectoral integration of public systems. Pilot programmes can serve as controlled environments to develop and test joint operating procedures, shared care pathways, new financing arrangements, and coordination roles.

Post-war recovery and ongoing public administration reforms create a unique policy window. Reconstruction of infrastructure, digital transformation initiatives, and alignment with European standards offer opportunities to embed integrated care principles into emerging system architectures. Rather than introducing ICOPE as a standalone project, it can be integrated into broader reforms of health financing, social services, and digital governance.

### **Threats: Consolidation of Fragmentation**

The main strategic threat is the potential consolidation of existing fragmentation. Without political and institutional decisions at the national level, pilot initiatives risk remaining isolated and donor-dependent. Integrated care may continue to function primarily as a humanitarian or project-based activity rather than a state responsibility.

Additional risks include continued workforce depletion, fiscal pressures on local communities, widening territorial inequalities, and demographic ageing. If coordination remains informal and unfunded, caregivers may continue to serve as an invisible and unsupported “shadow system” of care.

### **Strategic Implication of SWOT Findings**

The SWOT analysis leads to a central strategic conclusion: the core task is not to introduce a new model of care but to transform existing informal integration into a governed, financed, and accountable system. Integrated care should be framed as a system-level reform aligning health, social protection, decentralisation, and digital transformation policies.

This requires a shift from pilot logic to policy logic. Pilot implementation remains necessary but must be explicitly linked to institutional reform, development of regulatory frameworks, and creation of sustainable financing mechanisms. Without such alignment, the opportunity presented by the current policy window may be lost.

The following discussion examines governance and policy implications of these findings and outlines strategic pathways for embedding integrated care into Ukraine’s long-term system architecture.

### **Discussion: Governance, System Integration, and Implementation Pathways**

The findings of this study demonstrate that the central challenge of implementing integrated care for older people in Ukraine is not the absence of professional capacity or conceptual understanding, but the absence of systemic alignment. Elements of integrated care already exist across the Ukrainian health and social service landscape. However, these elements operate in parallel institutional environments and depend on individual initiative rather than structural design. As a result, integration occurs episodically rather than systematically.

### **Integrated Care as A Governance Challenge**

From a policy perspective, implementation of the ICOPE framework in Ukraine should be understood primarily as a governance reform rather than a service-delivery innovation. The assessment indicates that structural fragmentation between health and social sectors remains the principal barrier to coordinated care. Separate ministerial mandates, financing streams, accountability systems, and information infrastructures create institutional boundaries that inhibit collaboration.

In the absence of a national regulatory model for integrated care, coordination relies on informal professional relationships and local leadership. While such informal mechanisms demonstrate flexibility and commitment, they are inherently unstable and cannot support nationwide implementation. A transition toward integrated care, therefore, requires formal governance arrangements that define roles, responsibilities, and accountability across sectors.

Establishing an interministerial coordination mechanism or national integrated care platform could provide a structural foundation for alignment. Such a body would not necessarily require extensive new administrative structures but would need a clear mandate to harmonise policy development, financing strategies, and implementation planning across sectors. Without such a mandate, even successful pilot initiatives may remain isolated and difficult to scale.

### **Financing and Incentive Alignment**

Financing structures represent a second critical dimension of system integration. Current arrangements reinforce sectoral separation by allocating resources through distinct channels with minimal opportunities for joint planning or pooled funding. Health services financed through national contracting mechanisms and social services funded through local budgets operate under different logics and incentives.

Introducing integrated care, therefore, requires not only additional resources but new financing mechanisms that encourage coordination. Potential approaches include pilot funding streams for multidisciplinary teams, incorporation of functional ability indicators into NHSU service packages, and targeted state subventions supporting community-based long-term care. These mechanisms would signal institutional recognition of coordination as a core system function rather than an optional activity.

Equally important is addressing territorial inequality. Decentralisation has enabled local innovation but also produced disparities in service capacity between communities. Without equalisation mechanisms or minimum service guarantees, integrated care risks developing unevenly, benefiting only better-resourced regions. National policy frameworks must therefore incorporate equity considerations, ensuring that integrated care becomes a universal rather than selective feature of the system.

### **Workforce and Professional Integration**

Workforce capacity is both a constraint and an opportunity for integrated care implementation. Ukraine retains a strong base of committed health and social service professionals, many of whom already practice elements of person-centred care. However, high workloads, limited training opportunities, and a lack of formal coordination roles restrict their ability to operate within integrated models.

Introducing recognised roles for care coordination or case management would represent a significant step toward institutionalising integration. Such roles could be assigned to existing professionals – social workers, nurses, or primary care teams – rather than requiring entirely new positions. Complementary training programmes focused on multidisciplinary collaboration, geriatric care, and functional ability assessment would strengthen professional capacity.

Recognition and support for informal caregivers must also become a central component of system design. Currently, family members provide substantial care without formal training or institutional support. Integrating caregiver support into policy frameworks, including training, respite services, and information resources, would enhance the sustainability of care and align with the ICOPE emphasis on community-based support.

### **Digital Infrastructure and Information Sharing**

Integrated care requires shared information environments enabling providers to access relevant data across sectors. Ukraine has made progress in digitalising health records and social service registries, yet these systems remain largely disconnected. The absence of secure interoperability limits coordinated planning and monitoring of outcomes.

Developing a shared data architecture or, at a minimum, interoperable data standards represents a priority for implementation. Even incremental steps such as shared assessment templates, referral forms, or local registries could significantly improve continuity of care. Ensuring data protection and privacy will be essential, particularly given legal and institutional sensitivities around personal data sharing.

### **Implementation in Wartime and Recovery Context**

The wartime environment both complicates and reinforces the need for integrated care. Destruction of infrastructure, displacement of populations, and strain on public finances create substantial operational challenges. At the same time, these conditions highlight the inadequacy of fragmented systems and underscore the importance of coordinated responses to complex needs.

Post-war recovery planning provides a unique opportunity to embed integrated care principles into the reconstruction of public services. Rather than rebuilding pre-war structures, Ukraine can design new institutional arrangements that incorporate coordination between health and social sectors from the outset. Alignment with European integration processes and international ageing policies further supports this direction.

Pilot implementation remains a pragmatic starting point. Carefully selected communities representing diverse contexts can serve as demonstration sites for governance arrangements, financing models, and service-delivery pathways. However, pilot projects must be explicitly linked to national policy development and institutionalisation processes. Without such linkage, they risk remaining isolated experiments rather than catalysts for systemic change.

### **From Fragmented Practices to System Architecture**

The overarching implication of this analysis is that integrated care in Ukraine should be framed as a strategic system choice. The country faces a decision between maintaining a fragmented model reliant on informal coordination and developing a coherent architecture that recognises coordination, caregiver support, and functional ability as public responsibilities.

Transforming existing informal integration into a governed and financed system will require political commitment, administrative alignment, and sustained investment. Yet the necessary building blocks already exist. With deliberate policy action and strategic use of current reform and recovery processes, Ukraine has the potential to establish an integrated care system capable of supporting its ageing population in both crisis and recovery contexts.

### **Conclusion**

Ukraine's readiness to implement integrated care for older people can be characterised as partial but promising. The system possesses significant human, institutional, and policy foundations for integrated care, including ongoing primary health care reform, decentralised social service networks, professional motivation, and active civil society engagement. However, these elements remain insufficiently aligned to function as a coherent and sustainable model of care.

The analysis presented in this article demonstrates that the primary barriers to implementation are structural rather than conceptual. Fragmented governance arrangements, siloed financing, workforce constraints, and disconnected information systems limit the capacity of existing services to operate as an integrated continuum. At the same time, the current context of war and post-war recovery creates both urgency and opportunity for systemic transformation, while also constituting a significant constraint on institutional capacity, workforce availability, and public financing. These dual dynamics mean that implementation of integrated care must proceed under conditions of simultaneous pressure and reform.

Integrated care should therefore be understood not as a new programme to be introduced but as a framework for aligning ongoing reforms across health care, social protection, decentralisation, and digital governance. Implementation of the ICOPE approach offers a pathway for consolidating these reforms into a unified system oriented toward functional ability, dignity, and quality of life for older people.

A phased, governance-led strategy is required. Initial pilot implementation in selected communities can generate practical models and evidence, but must be accompanied by development of national regulatory frameworks, financing mechanisms, workforce strategies, and data-sharing infrastructures. Equity considerations must remain central to ensure that integrated care becomes accessible across diverse regions and communities.

Ultimately, Ukraine faces a strategic choice regarding the future of its ageing policy and care system. Maintaining the current fragmented model risks deepening inequalities, overburdening families, and limiting the effectiveness of public services. Conversely, embedding integrated care into recovery and reform agendas offers the possibility of building a resilient, person-centred system capable of responding to demographic change and post-war reconstruction challenges.

The experience of Ukraine illustrates that integrated care implementation in fragile and transitional contexts is both complex and feasible. By transforming existing informal practices into institutionalised and accountable structures, Ukraine can move from fragmented support toward a coordinated system that better serves its ageing population and strengthens the social fabric of recovery.

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