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FINANCIAL AND STRUCTURAL ASSESSMENT OF BUDGET FINANCING OF THE MEDICAL GUARANTEES PROGRAM UNDER DIGITAL ADMINISTRATION OF STRATEGIC PURCHASING

ABSTRACT

The relevance of the study is determined by the need to improve the justification of budget financing of the Medical Guarantees Program under wartime risks, inflationary pressure, and changes in the structure of healthcare needs. Particular importance is attached to distinguishing between the utilization of budget appropriations, the dynamics of payments made by the National Health Service of Ukraine, and the structural characteristics of their distribution, since each of these aspects describes a separate characteristic of financing and cannot independently be treated as evidence of its economic efficiency. The study aims to conduct a financial and structural assessment of budget financing of the Medical Guarantees Program and to determine analytical benchmarks for improving budget planning and monitoring of its implementation. The information base combines official state budget indicators, open data of the National Health Service of Ukraine on payments to healthcare providers, and official consumer price indices. The study applies analysis of budget appropriation utilization, nominal and consumer-price-index-adjusted payment dynamics, structural shifts, and payment concentration separately across healthcare providers and Medical Guarantees Program packages. The scientific novelty lies in combining indicators of budget appropriation execution with the characteristics of the transactional payment portfolio while maintaining a clear methodological distinction between them, thereby avoiding the interpretation of budget utilization as evidence of the economic efficiency of strategic purchasing. The findings demonstrate a simultaneous increase in the utilization of approved appropriations, a substantial divergence between nominal and inflation-adjusted payment dynamics, changes in the financing structure across types of healthcare, and different levels of payment concentration across providers and service packages. The practical value of the results lies in their applicability by the National Health Service of Ukraine, the Ministry of Health of Ukraine, and the Ministry of Finance of Ukraine for budget planning, analysis of the implementation of the Medical Guarantees Program, and decisions concerning its financing structure.

Keywords: budget financing, Medical Guarantees Program, strategic purchasing, National Health Service of Ukraine, budget appropriations, healthcare provider payments, structural shifts, payment concentration

JEL Classification: I18, H51, H57, O33, C43

INTRODUCTION

Budgetary financing of the Medical Guarantees Program is a key component of the current financing model for our country's healthcare system. The establishment of a single purchaser, represented by the National Health Service of Ukraine, has changed the very principle of allocating a significant portion of public resources to healthcare, as financing is linked to contracts for the provision of medical services specified by the program and the application of corresponding payment methods. Consequently, the subject of financial analysis is the flow of budgetary funds from the approval of allocations to their actual use and subsequent distribution among healthcare providers and individual packages of the Medical Guarantees Program. Distinguishing these stages is crucial, as the approval of a specific volume of resources, its actual use, and the payment structure

characterize different aspects of budgetary financing (Bredenkamp et al., 2022; WHO Regional Office for Europe, 2024a). Strategic purchasing of healthcare services involves active decision-making regarding which services should be financed, from whom they are procured, the payment methods used, and the needs of the population and the characteristics of the providers. Accordingly, the procurement of medical services from the state budget under the Medical Guarantees Program is the financial component of a broader strategic procurement system. This system includes the formation of a package of guaranteed services, contracting providers, determining tariffs and payment methods, providing and verifying data on services rendered, making payments, and subsequently analyzing financing results (Mathauer et al., 2017; Klasa et al., 2018; Hawkins et al., 2023). This approach clearly defines the place of budget funds in the strategic procurement system and avoids equating financing with the entire implementation mechanism.

A significant portion of the procedures for implementing the Medical Guarantees Program are carried out using the electronic healthcare system and the information systems of the National Health Service of Ukraine. In this study, digital administration of strategic procurement refers to information technology support for contracting, recording services rendered, providing and verifying reporting information, and establishing grounds for payment. Digital administration provides information support for financial relations between the state purchaser and healthcare providers, but in itself does not indicate the effectiveness or cost-effectiveness of budgetary funds. Assessing financial results requires the use of direct budget and payment indicators, whereas assessing the economic impact of digitalization would require a separate comparison of the costs of operating the relevant systems with the quantified results of their implementation. Particular attention is required to the concept of budgetary financing efficiency. From an economic perspective, it should characterize the ratio of budgetary resources used to the results achieved. A high level of utilization of approved appropriations indicates the full implementation of the budget program, but does not prove the effectiveness of the funds' use. Similarly, increases or decreases in payments, changes in the share of a certain type of medical care, or the concentration of funding among individual providers characterize the financial structure of the program, but without information on the volume, complexity, quality, and results of services rendered, they do not provide grounds for forming a definitive conclusion regarding its economic effectiveness.

The full-scale war, population displacement, damage to medical infrastructure, and inflation simultaneously alter the demand for various types of care and the cost of resources required to provide it. Under such circumstances, a nominal increase in budget funding is not sufficient to conclude a similar increase in resource provision to providers. Moreover, a high percentage of allocation utilization reflects the fulfillment of the approved financial plan but does not answer the question of the extent to which the volume of approved funds aligns with actual funding needs. The challenge of the study is the need to analyze the implementation of budget allocations, the dynamics of actual payments to the National Health Service of Ukraine, their changes after adjustment taking into account inflation, structural redistribution between types of medical care, and the concentration of payments. This approach to research allows us to determine actual changes in the financing of the Medical Guarantees Program without attributing economic content to the calculated indicators, which they do not directly characterize.

LITERATURE REVIEW

The scientific substantiation of budget financing of health services is closely linked to the development of the concept of strategic purchasing. Mathauer et al. (2017) consider strategic purchasing as the active use of available information to make decisions on the list of services, the selection of providers, and payment methods. This position shifts attention from the fact of spending budget resources to the conditions under which these resources are allocated.

Klasa et al. (2018), studying the practice of strategic purchasing in European countries, showed that the formal existence of a purchaser does not automatically ensure the achievement of set goals. The results largely depend on how the payer can use information, form financial incentives, and influence the behavior of health care providers.

A separate line of scientific research concerns payment methods for providers. Feldhaus and Mathauer (2018) demonstrated that different payment methods create different economic incentives for the volume, structure, and cost of health care services, and their combination has a direct impact on the behavior of providers. Consequently, the volume of payments alone cannot be used as a sufficient indicator of financing efficiency. This assessment requires taking into account the results achieved for the corresponding amount of resources.

Hawkins et al. (2023) complemented this view with the results of a comparative analysis of national purchasing agencies and demonstrated the importance of managerial autonomy, transparent decision-making, accountability, and the ability to use information to adjust purchasing decisions.

For our country, the comprehensive study by Bredenkamp et al. (2022) is of fundamental importance. They examined the formation of the Medical Guarantees Program, the creation of a single purchaser, the program's budgetary support, provider payment methods, and the development of strategic purchasing. The authors demonstrated that the transition to a contractual financing model created opportunities for more flexible use of funds and a stronger link between financing and provider activities. At the same time, further improvement of the system's effectiveness requires improvements in the budget process, payment methods, service prioritization, and the use of performance information.

Avila (2021), studying the implementation of healthcare financing policy in our country, pays special attention to the transition to new methods of payment for primary and specialized care, the formation of contractual relationships with providers, and the role of information infrastructure in ensuring the functioning of the new model.

Karol et al. (2023), using the example of inpatient care payment reform, showed that the effectiveness of changes depends on the quality of management, the clarity of powers, and decision-making mechanisms. Such findings are fundamental for the financial analysis of the Medical Guarantees Program, as they indicate the need to distinguish between direct payment indicators and the broader management characteristics of the system.

Dzhygir et al. (2023) studied the sustainability of healthcare financing reforms in our country and the role of procedural fairness in financial decision-making. The authors emphasize the importance of transparency, validity, and consistency of procedures in the allocation of limited resources.

Habicht et al. (2024), analyzing the functioning of the healthcare system during a full-scale war, draw attention to the need to maintain basic financing mechanisms and strategic purchasing even in the face of a significant external shock. At the same time, these studies characterize the institutional capacity of the system to continue functioning, which should not be automatically equated with the economic efficiency of specific budget expenditures.

Particular attention in modern research is paid to the financing of primary health care. Wilkens et al. (2025) identify its important role in reforming the healthcare system and ensuring accessibility of care in wartime conditions. However, analyzing primary care financing requires taking into account the population, patient structure, territorial conditions, actual costs, and the volume of services provided. Consequently, changes in its share of the overall payment portfolio can be an important analytical signal, but in itself do not prove the adequacy or inadequacy of the corresponding funding.

Ukrainian researchers provide a more direct basis for analysing the financial characteristics of the Medical Guarantees Program under the institutional and wartime conditions of Ukraine. Romanchenko and Kozhemiakina (2023) analysed changes in healthcare financing, the distribution of NHSU payments and the influence of wartime population migration on healthcare institutions. Their results demonstrate that changes in the volume of financial resources should be considered together with the distribution of providers, their assets, and regional differences.

Shelemina (2023) examined domestic healthcare financing models under the conditions of military aggression and emphasized the need for a financing system capable of maintaining resilience under extraordinary shocks.

Skrypnikova and Yurochko (2022), analysing individual Medical Guarantees Program packages, demonstrated that formal state financial guarantees do not necessarily correspond to the actual resource needs associated with the provision of particular types of specialized care. These findings are particularly important for the present study because they confirm that the amount of financing and its adequacy constitute analytically different characteristics.

More recent Ukrainian studies deepen this problem at the level of individual packages and interaction with the NHSU. Parii et al. (2025) identified significant regional differences in the financing and provision of perinatal care and showed that established tariffs may not fully correspond to actual provider costs, particularly under wartime changes in patient flows.

Rudinska et al. (2026) substantiate the importance of analysing tariffs, service packages, contracting requirements, and electronic healthcare data in the interaction between healthcare institutions and the NHSU. Hlushchenko (2026), examining the evolution of healthcare financing in Ukraine, directly connects the development of the Medical Guarantees Program with the transition toward strategic purchasing.

The structure of the provider network is an important component of strategic procurement. Hellowell et al. (2025), in analyzing the participation of private providers in the healthcare system of our country, showed that expanding contracting requires consideration of accessibility, market structure, incentives, and equity of access. From this perspective, assessing payment concentration can characterize the degree of concentration among providers; however, a high or low level of concentration does not in itself indicate the rationality of distribution. Significant payments to individual institutions may be justified by the number of patients, the complexity of cases, specialization, or the scale of medical care provided.

The WHO Regional Office for Europe's reports (2024a; 2024b) develop these scientific principles specifically in relation to the Medical Guarantees Program. They emphasize the interrelationships between the formation of the medical guarantees package, budgeting, the definition of financing mechanisms, contracting, and accountability. Consequently, the assessment of financial processes should include a clear distinction between approved budgetary resources, actual budgetary funds used, and transaction payments to providers.

Researchers in our country also examine the transformation of healthcare financing mechanisms and new approaches to budget resource allocation. In particular, Krynychko and Motailo (2021) systematized changes in the sector's financial support and substantiated the need to shift from the maintenance of institutions to the financing of medical services.

Taken together, existing studies provide a comprehensive description of the financing reform, payment methods, strategic purchasing, and the institutional conditions for the functioning of the Medical Guarantees Program. At the same time, the comparison of official budget allocation performance indicators with the transaction structure of payments to the National Health Service of Ukraine, their inflation-adjusted dynamics, and their concentration by providers and packages, remains less well-studied. Further research is aimed at addressing this aspect of the scientific problem.

AIMS AND OBJECTIVES

The purpose of the article is to conduct a financial and structural assessment of the budget financing of the Medical Guarantees Program in 2021–2025 under the conditions of digital administration of strategic procurement. Achieving the set goal involves:

- clarifying the place of budget financing of the Medical Guarantees Program in the strategic procurement system and the role of digital administration in the implementation of relevant financial procedures;
- assessing the ratio of approved budget appropriations and the actual volume of their use;
- determining the nominal and consumer price index-adjusted dynamics of payments by the National Health Service of Ukraine to providers of medical services;
- establishing structural changes in the distribution of payments by types of medical care and separately assessing their concentration by providers of medical services and packages of the Medical Guarantees Program;
- conducting a sensitivity analysis of the possible use of budget appropriations in 2026 based on the values of the corresponding indicator actually observed in previous years.

METHODS

The information base of the study was formed from several interrelated groups of data. The first group comprises open data of the National Health Service of Ukraine on payments to healthcare providers under the Medical Guarantees Program and selected other financing programs in 2021–2025. To ensure correct aggregation, the payment amount at the level of an individual package within a payment document was used, whereas the total document amount was not summed repeatedly. This procedure prevented double counting of the same payments. The transactional data were subsequently used to analyse payments by healthcare provider, package, and aggregated type of care. The second group includes approved budget appropriations and officially published actual expenditure indicators for budget program 2308060, 'Implementation of the State Guarantees Program for Medical Services to the Population', according to data from the Ministry of Finance of Ukraine, the Ministry of Health of Ukraine, and relevant regulatory documents. The period 2022–2025 was used to compare planned and actual values because comparable official annual data are available for these years. Importantly, the indicators of budget program execution are not equated with the total amount obtained from the National Health Service of Ukraine transactional open-data set. The latter includes payments under the Medical Guarantees Program and selected other financing areas and is used solely to analyse the dynamics and structure of the payment portfolio. The third group was formed using official consumer price indices published by the State Statistics Service of Ukraine. The general consumer price index was used as an available macroeconomic deflator to express nominal payment dynamics on a comparable basis. Its application has a methodological limitation because the expenditure structure of healthcare providers does not correspond to the composition of the consumer basket. Therefore, the resulting values characterise payment dynamics adjusted for the general consumer price index rather than the actual purchasing power of healthcare financing.

The methodology covers four interrelated directions of financial and structural analysis. The first assesses the utilization of approved budget appropriations. The second characterises nominal and consumer-price-index-adjusted dynamics of

transactional payments. The third determines the scale of structural redistribution of payments among aggregated types of healthcare. The fourth separately assesses payment concentration across healthcare providers and across Medical Guarantees Program packages. The applied set of indicators is not interpreted as an integrated methodology for assessing the economic efficiency of budget financing. Economic efficiency requires a relationship between resources used and outcomes achieved, whereas the available information base does not contain standardised and comparable indicators of the volume, complexity, and quality of medical services for the entire study period. Accordingly, the calculated indicators characterise appropriation execution, inflation-adjusted payment dynamics, payment structure, and payment concentration as separate characteristics of budget financing.

The budget appropriation utilization rate $K_{b,t}$ characterises the share of actually used budget funds in the approved amount of appropriations in year t and is determined as follows:

$$K_{b,t} = \frac{F_t}{P_t} \times 100\%, \quad (1)$$

where F_t is the officially reported actual amount of budget funds used under budget program 2308060 in year t , and P_t is the approved amount of budget appropriations under the same budget program in year t .

The amount of unused budget appropriations U_t is determined as follows:

$$U_t = P_t - F_t, \quad (2)$$

where U_t is the amount of budget appropriations not used in year t , while P_t and F_t have the meanings defined above.

The value of $K_{b,t}$ characterises the completeness of appropriation utilization and is not used as an independent indicator of economic efficiency, financing adequacy, quality, or effectiveness of medical services.

The nominal chain growth rate of payments g_t^n is calculated as follows:

$$g_t^n = \left(\frac{V_t}{V_{t-1}} - 1 \right) \times 100\%, \quad (3)$$

where V_t is the total amount of transactional payments to healthcare providers in year t , and V_{t-1} is the corresponding amount of payments in the previous year.

To adjust nominal dynamics for changes in the general consumer price level, the consumer price index coefficient $I_{CPI,t}$ is used. It is obtained by dividing the official consumer price index expressed as a percentage by 100. The CPI-adjusted payment growth rate g_t^r is determined as follows:

$$g_t^r = \left[\frac{1 + \frac{g_t^n}{100}}{I_{CPI,t}} - 1 \right] \times 100\%, \quad (4)$$

where g_t^r is the CPI-adjusted payment growth rate in year t , g_t^n is the nominal chain growth rate of payments, and $I_{CPI,t}$ is the consumer price index coefficient in year t .

The resulting value characterises the change in payments after adjustment for the general consumer price index and is not interpreted as an exact change in the purchasing power of healthcare providers.

To represent cumulative dynamics, a CPI-adjusted payment index is calculated with 2021 used as the base year. The index is defined by the following base condition and recurrence relationship:

$$I_{2021}^r = 100; I_t^r = I_{t-1}^r \left(1 + \frac{g_t^r}{100} \right), \quad (5)$$

where I_t is the CPI-adjusted payment index in year t , I_{t-1} is the index value in the previous year, and g_t is the CPI-adjusted payment growth rate in year t .

Structural analysis is performed using four analytically formed groups. The first group includes primary healthcare; the second includes emergency healthcare; the third includes specialised care and related clinical areas, including secondary

and tertiary care, palliative care, rehabilitation, child healthcare, pregnancy, and childbirth; and the fourth includes special and transitional payments. This aggregation is used solely to ensure comparability of the annual payment structure and does not constitute a normative assessment of the priority of the respective areas.

The structural shift index I_t^s is determined as follows:

$$I_t^s = 0.5 \times \sum_{i=1}^m |s_{i,t} - s_{i,t-1}|, \quad (6)$$

where $s_{i,t}$ is the share of the i -th aggregated type of healthcare in the total payment amount in year t , $s_{i,t-1}$ is the corresponding share in the previous year, and m is the number of aggregated groups.

The indicator characterises the scale of redistribution in the payment structure compared with the previous year. A higher value indicates larger structural changes, whereas the direction and economic meaning of those changes require separate substantive interpretation.

Payment concentration across healthcare providers and across Medical Guarantees Program packages is assessed separately. The provider payment concentration index is determined as follows:

$$HHI_t^{prov} = \sum_{j=1}^n \left(\frac{V_{j,t}}{V_t} \right)^2 \times 10,000, \quad (7)$$

where $V_{j,t}$ is the amount of payments to the j -th healthcare provider in year t , V_t is the total amount of payments to all healthcare providers in the corresponding year, and n is the number of healthcare providers.

The package payment concentration index is calculated separately:

$$HHI_t^{pack} = \sum_{k=1}^p \left(\frac{V_{k,t}}{V_t} \right)^2 \times 10,000, \quad (8)$$

where $V_{k,t}$ is the total payment amount under the k -th package in year t , V_t is the total amount of payments in the corresponding year, and p is the number of packages.

Following Rhoades (1993), HHI values below 1,000 are classified as low concentration, values from 1,000 to 1,800 as moderate concentration, and values above 1,800 as high concentration. These thresholds are used only for descriptive classification and do not determine the economic efficiency or justification of the observed distribution.

The share of the 10 healthcare providers receiving the largest annual payment amounts from the National Health Service of Ukraine is used as an additional descriptive concentration measure:

$$CR10_t = \frac{\sum_{j \in Top10} V_{j,t}}{V_t} \times 100\%, \quad (9)$$

where $CR10_t$ is the share of the 10 largest healthcare providers in year t , $V_{j,t}$ is the amount paid to a healthcare provider belonging to the annual Top 10 group, and V_t is the total annual amount of provider payments.

The 2026 analysis is designed as a sensitivity assessment rather than a forecast. The approved amount of budget appropriations for budget program 2308060 is held constant, while the appropriation utilization rate is varied within the range actually observed in 2023–2025. The lower level corresponds to the minimum observed value, the central level to the arithmetic mean, and the upper level to the maximum observed value for this period. For each sensitivity level h , the estimated amount of utilized appropriations is calculated as follows:

$$F_{2026}^h = P_{2026} \times \frac{K_h}{100}, \quad (10)$$

where F_{2026} is the estimated amount of utilized appropriations in 2026 under sensitivity level h , P_{2026} is the approved amount of budget appropriations for 2026, and K_h is the appropriation utilization rate corresponding to the lower observed, average observed, or upper observed level in 2023–2025.

The corresponding estimated amount of unused appropriations is determined as follows:

$$U_{2026}^h = P_{2026} - F_{2026}^h, \quad (11)$$

where U_{2026} is the estimated amount of unused appropriations in 2026 under sensitivity level h .

These calculations do not forecast demand for medical services, the efficiency of management, or the financial effect of digitalisation. They only show the arithmetic sensitivity of budget appropriation utilization to variation in the utilization rate within its recent observed range. The main indicators of the financial and structural analysis of budget financing and NHSU payments are shown in Table 1.

Indicator	Calculation	Subject of assessment
Budget appropriation utilization rate	Actual budget funds used/approved appropriations × 100%	Execution of approved appropriations
Unused budget appropriations	Approved appropriations – actual budget funds used	Budget execution
Nominal payment growth rate	Current payments / previous-year payments – 1	Transactional payment dynamics
CPI-adjusted payment growth rate	Nominal payment change adjusted by CPI	Transactional payment dynamics
CPI-adjusted payment index	Chain accumulation, 2021 = 100	Multi-year payment dynamics
Structural shift index	0.5 × sum of absolute changes in shares	Payment structure
Provider HHI	Sum of squared provider payment shares × 10,000	Distribution among healthcare providers

RESULTS

The first level of assessment characterizes the execution of budget allocations. In 2022, the planned volume of the Medical Guarantees Program was UAH 157.3 billion, while actual expenditures amounted to UAH 146.3 billion. The utilization rate was 93.01%, with unused resources amounting to UAH 11.0 billion. This gap reflects the exceptional conditions of the first year of a full-scale war, when patient routes, the provider network, territorial accessibility, and the need for certain types of care changed.

In 2023, the plan was reduced to UAH 142.7 billion, while actual expenditures amounted to UAH 139.4 billion. The utilization rate increased to 97.69%, while unused resources decreased to UAH 3.3 billion. In 2024, the system reached its highest value for the period under review, 98.93%. In 2025, actual expenditures increased to UAH 172.8 billion, with a utilization rate of 98.46% (Table 2).

Table 2. Planned and actual expenditure under the Medical Guarantees Program. (Source: calculated using data from the Ministry of Finance of Ukraine (2023; 2024; 2025a; 2026) and the Ministry of Health of Ukraine (2022a; 2022b; 2023; 2024))

Year	Plan, UAH billion	Actual, UAH billion	Absorption, %	Unused budget resource, UAH billion	Rate of change in actual expenditure, %
2022	157.3	146.3	93.01	11.0	–
2023	142.7	139.4	97.69	3.3	–4.72
2024	159.0	157.3	98.93	1.7	12.84
2025	175.5	172.8	98.46	2.7	9.85

The results obtained demonstrate a significant increase in the utilization of approved budget appropriations after 2022. While the corresponding level was 93.01% in 2022, it ranged from 97.69% to 98.93% in 2023–2025, with an average value of 3.3%. At the same time, the volume of unused appropriations decreased compared to 2022. This trend indicates more complete implementation of the approved annual financial plan, but is not sufficient to conclude the effectiveness or adequacy of budget financing. The approved appropriations volume may be almost fully utilized and simultaneously remain

below or above resource requirements, the determination of which requires data on the volume and cost of services actually provided.

Open data on supplier payments shows an increase in the nominal amount from UAH 123.01 billion in 2021 to UAH 165.69 billion in 2025. The number of healthcare providers under the legal entity name increased from 3,495 to 3,793, and the number of packages increased from 38 to 4 (UAH 35.20 million to UAH 43.68 million). The median value simultaneously decreased from UAH 11.27 million to UAH 7.67 million. This difference between the mean and median confirms an asymmetric distribution, with a significant number of small providers receiving relatively small amounts, while large multidisciplinary facilities form the upper portion of the distribution.

The ratio of mean to median payments further characterizes the network's heterogeneity. In 2021, the mean payment exceeded the median by 3.12 times. In 2025, the gap increased to 5.69 times. An increase in this ratio indicates increased asymmetry in the payment portfolio but does not prove excessive market concentration. The economic reason is the simultaneous presence of large multidisciplinary facilities, urgent care centers, specialized facilities, and small providers of select outpatient services. Therefore, the assessment should combine distribution indicators with the HHI and the share of the largest recipients (Table 3).

Table 3. Indicators of the open NHSU payment portfolio. (Source. calculated using open data from the National Health Service of Ukraine (2026). Payments to pharmacies under the reimbursement program are not included)

Year	Number of records	Provider payments, UAH billion	Providers, no.	Packages, no.	Average payment, UAH million	Median payment, UAH million
2021	174,802	123.01	3,495	38	35.20	11.27
2022	228,183	145.66	3,499	42	41.63	13.19
2023	199,392	133.85	3,671	42	36.46	8.96
2024	227,997	150.99	3,705	46	40.75	8.11
2025	213,137	165.69	3,793	49	43.68	7.67

Nominal and inflation-adjusted payment dynamics differed significantly. In 2022, the nominal volume of payments increased by 18.41%, while after adjusting for the general consumer price index, the change was -6.47%. In 2023, a nominal reduction in payments by 8.11% was accompanied by an adjusted decrease of 12.56%. In 2024, a nominal increase of 12.80% at a consumer price index of 12.0% corresponded to an adjusted increase of 0.72%, and in 2025, the adjusted increase was 1.61%. The accumulated value of the CPI-adjusted core payments index in 2025 was 83.69, with a base value of 100 in 2021. Thus, the nominal volume of transaction payments in 2025 exceeded the level of 2021, while after adjusting for the general increase in consumer prices, the corresponding index remained below the base value. The result obtained characterizes the discrepancy between the nominal and inflation-adjusted dynamics of the financial flow. It does not determine the actual purchasing power of providers, since such a conclusion requires a special deflator formed according to the structure of their costs for labor, medicines, medical products, energy, equipment and other resources.

The third level of assessment includes structural changes. In 2021, specialized and other care accounted for 71.84% of the open payment portfolio, primary care 16.38%, and emergency care 10.44%. In 2025, the share of specialized and other care increased to 78.13%, while the share of primary care decreased to 14.32% and emergency care to 6.55%. The highest structural shift index was recorded in 2024 at 5.26 percentage points, which is associated with the expansion of specialized areas and a reduction in the share of other payments.

The increase in the ratio of the average and median payment characterizes the increasing asymmetry in the distribution of payments between health care providers. However, this indicator does not characterize concentration directly, and therefore its results are further compared with the HHI by providers and the share of the 10 providers with the largest volume of payments (Figure 1).

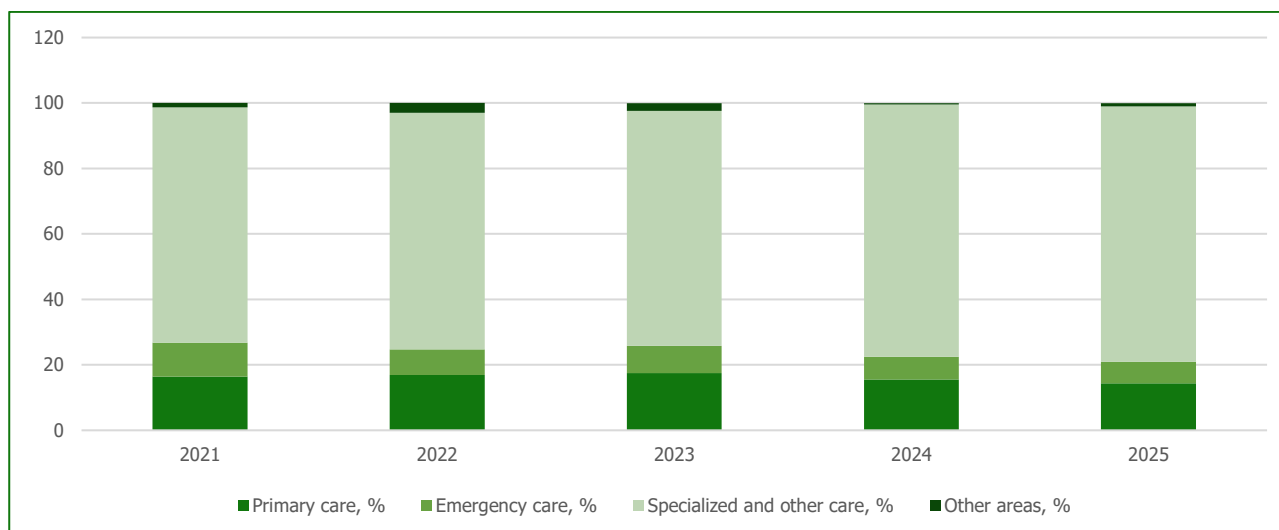


Figure 1. Nominal provider payments and the CPI-adjusted payment index in 2021–2025. (Source: calculated using open data from the National Health Service of Ukraine (2026))

The increase in the share of specialized care has two interpretations. On the one hand, it reflects expanded state coverage for complex and expensive services, rehabilitation, trauma treatment, and other wartime needs. On the other hand, a long-term decline in the share of primary care may weaken preventive care and increase future demand for more expensive treatment. This finding concerns the funding structure and requires further verification using data on the volume and complexity of services.

A concentration analysis revealed low dependence on individual providers. The HHI by provider ranged from 13.69 to 18.48 points, significantly below the 1,000 thresholds. The share of the 10 largest recipients was 5.63 to 6.83%. Meanwhile, the HHI by package ranged from 978.73 to 1,105.71 points. Consequently, the payment portfolio by package moved from the lower limit of low concentration to moderate, which is explained by the dominance of a few large funding areas (Table 4).

Table 4. Concentration of payments by providers and packages. (Source: calculated using open data from the National Health Service of Ukraine (2026))

Year	Provider HHI	Share of the ten largest providers, %	Package HHI	Assessment of package concentration
2021	14.02	6.23	1,040.79	moderate
2022	13.69	5.63	978.73	low
2023	16.38	6.44	1,049.97	moderate
2024	18.45	6.83	1,105.71	moderate
2025	18.48	6.79	1,024.13	moderate

During the studied period, the structure of the transaction portfolio changed in the direction of increasing the share of specialized care and related clinical areas and reducing the shares of primary and emergency medical care. The largest scale of annual structural redistribution was recorded in 2024, when the structural shift index was 5.26 pp. The above changes characterize the redistribution of the payment structure, but do not in themselves determine the adequacy of funding for any of the areas. In particular, the reduction in the share of primary medical care may be a consequence of both changes in its own funding and faster growth in payments in other areas. The conclusion on the adequacy of resources requires additional comparison of funding with the number of patients, the volume of services provided, and the structure of actual costs.

To assess the sensitivity of budget appropriations, use in 2026, no standard or expertly determined scenario levels were set. The calculation was based on the actual observed values of appropriations use in 2023–2025. The lower variant corresponds to the minimum value for this period, recorded in 2023 at 97.69%; the central variant corresponds to the average value for 2023–2025 at 98.36%; and the upper variant corresponds to the maximum value of 98.93%, recorded in 2024. This approach does not assume forecasting of demand for medical services or future management effectiveness.

It demonstrates exclusively the sensitivity of the potential volume of funds used to changes in the corresponding indicator within the range of its recently observed values (Table 5).

Table 5. Sensitivity of the utilization of 2026 budget appropriations to the appropriation utilization rate. (Source. calculated by the authors using Ministry of Finance of Ukraine (2025b) data on the 2026 budget appropriation)

Calculation variant	Appropriation utilization rate, %	Estimated utilized amount, UAH billion	Estimated unused appropriations, UAH billion	Basis
Lower observed level	97.69	187.17	4.43	Minimum observed in 2023–2025
Average observed level	98.36	188.46	3.14	Average for 2023–2025
Upper observed level	98.93	189.55	2.05	Maximum observed in 2023–2025

With the initial budget allocations unchanged, the difference between the calculated amounts for the lower and upper levels and the actual observed amounts is UAH 2.38 billion. This figure does not reflect the economic impact of digitalization, management savings, or loss assessment. It solely reflects the arithmetic sensitivity of the volume of funds used to changes in the level of allocation fulfillment within the range actually recorded in 2023–2025.

DISCUSSION

The results of the study primarily indicate a change in the completeness of the use of budgetary allocations for the Medical Guarantees Program. After a lower value in 2022, the level of their use in 2023–2025 exceeded 97%. This trend is consistent with the findings of Bredenkamp et al. (2022), Dzhygir et al. (2023), and Habicht et al. (2024) on the preservation of the main financing mechanisms and the functioning of the single purchaser in the face of significant external shocks. At the same time, the results obtained in this study have a narrower meaning. The high level of allocation use confirms the complete implementation of the approved financial plan, but does not allow us to establish the efficiency of fund use or the sufficiency of the budgetary resources themselves. The established difference between the nominal and consumer price index-adjusted payment dynamics complements the results of preliminary studies of the financial provision of the healthcare system. Bredenkamp et al. (2022) point out the need to match the resource provision of the Medical Guarantee Program with the needs of the system, while the WHO Regional Office for Europe (2024a) draws attention to the importance of improving financial planning in the face of increasing resource costs. The obtained results show that the nominal dynamics of payments may differ significantly from their dynamics after accounting for general inflation. At the same time, the applied consumer price index does not reflect the specific structure of expenses of health care providers. Therefore, the calculated indicator should be used for macroeconomic adjustment of payments, and not as an exact characteristic of their actual purchasing power. The identified structural changes in the payment portfolio also require careful interpretation. An increase in the share of specialized medical care and related clinical areas, along with a reduction in the share of primary care, characterizes a change in the proportions of financing, but does not determine its economic feasibility. Wilkens et al. (2025) emphasize the importance of primary health care for the functioning of the health system during wartime, while the WHO Regional Office for Europe, in special studies of primary care expenditures, emphasizes the need to take into account the actual structure of resource needs. Therefore, the reduction in the primary care share identified in our study should be considered as grounds for further analysis, rather than as evidence of underfunding.

The results of the payment concentration assessment also expand the analysis of the financing structure. A low HHI across providers indicates that, at the national level, transaction payments are not concentrated among a small number of legal entities. Hellowell et al. (2025) also demonstrate that the structure of participation of different types of providers in contracting should be analyzed taking into account territorial accessibility, specialization, and demand characteristics. Consequently, low national concentration does not preclude high concentration in certain local medical services markets. A higher HHI across packages, in turn, characterizes the concentration of a significant portion of the payment portfolio in the largest SGP funding areas, but is not an indicator of market concentration and does not provide grounds for concluding that such distribution is inefficient. The obtained results are consistent with the provisions of Feldhaus and Mathauer (2018) on the need to consider the methods and structure of provider payments and with the findings of Hawkins et al. (2023) on the importance of information for purchasing decisions. However, the available data do not allow us to establish a causal relationship between digital administration and changes in the volume of budget funds used. The National Health Service of Ukraine's information systems support contracting, data submission and verification, and the formation of an information

basis for payments. However, the economic impact of their use would require a separate study of the costs of operating the systems and the quantified results obtained through their use.

The scientific novelty of the present study lies not in the separate use of budget execution indicators, inflation adjustment, structural analysis, or concentration indices, but in their integration within a single financial and structural assessment of the Medical Guarantees Program while preserving the methodological distinction between different financial data levels. Unlike Romanchenko and Kozhemiakina (2023), who analyse healthcare financing and provider assets, and unlike Skrypnikova and Yurochko (2022) and Parii et al. (2025), who focus on particular types or packages of medical care, the present study simultaneously combines official execution data for budget program 2308060 with the transactional payment portfolio of the NHSU for 2021–2025. Unlike studies focused on institutional reform or general financing models, the proposed approach separately identifies appropriation utilization, nominal and CPI-adjusted payment dynamics, structural shifts between types of healthcare, provider concentration, and package concentration. This separation is important because it prevents a high level of budget execution from being interpreted as evidence of economic efficiency and prevents changes in the payment portfolio from being interpreted as evidence of financing adequacy without corresponding data on services, patients and actual provider costs.

The practical use of the proposed approach should be linked to regular financial monitoring, rather than to universal thresholds for management response. The dynamics of the level of use of appropriations, adjusted payments, financing structure and concentration should be analyzed in a time comparison, and significant deviations should become the basis for a more detailed analysis of their causes. Normative thresholds can be established only after accumulating sufficient empirical material and verifying their connection with the volume, cost and results of medical care provision. The study has a number of limitations. The transactional set of open data is not identified with the full cash execution of the budget program and is used to analyze payments separately. The general consumer price index does not take into account the specific cost structure of medical service providers. Identification of providers by legal entity name may be sensitive to renaming. The study has several limitations that determine the boundaries of interpretation of the obtained results. First, NHSU transactional open data are not identical to the cash execution of budget program 2308060 and are therefore analysed as a separate information set. Second, the general consumer price index does not reproduce the specific expenditure structure of healthcare providers and is used only as a macroeconomic adjustment factor.

CONCLUSIONS

The study allowed for a financial and structural assessment of budgetary funding for the Medical Guarantees Program for 2021–2025 and a clear distinction between budget allocation performance and the characteristics of the National Health Service of Ukraine's transactional payment portfolio. This approach is of fundamental methodological importance, as high utilization of budget funds does not independently prove their economic effectiveness, and the dynamics and structure of payments require separate analysis. From 2022 to 2025, actual utilization of funds under the Medical Guarantees Program increased from UAH 146.3 billion to UAH 172.8 billion, while the utilization rate of approved allocations increased from 93.01% to 98.46%. From 2023 to 2025, the corresponding indicator consistently exceeded 97%, demonstrating a high level of implementation of approved budget allocations. The obtained result does not determine the adequacy of funding, since such an assessment requires comparing allocated resources with the actual volume and cost of medical services provided.

The nominal volume of transaction payments to healthcare providers increased from UAH 123.01 billion in 2021 to UAH 165.69 billion in 2025. At the same time, the base payment index, adjusted for the general consumer price index, amounted to 83.69 in 2025, compared to 100 in 2021. Thus, the nominal increase in financial flows was not accompanied by a similar trend after adjusting for general inflation. This result should not be considered an exact change in the purchasing power of funding, since the structure of healthcare provider expenditures differs from the structure of the consumer basket. The structure of transaction payments changed over the study period. The share of primary care decreased from 16.38% to 14.32%, while the share of specialized care and related clinical areas increased from 71.84% to 78.13%. The largest annual structural shift was recorded in 2024. These changes characterize the redistribution of funding between types of care, but do not allow one to determine the adequacy or inadequacy of funding for a particular area without taking into account the number of patients, the volume of services, and actual costs.

A concentration analysis confirmed the need for a separate consideration of healthcare providers and the Medical Guarantee Program packages. The HHI for providers remained low at the national level, and the share of the 10 largest providers by payment volume did not exceed 6.83%. However, the concentration of payments within packages was significantly higher. These results describe the structure of financial flow distribution and do not determine its economic feasibility, as

concentration can be determined by the scale of activity, provider specialization, and the structure of demand for healthcare services.

The practical significance of the obtained results lies in their applicability to budget planning and regular analysis of the Medical Guarantees Program's implementation. The calculation for 2026 should be used as a sensitivity analysis based on the actual range of budget allocation utilization observed in 2023-2025, rather than as a forecast or assessment of the economic impact of management actions. Further research should include comparison of budget and transaction data with standardized volumes of medical services provided, number and structure of patients, complexity of clinical cases, territorial characteristics, actual costs of providers, and quality indicators.

ADDITIONAL INFORMATION

AUTHOR CONTRIBUTIONS

All authors have contributed equally.

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CONFLICT OF INTEREST

The Authors declare that there is no conflict of interest.

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ФІНАНСОВО-СТРУКТУРНА ОЦІНКА БЮДЖЕТНОГО ФІНАНСУВАННЯ ПРОГРАМИ МЕДИЧНИХ ГАРАНТІЙ ЗА УМОВ ЦИФРОВОГО АДМІНІСТРУВАННЯ СТРАТЕГІЧНИХ ЗАКУПІВЕЛЬ

Актуальність дослідження зумовлена необхідністю підвищення обґрунтованості бюджетного фінансування Програми медичних гарантій за умов воєнних ризиків, інфляційного тиску та зміни структури потреб у медичній допомозі. Особливого значення набуває розмежування повноти використання бюджетних асигнувань, динаміки платежів Національної служби здоров'я України та структурних характеристик їх розподілу, оскільки кожен із зазначених аспектів характеризує окрему сторону фінансування й не може самостійно розглядатися як доказ його економічної ефективності. Метою дослідження є проведення фінансово-структурної оцінки бюджетного фінансування Програми медичних гарантій і визначення аналітичних орієнтирів для вдосконалення бюджетного планування й моніторингу її виконання. Інформаційну основу сформовано за офіційними показниками державного бюджету, відкритими да-

ними Національної служби здоров'я України про платежі надавачам медичних послуг та офіційними індексами споживчих цін. Застосовано аналіз використання бюджетних асигнувань, номінальної та скоригованої на індекс споживчих цін динаміки платежів, структурних зрушень, а також концентрації платежів окремо за надавачами медичних послуг і пакетами Програми медичних гарантій. Наукова новизна полягає в поєднанні показників виконання бюджетних асигнувань із характеристиками транзакційного портфеля платежів та їх чіткому методичному розмежуванні, що внаслідок ототожнення повноти використання коштів з економічною ефективністю стратегічних закупівель. Отримані результати засвідчили одночасне зростання рівня використання затверджених асигнувань, суттєву відмінність між номінальною та інфляційно скоригованою динамікою платежів, зміну структури фінансування за видами медичної допомоги та різний рівень концентрації платежів за надавачами й пакетами. Практична цінність результатів полягає в можливості їх використання Національною службою здоров'я України, Міністерством охорони здоров'я України та Міністерством фінансів України під час бюджетного планування, аналізу виконання Програми медичних гарантій і ухвалення рішень щодо структури її фінансування.

Ключові слова: бюджетне фінансування, Програма медичних гарантій, стратегічні закупівлі, Національна служба здоров'я України, бюджетні асигнування, платежі надавачам медичних послуг, структурні зрушення, концентрація платежів

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