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Assessment of the capabilities and readiness of implementation of ICOPE in Ukraine

Research report

iAPS Ukraine
People-first development

HelpAge International

Content

1. Executive Summary

Ukraine is undergoing profound demographic shifts characterised by rapid population ageing — a process that has been significantly accelerated and compounded by the full-scale war. Prolonged displacement, widespread destruction of infrastructure, disruption of service delivery, and chronic overstrain of public systems have disproportionately affected older people, who face intersecting medical, functional, social, and economic vulnerabilities. These dynamics have exposed the structural limitations of fragmented, sector-based care models and underscored the urgency of transitioning towards integrated, person-centred approaches that address the full spectrum of older people's needs.

In response to this context, HelpAge International commissioned this assessment to examine the feasibility and readiness for implementing the World Health Organization's Integrated Care for Older People (ICOPE) approach in Ukraine[1]. The assessment does not focus on clinical effectiveness; rather, it explores the capacity of the health and social care systems to adopt, operationalise, and sustain integrated models of care that prioritise functional ability, dignity, and quality of life of older people.

The study was conducted in two regions representing diverse service delivery contexts, including both urban and rural communities. A mixed-methods design was applied, combining desk review, key informant interviews, focus group discussions, facility-level checklists, surveys of health and social workers, and structured questionnaires administered to older people and caregivers. This approach enabled triangulation of findings across system (macro), service (meso), and individual and community (micro) levels, providing a comprehensive picture of ICOPE readiness.

Overall readiness for ICOPE implementation

The assessment indicates that Ukraine demonstrates partial and uneven readiness for ICOPE implementation. While important enabling conditions are in place—including the ongoing primary health care reform, an established network of social services, and growing recognition of the need for integrated care—these elements remain insufficiently aligned to support systematic, coordinated, and person-centred service delivery for older people.

Across all data sources, respondents consistently described a system in which health and social services operate in parallel rather than as part of an integrated continuum of care. Existing coordination mechanisms are largely informal, dependent on individual initiative, and therefore highly vulnerable to disruption.

A core systemic challenge emerging throughout the assessment is the absence of institutionalised interaction between health and social professionals at the point of service delivery.

"In practice, family doctors and social workers often do not even have each other's phone numbers. They work with the same older person, but in two separate realities. There is no mechanism that compels the system to connect them." (KII, representative of a local civil society organisation)

This fragmentation fundamentally constrains Ukraine's current capacity to operationalise ICOPE as a functional model of integrated care.

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[1] The WHO Integrated Care for Older People (ICOPE) framework is the World Health Organization's global approach to organising integrated care for older people, aimed at maintaining and improving functional ability (intrinsic capacity), autonomy, and quality of life across the life course. ICOPE is grounded in a shift away from fragmented, diagnosis-driven services towards a coordinated system of health and social care built around the person's needs.

The ICOPE framework encompasses: (i) early identification of declines in functional capacity (including mobility, cognition, vision, hearing, psychological well-being, and nutrition); (ii) person-centred assessment and individualised care planning; (iii) multidisciplinary coordination of health and social services; (iv) support for caregivers; (v) a system orientation towards community-based care; and (vi) enabling governance and system-level conditions for integrated care delivery. In this report, ICOPE is applied as both an analytical and assessment framework to examine Ukraine's readiness to implement integrated care for older people.

"At the national level, there is no regulatory model of integrated care at all. At the local level, there is often willingness, but without resources, staff, or clear instruments this willingness cannot be translated into practice." (KII, representative of a local civil society organisation)

"With regard to direct communication between health and social professionals, there are no regulatory or methodological guidelines. In practice, such interaction exists only sporadically, for example in palliative care, and relies more on individual initiative than on a system." (KII, representative of a regional Department of Health)

Key findings in numbers

Table 1. Awareness of ICOPE and integrated care

Indicator (proxy)	Share of staff (%)
Staff who reported assessing social support and caregiver needs (proxy indicator of awareness of integrated care principles)	≈100% (practical orientation rather than conceptual awareness)

Survey results among health and social workers (Table 1.4) indicate that although formal awareness of the WHO ICOPE framework was not directly measured, key principles of this approach are already implicitly present in everyday practice at the service delivery level. The overwhelming majority of respondents indicated that in their work they assess social support and caregiver needs, which points to a practical orientation towards a person-centred and function-sensitive approach to care.

This pattern makes it possible to speak of the existence of "implicit ICOPE" — that is, the application of certain elements of integrated care without their formal consolidation or awareness of ICOPE as a holistic conceptual framework. In this sense, ICOPE functions not as an institutionalised model, but rather as a set of practices that have formed organically in response to real challenges in providing services to older people.

At the same time, the absence of clear conceptual consolidation limits the systematic nature, coherence, and scalability of such practices. Without a shared terminology, targeted training, and formalised implementation tools, integration remains fragmented, largely dependent on the individual initiative of professionals, and uneven across different services and territories.

Overall, the findings indicate significant unrealised potential for policy and capacity development: formalising and "naming" existing practices within the ICOPE framework may strengthen intersectoral coordination, improve continuity of care, and support the transition from implicit, practice-oriented integration to explicit, system-level implementation of integrated care for older people.

Table 2. Integration of functional capacity assessment of older people into the practice of medical and social workers

Indicator (proxy)	Share of staff (%)
Health and social workers who reported assessing functional status, autonomy, or daily activity of clients as part of their work	≈70–80%*

NOTE: There was no direct question in the questionnaire regarding assessment of functional capacity as a separate procedure. The indicator was calculated as a proxy based on responses related to assessment of autonomy, self-care ability, care needs, and social support needs. The range reflects variability of practices between health and social workers.

Survey results among health and social workers indicate that assessment of functional capacity of older people is partially integrated into routine practice, but does not have a systemic character. Based on proxy indicators, approximately 70–80% of respondents reported that in their work they assess autonomy, ability to perform self-care, or daily functioning of clients.

At the same time, such assessment is usually carried out in a fragmented and situational manner, without the use of standardised tools and without a clear link to subsequent care

planning. For most workers, it is not formalised as a distinct stage of the service delivery process, but rather embedded within a general understanding of the client's condition.

From an ICOPE perspective, this points to the presence of an implicit approach to functional capacity assessment, based on the professional experience of individual specialists, but not supported by systemic protocols, intersectoral coordination, or regular monitoring of changes in functional status over time.

Table 3. Coordination gap between health and social services

Indicator	Quantitative data (%)
Facilities that have any formalised referral pathway or coordination protocol between PHC and social services	≈20–30%*
Respondents who indicated that interaction between family doctors and social workers is situational and personalised	≈60–70%*

NOTE: There were no direct questions regarding the existence of formalised coordination pathways. The indicators were calculated as proxies based on responses about interaction practices, presence/absence of regular cooperation mechanisms, and the nature of communication between health and social workers.

Survey results among health and social workers point to a pronounced coordination gap between the health and social protection systems. Based on proxy indicators, only about 20–30% of facilities have any formalised referral pathways or coordination protocols between PHC and social services.

At the same time, the overwhelming majority of respondents (60–70%) characterised interaction between family doctors and social workers as situational and personalised, dependent on individual contacts, personal initiative, or specific crisis situations, rather than on institutionally закреплённые procedures that are formalised and defined. This means that coordination between sectors functions mainly as an informal compensation for systemic gaps rather than as a stable element of care organisation. In the absence of formalised referral pathways, feedback mechanisms, and shared documentation, continuity of care remains fragile, and responsibility for coordination is often effectively shifted onto patients themselves or their caregivers.

From an ICOPE perspective, these findings confirm that integration of health and social services remains at an early, fragmented stage, dominated by implicit interaction without systemic governance and scalable solutions.

Table 4. Caregiver burden

Indicator (proxy)	Quantitative data (%)
Caregivers who reported a high or very high level of emotional and physical burden	≈65–75%*
Caregivers who indicated that they do not receive any systemic support, training, or respite services	≈55–65%*

NOTE: The indicators were calculated as proxies based on caregivers' responses regarding self-assessed emotional and physical burden, access to support, training, and respite services. The questionnaire did not contain a single aggregated question on burden; therefore, values are presented as ranges.

Survey results among caregivers/social workers (Table 1.4) indicate a high level of burden and a structural deficit of support. Based on proxy indicators, approximately two thirds of respondents (65–75%) reported a high or very high level of emotional and physical burden, pointing to a systemic risk of burnout among informal caregivers.

In parallel, more than half of caregivers (55–65%) indicated that they do not receive any systemic support, including training, counselling, or respite services. This means that care for older people is to a large extent placed on private family resources without adequate institutional compensation or support.

From an ICOPE perspective, these findings indicate a critical gap between recognition of the role of caregivers and the actual level of support provided. This gap constrains sustainability of care, increases health risks for caregivers themselves, and negatively affects continuity and quality of care for older people. The absence of training and respite services also reduces the potential for integrating health and social interventions at household level.

Table 5 Access to services

Indicator (proxy)	Quantitative data (%)
Older people who reported difficulties or delays in accessing at least one key health or social service	≈55–65%*
Older people who described their care pathway as "unclear" or "difficult to navigate"	≈45–55%*

NOTE: Indicators were calculated as proxies based on older people's responses regarding experiences of accessing health and social services, delays, barriers, and subjective assessment of the complexity of care pathways. The questionnaire did not contain a single aggregated question; therefore, values are presented as ranges.

Survey results among older people indicate significant limitations in access to health and social services. Based on proxy indicators, more than half of respondents (55–65%) experienced difficulties or delays in accessing at least one key service, pointing to the systemic nature of accessibility barriers.

Nearly half of respondents (45–55%) described their own care pathway as unclear or difficult to navigate. This indicates that access problems are linked not only to physical or financial barriers, but also to the absence of transparent pathways, clear information, and coordinated support.

Table 6: Digital divide and data fragmentation

Indicator (proxy)	Quantitative data (%)
Facilities that use electronic systems compatible across the health and social sectors	≈10–15%*
Social workers who have access to any medical information relevant for care planning	≈15–25%*

NOTE: There were no direct questions regarding full intersectoral interoperability of information systems. The indicators were calculated as proxies based on responses from facility checklists and staff surveys regarding use of electronic systems, access to medical data, and practices of information exchange between sectors.

Results of the facility checklists and surveys of health and social workers (Tables 1.1 and 1.4) reveal a profound digital divide between the health and social sectors. Based on proxy indicators, only about 10–15% of facilities use electronic systems that can be considered interoperable or partially integrated across the health and social protection sectors.

At the same time, access of social workers to medical information necessary for care planning remains extremely limited: only 15–25% of respondents indicated that they have any such access. This means that in most cases social workers are forced to rely on verbal information from clients or caregivers rather than on structured medical data.

From an ICOPE perspective, such data fragmentation substantially undermines the possibility of integrated care, as needs assessment, intervention planning, and monitoring of changes in functional capacity take place in information-isolated environments. In the absence of shared electronic tools and access to relevant information, integration remains declarative, and intersectoral coordination continues to depend on informal contacts between professionals.

Taken together, these indicators quantitatively confirm that the current model remains structurally fragmented and poorly adapted to supporting coordinated, function-oriented care.

Overall readiness assessment (synthesis based on WHO methodology)

Based on the logic of the WHO ICOPE Implementation Scorecard, the assessment makes it possible to preliminarily define the overall level of Ukraine's readiness for ICOPE implementation at approximately:

≈ 30–40% of system readiness

This corresponds to the stage of "initiation / early readiness for implementation", characterised by the presence of political intentions and isolated practices, but the absence of institutional mechanisms for scale-up.

Table 7. Preliminary readiness table (WHO 1–4 scale)

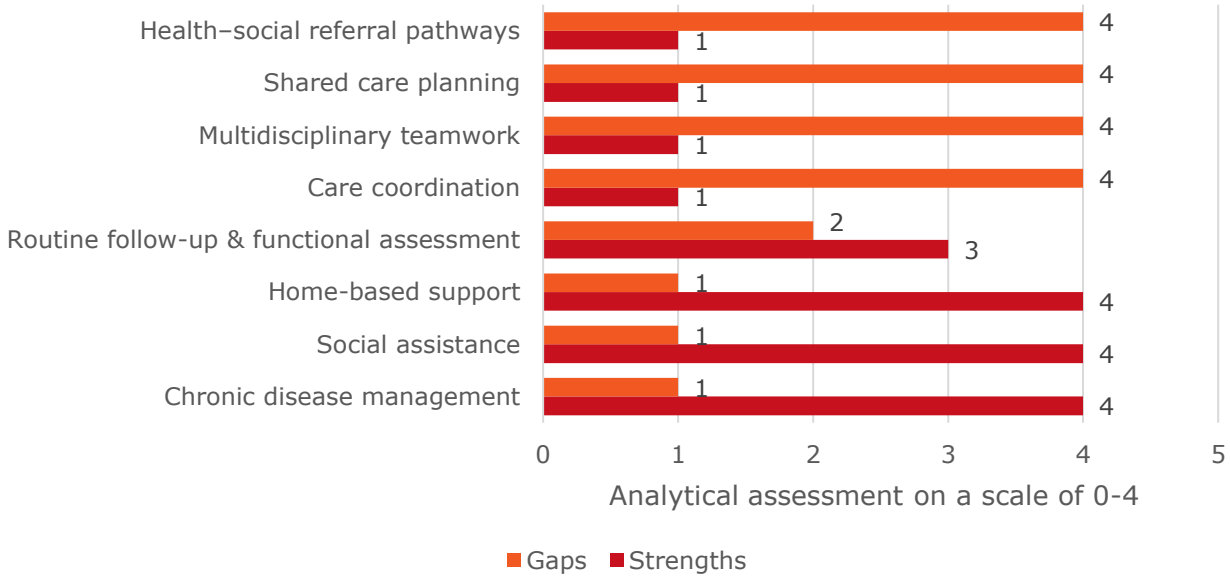
Domain	Level	Interpretation
Governance and accountability	2 / 4	Political and regulatory preconditions exist, but there is no national integrated care model or shared governance
Workforce capacity	2 / 4	Strong professional base, but staff shortages, overload, and lack of integrated competencies
Financing of integrated care	1–2 / 4	Financing is fully sectoral, with no incentives for coordination
Information systems and data	1 / 4	Health and social data are not integrated and do not support functional care trajectories

Overall system profile: an enabling environment for integration is emerging, but an operational ICOPE system is absent.

Service (meso) level: strengths and gaps

At the service level, primary healthcare facilities and social service providers already address many needs of older people, particularly in relation to chronic disease management, social assistance, and home-based support. Elements conceptually aligned with ICOPE—such as routine follow-up, elements of functional assessment, and community outreach—are present in practice, though not framed within an integrated care model.

Service-level strengths and gaps in integrated health and social care for older people



However, service delivery remains predominantly sectoral. Multidisciplinary teamwork is limited, shared care planning is rare, and referral pathways between health and social services are weakly formalised. Older people frequently navigate complex and fragmented service pathways independently, facing delays, unclear eligibility rules, and financial barriers.

Insights from focus group discussions with older people reinforce these findings, highlighting long waiting times, inconsistent information, and lack of continuity across providers. Caregivers similarly report high levels of burden, limited guidance, and insufficient coordination between medical and social support.

"If integrated care means more meetings, more reporting, and more workload, it will not work. People are exhausted. Integration must make work easier and services more effective, not heavier." [KII, Representative of WHO]

Community-based care models, including outreach services, day care, and supported living, are unevenly developed and largely dependent on local capacity and external support. Rural and remote communities face particular access constraints related to workforce shortages and transportation barriers.

System (macro) level: governance, workforce, and data

At the system level, Ukraine has established important foundations through healthcare financing reform and strengthened primary care. These reforms provide a potential platform for integrating ICOPE-related interventions. Nevertheless, the assessment identifies significant governance and coordination gaps between the Ministry of Health, the Ministry of Social Policy, Family and Unity of Ukraine, and subnational authorities.

Responsibilities for health and social care remain fragmented, with limited mechanisms for joint planning, pooled financing, or shared accountability. Data systems in health and social sectors operate separately, constraining the ability to track functional ability, psychosocial risks, and care trajectories over time.

"Medical data and social data exist, but they do not speak to each other. A family doctor does not see the social assessment, and a social worker does not see medical prescriptions. Information is lost between sectors." [KII, Representative of local NGOs]

"If it were possible to combine information systems — medical and social protection — it would significantly reduce the number of "invisible" elderly people and greatly facilitate coverage of services" [KII, representative of the regional Department of Social Protection]

Workforce capacity emerges as a critical bottleneck. Shortages of family doctors, nurses, social workers, rehabilitation specialists, and geriatric competencies are compounded by limited training on integrated, person-centred care. Motivation and professional recognition were repeatedly highlighted as prerequisites for successful implementation.

ICOPE Implementation Scorecard: summary insights

The application of the WHO ICOPE Implementation Scorecard indicates that most actions at both service and system levels remain at an early or initiating stage. While isolated initiatives and pilot practices exist, they are not yet embedded within a coherent, scalable framework.

System-level implementation of WHO ICOPE: summary scorecard insights

The chart reflects a consolidated assessment of system readiness to implement the ICOPE approach across the main dimensions of institutional capacity. All five dimensions — care coordination and continuity, information systems and data interoperability, financing mechanisms, workforce capacity and competencies, and governance and leadership — are at an early / initiating stage of development. In particular:

- **Care coordination & continuity.** Care coordination and continuity are assessed as only beginning to take shape. This is consistent with the findings on the limited availability of formalised referral pathways and the predominantly situational nature of interaction between health and social services.
- **Information systems & data interoperability**. Information systems and data interoperability are at an initial stage, reflecting deep data fragmentation and minimal intersectoral interoperability of electronic systems. This substantially limits the possibilities for integrated care planning and monitoring of functional capacity.
- **Financing mechanisms.** Financing mechanisms are also assessed as not providing systemic support for integrated care. Financing remains predominantly sectoral and oriented towards isolated medical services, without incentives for intersectoral interaction.
- **Workforce capacity & competencies.** Workforce capacity and competencies are at an early stage of development due to staff shortages, high levels of burnout, and limited training in intersectoral and person-centred approaches to care.
- **Governance & leadership.** Governance and leadership are assessed as insufficiently developed to support ICOPE: there are no clear mechanisms for interministerial coordination, shared accountability, or operationalisation of integrated care at national and local levels.

The consolidated assessment indicates that implementation of ICOPE in Ukraine is at an initial stage of systemic development. While certain elements of integrated care are present at the level of practice, they are not supported by mature governance, financing, digital, and workforce mechanisms. This confirms the need to move from fragmented and implicit practices

towards an explicit, system-supported model of integrated care aligned with the WHO ICOPE framework.

Critical gaps persist in governance arrangements, workforce development, financing mechanisms for integrated care, and the use of interoperable information systems to support coordination and continuity of care.

Generalization

The assessment indicates that Ukraine is not yet ready for nationwide implementation of ICOPE, but does have sufficient institutional, professional, and community-level preconditions for phased, pilot-based implementation.

The highest level of readiness is observed at the level of problem recognition and local motivation; the lowest level is at the level of system design: governance, financing, workforce structuring, and data systems.

Ongoing reforms, community-level practices, and the engagement of civil society create a real entry point for adapting ICOPE to the Ukrainian context—provided that early implementation focuses on community-level integration, formalisation of intersectoral coordination, and systematic support to caregivers.

Strategic implications

A phased approach to ICOPE implementation is recommended, focusing on selected regions and communities where enabling conditions are present. Priority actions include strengthening coordination between health and social services, building multidisciplinary capacity, engaging older people and caregivers as active participants in care, and developing governance and financing mechanisms that support integrated, community-based models.

This assessment provides an evidence base to inform national dialogue, donor engagement, and policy development on integrated care for older people in Ukraine, aligned with WHO standards and responsive to the country's current humanitarian and reform context.

2. Introduction and Context

2.1. Population ageing, war, and compounded vulnerability of older people in Ukraine

Population ageing in Ukraine is a long-term demographic process that began well before the full-scale war; however, the war has sharply accelerated its consequences and transformed them into a large-scale humanitarian crisis. Even before 2022, Ukraine was characterised by a steady increase in the proportion of older people, a high prevalence of non-communicable diseases, disability, and poverty among this age group. The full-scale war has radically deepened these trends, destroying sources of income, disrupting family and community support networks, and imposing additional physical and psychological burdens on older people.

At the same time, the war has not only intensified existing demographic trends, but has qualitatively changed the structure of population ageing in Ukraine. Mass internal displacement has led to a sharp increase in the proportion of older people living alone among internally displaced persons—people who have lost not only their place of residence, but also the family and neighbourhood support networks that traditionally performed the function of informal care.

Forced displacement has had a particularly devastating impact on older people. Many face severe mobility limitations, lack of accessible information, and difficulties navigating new service delivery environments. For older internally displaced persons, the war has meant not only the loss of connection to a family doctor, social worker, or familiar services, but also the loss of physical housing itself. The loss of home, familiar surroundings, and local social ties has led to delays in treatment, interruption of therapy, a sharp narrowing of access to social assistance, and deepened dependence on external support.

In parallel, another critical phenomenon has emerged in Ukraine—"left-behind" older people. Thousands of older persons have remained in their communities, often in rural or frontline areas, without family support, following the evacuation or death of younger family members. Loneliness, limited mobility, degradation of infrastructure, workforce shortages, and reduced

availability of services create an environment of systemic isolation and high risks to life and health.

In this context, the war has effectively created a new large social category—older internally displaced persons living alone, who have simultaneously lost their homes, social environment, and customary mechanisms of informal support. For this group, the family as the basic institution of care has often ceased to exist. For them, ICOPE in the Ukrainian context is not merely a model for improving service quality, but a survival tool—a mechanism capable of partially substituting lost family care through the combination of health, social, and community-based support components.

Older people in Ukraine are increasingly experiencing multiple, mutually reinforcing vulnerabilities. Chronic diseases are combined with functional limitations, cognitive impairments, and psychosocial distress, while low pensions and rising living costs deepen financial instability. Social isolation has intensified as a result of displacement, loss of loved ones, and destruction of local communities. These factors demonstrate that the vulnerability of older people in Ukraine cannot be adequately addressed through medical interventions alone, but requires coordinated responses from the health system, social protection system, and communities.

The war has also exposed the limitations of crisis response models that focus primarily on acute medical needs but fail to give adequate attention to long-term functional ability, dignity, and quality of life. It is precisely in this context that ICOPE acquires strategic importance in Ukraine as an approach that makes it possible to shift the focus from reactive treatment to the support of everyday functioning, autonomy, and continuity of care. In this context, population ageing in Ukraine ceases to be merely a demographic issue and becomes a central social and political challenge that requires integrated, systemic, and forward-looking approaches to care and support for older people.

2.2. Health and social protection systems for older people: parallel structures, shared responsibilities

Support for older people in Ukraine is organised through two interconnected but largely parallel systems: the health care system and the system of social protection and social services. Health services fall under the authority of the Ministry of Health and are financed primarily through the National Health Service of Ukraine, while social services and social protection measures are within the mandate of the Ministry of Social Policy and are implemented mainly at the local level.

Health sector reforms over the past decade have strengthened the role of primary health care and introduced new financing mechanisms aimed at increasing accessibility and efficiency of services. Family doctors are defined as the main entry point to the health system and play a key role in the management of chronic diseases, which disproportionately affect older people. At the same time, the full-scale war has significantly undermined these achievements. In many regions, primary and specialised care facilities have been damaged or destroyed, outpatient networks have been reduced, and shortages of medical personnel have sharply intensified. Under these conditions, the potential "foundation" of continuity of health care for older people has been physically destroyed or substantially weakened.

Thus, in the wartime context, ICOPE cannot be viewed as an "additional service" to the existing system. It emerges as a tool for optimising limited resources in a situation where primary health care is physically damaged, workforce-depleted, and unable on its own to respond to the complex needs of older people.

Even where facilities continue to function, the health system remains predominantly disease-oriented, with limited systemic attention to functional capacity, difficulties of everyday life, and the broader social context of older people's lives. Physicians' overload, workforce losses, and infrastructure destruction further narrow the possibilities for comprehensive, preventive, and multidisciplinary approaches.

In parallel, the social protection system provides a wide range of benefits and services relevant to older people, including pensions, targeted social assistance, home-based care, residential and semi-residential services, and social support to vulnerable households. Social workers and territorial social service centres are often the main point of contact for older people who have functional limitations, are socially isolated, or require care. Despite their key role, social

services are chronically underfunded, characterised by high workloads, staff shortages, and limited budgets, which has been further exacerbated by the war.

Critically, interaction between the health and social protection systems remains limited and weakly institutionalised. Needs assessments, eligibility criteria, information systems, and planning processes are sectorally separated, which constrains the development of shared care pathways or coordinated support plans. As a result, older people and their caregivers are often forced to navigate between these systems on their own, leading to fragmentation of assistance, duplication of efforts, and unmet needs.

In this context, implementation of ICOPE in Ukraine should be seen not only as a conceptual reform, but as a tool for the rational use of extremely scarce resources. In conditions of reduced numbers of outpatient facilities, shortages of doctors, and damaged hospitals, integrated care creates an opportunity to reduce unnecessary hospitalisations, relieve the burden on inpatient care, and prevent exacerbations through early identification of functional decline and mobilisation of social and community resources. It is precisely this logic—supporting older people at the community level rather than through constant recourse to overstretched hospitals—that is critical to sustaining system capacity in wartime conditions.

2.3. Decentralisation, communities, and the organisation of care and support

Decentralisation reforms have significantly transformed the governance of social services in Ukraine by transferring a substantial share of authority to local self-government bodies and territorial communities. Communities are increasingly responsible for assessing local needs, planning service provision, allocating resources, and contracting service providers, including non-governmental actors. These changes have direct implications both for the situation of older people and for the feasibility of implementing integrated care models.

On the one hand, decentralisation potentially creates opportunities for the development of community-based, flexible, and context-sensitive approaches to care that conceptually align with the principles of ICOPE. Local authorities are theoretically closer to the everyday problems of older people and better informed about the specifics of local needs, including those related to mobility, social participation, and access to services. Community-level solutions—such as home-based care, day centres, or supported living—can, where resources exist, be more adaptive and sustainable.

At the same time, in wartime conditions this logic does not consistently function in practice. A significant share of communities, particularly small, rural, frontline, and those hosting large numbers of internally displaced persons, effectively lack the financial, human, or administrative capacity to develop social services. In many communities, survival priorities have centred on basic functions—security, evacuation, housing, and emergency assistance—while systematic social services for older people have been pushed to the margins of, or beyond, real operational capacity.

In these conditions, decentralisation has substantially increased inequalities between communities. Financial capacity, managerial experience, and access to qualified personnel vary sharply across regions. More affluent or relatively stable communities may be able to experiment with new care models, whereas poorer, damaged, or overstretched communities are often unable to ensure even a basic minimum of support for older people, especially those with complex needs.

In this context, a direct systemic risk emerges: decentralisation without targeted centralised support for ICOPE implementation—in the form of earmarked subventions, methodological guidance, and national instruments—will lead to a situation in which older people in poor or war-affected communities are effectively left without support. Without external resources and national frameworks, integrated care will become a privilege of selected communities rather than a guaranteed approach to protecting the most vulnerable.

Therefore, the effectiveness of decentralisation as a foundation for integrated care depends directly on two factors: systematic coordination between the health and social protection sectors, and the ability of the state and partners to support communities through targeted financing mechanisms, shared tools, and partnerships with non-governmental and international organisations. Only under these conditions can communities become not a "site of responsibility shifting," but a genuine level for ICOPE implementation.

2.4. Rationale for assessing readiness for ICOPE implementation

The Integrated Care for Older People (ICOPE) approach was developed by the World Health Organization specifically to respond to the types of challenges currently observed in Ukraine: fragmented service delivery, insufficient intersectoral coordination, and a limited focus on functional ability and person-centred care. ICOPE emphasises integrated, multidisciplinary, and community-based interventions that combine medical and social components and place the older person at the centre of care planning.

In the context of war, this logic acquires an additional dimension: in Ukraine, ICOPE is not only a framework for improving service quality, but also a mechanism for preserving system capacity and supporting the survival of the most vulnerable groups, particularly older people living alone and internally displaced older persons.

The assessment of readiness for ICOPE implementation in Ukraine therefore goes far beyond the analysis of purely clinical capacity. It requires a comprehensive examination of governance mechanisms, service delivery models, workforce capacity, financing instruments, and information systems within both the health sector and the social protection sector. The interface between these systems is particularly critical, as successful ICOPE implementation directly depends on their ability to operate in a coordinated and complementary manner.

This assessment was designed as a study of readiness and feasibility, rather than an evaluation of effectiveness. Its objective is to identify enabling factors and systemic barriers, assess the level of alignment with ICOPE principles, and explore realistic entry points for piloting integrated care models in the Ukrainian context. The focus on readiness is intended to support evidence-informed decision-making and strategic planning for future implementation.

2.5. Role of INGOs, NGOs, and HelpAge International in advancing integrated care

In humanitarian contexts, non-governmental organisations are often the first to develop integrated, home-based support models aligned with the ICOPE approach, compensating for the destruction of formal infrastructure.

In the current Ukrainian context, international non-governmental organisations (INGOs) and national non-governmental organisations (NGOs) play a critically important role in supporting older people and strengthening the health and social protection systems. Their contribution is particularly significant in humanitarian settings, where they frequently fill gaps left by overstretched public services and pilot innovative approaches to service delivery.

INGOs and NGOs contribute to the development of integrated care across several dimensions. They provide direct services, including to vulnerable and hard-to-reach populations; support capacity development of health and social care workers; facilitate coordination across sectors; and advocate for policy changes grounded in evidence and international standards. Importantly, non-state actors often operate at the intersection of health care, social protection, and community engagement, positioning them as key providers and catalysts of integrated approaches, including ICOPE.

Within this landscape, HelpAge International occupies a distinct and strategic niche. As an organisation focused specifically on the needs of older people, HelpAge holds specialised expertise in ageing, functional ability, and rights-based, person-centred approaches to care. In Ukraine, HelpAge's work encompasses advocacy, technical support, and collaboration with national and local stakeholders to advance evidence-based, person-centred models of support for older people.

By commissioning this assessment, HelpAge International seeks to support national dialogue on integrated care, promote alignment with WHO standards, and identify practical pathways for piloting and scaling ICOPE in Ukraine. The organisation's engagement underscores the importance of combining international experience with local knowledge to respond to the complex and evolving needs of older people in contexts of humanitarian crisis and systemic reform.

3. Theoretical Framework: Integrated Care for Older People (ICOPE)

3.1. From disease-oriented care to integrated approaches in ageing societies

Population ageing constitutes a fundamental challenge for health and social protection systems worldwide. Traditional models of care, which are predominantly disease-oriented and organised around individual diagnoses or episodic interventions, are increasingly demonstrating their inability to adequately respond to the complex, interrelated needs of older people. Older age is rarely characterised by a single diagnosis; instead, it is associated with multimorbidity, functional decline, cognitive impairment, psychosocial vulnerability, and increasing dependence on both formal and informal support systems.

Fragmented service delivery models often result in duplication of services, gaps in care, inefficient use of resources, and suboptimal outcomes for older people. In such systems, health-care providers focus primarily on clinical indicators, while social services operate in isolation on social needs without systemic coordination. This division ignores the reality that health outcomes in older age are largely shaped by social determinants, living conditions, functional ability, and the availability of support in everyday life.

It is precisely in response to these systemic limitations that integrated care has emerged. At its core, integrated care seeks to coordinate services across sectors, disciplines, and levels of care in order to enhance continuity, efficiency, and person-centredness. For older people, integrated care is particularly critical, as it enables a shift from reactive, episodic treatment to proactive, preventive, and supportive approaches that preserve functional ability and quality of life over the long term.

In the case of Ukraine, these general dynamics are sharply intensified by the full-scale war. Fragmentation is not merely a routine systemic problem; it becomes a direct risk of disruption to life-sustaining support pathways for older people. The combined effects of infrastructure destruction, workforce shortages, internal displacement, and a sharp increase in the number of older people living alone among IDPs mean that the absence of integration between health and social support leads not only to inefficiency, but to the loss of access to basic services (medicines, care, nutrition, safe housing, mobility support). For this reason, the ICOPE theoretical framework in this report is treated as a strategic foundation for systemic survival and the restoration of support for older people in the Ukrainian context.

3.2. Conceptual foundations of the ICOPE approach

The Integrated Care for Older People (ICOPE) framework, developed by the World Health Organization, represents a paradigmatic shift in the understanding and organisation of care for older people. Instead of primarily focusing on diseases or age-related deficits, ICOPE centres on the concept of intrinsic capacity — the composite of an individual's physical and mental capacities — and its interaction with the environment as the key determinants of functional ability.

ICOPE recognises that maintaining functional ability is the primary goal of care in older age. This requires early identification of declines in intrinsic capacity, timely interventions, and coordinated support across medical, social, and community domains. The framework explicitly emphasises that health and well-being in older age cannot be ensured by health services alone, but depend on integrated responses that encompass social participation, living conditions, and access to support.

A central element of the ICOPE approach is its person-centred philosophy, which views older people as active participants in their own care rather than passive recipients of services. Care planning under ICOPE is intended to be tailored to individual goals, preferences, and life circumstances, and to evolve over time as needs change.

For Ukraine, the principle of intrinsic capacity is particularly important because, in practice, systems often "see" a person through formal categories (diagnosis, IDP status, disability group, pension, eligibility for benefits), while functional decline may occur long before a person receives an official disability status or becomes a client of social services. ICOPE introduces a

different logic: it assesses not only "what diagnoses a person has," but "what exactly they can and cannot do in everyday life" — and what combined (medical + social) responses are needed already at this stage.

The Ukrainian disability determination system has traditionally focused on medico-legal status (disability group as a legally significant category for pensions, payments, and benefits), whereas the WHO concept of intrinsic capacity is functional and dynamic: it describes a person's evolving "capacity profile," which may deteriorate or improve over time under the influence of interventions and support.

At the same time, it is important to maintain the understanding that ICOPE does not replace Ukrainian disability groups and is not a procedure for their determination. Rather, ICOPE offers a "parallel lens" that makes it possible to: (a) identify functional decline before the assignment of a legal status; (b) plan support regardless of whether disability status has been formally granted; and (c) refer a person to appropriate medical and social services based on actual needs, not solely on formal status.

Below is a descriptive correlational scheme, which should be understood as a reference point for communication between sectors:

1) High intrinsic capacity (intrinsic capacity preserved or minimally declined):

- in the Ukrainian system, disability status is often absent; a person may have no "formal grounds" for social services, but already requires early preventive interventions (screening, physical activity, nutrition correction, mobility support, fall prevention, management of cognitive risks).

2) Moderate decline in intrinsic capacity (noticeable functional limitations in ADL/IADL, but partial independence preserved):

- may correspond to situations where disability has not yet been formalised or has been assigned as less severe (in practice, this is often associated with Group III, although there is no direct equivalence).
- the key ICOPE distinction: support is assigned not after formal status, but on the basis of a functional profile (mobility, self-care, cognition, sensory functions, psycho-emotional state) and social risks (loneliness, poverty, lack of housing/care).

3) Significant decline in intrinsic capacity (persistent limitations, high risks, need for regular assistance):

- in the Ukrainian system this often correlates with established disability status (in practice — Group II or other determinations, depending on diagnosis and commission decisions).
- ICOPE requires a comprehensive support plan: medical interventions + social support + organisation of home care + caregiver support + housing/environmental adaptations.

4) Very low intrinsic capacity (high dependency, complex needs, need for intensive care):

- in Ukrainian realities this is often associated with Group I disability or an equivalent high level of dependency.
- ICOPE emphasises that even in such cases the guiding principle should be "maximum possible care at home/in the community," using supported living, day centres, respite services, and multidisciplinary follow-up; institutional placement should not be an "automatic response," but only a last resort in the absence of safe alternatives.

The concept of intrinsic capacity can serve as a foundation for interaction between physicians and social workers. It allows medical indicators to be linked to needs for social support and home-based care, and creates a basis for joint case management even in the absence of, or prior to, the formal assignment of disability status.

3.3. Levels of ICOPE implementation: micro, meso, and macro

The ICOPE framework operates across three interconnected levels: micro (individual and community), meso (service delivery level), and macro (system and policy level).

At the micro level, ICOPE focuses on older people and their immediate support networks, including family members, informal caregivers, and community actors. This level emphasises early screening of intrinsic capacity, shared decision-making, and empowering older people to manage their own health and well-being.

Within the ICOPE logic, the micro level is foundational, because it is at this level that the real demand for integrated care emerges. The focus is not on a "patient" or a "recipient of social services," but on an older person in their everyday living environment — with a specific home, mobility routes, way of obtaining food, access to water, medicines, social contacts, and support.

In the context of war, the micro level acquires a fundamentally different meaning than in stable systems: for a significant proportion of older people it is unstable, disrupted, or destroyed. Loss of housing, displacement, breakdown of family ties, isolation, destruction of infrastructure, and constant stress mean that functional ability is determined not only by health status, but primarily by the survival environment.

1. The older person as the "centre of the system," not as a bearer of diagnoses

At the micro level, ICOPE takes as its starting point not a list of diseases, but the assessment of intrinsic capacity and the person's real functional ability in the concrete conditions of their life.

For Ukraine, this is particularly important, because formal medical or social statuses (for example, possession of a disability group or a pension certificate) often do not reflect a person's actual ability to:

- move independently in a damaged or unfamiliar environment;
- prepare food, access water, heating, and medicines;
- navigate a new community;
- maintain social connections;
- adhere to treatment without support.

The ICOPE micro level requires a systematic assessment of how a person actually lives, not only what diagnoses they have.

2. Intrinsic capacity + environment = functional ability

From a theoretical perspective, ICOPE is based on the understanding that functional ability is the result of the interaction between a person's intrinsic capacity and their environment. In the Ukrainian context, it is often the environment that becomes the decisive factor in functional decline.

The same person with the same medical indicators may preserve autonomy in a community with accessible housing, transport, a social worker, and supportive neighbours — and rapidly lose functionality in a temporary accommodation centre, dormitory, partially destroyed home, or rural area without transport and services. Therefore, at the micro level, ICOPE in Ukraine critically requires not only assessment of the person's condition, but also assessment of housing conditions, safety, access to basic resources, and social support.

3. Older IDPs living alone as a focal micro-level group

The war has created in Ukraine a large group of older internally displaced persons living alone, for whom the micro level represents the highest-risk zone. This group is characterised by:

- loss of housing;
- loss of family support;
- disruption of contacts with doctors and social services;
- disorientation in new communities;
- high levels of psychosocial distress.

For this group, ICOPE at the micro level ceases to be merely a care model and becomes a mechanism for basic restoration of life manageability: screening, first contact, case management, connection to support, and development of an individual plan.

4. Key micro-level tools in the Ukrainian context

Functionally, the ICOPE micro level in Ukraine should include at minimum:

- regular screening of intrinsic capacity (mobility, cognition, vision/hearing, nutrition, psycho-emotional state);
- assessment of the living environment (housing, safety, access to water, food, heating, transport);
- assessment of social support (availability of a caregiver, relatives, contacts);
- identification of risks (falls, neglect, violence, loneliness, depression);

- development of an individual support plan combining medical, social, and community components;
- continuous monitoring and adjustment of the plan.

This means that the micro level is not a single visit and not a single questionnaire, but a continuous support process. Without systematic work at the micro level, ICOPE inevitably becomes reduced to a set of tools for professionals and loses its core meaning. It is precisely at the micro level that:

- the real need for integration is identified;
- the case for joint management is formed;
- the effectiveness of coordination is tested;
- the contribution of social workers and caregivers becomes visible.

In the wartime context of Ukraine, a weak micro level does not simply mean low quality of services; it means a direct loss of people from the system's field of vision — with all the consequences in the form of crisis hospitalisations, institutionalisation, or premature mortality.

At the meso level, ICOPE concerns how services are organised and delivered. This includes interdisciplinary teamwork, coordination between health and social services, joint care planning, and integration of services at community level. It is precisely at the meso level that the role of social workers and professional caregivers becomes especially critical, as they often act as intermediaries between systems and as key implementers of person-centred care plans.

For Ukraine, the "meso level" cannot be limited to declarative "coordination" or one-off referrals. In the Ukrainian context, the meso level means joint case management — that is, the existence of a designated responsible coordinator (often a social worker or a multidisciplinary team) who ensures a continuous support pathway for an older person between the family doctor / PHC, specialised care (if needed), community social services, and, where relevant, humanitarian providers.

In practical terms, joint case management for older people in Ukraine means:

- a unified initial assessment (medical + functional + social) with documentation of key risks (falls, cognitive changes, depressive symptoms, malnutrition, violence/neglect, lack of housing or safe living conditions);
- an agreed individual support plan (care plan) that includes clear tasks for the doctor/nurse, social worker, caregiver, and, where available, rehabilitation specialist/psychologist;
- regular review of the plan triggered by specific events (decline in mobility, exacerbation of chronic disease, loss of a caregiver, change of residence, repeated hospitalisation);
- a referral mechanism where not only a recommendation is issued, but actual contact between services is ensured (call/message/coordination of visit timing), which is critical in situations where an older person often does not have the capacity to "reach the next level" independently;
- documented exchange of the minimum necessary data between sectors, so that decisions are not made in an information vacuum.

At the macro level, ICOPE requires enabling governance, financing, workforce development, and information systems. Policies, legal frameworks, and financial mechanisms should not obstruct but support integration, while accountability systems should encourage intersectoral cooperation. The macro level is not a general declaration about the need for governance and financing, but a concrete set of systemic conditions without which the meso level cannot function sustainably or be scaled. If the meso level is "how a specific person is guided through the system," then the macro level is "what rules make this possible in every community, not only where there are enthusiasts or donor projects."

Macro-level components required for ICOPE implementation in Ukraine

1) Governance framework for integrated care

Ukraine needs a national "normative model of integrated care" (or at least an official framework/standard) that:

- defines integrated care as an intersectoral service (health + social care), not a set of parallel interventions;
- establishes a minimum standard for joint case management;
- defines the roles of the Ministry of Health, Ministry of Social Policy, Family and Unity of Ukraine, NHSU, NSSSU, local self-government / communities, and accountability for outcomes;

- creates mechanisms for inter-ministerial planning (shared goals, shared indicators, joint working bodies).

Without such a framework, integration will remain project-based and dependent on individual initiative.

2) Financing and incentives

Integrated care requires financial mechanisms that incentivise coordination rather than fragmented services. For Ukraine, this means:

- defining which elements of integrated care can be financed through PHC contracting (for example, functional screening elements, follow-up, coordination for high-risk cases);
- separate financial instruments for community social services (subventions / targeted programmes) so that poorer communities are not excluded from ICOPE;
- financial incentives linked to ICOPE-relevant outcomes (reduced readmissions, maintenance of functional ability, provision of home-based care, reduced burden on inpatient facilities);
- the possibility of bundled financing for joint teams / mobile multidisciplinary teams, especially for rural and conflict-affected areas.

3) Workforce development and professional standards

At macro level, it is necessary to:

- define shared competencies for family doctors, nurses, social workers, and caregivers within ICOPE (person-centredness, communication, joint case management, basic geriatric and psychosocial skills);
- develop standardised training modules (including short formats suitable for wartime conditions), supervision, and mentoring;
- address workforce motivation and retention (recognition, workload, remuneration, occupational safety, burnout);
- clearly define the role and status of caregivers / home-care assistants as part of the system, rather than as a "private family matter."

4) Data and interoperability

The macro level must establish:

- minimum common data elements for functional assessment (intrinsic capacity) and social risks, recognised by both sectors;
- rules for data exchange between PHC and social services (what can be shared, how, on what basis/consent, and who is responsible);
- a roadmap for interoperability (even if full technical integration is delayed, functional integration through standardised forms/protocols is required);
- mechanisms to monitor case trajectories (to track drop-out from care pathways, readmissions, and loss of access to services).

5) Accountability and outcome measurement

ICOPE is impossible without macro-level accountability for integration. This means:

- shared indicators for MoH / Ministry of Social Policy / communities (functional ability, access to home care, continuity, caregiver burden, digital barriers, readmissions);
- measurement not only of service volumes but of maintenance of functional ability and autonomy;
- regular intersectoral reviews of data and practices (inter-municipal learning), so that communities with different capacities can exchange solutions.

6) Equity and prevention of a "geography of abandonment". Ukraine's decentralisation context means that without central support instruments, ICOPE will be accessible only in some communities. The macro level must embed equity mechanisms:

- targeted subventions for integrated care in low-capacity communities;
- support for mobile teams for remote areas;
- standardised minimum service packages guaranteed regardless of place of residence;
- prioritisation of older people living alone, older IDPs, and "left-behind" older persons as highest-risk groups.

7) Terminology alignment: LTC as home- and community-based care

At macro level, it is necessary to закрепити the correct interpretation of long-term care (LTC) in Ukrainian policy and practice: in the ICOPE logic, LTC primarily means home- and

community-based care, not automatic institutional placement. This is critical to ensure that reforms and resources support "ageing in place" rather than reinforcing the historical inertia of the institutional model.

Successful ICOPE implementation depends on the coherence and mutual reinforcement of all three levels. Weaknesses at any one of them can undermine the functioning of the entire system.

3.4. The central role of social workers in integrated care for older people

Social workers play a key role in operationalising the ICOPE approach, particularly at the intersection of health care, social protection, and community systems. Their professional mandate includes assessment of social needs, service coordination, advocacy, and support to individuals and families in navigating complex systems. These functions are closely aligned with the core principles of integrated, person-centred care.

Within the ICOPE framework, social workers are indispensable in translating clinical assessments into meaningful, context-sensitive interventions. While health-care providers may identify declines in intrinsic capacity, social workers are often best positioned to assess environmental factors, living conditions, social support networks, and risks related to isolation, neglect, or poverty. This holistic perspective is essential for developing comprehensive care plans that address both the medical and social determinants of health.

Social workers also play a central role in care coordination and system navigation. Older people frequently interact with multiple service providers across the health and social protection sectors, each with its own procedures and access criteria. Social workers can facilitate referrals, ensure continuity of care, and help prevent fragmentation by maintaining an overarching view of the care trajectory. In decentralised systems, they often function as the primary link between community-level services and formal health-care providers.

In addition, social workers are central actors in empowerment and engagement of older people. Through counselling, information provision, and advocacy, they support older people in understanding their rights, accessing services, and participating in decision-making about their own care. This directly reflects the ICOPE emphasis on person-centredness and shared decision-making.

Despite their critical role, social workers in many contexts—including Ukraine—face significant constraints. High caseloads, limited resources, insufficient training on ageing-related issues, and weak integration with health systems restrict their ability to fully realise their potential within integrated care models. Addressing these constraints is therefore a prerequisite for effective ICOPE implementation.

In the Ukrainian context, the social worker is often the only professional who systematically observes living conditions, safety risks, and the real-life capacity of a person to live independently. In wartime conditions, this also includes assessment of Ukraine-specific factors: unstable access to medicines, disrupted logistics, housing destruction, repeated displacement, risks related to mines and shelling, and the absence of relatives and social networks. Accordingly, for ICOPE implementation in Ukraine, social work must be institutionally embedded within the medical care pathway, rather than remaining a "parallel" system of support.

3.5. Caregivers as a cornerstone of integrated care

Caregivers—both informal and formal—constitute another cornerstone of the ICOPE framework. Informal caregivers, often family members and predominantly women, provide a substantial share of care for older people, particularly in contexts where formal long-term care services are limited. Their contribution is decisive for maintaining older people's functional ability and enabling ageing in place.

The ICOPE approach explicitly recognises caregivers as key actors across the continuum of care. Their involvement is critical for monitoring changes in intrinsic capacity, supporting adherence to care plans, and facilitating communication between older people and service providers. Caregivers often possess detailed, experiential knowledge of the everyday functioning, preferences, and challenges of older people, making them indispensable partners in person-centred care.

At the same time, caregiving is associated with significant physical, emotional, and financial burdens. In the absence of adequate support, caregivers are at risk of burnout, which can negatively affect both their own well-being and the quality of care provided. For this reason, integrated care frameworks emphasise the need to support caregivers through training, psychosocial assistance, respite services, and involvement in care planning processes.

Formal caregivers, including home-care workers and community support service staff, also play a crucial role in ICOPE implementation. Their close proximity to older people enables them to detect early signs of functional decline and to deliver interventions that support daily living. However, their effectiveness depends on appropriate training, professional recognition, and integration into multidisciplinary teams.

In Ukraine, caregivers often function as an "invisible resource" of the system, compensating for deficits in formal services while themselves remaining without adequate support, training, or respite. For older IDPs, the situation is even more complex: a caregiver may be physically absent (family abroad, at the front, or deceased), or care may be provided by another vulnerable person (for example, an older spouse). Therefore, the ICOPE approach in Ukraine must go beyond declarative recognition of the caregiver role and incorporate mechanisms to support caregivers as a distinct group of service users (training, psychosocial support, respite, and assistance in navigating services).

3.6. Multidisciplinary teamwork and coordination across sectors

A defining characteristic of ICOPE is its emphasis on interdisciplinary teamwork. Integrated care requires collaboration between health professionals, social workers, caregivers, and community actors, each contributing their specific expertise toward a shared goal. Effective teamwork depends on clear delineation of roles and responsibilities, shared communication channels, and mutual respect between professions.

In practice, interdisciplinary coordination remains one of the most challenging aspects of integrated care. Differences in professional cultures, organisational structures, and accountability mechanisms can hinder collaboration. ICOPE addresses these challenges by promoting joint care planning, regular communication, and the use of shared assessment frameworks that facilitate mutual understanding across disciplines.

Social workers and caregivers are central figures within such teams, as they often serve as the bridge between clinical settings and everyday living contexts. Their inclusion in interdisciplinary teams is a necessary condition to ensure that care plans are realistic, context-sensitive, and responsive to changing needs.

"If it were possible to link information systems—the health system and the social protection system—it would significantly reduce the number of 'invisible' older people and greatly facilitate service outreach." [KII, representative of a regional department of social protection]

For Ukraine, formalisation of interaction between PHC and social services at community level is critical: designation of responsible focal points, communication protocols, and regular brief case discussions rather than formal meetings. Without this, multidisciplinarity remains theoretical. This is precisely why joint case management constitutes the practical "bridge" between ICOPE principles and the real organisation of work on the ground.

3.7. Information systems, data integration, and the role of social and functional data in ICOPE

A key precondition for implementing the ICOPE approach is the availability of information systems that support coordination, continuity, and person-centred decision-making. Unlike traditional health information systems, which are primarily designed to record clinical encounters and disease-oriented indicators, ICOPE requires a broader data ecosystem that integrates medical, social, and functional information.

Within the ICOPE framework, data serve not only administrative or reporting purposes, but also a clinical–social coordination function. Information on intrinsic capacity, functional abilities, living conditions, availability of caregiving support, and environmental risks is necessary to individualise interventions and to monitor changes over time. This fundamentally

challenges sectoral approaches to data management, whereby the health and social protection sectors collect and store information in isolation.

From an ICOPE perspective, social and functional data are not secondary or auxiliary, but constitute an integral part of understanding the well-being of older people. Social workers and caregivers are key producers and interpreters of such data. Through home visits, needs assessments, and ongoing contact with older people and their families, social workers generate in-depth information on everyday functioning, social participation, safety risks, and care dynamics. Caregivers, in turn, provide real-time insights into changes in behaviour, mobility, cognitive status, and adherence to care plans.

However, in many systems—including Ukraine—this information remains fragmented and underutilised. Health information systems typically prioritise diagnoses, prescriptions, and procedures, while social services maintain separate records focused on eligibility criteria and service provision. The absence of interoperable platforms means that critically important information does not follow the person across services, undermining continuity of care and joint decision-making.

"Teams exist, but communication is not digitalised. This is not a system—it is phone calls, paper, and personal arrangements." [KII, advisor of Minister of Health]

From a theoretical perspective, ICOPE calls for functional data integration even in contexts where full technical integration is not yet feasible. This may include shared assessment frameworks, harmonised data elements, or structured communication protocols that allow health and social professionals to exchange relevant information while respecting personal data protection requirements. Importantly, such systems must be designed to recognise and incorporate the professional contributions of social workers and caregivers, rather than reducing their role to an informal or "invisible" function.

In the Ukrainian context, strengthening information systems for ICOPE implementation implies not only technical investment, but also conceptual shifts in understanding the value and use of data. Recognition of social and functional data as essential components of care planning is a prerequisite for meaningful integration. At the outset, data integration may not mean creating a single IT platform, but rather establishing minimally sufficient standardised elements: a brief functional profile, agreed categories of risk, structured communication between doctor and social worker, and shared triggers for intervention (falls/hospitalisation/loss of caregiver/displacement). This is particularly critical in wartime conditions, when older people may change their place of residence and "fall out" of care pathways.

3.8. ICOPE as a framework for long-term care and community-based support systems

Although ICOPE was not originally developed as a comprehensive long-term care (LTC) model, its principles are highly relevant for the organisation and reform of LTC systems. In many countries, long-term care has historically evolved around institutional models that prioritised custodial care and basic support at the expense of autonomy, social participation, and quality of life. ICOPE offers an alternative conceptual lens that emphasises ageing in place, community-based support, and the preservation of functional ability.

From a theoretical perspective, ICOPE reconceptualises long-term care as a continuum of support rather than as a discrete category of services. It recognises that older people may move along this continuum as their needs change, requiring flexible combinations of medical, social, and community interventions. Social workers and caregivers are central figures in managing this continuum, as they often support transitions between levels of care and help prevent unjustified institutionalisation.

Community-oriented support models—such as home care, day centres, supported living, and respite services—are particularly aligned with ICOPE principles. These models rely heavily on social workers for assessment, care coordination, and monitoring, and on caregivers for daily support. The effectiveness of such models depends on the presence of interdisciplinary teams and mechanisms that link community services with primary health care.

Importantly, ICOPE emphasises that institutional care should not be the default response to functional decline. Instead, it should be used only when community-based support is insufficient to ensure safety and well-being. This theoretical position has significant implications for policy and practice, particularly in contexts where institutional care remains dominant due to historical legacies or limited alternatives.

For Ukraine, where reforms of social services as well as psychiatric and geriatric institutions are ongoing, ICOPE offers a normative framework for reorienting the long-term care system toward community-based solutions. Social workers and caregivers are indispensable actors in this transition, as they operationalise care outside institutions and support older people in maintaining social connections and autonomy.

In Ukrainian professional and public discourse, the term "long-term care" (LTC) is often informally equated with residential institutions. This perception is a consequence of a historical institutional legacy, in which residential facilities were the most "visible" form of support for older people. In international approaches, including the WHO ICOPE framework, LTC is interpreted much more broadly—as a continuum of support aimed at preserving functional ability, autonomy, and safety of older people in their familiar or as close as possible living environment.

Within this report, LTC is understood not as a type of institution, but as a set of medical, social, and community services that can be combined and adjusted in intensity depending on changes in functional ability. This implies movement along a continuum—from preventive and supportive interventions, periodic or regular home-based support, day-care formats and supported living—to institutional care as a last resort, when safety and basic needs cannot be ensured in the community.

ICOPE fundamentally prioritises ageing in place as a model that both better supports older people's quality of life and allows more rational use of limited system resources. For Ukraine, this approach has particular relevance in the context of war, infrastructure destruction, workforce shortages, and mass internal displacement. In this situation, institutionalisation may appear as a "simple" solution, but in practice it creates additional risks of social isolation, psychological maladaptation, and systemic overload.

"Integrated care is not a reform of one sector. It is about how the state and communities envision dignified ageing." [KII, representative of a local civil society organisation]

In the ICOPE logic, the core of LTC should consist of home- and community-based services: home care, social case management and navigation, outreach services, basic rehabilitation, psychosocial support, day-care formats, and systematic support for caregivers. These elements make it possible to reduce unnecessary hospitalisations, slow functional decline, and delay or prevent institutional dependence.

This approach is critical for two key groups shaped by the war: older people living alone among IDPs who have lost their homes and informal support, and "left-behind" older people in rural and frontline communities. For them, LTC in the ICOPE logic is not a social policy model, but a mechanism of basic safety and viability.

3.9. Implications of the ICOPE framework for system transformation in Ukraine

The application of the ICOPE framework in Ukraine requires a systemic transformation that goes far beyond the introduction of new tools or pilot projects. From a theoretical perspective, ICOPE challenges existing governance models, professional hierarchies, and ways of organising service delivery, requiring integration to become a basic organisational principle.

In the Ukrainian context, this systemic transformation has a concrete meaning: to ensure that an older person (especially someone living alone or an IDP) is not left alone with fragmented care pathways, but instead receives a coordinated support plan and a responsible coordinator/team at the community level.

First, ICOPE implies a rethinking of roles and responsibilities across sectors. Health-care providers can no longer remain the sole drivers of care for older people, just as social services

cannot function in isolation from clinical decision-making. Social workers and caregivers must be recognised as equal partners in integrated care teams, with clearly defined mandates, access to information, and opportunities for professional development. For Ukraine, this means institutionally embedding joint case management as a meso-level standard: defining roles (who coordinates, who delivers, who makes decisions), minimum standards for communication and information transfer, and ensuring that the social component of the care plan carries the same weight as the medical one.

Second, ICOPE requires a shift in how value and effectiveness are understood. Traditional performance indicators focused on service volumes or clinical metrics are insufficient to reflect the objectives of integrated care. ICOPE prioritises functional ability, quality of life, and person-centred outcomes, many of which fall directly within the domains of social work and caregiving. This requires new evaluation frameworks and accountability mechanisms that capture the contribution of non-clinical actors. In the wartime context of Ukraine, such outcomes should also include indicators of "retention in the community" (not entering institutional care due to lack of support), prevention of repeated hospitalisations, stability of access to medicines and basic services, and reduction of caregiver burden—outcomes that directly affect survival and the preservation of functional ability.

Third, the framework highlights the importance of governance at the community level. Decentralisation in Ukraine creates both opportunities and risks for ICOPE implementation. While communities are well positioned to develop adapted integrated solutions, disparities in capacity and resources threaten to deepen inequality. From a theoretical standpoint, the implementation of ICOPE must be accompanied by mechanisms that support equity, capacity building, and inter-municipal learning.

Finally, ICOPE has important implications for workforce development. Integrated care cannot be delivered by professionals trained exclusively within single-sector paradigms. Social workers, caregivers, and health professionals require shared competencies in person-centred care, communication, and collaboration. Investment in these competencies is not an optional add-on but a structural prerequisite for sustainable implementation.

"Medical and social workers conscientiously do everything they can. But bringing geriatrics and geriatric departments back into the system of medical and social services would be very meaningful and enabling." [KII, representative of the Institute of Gerontology]

For Ukraine, this also means practical modules and protocols: screening for functional impairments, basic principles of geriatric communication, working with cognitive changes, caregiver support, case management, and rules for data exchange between sectors. Without this "shared professional language," integration will remain declarative.

In summary, the ICOPE framework offers Ukraine a comprehensive conceptual foundation for responding to the complex challenges of ageing in the context of war, reforms, and decentralisation. Its successful application depends on recognising the central role of social workers and caregivers, integrating social and functional data into decision-making processes, and reorienting systems toward community-based, person-centred care. Without these elements, ICOPE risks being reduced to a technical or clinical intervention rather than becoming a catalyst for meaningful systemic transformation.

4. Methodology

4.1. Study design and methodological approach

This assessment was designed as a readiness and feasibility study to examine the extent to which the Ukrainian health and social protection systems are prepared to adopt and operationalise the Integrated Care for Older People (ICOPE) approach. In line with the objectives outlined in the inception phase, the methodology prioritised system-level and service-level analysis rather than measurement of individual health outcomes.

The study applied a mixed-methods design, combining qualitative and quantitative data collection tools to enable triangulation across sources, stakeholder groups, and analytical levels. This approach was selected to capture both structural dimensions (policies, governance, service organisation) and lived experiences of implementation (service delivery practices, coordination mechanisms, and perceptions of feasibility).

The methodological framework was aligned with the WHO ICOPE implementation logic and structured to generate evidence relevant to:

- service-level readiness (meso level);
- system-level readiness (macro level);
- the role of social workers, caregivers, and community-based actors in integrated care delivery.

The assessment explicitly integrates both healthcare and social protection perspectives, reflecting the cross-sectoral nature of ICOPE and the Ukrainian institutional context.

4.2. Analytical framework and alignment with ICOPE

The analytical framework was derived from the WHO ICOPE conceptual model and implementation guidance, with a specific focus on the ICOPE Implementation Scorecard. The scorecard was used as a reference structure to guide data collection, analysis, and interpretation across two main levels:

Service (meso) level, focusing on:

- engagement and empowerment of older people and communities;
- coordination of services delivered by multidisciplinary providers;
- orientation toward community-based and person-centred care.

System (macro) level, focusing on:

- governance and accountability mechanisms;
- system-level enablers such as financing, workforce, and information systems.

Rather than applying the scorecard as a purely quantitative scoring tool, the assessment used it as a qualitative-analytical scaffold. This allowed for a nuanced understanding of implementation stages, contextual constraints, and enabling factors, particularly in a humanitarian and decentralised setting.

4.3. Geographic scope and site selection

The study was conducted in two oblasts, selected during the inception phase to reflect diversity in:

- geographic location;
- levels of urbanisation;
- service delivery capacity;
- exposure to war-related disruptions.

The selected regions include:

- a western oblast with relatively stable service infrastructure and high numbers of internally displaced persons;
- a central-eastern oblast with higher levels of system strain and proximity to conflict-affected areas.

Within each oblast, data collection covered both urban and rural communities, enabling analysis of disparities in access, coordination, and service availability.

The selection was purposive rather than representative, consistent with the study's objective to assess readiness and feasibility rather than national prevalence or coverage.

4.4. Data collection methods

4.4.1. Desk review

A structured desk review was conducted to analyse:

- national policies and strategies related to ageing, health, social protection, and decentralisation;
- regulatory frameworks governing health and social services;
- relevant reform documents, guidelines, and donor-supported initiatives.

The desk review informed the development of data collection tools and provided contextual grounding for interpretation of findings, particularly at the system level.

4.4.2. Key Informant Interviews (KIIs)

Semi-structured key informant interviews were conducted with stakeholders representing:

- central-level authorities (health and social protection);
- regional and local administrations;
- health facility management;
- social service providers;
- experts involved in ageing, long-term care, and service integration.

The interview guide was developed during the inception phase and aligned with the ICOPE framework, covering governance, coordination, workforce, financing, and implementation feasibility.

KIIs were used to:

- explore institutional perspectives;
- identify perceived barriers and enablers to integration;
- assess readiness from a policy and operational standpoint.

4.4.3. Focus Group Discussions (FGDs)

Focus group discussions were conducted with:older people; caregivers.FGDs were designed to capture collective experiences and shared perceptions related to:

- access to health and social services;
- continuity and coordination of care;
- caregiving burden and support needs.

While FGDs did not serve as a source of individual quotations in the report, they provided critical insights into recurring patterns and user-level implications of system fragmentation.

4.4.4. Surveys

Several structured survey instruments were deployed, as outlined in the inception report:

- Survey of older people, focusing on access to services, functional challenges, and care pathways;
- Survey of caregivers, capturing caregiving roles, burden, support mechanisms, and interaction with services;
- Survey on clinical and community-level ICOPE implementation, targeting health and social workers to assess awareness, practices, and perceived feasibility of integrated care approaches.

Survey tools were designed to complement qualitative findings and to identify patterns relevant to service-level readiness.

4.4.5. Facility-level checklists

Facility-level checklists were administered in selected health and social service facilities to assess:

- availability of services relevant to older people;
- presence of coordination mechanisms;
- staffing and workforce capacity;
- infrastructure and referral practices.

The checklist data provided an institutional lens on service readiness and enabled cross-validation of information obtained through interviews and surveys.

4.5. Sampling approach

Sampling followed a purposive, feasibility-oriented approach, consistent with the objectives of the study and the constraints identified during inception.

The achieved sample includes:

- key informant interviews with institutional stakeholders;
- surveys with older people and caregivers across both regions;
- surveys of health and social workers involved in service delivery;
- facility-level checklists in selected institutions.

While the achieved sample size was smaller than initially planned in the inception phase, it remains methodologically sufficient for a readiness assessment, where depth of insight, triangulation, and contextual understanding are prioritised over statistical representativeness.

4.6. Data collection procedures and quality assurance

All data collection tools were piloted prior to deployment to ensure clarity, relevance, and contextual appropriateness. Enumerators and facilitators received targeted training covering:

- ethical considerations;
- informed consent procedures;
- engagement with older people and caregivers;
- data quality and consistency.

Data collection was conducted in accordance with humanitarian research principles, with particular attention to:

- do-no-harm approaches;
- sensitivity to war-related trauma;
- accessibility and inclusiveness.

Supervision mechanisms were established to monitor fieldwork, review completed tools, and ensure rapid response to emerging challenges. In addition to initial piloting of the instruments, additional internal validation and cross-source consistency control procedures were applied during data collection:

- Logical consistency checks of questionnaires: After each fieldwork day, supervisors conducted selective reviews of completed questionnaires to identify logical inconsistencies (for example, responses indicating "no access to a doctor" combined with reports of regular scheduled visits), as well as to verify the completeness of key variables (access, care pathways, barriers). Where critical gaps were identified, clarifications were sought from the interviewer/enumerator (without re-contacting the respondent if this could create additional burden or risk).
- Verification of institutional checklist data: Information on service availability, human resources capacity, and referral practices was cross-checked against responses from managerial staff in KIIs (for example, statements about "existing coordination mechanisms" were verified through the actual presence of referral/interaction protocols or designated responsible persons).
- Validation of statements across system levels: System-level statements obtained through KIIs with government representatives or facility managers (e.g., "interaction between the medical and social sectors is established at the local level") were verified through: (a) survey data from older people and caregivers regarding their actual experience of coordination (whether referrals were provided; whether care pathways were aligned; whether they had to navigate multiple institutions independently); (b) survey data from health and social workers regarding interaction practices (frequency of contact, existence of communication channels, presence of agreed procedures); (c) checklist results on the existence of institutional mechanisms. If discrepancies were identified across the three levels (micro/meso/macro), this was interpreted as an indicator of "formalised claims" of integration without confirmation in practice.
- Triangulation as an interpretive rule: Generalised conclusions were formulated only when a trend was confirmed by at least two types of sources (e.g., surveys + KIIs; or KIIs + checklists; or beneficiary surveys + worker surveys). Findings based on a single source were marked as contextual or hypothetical and were not used as the basis for systemic assertions.

4.7. Data analysis

Qualitative data from KIIs and FGDs were analysed using thematic analysis, guided by the ICOPE analytical framework. Coding focused on:

- governance and coordination;
- service integration;
- workforce roles and capacities;
- community-based care and caregiving.

Quantitative survey data were analysed descriptively to identify patterns relevant to readiness and feasibility. Rather than emphasising statistical inference, analysis focused on:

- consistency across data sources;
- convergence or divergence of perspectives;
- alignment with qualitative findings.

Findings from different methods were triangulated systematically to strengthen validity and interpretive depth.

A separate procedure of "cross-checking narratives" across respondent groups was also applied. In particular, responses from older people and caregivers regarding actual access, barriers, and care-seeking pathways were compared with the positions of officials/administrators in KIIs regarding service organisation and the "existing" coordination mechanisms. The purpose was to identify systemic gaps between declared models and real user experience. For example: if KIIs reported "established referral mechanisms" or "interaction between sectors," while beneficiary surveys demonstrated the absence of accompaniment and the need to navigate multiple institutions independently, this was recorded as a coordination gap; if workers' surveys indicated low awareness or absence of procedures, while at the macro level the existence of policies or instructions was declared, this was interpreted as an implementation gap between formal documents and practice.

4.8. Ethical considerations

The study adhered to ethical standards applicable to social and health systems research in humanitarian settings. Participation was voluntary, and informed consent was obtained from all respondents. Personal data were anonymised, and confidentiality was maintained throughout data collection and analysis.

Special care was taken when engaging older people and caregivers to ensure that participation did not create distress or risk.

4.9. Limitations and operational challenges

The implementation of this assessment took place in a highly constrained operational environment shaped by the ongoing war, systemic workforce shortages, and institutional overload across health and social protection sectors. While these conditions did not undermine the overall validity of the readiness and feasibility assessment, they had a tangible impact on data collection processes, timelines, and achievable sample sizes. The limitations outlined below should therefore be understood as context-driven operational constraints, rather than methodological shortcomings.

4.9.1. Challenges in beneficiary surveys

Field teams encountered significant difficulties during the recruitment and interviewing of older people as beneficiaries. One of the primary challenges was the high proportion of sampled individuals who could not be reached or interviewed for objective reasons. In particular, the sample included a notable number of individuals who had passed away, necessitating repeated replacement and revision of the sampling lists. This process required additional time and coordination and increased the operational burden on field teams.

In addition, high refusal rates were observed during telephone-based surveys. In multiple instances, several potential respondents declined participation before a single completed interview could be secured. This pattern significantly increased the number of contact attempts required to achieve the target number of completed questionnaires and extended the duration of the data collection phase. These refusals reflect broader contextual factors, including survey fatigue, distrust toward unsolicited calls, and heightened stress levels among older people during wartime.

4.9.2. Challenges related to facility-level visits and checklists

The completion of facility-level checklists in health and social care institutions was affected by limited availability of facility management and senior staff. Data collection coincided with reporting periods, during which facility leadership faced heightened administrative workloads. As a result, many managers reported an inability to allocate time for in-person meetings or to accompany assessment visits.

These constraints led to delays in checklist completion and, in some cases, required rescheduling or alternative arrangements. While the checklists were ultimately completed, the process underscored the operational pressure faced by facilities and the limited flexibility available for participation in external assessments.

4.9.3. Challenges in surveys of health and social workers

Data collection among health and social workers through online questionnaires revealed several systemic challenges. A primary constraint was the severe limitation of respondents' available time, reflecting high workloads, staff shortages, and competing priorities.

Consequently, a substantial number of questionnaires were submitted partially completed or left blank, limiting the usable dataset.

Workforce shortages further compounded this issue. In some localities, staffing levels were critically low, with individual professionals covering multiple roles. In extreme cases, facilities operated with only one staff member, making participation in surveys impractical and increasing the risk of underrepresentation of such settings. These conditions are themselves indicative of structural constraints relevant to ICOPE readiness and therefore constitute an important contextual finding rather than merely a data collection challenge.

4.9.4. Challenges in conducting key informant interviews

The organisation and conduct of key informant interviews were affected by systemic access barriers and limited institutional responsiveness. Many planned interviews did not take place due to respondents' inability to allocate time or their reluctance to participate. In numerous cases, scheduled interviews were postponed indefinitely without confirmation of alternative dates.

Additionally, the study team faced bureaucratic barriers and low response rates to formal information requests. Multiple written requests for interviews and institutional input were submitted, including follow-up letters and physical copies. Responses were received from only a limited number of institutions, with confirmation of receipt provided solely by the National Health Service of Ukraine. Notably, even formal legal requests submitted in accordance with statutory timelines did not yield substantive responses in several cases.

These challenges reflect broader institutional overload and administrative constraints, rather than a lack of relevance or interest in the subject matter.

4.9.5. National-level operational constraints

All stages of data collection were further affected by country-wide operational disruptions linked to the security situation. Frequent and prolonged air raid alerts repeatedly interrupted fieldwork and respondent availability. In addition, power outages and unstable electricity supply significantly constrained communication, online engagement, and access to digital data collection tools.

These factors had a cumulative effect on the pace of data collection, data processing, and adherence to initial timelines. Field teams were required to adapt data collection schedules dynamically and to prioritise respondent safety and accessibility at all times.

4.9.6. Impact of the security situation on the sample

The security situation affected the reachability of respondents and the configuration of the sample, particularly in the central-eastern region (Dnipro and surrounding communities). Frequent air-raid alerts and related interruptions in the functioning of institutions led to: (a) rescheduling or shortening of interviews/visits; (b) shifts in staff availability to other hours/days; and (c) prioritisation of urgent institutional tasks over participation in the assessment. In a number of cases, this meant that data collection was more difficult to achieve in communities located closer to risk zones or experiencing a higher intensity of alerts.

In addition, power outages and unstable connectivity affected telephone and online surveys. In Dnipro, this manifested in an increased proportion of: (a) unsuccessful call attempts and interrupted contacts; (b) postponed interviews that could not always be resumed; and (c) partially completed online questionnaires due to forced interruptions. Taken together, this could create a selection effect: respondents with better connectivity/access to electricity or those located in more stable settings were relatively more likely to be included in the sample, while the most unstable environments may have been underrepresented.

Accordingly, the findings for the central-eastern region should be interpreted with the understanding that the highest levels of vulnerability and the poorest service accessibility in more dangerous locations may be only partially reflected, precisely due to objective security-related access constraints.

4.9.7. Implications for interpretation of findings

Taken together, these operational challenges influenced the scale and timing of data collection but do not invalidate the study's conclusions. The assessment was explicitly designed as a readiness and feasibility study, prioritising depth of insight, triangulation, and system-level understanding over statistical representativeness. The use of multiple data sources and

methods mitigated the impact of individual limitations and enabled robust cross-validation of findings.

Importantly, many of the constraints encountered during fieldwork—such as workforce shortages, administrative overload, and fragmented communication—are themselves indicative of systemic conditions that directly affect the feasibility of ICOPE implementation. As such, these limitations provide valuable contextual insight into the operational realities that must be addressed in any future piloting or scaling of integrated care for older people in Ukraine.

4.9.8. Sampling bias and limitations regarding the transferability of findings to other types of territories

The study covered Lviv and Dnipropetrovsk oblasts—regions which, despite significant strain and war-related risks (particularly for Dnipro), are generally characterised by relatively functional service delivery infrastructure and the presence of institutional capacity to participate in research. This creates a potential sampling bias towards territories with higher levels of systemic "survivability" and greater operational manageability of services compared to de-occupied territories, communities close to the front line, or areas of active hostilities.

Accordingly, the findings on readiness and coordination practices may differ (and potentially be worse) in: (a) de-occupied territories with widespread destruction; (b) communities where primary health care is effectively non-functional or operates only intermittently; (c) areas experiencing acute shortages of social workers and medical personnel; and (d) zones with limited access for international and national actors due to security constraints.

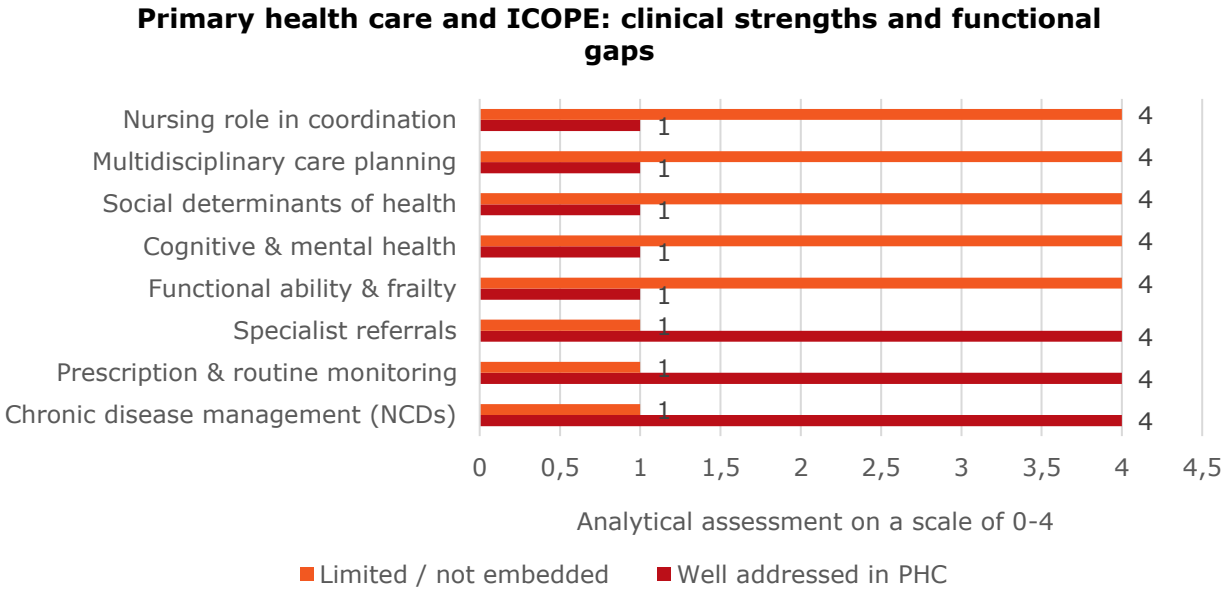
Thus, the results of this study should be considered relevant for assessing readiness in a context of a "strained but functional" service delivery system, and as a basis for piloting ICOPE in environments where a minimum level of institutional capacity is preserved. Extrapolation to de-occupied territories or areas of active hostilities would require separate assessments, adapted in both design and security protocols.

5. Overview of the Health and Social Care System for Older People in Ukraine

5.1. Primary health care and NCD management

Primary health care (PHC) constitutes the backbone of medical care for older people in Ukraine and represents the main entry point into the healthcare system. Following health sector reforms, PHC is organised around family doctors who are responsible for providing continuous care, managing chronic conditions, issuing referrals to specialised services, and coordinating access to diagnostic and treatment pathways. For older people, whose health profiles are typically characterised by multimorbidity, PHC plays a critical role in maintaining stability, preventing deterioration, and ensuring continuity of care.

Noncommunicable diseases (NCDs) such as cardiovascular conditions, diabetes, chronic respiratory diseases, and musculoskeletal disorders are highly prevalent among older people and dominate service utilisation at the primary care level. PHC providers are generally well positioned to manage these conditions from a clinical perspective, particularly with regard to prescription management, routine monitoring, and referrals to specialists when needed. In this sense, PHC provides an essential foundation for any integrated care model.



However, the prevailing PHC model remains largely disease-oriented and episodic, with limited systematic focus on functional ability, frailty, cognitive decline, mental health, or social determinants of health. Consultations are often constrained by time pressures, high patient loads, and administrative requirements, leaving little space for comprehensive assessments that extend beyond immediate clinical concerns. As a result, early signs of functional decline or psychosocial vulnerability may go undetected until they manifest as acute medical issues.

Financing of primary health care is centralised through the National Health Service of Ukraine (NHSU) under the Medical Guarantees Programme. The NHSU contracts PHC providers and reimburses medical services based on the "money follows the patient" principle. As a result, the medical component of care for older people has a relatively stable national funding source, standardised service packages, and clearly defined contracting mechanisms.

At the same time, this financial design is predominantly oriented toward clinical interventions, diagnostics, and pharmacotherapy. Functional assessment, social needs, prevention of loss of autonomy, and coordination with social services are not supported by dedicated financial instruments within NHSU contracts. Thus, even where PHC has clinical capacity, the system does not financially incentivise doctors and nurses to invest time and resources in integrated, cross-sectoral support for older people.

From an ICOPE perspective, this represents a structural constraint. Although PHC is a natural backbone for integrated care, its current orientation does not fully support proactive identification of declines in intrinsic capacity or systematic linkage with social support services. Screening tools, interdisciplinary case discussions, and joint care planning—core components of ICOPE—are not embedded in routine PHC practice.

The role of nurses in PHC also remains limited. Although they often have more frequent and closer contact with older people, their functions are largely confined to clinical tasks, with minimal involvement in care coordination or in addressing social and functional needs. This underutilisation of nursing potential further constrains the ability of PHC to act as a hub for integrated care.

5.2. Social services and long-term care for older people

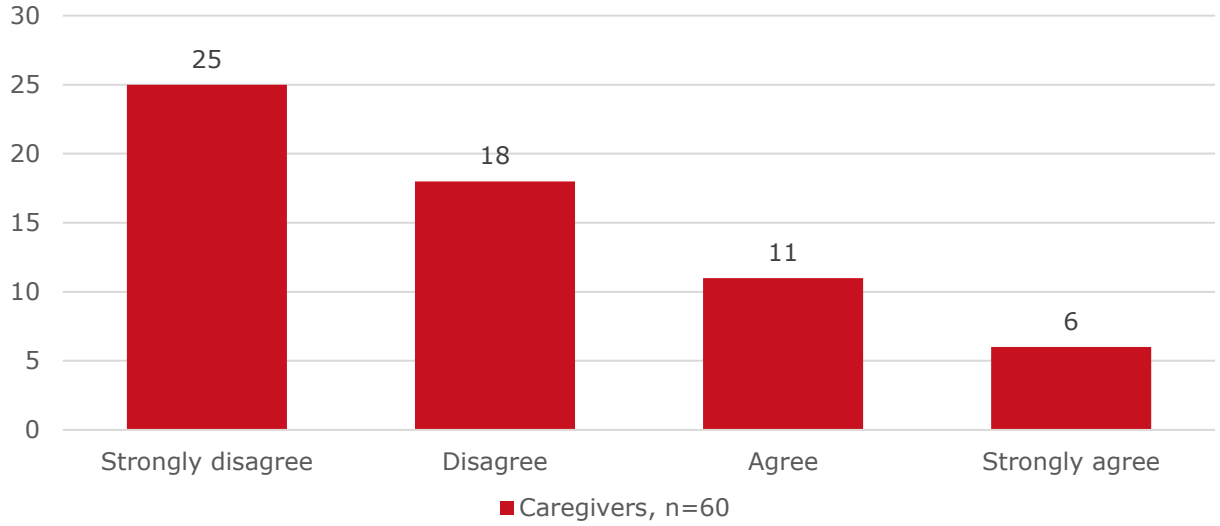
Social services constitute the second major pillar of support for older people in Ukraine and are particularly critical for those experiencing functional limitations, disability, social isolation, or poverty. The social protection system encompasses a wide range of interventions, including social assistance, home-based care, residential and semi-residential services, and targeted support for vulnerable groups.

Social workers operating at the community level are often the primary actors responsible for assessing social needs, arranging services, and providing ongoing support to older people. Their work frequently involves home visits, functional and social assessments, coordination

with family members, and engagement with local service providers. In practice, social workers are often the professionals with the most holistic understanding of older people's living conditions and daily challenges.

Long-term care (LTC) for older people is predominantly organised through **social rather than health systems**. Home-based care services, day care centres, and residential institutions fall under the mandate of social protection authorities and local governments. Despite ongoing reforms aimed at expanding community-based services, institutional care remains a significant component of the LTC landscape, partly due to limited alternatives in many communities.

Perceived adequacy of caregivers' support from social services (caregivers, n=60)



A defining characteristic of the social services system is its high degree of decentralisation. Local authorities are responsible for planning, financing, and delivering services, resulting in substantial variation in availability, quality, and coverage across regions and communities. Some municipalities have invested in diversified service models and partnerships with non-governmental providers, while others struggle to provide even basic home-based care due to financial and workforce constraints.

Financing of social services and long-term care in Ukraine is carried out predominantly through local budgets of territorial communities. Communities are responsible for maintaining territorial centres and social service centres, paying the salaries of social workers and care assistants, and procuring or developing new services.

In practice, this means that the scope and quality of long-term care directly depend on the financial capacity of a particular community. Social protection budgets are significantly smaller than health budgets, which are centrally pooled through the NHSU. As a result, a systemic "financial gap" emerges between the medical and social components of care: even when medical care is formally available, social and care services remain limited, unstable, or fragmented.

From an ICOPE perspective, this asymmetry in financing constitutes a critical structural barrier. It prevents the development of balanced models in which medical and social interventions are planned and delivered as a single, integrated package to support functional ability.

Workforce shortages are particularly acute in the social services sector. Social workers and care assistants often face high caseloads, low levels of remuneration, and limited access to specialised training on ageing, dementia, or complex needs. As a result, a substantial share of care is assumed by informal caregivers—predominantly family members—often without adequate support, guidance, or opportunities for respite.

From the perspective of ICOPE, social services are an indispensable component of integrated care. Their proximity to the everyday lives of older people and their focus on functional ability and social participation are directly aligned with ICOPE principles. At the same time, weak integration of social services with the health system significantly constrains their potential impact.

5.3. Role of the National Social Service of Ukraine

The National Social Service of Ukraine (NSSU) plays a central role in the governance and oversight of the social care system, including services relevant to older people and long-term care. Its mandate is primarily focused on inspection, compliance monitoring, and methodological supervision, rather than on service delivery, coordination, or financing.

First, the NSSU performs a systemic inspection and monitoring function. Through planned and ad hoc inspections, the Service assesses compliance of social service providers with national legislation, regulatory requirements, and approved standards of social services. This function positions the NSSU as the primary national mechanism for quality control and accountability within the social care sector. Inspections cover both public and non-state providers and generate evidence on service gaps, procedural violations, and implementation challenges at local level.

Second, the NSSU provides methodological support to territorial communities. This includes guidance on the organisation of social services, interpretation and application of regulatory norms, and implementation of national standards. In the context of decentralisation, this methodological role is particularly important, as communities are responsible for organising and delivering social services but often face capacity constraints. The NSSU thus acts as a bridge between national regulatory frameworks and local-level implementation practice.

Third, the Service contributes to the implementation and enforcement of standards of social services, including those relevant to home-based care, social support, and services for vulnerable older people. While these standards do not yet explicitly reflect integrated care or ICOPE principles, the NSSU is a key institutional actor for translating policy norms into operational practice and for identifying systemic weaknesses in standard implementation.

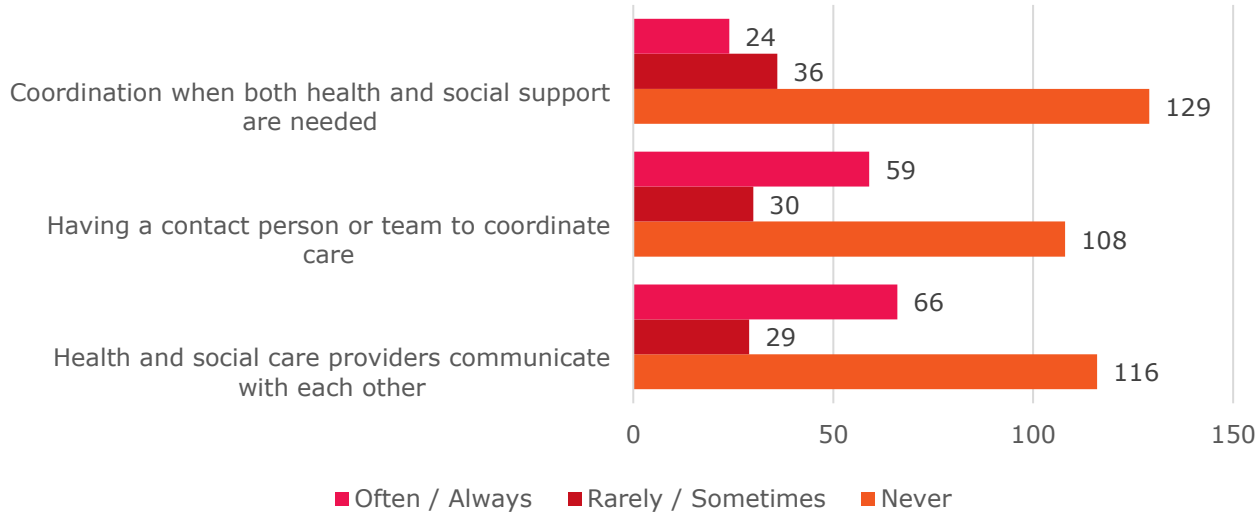
At the same time, the mandate of the NSSU has clear limitations. The Service does not coordinate health and social care, does not manage service delivery, and does not control financing mechanisms. Its role is therefore supervisory rather than integrative. As a result, while the NSSU generates valuable system-level information on service quality and compliance, this information is not systematically linked to health sector data or used within joint planning and coordination mechanisms. This institutional positioning is highly relevant for ICOPE implementation, as it highlights both the strengths and the structural constraints of the current governance architecture.

5.4. Existing coordination mechanisms between health and social sectors

Coordination between health and social sectors in Ukraine exists, but remains **largely informal, fragmented, and person-dependent**. In many communities, collaboration occurs through ad hoc personal relationships between family doctors, nurses, and social workers rather than through formalised protocols or institutional arrangements.

Referral mechanisms between PHC and social services are inconsistently applied. While healthcare providers may informally advise patients to contact social services, and social workers may encourage clients to consult family doctors, these interactions are rarely supported by standardised referral pathways, shared documentation, or feedback mechanisms. As a result, continuity of care is fragile and heavily reliant on individual initiative.

Existing coordination mechanisms between health and social sectors (older people, n=240)



Overall, the chart shows that the existing coordination mechanisms between the health and social sectors are not systemic in nature. Even where interaction does take place, it is predominantly situational, personalised, and dependent on the individual initiative of specific professionals. This confirms the presence of a structural coordination gap that substantially constrains the implementation of integrated care in line with the WHO ICOPE approach. It should be noted that coordination in complex cases proves to be particularly problematic—specifically where a client simultaneously requires medical and social support. The vast majority of respondents indicate that such coordination either never occurs or happens only rarely, pointing to the absence of formalised intersectoral care pathways.

Information systems constitute a major barrier to coordination. Health and social services operate separate data systems, with limited interoperability or data exchange. Healthcare providers generally lack access to social assessments, while social workers have no systematic visibility of medical diagnoses, treatment plans, or prescribed interventions. This separation undermines comprehensive care planning and increases the risk of duplication or omission of services.

At the governance level, responsibilities for health and social care are divided between different ministries and administrative structures, with limited mechanisms for joint planning or shared accountability. Although policy documents increasingly acknowledge the importance of intersectoral cooperation, these commitments are not consistently translated into operational guidance or funding arrangements at the local level.

5.5. Financial decentralisation and the structural gap between health and social financing

One of the key systemic characteristics of the Ukrainian model of care for older people is the financial decentralisation of the social sector combined with the centralised financing of healthcare. Healthcare is funded predominantly from the state budget through the National Health Service of Ukraine (NHSU), while social services and long-term care are financed from local community budgets.

This model creates not only an administrative, but above all a financial gap between the two sectors. The healthcare system operates with guaranteed benefit packages, predictable financial flows, and a single national purchaser. In contrast, social services depend on the financial capacity of individual communities, the political priorities of local authorities, and compete for resources with all other local needs (infrastructure, education, housing and communal services, security).

In the context of integrated care, this means that even where professional readiness for cooperation exists, communities often lack the financial instruments to deploy case management, multidisciplinary teams, outreach/home-based services, or caregiver support.

Objectively, the social sector is not able to "mirror" the health sector in terms of scale and stability of funding.

Financial decentralisation also deepens territorial inequalities. Communities with a stronger tax base or active donor support can develop home care, day centres, and mobile teams. By contrast, low-resource, rural, or frontline communities are often limited to minimal social services or institutional solutions as the "only available option."

From an ICOPE perspective, the absence of joint financial frameworks for health and social care is likely the most profound barrier to integration. Without co-financing mechanisms, pooled budgets, pilot integrated packages, or state subventions for long-term care, the integrated model will remain dependent on project-based logic and will not be able to scale at the systemic level.

5.6. Identified systemic gaps relevant for ICOPE

The overview of health and social care systems reveals several systemic gaps that are directly relevant to the feasibility of ICOPE implementation in Ukraine.

First, there is a structural imbalance between medical and social components of care. While PHC reforms have strengthened access to medical services, social services remain under-resourced and insufficiently integrated into care pathways. This imbalance risks reinforcing a medicalised approach to ageing that neglects functional ability and social wellbeing.

Second, the absence of formalised care coordination mechanisms limits the ability to implement multidisciplinary, person-centred care. Without shared assessment tools, referral protocols, and communication channels, integrated care remains aspirational rather than operational.

Third, workforce constraints across both sectors undermine readiness for integration. High workloads, staffing shortages, and limited training in integrated care principles reduce the capacity of health and social workers to engage in coordination, prevention, and proactive support.

Fourth, caregivers remain insufficiently recognised and supported within existing systems. Informal caregivers provide substantial care but are rarely included in care planning or offered systematic support. This gap directly contradicts ICOPE principles, which position caregivers as central actors in the care continuum.

Fifth, the financial architecture of the system is structurally incompatible with integrated care. Centralized financing of medicine and decentralized financing of social services create a chronic resource imbalance that prevents communities from building sustainable intersectoral models. The lack of common budgetary instruments, state subventions for long-term care, or contractual mechanisms for integrated services significantly limits the practical implementation of ICOPE.

Taken together, these systemic gaps suggest that while Ukraine possesses important foundational elements for ICOPE implementation, significant structural and operational adjustments are required. Addressing these gaps will be essential for transitioning from parallel health and social systems toward a coordinated, person-centred model of care for older people.

6. ICOPE Readiness Assessment — Service (Meso) Level

6.1. Engage and empower people and communities

(Participation of older people; role of communities; support to caregivers — incl. linkages to social protection and social services)

6.1.1. What "engage and empower" means at service level in the ICOPE implementation scorecard

Within the ICOPE implementation framework, "involvement and empowerment of people and communities" at the service level (meso-level) involves the structured, rather than ad hoc, participation of older people, families/carers and community actors in how health and social

services are planned, delivered and improved. This includes: (i) creating conditions in which older people can understand, influence and co-create decisions about their own care; (ii) formalising community involvement as a component of service delivery (including through peer support, volunteer networks and NGO-supported functions); and (iii) implementing practical mechanisms that reduce the burden on carers through training, psychosocial support and respite decisions.

Field evidence suggests that engagement often manifests itself as individual goodwill and sporadic communication, while the systemic "empowerment infrastructure" (standardised shared care planning, feedback loops, carer support packages and ongoing community links) appears to be patchy and patchy, particularly where continuity depends on overburdened primary care and fragmented social protection pathways. In addition, evidence suggests a significant gap between the "declared readiness" of some health workers (the willingness to "support a patient-centred approach" at the level of general principles) and the "real operational readiness" (the availability of the time, tools and procedures to do so systematically). In practice, the willingness to engage is often not a lack of will but a consequence of the design of the service: short appointments, high workload and administrative requirements make key components of ICOPE impossible – in particular the 30-minute comprehensive checklist assessment, setting functional goals and shared care planning.

6.1.2. Participation of older people in decisions about their health and care

a) Informed participation is inconsistent; paternalistic and ageist communication remains a barrier. Focus group discussions with older people revealed recurring patterns: limited consultation time, "prescription-only" interactions, and older people not being perceived as active participants in decision-making. In practice, respondents described situations where providers did not meaningfully explain options, side effects, or the long-term plan—a practice that directly contradicts ICOPE's emphasis on person-centered goal setting and shared decision-making.

Critically, some of the barriers are not only "cultural" but also structural: even where doctors declare a willingness to share decision-making, the format of the appointment is actually reduced to the minimum necessary clinical actions (adjustment of prescriptions, referrals, prescriptions). In such conditions, patient involvement becomes an "option" rather than the standard: there is no time to discuss alternatives, goals, risks, and even less to integrate social and functional aspects.

This directly undermines the "engage and empower" component of ICOPE, as without time to explain and negotiate the care plan, "informed participation" exists in a formal rather than substantive way.

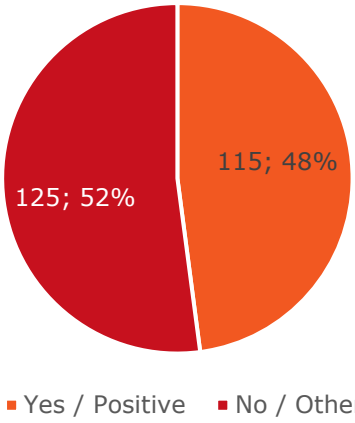
A recurring theme is the normalization of dismissive responses attributed to "age," which discourages older people from asking questions or pushing for further steps. One discussion clearly illustrates this dynamic:

"One doctor says… And another says: he prescribed medicine and that's it… Often they say it's age-related changes." [survey, elderly person]

b) Practical navigation burdens reduce real choice (appointments, referrals, and continuity). Older people describe the care pathway as a "chain" that is difficult to complete due to appointment delays and multi-step referral requirements, especially for chronic disease management and specialist access. This reduces the feasibility of proactive care planning and pushes people to delay help-seeking until exacerbations occur.

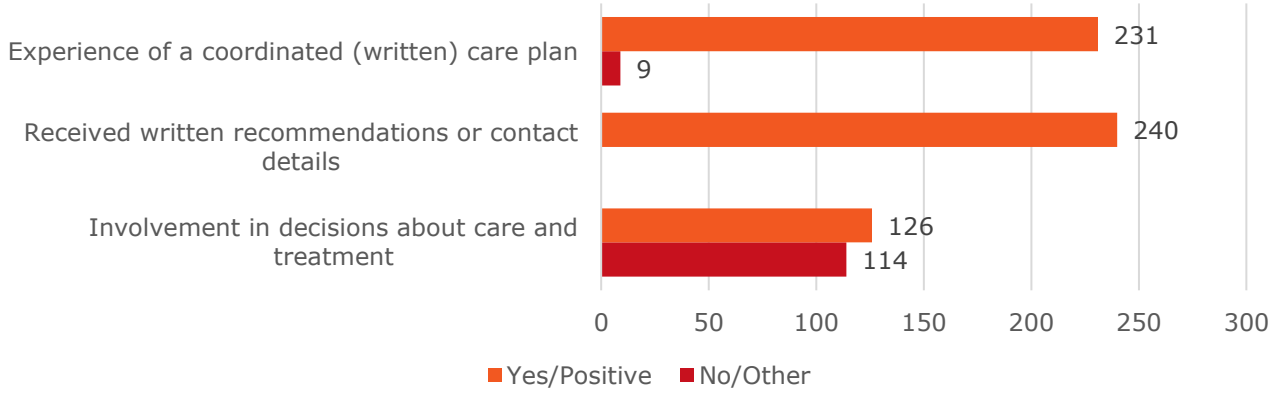
c) Perceived rights and available channels exist, but trust in enforcement is low. Discussions indicate that older people may know about "hotlines" or formal entitlements, yet experience them as ineffective in resolving access problems. This matters for "empowerment," because formal rights without reliable remedies do not translate into real agency.

Involvement in decisions about care and treatment (older people, n=240)

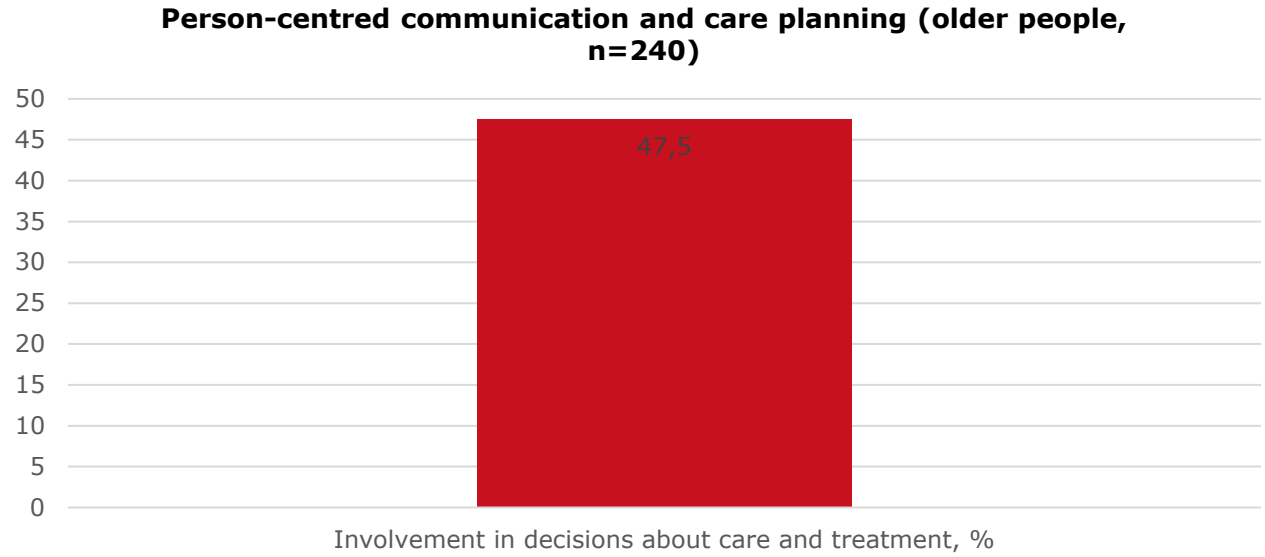


According to the survey results, 48% of older people reported a positive experience of being involved in decision-making about their own treatment or care (Yes / Positive). At the same time, 52% of respondents indicated that they were not involved in decision-making or had limited or alternative experience of participation (No / Other). Although almost half of the respondents have a positive experience of participation, for the majority, involvement remains inconsistent, situational and dependent on a specific professional or institution. From the perspective of the ICOPE approach and the principles of person-centered care, this pattern of responses indicates a partial but incomplete implementation of shared decision-making. Limited participation of older people in shaping decisions about care can negatively affect trust in the system, adherence to treatment and the effectiveness of long-term interventions.

Key indicators of involvement and care planning among older people (n = 240)



The data obtained, as shown in the graph, indicate that although individual elements of communication with clients function relatively well, a holistic approach to planning and coordinating care is practically absent. From the ICOPE perspective, this indicates a fragmented implementation of the principles of integrated care without systematic coordination of medical and social interventions. The majority of respondents reported receiving written recommendations or contact details (about 90–95%), which indicates relatively well-established communication at the level of individual services. At the same time, the presence of an agreed, written care plan is extremely limited - only a few respondents have it (less than 10%), which indicates the absence of a systematic approach to care planning. The level of involvement in decision-making regarding care and treatment is moderate and covers approximately half of the respondents, which confirms the situational nature of shared decision-making.



The graph shows the proportion of older people who have been involved in making decisions about their own care and treatment. According to the survey, this figure is around 48%, which indicates limited and inconsistent implementation of a person-centred approach. Therefore, we see that less than half of older people have experience of active participation in making decisions about their care, which indicates a lack of systematic practice of shared decision-making. From the ICOPE perspective, this means that person-centred communication is implemented mainly situationally and is not supported by formalised care planning tools, such as agreed written plans or regular discussions of treatment alternatives.

Interpretation for readiness (meso level): participation exists, but mostly at the level of individual interactions, not embedded service routines. The gap is especially visible in the absence (or weak practice) of documented shared care plans that incorporate older people's goals, preferences, and functional needs—an element directly referenced in the facility readiness logic (care planning "in partnership with older people and/or caregivers").

6.1.3. Role of communities: how community assets contribute to integrated care (and where the system fails to use them)

a) Communities are framed as essential for integrated medico-social services, but operational models are underdeveloped.

A key informant explicitly conceptualized integration primarily as services delivered "by the community for its population," combining medical and social components. This framing is aligned with ICOPE's community engagement logic and suggests conceptual readiness at least among some expert stakeholders.

At the same time, there is a practical constraint: community engagement often relies on informal actions rather than formalized service linkages. A separate expert interview underscores that what is missing is structured inter-departmental and cross-actor interaction (MoH/MoSP/local authorities/CSOs), describing current efforts as "point-by-point" rather than coordinated systems.

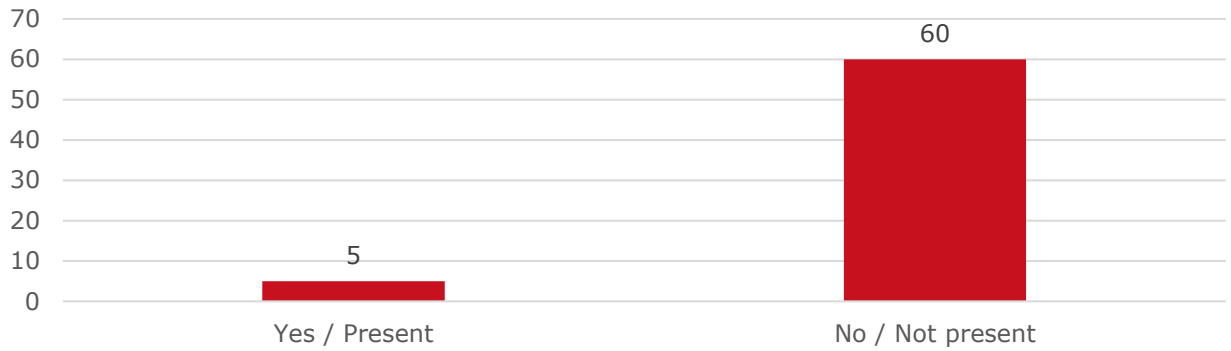
b) Community organizations of older people: potential is recognized, but capacity and incentives are not institutionalized.

One interview highlights the importance of organizations of older people and other civil society actors, but notes that effective engagement requires volunteer readiness, capacity-building, and deliberate "cultivation" and support—i.e., these structures do not automatically function as a service extension without investment and coordination.

c) Digital fragmentation blocks community-enabled continuity across health and social sectors.

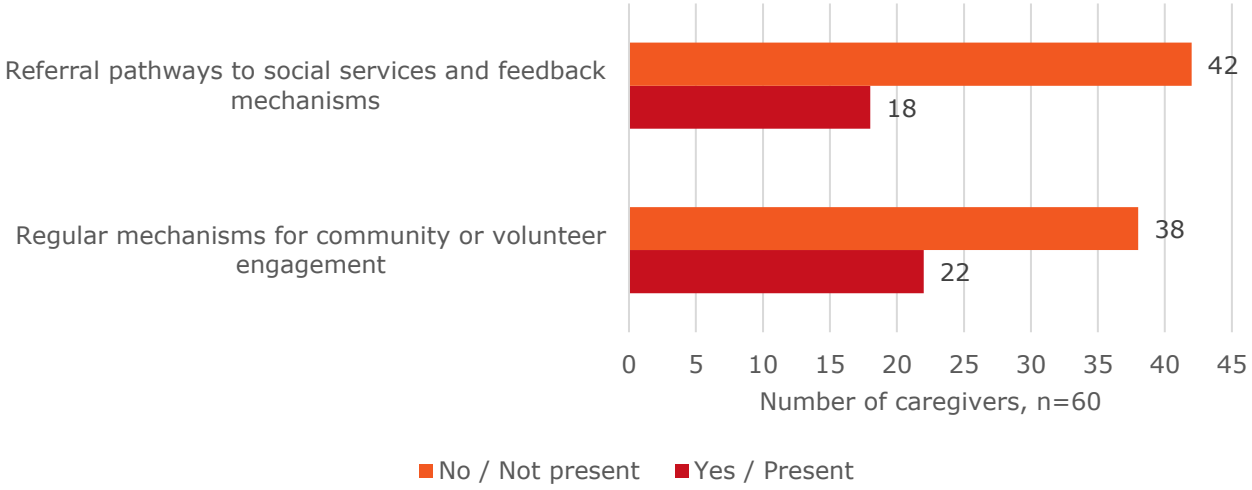
Even where communities and services use digital tools, informants point to the lack of integrated data flows between medical and social sectors, which reduces continuity and makes community-based follow-up harder to organize (e.g., shared understanding of vulnerability, functional decline, or caregiving context).

Interaction with social services / social protection / case management (n=240)



The data obtained indicate a significant gap between the medical and social components of care. In the absence of regular interaction with social services, older people receive care mainly within the medical system, without due consideration of social, functional and everyday needs. The majority of older people do not have any interaction with social services or case management, which indicates a weak integration of the social component of care. From the ICOPE perspective, this indicates a limited implementation of intersectoral integration and the absence of effective case management mechanisms that would combine medical and social interventions into a single care pathway.

Coordination mechanisms reported by health and social workers (n = 60)



Overall, the data confirm that coordination between the health and social sectors remains largely informal and limited. Even those mechanisms that exist cover only a fraction of facilities and do not form a systemic framework for integrated care. From ICOPE's perspective, this indicates an early stage in the development of intersectoral coordination and the need for institutionalization of referral pathways, feedback and community engagement.

Referral pathways to social services and feedback mechanisms

Only about 30–35% of respondents reported the existence of such mechanisms, while the vast majority (65–70%) reported their absence. This indicates a weak formalization of intersectoral referral pathways and limited opportunities for systemic feedback.

Regular mechanisms for community or volunteer engagement

Approximately 35–40% of respondents reported the existence of regular mechanisms for community or volunteer engagement, while the majority (60–65%) did not have such mechanisms in their practice.

Service-level implication**:** without formal community linkages, engagement remains episodic; older people and caregivers continue to rely on personal networks, rather than predictable community-based packages. This is particularly critical under war-related stressors

(displacement, isolation, disrupted access), which increase reliance on local community assets and social protection channels.

6.1.4. Support to caregivers: visibility, burden, and what empowerment would look like in practice

a) Caregivers experience high burden and low systemic recognition as "part of the care team." The caregiver focus group synthesis is unambiguous: caregivers combine strong moral commitment with physical and emotional exhaustion, limited support networks, and insufficient coordination between medical and social services.

A core empowerment failure is that caregivers often feel invisible to the system—despite being a critical workforce enabling older people to remain at home. As stated directly in the caregiver focus group's illustrative quotes:

"I am almost never asked about being a caregiver — as if I am not part of the process" [survey, caregiver].

b) Key caregiver needs are concrete and service-actionable (training, psychosocial support, respite, and inclusion in care planning).

Caregivers consistently prioritized: (i) clear information and skills training; (ii) psychological support and peer groups; (iii) better coordination of medical and social services; (iv) inclusion in care planning; and (v) temporary respite solutions so caregivers can address their own health or urgent needs.

These needs map directly onto the ICOPE scorecard's caregiver-support expectations (availability of caregiver well-being supports, training, and respite infrastructure such as day centres).

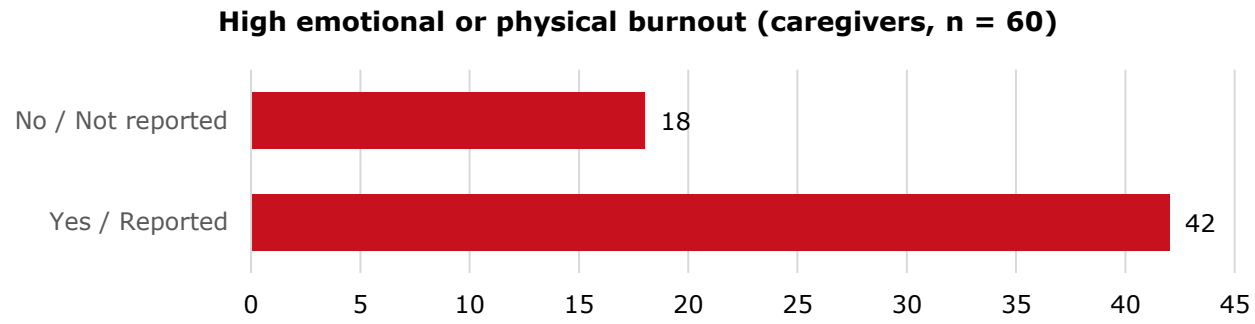
c) Social workers and social protection are central to caregiver empowerment, but the "handoff" between health and social systems remains weak.

The same caregiver evidence shows that assessment and planning remain fragmented, prioritizing biomedical indicators while leaving psychosocial and social dimensions—especially caregiver strain—outside systematic attention.

This is precisely where social workers (community-based, municipal, and CSO-linked) should function as:

- case managers / navigators for LTC-related services;
- coordinators of home-based support and access to benefits;
- facilitators of caregiver training and support groups;
- implementers of routine caregiver strain screening and referral.

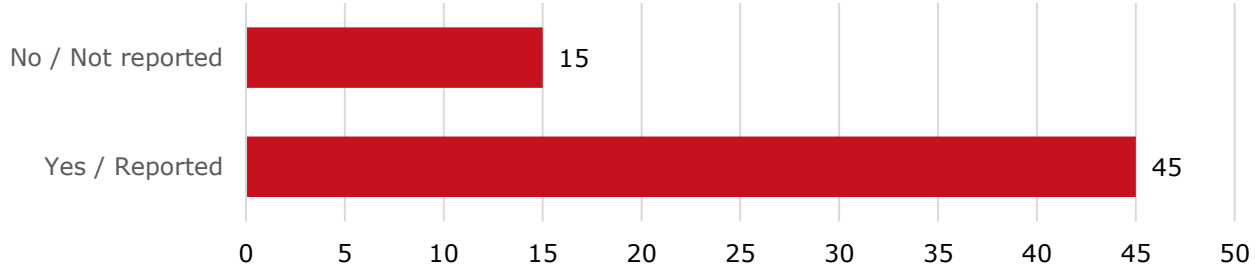
Notably, one key informant identified **training of informal caregivers** and **case management in the social sphere** as realistic mechanisms that can reduce pressure on health professionals and improve coordination—indicating a clear service-level pathway for operationalizing caregiver empowerment.



The graph shows the presence of key coordination mechanisms between health and social services, as assessed by health and social workers. The data indicate limited institutionalization of such mechanisms and their fragmented nature. Referral pathways to social services and feedback mechanisms. Only about 30–35% of respondents reported the presence of such mechanisms, while the vast majority (65–70%) reported their absence. This indicates weak

formalization of intersectoral referral pathways and limited opportunities for systemic feedback. The presence of regular mechanisms for community or volunteer engagement was noted by approximately 35–40% of respondents, while the majority (60–65%) do not have such mechanisms in their practice. Thus, the majority of health and social workers do not have formalized coordination mechanisms, including referral pathways and regular community engagement.

Lack of respite (caregivers, n = 60)

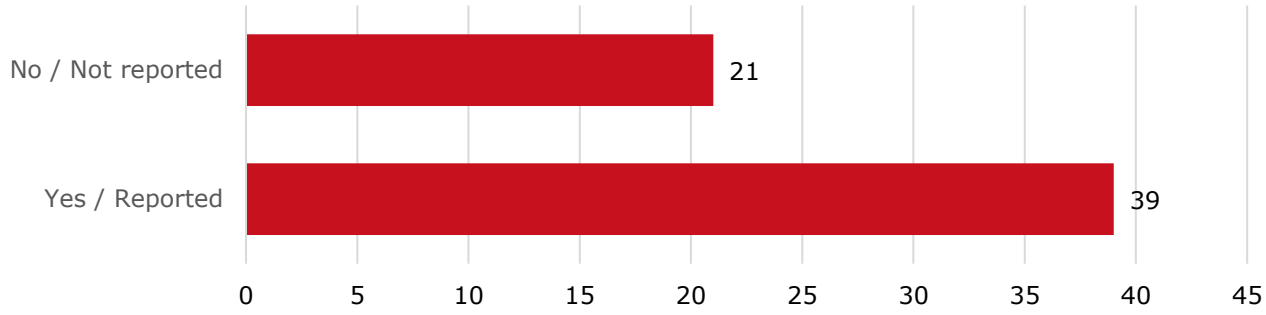


The graph shows that the vast majority of caregivers do not have access to respite services. Thus:

- About 45 out of 60 respondents (≈75%) reported the absence of any respite services.
- Only about 15 people (≈25%) reported no problems with access to respite.

The absence of respite services is a widespread and systemic phenomenon, significantly increasing the risk of emotional and physical burnout for caregivers. From an integrated care perspective (ICOPE), this indicates a critical gap in the support for informal care and the need to develop structured respite services as an element of a sustainable care system.

Lack of training or guidance (caregivers, n = 60)

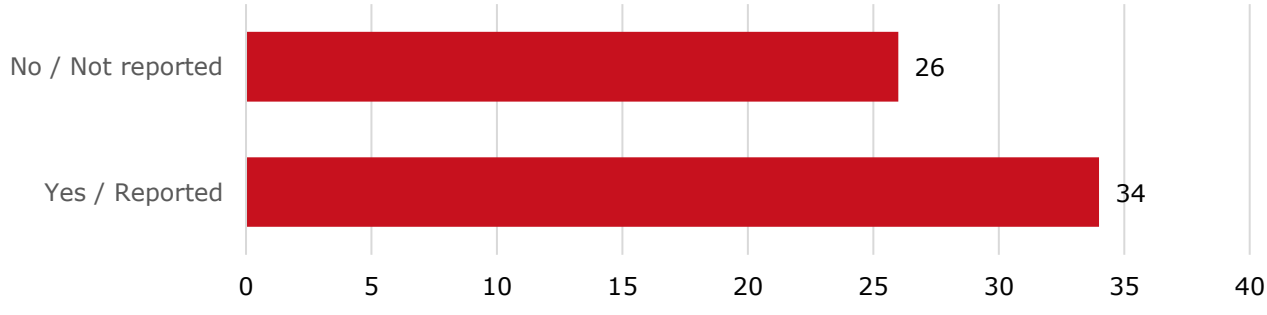


The graph shows that a significant proportion of caregivers do not receive any systematic training or guidance needed to perform their caregiving roles.

- About 40 out of 60 respondents (≈65–67%) reported a lack of training or guidance.
- About 20 people (≈33–35%) did not report this problem.

The data suggest a structural deficit in support for caregivers who perform complex and responsible roles without adequate training. In the context of ICOPE, this highlights the gap between health and social services and the lack of recognition of the role of informal caregivers as full participants in integrated care.

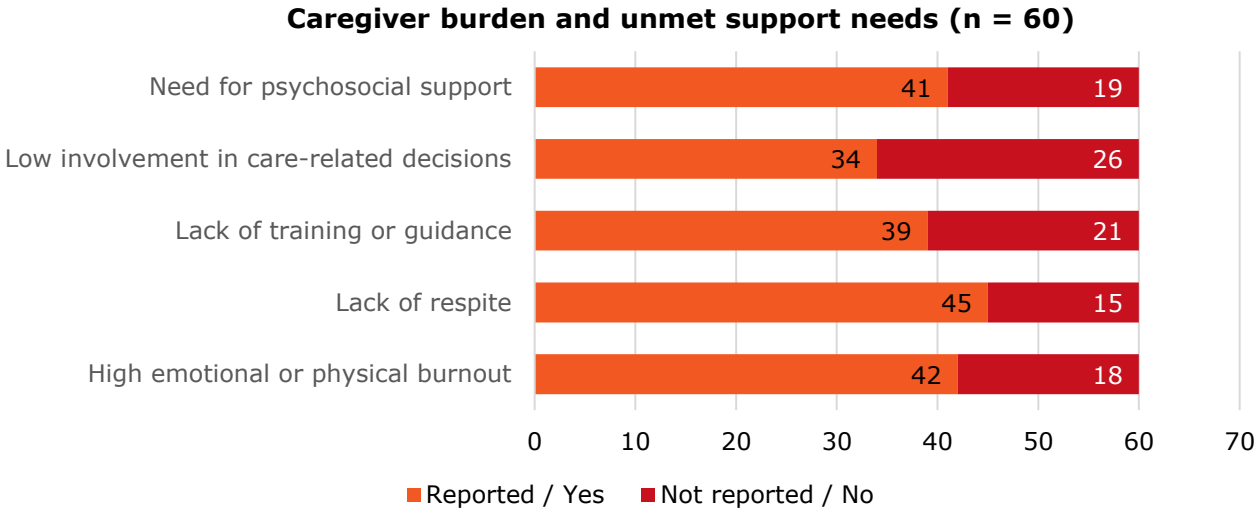
Low involvement in care-related decisions (caregivers, n = 60)



The findings indicate limited involvement of caregivers in planning and decision-making, despite their key role in everyday care. This highlights the discrepancy between the declared person-centeredness and actual practice, and also indicates the need to formalize the role of caregivers in integrated care models in line with the ICOPE approach.

The graph shows that low involvement of caregivers in decision-making processes is a widespread phenomenon.

- About 34 out of 60 respondents (≈58%) reported that they are not sufficiently involved in care decisions.
- About 25 people (≈42%) did not mention this problem.



The graph shows that most caregivers face multiple forms of overload and lack of support, which accumulate systematically.

High levels of emotional or physical burnout are reported by the vast majority of respondents (over two-thirds of the sample). The lack of respite services is one of the most acute problems: most caregivers do not have the opportunity to take a break or temporarily replace them.

Lack of training or guidance is also widespread, which increases feelings of insecurity and overload.

Low involvement in care decisions indicates the marginalization of the role of caregivers in care planning.

The need for psychosocial support is massive, indicating accumulated emotional pressure.

The results indicate the systemic invisibility of caregivers in care delivery models. The lack of training, support and involvement in decision-making creates a high risk of burnout and reduces the quality of care. In the context of ICOPE, this indicates a critical gap between the declared integration of care and actual practice, where caregivers are not seen as full participants in the system.

d) What "good practice" would look like at meso level (direction of change, not yet scale).

Based on the scorecard logic, service-level readiness would require moving from informal dependence on families to a model where:

- caregivers are routinely identified, registered (with consent), and assessed for burden;
- caregiver training and information are offered in accessible formats (including offline options);
- respite solutions exist (even limited pilots) through community day centres / temporary home support;
- social workers are integrated into multidisciplinary workflows (shared care planning, follow-up, and referral tracking); and
- older people and caregivers have functional feedback channels that lead to service improvements.

6.1.5. Preliminary readiness judgement for 6.1 (service/meso level) — expanded evidence-based narrative

Across both studied regions and all applied data-collection tools, service-level capacity to engage and empower older people, communities, and caregivers is characterised by fragmented and uneven readiness, which is more appropriately described as declarative and initial rather than operationally established. Although some elements aligned with ICOPE principles are present, they are not systemic and are not embedded in routine service delivery processes.

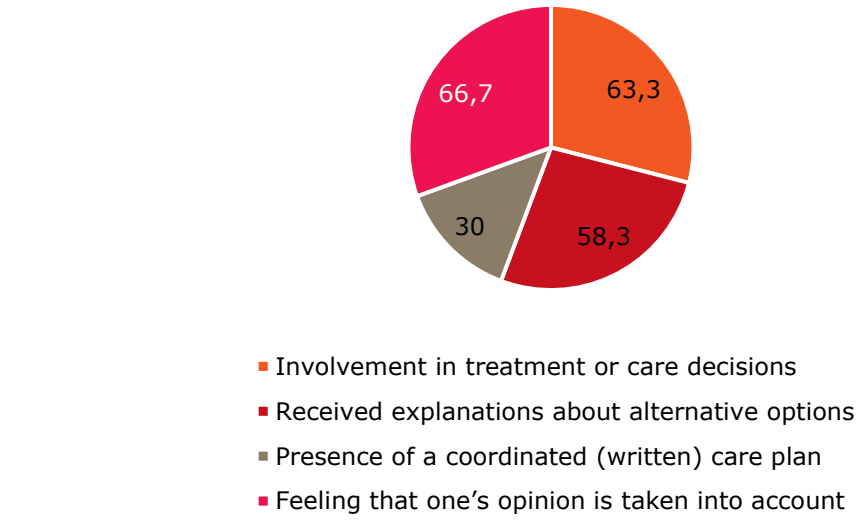
At the level of older people's participation, the data indicate that engagement remains predominantly consultative and passive rather than participatory or genuinely empowering. Older people are usually informed about clinical decisions or available social support options, but are rarely involved in the joint definition of care goals, prioritisation of interventions, or development of follow-up care plans. As a result, engagement depends primarily on the individual communication style and personal attitudes of specific professionals, rather than on service standards, tools, or accountability mechanisms.

Critically, the assessment identifies a persistent gap between declared readiness and operational (actual) readiness. Many health and social care professionals articulate support for person-centred and participatory approaches. However, this support does not translate into everyday practice. The dominant constraint is not a lack of motivation, but the structural design of services. High workloads, short consultation times, and administrative pressure systematically displace the time required for meaningful engagement, functional assessment, and joint care planning. In effect, the service environment is organised around short, problem-oriented contacts that are incompatible with the 30-minute comprehensive assessments, functional goal-setting, and interdisciplinary coordination envisaged by ICOPE.

This limitation is consistently reflected in qualitative evidence from key informants:

"We often talk about patient-centred care, but in reality, there is no structured mechanism that would require us to sit down with an older person and jointly plan care. It depends entirely on the doctor or social worker, not on the system." [KII, Representative of local NGO]

Level of involvement of older people in decision-making (n=240, %)



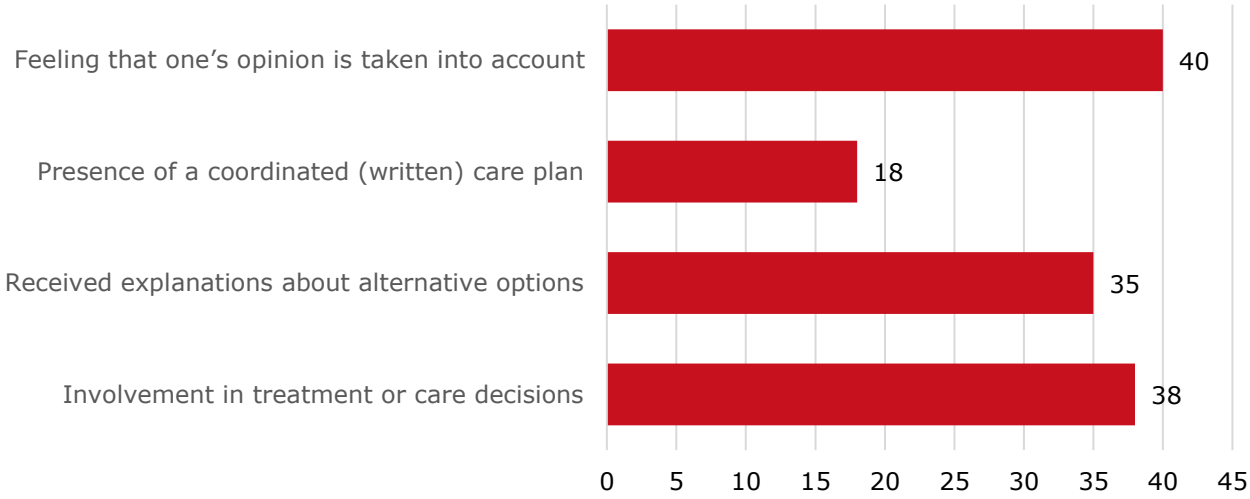
Although subjective elements of involvement (participation in decisions, feeling listened to, verbal explanations) cover approximately a quarter to a third of respondents, formalized tools of integrated care, in particular written agreed care plans, remain marginally widespread.

This indicates a fragmented and mostly informal model of involvement that does not translate into systematic care planning in accordance with the ICOPE principles.

The pie chart reflects four key aspects of older people's involvement in treatment and care processes, which are presented as relative shares of responses. Thus, we see that:

- Involvement in treatment or care decisions — about 30% of respondents (≈ 70–75 people out of 240);
- Receiving explanations about alternative care options — about 25–27% (≈ 60–65 people);
- Feeling that one's opinion is taken into account — about 30% (≈ 70–75 people);
- Availability of an agreed (written) care plan — only about 13–15% (≈ 30–35 people).

Number of older people involved in decision-making (n=240)



The graph shows the absolute number of respondents who reported different forms of involvement in treatment and care processes.

- Involvement in treatment or care decisions - 38 people
- Receiving explanations about alternative options - 35 people
- Feeling that one's opinion is taken into account - 40 people
- Having an agreed (written) care plan - only 18 people

The data show that subjective and communicative forms of involvement (explanation, feeling that one's opinion is taken into account, participation in decisions) cover a significantly larger number of people than formalized integrated care tools such as a written agreed plan.

This indicates the dominance of informal, personalized interaction over systemic care planning and confirms that the key elements of ICOPE are implemented in a fragmented manner, without proper institutional consolidation.

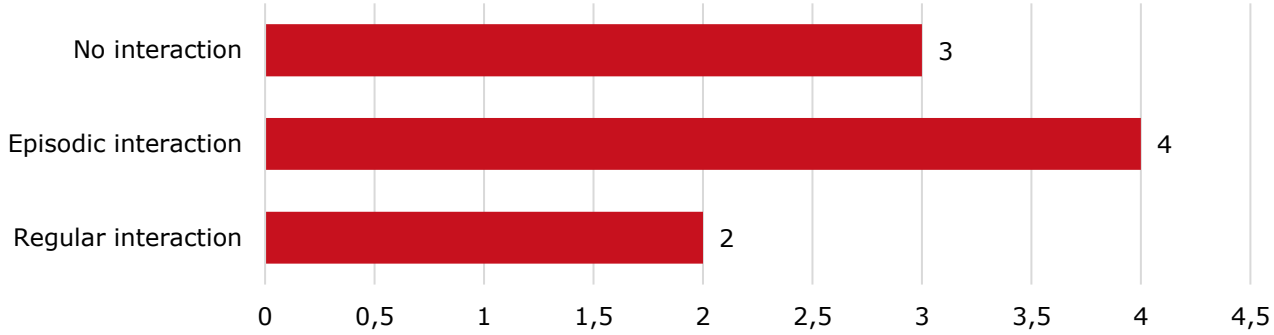
From a community engagement perspective, the assessment shows that communities are widely recognised as important actors in supporting older people, yet their role remains largely informal and under-institutionalised. Community-based resources—such as NGOs, volunteer initiatives, or informal neighbourhood support—often compensate for system gaps, but do so without stable integration into health or social service workflows.

Key informants repeatedly emphasised that community engagement is not structurally embedded into service delivery models, but relies on ad hoc cooperation or donor-supported projects:

"If there is an NGO or an active community organisation, something works. If not, everything stops. The system itself does not require or sustain community engagement." [KII, Representative of WHO]

This results in high territorial inequality, where older people's access to community-based support depends on local initiative rather than guaranteed service standards.

Regularity of community and volunteer engagement in work with older people
(analytical typology based on worker survey)



Note: This figure presents an analytical typology of community and volunteer engagement based on health and social workers' self-reported practices and qualitative interpretation of survey findings. It does not represent a direct quantitative distribution derived from a single survey question.

The graph illustrates that the involvement of public and volunteer resources is mostly irregular or absent. Episodic interaction is the most common model — it is recorded in approximately 4 conditional units of the typology. The absence of any interaction is also significant — about 3 units, which indicates the complete isolation of some institutions from public resources. Regular interaction is the least common model — only 2 units, which indicates limited institutional involvement of volunteers and the community.

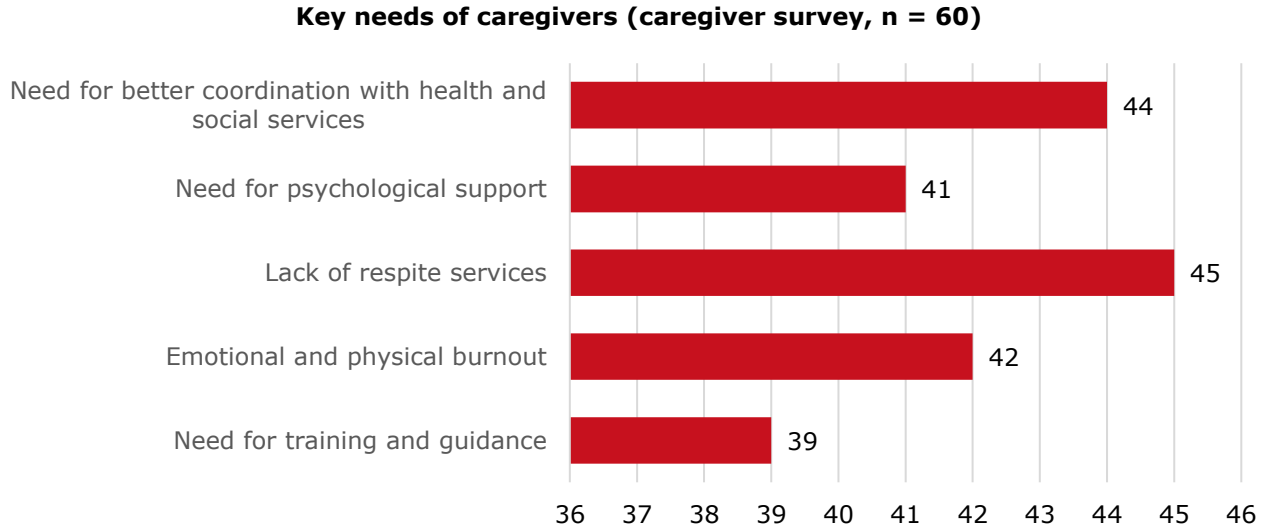
The results demonstrate that public and volunteer resources are not systematically integrated into work with the elderly. The dominance of episodic or absent forms of interaction indicates a project-based, non-institutionalized model of cooperation that does not ensure the sustainability and scalability of integrated care in the ICOPE logic.

The weakest dimension of readiness within this domain concerns caregivers, despite their central role in sustaining older people at home and in the community. Evidence from caregiver focus groups and surveys demonstrates that caregivers remain largely invisible at the service level: they are rarely formally identified, assessed, or included in care planning processes.

Caregivers describe a situation in which they carry substantial responsibility for daily care, coordination, and monitoring, yet receive minimal structured support from health or social services:

"Everyone asks about the older person, but nobody asks how I am coping. There is no place where caregivers are seen as part of the care team" [survey, caregiver]

The absence of standardised caregiver-support pathways—including training, psychosocial support, respite services, and case management—emerges as a critical service-level gap. This gap is not merely a social issue, but directly undermines the sustainability of care arrangements and increases the risk of caregiver burnout, neglect, or institutionalisation of older people.



The results demonstrate that public and volunteer resources are not systematically integrated into work with the elderly. The dominance of episodic or absent forms of interaction indicates a project-based, non-institutionalized model of cooperation that does not ensure the sustainability and scalability of integrated care in the ICOPE logic.

From an operational readiness standpoint, the assessment indicates that barriers to engagement and empowerment are not primarily related to lack of awareness or resistance among service providers. On the contrary, many respondents demonstrate a clear conceptual understanding of why engagement of older people, communities, and caregivers is necessary within an integrated care model.

Instead, the binding constraints are meso-level design and capacity issues, including:

- absence of mandatory service standards for shared care planning;
- lack of formal roles for social workers in multidisciplinary teams;
- limited time and staffing to support proactive engagement;
- fragmentation between health, social protection, and community actors;
- absence of financing or contractual incentives for caregiver support services.

This assessment is reinforced by system-level perspectives:

"There is understanding and even willingness. What is missing are instruments, time, and responsibility. Without this, engagement remains a declaration." [KII, Representative of Local NGO]

Overall readiness judgement for ICOPE Service Action 6.1

Based on triangulation of qualitative and quantitative evidence, readiness for Service Action 6.1: Engage and empower people and communities can be characterised as:

- mostly declarative compliance with ICOPE principles;
- minimal and episodic operational implementation;
- lack of a service architecture capable of supporting systemic engagement.

Engagement exists primarily at the level of individual relationships and project-based initiatives, rather than as an institutionalised component of service delivery. Without deliberate service-level redesign—particularly strengthening the role of social workers, formalising caregiver support, and embedding community engagement into routine workflows—this ICOPE action cannot be sustainably operationalised.

6.2. Support the coordination of services delivered by multidisciplinary providers

6.2.1. Coordination as a core meso-level requirement of ICOPE

Within the ICOPE framework, coordination of services provided by multidisciplinary providers is a central service level function without which integrated care cannot be operationalized. Coordination at the mesolevel involves not simply the coexistence of different professionals, but structured interaction, shared understanding of roles, formalized referral pathways, and

mechanisms for information exchange between health professionals, social workers, and community-level actors.

In the Ukrainian context, coordination is widely recognized as necessary, but remains poorly institutionalized. Evidence from all sources suggests that coordination is largely staff-based and informal, rather than built into service design. This creates significant variability in practices and undermines continuity of care for older people, especially those with complex medical and social needs.

In addition to the human factor, a critical barrier remains a structural and technical one: Ukraine lacks a digital environment that would support intersectoral coordination. The medical system and the social system operate as separate, unsynchronized platforms, which makes it impossible to share information, maintain a unified care plan, or digitally track a person's journey between sectors.

6.2.2. Coordination between primary health care and social workers

a) PHC as the medical anchor, social workers as the functional and social anchor

Primary health care (PHC) providers—particularly family doctors—are positioned as the main medical coordinators for older people. In parallel, social workers serve as the primary coordinators of social support, long-term care services, and community-based assistance. In theory, this division of roles is complementary and aligns well with ICOPE principles. In practice, however, the connection between these two anchors is weak and inconsistent.

PHC providers often focus on clinical management of chronic conditions, while social workers address functional limitations, home-based care, and social risks. The absence of formal coordination mechanisms means that these parallel efforts are rarely synchronised into a single, coherent care pathway.

"The family doctor and the social worker often work with the same person, but they do not work with each other. Each one sees only their own part of the picture." [KII, Representative of Local NGO]

Additionally, coordination is complicated by the structural conflict of interests and priorities between sectors. The family doctor works within the logic of NHSU contracts, clinical indicators, electronic declarations and limited reception hours. The social worker is subordinate to local government bodies, works within the framework of local programs, social standards and deficit budgets of communities. In the absence of common performance indicators, joint financing and legally established responsibilities for interaction, coordination is not a priority for either the medical or social system. As a result, each sector optimizes its own processes, rather than a common outcome for the elderly person.

b) Lack of routine multidisciplinary interaction

Multidisciplinary case discussions involving PHC providers, nurses, and social workers are **not a routine practice**. Where such interactions occur, they are typically triggered by crisis situations, personal relationships, or external projects, rather than by service-level requirements.

Social workers report that they often learn about medical changes incidentally—through the older person or their caregiver—rather than through direct communication with healthcare providers. Conversely, PHC providers frequently lack awareness of whether a patient receives social services, what type of support is provided, or whether caregivers are experiencing overload.

A critical limitation is the digital divide: doctors and social workers do not have shared access to care plans, needs assessments, or intervention outcomes. Even if they were willing to collaborate, they do not see each other's records in digital format. eHealth/HELSI and E-Social are not integrated, which technically makes it impossible to manage a single case.

The role of the nurse requires special attention. In the ICOPE model, it is the nurse who often acts as a case manager or care coordinator, maintaining regular contact with the patient, monitoring functional status, and connecting the medical and social components. In Ukrainian primary health care, the nurse is mostly perceived as a technical assistant to the doctor. She usually does not have formalized authority, allocated time, or tools for communication with

social services. This significantly limits the potential for the transition from a "doctor-centric" model to a true interdisciplinary team.

6.2.3. Referral pathways: from ad hoc advice to structured navigation

a) Informal referrals dominate service practice

Referral pathways between health and social services are predominantly **informal and advisory**. Healthcare providers may verbally suggest that an older person contact social services, while social workers may recommend visiting a family doctor or specialist. These recommendations are rarely accompanied by formal referral documents, shared assessments, or follow-up mechanisms.

As a result, responsibility for navigating the system is shifted to older people and caregivers, who may lack the capacity, information, or energy to complete complex referral chains.

"We 'refer' people by telling them where to go. Whether they actually get there, and what happens next, we usually do not know." [survey, social worker]

The key reason for this situation is the lack of a legally established mechanism for a "social prescription" or official referral from a doctor to a social service that would be binding for the provision of services. There are no unified standard operating procedures (SOPs) for referral, joint assessment or opening a "social case" upon medical request. This forces professionals to act at their own discretion, creating risks of a person being "lost" between systems, as well as potential corruption risks due to informal decisions.

b) Absence of feedback loops and referral tracking

A critical gap identified in the interviews is the lack of feedback mechanisms. After a referral — formal or informal — there are no systematic tools to confirm the fact of receiving a service, assess the results, or determine the need for further support.

The situation is significantly exacerbated by legal and procedural uncertainty in the area of personal data protection. Doctors often directly indicate a reluctance to share any information with social workers due to the fear of violating medical confidentiality and personal data protection legislation (including requirements interpreted through the prism of the GDPR and the Law of Ukraine "On Personal Data Protection").

In Ukraine, there are no interdepartmental data exchange protocols, standardized informed consent forms, and defined lists of information that can be legally transferred between the medical and social systems. As a result, even where professionals are aware of the need for coordination, they deliberately avoid sharing information in order not to bear personal legal liability.

Thus, fragmentation is caused not only by organizational problems, but also by a regulatory vacuum: without clear rules for data exchange, integrated care cannot be legally secure and therefore does not scale.

c) Caregivers as de facto care coordinators

In the absence of structured referral pathways, caregivers frequently assume the role of **de facto coordinators**, managing appointments, transporting older people, transmitting information between providers, and ensuring continuity. While this compensates for system gaps, it also significantly increases caregiver burden and reinforces inequities for older people without strong family support.

"If I do not call, remind, and follow up myself, nothing happens. The system does not connect things for us." [survey, family doctor]

6.2.4. Intersectoral interaction beyond individual cases

a) Governance and organisational silos

At the meso level, coordination is further constrained by organisational and governance silos. Health and social services operate under different administrative hierarchies, reporting requirements, and performance indicators. These structural separations discourage joint planning and shared accountability at the service level.

Even when policy documents emphasise intersectoral cooperation, service providers lack operational guidance on how to collaborate in daily practice.

"Everyone talks about intersectoral cooperation, but no one explains what it should look like on Monday morning at the clinic or social service centre" [KII, Representative of Local NGO]

b) Role of NGOs as informal integrators

Non-governmental organisations often play a bridging role, facilitating coordination through case management, outreach, and project-based service delivery. While these efforts demonstrate feasibility and innovation, they are typically time-bound and dependent on external funding.

At the same time, such coordination is artificial from a systemic point of view: it depends on grant funding, is not integrated into state protocols, and is not supported by NHSU packages or stable local budget programs. When the project ends, the coordination function usually disappears along with the team. This poses a direct threat to the stability and scalability of integrated care.

6.2.5. Implications for ICOPE readiness at service level

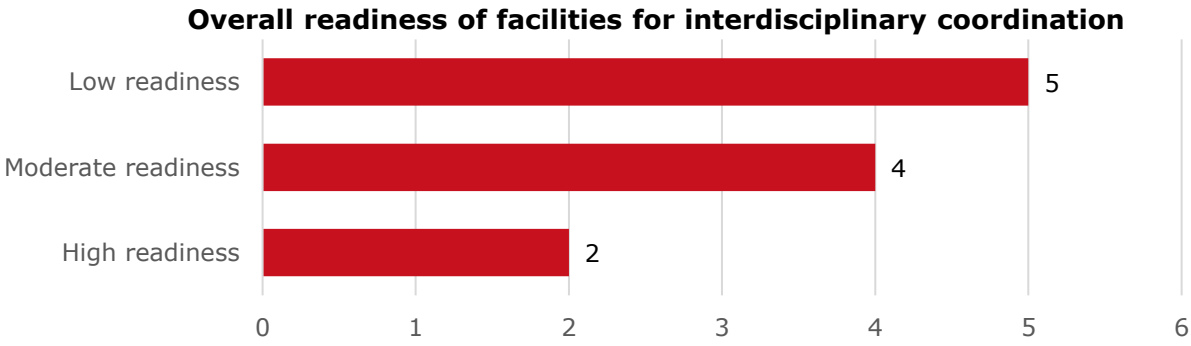
The evidence indicates that coordination of services delivered by multidisciplinary providers is currently at a low to initiating level of readiness. While the conceptual understanding of integration exists, practical mechanisms remain underdeveloped.

Key service-level gaps include:

- absence of formalised multidisciplinary workflows involving PHC, nurses, and social workers;
- reliance on informal, non-documented referrals;
- lack of referral tracking and feedback loops;
- over-reliance on caregivers as system navigators;
- project-based rather than institutionalised intersectoral coordination.

A critical systemic barrier is the lack of a defined role for the Care Manager / Care Coordinator in staffing and funding models. Within ICOPE, this role should be personified — with clear responsibility for case management, communication between sectors, and outcome for the person. In Ukrainian practice, this function is blurred between the doctor and the social worker and is actually not assigned to anyone.

"Integration exists where someone personally pushes it. Once that person leaves, everything collapses." [KII, Representative of WHO]



The visualization shows that the readiness of institutions for interdisciplinary coordination remains low in general. The assessment of the low level of readiness dominates, indicating the absence of the necessary institutional, organizational and procedural conditions for sustainable inter-sectoral cooperation.

The moderate level of readiness is represented by a smaller share and probably reflects the presence of individual elements of coordination, which, however, do not form a holistic and systemic model of interaction between specialists from different sectors. The high level of readiness remains marginal and is rather an exception than an established practice.

General judgment on readiness under point 6.2

Based on the triangulation of results, the readiness to implement ICOPE action 6.2 "Support coordination of services provided by multidisciplinary providers" is most accurately characterized as:

- no or minimal implementation as a standard service function;
- initial implementation in isolated practices, driven by individual initiative or NGO involvement.
- systemic barrier - a combination of digital incompatibility of systems and legal uncertainty regarding data exchange, which effectively blocks any attempt to create a shared care plan or real case management.

Without targeted reforms at the service level - primarily formalizing collaboration between PMTCTs and social workers, introducing structured referral pathways, and reducing reliance on caregivers as informal coordinators - this ICOPE action cannot be sustainably implemented.

6.3. ICOPE Implementation Readiness Assessment — Service Level (Meso-Level): Community-Based Care Service Orientation

6.3.1. Community-based care as a core pillar of ICOPE at service level

Within the ICOPE framework, orienting services towards community-based care is not a supplementary option, but a **foundational service-level requirement**. Community-based care implies that older people receive the majority of health, social, and supportive services **as close as possible to their place of living**, minimising unnecessary institutionalisation and reliance on inpatient care. This orientation is particularly critical for older people with limited mobility, chronic conditions, functional decline, or caregiving needs.

In the Ukrainian context, community-based care is widely recognised as desirable, yet its implementation remains **partial, uneven, and highly dependent on local capacity**. Evidence from interviews, focus groups, surveys, and facility checklists indicates that services continue to be organised primarily around facilities rather than around people's daily environments. As a result, older people with reduced mobility or complex needs face structural barriers to accessing care.

6.3.2. Accessibility of services for older people

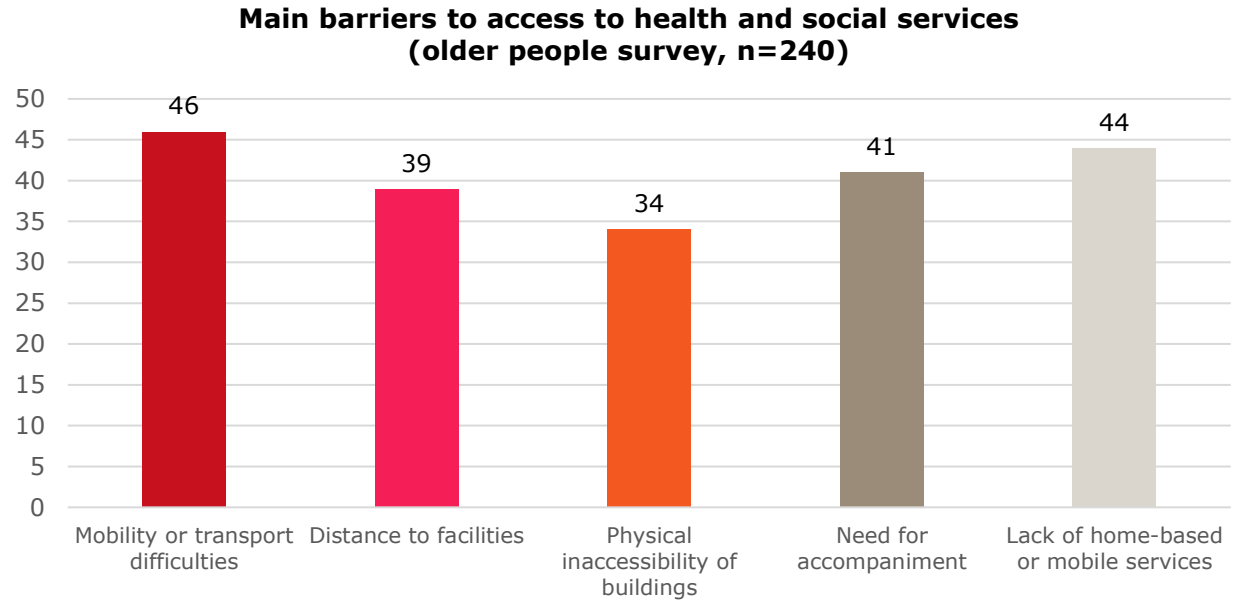
a) Physical and geographic accessibility

Accessibility emerged as a persistent challenge across regions and service types. Older people and caregivers described difficulties related to transportation, distance to facilities, architectural barriers, and limited availability of outreach services. These barriers disproportionately affect rural communities and older people living alone.

While PHC facilities are generally geographically widespread, their accessibility for people with mobility impairments is not consistently ensured. Social services face similar constraints, with home-based support often limited by workforce shortages and travel time.

"We talk about access, but for many older people access ends at the door of their home. If someone cannot physically reach the service, the service does not exist for them." [KII, Representative of Local NGO]

In addition to physical barriers, in the Ukrainian context, the war has created an additional "functional" barrier to accessibility—social isolation. The destruction of social ties through displacement, loss of family, evacuation of neighbors, depopulation of villages, and a general decline in the level of mutual assistance reduces the ability of the community to fulfill the role of a "social framework" of care. This is critical for ICOPE, as the model relies heavily on the presence of daily informal observation and support (neighbors, volunteers, local initiatives) as a mechanism for early detection of risks (falls, disorientation, acute loneliness) and rapid response. In the context of destroyed social networks, even the presence of formal services may not be converted into real support, because "there is no one to take a person to a service" or to report a deterioration in the condition.



Note: The figure summarises self-reported barriers to accessing health and social services among older people, based on aggregated survey responses

The graph shows that access to services for older people is limited primarily by structural and physical factors that are not dependent on individual choice.

The most common barriers are difficulties with movement or transport and the lack of home or mobile services, which indicates the critical role of spatial accessibility and forms of care provision outside of stationary institutions. The need for accompaniment is also highly significant, reflecting both physical limitations and the lack of support services. Remoteness of facilities and physical inaccessibility of buildings also remain significant obstacles, although their significance is somewhat lower compared to other factors. Taken together, these barriers form a complex and fragmented path to access care, requiring significant additional resources from older people themselves and their caregivers.

The results suggest that limited access to services is systemic and is related not only to infrastructure, but also to the lack of adapted, people-centred models of care provision. In the context of ICOPE, this highlights the need to expand home-based, mobile and intersectoral coordinated services focused on the functional needs of older people.

b) Administrative and informational accessibility

Beyond physical access, older people face administrative and informational barriers. Complex eligibility rules, fragmented information sources, and reliance on digital tools without adequate alternatives create additional exclusion risks. These barriers often require caregiver involvement or support from social workers, reinforcing inequalities between those with and without such support.

6.3.3. Mobile and home-based services: potential and limitations

a) Home-based services as the backbone of community care

Home-based services are a critical component of community-oriented care for older people, particularly those with functional limitations. Social services play a leading role in delivering home care, including assistance with daily activities, monitoring of living conditions, and psychosocial support. In theory, these services align closely with ICOPE principles by supporting ageing in place and maintaining functional ability.

In practice, home-based services are constrained by limited coverage, staffing shortages, and prioritisation criteria. Many older people who could benefit from such services either do not receive them or receive them at a minimal level insufficient to meet their needs.

"Home care exists on paper, but in reality one social worker is responsible for too many people. You cannot talk about quality or continuity in such conditions." [KII, Representative of NSSU]

An important clarification for the ICOPE framework: in Ukraine, what is called "home care" in the social services system is mostly domestic support (cleaning, food/medicine delivery, assistance with payment, accompaniment), i.e. social care, but not integrated care in the sense of ICOPE.

ICOPE requires that home contact with an older person includes systematic observation and early detection of functional deficits (vision, hearing, cognition, mobility, risk of falls, symptoms of depression), as well as the initiation of intersectoral interventions. Social workers in Ukraine, as a rule, do not have medical protocols and powers to assess intrinsic capacity and are not integrated into clinical pathways, so their visits rarely translate into prevention of functional degradation — which is the central goal of ICOPE.

As a result, "aging in place" often boils down to supporting survival at home rather than structured preservation of functional capacity.

b) Mobile medical services and outreach

Mobile medical services, including outreach by nurses or family doctors, are sporadically implemented and often linked to pilot projects or emergency responses rather than routine service provision. While such services demonstrated high value during periods of displacement and insecurity, they are not embedded as a standard component of PHC delivery.

The lack of systematic mobile services limits early identification of functional decline and reduces opportunities for preventive interventions, both central to the ICOPE approach.

"Mobile teams appear when there is a project. When the project ends, the service disappears." [KII, Representative of WHO]

The current model of financing primary care through the NHSU does not create stable financial incentives for regular home visits to patients with limited mobility as a "normal" standard. For a family doctor, home visits are often an exception, occurring due to personal motivation or local agreements, rather than as a paid, planned function. Without changing contractual requirements and/or tariff incentives, the "facility-centric" approach will persist, and mobility will remain a project or crisis practice, rather than a systemic component of ICOPE.

6.3.4. Role of social workers in community-based care orientation

Social workers are the **primary operational actors** enabling community-based care for older people. Their responsibilities include needs assessment, coordination of home-based services, engagement with caregivers, and linkage to community resources. In many cases, social workers are the only professionals who regularly enter older people's homes and therefore possess the most comprehensive understanding of functional and social realities.

Despite this central role, social workers operate under severe constraints. High caseloads, limited transport options, and administrative burdens restrict the frequency and depth of home visits. Moreover, their integration into health service workflows remains weak, limiting their ability to influence care planning or trigger medical follow-up when needed.

"Social workers see what is happening at home, but this information rarely reaches the doctor. There is no channel for that." [KII, representative of a local NGO]

From an ICOPE perspective, the underutilisation of social workers' knowledge represents a missed opportunity to operationalise community-based care in a coordinated and person-centred manner.

At the same time, it is necessary to critically record the objective limit of the social worker's influence in the existing model. The typical visiting schedule (for example, 2 times a week for 1–2 hours) means that for a person with dementia, a high risk of falls, or a need for 24-hour supervision, there remains a "care void" for most of the time (over 160 hours a week out of contact with the service). This is not a shortcoming of an individual worker, but a structural deficiency in the level of intensity of community-based care.

That is why the absence or minimal availability of respite care services and day centers/day care in Ukraine is a critical barrier to the implementation of ICOPE: without such "intermediate" formats, the system cannot close the gaps between short visits by a social worker and the need for constant supervision.

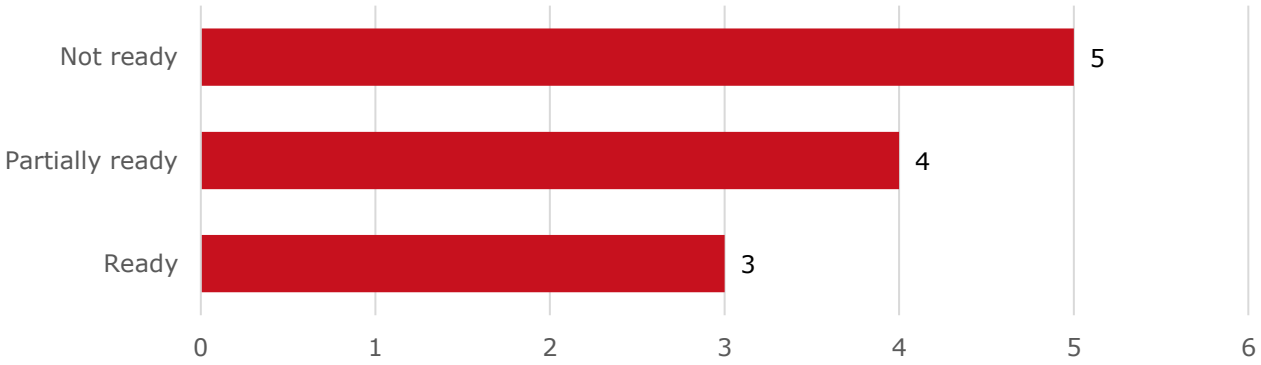
6.3.5. Implications for service-level readiness

The evidence indicates that orientation towards community-based care is conceptually acknowledged but operationally underdeveloped. Services remain facility-centric, with community-based elements functioning as add-ons rather than as the organising principle of care delivery.

Key constraints include:

- limited availability and coverage of home-based and mobile services;
- insufficient workforce capacity, particularly among social workers and care assistants;
- weak integration between PHC and community-based social services;
- reliance on project-based initiatives rather than institutionalised service models.

Facilities' readiness to deliver community-based services (aggregated assessment based on facility checklists)



Note: This figure presents an aggregated analytical assessment of facilities' readiness to deliver community-based services based on facility checklists. Values represent an illustrative scale rather than exact quantitative scores.

The graph shows that most of the surveyed facilities are not ready or only partially ready to provide community-based services for older people. The category of "not ready" dominates, indicating the lack of the necessary organizational, personnel and procedural conditions for the deployment of services at the community level. Partial readiness indicates the presence of individual elements or pilot practices, which, however, do not form a full-fledged and sustainable model of service provision outside of stationary facilities. Full readiness for community-based approaches remains limited and rather exceptional.

The results obtained indicate the structural unreadiness of the system for the transition from an institutional-oriented model to services based on community needs, which is a key element of the ICOPE approach. Without targeted investments in personnel, coordination and intersectoral mechanisms, the potential of community-based care will remain unrealized.

6.3.6. Service-level Scorecard Summary

Table 8. Service-level ICOPE Scorecard — Summary (Meso Level)

ICOPE Service Action	Observed stage of implementation	Key evidence
Engage and empower people and communities	Initiating	Individual participation without systematic tools; limited caregiver support
Support coordination of multidisciplinary services	No-to-minimal / Initiating	Informal PHC–social worker interaction; weak referral pathways
Orient services towards community-based care	Initiating	Home-based services exist but limited; mobile services project-dependent

Short analytical summary

Overall, the readiness to implement ICOPE at the service level is characterized by partial compliance with the ICOPE principles without institutional consolidation. Community-based care functions as a compensatory mechanism, not as a basic model of service delivery. Social workers and caregivers play a critical role in supporting older people in the community, but do not have sufficient structural support, integration and recognition in the work processes at the service level.

Given the lack of a common client/patient register between the medical and social systems, the lack of regulated multidisciplinary team meetings and the lack of financial incentives for primary health care to go beyond the "office" model, a more correct interpretation is a strict one: key components of community-based care are mainly at the "No-to-minimal" stage, and "Initiating" is manifested only as individual practices dependent on local initiative or grant projects.

Without targeted reforms at the service level—including expanding the content of home-based services to include functionally-oriented monitoring (intrinsic capacity), introducing day/respite formats, and changing the funding and contractual logic of PHC to support outreach services—progress in implementing ICOPE will remain fragmented and vulnerable to external shocks.

7. ICOPE Readiness Assessment — System (Macro) Level

7.1. Strengthen governance and accountability systems

7.1.1. Governance as a determining factor for ICOPE implementation

Within the ICOPE framework, governance and accountability systems constitute the primary macro-level enablers of integrated care. Even where service-level practices demonstrate partial alignment with ICOPE principles, the absence of coherent governance arrangements, regulatory clarity, and aligned accountability mechanisms significantly constrains scalability and sustainability.

In Ukraine, governance of services relevant to older people is characterised by institutional fragmentation, with responsibilities distributed across multiple ministries, agencies, and levels of government. While this distribution reflects historical development and decentralisation reforms, it also creates structural barriers to integrated, person-centred care.

Evidence from key informant interviews consistently indicates that no single institution currently holds a clear mandate for integrated care for older people as a cross-sectoral policy objective.

"Everyone is responsible for their own sector, but no one is responsible for the person as a whole. Integrated care exists between institutions, but not within the system." [KII, representative of a local NGO]

The absence of a national inter-ministerial governance body (Inter-ministerial Steering Committee) on ageing and integrated care is particularly critical.

Such a body is needed not formally, but functionally — as a single centre of political leadership for integrated care. Within the logic of ICOPE, it should perform at least five core systemic roles:

- shaping a unified national policy on healthy ageing, shared by the Ministry of Health, the Ministry of Social Policy, Family and Unity of Ukraine, the Ministry of Finance, the National Health Service of Ukraine, and the National Social Service of Ukraine;
- strategic coordination of reforms, ensuring that changes in health care, social policy, and decentralisation do not create new barriers;
- governance of integrated financial instruments (joint budgeting, pooled funds, intersectoral programmes);
- regulatory harmonisation (in particular with regard to data sharing, professional roles, and accountability for care outcomes);

- political accountability for person-level outcomes (functional ability, quality of life, caregiver burden), rather than only for sector-specific indicators.

In the absence of such a body, integrated care has no institutional owner. In this configuration, ICOPE is structurally unable to move from the pilot stage to the level of state policy.

7.1.2. Policies of the Ministry of Health: strengths and structural limitations

The Ministry of Health has implemented large-scale reforms aimed at strengthening primary health care, improving access to services, and introducing new financing mechanisms through the National Health System. These reforms have created an important basis for the continuity of health care for older people, in particular in the management of noncommunicable diseases.

At the same time, from the ICOPE perspective, the policy of the Ministry of Health remains predominantly biomedical and service-oriented. Despite the declaration of patient-centricity and prevention, it lacks the systemic integration of the concepts of intrinsic capacity, functional capacity, and intersectoral care pathways.

A critical deficiency is the lack of an up-to-date national strategy for healthy aging in Ukraine that would unite the Ministry of Health and the Ministry of Social Policy in a single policy framework. The issues of aging and geriatrics are effectively "solved" in general protocols for the management of chronic diseases, without singling out older people as a separate political and managerial category.

This means that at the state policy level, there is no identified entity responsible for integrated outcomes for older people. There is no interdepartmental steering body, no common reform roadmap, and no common performance indicators.

"The health reform has moved forward. But it moved on its own. The social sector did not move with it, and now integration is discussed more rhetorically." [KII, WHO representative]

7.1.3. Policies of the Ministry of Social Policy, Family and Unity of Ukraine: decentralisation without integration

The Ministry of Social Policy, Family and Unity of Ukraine is responsible for social services, social protection and long-term care. Current reforms emphasize decentralization, the development of community-based services and the expansion of home care.

From the ICOPE perspective, these policies have a high conceptual correspondence to the principles of community-based care and the maintenance of functional capacity. Social services are directly focused on everyday needs, social participation and care relationships.

At the same time, they are implemented mostly in isolation from the health sector. Regulatory acts do not contain mandatory mechanisms for coordination with medical providers, joint needs assessments or intersectoral care plans.

Decentralization has exacerbated another systemic problem - horizontal inequity. The ability of a community to organize social services depends not on the needs of older people, but on the availability of local budgets. Rich communities can afford social workers and service models; poor ones often cannot provide even basic support.

In such a model, ICOPE as a WHO standard becomes de facto a privilege of financially capable communities, rather than a guaranteed public policy approach. There are no government subsidies specifically aimed at integrated care and intersectoral teams.

"Communities are now responsible for social services, but health care remains outside their influence. Integration is expected, but the tools are missing." [KII, representative of department of social policy]

7.1.4. Regulatory frameworks: fragmentation and accountability gaps

Regulatory frameworks governing health and social services remain **sector-specific and siloed**. Separate laws, by-laws, standards, and reporting systems regulate service provision, quality assurance, and accountability within each sector.

Key regulatory gaps relevant to ICOPE include:

- absence of a legal definition or mandate for integrated care for older people;
- lack of standards for multidisciplinary care planning;
- no regulatory requirement to identify, assess, or support caregivers;
- limited accountability mechanisms for intersectoral outcomes.

A separate systemic problem is legislative friction between the medical and social sectors. The Law "On Social Services" and the Fundamentals of Healthcare Legislation contain different requirements for confidentiality and access to personal data. As a result, the doctor takes legal risks by transferring information to a social worker, even if it is necessary for care. The lack of agreed consent protocols, interdepartmental data exchange standards, and legal protection for professionals effectively blocks the information basis for integrated care.

"Accountability exists only within sectors. No one is responsible for failures of coordination between sectors." [KII, representative of a local NGO]

7.1.5. Role of the National Health Service of Ukraine (NHSU)

The NHSU is a key actor in shaping the behavior of service providers through procurement and contracting mechanisms.

On the one hand, procurement reform has increased the accessibility and standardization of health services. Theoretically, NHSU contracts could become a tool to stimulate integrated practices.

On the other hand, the current contracting model focuses almost exclusively on medical activities.

A critical systemic barrier is budgetary fragmentation. Medical funds (state budget through the NHSU) and funds for social services (local community budgets) cannot legally and procedurally be combined to finance a single multidisciplinary team, case management, or shared services.

In the absence of joint budgeting mechanisms, any management model of integration remains declarative.

An additional limitation is the NHSU tariff logic. Funding packages do not take into account the complexity of the geriatric patient. A person with dementia, diabetes, and falls is funded in the same way as a "light" patient. This structurally discourages spending time on comprehensive assessment, teamwork, and coordination.

"The NHSU pays for medical actions. Social work, coordination, caregiver support exist outside the contract and outside accountability." [KII, WHO representative]

7.1.6. National Social Service of Ukraine within Governance and Accountability Systems

Within the system architecture of governance, the National Social Service Service of Ukraine is the only institutionalized nationwide mechanism for overseeing the quality of social services. Its inspection and monitoring functions provide important data on the availability of services, compliance with standards and practical implementation problems in regions and communities. In this sense, the NSSU is a key pillar of the accountability system in the field of social care.

At the same time, despite this central role, the NSSU remains largely disconnected from the health-social intersection. Its monitoring and inspection processes are carried out in isolation from quality assurance mechanisms in the health system, and the results of inspections are not systematically integrated into intersectoral reviews, joint planning or integrated care management structures. In the current model, the NSSU functions mainly as a review body, rather than as a partner in reforms, and its analytical potential is hardly used to develop intersectoral models.

In ICOPE's logic, this institutional position is both a challenge and an opportunity. Although the NSSU does not have a mandate to coordinate services, its oversight function objectively makes it a strategic systemic actor. Provided formalized interfaces are created with the health sector's governance mechanisms, the NSSU could evolve from monitoring compliance with formal standards to the role of a quality certification body for integrated services—with a focus not only on procedural compliance but also on intersectoral coordination, caregiver support, and

outcomes for the functional capacity of older people. At present, the potential of the NSSU in integrated care reform remains systemically underutilized.

Overall readiness judgement for governance and accountability

At the macro level, Ukraine's readiness to implement ICOPE should be assessed as low. While important reforms have taken place in the health and social protection systems, they have developed in parallel, without a common framework for aging policy or integrated care. As a result, there is no governance architecture capable of supporting ICOPE not as a set of pilots, but as a state model.

A key systemic problem is the deep institutional divide between the Ministry of Health and the Ministry of Social Policy, Family and Unity of Ukraine. Responsibility for older people is fragmented across sectors, no body has a mandate for a "holistic outcome," and interdepartmental mechanisms for managing integrated care are absent. Integration exists at the rhetorical level, but not as a mandatory political function.

This divide is exacerbated by budgetary fragmentation. Medical services are financed from the state budget through the National Health Service, while social services are financed from local community budgets. There are no mechanisms for joint budgeting or financing multidisciplinary teams. Under such conditions, integrated care is mechanically impossible: no single fund manager can finance the full cycle of support for one person.

Decentralization has also created horizontal inequality. Access to social and care services depends on the financial capacity of the community, not on the level of needs of the elderly person. For ICOPE, this means structural incompatibility without state subsidies and national equalization instruments.

An additional barrier is legislative conflicts between sectors: different confidentiality regimes and the lack of interdepartmental data exchange protocols create legal risks for doctors and social workers and effectively block systemic coordination.

Taken together, this means that without the creation of an interdepartmental management center, joint budget mechanisms, and regulatory harmonization, ICOPE in Ukraine can only exist in the format of local projects, but not as a scaled-up state model of integrated care.

7.2. Enable system-level strengthening

7.2.1. Workforce capacity as a binding constraint for integrated care

Workforce capacity is one of the most critical systemic determinants of Ukraine's readiness to implement ICOPE. In both sectors — health care and social protection — shortages of qualified staff, uneven distribution of personnel, and limited ageing-related competencies significantly constrain the feasibility of integrated care for older people.

In the health sector, primary health care providers are increasingly required to manage complex clinical cases combining multimorbidity, polypharmacy, and age-related functional decline. At the same time, workforce planning has not systematically accounted for population ageing or for the additional workload generated by integrated care models (coordination, multidisciplinary work, communication with social services and caregivers). As a result, PHC physicians operate under conditions of chronic overload, which practically precludes proactive, person-centred, and interdisciplinary approaches.

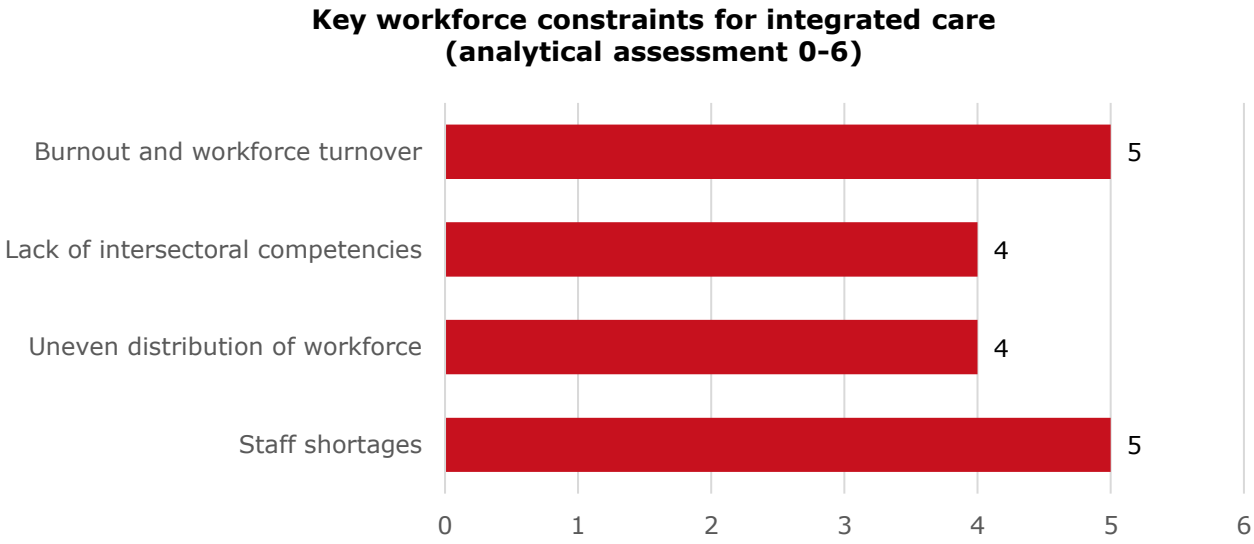
However, the current workforce shortage is driven not only by structural planning failures but also by the direct physical loss of human capital due to the war. A significant proportion of PHC and social-service staff (predominantly women) have left the country as refugees, while a number of male medical workers, mobile team drivers, and technical personnel have been mobilised. This has created a dual burden of depopulation: the simultaneous growth of older people's needs and a physical contraction of the workforce. Under such conditions, the ICOPE model, which is based on stable multidisciplinary teams, faces a fundamental human-resource constraint.

In the social sector, workforce problems are even more pronounced. Social workers and home-care assistants often carry excessive caseloads, cover large geographic areas, and work without adequate logistical support. This directly affects the availability and quality of home- and community-based services and undermines continuity of care.

"We expect social workers to do everything: assess needs, provide care, coordinate, support families. But one person cannot do the work of five." [KII, representative of a local NGO]

From an ICOPE perspective, workforce shortages are not only quantitative but also qualitative. Integrated care requires competencies that go beyond traditional professional training, including intersectoral communication, shared decision-making, caregiver engagement, and functional assessment. These competencies are not currently embedded in workforce development frameworks.

In wartime conditions, an additional critical dimension is added: secondary traumatisation of staff, professional burnout, and reduced psychological resilience. Expecting overloaded and emotionally exhausted personnel to implement complex person-centred care models is structurally unrealistic without parallel investments in mental-health support for professionals.



Note: This figure presents an expert-based analytical assessment of key workforce constraints for integrated care. Values represent an illustrative scale rather than exact quantitative measurements.

The chart reflects a set of workforce factors that significantly constrain the implementation of integrated care. All identified constraints are rated as highly significant, indicating the systemic nature of the workforce crisis.

Experts identify staff shortages and burnout and turnover as the most critical constraints, pointing to overload of existing workers and loss of workforce stability. Uneven territorial distribution of staff and the lack of intersectoral competencies are also rated as highly significant, complicating coordination between health and social services.

The findings underline that workforce constraints constitute one of the key structural barriers to ICOPE implementation. Without addressing staff shortages, professional burnout, and the development of intersectoral competencies, integrated care will remain a declarative rather than an operationally implemented approach.

7.2.2. Financing: misalignment of incentives and fragmented funding streams

Financing arrangements constitute a central system-level enabler—or barrier—to ICOPE implementation. In Ukraine, financing of services relevant to older people is characterised by segmented funding streams, with healthcare services financed through central purchasing mechanisms and social services funded primarily at the local level.

This segmentation creates misaligned incentives. Healthcare financing prioritises measurable medical outputs, while social services operate under constrained local budgets that prioritise basic coverage over service integration or innovation. Integrated care activities—such as care coordination, multidisciplinary case management, and caregiver support—often fall between these funding streams and lack a clear financing source.

"Everyone agrees that coordination is needed, but no one pays for coordination." [KII, WHO representative]

The war has sharply intensified this problem through a crowding-out effect. A significant share of community resources is being redirected to defence, the restoration of critical infrastructure, and basic survival functions. Social services for older people are increasingly financed on a residual basis. Under these conditions, financing integrated care is virtually impossible without external donor inputs.

The absence of dedicated financial mechanisms for integrated care severely limits scalability. Even effective pilots fail to transition into routine practice due to the lack of sustainable funding.

From an ICOPE perspective, financial systems should enable:

- joint intersectoral planning;
- financing of coordination and case-management functions;
- support for community-based and preventive services;
- recognition of caregiver support as a legitimate cost category.

In the Ukrainian context, this is currently systemically impossible due to budget fragmentation and the absence of mechanisms for joint financing of the medical and social components of integrated teams.

7.2.3. Digital health and data systems: fragmentation and untapped potential

Digital health and data systems are increasingly recognised as essential enablers of integrated care. In the Ukrainian context, significant investments have been made in digitalisation of healthcare, particularly through electronic health records and eHealth platforms. These developments create a strong foundation for continuity of medical care.

However, from an ICOPE perspective, digitalisation remains sector-specific and incomplete. Health data systems focus primarily on clinical information, while social services maintain separate registries and documentation systems. There is limited interoperability between these systems, and no shared platform for tracking functional ability, caregiving arrangements, or social risks.

"Digitalisation exists, but in parallel worlds. Health care has its own system, social services have theirs, and they are not connected." [KII, representative of a local NGO]

Simultaneously, data integration in wartime conditions creates additional risks. The development of shared platforms for health and social protection requires not only IT solutions, but also a new security architecture. Data on the location, health status, and social vulnerability of lonely older people, especially in frontline regions, are highly sensitive and require enhanced protection. Without this, the integration of digital systems may create serious security threats.

At the same time, digital tools have significant unrealised potential for ICOPE, in particular for:

- shared assessment templates;
- tracking care pathways and feedback loops;
- remote monitoring and follow-up;
- intersectoral communication.

7.2.4. Training and capacity building for integrated care

Training and capacity building are critical system-level investments for sustainable ICOPE implementation. Integrated care requires a workforce equipped with shared competencies and a common conceptual understanding of ageing, functional ability, and person-centred care.

Current training systems in both health and social sectors remain largely **profession-specific and siloed**. Medical education prioritises clinical knowledge, while social work training focuses on social assistance frameworks, with limited overlap or joint learning opportunities. As a result, professionals often lack understanding of each other's roles, mandates, and constraints.

"We were never taught to work together. Doctors, social workers, caregivers—we all learn separately, and then coordination is expected of us." [survey, family doctor]

From an ICOPE readiness perspective, capacity building should focus on:

- interprofessional education;
- practical skills for care coordination;
- engagement of caregivers as partners;
- use of shared tools and frameworks.

In Ukrainian conditions, this must necessarily include a component of supporting the mental health of professionals: prevention of burnout, work with secondary trauma, development of psychological resilience. ICOPE provides for empathetic, partner care, which is impossible in an environment of chronic stress and emotional exhaustion of staff.

7.2.5. System-level Scorecard Summary

System-level ICOPE Scorecard — Summary (Macro Level)

ICOPE System Action	Observed stage of implementation	Key system-level evidence
Strengthen governance and accountability systems	No-to-minimal / Initiating	Fragmented mandates, weak cross-sectoral accountability
Enable system-level strengthening	No-to-minimal	Workforce shortages, misaligned financing, siloed data systems

Short analytical summary

At the macro level, the system's readiness to implement ICOPE remains structurally limited. While individual components—primary health care reform, digitalization, and social service decentralization—are showing progress, they are not brought together in an integrated framework focused on the needs of aging.

The combination of factors—physical loss of personnel due to the war, chronic staff overburdening, budget fragmentation, depletion of local budgets, lack of coordination funding, sectoral digital systems, and lack of interprofessional training—creates a systemic environment in which ICOPE cannot scale beyond individual projects.

Without parallel systemic solutions—in the areas of human resources policy, joint financing, secure data integration, and comprehensive capacity development that takes into account the mental health of staff—any attempt to implement ICOPE in Ukraine will remain fragmented, unsustainable, and dependent on external support.

8. Integrated Analysis: Barriers and Opportunities

This section presents an integrated, cross-cutting analysis of the barriers and opportunities for implementing ICOPE in Ukraine, drawing on evidence generated at the service (meso) and system (macro) levels. The analysis brings together structural, institutional, workforce, financial, socio-cultural, digital, and intersectoral dimensions and demonstrates how these factors interact and cumulatively shape the real level of readiness for integrated care for older people.

Rather than following a "list of problems" approach, this section traces chains of causality: how one gap generates another (for example, lack of a legal mandate → no SOPs and defined roles → no financing for coordination → coordination is shifted onto families → caregiver burnout →

institutionalisation or crisis hospitalisations). It also identifies leverage points where intervention can "unlock" the system.

The key conclusion from the preceding sections, which underpins the logic of this analysis, is that ICOPE in Ukraine is not primarily constrained by "lack of awareness," but by a set of hard systemic limitations — budgetary, legal, digital, and workforce-related — that make integration mechanically difficult even where goodwill exists.

8.1. Legal and institutional barriers and opportunities

Structural and regulatory barriers

A fundamental legal barrier to ICOPE implementation is the absence of an explicit legal and policy mandate for integrated care for older people. While health and social care systems both serve older populations, they are governed by separate legislative frameworks that do not require alignment or coordination.

This fragmentation results in:

- lack of legally defined integrated care pathways;
- absence of binding standards for multidisciplinary cooperation;
- unclear institutional responsibility for coordination outcomes.

As a consequence, integrated care remains an optional practice, dependent on individual initiative rather than enforceable norms.

"Integration is discussed as a concept, but legally it does not exist. If something is not defined in normative acts, it cannot be required or controlled." [KII, representative of a local NGO]

A separate blocking factor is legislative friction in the area of confidentiality and data sharing. The regulations governing medical confidentiality and personal data protection within the health system, and the requirements/procedures within the social services system, have not been consolidated into a single inter-agency protocol. In practice, this creates a situation of legal risk for physicians: by sharing data with a social worker without a clearly defined consent form and an inter-agency regulation, they may potentially violate confidentiality requirements. This is not an "unwillingness to cooperate," but legal uncertainty that discourages any form of systematic information exchange.

In addition, there is no legally закреплена form of "social prescription" — that is, an official referral from a physician to social services that would carry normative force to trigger or prioritise a service. In the absence of standardised SOPs and referral forms, physicians act at their own discretion. This creates two types of risks: (1) the risk of losing the person along the pathway (the person "gets lost" between institutions because there is no tracking mechanism); and (2) corruption and non-transparency risks, where access to services depends on informal arrangements or personal contacts.

Decentralisation reforms, on the one hand, have given communities authority in the social sphere, but on the other hand have reinforced an institutional schism: communities are responsible for social services but have no levers of influence over the health system, which is financed and governed through different mechanisms. As a result, "integration" is expected at the local level, while the key levers (funding, contracting, PHC standards) lie outside local control.

There is also a distinct governance deficit: there is no inter-ministerial steering body/mechanism at the national level that would simultaneously set goals, KPIs, and accountability for the Ministry of Health, the Ministry of Social Policy, Family and Unity of Ukraine, the National Health Service of Ukraine, and the National Social Service of Ukraine in the area of integrated care and healthy ageing. As a result, the geriatric/ageing component within MoH policies is "dissolved" into broader NCD agendas, while the social sector moves in parallel — without a shared framework.

Institutional opportunities

Despite deep structural barriers, the previous sections show that certain institutional preconditions have already been formed in Ukraine that could potentially serve as a foundation for the implementation of ICOPE. This is not about a ready-made system, but about the

existence of fragments from which an architecture of integrated care could theoretically be assembled.

First, at the level of policy and discourse, an important shift in framing has already taken place. In the documents of the Ministry of Health, the Ministry of Social Policy, Family and Unity of Ukraine, donor programmes, and humanitarian approaches, concepts such as person-centredness, prevention, community-based care, support for autonomy, and the role of communities are increasingly present. This means that ICOPE is not entering an "empty" normative field — its logic is not foreign to the Ukrainian context. On the contrary, it resonates well with the already declared reform objectives. This creates a political window of opportunity: integrated care can be introduced not as a separate reform, but as an operationalisation of already proclaimed principles.

Second, the existence of a reformed contracting system in health care (the National Health Service of Ukraine, NHSU) creates a management instrument of influence over practice that is unique for Ukraine. Unlike many previous periods, the state today actually possesses a mechanism through which it can change provider behaviour: contract requirements, service packages, indicators, and payment conditions. This potentially makes it possible to embed elements of ICOPE not only in recommendations, but in binding rules of the game — for example, requirements for functional screening, the involvement of nurses in coordination, documentation of joint care plans, and communication with social services. Without such an "anchor" institution, scaling integrated care is almost impossible.

Third, in the social sector there is already a national institution responsible for quality oversight — the National Social Service of Ukraine. Although it currently performs primarily an inspection function, the very existence of a centralised oversight mechanism creates the possibility of transforming its role: from control of formal compliance to assessment of the quality of integrated services, standards of home- and community-based care, and intersectoral interaction. In the ICOPE system, such bodies can become "carriers" of integrated care standards, rather than merely supervisory structures.

At the same time, the analysis of the previous sections clearly shows that these institutional opportunities currently exist mainly at the level of rhetoric, individual instruments, and fragmented reforms. They have not been brought together into a governed system. This is why the key issue is not the proclamation of new principles, but their translation into concrete governance mechanisms.

This concerns, first and foremost, the need to formalise integration: joint interministerial orders of the Ministry of Health and the Ministry of Social Policy; normatively approved care pathways; standard operating procedures for referral; informed consent and intersectoral data-sharing protocols; formal definition of the care coordinator role as a separate function; and the establishment of mechanisms for joint planning at community level.

A separate point concerns the financial and governance dimension. Without the creation of mechanisms for joint budgeting or at least coordinated financing (for example, through pilot subventions for integrated care, blended packages, or donor–state models), any institutional integration will remain symbolic. Governance without money, in the Ukrainian context, does not create practice.

Thus, institutional opportunities for ICOPE in Ukraine do in fact exist, but they are at the stage of "pre-integration potential." They can be transformed into drivers of systemic change only under conditions of purposeful institutional design: the creation of shared rules, instruments, roles, responsibilities, and financial mechanisms. Without this, so-called "windows of opportunity" will remain at the level of declarations, and integrated care will remain at the level of pilots and good intentions.

8.2. Workforce-related barriers and opportunities

Workforce shortages and overload

Workforce constraints are among the most critical and cross-cutting barriers to ICOPE. In primary health care, doctors and nurses operate under constant overload, which limits the possibility of proactive practices (functional screening, follow-up, team case discussions).

"Declared readiness" of staff does not equal "operational readiness." In practice, ICOPE requires time (for example, a 30-minute checklist-based assessment and updating of a care plan), while the real mode of PHC appointments and the bureaucratic burden make this highly

unlikely as a routine practice. In other words, even if a doctor says "we are ready," the system does not provide time — and this transforms readiness into a declaration.

The war has added a "double burden of depopulation": part of the workforce (predominantly women in the social sector and nursing) has left the country; part of the male workforce (including doctors of certain specialties, drivers/logistics staff of mobile teams) has been mobilised; and the remaining personnel are working under conditions of secondary traumatisation and burnout. ICOPE is structurally based on stable teams, while the war is precisely destroying team stability.

The social sector faces even harsher workforce constraints: high caseloads, large service areas, low pay, and weak logistics. In addition, the actual contact time between a social worker and a client (for example, 1–2 hours several times a week) leaves a "care gap" for the rest of the time, which is especially critical in cases of dementia or high fall risk. Without respite care and day care services (which are almost absent), the ageing-in-place model remains fragile.

"We want social workers to be the backbone of community support, but we do not create the conditions for them to perform this work properly." [KII, NSSSU representative]

Skills and role-related gaps

Even where staff are available, a competency gap exists. Social workers predominantly provide domestic assistance (food delivery, cleaning, basic accompaniment). This is important social care, but it is not integrated care in the ICOPE sense: during visits, there is no standardized monitoring of intrinsic capacity (vision, hearing, cognition, fall risk), and there are no medical protocols or delegated assessment tools. In other words, "home services exist," but their content does not correspond to the preventive logic of ICOPE.

"We are trained to work within our profession, not across professions. Integration is expected, but no one teaches how to do it." [survey, caregiver]

The potential role of nurses as case managers is also underestimated. In ICOPE, nurses often serve as the link between doctors and social workers. In Ukraine, however, PHC nurses are institutionally perceived mainly as technical assistants to doctors, without the time or authority to communicate with social services. This blocks the transition from doctor-centred care to a multidisciplinary team model.

Workforce opportunities

Opportunities in the workforce dimension do exist, but the previous sections show that they can only be realised under a fundamentally different approach to human resource development than the one currently applied. Integrated care in the ICOPE logic cannot be implemented through one-off trainings or additional "capacity-building modules." It requires a rethinking of roles, work processes, and the very professional identity of key actors — the family doctor, nurse, social worker, and care coordinator. Interprofessional learning must be not optional but systemic: joint trainings, joint case discussions, joint use of functional assessment tools, and joint care planning. Without the formation of a "shared language" and mutual understanding of each other's working logic, any coordination protocols will remain formal documents rather than real practice.

A particular potential lies in redefining the roles of nurses and social workers as key operational actors of integrated care. In the Ukrainian context, these professions objectively have the closest contact with the everyday life of older people. With appropriate training, they could perform functions of primary functional screening, regular monitoring of changes, service navigation, intersectoral communication, and caregiver support. However, this requires not only educational programmes, but also institutional закріплення of new mandates, redistribution of time within workloads, and formal recognition of the care coordinator role within organisational structures. Without this, any training risks raising expectations without creating real opportunities to meet them.

It is critically important that, in the Ukrainian context, competency development for ICOPE is impossible without systemic support for the psychological resilience of staff. War, constant work with vulnerable populations, overload, and personal losses generate high levels of chronic stress, secondary traumatisation, and professional burnout. Under such conditions, expecting workers to be empathic, person-centred, and engaged in long-term support without investing

in mental health support for providers themselves is structurally unrealistic. Preparation for ICOPE implementation must include burnout prevention programmes, supervision, peer support groups, and basic skills in working with stress and trauma. This is not an "additional component," but a prerequisite for staff to be able to support others without themselves remaining in a state of constant exhaustion.

In this logic, workforce opportunities for ICOPE lie not so much in increasing the number of trainings, but in creating a sustainable ecosystem for workforce development: interprofessional, practice-oriented, embedded in real work processes, and reinforced by systems of psychological support. It is precisely such an ecosystem that can gradually transform declared readiness for integrated care into real operational capacity.

8.3. Financial barriers and opportunities

Fragmented financing as a systemic constraint

Finances are a key barrier not only because of the lack of money, but also because of how they are structured. In Ukraine, there is budgetary fragmentation: medical funds come from the state budget through the National Health Insurance Fund, while social services are financed mainly from local community budgets. There is practically no joint budgeting mechanism for financing one multidisciplinary team (doctor/nurse + social worker + coordination). This creates a "mechanical impossibility of integrating money": even if a management model of integration is invented, it remains declarative without a tool that would allow paying for a common result.

Additionally, there is a crowding-out effect at the local level: communities direct resources to defense, critical infrastructure, and repairs after attacks; social services are financed on a residual basis. This means that large-scale implementation of ICOPE without external donor infusions or a state targeted subvention for integrated care is currently structurally unlikely.

"Coordination is invisible in the budget. If it is invisible, it does not exist." [KII, WHO representative]

In medicine, the incentive model also does not capture geriatric complexity: tariff packages/payments do not take into account that a "complex" patient (with a complex of chronic non-communicable diseases) requires significantly more time and coordination than a "mild" case, but the payment is often no different. This discourages healthcare professionals from investing in ICOPE logic (functional assessments, planning, follow-up).

Financial opportunities

The financial analysis of the previous sections shows that the key problem for implementing ICOPE in Ukraine is not only a lack of funds, but first and foremost the absence of an economic model for integrated care. Today, the system finances separate medical actions and separate social services, but it does not finance what constitutes the core of ICOPE: coordination, continuity, interdisciplinary work, prevention of functional decline, and support for caregivers.

At the same time, Ukraine already has potential entry points for ICOPE financial instruments, which theoretically make it possible to move from declarations to economically backed models.

First, the NHSU contractual model creates an opportunity to pilot blended or bundled financing — that is, packages in which payment is made not for a single service, but for a комплекс of support around the older person. This may include basic medical care, functional screening, coordination with social services, the involvement of a nurse as a case manager, and ongoing monitoring. Such models are widely used in ICOPE-oriented systems, as they shift the focus from "volume of actions" to "maintenance of functional ability."

Second, it is theoretically possible to introduce specific financial incentives for coordination — top-ups or coefficients to base tariffs for managing complex older patients, having an individual care plan, documented interaction with social services, and work with caregivers. This corresponds to the ICOPE logic, where coordination is a service in its own right, not a "free add-on" to a doctor's visit.

Third, in the longer term, payment-for-results models are possible, in particular for reducing avoidable hospitalisations, decreasing emergency visits, stabilising functional status, or enabling safer ageing at home. In the context of population ageing and hospital overload,

precisely such indicators can create a financial argument for investing in home- and community-based care.

However, the analysis shows that all these financial opportunities currently remain theoretical, because Ukraine lacks the basic structural conditions for their launch.

First, there are no legal grounds for joint intersectoral work, and therefore no legal object that can be financed as an "integrated service." As long as shared care pathways are not defined, the role of the care coordinator is not закреплена, and data exchange is not regulated, any bundled package is impossible from the perspective of budgetary and contracting law.

Second, the role of the care coordinator does not exist as a paid function. Neither NHSU tariffs nor local social service programmes contain a budget line that would finance systematic coordination. This means that any integration is based on "enthusiasm" or grants, not on sustainable budget mechanisms.

Third, there are no digital tracking tools without which it is impossible either to administer bundled models or to verify outcomes. The system does not see an older person as a single "care case," and therefore cannot make them the subject of integrated service financing.

Fourth, the analysis of the financial context demonstrates a strong crowding-out effect: local budgets, which are responsible for financing social services, are exhausted by war, defence spending, and infrastructure recovery. Under such conditions, integrated care cannot be financed "from within the system" without external inflows. This means that state targeted subventions and donor transition instruments are not additional, but necessary for any ICOPE financial pilots.

Thus, financial opportunities for implementing ICOPE in Ukraine do in fact exist — but only as potential. They can be realised exclusively under the simultaneous launch of five interconnected components:

- a legal framework for an integrated service;
- a defined and paid role of the care coordinator;
- digital systems that allow the "care continuum" to be seen;
- a dedicated funding source for coordination and prevention;
- state and donor support to compensate for the exhaustion of local budgets.

Without this architecture, any hypotheses about blended or bundled financing in the field of older people's care will remain not a financial reform, but a declaration.

8.4. Social and cultural barriers and opportunities

Cultural norms and expectations

The family is traditionally the basis of care, but this masks the deficits of the system. In addition, war destroys social ties: displacement, loss, family breakdown, depopulation of villages. Social isolation becomes not just a "social problem", but a functional barrier to ICOPE, because the model relies heavily on informal support networks (neighbours, volunteers, local initiatives). When these networks are destroyed, ageing in place becomes less feasible, and the risk of institutionalisation or crisis hospitalisation increases.

"The system assumes that the family will cope. When the family cannot cope, the crisis becomes visible." [KII, representative of the social protection department]

Paternalistic/ageist communication in medicine further reduces the older person's participation in planning, and without participation (goals/preferences) ICOPE becomes another "medical procedure" rather than a person-centred path.

Older people often take a passive role in interactions with care, limiting participation in decision-making and care planning.

Social opportunities

The analysis shows that in Ukraine there is a powerful, but not systematically formalized social resource for the implementation of ICOPE - family care, neighborly mutual aid, community initiatives, volunteer networks and local NGOs. These actors actually maintain a significant part of the elderly care system in conditions of war, migration, staff shortages and limited public services. In many communities, they perform functions that in integrated care models usually

belong to the formal system: regular contact with the elderly, household support, emotional presence, assistance with navigating between institutions, informal monitoring of the condition. From the ICOPE point of view, this is not a weakness, but a potential social infrastructure of integrated care. Strong family ties, local communities, church and volunteer networks can become key channels for early detection of functional decline, support for adherence to care plans, prevention of isolation and reduction of the burden on the health system. In conditions where formal services are physically unable to reach everyone, the social environment itself may be the level at which a significant part of the logic of "ageing in place" is implemented.

At the same time, all previous sections of the report demonstrate the fundamental limit of this model: in Ukraine, social resources are exploited, but not supported by the system. Caregivers are not identified, trained, assessed in terms of overload, and not included in care planning. Volunteer and community initiatives operate in a project logic, without integration into state routes, without stable funding, and without access to information. Feedback from families and communities is almost never used as a management tool for correcting services.

In such a configuration, the family actually plays the role of a "free system buffer" that compensates for the lack of coordination, lack of staff, and lack of home services. This creates the illusion of stability, but in practice it leads to chronic burnout of caregivers, hidden neglect, crisis hospitalizations and forced institutionalization. Social resources are not converted into social opportunities.

From the ICOPE perspective, social opportunities can only be realized if the community and family cease to be "informal rear" and become formally recognized partners in the system. This involves structural changes: systematic training of caregivers, regular screening of their workload, development of respite care and day care as basic community services, creation of accessible communication channels with medical and social services, feedback mechanisms and participation in care planning.

Thus, social opportunities in Ukraine are not absent, but disordered. They can become one of the strongest catalysts for ICOPE — but only if they are supported by the system. Without this, social capital will continue to serve as an emergency mechanism that hides structural failures, instead of becoming a pillar of integrated care.

8.5. Intersectoral barriers and opportunities (health–social nexus)

Structural fragmentation at the nexus

The most critical bottleneck is the health–social nexus.

First, the digital divide: the health system (eHealth/HELSI) and the social system (e-Social) are not technically synchronised. Doctors and social workers do not have shared access to care plans, do not see each other's records in digital form, even if they are willing to cooperate. This turns "information exchange" into manual transfer through the older person or the caregiver — with a high risk of data loss.

"Health care and social services meet only at the level of the individual, not at the level of the system." [KII, representative of a local NGO]

Second, the absence of SOPs and legally recognised referral tools (social prescriptions) makes care pathways unstructured. As a result, referral chains remain merely "advice," without tracking, without feedback loops, and without accountability for outcomes.

Third, there is confusion between coordination and case management: coordination is described as "interaction," whereas ICOPE requires a clearly designated person (Care Coordinator/Care Manager) responsible for the pathway and for results. In Ukraine, this role is not institutionally defined and is blurred between the doctor, the social worker, and the family. The absence of a formally defined care coordinator role is a critical barrier that makes integration unstable and dependent on individual personalities.

Fourth, there is a conflict of priorities and incentives between sectors: the health sector operates according to medical indicators and NHSU contracting requirements, while the social sector operates according to the logic of available local budgets and "minimum coverage."

Without shared KPIs and joint financing mechanisms, each sector optimises "its own" objectives rather than a shared outcome for the person.

Fifth, data privacy issues: even when there is willingness to share information, doctors often avoid transferring data to social workers for fear of violating medical confidentiality or personal data protection legislation (GDPR logic). Without an interministerial protocol on consent and access roles (who sees what), data exchange is effectively blocked.

Intersectoral opportunities

The data collected through this assessment clearly show that integration in Ukraine is not a theoretical abstraction — it is already happening locally, but not because of the system, rather in spite of it. Across different communities and projects, recurring conditions can be observed under which coordination between the health and social sectors begins to function:

- a responsible person emerges (a social worker, project-based case manager, mobile team coordinator) who effectively holds and manages the person's pathway;
- stable informal communication channels are built between doctors, social services, NGOs, and caregivers;
- local leadership is present (head of a PHC facility, director of a social service, an active community, a strong NGO) that politically and organisationally supports cooperation;
- donor or civil society organisations temporarily create "artificial coordination": financing case managers, mobile teams, joint meetings, information exchange, and staff training.

Under such conditions, de facto elements of ICOPE begin to appear: joint case discussions, home visits with a dual focus (medical and social), inclusion of caregivers, early response to deterioration, and navigation between services. This demonstrates a fundamentally important conclusion: Ukraine's problem is not "cultural unreadiness" for integrated care, but the architecture of the system.

However, previous sections of the report just as clearly show the other, critical side of this picture: almost all existing coordination is externally induced and structurally unstable. It exists where and as long as there is grant funding, project-based positions, informal agreements, and the personal motivation of specific individuals. When funding ends, the coordinator disappears, the mobile team dissolves, information exchange stops, and the system returns to its basic configuration: the parallel existence of PHC and social services without a shared pathway for the person.

In this sense, this is not a "paradox," but a systemic threat to the sustainability of reforms. Donor and civil society projects effectively function as prototypes of an integrated system, but the state lacks mechanisms to absorb them:

- there is no NHSU package or other budgetary instrument that would allow financing of the coordination function;
- there is no staff position of Care Coordinator / Case Manager in the public sector;
- there are no interministerial standards obliging services to reproduce these models;
- there is no joint budgeting that would allow multidisciplinary teams to be sustained.

As a result, a dangerous situation of "integration without institutionalisation" is emerging. Practices appear, expectations are formed among professionals and communities, but the state is structurally unable to support, scale, and reproduce them. This creates a risk of loss of trust, staff demotivation, and "rollback" of the system once projects end.

From an ICOPE perspective, this means that the key intersectoral opportunity for Ukraine is not the creation of new pilots as such, but the transition from project-based integration to governance-based integration: embedding roles, financing, accountability, and procedures within the system itself. Without this, any local successes will remain temporary islands of practice rather than elements of a new model of care.

Integrated synthesis: cumulative effects and leverage points

The barriers are cumulative in nature. Legal uncertainty and legislative friction block data exchange and SOPs; the digital divide makes coordination technically impossible; budgetary fragmentation does not allow payment for a joint team; PHC overload eliminates the possibility of 30-minute ICOPE assessments; workforce depopulation destroys stable teams; the family becomes the de facto coordinator; caregiver burden increases; and the absence of respite and day care makes ageing in place unsustainable.

At the same time, opportunities are also cumulative. Realistic leverage points that can "unlock" the system include:

- a national inter-ministerial steering mechanism with shared KPIs for the MoH, Ministry of Social Policy, Family and Unity of Ukraine, NHSU, and NSSSU;
- legal instruments: data-sharing consent protocols, standardised referral forms (social prescriptions), SOPs, and tracking mechanisms;
- a clearly defined Care Coordinator role (often a nurse acting as a case manager within ICOPE) with protected time and remuneration;
- financial instruments that overcome budgetary fragmentation (targeted state subventions/donor mechanisms plus blended-financing pilots);
- bundled solutions for caregiver support: respite/day care, training, and psychosocial support;
- digital integration with a new data-security architecture adapted to wartime conditions (especially for location data and vulnerable groups).

Without simultaneous progress across these directions, ICOPE risks remaining a collection of pilots and "islands of practice" sustained by individual initiative or grants, and collapsing when people or funding change.

9. Proposed Model for ICOPE Pilot Implementation in Ukraine

This section proposes a practical, phased model for piloting ICOPE in Ukraine that is explicitly adapted to the Ukrainian governance and financing environment, and that recognises the dual nature of integrated care: (i) clinical/service delivery reform within PHC, and (ii) long-term care and social support reform at community level. The model is designed to be implementable under wartime constraints, to generate actionable evidence for national scale-up, and to directly address barriers identified through the readiness assessment.

The TOR explicitly requires the study to propose a pilot model for one or more oblasts and anticipates risks such as low stakeholder interest, data gaps, and war-related constraints. The proposed model therefore prioritises (a) institutional feasibility, (b) demonstrability of results within a defined period, and (c) scalability.

9.1. Criteria for selecting pilot region(s) and pilot communities

While Lviv and Dnipro oblasts were used in the readiness assessment design, a pilot implementation phase (if launched) should select specific communities (hromadas) and facility clusters within regions using transparent criteria. A core insight from qualitative evidence is that implementation will differ significantly depending on local capacity; therefore, the pilot should intentionally include communities with different levels of capacity to test transferability.

"It is important to choose communities with different capacity… if we implement only in one type of community, we will not understand how it works in other conditions." [KII, Representative of local NGO]

A. "Must-have" selection criteria (eligibility gate)

Minimum PHC platform and management stability

- At least one functioning PHC facility (urban or rural) with stable family doctor/nurse staffing sufficient to run routine screening and follow-up.
- Facility leadership willingness to pilot new workflows (screening, care planning, referrals).

Minimum social service presence

- A functioning territorial centre / social service unit or contracted non-state provider able to support home care, case follow-up, caregiver engagement, or social needs assessments.

Local political/administrative willingness

- A hromada leadership ready to include integrated care priorities into local planning and support coordination arrangements.

"Integrated care is possible only with political will at community level… and when social services have capacity and professional development support." [KII, Representative of local NGO]

Basic feasibility under security constraints

- Ability to continue minimum operations during outages/alerts (alternative power/internet or hybrid paper-to-digital flow).
- Reasonable travel feasibility for supervision and monitoring.

B. "Differentiating" criteria (to maximise learning and scalability)

Variation in community capacity (intentional heterogeneity)

- Include at least one larger, more resourced community and one smaller, resource-constrained or more remote community.

"The best readiness is where there is already good cooperation between social services and PHC and where there is budget — mostly larger communities; smaller and remote communities lack resources and staff." [KII, Representative of local NGO]

Degree of existing health–social cooperation

- Preference for communities with at least informal collaboration, to accelerate early wins, plus one site with minimal collaboration to test start-up mechanisms.

Presence of active civil society / older people's organisations

- The pilot should test community engagement models where older people's clubs/associations exist (or can be catalysed).

"This needs to be cultivated and supported… when people unite, they help each other and are motivated to improve quality and length of life." [KII, Representative of WHO]

Digital readiness and data environment

- Minimum eHealth connectivity in PHC and willingness to trial data exchange mechanisms with social services (even if initially manual or semi-digital).

"e-Health can track clinical data… but it does not capture social information… data are disconnected; family doctors don't see social assessment and vice versa." [KII, Representative of local NGO]

Feasibility of caregiver inclusion

- Sufficient number of informal caregivers and/or home care workers to test caregiver support pathways and burden mitigation.

9.2. Roles and responsibilities in the pilot model (MoH / MinSoc / NHSU / communities + partners)

A major readiness barrier is the absence of a national normative model and missing SOPs/algorithms for integrated care.

"At national level there is no normative model of integrated care… and there are no inter-agency coordination tools and financing mechanisms" [KII, Representative of local NGO]

"We often adopt something in legislation, but there are no algorithms, SOPs, instruments… specialists are like blind kittens trying to implement" [KII, Representative of local NGO]

Therefore, the pilot governance must explicitly allocate ownership across actors:

9.2.1. Ministry of Health (MoH)

Primary mandate in the pilot:

- Endorse the pilot concept as aligned with PHC strengthening and person-centred care.

- Lead development/approval of **clinical workflow SOPs** for ICOPE screening, care planning, follow-up, and referral within PHC.
- Coordinate clinical training packages (doctors/nurses) and ensure compatibility with clinical protocols.
- Convene a national steering mechanism with MinSoc and NHSU

Key deliverables from MoH during pilot:

- Draft/approve minimum clinical ICOPE workflow package for PHC (screening → care plan → follow-up).
- Define minimum dataset for functional assessment elements to be captured (even if initially not fully digitised).

9.2.2. Ministry of Social Policy (MinSoc)

Primary mandate in the pilot:

- Ensure the social care component is not "auxiliary" but structurally integrated: needs assessment, home care, caregiver support, social inclusion, benefits navigation.
- Lead development/approval of **social sector SOPs** for:
    - community needs assessment of older people;
    - case management / follow-up routines;
    - caregiver support and respite pathways;
    - referral rules and documentation standards for intersectoral exchange.

Strategic issue highlighted by respondents (KIIs):

Workforce motivation and competence in social services require systemic attention, including training/supervision and realistic workload norms.

"MinSoc asked for training, supervision for territorial centre staff… people are unmotivated and often lack knowledge" [KII, Representative of local NGO]

9.2.3. National Health Service of Ukraine (NHSU)

Primary mandate in the pilot:

Translate integrated care logic into **purchasing incentives** and monitoring instruments.

Explore whether elements of ICOPE can be:

- embedded into existing PHC payment conditions/quality indicators; or
- piloted as an add-on module with defined outputs (screening coverage, follow-ups, documented care plans, referral completion).

This aligns with the need to move from "concept" to funded practice—repeatedly emphasised in qualitative evidence.

"We need standards, protocols, service packages and financing mechanisms… and to include ICOPE elements into national protocols or NHSU packages." [KII, Representative of local NGO]

9.2.4. Communities (hromadas) and local authorities

Primary mandate in the pilot:

Provide local coordination backbone and "place-based" governance:

- appoint a pilot focal point;
- integrate pilot objectives into local planning;
- ensure operational support (space, transport/logistics for social workers/home visits, convening capacity).

A critical gap is that community needs assessments are often absent or formalistic, which undermines planning and budgeting.

"A very often missed moment is comprehensive needs assessment of older people at community level… without assessment, there is 'no need' and resources are not allocated." [KII, Representative of local NGO]

Communities also play a central role in enabling subsidarity and contracting of non-state providers.

"If the market of social services were truly open locally… non-state providers and charities could join through subsidiarity." [KII, Representative of local NGO]

9.2.5. Role of INGOs, NGOs, and HelpAge in particular

In Ukraine's current environment, INGOs/NGOs can provide the **bridge functions** that the state systems cannot yet deliver consistently: technical assistance, convening, capacity building, evidence generation, and safeguarding of person-centred principles.

HelpAge's specific value-add in the pilot:

- Convene and facilitate a national steering group (MoH–MinSoc–NHSU + regional representatives) to co-own the pilot design and unblock inter-institutional barriers (consistent with the TOR risk mitigation approach of active engagement of ministries and stakeholders
- Provide technical assistance for adapting WHO tools and the scorecard, ensuring fidelity to ICOPE principles while respecting Ukraine's system constraints.
- Support training architecture across both sectors (PHC + social services + caregivers/community actors), including supervision models.
- Build learning loops: implementation monitoring, rapid feedback, and packaging evidence for scale-up decisions.

Evidence also highlights that pilots succeed when there is **continuous expert accompaniment**, not only initial training.

"A pilot needs constant accompaniment from the ministry and experts… responsible persons who proactively provide support… and then monitoring of implementation." [KII, Representative of local NGO]

9.3. Phased logic for pilot implementation (step-by-step)

The pilot model is proposed as a **sequenced pathway** from enabling conditions → workflow deployment → monitoring → scale-up readiness. This aligns with the staged approach and the WHO implementation logic embedded in the ICOPE implementation framework/scorecard approach.

Objective	Core actions:	Key risk to avoid	Output
Phase 0 (0–1 month): Political and institutional set-up ("permission to integrate")			
secure multi-actor commitment so integration is not voluntary or symbolic.	establish National Steering Group (MoH, MinSoc, NHSU, selected oblast and hromada reps; HelpAge as facilitator); define pilot scope (services, target groups, minimum outcomes); approve a joint "pilot charter": roles, data principles, referral approach, monitoring arrangements.		signed pilot charter + governance structure.
Phase 1 (1–2 months): Design and tool finalisation ("make it operational")			
convert ICOPE into implementable SOPs for both sectors	adapt ICOPE screening/care planning workflow to PHC realities; define social service workflow for needs assessment, home-based	"legislation without SOPs," highlighted in KIIs.	finalised SOP package + training plan + monitoring framework.

	support, caregiver support, and referrals; define minimum shared referral documentation (paper + digital options); develop training curricula and supervisory model.		
Phase 2 (2–4 months): Capacity building and micro-piloting ("train, test, correct")			
ensure teams can implement and iterate before scaling within pilot sites	conduct joint trainings (PHC + social workers + community focal points); run simulation exercises (case scenarios); start micro-pilots in a small subset of patients/clients; establish supervision cadence; implement supportive supervision and troubleshooting channels.		trained teams + tested workflows + revised SOPs.
Phase 3 (4–9 months): Full pilot rollout in selected sites ("deliver, coordinate, document")			
implement integrated pathway end-to-end.	systematic screening (or targeted screening for defined high-risk groups); individualised care plans co-owned by older person/caregiver (where appropriate); structured referrals between PHC and social services; caregiver support touchpoints (education, psychosocial support, navigation, respite linkage where feasible); community engagement (older people groups, peer support, volunteering).	The pilot should include a pragmatic "minimum viable data exchange model": aggregated dashboards for community planning; case-level coordination documented through consent-based referral forms and shared care plans.	functional integrated pathway with documented cases and measurable outputs.
Phase 4 (9–12 months): Evaluation, scorecard consolidation, and scale-up decision package			
assess what worked, for whom, and at what system cost/complexity.	apply the ICOPE implementation scorecard systematically as planned summarise readiness improvements and remaining gaps; produce policy options (NHSU purchasing; MinSoc social contracting; digital roadmap);	The WHO framework emphasises routine capacity/performance assessment and meaningful outcomes for system managers —this should be translated into Ukraine-ready indicators.	scale-up package + costed options + regulatory recommendations.

	present scale-up scenarios: expansion to additional hromadas/oblasts.		

"Data from medical information systems can give a community profile, but not individual—individual is confidential." [KII, Representative of WHO]

9.4. Risks and mitigation measures

The TOR anticipates multiple risks including low stakeholder interest, data gaps, resistance to change, war-related constraints, and reliability issues. Field evidence also highlights systemic constraints: missing normative model, workforce shortages, fragmented data, and limited local budgets

Political/institutional risks

- Risk: Low ownership across MoH–MinSoc–NHSU-NSSU leading to "pilot as NGO project."
- Mitigation: formal steering group, pilot charter, named accountable focal points.

Workforce risks

- Risk: Staff overload and low motivation, especially in social services.
- Mitigation: workload-sensitive pilot design; micro-pilots; supervision; clear role division; incentives (financial or non-financial) through NHSU/ NSSU / local mechanisms.

Data and digital risks

- Risk: Disconnected platforms prevent continuity and joint planning.
- Mitigation: minimum viable linkage; shared referral documentation; aggregated dashboards; roadmap for eHealth + social registry interoperability.

Community readiness and financing risks

- Risk: Communities interested but unable to finance coordination/home services.
- Mitigation: co-financing models; contracting non-state providers; targeting early wins in higher-capacity hromadas while testing feasibility in low-capacity ones.

War-related operational risks

- Risk: disruption due to alerts/blackouts; travel constraints.
- Mitigation: hybrid data collection and supervision; flexible scheduling; decentralised support; contingency communication channels—consistent with TOR mitigation approaches

Preconditions for success

Based on evidence and feasibility realities, the following are non-negotiable prerequisites:

- A normative/operational backbone (even if temporary): SOPs, referral rules, role descriptions.
- Continuous accompaniment and supervision, not one-off training.
- Explicit inclusion of social workers and caregivers as core implementers (not peripheral stakeholders).
- A minimum financing logic for coordination tasks and time (NHSU/NSSU/local/partner-supported).
- A pragmatic data strategy that respects confidentiality while enabling continuity.
- Community needs assessment as a planning trigger for budgets and service mix.
- Mechanisms to mobilise civil society and older people's organisations, with recognition that self-organisation needs cultivation and support.

9.6. Pilot Monitoring and Learning Framework

9.6.1. Purpose and principles of monitoring within the ICOPE pilot

Monitoring and learning within the proposed ICOPE pilot are conceived not as a compliance or reporting exercise, but as a core system-strengthening function. Given the novelty of integrated care implementation in Ukraine, the pilot monitoring framework must serve three simultaneous purposes:

- Operational learning — enabling implementers at service and community level to adjust workflows in real time;

- System learning — generating evidence for national institutions (MoH, MinSoc, NHSU, NSSU) on what is feasible, scalable, and sustainable;
- Accountability and decision support — informing decisions on financing, regulation, and scale-up.

Evidence from qualitative interviews underscores that previous reforms often failed to translate into practice due to weak feedback loops and lack of adaptive learning.

Accordingly, the pilot monitoring framework is grounded in the following principles:

- Simplicity and feasibility under wartime constraints;
- Mixed-methods approach, combining quantitative indicators with qualitative learning;
- Integration of health and social perspectives, rather than parallel monitoring tracks;
- Use-oriented design, ensuring that data are actively used by decision-makers.

9.6.2. Monitoring architecture and governance

a) Multi-level monitoring structure

Monitoring responsibilities are distributed across three levels, each with a distinct function:

- Service level (micro/meso): PHC facilities, social service units, and community focal points generate routine operational data.
- Pilot coordination level (meso): Oblast or inter-hromada coordination teams consolidate data, facilitate learning, and provide feedback.
- National level (macro): MoH, MinSoc, and NSSU, NHSU review aggregated evidence to inform policy and financing decisions.

b) Roles and responsibilities

Clear ownership is critical to avoid data collection without use.

- PHC providers: document screening coverage, care plans, referrals initiated and completed.
- Social workers: document social assessments, home visits, caregiver engagement, service uptake.
- Community focal points: track coordination meetings, community activities, and bottlenecks.
- HelpAge / technical partner: provide methodological support, quality assurance, and synthesis.
- MoH / MinSoc / NHSU / NSSU: interpret findings and trigger corrective or scaling decisions.

9.6.3. Indicator framework: what is monitored and why

The indicator framework is intentionally tiered, focusing on a limited number of high-value indicators that reflect ICOPE logic rather than exhaustive service statistics.

A. Coverage and process indicators (service-level functionality)

These indicators answer the question: Is the integrated pathway actually being used?

Examples include:

- proportion of older people screened using agreed ICOPE-aligned criteria;
- proportion of screened individuals with a documented care plan;
- number and type of referrals between PHC and social services;
- proportion of referrals with documented feedback.

B. Quality and coordination indicators (integration in practice)

These indicators capture whether integration is meaningful, not merely procedural:

- frequency of PHC–social worker interactions per case;
- timeliness of referral completion;
- caregiver involvement in care planning;
- reported continuity of care from the perspective of older people.

C. Capacity and system-readiness indicators

These indicators track changes in readiness rather than outcomes:

- staff confidence in integrated workflows;
- perceived workload implications;
- availability of coordination tools and SOPs;
- functioning of referral and documentation mechanisms.

These indicators link directly to the ICOPE implementation scorecard domains.

9.6.4. Qualitative learning components

Quantitative indicators alone are insufficient to understand why integration works or fails. Therefore, the pilot embeds structured qualitative learning mechanisms.

a) Rapid learning interviews and reflection sessions

Short, periodic reflection sessions with:PHC teams, social workers, caregivers, community representatives.

These sessions focus on: what works well; where processes break down; unintended consequences; adaptations made by frontline staff.

b) Case-based learning

Selected anonymised case trajectories are followed end-to-end to illustrate: coordination successes; system gaps; caregiver burden points.

9.6.5. Data sources, tools, and feasibility considerations

Given data fragmentation and confidentiality constraints, the pilot adopts a "minimum viable data" approach.

Primary data sources include:

- PHC documentation (existing eHealth fields + pilot forms);
- social service case files;
- referral tracking sheets;
- brief client and caregiver feedback tools;
- meeting minutes and supervision notes.

9.6.6. Learning loops and adaptive management

A defining feature of the framework is the establishment of explicit learning loops.

a) Monthly operational learning

- Rapid review of process indicators;
- Identification of bottlenecks;
- Immediate adjustments to workflows or SOPs.

b) Quarterly strategic learning

- Review of scorecard domains;
- Discussion of financing and workforce implications;
- Adjustment of pilot scope or intensity.

c) National learning moments

- Structured briefings to MoH, MinSoc, NHSU, NSSU;
- Translation of pilot evidence into policy and purchasing options.

9.6.7. Use of the ICOPE implementation scorecard

The ICOPE implementation scorecard functions as a unifying learning instrument, applied at:

- baseline (pre-pilot),
- mid-pilot,
- end-pilot stages.

Rather than serving as a static assessment, the scorecard is used to:

- visualise progress across domains;
- identify lagging components;
- support prioritisation decisions.

9.6.8. Feedback to stakeholders and transparency

To sustain engagement, monitoring results must be visible and meaningful to all stakeholders.

Mechanisms include:

- simple dashboards for service teams;
- brief learning notes for communities;
- policy briefs for national institutions;
- learning exchanges across pilot sites.
- This transparency reinforces trust and collective ownership of the pilot.

9.6.9. Contribution of monitoring to scale-up readiness

Finally, the monitoring framework is explicitly designed to support scale-up decisions by answering:

- Which components are feasible within existing systems?
- Which require regulatory or financing changes?
- What is the realistic cost and workforce implication?
- Under what conditions does integration fail?

By the end of the pilot, monitoring outputs should constitute a decision-ready evidence package, not merely an evaluation report.

9.7. Scale-up Scenarios and Policy Options

9.7.1. Purpose of scale-up scenarios

The purpose of defining scale-up scenarios is not to propose a single "ideal" model, but to provide decision-makers with realistic options, each with clearly articulated trade-offs in terms of complexity, cost, institutional change, and political feasibility.

Evidence from the pilot readiness assessment indicates that full system-wide implementation of ICOPE is not immediately feasible under current legal, financial, and workforce conditions. However, staged and differentiated scale-up pathways are possible if aligned with existing reforms and capacities.

"We should not expect one big reform. Integration can only be built step by step, where each step is realistic for the system." [KII, Representative of local NGO]

Accordingly, three scale-up scenarios are proposed:

- Minimal (adaptive) scale-up
- Phased (system-aligned) scale-up
- Transformational (integrated system) scale-up

Each scenario is cumulative: higher-level scenarios assume successful implementation of the preceding ones.

"If the NHSU and the Ministry of Social Policy, Family and Unity of Ukraine both recognize coordination as a function of the service, everything becomes easier." [KII, local NGO representative]

	Scenario 1	Scenario 2	Scenario 3
	Minimal (Adaptive) Scale-up	Phased (System-aligned) Scale-up	Transformational (Integrated System) Scale-up
Core logic	This scenario prioritises feasibility and speed over systemic transformation. It focuses on expanding ICOPE practices to additional communities without major legal or financing reforms, relying instead on adaptive use of existing instruments.	This scenario aligns ICOPE scale-up with existing national reforms, particularly in PHC financing, decentralisation, and social services development. It introduces selective regulatory and purchasing adjustments while preserving overall system architecture.	This scenario represents a structural shift toward a fully integrated health–social care system for older people, with ICOPE embedded as a national standard. It assumes strong political commitment and post-war recovery context.
Key features	Expansion of ICOPE workflows to additional	Gradual expansion to multiple oblasts using	National legal recognition of

	hromadas within pilot oblasts. Voluntary adoption by PHC facilities and social services. Continued reliance on NGOs/INGOs for coordination, training, and supervision. Use of simplified tools (paper or semi-digital) for referrals and care planning.	standardised SOPs validated during the pilot. Formalisation of PHC–social service referral pathways. Introduction of limited financial incentives for coordination and follow-up. Systematic training and supervision embedded into state-supported programmes.	integrated care for older people. Unified regulatory framework across health and social sectors. Integrated financing mechanisms (blended budgets, bundled payments). Interoperable digital systems supporting shared assessments and care plans. Formal recognition and support of caregivers as part of the care continuum.
Institutional implications	MoH: endorses ICOPE as a recommended practice (guidelines, methodological letters). MinSoc: issues clarifications allowing social services to prioritise ICOPE-related activities. NHSU: no change in purchasing; activities absorbed within existing contracts. Communities: support coordination informally, without dedicated budgets.	Ministry of Health Integrates ICOPE elements into PHC clinical standards and guidelines. Supports national training modules for PHC teams. Ministry of Social Policy Updates service standards to explicitly include coordination, caregiver support, and functional assessment. Enables contracting of non-state providers for home-based and respite services. National Health Service of Ukraine Pilots add-on payment or quality indicators linked to: screening coverage, documented care plans, completed referrals. Communities Allocate modest co-financing for coordination roles and transport/logistics. Institutionalise community coordination platforms.	MoH & MinSoc: joint ownership of integrated care policy and governance. NHSU: purchaser of integrated care packages, not only medical services. Communities: act as place-based coordinators with clear mandates and funding. Education sector: redesigned curricula for integrated care competencies.
Advantages	Fast to implement. Low political and fiscal risk.	Balanced feasibility and sustainability. Reduced dependence on external actors.	High sustainability and equity. Maximum alignment with ICOPE principles.

	Suitable under wartime and fiscal uncertainty.	Greater equity across regions.	Strong impact on ageing outcomes.
Limitations	High dependence on individual champions. Limited sustainability once external support ends. Risk of territorial inequality.	Requires interministerial coordination capacity. Slower rollout than Scenario 1. Sensitive to workforce shortages.	High political and fiscal cost. Requires long-term reform horizon. Not realistic under current wartime constraints.

9.7.2. Comparative overview of scenarios

Dimension	Scenario 1: Minimal	Scenario 2: Phased	Scenario 3: Transformational
Speed of rollout	High	Medium	Low
Institutional change	Minimal	Moderate	High
Financial reform	None	Partial	Substantial
Sustainability	Low–Medium	Medium–High	High
Equity across regions	Low	Medium	High
Dependence on NGOs	High	Medium	Low

9.7.3. Policy options and decision points

Based on the scenarios, the following policy options emerge:

Option A: Adopt Scenario 1 as a short-term bridge

- Appropriate for immediate post-pilot continuation.
- Prevents loss of momentum.
- Should be time-bound and explicitly transitional.

Option B: Commit to Scenario 2 as the national medium-term pathway

- Most realistic and balanced option.
- Allows incremental reform without system shock.
- Recommended as the default policy choice.

Option C: Use pilot evidence to prepare for Scenario 3 post-war

- Embed integrated care into recovery and EU-alignment agendas.
- Develop legal and financing roadmaps in advance.

9.7.4. Strategic recommendation

Based on readiness evidence, stakeholder capacity, and contextual constraints, the recommended approach is:

A staged scale-up strategy combining Scenario 1 (short-term continuity) and Scenario 2 (medium-term institutionalisation), with Scenario 3 positioned as a post-recovery reform objective.

This approach maximises learning, preserves feasibility, and creates a credible pathway from pilot to policy.

Strategic objective	Key actions	Lead institutions	Key outputs / decision points
Phase 1: Consolidation & Controlled Expansion (Months 0-12)			
Preserve pilot results and expand cautiously	Expand ICOPE practices to additional hromadas in pilot oblasts	MoH, MinSoc, HelpAge, selected	Updated ICOPE Scorecard (baseline → endline) Consolidated learning report

without systemic shock	Use validated SOPs without major redesign Continue supervision & learning loops Formal recognition of ICOPE as recommended practice	oblasts & hromadas	Decision Gate 1: proceed / adapt / stop
Phase 2: Institutional Alignment & Phased Roll-out (Months 12–24)			
Move from project logic to state-aligned implementation	Integrate ICOPE elements into PHC guidelines Update social service standards (coordination, caregivers) Pilot NHSU add-on payments / quality indicators Introduce local coordination roles	MoH, MinSoc, NHSU, local authorities	National "pilot standard" SOPs Limited financial incentives operational Coverage expanded to multiple oblasts (≈30–40%) Decision Gate 2: institutionalise
Phase 3: System Integration & National Framework (Months 24–36)			
Embed ICOPE into national health–social system	Develop national integrated care framework Prepare legal/regulatory amendments Introduce blended financing concepts Pilot interoperable data flows Integrate ICOPE into workforce training	MoH, MinSoc, NHSU, Cabinet of Ministers	National integrated care policy package Costed scale-up plan National indicator framework Decision Gate 3: full national roll-out

10. Conclusions

This assessment set out to examine the feasibility of implementing the WHO Integrated Care for Older People (ICOPE) approach in Ukraine, with a particular focus on real-world service delivery, governance structures, and system-level enablers. The findings demonstrate that Ukraine does not face a conceptual or normative vacuum regarding integrated care for older people. Rather, the country is confronted with a structural and operational gap between declared policy intentions and the practical capacity of health and social systems to deliver integrated, person-centred care at scale.

Across all levels of analysis—service (meso) and system (macro)—the evidence points to a system that is partially aligned with ICOPE principles in intent, but fragmented in execution. Integrated care exists in Ukraine today not as a coherent system function, but as a set of isolated practices, individual efforts, and project-based initiatives that compensate for structural weaknesses rather than resolve them.

This concluding section synthesises the key analytical insights, articulates the overarching lessons from the readiness assessment and pilot design, and clarifies what these findings imply for the future of integrated care for older people in Ukraine.

10.1. Integrated care in Ukraine: present in fragments, absent as a system

One of the most consistent findings, confirmed through interviews, focus groups, surveys, and document review, is that integrated care is already "happening" in practice — but informally,

fragily, and without institutionalisation. Family doctors coordinate support for older patients within the limits of available time and workload; social workers provide assistance under conditions of chronic resource scarcity; and caregivers fill the gaps between services on a daily basis.

At the same time, these efforts remain structurally unsupported. There are no mandatory standards, financing mechanisms, or accountability systems that would transform individual "goodwill" into a stable, system-level function of integrated care. Moreover, Ukraine is characterised by budgetary fragmentation: medical funding (state budget through the NHSU) and funding for social services (local community budgets) lack a functioning mechanism of joint budgeting to finance a single multidisciplinary team. This makes any governance model of integration vulnerable to being reduced to declarations rather than operational practice.

This fragmentation has three systemic consequences:

- Inequality of access — the care experience of older people depends heavily on place of residence and on who happens to be available locally to provide support.
- Lack of sustainability — integrated practices collapse with staff turnover, the end of grants, or the withdrawal of external support.
- Invisible labour — coordination work and caregiving remain largely unrecognised and unpaid.

Thus, the key challenge is not to "introduce ICOPE as a new idea," but to transform existing fragments of practice into a recognised, resourced, and governable system function.

10.2. Service-level readiness: willingness without instruments

At the service (meso) level, the analysis reveals a high degree of professional readiness in terms of values and understanding, combined with a low level of operational readiness.

Healthcare providers, social workers, and community actors consistently articulate the need for:

- person-centred approaches;
- coordination across sectors;
- community-based care;
- caregiver support.

Yet these same actors operate in an environment where:

- coordination is not mandated;
- referral pathways are informal;
- data systems are disconnected;
- time and staffing are insufficient.

The declared readiness of medical professionals is often mistakenly perceived as "real" readiness. In practice, consultation time constraints, administrative burden, and high patient caseloads make regular 30-minute ICOPE checklist-based assessments and systematic joint care planning unlikely. Without changes in workflows and incentive structures (contractual arrangements, indicators, time norms), this readiness will not scale.

A particularly significant finding concerns the role of social workers. Social workers are de facto central actors in community-based care and long-term support, yet they are marginalised within "medically dominated" care trajectories and excluded from systemic care planning. Moreover, their contribution is often limited to domestic support (social care), whereas ICOPE requires monitoring functional decline and working with intrinsic capacity — for which social services typically have neither protocols, nor time, nor tools.

Without strengthening the service role of social workers and integrating them into multidisciplinary workflows, ICOPE cannot be operationalised.

10.3. Caregivers: the invisible backbone of the system

The most salient and ethically significant finding concerns the role of informal caregivers. Caregivers — predominantly family members — constitute the unrecognised "backbone" of care for older people in Ukraine. They coordinate appointments, provide day-to-day care, manage medications, and transmit information across fragmented services.

Despite this central role, caregivers largely remain "invisible" to the system. They are rarely systematically identified, assessed, trained, or supported within formal care pathways. This has profound consequences:

- caregiver burnout increases the risk of institutionalisation;
- continuity of care depends on individual endurance rather than system design;
- inequalities are deepened for older people without family support.

From the perspective of ICOPE, this means that any model of integrated care that does not formally recognise and support caregivers (training, psychosocial support, respite care, day care services, service navigation) is structurally incomplete and ethically problematic.

10.4. System-level constraints: alignment without integration

At the macro (system) level, Ukraine has important elements that could potentially serve as entry points for ICOPE:

- a reformed primary healthcare system;
- decentralised provision of social services;
- a national purchaser of medical services (the NHSU);
- a growing digital infrastructure.

However, these elements are not aligned around a shared goal of integrated care for older people. Governance and accountability remain sector-based, reinforcing the "silo effect" rather than cooperation. The problem goes deeper than simple "institutional fragmentation" and takes the form of an institutional schism between sectors. Key systemic constraints include:

- the absence of a legal/political mandate for integrated care;
- "legislative friction" and different confidentiality regimes between social services legislation and health legislation, which create legal risks for data exchange and effectively block inter-agency coordination in the absence of consent protocols;
- misaligned financial incentives and budgetary fragmentation;
- workforce planning that does not take population ageing and coordination workload into account;
- disconnected medical and social data systems.

The role of the NHSU is decisive. The NHSU has ensured standardisation and transparency in the health sector, but the current purchasing model provides virtually no incentives for coordination, prevention, or caregiver support. In addition, tariff packages/payment approaches do not reflect geriatric "patient complexity" (for example, dementia plus diabetes require significantly more time and coordination but are reimbursed without proportional recognition of this workload).

Without selective but clear macro-level adjustments, service innovations will remain confined to pilots and projects.

10.5. ICOPE feasibility: realistic, but conditional

Taken together, the findings lead to a clear but nuanced conclusion: ICOPE in Ukraine is feasible, but not as a "stand-alone technical tool" and not as a purely clinical innovation. Its implementation depends on the deliberate creation of enabling conditions, which must be intentionally put in place:

- formalised coordination roles and workflows (including a clearly defined responsible care coordinator);
- recognition of social workers and caregivers as key implementers;
- financing of non-clinical functions (coordination, case management, caregiver support);
- pragmatic solutions for data exchange with due regard to confidentiality;
- continuous supervision and learning cycles;
- needs-based planning at community level.

In the context of war, these conditions are compounded by requirements for resilience: workforce losses and migration/mobilisation create a "double burden of depopulation," while digital integration requires not only IT solutions but also a data-security architecture to protect vulnerable groups.

The proposed pilot model and scaling scenarios respond to these conditions through phasing, adaptive learning, and institutional co-ownership

10.6. From pilot to policy: the strategic significance of scale-up choices

The biggest risk is not the failure of the pilot, but the lack of decisions after the pilot. The Ukrainian history of reforms contains many examples of successful pilots not scaling up due to a lack of political will or institutional "fine-tuning" of budgets, regulations and accountability mechanisms.

The scaling-up scenarios presented in the report are not just technical options, but strategic choices for the future of elderly care. A phased scaling-up, coordinated with the system, is the most realistic path under current conditions, as it balances ambition with accessibility. A key condition for success is the creation of an inter-ministerial steering committee, without which "integration" will remain a distributed responsibility without a responsible owner.

10.7. Final synthesis: integrated care as a system choice

In conclusion, this evaluation demonstrates that implementing ICOPE in Ukraine is not so much a question of technical capacity as a question of systemic choice. The country can continue to rely on fragmented services, informal coordination, and the invisible work of caregivers—or it can gradually build a system that recognizes integrated care as a public responsibility.

ICOPE offers a holistic framework for this transition. Whether it becomes a pilot, a program, or a pillar of the system will depend on the decisions that politicians, institutions, and communities make in the coming years. Unless these decisions include addressing budget fragmentation, legislative friction, defining the role of the care coordinator, supporting caregivers, and securely integrating data, ICOPE risks remaining a "clinical add-on" rather than a catalyst for systemic transformation.

11. Recommendations

This section presents a set of **strategic and operational recommendations** addressed to key institutional actors involved in the design, financing, implementation, and scale-up of ICOPE in Ukraine. The recommendations are grounded in the empirical findings of the assessment and are explicitly aligned with the conclusions presented in Section 10. They are formulated to support **realistic, phased system transformation**, rather than isolated or short-term interventions.

11.1. Recommendations for the Ministry of Health (MoH)

11.1.1. Formally recognise integrated care as a system function within healthcare

The Ministry of Health should move beyond general references to "patient-centredness" and clearly define integrated care for older people as a functional responsibility of the health system, implemented through primary health care (PHC) in coordination with social services.

This entails:

- formal recognition of integrated care aligned with ICOPE in MoH policies and methodological documents;
- defining the coordination role of family doctors and nurses in relation to functional impairments, long-term needs, and social risks;
- recognising interaction with social services and caregivers as an integral component of the quality of medical care for older people.

It is also advisable to explicitly state that integrated care includes not only clinical interventions, but also coordination, prevention of functional decline, and support for caregivers.

11.1.2. Develop and approve practical SOPs for PHC in line with ICOPE

The MoH should prioritise the development of short, pragmatic standard operating procedures (SOPs) for PHC teams that translate ICOPE principles into feasible daily practice. These should cover:

- basic identification of functional decline;
- joint care planning with the older person and caregiver;
- initiation and follow-up of referrals to social services;
- interaction with social and medical professionals at community level.
- The emphasis should be on usability and realism, without excessive administrative burden.

It is important that SOPs explicitly take into account consultation time constraints and provide simplified, "minimum viable" algorithms for screening and coordination.

11.1.3. Integrate ICOPE competencies into the continuing professional development system

The MoH should ensure the inclusion of integrated care competencies in the CPD system for health professionals, in particular:

- modules on geriatrics, functional ability, and multimorbidity;
- training on intersectoral coordination and teamwork;
- joint learning formats with social workers.

This will support the development of a shared professional vision across sectors.

11.2. Recommendations for the Ministry of Social Policy, Family and Unity of Ukraine

11.2.1. Explicitly formalise the role of social workers in integrated care

MinSoc should officially recognise social workers as core actors in integrated care, rather than auxiliary or peripheral contributors. This requires:

- updating social service standards to include coordination with PHC;
- formal inclusion of social workers in care planning processes;
- explicit recognition of caregiver support as a standard service function.

11.2.2. Invest in workforce capacity and sustainability of social services

Without addressing workforce constraints, integrated care cannot be sustained. MinSoc is therefore encouraged to:

- review and adjust caseload norms for social workers;
- introduce regular supervision and professional support mechanisms;
- expand specialised training in ageing, long-term care, and caregiver engagement.

It is also advisable to consider tools for non-material motivation and professional recognition of the role of social workers in multidisciplinary teams.

11.2.3. Prioritise community-based and home-based services

MinSoc should continue shifting the focus away from institutional care toward:

- home-based services;
- community-based long-term care;
- contracting of non-state providers through subsidiarity mechanisms.

This shift is essential for operationalising ICOPE at community level.

11.3. Recommendations for the National Health Service of Ukraine (NHSU)

11.3.1. Recognise care coordination as a payable function

NHSU has a decisive role in shaping service delivery through purchasing mechanisms. It is recommended to:

- pilot add-on payments or quality indicators linked to care coordination;
- incentivise documented care plans and completed referral pathways;
- test models that reward continuity rather than isolated medical actions.

The complexity of elderly patients (multimorbidity, cognitive impairment, social factors) should be separately taken into account when forming payment mechanisms.

11.3.2. Use the ICOPE pilot as a procurement innovation laboratory

NHSU should use the pilot to:

- test different incentive structures without system-wide risk;
- generate evidence on the cost and impact of integrated care;
- inform longer-term purchasing reforms.

11.4. Recommendations for National Social service of Ukraine (NSSU)

11.4.1. Strengthen the role of the NSSU in quality assurance for community-based and integrated care

The National Social Service of Ukraine is the key institutional mechanism for quality oversight and compliance monitoring in the social care sector. To support ICOPE implementation and integrated care for older people, it is recommended to:

- adapt inspection and monitoring instruments to better capture community-based, home-based and integrated care models;
- include elements related to care coordination, caregiver support and continuity of services in inspection checklists;
- use inspection findings not only for compliance enforcement but also for system-level learning and service improvement.

11.4.2. Integrate NSSU monitoring data into equity and planning processes

The NSSU collects valuable data on service availability, compliance and territorial disparities. To strengthen equity-oriented planning and integrated care governance, it is recommended to:

- systematically analyse NSSU monitoring data to identify regional and community-level gaps in access to social services for older people;

- share aggregated findings with the Ministry of Social Policy and other relevant actors to inform planning and resource allocation;
- support the use of NSSU data in identifying priority areas and communities for ICOPE pilot implementation.

11.4.3. Provide methodological support to communities implementing ICOPE

In the context of decentralisation, communities require practical guidance to organise integrated, community-based care. The NSSU is well positioned to contribute through its methodological mandate. It is recommended to:

- develop and disseminate practical guidance for communities on organising social services aligned with integrated care principles;
- support clarification of roles of social workers, caregivers and service providers within community-based care models;
- accompany pilot communities through targeted methodological support during ICOPE implementation.

11.4.4. Participate in intersectoral governance and coordination mechanisms for ICOPE

While the NSSU does not have a coordination mandate, its participation in intersectoral platforms is critical for system coherence. It is recommended to:

- engage in national and subnational intersectoral working groups related to ICOPE and integrated care;
- contribute quality and compliance perspectives to discussions on service design and system reform;
- support alignment between regulatory requirements and emerging integrated care models.

11.4.5. Contribute to the development of integrated quality indicators

To support accountability across the health–social care continuum, it is recommended to:

- participate in the development of integrated quality indicators relevant to older people's care;
- ensure that social service quality standards and inspection experience inform indicator design;
- maintain the NSSU's supervisory and oversight role while contributing to shared system-level accountability.

11.4.6. Strengthen feedback loops between monitoring and policy development

Inspection and monitoring results represent a critical source of system intelligence. To maximise their policy value, it is recommended to:

- establish structured feedback mechanisms between NSSU monitoring outcomes and national policy development processes;
- ensure that recurring systemic issues identified through inspections inform regulatory and programmatic adjustments;
- support evidence-based refinement of policies related to ageing, long-term care and integrated service delivery.

11.5. Recommendations for HelpAge International

11.5.1. Act as a system facilitator rather than only an implementer

HelpAge International is uniquely positioned to play a **system-level facilitation role**, rather than focusing solely on project implementation. This includes:

- convening and supporting interministerial dialogue;
- facilitating a national steering group on integrated care;
- maintaining coherence between MoH, MinSoc, and NHSU approaches.

11.5.2. Invest in learning-by-doing and documentation of practice

HelpAge should prioritise:

- joint training formats across sectors;
- case-based learning and supervision;
- systematic documentation of lessons learned to support scale-up.

11.6. Recommendations for Donors and Partners

11.6.1. Support integration, not isolated sectoral projects

Donors are encouraged to:

- avoid narrowly vertical interventions;
- fund coordination, supervision, and learning functions;
- support cross-sectoral pilots and system alignment.

11.6.2. Enable adaptive management and iterative learning

Given the complexity of integrated care, donors should:

- allow flexibility in indicators and activities;
- support iterative adjustment based on evidence;
- avoid rigid logframes that limit learning.

11.7. Recommendations for Communities and Local Self-Government

11.7.1. Recognise integrated care as a local governance responsibility

Local authorities should:

- include care for older people in local development and budgeting;
- designate community-level coordination roles;
- establish platforms for cooperation between PHC, social services, and NGOs.

11.7.2. Invest in accessibility and caregiver support

Communities are encouraged to:

- develop local caregiver support services;
- mobilise volunteers and community initiatives;
- create conditions that enable ageing in place.

Concluding remark

Taken together, these recommendations underscore that ICOPE cannot be treated as a standalone programme, a pilot project, or a technical tool for the health system. It represents a shift in the logic of how the entire system of support for older people functions — from reactive, fragmented, and institution-centred to proactive, integrated, and people-centred. Implementing ICOPE in the Ukrainian context inevitably goes beyond the mandate of any single institution and requires aligned decisions across policy, financing, governance, workforce development, and accountability.

In effect, Ukraine is facing a systemic choice. Either to preserve the current model, in which the primary burden of care rests on families and integration between medical and social services depends on the personal initiative of individual professionals or donor-funded projects. In such a model, fragmentation, territorial inequality, workforce burnout, and the "invisible" labour of caregivers will remain structural norms. Or to gradually build a system in which coordination, support for functional ability, work with caregivers, and intersectoral collaboration are recognised as public responsibilities and receive institutional, regulatory, and financial anchoring.

In this sense, ICOPE functions less as a care methodology and more as a framework for strategic rethinking of ageing policy. It makes it possible to bring together primary health care reform, the development of social services, decentralisation, and post-war recovery into a single logic oriented toward functional ability, dignity, and quality of life of older people. Whether ICOPE becomes a temporary pilot, a collection of local initiatives, or the foundation of a new systemic architecture of care will depend on the decisions that state institutions and communities take in the coming years.

SWOT Analysis of ICOPE Implementation in Ukraine

(based on the final readiness assessment report)

STRENGTHS	WEAKNESSES
The primary health care (PHC) reform has created a basic platform for long-term follow-up of older people.	Absence of a national regulatory model for integrated care and an inter-ministerial governance body.
An established network of social services and territorial centres.	Institutional schism between the Ministry of Health and the Ministry of Social Policy, Family and Unity of Ukraine: different mandates, budgets, accountability systems, and IT systems.
High level of problem awareness among professionals.	Coordination exists only informally and is person-dependent, without SOPs and care pathways.
Motivation of medical and social workers toward more people-centred models.	Absence of a Care Coordinator / case manager role.
Active NGO/INGO sector capable of piloting.	Workforce shortages, exacerbated by the war.
Decentralisation creates a window of opportunity for pilots.	Budgetary fragmentation: inability to jointly finance multidisciplinary teams.
Existing eHealth infrastructure in the health sector.	Complete lack of integration between eHealth and e-Social; absence of secure data-sharing mechanisms.
Presence of social workers at community level.	Social workers are limited to household functions and are not integrated into care pathways.
Existing resource of informal caregivers.	Caregivers are invisible to the system, without support, training, or respite services.
Existing experience of pilot and project-based integration.	Services remain institution-centred.
OPPORTUNITIES	**THREATS**
ICOPE as a legitimate WHO framework for intersectoral alignment of reforms.	Prolonged war: continued workforce losses, instability, and infrastructure destruction.
Pilots can become the basis for a national integrated care model.	Exhaustion of community budgets.
Possibility to gradually integrate ICOPE elements into NHSU benefit packages.	Risk of "permanent pilots" without political decisions.
Using post-war recovery as a point of systemic transformation.	Widening regional inequality between communities.

Development of joint SOPs and care pathways.	Professional burnout of personnel.
Formalisation of the role of social workers and nurses as care coordinators.	Legal risks related to personal data sharing.
Creation of a secure shared data architecture.	Further institutionalisation of fragmentation.
Integration of caregiver support as part of the system.	Demographic pressure of population ageing.
Donor interest in long-term care.	Shifts in political priorities.

Analytical Commentary to the SWOT

Strengths: potential already exists, but it is not structured

Ukraine's strengths lie not in system readiness, but in the presence of individual elements that can be assembled into an integrated model. The PHC reform has created an institutional backbone capable of performing a long-term coordinating function. Social services are already de facto operating in a community-based logic. Medical and social professionals have a strong understanding of the limitations of purely sectoral models. An active civil society sector is already performing "integration" functions that the state is not yet able to ensure.

The key strength lies in human and professional capital and in existing practices that do not need to be invented from scratch, but rather formalised, supported, and scaled.

Weaknesses: the weakness is not in ideas, but in the system architecture

The weaknesses are structural rather than operational. Ukraine lacks the very "engine" of integrated care: there is no single mandate, no joint governance, no financing mechanisms, no defined roles, and no integrated data flows. Coordination is not prohibited — but it is also not designed into the system.

Critical weaknesses include:

- the institutional schism between the Ministry of Health and the Ministry of Social Policy;
- budgetary fragmentation;
- workforce erosion caused by the war;
- absence of a care coordinator role;
- complete lack of data integration;
- overburdening of social workers with household functions;
- systemic exploitation of family caregivers as an unpaid resource.

This means that ICOPE cannot currently become a systemic practice — only a local exception.

Opportunities: ICOPE as a tool of state intersectoral integration

ICOPE opens the possibility not only to introduce a new care model, but to use it as an instrument of interministerial reintegration of the state. Pilots can serve as a safe space to develop and test:

- intersectoral SOPs;
- joint care pathways;
- new financial incentives;
- the role of social workers and nurses as coordinators;
- caregiver-centred models.

Post-war recovery, social services reform, the development of eHealth, and revision of NHSU benefit packages represent "windows of opportunity" into which ICOPE can be embedded not as a standalone project, but as an organisational principle of the care system.

Threats: the main threat is the consolidation of fragmentation

The main threats are linked not only to the war, but to the risk of institutional inertia:

- pilots without political decisions;
- donor-driven models without state institutionalisation;
- further workforce exhaustion;

- deepening inequality between communities;
- transformation of caregivers into a "hidden social sector."

The greatest strategic threat is that ICOPE will remain a humanitarian or NGO practice rather than a state response to population ageing.

The SWOT profile of Ukraine regarding ICOPE implementation demonstrates a system that is not at an initial, but at a transitional stage of development. Ukraine already possesses key prerequisites for integrated care for older people — a reformed primary care system, a decentralised social services network, an active civil society, growing digital infrastructure, and high professional motivation among specialists. At the same time, these elements exist as parallel systems that interact situationally rather than structurally.

From a donor perspective, this means that Ukraine does not need to build a system "from scratch." It needs systemic integration of what already exists — and this is precisely where the unique window of opportunity lies. The current care model is already partially integrated at the level of people and practices: family doctors informally coordinate care, social workers address multidisciplinary needs, and caregivers effectively perform case-management functions. However, this integration is person-dependent, unfunded, and institutionally invisible, which makes it unsustainable and socially unjust.

Hence the key conclusion: the strategic logic of intervention lies not in "introducing a new model," but in transforming existing informal integration into a governed, financed, and accountable system.

PEST Analysis

Macro-environmental factors affecting ICOPE implementation in Ukraine

P — Political factors

The political environment in Ukraine simultaneously creates a unique "window of opportunity" for systemic reforms and significant structural constraints for the implementation of integrated care models.

A key positive factor is the ongoing primary health care reform and the overall transformation of public administration towards people-centred services. The NHSU financing model, development of contractual relations, and orientation towards results form an institutional basis that is potentially compatible with ICOPE. In parallel, decentralisation has granted communities real powers in the field of social services, opening space for piloting integrated models at the local level. Ukraine's European integration trajectory also stimulates alignment with WHO standards, human rights approaches, and active ageing policies.

At the same time, a systemic political barrier remains the absence of an intersectoral mandate. The health and social protection sectors are regulated by different normative logics, without mandatory coordination mechanisms. The report explicitly notes that at national level there is no regulatory model of integrated care, and coordination depends on informal arrangements. This creates a risk that even successful pilots cannot be scaled without political decisions at the level of the Cabinet of Ministers and профильних ministries.

An additional factor is the wartime context. On the one hand, the war has heightened political attention to vulnerable groups, including older people. On the other hand, the prioritisation of defence and crisis management reduces political bandwidth for complex interministerial reforms.

Donor implication**:** ICOPE in Ukraine cannot be only a "service" project. Any investments must include a policy component: support to interministerial platforms, development of regulatory frameworks, and piloting models that can be institutionalised.

E — Economic factors

The economic environment is one of the most rigid constraints for ICOPE sustainability.

The core problem is structurally fragmented financing. Medical services are funded through the NHSU, while social services are funded from local community budgets. Between these flows there are virtually no instruments for joint planning or procurement of integrated service packages. This means that even when political will exists, communities often lack mechanisms to finance coordination, case management, or multidisciplinary teams.

The second critical factor is the high donor dependence of innovative roles (medical-social coordinators, mobile teams, case managers). The report directly states that a significant share of practices exists due to project-based financing and carries a high risk of disappearing after grant completion.

At the same time, the war has sharply narrowed the state's fiscal space, while the economic vulnerability of older people (low pensions, medication costs, displacement) reduces the potential for co-financing or private service development.

At the same time, the payment role of the NHSU remains an economic window of opportunity. With political decisions in place, the NHSU could become a key instrument for paying for coordination, prevention of functional decline, and interdisciplinary work.

S — Social factors

The social environment creates both the objective need for ICOPE and complex behavioural barriers.

Ukraine is experiencing accelerated population ageing, intensified by the war, migration of younger groups, and the high vulnerability of older people in frontline and de-occupied communities. The destruction of family and community ties, mass internal displacement, and social isolation all reinforce the demand for an integrated approach.

A key social resource remains communities, NGOs, and strong informal support networks. However, the report clearly documents the problem of "invisible caregivers": most care is provided by family members, mainly women, without systematic support, training, or respite. This creates a risk of collapse of the informal care sector.

At the same time, a cultural barrier is the medicalised perception of ageing. Functional decline is often viewed as a "normal" process rather than an object of prevention and rehabilitation, complicating the introduction of the ICOPE logic focused on functional ability.

T — Technological factors

The technological environment in Ukraine is paradoxical: simultaneously a strong base and deep fragmentation.

Ukraine has a developed eHealth system and extensive experience in digitalisation of public services. This creates a unique foundation for scaling tools for screening, monitoring, and coordination.

However, in practice the digital ecosystem is divided into "parallel worlds": medical registries and social databases are not integrated. There are no interoperable solutions for shared cases, functional assessment, or interdisciplinary planning. This forces professionals to rely on paper certificates and on service users themselves as "information carriers."

Additional risks are created by the digital divide among older people and wartime disruptions of electricity and connectivity. This means that ICOPE models cannot be purely "digitally dependent" and must include hybrid solutions.

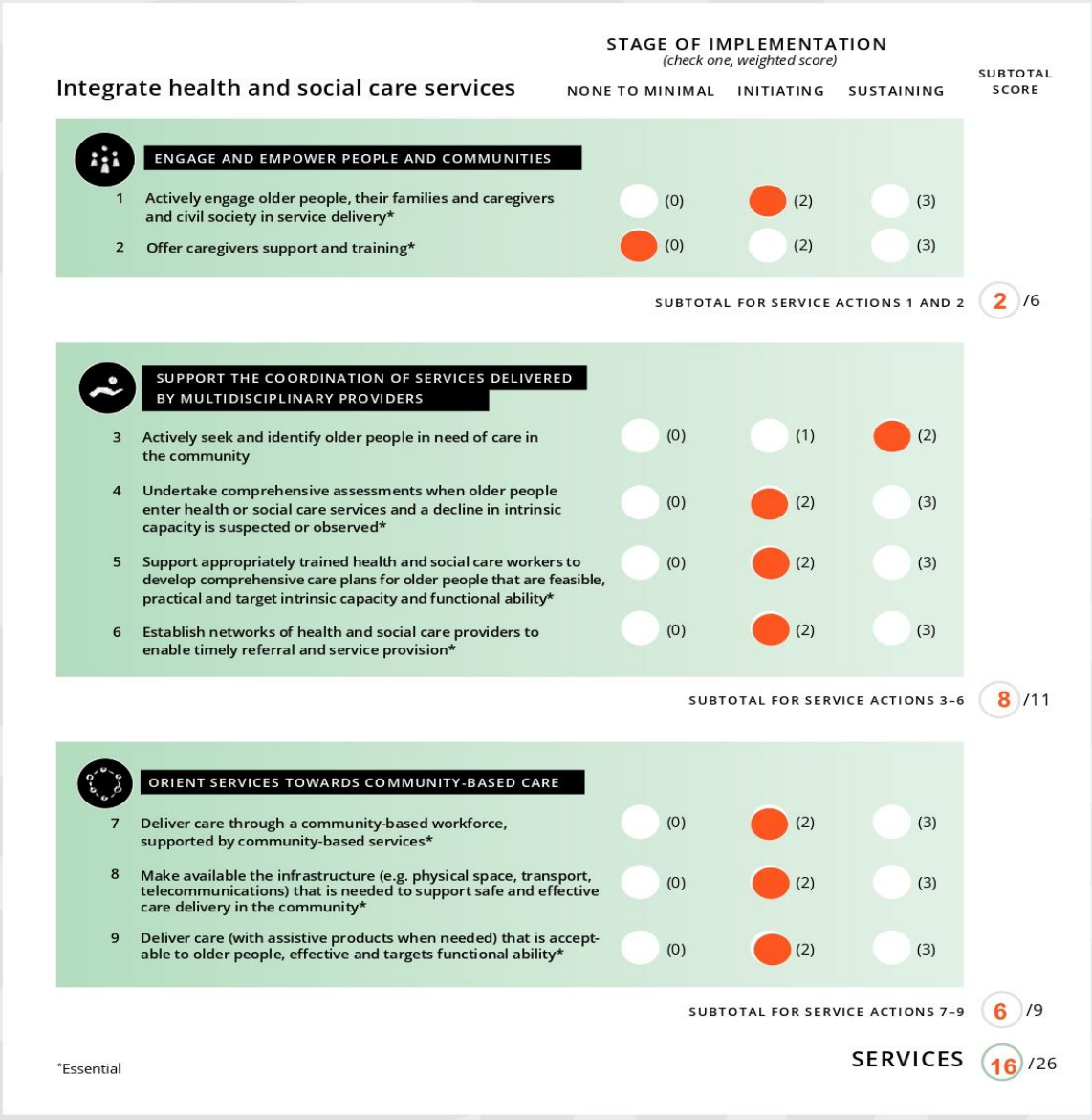
Overall conclusion

Thus, Ukraine's PEST environment makes ICOPE not a "pilot service," but a systemic transformational programme, where:

- the political dimension (intersectoral governance),
- the economic dimension (financing and sustainability),
- the social dimension (caregivers, communities, ageing culture),
- the technological dimension (interoperability rather than mere digitalisation) are equally critical.

Therefore, strategies grounded in this environment must be multi-level: combining pilots, policy, financial modelling, and systemic capacity development.

Annex 1. ICOPE Implementation Scorecard — Ukraine



Integrate health and social care services

STAGE OF IMPLEMENTATION (*check one, weighted score*)

	NONE TO MINIMAL	INITIATING	SUSTAINING	SUBTOTAL SCORE
ENGAGE AND EMPOWER PEOPLE AND COMMUNITIES				
1 Actively engage older people, their families and caregivers and civil society in service delivery*	(0)	(2)	(3)	
2 Offer caregivers support and training*	(0)	(2)	(3)	
SUBTOTAL FOR SERVICE ACTIONS 1 AND 2				2 /6
SUPPORT THE COORDINATION OF SERVICES DELIVERED BY MULTIDISCIPLINARY PROVIDERS				
3 Actively seek and identify older people in need of care in the community	(0)	(1)	(2)	
4 Undertake comprehensive assessments when older people enter health or social care services and a decline in intrinsic capacity is suspected or observed*	(0)	(2)	(3)	
5 Support appropriately trained health and social care workers to develop comprehensive care plans for older people that are feasible, practical and target intrinsic capacity and functional ability*	(0)	(2)	(3)	
6 Establish networks of health and social care providers to enable timely referral and service provision*	(0)	(2)	(3)	
SUBTOTAL FOR SERVICE ACTIONS 3–6				8 /11
ORIENT SERVICES TOWARDS COMMUNITY-BASED CARE				
7 Deliver care through a community-based workforce, supported by community-based services*	(0)	(2)	(3)	
8 Make available the infrastructure (e.g. physical space, transport, telecommunications) that is needed to support safe and effective care delivery in the community*	(0)	(2)	(3)	
9 Deliver care (with assistive products when needed) that is acceptable to older people, effective and targets functional ability*	(0)	(2)	(3)	
SUBTOTAL FOR SERVICE ACTIONS 7–9				6 /9
SERVICES				16 /26

*Essential

Align care systems to support integrated care

		STAGE OF IMPLEMENTATION (check one, weighted score)			SUBTOTAL SCORE
		NONE TO MINIMAL	INITIATING	SUSTAINING	
STRENGTHEN GOVERNANCE AND ACCOUNTABILITY SYSTEMS					
10	Support the active engagement of older people and their families or caregivers, civil society and local service providers in policy and service development*	(0)	(2)	(3)	
11	Create or update policy and regulatory frameworks to support integrated care and to protect against elder abuse*	(0)	(2)	(3)	
12	Implement quality assurance and improvement processes for health and social care services*	(0)	(2)	(3)	
13	Regularly review the capacity to deliver care equitably*	(0)	(2)	(3)	
	SUBTOTAL FOR SYSTEM ACTIONS 10–13				8 /12
ENABLE SYSTEM-LEVEL STRENGTHENING					
14	Develop capacity in the current and emerging workforce (paid and unpaid) to deliver integrated care*	(0)	(2)	(3)	
15	Structure financing mechanisms to support integrated health and social care for older people*	(0)	(2)	(3)	
16	Establish equitable human resource management processes to support the paid and unpaid workforce	(0)	(1)	(2)	
17	Use health information and communication technologies to facilitate communication and information exchange	(0)	(1)	(2)	
18	Collect and report data on the intrinsic capacity and functional ability of older adults within existing health information systems	(0)	(1)	(2)	
19	Use digital technologies to support older people's self-management	(0)	(1)	(2)	
	SUBTOTAL FOR SYSTEM ACTIONS 14–19				8 /14
	SYSTEMS				16 /26
	TOTAL SCORE FOR SERVICES AND SYSTEMS IMPLEMENTATION OF ICOPE				32 /52

Overall levels of implementation

	NO TO MINIMAL IMPLEMENTAION	INITIATING IMPLEMENTATION	SUSTAINING IMPLEMENTATION
SERVICES	0–10	11–18	19–26
SYSTEMS	0–10	11–18	19–26
OVERALL	0–20	22–36	38–52

Service (Meso) Level

Engage and Empower People and Communities

Action 1. Actively engage older people, their families, caregivers and communities in service delivery

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Engagement of older people and communities occurs primarily through local initiatives, NGOs, faith-based organisations and territorial social service centres. These practices are uneven across regions and are not formally embedded in PHC or social service delivery pathways. Older people are rarely involved in shared care planning or decision-making processes.
Implications for ICOPE	ICOPE implementation can build on existing community practices by formalising engagement mechanisms, clarifying roles of social workers and community actors, and strengthening participation of older people in care planning.

Action 2. Offer caregivers support and training

Element	Content
Current stage	No to minimal implementation
Score	0
Evidence / justification	Informal caregivers provide the majority of daily support and long-term care for older people, but they are not systematically identified, trained or supported by health or social services. Existing caregiver support initiatives are fragmented, project-based and not institutionalised.
Implications for ICOPE	Caregiver support represents a critical gap and a priority entry point for ICOPE piloting, including training, psychosocial support and respite mechanisms at community level.

Subtotal — Engage and Empower People and Communities

Action	Score
Actively engage older people, their families, caregivers and communities in service delivery	2
Offer caregivers support and training	0
Subtotal (Engage and Empower People and Communities)	2 / 6

SUPPORT THE COORDINATION OF SERVICES DELIVERED BY MULTIDISCIPLINARY PROVIDERS

Action 3. Actively seek and identify older people in need of care in the community

Element	Content
Current stage	Initiating implementation

Score	2
Evidence / justification	Proactive identification of older people in need of care is carried out in a fragmented and non-systematic manner. Identification is largely reactive and depends on individual PHC providers, social workers, territorial social service centres, NGOs, or informal community networks. There is no standardised outreach mechanism, routine community mapping, or systematic use of functional decline or frailty screening tools at community level.
Implications for ICOPE	ICOPE piloting should introduce simple and feasible case-finding mechanisms, including joint PHC–social worker identification triggers, prioritisation criteria based on functional decline and social vulnerability, and structured outreach approaches.

Action 4. Undertake comprehensive assessments when older people enter health or social care services and a decline in intrinsic capacity is suspected or observed

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Elements of comprehensive assessment exist within both health and social sectors, but they are conducted separately and focus on sector-specific mandates. Medical assessments prioritise clinical conditions, while social assessments focus on eligibility and service needs. Integrated assessments covering intrinsic capacity, functional ability, psychosocial factors and environmental risks are not routinely conducted or shared across sectors.
Implications for ICOPE	ICOPE implementation provides an opportunity to pilot integrated assessment approaches that combine medical, functional and social dimensions and support shared understanding across health and social care providers.

Action 5. Support appropriately trained health and social care workers to develop comprehensive care plans for older people that are feasible, practical and target intrinsic capacity and functional ability

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Care planning for older people is currently fragmented and largely discipline-specific. Health care providers and social workers develop parallel plans based on their respective mandates, with limited coordination or shared goal-setting. Training on integrated care planning, intrinsic capacity and functional ability remains limited, and comprehensive care plans are not systematically developed or reviewed jointly.
Implications for ICOPE	The pilot should support joint training and practical tools for integrated care planning, focusing on feasibility, shared goals, and alignment of medical and social interventions around functional ability.

Action 6. Establish networks of health and social care providers to enable timely referral and service provision

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Informal networks between health and social care providers exist in some communities, often based on personal relationships rather than institutional arrangements. Formalised provider networks, standard referral pathways, feedback mechanisms and accountability structures are largely absent. Referral processes are inconsistent and depend on local initiative and capacity.
Implications for ICOPE	ICOPE piloting can help formalise provider networks through agreed referral pathways, simple referral tools, and defined roles and responsibilities to support timely service provision.

Subtotal — SUPPORT THE COORDINATION OF SERVICES DELIVERED BY MULTIDISCIPLINARY PROVIDERS

Action	Score
Actively seek and identify older people in need of care in the community	2
Undertake comprehensive assessments when older people enter health or social care services and a decline in intrinsic capacity is suspected or observed	2
Support appropriately trained health and social care workers to develop comprehensive care plans for older people that are feasible, practical and target intrinsic capacity and functional ability	2
Establish networks of health and social care providers to enable timely referral and service provision	2
Subtotal (Service Actions 3–6)	8 / 11

ORIENT SERVICES TOWARDS COMMUNITY-BASED CARE

Action 7. Deliver care through a community-based workforce, supported by community-based services

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Community-based care for older people is delivered primarily through social workers, territorial social service centres, home-care providers, and, in some cases, NGOs and volunteers. While these actors play a critical role, workforce capacity is limited, coverage is uneven across communities, and coordination with PHC is inconsistent. Community-based services are not systematically integrated into health care pathways.
Implications for ICOPE	ICOPE piloting can strengthen the role of community-based workforce by improving coordination with PHC, clarifying roles in integrated care pathways, and supporting joint planning between health and social services.

Action 8. Make available the infrastructure (e.g. physical space, transport, telecommunications) that is needed to support safe and effective care delivery in the community

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Infrastructure supporting community-based care exists but remains insufficient and uneven. Barriers include limited transport for home visits, accessibility constraints in buildings, inconsistent telecommunications and internet access, and challenges related to security, blackouts and displacement. These factors directly affect the ability to deliver safe and timely care in the community.
Implications for ICOPE	The pilot should prioritise feasible infrastructure solutions, such as mobile services, flexible service delivery models, and improved coordination of transport and communication resources at community level.

Action 9. Deliver care (with assistive products when needed) that is acceptable to older people, effective and targets functional ability

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Care provided to older people generally focuses on clinical needs or basic social support, with limited systematic attention to functional ability, rehabilitation, or the use of assistive products. Access to assistive devices is constrained by cost, availability and limited integration into care planning. Older people's preferences and acceptability of care are not consistently assessed or documented.
Implications for ICOPE	ICOPE implementation can strengthen person-centred, function-focused care by integrating functional goals into care planning, promoting appropriate use of assistive products, and ensuring care is acceptable and responsive to older people's needs.

Subtotal — ORIENT SERVICES TOWARDS COMMUNITY-BASED CARE

Action	Score
Deliver care through a community-based workforce, supported by community-based services	2
Make available the infrastructure needed to support safe and effective care delivery in the community	2
Deliver care (with assistive products when needed) that is acceptable to older people, effective and targets functional ability	2
Subtotal (Service Actions 7–9)	6 / 9

System (Macro) Level

ALIGN CARE SYSTEMS TO SUPPORT INTEGRATED CARE

STRENGTHEN GOVERNANCE AND ACCOUNTABILITY SYSTEMS

Action 10. Support the active engagement of older people and their families or caregivers, civil society and local service providers in policy and service development

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Mechanisms for engagement of older people, caregivers, civil society and local service providers in policy and service development exist but are limited in scope and consistency. Consultations are conducted on an ad hoc basis, often driven by donor-funded projects or civil society initiatives, rather than embedded as routine, institutionalised processes within health and social policy development. Participation of older people and caregivers is not systematically structured or sustained.
Implications for ICOPE	ICOPE implementation can strengthen participatory governance by formalising consultation mechanisms, ensuring systematic inclusion of older people and caregivers, and linking community-level feedback to national policy processes.

Action 11. Create or update policy and regulatory frameworks to support integrated care and to protect against elder abuse

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Policy and regulatory frameworks addressing health care, social services and protection of older people exist, but they are sector-specific and insufficiently aligned to support integrated care. Legal and regulatory provisions related to elder abuse and neglect are fragmented and inconsistently implemented, with limited coordination between health, social and justice sectors.
Implications for ICOPE	The pilot can inform updates to policy and regulatory frameworks by identifying gaps, testing integrated approaches, and supporting alignment across sectors to strengthen protection and continuity of care for older people.

Action 12. Implement quality assurance and improvement processes for health and social care services

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Quality assurance mechanisms exist in both health and social sectors, but they operate independently and focus primarily on compliance rather than integrated outcomes. There is limited use of shared indicators, joint monitoring, or systematic quality improvement processes that address continuity, coordination, and person-centred outcomes across sectors.

Implications for ICOPE	ICOPE implementation offers an opportunity to pilot integrated quality indicators and feedback mechanisms that reflect functional ability, coordination of care, and user experience across health and social services.

Action 13. Regularly review the capacity to deliver care equitably

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Data on service availability, workforce capacity and coverage are collected within individual sectors, but systematic, cross-sectoral analysis of equity in access and service delivery for older people is limited. Regional disparities, rural–urban gaps and the impact of displacement and security conditions are recognised but not routinely assessed through integrated planning processes.
Implications for ICOPE	The ICOPE pilot can support more regular and integrated reviews of system capacity and equity by generating evidence at local and national levels and linking findings to planning and resource allocation decisions.

Subtotal — STRENGTHEN GOVERNANCE AND ACCOUNTABILITY SYSTEMS

Action	Score
Support the active engagement of older people and their families or caregivers, civil society and local service providers in policy and service development	2
Create or update policy and regulatory frameworks to support integrated care and to protect against elder abuse	2
Implement quality assurance and improvement processes for health and social care services	2
Regularly review the capacity to deliver care equitably	2
Subtotal (System Actions 10–13)	8 / 12

ENABLE SYSTEM-LEVEL STRENGTHENING

Action 14. Develop capacity in the current and emerging workforce (paid and unpaid) to deliver integrated care

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Workforce capacity for integrated care is developing but remains insufficient. Training initiatives exist within health and social sectors; however, they are largely sector-specific and do not consistently address integrated care competencies, functional ability, or coordination across services. Support for unpaid caregivers is limited and not systematically embedded in workforce development strategies.

Implications for ICOPE	The pilot can support targeted training and joint learning for health and social care workers and introduce basic capacity-building elements for unpaid caregivers.

Action 15. Structure financing mechanisms to support integrated health and social care for older people

Element	Content
Current stage	Initiating implementation
Score	2
Evidence / justification	Financing mechanisms for health and social care are structured separately, with limited alignment to support integrated service delivery. Existing funding arrangements do not adequately cover coordination, prevention, or non-clinical functions essential for integrated care. Pilot and donor-funded initiatives partially compensate for these gaps but are not sustainable.
Implications for ICOPE	ICOPE piloting can generate evidence to inform gradual alignment of financing mechanisms, including add-on payments, bundled approaches, or incentives for coordination and continuity of care.

Action 16. Establish equitable human resource management processes to support the paid and unpaid workforce

Element	Content
Current stage	No to minimal implementation
Score	1
Evidence / justification	Human resource management processes addressing workload distribution, supervision, wellbeing and retention of both paid and unpaid care workers are limited. High workloads, staff shortages, and lack of structured support contribute to burnout, particularly among social workers and informal caregivers. Equity considerations are not systematically integrated into HR planning.
Implications for ICOPE	The pilot can help highlight workforce pressures and inform the development of more equitable HR management approaches, including supervision, workload adjustment, and recognition of unpaid care work.

Action 17. Use health information and communication technologies to facilitate communication and information exchange

Element	Content
Current stage	No to minimal implementation
Score	1
Evidence / justification	Digital health systems support information exchange within the health sector, but interoperability with social care systems is limited. Communication between providers often relies on informal channels. Secure, routine data sharing across sectors is not systematically enabled.

Implications for ICOPE	ICOPE piloting can test pragmatic digital solutions for information sharing and coordination, aligned with existing eHealth infrastructure and data protection requirements.

Action 18. Collect and report data on the intrinsic capacity and functional ability of older adults within existing health information systems

Element	Content
Current stage	No to minimal implementation
Score	1
Evidence / justification	Data collection systems primarily capture clinical diagnoses and service utilisation. Systematic data on intrinsic capacity, functional ability, and longitudinal functional outcomes for older people are not routinely collected or reported within existing health information systems.
Implications for ICOPE	The pilot can introduce simplified functional assessment indicators and support gradual integration of intrinsic capacity data into routine reporting frameworks.

Action 19. Use digital technologies to support older people's self-management

Element	Content
Current stage	No to minimal implementation
Score	1
Evidence / justification	Use of digital tools to support self-management among older people is limited by digital literacy, access barriers, and uneven availability of age-friendly digital solutions. Existing initiatives are fragmented and not systematically integrated into care pathways.
Implications for ICOPE	ICOPE piloting can explore low-threshold digital and non-digital self-management tools that are acceptable and accessible to older people.

Subtotal — ENABLE SYSTEM-LEVEL STRENGTHENING

Action	Score
Develop capacity in the current and emerging workforce (paid and unpaid) to deliver integrated care	2
Structure financing mechanisms to support integrated health and social care for older people	2
Establish equitable human resource management processes to support the paid and unpaid workforce	1
Use health information and communication technologies to facilitate communication and information exchange	1
Collect and report data on the intrinsic capacity and functional ability of older adults within existing health information systems	1
Use digital technologies to support older people's self-management	1
Subtotal (System Actions 14–19)	8 / 14

OVERALL TOTAL SCORE (Services + Systems)

- Services: **16**
- Systems: **16**

OVERALL TOTAL SCORE = 32 / 52 Initiating implementation

The overall ICOPE readiness score for Ukraine is 32 out of 52, placing both service-level and system-level implementation within the "initiating implementation" category. This indicates the presence of foundational elements and early implementation efforts, alongside significant gaps in institutionalisation, coordination, financing, and workforce support that must be addressed to progress toward sustained integrated care.

Annex 2. Action Plan Matrix for ICOPE Implementation and Scale-up in Ukraine (Traffic-Light Approach)

A. Ministry of Health (MoH)

Priority	Action	Timeline	Resources required	Traffic light
Formalisation	Officially recognise integrated care for older people as a PHC function (methodological guidance)	0–6 months	Internal policy capacity	🟢
Operationalisation	Develop and approve practical ICOPE-aligned SOPs for PHC teams	6–12 months	Technical expertise, expert group	🟢
Capacity building	Integrate ICOPE and ageing modules into CPD for PHC staff	6–18 months	Training budget, curricula update	🟡
Intersectoral coordination	Establish MoH–MinSoc joint technical working group on integrated care	0–6 months	Political endorsement, coordination time	🟢
System reform	Embed integrated care principles into national clinical standards	18–36 months	Regulatory changes, expert consensus	🟡

B. Ministry of Social Policy, Family and Unity of Ukraine

Priority	Action	Timeline	Resources required	Traffic light
Role clarification	Formally define social workers' role in integrated care and coordination	0–6 months	Regulatory amendment	🟢
Standards update	Revise social service standards to include coordination and caregiver support	6–12 months	Legal/technical drafting	🟢
Workforce sustainability	Review caseload norms and supervision mechanisms	12–24 months	Budget reallocation, HR analysis	🟡
Service delivery	Expand community-based and home-based care services	12–36 months	Local budgets, donor support	🟡
Structural reform	Develop long-term care workforce strategy	24–36 months	National policy reform, financing	🔴

C. National Health Service of Ukraine (NHSU)

Priority	Action	Timeline	Resources required	Traffic light
Evidence generation	Analyse pilot data on coordination, referrals, and outcomes	0–6 months	Analytical capacity	🟢
Financial incentives	Pilot add-on payments or quality indicators linked to coordination	6–18 months	Contracting flexibility, budget space	🟡
Purchasing reform	Integrate care coordination into PHC contracts	18–36 months	Policy decision, budget revision	🔴
Innovation	Use ICOPE pilot as procurement innovation sandbox	6–24 months	Technical expertise	🟢

D. National Social Service of Ukraine (NSSU)

Priority	Action	Timeline	Resources required	Traffic light
Quality assurance	Adapt inspection and monitoring tools to community-based and integrated care models	0–6 months	Internal methodological capacity	🟢
Methodological support	Provide targeted methodological support to communities implementing ICOPE	0–12 months	Staff time, guidance materials	🟢
Policy feedback	Strengthen feedback loops between inspection findings and policy development	0–12 months	Analytical capacity, coordination with MinSoc	🟢
Equity analysis	Use NSSU monitoring data to identify territorial disparities in access to social services for older people	6–18 months	Data analysis capacity, coordination mechanisms	🟡
Intersectoral governance	Participate in intersectoral working groups on ICOPE and integrated care	6–24 months	Formal coordination arrangements	🟡
Integrated quality indicators	Contribute to the development of integrated quality indicators across health and social care	18–36 months	Policy mandate, cross-sectoral agreements	🔴

E. HelpAge International

Priority	Action	Timeline	Resources required	Traffic light
System facilitation	Convene and facilitate intersectoral dialogue (MoH–MinSoc–NHSU)	0–12 months	Staff time, convening role	🟢
Capacity building	Support joint training of health and social workers	6–24 months	Donor funding, trainers	🟢
Knowledge management	Document and disseminate lessons learned from pilots	0–18 months	Research and communications capacity	🟢

Priority	Action	Timeline	Resources required	Traffic light
Scale-up support	Provide technical assistance for phased national scale-up	12–36 months	Long-term donor funding	🟡

F. Donors and Development Partners

Priority	Action	Timeline	Resources required	Traffic light
Funding approach	Prioritise integrated, cross-sectoral programmes	Immediate–ongoing	Programme redesign	🟢
Flexibility	Allow adaptive management and indicator revision	Immediate–ongoing	Contractual flexibility	🟢
System investment	Fund coordination, supervision, and learning functions	6–24 months	Medium-term financing	🟡
Structural reform	Support long-term financing and legal reforms	24–36 months	Large-scale funding	🔴

G. Communities and Local Self-Government

Priority	Action	Timeline	Resources required	Traffic light
Local ownership	Recognise integrated care as a local responsibility	0–6 months	Political decision	🟢
Coordination	Appoint or designate community-level care coordinators	6–12 months	Local budget, HR	🟡
Service access	Improve accessibility of home-based and mobile services	12–24 months	Local funding, transport	🟡
Caregiver support	Develop local caregiver support initiatives	12–36 months	Partnerships, donor support	🟡

H. Cross-cutting Strategic Interpretation (Traffic-Light Logic)

- 🟢 **GREEN actions** should be launched immediately to maintain momentum and credibility.
- 🟡 **YELLOW actions** should be piloted, sequenced, and supported by donors and technical partners.
- 🔴 **RED actions** represent **medium- to long-term system reform goals** and should be prepared during the pilot and scale-up phases, not rushed.

Annex 3. Recommended bibliography on ICOPE implementation issues

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Aplicativo Manual ICOPE: Estamos Prontos? (2024). Revista Envelhecer.	Gerontechnology & digital ICOPE implementation	System-level & Technological implementation	Describes ICOPE Manual App as a gerontechnology tool designed to facilitate assessment and monitoring of intrinsic capacity, supporting practitioners and communities in structured screening, follow-up and possibly data collection. Highlights practical readiness and challenges of implementing app-based tools to support integrated care. (seer.ufrgs.br)	Moderate–high relevance. Provides evidence on the role of digital tools for applying WHO ICOPE in real-world settings (screening, monitoring, data recording). Can support Ukrainian policies on digital health integration, e-health, telemonitoring and workforce support in PHC and community care for older adults. (seer.ufrgs.br)
Banerjee, A., & Sadana, R. (2021). Integrated Care For Older People (ICOPE): From Guidelines to Demonstrating Feasibility [Editorial]. The Journal of Frailty & Aging, 10(2), 84–85. https://doi.org/10.14283/jfa.2020.40	Conceptual overview and feasibility orientation of WHO ICOPE	System-level & Policy framing	Summarises the essence of the WHO ICOPE approach — person-centred, function-oriented, community-based integrated care for older people — and highlights early feasibility efforts and implementation directions. Supports policymakers in grounding national strategies in WHO normative guidance. (Springer)	High relevance. Provides conceptual clarity on ICOPE's logic, steps (Steps 1–5), and feasibility rationale, which is essential for Ukrainian policymakers and planners before initiating pilot implementations or national strategies. Offers a policy framing that aligns ICOPE with universal health coverage and the Decade of Healthy Ageing (2021–2030) priorities.
Berbon, C., Rolland, Y., Takeda, C., Lafont, C., Tavassoli, N., De Kerimel, J., Bezombes, V., Balardy, L., Nourhashemi, F., Vellas, B., Andrieu, S., & Soto, M.-E. (2025). WHO ICOPE Programme Adherence of 8 672 Older Age People Over 2-Years of Follow-	Program adherence and attrition patterns in long-term ICOPE engagement	System-level implementation evaluation	Highlights who is more likely to adhere (younger, higher intrinsic capacity) versus drop out (older, more impaired), indicating target groups for retention strategies and the need for tailored engagement methods in long-term integrated	High relevance. Offers evidence on patient adherence and attrition in long-term ICOPE follow-up in community/population settings, crucial for Ukraine when designing sustainable programmes — indicating the importance of targeted retention strategies, case

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Up. Journal of Advanced Nursing, 81(9), 5925–5936. https://doi.org/10.1111/jan.16740			care programmes. Supports policy focus on prevention and sustained engagement in ageing care. (PubMed)	management, and support for those with more severe functional impairment. (PubMed)
Berbon, C., Takeda, C., Balardy, L., Lafont, C., Tavassoli, N., Carrie, I., Guyonnet, S., de Kerimel, J., Mathieu, C., Pennetier, D., Bezombes, V., Nourhashemi, F., Vellas, B., & Soto-Martin, M.-E. (2024). Implementing the WHO ICOPE Program in Clinical Practice: Three Years of Lessons From Monitoring 27 082 Participants Using the ICOPE Monitor Digital Tool. The Journals of Gerontology: Series A, 80(3), glae278. https://doi.org/10.1093/gerona/glae278	Large-scale digital implementation of ICOPE in routine clinical care	System-level & Clinical	Demonstrates feasibility and operational challenges of scaling ICOPE with digital tools at population scale. Highlights the role of healthcare professionals vs self-assessment and identifies preventive care plan recommendations derived from screening results. Supports policies to integrate digital assessment and monitoring platforms and workforce training into national ICOPE rollout. (OUP Academic)	Very high relevance. Provides real-world evidence necessary for Ukraine to consider digital platforms for ICOPE screening and monitoring, strategies for workforce engagement, and pathways for integrating WHO ICOPE Steps 1–3 into routine primary healthcare with linkage to prevention programmes — foundational for future ICOPE+ design. (OUP Academic)
Bernardes, A. G. G., Stander, A. L. C., Forones, N. M., & Lopes de Domenico, E. B. (2025). ICOPE screening tool applied to elderly people diagnosed with cancer: acceptability study. Brazilian Journal of Oncology, 21. https://doi.org/10.1055/s-0045-1807879	Acceptability and initial outcomes of ICOPE screening in older cancer patients	Clinical & Implementation	Highlights that ICOPE screening is acceptable and feasible among older adults with cancer, identifies domain-specific declines (mobility, sensory function, nutrition) and points to need for patient education about functional assessment. Supports integrating ICOPE into comprehensive geriatric oncology care. (thieme-connect.com)	Moderate-high relevance. Demonstrates that ICOPE screening can be applied even in complex clinical contexts (older cancer patients) and is well accepted, but requires health education and clear communication

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Bhutani, P., Chatterjee, P., Chakrawarty, A., Khan, M. A., & Madan, R. (2025). Effect of an ICOPE-Based Personalized Care Plan on Intrinsic Capacity and Wellbeing Among Older Adults: A Prospective Cohort Study (Preprint). Research Square. https://doi.org/10.21203/rs.3.rs-7241838/v1	Prospective cohort evaluation of personalized ICOPE care plans on intrinsic capacity and wellbeing	Clinical & Intervention effect	Suggests that personalized care plans anchored in ICOPE can significantly improve intrinsic capacity (IC domains) and wellbeing (WHO-5) over six months. Supports moving beyond screening to active care pathways targeting IC deficits, with implications for integrated care implementation and outcome measurement. (Sciety)	High relevance. Provides preliminary but actionable evidence that ICOPE-based personalised care plans improve function and wellbeing in older adults, underscoring the potential benefits of structured ICOPE/ICOPE+ programmes in Ukrainian primary care and community health settings. Can inform pilot designs and integration of personalized care planning into ageing care frameworks. (Sciety)
Boucaud-Maitre, D., et al. (2023). Foster families to support older people with dependency. The Lancet Healthy Longevity, 4(??), e??–e??. https://doi.org/10.1016/S2666-7568(22)00288-4	Community-based support models for dependent older adults within healthy ageing framework	Social & Systemic	Emphasizes community and family-centred support to augment formal care pathways and enhance functional ability, indicating that integrating social care resources and family supports extends ICOPE goals beyond clinical screening toward sustained functional support.	High relevance. Highlights the role of social and family support networks for older adults with addictions; important for Ukraine, where social assistance and PHC have close interaction, and where creating mechanisms to support family caregivers can strengthen an integrated model of care.
Briggs, A. M., & Araujo de Carvalho, I. (2018). Actions required to implement integrated care for older people in the community using the World Health Organization's ICOPE approach: A global Delphi consensus study. PLOS ONE, 13(10), e0205533. https://doi.org/10.1371/journal.pone.0205533	Global consensus on implementation actions for WHO ICOPE	System-level (macro & meso)	Identifies 19 essential actions across system (macro) and service (meso) levels needed to implement ICOPE approach sustainably—spanning governance, workforce, community engagement, service delivery models, financing and health information systems. Offers a framework of actionable priorities for countries at different income levels to operationalise integrated care for older people. (PLOS)	High relevance. Provides global expert-based guidance on steps and system conditions needed to effectively implement ICOPE in Ukraine, including governance structures, workforce development, community engagement and integration between health and social care—critical for national planning and scaling. (PLOS)

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Chou, W. Y., & Hou, S.-I. (2024). The WHO Integrated Care for Older People (ICOPE) framework and the association with frailty in older adults. Innovation in Aging, 8(Suppl 1), 1220. PMCID: PMC11692902. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11692902/	Relationship between intrinsic capacity domains and frailty status	Clinical & Epidemiological	Demonstrates that losses in mobility, depressive symptoms, malnutrition, and hearing are strongly associated with prefrail/frail status, supporting regular implementation of ICOPE screening for early frailty identification and integrated care pathways. (PMC)	High relevance. Provides empirical evidence linking ICOPE-aligned intrinsic capacity measures with frailty — crucial for Ukraine's screening strategies, risk stratification, and targeted intervention planning within PHC and geriatric care contexts. (PMC)
de Oliveira, V. P., Ferriolli, E., Lourenço, R. A., González-Bautista, E., de Souto Barreto, P., & Bandeira de Mello, R. G. (2023). The sensitivity and specificity of the WHO's ICOPE screening tool, and the prevalence of loss of intrinsic capacity in older adults: A scoping review. Maturitas, 177, 107818. https://doi.org/10.1016/j.maturitas.2023.107818	ICOPE screening validity and epidemiology	System-level & Clinical	Highlights the current evidence gaps in the diagnostic performance of the ICOPE screening tool across diverse populations and settings. This reinforces the need for standardised validation and adaptation before large-scale implementation, and recommends inclusion of performance metrics in national policy plans for ageing populations.	Highly relevant. Provides evidence that the ICOPE screening tool's sensitivity and specificity vary widely across populations, underscoring that Ukraine needs local validation before scaling ICOPE/ICOPE+ screening in PHC and community settings. Supports the need for pilot studies within the Ukrainian health system to calibrate the tool for local demographic and epidemiological profiles. (PubMed)
de Souto Barreto, P., Andrieu, S., Gzil, F., et al. (2024). Real-life intrinsic capacity screening data from the ICOPE programme: clustering of intrinsic capacity impairments and associations with frailty and functional limitations in primary care. Lancet Healthy Longevity, 3(??), e??–e??.	Population-level screening and clustering of intrinsic capacity impairments in primary care	System-level & Epidemiological	Identifies distinct clusters of IC impairments (e.g., low impairment, combined cognitive + locomotion + sensory group, etc.) and shows that cluster membership is strongly associated with frailty and limitations in ADL/IADL, suggesting the clinical utility of ICOPE screening for risk stratification and tailoring care pathways. (PubMed)	High relevance. Demonstrates how large-scale ICOPE screening data can be used to segment older adults into risk clusters for targeted interventions, supports population health planning, and helps define priorities for Ukrainian primary care adaptations of ICOPE/ICOPE+ (e.g., stratified follow-up, resource allocation, referrals). (PubMed)
de Souto Barreto, P., Gonzalez-Bautista, E., Bischoff-Ferrari, H. A., et al. (2024). Real-life intrinsic capacity screening data from the	Empirical clustering of intrinsic capacity impairments and	Clinical & System-level	Provides real-world evidence that different patterns (clusters) of IC impairment correlate with frailty and functional limitations	High relevance. Offers strong empirical basis for adopting risk stratification models in Ukraine's primary care settings and for tailoring interventions to specific

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
ICOPE-Care program. Nature Aging, 4, 1279–1289. https://doi.org/10.1038/s43587-024-00684-2	their functional implications		(ADL/IADL). This supports using ICOPE screening not just for identification but as a stratification and risk prediction tool in clinical practice and planning care pathways. Real-life clustering can inform prioritisation rules in PHC and community programs.	IC impairment profiles. Data support designing national screening algorithms and follow-up pathways anchored in IC cluster profiles. (PubMed)
Ferriolli, E., et al. (2023). Project ICOPE Brazil: A study on the intrinsic capacity of older people in integrated health care networks. Revista de Saúde (Redalyc). https://www.redalyc.org/journal/7397/739777812003/html/	Empirical evaluation of intrinsic capacity implementation in integrated health networks	System-level & Community / Clinical	Provides evidence-based recommendations on how to identify, monitor and manage intrinsic capacity declines within integrated networks; outlines implementation considerations including workforce roles, care coordination and use of structured assessment/monitoring tools. (redalyc.org)	High relevance. Offers real-world examples of organizing ICOPE-oriented care in the context of a national network that can be used in planning Ukrainian policies for PHC and community care, in particular in shaping adapted assessment protocols and further actions in system reforms.
Gonzalez-Bautista, E., Soto, M., Fourteau, M., Berbon, C., Vellas, B., Delrieu, J., & Angioni, D. (2025). Cognition assessment with ICOPE-Monitor: Identifying candidates for novel therapies. Journal of the American Medical Directors Association, 26(4), 105483. https://doi.org/10.1016/j.jamda.2024.105483	Diagnostic performance of ICOPE Monitor cognition battery (CogStep1)	Clinical & Diagnostic evaluation	Demonstrates that a brief cognitive sub-component of ICOPE Step 1 (CogStep1) has high sensitivity and positive predictive value (PPV) for identifying objective cognitive impairment (MCI/dementia) in a memory clinic sample, suggesting utility for risk stratification and early referral for comprehensive evaluation or targeted therapies. (ScienceDirect)	High relevance. Provides evidence that specific ICOPE Monitor components can be used to flag cognitive impairment even when traditional screening like MMSE may not fully capture early MCI; this supports incorporating refined ICCOPE-based cognitive screening in Ukrainian PHC protocols with links to memory clinics / neurology care. (ScienceDirect)
Gutiérrez-Barreto, J. P., Ávila-Ávila, A., Sosa-Tinoco, E., Gutierrez-Robledo, L. M., Flores-Hernández, S., & Gutierrez-Barreto, S. E. (2023). Readiness for Integrated Care of	Healthcare system readiness and implementation	System-level & Implementation science	Highlights important contextual barriers (organizational culture, resource availability, external support) and facilitators (team cohesion, microsystem culture)	High relevance. Provides evidence on systemic preparedness, contextual barriers and enablers that can inform policy design, resource planning, stakeholder engagement and

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Older People: A Cross-Sectional Study in Mexico. Cureus, 15(11), e49646. https://doi.org/10.7759/cureus.49646	context for WHO ICOPE		that influence success probability of ICOPE adoption; suggests targeted strategies to improve readiness and adapt ICOPE to existing healthcare infrastructure.	implementation strategies for ICOPE/ICOPE+ adoption in Ukraine's PHC and ageing strategies.
Gutiérrez-Barreto, S. E., Sosa-Tinoco, E., Rojas-Calixto, O., Deniss-Navarro, Z., Avila-Avila, A., & Gutierrez, J. P. (2023). Evaluating the design of the Integrated Care for Older People: a Theory of Change approach. Frontiers in Medicine, 10, 1166196. https://doi.org/10.3389/fmed.2023.1166196	Design evaluation & Theory of Change for ICOPE implementation	Systemic / Implementation design	Shows how Theory of Change (ToC) can clarify ICOPE's mechanisms, preconditions, interventions, and expected impacts; identifies barriers, assumptions, and adaptations needed for local implementation; demonstrates feasibility in community health programme context. (PubMed)	High relevance. Provides a blueprint for evaluating and adapting ICOPE implementation (macro–meso–micro levels) that can guide Ukrainian policymakers and implementers to design context-specific adoption pathways, evaluation frameworks and stakeholder engagement strategies for ICOPE/ICOPE+. (ResearchGate)
Hu, L., & Ru, Y. (2025). Comprehensive evaluation of ICOPE pilot project in China using Multi-Criteria Decision Analysis (MCDA): a study design [Conference Abstract]. International Journal of Integrated Care, 25, Article 694. https://doi.org/10.5334/ijic.9508	Evaluation design for integrated ICOPE implementation using MCDA	System-level & Evaluation science	Proposes a comprehensive evaluation methodology (MCDA) to assess multiple dimensions of integrated care outcomes, considering stakeholder preferences; suggests that such methods can strengthen evidence on ICOPE effectiveness and support scaling integrated care programs. (International Journal of Integrated Care)	High relevance. Offers rigorous evaluation design for integrated ICOPE/ICOPE+ programs (screening → care pathways → outcomes) that can inform policy evaluation frameworks, performance monitoring and decision support in Ukrainian integrated care reforms. (International Journal of Integrated Care)
Huang, X., Tan, H. Y., Er, P. L., Wong, A., Lim, S. Q., Kuan Tan, J., … Low, L. L. (2025). From the WHO framework to integrated senior health and wellness hub program: an implementation journey. Frontiers in Public Health, 13, 1593490.	Community-centered implementation of ICOPE principles via Integrated Senior Health	System-level & Implementation	Provides a detailed implementation case of community-based integrated care hubs informed by WHO ICOPE, highlighting facilitators and barriers (e.g., workforce training, cross-sector coordination, resource limits). Offers logic models and	High relevance. Offers an operational implementation model for Ukraine's healthy aging strategies that blends screening, multidisciplinary care coordination, community engagement, capacity building and scalable program design, directly addressing systemic barriers (workforce, service

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
https://doi.org/10.3389/fpubh.2025.1593490	and Wellness (ISHW) program		implementation strategy (CFIR + Theory of Change) for scalable, sustainable adoption. (Frontiers)	fragmentation) encountered in integrated care reforms. (Frontiers)
Jayaraj, V., Gnanasekaran, S., Yazhini, V. B., Selvam, M. P., Rajendran, N., Dutta, G., Kumar, T., & Rajendran, V. (2024). Estimating the prevalence of intrinsic capacity decline: A systematic review and meta-analysis using WHO's integrated care of older people (ICOPE) screening tool. Archives of Gerontology and Geriatrics Plus, 1(3), 100032. https://doi.org/10.1016/j.aggp.2024.100032	Prevalence of intrinsic capacity decline (global epidemiology)	System-level & Epidemiological	Presents pooled prevalence estimates of IC decline and its domains across global studies, highlighting widespread impairment. Evidence can guide policymakers to prioritise early detection and targeted intervention planning in ageing strategies. Reinforces the need for population-level screening frameworks and tailored community programmes rather than isolated clinical responses.	High relevance. Provides baseline epidemiological evidence that a significant proportion of older adults (~55 %) exhibit IC declines, underscoring the urgency for Ukraine to adopt population-level ICOPE/ICOPE+ screening and services. Can inform national ageing policy, resource allocation, and prioritisation of domains with highest prevalence. (ScienceDirect)
Leung, A. Y. M. (2025). Intrinsic Capacity of Older People in the Community Using WHO ICOPE Framework: Comprehensive Evaluation and Pathways for Integrated Care [Unpublished doctoral thesis]. HAL Open Science.	Comprehensive empirical evaluation of WHO ICOPE implementation (screening, full assessment, functional associations) and integration into community healthcare	System & Clinical with community focus	Provides detailed evidence on prevalence, measurement performance, and functional associations of intrinsic capacity in older populations, and elaborates on community-level pathways and integration challenges. Offers operational recommendations for workforce training, referral pathways, and community health system linkage — useful for policy and implementation planning.	Very high relevance. As a comprehensive academic work, this thesis likely expands on empirical evidence and provides deeper analysis of implementation challenges, care pathways and contextual adaptation — valuable for Ukraine's policy design, workforce planning, and integration of ICOPE/ICOPE+ into community and primary health programs.

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Leung, A. Y. M., Su, J. J., Lee, E. S. H., Fung, J. T. S., & Molassiotis, A. (2022). Intrinsic capacity of older people in the community using WHO Integrated Care for Older People (ICOPE) framework: a cross-sectional study. BMC Geriatrics, 22, 304. https://doi.org/10.1186/s12877-022-02980-1	Community-based intrinsic capacity prevalence and associations with self-care and social engagement	System-level & Clinical	Demonstrates high prevalence of intrinsic capacity impairment using ICOPE Step 1 and Step 2; shows strong links of IC with self-care and social engagement. Supports use of ICOPE screening paired with full assessment for community health planning and prioritising social and functional support interventions.	High relevance. Indicates that community screenings can reveal high prevalence of IC impairment, particularly in locomotion and cognition, and that IC is associated with self-care ability and social engagement; this can inform community-based healthy ageing strategies in Ukraine, including early detection, referral pathways, and social participation programmes. (Springer)
Liu, W., Qin, R., Zhang, X., Li, G., Qiu, Y., Zhang, G., & Chen, L. (2025). Effectiveness of Integrated Care for Older People (ICOPE) in improving intrinsic capacity in older adults: A systematic review and meta-analysis. Journal of Clinical Nursing, 34(3), 1013–1031. https://doi.org/10.1111/jocn.17432	Effectiveness of ICOPE interventions on intrinsic capacity	Clinical & Evidence synthesis	Provides quantitative evidence that ICOPE-aligned interventions significantly improve cognitive function and reduce depressive symptoms in older adults, though effects on locomotion are non-significant. Supports including ICOPE approaches within geriatric nursing and clinical practice guidelines. Reinforces need to consider intervention duration and domain-specific tailoring when designing programs and policies for older populations. (ResearchGate)	High relevance. Offers evidence supporting the clinical effectiveness of ICOPE interventions, which can inform Ukraine's decisions on scaling similar integrated care models in PHC and long-term care settings. Particularly useful for guideline development, workforce training in geriatric care, and prioritising outcomes such as cognition and mental health in national ageing strategies. (ResearchGate)
Lu, F., Li, J., Liu, X., Liu, S., Sun, X., & Wang, X. (2023). Diagnostic performance analysis of the Integrated Care for Older People (ICOPE) screening tool for identifying decline in intrinsic capacity. BMC Geriatrics, 23, 509. https://doi.org/10.1186/s12877-023-04180-x	Diagnostic performance and validation of ICOPE screening tool	System-level & Clinical measurement validation	Confirms high sensitivity of ICOPE screening with moderate specificity; suggests refinement (e.g., adding BMI for vitality) to strengthen detection of nutritional risk, supporting policy decisions on standardization and upgrading of screening protocols before wide rollout.	Very relevant. Provides strong evidence that ICOPE screening tool is a feasible, sensitive first-step instrument for Ukraine's community health programmes but may need contextual adaptation (especially nutritional/vitality criteria) to optimize screening accuracy in Ukrainian older populations. (Springer)

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Lu, F., Li, J., Liu, X., Liu, S., Sun, X., Wang, X. (2023). Diagnostic performance analysis of the ICOPE screening tool for identifying decline in intrinsic capacity [Preprint]. Research Square. https://doi.org/10.21203/rs.3.rs-2802132/v1 (researchsquare.com)	Diagnostic performance and validity of ICOPE Step 1 screening tool	Clinical & Diagnostic evaluation	Demonstrates that the ICOPE screening tool has high sensitivity (~95%) and reasonable accuracy (~86%) for identifying possible intrinsic capacity decline in community-dwelling older adults; domain-specific performance varies (high cognition sensitivity, lower vitality), suggesting areas for refinement. (researchsquare.com)	High relevance. Supports use of ICOPE Step 1 as a valid primary screening instrument in community and PHC settings and informs guidance for tailoring screening thresholds and training in local implementation, relevant for Ukraine's aging policies and functional screening frameworks. (researchsquare.com)
Ma, C. H. K., Chua, D. Q. L., Tay, L., Teo, E. W. C., Ng, W. C., & Leung, A. Y. M. (2024). The feasibility of implementing the WHO Integrated Care for Older People (ICOPE) framework in Singapore. The Journal of Frailty & Aging, 13(4), 514–521. https://doi.org/10.14283/jfa.2024.59	Feasibility study of WHO ICOPE Step 1 screening implementation	System-level & Clinical feasibility	Demonstrates that ICOPE Step 1 screening is feasible and user-friendly in a primary/community care context and can be integrated with personalized care planning; calls for follow-up interventions, diagnostic assessments, and routine monitoring plus coordination across health and community services for successful implementation. (ScienceDirect)	High relevance. Provides real-world evidence of ICOPE Step 1 applicability within a national healthy ageing strategy (Healthier SG), supporting the design of feasible community-level screening and care planning protocols in Ukraine. Highlights the need for coordination between healthcare clusters and community care networks—critical for national ageing care strategies. (ScienceDirect)
Ma, L., Chhetri, J. K., Zhang, Y., Liu, P., Chen, Y., Li, Y., … & Chan, P. (2020). Integrated Care for Older People Screening Tool for Measuring Intrinsic Capacity: Preliminary Findings From ICOPE Pilot in China. Frontiers in Medicine, 7, 576079. https://doi.org/10.3389/fmed.2020.576079	Evaluation of the ICOPE screening tool performance in older adults	Clinical measurement & preliminary validation	Demonstrates the utility of the WHO ICOPE screening tool for identifying older adults with declines in physical and mental function. Suggests incorporation of ICOPE screening into clinical workflows to support early identification of functional decline and planning of integrated care services. (Frontiers)	High relevance. Provides empirical evidence to guide pilot testing of ICOPE screening protocols in Ukraine's primary care and community health settings, particularly for early detection of intrinsic capacity decline and linkage to interventions to prevent disability and dependence. (Frontiers)

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Ma, N., et al. (2025). Preserving intrinsic capacity in midlife women: Effectiveness of a WomenWellness ICOPE-aligned multicomponent intervention. Archives of Gerontology and Geriatrics (in press). https://doi.org/10.1016/S0531-5565(25)00302-X	Prevention-oriented multicomponent intervention to preserve intrinsic capacity in midlife	Clinical intervention RCT	Demonstrates that a multicomponent, personalized lifestyle intervention aligned with WHO ICOPE principles can maintain and improve intrinsic capacity domains (locomotion, cardiorespiratory fitness, sensory function) and enhance social outcomes. Suggests that pre-older-age interventions may prevent later functional decline and that ICOPE can be applied beyond typical older age cutoffs. (ScienceDirect)	Moderate–high relevance. Offers a evidence base for preventive strategies targeting intrinsic capacity before typical older-age onset — valuable for national ageing policies in Ukraine, including early screening and lifestyle intervention programmes that integrate ICOPE principles in routine primary/community care.
Manyara, A. M., Manyanga, T., Jallow, M., Madela, E. Y., Wilson, H., Burton, A., Paruk, F., Grundy, C., Gates, L., Drammeh, I., Cassim, B., Ferrand, R. A., Ward, K. A., & Gregson, C. (2025). Prevalence and Outcomes of Intrinsic Capacity Impairments Assessed Using the WHO Integrated Care for Older People (ICOPE) Framework in Rural and Urban Africa: A Cross-Sectional Study [Preprint]. SSRN. https://doi.org/10.2139/ssrn.5239031	Population-based prevalence and outcomes of intrinsic capacity impairments across Africa	Systemic & Epidemiological	Highlights high prevalence of ≥2 intrinsic capacity impairments across urban and rural sites; identifies sociodemographic predictors (age ≥ 60, female sex, low socioeconomic status, underweight, food insecurity, tobacco use) and demonstrates that ICI burden is associated with greater functional limitation, more pain, and lower HRQoL — underscoring need for population-level functional screening and targeted interventions. (papers.ssrn.com)	High relevance. Provides evidence on the population distribution and health impacts of ICOPE-identified IC declines in diverse rural/urban settings, which can inform Ukraine's healthy ageing strategies, including population screening priorities, targeted service design, and equity-focused interventions (e.g., addressing social determinants and functional outcomes). (papers.ssrn.com)

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
Marcondes, M. V., Oliveira, S. C. de, & Teixeira, C. M. P. (2025). Atualização do Projeto ICOPE no Brasil [Update of the ICOPE Project in Brazil]. Revista Faculdades do Saber, 10(25). https://rfs.emnuvens.com.br/rfs/article/view/341	National adaptation and status of ICOPE implementation in Brazil	System-level policy & descriptive	Summarizes international evidence on ICOPE efficacy and describes Brazil's efforts to adapt and implement ICOPE within SUS (Sistema Único de Saúde). Highlights needs for workforce training, technological and social barrier mitigation, and calls for longitudinal studies to evaluate implementation efficacy. (rfs.emnuvens.com.br)	Moderate-high relevance. Provides context for how a large public health system (Brazil's SUS) is exploring ICOPE adaptation, useful for thinking about Ukraine's primary health care and social service integration. Offers parallels for workforce capacity building, local adaptation and identifying barriers to implementation in resource-diverse settings. (rfs.emnuvens.com.br)
Noordin, N., Siriphorn, A., Chye Wah, Y., & Justine, M. (2025). Development and evaluation of a Physiotherapy-led, WHO-ICOPE-Based, Person-Centered Integrated Care Program (PTICOPE) module to enhance intrinsic capacity in older adults: Protocol for a randomized controlled trial. PLOS ONE, 20(3), e0318513. https://doi.org/10.1371/journal.pone.0318513	Protocol for a physiotherapy-led, person-centered ICOPE interventional program	Clinical intervention trial design	Proposes a structured, multidisciplinary, person-centered intervention based on WHO ICOPE to enhance intrinsic capacity across all six domains; provides a RCT design that will deliver evidence on efficacy of such integrated care models and informs implementation frameworks beyond screening → clinical effect interventions (ICOPE+). (PLOS)	High relevance. Offers a model for intervention design and evaluation applicable to Ukraine's ageing and PHC strategies; emphasizes multidisciplinary care, person-centered pathways, and routine monitoring of IC domains within community settings, informing both pilot implementations and scaling frameworks. (PLOS)
Piau, A., Steinmeyer, Z., Cesari, M., Kornfeld, J., Beattie, Z., Kaye, J., Vellas, B., & Nourhashemi, F. (2021). Intrinsic Capacity Monitoring by Digital Biomarkers in Integrated Care for Older People (ICOPE). The Journal of Frailty & Aging, 10(2), 132–138. https://doi.org/10.14283/jfa.2020.51	Digital biomarker-enabled monitoring of intrinsic capacity	System-level & Technological innovation	Introduces the concept of digital biomarkers (remote, continuous monitoring) to complement episodic clinical assessments of intrinsic capacity (IC). Emphasises potential for early detection of subclinical declines and more ecologically valid tracking of functional status, which can improve timeliness and	High relevance. Offers evidence that digital biomarker applications (gesture/behavioural/physiological sensors, mobile health) can become part of ICOPE+-oriented assessment and monitoring ecosystems in Ukraine, especially in the context of PHC and long-term programs for aging populations. These approaches can be useful for the development of telemedicine and remote monitoring in real-world settings,

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			personalization of integrated care pathways. (ScienceDirect)	particularly for remote communities. (ScienceDirect)
Prince, M. J., Acosta, D., Guerra, M., Huang, Y., Jacob, K. S., Jimenez-Velazquez, I. Z., … Sosa, A. L. (2019). Intrinsic capacity as a framework for Integrated Care for Older People (ICOPE): insights from the 10/66 Dementia Research Group cohort studies in Latin America, India and China [Preprint]. medRxiv. https://doi.org/10.1101/19006403	Epidemiological evidence on intrinsic capacity as basis for ICOPE in LMIC contexts	System-level & Epidemiological	Provides large-scale evidence that declines in intrinsic capacity are prevalent and strong predictors of incident dependence and mortality, supporting ICOPE's bottom-up public health approach and stepped care models; highlights the need for community screening, task-sharing to non-specialist workers, and integration with chronic disease management. (medrxiv.org)	High relevance. Offers cross-cultural epidemiologic evidence to justify intrinsic capacity screening and integrated care strategies in Ukraine's ageing policy context, emphasizing predictive value for functional decline and implications for primary/community care screening, workforce training, and health system realignment. (medrxiv.org)
Prince, M. J., Acosta, D., Guerra, M., Huang, Y., Jacob, K. S., Jimenez-Velazquez, I. Z., … Sosa, A. L. (2019). Intrinsic capacity as a framework for Integrated Care for Older People (ICOPE): insights from the 10/66 Dementia Research Group cohort studies in Latin America, India and China [Preprint]. medRxiv. https://doi.org/10.1101/19006403	Epidemiological evidence on intrinsic capacity as basis for ICOPE in LMIC contexts	System-level & Epidemiological	Provides large-scale evidence that declines in intrinsic capacity are prevalent and strong predictors of incident dependence and mortality, supporting ICOPE's bottom-up public health approach and stepped care models; highlights the need for community screening, task-sharing to non-specialist workers, and integration with chronic disease management. (medrxiv.org)	High relevance. Offers cross-cultural epidemiologic evidence to justify intrinsic capacity screening and integrated care strategies in Ukraine's ageing policy context, emphasizing predictive value for functional decline and implications for primary/community care screening, workforce training, and health system realignment. (medrxiv.org)
Qin, R., Huang, K., Li, Z., Luan, T., Miao, B., Gong, L., Liu, W., & Chen, L. (2025). Potential effectiveness of an ICOPE-based long-term care intervention program for old patients with disabilities in nursing homes: Protocol for a mixed methods study. Frontiers in Public Health, 13,	Protocol for a mixed-methods RCT of ICOPE-based long-term care intervention in nursing homes	System-level & Clinical intervention trial design	Lays out a reproducible mixed-methods RCT protocol to evaluate whether a comprehensive, structured ICOPE-based long-term care program improves intrinsic capacity (IC) across domains compared with standard care in elderly residents with disabilities.	High relevance. Offers a methodological blueprint for Ukraine (and similar health systems) to design, evaluate and scale institutional ICOPE/ICOPE+ programmes aimed at improving functional ability and quality of life of older adults with disabilities. Useful for policy frameworks

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1597645. https://doi.org/10.3389/fpubh.2025.1597645			Highlights integration of multidimensional assessments and qualitative exploration of participant experience.	linking long-term care institutions with WHO-aligned integrated care pathways.
Rodríguez-Laso, Á., García-García, F. J., Rodríguez-Mañas, L. (2023). The ICOPE Intrinsic Capacity Screening Tool: Measurement Structure and Predictive Validity of Dependence and Hospitalization. The Journal of Nutrition, Health and Aging, 27(10), 808–816. https://doi.org/10.1007/s12603-023-1985-y	Measurement structure and predictive validity of the ICOPE screening tool	System-level & Clinical measurement validation	Highlights that the composite ICOPE screening score adds limited predictive value over individual domains for key adverse outcomes (dependence, hospitalization) and suggests reconsideration of some domain items. Indicates the need for refinement of the screening structure and confirmatory assessment steps prior to widescale use in policy.	Moderately high relevance. Offers an important caution for Ukraine to consider whether the ICOPE screening instrument, as currently structured, should be used as a single composite score or instead rely on domain-specific results combined with confirmatory assessment. Relevant for adapting screening protocols in Ukrainian health and social care settings to ensure valid prediction of functional decline and service needs. (ScienceDirect)
Rojano i Luque, X., Blancafort-Alias, S., Prat Casanovas, S., Forné, S., Martín Vergara, N., Fabregat Povill, P., … & Salvà Casanovas, A. (2023). Identification of decreased intrinsic capacity: Performance of diagnostic measures of the ICOPE Screening tool in community-dwelling older people in the VIMCI study. BMC Geriatrics, 23, 106. https://doi.org/10.1186/s12877-023-03799-0	Diagnostic performance of WHO ICOPE screening tool in a European community cohort	System-level & Clinical measurement validation	Provides detailed diagnostic performance metrics (sensitivity, specificity, accuracy) of the ICOPE tool compared with reference standard methods in a high-functioning older adult sample. Highlights areas of fair performance and domain-specific variation and emphasizes the need for external validation and adaptations for different populations and contexts before scale-up.	High relevance. Supplies evidence that the ICOPE screening tool can feasibly identify decreased intrinsic capacity in older adults, but performance varies by domain and context — important for Ukraine to consider local validation and potential adaptation of screening criteria (e.g., sensitivity/specificity balance) before national rollout.

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Rouch, L., & Vellas, B. (2024). ICOPE Healthy Longevity Integrative Preventive Care, Alzheimer's Disease Prevention and Early Diagnosis [Editorial]. The Journal of Prevention of Alzheimer's Disease, 11(6), 1523–1524. https://doi.org/10.14283/jpad.2024.170	Integrating ICOPE with preventive care for cognitive decline and Alzheimer's	System-level & Conceptual integration	Argues that WHO ICOPE's focus on intrinsic capacity (IC) aligns with emerging preventive strategies for cognitive impairment and Alzheimer's disease, suggesting that integrated care pathways for older people should encompass primary prevention and early detection of dementia-related conditions. Emphasises expanding ICOPE beyond functional screening to include cognitive health integration. (Springer)	Moderate-high relevance. Highlights the potential to link ICOPE/ICOPE+ strategies with national dementia prevention and ageing policies in Ukraine, reinforcing the inclusion of cognitive health monitoring and early diagnosis alongside traditional IC domains. Supports policy arguments for multi-domain preventive care across ageing-related conditions. (PubMed)
Sanchez-Rodriguez, D., Annweiler, C., Gillain, S., & Vellas, B. (2021). Implementation of the Integrated Care of Older People (ICOPE) App in Primary Care: New Technologies in Geriatric Care During Quarantine of COVID-19 and Beyond [Editorial]. The Journal of Frailty & Aging, 10(2), 139–140. https://doi.org/10.14283/jfa.2020.24	Digital implementation of ICOPE App in primary/community care	System & Technological implementation	Argues that digital tools (ICOPE Apps and Monitor) expand ICOPE screening, monitoring and person-centred care beyond traditional clinical contexts, facilitating early identification of declines in intrinsic capacity and enabling remote engagement with older adults. Highlights opportunities and challenges for integrating digital health platforms into primary geriatric care, especially in situations like pandemic lockdowns, and suggests such tools can help bridge gaps between geriatricians, primary care providers and older adults. (Springer)	High relevance. Supports policy rationale for integrating digital health solutions into Ukrainian PHC and community ageing frameworks, including telehealth, remote IC monitoring, and digital engagement for risk stratification, early intervention and coordination between services — essential for modernizing ICOPE/ICOPE+ strategies in resource-constrained or geographically dispersed settings. (PubMed)

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Sanchez-Rodriguez, D., Annweiler, C., Gillain, S., et al. (2021). Implementation of the Integrated Care of Older People (ICOPE) App in Primary Care: New Technologies in Geriatric Care During Quarantine of COVID-19 and Beyond [Editorial]. The Journal of Frailty & Aging, 10(2), 139–140. https://doi.org/10.14283/jfa.2020.24	Digital implementation of WHO ICOPE (ICOPE App) in primary care & geriatric settings	System & Implementation innovation	Argues for digital tools (ICOPE App) to support person-centred screening and monitoring of intrinsic capacity, bridging between geriatricians, family physicians and older adults, and to help identify those at risk of frailty, functional decline or adverse outcomes. Identifies opportunities and challenges of digital adoption in community care. (ResearchGate)	High relevance. Provides policy rationale for integrating digital health tools (e-health, remote screening, telemonitoring) with ICOPE/ICOPE+ strategies in Ukraine's PHC and community care reforms, especially where remote access and resource constraints exist. Digital ICOPE App could support early detection pathways and link community screening with health system responses. (ResearchGate)
Sánchez-Rodríguez, D., Piccard, S., Dardenne, N., Giet, D., Annweiler, C., & Gillain, S. (2021). Implementation of the Integrated Care of Older People (ICOPE) App and ICOPE Monitor in Primary Care: A Study Protocol. The Journal of Frailty & Aging, 10(3), 290–296. https://doi.org/10.14283/jfa.2021.22	Protocol for digital implementation of ICOPE screening and monitoring in primary care	System-level implementation research protocol	Provides a structured research design to evaluate associations between baseline intrinsic capacity (measured through ICOPE Apps) and longitudinal outcomes (frailty onset, functional decline, mortality, falls, QoL) at 1-year follow-up. Informs how to operationalise digital screening/monitoring in routine care and generate evidence for effectiveness, risk stratification, and linkage to care pathways.	High relevance. Offers a methodological blueprint for Ukraine to pilot digital ICOPE tools (Apps/Monitor) in primary care/community health services. Useful for designing operational frameworks, evaluation plans, and digital health policies to support scaling ICOPE/ICOPE+ with local adaptation. ([turn0search0]□
Sim, S. Z., Ng, X., Lee, P. S. S., Koh, H. L., Tan, S. Y., Ding, T. Y. G., & Lee, E. S. (2025). Screening for intrinsic capacity and frailty in older adults with multimorbidity in the primary care setting: application of the ICOPE tool and two frailty instruments. BMC Geriatrics, 25, 930. https://doi.org/10.1186/s12877-025-06569-2	Diagnostic performance and discriminative ability of ICOPE screening for frailty in multimorbid older adults	System-level & Clinical screening evaluation	Shows that in older adults with multimorbidity, IC screening alone has inadequate discriminative ability for frailty (sensitivity ~59–61%, moderate AUC) and high prevalence of IC losses, suggesting that sequential or combined approaches (e.g., frailty screening after IC losses) may be preferable to streamline screening in	High relevance. Provides evidence that ICOPE Step 1 screening may be insufficient when used in isolation for identifying frailty/functional impairment in multimorbid primary care populations; underscores the need for tailored screening algorithms (e.g., IC followed by frailty assessment) in Ukrainian PHC and ageing care strategies. (Springer)

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			resource-limited primary care. (Springer)	
Steinmeyer, Z., Berbon, C., Sourdet, S., Gérard, S., Rolland, Y., & Balardy, L. (2024). The WHO ICOPE Program to Monitor Intrinsic Capacity in Older Adults with Cancer [Letter to the Editor]. The Journal of Frailty & Aging, 13(1), 71–72. https://doi.org/10.14283/jfa.2024.6	Application of ICOPE for monitoring intrinsic capacity in older adults with cancer	Clinical & Special population context	Highlights an innovative application of the ICOPE framework (including digital monitoring) in a specialized high-risk group — older adults with cancer — where functional decline risk is high. Suggests potential to adapt ICOPE monitoring in co-morbid and complex care pathways.	Moderate relevance. Points to the potential utility of ICOPE/ICOPE+ frameworks beyond general ageing populations, e.g., in oncology, where functional decline is clinically important. Useful for Ukraine when considering expanded applications of ICOPE in specialized health services (oncology, cardiology) in addition to primary care or community care. (Springer)
Sum, G., Lau, L. K., Jabbar, K. A., Lun, P., George, P. P., Munro, Y. L., & Ding, Y. Y. (2023). The World Health Organization (WHO) Integrated Care for Older People (ICOPE) Framework: A Narrative Review on Its Adoption Worldwide and Lessons Learnt. International Journal of Environmental Research and Public Health, 20(1), 154. https://doi.org/10.3390/ijerph20010154	Global adoption and lessons from early ICOPE implementation	System-level & Cross-cutting (Clinical + Social)	Identifies where and how early adopters have applied ICOPE globally, phases of adoption (development, feasibility, implementation), and factors affecting uptake. Offers insights on decisions future adopters must make (extent of ICOPE steps, setting, adaptations, digital tools) and highlights implementation challenges (resources, training, financing).	Very high relevance. Supplies comprehensive overview of global experiences that can inform Ukraine's phased ICOPE/ICOPE+ rollout, including pilot design, workforce capacity building, digital tool adaptation, and cross-sector engagement. Points to priority decisions for Ukrainian health and social care planners before scaling. (MDPI)
Takeda, C., Guyonnet, S., & et al. (2022). WHO Integrated Care for Older People (ICOPE). In Pathy's Principles and Practice of Geriatric Medicine (Chapter 100). Wiley. https://doi.org/10.1002/9781119484288.ch100	Comprehensive conceptual overview of WHO ICOPE framework within geriatric medicine	System-level & Clinical framework	Provides authoritative synthesis of the WHO ICOPE reformulated approach — five core steps (screening, person-centred assessment, personalised care plan, care coordination, community/long-term follow-up), implementation considerations and clinical integration. Supports development of national clinical	High relevance. Offers a comprehensive conceptual and clinical foundation for Ukraine to develop policy and practice guidelines. Useful for understanding how ICOPE fits within geriatric medicine, how WHO defines key components, and how to adapt the framework to national primary care, long-term care, and community health systems. (onlinelibrary.wiley.com)

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			guidelines and training curricula for integrated care for older people.	
Tavassoli, N. et al. (2022). Implementation of the WHO Integrated Care for Older People (ICOPE) programme in clinical practice: A prospective study. The Lancet Healthy Longevity, 3(6), e394–e404.	ICOPE implementation in national health systems	Clinical & System-level	Demonstrates that successful ICOPE implementation requires institutional adaptation, workforce training, and reorganisation of care pathways. Supports policy decisions on embedding ICOPE screening and care planning into primary health care rather than treating it as a pilot or vertical programme.	Highly relevant. Offers a realistic implementation model for Ukraine's primary health care system, particularly for family doctors and outpatient clinics. Highlights constraints (human resources, coordination) that mirror Ukrainian realities and informs gradual transition toward ICOPE+ through strengthened intersectoral coordination.
Tavassoli, N., de Souto Barreto, P., Berbon, C., Mathieu, C., de Kerimel, J., Lafont, C., Takeda, C., Carrie, I., Piau, A., Jouffrey, T., Andrieu, S., Nourhashemi, F., Beard, J. R., Soto Martin, M. E., & Vellas, B. (2022). Implementation of the WHO Integrated Care for Older People (ICOPE) programme in clinical practice: a prospective study. The Lancet Healthy Longevity, 3(6), e394–e404. https://doi.org/10.1016/S2666-7568(22)00097-6	Large-scale implementation and feasibility of ICOPE in real-life primary care (INSPIRE ICOPE-CARE programme)	System-level & Implementation science	Evidence that large-scale implementation of ICOPE is feasible in clinical care, identifies very high prevalence of IC impairments at screening and confirms deficits at full assessment, emphasises need for training, digital infrastructure, and follow-up care planning as part of system integration. (ScienceDirect)	High relevance. Demonstrates feasibility of embedding ICOPE screening and follow-up assessment in routine primary care services, provides a model for policy planning, workforce capacity building, and digital support systems relevant to Ukrainian PHC and ageing strategies. (ScienceDirect)
Tavassoli, N., Piau, A., Berbon, C., de Kerimel, J., Lafont, C., de Souto Barreto, P., … & Vellas, B. (2021). Framework implementation of the INSPIRE ICOPE-CARE program in collaboration with the World Health Organization (WHO) in the Occitania Region. The Journal of Frailty &	Large-scale implementation of ICOPE in primary and integrated care	System-level & Clinical	Illustrates how ICOPE can be operationalised at scale using digital screening and monitoring tools, interprofessional coordination, and linkage with community actors. Highlights the need for workforce training, digital health strategies, and multi-	Very high relevance. Offers a contextualised roadmap for Ukraine's adoption of ICOPE/ICOPE+, including adaptation to digital health platforms (e-health), structured screening follow-up pathways, and intersectoral governance models. Demonstrates concrete steps for national roll-out (phased implementation,

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Aging, 10(2), 103–109. https://doi.org/10.14283/jfa.2020.26			sectoral partnerships. Supports development of policy frameworks for routine integration of intrinsic capacity monitoring into health systems. (link.springer.com)	monitoring system, training pathways) that Ukraine can tailor to its primary care and social support infrastructure. (link.springer.com)
The Lancet Healthy Longevity Editorial Team (2024). Mental health deserves attention at all ages. The Lancet Healthy Longevity, published online Oct 15, 2024. DOI:10.1016/S2666-7568(24)00176-4	Editorial on role of mental health for healthy ageing	Systemic / Public Health editorial	Highlights centrality of mental health across life course as critical for functional ability, wellbeing, and healthy longevity; suggests integrating mental health into broader ageing and functional capacity policy frameworks. (thelancet.com)	Moderate relevance. Offers high-level conceptual support for including mental/psychological capacity within models like ICOPE, and can inform national ageing and PHC policies in Ukraine regarding mental health integration in functional screening and care pathways.
Voronina, E. A., et al. (2024). Comparability of comprehensive geriatric assessment and the methodology of integrated care for elderly in social protection institutions. [Adv Gerontol. 2024;37(6):744-747.]. PMID: 40099600	Comparison of comprehensive geriatric assessment vs integrated care screening (ICOPE-related methodology)	Clinical & Social care evaluation	Suggests that ICOPE-aligned functional screening (intrinsic capacity domains) shows comparable results to conventional geriatric assessment tools, supporting task-sharing and expansion of functional assessment in social/health systems	High relevance. Supports integration of functional screening frameworks (similar to ICOPE Step 1) into social protection and community care practice in Ukraine, reinforcing evidence for multidisciplinary screening and care planning
Wang, N. Y., Liu, X., Kong, X., Sumi, Y., Chhetri, J. K., Hu, L., Zhu, M., Kang, L., Liang, Z., Ellis, J. W., & Shi, L. (2024). Implementation and impact of the World Health Organization integrated care for older people (ICOPE) program in China: a randomised controlled trial. Age and Ageing, 53(1), afad249. https://doi.org/10.1093/ageing/afad249	Randomised controlled implementation trial of ICOPE approach	System-level & Clinical outcomes	Demonstrates feasibility of ICOPE implementation and preliminary impact on health outcomes (mobility, psychological health, vitality) in a real-world primary care environment; suggests that structured ICOPE pathways can improve functional health indicators and resource use compared with standard care, supporting inclusion of such	Very high relevance. Provides the strongest current experimental evidence for adopting ICOPE/ICOPE+ models in Ukraine's primary care settings, especially where resources are fragmented. Supports policy decisions on training integrated care teams, embedding ICOPE pathways into national ageing strategies, and monitoring outcomes across WHO ICOPE Steps 1–5 in community health services. (OUP Academic)

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			integrated models in public health planning. (OUP Academic)	
Won, C. W., Ha, E., Jeong, E., Kim, M., Park, J., Baek, J. E., … & Kim, H. (2021). World Health Organization Integrated Care for Older People (ICOPE) and the Integrated Care of Older Patients with Frailty in Primary Care (ICOOP_Frail) Study in Korea. Annals of Geriatric Medicine and Research, 25(1), 10–16. https://doi.org/10.4235/agmr.21.0025	WHO ICOPE framework overview and integration with frailty-focused integrated care (ICOOP_Frail)	System-level & Policy-practice interface	Provides a detailed conceptual and early implementation overview of ICOPE within the context of the WHO Decade of Healthy Ageing, and introduces the ICOOP_Frail program as an integrated care model for community frailty. Emphasises functional ability (intrinsic capacity), multi-module guidelines, and steps toward feasibility/efficacy testing.	High relevance. Supplies international policy framing of ICOPE, links to frailty concepts and pilot integrated care in primary care, and outlines readiness pathways for roll-out that can inform Ukraine's integrated ageing care strategies and alignment with WHO guidelines.
Wu, M.-C., Li, L., He, C.-Y., Yu, S.-H., Chen, C.-T., & Lai, P.-C. (2025). Exploring ICOPE's Impact on Delaying Elderly Disability Management. Studies in Health Technology and Informatics, 315, 742–743. https://doi.org/10.3233/SHTI240308	Digital ICOPE information assessment system for disability risk screening & management in hospitalized elderly	Clinical implementation & Health Informatics	Demonstrates utility of a digital ICOPE assessment system to (1) rapidly screen older hospitalized patients, (2) identify potential disability risk, (3) refer for case management, and (4) support intervention planning, linking screening with follow-up and care coordination. (ebooks.iospress.nl)	High relevance. Provides evidence for integration of ICOPE into digital clinical workflows (hospital/PHC), supporting policy for electronic decision support systems and structured care coordination pathways in Ukrainian health services.
Yang, Y., Dong, J., Qin, P., Guo, Y., Ge, H., Li, D., Wu, Z., Xiao, L., Hu, L., & Dong, Y. (2025). Impact of multimorbidity on health-related quality of life: the mediation role of intrinsic capacity – evidence from the WHO ICOPE pilot program in Lianyungang of China. Archives of Public Health, 83, 302. https://doi.org/10.1186/s13690-025-01791-1	Mediating role of intrinsic capacity between multimorbidity and HRQoL	System-level & Clinical epidemiology	Suggests that intrinsic capacity partially mediates the adverse effect of multimorbidity on health-related quality of life. Policy responses should integrate multimorbidity management with functional capacity enhancement, not only disease control, and prioritise person-centred, integrated care pathways that address both.	High relevance. Provides evidence to support Ukraine's shift from disease-centric to function-oriented integrated care for older adults. Reinforces the use of ICOPE metrics for assessment and planning of services that address multimorbidity as well as declines in intrinsic capacity, which is important in contexts with high chronic disease burden and ageing. (Springer)

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Yu, R., Lai, D., Leung, G., Tam, L. Y., Cheng, C., Kong, S., Tong, C., & Cheung, B., & Woo, J. (2023). Moving towards the ICOPE Approach: Evaluation of Community-Based Intervention Activities on Improving Intrinsic Capacity. The Journal of Nutrition, Health & Aging, 27(11), 1028–1037. https://doi.org/10.1007/s12603-023-2003-0	Community-based intervention activities and IC change	System-level & Community intervention evaluation	Indicates that participation in targeted activity types (especially cognitive, physical, nutritional, psychological) is associated with improvements in intrinsic capacity, with differential patterns across subgroups of older adults. Supports policies promoting tailored, people-centred community programmes to enhance functional ability in ageing populations. (ScienceDirect)	High relevance. Offers evidence that community-based activity programmes—when aligned with IC domains—can improve functional outcomes among older people. This supports Ukraine's design of community health and social engagement initiatives as part of an ICOPE/ICOPE+ strategy to maintain intrinsic capacity and healthy ageing. (ScienceDirect)
Zhang, N., Zhang, H., Sun, M.-Z., Zhu, Y.-S., Shi, G.-P., Wang, Z.-D., Wang, J.-C., & Wang, X.-F. (2023). Intrinsic capacity and 5-year late-life functional ability trajectories of Chinese older population using ICOPE tool: the Rugao Longevity and Ageing Study. Aging Clinical and Experimental Research, 35(10), 2061–2068.	Longitudinal association between intrinsic capacity and functional ability trajectories in older adults	Epidemiological longitudinal cohort	Demonstrates that baseline intrinsic capacity profiles and changes over time are significantly associated with trajectories of functional ability and mortality risk, supporting the use of IC as a predictive marker for adverse outcomes and as a basis for early intervention planning.	High relevance. Provides longitudinal evidence that measuring intrinsic capacity (via ICOPE tool) predicts functional trajectories and adverse outcomes, underpinning the case for early IC assessment in Ukrainian ageing policies and for integrating longitudinal monitoring into primary and community care frameworks. (Springer)
Zhou, Y., Li, Y., Zhu, X., Ma, L., et al. (2021). Medical and old-age care integration model and implementation of the Integrated Care of Older People (ICOPE) in China: opportunities and challenges. The Journal of Nutrition, Health & Aging, 25(6), 720–723. https://doi.org/10.1007/s12603-021-1595-5	Integrated care models for ageing: China's ICOPE experience and medical–old-age care integration	System-level & Policy orientation	Discusses how China is adapting ICOPE principles within broader medical and long-term care models, stressing that integration requires policy alignment, financing mechanisms, workforce upskilling, and linkage of health and social care services. The model points to opportunities (demographic needs, existing reforms) and challenges (fragmented systems, workforce	Highly relevant. Offers context for how a large middle-income country is attempting to embed WHO ICOPE concepts within existing health and social care reforms. These insights can inform Ukraine's strategy for integrating primary care, social support, long-term care, and community services in ageing policies, particularly in aligning ICOPE/ICOPE+ with national health insurance and social service delivery frameworks. (Springer)

Article (APA short reference)	Thematic category (rubric)	Level of analysis	Policy implications	Relevance for Ukraine
			constraints) for scaling ICOPE-type integrated care. (Springer)	
Zyukov, O. L., & Horlach, T. M. (2024). Prevalence of intrinsic capacity impairments among elderly people based on the ICOPE screening results. Problems of Ageing and Longevity (Ukraine), 30(4), 23–42. (In Ukrainian). https://pro-ageing.org.ua/index.php/journal/article/view/66	Population prevalence of intrinsic capacity impairments using WHO ICOPE screening	System-level & Epidemiological	Evidence of very high prevalence of IC impairments in older adults; supports prioritizing systematic screening in PHC, planning targeted evaluations and interventions, and integrating long-term care strategies. (ResearchGate)	Very high. Provides locally relevant data from Ukraine showing functional deficits by age group and reinforcing the case for nationwide adoption of ICOPE screening and integration with medical-social services. (ResearchGate)
Zyukov, O. L., & Horlach, T. M. (2024). Prevalence of intrinsic capacity impairments among older age groups based on the results of ICOPE screening. Clinical and Preventive Medicine, (8), 123–128. https://doi.org/10.31612/2616-4868.8.2024.14	Population-level prevalence of IC impairments using ICOPE screening	System-level & Epidemiological	Highlights extremely high prevalence of intrinsic capacity impairments in older adults and argues that systematic ICOPE screening is a priority for diagnosis, planning further assessment, and organizing long-term integrated care; underlines the need for medical-social service collaboration in long-term monitoring and support. (cp-medical.com)	Very high relevance. Provides country-context evidence (Ukraine) on real-world ICOPE screening results, demonstrating age-related patterns of IC decline and supporting nationwide adoption of functional screening, stratified care planning, and integrated PHC/community services aligned with WHO ICOPE/Decade of Healthy Ageing goals. (cp-medical.com)

HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

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