Healthcare clustering as a strategy for business process optimization in Ukraine

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Original Article

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Abstract:

This article presents a conceptual framework for establishing a virtual, non-state medical cluster in Ukraine's metropolitan regions, financed through a dedicated private insurance fund. The proposed model responds to the urgent need for more sustainable financing mechanisms, improved coordination among providers, and structural modernization of urban healthcare delivery. It integrates public and private medical institutions into a unified digital and contractual network supported by performance-based funding. Drawing on international ex-

perience - such as France's GHT, Germany's sickness funds, and the U.S.- based Kaiser Permanente - the model aims to optimize resource use, enhance service quality, and incentivize preventive care. Core elements include shared clinical protocols, integrated patient pathways, and transparent insurance operations. A qualitative analysis examines the model's institutional design, implementation scenarios, and potential policy implications. The study argues that virtual healthcare clusters offer a scalable, innovative strategy to strengthen system resilience and equity, and could serve as a practical foundation for future health insurance reform in Ukraine.

Objective

This study aims to substantiate the concept of establishing a virtual, non-state medical cluster within a major urban agglomeration, supported by a dedicated private financing mechanism. The relevance of this inquiry is underpinned by the persistent underfunding of Ukraine's healthcare system and the disproportionate reliance on informal out-of-pocket payments by patients. Currently, public healthcare expenditure accounts for only approximately 50% of the total national health spending, leaving a significant financial burden on individuals. Despite the creation of the National Health Service of Ukraine (NHSU) in 2018, and its administration of state-funded health services via the Medical Guarantees Program, funding levels remain grossly inadequate. Official requests for financing from the Ministry of Health and the NHSU have consistently exceeded budget allocations by a factor of three, resulting in limited service coverage and the transference of costs to patients [1] [2]. Healthcare challenges in post-COVID settings have further amplified system stress. As study by Kralik et al. (2023, 2022), Radkova et a. (2022, 2024) and Ludvigh Cintulova et al. (2022, 2023) highlight, the long-term effects of COVID-19, including Post-COVID Syndrome, place new demands on service provision and necessitate integrated psychosocial and therapeutic support structures, particularly for vulnerable populations affected by social, economic barriers and mental health problems.

In light of these constraints, the necessity arises for alternative mechanisms to mobilize private capital and optimize the allocation and utilization of existing healthcare resources. A strategic solution lies in the formation of non-state medical clusters in large cities, where healthcare demand and institutional concentration are highest. However, the current hospital clustering efforts led by the Ministry of Health largely address rural and regional contexts, insufficiently addressing the complex dynamics of metropolitan healthcare. Experts critique the lack of well-defined patient flow pathways within urban clusters, where overlapping institutional functions often create inefficiencies. For example, both a specialized cardiology center and a general hospital with a robust cardiology department may coexist within a metropolis, leading to ambiguity in emergency routing decisions. Additionally, urban facilities frequently attract patients from surrounding areas due to superior care standards, an aspect inadequately reflected in official service planning [3].

The core proposition of this article is the conceptualization of a «virtual» metropolitan medical cluster that integrates institutions of diverse ownership structures under a unified service and financing framework, mediated through a private insurance fund. This cluster model is intended to achieve dual objectives: first, to enhance care coordination and operational efficiency across healthcare providers; second, to aggregate and mobilize supplementary financial resources through private health insurance schemes, employer-sponsored coverage, and regulated patient contributions. A delicate equilibrium between public oversight and private sector dynamism is critical: while the state defines regulatory parameters and guarantees a baseline of care, private actors complement the system through innovation, managerial flexibility, and co-financing.

Design/Concept

Unlike traditional brick-and-mortar healthcare complexes, the proposed cluster does not involve the construction of new facilities. Instead, it integrates existing metropolitan healthcare providers into a coordinated network through contractual agreements and digital interoperability. Participants may include large multiprofile hospitals (both municipal and ministerial), specialized care centers (e.g., cardiology, oncology), private clinics, diagnostic laboratories, rehabilitation units, and primary care practices. A defining feature is the cluster's multi-ownership model, fostering collaboration between public and private entities.

As Petrovic et al. (2024) and Kobylarek et al. (2022) emphasize, the mental health of university students in Slovakia suffered markedly during the pandemic, reinforcing the need for well-coordinated urban care systems. Thus, the proposed cluster model integrates multiple healthcare providers under a virtual, multi-owner structure. It aims to facilitate effective patient navigation and reduce institutional redundancies. Such clustering echoes integrated models in Western Europe and aligns with domestic calls for healthcare decentralization and diversification.

Central to the governance structure is an independent private insurance fund, functionally akin to the NHSU but capitalized through private contributions. This fund establishes service-level agreements with cluster members, reimbursing them for patient care at negotiated tariff rates. Revenue streams for the fund include premiums from voluntary health insurance plans, corporate insurance contributions (sponsored by employers), and payments for out-of-pocket services not covered by public guarantees. In effect, the fund consolidates currently fragmented private health expenditures. For instance, approximately 95% of French citizens possess supplementary insurance (mutuelle) to cover copayments and non-basic services [4]; although uptake in Ukraine remains low, it is on an upward trajectory. The proposed fund would serve as a catalyst for expanding this sector by introducing standardized and transparent financial instruments.

The organizational architecture of the cluster features a coordination unit - either a management company or a representative cluster council - which may be embedded within the insurance fund or formed as a separate governance entity. This unit is tasked with strategic care planning, fiscal distribution, contract administration, quality assurance, and the implementation of clinical and procedural standards. Internationally, analogous functions are performed by Germany's sickness funds, which operate as non-state insurers under a framework of social solidarity, covering around 86% of the population [5]. In this system, the state primarily acts as regulator and co-financer, while service provision is carried out by a diverse set of public, nonprofit, and commercial institutions. The Ukrainian model proposed here mirrors this arrangement: public authorities define the operational framework, but the cluster is managed according to principles of stakeholder competition and collaborative governance.

A foundational tenet of the cluster is integrated care delivery. This entails the seamless navigation of patients through all stages of treatment - initial consultation, specialized intervention, and rehabilitation - within a single coordinated network. Such an approach aligns with global paradigms of integrated healthcare. In the United Kingdom, for example, Integrated Care Systems (ICS) consolidate the NHS, local authorities, and affiliated organizations to jointly administer healthcare services at the regional level. Forty-two ICS entities span all of England, each serving between 0,5 to 3,5 million people, with the objective of enhancing health outcomes and cost-efficiency through collaborative local governance [6]. The proposed Ukrainian cluster mirrors this strategy but is rooted in a non-state infrastructure confirmed by studies [14,15].

Implementation requires a unified digital health platform: shared electronic health records, centralized service and pricing registries, streamlined referral systems, and telemedicine capabilities. In Germany's Gesundes Kinzigtal initiative - one of the most successful integrated care models - the IT platform enabled data interoperability and collaboration among disparate providers. The coordinating organization established clinical protocols and aligned financial incentives between payers and providers, facilita-

ting coherent service delivery [7]. The Ukrainian cluster aims to replicate this logic, optimizing business processes via systemic reengineering and Lean management principles. Lean methodology mandates the evaluation of each procedural step in terms of its value addition and the elimination of waste. The inculcation of a continuous improvement culture, patient-centered practices, and participatory decision-making are key hallmarks of this approach [8]. As such, cluster governance will collaborate with institutional leadership to streamline care pathways, eliminate procedural redundancies, and enhance patient logistics (e.g., inter-facility transportation).

The financial model is structured to incentivize quality and operational efficiency. Remuneration schemes may range from fee-for-service arrangements to more sophisticated mechanisms such as episode-based payments or capitation (fixed per capita rates). Contractual agreements will embed performance metrics and quality benchmarks. These may include targets for reducing avoidable hospitalizations or minimizing elective surgery wait times. Achievement of such benchmarks will trigger incentive-based compensation. This alignment of economic incentives between funders and providers fosters system-wide improvements in health outcomes and cost control. The Kinzigtal case illustrates this point: shared savings agreements between the coordinating company and two sickness funds resulted in a 7% reduction in healthcare expenditure (equivalent to €4,6 million for 31000 patients in 2012) while improving service quality [7]. Governance will involve a management council or coordinating unit responsible for standardizing clinical pathways, auditing outcomes, and ensuring efficient use of resources. As Ludvigh Cintulova et al. (2023, 2024b), Buzalova (2024, 2025) and Budayova et al. (2023) observed in marginalized Roma communities, decentralized yet coordinated healthcare interventions can significantly improve access and health equity. Vansač and Noga (2021) further emphasize the necessity of spiritual and psychosocial care in health delivery, especially under stress-inducing conditions like the COVID-19 pandemic.

Health institutions within the cluster will contract with the fund based on service-level agreements and key performance indicators, promoting transparency and continuous improvement. Authors Noga and Vansač (2022) and Vansač and Gulašova (2022) on long-term care demographics further supports the inclusion of elderly care facilities within such a cluster, with services tailored by both need and region.

In summary, the cluster functions as a cohesive network linked by a unified insurance fund, interoperable digital infrastructure, and standardized clinical and operational workflows. It operates in parallel with the public healthcare system yet remains interlinked. Some institutions may receive dual funding - public financing for baseline services via the NHSU and private compensation for supplementary services delivered to insured patients. This configuration embodies a public-private partnership model wherein the state ensures universal baseline access while the cluster delivers value-added services and innovation.

The proposed cluster would operate alongside the NHSU, with some institutions receiving dual funding. This public-private synergy promotes innovation while safeguarding universal coverage. Vansač et al. (2024a, 2024b) and Bundzelova et al. (2023) trace the transformation of senior care services in Slovakia—a contextually relevant example of how cross-sector collaboration can evolve traditional models into flexible, multi-stakeholder networks.

Participants

The architecture of stakeholder involvement within the proposed medical cluster encompasses a spectrum of interrelated entities whose functions collectively shape the system's operational coherence. Chief among these are metropolitan healthcare institutions - municipal hospitals and outpatient centers - that constitute the principal care delivery infrastructure. Their participation is motivated by the opportunity to access supplementary financial inflows and expand patient reach without relinquishing their alignment with state-guaranteed service packages. Additionally, private clinics and diagnostic laboratories benefit from broadened client access via

their integration with the insurance fund. University-affiliated and departmental hospitals are envisioned to fulfill niche roles as centers of clinical excellence within the cluster.

The private insurance fund operates as the financial nexus of the cluster ecosystem. Conceived as a non-state, non-profit institution - or potentially a joint-stock organization - its founding stakeholders may include consortia of insurers, corporate employers, or health service provider associations. The fund functions analogously to sickness funds in social health insurance systems, aggregating premiums and disbursing reimbursements based on service contracts. Drawing parallels to the German model, where approximately 105 non-profit sickness funds coexist with a diversity of private insurers [5], the Ukrainian fund would blend principles of solidarity-based pooling with optional private participation.

The population base - encompassing residents of urban and adjacent peri-urban zones - represents the cluster's demand-side actors. This heterogeneous group can be categorized as follows:

- Voluntarily insured individuals, who purchase coverage independently or through employer-sponsored schemes, receiving preferential access to cluster services with limited or no co-payments.
- Corporate plan beneficiaries, consisting of employees whose employers have negotiated comprehensive coverage through the fund, thereby ensuring seamless, cashless access to care.
- Self-paying patients, who access services directly on a fee-for-service basis and are afforded transparent pricing, standardized service quality, and opportunities for insurance enrollment.

Employers and corporate stakeholders serve as pivotal institutional actors, particularly on the demand side. By investing in workforce health through premium contributions and preventive programs, employers are positioned as strategic partners. The cluster offers them streamlined engagement via a singular contract encompassing a broad, integrated provider network. This arrangement enhances employee access while offering employers robust quality monitoring via performance metrics provided by the fund.

Public authorities, including national and municipal bodies, retain a regulatory and facilitative presence. The Ministry of Health and the NHSU establish regulatory frameworks, oversee quality assurance, and coordinate emergency medical response. Local governments may reinforce cluster operations by providing infrastructural support, enabling hospital autonomy, or spearheading public awareness initiatives regarding insurance literacy. Crucially, public oversight ensures equity by mandating that the private fund upholds non-discriminatory access and fulfills its contractual obligations to all patient demographics. In this regard, the state functions as both arbiter and integrator, aligning private innovation with overarching public health goals.

All cluster participants are bound through contractual relations mediated by the insurance fund. Providers sign agreements detailing reimbursement rates, performance expectations, and covered service volumes. Policyholders accept the fund's regulations, including network participation and service protocols. Employers enter into formal arrangements to extend coverage to their workforce, and municipalities may sign memoranda of understanding to coordinate service delivery, including emergency care protocols for both insured and uninsured individuals.

Given this complex multi-actor environment, a formalized governance structure is imperative. A cluster coordination council - composed of provider representatives, fund administrators, insured population delegates, and public observers - can provide strategic oversight, participatory decision-making, and system transparency.

France's experience with territorial hospital groupings underscores the importance of inclusive stakeholder representation. Exclusion of private actors in nearly all 135 clusters undermined integrative potential and impeded care coordination. In contrast, the Ukrainian model's deliberate incorporation of mixed-ownership institutions is a foundational strength, enhancing both operational viability and systemic resilience [9].

In recent years, systemic stressors—including the COVID-19 pandemic, rising elderly care needs, and growing social inequalities—have

underscored the necessity for integrated, multidisciplinary approaches within healthcare and social services. As highlighted by Tománek, Radková, and Buzalová (2024), the pandemic exacerbated poverty and social exclusion among the elderly in Slovakia, revealing critical vulnerabilities in both institutional support and community resilience. These insights align with earlier findings by Subramaniam et al. (2018), who emphasized that elderly and homeless populations residing in rehabilitation and nursing homes present not only physiotherapeutic but also epidemiological and social care challenges. Their study underscored that multidisciplinary teamwork—combining clinical, epidemiological, and psychosocial perspectives—is essential for effective intervention.

Furthermore, manipulation and psychological exploitation have emerged as significant risk factors impacting psychosocial health. Svoboda et al. (2024) argue that manipulation in interpersonal or media contexts contributes to emotional instability and long-term social dysfunction, especially among youth and vulnerable individuals. This finding reinforces the importance of mental health awareness and preventative social strategies in both education and practice.

Lifelong learning and continued professional education are also central to enhancing the quality of social work. As Taraj et al. (2023) demonstrate, continuous education strengthens the capacity of social workers to address new and evolving social challenges, particularly those affecting marginalized groups. Their research stresses the need for adaptive training curricula that respond to demographic shifts, new technologies, and global crises such as migration and pandemics.

Together, these studies contribute to a broader understanding of systemic care for at-risk populations. They support a transition toward integrated, interdisciplinary models of service delivery—encompassing social work, public health, education, and psychology. The clustering of care networks, supported by regulatory public bodies and enhanced by private sector innovation, reflects the kind of collaborative structure needed to address complex social and medical needs [16, 17]. Crucially, public governance remains the guarantor of equity and accessibility, ensuring that even in diversified care ecosystems, the rights and dignity of the most vulnerable are upheld [18,19].

Methods

This investigation employs a conceptual analytical framework, enriched with structural modeling components, to examine the applicability and potential impact of a metropolitan medical cluster within Ukraine's healthcare system. The research synthesizes peer-reviewed literature, comparative health policy analyses, and case study evaluations of integrated care models across multiple jurisdictions.

Empirical cases include France's territorial restructuring of hospital systems, Germany's insurer-based competition and integrated care experiments (e.g., Gesundes Kinzigtal), the United Kingdom's Integrated Care Systems (ICS) combining public and private actors, and the United States' vertically integrated private networks exemplified by Kaiser Permanente. Each model is assessed for contextual transferability and strategic relevance to Ukrainian healthcare realities.

Based on this review, a conceptual model of the cluster is developed, delineating four core subsystems - financial, clinical, informational, and managerial - and mapping the interdependencies that underpin their integrative function. A qualitative SWOT analysis is applied to anticipate operational challenges, resource constraints, and system-level synergies.

A comparative diagnostic contrasts the proposed cluster with the existing fragmented service landscape, characterized by patient self-navigation between siloed providers and disjointed financial streams.

The study draws on the theoretical foundation of economic cluster theory, which posits that co-location and collaboration among market actors enhance innovation diffusion, resource efficiency, and responsiveness. Business Process Reengineering (BPR) principles are embedded to explore radical simplification and workflow redesign, aligned with Lean healthcare management and continuous quality improvement philosophies.

Quantitative modeling was not conducted, given the pre-implementation status of the cluster concept. Instead, the analysis emphasizes logical coherence and feasibility within scenario-based planning. The transformation of abstract principles - such as financial incentive alignment - into tangible mechanisms (e.g., shared risk pools, outcome-based contracting) serves as a critical methodological axis. Kaiser Permanente's experience with capitation and preventive care models is invoked to illustrate the practical implications of prepaid systems and their alignment with system sustainability goals [11].

In sum, the methodology integrates conceptual theorization, systemic design, and applied translation of managerial and policy principles into an actionable cluster framework.

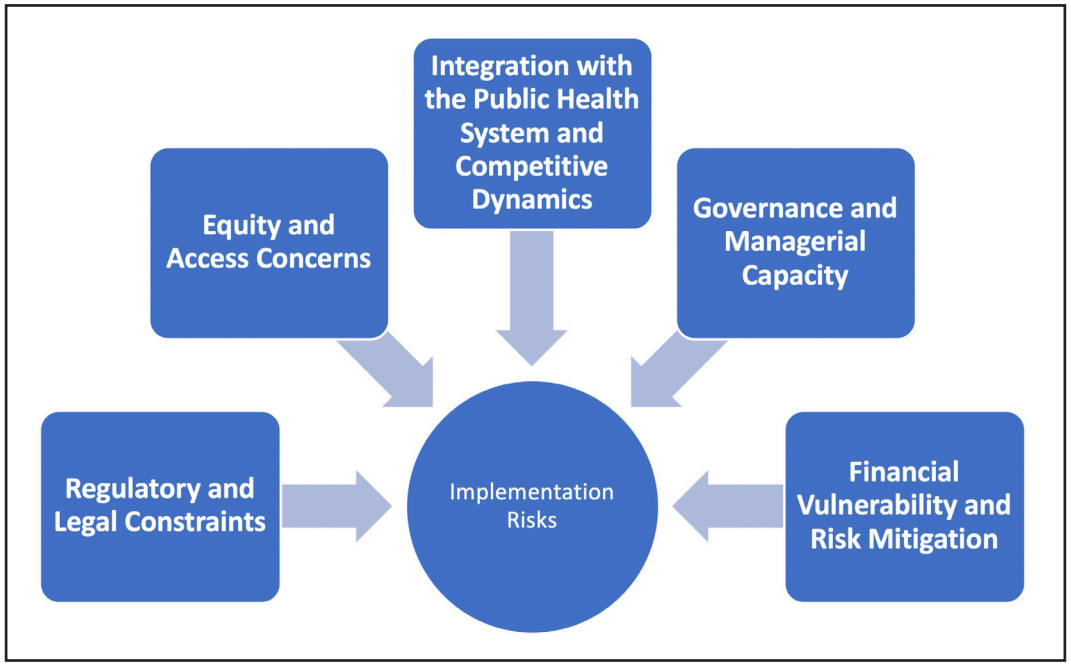
Results

The proposed model of a virtual metropolitan healthcare cluster demonstrates substantial potential across key dimensions of system performance, as supported by theoretical projections and international benchmarking. The outcomes of this analysis are delineated along the following core dimensions (see Figure 1):

- Enhanced Resource Efficiency: Cluster integration eliminates service duplication and optimizes facility use. Coordinated patient routing and centralized diagnostics increase efficiency, as seen in France's GHT reform [9]. The Ukrainian model, backed by a private fund, enables reinvestment of savings and resource redistribution. Kinzigtal (Germany) achieved 7% savings through integrated care [7]. With 70% of Ukraine's budget spent on inpatient care [1], clusters can rebalance focus toward outpatient and preventive services.
- New Funding Streams and Sustainability: The cluster fund pools fragmented private spending into a transparent, accountable mechanism. Addressing historical mistrust in Ukraine's insurance sector, it enforces standards and accountability. Corporate wellness programs evolve into scalable insurance schemes. France's system shows that private insurance (13.7% of spending [10]) strengthens financial resilience. Like Germany's non-profit sickness funds, the model emphasizes reinvestment over profit, ensuring long-term viability.
- Improved Quality of Care: Standardized protocols ensure consistent service quality across providers. Centralizing complex procedures in high-volume centers improves outcomes ("volume-to-value"). France's shared medical projects support this [9]. Ukraine's fund could incentivize accreditation and continuous education. A unified quality monitoring system would track key indicators like mortality, readmission, and satisfaction.
- Prevention and Population Health: Prepaid models incentivize prevention over treatment. The cluster focuses on vaccinations, screenings, and chronic disease management. Kaiser Permanente exemplifies this model [11]. Physicians are salaried, hospitals are cost centers, and unnecessary hospitalizations are minimized. Ukraine's fund could reward GPs for meeting preventive health targets, reducing future costs and boosting productivity.
- Patient Experience and Equity: A unified digital platform streamlines access, scheduling, and coverage verification. Patients benefit from consistent quality, transparent pricing, and shared medical records. This improves trust in the system - especially vital in Ukraine. The fund can support a solidarity mechanism to subsidize care for the

Figure 1 Key Analytical Outcomes (Compiled by the Author)

Figure 2 Structural and ethical implementation model risks (Compiled by the Author)



uninsured and co-finance services beyond state coverage.

Despite its advantages, the model faces structural and ethical implementation risks, as summarized in Figure 2:

- Regulatory and Legal Constraints: Ukraine's current legislative framework does not yet accommodate regionally based non-state health insurance entities. Comprehensive legal reform - including amendments to insurance, health, and fiscal codes - is required to authorize parallel fund operation without jurisdictional conflicts. Safeguards must also be established to prevent service double-financing. Encouragingly, the Ministry of Health has articulated a vision for systemic insurance reform, formalized in its August 2023 roadmap (Order No. 1530) [12], which may eventually legitimize this cluster-based financing architecture.
- Equity and Access Concerns: A pronounced risk lies in the emergence of a two-tiered system, wherein uninsured or economically disadvantaged populations are structurally marginalized from superior cluster-based services. To mitigate inequity, state actors must reinforce public system investment and explore mechanisms for subsidizing private insurance acquisition among vulnerable populations. France's practice of covering supplementary Mutuelle insurance premiums for its lowest-income citizens (approx. 7%) offers a viable template [4]. Policy instruments such as targeted vouchers, tax deductions, or means-tested premium subsidies could be adapted for the Ukrainian context to ensure inclusivity.
- Public-sector medical institutions may view the formation of privately coordinated clusters as a threat to their professional staff retention and patient volume, particularly with regard to affluent and insured segments. Such dynamics risk exacerbating disparities between cluster-affiliated and non-affiliated facilities. This concern is supported by regional research highlighting systemic imbalances when services and care standards are not uniformly distributed (Slašťan, Lesňáková, & Zámková, 2024; Buzalová, Oláh, Pavlovičová, & Dirgová, 2025). To preclude systemic fragmentation, cluster integration should be conceptualized not as a parallel structure, but as a supplementary financial and organizational layer within the existing hospital district fra-

mework. In this construct, hospitals designated by the Ministry of Health as core or supra-cluster facilities continue to receive public funding via the NHSU while concurrently accessing private resources through cluster participation—thereby reinforcing, rather than isolating, their systemic function.

- **Governance and Managerial Capacity:** The cluster's operational success hinges upon the availability of cross-disciplinary managerial expertise capable of navigating complex inter-organizational environments. Strategic leadership must encompass proficiency in healthcare delivery, insurance operations, financial modeling, and stakeholder engagement. Identifying and cultivating such leadership constitutes a critical path dependency. Previous case studies highlight resistance from healthcare personnel, rooted in apprehensions about new accountability and performance evaluation mechanisms (Šupolová, Barkasi, & Bárta, 2024; Majda et al., 2024). A staged implementation—initiated through a pilot cohort of voluntarily participating facilities—offers a pragmatic approach to demonstrating viability and fostering institutional buy-in.
- **Financial Vulnerability and Risk Mitigation:** The sustainability of the insurance fund requires proactive risk management strategies to buffer against systemic shocks, such as epidemiological crises, geopolitical disruptions, or environmental catastrophes. Institutional resilience can be enhanced via catastrophe reinsurance contracts, actuarially sound premium structures, and the establishment of contingency reserves. Research on healthcare service delivery during conflict and post-crisis settings underlines the necessity for such buffers (Murgová et al., 2022; Jackulíková et al., 2021). During early-stage operations, capitalization from donor institutions or municipal co-funding mechanisms may serve to offset initial liquidity constraints and promote financial equilibrium.
- While challenges exist, the empirical and theoretical basis for the proposed model is robust. International exemplars—including Kaiser Permanente, Gesundes Kinzigtal, and the NHS's Integrated Care Systems—demonstrate that vertically and horizontally integrated health systems can achieve superior health outcomes, optimize cost structures, and improve stakeholder satisfaction. Moreover, from a theoretical standpoint, health clusters enable systemic synergy by fostering collaborative learning, resource optimization, and adaptive governance across institutional boundaries (Laca et al., 2024; Ludvigh Cintulová & Budayová, 2024). In the Ukrainian context, where the healthcare delivery ecosystem remains largely fragmented and devoid of coherent private network organization, the proposed model addresses a critical structural gap by offering a framework for coordinated multi-stakeholder engagement.

Conclusion

Amid persistent underfunding and rising demand for accessible, high-quality medical services in Ukraine's metropolitan regions, the conceptualization of a virtual, privately coordinated medical cluster represents a strategic avenue for systemic modernization. The model facilitates a hybridized governance architecture wherein private actors contribute financial flexibility, operational agility, and user-centric design, while the public sector retains its foundational mandate for regulatory oversight and equity assurance

Rather than displacing the existing public health infrastructure, the cluster model complements and reinforces it. Public institutions within the cluster continue to deliver state-guaranteed services while accessing supplementary investment to modernize infrastructure, enhance staff remuneration, and strengthen clinical capabilities (Trnková, 2019; Nemčoková & Trnková, 2025, Barkasi, Barta, 2024). Financial incentives are oriented toward outcomes and value-based care, promoting disease prevention and long-term efficiency gains. In doing so, the model operationalizes international best practices while remaining attuned to local institutional realities.

Comparative international experience—spanning France's territorial hospital integrations, Germany's cooperative insurance-provider frameworks, the UK's regional care partnerships, and the United States' integrated

private networks—affirm the efficacy of such interventions in diverse health system contexts. Although each national setting possesses unique constraints, shared principles of solidarity, transparency, and managed competition remain universally relevant. The Ukrainian model draws on these principles to synthesize a reform pathway that combines accessibility with market-oriented efficiency.

Importantly, the cluster initiative could serve as a scalable pilot for broader health insurance reform in Ukraine. Initially operating on a voluntary basis, it provides a platform for testing governance structures, reimbursement mechanisms, and regulatory instruments in a semi-autonomous, learning-oriented environment. Through iterative adaptation and evidence-based refinement, the model holds the potential to evolve into a cornerstone of national insurance architecture (Vansač, Kenderešová, & Noga, 2024; Poloňová & Bednáriková, 2022).

In sum, metropolitan health clusters supported by private insurance funds offer a practical, theoretically grounded, and internationally validated approach to addressing systemic inefficiencies and equity gaps in Ukraine's healthcare system. Their phased implementation - grounded in strategic collaboration among public institutions, private stakeholders, and civic actors - can deliver measurable improvements in care quality, financial protection, and institutional trust. With appropriate regulatory facilitation and outcome-based evaluation, the model warrants experimental deployment in one of Ukraine's major urban regions as a precursor to nationwide adaptation.

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