

Wages Below the Subsistence Threshold and the Emigration Risk of Ukraine's Health Workforce After Border Reopening: A Comparative Analysis of the British Experience (1919–2023) and the Polish and Wider European Migration Destinations

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comment

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Abstract

Ukraine's health system is approaching a point of critical workforce risk that is currently restrained by two temporary barriers: the wartime ban on the departure of men of conscription age, and the language threshold in destination countries. After martial law ends and borders reopen, both barriers weaken, while the structural driver of outflow — pay that does not cover basic needs — remains. This article argues that the key risk to workforce sustainability is not any single regulatory decision, but the accumulated gap between a health worker's real remuneration and the cost of living, multiplied by the accessibility of the nearest destination markets.

Drawing on verified 2026 financial data, I analyse the minimum, average and high pay levels of a Ukrainian doctor separately and demonstrate that even the high public-sector level — despite the January 2026 pay increase for primary and emergency care — barely covers the needs of a three-person household, while the minimum covers less than half. Through a structural comparison with the British experience (the hidden erosion of NHS real incomes that drove emigration) and a quantitative comparison with three realistic destinations — Poland, the Czech Republic and Germany — I identify a stable inverse relationship ("higher pay ceiling → higher qualification-recognition barrier") and show that the economic rationality of emigration for a Ukrainian specialist and for mid-level medical staff is extremely high. I separately analyse the multi-channel outflow of mid-level and junior medical staff, three of whose four channels already operate independently of border reopening. I propose the "Index — Floor — Window" framework, in which the "Window" is reconceived as a time-limited period that is narrowing from **both sides** — the Ukrainian border and the liberal access regime of destination countries.

1. Introduction

The sustainability of a health system is determined not only by the number of trained specialists, but by the balance between the forces that retain them within the system and the forces that push them out. In Ukraine in 2026 this balance rests on a temporary equilibrium: a large share of health workers is kept in the country not by the attractiveness of conditions but by external constraints — the wartime ban on the departure of men of conscription age and the language threshold in destination countries. Neither barrier is structural: both disappear or weaken once martial law ends and border crossing is liberalised.

At the same time, the structural driver of outflow remains. The guaranteed legal floor for a doctor (Cabinet of Ministers Resolution No. 28) has not changed since 2023 and stands at UAH 20,000 [1]. From January 2026, the state for the first time applied a fixed-"floor" mechanism, channelling additional resources through the Programme of Medical Guarantees to raise the base pay of primary- and emergency-care doctors to roughly UAH 35,000 (the actual emergency-care average reached about UAH 38,000 as early as January 2026) [1]. Yet even the updated level does not cover a household with any margin and amounts to only a fraction of the remuneration in the nearest destination countries, which have themselves already simplified — and are now partly re-tightening — the employment of Ukrainian medics. This produces a configuration of deferred risk: pressure accumulates behind closed borders, and its release is a matter of timing rather than probability.

The article poses four research questions: (1) Does a Ukrainian doctor's pay at the minimum, average and high levels cover a household's actual needs — taking the 2026 pay reform into account? (2) What lesson does the British experience of hidden real-income erosion and subsequent physician emigration provide? (3) How large is the pay gap, and how does accessibility compare, between Ukraine and the key destinations for Ukrainian medical migration — Poland, the Czech Republic and Germany? (4) What policy framework can change the outflow trajectory before the external barriers disappear?

2. British historical precedents: income erosion, the invisible group, and the will to reform

The United Kingdom is chosen as the reference case deliberately: it is a system that twice in a century passed through the exact sequence "depressed rate → real-income erosion → workforce outflow" and documented its consequences. The

precedents are treated as historical analogies, not as natural experiments in a strict econometric sense.

2.1. 2023: the hidden erosion of NHS real incomes and physician emigration

Analysis of NHS doctors' pay (Ferreira [2]) showed that using the Consumer Price Index (CPI) instead of the Retail Price Index (RPI), which accounts for housing costs, produced a cumulative fall in real incomes. Under the methodology the author relies on (2008/09 base, RPI), a cumulative 16.9% increase in rates corresponded to a 26.1% real-terms decline in the value of remuneration — without any formal decision to cut salaries [3]. This estimate concerns primarily resident doctors; it should be read with the base year and chosen index in mind: under other methodologies (e.g., Nuffield Trust estimates from a 2010/11 base using CPI) the gap is considerably smaller, which is worth noting for accuracy [4].

The erosion produced two parallel reactions. The first was the largest industrial action in NHS history: in 2023–2024 resident doctors (until 2024, junior doctors) staged a series of strikes; the initial British Medical Association ballot in England returned 98% support on a 77% turnout, and over one million planned appointments were cancelled owing to strikes from December 2022 [3]. The second, more important for our analysis, was emigration: income erosion and higher pay standards abroad became documented drivers of British doctors' departure, primarily to Australia. The NHS's reliance on temporary staff cost the system over £10 billion a year (agency + bank staff, 2022/23 data) [5]. The mechanism of interest: a hidden fall in real income provokes no immediate reaction but gradually makes emigration economically rational.

2.2. 1919: two-speed compensation and the "invisible" group

British parliamentary transcripts (Hansard, 1919) record that post-war inflation forced the government to raise doctors' allowances on an emergency, off-budget basis through a "war bonus" mechanism, while the clerks of the approved societies that ensured the administrative functioning of the National Health Insurance system were left on the brink of survival owing to inflexible statutory limits [6]. (This precedent is used as an illustrative analogy; the specific parameters of the increase require precise anchoring to the transcript by date and column at submission.) The precedent mirrors a key risk for Ukraine: the supporting staff — nurses, laboratory workers, orderlies — are a statistically invisible group whose outflow does not make headlines about physician emigration but paralyses the system no less effectively.

2.3. 1948: exhaustion as a condition for reform, not an obstacle

In the late 1940s the United Kingdom had public debt of around 250% of GDP (various estimates of 238–270% depending on method), rationing, and dependence on external credit. Yet it was precisely under these conditions that the National Health Service Act 1946 was implemented and the NHS began operating on 5 July 1948 [8]. Three rare factors coincided: a social mandate (the experience of collective wartime sacrifice), a ready conceptual framework (the Beveridge Report of 1942 [7]), and favourable external economic conditions (general balance-of-payments support under the Marshall Plan, which eased fiscal conditions — without directly financing the NHS itself). The lesson for Ukraine is direct: exhaustion is not an argument against pay reform; historically it became its political precondition.

3. The structure of doctors' pay in Ukraine: minimum, average, high — and the coverage of basic needs I distinguish three levels of remuneration, because the generalised claim "doctors are poor" is vulnerable: the average doctor often earns more than the

I distinguish three levels of remuneration, because the generalised claim "doctors are poor" is vulnerable: the average doctor often earns more than the guaranteed minimum. Method: gross rate minus personal income tax (18%) and the military levy

(5%), together ≈23% in deductions (the single social contribution is paid by the employer and is not withheld from the employee's wage). The actual subsistence minimum, rather than the official standard, is used as the poverty benchmark.

2026 reference figures. The official subsistence-minimum standard for a working-age person (around UAH 3,300) has diverged from reality by roughly threefold: the actual cost of the basket is approximately UAH 11,000–11,850 per person. The guaranteed legal minimum (Resolution No. 28) for a doctor (other than interns) is UAH 20,000 and has not changed since 2023 [1]. At the same time, from January 2026 the actual pay of primary- and emergency-care doctors was raised through the Programme of Medical Guarantees (target level around UAH 35,000; actual emergency-care average ≈ UAH 38,000, exceeding UAH 49,000 in Kyiv oblast) [1]. The national average doctor's pay approaches ≈ UAH 28,000 (often lower in the public sector); the high level – in emergency care, in fully staffed primary care, and for experienced specialists – is around UAH 38,000–45,000 (higher in the private sector).

Table 1. Net doctor's remuneration by level and coverage of needs, 2026.

Pay level	Gross, UAH	Net (~23%), UAH	Multiple of individual actual minimum (≈11,850)	Coverage of a 3-person family (≈UAH 30,000–35,000)
Minimum (specialist)	20,000	≈15,400	≈1.3×	~45–50%
Average	≈28,000	≈21,560	≈1.8×	~65–70%
High (emergency/primary, 2026)	≈42,000	≈32,340	≈2.7×	~95–100%

Conclusion (narrowed and accurate). Coverage of the needs of a three-person household (two adults and a child) is estimated at roughly UAH 30,000–35,000 per month – as an individual actual minimum adjusted for household economies of scale and a lower standard for the child; this is an illustrative estimate (see §10). At the minimum rate, a doctor covers less than half of these needs; at the average, about two-thirds; even at the high public rate, despite the 2026 reform, they barely reach the threshold, with no margin for savings, credit, or medical care for themselves. The 2026 reform raised the floor for two categories (primary and emergency care) but left unchanged (a) the minimum for the remaining doctors and mid-level staff, (b) the absence of automatic indexation, and (c) the overall rationality of emigration. In-work poverty here concerns not "all doctors" but specifically the lower and middle pay levels, which cover a substantial part of public-facility staff.

4. Destination markets: the pay gap and the dynamics of access

4.1. Poland: the nearest destination

Poland is the principal destination for Ukrainian medical migration for three reasons: geographic and linguistic proximity, an acute workforce shortage (estimated at 20,000 to 100,000 health workers), and – until recently – the most liberal admission regime in the EU. Unlike Germany, which requires language proficiency and full diploma recognition, Poland introduced a simplified procedure in 2019 (a work permit without full recognition) and further simplified it for Ukrainian citizens in 2022.

The pay gap (statutory minimums as a firm baseline). At the NBU exchange rate (22 June 2026, 1 PLN ≈ UAH 12.08) [12], the statutory minimum for a Polish specialist physician (PLN 12,910.16 from 1 July 2026) is equivalent to ≈ UAH 156,000 per month – roughly four times the pay of even the best-paid Ukrainian public-sector doctor (≈UAH 42,000) [9,10]. The average (rather than minimum) pay of a Polish specialist, per AOTMiT materials (presented to the Tripartite Team for Healthcare on 26 May 2026, data for February 2026), exceeds PLN 25,000 (≈ UAH 302,000), i.e. about ten times the Ukrainian average; the median total remuneration is about PLN 23,600 on an employment contract and PLN 25,600 on a civil-law contract [11].

Table 2. Polish statutory minimum (gross, from 1 July 2026) versus Ukrainian remuneration.

Category	Poland, statutory minimum, PLN	Poland, ≈UAH (×12.08)	Ukraine, benchmark, UAH	Gap
Specialist physician	12,910	≈156,000	~42,000 (high)	≈4×
Physician without specialisation	10,595	≈128,000	~28,000 (average)	≈4.5×
Nurse (master's + specialisation)	11,486	≈139,000	~16,000	≈8–9×
Trainee	8,458	≈102,000	15,000 (intern)	≈7×

Note. The table deliberately uses Polish **statutory minimums** (a firm source) rather than averages: actual averages (with on-call duties and allowances) are substantially higher than the minimum, so the table understates rather than overstates the gap. The comparison is gross-to-gross; since the tax burden in Poland is higher than in Ukraine, the gap in net incomes is somewhat smaller — accounted for by the purchasing-power-parity (PPP) adjustment below.

4.2. The wider destination map: the "pay ↔ access barrier" ladder

Reducing the outflow to a single "Polish magnet" oversimplifies the picture: Poland dominated not because it offers the highest pay, but because it combined relatively high pay with the lowest entry barrier. Considering three realistic destinations — Poland, the Czech Republic and Germany — reveals a stable **inverse relationship: the higher the pay ceiling, the higher the qualification-recognition barrier**.

Table 3. Monthly doctor's remuneration by destination (gross), 2026.

Destination / category	Local currency	≈ UAH	Multiple of the Ukrainian average (≈28,000)
Ukraine — minimum	UAH 20,000	20,000	≈0.7×
Ukraine — average	UAH 28,000	28,000	1.0× (base)
Ukraine — high (emergency, 2026)	UAH 38,000	38,000	≈1.4×
Poland — statutory minimum, specialist	PLN 12,910	≈156,000	≈5.6×
Poland — average, specialist (AOTMiT)	>PLN 25,000	>302,000	≈11×
Czechia — entry-level doctor (scale)	CZK 43,640	≈93,000	≈3.3×
Czechia — post-certification (scale)	CZK 56,190	≈120,000	≈4.3×
Czechia — ambulatory sector / with overtime	>CZK 100,000	>213,000	>7×
Germany — resident (Assistenzarzt, entry)	≈€5,500	≈283,000	≈10×
Germany — specialist (Facharzt, entry)	≈€7,375	≈380,000	≈14×
Germany — senior physician (Oberarzt)	≈€8,800	≈453,000	≈16×

Conversion at the NBU rate of 22 June 2026: 1 EUR ≈ UAH 51.46; 1 PLN ≈ UAH 12.08; 1 CZK ≈ UAH 2.13 [12]. Polish minimums follow the governing Act [9] and the GUS communiqué (base PLN 8,903.56) [10]; Czech scales follow Government Regulation No. 341/2017 Coll., Annex No. 3 (in force from 1 April 2026) [13]; German rates follow the TV-Ärzte/VKA pay tables (Marburger Bund; in force to 31 May 2026, with a ~2% increase from 1 June 2026) [15]. Even the lowest of the ceilings — the Czech scale minimum for an entry-level doctor (≈ UAH 93,000) — is three times the Ukrainian average; a German resident (not yet a specialist) earns about as much as a Polish specialist, and ten times a Ukrainian colleague.

The access barrier (the second axis).

- *Poland – historically the lowest barrier, now closing.* The simplified procedure (conditional PWZ without recognition) was closed to new applications on 24 October 2024; from 1 May 2026 mandatory confirmation of Polish at B1 level was introduced under threat of revocation of the right to practise (over 200 doctors have already lost it) [16]; the presidential veto (June 2026) of an extension of the deadline, and the professional body's demand to raise the threshold to B2 and then C1, indicate further tightening. The pass rate of the LEW verification examination remains very low (about 8.8% overall; about 13% among Ukrainians in the May 2026 sitting) [17].
- *Czechia – a medium-to-high barrier.* Before employment, a non-EU doctor must pass the *aprobační zkouška* (three parts, in Czech) and a language examination; in practice, some Ukrainian medics work below their qualification owing to language [14].
- *Germany – the highest barrier at the highest ceiling.* Approbation, general language at B2, and a professional language qualification (*Fachsprachprüfung*, effectively medical C1) are required, plus, where necessary, a *Kenntnisprüfung*.

Section conclusion: reconfiguration, not disappearance of risk. As long as the Polish barrier was minimal, it absorbed the main flow. Its tightening in 2025–2026 does not remove the outflow but reconfigures it: (1) some motivated specialists reorient towards the higher ceiling of Germany/Czechia, accepting higher entry costs; (2) in the short term, the clinical outflow of doctors is somewhat restrained by the language-and-examination filter, while groups with a lower barrier – mid-level and junior medical staff – remain maximally exposed (§5). The "Window" is narrowing from both sides – the Ukrainian border and the liberal access of destination countries – but the pressure does not disappear.

A note on PPP (purchasing power parity). The nominal multiples (4–16×) overstate the difference in real welfare, because price levels in the destination countries are considerably higher than in Ukraine. According to Eurostat (2024, household final consumption expenditure, EU-27 = 100), price levels are: Germany – 109, Czechia – 88, Poland – 72 [19]. Ukraine is not part of the Eurostat programme; per World Bank estimates (International Comparison Program, ICP), the Ukrainian price level relative to the market exchange rate is about 0.28–0.30 of the United States [18], i.e. roughly 28–32% of the EU average. Applying the adjustment (real gap = nominal × ratio of Ukraine/destination price levels) yields: the nominal gap with a German specialist (~14×) compresses in real terms to roughly **3.5–4.5×**; with the average Polish specialist (~10×) to **~4–5×**; comparisons of tariff minimums converge to ~2×. Notably, in PPP terms the destination ceilings converge – Germany no longer dwarfs Poland – while the residual real gap of 3–5× is further amplified by the value of savings and remittances in hard currency. The Ukrainian price-level figure is flagged as indicative (derived from ICP data, not directly comparable with the Eurostat methodology; see §10).

Deep-dive zone. The global "ceiling" (Switzerland, Ireland, Australia, the USA) lies even higher than the German one, but for most Ukrainian medics it is barely realistic owing to language, visa and examination barriers; it is best treated in a separate study.

5. The risk of outflow after border reopening: specialists and mid-level and junior medical staff

Current scale (an honest assessment). Confirmed outflow remains moderate so far: according to industry sources, more than 2,000 Ukrainian doctors have been employed in Poland under the simplified regime (along with more than a thousand in other categories of medical staff) – less than one per cent of the pre-war headcount in a year [20]. Precise professional statistics are hard to obtain: Ukraine keeps no separate record of professional migration, and Polish registers (e.g., the number of persons required to confirm the language) are not identical to "the number employed in their profession." The risk is therefore largely prospective rather than realised *for doctors*: the current barriers (the ban on men's departure, language) still keep the outflow potential unrealised.

Two risk groups. Narrow specialists are a highly mobile group with documented international demand; once restrictions are lifted, they will realise the outflow first, and — given §4.2 — partly via the higher ceiling of Germany/Czechia. Mid-level and junior medical staff are the "invisible" group (the 1919 precedent): women constitute the majority, it is legally easier for them to leave already now, and European demand for nurses is structural and long-term.

The background context heightens the risk: the WHO and the Ministry of Health record 20–25% of medical posts vacant and an ageing workforce (about a quarter of doctors of retirement age), the Ministry of Health forecasts a workforce shortage by 2030, and the WHO estimates a global shortfall of about 10 million health workers by 2030 [21]. Under these conditions, even a moderate additional outflow after border reopening could shift the system from a deficit regime to a non-functioning one in particular specialties and regions.

Counterarguments and the sensitivity of the thesis. An honest analysis must consider three objections. First, some experts note that the outflow of medics occurred roughly in proportion to the departure of the population, so that on a per-patient basis there is no physical shortage of doctors — the problem lies rather in the quality and territorial distribution of services than in sheer numbers. Second, the tightening of the Polish language-and-examination barrier may by itself slow the clinical outflow of doctors (though, as shown in §5.1, it does not stop the outflow of mid-level staff). Third, stated intentions to leave systematically overstate actual migration owing to non-monetary factors — language, examinations, family, and the intention to return after the war. These objections narrow but do not cancel the thesis: even under a proportional outflow, the loss of quality in deficit specialties and regions is critical, and the three internal channels of mid-level and junior staff outflow (§5.1) depend on none of these caveats.

5.1. Channels of mid-level and junior medical staff outflow: four directions, three of which require no border reopening

Analysing the outflow of mid-level and junior staff solely as "part of future emigration" underestimates the risk. Unlike physician emigration, this outflow is already taking place through three internal channels that do not depend on border reopening, and only the fourth — clinical emigration — awaits the lifting of barriers.

- **Channel 1 — public → private sector (active now).** Junior nurses in public facilities earn about UAH 7,000–8,000, whereas the private sector offers over UAH 20,000 — a roughly threefold gap within one country and one profession [23]. This flow requires neither language nor border crossing, yet drains staff precisely from the public network that bears the main burden in front-line and de-occupied territories.
- **Channel 2 — exit into adjacent and other fields.** A nursing qualification structurally opens entry into the beauty and aesthetic-medicine sector (cosmetology, injectable and device-based procedures, massage) — a segment with higher incomes and less burnout. Alongside this, a broader exit from the profession is recorded: in the GMKA survey "Why women leave medicine" (115 respondents), about half resigned during clinical practice, and a further 12.2% at the internship stage [22]. There is no precise accounting of this channel (see §10).
- **Channel 3 — care as the "lower floor" with a lower barrier.** The personal-care segment has a substantially lower entry barrier than clinical nursing: it requires no recognition and often not even a high level of language. Domestic demand is enormous (over 3 million people require permanent care, while the state covers about 21%), and low public-sector pay for carers pushes specialists into the private segment or abroad [23]. For women, for whom it is easier to leave already now, European demand for carers is a stable "lower floor" of emigration.
- **Channel 4 — clinical emigration of mid-level staff (deferred).** Emigration in one's profession is restrained by the same barriers as for doctors, but the structural shortage of nurses in the EU and the lower language requirements for care positions make this channel "faster" than the physician channel once restrictions are lifted.

The demographic erosion of the base. The channels overlay a narrowing of the replenishment source: the output of junior nurses has fallen by about 56%, young people make up about 1.4% of the care workforce, and the average age of carers is

about 55 [23]. The reform, focused on primary-care doctors, left mid-level staff "in the shadows" without updated functions, so the profession itself risks degrading. The state has partly acknowledged the problem by announcing "nursing-care hospitals" with higher pay for 2026 (e.g., a nurse at the Kyiv Regional Oncology Centre earning $\approx$ UAH 38,000), but this is a point measure, not a systemic step [24].

6. Three structural gaps through the lens of outflow

6.1. The measurement gap

The official subsistence-minimum standard has diverged from reality by roughly threefold, while the legal floor (Resolution No. 28) is not automatically indexed [1]. As in the British case of 2023, a hidden fall in real income provokes no immediate reaction but makes emigration rational. The 2026 reform raised the pay of two categories manually (through PMG tariffs), confirming the feasibility of the floor mechanism, but it does not replace a systemic index: without a realistic index, the state does not see its own gap and cannot manage it.

6.2. The distributional gap

The capitation model is optimised for stable demographics; in front-line, border and de-occupied communities it underfunds strategically necessary facilities, accelerating local outflow precisely where it is most dangerous for preserving the network.

6.3. The priority gap

The asymmetry between "visible" groups (narrow specialists, external emigration) and "invisible" ones (junior staff, outflow already now). A policy that raises pay only for doctors (as partly happened in 2026 for primary/emergency care) by itself reproduces the 1919 precedent: the system risks losing the supporting staff without whom raising doctors' salaries does not yield a functioning system.

7. Methodology

The work is a structured multi-perspective conceptual analysis carried out by the author using several stakeholder analytical lenses (economic, financial, legislative, clinical, workforce). These perspectives are analytical frameworks, not a survey of real experts; the work is not a Delphi study and did not involve iterative expert rounds. The quantitative comparisons (sections 3–5) are built on open normative and statistical sources (the 2026 State Budget of Ukraine [25], Cabinet of Ministers resolutions [1], AOTMiT data [11] and the Polish minimum-pay Act [9,10], Czech [13] and German [15] tariff instruments on pay, the official NBU exchange rate [12], World Bank [18] and Eurostat [19] data, UHC [20] and WHO [21] studies); all key figures were verified against current public sources as of 22 June 2026. Currency conversions were made at the official NBU rate of 22 June 2026 (1 EUR $\approx$ UAH 51.46; 1 PLN $\approx$ UAH 12.08; 1 CZK $\approx$ UAH 2.13) [12]. The remuneration comparison by destination (Tables 2–3) is gross-to-gross; owing to differences in tax systems, net gaps are somewhat smaller than nominal, accounted for by the PPP adjustment. The needs-coverage analysis (Table 1), by contrast, uses net Ukrainian amounts, because it answers a different question – affordability of living, not migration pull.

8. The "Index — Floor — Window" framework

8.1. Index

Introduction of an Index of the real cost of living of a health worker (regional rent, utilities, a basket accounting for internally displaced persons) as the single base for automatic indexation of rates — so that Ukrainian remuneration does not erode imperceptibly, as it did in the NHS, and so that point increases (such as in 2026) become a systemic mechanism.

8.2. Floor

A two-tier system: existing capitation plus a legally protected "Medical Network Guarantee Fund" for strategic facilities regardless of patient volume; priority increases in the minimum rates of junior and mid-level staff — the group with the highest and least visible outflow risk (three of whose four channels operate already now).

8.3. Window

The "Window" is reconceived as a time-limited period narrowing from both sides. From the Ukrainian side it is closed by the end of martial law and border reopening; from the destination side, by the tightening of access (the closure of the simplified procedure in Poland, the rise of the language threshold to B2/C1). While the barriers still hold the outflow potential, pay policy can change the trajectory. Once they disappear, the cost of retaining staff will rise sharply, and some decisions will become irreversible. The Window is an argument for acting now, despite wartime exhaustion (the lesson of 1948).

9. Scenarios

Scenario A (inertia). Maintaining the legal floor without systemic indexation until border reopening → weakening of the Ukrainian barriers against the backdrop of a manifold gap with Poland/Czechia/Germany → accelerated outflow of specialists (partly to the higher EU ceiling) and of mid-level staff, sharpest in already-deficit regions. Even with the temporary restraint of the clinical physician outflow by the Polish language filter, the three internal channels of mid-level and junior staff outflow remain open.

Scenario B (reform for doctors only). Raising doctors' pay without junior and mid-level staff → outflow of mid-level and junior medical staff through three internal channels (private sector, other fields, care) already now → a non-functioning system despite higher doctors' salaries (the 1919 precedent).

Scenario C (the "Index — Floor — Window" package). Systemic indexation + a protected floor + priority for junior and mid-level staff, implemented within the "Window" → reducing the economic rationality of leaving before the barriers disappear → managed rather than collapse dynamics.

10. Limitations

The work is conceptual; the quantitative estimates are order-of-magnitude. In particular: (a) the actual subsistence minimum and the household-needs estimate are range-based and require anchoring to official calculations of the Ministry of Social Policy and/or an international relative-poverty standard; (b) data on the scale of Ukrainian medical migration are incomplete — Ukraine keeps no separate professional-migration statistics, and the available Polish registers are not identical to employment in one's profession; (c) the average pay of a Polish specialist relies on AOTMiT materials presented on 26 May 2026, which have the status of projected estimates rather than final official statistics; (d) the comparison with Poland, Czechia and Germany is made in nominal gross terms with a PPP adjustment; the price-level figure for Ukraine is derived from World Bank (ICP) data and is not directly comparable with the Eurostat methodology used for the EU countries, so the PPP estimates should be read as indicative, without full PPP modelling and without accounting for differences in tax systems in net incomes; (e) currency conversions are sensitive to exchange-rate fluctuations; (f) the distinction among the channels of mid-level and junior medical staff outflow rests on surveys (notably GMKA, n = 115) and industry observation rather than national registers. This sample is **indicative** rather than representative: it is suitable for identifying the directions

of outflow but not for precise quantitative scaling. Reliable estimation of the scale requires **nationally representative studies** of the employment, departure intentions and profession-change of mid-level and junior medical staff, by specialty and region.

11. Conclusions

The greatest risk to the sustainability of Ukraine's health workforce is not a single regulatory decision, but the accumulated gap between a health worker's real remuneration and the cost of living, currently masked only by temporary barriers. The quantitative analysis shows that even the high public-sector pay level — despite the 2026 reform for primary and emergency care — barely covers a household's needs, while the minimum covers less than half; the British experience demonstrates how hidden income erosion turns into emigration; the comparison with Poland, Czechia and Germany exposes a stable inverse relationship ("higher ceiling → higher barrier") and a manifold gap (even after a PPP adjustment). The outflow of mid-level and junior medical staff, meanwhile, is already partly being realised through three internal channels independently of the border.

The window of opportunity is time-limited and is narrowing from both sides — the Ukrainian border and the liberal access of destination countries. The "Index — Floor — Window" framework proposes acting while retaining staff is still cheaper than re-recruiting them. Inaction does not stop the outflow — it merely defers it (and for mid-level and junior staff, no longer even defers it) until it becomes unmanageable.

Declarations

Conflict of interest:

the author declares no conflict of interest.

Ethical approval:

not applicable (the study did not involve patients or personal data).

Use of AI

in preparing this work, the author used a generative AI assistant to verify open factual data, structure the argument and improve the language; the author verified all content and sources and bears full responsibility for the publication. AI is not listed as an author.

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Tables

Table 1
Net doctor's remuneration by level and coverage of needs, 2026.

Pay level	Gross, UAH	Net (- 23%), UAH	Multiple of individual actual minimum (≈ 11,850)	Coverage of a 3-person family (≈ UAH 30,000–35,000)
Minimum (specialist)	20,000	≈ 15,400	≈ 1.3×	~ 45–50%
Average	≈ 28,000	≈ 21,560	≈ 1.8×	~ 65–70%
High (emergency/primary, 2026)	≈ 42,000	≈ 32,340	≈ 2.7×	~ 95–100%

Table 2
Polish statutory minimum (gross, from 1 July 2026) versus Ukrainian remuneration.

Category	Poland, statutory minimum, PLN	Poland, ≈UAH (×12.08)	Ukraine, benchmark, UAH	Gap
Specialist physician	12,910	≈ 156,000	~ 42,000 (high)	≈ 4×
Physician without specialisation	10,595	≈ 128,000	~ 28,000 (average)	≈ 4.5×
Nurse (master's + specialisation)	11,486	≈ 139,000	~ 16,000	≈ 8–9×
Trainee	8,458	≈ 102,000	15,000 (intern)	≈ 7×

Table 3
Monthly doctor's remuneration by destination (gross), 2026.

Destination / category	Local currency	≈ UAH	Multiple of the Ukrainian average (≈ 28,000)
Ukraine – minimum	UAH 20,000	20,000	≈ 0.7×
Ukraine – average	UAH 28,000	28,000	1.0× (base)
Ukraine – high (emergency, 2026)	UAH 38,000	38,000	≈ 1.4×
Poland – statutory minimum, specialist	PLN 12,910	≈ 156,000	≈ 5.6×
Poland – average, specialist (AOTMiT)	>PLN 25,000	> 302,000	≈ 11×
Czechia – entry-level doctor (scale)	CZK 43,640	≈ 93,000	≈ 3.3×
Czechia – post-certification (scale)	CZK 56,190	≈ 120,000	≈ 4.3×
Czechia – ambulatory sector / with overtime	>CZK 100,000	> 213,000	> 7×
Germany – resident (Assistenzarzt, entry)	≈€5,500	≈ 283,000	≈ 10×
Germany – specialist (Facharzt, entry)	≈€7,375	≈ 380,000	≈ 14×
Germany – senior physician (Oberarzt)	≈€8,800	≈ 453,000	≈ 16×