Towards Self-governance for Healthcare Professions in Ukraine

Considering the legal, ethical, and public policy implications, drawing on UK and international experience.
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On 24th February 2022, the Russian Federation launched a full-scale invasion of Ukraine, resulting in substantial civilian casualties, the displacement of millions of people, and widespread destruction of public services—including in the health system. In addition, the war has reduced the availability of human resources, due to internal and external migration, with the total number of health workers falling by 13.7% in 2022. It has also undermined the population’s ability to pay for health care, while pushing up the costs of medicines and other critical supplies.1

In spite of these pressures, the Ukrainian health system has demonstrated extraordinary resilience—testament to the dedication and professionalism of the workforce. The vast majority of health facilities are fully functioning, even in the most conflict-affected areas.2 And, in these areas, the process of recovery is already underway.3 The government of Ukraine’s plans for recovery go beyond mere reconstruction. They incorporate plans for institutional change—one example of which is a proposal to rebalance power across the state, health workers, and civil society, in relation to the regulatory apparatus for the healthcare professions. Specifically, a draft Bill, entitled On Self-Governance in the Sphere of Health Care in Ukraine, has been developed by the Ministry of Health in cooperation with Members of the Verkhova Rada (the Ukrainian parliament), and has undergone a public consultation process.4

The intended effect of the Bill is to enhance the self-governing role of the healthcare professions in several key regulatory functions of which have traditionally been undertaken by the state. These include: overseeing the registration and licencing of professionals; setting standards for professional education and training; setting professional and ethical standards; and dealing with, and acting upon, concerns raised about professionals. The draft Bill is due to be considered by legislators in the coming months and is at the time of writing the subject of sustained public debate in Ukraine.

To inform that debate, an online seminar took place on 20th July 2023, bringing together legislators and regulatory stakeholders in Ukraine and the United Kingdom, alongside academic researchers in law, ethics and public policy (see Appendices 1 and 2). The event, organised as part of a collaboration between the Taras Shevchenko National University of Kyiv and the University of Edinburgh, had the following objectives:

(i) to consider the legislative proposals in detail;
(ii) to share insights between participants, drawing on both domestic and international experiences; and
(iii) to identify ways in which the reform proposals could be strengthened, to ensure they support the further development of the healthcare professions, while enhancing public accountability.

This Policy Brief begins with a brief overview of the current regulatory regimes in Ukraine and the UK, and proceeds to set out the objectives and content of the forthcoming Bill. It then summarises the main themes that emerged during the seminar, and concludes with a series of policy considerations, which may help to inform ongoing debates related to this critical area of health system reform in Ukraine.

2. Comparing professional regulation in Ukraine and the UK

2.1 Ukraine

Over the last decades, the structure of Ukraine’s health system has changed dramatically. In 2017, a single-payer system was introduced, headed by the National Health Service of Ukraine (NHSU). This was motivated to ensure universal access to high-quality services. As part of this reform, primary care services have been strengthened, while specialist outpatient and inpatient services have been streamlined, laying the foundation for greater efficiency in service delivery.5 These reforms also reflect a commitment to refocus the role of the state vis-à-vis other social actors. For example, formerly ‘state’ health care institutions have been re-constituted as communal non-profit enterprises (Komunalne Nekomertsiyne Pidpriymstvo, or KNP), with considerable operational and financial autonomy from central and local government authorities. The role of private health care providers has also increased. Such providers are eligible to enter into contracts with the NHSU to deliver health services, and those that do so provide care to patients free at the point of use, alongside (and on the same terms as) their non-profit counterparts.

As a result of the reforms, the levers of influence available to the state—to ensure that services are safe, appropriate, and effective—are changing. Increasingly, those levers derive not from ownership or direct control, but from the person may then be considered of regulating the public health system in place. As a result, the adequacy of that regime, in terms of its impacts on professional competence and behaviours, remains of major importance for population health and the public interest more generally.

Currently, the Ministry of Health (MoH) retains a prominent role across all four of the regulatory domains cited in Section 1 above (namely: registration and licencing; standards for professional and ethical conduct; and the conduct of disciplinary procedures). The capacity of the MoH to perform all of these roles—alongside its many other responsibilities—is limited, and thus there are many gaps and limitations in the regulatory arrangements. Perhaps most notably, and in contrast to international norms, there is no individual licensing of healthcare professionals in Ukraine. This means that professionals may only provide health services if:

• they are employed by a healthcare provider licensed by the MoH; or
• they are registered as a private entrepreneur (a so-called Fizychna Osoba-Pidpryiemets, of ‘FOP’) and hold an MoH licence to provide medical services.

These arrangements restrict professional autonomy and place the responsibility for ensuring that professionals meet standards for education, training, and ethical conduct on employers; their actions in response to any shortcomings are then handled by the MoH. As a result, these arrangements fail to serve professional interests—and also fail to protect the public.

Further, regulations relating to standards for higher education and continued professional development are issued by the MoH with limited involvement of healthcare professionals and the associations that represent them. This raises potential concerns about the extent to which the regulations are fit-for-purpose, as well as issues of transparency. In addition, all healthcare professionals are obliged to observe MoH-defined medical standards and clinical protocols; healthcare providers must ensure that these are followed. However, healthcare professionals and their associations play little role in the development of these guidelines.

Further, the capacity of the MoH and the State Expert Centre (to which the MoH has delegated some of its powers) is limited. As a result, MoH-approved standards and protocols for the treatment of many diseases are absent, and those that do exist are updated irregularly—such that they are misaligned with contemporary clinical practices. Currently, there is no overarching set of ethical standards for healthcare professionals. Many independent professional associations specify ethical standards that their members are supposed to observe. However, the number of such associations is very large (e.g., dentistry alone has more than 100 associations), such that each association (and thus, each set of ethical standards) covers only a fraction of the relevant workforce. In addition, in the absence of monitoring or enforcement, it is not clear that such rules have any impact on professional behaviours in practice. As a result, disciplinary action related to any (non-criminal) breach of performance or ethical standards is a matter solely for employers (e.g., a healthcare professional may be subject to disciplinary action only for failure to perform in accordance with his/her job description and related criteria). The sanctions that may result include dismissal from the place of employment, but the disruption is often limited to the person employed by another employer, or become a ‘FOP’, practising on an independent basis.

For all these reasons, the introduction of healthcare professionals’ self-governance may be desirable. There have been numerous proposals to take this forward but, for various reasons (such as a lack of agreement on the content of the relevant laws, and the absence of political will), none of these has, so far, been implemented.

2.2 UK

The UK, like Ukraine, provides healthcare free at the point of delivery via the National Health Service (NHS). Delivery of healthcare care is regulated by respective governments within the four UK nations (England, Northern Ireland, Wales, and Scotland). The
The precise form of regulation is aligned to the individual professions which are governed by the relevant regulatory body. There is no single piece of omnibus legislation that governs the operation of these regulators; rather, each regulator operates in accordance with its own statutory framework. Broadly, however, the regulators’ key functions are to:

- oversee the registration and licencing of professionals;
- set standards for professional education and training;
- set and maintain professional standards; and
- deal with concerns raised about the professionals for whom they are responsible.

Regulated professionals must be included in the relevant register if they are to practise in the UK. These registers are made available to the public online via the regulators’ websites. To remain on the register, professionals need to keep up to date with current standards of practice and may be required to provide evidence of this to their regulatory body. Some professionals, such as doctors, nurses, and midwives, are required to revalidate their licence with their regulatory body over a specified period of time (for example, every three or five years). This rigorous process includes providing evidence of matters such as fitness to practise, ongoing adherence to professional standards, and CPD.

Professional and ethical standards of practice are set by the regulators and updated over time in consultation with registrants and wider publics, alongside resources which provide guidance to professionals on meeting these standards. An example of this is the GMC’s Good Medical Practice, which describes “what it means to be a good doctor” and sets standards in four domains: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust.

Concerns or complaints are dealt with via regulators’ “fitness to practise” processes. These may be raised by patients or their families, employers, or other bodies such as the police, and will be taken forward by regulators, broadly speaking, in cases where the professional’s actions may pose a risk to patients or may harm public confidence in the profession. The fitness to practise process is not intended to be punitive (although it may be so in exceptional cases). The key question is whether the professional’s current fitness to practise is impaired; as such this can take into account steps that a registrant has taken to remedy their practice (as explored further below).

The precise details vary as between the regulators but, as an overview, concerns may be investigated by the regulator, who can decide to take no further action or to conduct the process with the issue of a warning (dependent on the regulator) or by agreeing undertakings with the professional. More serious concerns may be referred on for consideration by an independent Fitness to Practise Panel or Tribunal, which, in accordance with the outcomes available to the regulator, may take steps such as placing conditions on the professional’s practice or suspending their practice for a specified period of time, or, in the most serious cases, removing their name from the register so they can no longer practice.

The role of the PSA is to oversee the regulators from a position of independence, and to provide assurance to Parliament and to the public that these regulatory bodies are undertaking their functions appropriately.

The UK regulatory framework, which varies across the professions, has been described as complex and piecemeal, which is largely a consequence of its incremental development over time. However, it should not be viewed as static; the framework continues to evolve and develop over time. There have been various proposals for reform, including a 2021 consultation on a comprehensive overhaul of the regulators’ primary legislation. This is directed to enhancing consistency between the regulators in some key respects, while also allowing greater autonomy for the regulators to set out the details of their own regulatory procedures. 3. Proposals for reform in Ukraine

The draft Bill would, if enacted, provide a mandatory framework for the self-governance of the healthcare professions in Ukraine. Specifically, it would create five ‘Chambers’ as independent organisations for professional self-governance, made up of representatives from the relevant professions. There would be separate chambers for: 1) pharmaceutical professionals; 2) family medicine doctors (i.e., General Practitioners); 3) specialist doctors; 4) dentists; and 5) midwives, nurses, and allied health professionals.

Key functions of the Chambers would include:

- Managing and overseeing the registration and licencing of relevant professionals, by issuing certificates that provide professionals with the right to practise. Professionals would apply to be added through the online state portal by providing appropriate documentation. The register of licenced professionals would be made publicly available on the Chambers’ websites.
- Developing and maintaining professional standards. This would include participating in the creation of standards for the provision of specialist care and the development and approval of a code of ethics for professionals.
- Working with relevant institutions regarding the standards for medical education and CPD.
- Cooperating with other state bodies, trade unions, and public and private organisations on matters of public health protection and the performance of professional duties.

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- Working with relevant institutions regarding the standards for medical education and CPD.
- Cooperating with other state the regulation of health and social care professionals is mainly delivered by ten statutory regulators, most of which operate on a UK-wide basis and are overseen by the Professional Standards Authority for Health and Social Care (PSA). These regulators are summarised in Figure 1 below and span health and social care professions.3,4

The key question is whether the professional’s current fitness to practise is impaired; as such this can take into account steps that a registrant has taken to remedy their practice (as explored further below).

The precise details vary as between the regulators but, as an overview, concerns may be investigated by the regulator, who can decide to take no further action or to conduct the process with the issue of a warning (dependent on the regulator) or by agreeing undertakings with the professional. More serious concerns may be referred on for consideration by an independent Fitness to Practise Panel or Tribunal, which, in accordance with the outcomes available to the regulator, may take steps such as placing conditions on the professional’s practice or suspending their practice for a specified period of time, or, in the most serious cases, removing their name from the register so they can no longer practice.

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The UK regulatory framework, which varies across the professions, has been described as complex and piecemeal, which is largely a consequence of its incremental development over time. However, it should not be viewed as static; the framework continues to evolve and develop over time. There have been various proposals for reform, including a 2021 consultation on a comprehensive overhaul of the regulators’ primary legislation. This is directed to enhancing recognition, the successful implementation of the Bill, should it become legislation, will require collaborative working across a wide range of stakeholders. This will be necessary to build trust in the new system, and to facilitate consent and buy-in from both professionals and publics—something that is considered crucial to its success. To feed into this ongoing process of legislative and regulatory reform, key themes of the discussion are provided below, alongside considerations for various policy options going forward.

4.1. The purpose of the reform and its communication to stakeholders

Various participants emphasised the importance of being clear on the purpose of the legislation and the framework for governance it will engender. Only if this clarity of purpose is established and is understood by all stakeholders (including professionals, publics, and politicians) can the required structures be created and institutionalised. Navigating the tensions between, on the one hand, supporting the profession and, on the other, protecting the public, is a central challenge in all regulatory
expressed the view that as much different regulatory bodies is feasible or desirable. to which regulatory consistency decisions around which positive navigating this approach requires (for example, supporting best on a more preventative basis trying to tackle potential issues (for example, when a patient porting professional activity. Con-

consider their approach to sup-

rior balance, then, between consistency across professions and flexibility in accounting for specific professional needs, will be a key consideration for the future development of the Bill.

4.2. Tackling political interfer-

ence and corruption A key aim of self-governance is the potential it affords for tack-

ieracy, political inter-

were that many of the functions that would be taken up by the Chambers currently sit with the MoH (albeit final decisions as to exactly what would be delegated still to be made). Participants emphasised the importance of the independent of regulatory bodies from the state. From the UK experience, this is seen to be beneficial in enabling regu-

ators to set their own priorities without political interference.

Participants also focused on the registration and licencing, and how human interference or corrupt practices in this regard can be eliminated. Some participants suggested that this remains a risk within the Chambers, and felt that using an Online Portal and verification of documentation electronically and automatically will be im-

ormative 'human element' from decision-making, and thus the related problems of bureaucratic inertia and the aggravation of corruption risks. In addition, participants empha-

ated the importance of moving away from a model of licensing focused on institutions and loca-

tions, and towards one focused on individual professionals. This is seen by some participants as facilitating greater autonomy among medical profession-

als. However, concerns were raised that this may lead to the centralisation of expertise in the hands of a few select medical specialists (and their autonomy should not be to the detriment of the profession at large).

Other elements which partici-

pants felt required consideration were the number of Chambers. With four chambers for the medical profession, this could cause challenges for those who practised across Chambers (e.g., those who and both patients and family doctors, especially in identified standards and processes differ between them.

Discussion also focused on the role of national vis-a-vis regional bodies. On the one hand, some participants were supportive of the current proposal not to de-

olve power to regional bodies, seeing them as a source of po-

encial corruption. Others felt that some form of regional affiliation would be useful, for instance to ensure that self-governance is led by those ‘on the ground’ and with an understanding of local realities. Although created in very different circumstanc-

es, an important starting point for an interface between national regulation and the local context is the ‘Responsible Officer’ (RO) (established by the GMC). ROs work within healthcare organisations and may, for example, make recommendations about matters such as the reval-

uation of the doctors for whom they are responsible. However, the ultimate decision as to wheth-

er to revalidate a doctor remains with the ‘RO as the national regulator.’

4.3. Transparency and public ac-

countability Linked to the concept of corrup-

tion is the wider issue of trans-

parency and accountability. Par-

ticipants recognised that there are measures within the draft Bill that will support transparent-

cy and accountability; these include a public-facing register of licensed professionals on the Chamber’s website, on which patients would be able to search for information about their health professional. While adhering to applicable data protection prin-

ciples, policy makers ought to consider what information should be included in the register. In the UK, information made available to the public can include (de-

pendent on the regulator): the practitioner’s status in terms of their licence to prac-

tice, and their registration number; details on the type of regis-

tration they have; the date that they were first registered; and any current restrictions on their practice, and their fitness to practise habitat (if any). As an example, doctors who have previously held a licence to practise but have been sus-

pended or removed and are no longer allowed to practice are also included in the register. This allows patients to take informed decisions regarding seeking care from their doctor and for prospective employers to make checks on professionals they are considering.

An important question raised in relation to this theme was the extent to which patients and publics will be involved in the work of the Chambers. This is not currently explicitly addressed in the Bill, although discussions are ongoing regarding this. Most participants agreed that patient/public involvement in the operation of the Chambers would be desirable to ensure that these stakeholders are able to inform the conduct of regula-

tion and to ensure the system meets the needs of society as a whole. UK stakeholders noted that, from their experience, exclusive self-governance of the professions is not desirable, as it can lead to protection of professionals at the expense of patients. They emphasised that the UK experience suggests that maintaining some form of patient and public involvement is crucial in relation to matters including: (i) how the regulator is run, (ii) the standards it sets for the profes-

sion, and (iii) processes relating to fitness to practise. Participants pointed to this involvement as a crucial facet of maintaining public trust in the regulators.

Further, participants felt that practices within the Chambers will need to be transparent to help prevent corruption taking root in the new regime. For example, it was proposed that an Audit Committee for each Chamber might help to ensure financial transparency. Par-

ticipants further suggested that it would be important to be clear on the relationship between the bodies within each Chamber and the lines of accountability, and to make individual processes within these bodies transparent, with checks and balances in place. From the UK experience, it is ev-

dent that the oversight of the ‘natio-

ta-regulator’, such as the PSA, can provide such a mechanism, helping to ensure that regulators are undertaking their functions appropriately.

A final key aspect of account-

ability relates to the processes for dealing with concerns about professionals’ fitness to prac-

tise. Currently, mechanisms for dealing with patient complaints in the UK are undertaken by local organisations (such as the MoH, local health departments or by petitioning the courts) were generally considered as inappro-

riate. For example, court litiga-

tion may be lengthy and costly, is both insufficient and effective as a means of protecting patients, and also punitive for professionals (and would fail to promote learning among them). While it is anticipated that, in the case elsewhere, only a very small number of professionals will be involved in fitness to practise processes, they often attract disproportionate media attention and become a major cause of anxiety and concern for professionals. It is therefore critical that such pro-

cesses are fair and appropriate to adequately support profes-

sionals and ensure due process. UK stakeholders emphasised that the language ‘fitness to prac-

tise’ had been chosen carefully, as the process should consider whether a professional in ques-

tion was safe to practice at the present time.

Participants also considered how to deal with allegations against professionals in such a way that can take account of contextual factors. It was noted that, in the context of not only teams, but also over-stretched health systems which are under acute pressure—an observation that may be relevant to Ukraine, given the operational and financial pressures that health workers are currently operating in. Some noted that the impact of these conditions requires that the ‘framework’—as the phrase is oftentimes accounted for when considering professionals’ fitness to prac-

tise.

Discussions also focused on the provision of public-facing information about disciplinary outcomes. Some considered this information to be confidential
to the professionals involved and felt that it would be difficult to persuade professionals that wider public engagement is necessary. However, others suggested this would be important to facilitate learning from mistakes and therefore better protect patients. From a UK perspective, disciplinary outcomes are made specific to facilitate learning and public trust. One option—to try and find a balance between these competing viewpoints—would be to provide anonymised outcomes, allowing learning to be gained but individual identities to be protected.

4.4 Building back better—and securing the right to healthcare

Participants recognised that proposals to introduce self-governance are just one part of a wider process of building a health system in Ukraine that can achieve sustained progress towards universal health coverage, thereby realising the population’s right to healthcare.

In addition, the creation of the Chambers as public law entities with delegated authorities and real influence on the practice of healthcare has the potential to decentralise power in Ukrainian society, while enhancing transparency and accountability for both professionals and publics. For example, they can help facilitate the provision of care and practice without excessive hurdles and to support professionals to feel safe within their practice. Some UK participants noted that professional regulation could form part of a broader system—in which professional self-interest is favoured ahead of public protection. 10 This challenge has proved to be an important focus of debate, both in Ukraine (contributing to a series of stalled reform efforts since independence in 1991), and internationally (including in jurisdictions in which professional self-governance has been a long-standing feature). Indeed, in the latter case, the need to consider the balance between professional self-governance and public accountability has been an important driver of reform. The discussions in the seminar indicated broad support for self-governance as part of the Ukrainian legislative agenda, but identified some crucial elements for consideration—either as part of the legislation or in subsequent policy interventions in support of its implementation. While the UK context is undeniably different, and each country’s regulatory apparatus reflects different contextual challenges and opportunities, the discussions suggest that there are opportunities for cross-border learning between the two countries.

In taking forward the reform process in Ukraine, key policy considerations that emerged from the seminar include the following:

Policy Considerations

1. The purpose of self-governance should be communicated to professionals, patients, and broader society in terms of its place in the wider reform agenda, to enable well-informed and purposeful policy dialogue on the proposed Bill, and how this will be implemented. This will likely include careful consideration of the relationship between supporting professionals and protecting patients and publics.

2. The powers that will be delegated to the new Chambers should be clearly defined, and steps taken to ensure that they have the legal competence and resources (e.g., including funding and specialist human resources) required to execute those powers.

3. Over time, thought should be given as to what extent, and in what ways, consistency in approach between the professional Chambers can be encouraged and facilitated.

4. A focus on enhanced ethical and performance standards seems appropriate in Ukraine to increase public trust in the health system, however, over time, it will also be important to consider how learning from mistakes can be encouraged, alongside enhanced public-facing information on activities and outcomes.

5. To be sustainable, a system of self-governance must ensure transparency in its decision-making processes, and accountability to the professions, patients, and publics. In particular, new mechanisms for ensuring patient and public involvement in self-governance may need to be facilitated to achieve long-term public trust in, and support for, the self-governance arrangements.

References

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References

1 World Health Organization. ‘Surveillance System for Attacks on Health Care. Ukraine. 01/02/2022 to 26/06/2022.’ Available at: https://extranet.who.int/ssa/Index/RO-2023-7706-47473-69781.

2 National Health Service of Ukraine, Government Portal. ‘Analytical dashboard.’ March 3, 2023. Available at: https://analyt.e-health.gov.ua/uk/ukraine/dashboard and efficacy of health services). Challenges to the public interest may emerge, however, if patient and public involvement in decision-making is absent or inadequate, or in circumstances in which professional self-interest is favoured ahead of public protection. This challenge has proved to be an important focus of debate, both in Ukraine (contributing to a series of stalled reform efforts since independence in 1991), and internationally (including in jurisdictions in which professional self-governance has been a long-standing feature). Indeed, in the latter case, the need to consider the balance between professional self-governance and public accountability has been an important driver of reform. The discussions in the seminar indicated broad support for self-governance as part of the Ukrainian legislative agenda, but identified some crucial elements for consideration—either as part of the legislation or in subsequent policy interventions in support of its implementation. While the UK context is undeniably different, and each country’s regulatory apparatus reflects different contextual challenges and opportunities, the discussions suggest that there are opportunities for cross-border learning between the two countries.

In taking forward the reform process in Ukraine, key policy considerations that emerged from the seminar include the following:

Policy Considerations

1. The purpose of self-governance should be communicated to professionals, patients, and broader society in terms of its place in the wider reform agenda, to enable well-informed and purposeful policy dialogue on the proposed Bill, and how this will be implemented. This will likely include careful consideration of the relationship between supporting professionals and protecting patients and publics.

2. The powers that will be delegated to the new Chambers should be clearly defined, and steps taken to ensure that they have the legal competence and resources (e.g., including funding and specialist human resources) required to execute those powers.

3. Over time, thought should be given as to what extent, and in what ways, consistency in approach between the professional Chambers can be encouraged and facilitated.

4. A focus on enhanced ethical and performance standards seems appropriate in Ukraine to increase public trust in the health system; however, over time, it will also be important to consider how learning from mistakes can be encouraged, alongside enhanced public-facing information on activities and outcomes.

5. To be sustainable, a system of self-governance must ensure transparency in its decision-making processes, and accountability to the professions, patients, and publics. In particular, new mechanisms for ensuring patient and public involvement in self-governance may need to be facilitated to achieve long-term public trust in, and support for, the self-governance arrangements.

References
Appendix 1: Seminar Overview, Thursday 20th July 2023

09:15 - 10:00 BST
11:15 - 12:00 EEST
Welcome and Opening Remarks

Session 1
10:00 – 11:00 BST
12:00 - 13:00 EEST
Setting the Scene: an overview of the regulation of healthcare professionals in Ukraine and UK (current position)
• Speakers provided a brief summary of the healthcare system in Ukraine and the UK and the contours of the existent regulatory framework.
• This provided an understanding of the impetus for reform in Ukraine and the key differences between the two systems and their regulatory journeys.

11:00 - 11:15 BST
13:00 - 13:15 EEST
Break

Session 2
11:15 - 12:30 BST
13:15 - 14:30 EEST
Ukrainian legislative agenda: the introduction of a regime for the self-governance of healthcare professions
• Members of the Rada provided a summary of the Bill on self-governance and its key elements.
• Participants asked questions and provided feedback.

12:30 - 13:15 BST
14:30 - 15:15 EEST
Break

Session 3
13:15 - 14:45 BST
15:15 - 16:45 EEST
Public and professional views on legislative agenda: challenges and opportunities
• Representatives from medical associations, patient organisations and civil society organisations provided their views on the proposals and key questions or insight they felt should be considered.

14:45 – 15:00 BST
16:45 - 17:00 EEST
Break

Session 4
15:00 - 15:45 BST
17:00 - 17:45 EEST
Observations from regulating healthcare professionals in the UK
• UK regulatory stakeholders provided comments on the discussion to date, drawing on their experience of regulating healthcare professionals and aspects of this that could be considered.
• Final remarks to draw together insights were offered and next steps discussed.

15:45 - 16:00 BST
17:45 - 18:00 EEST
Close

Appendix 2: Seminar Participants

Ukraine
Dr Artem Dubnov, Deputy Chairperson of the Committee of the Supreme Rada of Ukraine on the Health of the Nation, Medical Care and Medical Insurance.
Oksana Dmytryieva, Deputy Chairperson of the Committee of the Supreme Rada of Ukraine on the Health of the Nation, Medical Care and Medical Insurance, the Honored Medical Doctor of Ukraine
Dr Radyma Hrevtsova, Associate Professor, Public Administration and Health Law, Institute of Law, Taras Shevchenko National University of Kyiv. For more information see: https://docs.google.com/document/d/1NyW6OqDzLqjK4tBqCQuUzIfXg1TFw/edit
Dr Ivan Soroka, President of the Ukrainian Medical Club
Professor Roman Cregg, President of the Ukrainian Medical Association of the UK. For more information see: https://www.uma.uk.org/
Inna Ivanenko, Executive Director, Patients of Ukraine. This is a non-governmental organisation which actively protects the rights of patients in Ukraine. For more information see: https://patients.org.ua/en/
Liiubov Hura, Ukrainian Health Centre. The UHC is a think tank based in Kyiv, Ukraine, which provides consultancy, analytics and educational services. For more information see https://uhc.org.ua/en/home/
Victoria Tymoshevskaya, Executive Director, Health Solutions for Open Society. Health Solutions is a non-governmental organisation and foundation that works towards building human capacity and leadership amongst health professionals. For more information see https://healthsolutions.ngo/eng
Tetiana Gavrysh, Co-Founder, Health Solutions for Open Society, Managing Partner, ILF Law Form. For more information see https://www.ilf-ua.com/en/

UK
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Christine Braithwaite, Director of Standards and Policy, Professional Standards Authority for Health and Social Care. This body oversees ten health and care regulators, which regulate various health and social care professionals (for example, doctors, nurses, pharmacists amongst others). For more information see: https://www.professionalstandards.org.uk/about/directors/director-of-standards-and-policy
Dr Roman Cregg, President of the Ukrainian Medical Association of the UK. For more information see: https://www.uma.uk.org/

Dr Artem Dubnov, Deputy Chairperson of the Committee of the Supreme Rada of Ukraine on the Health of the Nation, Medical Care and Medical Insurance.
Oksana Dmytryieva, Deputy Chairperson of the Committee of the Supreme Rada of Ukraine on the Health of the Nation, Medical Care and Medical Insurance, the Honored Medical Doctor of Ukraine
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Dr Ivan Soroka, President of the Ukrainian Medical Club
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Liiubov Hura, Ukrainian Health Centre. The UHC is a think tank based in Kyiv, Ukraine, which provides consultancy, analytics and educational services. For more information see https://uhc.org.ua/en/home/
Victoria Tymoshevskaya, Executive Director, Health Solutions for Open Society. Health Solutions is a non-governmental organisation and foundation that works towards building human capacity and leadership amongst health professionals. For more information see https://healthsolutions.ngo/eng
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