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Task support, delegation, and shifting in social security assessments in Europe

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Foreword

Decades ago assessments for social security benefits were undertaken exclusively by medical practitioners. But with increased demand for assessments, financial constraints and reduced availability of physicians, countries in Europe have looked at ways of continuing to operate efficient and cost-effective assessment systems using task support, task delegation and task shifting to other healthcare and non-healthcare professionals.

Despite starting with the same origin of a medical based assessment system and with the same challenges, assessment systems have evolved differently in different countries.

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The authors are fully responsible for the content of the report.

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Content

Executive summary

European social security administrations foresee a shortage of medical assessors in their organisations. They also face many challenges such as limited financial resources, the need to safeguard the quality of assessments, and to introduce more updated and efficient disability assessment procedures, including multi-professional teamwork.

European Union of Medicine in Assurance and Social Security (EUMASS) carried out an exploratory survey and case studies on task transfer (task shifting, delegation, and support) in European social security systems.

The aim was to describe and compare the use of task transfer in disability assessments.

The approach was threefold: 1. A survey questionnaire was sent to all 20 EUMASS members, inquiring about the present and planned use of task transfer in disability assessments, and how it has been evaluated. 2. A literature study was undertaken on task transfer. 3. Case studies were developed in selected countries (Belgium, France, the Netherlands, Norway, the United Kingdom) where different approaches to task transfer have been used.

Task transfer in disability assessments has been introduced in seven countries, mostly in Western Europe. A mixture of task shifting, delegation, and support was often used. Nurses were the dominant group taking over new tasks, but physiotherapists, psychologists, secretaries, social workers, pedagogues, rehabilitation specialists, and occupational specialists were also involved. Administrative staff often takes over tasks from the doctor in the input phase of the assessment process by collecting information and contacting the claimants. The Social medical nurse appears to be an emerging speciality taking over tasks from the physician in all phases, most importantly in the throughput phase.

Task transfer is implemented in different ways in line with the cultural traditions and specific organisations in the political and financial framework of the individual country. Education and training was important for a successful change of tasks. The changes were mostly seen as positive. Innovative and flexible approaches were described which can provide examples for other countries and lead to further study.

1. Background

European social security administrations experience various degrees of shortage of medical assessors in their organisations. Many administrations are also strained by limited financial resources, a situation that worsened after the global financial crisis in 2009. There is a growing interest in reducing costs and streamlining the assessment procedure in disability assessment services. In addition, there is a search for ways to improve quality in the assessment services and to maximize staff skills in the organisations. Multi-professional work in teams has been given increasing attention as a way to assess work ability more thoroughly. Many countries also aim to replace the traditional biomedical model for assessments with a bio-psycho-social model that better meets updated approaches to disability evaluation (Escorpizo et al 2015).

In European social security, the evaluation of need for short-term (sickness) and long-term (disability) benefits is a task that mainly involves physicians. In almost all countries, the physicians perform medical assessments of the claimants to determine the degree of work disability (de Boer et al 2004, de Wind 2016). In some countries, this is supplemented with evaluation of need for rehabilitation/reintegration programs. The involvement of other professionals in the assessment process can help (i) reduce the workload of physicians; (ii) contain the costs of the assessment process; (iii) broaden the scope of the assessment by complementing the medical assessment with relevant expertise from other professions (e.g. occupational therapists or social workers), and (iv) improve decision quality.

In some countries, assessments are already partly done by multi-professional teams, and that should be considered different to task shifting and task delegation where one professional replaces another in performing the task. A reduction of physician work tasks could also be achieved by the introduction of artificial intelligence, but this is so far beyond the scope of study.

The World Health Organization has described task shifting as the rational redistribution of tasks among health workforce teams (WHO 2008). Healthcare tasks are usually shifted from higher-trained health workers to less highly trained health workers in order to maximize the efficient use of limited health workforce resources. In general, it is possible to transfer the work of physicians to other professionals on three levels:

1. Task support: moving administrative and logistical support tasks, usually to administrative staff.

2. Task delegation: delegation of tasks or parts thereof to a third party, depending on the situation, but still under the supervision and responsibility of the physician.

3. Task shifting: structural redistribution of tasks between professions.

In this report, we use the term task transfer as an umbrella term for these three levels. In the case studies, we try to specify which type of task transfer that is being used.

In all three cases, a change in the attribution of tasks needs careful regulation, planning, and training in order to ensure successful implementation and the sustainability of the task change.

Task shifting in the health sector has been an important policy issue over the last decades around the world (WHO 2008). Shifting and delegation of tasks are already applied in many fields of health services, in particular after the outbreak of the HIV epidemic. The underlying reason has mostly been shortage of physicians or other health professionals. The experiences drawn in health care have been an inspiration for social security agencies, and task transfer has gradually been established on their policy agenda.

Many European countries have changed the physicians' work tasks in social security for other reasons as well. One common theme has been a stronger emphasis on the assessment of functional and work ability, and a weaker focus on diagnoses per se. There has also been a clearer description of the balance of responsibilities between the social insurance institutions and health services, and between physicians and social insurance officers. Although the cultural heritage, historic development, and economic possibilities differ greatly, there are many common features in the physician assessment of disability across European countries (de Boer 2004, de Wind 2016). These are summarized in Box 1.

Box 1 Common physician tasks in work disability assessment

In most European countries, eligibility for disability benefits is decided by a state institution. To qualify for disability benefits, the claimant has to fulfil certain criteria. Criteria on minimum income, residency, and age are assessed by social insurance officers. The physicians' tasks are to assess health-related criteria:

- Is health condition the main cause for disability?
- Is the condition long-standing?
- Has enough medical rehabilitation been tried?
- How much functional/work/income ability has been lost?

The social insurance institutions assess the degree of work ability loss, evaluate if illness is the main cause of reduced work ability, and assess whether rehabilitation has been tried to a sufficient degree. The process of assessing the eligibility of disability claims can be divided in three phases (Donabedian 1988, de Wind 2016):

Input phase: The application for benefit is supplied with medical forms from the treating physician on medical conditions, diagnoses, and previous medical treatment. In some countries, the applicants also fill out questionnaires about medical examinations and tests, treatment, diagnosis and self-assessed functional abilities. The social insurance institutions check the information.

Throughput phase: A social insurance officer has usually the responsibility for handling the application. The officer consults a social insurance physician (SIP) on medical aspects of the claim. The SIP can base the assessment on a meeting face-to-face with the claimant and/or on existing documentation.

Output phase: The SIP gives a conclusion or advice, often written, to the social insurance officer responsible for the decision.

For all three phases, medical competence is needed. The SIP can have other work tasks in addition. This varies considerable between countries. They might give advice on vocational rehabilitation, do preventive work, participate in education, and interact with physicians in the national health services.

The need for task transfer in European social security is of relatively recent date. Currently, there is only sporadic knowledge of the extent to which task transfer - task support, task delegation and task shifting - is used in European social security systems.

2. Objective and aim of study

The objective of the study is to increase the knowledge of the extent to which task transfer is used and to obtain an overview of the present situation in selected European countries. The

main aim is to obtain a detailed and comparable description of the way in which transfer of tasks is used in national disability assessment systems.

3. Methods

3.1. Questionnaire survey in EUMASS member states

A survey on task support, delegation, and shifting was carried out across Europe. A questionnaire was prepared in cooperation with the European Union of Medicine in Assurance and Social Security (EUMASS), a cross European group of disability specialists nominated by an EU/EFTA country. It focused on medical assessment of disability in determining the eligibility for benefits and covered the following aspects: (i) the tasks that are transferred; (ii) the legal framework / regulation for the transfer; (iii) supervision of the delegation; and (iv) type of education/training provided for the delegate and the delegating physician. The questionnaire was sent out to all 20 EUMASS member states. Each non-responder was given one reminder. The questionnaire is shown in appendix A.

3.2. Literature review

The project group conducted a review of relevant literature on the use of task support, delegation, and shifting in disability assessment. The results of this review complemented the information collected through the questionnaire survey among EUMASS member states and the case studies. We searched relevant literature both through known publications and our contacts in the relevant countries. It was also made a simplified search in PubMed and Medline with MESH terms: “task shifting”, “social medicine”, “insurance medicine”, and “disability assessment”. 110 papers were identified but none were relevant. Most papers on task shifting related to the provision of healthcare particularly for patients with HIV in developing countries through the training of a wide range of “lay” healthcare workers.

We concluded there is little published literature on the transfer of tasks in social security. Such shortage is probably caused by lack of scientific evaluation and communication of changes in administrative layouts, as elaborated by MacEachen (2019): “It is difficult to find coordinated collections of literature on how work policies have evolved within jurisdictions, why these take their suggestion and what failures as well as successes have occurred in implementation”.

3.3. Case studies of five EUMASS member states

Based on the results of the survey and in consultation with the EU: Structural Reform Support Service and the Czech Ministry of Labour and Social Affairs, five countries were selected for case study on the use of task support, delegation, and shifting in disability assessments: Belgium, France, the Netherlands, Norway, and the United Kingdom. The project group discussed details of the survey with informants in the respective country, and expanded the information on why, how, and with whom task transfer was carried out. Key terms are listed in Box 2.

Box 2. Key terms

Task transfer is an umbrella term that includes task support, task delegation and task shifting

Task support: involves administrative and logistical support tasks, usually from administrative staff.

Task delegation: delegation of tasks or parts thereof to a third party, depending on the situation, under the supervision and responsibility of the physician.

Task shifting: structural redistribution of tasks between professions, including professional responsibility.

Work disability: refers primarily to the employment situation of the client who is unable to stay at or access work. (It is opposed to general disability)

General disability: health-related impairments, activity limitation and participation restriction pertaining to life situation in general (synonym: daily life disability)

Social insurance physician (SIP) is usually employed by the social security agency to do medical assessments and give medical advice. The terms medical adviser or medical counsellor are also used (regardless of tasks).

Social Medical Nurse (SMN): nurse in charge in the medical service of the social insurance institution (without care tasks).

Health care professional (HCP): any health actor: physician, nurse, physiotherapist, psychologist, occupational therapist, etc.

A*dministrative staff*: secretaries, medical secretaries, technical agents and IT staff. They are supposed to master office work, medical vocabulary and diagnostic coding.

4. EUMASS Survey

4.1 Task transfer in assessments for disability

15 out of 20 EUMASS member states (75%) responded to the questionnaire. Of these 15 countries, seven reported to have introduced task transfer in the assessments of work disability (table 1): Belgium, Croatia, Finland, France, the Netherlands, Norway, and the United Kingdom. In Belgium, Finland, the Netherlands, and the United Kingdom further task transfer was planned, and, in addition, Poland planned to introduce task transfer in the near future.

Table 1. Existing or planned task transfer in assessment for work or general disability in 15 EUMASS countries

	Yes	No	No answer (NA)
Has task transfer in medical assessment for work disability been introduced in your social security system?	7	8	0
Is task transfer in medical assessment for work disability considered or planned in the future?	5	9	1
Has task transfer in assessment for general disability been introduced in your social security system?	6	9	0
Is task transfer in assessment for general disability considered or planned in the future?	2	12	1

In the assessments of general disability, six countries reported to have introduced task transfer of some kind: Belgium, Croatia, Finland, Norway, Sweden, and the UK. Only two, Belgium and the UK had plans to introduce further task transfer in the assessments for general disability. In their responses, some countries made it clear that the assessment of general disability was not within the scope of the social security agency, but carried out by a different agency often at the local or regional level.

Some comments could not be clearly interpreted as “yes” or “no”. These responses can be seen in Appendix B.

4.1.1 Task transfer in the assessments of work disability

Task transfer in assessments of work disability was mainly reported from Western European and Nordic countries (Figure 1). However, the transfer in these latter countries occurred many years ago, and is now an integral part of their way of handling work and general disability claims.

Figure 1. European countries with transfer of tasks in work disability assessments

In the seven countries reporting any kind of task transfer in work disability assessments, six reported task shifting while four reported task delegation and four reported task support (Appendix B; tab 2). In Finland and Norway only task shifting was reported but the other countries had two or three types of task transfer.

Several professional groups were reported to have taken over tasks from the social insurance physicians. Most frequently were nurses given new tasks (4 countries) but also physiotherapists (2), psychologists (2), and secretaries (2). Social workers, pedagogues, rehabilitation specialists, and occupational specialists were singularly mentioned.

There were a large number of reasons mentioned for task transfer. Most frequently was shortage of physicians mentioned as a cause (4 countries), but also aims to reserve the competence of physicians to more complex cases (2), and reduce their workloads. It was mentioned that introduction of multidisciplinary work, financial restraints, and a need to speed up the process time in disability evaluation was important. To underpin the decision for task shifting and delegation it was mentioned that the quality of the assessments after task transfer was better or not shown to be lower than before.

The change in tasks was based on administrative regulations (6 countries) and on law (4 countries). In the case of the Netherlands, it was also necessary to reach employment agreements on task delegation. The transfer of tasks was supervised within the social insurance institution in five countries (in three cases by the social insurance physician) and by external bodies in four.

Education and training of the professionals taking over new tasks and of the social insurance physicians whose work changed, was reported from all countries having had task transfer. The extent of this training varied and so did the content.

The outcome of the changes was commented upon by six countries. In one country no outcome evaluation had been done. Many different and positive outcomes were mentioned such as more interdisciplinary work, more integrated assessment of work disability, equalized criteria, improved quality, quicker process time, more time for complex cases, more claimant contact, less appeals, and no quality change. The United Kingdom reported remaining capacity problems in spite of task shifting. No cost/benefit analysis was reported from any country.

4.1.2. Task transfer in assessments for daily life disability

Task transfer for daily life disability was reported from fewer countries but in the same regions of Europe as task transfer for work disability (Table 1). Only in the report from Belgium were the areas specified: 1. Assessment of the need for a) wheelchairs and other mobility equipment b) home care nursing services and c) institutional nursing care. 2. Assessment for extra compensation for persons with a handicap or needing personal assistance in daily life, whatever the origin of the disability (Appendix B; tab 3).

4.2. Discussion of findings in survey

4.2.1. Methodological issues

The response rate – 75 % - was acceptable. The reasons for non-responding were known for four of five countries: One member country was not sent the survey since it was the target country for later technical support, and in three countries the representatives were either absent from work or leaving their position.

4.2.2. Regional variations

There was a tendency towards regional patterns in responses to the survey. **Eastern European countries** (Poland, Romania, Slovenia) currently had no transfer of tasks. Poland, however, reported plans for task transfer in the future with task support being given to administrative staff to computerize sick leave certificates. The changes in Croatia consisted of implementation of multi-professional teams for decisions where the social insurance physician still carries the main professional responsibility. Due to ageing and migration of doctors from Eastern European countries, there was recognition of the risk of shortage of social insurance physicians and transfer of tasks might become needed in the future.

In the responding **Southern European countries** (Italy, Portugal) no transfer of tasks from physicians to other professional groups had taken place or was planned. In both, the social insurance physicians form their assessments independently of other professional groups.

The Nordic countries (Finland, Iceland, Norway, Sweden) have many similarities in welfare provisions and social insurance organisations. Formal decisions on benefits are taken by

social insurance officers and the role of the social insurance physician is to provide advice based on written medical information. No clients are met face-to-face. This distribution of tasks dates back to the 1950's, has not been changed in the last years, and there are no plans for changes is the near future. The assessment for general disability is done in the same way as assessment of work disability.

In the **Western European countries** (Belgium, France, Germany, the Netherlands, United Kingdom) considerable task transfers have taken place in the last decades, except for German Health Insurance. All types – shifting, delegation, and support – have been used. Threatening shortage of social insurance physicians and a wish to improve efficiency and quality have been frequent reasons to introduce the changes. Transfer of tasks has also taken place in the assessment of general disability.

As a summary, the transfer of tasks has mainly taken place in Western European countries. In the Nordic countries, the social insurance officers were given more tasks a long time ago with no structurally important changes in the last years. In Southern and Eastern Europe transfer of tasks has so far been rare.

4.2.3. Mechanisms

As a rule, combinations of task shifting, delegation, and support were used when transfer of tasks was implemented in a country. It is highly probable that the social insurance administrations, when they face challenges from shortage of physicians and increasing work load, seek several ways to uphold efficiency and quality in the assessment processes.

The main group receiving new tasks was nurses. This finding is in line with the development in the health sector, where nurses have been taken over tasks from physicians in general practice, preventive medicine, drug prescription, and home care (Kroezen 2011; Niezen 2014; Laurent 2018). But it is equally evident that a wide variety of health and non-health professionals was engaged in transfer of tasks, probably depending on local supply and needs.

Education and training for new tasks was uniformly introduced together with the transfer. To keep quality at the same (or preferably higher level) seems to be a prerogative, and that necessitates a careful and thorough training. This has also been the experience from the health sector.

4.2.4. Outcome

In general, the respondents from countries with transfer of tasks expressed satisfaction with the outcome. Quality was largely kept, there was more time for social insurance physicians to focus on difficult cases, the added competence from other professional groups enhanced the assessments, and processing time was upheld fairly well. From the outcome comments in the survey, however, two important domains were missing:

1. There are few reported studies on the satisfaction of the claimants. It could be imagined that the claimant would be negative to meet another health professional rather than a physician as they would expect, and this could have effects on the outcome of the assessment.

2. There are few formal process and effect evaluations of the introduction of task transfer. For example, it is not known whether such transfer is followed by increased disability benefit rates in a country. Are other professional groups more lenient, or less?

5. Case studies

Seven countries were possible as objects for case studies as they had carried out transfer of tasks. The changes in Croatia, however, were restricted to introduction of a multi-professional team for decision making, and were not included. Finland had more comprehensive changes, but was not included for capacity reasons and because it has many similarities with Norway. Thus five countries were selected for in-depth case studies: Belgium, France, the Netherlands, Norway and the United Kingdom.

In Belgium and France all three types of task transfer are implemented, while more limited combinations are used in the other countries (Table 2).

Table 2. Type of task transfer in work disability assessments in 5 case study countries

Type of transfer	Belgium	France	Netherlands	Norway	United Kingdom
Shifting	x	x		x	x
Delegation	x	x	x		
Support	x	x	x		x

5.1. Belgium

Solidarity is the central concept of the Belgian social security system which consists of social security for employees (with important differences between workers, employees, and civil servants) and social security for the self-employed. Social security provides replacement incomes and supplement to income. Furthermore social assistance serves as a residual safety net.

Belgian social security fulfils three functions:

- In case of loss of the income from employment (unemployment, retirement, incapacity for work) a replacement income is paid
- For certain social charges (additional costs), such as medical expenses, a supplement to the income is provided
- Those who do not have a professional income involuntarily receive welfare benefits.

The legal framework within which social security is implemented is formed by Law in mutual health insurance organisations (also named mutual health funds or sickness funds) (1990), Law on social security (1944), and Law on Health and Disability Insurance (1994).

The global administration is assigned to the Ministry of Social Affairs, Public Health and the Environment and the National Institute of Health and Disability Insurance (NIHDI), which coordinates healthcare and disability insurance.

The implementation of the healthcare and disability insurance is assigned to seven coexisting different mutual health funds. Each of the seven recognized health insurance funds offers the compulsory free health insurance. It is paid by employer and employee contributions to social security and by subsidies from the federal government. The compulsory insurance pays (in part) the medical benefits recognized by the National Social Security Institute (RIZIV-INAMI). The compulsory health insurance also pays the benefits in the event of incapacity for work.

In addition, the health insurance funds also offer additional insurance policies. In this way they reimburse benefits that are not or insufficiently covered by the compulsory health insurance. The health insurance reimburses most of the costs of medical advice, treatments, medicines, use of medical aids or other facilities based on medical necessity.

5.1.1. The medical advisers

The medical advisers are insurance physicians and hence experts in social legislation and the regulation of compulsory health insurance. They play a key role in the health insurance fund. They assess and check whether someone is entitled to an allowance for a particular treatment, a medicine or a medical dispensation and advise both beneficiaries and providers. In addition, they evaluate whether someone meets the medical conditions for incapacity for work and advise on healthcare issues. Thus the medical advisers inform, evaluate, advise and provide information to the health insurance claimants and health care

providers about the application of the health insurance rules and the recognition of incapacity for work. They evaluate the recognition of incapacity for work and advise on vocational rehabilitation and social support, in order for the claimant to receive the most suitable care and treatment within the insurance. The medical advisers are assisted by the social service of the health insurance fund.

5.1.2. Transfer of tasks

There is an ongoing process in Belgium with implementation of several types of task transfer, mainly as task delegation. In the assessments of work disability delegation depends on diagnosis. Nurses carry out general interviews, physiotherapists are in charge of evaluation of musculoskeletal diseases and psychologists evaluate psychological disorders. The implementation takes place at both national/federal and regional level and must ultimately be implemented throughout the country. More task delegation and shifting is still under discussion.

Task delegation in the different sickness funds is supervised by the department of medical evaluation and control of the National Institute for Health and Disability Insurance (NIHDI). The team involved in task shifting management is a platform of the medical directions of sickness funds and the board of NIHDI in collaboration with the national and regional governments.

5.1.3. Reasons for change

The need to start with task transfer was the shortage of insurance physicians, which was mainly caused by an increasing imbalance between the tasks that have to be performed and the time available to do so. First of all, there is a demographic effect, because the majority of the currently employed insurance physicians belongs to the so-called baby boomers (born in the 1950's and 1960's), so the number of approaching pensions is greater than the number of young doctors being recruited. Besides a population increase means that the number of claimants rises.

Because of epidemiological evolutions, with an observed gradual shift from physical to mental problems and more complex pathological situations, as well as sociocultural evolutions (e.g. jurisdictionalization, linguistic problems) more time is needed for assessments. Moreover, in recent years new tasks concerning vocational rehabilitation have been added to the insurance medical assessment. This affects the cooperation with the general practitioners and the occupational health physicians. Due to all these changes, the work incapacity assessments have become more complex and time-consuming. Assessments in health care show the same increase in work pressure due to an ageing population, multi-pathology and more complex reimbursement terms.

In addition, institutional developments, with transfer of certain matters to regional authorities, cause more work for insurance physicians.

Another reason for the shortage of insurance physicians is the decreasing job satisfaction and attractiveness of the profession, for which the main reasons are:

- The content of the job has become outdated
- Multiple conflicts with the clinical world
- Salary backlog (e.g. in relation to the earnings of a general practitioner)

The shortage of doctors meant that there was a need for a more comprehensive approach. So the work is now or will be executed in multidisciplinary teams.

5.1.4. Multidisciplinary teams

The insurance physician directs a qualitative team of paramedical staff, other health professions, social workers, employment advisers, ability managers and administrative staff, to achieve an optimal evaluation of a work incapacity claimant or to assess the need for health care.

The team works under delegation of the insurance physician and aims for higher quality of the assessment by collecting different point of views. The new approach should lead to a better insight of both the (para) medical and socio-professional factors in the evaluation and thus offer:

• More possibilities for early intervention in occupational disability
• More intensive guidance towards reintegration
• More extensive and focused cooperation with the regional employment services
• More intensive communication and cooperation with the general practitioner and the occupational health physician
• The realization of optimal communication and guidance for work resumption and social reintegration
• Integrated evaluation of healthcare applications
• The optimal use of the specific talents

The medical and paramedical staff involved in multidisciplinary evaluation is employed by the sickness funds.

5.1.5. Task transfer in other assessments

Recently, task transfer has also been implemented for assessments of general disability. This covers the assessments of need for wheelchairs and other mobility equipment, home care nursing services and institutional nursing care. It also covers the assessments for extra compensation for persons with a handicap or needing personal assistance in daily life. It is considered also to include the assessments of need for extra support for elderly persons.

The data collected for the Belgian case study are mainly from comprehensive national official documents (reports, law, instructions, regulations) describing the process, and may slightly differ from daily practice since the actual implementation is still in the starting phase.

5.2. France

In France, social protection is secured by agencies funded by workers and employers, whose payments are backed by complementary taxes. There are 30 agencies or funds, depending on occupation (farming, professional, military, railways, etc.) The main fund is the CNAM (National Workers Health Insurance Fund) which runs the health branch of all private-sector salaried workers, and which includes, since January 2018, independent workers. It represents 85 % of workers in France and is what will be described in the study. Social security is divided into five branches: health, industrial accident and occupational illness branch, old-age branch, family branch, and the contribution and collection branch. The Health insurance branch includes five fields: health, disability, maternity, paternity, and death (for more information, see CLEISS 2018). The first two will be considered in the study. The doctors involved in disability assessment are the social insurance physicians (SIP: *médecin conseil* or medical adviser), employed by the agencies. The doctors involved in ability assessment are the occupational physicians, employed by the enterprises. The task transfer from SIP will be considered in the study.

5.2.1. Comprehensive transfer of tasks

Task support has been introduces in two areas:

One is performed by the **Social Medical Nurses (SMN)** who are registered nurses with at least 5 years of previous work experience. They are full-time salaried employees of the CNAM and have been employed since 2016. They are in charge of collecting information preliminary to doctor's advice on healthcare usage and reports from hospitals and specialists. Nurses can take the initiative and make pro-active predictions of the doctor's needs. The SMN/doctor ratio depends on medical shortage.

The other task support comes from the **Health Fund Counsellors (HFC)** (Conseiller en Santé de l'Assurance Maladie). Basically, they are members of the CNAM administrative staff, trained to intervene in the follow-up of claimants on long-term sick leave and/or having chronic diseases to facilitate compliance, orientation, and information. Thus, they could also advise patients with partial disability on their administrative and professional course. The HFCs currently take part in the nurse tasks but in the context of health follow-up.

There are two fields of **task delegation:**

There is a delegation of tasks to the **SMN** in the preparation of medical records concerning the allocation of sick leave and disability benefits, through a targeted collection of relevant information. They can decide when a medical consultation has to be organized. But the SMNs do not physically examine the patient, nor do they take part in the medical decision toward the agency, which remains the doctor's responsibility.

The **HFCs** take part in the task of medical counselling from the doctors and nurses on what to do in case of standard, currently identified health conditions (diabetes mellitus, obesity, low back pain, etc.), and in coaching the patient for financial or administrative problems.

Task shifting has been introduced in two areas:

A task shift for the **SMN** has been implemented in the restricted field of assessment of total permanent disability and related benefits. A nurse can tell, as well as a doctor, how the claimant moves, eats, get dressed, etc. There is no need of access to a diagnosis to perform these tasks. This is very useful for claimants with severe work disability needing an examination at home.

Another task shift relates to the **HFC** at the end of a consultation. The doctor is supposed to explain the decision to the claimant, especially for a refusal. This is time consuming and difficult to perform in a restrained context**.** So the HFC can explain and guide the claimant, for example: what to do or not to do with a temporary disability, the role of the occupational doctor, retraining, and management of the balance between unemployment and disability.

There are 3 levels of health fund regulations in France: departmental (district), regional, and national (federal). The onset of task shifting was given by the head of the CNAM. However, a very wide delegation of organisation was granted to the departments under the supervision of the regional authority. The only redline in the memorandum framework was that the ancillary staff could not give medical advice directly to the agency.

5.2.2. Reasons for change

Several reasons lie behind the transfer of tasks. It is necessary to meet an *increase of needs* of claimants for medical advice about sick leave and retirement secondary to the aging of the population. There is a *decrease of supply,* both decrease and aging of the medical staff and declining attractiveness of the medical adviser job. Finally, there is a need for *internal adjustments* since staff whose basic office tasks are eliminated by computers are directed towards new skill perspectives. There is also is a shift in the missions of the Health fund from the traditional distribution of benefits towards case management and taking a more active role than before in work disability prevention (Fassier 2019).

The changes were initiated by the CNAM. There is no change in legislation in this specific topic, but in 2018 the government initiated a new profession: “medical assistant”, with the purpose of reinforcing the general practitioners on administrative tasks and health counselling in *healthcare*. The medical assistants’ tasks in the health sector are quite similar to the Health Fund Counsellor in insurance medicine.

5.2.3. Control and supervision of the new procedures

The medical advice prepared by the SMN allows for payment of sick leave on individual or batch mode under the supervision of the *head physician* or their delegate.

There is a process for controlling conformity to the medical regulations through a random sample of five medical reports a week per production unit. The control process is under the responsibility of the Health fund regional authority.

We know that medical advice in the area of disability is poorly replicated (Barth et al 2017). The least that could be done to improve this is, first, a weekly control to check that the assessment is shared by the nurses and the doctor; second, that the SMNs do not give negative advice and send the case back to the doctor when he/she considers it contentious.

5.2.4. Training of new and old staff

New and external staff in the SMN pool are trained in the general regulation of the Health fund, and secondly, trained to their specific task of patient and doctor assistant. The ultimate training of the SMN lasts for one year on average, at the end of which the MSN can prepare medical advice. The trainer is the physician in charge of the service or his delegate.

The established *and internal staff* are already aware of CNAM regulations, and only have to master the task of health fund counsellor of the claimant. The trainers are the SMN of the service.

The transfer of tasks is quite recent. The roll-out of HFC began in 2015 in 3 pilot regions. In 2016 the SMN started to reform and it is now nationally widespread. There will not be further major changes in the field. However, some legal amendments will have to be made to cope with the national public health regulation of the new tasks.

5.2.5. Was the intention met?

The SIPs are generally happy to have fewer administrative tasks which was the intention. The reform is considered to be satisfactory by the authorities, which has been seen by the hiring of more nurses.

No systemic evaluation for the replacement processes has been carried out. Some very limited measures have been implemented, as mentioned in 5.2.3.e, but they have never been published. The evaluation is difficult for technical and political reasons. First, the SMNs are involved in more tasks than sick leave or disability assessment, such as encoding diagnoses and control of regulations. Second, the early extension of internal coverage by the medical service in information, coaching, counselling, and advice on rehabilitation options, makes it more complicated to carry out comparative discrete time series.

From a political standpoint, the unions of medical advisers, whilst not directly against the change, are suspicious and see it as a possible competition.

5.2.6. Views on the change

The reforms have sometimes been challenged in certain areas because of some misunderstanding (see disadvantages), but are now largely accepted.

Advantages:

- The service to the claimants is kept within an acceptable time frame in places which have severe shortage of physicians.
- The saving of time for medical assessment, however difficult to measure, is considered as important and useful to sustain the quality of service.

- The general design leads to a better understanding and coaching of the claimant.

Disadvantages:

- There is a possibility of conflicts between the actors on the limit of tasks about the medical decision. The SMNs are allowed to gather information, but not to give advice to the agency, even though they can do that to the medical adviser. This redline can be unclear. An unclear delineation of tasks and the rise of multiple counsellors surrounding the patient can lead to confusion and misunderstanding.
- The management of the process is a decentralized responsibility which is rare in France. The advantage is ease of the implementation, while the disadvantage is a complicated task for the regulators.

Limitations:

- In the event of complex cases or when benefits are turned down, the doctor is still needed.
- Legal measures might have first been required to address the problems mentioned above. This has not been carried out, probably to avoid resistance from the board and/or from the unions that could have challenged the unclear delineation of SMN and doctors.

5.2.7. What problems were met?

Conflicting situations were sometimes seen. The delegation of tasks to nurses is legally supported by a decree of July 29th, 2004, “Décret de compétence de la profession d’infirmier”, describing how far the nurses can go in medical tasks. This is extended to monitoring the patient, counselling, and comprehensive care management, but not going so far as to specify a diagnosis or disability, which is currently reserved to doctors. The critical issue is that nurses cannot examine a claimant nor give any medical advice to the Agency. This would be considered as an “illegal practice of medicine“. This highlights the difference with the Scandinavian and UK models in which civil servants make a decision about a claimant. A weakness in the legal frame is clearly present and needs to be resolved by further legal steps. One of them is the on-going “Plan santé 2022” presented by president Macron on September 18th, 2018 introducing the “medical assistant“ for the general practitioner, whose tasks consist of preparing records and guiding the patient through the health system. The SMNs are in charge of that now. The nurse will collect medical data about a patient’s condition, and give advice to the doctor who makes the decision. The limitations are: no physical examination, no negative advice (denying pension or sick-leave).

5.2.8. Keys to success

The storytelling of the implementation is a major key of success. It must not be presented as a pathway to save money - which it probably is not - but as a new interactive work organisation, improving claimant as well as staff conditions. Whatever their specialization, all doctors have to cope with some hours of administrative tasks every day. So, all attempts to discard parts of this burden are generally welcome. Furthermore, the tasks of all the actors must be properly defined and, if necessary, reallocated.

5.2.9. Economic consequences

The question of saving money from delegation or shifting of tasks to the SMNs remains unclear. We must be cautious about the economic consequences as related in 5.2.2. However, this has only been measured in the department of Val d'Oise (Ile de France). The investigation included 11 doctors and 4 hired SMNs. It was found that the supply of nurses led to saving of two full-time doctor jobs. The cost of a nurse is about half of a doctor's wage at the beginning of their career.

5.2.10. Claimant views

Claimants are generally content to meet SMNs or HFCs who are more available and can spend more time explaining than the doctors usually do. Some of them may be surprised not to have been examined by a doctor, but, as previously seen, the MSNs do not turn down benefits, so there is no harm for the patient from ancillary staff.

5.3. The Netherlands

The Employee Insurance Agency (UWV) is an autonomous administrative authority which is commissioned by the Ministry of Social Affairs and Employment to implement employee insurances and provide labour market and data services.

The Dutch employee insurances are provided for by laws such as the WW (Unemployment Insurance Act), the WIA (Work and Income according to Labour Capacity Act, which contains the IVA (Full Invalidity Benefit Regulations), WGA (Return to Work (Partially Disabled) Regulations), the Wajong (Disablement Assistance Act for Handicapped Young Persons), the WAO (Invalidity Insurance Act), the WAZ (Self-employed Persons Disablement Benefits Act), the Wazo (Work and Care Act) and the Sickness Benefits Act.

UWV is a public organisation with a social mission. UWV's Social Medical Affairs department (SMZ) carries out socio-medical assessments and gives participation advices. UWV's vision is in line with the general opinion in the Netherlands that people are at their best when they can participate in society by working. Only if work is impossible, income has to be ensured. The mission of SMZ is that the client can take the decisive step towards participation.

The social ambitions of SMZ are:

- SMZ is the entitlement assessment agency in the field of Work and Income and
- the knowledge-intensive service provider that performs its social mission in an innovative and professional way.

SMZ has traditionally been the executor of statutory regulations such as short-term and long-term sick leave and disability pension, on behalf of the Ministry of Social Affairs and Employment (SZW) in the Netherlands. SMZ now also offers its services to third parties, including municipalities and the organisation that implement national insurance schemes in the Netherlands (SVB). This means that the SMZ environment is becoming much more dynamic and there is a great need for flexibility: the various clients require different types of advice and assessments. UWV wants to indicate and advise their internal and external clients according to need and expertise.

5.3.1. Task delegation and task support

Since 2011 SMZ has been working with task delegation and task support. Task shifting, up till now has not been considered. After a pilot at a few offices of UWV had the desired results, the working method was implemented throughout SMZ. Task support and task delegation contribute to achieving SMZ's ambitions and become one of the pillars in achieving the organisational goals. It also contributes to increasing the added value that SMZ can deliver socially.

UWV-SMZ's vision on task delegation in short:
Task delegation creates opportunities for the further professional development of the insurance physician and for the innovation of their field. Task delegation also contributes to resolving long-term capacity issues for insurance physicians. As a result, UWV can respond

more flexibly to questions from laws and regulations and to changes in its services. UWV sees a place for task delegation as a standard part of its future work process.

5.3.2. Reasons for change

UWV beliefs that an organisation with a good innovation climate continues to lead the way as the vitality of the organisation is determined to a large extent by the extent to which it is able to innovate and through the ability to attract, train, and retain talent. Innovation goes hand in hand with the professionalization of the disciplines. Both are the main sources of further growth in the quality and effectiveness of social medical care for the clients. That is why SMZ invests heavily in the field through academisation and innovation.

Task support and task delegation are an innovation of the field of insurance medicine. Thanks to this new, innovative way of working, the delegation of tasks to support staff, the professional comes more into his or her strength. The insurance physician focuses on his/her unique expertise and increases his/her added value for the organisation. The insurance physician works more remotely, while remaining ultimately responsible. The insurance physician delegates duties legally and gives guidance.

Task delegation contributes to the further quality improvement of the service. The individual insurance physicians ensure better quality because they focus on their core expertise. The quality approach also applies to the professional group within SMZ as a whole. As shown by monitoring through the use of dashboards, the insurance physicians free up more capacity due to task delegation. Hence they deliver more production and are thus able to work cost-neutral with a delegate.

5.3.3. New role for the social insurance physician

Working with task delegation sets new requirements for the insurance physician. The insurance physician with task delegation, in addition to its role as social medical assessor, also has a coaching and leadership role. The insurance physician is also accountable for achieving higher productivity and effectiveness. In this way, task delegation is cost-neutral. These new requirements improve the career perspective of the insurance physician through the newly created function of insurance physician task delegation. In addition, the extra capacity can also partly be used to deal with new developments, innovations and new products from insurance medicine.

In general task delegation promotes the job satisfaction of the doctors who work with task delegation. As professionals, they come into their own strength, get more space and may rightly be proud of the increased quality, efficiency and effectiveness.

In a work disability assessment in social insurance in the Netherlands the degree of work incapacity and hence the amount of benefit is determined by the difference between what someone would have earned if he had not stopped his work due to health problems and what he could still earn despite the illness or impairment. An insurance physician and a

labour expert carry out the disability assessment in close cooperation with each other and in consultation with the claimant. The insurance physician determines the functional capabilities of the claimant. The labour expert examines which functions are in principle suitable for the claimant.

The insurance physician, who is a fully trained and registered medical specialist, will be provided with data that have already been collected. Often by a doctor from an occupational health service, but in cases where no occupational health physician is involved, with additional information via task support or task delegation. The Medical Secretary or Social Medical Nurse can obtain information from therapists (doctors, psychologists, social workers, psychotherapists, physiotherapists, etc.).

5.3.4. How does task support and task delegation work?

Insurance doctors only delegate their own tasks to the Social Medical Nurse or Medical Secretary, from their own work package. The Social Medical Nurse or Medical Secretary works under the direct responsibility of the insurance physician and is coached by him or her in the execution of the work. In addition, the insurance physician provides subject-specific instructions to the delegate. The insurance physician only delegates tasks that can be legally delegated.

It differs for each insurance physician which tasks he or she delegates. Tasks that insurance doctors in practice delegate most to a Medical Secretary are:
1. Work out consultation notes
2. Summarize the claimants' history
3. Prepare files for consultation
4. Request additional medical information from specialists
5. Contact claimants for additional information

Tasks that insurance physicians most often delegate to a Social Medical Nurse are:
1. Carry out follow-up assessment
2. Collect information
3. Prepare problem analysis
4. First contact with the claimant
5. Monitoring the claimant / follow up actions
6. Draw up an action plan

A Legal Framework has been developed, which outlines the legal context within which insurance physicians and delegates can/have to operate and provides tools to do so.

5.3.5. Education and training

The first three months of task support and task delegation are considered to be training time. Besides, both the insurance physician and the delegates need education.

The insurance physician needs to be educated and trained in functional leadership. The education consists of workplace training and a three day course including delegation of work, discussing and stimulating quality improvement of delegates, coaching and facilitating delegates (giving feedback), while taking on his/her own professional responsibility and conferring with the delegates in the context of the Human Resource Management cycle.

The delegate needs task-oriented education and training, depending on the required competencies and the professional background. The medical secretaries have a six day training on how to proactively recognize, collect, complete and record required data and the elaboration of social medical reports.

The social medical nurses have workplace training with 11 contact days on how to collect and analyze relevant social medical information, prepare and draft medical reports and problem analyses, and advise on follow-up actions.

The quality of the work of the insurance physician and the delegates is tested by means of the usual monthly quality test of the files from the centralized sample.

The ability to work is not only determined by the functional possibilities, as determined by the insurance doctor. In order to be able to work, relevant knowledge and adequate skills are also important. The labour expert therefore explores the training and employment history of the client in a face-to-face interview. Information from the employer can be a useful addition to the information provided by the client.

5.3.6. The consequences of task support and delegation

The insurance physician and the labour expert have traditionally been assisted in the team by legally trained employees and administrative staff. Task support and task delegation has also a positive effect on this team. The deployment of the social medical nurses and the medical secretaries brings a different dynamic to the team. The team has to deal with a broader function mix, which offers opportunities to steer on the right and proper deployment of an official.

In addition, task delegation gives an impetus to the further development towards result-responsible teams, which are small working units, which are *responsible* for their own performance targets. After all, with the choice of task support and task delegation, the insurance physician is given more space and responsibility for the quality of services and results. In fact, the insurance physician functions with the delegates in a small way as the Result Responsible Team functions as a whole.

Task delegation puts the focus of the professionals on their professional skills. Having sufficient capacity of insurance physicians is an important condition for achieving the ambition of the indication assessment agency. The capacity that has become available offers more possibilities and flexibility to deploy insurance physicians in the places where they are needed. This can vary per period and per district. With this flexibility, SMZ can respond

better to new legislation and to requests from other internal and external clients and invest more easily in the innovation of the service through flexibility.

In addition, UWV is facing a major demographic shift within SMZ in the coming years: a large proportion of insurance physicians will retire within a few years. This shift can be better accommodated through task delegation.

Finally SMZ is less dependent on the hiring of external insurance physicians due to the increased capacity, and it can fulfil its agreements with other divisions about the deployment of insurance physicians.

The number of assessments performed and cases handled by an insurance physician with task support or task delegation is higher, because various administrative and substantive tasks are delegated, hence the insurance physician can focus on his/her expertise.

As a public service provider, UWV must deal responsibly with public money. Cost neutrality, meaning that the costs of the services that UWV provide remain the same, was and is therefore inextricably linked to and a precondition for task delegation.

5.4. Norway

Norway is a Nordic welfare state adhering to basic principles such as universal arrangements, equality, income and expenditure compensation in unemployment, sickness, maternity, invalidity and old age, redistribution during life span and between groups, and assistance towards self-sufficiency.

5.4.1. The large reform of 2006

Since the reform of 2006, the Labour and Welfare Administration (LWA) has been the main public welfare agency. It includes both the Labour and Welfare Services, run by the state, and municipal welfare agencies. Both before and after the reform, decisions on disability benefits and other health-related benefits are taken at local or regional offices of the LWA. Social insurance officers (SIOs) handle the claims, evaluate work ability, and make the formal, legal decisions on benefits. In most cases, the general practitioner has sent necessary documentation on the claimant's health and functioning to the LWA. Medical specialists, psychologists, and other professionals can also be requested to supply documentation. In addition, the officer meets with the claimant and collects written reports from employers and rehabilitation centers. Since the officers lack medical training, they can seek advice on the assessments of the medical grounds for disability from a social insurance physician (SIP) employed by the LWA. In almost all cases the SIP provides advice and recommendations only on the written documentation. Exceptionally, the SIP can meet the claimant when the communication around medical issues is unclear, when the case coordinator has been unable to retrieve necessary medical information, when medical treatment/rehabilitation has been seriously delayed, or when the SIP possibly can motivate the client to participate in vocational rehabilitation.

The reliance on assessments from the treating physician goes back at least to the first national laws on disability pensions from 1948, and is firmly rooted. The SIP has traditionally been a controller; checking the adequacy and relevance of medical documentation and if the claimant meets with the medical criteria for benefits. The SIP can request further medical documentation if that is necessary, in particular if the functional (dis)abilities are poorly described. In the reform of 2006, this basic structure was unchanged, but afterwards there has been an increased emphasis on the claimant's work and functional ability and less on the diagnosis. The social insurance officers have been given greater personal responsibility and independence, and they are not obliged to seek advice from the SIP. The social insurance officers act as case coordinators or case managers. They have highly variable background and training, but college and higher education is increasingly being required and becomes more and more prevalent.

Since the reform of 2006, the number of physician employed in the National Insurance Agency has been relatively stable around 120. Many are part-time employed. There is no significant shortage of physicians in Norway.

5.4.2. Gradual transfer of tasks

The general practitioner or other external physician completes the medical assessment of disability **(**a medical form) and sends it to the local LWA office. The social insurance officer (case coordinator) **evaluates work ability** where the medical assessment only is one part of the whole process. The case coordinator may ask the SIP for medical advice. If recommended by the SIP, the administrative staff can request additional medical information and/or medical assessment of disability from other external physicians.

As described, this process has basically been the same over many years. The gradual transfer of tasks that has taken place over the last decade is a slow increase in the responsibilities of the SIO, first and foremost in collection of medical information (input) and in larger independence in the evaluation stage (throughput). In these two stages of the process, a factual task shifting has occurred. The final decision (output) has basically remained unchanged as a task for the case manager. It has also been increasingly emphasized that the general practitioner shall not assess the claimant's work ability, but only the consequences of health on the general functioning. The overall evaluation of work ability should be done by the SIO. The task shifting has occurred on the national level, without regional or local variations of importance.

The insurance physicians were given additional tasks after 2006. To use their competence more efficiently, the SIPs should do education/teaching on health-related matters at the local/regional LWA offices, do more preventive work for sickness absence together with general practitioners, and give advice on rehabilitation matters in LWA. They have also been increasingly used in team work together with coordinators, managers, psychologists and other consultants for team assessments on short and long term health-related benefits.

5.4.3. Reasons for change

The large reform of 2006 had three main goals: a) to get more people into work and reduce the number of persons on welfare schemes; b) to create a more efficient administrative apparatus, and c) to make the administration more service-oriented (Aakvik et al 2014). To meet these goals, it was considered necessary to drastically change the tasks of the social insurance officers. They should be more independent, rely less on formal bureaucratic rules, and have closer contact with the clients. The need for a wider case coordinator role (and also case manager role) is probably the main reason for the transfer of tasks that has taken place after the reform. Thus, the transfer was not carried out to meet a need for more medical competence, but rather a political will to change the structure and aims of the labour and welfare agencies to meet the rising costs of welfare benefits and to modernize the agencies.

The reform was gradually institutionalized in 2006-2010. The changes in work tasks in the different professional groups were covered by amendments in the National Insurance Act from 1997, by introducing a new Law on Labour and Welfare Administration 2006, and by administrative regulations.

5.4.4. Supervision and training

The supervision of the social insurance officers is provided through internal and external systems that combine peer support and expert revision that are provided at distinct judicial management levels.

Training of case coordinators is currently being expanded to improve quality in performance of delegated tasks and make the process more efficient. Their training now follows the National Qualifications Framework for Lifelong Learning which is based on the European Qualifications Framework and the Bologna Process (Ministry of Education 2011).

Training of social insurance physicians is also currently being revised by the LWA and by the Directorate of Health with implementation at the national level for all medical specialties common for social insurance physicians and other physicians with task in disability assessments[1]. Training in insurance medicine is currently part of the core curriculum at all medical schools in Norway. New guidelines for medical schools will be implemented in 2020 with a strengthening of learning outcomes of relevance for insurance medicine.

5.4.5. Was the intention met?

Several large evaluations have been carried out on the effects of the 2006 reform. The intention to give case coordinators a more extensive and independent role in the handling of disability claims, rehabilitation, and sick leave management appears to have been met to a large extent, but there has been small or no effect on benefit levels and on return to work. The changes in tasks have been readily accepted by the LWA staff, but there have been problems in limiting their work load.

5.4.6. Views on the change

The overall effects of the 2006 reform on return to work and on benefits have been evaluated in several large studies. Both Løvvik (2012) and Schreiner (2012) reported increased propensity for benefits, fewer clients returning to work, and increased claim processing time in LWA in the first years after the reform. In a later report (Fevang et al 2014), these negative effects had been normalized, and it has been hypothesized that the effects were temporary and caused by too comprehensive changes in the organisations. The reform has been extensively criticized for giving few desired outcomes, in spite of considerable costs. The three main goals have not been reached, possibly with the exception of a more client-oriented LWA.

Physician change of task has been given little attention in the evaluation reports (Aakvik et al 2014; Helgøy et al 2013, Schreiner 2012), probably because the change for SIPs has taken place very gradually after the reform, and the SIPs are peripheral actors in the LWA. The desired change of work tasks for the SIP (more work with education, prevention, and

[1] Social insurance medicine is not a distinct medical specialty in Norway.

rehabilitation) appears to have occurred to only some extent although it has been strongly requested by the LWA. At the same time have the SIP been asked to use more time on medical assessments in the claims of disability benefits to secure just and safe benefits management. In this situation with conflicting demands, the overall changes in the work tasks of SIPs have not been clearly significant.

More attention has been given to the changes in the role of social insurance officers (Helgøy et al 2013). In the beginning it was the clear intention to create a "generalist role", meaning that the officer should handle insurance claims as well as labour issues and matter of social benefits. This turned out to be time-consuming and inefficient, and the generalist role has in many local offices been downplayed in favour of a specialist role, where insurance, labour, and social issues are handled separately by different social insurance officers. However, the increased independence and personal responsibility of the social insurance officer has been kept.

There has been no evaluation of the quality of the medical assessments for disability after the reform. The social insurance officers still tend to follow the advice of the SIP. It has been pointed out that it is important for the physicians to distinguish between the more narrow medical assessment of disability and the broader assessment of work disability – where far more factors have to be considered than what a physician usually know about. It is a widespread opinion that the assessment of work disability should be an interdisciplinary task.

5.4.7. Social insurance physicians are more restrictive

For the Nordic social insurance agencies, it should be important to know the consequences of moving assessments and decisions from the social insurance physicians to general practitioners or case coordinators. An early study (Getz and Westin, 1996) indicated that SIPs often are more restrictive than general practitioners in suggesting benefits. It is possible that the distant position of the SIP vis-à-vis the claimant makes it easier for them to follow existing criteria and regulations. The strong and long-lasting personal relationship with the claimant could make the general practitioner more inclined to suggest benefits (de Boer 2004). The OECD (2010) has also pointed out that the dependence on assessments from the general practitioner could potentially lead to higher disability rates, and that it is necessary to check quality and accuracy of the GP's assessments in disability claims.

These finding has recently been confirmed in international studies. A systematic review of reliability has shown large variations between the treating physician and the SIP in work ability assessments, and treating physicians are often more lenient than the SIP (Barth et.al. 2017).

It is difficult to find studies on the consequences of moving assessment to case coordinators from the SIPs. The social insurance officer has a much closer connection to the client than the SIP has. Such closeness could potentially lead to more lenient assessments. Furthermore,

the social insurance officers use a discretionary method for their work ability assessments. Discretionary methods tend to give large variation in inter-rater reliability of decisions (Baumberg Geiger 2017).

5.5. The United Kingdom

The Department for Work and Pensions (DWP) is the Government department responsible for the administration and delivery of the two social security benefits payable to people of working age (16-64 years old) and in certain circumstances a different benefit for those children less than 16 years of age. Other benefits such as industrial injuries benefit and severe disablement allowance are beyond the scope of this review.

The two main benefits are Employment Support Allowance (ESA) Personal Independence Payment (PIP).

5.5.1. Employment Support Allowance (ESA)

ESA began to replace Incapacity Benefit in 2010. It is payable to people who are unable to work due to health conditions and aims to provide financial support and help seeking work provided certain criteria are met regarding previous social security contributions or low income. A "new style" ESA is also currently being introduced as part of wider reforms. The assessment for the benefit is called the Work Capability Assessment (WCA), the result of which places applicants into one of two categories, fit for work-related activity and the support group, depending on their degree of disability. Special arrangements are made for applicants with terminal illnesses who do not need to undergo the assessment with a healthcare professional (HCP).

The organisation and undertaking of the health assessments is carried out by a private contractor and not by the DWP but decisions as to eligibility are made by trained non healthcare professionals called decision makers who are DWP employees. Assessors may be doctors, nurses, physiotherapists or occupational therapists. Doctors and physiotherapists are able to assess any neurological condition. Nurses and occupational therapists who have undertaken relevant approved training may assess some neurological conditions such as peripheral nerve conditions but not central nervous system disorders. All assessors require to be approved by the department following a period of training on the benefit system and the assessment instrument.

5.5.2. Personal Independence Payment (PIP)

PIP has replaced disability living allowance (DLA) for adults. DLA is still paid to children up to the age of 15 at which time they are then invited to apply for PIP. The aim of the benefit is to provide a contribution towards the extra costs that disabled people face. It is paid independent of whether a person is in full time or part time work or whether they are in education. It is a benefit for daily disability unrelated to work and is not taxable. There are also no eligibility criteria in terms of previous contributions to the state social security system and no restriction on the financial position of the applicant. The same fast track arrangement for people with terminal illnesses exists as for ESA.

There are no doctors undertaking PIP assessments. Approved HCPs are nurses, physiotherapists, occupational therapists and paramedics. In PIP all HCPs are approved to

assess all conditions, including conditions affecting the central and peripheral nervous systems.

Legislation was changed many years ago to allow the move from doctor based assessments to allow the range of HCPs to undertake the work. All assessors require to be approved by the department following a period of training on the benefit system and the assessment instrument.

Healthcare professionals are recruited through open competition via national advertising in the medical and non-medical press and social media.

The following is a description of the PIP benefit but there are many similarities with ESA.

5.5.3. Process

The claimant completes an application form (either online or on paper) and sends it to DWP. The form asks about the impact of the claimant's health on 10 domains of daily living and 2 domains relating to mobility. DWP reviews the information and evidence supplied by the claimant and usually requests a medical report from the claimant's general practitioner (or, less commonly from a treating specialist). A face to face assessment at a local examination centre or at the claimant's home is then arranged by the contractor. The HCP performs a structured assessment looking at physical, psychological, sensory and cognitive impacts of the health condition(s). Each of the activities of daily living (e.g. washing, eating, managing medication etc.) has a scoring system and points are awarded for the level of disability for each activity. Points are added up and if they reach a threshold for the two separate components of the benefit - daily living and mobility - then the benefit is awarded at either a standard or enhanced rate by a decision maker who is employed by DWP. If the claimant does not agree with the level of award then they have the right to request that DWP reviews its decision (called a "mandatory consideration") but if they still disagree with the decision they can appeal to a social security tribunal where the case is reviewed either by paper or in a face to face hearing.

5.5.4. Reform

DLA for both adults and children was introduced in 1992 and did not undergo any reform until 2013 when new applicants were required to apply for PIP instead. The reform occurred as the then Government saw DLA as fundamentally flawed and financially unsustainable. The criteria for eligibility were loosely defined and often led to unclear and inconsistent decisions so applicants with similar needs were awarded different levels of benefit. Overall there was a lack of confidence that the benefit was focusing on people of greatest need. It also was intrinsically biased towards claimants with physical disabilities and followed more of the medical rather than the biopsychosocial model of disability. Finally the costs of the old DLA system without reform were projected to rise from £12 billion in 2010/2011 to £14 billion in 2015/2016 which was unsustainable.

One of the features of DLA was that medical evidence was only sought in around 50% of cases and a face to face assessment with an HCP occurred in less than 5% of cases – the benefit had been awarded largely on self-assessment.

5.5.5. Transfer of tasks

The introduction of PIP has occurred gradually since 2013 with new claimants being assessed for PIP and existing adult DLA claimants being migrated to PIP gradually from 2015. Migration of 2 million existing claimants continues as of 2018.

With the increase in face to face assessments for both new and migrating claimants there was a need for a large increase in HCPs. Doctors undertook the DLA face to face assessments but due to difficulties in recruitment, HCPs from other specialisms were recruited. Initially this was largely general nurses but now includes general nurses, mental health nurses, physiotherapists, occupational therapists and paramedics.

5.5.6. Reasons for change

There were a variety of reasons for task transfer and the move from purely doctor based to wider HCP based assessments, including the lack of availability of doctors, the volume and geographical spread of claimants needing assessment and reassessment, costs of the assessments and very importantly, the need for different skill sets e.g. mental health nurses to undertake assessments of claimants with mental health conditions and physiotherapists to assess claimants with musculoskeletal disorders.

5.5.7. Supervision and training

Each HCP undergoes training on the benefit and the application of the scoring system and have training on the treatment of specific medical conditions. Further training is provided dependent on the specialism. All assessors have continuing professional development. Training is both theoretical in the classroom and in the field.

The HCPs are supervised and audited when they begin to undertake assessments. Remedial support is available from more senior HCPs. The HCPs act as independent practitioners. Their work is not passed to doctors for checking (this is an example of task shifting).

5.5.8. Was the intention met?

DWP views the use of varied HCPs meets the needs of the service. Although reports completed by doctors were of good quality, the volume of assessments and the lack of an available medical workforce has brought about a wider use of healthcare skills. Quality monitoring is undertaken as an ongoing activity and supports the use of HCPs in the task. One disadvantage is that reports completed by non-doctor HCPs are sometimes viewed by claimants as inferior to both doctor assessments and to the views of individuals own family doctor reflecting a lack of understanding of the award of benefit being based on functional impact of conditions rather than the medical diagnosis.

Costing information on the impact of task shifting is not available.

5.5.9. Claimant views

There is no direct information on the views of claimants regarding assessment being undertaken by the range of HCPs but feedback on the general PIP process (application and assessment) generally has been sought in both qualitative and quantitative research and can be found at: https://www.gov.uk/government/publications/personal-independence-payment-evaluation-wave-1-claimant-survey-findings and https://www.gov.uk/government/publications/personal-independence-payment-evaluation-wave-2-claimant-survey-findings.

6. Discussion

6.1. Transfer of tasks in the health sector

Although task shifting in the health sector always has been a relevant policy issue, it became increasingly important after the outbreak of the HIV epidemics in Africa in the 1980's (WHO 2008). The underlying reason has mostly been shortage of physicians or of health professionals in general. In other instances, aims for higher care quality and cost containment have been important reasons for introducing changes of tasks for health professionals.

As opposed to social security (see 3.2.), there are many studies on task transfer in the health sector. They describe various types of transfer, which professional groups that are involved, and what factors obstruct or facilitate changes of tasks. The most frequent task transfer is task delegation, where nurses take over tasks from physicians but where the physician still has the medical responsibility. In an early study by Richardson and Maynard (1995) it was found that between 30 and 70 % of the tasks performed by physicians could be equally well tended to by nurses. Task shifting has occurred to a lesser extent, possibly because of institutional and professional hindrances (Niezen and Mathijssen 2014). Task delegation where the physicians still has the ultimate responsibility appears to be easier to implement. In primary health care nurses have, in some instances, taken over tasks from physicians and expanded them. This has been called a complementary role, meaning that a nurse extends the care of the physician by providing a new care service (Niezen and Mathijssen 2014).

Many studies have focused on the quality of care given by other professions instead of physicians. A recent Cochrane review showed that for some urgent physical complaints and for chronic conditions, trained nurses provide equal or possibly even better quality of care compared to primary care physicians, and probably achieve equal or better health outcomes for the patients (Laurant et al 2018). Tentatively, the reasons were suggested to be that nurses are closer to the patient's life style, have more time for exchange, and that claimants are less intimidated to disclose private problems. For elderly patients, Lovink et al (2017) showed that reallocation of tasks from physicians to nurses in healthcare may achieve at least as good patient outcomes and process of care outcomes compared with care provided by physicians.

A review on drug prescription showed that the legal, educational, and organisational conditions under which nurses prescribe drugs vary considerably between countries; from situations where nurses prescribe independently (task shifting) to situations in which prescribing by nurses is only allowed under strict conditions and supervision of physicians (task delegation) (Kroezen et al 2011).

In general, these studies have included task changes where specially trained nurses have taken over new tasks, either in shifting or in delegation. Task shifting seem to give ground for more professional rivalry than delegation, and it is strongly advised to consider

professional boundaries carefully before any ask task transfer is implemented (Niezen and Mathijssen 2014).

There are, as a summary, some important lessons to be learned from the use of task transfer in the health sector (WHO 2008):

- traditional healthcare workers will be reluctant to turn over their traditional roles to less highly trained workers
- the emphasis on task shifting might overshadow persistent challenges with training and retaining high-quality traditional healthcare workers
- task shifting must be aligned with the broader strengthening of health systems if it is to prove sustainable

6.2. Limitations in the study

The aim of the study was to obtain a description of task transfers in disability assessments across Europe. Basic data were collected in a survey, and by adding five case studies, it was possible to get additional details for comparisons. However, the great diversity between countries makes it clear that all aspects of norms, practice, values and culture in European social security cannot be taken into consideration in a mere descriptive study (de Rijk 2018). For a deeper understanding of the reasons for policies and actions, it would be necessary to conduct a stricter comparative cross-country study with pre-set criteria (Cacace et al 2013). This was far beyond the scope of the present study. The results must then be regarded with caution.

Both the survey and the case studies were based on reporting by key actors in the implementation of task transfers. The information might be affected by reporting bias, potentially exaggerating the positive outcomes of the reforms, and suppressing conflicts of interest and negative side effects. When, for example, quality or process control was described, it was not always possible to check if this actually was available or operational.

It is also possible that reporting was biased, since the issue of task transfer can be sensitive in relation to law-making and other political decisions. A substantial part of the information in the report comes from organisers of the task transfer. Although they might have wanted to downplay the negative sides of the reforms, they did not deny conflicting situations when the question was raised. These situations were often highlighted by members of unions or disclosed on the internet. By using several sources of information, we attempted to minimize this bias as much as possible.

6.3. New professional roles

The case studies show several ways of transferring tasks. These are carried out in line with the cultural traditions and specific organisations in the political and financial framework of the individual country. Case managers who usually have a coordination mandate, can be used as examples to illustrate the variety of professional roles. They may be social insurance

officers (Norway), nurses (the Netherlands), health fund counsellors (France), or health care professionals (UK).

To analyse similarities, Donabedian's model (1988) for institutional processes (a triage with input, throughput and output stages) can be useful. However, the example from France shows that task transfer also can be implemented after the assessment process itself. Here, health fund counsellors now draw up action plans and explain medical consequences to claimants as part of the follow-up after the decisions.

In the five countries we studied, administrative staff was mostly taking over tasks from the doctor in the input phase by collecting and summarizing information and contacting the claimants. In France, however, they also have taken over tasks in the throughput phase by carrying out follow-up assessments, and in the output phase by creating action plans, and explain medical decisions and consequences.

The Social medical nurse appears to be an emerging speciality in several countries. They are taking over tasks from the SIP in all phases of the assessment process, most importantly in the throughput phase where they more or less independently take part in the assessment itself. They can also have tasks in the output phase where they can request more information and form further action plans.

The shifting or delegation of tasks to other health or non-health professionals can be linked to the creation of new and expanded professional roles. This could make the new task more attractive. Norway and other Scandinavian countries are examples. The Social Insurance Officer, in addition to take over tasks from the SIP, also has got an increasingly independent role with higher decision latitude and more contact with the claimant.

6.4. Multi-professional teams

Although not specifically asked for, several countries (e.g. Belgium, Croatia, Norway, Sweden) reported that the assessment procedure itself undergoes changes. Instead of using a single social insurance physician (or a group of SIPs) to assess the claimant, assessments are performed by multi-professional teams to an increasing degree. It is claimed, on basis of scientific studies, that increased competence and the multifocal approach improve the quality of the assessment.

The introduction of multi-professional teams for assessment is often linked to a transfer of tasks. To include nurses, physiotherapists, occupational therapists, and psychologists in such a team probably relieves the SIP of some work load, and makes up for a shortage of physicians. From the survey, however, it is important to note that there are several reasons for the introduction of multi-professional teams, and shortage of health care professionals is only one, and subordinate in some cases. Also in countries without shortage, multi-professional teams are used increasingly to improve quality of decisions, and to replace a strict biomedical model for assessments with a bio-psycho-social model in line with the model of the International Classification of Functioning, Disability, and Health. Therefore it is

wise to regard the use of multi-professional team partly as separate from the issue of task transfer.

6.5 Education and training

The transfer of task can only be successful if the professional who takes over new tasks is adequately trained and competent to perform them. This is particularly the case for task shifting and task delegation where comprehensive education and training is necessary. In countries with extensive transfer of assessment tasks, such as in the UK, France, and the Netherlands, clearly defined training programs have been introduced to secure continuous satisfactory quality of the assessment procedures.

The example from the Netherlands also demonstrates that training for the delegating physician is required to secure good structural consultations between physician and social medical nurse on the delegated tasks. The delegating physician must be convinced of the nurse's ability and competence and consultation. Verifying and taking back of the assessment by the physician should always be possible. This role is new for the SIPs, and they need communication training.

6.6 Critical issues

When a transfer of task is implemented, there is considerable potential for inter-professional conflict. This conflict has been most clearly described between physicians and nurses, but could also occur between other groups. It seems necessary to reach a mutual agreement in advance on the limits of the tasks that should be transferred, and, in the case of task delegation, how the cooperation between physicians and other health care professionals should be handled.

A successful transfer of tasks is furthermore dependent on a continuous acceptable quality of the assessments. Where it comes to task delegation and task support (but not task shifting as occurs in the United Kingdom), the delegates still work under the responsibility of the physician, and hence the regular quality checks are applicable. Quality could be impaired when tasks are shifted to professions with shorter education and training. In that case, new quality procedures need to be set up. As mentioned in 6.5. Education and training, the case study countries have been very aware of this threat, and have implemented comprehensive training for the new professions.

It is also important to assess how well the claimants accept the new professionals they meet in the evaluation process. A shift from meeting with a physician to a nurse could potentially lead to lower satisfaction. This is further strengthened by differences in professional approach. Physicians, and the claimant's treating physician in particular, are often more prone to focus on disease processes and treatment. Social medical nurses, on the other hand, are trained to assess and discuss functional ability and work ability. For some claimants, the traditional physician approach focussing on cure and a sickness role is more attractive, and leads to less acceptance of the SMN.

The United Kingdom has experienced a shortage of other health care professionals after transfer of tasks from physicians. If a shortage of professionals depends on less attractive working conditions or less stimulating work tasks (and not on ageing or migration) a mere transfer of tasks will not be sufficient in itself. It will also be necessary to change the content of the elements in the job to avoid the situation when shortage just moves from one profession to the other.

It is still unclear if a transfer of tasks from one professional group to another can lead to a rise or a decline in disability rates. The outcome studies in Norway (see 5.4.7) could indicate that reforms of this type, at least in a shorter perspective, could lead to higher rates for benefits and this needs further study.

6.7. Are the described models transferable to other countries?

There are mainly two reasons for great caution when considering import of models to other countries or social agencies. First of all, a change, an ”implant”, of social protection from one country to another must take into consideration much more than the legal frame, but also culture, norms, values, and labour market characteristics (MacEachen 2019; de Rijk 2018). That being said, it is nevertheless possible to find new approaches: “Existing social contracts, policy systems, beliefs, and the priorities of implementing agents, along with complex multiple layers of local and national for new revised work policy approaches, can offer more or less fertile terrain for new or revised work disability policy approaches” (Cerna 2013).

Secondly, there is a management saying that “80 % of the success of a project results from the patterns of deployment”. Difficulties in implementation with unintended consequences can be a warning to any careless copy-and-paste transfer attempt of the described models. In Norway, the general practitioner has an important role as assessor of functional ability, and the personal relationship with the claimant could make him/her more inclined to suggest benefits (see 5.4). Such a model works in the Norwegian setting with frequent contact between the doctor and the Labour and Welfare Agency, but cannot be applied if too many general practitioners just write down reports from the claimant’s own statements without negotiation or critical judgement. This cultural feature has been described more than published and often escapes literature reviews. That means that comprehensive testing in different context is necessary before any implantation of new approaches.

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Appendix A: Survey questionnaire

Task support, task delegation, and task shifting in European social security

We want you to describe existing or planned changes of tasks in the medical assessment of disability (incapacity) in your social security system. Such assessments are usually done by social security doctors for work disability (work incapacity) benefits, or for other, more general disability benefits or supplements. Changes of tasks can take at least three different forms, and we want you to consider all when you write your answers:

- **Task support**: This is the simplest type, and only involves administrative and logistical support tasks. A typical example could be that the social security doctor gets help from administrative staff to acquire medical information from other doctors/hospitals. The doctor is still fully responsible for the assessment.
- **Task delegation**: This is more complex, and here the social security doctor delegates tasks or parts of tasks to another professional. A typical example would be that a nurse is given the task to interview the claimant. The doctor will supervise, review and approve of the report from the interview. The doctor is still fully responsible for the assessment.
- **Task shifting**: This is the most comprehensive change. The tasks or parts of tasks are given to another professional who then also has the full professional responsibility for that task. An example would be that a part of the medical assessment is carried out by a nurse who then also writes an independent report to the social security agency on *eg.* the claimant's functional abilities. The social security doctor is only responsible for those parts of the tasks that still remain in the doctor's domain.

About the survey:

First, we have questions about task changes in the assessment of work disability. These assessments are done both for short-term absence from work (sick leave, sickness benefits), and for long-term/permanent absence (disability pension, invalidity pension, incapacity benefits, or rehabilitation allowance). In some countries, *e.g.* Germany, rehabilitation benefits and incapacity benefits are given by different authorities. The extent of task support/delegation might vary between these authorities. Please specify in your answer which authority you are referring to.

Thereafter we have two questions on the assessment of ability in general (daily life disability). These assessments can take place, for example, to grant care allowance for a disabled family member, to give financial support for special aids (hearing aids, wheel chairs) and to give exceptional assistance to persons with serious disability.

Task changes in assessment for work disability

1. Has any task support/delegation/shifting been introduced in assessment for work disability in your social security system?

YES_____ NO_____

(If yes, please describe which tasks have been supported/delegated/shifted)

2. Is task support/delegation/shifting considered or planned in the future?

YES_____ NO_____

(If yes, please describe which tasks might be supported/delegated/shifted)

If task support/delegation/shifting has been introduced or is planned in the assessment of work disability, please answer question 3-10. If not, you can go directly to questions 11-13.

3. To whom have tasks been transferred?

4. What was the reason for introducing these changes?

5. How is the transfer of tasks (legally) regulated?

6. If you have or if you plan to have task delegation in your system, how is supervision of the delegate arranged?

7. Is education/training provided for the delegate?

8. Is education/training provided for the delegating social security doctor? What does it consist of?

9. What has been the outcome of task support/task delegation/ task shifting?

10. How is the medical assessment of work disability carried out by the social security doctor in your country?

a. In a face-to-face meeting/consultation/examination with the claimant

b. The claimant is not met in person. The social security doctor only assesses information provided by other doctors/hospitals

c. Both a. and b. are often used

Task changes in assessment for general (daily life) disability

11. Has any task support/delegation/shifting been introduced in assessment for general (daily life) disability in your social security system?

YES_____ NO_____

(If yes, please describe which tasks have been supported/delegated/shifted)

12. Is task support/delegation/shifting considered or planned?

YES_____ NO_____

(If yes, please describe which tasks might be supported/delegated/shifted)

13. Do you have any further comments on task support/delegation/shifting? What are the advantages/disadvantages?

Thank you for your answers

Appendix B: Table 2 and 3

Table 2. Task transfer in work disability assessments in 15 European countries

		BE	CR	FI	FR	GE	IC	IT	NL
1	Has task substitution been introduced in work disability assessments in social security?	yes	yes	yes	yes	no	no	no	yes
	If yes, describe	Federal level: task delegation and task support. Regional level: task shifting.	Council of experts (assessors)	Officers make final decisions, physicians (medical advisors) are consulted when > 60 days, or in special cases	*Nurses can proactively collect healthcare information, prepare medical records for sick-leave and disability benefits, and plan medical assessment. **They do not take part in the medical decision-making . *** They provide information on consequences of the decisions on later course				Task delegation by SMN: gather (medical) information, have consultations and stimulate reintegration activities. Task support by medical secretaries: summarise existing medical records, type (recorded) medical reports and request (additional) medical data.
2	Is task substitution considered or planned?	yes	no	yes	no	no	no	no	yes
	If yes, describe	More delegation and/or shifting is under discussion		Use of artificial intelligence in short-term sick leave					Consideration is given to further use of task support and delegation.
3	To whom have tasks been transferred?	Delegation depends on diagnosis: Nurses do global interview, physiotherapists evaluate musculoskeletal diseases, psychologists evaluate psychological disorders.	Social workers, psychologists, pedagogues, speech therapists	Physicians are consultants on medicolegal aspects, decisions are made by officials (various background). If disagreement the medicolegal team is consulted.	Task support: from secretaries and doctors to socialmedical nurse (SMN) and Health Fund Counsellors (HFC). Task delegation: from doctors to SMN , and from nurses to the HFC. Task shifting: from doctors to SMN and HFC.				To medical secretaries (task support) and social medical nurses (task delegation).
4	Reason for changes?	Lack of medical doctors		Target time on complex cases; shorten time from application to decision making in clear cases	1) Decrease of medical staff and increase of the work load. 2) Ageing population causing more claims. 3) Raise level of skill of staff. 4) Introduce case management				Shortage of insurance physicians. Make medical profession more attractive.
5	How is transfer of tasks regulated?	By law or by regulation of the National institute for health and disability insurance (NIHDI)	Reform of pension and social security 2015. New (legal) regulations	Social insurance agency can determine when the adviser is consulted	Memorandum frame work from the Health Fund Network				Task support needed no further legal steps except securing secondary professional secrecy. For task delegation individual employment agreements were recorded
6	How is supervision arranged?	supervised by the NIHDI	Each council member responsible for their part, physician responsible for evaluation and report.	Social insurance agency plan and conduct training and write guidelines	1) Supervision of *medecin chef* or his delegate. 2) Five medical report random samples a week per production unit. 3) Satisfaction survey of the claimants every 3 months. 4) The control process is under the responsability of the Health Fund Region headquarters				Under supervision of the insurance physician.

Table 2. (cont)

	Country	NO	POL	POR	RO	SL	SW	UK
1	Has task substitution been introduced in work disability assessments in social security?	yes	no	no	no	no	no	yes
	If yes, describe	GP provides medical information to the social insurance agency. The case coordinator ask for medical advice. Additional medical information can be asked for by AS.					Task shifting has never been introduced – it has always been there	For Employment and Support Allowance: Support – administrative support for collating medical evidence after it has been returned from doctors/other healthcare professionals; Delegation – none; Shifting – most assessments for disability are done by non-doctors
2	Is task substitution considered or planned?	no	yes	no	no	no	no	no
	If yes, describe		It is planned that doctors will get help from AS in computerization of sick leave certificates.					No further anticipated
3	To whom have tasks been transferred?	To administrative case coordinators.	To medical assistant					To other healthcare professionals (HCPs) - nurses, physiotherapists,occupational therapists- Physicians only assess industrial injuries, vaccine damage and war pensions.
4	Reason for changes?	In 2006, case coordinators were a given a broader occupational role.	To make doctors work more efficient.					Several reasons - pilot evidence that quality of assessments is equivalent to doctors'; lack of doctor capacity; financial
5	How is transfer of tasks regulated?	In the National Insurance Act and explanatory legal texts.	To implement the act.					Regulations allow for use of the current cadre of HCPs
6	How is supervision arranged?	Supervision of delegate is provided through internal and external systems that combine peer support and expert revision that are provided at distinct judicial management levels	Medical assistants will be supervised by doctors.					No supervision by doctors - the HCPs are responsible. The quality monitoring systems in place for doctors continue to be used for HCPs but have been enhanced over time

Table 2. (cont)

		BE	CR	FI	FR	GE	IC	IT	NL
7	Is education/training provided for the delegate?	By sickness funds and NIHDI.	Daily work and workshops	Systematic and ongoing	SMN have a one year training, enabling them to prepare medical advice. Trainer is the *medecin chef* or his delegate				Medical secretary (MS): proactively recognize, collect, complete and record required data and elaboration of social medical reports (a 6 day training). SMN: collect and analyze relevant social medical information, prepare and draft medical reports and problem analyses, advise on follow-up actions (workplace training with 11 contact days)
8	Is education/training provided for delegating social security doctor?	By sickness funds and NIHDI.		Videos, skype educating, written guidelines, website including: a) rules and regulations for each benefit, b) guidelines for assessment, c) typical cases, d) links to education material	Training to delegation is implemented by the medical adviser in charge.				Insurance physician: provide functional leadership (a 3 day training): 1) Delegate work to MS/SMN, 2) Discuss and stimulate quality improvement of MS/SMN, 3) Coach, stimulate and facilitate MS/SMN (ask and give feedback), 4) Thereby taking on his own professional responsibility, 5) Confer with the MS/SMN in the context of the Human Resources Management cycle
9	Outcome of task substitution?	More interdisciplinary, more integrated, compensates for lack of doctors.	Equalizing criteria and improving quality	Shorter time between application and decision. More time for complex cases by the medical assessors.	1) Saving time for doctors to focus on pure medical tasks. 2) Better know-how and understanding of conditions and consequences by the patients				More claimant contacts are possible with less physician capacity.
10	How is work disability assessment carried out by the social security doctor?	Both personal meeting and documents only	Personal meeting	Documents only	Both personal meeting and documents only	Both personal meeting and documents only	NA	NA	Both personal meeting and documents only
13	Any further comments? Advantages/disadvantages?		Advantage: insured person is looked at from several aspects but procedural shortcomings are prolonged.	More time can be given to complex issues/cases	Advantages: 1) Medical time saved and sustained quality of service. 2) Doctors prefer medical to administrative tasks. 3) Better understanding and coaching to the claimant. 4) Question of saving money remains unclear. Disadvantages: 1) Possible conflicts on the task limitation regarding advices which can lead to confusion and misunderstanding. 2) Decentralized responsibility eases implentation but complicates regulatory tasks				More can be done with less insurance physicians capacity and physicians can focus more on their actual tasks, but the organisation of the continuous deployment of delegates is sometimes difficult in practice.

Table 2. (cont)

		NO	POL	POR	RO	SL	SW	UK
7	Is education/training provided for the delegate?	Yes, but is being expanded to improve quality in delegated tasks and make process more efficient.	No					Comprehensive induction and ongoing training in disabiity assessment medicine and specific medical topics – our clinical providers have a contractual obligation to provide an ongoing programme of CPD to all their healthcare professionals including doctors.. HCPs doing the work have mentoring and work to established protocols.
8	Is education/training provided for delegating social security doctor?	Currently under revision, aiming for implementation of education for all medical specialties involved in social security.	No					Doctors conducting assesments undergo similar training to other HCPs – this consists of inital benefit specific training and ongoing CPD
9	Outcome of task substitution?	It has been has been a very gradual process that has not been evaluated.	That is still a project.					Quality monitoring measures demonstrate no significant change in the quality of assessments since the introduction of other HCPs; capacity remains a challenge despite expanding the pool of HCPs; unable to comment on financial aspects
10	How is work disability assessment carried out by the social security doctor?	Documents only	Personal meeting	0	Personal meeting	Both personal meeting and documents only	Documents only	Both personal meeting and documents only
13	Any further comments? Advantages/disadvantages?	The assessment of work disability ought to be an interdisciplinary task.		Social security physicians have no other health professional to deal with. Considered to be simple analysis of patients based on clinical reports. Since administration and AS are close to medical procedures, medical final decision is rarely interferred with. A closer connection between Social Security and Portuguese Medical Association is the way to keep/reinforce physician autonomy.	We work hard on harmonisation of the European legislation. So we use a form, Medical Report, similar to E 213, for internal use, for long term sick leave.	Given the lack of doctors, and more complex treatment, it would be sensible to introduce task support/delegation/shifting in Slovenia too.	In Sweden the SIO is the decision maker and can call for, if they deem of need, for the assistance of SIP. The SIP will then discuss the claim and get help from the SIO (administrative staff) to acquire additional medical information from other doctors/hospitals.	Advantages: see answer to 9. Disadvantages: perception among certain external groups that quality of assessments of other HCPs is poorer than if doctors conduct them; training requirements for non doctors is longer to upskill knowledge in specific medical conditions

Table 3. Task transfer in assessment of general disability in 15 European countries

		BE	CR	FI	FR	GE	IC	IT	NL	NO	POL	POR	RO	SL	SW	UK
11	Has task substitution been introduced in general disability assessment?	yes	yes	yes	no	no	no	no	Not at UWV	yes	no	no	no	no	yes and no	yes
11	If yes, describe	In assessment of need for mobility equipment, home care and institutional care. In assessment for extra compensation for persons with handicap or needing personnal assistance in daily live.	According to reform 2015	Medical advisors are consultants, officers make decisions					Carried out by different organisations (different laws/ministry).	GP provides medical information to the social insurance agency. The case coordinator ask for medical advice. Additional medical information can be asked for by the AS.					In 2003, a secondary assessment of work ability with face-to face assessment was introduced. Performed by assessment physicians in teams. These do have both task shifting to AS and task delegation to paramedics in the assessment process. Does not primarily affect the SIP working at the Social Security Administation	The main disability benefit is Personal Independence Payment. Support – administrative support for collating medical evidence after it has been returned from doctors and other healthcare professionals; Delegation – none; Shifting – most assessments for disability assessment are conducted by non-doctors
12	Is task substitution in general disability assessments considered or planned?	yes	NA	no	no	no	no	no	no	no	no	no	no	no	no	yes
12	If yes, describe	Assessment of need for extra support for elderly persons.		Medical advisors often consulted when individual cases require content expertise												see above