Disclaimer: The opinions expressed and arguments employed in this report are solely those of the participants and do not necessarily reflect the official views of the European Commission nor its services.

Expert Panel on Effective Ways of Investing in Health (EXPH)

Hearing on task shifting in health systems

Brussels, 5 June 2019

Aim and objectives

The Opinions of the Expert Panel on Health support the Commission by providing the views of the Panel, informed by evidence, on issues that can make a real change to health systems reforms and investments within the EU.

The aim of the Hearing was to provide stakeholders with an opportunity to share their views on the draft Opinion of the Expert Panel on Task Shifting and Health System Design; the draft Opinion was made available on the Panel website prior to the hearing.

Presentation of the draft Opinion

Panel members: Dr Aleš Bourek, Dr Dionne Kringos, Prof. Luigi Siciliani, Prof. Martin McKee (presenter/rapporteur), Assoc. Prof. Liubove Murauskiene

Dr Bourek opened the hearing by saying that although the Expert Panel includes 14 members of various backgrounds and is strongly supported by DG SANTE, there is always expertise to be gained by being aware of points of view from other communities.

Prof. McKee started with an overview of the draft Opinion on "Task shifting and health system design". He first gave some background information on the Expert Panel: it has been established by DG SANTE, is composed of independent scientists, and is tasked with providing independent non-binding advice on effective ways of investing in health. The Panel's tasks regarding the opinion on "Task shifting" more specifically include identifying and characterising "tasks" suitable for a "task shifting" process; determining the main enabling conditions and difficulties/risks that have to be taken into account when defining "task-shifting" measures as part of health system reforms; determining how to measure the impact of "task shifting" in contributing to the effectiveness of the health care system using an evaluation framework to inform decision-making. Prof. McKee also gave the WHO definition of task shifting: "the rational re-distribution of tasks among health workforce teams. . . specific tasks are moved, where appropriate, from highly qualified health workers to health workers who have fewer qualifications in order to make more efficient use of the available HRH [human resources for health]". However, he also noted that there is considerable evidence pointing to the need of some tasks being shifted to more qualified workers. At the same time, there are many things that could potentially be taken care of by the patients, their carers and technology. So an updated approach includes task distribution (an overview of who does what, without any implied imperative to change it) and task

sharing and competency sharing (responsibilities are often shared between different professional groups, with the patients and, in some cases, their families).

This update is necessary because of the heterogeneity of the healthcare systems and professions across Europe. Also, it is necessary to consider the factors driving change in the whole nature of healthcare, which also explains the need for changing:

- Changing patterns of disease (multimorbidity, frailty, antimicrobial resistance)
- New technology (minimally invasive surgery, intravenous anaesthetics, diagnostic kits, artificial intelligence for image processing, telemedicine)
- Changes in professional norms (rejection of traditional hierarchies, the growing autonomy of non-physician staff (which is still very variable in the EU)
- Shortage of health workers
- Cost containment
- Decentralisation of organisational structures

When it comes to the challenges faced in bringing about changes, Prof McKee spoke of a limited evidence base on task-shifting, which is concentrated to a few countries. There is a wealth of evidence from the US (which has a different healthcare system), from the UK, the Netherlands and Scandinavia, while there is much less from other parts of Europe. He also mentioned the threat to power in established hierarchies, especially where there are financial interests involved – it is difficult to give up financially compensated tasks to someone else. Sometimes there are also problems with obsolete regulation, which prevent tasks from being shifted.

To explain why task shifting is important now, Prof. McKee first pointed out the main problem – we do not have enough health workers, so we need to use those we have as effectively as possible. The right people need to be performing the right tasks, as it is morally wrong to waste scarce resources at a time, when there is so much unmet need in Europe, as a previous report of the Panel outlines. Improved quality of care means those who do the jobs best must be the ones to do them. We also need to promote the resilience of healthcare services, because in emergencies we need different groups to cover for each other.

Prof McKee explained how to think about changing roles: the three options listed were **enhancement, substitution/delegation and innovation**. *Enhancing* means increasing the depth of the job by extending the roles or skills of a particular group of workers. *Substitution* or delegation means exchanging one type of work from one profession to another profession, while at times breaking professional divides. *Innovation* means creating new jobs by introducing a new type of worker or technology.

As concerning the work done so far, Prof. McKee explained that the Panel has looked at task shifting along **the following main lines**:

1. **From health professionals to patients**: though it seems like a good idea, the evidence base is surprisingly weak. The problem is that many of the studies undertaken also have methodological weaknesses, and some areas haven't been studied. The Panel did find some evidence of improved quality of life for patients with stroke and COPD (Chronic obstructive pulmonary disease), although the self-management of exacerbations of COPD may be associated with higher respiratory mortality. Patients should also be able to do much more with the help of technology,

however, evidence in support of technology is also limited. For example, it has been associated with better control of oral anti-coagulation, but in other forms of monitoring, such as pulse oximetry, the use of technology is not supported in evidence.

2. **Task shifting to community workers.** In this, the Panel drew on a recent umbrella report compiled by Prof. McKee's team, who looked at low- and middle-income countries. The report showed that in those settings services provided by volunteers are often not inferior to those provided by other health workers and sometimes better. However, they performed less well with more complex tasks, such as diagnosis and counselling. Many reviews concluded that their performance could be strengthened by regular supportive supervision, in-service training and adequate logistical support, as well as a high level of community ownership. This is an option mainly for under resourced areas, for example, the 'medical deserts' in France or parts of Romania and Bulgaria, where there are serious shortages of health workers.
3. **Task shifting from health workers to machines.** There is a wealth of options here, of which Prof. McKee gave some examples:
    - autonomous embodied agents (for example, apps to support people with mental health problems)
    - digital image processing (radiology, sperm counts, haematology/cytology)
    - replacing laboratory personnel by automated production lines (3D printing of implants, automated biochemical analysis, microbial genetic analysis replacing culture)
    - autonomous monitoring and alert systems based on wearable technologies supported by artificial intelligence on servers and cloud technology (blood pressure, ECG, oximetry, blood glucose, ovarian cycle monitoring)
    - robot assisted physiotherapy and rehabilitation
    - replacement of administrative staff (e.g. automated hospital coding replacing human coders)
    - automatic/robotic medication dispensing systems
    - artificial intelligence supported decision making

    However, when it comes to task shifting to technology, Prof. McKee said that the finding of the Panel once more was that the evidence base is surprisingly weak, and the methodology used is often poor. While there is considerable potential, at least in theory, and some clear benefits in limited areas, there are substantial problems with conflicts of interest. The manufacturers of the solutions provide studies that show vastly better results than independent ones, which is unsurprising. When it comes to technology, there are also major concerns about the abuse of data for commercial gain. These days people are very much inclined to share and allow the collection of sensitive personal data through apps, while the regulatory system currently in place is not fit for purpose.

4. **Task shifting to different types of health workers.** This is the main focus of interest. There are many studies that show nurses achieve similar outcomes to doctors, when managing routine conditions, such as diabetes and asthma. Actually, nurses often provide better patient satisfaction results. However, nurses tend to recall more patients and request more investigations. There are many examples in the report, Prof.

McKee listed some, such as: nurses are as good as doctors in routine pre-operative assessment; pharmacists achieve better results than doctors in medicines reviews and add benefit to multidisciplinary teams; prescribing by nurses and pharmacists in routine care often achieves greater adherence; however, evidence on the enhanced role of nurses is mixed.

Prof. McKee summarised the evidence as follows. There is little evidence for the rigid demarcation that there is between different health professionals, such as doctors and nurses, that exists in many countries. Groups other than physicians, and especially nurses and pharmacists, can undertake substantially expanded roles compared to what has traditionally been the case. However, they **must be adequately trained and supported and function in integrated teams with information-sharing**. There is a need to better understand the optimal combination or "package" of changes and additions that can act synergistically to improve the quality and safety of healthcare as well as patient experience. While it is not necessary to evaluate every change, there is a strong argument for doing so where major changes are taking place, as there is scope for unintended consequences. This should not, however, be an argument for doing nothing. Perhaps the big message here, he pointed out, is the idea that the single professional, the single doctor is a thing of the past.

Next the Panel looked at enablers and barriers, which Prof. KcKee listed: staff shortages, the increasing complexity of care, legal factors (such as laws implemented decades ago, so obsolete legal barriers), professional associations (which play a positive role, but not always), financial incentives (some people will be losing money), changing professional attitudes (especially considering mobility within the EU). Pilot projects and experiments are always a good idea, but not every location has the capacity to implement changes. Often what is required is not a major change, but the regularisation of informal practices, which are taking place in real life anyhow. Of course, there are always legal indemnity issues as well.

Prof. McKee then gave the example of the Calderdale framework, selected from the reviewed literature, as one that has been evaluated and seems to work.

Recommendations:

1. In all cases of task shifting, the objective being pursued is clearly specified, the rationale for selecting task shifting as a means to achieve that objective is explained, and the evidence on which the decision is based is presented.
2. More research is needed, so there should be increased investment in research on task shifting, with the goals of increasing the number of studies from settings that are inadequately represented and understanding the contextual factors that determine what works in what circumstances.
3. Those responsible for training health workers should ensure that they:
    - convey positive attitudes to interprofessional and teams working and that those being trained have opportunities for interprofessional learning experiences.
    - provide the specific skills necessary for task shifting, in those cases where the evidence indicates that task shifting is likely to be effective.
4. Those responsible for implementing task shifting should engage in dialogue to understand the expectations and fears of those who will be affected by it, including patients and their carers, where appropriate.

5. Those responsible for health services should evaluate, and where necessary, intervene to improve the organisational culture of the facilities that are within their remit to ensure that they promote flexible approaches to working.
6. Legislative and regulatory authorities review the rules that exist in their jurisdiction to assess the extent to which they place unjustifiable barriers in the way of more flexible ways of working, taking account of the growing body of evidence on the potential benefits of task shifting in particular contexts.
7. Task shifting to patients and their carers should recognise the goals, expectations, and capacities of those adopting new roles, ensuring that they are empowered to engage fully with health workers to design care packages and with the ongoing monitoring and evaluation of these packages.
8. Decisions to engage in task shifting should be planned carefully, taking full account of the implications both for the individuals concerned and for the wider health sector.

Dr Bourek thanked Prof. McKee for the extensive analysis of the extremely broad issue of task shifting, highlighting that it is not just a tool for patching personnel shortage issues but also a way to improve efficiency of health service provision. It is an opportunity, but it can be also viewed as a threat if implemented poorly. He called on participants to discuss the matters over the break, before coming back for next session, where the Panel would like to hear the participants' views from the communities they represent on the opportunities and risks involved in task shifting.

Open discussion: stakeholders' views

Prof. Siciliani chaired the discussion and opened the floor for questions and comments from the participants. He reminded the participants to state their name, organisation, and the part of the Opinion that they would like to comment on.

Mr Stefan Gijssels, Digestive Cancers Europe, Executive Director, Belgium.
Mr Gijssels first comment concerned the types of interventions and stakeholders that were mentioned. He noted that for doctors and other medical workers, managing a disease is a succession of individual intervention points: there is a moment of diagnostics, a moment of treatment, consultation, etc. However, from a patient's perspective, it is one continuous flow. So for them, it does not matter how or by whom the diagnostics are made, but the question is rather when is the diagnostics made after the initial complaint to a doctor. Then the next question is when the procedure is done after the diagnosis is made. There is a lot of inefficiency in the system. Mr Gijssels recommendation: there is a lot of work done and intelligence gathered by patient organisations, who see the inefficiencies of the system, because they follow the entire patient journey. Mr Gijssels is convinced that it is possible to reduce 30% of the costs and increase 30% of overall survival by managing the system in a better way. Every disease will have its own specificity on how that should be done, for example, mental health and cancer have entirely different requirements, so recommendations should be done based on diseases. There is a lot of value to be gained by looking at a patient's journey and seeing how it can be made more compact. Even in the richest countries, these organisations know which hospitals deliver quality care and which are lacking. The value of non-medical consultations to patients in their recovery is also well known – physical activity, not being socially isolated, continued professional activeness, however, these are

issues that stand outside of the medical system, which concentrates on interventions. Patient organisations should be part of that process in a more systematic way. Those organisations that produce results, however, are faced with financial concerns. Research in these areas, however, is lacking funding, because it is not technology-driven. So patient organisations should have a much more systematic role in managing the patient's journey.

Prof. Siciliani remarked that these were topics related to patient pathway and patient organisations, and passed the floor to Prof. McKee for comments.

Prof. McKee asked Mr Gijssels to send an overview of the peer-reviewed literature on the topic. He agreed to some extent about the disease-specific nature of patient pathways and gave the example of the International Cancer Benchmarking project, which deals with patient pathways, which can be very complicated. However, another issue is the fact that nowadays people can have multiple diseases, so multimorbidity is the challenging issue. In a way, going towards a disease-specific approach would mean moving backwards and be a danger to complex approaches, which deal with a holistic view of the patient.

Mr Gijssels added that at the moment there is almost no follow-up on patients. Patient coaching along the journey is not done in most countries. He believes that in the next 10 years, most patient organisations will start fulfilling that role. He specified that there is a shifting role from the current healthcare providers towards patient organisations.

Prof. McKee also added that if we were to look at patient and public involvement in research, there is a strong impetus towards funding and involving patient organisations as partners.

Mr Gijssels specified that often patient organisations are token participants in research studies. He called for more funding to patient organisations, so that they could demonstrate their effectiveness in terms of patient outcomes.

Prof. McKee remarked that the funding bodies he is familiar with certainly encourage the participation of patient organisations, whose role it is to develop relationships with researchers and apply for the funding. He added that he is not aware of any legal restrictions to the inclusion of patient organisations in research.

Mr Jan de Belie, **Pharmaceutical Group of the European Union (PGEU**), professional affairs advisor, community pharmacist.
Mr de Belie commented on the recommendations, saying that they are very well balanced and cover some very important challenges, such as training ahead of task shifting, and praised them for not offering one-size-fits-all solutions, which tends to polarise debates. He raised a point about terminology – 'task shifting' here also covers 'task sharing' and 'task distribution', however, he called on recommendations to emphasise that these two concepts are also covered, since he sees more focus on task shifting. For example, in the area of pharmacies, medication reviews, medication management, there is no focus on prevention or screening services, for example, no smoking cessation. He also opined that 'task shifting' can have a negative undertone, while 'sharing' and 'distribution' reflect better what is going on. So instead of taking a task away, it is instead a process of opening up and sharing the task, about multidisciplinary collaboration.

Prof. McKee replied that it is referenced in the research that having pharmacists on board improves the medication management. Of course, the difficulty is that it is not possible to

cover everything, especially in an already heavily referenced report. He added that it seems like what Mr de Belie is asking for is more detail, while it wouldn't fundamentally change the message of the recommendations. He agreed that the current definition goes beyond what is usually looked at in terms of 'task shifting', so he agreed on the importance of terminology.

Ms Dorota Sienkiewicz, EuroHealthNet, policy coordinator.
Ms Sienkiewicz thanked the Panel for a comprehensive draft Opinion, which deals with an urgent and important issue. The actions recommended are reasonable, especially considering the limited evidence available. Accordingly, their organisation would like to call for further research and evidence, further health equity impact assessments, which they carry out, and which in their view would also provide potential for the issue to be taken more into account. They also recommend learning from other sectors and comparable settings and models. It would be interesting to see, how it could be done via EU Research and other EU funded programmes and tools. On the issue of principles of equity, health equity and equality, in their view, strong emphasis should be put on ensuring that task shifting strengthens principles of equality and does not undermine them. It should also not be viewed in isolation, but in a wider context, outside of the narrowly defined health systems, from a whole system perspective, towards healthy populations and better quality of life. On the topic of community workers, Ms Sienkiewicz added that they are mentioned, but in terms of requiring better integration *into* healthcare systems, while they have observed that in the real world, the opposite could also be true – health professionals could and should be better integrated within the wider public health work forces system, which includes public, private and voluntary sectors. On the issue of the changing roles of healthcare professionals, the changing roles of patients and healthy populations, and the inclusion of families and patients into care processes, she added the issue of investing in the health literacy of patients and healthy populations, especially digital health literacy, which represents the shift to the digital and the uptake of technology. In summary, her key messages were about calling for more evidence (further health equity impact assessments).

Prof. McKee asked for an example of how to add the health equity lens to a research study, for example, one referenced for the Opinion. He added that throughout the report, there is the topic of the sustainability of health care services, which is absolutely about providing more equity, such as the medical deserts in France, the depopulation of rural areas in Romania and Bulgaria. He suggested viewing the Opinion from the opposite angle – does it undermine equity in any way, which in his opinion it does not, so is it necessary to emphasise equity further?

Prof. Siciliani added his interpretation of the comment – perhaps if there were more impact assessments, then there would be more systematic attention paid to health equity. He confirmed that the Panel is aware of the issue and would consider how to tackle it.

Mr Hans Winberg, Leading Health Care Foundation, Secretary General.
Mr Winberg commented on the definition of 'task shifting'. He began with noting that there are basically three forms of societal coordination: markets, hierarchies and networks, as outlined in the literature on economics and sociology, i.e. research from other disciplines, outside the medical one. He said that the current definition depends on a hierarchical one and that it was correctly stated that it depends on the laws, the regulations, the systems, and over time medicine has also become very hierarchical. Medical systems have both vertical and

horizontal hierarchies, in defining who can do what. Mr Winberg stated that task shifting is a very important undertaking, trying to shift tasks to the lowest possible level, due to our changing realities. However, he said, task shifting is not sufficient, because we need to go into the network part of the issue as well. He went on to talk about the concept of 'collective intelligence', whereby correctly distributed collective intelligence surpasses that of the individual. However, that entails not task shifting but building relationships, in order to know what the other is doing, to build trust, to act smarter and divide tasks according to context. This is not possible in a hierarchical context. There needs to be flexibility and these kinds of relations in the microsystem, not the macrosystem level, such as the EU policy level. Mr Winberg also stated that there is talk of networks; however, they are not included in the recommendations or the literature review. His last point was about evidence – how to get knowledge and what is the ontological status of knowledge. Is it movable, is it social, is it contextual, is it there, he asked. Informed theoretical positions on different issues that are not as solid as pure, scientific facts, he specified.

Prof. Siciliani explained that some of these issues are covered in the Opinion under different wording, in parts about teamwork, culture, and the professions. He argued that the work has thus far been very strongly based on evidence.

Prof. McKee expressed his surprise, since the main thread that runs through the work is about challenging hierarchies and moving to networks, even if the language might not specifically point it out. There is content about substitution, about covering for each other, in the Opinion. He added that they, of course, couldn't draw on all the literature from organisational theory, management and governance, since there is such a wealth of it available.

Mr Winberg added that perhaps another act of task shifting would be to consult with competences from other disciplines as well. For example, randomised controlled studies on task shifting will fail because it is the wrong method, since there are faster, more appropriate ways to study the topic.

Prof. McKee noted that the European Society of Cardiology meeting, to be held in September, will hear a presentation on cluster randomised control study on task shifting, for which the results will be available in due course.

Mr Winberg added that besides doctors, nurses and pharmacists, for example, UX designers should be included, since thanks to their competence the private sector is surpassing what is being done within healthcare systems, when it comes to digitalisation. In Sweden, for example, nearly 2 million visits are currently being done through UX digital systems, and the professionals are starting to move there more, since things can be done faster. It is just a matter of different forms of distributing the knowledge we already have.

Prof. McKee explained that there is indeed a lot of literature, which they could have easily added, but did not, since they cannot write a textbook on the sociology of professions or on power relationships. The danger with theoretical material is that the text becomes impenetrable for some people and the final text would be a thousand pages long. He said that they are definitely not disagreeing with the point and could address the issues within the Panel.

Dr Bourek referred in response to a report that the EXPH compiled on assessing the impact of digital transformation on health services as it includes a chapter on decentralisation and

shifting to networking environments, which is also why the topic was not explicitly included in this Opinion, however, based on Mr Winberg's comment, it will be cross-linked later to the final report.

Mr Jacques von Haller, Standing Committee of European Doctors (CPME), Immediate Past-President. Mr von Haller stated that the CPME position on task shifting will mostly please the Panel, since it states that "the shift of some tasks may enable the better use of manpower and resources, free valuable time for physicians and, therefore, contribute to better care for patients. In order to guarantee the safety of patients, this should always take place under the condition that the responsibility for diagnosis and therapeutic decisions cannot be divided and remains with the doctor." The second part, he added, might please the Panel less. However, in broad terms it means that doctors are not allergic to task shifting at all. He emphasised that it is not an ideological opposition, but rather an idea centred on patient safety. Mr von Haller also expressed surprise at the idea of the patient organisation representative that healthcare budgets could be decreased by 30%, as in his opinion the budgets should be increased instead, since the existing budgets aren't meeting needs. He also pointed out that there is a shortage of nurses, so doctors cannot be replaced with nurses, since there isn't enough of them either. He added that when choosing professions, people do not have similar visions regarding their professional lives, so just shifting people from one job to another is not enough. Instead, better allocation of resources is needed. The Opinion centred on tasks, however, he suggested also focussing on people. Mr von Haller added that there is indeed a need for a coaching overview of patients, which can be carried out by those with a sufficiently broad educational background. In his opinion, the GPs are the best people for the job. He also remarked on task shifting to patients and mentioned the Self-Care Initiative of the Commission, which was completed 1,5-2 years ago, and suggested referring to that work. He finished by commenting that task shifting is an important solution, but not to money problems and not without regarding the people and the patients' interests.

Prof. McKee replied by pointing out that they are in agreement, as the Opinion expressly states that task shifting should not be done only for cost containment. The only point of disagreement he noticed was perhaps the autonomy of some of the other professional groups, and recalled that the general direction taken is to move past hierarchies towards networks.

Mr von Haller agreed that medical practice is very much teamwork and requires a lot of communication, and with nurses and pharmacists taking over some of the tasks, he sees that there is a huge communication need, with the GPs leading the oversight of the patient.

Prof. McKee added that, of course, technical knowledge is one thing, however, not everyone might have the necessary communication skills. Experimental studies, for example, have demonstrated the short attention span that people have towards information gained from doctors, there is a lot of literature on cognitive bias and optimism bias. In fact, there is a whole area of communication science, which needs to be taken account of and is used in some countries in GP training, for example, in the UK's Royal College of Practitioners. The situation varies, because not all countries place such great importance on communication skills training.

Mr Rudolf Reibel, Bundesärztekammer / German Medical Association, Head of Brussels Office. Mr Reibel expressed appreciation for the report not offering one-size-fits-all solutions. Another aspect he found to be positive was the potential for relieving medical staff

from administrative tasks, which is getting more burdensome and represents a risk, especially with the addition of e-health. An issue they found to be a bit missing was a clearer distinction between substitution and delegation. Mr Reibel sees these two concepts as different, since it comes down to with whom the responsibility lies, not only for giving the orders, but also in case something goes wrong, who can be held liable. Issues such as indemnity insurance, whether criminal and civil liability is enough, whether professional supervision is needed and who carries it out – these issues are important to consider and should perhaps be emphasised more, when drawing the distinction between substitution and delegation.

Prof. McKee replied that the Panel has looked at the topic of legal indemnity and one of the difficulties is that the issue is so diverse across Europe (the whole issue of regulation of professions differs). Some years ago Prof. McKee's team carried out a study, where they looked at vignettes of behaviour by physicians, which varied in content, and gave them to medical regulators across Europe, asking whose responsibility these cases represented. The results and answers were completely variable across countries. For example, in the UK it is much more likely for any action to ensue, which is why they contribute so much to alert systems. There is some argument for a no-fault compensation scheme, like in New Zealand, which may solve the problem, but is not a subject for this report. So while the report picks it up a bit, the difficulty is that it is being written for the whole of Europe.

Ms Simone Mohrs, European Hospital and Healthcare Employers' Association (HOSPEEM), Policy Officer. Ms Mohrs commented on the fact that the report does not mention national social partners. Social partners could be included, because they are the ones setting and bargaining the collective agreements, in some countries, on task shifting and how doctors and nurses are remunerated. She asked whether the Panel had come across any literature on the issue. Ms Mohrs also raised the topic of how there was less than a page total on healthcare professionals and trade unions were mentioned only once and asked whether there was any literature on employers in this regard.

Prof. McKee replied that they had not come across such literature.

Ms Ioana Enache, Baxter, Senior Manager of Government Affairs. Ms Enache thanked the Panel for the comprehensive draft Opinion. She went on to echo some of the previous comments on patient empowerment to self-manage chronic conditions, which is very important. She suggested expanding the section on the issue of patient education, given the increasing number of chronic ailments that can be treated at home. However, she also recalled the barriers to the uptake of solutions, to shifting more tasks to the patients, so there are a lot of things to be done for the education of patients, as well as health care professionals. For example, there are kidney treatment options that patients and even doctors might not be aware of. She also mentioned the financial incentives issue, which in some cases might prevent out-patient treatment and result in the selection of in-patient treatment. Regarding the section of shifting care from people towards machines, she added that much of the focus is on machines, but the digitalisation issue is much broader, so for the sake of completion, the topic could be expanded with concrete examples of how software or digital tools can enhance care (telemedicine, remote consultations, etc.). Ms Enache finished with a question about another, separate Opinion on value-based healthcare, which has been published concurrently with this Opinion. Since there is a lot of overlap, are there plans to integrate them further?

Prof. Siciliani summarised that there were several examples that could be discussed for possible additions under the section on shifting tasks to patients.

Prof. McKee answered by calling on the participants to send the Panel any good quality, peer-reviewed evidence that they might have missed. While the Panel did take a rigorous approach, drawing on systematic reviews, there might be areas that went unnoticed.

Mr Stefan Gijssels, Digestive Cancers Europe, Executive Director, Belgium. Mr Gijssels added that there are patient organisations that provide 24/7 care of patients, coaching patients through the healthcare system, assisting with questions, however, the work they do is not in peer-reviewed journals. The organisations help patients with medical and non-medical questions, and without them the patients would be lost in the system, would not have adequate care or would have late care. Mr Gijssels called on the Panel to not undervalue the work of patient organisations moving forward.

Prof. McKee answered explicitly that the Panel is a Panel of experts that works based on evidence. If there is evidence, the Panel is very happy to review and include it, however, assertions are not evidence. While there is empirical evidence of their existence, the effectiveness of their work has not been demonstrated in research.

Mr Gijssels called on the Panel to make a recommendation to research the topic, since patient organisations are the only ones with the energy and the sense of urgency to move things forward. They are the drivers behind screening programmes in Europe, such as the ones for colorectal cancer. Currently there are only 3 countries screening for colorectal cancer.

Prof. McKee suggested a look at the published work on the EU funded EU-Topia project, which looks at the barriers to screening in Europe and deals with the issue in great detail.

Dr. Bourek commented that the "golden line" that runs through all the comments is that there are changing roles of the stakeholders that are involved in healthcare systems. The changing of roles have to be evidence-based. The European Patient Forum has done several studies addressing the existing evidence on self-care, self-prevention. There is also evidence on task shifting in areas such as efficacy of population-wide screening programmes versus targeted provision of care based on digital stored data of genetic information allowing targeted screening. All these have been considered. However, when drafting an Opinion, all included recommendations must be based on evidence, which sometimes limits what can be included. He agreed that there are changing roles among the stakeholders and the evidence is being produced, and also mentioned, that some of projects related to the task shifting to the patient community have been co-financed by the European Commission, especially when it comes to self-care, self-prevention and role of patient organisations, as can be confirmed by the European Patients Forum (EPF).

Prof. McKee added that they are absolutely not ignoring patient organisations.

Mr Jan Geert Wagenaar, European Chiropractic Union, Vice-President. Mr Wagenaar thanked the Panel and made a few additional suggestions to the draft. He also stated that he has sent ahead a document with comments and references. His first comment was about non-communicable diseases, with a focus on musculoskeletal ones, which are not mentioned in the report. Musculoskeletal diseases present a growing burden on Europe. In addition, there are less GPs and less nurses in Europe. 30% of the GPs see their patients with

musculoskeletal problems so, for example, NHS in the UK is now using first-contact practitioners (FCPs), who are physiotherapists with special training and chiropractors; this seems to be working well in UK but also in Norway and Denmark. Therefore, the task shifting in this case would mean relieving the GPs' burden and shifting the task of seeing musculoskeletal patients to FCPs.

Prof. McKee replied that they would look at the evidence and include a section on that topic. He also reiterated his plea for more evidence to be submitted, if it is available.

Mr Marcin Rodzinka, Mental Health Europe, Advocacy and Policy Officer. Mr Rodzinka stated that he is very pleased with the general message of the report, because for mental health it is very important to work as an integrated team. Recognising that not everything can be covered by the report, he pointed to an issue missing from the report – there is existing evidence on peer workers, because in mental health, patients can also provide help to other patients.

Prof. McKee thanked him for the addition and asked for the evidence to be sent.

Ms Sarada Das, Standing Committee of European Doctors (CPME), Deputy Secretary General. Ms Das thanked the Panel for the event and for the compilation of a huge amount of evidence into the report. Her question touched on the methodology of presentation of the evidence in the report. She asked if it was possible to go into more detail about task shifting decisions, to look at which level they were made at, what additional training was provided, whether there were changes to reimbursement systems, possible legal changes – would it be methodologically possible to include that information, because it would be interesting to have.

Prof. McKee agreed that it would be definitely very interesting and if there is a PhD student willing to extract that information, the Panel would be very happy to see the results. The task, however, goes beyond the capacity of what the Panel can do. He added that the information, however, might not be available for extraction, because often aspects like that are not captured.

Mr Hans Winberg, Leading Health Care Foundation, Secretary General. Mr Winberg added that when undertaking a systematic review, if only including medical publications, when it comes to innovation processes, which are really shifting by the month, it is only one perspective, albeit a very good one. He called on the Panel for a recognition of the fact.

Prof. McKee replied that there is a whole series of disciplines that have an interest in this particular area, like the theory on professions, the literature on power, markets, hierarchies, and networks, all of which could easily have been included, however, the danger is that they create an encyclopaedia of organisational theory. The Panel members do look beyond the medical literature and sometimes are even accused of going too far beyond.

Prof. Siciliani summarised the event and announced 10 June as the deadline for comments to be submitted at the e-mail address (SANTE-EXPERT-PANEL@ec.europa.eu).

Dr Bourek concluded by thanking all the participants for their comments and stated that EXPH will try to incorporate them into the Opinion, if they are supported with evidence. The Panel will finalise the Opinion and present it in the plenary meeting of the Panel on 26 June for adoption. He added that the changing roles of stakeholders engaged in health care mean

that the comments from participants of the Hearing are very much needed and appreciated and thanked all the participants for their contributions.