

Table S1: The 16 cases: settings, cadres, tasks redistributed, and data sources

SSI = semi-structured interview; PO = participant observation; FGD = focus group discussion. All cases were constructed from SSIs and POs, supplemented by FGDs where indicated.

Case	Domain	Setting and cadres	Tasks redistributed	Data sources
01	Primary health care	NGO community health programme, rural; CHWs taking on work of doctors and nurses	Screening, health education, referrals, and water-sanitation-hygiene activities, from doctors/nurses to CHWs	SSIs with 4 participants; PO (CHW-led screening and education); 3 members represented in FGDs*
02	Primary health care	Government PHC, Gujarat; medical officers, nurses, ASHAs, and female health workers	Malaria rapid-test diagnosis, TB identification, and antenatal care to nurses; outreach, health education, and digital data entry with ASHAs and FHWs	SSIs with 3 participants; PO (ASHA- and FHW-led outreach)
03	Primary health care	NGO nurse-led primary care clinics, rural/tribal Rajasthan (six clinics, ~90,000 population)	Outpatient consultations, acute and maternal care, pharmacy and inventory management, and CHW supervision, from doctors to nurses	SSIs with 6 participants; PO (nurse-managed outpatient care without an on-site doctor)
04	Primary health care	NGO rural clinics, Chhattisgarh; nurses and locally recruited mid-level health workers (MLHWs)	Outpatient consultations to nurses; blood draws and vital signs to MLHWs, who also assist nurses in pharmacy and laboratory	SSIs with 2 participants
05	Primary health care	State government directorate, Delhi; co-located AYUSH and allopathic doctors, non-clinical staff	Complementary caseload management via cross-referrals between AYUSH and allopathic doctors; pharmacy dispensing by non-clinical staff	SSI with 1 participant
06	MH	NGO, rural Gujarat; CHWs taking on work of psychiatrists	MH screening, counselling, medication management, and rehabilitation, from psychiatrists to CHWs	SSIs with 4 participants (including a group interview with

				trustees); PO (home-based MH follow-up)
07	MH	NGO, Kerala; ~80 community MH clinics for marginalised fishing communities; clinical psychologists and CHWs	Independent home visits for medication adherence monitoring by CHWs; behavioural components of therapy delivered jointly with psychologists	SSIs with 3 participants
08	MH	Corporate peer mental-health programme, Mumbai-headquartered conglomerate (>200,000 staff)	Early identification, initial psychological support, and referral of distressed colleagues, from professional counsellors to trained peer volunteers	SSI with 1 participant
09	MH	Border security force programme training nurses as peer counsellors	Peer counselling, from MH professionals to nurses	SSI with 1 participant
10	EMS	ASHA paediatric first-responder programme	Paediatric emergency first response (CPR, airway and choking management), from doctors to ASHAs	SSI with 1 participant
11	EMS	Occupational health centres across industrial sites, Gujarat and Rajasthan; single-paramedic port centre	Outpatient consultations, trauma assessment, suturing, and cardiopulmonary resuscitation, from doctors to a paramedic	SSI with 2 participants
12	EMS	Private road and air ambulance service, national	Electrocardiogram interpretation, emergency cardiac protocols, and medication administration during transport, to paramedics guided in real time by call-centre doctors	SSIs with 5 participants; PO (training session preparing ambulance drivers to assist paramedics); 1 member represented in FGDs*
13	EMS	State trauma centre, New Delhi; dedicated trauma nursing cadre	Triage, vital-sign assessment, blood sampling, and equipment setup, from residents to trauma nurse coordinators	SSI with 1 participant
14	EMS	Programme transferring specialist emergency	Specialist emergency care for high-burden, time-	SSI with 1 participant; 6 members represented in FGDs*

		care to MBBS doctors at PHC level	sensitive conditions, from specialists to MBBS doctors	
15	EMS	Trauma-care training programme for AYUSH doctors	Pre-hospital trauma and emergency response, from allopathic to AYUSH doctors via structured training	SSIs with 4 participants; PO (one-day trauma-care workshop for AYUSH doctors); 1 member represented in FGDs*
16	EMS	Private multispecialty hospital emergency room, Gujarat; AYUSH doctor alongside allopathic consultants	Emergency-room patient assessment, history-taking, and routine case management, from consultants to an AYUSH doctor	SSIs with 6 participants; PO (AYUSH-staffed emergency care)

*FGD representation counts members of a case among the eight focus group discussions of the parent study, which gathered stakeholder feedback on the SHIFT-SHARE framework rather than case-level data and drew additional participants from eight organisations outside the sixteen cases; their contribution to this paper is therefore indirect. Counts are derived from participants quoted in the parent study and may understate representation.

Table SS2: Classification patterns under classical definitions and the ambiguities observed

Type A = both strategies used for different tasks within one service.

Type B = observed practice diverged from design intent or initial appearance.

Case	Pattern under classical definitions	Ambiguity and main-text discussion
01	Leans towards shifting	None observed; classified consistently; not discussed individually in main text
02	Leans towards shifting; both patterns present at task level	Type A; discussed in main text
03	Shifting (unambiguous)	None; discussed in main text as a confirmatory case
04	Shifting; mixed at task level	Type A; discussed in main text
05	Sharing and shifting elements	Discussed in main text as a confirmatory sharing case
06	Shifting	None observed; classified consistently; not discussed individually in main text
07	Leans towards sharing; mixed at task level	Type A; discussed in main text

08	Designed as sharing; functioned as shifting	Type B; discussed in main text
09	Leans towards sharing	None observed; classified consistently; not discussed individually in main text
10	Shifting	None observed; classified consistently; not discussed individually in main text
11	Shifting (unambiguous)	None; discussed in main text as a confirmatory case
12	Leans towards shifting; classifies as sharing under the presence/absence criterion	Discussed in main text (remote functional presence)
13	Shifting (initially appears collaborative)	Appearance-practice divergence; not discussed individually in main text
14	Shifting	None observed; classified consistently; not discussed individually in main text
15	Leans towards shifting	None observed; classified consistently; not discussed individually in main text
16	Designed as shifting; functioned as sharing	Type B; discussed in main text

Table S3: Typology of supervision arrangements and their classification under the presence/absence criterion

Threshold: the delegating provider is functionally present when engaged in synchronous, bidirectional clinical decision-making during the execution of the task itself, with the capacity to alter the task while it is underway. Availability (before, after, or on request) does not constitute presence.

Level	Arrangement	Description	Case example	Classification
(i)	On-site co-presence with active collaboration	Both cadres physically co-located and jointly engaged in decision-making during the task	Case 05: co-located AYUSH and allopathic doctors managing complementary caseloads; Case 04: MLHWs assisting nurses under direct supervision in pharmacy/laboratory	Functional presence → task sharing
(ii)	Remote, real-time clinical engagement	Delegating provider physically remote but synchronously engaged: continuous guidance, decisions confirmed	Case 12: paramedics performing advanced procedures during transport with continuous	Functional presence → task sharing

		during the task, structured read-back	call-centre physician guidance	
(iii)	On-demand availability	Delegating provider reachable if needed but not engaged in the task; contact initiated only by exception	Case 03: doctors available by telephone to nurse-led clinics; Case 11: doctors at other sites reachable by the lone paramedic	Functional absence → task shifting
(iv)	Periodic scheduled supervision	Regular but non-synchronous oversight: scheduled visits or calls, feedback on past performance	Case 03: weekly doctor visits to nurse-led clinics	Functional absence → task shifting
(v)	Retrospective or administrative review	Oversight expressed only through documentation, compliance, or post-hoc review	Case 11: documentation maintained under a visiting doctor's name for compliance	Functional absence → task shifting

Note: Borderline arrangements, for instance, intermittent synchronous contact during a task, need judgment and domain-specific guidance. Testing whether this typology supports consistent classification across raters is the first stage of the validation pathway proposed in the main text.