Executive Summary

- The research focussed on three clinical conditions and their associated pathways: breast cancer; type 2 diabetes; and heart disease. 2,611 health care professionals, 800 health care mangers and 2,944 patients on these pathways completed questionnaires.
- Responses revealed there was variation between countries in the tasks undertaken by new professional roles and in the share of tasks undertaken by the different professional groups.
- The relatively large number of tasks undertaken by advanced or specialist nurses, and correspondingly lower number undertaken by physicians, in England, Scotland and The Netherlands suggested that there had been task substitution between professional groups, with the nurses taking on tasks perhaps traditionally conducted by physicians
- Logistic regression models estimated for the two largest professional groups working on the pathway, physicians and nurses, revealed differences between countries in the share of tasks undertaken by these two groups.
- A measure of the involvement of nurses relative to physicians (MORNI) revealed substantial differences between pathways and countries.
- Patients experience and perceptions of task delegation suggested that the skill mix across the workforce was changing slowly. A minority had experienced task delegation. They reported a general trend toward tasks previously done by a doctor now done by another professional.
- The frequency with which professions, other than doctors and nurses, were reported as contributing to care was comparatively small though in some conditions and countries there was a move away from the traditional doctor-nurse team to a wider team. Where patients experienced such substitution their response was favourable.
- Patient preferences, examined in a discrete choice experiment survey, revealed a very strong preference for the type of professional seen. Patients with breast cancer strongly favoured seeing a specialist doctor, while patients with heart disease and type 2 diabetes, favoured the specialist nurse.
- Total health care costs over a three months period averaged €2,590 for breast cancer, €2,140 for heart disease and € 400 for type 2 diabetes across the nine countries. Additional productivity and informal care costs were €100 and €30, respectively.
- Multilevel fixed-effects regression analyses revealed poorer self-reported health was associated with higher health care costs, while higher values of the MORNI were associated with lower costs.
- Multivariate analysis revealed no general association between the MORNI and health outcomes and no significant association between the MORNI and patient self-reported health.
- Countries with higher levels of staff role change over the last five years experienced high levels of both professional and patient satisfaction, better patient health and lower costs.
- The data collected in MUNROS was used to illustrate a ‘competency approach’ to workforce planning and the cost savings that could be achieved by transferring tasks between professional groups,
- The willingness of health care professionals to pursue a new role and the opportunities to do so differed between countries and condition. Personal satisfaction was the dominant motivation for a health care professional taking on a new role. Cost effectiveness and regulations were regarded by managers as the most important influences on their decisions over the allocation of roles.