Report of Travel Fellowship awarded by the ESRC/MRC Innovative Health Technologies Research Programme

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Description of Travel Fellowship Hosts

Finland
Dr Marja Vehvilainen, Senior Lecturer, Communications Dept, Helsinki University

Dr Vehvilainen hosted our stay in Finland in December 2003.

Dr Vehvilainen undertakes research on use of ICTs and runs an International Masters level course: The Argononaut Study Programme. This is a continuing, international programme in English, where students can specialize in information society and in social and cultural shaping of modern communications technologies.

The programme is multidisciplinary, with a focus in social sciences. It aims to

- provide research based knowledge of the complex relations of agency, communication and technology;
- practical skills both in using virtual evironment and producing material for the Internet;
- as well as skills for evaluating and researching technologies in the context of cultures and societies.

Dr Vehvilainen is particularly interested in gender and ICTs. Her recent publications include:

Gendered Local Agency: The Development of Regional Information Society, in Jeff Hearn & Tuula Heiskanen (eds.) Information Society and the Workplace: Spaces, Boundaries and Agency, Routledge, London (forthcoming 2003).

The Construction of ”Equal Agency” in the Development of Technology, The Proceedings of the COST Conference, User aspects of ICTs: Good, Bad and the Irrelevant, 3-5.9.2003, University of Arts and Design, Helsinki.

Gendered Agency in Information Society: On located politics of technology, in Mia Consalvo & Susanna Paasonen (eds.) Women and Everyday Uses of the Internet: Agency and Identity, Peter Lang Publishing, New York, 2002, 275-291.

During our visit we presented our UK project results in a departmental seminar for international research student.

Crete
Professor Christos Lionis, Professor of Primary Care, University of Iraklion and Vice President of Crete Regional Health Authority

Professor Lionis hosted our stay in Crete in September 2003 assisted by Ms Maria Trigoni

The University of Iraklion is the only University in Greece to recognise Primary Care as a discipline. As Deputy Director of the Regional Health Authority Professor Lionis

has responsibility for public provision of primary and social care for Crete. Professor Lionis was born and brought up in Rethymnon, Crete, where he still lives. He trained in medicine in Athens. He was the first general practitioner with formal training as a GP at Spili Health Centre, Crete. Along with his colleagues at the Department of Social and Family Medicine he has been very involved with the development of Primary Care in Crete. He was particularly involved in the development of community health programmes such as that run by Tasula (see below), midwife, and the development of team working at Spili Health Centre. Spili Health Centre is held up as an example of team work in primary care within Greece.

Ms Trigoni is a social worker in the Department of Oncology and head of the Department for the University Hospital of Iraklion. She has worked in her current job for 5 years and has been a social worker for 20 years. She sees women who have had a diagnosis of breast cancer to provide support during treatment. Ms Trigoni is also undertaking her PhD with Professor Lionis on breast screening from the perspective of women and health professionals, using the methodology of our UK project. Ms Trigoni visited the UK project in 2002. During our visit to Crete we undertook and extended supervision as international advisors on her PhD and continue to provide advice as needed. Ms Trigoni made a presentation of her developing research to the European General Practice Research Workshop in October 2003.

Aim, objectives and their achievement

The UK project associated with this travel fellowship explored the micro process of use/non-use of innovative health technologies aimed at midlife women, including the decision making process of individual women and their health professionals. The technologies at the focus of the research were breast screening using mammography and breast awareness, screening for risk of osteoporosis using bone densitometry and use of hormone replacement therapy (HRT).

The micro-processes studied in the UK study, occur within the context of the UK health service, epidemiology (e.g. high incidence of breast cancer) and socio-political context including the level of diffusion of the technology. Our data indicates the influence of context as constraining or enabling in the micro-processes. The fellowship enabled visits to two contrasting health delivery contexts, Greece and Finland.

Aim: to increase understanding of the way contextual factors influence the micro-processes and vice-versa, in relation to the use/non-use of the health technologies at the focus of the study, through comparison with contrasting European contexts.

The objectives were

1. To interview health professionals about the use of the health technologies focused on women at midlife. These interviews sought to understand how the technologies are provided/used at the local level, the enabling and constraining factors, the professional's views on the technologies and how they perceive their patient's knowledge and attitudes.
2. To confirm collaboration with colleagues for future research.
3. From 2 and 3 write a proposal for a Framework 6 Marie Curie Research Training Network based on a comparative study of health technologies at women's midlife in contrasting European countries.

Achievement of objectives

Objectives 1 and 2 have been achieved. The results of objective 1 are the main focus of this report.

Exploratory work for objective 3 was undertaken. A decision was made to postpone submission of a proposal until end 2004/early 2005 (call expected late 2004). Initial ideas about how a research training network might be formed and work had to be reviewed in the light of very helpful advice from Dr Vehvilainen on issues including language ability, recruitment and retention of early stage researchers to the Network. Further meetings with collaborators in the Research Training Network are being planned for 2004. Collaborators for the RTN include

Lead: Dr Frances Griffiths, University of Warwick with Professor Eileen Green (visiting): primary health care/sociology/social policy

Dr Marja Vihvilainen, University of Helsinki Communication/STS

Professor Christos Lionis, University of Crete Public Health

Professor Norbert Donner Banzhoff, University of Marburg Clinical Epidemiology

Professor Paul van Royen, University of Antwerp, General Practice with particular interest in influence of culture on health care processes and outcome.

Dr Sally Wyatt, University of Amsterdam with Dr Flis Henwood (visiting) STS, information technology and social policy

Research method

Prior to each visit the travel fellows read for Finland (2002) and Greece (1996) reports published by the WHO Regional Office for Europe on Health Care Systems in Transition plus data collected on primary care developments by Professor G Meads (International Primary Care Unit in the Centre for Primary Health Care Studies, University of Warwick). This familiarised them with the country's health care service.

In Finland Dr Vihvilainen arranged the interviews. She contacted individual health care sites in Helsinki explaining our interest. She is not involved in health care except as a user. All the interviews were with health care professionals working in central Helsinki, so very urban, relatively affluent and relatively cosmopolitan for Finland. Dr Vihviainen did not accompany us to interviews but acted as a resource for checking our understanding of health service provision.

In Crete Professor Lionis arranged the interviews with health care professionals all of which were current or previous colleagues, and well known to Professor Lionis. As a medical practitioner in Greece, Professor Lionis is unusual in having worked all his career in the public health service. Crete is also unusual in Greece for having a well developed primary care service in the rural areas. The interviews were all with health professionals working in the rural public primary care service or the public University Hospital. The focus was therefore on a relatively small section of the Greek health care service. Accounts of the very large private health care sector were through these health professionals working in the public service. We were accompanied on all our interviews by Ms Trigoni although she did not sit in with all interviews. Professor Lionis was also present at some interviews. Both acted as a resource for checking our understanding of the interview data and also provided their own reflections.

All the interviews were undertaken in English and audio-recorded. For one interview in Crete a non-English speaker participated through her colleague who spoke English. Extensive field notes were also taken of the interviews, of informal conversations, the discussions with our hosts and our own reflections. Field notes were written up and reviewed immediately after each interview so issues arising could be fed into subsequent interviews.

The interview schedule was based on that used in the UK project, but with an emphasis on mammography (and in Finland bone densitometry), although all interviewees were asked about HRT. This focus was determined by the interests of our hosts and who they felt able to ask to participate. In both countries before starting interviews the schedule was checked with our hosts and revised for the health care setting.

Table 1 summarises the roles of the health care professionals interviewed in the UK study and the role of the key informants interviewed in Crete and Finland.

For this report an analysis has been undertaken of the contrasts identified between the background literature informing the study and the accounts in interview. This raises methodological issues for this type of comparative study, which will inform the development of the Marie Curie Research Training Network proposal. Further analysis of the interview data will be undertaken on substantive issues related to the

health technologies for publication. These issues include: perception of risk, role of health professional as extension of technology and/or interpreter of technology, the impact of social and cultural issues on women's experience and the effect of technology to create a commonality of experience.

Table 1 The roles of the health care professionals interviewed in the UK study and the role of the key informants interviewed in Crete and Finland.

Role	**UK**	**Crete**	**Finland**
General practitioner	Public Y Private N	Public Y Private N	Public Y Private N
Nurse in general practice	Public Y Private N	Public Private N	Public N Private N
Radiographer in mammography clinic	Public Y Private N	Public Y Private N	Public Y Private Y
Specialist nurse in mammography clinic	Public Y Private N	Not found	Not found
Radiologist in mammography clinic	Public Y Private N	Public Y Private N	Public Y Private Y
Radiographer in bone densitometry clinic	Public Y Private N	Not accessed	Public Y Private Y – also had nurse specialist role
Specialist doctor for bone densitometry clinic	Public Y Private N (although they may have undertaken private practice elsewhere)	Not accessed	Public N Private Y
Lay informant	Y	N	Y

The contrasting health care contexts of UK, Greece and Finland: the literature

Choosing contrasting health care sites

The aim of the travel fellowship to increase understanding of the way contextual factors influence the micro-processes and vice-versa, in relation to the use/non-use of the health technologies at the focus of the study led us to seek field sites where the health care service provision, epidemiology and social context were very different. At the time most of our contacts for potential hosts were in Europe and we had considerable knowledge of the different contexts in European countries. Thus we restricted the fellowship to countries in Europe. The following contrasts (Table 2) were identified though the literature and lead to the choice of these countries for the study.

Table 2: contrasts between UK, Greece and Finland according to literature

	UK	**Greece**	**Finland**
Rate of HRT use (1)	High>20%	Low <4%	High >20%
Incidence and mortality from breast cancer (2)	High	Low	Low
Use of mammography women age 50-59y (2)	40%	30%	60%
Breast screening system	National organised programme	No organised programme	National organised programme
Incidence osteoporosis (3)	High	Low	High
Use of test for osteoporosis by women age 50+ years (2)	6%	20%	5 %
Character of health system (4)	National Health Service, growing private sector. Variable access to technology such as osteoporosis screening, variable use of IT.	Mixed service provision, aspirations for access exceed ability to provide, large private sector and widespread inequalities.	Well funded, early uptake of technology, population wide health records using IT.

All rates relative to other European Countries

(1)The Menopause in Europe 2000 Int J Fert 45(2) pp 182-189

(2)The state of women's health in the European Community. Report from the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions, European Communities, 1997.

(3)Women in Europe towards healthy ageing. European Institute of women's Health 1997

(4) Multiple sources including International Comparative Case Study of Primary Health Care lead by G. Meads underway at Centre for Primary Health Care Studies, University of Warwick and visits by the applicants to the countries in the past.

Contrasts between the literature and fieldwork accounts in Finland and Crete

This section summarises where the literature we read before the fieldwork contrasted with the accounts given us while undertaking the fieldwork. During the fieldwork we checked these issues with more than one informant wherever possible. The fieldwork was limited in scope so checking of the data was limited. However, the contrasts were identified from accounts given by our informants and represent their view of the situation.

Finland

- 'Neighbourhood' health centres (run by municipalities) suffering from lack of resources in last 5-10 years: experience of health centres having no doctor even though by law there should be one. General decline in the standard of care these local health centres are able to provide. Informant was used to relying on them but now realised that she needs to use her private medical insurance provided by her employer.
- Her experience is similar to that of many in Finland: most people in employment rely on the private insurance provided by employer. Officially in Finland there is a public health service but this is not how it really works. She has experienced health professionals in the public sector suggesting she seek care through her private insurance.
- Recession in Finland in the early 1990s used as an 'excuse' for not putting resources into public health care but since the economy has recovered there has been no increase in resourcing of the health service.
- Individuals can use the private sector if they have no health insurance and they receive reimbursement of a small proportion of the cost through the national insurance system.
- When private bone density service contacted, they said that bone denistometry is 'behind' in development in Finland.
- Private bone densitometry: patients can come via referral from public sector (some) or via private referral or arrange it themselves. Municipalities are contracted to refer patients to public screening centres but since 1995, the recession and associated cuts, public sector clinics are very under-resourced and waiting lists long, so women come into private screening but have to be referred by a private doctor. Before recession the situation was more flexible.
- There are local guidelines on referral to bone densitometry
- Publicly funded screening mammography for women aged 50-59 years every 2 years: women identified from civil list: uptake rate 75-80%
- Specialist mammography clinics exist everywhere, mixture of urban centres and mobile units.
- After aged 59 years women can go to private clinics and pay for screening mammography
- Diagnostic mammography available in public system or in private sector with a one third refund of the fee, through referral by public health centre. Referral to private sector often is through employers health insurance.
- Recruitment of radiographers is a problem for the mammography service especially in the rural areas and Northern Finland.

- There is a national cancer registry which the radiologist informs on diagnosis of any breast cancer.
- Radiographer noted increase each year of younger women having bone densitometry, due to increased anxiety about risk of osteoporosis
- There is computerisation of medical records within departments, for example the public mammography clinic and the public X-ray department housing bone densitometry. There was no evidence of linkage to medical records beyond the individual departments.
- General practitioners do not routinely receive letters from specialists to whom they have referred patients to inform them of the outcome of the referral. The GP does not hold a full record of a patients health care/issues.
- Private clinics do not archive results of tests: the individuals are given them as they own them.

Crete

- Rural areas have women's health initiatives where health professionals trained as midwives engage with the local communities and encourage women to take up screening including breast examination (self and by the midwife) – following community health approach.
- Awareness of cases of first presentation to health professionals of advanced breast cancer, particularly unmarried women from rural areas: many possible reasons suggested by interviewees
- Incidence of breast cancer is rising in Greece: currently about 14.5/1000 population. Possibly lower incidence in Crete than rest of Greece but accurate data not available. Most common cause of death from cancer among women.
- Cancer registry exists but some interviewees mentioned it is not efficient, others had not heard of it. There is a relatively new Government initiative for collecting data on morbidity which is being implemented by Regional Health Authorities – data is coming from services provided by this Authority (not the extensive private sector) and there are problems with the quality of the data.
- There is no established mammography screening programme in Greece however, women have mammography through various routes including: encouraged by midwives to have it done privately or in public sector (they recommend it to any woman over 35 years old); referral for 'diagnostic' mammography by gynaecologist (except in rural areas women would see a gynaecologist for breast concerns, usually paid for by one of the health insurance systems) although underlying reason is screening (national insurance funds do not recognise mammography as a screening procedure); mammography screening in one of the many private diagnostic centres in the urban areas; self referral to private or public sector mammography service if woman has a concern. Medical records in private sector are property of patient. Thus there is no straightforward way of knowing how many women have mammography that is really screening.
- View from an interviewee that the infrastructure of the health service would not support an effective mammography screening programme at present.
- Women have an authoratitive role in the family regarding decisions about access to health care e.g. mother/mother in law would influence decision about a younger family member going to see doctor.
- Rural primary care does not deal with HRT and bone densitometry: would refer to specialist.
- Rural midwives do not encourage use of HRT

- We were unable to gain much impression of the use of HRT and bone densitometry: the health professionals interviewed did not deal with it themselves.

Summary
The fieldwork suggests contrasts with the literature as summarised in table 3

Conclusions and future research
The interviews with health professionals revealed a view of the health services and the provision of mammography and bone densitometry that was on some dimensions very different from that in the literature, or the field work revealed issues about quality of and its retrieval for morbidity or service provision statistics. Most of the literature on which the choice of countries was made was written for the European Commission and some of it was not very recent.

The access to health professionals within the two countries was very different and yet both may have led to us interviewing health professionals working in settings that were not found commonly in other parts of the country. For example, in Crete we were restricted to public sector health professionals in a medical system dominated by the private sector. In Finland we were able to access the private sector relatively easily yet it is not the major health care provider for the country as a whole as far as we know. This needs to be taken into account when interpreting our data.

Both our hosts are interested in participating in the development of an application for a Marie Curie Research Training Network. However, the type of data collection undertaken as part of this proposal needs to take into account the language issues: RTNs are designed for early stage researchers to have experience of research in a country other than their own. Unlike laboratory research, clinical and social science research often required considerable ability in the host language. However, we are developing a project that can be innovative and interdisciplinary for training future researchers.

In addition to the RTN, links with Crete will continue through our role in advising on Ms Trigoni's PhD. It may also be possible to develop research related to women's health building on the expertise of one of the midwives in Crete who has a Masters degree, fluent English and a commitment to research: more thought is needed for this.

Having undertaken a pilot study involving health professionals in both countries, the potential exists to return to undertake a larger study.

We are planning to write a paper for publication drawing on the data from the three countries and we are presenting a poster on the results at the Annual Scientific meeting of the Society for Academic Primary Care in Glasgow in July 2004.

Table 3 Contrasts between the literature and fieldwork accounts in Finland and Crete

	Finland		Crete	
	From literature	**Contrast in fieldwork with literature**	**From literature**	**Contrast in fieldwork with literature**
Rate of HRT use (1)	High >20%	No data obtained	Low <4%	No data obtained
Incidence and mortality from breast cancer (2)	Low	No data from fieldwork but evidence of robust recording system	Low	Low but rising
Use of mammography women age 50-59y (2)	60%	Higher	30%	Unknown: probably higher than estimated as high level of use of private diagnostic centres and also labelling of screening as diagnosis
Breast screening system	National organised programme	Yes but public provision limited age group (50-59). Increasing use of private mammography. Use of 'diagnosis' label for screening outside of age group in National programme.	No organised programme	No organised programme but all health professionals recommended screening to women
Incidence osteoporosis (3)	High	Yes	Low	No data obtained
Use of test for osteoporosis by women age 50+ years (2)	5 %	Evidence from fieldwork correlates with this although no figure given.	20%	No direct evidence but impression that not much use
Character of health system (4)	Well funded, early uptake of technology, population wide health records using IT.	Public system not well funded, possibly particularly primary health care. No evidence early uptake of technology. No mention of population wide health records that impact upon day to day clinical practice.	Mixed service provision, aspirations for access exceed ability to provide, large private sector and widespread inequalities.	Evidence from fieldwork agrees with this. Use of private sector seems to be very high even by those of relatively low socio-economic status. Family members have role in deciding access to health services.