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Salute e Società

Comparative Research
Methodologies in Health
and Medical Sociology

edited by

Guido Giarelli
on behalf of **European
Society for Health
and Medical Sociology**



FrancoAngeli

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For Info

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EDITORIAL

Eero Lahelma*

1. Origins of the comparative method

In his *The Rules of the Sociological Method* Durkheim (1882/1895) taught us over a hundred years ago that “there is only one way of proving that a phenomenon is the cause of another, and that is comparing different cases”. This comparative method is inherently woven into the whole discipline to the extent that for Durkheim “comparative sociology is not a particular branch of sociology; it is sociology itself, in so far as it ceases to be purely descriptive and aspires to account for facts”. It can even be said that modern science has proceeded through adopting the comparative method. Thus the comparative method is a general procedure in sociology and international comparisons across cultures and societies a particular application of it (Allardt, 1990).

Following Durkheim, examining single descriptive observations from single studies does not make much sense. For example, in a study the point prevalence of diabetes in Italy was 4.6% (Dalstra *et al.*, 2005). Without any further information it is hard to say whether this is a high or a low figure. Luckily that study also collected data from a number of other countries and the corresponding prevalence in Great Britain was 1.5%. Comparing these two figures makes much more sense. We now know that the prevalence of this disease is likely to vary between countries and in this example diabetes was more common in Italy than in Great Britain. Further comparisons of similarities and dissimilarities in the two countries provide us with cues for the reasons why diabetes is more common in Italy than in Great Britain. Thus identifying differences in the disease between the two countries is the starting point for comparative medical sociological research ultimately aiming at understanding the social variations in health between cultures and societies.

* PhD, Professor of Medical Sociology in the Department of Public Health at the University of Helsinki in Finland. He is head of the Helsinki Health Study examining health and well-being among the staff of the City of Helsinki with counterparts in Britain and Japan. His research focuses on the social determinants and consequences of health as well as their international variation, eero.lahelma@helsinki.fi

Durkheim himself already initiated studies comparing societies with different cultures, structures, morals and religions in his *Suicide* (1979/1897), although international comparisons in social sciences started in earnest only after World War II. One reason for the proliferation was the development of empirical research methods, including analyses of population registers and survey data representing national populations (Allardt, 1990). These new opportunities for quantitative comparative research have been utilized within medical sociology particularly extensively for the study of socioeconomic inequalities in health during the last few decades. That experience is worth assessing since many substantial and methodological issues are equally relevant for comparative studies on the level of health, health behaviours, health care utilization as well as other branches of sociology aiming at international comparisons.

2. Comparisons of health inequalities across European countries

Already the early comparative studies showed that hierarchical socioeconomic inequalities in morbidity could be found in the Nordic countries (Karisto *et al.*, 1978), and in mortality inequalities could be confirmed in a number of other European countries as well (Valkonen, 1989). Systematic evidence from international comparisons started to accumulate from the 1970s on. A major impetus came from a broad comparative EU supported research programme that has provided extensive evidence of inequalities in mortality and morbidity across European countries. The breakthrough report covered 11 western European countries in the 1980s and corroborated that hierarchical socioeconomic inequalities in mortality and morbidity existed without exception even in the most affluent western European countries (Mackenbach *et al.*, 1997). The striking feature was that the magnitude of inequalities in mortality in the Nordic welfare states tended to be larger than elsewhere in western Europe. It was noted that this finding concerned relative inequalities and a further question was whether the picture would hold for absolute inequalities as well.

Following up trends of health inequalities in the 1990s and the early new millennium showed that health inequalities are deeply rooted in modern societies. Even a widening trend in relative inequalities in mortality was observed while absolute inequalities had mostly remained (Mackenbach *et al.*, 2003). Corresponding trends in morbidity showed that relative inequalities had remained, with a somewhat widening trend in some countries and a stable trend in some others (Kunst *et al.*, 2005). Unfortunately, there are no examples of narrowing inequalities.

The latest European update until early years of 2000 covers a much larger variety of countries, now also from eastern Europe (Mackenbach *et*

al., 2008). The order of western European countries in terms of the magnitude of relative inequalities in mortality had remained more or less similar. However, expanding the scope to eastern Europe also expanded the earlier picture of differences between groups of countries. Now a clear East-West divide in health inequalities could be detected suggesting that the magnitude of inequalities in mortality was clearly larger in eastern European and Baltic countries than in western Europe. Inequalities in morbidity were continuously large in some Nordic countries, in particular among women, but also some eastern European countries showed very large inequalities in morbidity.

The above evidence comes from European comparisons only and one can ask to what extent the evidence can be generalised to affluent non-European countries. Some smaller scale comparisons are illustrative and suggest that in the United States (Elo *et al.*, 2006) and in New Zealand (Fawcett *et al.*, 2005) the magnitude of inequalities in mortality does not necessarily differ from that found in western European countries.

3. Issues for future comparative studies

The comparative research made so far confirms the universal nature of hierarchical inequalities in both mortality and morbidity across European countries and even affluent countries beyond Europe. The existing evidence has contributed a lot to our understanding of the international patterning of health inequalities, but a lot more work needs to be done. In every single study there always are limitations and comparing many studies there are many limitations. A number of puzzling issues need to be raised for consideration in future studies. Three broad areas can be highlighted: 1) How can we interpret country differences in health inequalities; 2) How can we study, measure and compare health inequalities; and 3) How can we draw policy implications from the comparative evidence of health inequalities.

Firstly, Esping-Andersen's (1990) typology of different welfare state regimes is an example of a framework primarily based on the analysis of structural and institutional arrangements in affluent countries. This typology underlines the specific character of the Nordic countries being more equal than other types of welfare states. Thus efforts have been made to interpret the country differences in health inequalities using welfare state regime analysis (Dahl *et al.* 2006, Eikemo *et al.*, 2008). However, we have seen that the Nordic/Scandinavian social democratic welfare state regime has not shown smaller relative inequalities in mortality or morbidity than countries within the liberal (e.g. Britain) or conservative regime (e.g. Germany). This "Nordic anomaly" remains an

unresolved issue but the debate has been illuminative of the complexity of the production of health inequalities. The anomaly has primarily been identified using relative inequalities, and looking at absolute inequalities complements the picture. Thus Sweden fares better when absolute than relative inequalities are compared between countries. Part of the story for Sweden is that the overall level of mortality in that country is very low and small absolute differences in mortality between socioeconomic groups may produce large relative inequalities. However, the story for the other Nordic countries is not necessarily identical, and e.g. in Finland both relative and absolute inequalities in mortality are large. Taken as a whole the variation in health inequalities among the western European countries is not extremely large and the differences between the welfare state regimes may be smaller than previously thought (Dahl *et al.*, 2006). Nevertheless, major structural differences do matter as shown by the alarmingly large health inequalities in many eastern European countries confirming an East-West divide in health inequalities (Mackenbach *et al.*, 2008).

Secondly, not only theoretically but also methodologically the comparative evidence on health inequalities should be put under critical scrutiny. The comparability of data is a major concern and various approaches have been used to achieve this. One is collecting available survey data sources from various countries and harmonizing these as much as possible. Another is using data specifically collected for comparable purposes, such as the European Social Survey (Eikemo *et al.*, 2008). Irrespective of the approach pitfalls cannot be avoided. Data sources vary in terms of the method of collection, coverage and participation. Even when identical methods are used the variation in participation may be very large and prevent reliable conclusions to be drawn. Mortality data are at best obtained from reliable national registers with good coverage, but such data are available from a number of countries only, notably the Nordic ones. The measurement of morbidity is a very complicated task in comparisons. For example, the level of self-reported health varies a lot from one country to another. The reasons are manifold. The measurements are seldom fully identical between studies and, even if they are, due to linguistic and cultural differences the concepts as well as meanings of indicators may vary between countries and population groups (Palosuo, 2000). As a result, comparing absolute levels of self-reported health is practically impossible and we have to rely on comparisons of relative inequalities in morbidity only. For mortality both relative and absolute inequalities can more readily be measured. As apparent from what has been said above the relative-absolute issue should be considered in each study.

Thirdly, conclusions from comparative studies on health inequalities provide important messages for health and welfare policies. As the magnitude of health inequalities varies this suggests that there is potential to reduce these inequalities in countries where they are larger than

elsewhere. It is clear from the existing work that the production of health inequalities is a complex process ranging from upstream structures to socially patterned individual factors. The measures that are needed equally range from upstream to downstream ones and include e.g. reducing the strong divisions by social class, income and resources in general, reducing the large inequalities in living and working conditions, and promoting smaller inequalities in healthy lifestyles and behaviours. We still lack comparative evidence on the variation of the determinants of health inequalities, but country specific evidence is helpful in showing what factors are of importance. Policy analyses and documents further suggest measures, interventions and policies that are likely to work in curbing the widening of health inequalities and reducing them (Mackenbach and Bakker, 2002; The Marmot Review, 2010).

Sociology in general has learned a lot from comparative studies since Durkheim and so has done medical sociology from comparative studies on health inequalities over the last few decades. A key message from the comparative medical sociology to sociology in general is that hierarchical class divisions and social inequalities in health continue to exert major impacts on people's life chances. The magnitude of health inequalities does vary between countries but the phenomenon itself is universal. Future comparisons should add our understanding of the reasons for the international variation of health inequalities.

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INTRODUCTION

Guido Giarelli*

This special issue of the journal is devoted to the International Summer School on “Comparative Research Methodologies in Health/Medical Sociology’ jointly organized by the European Society for Health and Medical Sociology (Eshms) and the Centro di Ricerca Interdipartimentale sui Sistemi sanitari e le Politiche di welfare (CRISP) of the University “Magna Græcia” in Catanzaro on 6-10 July 2009.

There is no need to explain the rise of comparative research in an era of increasing globalization, transnational organizations (UNO, EU, etc.) and cross-cultural *métissage*: what is at stake, if anything, is the meaning and the definition of “comparative research’. If we agree with Lahelma’s reminder in his Editorial about Durkheim’s statement on comparative sociology not as a particular branch of sociology but as the sociology itself insofar as it aspires to be scientific “by accounting for facts’, the first point we would like to underline is that there is not such a thing we could term “comparative method’.

The latter was proposed, among others, by Lijphart (1971), Ragin (1981) and Collier (1991): in particular, the hierarchical ladder proposed by Lijphart – who locates the comparative research on the third step of an ideal ladder just behind the experimental method (regarded as the most scientific one) and the statistical method (which is regarded as more scientific than the comparative method just because it considers a higher number of cases) and before the case-study (one case only) – is a quite positivistic view, which should be strongly rejected in order to properly understand the nature of comparison. This is the reason why in this issue we talk about “comparative research’ and not about “comparative method’: the difference is salient, and it should not be underplayed.

However, if there is not a “comparative method’ as such, which methodologies can be used in comparative research with specific reference to Health and Medical Sociology? And what kind of problems their utilization

* Ph.D. at University College London (UCL), Associate Professor of Sociology at the Faculty of Medicine of the University ‘Magna Græcia’, Catanzaro (Italy), President of the European Society for Health and Medical Sociology (Eshms), giarelli@unicz.it

raises in terms of research designs, possible integration among them, type of units and levels of analysis selected, conceptual fallacies, comparability of instruments and data? This is the sort of key methodological issues for comparative research the following essays are dealing with from different perspectives.

Graham Scambler, in his stimulating essay, helps us to make clear some of the preliminary issues: first of all, the “common fallacies” which can be discerned in sociological research in order to try to avoid them. His main argument is that ‘making a case’ empirically amounts to much the same things as ‘making a case’ theoretically: this is why he suggests to go beyond the conventional debate between opposite supporters of both quantitative versus qualitative research - and even the blurring of this opposition by ‘mixed-methods’ research - to show that the methodological problems which arise in comparative research are quite the same in both quantitative and qualitative approach. Rejecting any impermeable boundary between them, he deals with the problems of research strategies by concentrating on the main differences among the four types of logic available for research design: that is, inductive, deductive, retroductive, and abductive. He advocates a critical realist approach following Bhaskar (1978, 1989), favouring retroductive and abductive rather than inductive and deductive research strategies, since they better allow the theoretical dimension implicit in all research and too often neglected to be fully displayed.

During recent years, one of the most popular methods among researcher in comparative research has become the multilevel analysis: Dimitri Mortelmans focuses on the consequences that such widespread interest has raised by pointing to the possibilities but even to the problems implied in the utilization of multilevel models. The potential pitfalls in using such a technique are described in details starting with the definitional issue of multilevel analysis in the context of comparative research, by locating the macro-micro multilevel approach on the background of other research strategies such as the case study approach or the welfare regime typologies. His definition of the multilevel analysis “as a statistical model that allows the simultaneous analysis of effects on different levels of clustering on an outcome variable” brings him to identify five distinguishing characteristics of this approach: the hierarchical order of data, the nesting in terms of levels of analysis which are considered relevant in causal terms, the making of multistage samples, the capacity to include analyses at each level separately, and the possibility to introduce random slopes and cross-level effects and interactions into the model.

His second issue is related to the longstanding problem of the correct use of units and levels of analysis in comparative research already identified by Smelser (1976): by arguing that this should necessarily be reconsidered in multilevel analysis, he points at the possible types of levels and units to be regarded, from macro-level typologies of clustering to the fallacies in using multiple levels. The third issue, comparability of

instruments, is usually rarely treated in multilevel analysis textbooks, but it appears of fundamental importance for the validity and reliability of its outcomes: a conceptual framework for the cross-cultural equivalence of measurement scales is presented and the problem of measurement isomorphism is identified as particularly relevant for multilevel analysis.

Even the issue of getting comparable data is a longstanding debated issue in comparative research, especially since when data are not collected directly by the researcher but he has to rely on secondary sources yielded by transnational sources as it is increasingly the case. Mortelmans revises both micro-level data available from international comparative databases and group-level types of indicators stressing that the need for easy accessible data and ready made indicators conceals the risk of a naive automatic confidence by the researcher in the trustworthiness of such sources, which is not always so granted. Finally, his last issue is concerned with the analytical strategy available to comparative researchers wishing to use multilevel models: a six phased procedure to build such models is proposed and discussed in its detailed application.

The third essay by Rosaline Barbour moves the focus on qualitative methods beyond their usual utilization, either at the outset of research projects for developing survey instruments or in order to enhance cultural sensitivity of tools used. She suggests such methods can make an important contribution both to pan-European and country-specific comparative research: firstly, to better understand the mechanisms linking variables as identified by quantitative work, especially by exploring surprising or anomalous findings, and, secondly, by stand-alone studies in enhancing understanding of different cultural contexts and country differences, whether at the regional or population sub-groups levels. However, in order to fully exploit the potential of qualitative studies in comparative research, there is a need for more attention to research design issues by using the sociological imagination in the sequencing of methods and in purposive sampling.

The last three essays are all devoted to the problem of utilization and combination of different sources in comparative research with specific regard to the field of Health/Medical Sociology. Siegfried Geyer opens by considering how data from different origins and of different qualities can better be combined in empirical research, how they can be compared in meaningful ways, and how they can be analyzed together in statistical analyses. He also deals with the problem of utilization of registry data in order to add "objective" information to survey data, even though this kind of information have their specific weaknesses which must be taken into account.

Then, two of the most significant international comparative survey for Health/Medical Sociology are considered: the European Social Survey (ESS), a biennial, academically-driven social survey which is also the first methodological effort into which social values, attitudes, attributes and behavioural patterns can be analyzed and compared between large numbers of European

countries, and the International Social Survey Program (ISSP), a multinational survey research carried out by voluntary association of survey organizations from 46 countries, many of which are affiliated with academic institutions.

Terjie Andreas Eikemo reviews the twenty-one comparative studies recently published in our field using data from the ESS, highlighting the main methodological differences among them and the flexibility that the ESS offers as a data source, with special regard to health inequalities.

Noah Lewin-Epstein presents the ISSP in its rather unique and democratic, participatory model for the development of survey topics and questionnaire design. After describing and discussing the advantages as well as shortcomings of this model, he shows the working of the ISSP by focusing on the module on health and health policy which will be fielded by the ISSP for the first time in 2011.

We thought useful to add to the above for the international reader also a panel discussion on comparative research in the Italian Health/Medical Sociology by outstanding Italian methodologists in the Social Sciences; and a couple of research studies of Italian scholars. The first study by Emmanuele Pavolini offers an overview of the international and Italian literature that, in recent years, have studied how to measure and to evaluate the results and the performance achieved by health care systems, with specific regard to the WHO (2000) classification. In the second study, Angela Genova proposes an original theoretical framework for comparative research based on the concept of ‘health regime’.

At last, in the International Perspectives section we reprint an interesting essay by Viola Burau and Robert Blank assessing the different typologies of health systems and policies, followed by a comment of Willem Tousijn.

We hope that all this will contribute to the development of current comparative research in our field and that the next International Summer School run by the ESHMS will be able to further elaborate on these premises.

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THEORY

Qualitative and quantitative methodologies in comparative research: An integrated approach?

Graham Scambler*

This paper starts by characterizing conventional notions of quantitative ‘versus’ qualitative research and considers their potential displacement by ‘mixed-methods’ research. The claim that mixed-methods research is necessarily an advance on its predecessors is critiqued. Using a critical realist approach favouring retroductive and abductive rather than inductive and deductive research strategies, it is suggested that the theoretical dimension implicit in all research is too often neglected. It is further contended that ‘making a case’ empirically amounts to much the same things as ‘making a case’ theoretically. More ‘meta-reflection’ is commended. Brief references is made to the literature on health inequalities to add some flesh to the bones of the argument.

Key-words: mixed methods, realism, retroduction, abduction, ‘making a case’, health inequalities research.

The overriding purpose of this paper is to promote the idea that sociologists are in the business of ‘making a case’ for seeing and accounting for things this way rather than that. Making a case here involves not only describing how things are, but, crucially, explaining why they are this way; and explaining is taken to necessarily invoke a concept of causality. The methods conventionally employed by sociologists to this end typically focus *either* on surveys of many individuals’ general backgrounds, circumstances, attributes, and so on, *or* on the detailed explication of a few individuals’ specific experiences. This contribution begins by highlighting some common fallacies about sociological research in general, and quantitative *versus* qualitative methodologies in particular. This leads on to a more systematic debunking of the elaborate stereotypes of recipe and critique which these fallacies have spawned. It will surprise few that somehow or

* Professor of Medical Sociology and Director of the Centre for Sociological Theory and Research on Health at University College London. His special areas of interest include chronic and disabling conditions, stigma, health inequalities, sex work and social and critical theory. He is co-editor of the international journal ‘Social Theory and Health’, rmhagns@ucl.ac.uk