EDITORIAL

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1. Origins of the comparative method

In his *The Rules of the Sociological Method* Durkheim (1982/1895) 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.

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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 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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