Jenny Billings

Towards rigour in qualitative health and social research across European partnerships

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Abstract Undertaking projects with European partners is an enterprising and rewarding activity, where societies can start to learn how to transfer knowledge and take advantage of best practices to further the benefits to health and social care service users. However, this can also be a challenging experience, more so when there is scanty guidance about the best way to conduct European partnership research. Using an on-going study of integrated care for older persons as an example (the PROCARE project), this paper provides an account of the methodological strengths and challenges of the qualitative approach used. It suggests that factors assisting a rigorous approach include sound and inclusive coordination, a strong research design, the construction of universally acceptable selection criteria, detailed interview schedules, and a transversal approach to data analysis

Keywords European partnership research · Gerontology · Health and social research · PROCARE project · Qualitative methods

Introduction

This paper provides an account of the methodological strengths and challenges of qualitative approaches used in European partnership health and social research. It focuses particularly on the author's current involvement in a study of integrated care for older persons, the PROCARE project, giving a rationale for the research design and the plan of investigation, and providing an account of how challenges to methodological rigour were pre-empted, identified and tackled.

J. Billings
Centre for Health Service Studies, University of Kent,
Canterbury, CT2 7NF, UK
E-mail: j.r.billings@kent.ac.uk
Tel.: +44-1227-823876

The use of qualitative methods in European research

Qualitative methods are increasingly being used to explore health and social issues within a European context. Commentators believe that there has been a gradual realisation among policy makers that simply relying on statistical data sets is insufficient to understand certain health and social phenomena and develop robust policy (Fountain et al. 2000). The growth of qualitative research has been particularly evident in the field of drug use in the European Union, where the European Monitoring Centre for Drugs and Drug Addiction (EM-CDDA) is increasingly focusing attention on developing comparable methodologies in qualitative methods across the EU (Greenwood and Robertson 2000). Other areas of investigation include HIV/AIDS (Goodwin et al. 2004) and female career moves (Linehan 2001). Not all of these projects have taken place within a European collaborative, however; some, for example, have used a team of investigators from one country and overcome the language barriers by interviewing in English (Linehan 2001).

Without doubt there are particular challenges confronting investigators when undertaking research across European partnerships, where local investigators take responsibility for the planning and execution of an agreed research process. These include overall management and communication factors particularly when the projects are large, gaining consensus with plans of investigation, translation issues, and methodological comparability through sampling and data analysis processes. To heighten this difficulty, there appears to be little in the way of published methodological details to guide researchers, resulting in limited tried and tested examples of process for application to new projects.

The study by Oates et al. (2004) into postnatal depression does, however, provide some useful details about management structure, instrumentation development and data analysis. This study was concerned with developing, translating and validating research

instruments that could be used in future studies of postnatal depression in different cultures and contexts. A project management team consisting of a member from each of the participating countries was convened, to encourage equal dissipation of management accountability. All researchers received training in interviewing, and the management team developed clear data collection protocols. With data analysis, the transcripts were subjected to textual analysis in the original language, concept coding was developed and themes extracted. Then all the data were collated in one coordinating centre to ensure that final themes were not only relevant but accurately reflected the data from each centre.

Oates et al. (2004) acknowledge that, while the method appeared sound and comprehensive, there were some limitations to the study, which included the small numbers of informants in the individual centres, and what the authors describe as the 'perhaps controversial conflation and comparison' across centres after translation. The study does, however, provide some useful insight into methodological processes in European partnership research.

Following on from this, on-going research into the treatment of drug dependent offenders in six European countries (QCT Europe: <http://www.kent.ac.uk/eiss/projects/qct-europe/index.htm>) has tackled the issue of data analysis comparability by employing one researcher to undertake all the qualitative data analysis. While this does overcome a potential problem, it could weaken the impact of country specific data. Constant feedback to partners to ensure correct interpretation may be a way forward.

In addition, some lessons from quantitative studies can provide some transferable management and communication tactics to help inform investigation plans. As with the Oates et al. (2004) approach, Cook et al. (2002) agree that partnership projects are best managed by a small number of experienced professionals at a few centres. They add that electronic and other communication vehicles can be used effectively to aid study management.

Thus while some evidence exists to guide research plans in qualitative studies, there appear at present too few accessible and detailed examples to comprehensively guide project development, particularly in the area of integrated care for the elderly. This paper provides an opportunity to build on this deficit through the author's involvement in the PROCARE project.

Overview of PROCARE

PROCARE is a collaborative European project funded by the European Commission's Fifth Framework Programme, involving nine partner countries. It is a 30-month project due for completion in December 2004. The countries participating are Austria, Denmark, Finland, France, Germany, Greece, Italy, The Netherlands and the United Kingdom. With a focus on integrated

care for older persons, the aim of the project is to provide an overview of health and social care services in the participating countries, evaluate innovative models and identify a sustainable model of integrated health and social care for older persons in need. The project involves a number of phases:

- Phase 1: This has been completed and consisted of each country providing a National Report that critically reviewed integrated care services from the political, organisational and structural viewpoints (Leichsenring and Alaszewski 2004).
- Phase 2: This empirical part of the study was concerned with identifying and evaluating two case studies of good practice in the delivery of services and collaboration between health and social care in each country. Each model was evaluated from an organisational and user perspective.
- Phase 3: The purpose of this final phase is to undertake a cross-national analysis. The results will be presented and discussed with key stakeholders with the aim of identifying quality indicators for integrated care services. Recommendations will be made and results widely disseminated.

The project is currently at phase 3, and partners are in the throes of data analysis. This paper focuses on phase 2 and the analysis framework in phase 3 to highlight how, in practical terms, the research was planned and conducted to maximise the overall quality of the project.

It is important at this point to explain the organisational and management structures within this collaboration, as this had a bearing on the manner by which the project worked towards a positive outcome. The central coordination and management of the project was organised through the European Centre for Social Welfare Policy and Research in Austria. Each of the nine partner countries provided an academic lead and research team for the country-specific work packages. There was also a 'quality assurance' team consisting of representatives from some of the countries to monitor progress. In general, these organisational processes have promoted a sustainable 'buy-in' to the project, encouraged by a collaborative coordination style. As with most collaborations, partners met at intervals in various European cities to discuss progress. Translation problems were largely minimised at meetings due to the verbal fluency of partners and multi-lingual skills of the lead centre team. Electronic networks were also established from the onset of the project, encouraging continuous dialogue.

Plan of investigation and rationale for research design

The purpose of the empirical data collection phase of PROCARE was to reveal the nature and practice of two integrated care services in each of the nine partner

countries from the organisational and user perspective. Specifically, the objectives of the investigation were: (a) to describe how services work to provide integrated care, (b) to explore the experiences of integrated care from the user and carer perspective, (c) to ascertain the impediments to effective working and how to overcome them and (d) to assess the extent to which the service was person-centred.

The development of the methods was guided by an initial theory paper generated from the National Reports (Alaszewski et al. 2004) followed by a more detailed methods discussion paper (Billings et al. 2003). An overview of the design and plan of investigation is given below, highlighting details of process and indicating where challenges were envisaged or occurred and efforts that were made to overcome them.

Research design

Given the European scope of the PROCARE programme, it was important to ensure a valid and consistent approach across diverse contexts and environments; therefore the provision of a suitable research design was paramount. The most fitting approach was a case study design which brought together different forms of data and permitted a robust study of both the objective characteristics of systems and subjective experiences across contrasting areas (Yin 2003). Using Yin's classification, 'integrated care' became the unit of analysis. There were two case studies per country and 18 case studies in all (multiple case study design).

Different types of data were brought together to generate insight into integrated care from a user, carer and organisational perspective (see Fig. 1 for illustration). Most of the data sources were qualitative in order to permit the exploration of experiences, processes and perceived outcomes within the models (Pope and Mays 2000), and the quantitative data related to the collection of some simple baseline organisational data and health profile information of the users taking part. As far as

possible these data sources were intended to be the same for each case in order to permit meaningful comparison and 'replication logic' (Yin 2003). This serves to strengthen developing theories across the case studies.

The method of data analysis associated with this approach uses 'pattern-matching' that permits the blending of different types and levels of data from all the cases into an explanatory model, purported to enhance rigour (Yin 2003). The external validity of case study research is supported through the use of a number of tactics, in particular the concept of analytical generalisation, which involves generalising to established theory (Keen and Packwood 2000; Yin 2003).

It can be seen that this design had some potential for European collaborative research in having an overall strong emphasis on blending data permitting a cross national analysis and consequent inclusive thematic generation. In this way, it would make allowances for some natural data imprecision (such as not being able to accurately match models of integrated care across countries).

Plan of investigation

An important feature of the planning was to ensure that common understanding and agreement was reached regarding key terms. The establishment of criteria became an important feature of the method and considerable discussion at project meetings took place until consensus was reached. As the meetings were quite large and consisted of senior academic representatives with strongly held, diverse views, this was lively at times. Success was greatly enhanced by small group work of comparable membership and setting tasks, with timed feedback to the larger group. During this process the value of qualitative research and the research design in particular became apparent in that it permitted the necessary degree of flexibility and allowed this diversity of integrated care delivery and context to be embraced and captured.

Selection of sites

An initial consideration was to achieve a mutual understanding of what was meant by 'integrated care' in order to ensure some consistency of site selection. What was clear from the National Reports produced in phase 1 was that models of integrated care were very disparate, with varying organisational structures, staffing levels and types, and available resources. Across the European spectrum concepts applied to these models included seamless care (Denmark and UK), coordinated care (France), transmural care (The Netherlands) and joint working (UK).

However, some key process features common to all were identified and were included in the selection criteria. One factor was that there had to be an organisa-

Fig. 1 Case study unit of analysis and data sources

tional goal of providing integrated health and social care for older persons; another that there had to be existing evidence that there was integrated/collaborative working between health and social care workers/professionals (i.e. at least one interface between health and social care provision). Practical criteria were also developed. For example the models had to be established for longer than 6 months, and the organisation had to be large enough to support the sampling requirements.

For both the user and carer, and organisational perspectives, the sampling framework was purposeful in order to engage those respondents who could inform the most (Pope and Mays 2000). The number of users and carers per integrated care model was between 10 and 15 (20–30 per country) and 5 key workers were also interviewed (10 per country). For the organisational perspective a focus group of between 6 and 12 staff were recruited per model (12–24 per country).

There were particular problems to overcome regarding identification of staff role and achieving comparability. With the organisational perspective there were some fundamental differences between staff types, particularly in health. Care needed to be taken when using the work 'professional' as it was not easily translated in other countries, particularly from the health perspective. Taking nurses as an example, in most countries other than the UK there is not a professional registration requirement. Also, there is not an 'unqualified' health care assistant equivalent; in France for example, health care aides have a diploma equivalent to a nursing qualification. In the UK there is a clear hierarchy relating to qualification, but this is not so evident in other countries. In turn this factor could potentially have had an impact on the focus group mix and the ensuing views expressed, and needed to be taken into consideration.

Data collection

An important but simple factor in ensuring rigour and gaining agreement at the data collection stage was recourse to the wider methods literature for guidance about best approaches. Key data collection issues were agreed and implemented. This included interviewing carers separate from users to obtain honest and candid opinions of integrated care (Burnside et al. 1998) and providing researchers with key texts on conducting interviews and focus groups to ensure a common understanding and application of the process (Morgan 1997; Robson 1993). The Social Research Update website also proved useful (<http://www.soc.surrey.ac.uk/sru/sru.htm/>).

Some variations were encountered with respect to how the data were to be recorded. Whilst taping of interviews is considered the approach of choice for full data capture (Fontana and Frey 2003), this was not deemed possible by some partners or even permitted in some countries under certain circumstances. Therefore some countries taped interviews and focus group ses-

sions, while others took written notes. To combat the problems with data quality differences the latter researchers were advised to ensure that notes were read back to respondents on completion of the interview to verify completeness and accuracy (Flick 1998). In addition, the interview schedules were developed to be sufficiently detailed in order to assist in maximising data capture (see below).

Development of the interview schedules

The interview schedules were developed through identification of gaps and priorities highlighted within the National Reports completed in phase 1 of the research, and lengthy and intensive discussion. It was felt to be important to develop detailed easily understood questions to avoid difficulties in translating key concepts and themes between different languages and cultural contexts.

Four schedules were developed for each of the sample groups (users, carers, key workers and staff focus groups) that had common question areas but were applicable to the different configurations and organisational structures of the models. Broad sections were developed, within which the detailed questions were developed. These sections were assessment of need, evidence of person-centred care and joint working, discharge planning and experience of the integrated care service from the different perspectives.

Questions also covered every eventuality (e.g. related to home, residential centre or day care facilities and covering issues around the purchasing of care). This resulted in a series of optional questions that could be clearly navigated on the schedule. Despite efforts, piloting did not take place as it was felt to be too time consuming and onerous to manage any additional changes and that the area had been sufficiently debated.

As previously outlined, case study design provided an analytical framework to enable the development of explanatory models in relation to integrated care for each case study. Whilst this may seem appropriate, there were some challenges in reaching agreement about the actual data analysis process. Due to the different research backgrounds of some the partners (such as economics) ideas ranged from making abbreviated notes from the data to intense coding and thematic development. Recourse to the literature confused the issue as there are a wide spectrum of approaches to choose from ranging from simple content analysis using pre-determined themes (Flick 1998) to in-depth familiarising, coding, categorising and conceptualising (Miles and Huberman 1994).

A factor assisting agreement on the approach was the method of data collection, which in some instances as stated, was written notes. This, along with the added problem of time, disallowed the implementation of more depth analysis. Ultimately an innovative two stage approach was developed to firstly organise the data and secondly to permit the emergence and analysis of themes across the data—'transversal' analysis.

Stage 1. In order to organise the data into a more manageable and comparable form a content analysis approach was adopted along the lines of Flick's (1998) guidance. Four analysis protocols were developed using pre-determined themes that encompassed all the sections from the four interview schedules. Partners were required to place data within these themes justified by actual anonymised quotes, where available. While this approach signalled the way forward for the European perspective in this study, partners wishing to do more detailed analysis were encouraged to conduct this with their country specific data for local use alongside the project requirements.

Stage 2. One of the prearranged meetings was used to identify early emerging ideas from the analysis protocols. Following discussion, different issues coming from the data were clustered into a number of transversal themes that appeared in general to have a European, cross-country applicability: (a) definition and perception from stakeholder's view, (b) access and pathways to integrated care provision, (c) professional cultures and joint working, (d) key innovations, (e) the role of the family in integrated care, (f) quality of service; outcome indicators and orientation towards clients' needs, (g) working conditions and (h) context and framework—financing. Partners were then organised into preferred topic areas, resulting in cross-national teams, the purpose being to explore and analyse the theme more widely within the parameters of the project aims through the collection and analysis of relevant data. These data were requested from partner countries using a specially constructed data request sheet.

At the present time colleagues have exchanged information and are commencing data analysis. The data exchange has been monitored centrally to minimise overlap and repetition between themes. The themes have remained as originally constructed and are in general relevant. Some aspects of the process have been challenging and arduous. For example, partners have had to provide copious amounts of different information on the request sheets in English by scanning large amounts of raw data. In order for the teams to analyse the data in a meaningful way partners are required to produce high quality translations, which is time consuming but necessary to prevent data sources from losing their impact.

However, despite these difficulties this method is proving to be innovative and rewarding in terms of European research. The development of cross national teams has the potential to reduce interpretive difficulties and translation errors. Furthermore, it will help to focus on the chosen issues and to concentrate on comparative views.

Summary and conclusion

In summary, this project has provided the opportunity to place the process of qualitative partnership research in Europe under the microscope and to develop ways of

working towards rigour in ageing research. Factors that facilitated this included the inclusive coordination and management processes, which are providing a good 'steer' to the project, the construction of universally acceptable selection criteria, detailed interview schedules, and a transversal approach to data analysis with cross-national teams. In addition, a strong feature was the research design which provided a sound underpinning and promoted an understanding of how the partner projects could be integrated and blended.

Weaknesses of the study included the lack of adequate piloting due to the complexities of managing any changes to the method, and the inconsistencies between the richness of data collected and that put forward for analysis, for which there is not an easy solution. In addition, although good electronic systems were set up swiftly, they were in general underused by all but the central management team, despite encouragement. Although not a weakness, a challenge of the project was the sometimes necessary but protracted and occasionally 'angst-ridden' discussion, especially around developing definitions and criteria. This was due to the large group and the importance attached to partner involvement, and the complexity of the projects stimulating the need to capture and incorporate every eventuality.

Reflecting on this process, it could be argued that in order to combat threats to rigour, it is possible to impose too much structure. Qualitative methods are purposefully designed to encourage the emergence of ideas not previously planned for, and confining the methods in less flexible criteria and schedules could reduce this potential. This could be compounded by the use of pre-determined themes, which has a tendency to generate data within its confines, with the result that more meaningful data could become disassociated from the main body of analysis. However, alternative methods of handling vast quantities of data would necessitate adding length and resources to projects, which, given European commissioning requirements, may be less acceptable.

Added to this is the fact that condensing large amounts of country-specific case studies into a European level analysis will inevitably strip away colourful local context. However, partners are producing country specific reports for local application to counteract this. In general it is perhaps important to strike a balance between conformity of approach and natural inconsistencies that will result from the variations. Qualitative approaches are of course ideal to absorb these anomalies and case study design in particular, in that it promotes the blending of data and lends itself to a natural comparative element.

To conclude, persons joining European academic partnerships come with a diverse range of expertise, experience and expectations about what the project is to achieve, and how it should be done. It is rarely possible to do the 'textbook' approach, but it is possible to work towards this. Achieving success is largely about compromise to ensure the 'greater good', with negotiation and debate being important elements to overcoming challenges.

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