Coalition theory as a framework for understanding and implementing intersectoral health-related interventions

MICHEL O’NEILL1,4, VINCENT LEMIEUX2,4, GISÈLE GROLEAU2,3, JEAN-PAUL FORTIN3,4 and PAUL A. LAMARCHE3,4

1École des sciences infirmières et Groupe de recherche et d’intervention en promotion de la santé (GRIPSUL), Université Laval, Québec, Canada, 2Département de Science politique, Université Laval, Québec, Canada, 3Département de Médecine sociale et préventive, Université Laval, Québec, Canada and 4Réseau de recherche sociopolitique et organisationnelle en santé, Québec, Canada

SUMMARY
Although it is regarded as a central concept in the practice of health promotion, intersectoral health-related action (IHA) has, to date, failed more often than it has succeeded. In this paper we review relevant social scientific literature, offer a working definition of intersectoral action and explore the usefulness of coalition theory as a theoretical framework through which to understand IHA theoretically and practically. Coalition theory has been previously used to study political alliances but it encompasses a series of parameters pertinent to the analysis of IHA. These parameters are: the rewards people expect to gain from participation in a coalition; the political assets they have to bring to the coalition; the non-utilitarian preferences they develop; the coalition’s rules for decision-making; and the organisational context in which the coalition operates. We used these five parameters to study three intersectoral endeavours in Quebec, one at the local level and two at the provincial level, including activities associated with the Healthy Cities movement. Coalition theory proved useful in unravelling the mechanisms of these endeavours and appears promising as a tool for studying and/or implementing intersectoral health-related interventions.

Key words: Healthy Cities; health promotion; intersectoral action; Quebec

INTRODUCTION
Despite being central to current conceptualisations of health promotion [World Health Organization (WHO), 1984, 1986c; Kickbusch, 1986; de Leeuw, 1989; Nutbeam, 1994], the idea of intersectoral action for health suffers from the same problem that Pederson et al. (1988) identified regarding most health promotion concepts: because these concepts are primarily ideological and action driven, they are usually not soundly scientifically or theoretically based, despite significant efforts by early health promotion thinkers to connect action and science (Kickbusch, 1994).

With this in mind, in 1991 we established a research project with three aims: (i) to clarify the notion of intersectoral health-related action (IHA); (ii) to specify a precise conceptualisation of it; and (iii) to use this conceptualisation to analyse concrete actions from which to subsequently formulate recommendations for practitioners.

This paper reports on the more theoretical elements of our explorations, the practical recommendations having been disseminated elsewhere (Fortin et al., 1994a, b, 1996) in accordance with our wish to produce sound but readily applicable science (O’Neill et al., 1994). We begin this paper with a presentation of the conclusions of a literature review we conducted, ending with our working definition of IHA, as well as our rationale for
choosing coalition theory as the conceptual framework for our empirical analysis of IHA. We then outline coalition theory in more detail. The third part of the paper uses coalition theory to analyse three cases of intersectoral interventions. Finally, we offer some preliminary recommendations for further study of IHA.

POSITIONING INTERSECTORAL HEALTH ACTION IN THE LITERATURE

Our first foray into the literature included international materials (Milio, 1986a; WHO, 1986a, b; Eklundh and Pettersson, 1987; Taket, 1988a, b; Springett, 1989; de Kadl, 1989; de Leeuw and Hueben, 1991; Means et al., 1991), as well as those with a special emphasis on Quebec (Ministère de la santé et des services sociaux du Québec (MSSS), 1986, 1992a, b; Bélanger, 1987; Harnois et al., 1987; Commission d’enquête sur les services de santé et les services sociaux (CESSS), 1988; Veilleux, 1990; Beaulne, 1991), pertaining directly to IHA. We were immediately struck by the paucity of materials in this field. Nevertheless, we came to three major conclusions.

First, there is a clear consensus in this literature about the necessity of intersectoral action to promote the health of populations. Consistent with the perspective of healthy public policies popularised by health promotion writers (Hancock, 1982; Milio, 1986; O’Neill, 1990; Evers et al., 1990), it is now taken for granted that a great deal, if not most, of what has a direct impact on health is outside the realm of curative or even preventive health services. Hence, the authors reviewed stress the necessity of involving the non-health sectors which have such significant impact on health in health-related policies and interventions. Second, there is a clear consensus in this literature about what the key elements of a definition of IHA should be. Finally, although concrete and specific suggestions are occasionally made on how to work intersectorally (e.g. Asval, 1988; Roberts, 1988; Saan, 1988; Van Londen, 1988; Winsemius, 1988), there is very little consensus. What the authors generally do concede, in fact, is that this type of work fails more often than it succeeds.

We attribute such failures to two factors. First, because health-related professionals are used to operating in a very prestigious sector of society, they often approach other sectors expecting them to ‘buy in’ to health-related issues without regard for how the health sector can support the legitimate agendas of other sectors. Second, recommendations for IHA are usually based on lessons derived from trial and error rather than on science. Accordingly, we decided to explore several bodies of social scientific literature that we thought pertinent.

We thus looked at research on collaboration and co-operation (e.g. Mazur, 1968; Aldrich, 1976; Booth, 1981; Weiss, 1981; Stahlberg, 1983; Gray, 1985; Gray and Hay, 1986; Schneider, 1987) but, more importantly, at studies on inter-organisational relationships. We found the work done on ‘organisational sets’ (e.g. Caplow, 1956, 1964, 1968; Evan, 1971; Hall, 1972) especially interesting, as well as the pioneering research on inter organisational exchange by Levine and White (1961). From these studies, we came to three conclusions. First, it is vital to move beyond the ideological statements favourable to IHA found in the health promotion literature and to conceptualise intersectoral action in terms of the (often selfish) interests pursued by individual or organisational actors. Second, the relative power of actors interacting in intersectoral ventures is of paramount importance. Finally, the nature of the formal—but especially the informal—ties between the actors, is also of central importance in shaping collaborative efforts.

Following this literature review, to which more recent work (Delaney, 1994; Eisenga, 1994; Nutbeam, 1994; Ouellet et al., 1995; Springett, 1995) does not, in our view, add anything substantially new, we decided that the notion of coalition was probably the most useful way to conceptualise IHA. The notion of ‘coalition’ not only incorporates most of the characteristics identified by our literature review as relevant for IHA, but it also has been the subject of a significant body of theoretical and empirical work, especially in political science and sociology. The study of coalitions in the health sector has also begun to receive some interest (e.g. Health Education Research, 1993), but the focus of these studies has not been on their contribution to the understanding of IHA.

We thus ended the first part of our research by tentatively defining IHA as ‘a process through which actors belonging to different sectors unite to address a given health-related issue’ (Fortin et al., 1994a, p. 15) and by choosing coalition theory as our conceptual framework for IHA.
Let us note at the outset that we do not mean to imply that intersectoral groups in the health sector always have all the characteristics defining a coalition. However, we decided to employ coalition theory heuristically in the hope of constructing a new and useful approach to analysing intersectoral action.

While there are numerous researchers in this arena (e.g. Von Neuman and Morgenstern, 1944; Riker, 1962; Caplow, 1964, 1968; Adrian and Press, 1968; Kelly, 1968; Deswaan, 1970; Groenings et al., 1970; Hirshman, 1970; Browne, 1973; Komorita, 1974, 1979; Lawler, 1975; Lawler and Youngs, 1975; Brudge and Herman, 1978; Warwick, 1979), William A. Gamson is probably the most important among the founders of coalition theory (Bolduc and Lemieux, 1992). In a highly influential article, Gamson (1961) defined coalitions as temporary alliances among individuals or groups which differ in goals. He proposed four parameters which predict the formation and evolution of a coalition, that is who will join with whom in any specific instance. These four parameters define, in our opinion, key conditions for IHA as well.

Gamson’s first parameter is the ‘initial distribution of resources’. Participants in intersectoral activities bring with them different resources, including a sense of purpose, information, prestige, contacts, authority derived from their size, wealth, and so on. These resources are important predictors of the processes by which intersectoral activities will occur.

Second, there are the ‘payoffs’ or the ‘rewards’ that the members expect from their participation in the coalition. Fundamentally, the individual members hope to receive rewards that they would not obtain if they were to act alone. In many cases, as Gamson describes it, the payoff for joining a coalition is the expected value of future decisions multiplied by the probability of the coalition functioning. The same phenomenon occurs with intersectoral action: it is not the immediate but the future payoffs which, generally speaking, are of interest.

Gamson’s third parameter he calls ‘non-utilitarian preferences’. This parameter relates to each participant’s inclination to join with any other player, whatever that player’s control of the resources might be. The participant’s inclinations can be seen as ties, some being positive whereas others are negative or neutral. There is often a big difference between intersectoral groups where positive ties are numerous and others where this is not the case.

The fourth of Gamson’s parameters is the ‘effective decision point’. These ‘rules of the game’ will frequently specify the portion and nature of resources formally necessary to control decisions. One approach is majority rule. In other cases there may not be a formal rule, but rather a kind of informal agreement to aim toward consensus or unanimity in decisions. In the same way, if there were conflict within the coalition, another informal rule could specify that the members have to find a consensual way to resolve the conflict.

Considering that IHA usually take place within an organisational context independent of the members, we added a fifth parameter to Gamson’s list based on Hinckley’s (1981) suggestions: the ‘organisational context’ refers to rules defined by the environment. Among these rules are those concerning the number of players, the occurrence (or not) of meetings, the bargaining rules and the information conditions. As we shall see, in the empirical case studies we conducted the organisational context turned out to be significant in determining the existence and effectiveness of IHA. Consequently, this fifth parameter is an important addition to our conceptual model of IHA.

THREE EMPIRICAL CASE STUDIES: KEY METHODOLOGICAL ELEMENTS

In our empirical study, three different types of health-related intersectoral actions were studied from the viewpoint of coalition theory, with the adjustments just discussed. In addition to the five characteristics of coalition theory, we identified a number of other parameters to consider in our analyses. First, we chose to examine IHA at different levels of action, ranging from the local to the central, as also recommended by Delaney (1994). In Canada, ‘central’ tends to mean at the provincial level, because the provinces have constitutional responsibility for health and welfare services. At the central level, we decided to distinguish between governmental intersectoral actions and actions not driven by the provincial government. This led us to conduct three case studies; one at the local level and two at the provincial one.

In addition to considering different levels of action, we analysed our cases according to time,
i.e. to see whether being at the emergence or at the implementation phase of an intersectoral process made any difference. Taking into account the stage of the process was prompted by earlier findings from study of the Quebec Healthy Cities network (Fortin et al., 1992).

Data were collected through semi-structured interviews with key informants and a written questionnaire, between February and August 1992, with final contacts in 1993 and 1994. Content analysis of various historical documents was also performed. A total of 36 individual or small group interviews, lasting an average of 2 h, were conducted; 26 questionnaires were completed well enough to be usable in the analysis and a total of 371 documents were perused. A combination of qualitative and quantitative analyses was conducted, including Lemieux’s (1991, 1992) classifications of the various power resources of political actors as well as the payoffs expected from the coalition. Additional details on the methodological choices made for these case studies as well as on the data collection and analytic procedures are available elsewhere (Fortin et al., 1994a).

MAJOR FINDINGS OF THE CASE STUDIES

The local level

The local case we studied was that of a medium-sized city (population 80 000), where we looked at the coalitions established to launch the Healthy Cities project as well as to implement five specific actions. We chose these actions from several others because they captured variations in the duration of the coalition, the stability of coalition membership over time and the level of achievements of the group. The issues addressed by the actions studied were: toxic waste disposal; improvement of an inner-city pedestrian mall plagued by marginal teenage groups; architectural adaptation of housing to suit the needs of the elderly; prevention of at-risk situations among the elderly population; and bicycle paths. The intersectoral groups studied had a life span ranging from 0 to 48 months.

Several observations were made from this case. The most interesting findings were that the effective coalitions started among people who were already acquainted. This situation, however, sometimes made life difficult for newcomers who joined subsequently. We also realised that the more practical the projects, the more likely they are to rally people and succeed. Keeping a strong political link with the political authorities was definitely advantageous, as was the capacity to establish a minimal material infrastructure. Decision-making was consensual and the capacity of group leaders to provide conflict resolution strategies was very central to the survival of the coalition. Indeed, in several cases, due to natural affinities among certain group members, subgroups emerged, which had the tendency to generate conflict. Another conclusion we drew was that at the emergence phase of the coalitions, believing in the cause is the key resource brought in and the main benefit expected from participating in the coalition. At a later stage, the fact that someone was an expert (informational resource) or was well placed in the power structure of the community (positional resource) could become more prominent reasons for a person joining.

Governmental intersectoral action at the provincial level

The governmental intersectoral action we studied was the development and implementation of a provincial nutrition policy for elementary and secondary schools. This policy initiative involved people from three provincial ministries (Health and Social Services; Agriculture and Nutrition; and Education), one regional public health agency, and one school board known for its long-term involvement in this area. The developments analysed lasted nearly a decade. The original phase spanned from 1984 to 1987. It was followed by a reorientation phase, with a different set of members, which began in 1987 with a change of the party in power in the provincial government and which continued at least until 1993 when we last gathered information on this venture.

There are several important findings from this case. The first is that even at this central level, the policy was initiated by a group of people who had worked together on a pilot project and who had successfully pushed their various ministries to put their concern on the policy agenda. The second finding pertains to the importance for all the delegates on intersectoral inter-ministerial committees of keeping the channels of information with their administrators open and of having good political sensitivity. Failing on these two criteria was one of the major reasons why the work of the committee was totally disregarded by one of the ministers concerned, resulting in a major switch in the committee’s mandate following an election.
Open and ongoing communication links with administrative officials are critical in cases such as this because, more often than not, decision-making authority resides with the administrators or the politicians, not with those sitting on the inter-ministerial committee itself. Our third finding is that because the civil servants on these committees cannot resign in the same way as volunteers might (if they resign, they are replaced by someone else from their ministry), these intersectoral ventures often have a kind of structural guarantee that they will survive and are almost doomed to succeed at something, even if the something is very different from what was originally planned.

**Provincial coalition of public health agencies**

The last intersectoral coalition we studied was a provincial coalition created by a group of regional public health agencies and people from the Ministry of Health. This group, though composed only of people from the public health sector (thus more sectoral than intersectoral), had a reputation for effectiveness. This reputation was arising from a series of very visible interventions on trauma prevention, including mobilising local communities about dangerous spots for traffic accidents and lobbying campaigns at the municipal, provincial and federal levels on safety belts, gun control, crash helmets for cyclists, safe equipment for semi-professional hockey teams, the banning of three-wheeled all-terrain vehicles, etc. This coalition was established in 1980 and though initially it operated informally, it has been a more formal organisation since 1986. We studied it in 1991–1992.

Our main findings were that this coalition, while made up of quasi-governmental or governmental agencies, acted like a non-governmental organisation (NGO) or an interest group. Its style of intervention was very political, in contrast to how most governmental organisations operate and, like many NGOs, its power base from which to mobilise participants from various sectors was not very strong. The coalition relied heavily, to carry out its activities, on purposive assets and on the personal capacity of coalition members to develop non-material ties with a variety of individuals occupying key positions in organisations. The coalition was not generally constructed in an intersectoral manner, but mobilised in different sectors, depending upon the issue at hand. This approach partially explains the coalition’s variable rate of success and also why it had a reputation, in the public health sector, for being unusual. Ironically, this coalition acted in a manner that was ultimately to become, in 1993, part of the legal mandate of public health agencies in Quebec, i.e. advocacy to inform the general public on health related issues.

**DISCUSSION: THE USEFULNESS OF COALITION THEORY PARAMETERS TO STUDY IHA**

Returning to coalition theory as an analytic tool, our particular case studies exemplified the importance of organisational context (the parameter we added to the Gamson’s original four) in the formation and evolution of intersectoral groups. Among the different rules pertaining to the organisational context, the criteria for selecting coalition members appeared to be the most important in both the formation and consolidation phases of the group. Two aspects of the selection process were particularly decisive. First, the ideal case was when the members to be selected were persons who had worked together in the past and who had convergent views on the action to be conducted by the group. Second, these persons were better off if they had the capacity to be legitimately mandated to participate by their own group, especially if they joined the coalition after it had been started.

What may be called the ‘tutorial rule’ also proved important, particularly in the case of inter-ministerial action. When an intersectoral group depends on governmental or administrative authorities external to the coalition and having the ultimate decisional powers, it has to maintain a direct link with these authorities, and to manage frequent contacts with the intermediate authorities who are accountable for the group. This is the best way to ensure continuous support for the group mandate and a uniform interpretation of it among the members.

The resources are instrumental to the rewards the members try to obtain from their participation in the coalition. It is useful to think of rewards in terms of Clark and Wilson’s (1961) distinction between purposive, utilitarian and solidarity incentives in organisations. In the intersectoral groups we studied, purposive incentives or rewards were the most important. The sense of purpose is both a resource and a reward to its members, functioning like a self-nourishing asset. In other words, purposive resources are
invested in intersectoral action and often end up in producing purpose as a result. In the coalitions studied, that health or quality of life are goals that can generate significant mobilisation or motivation is obvious. While there were certainly additional rewards sought by group members, generally speaking they are not satisfied with those other rewards without a purposive dimension in them. One could explain this perhaps by the unconventional nature of intersectoral action, which stirs up a very special sense of purpose among participants. Another explanation, more consistent with coalition theory, is that purpose, when shared among the members, is a means of ensuring the domination of co-operation over conflict.

Though many authors (e.g. Springett, 1989; Delaney, 1994) contend that non-instrumental ties are a key parameter in the operation of intersectoral coalitions, we found it somewhat difficult to obtain information about such ties. Some of these ties are undoubtedly of an affective nature, so there may be reluctance to speak about them to interviewers. Fortunately, other positive ties are of a less affective nature and are easier to see. For instance, we observed that when the organisational context is not too constraining at the moment of the group formation, the positive ties between a small number of persons are usually crucial, as they are when there are tensions within the group, or if it becomes necessary to transform the group in some way.

The ‘effective decision point’, the last of Gamsom’s parameters, operates on a coalition differently when a group has no adversaries as compared to a situation where many groups are in conflict. In an intersectoral group without external adversaries, it is intra-group conflicts which are significant. Consequently, we observed that measures have to be taken to reduce the possibility of such conflicts, or at least to manage them if they occur. From this viewpoint, rather than sophisticated formal processes as are often used in complex political coalitions, consensus is the decision-making strategy in these kinds of groups and, more generally, in small or medium-sized groups. We found that a persuasive style of conflict resolution by a leader is better than an authoritative one if there is a failure in reaching a consensus. Perhaps such a leadership style is more appropriate to the purposive nature of health-related intersectoral groups.

To conclude about the five parameters as a whole, we suggest that the key to whether a coal-
opponents, but the internal ones. In the same way, payoffs depend mainly on co-operation within the coalition rather than on other actors in the environment. Negative ties with some actors in the environment typically absent, the coalition is deprived of ‘common enemies’ to bind itself together. Finally, the effective decision point depends to some degree on the organisational authorities which are managing the intersectoral activities, but also on the consensus to be reached within the members of the coalition.

CONCLUSION

The exploratory nature of this research and methodological limitations obviously constrain the conclusions to be drawn from this work. Nevertheless, we are convinced of several things at this stage in our exploration of IHA. First, it is important to go beyond ideological enthusiasm for intersectoral action, especially since most empirical evidence actually points to the failure of intersectoral coalitions. Second, using theoretical insights about coalitions helps understanding of how IHAs succeed or fail. Third, among the various possible theoretical formulations available, our revised coalition theory seems to be useful, regardless of whether one is interested in advancing social science or health action.

About one thing we are certain. IHA is heralded as a significant strategy in restructuring health care systems world-wide. It is important to conduct further additional research on IHAs, lest they remain a theoretical and/or ideological panacea for the problems in health care delivery today. It is our belief that coalition theory provides a good starting point for such future research and warrants further examination.

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Address for correspondence:
Michel O’Neill
GRIPSUL
École des Sciences infirmières
Université Laval, Ste-Foy
Qc, Canada, G1K 7P4

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