Reverse decoupling: Ukrainian case of healthcare financing system reform

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Abstract

Purpose – To explore inter-organizational interactions that might result in prolonged decoupling between central governments' ideas and local governments' practices during the reform of an institutional field (i.e., healthcare).

Design/methodology/approach – The paper is based on a qualitative study of the centrally directed reform of the healthcare financing system in Ukraine and focuses on practices and reform ideas from 1991 to 2016.

Findings – The findings show that, for more than 25 years, local governments, as providers of healthcare services, faced two major problems associated with drawbacks of the healthcare financial system: line-item budgeting and fragmentation of healthcare funds. Over 25 years, central government's attempts to reform the healthcare financing system did not comprehensively or systematically address the stated problems. The reformers' ideas seemed to focus on creating reform agendas and issuing new laws, instead of paying attention to challenges in local practices.

Practical implications – This article has two main points that are relevant for practitioners. First, it calls for greater involvement from local actors during all stages of public sector reforms, in order to ensure the relevance of developed reform strategies. Second, it points to potential challenges that central governments may face when conducting healthcare financing system reforms in transitional economies.

Originality/value – The paper's contribution is twofold: it outlines reasons for problematic implementation of healthcare financing system reform in Ukraine and explains them through a 'reverse decoupling' concept.

Keywords Decoupling, intergovernmental interactions, public sector reforms, healthcare, Ukraine.

Paper type Research paper

Introduction

In the public sector context, decoupling of local actors from central actors' reforms is usually considered a reasonable consequence of any top-down driven change. Decoupling is a strategy that can take various forms – an attempt to survive (George *et al.*, 2006), a safe-guarding mechanism in a heterogeneous field (Boxenbaum and Jonsson, 2008), a response to conflicting objectives (Alexius and Grossi, 2017) or expectations (Greenwood *et al.*, 2011), and the result of a complex and dynamic process of resistance (Modell, 2009). Local actors' decoupling is considered undesirable, because it goes against the efficiency of a reform-driven change process. In most cases, decoupling brings unintended results of top-down institutional change, since 'Rules are often violated, decisions are often unimplemented, or if implemented have uncertain consequences […], and evaluation and inspection systems are subverted or rendered so vague as to provide little coordination' (Meyer and Rowan, 1977, p. 343). Thus, understanding the reasons for decoupling might facilitate the development of measures that allow local resistance to central reforms to be overcome.

In this paper, we seek to extend the understanding of decoupling, specifically to study the conditions under which decoupling between central and local actors, rather than becoming an unintended fixable consequence of institutional change, appears to be a stable state that dominates in the institutional field. To this aim we focus on the case of Ukrainian healthcare financing system reform during 1991-2016.

In the early 1990s, the economy in Ukraine and other Central Eastern European (CEE) countries was challenged by institutional upheaval. The overwhelming institutional changes (Tilcsik, 2010) of transitioning from central planning to a market economy affected all spheres of public management and had a particularly notable effect on healthcare financing systems (Nemec and Kolisnichenko, 2006). Thus, this paper's research question is: how had inter-organizational interactions developed in such a way that they resulted in prolonged decoupling between central and local governmental levels during Ukrainian healthcare reform? The evidential base came from interviews with actors (i.e., politicians, public servants and economic experts at central and local levels) involved in Ukrainian healthcare reform, supported by an analysis of secondary data.

The paper is structured as follows: first, a literature review is outlined, followed by a method section. Next, the case of Ukrainian healthcare financing reform is presented, with a focus on central-local governmental interactions. The discussion section then presents the concept of 'reverse decoupling' to explain the issues of inter-organizational interaction during Ukrainian healthcare financing reform. The paper ends with conclusions and suggestions for future research.

Literature review

Institutional theory on decoupling

'Similar to much management and organizational research informed by NIS [Neo-institutional theory], one of the most widely examined themes […] concerns the decoupling (or loose coupling)'[1] (Modell, 2009, p. 281).

Over the years, the idea of decoupling has received considerable attention in the literature. The conceptualization of decoupling developed by Meyer and Rowan (1977) depicts a situation in which organizations adopt external symbolic policies and simultaneously try to maintain institutionalized myths for legitimization purposes. In such a situation, an organization conforms to ceremonial rules and maintains ritualistic practices. Since an organization is comprised of human actors, who may have varying interests and are capable of independent actions (Scott, 2014), weak connections

between social systems are often enacted (Scott and Davis, 2007). This creates a vision of a sort of 'double life' (Hernes, 2005, p. 12), which an organization might follow during the decoupling process.

Decoupling does not occur spontaneously; often, it appears when external actors prescribe regulatory requirements (Scott, 2014) that contradict institutionalized practices in an organization (MacLean and Behnam, 2010). Organizations frequently decouple to protect established routines from external uncertainties (George *et al.*, 2006). Seeking survival, organizations struggle to balance rules and logics that are institutionalized within the surrounding social context (Freidland and Alford, 1991) or that emanate from a strong institutional environment (Alexander and D'Aunno, 1990). According to Boxenbaum and Jonsson (2008), decoupling is an organization's superficial abidance by institutional pressures and adoption of formal structures without implementing them in related practices. However, this interpretation neglects several important dimensions of decoupling, such as the activeness of organizational responses, endurance of these processes and levels other than organizational at which decoupling may occur.

To understand how organizational responses to institutional pressures vary, patterns of organizational behaviour can be explored. Oliver (1991) argued that organizational behaviour may be motivated by a variety of strategic responses – from passive conformity to active resistance – depending on the types of institutional pressures organizations face. Specifically, organizations may apply dismissing tactics as part of a defiance strategy, ignoring external directives when conflicts arise between internal goals and institutional requirements. Challenge tactics within this strategic response, as an active form of resistance, highlight 'a virtue of their [organizations'] insurrections' (Oliver, 1991, p. 156), when organizations contest the rules of the institutional environment.

Tilcsik (2010) attempted to study decoupling as a durable process. By focusing on how the process of decoupling had evolved over time, he suggested that, when an organization deals with 'inconsistency between the policy and the decision makers' ideological beliefs about how their organization should be run' (p. 1488), decoupling could take the form of active resistance. The dilemma of contradictory demands (Brunsson, 1989) might be another reason for decoupling. Supporting his arguments with examples from Swedish municipalities, Tilcsik exemplified a conflict between the rational logic of organizations and the political logic of decision-makers. Such contradictions usually characterize transitional periods, as conflicting requirements can simultaneously affect several policies (Alexius and Grossi, 2017). These scholars identified decoupling in a hybrid organization by accounting for long-term institutional complexity and competing institutional logics.

Decoupling in reformers-reformees' interaction

Institutional theorists have recently scrutinized large-scale societal transformations such as national economy reforms. Studied topics include: organizations; their actions, structures and connections; and the processes of macro-social and economic change (Lawrence *et al.*, 2011). North (1990) contrasted institutions and organizations, stating that the former set the rules of the game while the latter play according to the rules. The establishment of rules and taken-for-granted practices is typical within strong institutional environments such as healthcare (see Arndt and Bigelow, 2000). However, the assumption that organizations are passive recipients of set rules limits further studies on this topic (Oliver, 1991).

Research should now seek new explanations for institutional action, by shifting focus from the processes of organizational fields to interactions between institutions and their actors (Lawrence *et al.*, 2011). For example, during times of radical change, organizations might remain stable and consistent in internal political and economic spheres, while simultaneously appearing to implement institutional frameworks introduced by changing external contingencies (Hirsch and Bermiss, 2009), thus taking an active position of 'creative navigation' within their organizational fields.

As suggested by Brunsson (2007, 2009), it is necessary to equalize the roles of reformers and of those at whom reforms are directed – the reformees. Reformers produce ideas, negotiate, introduce reform packages and then issue documents as institutionalized norms (i.e., legal acts and regulations). Reformees carry out actions and simultaneously deal with conflicting demands and inconsistencies caused by reforms (Brunsson, 2009). Reforms usually produce insoluble problems or generate too many promises, resulting in a constant need for further reform. One suggestion for synchronizing ideas proposed by reformers with actual practice is to ensure reformees' control over reformers, instead of the reverse (Brunsson, 2007). If reformees can take a strong position and communicate the practices that should be reflected in reforms, then ideas and practices will correspond with each other.

However, depending on whether the institutional environment is strong and well-established or weak and unstable, the roles of reformers and reformees during reforms can change. For example, as previously discussed, within a strong institutional environment, reforms are generally guided by reformers' ideas, and reformees should either play according to the rules or – for several reasons – decouple from these rules. Within an institutional environment that is transforming, and thus has weaker structures, reformees can play a more active role in the reforming process, by proposing practices and thus becoming rule-setters themselves. Considering the nature of the institutional environment, which seems to be less discussed by academia, this perspective opens up new opportunities for studying inter-organizational interaction during the reform process.

Decoupling in the field of healthcare and during reforms

Decoupling during healthcare reform may take various forms. Kern *et al.* (2018) recently revisited the concept of decoupling and identified power and political aspects of decoupling. They discuss forms of decoupling besides symbolic policy adoption and examine the role of institutional complexity, to show the political approach to decoupling in a case of internal dynamics and professional logics in French healthcare institutions. A case study of a Norwegian hospital (Modell, 2001) showed that decoupling between various practices could be caused by conflicts and inconsistencies between norms and rationalities. That study focused on the responses of senior management as 'absorbers' of healthcare reforms (Modell, 2001, p. 441), in order to examine managerial manoeuvres in response to conflicting interests.

Despite academic interest in recipients' reactions to reform, the interactions between a state and its local governments have received relatively little attention. Ferrè *et al.* (2012) touched on the decentralization of healthcare policy, by comparing Italian regions. They discovered that, due to the central government's failure to recognize variations among regions, regional recovery plans seemed to prescribe only 'cosmetic' interventions. One reason for such decoupling was a lack of coordination of control mechanisms between the Ministry of Economy and Finance and the Ministry of Health.

The results of healthcare reform have also been studied in CEE countries. Nemec and Kolisnichenko (2006) found that, after ten years of change in Armenia, the Czech

Republic, Russia and Ukraine, reforms did not bring desired outputs because of contradicting actions of central governments, which introduced market mechanisms while frequently changing the rules. This created barriers for the actual implementation of new mechanisms. An evaluation of the results of healthcare system reforms in Poland suggested that the post-New Public Management concept reflected in de-marketization and de-agencification of healthcare was a politically driven action (Mikuła and Kaczmarek, 2019). Moving beyond Europe, a case of Chinese reform of the public hospital system developed under a command and control system showed that market reforms resulted in a hybrid model of hospital funding, during which public hospitals, partially dependent on the state, operated within the private market (Mei and Kirkpatrick, 2019). Thus, in order to financially cover all their expenses, Chinese public hospitals focused on generating profits from particular drugs and services (Mei and Kirkpatrick, 2019).

In summary, an overview of recent literature revealed research gaps that this paper attempts to fill. The first gap concerns analysis of the inter-organizational level, as previous studies have focused on extra-organizational (Meyer and Rowan, 1977), intra-organizational (Kern *et al.*, 2018) or organizational (Boxenbaum and Jonsson, 2008) decoupling. Another gap involves the roles (i.e., decoupling tactics) of reformers and reformees during the decoupling process. Finally, interactions between central and local actors during healthcare financing reform appear to be relatively less discussed. To cover these gaps, our research question focuses on how inter-organizational interactions developed such that they resulted in prolonged decoupling between reformers' ideas on reforming the healthcare financing system and reformees' practices related to day-to-day system operation.

Method

Studying decoupling in a post-Communist context is particularly intriguing (Tilcsik, 2010). This qualitative case study was conducted in the context of Ukraine, a post-Communist country and ex-member of the Soviet bloc. The data was collected via fifteen in-depth interviews structured around open-ended questions. A period of 25 years (1991–2016) was chosen because the process of conducting and implementing reforms requires time. In this case, it was crucial to present evidence of the effect of these reforms on local practices. To provide a balanced view of healthcare financing reform, both central and local actors were approached in 2016 and again in a second round of interviews in 2017.

Prior to the meeting, interviewees were given a brief description of the research and the interview questions. The questions concerned major laws that provided a normative basis for the healthcare financing system in Ukraine and the influence of these changes on healthcare financing legislation at the local level. Interviewees comprised groups of Ukrainian public servants and economic experts (see Appendix 1). The local-level interviewees represented eight local governments and were selected based on one of the authors' previous acquaintance with several interviewees, in order to analyse local practices in different administrative units (city, region or district). The other seven interviewees belonged to central government. This particular group of fifteen interviewees was chosen for several reasons:

(1) Since reformers tend to oversell their reforms (Brunsson, 2009), the views of economic experts and a representative of academia were considered.
(2) To cover a whole period of reform and show the reform's impact on various local governments, people involved at different stages of the reform, as well as representatives of heterogeneous local authorities, were interviewed.

(3) All respondents had expertise in financial issues of public healthcare.

Along with primary data, national legislation was studied, to facilitate an understanding of the Ukrainian healthcare financing system and support evidence from the interviewees.

During data collection and analysis, several issues were experienced, which might be considered limitations of the study. First, some potential participants were hesitant to be interviewed. This was addressed using a 'snowball' method (i.e., potential interview candidates were proposed by previous interviewees). Second, interviews were conducted in Ukrainian and conversations were recorded. Since one of the authors is a native Ukrainian speaker, there were no problems in reaching mutual understanding. However, challenges were experienced when manually transcribing the interviews, as some specific terms had no precise English equivalent (Veselý, 2013). Footnotes are used to clarify these cases; furthermore, during the second round of interviews, the meanings of terms were double-checked with interviewees. Finally, this study analyses the reform over a relatively long time period, which may raise doubts regarding the accuracy of the interviewees' interpretations of past events (Menard, 2008). The 'retrospective interviewing' (Czarniawska, 2000) technique was applied, to elicit important details of the reform. Interviewees were asked about recent changes made to the healthcare financing system, to compare those with previous changes and to provide examples.

Recently, researchers have been inventive in dealing with data-collection difficulties in various settings (Neu, 2006; Courtois and Gendron, 2017; Laguecir and Leca, 2019). We applied a bricolage of several data sources (Wibberley, 2017) to study central-local interaction during the reform. Given that 'the analysis of rich field data is a creative, ongoing process' (Ahrens and Chapman, 2004, p. 284), the data collection and analysis was organized as a holistic three-stage process. The first stage involved a 'top-down' approach, with interviews at the central level supported by secondary data analysis. During this stage, an understanding of the reform's challenges was formed, and the interview guide was updated. The next stage applied a 'bottom-up' approach, as local representatives gave examples of how the Ukrainian healthcare financing system operates. The final stage included the last round of interviews with central and local actors to gather specific empirical evidence on legislative reforms and respective local responses.

According to Morse et al. (2002, p. 14): 'Without rigor, research is worthless, becomes fiction, and loses its utility'. While internal validity considerations, such as consistency, credibility of interpretations, and choice of respondents (Onwuegbuzie and Leech, 2007), were discussed above, it is necessary to address the issues of external validity, i.e., how the study's findings can be generalized in alternative contexts. This paper informs the reader about the reform of healthcare financing system, by providing rich descriptions of practical inconsistencies and central government's attempts to solve them. The outline of problems experienced in Ukraine might be useful to other CEE countries, which share similar characteristics of a healthcare system previously built on principles of a command economy. Thus, analysis of Ukrainian healthcare financing system reform may serve as a helpful example for other countries in the region, by anticipating potential issues when introducing similar reforms.

Empirical findings

Inconsistencies embedded in the healthcare financing system

The Ukrainian public healthcare regulative framework was built upon principles inherited from the Soviet healthcare system, which was developed by the physician and

academician, Nikolai Semashko; the system was then inherited by the Ukrainian government after the dissolution of the USSR in 1990–1991. Features of the Semashko system included free medical treatment for every citizen and state ownership of all healthcare facilities. Workers in this sphere were state employees with fixed salaries (Roberts, 2009). All citizens were assigned to the hospital closest to their residence, with no opportunity to change hospitals without moving their residence. The central state held primary responsibility for providing healthcare services; thus, funding was centralized, and budget allocations were made according to numerical input indicators (e.g., numbers of hospital beds or medical posts).

In 1991, Ukraine, like other CEE countries, initiated broad healthcare reforms aimed at moving from the Semashko system, which had been institutionalized under a planned economy, towards new market-type logics, by introducing mechanisms such as medical insurance, privatization and decentralization (Nemec and Kolisnichenko, 2006). Here, we describe inconsistencies produced by the previous healthcare financing system[2] to enable an analysis of the practical challenges faced by reformees.

To start with, healthcare services that are free of charge to each citizen seem utopian – declared only on paper. According to the Constitution of Ukraine (1996) art. 49, 'All Ukrainian citizens have a right to free medical services'. In order to provide healthcare services for over 42 million Ukrainian citizens, the state collects taxes centrally and redistributes them to regional and municipal governments. Although official Ukrainian statistics show that national healthcare expenditure increased over the years, the state actually covered little more than half of these expenses; the other half was paid by patients (in some cases via unofficial fees)[3]. Moreover, according to the State Treasury of Ukraine, recently the share of healthcare expenditure to GDP decreased (from 4.2% in 2013 to 3.4% in 2017). Thus, since 1991, the Ukrainian healthcare financing system has been gradually transforming into a fusion of government-funded healthcare services with traces of private medicine, meaning that the institutional environment has been quite weak. This situation put increasing financial pressure on citizens, who had to co-finance their healthcare in case of illness (e.g., buy medical supplies or make charitable contributions to the hospital). These numerous unofficial fees indicate that the healthcare system lacked state financing.

> Unfortunately, the Ukrainian system of healthcare is unbelievably chaotic. It is a vicious circle: inconsistency of legislation caused the lack of funding; new laws are adopted, but the issue of underfinancing remains. These laws [the Budget Code, decrees of the Cabinet of Ministers, orders form the Ministry of Healthcare] declare the rules and simultaneously contradict and duplicate each other. Local governments, when trying to deal with these circumstances, probably feel themselves in a mental hospital. (Interviewee 1)

The reason why state finances 'dissolve' during redistribution to local governments might be found in two main drawbacks of the Semashko system.

First, the majority of healthcare facilities in Ukraine are public entities, financed from budgets from respective governmental levels on the basis of a line-item budgeting method used since the Soviet times. It prescribes that a medical facility is funded according to the estimated level of expenditure for its maintenance (i.e., inputs: salaries, electricity, heating, purchase of medical supplies). In a sense, institutional pressure to implement this method forced local governments to maintain the same excessive level of healthcare expenditure.

> The major part of healthcare expenditure is used for the physical maintenance of buildings and salaries for employees. We would like to optimize expenditure. However, our hands are tied, due to strict frames of line-item budgeting. For example, if we invest in modernizing the heating

> system of our facility, we will not be allowed to spend the future saved funds on something else because the budget line on heating will simply be reduced. Besides, it is unthinkable that expenses for modernization can be refunded from the central budget. All innovations are our own concern. (Interviewee 12)

> We still refer to outdated Ministry of Healthcare legislation [e.g., the order 'On proving the List of orders of the Ministry of Health of the USSR applicable in Ukraine' from 1996] that prescribes irrelevant standards and rules. For example, only one doctor and two nurses work in a village clinic. There are nine other employees, including guardians, stokers, methodologist, etc., and they are all considered to be employees in the public medicine sphere. (Interviewee 13)

Thus, funding was assigned to a hospital on the basis of its 'existence'; staff salaries depended on the number of working hours, and the number of personnel was centrally regulated. Given such institutional requirements, local governments had no incentive to improve the quality of healthcare services or optimize their quantity.

The second drawback concerns the redistribution of funds at each governmental level to finance healthcare services. As mentioned before, the state plays the major role in financing the Ukrainian healthcare system and guarantees all types of healthcare services: primary healthcare, specialized treatment, highly specialized treatment, rehabilitation and sanitary-epidemiological treatment. The central government delegates responsibilities to each level of the Ukrainian government and provides funds to finance specific services. In particular, regional state administrations are responsible for regional hospitals and diagnostic centres, emergency medical services and specialized medicine (the latter was valid until 2017). Local governments (i.e., district state administrations, cities, districts within cities, villages and rural local governments) finance primary healthcare services.

Since local governments act as the owners of public healthcare facilities, excluding clinics functioning under national authorities, the central pool of healthcare funds becomes fragmented among numerous local budgets[4]. Thus, if a patient visits his or her therapist (primary healthcare) and is then referred to a specialist (specialized medicine), he/she 'moves not only between different healthcare facilities but also between different governmental budgets'[5]. Furthermore, even though each citizen is assigned to the nearest hospital, most patients choose other healthcare facilities. Thus, local governments face uncertainties, since forecasting potential funding to treat patients becomes almost impossible. The unpredictable movement of patients has caused imbalances in hospitals' capacity, with some becoming overcrowded, while others lack patients.

> The main problem is the healthcare infrastructure, because it is financed from the local budgets, and not actual services provided to patients. Examples of this could easily be found all around the country. For instance, in Kyiv, several medical facilities are located very close to each other, thus increasing the supply of medical services. In an area of less than 10 km^2, similar services are provided by municipal hospitals, departmental medical institutions and private clinics. This increases local healthcare expenditure, due to the excessive number of employees and technical equipment used. (Interviewee 2)

To summarize, reformees faced two major problems caused by the Semashko system: local budgets were tied to centrally set norms of standard costing, preventing healthcare funds from being used to improve local efficiency; and discrepancies existed between the allocated funds and actual local healthcare expenditure. Considering the problems that local governments associated with the operationalization of the previous Semashko system, central governments' reforms are traced further, to see whether and how these inconsistencies were resolved.

Central government's attempts to reform the healthcare financing system

The reform started in 1996, when the Constitution of Ukraine declared the accessibility of free medical services (see the visualization of the reform sequence in Figure 1). However, central government produced no comprehensive healthcare development programmes until 2002. The first programme accepted by the Cabinet of Ministers of Ukraine, 'The Health of the Nation' (2002–2011), aimed to satisfy citizens' need for accessible, high-quality medical services. A lack of financial resources was itemized at the end of a list of acute problems in the Ukrainian healthcare system, indicating that this issue was not a priority for politicians. Rather, the focus was on a lack of medical supplies, outdated equipment and the promotion of a healthy lifestyle.

< insert Figure 1 here >

The change in the healthcare financing system was traceable in the budgetary legislation and in other regulations issued by the Ministry of Finance and the Ministry of Healthcare. In 2001, the Ukrainian Parliament approved the Budget Code, which aimed to decentralize healthcare expenditure, by assigning responsibilities for particular services and facilities to multiple governmental levels. Before this, central government manually assigned expenditure to local governments, in a typically subjective and non-transparent manner. The 2002 state budget was the first to contain local expenditure transfer calculations, using a formula based on the number of inhabitants (specified in the order of the Cabinet of Ministers of Ukraine #1195 'On Approving the Formula for the Distribution of Intergovernmental Budget Transfers (Equalization Grants and Funds Transferred to the State Budget) between the State Budget and Local Budgets'). However, centrally assigned transfers sometimes did not meet actual local needs.

> Central government controlled all financial distributions up to 2001. This made regions 100% dependent on central government during the redistribution of financial resources. Local authorities spent a lot on social spheres but still did not have enough self-generated revenues and thus covered budget gaps with transfers from central government. At that time [before 2001], the central authorities used the transfers as a tool to generously hand out subventions to 'loyal' regional governments, punishing others [opponents] with little funding. So, introduction of the Budget Code was a real step towards equalization and transparency of state transfers to local governments. (Interviewee 2)

> Despite the 'breakthrough' of the Budget Code in 2001, several inconsistencies remained. We were still confused because of a mess in responsibilities for healthcare expenditure. Who [local government] is responsible for what [type of healthcare expenditure]? Besides, the transfers were calculated based on the number of inhabitants of an administrative unit. This approach did not and still does not consider the actual need for financial resources. Recently, we had a lowered fertility rate, which resulted in a decrease in child healthcare funding. However, this did not reflect the reality, as in fact the number of ill children increased. (Interviewee 9)

In 2011–2012, a new healthcare reform was initiated, as part of the Programme of Economic Reforms 'Wealthy society, competitive economy, efficient state' for 2010–2014, set by the newly elected president of Ukraine. The presidential programme outlined the main problems of the healthcare system, stages of the reform and reform 'success indicators' (e.g., decreasing the rate of unofficial fees to 5%–7%), with which to evaluate the reform's achievements. However, the new policies neither referred to nor continued the previous government's attempts to change the healthcare financing system.

Based on the amendment introduced in 2011 to the new edition of the Budget Code issued in 2010, from 1 January 2012, new legal and financial public healthcare

mechanisms were probed in four pilot investigations in regional administrations[6], with the aim of improving the accessibility and effectiveness of medical services. However, to some extent, this programme duplicated previous plans to change the intergovernmental relations of healthcare funding.

> From […] 2005 the European Union project 'Health Financing and Management in Ukraine' has aimed at changing the mechanisms of health care facilities financing in two pilot rayons [districts] in Kharkiv and Zhytomir regions, each with a population of approximately 35 000. (Lekhan *et al.*, 2007, p. 18)

A more technocratic government came into power in 2014. The new Minister of Finance also initiated a change in the budgetary system, to reshape the healthcare financing system. Consequently, medical subvention (according to the Budget Code, intergovernmental transfer of healthcare funds) was introduced, which included additional local expenditure. As expected by reformers, the new regulation benefitted local actors, as follows:

1) The financial independence of municipalities increased. Before 2014, municipalities received transfers from regional authorities. Medical subvention allowed local governments to establish a direct link with a state budget, which partially solved the problem of healthcare fund redistribution, since some municipalities lacked residual funds after the regional allocation of healthcare expenditure.
2) The formula-based subvention included more local indicators, such as a financial ratio of budget adequacy (the level of financial provision guaranteed by the state to local governments at all levels), the number of local inhabitants and adjustment coefficients concerning the differences in costs for providing healthcare services.
3) Local governments were granted additional rights to use surplus in a future budgetary period to provide healthcare services. Before this, surplus was returned to the central budget.

Meanwhile, the period 2014–2016 contained many changes to national healthcare policy. During these years, there were six different Ministers of Healthcare, each with his/her own vision of reform. A comprehensive document, 'Concept of healthcare financing system reform', was approved in 2016, with a provision until 2020. Parliament approved several changes related to medical subvention recalculation requirements. In 2016, the new minister suggested another concept of healthcare reform, with a greater focus on the financing system, which was supported by the Cabinet of Ministers. By the end of 2016, nine documents were approved to support this concept.

> Now we are trying to clear up the mess after previous governments. There was no coherent view on the healthcare reform before; since 1991, we have had 22 Ministers of Healthcare, and almost all had their own reform ideas, regardless of the achievements of previous reforms or the current problems. It was so naïve to believe that just approving new legislature would actually improve the healthcare financing system. (Interviewee 14)

The Ukrainian central government's 'hyperactivity' in introducing new reform strategies and amendments to laws, although the latter might be positive *per se*, caused 'a paradox of extensive overproduction' (A'Gh, 2001, p. 242). Frequent changes in legislation and inconsistencies in the Semashko system influenced organizational behaviour, causing local actors to become active in articulating their perceptions of the reform.

> We are unable to plan properly – either revenues or budget expenditure. For example, in November [2015], we were holding public hearings on the draft city budget for the next year, where we discussed and planned incomes and expenses. And in January [2016], we suddenly found out that our planned revenue and expenditure do not correspond to the State budget. We, as a "fire brigade", had to adjust already made decisions within two weeks, because the new budget does not correspond to the one we decided on at the public hearings. (Interviewee 15)

> Several colleagues from other regions, together with the Association of Cities of Ukraine [NGO], were trying to make an official statement and place a moratorium on legislative changes, particularly on Budget and Tax Codes. I support this initiative. Local governments need time to stabilize and adopt a new framework. (Interviewee 11)

In summary, central government's attempts to reform the healthcare financing system did not comprehensively or systematically address the main problems faced by local governments – that is, line-item budgeting and fund fragmentation. The reformers' ideas focused on creating new reform agendas and issuing different laws, instead of paying attention to the reformees' voices and accepting challenges in local practices. These findings reflect the 'reverse decoupling' concept, which is elaborated in the following section.

Discussion

The aim of this paper is to explore inter-organizational interactions that might result in prolonged decoupling between central governments' ideas and local governments' practices during the reform of an institutional field (i.e., healthcare). To achieve this goal, we studied the centrally directed reform of the Ukrainian healthcare financing system, focusing on practices and reform ideas, to explain the reasons for prolonged inter-organizational decoupling from the bottom-up perspective.

In this study, we propose a new concept – reverse decoupling – to explain the challenges of implementing healthcare financing system reform (see comparison of traditional understanding of decoupling with the concept of reverse decoupling in Table 1).

< insert Table 1 here >

The findings showed that reverse decoupling occurred between reformers and reformees during the following situation. The Ukrainian central government introduced coercive institutional pressures, by accepting reform strategies, issuing laws and amending them. Local governments tried to enact the reforms but struggled due to inconsistencies in the inherited Semashko system and reformers' 'hyperactivity' in introducing new reform strategies and amendments to laws. The local governments, supported by NGOs, attempted to articulate these problems by issuing an official statement regarding the ever-changing regulations, thus applying challenging tactics. However, the central politicians seemed to ignore the problems affecting local governments regarding the healthcare financing system and continued to introduce changes. Thus, two major problems caused by the Semashko system – line-item budgeting and the fragmentation of healthcare funds – were not addressed. One main reason why such a mismatch between reformers' ideas and reformees' practices remained for such a long time was the high turnover of reformers, each with his or her own vision for reforming the healthcare financing system. Figure 2 schematically shows the concept of reverse decoupling.

< insert Figure 2 here >

To be concise, reverse decoupling involves a mismatch between reformers' ideas and reformees' practices. The Ukrainian case depicted a story of stability-seeking reformees and reformers who ignored practical concerns. Several factors can explain the ignorance of the political leaders. First, they lacked comprehension of the healthcare system's complexity, as experienced by post-Soviet countries (i.e., the transition from the Semashko system). Second and third, there was a high level of political turnover and legislature overproduction. Fourth, politicians launched reforms without analysing the results of their predecessors' reforms. Finally, politicians did not pay attention to local responses to these reforms.

To conduct successful reform, conformity between decisions made at the central level and local actions is required (Brunsson, 1989). Although the reformees understood the reform's failures and tried to convince reformers that local governments' everyday reality differed from that imagined by those inside the walls of Parliament or ministries, local problems were barely addressed at the central level.

Conclusion

Simultaneous metamorphoses of political and economic systems have given rise to several types of challenges for reforming countries with transitional economies (A'Gh, 2001; Hirsch and Bermiss, 2009). The Ukrainian case revealed that decoupling did not occur at an organizational level. As usually argued in the literature, decoupling focuses on organizations that face externally driven institutional pressures and symbolically adopt new structures without implementing them in practice (Boxenbaum and Jonsson, 2008). How organizations respond to institutional pressures has been widely discussed in the literature, along with a wide range of strategic responses (Oliver, 1991). However, previous studies have not extensively addressed the roles of reformers and reformees during the decoupling process and particularly how central and local actors interacted during healthcare financing reform. Hence, the study contributes to both literature streams – public management and institutional theory – by exploring prolonged inter-organizational interaction (between central and local governments in Ukraine while implementing the reform) and explaining reasons for healthcare financing system reform's problematic implementation through the reverse decoupling concept.

The findings showed that decoupling occurred between reformers' ideas regarding reforming the healthcare financing system and reformees' practices related to day-to-day system operation. Despite actively challenging reformers' ideas for stability-seeking purposes, local governments' responses were not considered by central authorities, which conducted chaotic reforms for over a quarter of a century. Two main problems of line-item budgeting and fragmentation of healthcare funds were not comprehensively addressed by reformers.

From a practical perspective, the study points to challenges that central governments may face when conducting reforms in the field of healthcare. Besides a need to adjust resource allocation approaches to contextual features of the healthcare sphere (Candreva and Eger, 2018), it might first be worth considering the high uncertainty caused by economic transformations, in order to avoid legislative overproduction, which may complicate healthcare financing system reform. Additionally, the study points to the importance of local actors' involvement in the reform process to ensure the relevance of reform strategies.

Finally, the paper encourages further studies to adopt an actor perspective to investigate mechanisms by which local governments can convey their practices to

central government and deepen the understanding of how final users of the healthcare reform – medical institutions – perform their daily routines and adapt to new reforms under such unstable conditions.

Notes

1. The difference between these two concepts is acknowledged; in order to maintain consistency, decoupling and loose coupling are treated here as synonymous.
2. We define the healthcare financing system as a set of procedures starting from the collection of funds for healthcare to their further redistribution.
3. Citing Interviewee 8.
4. As of 2016: 490 district budgets, 178 city budgets and 24 regional budgets.
5. Quoting Interviewee 4.
6. Vinnitskiy, Dnipropetrovskiy, Donetskiy regions and Kyiv city.

References

A'Gh, A. (2001), "Public sector reforms, institutional design and strategy for good governance in East Central Europe", *Studies in East European Thought,* Vol. 53 No. 3, pp. 233-255.

Ahrens, T. and Chapman, C.S. (2004), "Accounting for flexibility and efficiency: a field study of management control systems in a restaurant chain", *Contemporary Accounting Research,* Vol. 21 No. 2, pp. 271-301.

Alexander, J.A. and D'Aunno, T.A. (1990), "Transformation of institutional environments: perspectives on the corporatization of U.S. health care", in Mick, S. (Ed.), *Innovations in Health Care Delivery*, Jossey-Bass, San Francisco, pp. 53-85.

Alexius, S. and Grossi, G. (2017), "Decoupling in the age of market-embedded morality: responsible gambling in a hybrid organization", *Journal of Management and Governance,* Vol. 21 No. 4, pp. 1-29.

Arndt, M. and Bigelow, B. (2000), "Presenting structural innovation in an institutional environment: hospitals' use of impression management", *Administrative Science Quarterly,* Vol. 45 No. 3, pp. 494-522.

Boxenbaum, E. and Jonsson, S. (2008), "Isomorphism, diffusion and decoupling", in Greenwood, R., Oliver, C., Sahlin, K. and Suddaby, R. (Eds.), *The SAGE Handbook of Organizational Institutionalism*, Sage Publications Inc., London, pp.78-98.

Brunsson, N. (1989), *The Organization of Hypocrisy: Talk, Decisions and Actions in Organizations*. Wiley, New York.

Brunsson, N. (2007), *The Consequences of Decision-Making*, Oxford University Press, Oxford.

Brunsson, N. (2009), *Reform as Routine: Organizational Change and Stability in the Modern World*, Oxford University Press, Oxford.

Candreva, P. and Eger, R. (2018), "Can health benefit outcomes benefit public health budget professionals", *Journal of Public Budgeting, Accounting & Financial Management*, Vol. 30 No. 1, pp. 40-52.

Courtois, C. and Gendron, Y. (2017), "The 'normalization' of deviance: a case study on the process underlying the adoption of deviant behaviour", *Auditing: A Journal of Practice & Theory,* Vol. 36 No. 3, pp. 15-43.

Czarniawska, B. (2000), "The Uses of Narrative in Organization Research", GRI Report no. 2000:5, Göteborg University, Sweden.

DiMaggio, P.J. and Powell, W.W. (1983), "The iron cage revisited: institutional isomorphism and collective rationality in organizational fields", *American Sociological Review*, Vol. 48, pp. 147-160.

Ferrè, F., Cuccurullo, C. and Lega, F. (2012), "The challenge and the future of health care turnaround plans: evidence from the Italian experience", *Health Policy*, Vol. 106, pp. 3-9.

Freidland, R. and Alford, R. (1991), "Bringing society back in: symbols, practices, and institutional contradictions", in Powell, W.W. and DiMaggio, P. (Eds.), *The New Institutionalism in Organizational Analysis*, University of Chicago Press, Chicago, pp. 223-262.

George, E., Chattopadhyay, P., Sitkin, S.B. and Barden, J. (2006), "Cognitive underpinnings of institutional persistence and change: a framing perspective", *The Academy of Management Review,* Vol. 31 No. 2, pp. 347-365.

Greenwood, R., Raynard, M., Kodeih, F., Micelotta, E.R. and Lounsbury, M. (2011), "Institutional complexity and organizational responses", *Academy of Management Annals,* Vol. 5 No. 1, pp. 317-371.

Hernes, T. (2005), "Four ideal-type organizational responses to New Public Management reforms and some consequences", *International Review of Administrative Sciences*, Vol. 71 No. 1, pp. 5-17.

Hirsch, P.M. and Bermiss, Y.S. (2009), "Institutional 'dirty' work: preserving institutions through strategic decoupling", in Lawrence, T., Suddaby, R. and Leca, B. (Eds.), *Institutional Work: Actors and Agency in Institutional Studies of Organization,* Cambridge University Press, Cambridge, UK, pp. 262-283.

Kern, A., Laguecir, A. and Leca, B. (2018), "Behind smoke and mirrors: a political approach to decoupling", *Organizational Studies,* Vol. 39 No. 4, pp. 543-564.

Laguecir, A. and Leca, B. (2019), "Strategies of visibility in contemporary surveillance settings: insights from misconduct concealment in financial markets", *Critical Perspectives on Accounting*, Vol. 62, pp. 39-58.

Lawrence, T., Suddaby, R. and Leca, B. (2011), "Institutional work: refocusing institutional studies of organization", *Journal of Management Inquiry*, Vol. 20 No. 1, pp. 52-58.

Lekhan, V., Rudiy, V. and Shishkin, S. (2007), "The Ukrainian health financing system and options for reform", Health Financing Policy Paper 2007/1, World Health Organization Regional Office for Europe, Copenhagen, available at: http://www.euro.who.int/__data/assets/pdf_file/0007/97423/E90754.pdf (accessed 10 June 2017).

Maclean, T. and Behnam, M. (2010), "The dangers of decoupling: the relationship between compliance programs, legitimacy perceptions, and institutionalized misconduct", *The Academy of Management Journal,* Vol. 53 No. 6, pp. 1499-1520.

Mei, J. and Kirkpatrick, I. (2019), "Public hospital reforms in China: towards a model of new public management?", *International Journal of Public Sector Management*, Vol. 32 No. 4, pp. 352-366.

Menard, S. (2008), *Handbook of Longitudinal Research: Design, Measurement, and Analysis,* Academic Press, San Diego, CA.

Meyer, J.W. and Rowan, B. (1977), "Institutionalized organizations: formal structure as myth and ceremony", *American Journal of Sociology,* Vol. 83 No. 2, pp. 340-363.

Mikuła, Ł. and Kaczmarek, U. (2019), "From marketization to recentralization: the health-care system reforms in Poland and the post-New Public Management concept", *International Review of Administrative Sciences*, Vol. 85 No. 1, pp. 28-44.

Modell, S. (2001), "Performance measurement and institutional processes: a study of managerial responses to public sector reform", *Management Accounting Research,* Vol. 12 No. 4, pp. 437-464.

Modell, S. (2009), "Institutional research on performance measurement and management in the public sector accounting literature: a review and assessment", *Financial Accountability & Management,* Vol. 25 No. 3, pp. 277-303.

Morse, J.M., Barrett, M., Mayan, M., Olson, K. and Spiers, J. (2002), "Verification strategies for establishing reliability and validity in qualitative research", *International Journal of Qualitative Methods*, Vol. 1 No. 2, pp. 13-22.

Nemec, J. and Kolisnichenko, N. (2006), "Market-based health care reforms in Central and Eastern Europe: lessons after ten years of change", *International Review of Administrative Sciences,* Vol. 72 No. 1, pp. 11-26.

Neu, D. (2006), "Accounting for public space", *Accounting, Organizations and Society*, Vol. 31 No. 4-5, pp. 391-414.

North, D.C. (1990), *Institutions, Institutional Change and Economic Performance*, Cambridge University Press, Cambridge, UK.

Oliver, C. (1991), "Strategic responses to institutional processes", *The Academy of Management Review*, Vol. 16 No. 1, pp. 145-179.

Onwuegbuzie, A.J. and Leech, N.L. (2007), "Validity and qualitative research: An oxymoron?", *Quality and Quantity*, Vol. 41 No. 2, pp. 233-249.

Roberts, A. (2009), "The politics of healthcare reform in postcommunist Europe: the importance of access", *Journal of Public Policy,* Vol. 29 No. 3, pp. 305-325.

Scott, W.R. (2014), *Institutions and Organizations,* Sage Publications, Thousand Oaks, CA.

Scott, W.R. and Davis, G.F. (2007), *Organizations and Organizing: Rational, Natural, and Open System Perspectives*, Pearson Prentice Hall, Upper Saddle River, NJ.

Tilcsik, A. (2010), "From ritual to reality: demography, ideology, and decoupling in a post-Communist government agency", *The Academy of Management Journal*, Vol. 53 No. 6, pp. 1474-1498.

Veselý, A. (2013), "Accountability in Central and Eastern Europe: concept and reality", *International Review of Administrative Sciences,* Vol. 79 No. 2, pp. 310-330.

Wibberley, C. (2017), "Bricolage research methods", in Glasper, E.A. and Rees, C. (Eds.), *Health Care Research: At a Glance*, Wiley-Blackwell, Oxford, pp. 6-107.

Appendix 1

< insert Table A1 here >

Figure 1. Timeline of Ukrainian healthcare financing system reform

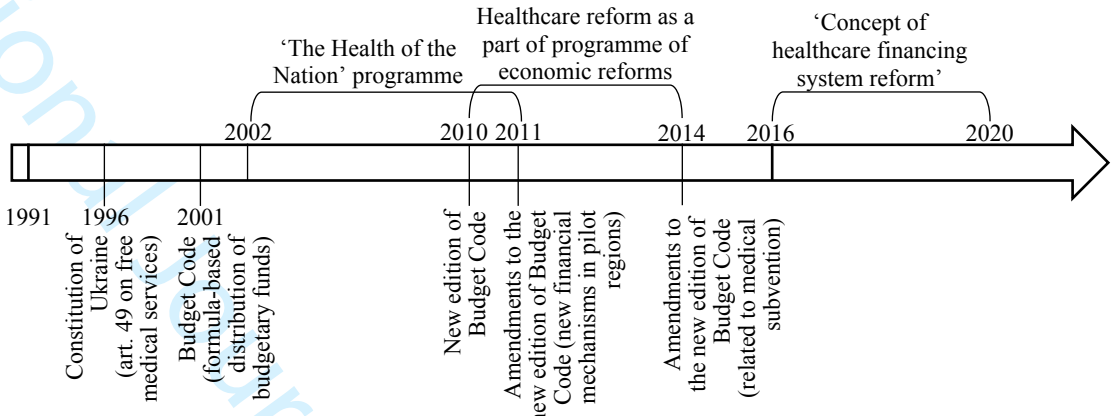

Table 1. Comparison of traditional and reverse decoupling

	Traditional decoupling	Reverse decoupling
Focus (*What?*)	Symbolic adoption of formal structures by organizations without their implementation in practice (Boxenbaum and Jonsson, 2008)	Mismatch between reformers' ideas and reformees' practices
Levels (*Where?*)	Extra-organizational level (Meyer and Rowan, 1977), intra-organizational level (Kern *et al.*, 2018), organizational level (Boxenbaum and Jonsson, 2008)	Inter-organizational level (central government and local governments)
Tactics (*How?*)	Variation of organizational strategic responses, from passive conformity to active resistance (Oliver, 1991)	Ignoring tactics of reformers, despite challenging tactics of reformees
Reasons (*Why?*)	Coercive pressures (DiMaggio and Powell, 1983), contradictory demands (Brunsson, 1989), maintain legitimacy (Meyer and Rowan, 1977)	Instability and lack of systemization of reformers' ideas (i.e., high politician turnover, with each having their own vision of reform)

Figure 2. Reverse decoupling in the context of the Ukrainian healthcare financing system reform

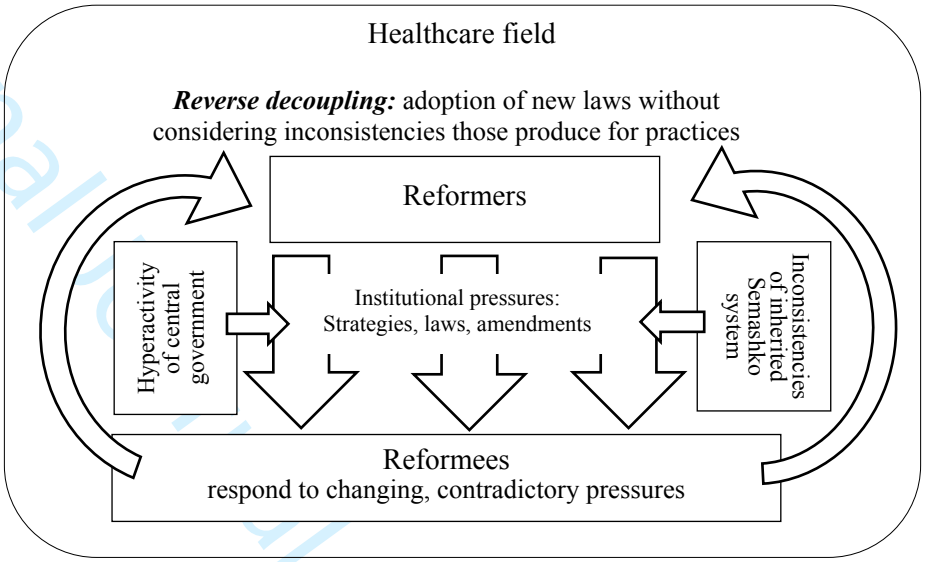

Table A1. Professional background of interviewees

Interviewee	Level	Position (on the date of interview)	Previous positions (if relevant)	Duration of interview in minutes (1st/2nd round)
1	Central	Adviser to Minister of Healthcare of Ukraine (2016–2017)	Public Finance Consultant at Coffey International Ltd (2011–2012)	90/50
2	Local	Economic expert at the Open Society Foundation, Kyiv		60/45
3	Central	Deputy of Ukraine, Chairman of the Subcommittee on the Evaluation of Draft Laws Regarding the Impact of Budget Figures and Compliance with Budget Legislation, Parliament of Ukraine (2014–2016)		75
4	Local	Economic expert at the Open Society Foundation, Poltava		60/60
5	Central	Deputy of Ukraine, First Deputy Chairman of European Integration Committee, Parliament of Ukraine (2014–2016)	Deputy of Ukraine, member of the Budget Committee, Parliament of Ukraine (2007–2012)	50
6	Central	PhD, Head of the Department of Regional Development, National Institute for Strategic Studies of Ukraine		60
7	Central	Lecturer at National University	Deputy of Ukraine, member of the Budget Committee, Parliament of Ukraine (2011–2012)	30/30
8	Central	Member of the Board of the Institute of Civil Society (NGO)	Deputy of Ukraine, Chairman of the Subcommittee on Legislation, Parliament of Ukraine (1990–1994)	55
9	Local	Deputy Director of the Financial Policy Department, Cherkasy City Council		60/45
10	Local	Economist of Category I of the Budget Department of Finance Administration, Makarivska District Administration		30/30
11	Local	Deputy Head of Healthcare Department, Odesa Regional Administration		40
12	Local	Head of Sector of Planning and Financing of Healthcare, Education and Culture, Dnipropetrovsk Regional Administration		45/30
13	Local	Senior specialist in HR, planning and accounting, Department of Healthcare Management, Volyn Regional Administration		40
14	Central	Deputy Head of the Ministry of Healthcare of Ukraine (2016–2017)		40
15	Local	Head of Healthcare sector, Fastiv City Council		40