Private management and governance styles in a Japanese public hospital: A story of West meets East

1.0 Introduction

Healthcare reforms relating to governance and management have been widely undertaken by governments worldwide (Mattei et al., 2013). The major aims of the healthcare reforms driven by New Public Management (NPM) ideals rested on productivity but arguing for equity and quality (Martinussen and Magnussen, 2011; Maupin, 2009; Zhou et al., 2014). These claims have been scrutinised by researchers predominantly in Western countries (Dan and Pollitt, 2014). Previous studies have attempted to understand the health care reforms from macro perspectives such as the role of the state (Fredriksson and Winblad, 2008); engagements of NGOs (Maupin, 2009); an outcome of hegemonic struggles (Filc, 2014); and the introduction of neo-liberal ideology (Walker, 2017). Micro processes such as managerial accountability, performance management, the role of key actors have also been examined (Ferlie et al., 2016). Nevertheless, very few have engaged in deeper analysis of how underlying institutional and cultural conditions constrain or enable key actors in shaping healthcare governance mechanisms at the organizational level. We believe that such analysis will provide deeper explanations of why reforms such as healthcare governance often produce a variety of unanticipated consequences.

Healthcare governance reforms in Asian countries have been limited. Japanese healthcare reforms are of particular interest, as debate about healthcare costs has been high on the agenda of recent Japanese governments (Otaki, 2017). This debate has been directed partly toward the medical insurance system, which has led to overuse of tests and drugs, affordability gap increased between rich and poor, unconstrained demand from patients, spiralling costs and imbalanced geographical distributions of healthcare service providers

(Nomura and Ishikawa, 2005; Watanabe and Hashimoto, 2012). It has also been directed toward the recruitment politics in local public hospitals (Takaku and Bessho, 2018). Nevertheless, academic research on healthcare governance reforms in Japan is scarce.

The existing literature calls for country-specific analysis of NPM implementations to build a better understanding of the dynamics of underlying conditions that lead to success or crisis (Reiter and Klenk, 2018). Responding to this call, we examine healthcare governance and its implementation in the historical, institutional and cultural context of Japan. In particular, we examine the role of key actors, and specifically physicians, in accepting, adapting or rejecting healthcare reforms at the organizational level.

The next sections provide a brief review of healthcare reforms, and present the cultural political economy of health care reforms and research methods employed in this study. Empirical findings are then presented. The paper finishes with a discussion and some concluding remarks.

2.0 Healthcare governance reforms and Medical Professionals

The role of medical professionals including physicians in healthcare is crucial and has been studied extensively (Smith et al., 2016). They are viewed as facilitators and key change agents in health care (Collyer et al., 2017; Lockett et al., 2012). The role of healthcare professionals in NPM driven reforms has also been studied (Dahan, 2015; Turner et al., 2016). Andersen's (2009) study of Danish GPs, surgeons and dentists reveals that healthcare professionals' values often outweigh NPM-driven financial incentives. Turner et al. (2016) find that healthcare professionals, and especially frontline managers in NHS England, are more resistant to reforms owing to their autonomous, highly creative and enduring professional associations. Similarly, doctoral training in France has been found to exhibit

strong professional autonomy and values that create inflammatory discourses and tensions between healthcare professionals and academics (Dahan, 2015).

Accountability and governance in healthcare is one of the key aspects of reforms reflected in previous studies (Pérez Durán, 2016; Greer et al., 2014). Various consequences of these reforms have been reported (Simonet, 2016; Mattei et al., 2013). Simonet (2016) argues that the strong presence of an 'elite' civil service diverts accountability toward managers rather than the public. Similarly, Mattei et al. (2013) report that, in Germany, Norway and Denmark, as a consequence of reforms to hospital funding motivated by the corporatization and professionalization agenda, hospital managers find themselves in an ever-increasing web of accountability to bureaucrats in various layers of government.

However, how do the healthcare professionals such as physicians respond to reforms is not well researched. Such research is important, as NPM reforms spread progressively into the conduct of actors and associated governing structures (Osipovič et al., 2016; Van de Bovenkamp et al., 2014). Any form of healthcare reforms requires, Martinussen and Magnussen (2011) argues, due considerations of key actors' embeddedness in historical, cultural and institutional conditions. Thus, building on studies of healthcare professionals' accountability and governance, we examine the role of healthcare professionals such as physicians in diverting, accepting or resisting healthcare governance reforms in hospitals. Adopting a cultural political economy (CPE) approach, we interrogate how institutional, historical and cultural values shape healthcare professionals' responses to reforms.

3.0 Japanese healthcare reforms

Since the 1980s, Japan has faced increasing healthcare spending and growing regional disparities in access to healthcare. In the 1990s, the average rate of real growth in Japan's total healthcare expenditure started to exceed the rate of real GDP growth. Economic

pressures, an aging population and rising costs led to a call for radical reforms (Hashimoto et al., 2011). One focus of the reforms has been the healthcare delivery system, especially public hospitals.

Two government ministries, the Ministry of Health, Labour and Welfare (MHLW) and the Ministry of Internal Affairs and Communications (MIAC) have been involved in the healthcare reforms. The MHLW has initiated most reforms, ranging from redeploying hospital bed functions from acute to long-term care stages, to implementing home care, maintaining quality of care and establishing future regional medical plans. On the other hand, the MIAC has been involved only with public hospitals and their reform, mainly because public hospitals are owned by local governments, which in turn are supervised by the MIAC. In this paper, we focus mainly on local public hospitals, as they are one of the main providers of critical care serving approximately 64% of infectious disease beds, and 34% of tuberculosis beds whilst only accounting for approximately 14% of the total hospital beds (MHLW, 2017).

A major reform was brought in by the MIAC in late 2007 in the context of increased outlays and huge debts of local public hospitals. The latter have been targeted mainly because more than three-quarters of public hospitals operate at a loss (The Economist, 2011). Comprehensive measures aimed not only at enhancing fiscal soundness, but also at improving hospitals' governance and accountability. Local governments were asked to take measures such as corporatization of public hospitals, followed by a review of governance and management mechanisms; regular performance reporting on occupancy rates, the ratio of ordinary revenues and remuneration to expenditure; and concentrating beds in well-functioning 'magnet hospitals' and building 'satellite clinics' to safeguard healthcare services in rural areas. Local public hospitals with occupancy rates of less than 70 per cent in the last three years were also expected to reduce their number of beds or be replaced by clinics.

Financial incentives were introduced to encourage local governments to be fully engaged in the reforms.

Within a year, by 2008, 22 local public hospitals had been transferred from local governments to independent local administrative corporations (Zhang and Oyama, 2016). This was supposed to allow them to be more independent and financially solvent. However, only 10 per cent of local public hospitals were generating surplus according to the survey conducted by MIAC. These reforms began to filter into all local hospitals, including our case study which was formed as a corporation in 2013. A second wave of reforms began in 2015. These were formulated on the basis of NPM ideals as before, but gave more specific directions to local governments. The reforms were to focus on private style governance assuming this will lead to cost management efficiency, reduction in deficit and increasing engagement with citizens. We aim to understand how the new set of governance reforms has played out in the new hospital.

4.0 Cultural political economy of medical education and physicians in Japan

We conceive the healthcare system is a socio-cultural system. Cultural constructions of health and illness is not new. Medical anthropologists through the lens of ethnography have been studying culture and illness and healthcare since 1950s and 1960s (Good et al., 2010; Kleinman, 1995). Since then a plethora of studies dealing with health, illness, life and death in deeply rooted cultural contexts such as Crandon-Malamud's work (1991) on viewing medicine as social idiom, Frankel's work (1986) on Huli's response to illness and other works (see for details, Scheper-Hughes, 1992; Good, 1994; Young, 1995). Similarly, the study of health and illness in Japan has also been studied thoroughly inspired by notions of 'meta-medical' and 'medical plularism' (Worsely, 1982; Ohnuki-Tierney, 1984). Seminal works by Lock (1993) and Ohnuki-Tierney's work (1984) have been invaluable in laying the groundwork for a culturally informed analysis of heath and illness in Japanese context.

Inspired by these works and extending this to the domain of policy but building on previous studies in health governance literature (Osipovič et al., 2016), we believe CPE as a methodological approach would be useful to provide a point of departure for an analysis of health care reforms in Modern Japan. This approach considers the cultural turn (meaning-making) to the analysis of the articulation between the economic and the political and their embedding in broader sets of social relations (p. 336, Jessop, 2010). The meaning-making, in turn, is shaped by neural, cognitive, and semiotic frames as well as social interaction and meaning-making technologies (Jessop, 2010). Jessop (2010) refers meaning-making to semiosis which is more than the intersubjective production of meaning but also an important element of 'the social'. Following the CPE tradition, we consider both extra semiotic (historical and institutional conditions) features of health care in Japan and semiotic (cultural norms and values) features, and the interactions of social actors in assessing the limits of NPM style governance in Japanese healthcare. This will provide us a broader understanding of the role of healthcare professionals in resisting, adopting and adapting a particular reform agenda. Our aim here is not to develop a particular model but explore how social actors interact with the new economic imaginary (such as NPM governance) in the given context of institutions and cultural conditioning. Thus, an examination of socio-cultural health system including the medical education and profession, Japanese cultural values and ideologies is apt.

The Japanese medical education system was compared to the Galapagos Islands for its unusual and singular evolution (Kuwabara et al., 2015). During the Meiji period (1868-1912), Japan began to move from the Chinese traditional to the Western medical system influenced by the visits of medical professors from the German Military from 1871. The extent of German Military Medical unit' influence on Japanese medical education can still be seen today (Nakagawa, 1993).

After graduation from university, medical graduates were traditionally enrolled into the trainee programme called *ikyoku* (literal translation is work place) (Otaki, 1998). The *ikyoku* is extremely important for understanding the power of medical professors and schools. In the *Ikyoku* system, the professor is at the top of the hierarchal totem pole often make many career decisions for the trainees (p.101, Kuwabara, 2015). It works as a specialist training programme as well as an employment agency/internal labour market benefiting its members. This is consistent with ancient medical tradition in Japan, whereby the teachers used to send students (physicians) to specific communities on the basis of the latter's needs. Now hospitals, especially hospitals in small cities and rural areas send requests to multiple *ikyoku systems* to recruit physicians.

In 2004, the New Postgraduate Medical Education Programme (NPGME) was introduced to bypass the *ikyoku* system of training (Iizuka and Watanabe, 2016; Kuwabara et al., 2015). Consequently, the professors at the university hospitals lost control over entry-level physicians but still attract 45.2% of the total new trainees to the *ikyoku* sysem (Kuwabara et al. 2015). However, the power of *ikyoku* system, though waning, remain significant as trained physicians find it advantageous to join the *ikyoku* system for specialist training, career choices and referrals (Iizuka and Watanable, 2016). MHLW's recent surveys on all newly trained physicians revealed that most of the physicians wishes to join the Ikyoku - 80.6% in 2018 and 85.9% in 2017 (MHLW, 2018).

The power of the medical schools and physicians must also be understood in relation to the respect held by physicians in Japanese society (Davies and Ikeno, 2002; Sunda, 2015). Commentators argue that their methods and mistakes are barely questioned – they are, after all, *sensei*, a title of respect used for teachers, academics and others who are looked to for guidance (Watts, 2000). This was reflected in the patient-doctor relationship even in the recent past as Ohnuki-Tierney, (1984) argues: *'in Japanese doctor-patient relationship,*

patients place the entire responsibility for their wellbeing in the doctor's hands, giving in turn a deep sense of trust, especially in the case of serious illness' (p.177). Nevertheless, in modern Japan, the physicians are now forced to provide explanations to patients due to patients' education and rights among other factors. Increasingly, patients seek second opinions and rankings before choosing physicians. Studies have also showed Japanese physicians are losing trusts from patients (Murata and Aramaki, 2014), yet they still enjoy a revered status.

The above historical and institutional conditions of the medical profession and physicians need to be understood in conjunction with Japanese cultural norms (semiotic) where the social actors operate. We draw heavily on Nakane's (1970) work, as well as on other studies of Japanese culture (Davies and Ikeno, 2002; Jun and Muto, 1995) to make sense of how ingrained cultural orientations defeat the purpose of NPM styles of reform in public hospitals. Some of the cultural norms such as group consciousness and *wa* (harmony or oneness), *senpai–kōhai* (senior-junior) relations, and *seken* (common interest group or informal personal relationship in workplace) are significant especially in organizational contexts. These three are interrelated and complementary.

Maintaining *wa* or *oneness* is the most important element of Japanese society. Maintaining silence (*chinmoku*) helps to preserve harmony in groups and public meetings. Losing face is inconceivable and deters members from opening up. *Tatemae* (façade) is used to maintain this harmony and create a comfortable atmoshphere. *Honne* (true sound) is applied in one own's space, whereas *tatemae* is used in more public forums. Skillful players use it without even realizing it. This goes against the notion of seeking accounts from the accountable, and especially the powerful. Hierarchy or vertical relationship is important for group coherence and survival (Nakane, 1970, p. 39).

In vertical group formation, *senpai–kōhai* (senior–junior) relationships are crucial. The rules of superiority between a *senpai* and a *kōhai* are analogous to a teacher–student relationship, in which the age and experience of the teacher must be respected and never questioned (Davies and Ikeno, 2002). The *ikyoku* system is embedded in the *senpai–kōhai* relationship. Although these relationships have not been strictly observed in recent times, they remain strong in Japanese minds (Davies and Ikeno, 2002). These vertical relationships last for life, emphasizing respect for authority and chains of command. This is clearly visible in meetings, as employees are rarely willing to express opinions without prior consent from their seniors. Challenges in meetings are rare and has negative consequences (McVeigh, 2015). This is also connected to the notion of being in *seken* which means that all members of the group should act cohesively, so *seken* will purge individual differences to impose *wa*. This is not as strong as before as Kokami (2009) refers to this loosely coupled *seken* as '*kuki*' (mood of surroundings). Whatever, it still contributes to maintaining *wa* (harmony) within the group. In summary, a deeply-embedded Japanese consciousness of vertical relationships and oneness or *wa* has serious implications for governance and accountability mechanisms in Japanese organizations.

5.0 Research methods

Following the research tradition of a CPE approach, we not only wished to draw on historical literature and previous studies to understand the structural conditions (material/historical and cultural) affecting agents' (key stakeholders) actions but also sought to trace these structural conditions from actors' own accounts. Thus, this research employed data triangulation conducting documentary research, observations and semi-structured interviews following the ethical approval guidelines of University of Shizuoka. Data for this case study were collected in 2018 over a period of six months.

Important data sources for identifying societal and cultural conditions included a preliminary review of the historical literature on the medical profession and hospitals, as well as broader politico-economic and historical literature. As a next step, in order to develop a better understanding of the structural conditions faced by key actors in two city councils, we collected annual statements, official documents and minutes of meetings relating to the hospital. One of the authors attended some governance meetings. This provided a deeper insight into intricate relationships between board members and the hospital authority.

To supplement the observational and documentary evidence, semi-structured interviews were conducted. This was one of most important sources of data, contributing to an understanding of how key actors shape the hospital's governance mechanisms. Two authors (one native speaker) were involved in facilitating the interviews. One had been an advisor to the city council, and his contacts were useful in gaining access to these key interviewees.

Using one of the author's knowledge about the key stakeholders of hospital's governance mechanisms and health sector, we interviewed 28 individuals in total, and contacted them again to ask follow-up questions where necessary. Our interviewees included one community leader, one current and two retired city council officials, Mayor of the city council, one assembly member of the city, the CEO/Director of the hospital, the Deputy Director of the hospital, Head of nursing, two hospital officials, ex CEO of an old hospital, one academic (advisory committee member), one ministry official and the physicians (13) working in the case hospital, clinics and university hospitals in the region. We also engaged in email correspondence with the hospital's CEO and other interviewees. We fully explained the projects and assured the interviewees of their anonymity before setting up the meetings.

The interviews were conducted mainly in Japanese, but translated immediately into English so that the non-Japanese author could follow them. Most interviews lasted around 60-120 minutes and were digitally recorded. These were later transcribed by one of the co-authors.

Various issues were discussed during the interviews, including the context of healthcare and the social status of medical physicians; *Ikyoku* system, control of the hospital by two central government ministries; accountability and levels of participation by citizens and politicians; the governance and management structure of public hospitals; and financial conditions pre- and post-merger, and the hospital's cost control and management.

At the end of each interview, we shared with respondents our understanding of what they had said during the interview to provide them with an opportunity to endorse or amend anything that they had said. These interviews were further corroborated and complemented especially by documentary evidence collected throughout the period. One of the authors had access to city council board meetings, observations and minutes of the meetings provided a great insight into the perceptions, intentions, and actions of the Mayors and Physician-cum-CEO of the hospital and other key actors. Thus, three sources of evidence (data triangulations) complemented each other to make sure we receive reasonable accounts of governance mechanisms.

After the collection of data, the next stage was the analysis. This analysis took two forms: one that led to uncovering the historical and cultural conditions and another that involved the key actors' strategies and actions. First, for understanding/interpreting the historical and cultural conditions, we drew on our knowledge of the historical and institutional context of Japanese society, as well as cultural values such as *senpai–kōhai* relationships and maintaining *wa* and *seken*. The second line of analysis involved the identification of key actors' interpretations of these institutional conditions and their strategies. In this line of analysis, we developed codes (manually) that captured the contextualized interpretations of agents and their actions (Mason, 2002; Miles and Huberman, 1994, p.56). Our data analysis helped us understand the differences between intended and actual governance structure.

Our final analysis involved converting all data relating to contextual conditions and agents' actions into a deeper and more meaningful theoretical narrative (Miles and Huberman, 1994, p.91). In order to do this, we developed a coding scheme that would capture the empirics of the case study (Mason, 2002; Miles and Huberman, 1994, p56). While developing this coding scheme, we had to keep in mind the broad theoretical framework, i.e., historical conditions of healthcare and cultural norms of Japanese society.

For this purpose, we used a coding scheme borrowed from Strauss (1987). According to Strauss (1987), a researcher should start with a coding scheme that differentiates between 'conditions', 'interactions among actors', 'strategies', and 'outcomes'. The benefit of this coding scheme is that it fits in very neatly with the tenets of CPE, which analytically categorise the flow of social action into structural conditions and agents' actions that cause outcomes. The next two codes, i.e., '(inter)action amongst actors' and 'strategies' helped us see different strategies and actions of agents in the context of intended governance framework. The last coding scheme, i.e., outcomes, would capture the consequences such as the actual form of governance structure. As we analysed the data, we constantly reworked our coding scheme to capture the nuances of the data and to understand the process of conditions, (re)actions, strategies, and outcomes. For example, during our data analysis, we realised that the condition such as *ikyoku* is both constraining and enabling the recruitments of physicians. As a final step, we re-checked the consistency between the data sources, the data codes, and the implications we had drawn.

6.0 Case study: New hospital

Our case – new hospital came into existence in 2013 as a result of a merger of two old hospitals managed by two different city councils (local government units). Both hospitals were running below capacity, and at times below 70 per cent occupancy triggering the MIAC

and the city councils to adopt remedial measures. The new 500-bed hospital began to operate in 2013 replacing the old hospitals funded by the city councils issuing public bonds.

6.1 Governance structure

The new hospital's governance structure was conceived as a private-corporation style of governance, as expected by the NPM ideals taken up the MIAC following the 2008 and 2015 reforms. The underlying idea was that both councils would stay away from running the hospital, and there would be a corporate board to oversee operations. The intended/ideal form of governance is presented in Figure 1.

[Insert Figure 1 about here]

The structure presented in Figure 1 was conceived in the spirit of NPM. The Mayors – key stakeholders - (in this case, two mayors from two cities), though not involved in the corporate board, has the right to appoint and remove the president/CEO. The president was the Chief Executive Officer (CEO) of the hospital and supposed to be responsible for strategic matters (clinical and non-clinical), and the COO (chief operations officer – *Incho*) was to run the hospital day-to-day, focusing only on clinical matters.

It was conceived that citizen were the primary shareholders. Like a private corporation, they were accountable to shareholders. The president/CEO was supposed to directly report managerial and business conditions to the citizens. However, it was not exactly specified how this should be done.

The corporate board – seen as a representative of stakeholders/shareholders - was formed for the hospital also known as a corporate assembly. It was formed, with five assembly members from each city. The president was to report to the board twice per year. The board was expected to interrogate the president/CEO on strategic matters and budgets. The president

was also needed the board to approve the budget. The hospital was also supposed to be audited and approved by the board.

In addition to the corporate board, an advisory committee was also formed to provide support to the president, consisting of two assembly members from each city, the mayors, one academic, and two physician representatives from the regional physicians' association. The advisory committee was to meet twice per year. The function of this committee was conceived as advisory (not mandatory) but an important committee as it involved wider stakeholders and the two Mayors. The Mayors saw the committee as a vehicle to pass on the concerns of citizen and other strategic matters to the President/CEO.

Nevertheless, the above governance was never operational in its exact/idealised form. As we gleaned from the interviews, observations and documentation, the actual form of governance structure is different in both form and spirit (see Figure 2).

[Insert Figure 2 about here]

Accountability to citizen is non-existent, COO and President posts are merged, the influence of the corporate board and advisory committee on hospital management is weak. These are discussed below.

First, *the power of appointments and removal of top executives* of the hospitals by two Mayors are severely curbed in reality. The top executive of the hospital must be the physicians or dentists (Medical Service Act, Article 46-6). One comment was that 'it is partly because of the respect and the status that physicians have in Japanese society'. It is partly because of the *ikyoku* system where the physician cum CEOs have much more clout to attract and appoint other physicians in Hospitals. The challenge for the Mayors is experienced physicians are not readily available to work in smaller city hospitals such as our case study.

Thus, Mayors had to participate in a labour market governed by the *ikyoku* system. This is also because as one interviewee suggested that 'a high-level appointment in the hospital is an important signal of the regional *ikyoku* system and the medical schools'. One physician commented on the clout of the head of the *ikyoku* system: *Recruitment depends on the chief professor. Orders from the chief cannot be refused. All personnel replacement of Ikyoku members are under his control. Recently one doctor wanted to move to a larger hospital, but he was ordered to go to different hospitals which he finally had to accept it.* The *ikyoku* system, in particular, is influential when it comes to the smaller hospital. The interviews with physicians revealed that smaller hospitals such as our case hospital are not especially a lucrative destination. Exploiting traditional cultural values *senpai–kōhai* relationship, heads/professors of the *ikyoku* in the medical school encourage physicians to join the hospital. This is also backed up by the better compensation packages than the other big city hospitals reflected in our interviews and previous studies (Iizuka and Watanabe, 2016).

The consequence of the power of the *ikyoku* system and medical schools puts city council mayors in a precarious position when it comes to appointing or removing public hospital chiefs. This was no different in our case. For instance, the first COO was not keen on someone else supervising him, so he took over the post of president (first president/CEO) as well. Thus, the first president covered not only strategic matters but also daily matters. The mayors had to agree. The removal of the first president is a good example of how difficult for Mayors to deal with the powerful physicians rested on *ikyoku* but exacerbated by a lack of physicians. According to law, the mayors have the authority to hire and fire the president. Interestingly, rather than firing the president directly, they adopted an indirect process by going back to the same the medical school and asked his *senpai* (who recommended him at the first place!) to persuade him to resign, which he did in 2017. At the same time, the *senpai* promised to send the next candidate, who is now the hospital's CEO. The current (recently

recruited) head of the hospital identifies himself as CEO (President's Job) and Director (doing the COO's job) continuing the similar structure. The concentration of power has continued even though the titles of the posts have changed.

Second, *formal accountability to citizens is lacking*. The hospital currently engages with citizens in two ways. One is through feedback boxes placed in hospitals, and the other is through physicians' attendance at meetings organized by an NGO to meet with citizens. Our interviews with hospital employees and the CEO indicate that this is not a critical part of their activities. The CEO revealed: 'No. I do not meet with the patients' group directly. I do not have a formal way to get their opinions, but we put an opinions box in our hospital. And we set up several lectures for citizens, we hear requests in Q&A sessions.' This was corroborated by senior managers: 'Almost no chance [to get feedback from stakeholders such as citizens and the local community]. One hospital administrator commented 'citizen and patients only complain to the assembly members but not to the hospitals or physicians.' This is confirmed by other interviewees including assembly members.

We discovered that since 2009, before its establishment of the new hospital, the old hospitals have been publishing a glossy brochure for patients and citizens monthly. This has continued under the new Hospital. Nevertheless, there have not been any form of substantial dialogue between patients and citizen with the hospital. The ex-chief of an old hospital reflected: *physicians are sent by the ikyoku, so their primary obligations to the ikyoku not to the hospital! There have no strong incentives for them engage with the citizen.* Hospital administrator candidly commented: *engagements with patients are very superficial but in fact these kinds of activities will be unattractive to physicians.* Lack of accountability to external constituents is unsurprising, as the Japanese healthcare system has been constantly criticized for its lack of quality assurance systems (Arai and Ikegami, 1997).

Third, *the board (corporate assembly) is unable to hold the hospital management to account.* The president/CEO report to the corporate assembly twice per year to give an account of the hospital. Our interviews with corporate assembly members and published minutes of meetings indicate that these meetings have turned into monologues. Audit reports are submitted to this meeting for discussions and approval. Usually no questions asked about the reports with one exception in 2014. There were heated exchanges between the corporate assembly members and the then president at the second meeting on 20 August 2014. The meeting began with introductory comments from the president, followed by the administrator's presentation of financial data and the auditors' comments. A question and answer session then began. One exchange (extracted and translated from published minutes) went as follows:

> An assembly member: I am very concerned about the payroll cost. According to the reforms of MIAC, the payroll cost should be 50 per cent of your revenue. At the moment, it consumes 63.4 per cent of your revenue. According to your plan it remains over 50 per cent even 10 years down the line. How do you plan to control this cost?
>
> President: You have absolutely no logic in your argument. This is a nonsensical argument. You said the payroll ratio is 65 per cent, but after August it goes down to 56 per cent as patient numbers increase. So you talk about revenue; we need to walk first before we run.

The president continued angrily:

> President: Do you remember what this project is? We open a new hospital and run it properly. If we save money on hiring, nobody will join the hospital. The crucial thing is we must recruit physicians, nurses, staff to run our hospital properly. So stop these financial matters now. We should talk about financial matters three, four years later. I said we struggle to run this hospital. We do. I have never seen this kind of hospital, I must emphasize. You should understand this. We have not done nothing. We have fully

engaged with all our duties. … Your logic is only for normal situations. Your logic is nonsense. That's all from me.

Administrator: As the president said, this year is a special year as we have just started. This first financial data should be compared with other good hospitals at the same stage. The comparison is not like with like.

President: As I said before, I want you to understand our effort. We are doing everything we can. We have emphasized hiring staff in the first year. Then this year, we are trying to improve the quality of care and managerial matters in this second year. So, based on this first-year conclusion, do not complain at all. That is all.

The assembly member responded defensively:

Assembly member: This is the corporate assembly. We can discuss freely and I do not intend to criticize you. I took part in this merger process. This is special for me. I understand the first year is very hard … So, I intended to ask about your orientation for the following years. If you say my question is nonsense, I need to ask what is our assembly role? I note that your plan is for it to be 56 per cent of total income in future.

Our examination of the minutes of subsequent meetings suggests that there have been no discussions or dialogue in any meetings held since, even under the new CEO. This has been a one-way process. The hospital administrators present their information to corporate assembly members, and the assembly accepts the budgetary statements with little or no discussion (see Figure 3 - an example of monologue).

[Insert Figure 3 about here]

This is similar to Arai and Ikegami's (1997) finding that physicians are simply unaccustomed to outside criticism, no matter how well-intended. The role of corporate board – voices of the city councils – is clearly overpowered by the Physicians.

Fourth, *the role of the advisory committee is superficial*. The advisory committee was originally seen as a forum where the committee would provide candid advice to the

president/CEO of the hospital. It was expected that the committee would play a stronger role, given its membership, but it has become subservient to the president/CEO. By law, the president/CEO and his staff do not need to accommodate the committee's demands nor heed its advice. The place of the advisory committee was defended by one of the mayors, who argued that, within the governance structure, the advisory committee is the only place where the two mayors sit together. This offers them opportunities to convey citizens' demands to the hospital authority. Several committee members, including the mayor, expressed doubts that this committee has any meaningful vitality. The Mayors often advice the hospitals to keep the short waiting time and maintain good relationship with the local physicians for referrals.

The role of the advisory committee was called into question during the first president's term in office. Acting on serious concerns from employees and other stakeholders, including board members, on several occasions the mayors, through the advisory committee, sought to pass these concerns on to the president, with little success. Rather, the acrimonious relationship between the president and the mayors and other members continued to deteriorate. They decided to fire the first president in 2017. Nevertheless, the role of advisory committee remained the same as before.

6.2 Cost and financial performance

Cost management or reduction in public hospitals is a key aim of the reform. The new hospital with private sector style governance model was established to achieve the aim. The Mayor commented: 'Financially, I set an upper limit of 10,000 JPY per citizen to give out to the new public hospital. They were also asked to serve the residents in both cities for emergency care and achieve patient satisfaction.' The new hospital, formed as a corporation, has independence to run its affairs, although it depends entirely on the councils financially to

fund the deficit. Table 1 shows the profit and loss statements for the pre- and post-merger periods.

[Insert Table 1 about here]

In the post-merger period since 2013, financial performance has not improved and the deficit is still large. However, operational aspects such as the number of physicians and capital utilization rate are much higher in the new hospital (see Table 2).

[Insert Table 2 about here]

By 2015, the number of physicians had risen to 107 and the bed utility rate had increased to 86.3 per cent. This is on a par with or better than the national average for similarly sized hospitals. The bed utility rate usually keeps the bottom line positive, but this has not happened in our case. The current CEO threw interesting light on his views on cost management and deficit reduction efforts. The CEO commented: 'I feel burdened. To cover costs, we need to get more physicians … The payroll rate at this hospital is relatively high, at 57 per cent, so we should have decreased it. But if so, it would cause a decrease in physicians.' He went on to say:

> We need 30 more physicians. New physicians mean revenue is up. … If physicians are
> scarce, if physicians are tired from too much extra work, then they quit. First, we must invite
> more physicians to keep the minimum number of physicians, and then think about
> effectiveness.

The approaches adopted by the current and previous CEOs are similar. There appeared to be a general understanding among our interviewees that recruiting more physicians is way to attract more patients, generate revenues and ensure quality of care. The new CEO aims to recruit 30 more physicians to take the number of physicians to 137. When we questioned whether the hospital would reach the saturation point in generating revenues, he answered

negatively. This is at odds with our calculations, since the national average for physicians is 112 for a 500-bed hospital, and the new hospital already has 107.

A similar discourse of preferring revenue generation over cost reduction was found in conversations with the hospital's senior managers. One manager said: 'cost matters are not discussed directly in internal management meetings.' The management meeting involves the CEO, deputy directors and other departmental heads of the hospital. He further stated: 'We do not emphasize cost itself. Moreover, we put emphasis on the number of patients, operations, length of hospital stay, from the point of view of revenue and profitability.' This is partly because managers see no scope for reduction strategies, as argued by one manager:

> Of course, we pay much attention to cost. We always buy cheaper medicine and goods. We use nationwide benchmarks for price negotiations on medicine and goods. We search all over for the best price and negotiate with sellers to the bottom … We did do outsourcing, but we have a limit, so we must see revenues go up. This is a message from [the CEO]. Before the merger, the old hospitals suffered from a shortage of patients, so at first, we are focusing on getting more and more patients.

Interestingly, the new hospital has reached almost 90 per cent occupancy, which is a relatively high capacity rate, so there is little room for revenue generation. This does not seem to be deterring the current CEO and his team from recruiting more physicians. On the point, one of the Mayors commented: *The reason we established new hospital is to provide emergency cares to the citizen. So, as long as the hospital never refuses to accept emergency patients and absence of complains from citizen, we are happy with the hospital.* The Mayor of the city council wishes to keep the expenses under control but the most important criteria for them is hospitals offer good services to the citizens.

6.3 Evaluation and reporting

Evaluation and periodic reporting to both the ministries are an essential part of the reform. These evaluations must be organized by the hospital, involving external stakeholders such as advisory committee members. In our case, the hospital asks the advisory committee to conduct evaluations. The evaluation seems to cover many aspects, such as operational and financial data, future plans, clinical functions, trials and future plans. However, it is questionable to what extent these evaluations are taken seriously. As one manager reported: 'Unnn. Would I say honestly? … Beforehand we prepare this evaluation, then circulate the evaluators and get their opinions.' Our conversations with managers revealed that this is seen as a symbolic practice. The CEO was not even aware fully what's on the report.

The focus of the report is mainly to prepare a wish list. Evaluative aspects of the hospital are clearly missing from the reports. For instance, the reports from 2014 to 2017 never reflected on the circumstances under which the post of president had become untenable. The evaluation score was "A" overall, yet the CEO/president was asked to resign in 2017. The MIAC's 2015 reform required hospitals to publish the report and submit it to the MIAC and city councils. Our interviews with a ministry official suggest that the ministry is not in a position to evaluate public hospitals' reports. In fact, these reports do not seem to have any feedback system.

7.0 Discussions

To sum up, first, the intended governance structure in the new hospital has not emerged. The corporate assembly does not seem to be able to hold the hospital management to account. Second, absence of engagement with citizens is very noticeable. Third, cost management and reduction efforts are absent, and the focus on revenue generation continues. The deficit seems to be increasing rather than decreasing, and self-sustainability is still a distant target. Fourth, reporting and evaluation are symbolic. Reporting has become a vehicle for seeking more resources from city councils in the form of subsidies. Thus, the NPM-style agenda of reforms

is still far from reality. We have sought to understand why this is so. How do reform agendas interact with the Japanese way of doing things?

Drawing on CPE, we have argued that we need to understand both cultural traditions and the historical and institutional context of the medical profession and education. We find that medical professionals, and especially physicians, are key actors in executing hospital reforms in Japan. The history of the medical profession indicates that the *ikyoku* system work as an internal labour markets is central to physicians' careers and professional lives. Hospitals in small cities need to attract physicians who are embedded in the *ikyoku* system controlled by the medical schools. Similarly, physician themselves find the *ikyoku* system or being in *senpai–kōhai* useful for the advancement of their careers. Thus, it is natural for the two mayors to go to the regional medical school to persuade it to nominate a president/CEO and send more physicians to the hospital instead of attempting external labour markets.

The *ikyoku* system plays, we find, both as enabling and constraining roles at the same time. Two mayors in our case hospital exploited the system in their favour, in some ways, to appoint CEOs. Without the *ikyoku i*n place, it would have been much more difficult for them to attract experienced physicians. Subsequently, the appointed CEOs also played a strong role to attract other physicians to join the hospitals. *Ikyoku* is also constraining as the new hospitals have little opportunities to use the external labour markets. It is also difficult, as the ex-directors and the current CEO/COO commented, to have strong controls over physicians as they see their careers linked with the *ikyoku* instead of the hospitals they are working.

Historically, Japanese medical education is based on creating experts in a particular field. They see themselves as part of a scientific research community, and the practical training they receive at the hospital is interspersed with scientific research. Any job opportunities at the university hospital even with lower salaries is perceived to be a far better option than the joining the 'new clinical training system for physicians.' Given the shortage of physicians,

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keeping physicians at the university hospitals, the *ikyoku* systems creates further constrains the supply of physicians for local public hospitals, a phenomenon that had a severe impact resulting in the closure of the old hospitals in the two-city council. This, in turn, creates panic among hospitals, who will do anything to keep the physicians in the hospital, strengthening the physicians' power while raising payroll costs.

We argue that medical schools' power via the *ikyoku* system resides not only in the context of chronic shortages of physicians, but also arises from the respect afforded to physicians by wider society. This has implications for the hospital's management and physician-patient relationships. NPM advocates private-sector governance in public-sector hospitals, which inevitably leads to the introduction of non-physician/professional managers in the hospital administration (Garman et al., 2010; Kirkpatrick et al., 2009) and should create space for accountability and transparency. This was not the case in Japan. Physicians remain the key actors in governance riding on the legal bindings that only medical professionals (dentists and physicians) can be the head of a hospital reflecting their status in Japanese society. We argue that this status and respect coupled with their careers being linked with *ikyoku* may have led to a lack of interest in engaging with citizens.

At the same time, the aura and power of physicians create tensions in the corporate board, where corporate assembly members find it difficult to ask questions of the physician-cum-CEO. The angry response from the then President reflected his awareness of his position in wider society and unwillingness to be questioned. The lack of strong voice of the city councils in the corporate board is also linked with the fact that ultimately the councils will be blamed for lack of medical services. They are also fully aware the fact the level of difficulty to attract physicians in the hospitals outside the big cities.

The above structural/material conditions do not take away the role of Japanese cultural norms and values played in seeking accounts from the hospital management by the corporate board

members. The case in point the way two Mayors went about firing the previous president of the hospital. They refused to fire the president directly. The desire of maintaining social order through *wa* is reflected in the whole process. This is also reflected in the board meeting monologues and the passive responses of council members. Silence or *chinmoku* is part and parcel of maintaining this harmony. No member wants to be the one who sticks out (*deru kui wa utareru* - sticks out gets hammered in), which prevents them from seeking accounts from others. The heated exchanges in the second corporate board meeting at the new hospital was the defining moment. Angry dialogues, direct verbal expressions, refusals, disagreements and defiance are avoided at all costs (Davies and Ikeno, 2002). Where people wish to identify themselves primarily as members of certain groups, not asking questions or keeping silence plays a very important role in creating harmony and avoiding conflict. According to Davies and Ikeno (2002, p.53), many people in Japan think that it is better to say nothing than to cause misunderstandings or trouble.

Among the Japanese, social position, age and job status receive the highest consideration in social interactions such as board meetings (Davies and Ikeno, 2002). An explanation for this is given by Ishii and Bruneau (1994, p.250):

> Ideas and feelings that might hurt the other person or damage the general atmosphere when expressed are carefully sent back for reexamination in an internal self-feedback process. Only those ideas judged safe and vague are allowed to be sent out through the small exit that functions as a screen filter. This message screening process … is *enryo* (restraint); it makes the Japanese appear silent, vague, and awkward in communicating with superiors, strangers and people from different cultures.

This desire to maintain *wa* or harmony and avoid seeking accounts may have contributed to the series of monologues rather than dialogues in formal board meetings at this hospital. We do not wish to claim that all Japanese public hospital governance exhibits exactly the same

feature, but the general patterns of interaction between and among key stakeholders in relation to accountability and the governance process are perhaps likely to be shaped by some form of verticality, monologues rather than dialogues, indirectness and silence.

8.0 Concluding remarks

The paper provides some explanations of why physicians may resist NPM ideals in healthcare complementing previous studies (Dahan, 2015; Turner et al., 2016; Andersen, 2009). CPA approach guided us to examine both semiotic and extra semiotic features and their dialectical moments with key actors in assessing the limits of NPMs in non-Western contexts. In doing so, it contributes to debate on the role of healthcare professionals in reforms in light of broader socio-cultural, historical and institutional contexts (Martinussen and Magnussen, 2011). We argue that the social embededness of physicians is an improtnat factor to consider. For instance, the power and constraints of physicians cannot be fully understood without invoking the concept of the *ikyoku* system and the historical power position of physicians in Japanese society. At the same time, the evolution of the *ikyoku* system, despite originating from Germany, has been shaped by cultural norms such as the *senpai–kōhai* relationship. Thus, both cultural norms and historical and institutional contexts provide us with some sense of the unanticipated consequences of Western-centric NPM ideals in Japanese hospitals.

The paper also contributes to a critique of the unquestioning adoption of NPM styles of governance without considering the local context. Researchers have already highlighted the unanticipated consequences of unmodified adoptions of NPM reforms. It might be argued that, in Japan, economic and political certainties are relatively similar to Western countries, yet the institutional context, historical legacy and cultural attributes are far from similar.

Although Japan has a strong tradition of borrowing rich cultures, religions, philosophies and technologies, it has also been through a process of *iitoko-dori*, or adaptation rather than adoption (Davies and Ikeno, 2002). Appreciation of these conditions is key to a better understanding of the (un)intended consequences of healthcare reforms in Japan and worldwide.

Finally, the paper has practical implications as it provides some explanations of how, for instance, key social actors interact with the healthcare reforms. Theoretically, we are arguing identifying these cultural and historical conditions will provide healthcare policy makers with a better understanding of unintended consequences and perhaps possible remedies. Health care professionals such as physicians in Japan do not appear to engage with the cost management ideals as perceived by policy makers. Healthcare bodies need to engage with medical and business schools to popularize the cost management reform agenda. The findings suggest that reforms may be less controversial if their dynamics arise from the healthcare professionals themselves rather than being imposed upon them.

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