

# The First Phase of Japan’s Response to COVID-19

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**Abstract:** *As the first phase of Japan’s response to COVID-19 ends with reasonable success, the country now moves on to the second phase. This essay aims to explain the first phase response from three perspectives. First, how does Japan’s response compare to that in Taiwan and South Korea? How and why did Japan lag behind? Second, despite not matching the success of these regional neighbors, Japan has been relatively successful. What accounts for this success? Third, we will examine several unresolved issues during this first phase such as testing capacity, drug treatment and development of a vaccine.*

lower than any of the other G7 countries, a more detailed comparative analysis of the differences between Japan versus Taiwan and South Korea can help us to understand why Japan fell short.

In the case of Taiwan, when Wuhan was shut down on 23 January, Taiwan’s borders were closed to Chinese entry by 6 February. The number of infected people gradually increased, reaching 429 infections and 6 deaths by 2 May. However, since then, these two numbers have not increased much (Chiou, 2020).

In the case of South Korea, the coronavirus was more volatile. A cluster of infections occurred in February due to a religious organization in Daegu, and by mid-March South Korea became the 4<sup>th</sup> worst infected country in the world. South Korea combated this outbreak by way of what are now known as the three T’s - tracing, testing, and treatment. By April, South Korea’s infection rates stabilized. On April 26, the number of infected people (10,674) in South Korea was exceeded by Japan, and the death total of 236, equaled that of Japan. Korean figures, despite a second wave in May, have been stable, whereas Japan’s death toll has nearly quadrupled since then to 971 as of June 27, 2020.

## Why Did Japan Lag Behind Taiwan and South Korea?

**Table One: Comparison of the COVID-19 Outbreak Japan-S. Korea-Taiwan**

Country	Death	Infected	Population (UN2019)	Death/100,000
Japan	955	17,725	126,850,000	0.75
S. Korea	280	12,411	51,255,000	0.55
Taiwan	7	446	23,774,000	0.03

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Of these three countries, Taiwan achieved the best result, followed by South Korea, with Japan’s outcome being the poorest. Even though the death per 100,000 population is far

Why is Japan failing in comparison to Taiwan and South Korea? One possible answer lies in the history of recent outbreaks in the northeast Asian region, and how each country has responded. During the SARS, HINI and MERS outbreaks, Taiwan and South Korea suffered greatly, but learned valuable lessons about fighting virus infections in the 21<sup>st</sup> century.

Evidently, Japan did not learn these same lessons.

(1) 2002~03 SARS Pandemic

Table Two: SARS Comparison (NIID-Report)

SARS	Infected	Death
PRC (China)	5,327	349
Hong Kong	1,755	299
ROC (Taiwan)	346	37
S. Korea	3	0
Total (32 regions)	8,096	774

During the SARS outbreak, Taiwan suffered more than South Korea and Japan. Vice President Chen Chien-jen, who devised Taiwan’s strategy against COVID-19, is well known for combating SARS twenty years ago. South Korea was not much affected, and NIID reported that “16 possible cases and 52 doubtful cases seen in Japan all proved to be otherwise diagnosed” (NIID-Report). It seems there was no learning experience to be found in Japan.

(2) 2009~10 Pandemic H1N1

Table Three: International Comparison of 2009 Pandemic (Okabe, 2010)

	America	Canada	Mexico	S. Korea	Japan
Death	12,000 about	428	1,111	257	199
Death/100,000	3.96 about	1.32	1.05	0.53	0.16
PCR	-	All	-	All cases	184 (confirmed)

Regarding the H1N1 pandemic, it was South

Korea that suffered most in northeast Asia, whereas Taiwan did not seem to be affected. Japan’s case needs further attention, considering how it originally took rigorous measures requiring hospitalization, but soon after the WHO declared H1N1 a pandemic, it changed the diagnoses immediately to consider it a normal, seasonal influenza. Overall it seemed that Japan’s approach was a success (Japan Infectious Disease Association, 2010). However, a recent article in the Nihon Keizai Shimbun disclosed an old account of H1N1 by the Ministry of Welfare “criticizing the lack of multiple choices of treatment, shortage of crisis management capability, and weakness of PCR and other testing capacity.” The paper argued that, because of bureaucratic inertia, no effective reforms were initiated since then (Nihon Keizai).

(3) 2012~2015 MERS

MERS originated in 2012 from the Middle East, but in northeast Asia it was South Korea that was most seriously affected, as from May to December 2015, 185 people were infected and there were at least 38 deaths (Ministry of Welfare-1). South Korea seems to have adopted many new policies based on what they learned from MERS. To my knowledge, no such cases were recorded in Japan.

Essentially, the Japanese bureaucracy with the acquiescence of politicians assumed that they did a good job in keeping the three previous virus infections under control, so when COVID-19 appeared in Wuhan, Japan was taken entirely off guard, and as such did not treat the situation with sufficient alarm and policy countermeasures were taken very slowly.

Perhaps because South Korea faces a threat from North Korea and Taiwan has its tensions with China, the two countries view pandemics as serious security issues and act accordingly while Japan has never treated pandemics as a

serious security issue. Clearly Taipei and Seoul acted with urgency based on lessons learned from past pandemics while Japan was lulled into a false sense of security because it had been relatively unaffected by previous outbreaks.

**Lesson 2: Why Did Japan Achieve a Reasonable Success in Its First Phase Response to COVID-19?**

Largely due to being inattentive to the severity of the coronavirus situation, the initial reactions in Japan from January to March 2020 were clumsy and slow. Three coinciding developments delayed Abe’s response, but don’t justify the official complacency regarding Japan’s coronavirus outbreak.

The first development occurred on 5 February when an infected person was detected aboard the cruise ship ‘Diamond Princess’ that docked in Yokohama. The Japanese authorities botched the quarantine of passengers and crew, creating the impression that the government was unable to manage this major public health risk. The second development was the plan for President Xi Jinping to visit Japan in April. Abe had a lot riding on this summit, but the two governments decided to postpone it on March 4. It was only afterwards that serious travel restrictions were imposed on arrivals from China. The third coinciding development was that Japan was scheduled to host the 2020 Summer Olympics from the end of July. In order to maintain the possibility of doing so the government stalled on enacting COVID-19 countermeasures until late March after it became apparent that the games could not be held. It was precisely at this time that the number of infections began to rise rapidly, and Japan finally took more comprehensive actions to limit entry of foreigner travelers to Japan (MOFA announcement).

It is incorrect to suggest, however, that the

government of Japan was completely paralyzed in those initial three months. As the following table shows, important decisions were taken step by step over that period to prepare for the next stage in the response.

**Table Four: Important decisions taken from January to March 2020**

Date	Policy decisions
January 29~31	Return of Japanese from Wuhan aboard three charter flights
January 30	'Novel Coronavirus Response Headquarters' established
February 13	Emergency Response (First Round) : 15.3 billion Yen
February 14	'Experts Committee on Response Policy' established
February 25	'Basic Policy' adopted: Japan has not yet reached large scale infection
March 10	Emergency Response (Second Round): Medical treatment is vital
March 13	Laws on declaration of a National Emergency enacted

Among these initial measures taken to establish organizational structures, perhaps the most important was the creation of the ‘Experts Committee’ on February 14. In Japan, there are two organizations that deal with infectious disease: the National Institute of Infectious Diseases (NIID), which is associated with the Ministry of Health, Welfare and Labor (MHLW),

and the Japanese Association for Infectious Diseases (JAID), which is an academic organization where scholars and experts study such diseases.

The new Experts Committee was created to bring together the best and brightest among these experts. Many names have become well known due to media exposure, with at least three worthy of mention here. First is Professor Omi Shigeru, president of the Japan Community Health Care Organization. He became the deputy chairman of this Experts Committee, and subsequently the chairman of the Basic Counselling Policy Advisory Committee, which was established as a formal advisory mechanism to implement ‘Emergency State Measures’ in relation to COVID-19. Next is Professor Oshitani Hitoshi, who teaches at the Graduate School of Tohoku University. He is known as one of the WHO officials who played a key role in combating SARS and served as a key strategist in establishing the Japanese strategy against the virus. Third is Professor Nishiura Hiroshi, who teaches at the Graduate School of Hokkaido University. He was not a formal member of this committee yet due to an expertise in mathematical calculations he was able to model the COVID-19 outbreak. Although the Abe government’s response drew criticism for relying too much on politicians and emphasizing public relations over public health, this is misleading as these three experts, played a key role in crafting a coherent strategy based on ‘scientific’ analysis. (Hirono, 2020).

In the latter half of March, the coronavirus outbreak worsened. The number of infected people rose sharply, and numerous reports began to assert that PCR testing was unduly restricted. Yet, no emergency state measures had been implemented. Reflecting the growing sense of anxiety and uncertainty, on March 31 Yamanaka Shinya, professor at Kyoto University and Nobel prize winner in 2012 for

his research on IPS cells, announced ‘Five Proposals’ for combatting the coronavirus on his blog. In his third proposal, he wrote that, “provided there would be sufficient division of lightly infected people (to one’s home or designated hotels et.al) and seriously infected people (to the hospitals), a new system would be needed to allow those who wished to be tested by PCR to do so” (Yamanaka HP).

In April the government swung into action. The logic behind the new policy was spearheaded by the three experts mentioned above with the support and advice from other infectious disease specialists. The key policy to combat the coronavirus was social distancing. Finally, on April 7, PM Abe declared an emergency in seven prefectures by invoking the authority granted him under the Emergency State Measures (ESM) legislation passed in March.

Japan adopted a cluster-based approach to tracking and containing the coronavirus outbreak. When clusters of infections erupt, health authorities focus on tracking transmissions by tracing the contacts of infected people. But in the course of March, because of the sharp rise in untraceable infections, the emphasis shifted to social distancing. Public announcements calling for “Reducing 80% of contact,” “self-restraint from going out,” and “avoiding the three Cs: confined and crowded spaces, and close human contact” all signaled the same strategy of social distancing, on a request basis, without the legally binding lockdown approach adopted in Western countries and China.

This policy initiative was followed by a strengthening of treatment capacity. Those with light symptoms were to recover either at home, in hotels, or at other public facilities in order to leave hospital beds to the more seriously infected. Expanding PCR testing also became a stated objective when Abe declared his intent to ramp up PCR testing to 20,000 per day. Abe also emphasized the need to actively

develop a vaccine and medicine, and to increase threefold the stockpile of Avigan, at the time considered an effective drug for mitigating symptoms that was produced in Japan.



Abe declaring increase of PCR tests

From that day, introduction and lifting of ESM was enacted in a systematic manner.

**Table Five: Introducing Emergency State Measures**

Date	Emergency State Measures (ESM)	Infected (+day before)	Death (+day before)
April 7	Seven Prefectures ESM	4,479 (+368)	98 (+1)
April 16	All nation~05/06, 13 Special Alert	9,363 (+576)	191 (+12)
May 4	Extended until 5/31	15,372 (+176)	556 (+20)
May 14	8 ESM remained, 39 lifted	16,243 (+100)	713 (+17)
May 21	3 Kansai area ESM lifted	16,511 (+38)	799 (+15)
May 25	5 final prefectures ESM lifted	16,625 (+21)	851 (+13)

June 19	Inter-prefectural travel is OK	17,817 (+58)	954 (+18)
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**NHK Statistics 2020**

Reducing social contact apparently worked. The typically busy tourist hotspots and animated city scenes were suddenly empty and quiet from April through May, including all sporting, musical, and theatrical events. Shops, department stores, and hotels were closed in order to promote the 3 C's. NHK statistics indicated that after May 15, the daily increase of infections stabilized at around 50, and from June onwards, the daily death toll remained around 5. Still, in June, social distancing protocols persisted, and the request for inter-prefectural travel restriction was only removed on June 19.

**Lesson 3: What are the Unresolved Issues that Still Need Fixing?**

Several major issues remain unresolved. First and foremost, despite the government's declared efforts to increase PCR testing to 20,000 per day, the daily number never exceeded 10,000. From early May until the latter half of June, PCR testing fluctuated between only 6,000 and 8,000 per day (Toyo-Keizai Online 2020).

On May 8, the MHLW rescinded the widely criticized rule which restricted PCR testing to only those who had a fever exceeding 37.5 degrees for more than four days in a row. On May 13, it approved the usage of an antigen kit that allowed quick testing. On June 2, new PCR testing using saliva was approved by the MHLW, despite some restrictive conditions. Nevertheless, there seemed to be an invisible ceiling restricting PCR testing to below 10,000 per day.

The lack of PCR testing impairs the ability to determine accurately the number of infections

and renders virtually impossible any mathematical calculation of the Effective Reproduction Number (ERN). Meaning, if one defines ERN as the number of people whom one infects, this calculation cannot be done without knowing the accurate number of infected people. Although the MHLW itself does not produce an ERN number, Toyo-Keizai, whose data comes from the ministry, reported that from the beginning of May, ERN was kept lower than “1” with two exceptions: between the dates of 29 May to 5 June, and from 13 June to 21 June and beyond (Toyo-Keizai 2020). Without accurate PCR data, we can only wonder what purpose is served by such estimates.

A lack of credible testing affects another aspect of combating the coronavirus: contact tracing. From mid-March the government was unable to trace half of infectious transmissions rendering the cluster-based approach ineffective. On May 25, Abe declared that “research of tracing through contact-confirming applications is underway. It aims to effectively trace those who might have contacted the infected person while strictly protecting privacy.” On 19 June, the MHLW released the ‘COVID-19 Contact-Confirming Application (COCOA)’ for mobile phones which was then downloaded 6.26 million times by 22 June. That number, however, is insufficient for the application to be effective in tracing transmissions.

Finally, there is the issue of vaccine and drug development. On 7 April, PM Abe called for tripling the stockpile of Avigan stockpile, but on 4 May, he indicated approval of the U.S. produced Remdesivir as the first antiviral medication for COVID-19. On 14 May, he proposed several Japanese medications in addition to Avigan for treatment, pending approval, while emphasizing international cooperation through the Coalition for Epidemic Preparedness Innovations. On 25 May, he announced that he would propose developing and distributing a COVID-19 vaccine and

medication for developing countries at the upcoming G7 meeting. Abe’s proposals, however, have yet to bear any fruit.

Responding to the lack of PCR testing, and vaccine and medication development, two separate initiatives emerged. On May 8, the Kajima Institute of International Peace (Group of State Power Studies), Society of Security and Diplomatic Policy Studies (SSDP) and a group of like-minded supporters announced ‘Urgent Recommendations Toward a V-shaped Recovery after the Novel Coronavirus Pandemic: “Coronavirus Testing for All” - suggesting the first steps in the next phase of the pandemic response. Around 30 scholars on foreign policy, including former high-ranking defense and financial officials, gathered to propose “immediate COVID-19 testing for [anyone] who wishes it and [to build] a testing capacity of 10 million tests, instead of the current 10 thousand per day.” (SSDP 2020).

Urging a budget that could support the gigantic scale of this proposal might not sound realistic, but the core of this proposal meets the legitimate desire of many Japanese who want to know the true state of their health through PCR and other testing. The proposal asserts that confidence gained from having accurate knowledge about the scale of the outbreak is the best way to promote both the Japanese economy and public health.

In regard to the need for a vaccine and medication, Kawakatsu Heita, governor of Shizuoka prefecture, made four emergency requests between the end of April through the beginning of June that addressed the government, governors nationwide, and other experts and key figures on COVID-19. He proposed: (1) to establish a one trillion yen ‘Special Fund for developing vaccine and medication against Novel Coronavirus’, (2) to run this Special Fund under the newly established economic section of the National Security Secretariat, and (3) to utilize the

Special Fund so that part of patent-rights and royalties of the developed vaccine and medicine would be distributed to developing countries, where the pandemic is expected to weigh most heavily (Shizuoka Prefecture HP).

## Conclusion

As Japan moves into a second phase in handling COVID-19, we must think on a global scale. COVID-19 is most likely to hit hardest those countries with refugee communities and developing countries with inadequate medical infrastructure. Japan must assist in all possible ways to strengthen medical treatment capacities and to explore options for distributing vaccines and medicine. In a global pandemic, international cooperation is essential. Japan may also have a chance to bridge the gap between the United States and China, to enhance international cooperation on the pandemic.

To overcome the COVID-19 health crisis and to revitalize the economy are parallel objectives. Since the key policy to combat COVID-19 so far has been ‘social distancing,’ developing a new type of connectivity is essential. The pandemic is a wake-up call not just for government and employers but for everyone to rethink norms, values and how we live and interact. On-line communication is shaping the emerging new normal in various positive ways, but there also must be efforts towards community building particularly among socially under-privileged people without reliable access to internet and digital communications. Ultimately the outbreak forces us all to promote and embrace a more sustainable harmony between nature and human development.

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This article is a part of the **Special Issue: Pandemic Asia, Part I**. See the Table of Contents

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Readers of this special may be also interested in another COVID-19 special, [Vulnerable Populations Under COVID-19 in Japan](#), edited by David H. Slater.

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