Understanding Japan's response to the COVID-19 pandemic

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Jecker and Au's paper raises important issues concerning health equity in pandemic responses, and the importance of considering the long-term effects of pandemic strategy on population health and well-being.[1] We welcome their focus on the experience of Asian countries, including Japan. However, we have some concerns with both the distinction which they draw between elimination and mitigation, and their account of the nature and origins of the Japanese response to the COVID-19 pandemic.

First, we believe that the distinction between elimination and mitigation is not fine grained enough to capture the various strategies which countries have taken towards the pandemic. Many of Jecker and Au's criticisms of the elimination strategy relate to specific policies such as lockdowns, travel restrictions and restrictions on businesses, which have been employed by numerous countries irrespective of their end goal. By contrast to the simple elimination/mitigation dichotomy with which Jecker and Au work, Baker *et al* have identified five separate COVID-19 strategies, namely: exclusion, elimination, suppression, mitigation and no substantive strategy.[2] Baker *et al* define an elimination strategy as 'maximum action to exclude disease and eliminate community transmission' with the goal of reaching 'zero [disease] transmission in the community'.

On this account, Japan's strategy does not meet the elimination criteria. Although Japan's number of infections and deaths is low by comparison to European countries, it is high by comparison to Asian countries, and zero transmission has never been achieved in Japan. The Japanese government's 'basic policies for novel coronavirus disease control' released in March 2020 outlined the following objectives: (1) slow down the speed of infection by reducing clusters and reducing chances of contact; (2) minimise incidence of severe cases and death through surveillance and appropriate medical care, especially for the elderly; and (3) minimise the impact on society and economy through pandemic prevention.[3] No mention was made of elimination as a goal. In addition, the governor of Tokyo famously declared as early as May 2020 that Japanese people would have to live 'with Covid' (*wizu-korona*) for the foreseeable future.[4]

Furthermore, although Japan has deployed sporadic lockdowns since the first state of emergency was declared on 7 April 2020, these were modest compared with the hard and strict lockdowns seen in many other countries. The Act on Special Measures for Pandemic Influenza and New Infectious Diseases Preparedness and Response (hereafter ASMPI) allowed each prefectural governor to request quarantine cooperation from the public but without enforcing penalties on non-compliance. The ASMPI and the Infectious Diseases Control Law were amended in February 2021 to impose fines on businesses that do not comply with requests to suspend operations, and to impose limited administrative penalties in special circumstances, such as in the case of an infected person violating a quarantine order. However, these remain modest when compared with the penalties imposed in other countries.

Jecker and Au suggest that Japan's response to COVID-19 can be explained by reference to its being a 'collectivist' society, in which contracting the disease would lead to a loss of face. They explain this by reference to two Japanese concepts, namely *seken-tei* and *kegare*. We doubt the plausibility of this explanation. First, the claim that Japan is more 'collectivist' than 'individualist' is poorly supported by evidence. Indeed, research by Takano and Osaka suggests that Japanese people are no more collectivist than their American counterparts.[5] Second, the association between disease and impurity latent in the notion of *kegare* is not unique to Japanese culture, as cultural anthropologist Emiko Namihira has pointed out.[6] Finally, although *seken-tei* may be somewhat important in Japanese society, more empirical research is needed to ascertain whether this concept explains the relatively lower infection rates seen in Japan, or whether it is better accounted for by factors such as a general willingness to wear masks in public and a relative lack of physical contact in greetings.

Jecker and Au speculate that the experience of the SARS epidemic in 2003 explains why Asian countries have adopted a more risk-averse strategy with respect to COVID-19. However, SARS neither was confined to Asia, nor did it affect all Asian countries equally. Japan, in particular, did not experience any domestic cases of SARS.[7] Japan was, in fact, ill prepared for the COVID-19 pandemic for other reasons. Unlike SARS, the so-called Swine Flu (Influenza A (H1N1)) pandemic between 2009-10 significantly affected Japan and led to the Japanese government commissioning a review on pandemic preparedness in 2010. However, due to the Tohoku earthquake and the ensuing Fukushima nuclear disaster in 2011, there was not much continuity in the government's planning and awareness of the importance of pandemic preparedness. Moreover, public attention was diverted from concerns over potential pandemics to issues around nuclear safety and natural disaster preparedness.

Therefore, Japan's 'success', if we can call it such, in keeping the number of infections relatively low was not due to any elimination strategy. Rather, we suggest that it was due to the general public and public health workers' patient efforts to comply with the government's sometimes haphazard requests to wear masks, close shops and track and trace suspected cases of infection to prevent cluster infections, together with strict border controls. Compliance with these measures came at a high social cost, and, as Jecker and Au point out, health and social inequality may have widened as a result. More research is needed to determine the extent of such inequalities, and to devise policies to combat them effectively.

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Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This study does not involve human participants.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Kodama S, Campbell M, Tanaka M, *et al*. *J Med Ethics* 2022;**48**:173.

Received 1 February 2022
Accepted 7 February 2022

J Med Ethics 2022;**48**:173.
doi:10.1136/medethics-2022-108189

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