Exploring Japan’s Approach to Combating COVID-19: Is Culture the Ultimate Safety Net or Our First Line of Defense?

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This publication was part of Ms. Morrell’s participation in Sasakawa Peace Foundation USA’s Sasakawa USA Emerging Experts Delegation (SEED) program, where nine U.S. public health experts traveled to Japan from July 31 to August 6, 2022. The 2022 SEED delegates engaged with Japanese public health experts to understand the challenges and opportunities Japan faced in responding to COVID-19 and to explore the avenues for future U.S.-Japan collaboration on public health and emergency preparedness.

Introduction

This report will highlight observations and viewpoints from my participation in the 2022 Sasakawa USA Emerging Experts Delegation (SEED), which took place in Tokyo, Japan from July 31, to August 6, 2022. I based my findings on discussions with Japanese officials and experts who played a key role in Japan’s response to the COVID-19 pandemic. The following report will also comment on the successes, challenges, and lessons learned experience by Japan and the United States due
Learning from *Diamond Princess* and the Global Health Security Landscape

The February 2020 outbreak of COVID-19 aboard the *Diamond Princess* cruise ship remains a shining example of how to successfully leverage an existing relationship in a time of uncertainty and crisis. It also serves as a reminder of the importance of strengthening global health capacity to prevent the refusal of cruise ships by coastal states when the next pandemic occurs.

Efforts undertaken by responders from both the U.S. and Japan are a credit to both nations and the field of public health. The *Diamond Princess* represents the intersection of public health, national security, and the importance of strengthening the decades-old U.S.-Japan alliance. The *Diamond Princess* and the COVID-19 pandemic also presented opportunities for likeminded nations to collaborate on pressing health security issues through various global health partnerships such as G7.

Discussion among SEED delegates and Japanese experts and officials underscored the key areas of cooperation in the U.S.-Japan alliance, namely: (1) Ensure strategic balance to maintain influence globally; (2) Set, maintain, and enforce rules that support economic order; (3) Support people-to-people exchange to enhance collaboration among the two countries in a wide array of fields such as politics, technology, and economic security.

Japanese officials noted renewed efforts in support of achieving universal healthcare worldwide. These renewed efforts are a key link in the chain of global health preparedness especially as our near borderless societies hastened the spread of the current COVID-19 pandemic. Capacity building for universal healthcare will level the outcome for lower- and middle-income countries and can minimize the disparities in health outcomes across nations with differing incomes so that when the next emerging infectious disease (EID) threat arises, we will have already made the necessary global health preparedness investments.
Officials and experts also spoke at length about the challenges of designing the architecture of global health and emphasized that a governance structure and a legal framework with roles and enforceable responsibilities is paramount. According to Japanese officials, relying on the World Health Organization (WHO) reforms to shape this structure may not be the winning strategy going forward because there are other important players working in areas for mass production of medical countermeasures (MCMs), crisis management system development, and health financing that also require strategic collaboration and capacity building. Strengthening the capacities of the International Health Regulations and fortifying the role of the WHO and other essential global health partnerships are the minimum corrective actions to consider post COVID-19.

Japan’s Government-led Response to the COVID-19 Pandemic

According to Japanese officials, once the *Diamond Princess* triggered Japan’s response, suppression of COVID-19 became the objective. Japan’s COVID-19 strategy included a cluster-based approach with minimal polymerase chain reaction (PCR) testing at the initial stages. Japan conducted contact tracing, albeit with some privacy issues, and encouraged isolation for infected patients. Experts commented that the initial vaccine rollout was slow, but Prime Minister Suga decided to increase coverage through Japan’s accelerated vaccine program. The program prioritized the elderly as its main objective because of Japan’s highly aging society and succeeded in targeting this population. However, vaccination rates among younger populations were significantly lower as the focus was on the elderly. Japan recently began to target the younger population because high vaccination rates in this group will be key to returning to normalcy. Another feature of Japan’s response to COVID-19 was that it did not mandate lockdowns and relied on the public to follow recommendations. Although, Japan maintained strict border controls throughout its COVID-19 response. Balancing the social and economic impact of these pandemic measures with the potential for negative health outcomes presented challenges to response and was especially prominent during the 7th wave of COVID-19, which took place during the SEED study trip.

Governance and response structures present in Japan partially explain the decision not to mandate lockdowns. Japan lacks a comprehensive, national legal framework for preparedness and response that can address emerging infectious diseases. The absence of a legal framework throughout the
COVID-19 response created challenges for the central government in terms of their ability to leverage the legal and regulatory authorities necessary for guiding and enforcing disease control measures.

The central government and prefectural governments play a key role in emergency response. The workforce is under the control of governors who have a great deal of autonomy within their respective prefectures and the central government lacks the authority to promulgate enforceable courses of action at this level. The central government could only request public health measures such as to stay home or work from home. Ultimately, it was up to the public to comply.

Recommendations include:

1. Organize efforts under a national government-level infrastructure that would allow for routinized mechanisms for collaboration among partners and a clear sense of roles and responsibilities among governmental entities and relevant institutions.

Experts shared that they had information and ideas relevant to response efforts but did not receive sufficient opportunities to share and collaborate with the central government. Prior to the COVID-19 response, codified standards for this type of collaboration did not exist in Japan.

2. Exhibit strategic agility by redirecting investment and efforts as the pandemic progressed.

Experts emphasized that Japan built a public health and medical system for steady state functioning. A large-scale EID outbreak had not affected the Japanese population until the COVID-19 pandemic. Experts explained that their infrastructure lacks the flexibility required to pivot or alternate response strategies as evidenced by the challenges associated with the nation’s transition from closed to open borders. Some experts expressed that Japan lagged behind other countries in this regard by not clearly communicating to the public the level of protection vaccination provided against the virus and variants.
In the United States, an array of legal tools, ranging from legislation to presidential directives, exist and define how the federal government uses its authorities and interacts with state and local entities. The U.S. also has departments and agencies, such as the Centers for Disease Control and Prevention and the Administration for Strategic Preparedness and Response within the Department of Health and Human Services, dedicated to preparing for, responding to, and recovering from public health emergencies. However, the U.S. still experienced challenges associated with compliance with mandates at the state and local level; issues communicating guidance and scientific evidence to the public; and providing resources to health departments, hospitals, and other stakeholders. Demonstrating that no nation, even ones with elaborate preparedness infrastructure, is immune to the potential risks of novel and emerging infectious diseases.

In addition, Japan and the U.S. faced unique challenges due to their differing healthcare systems and demographic makeup of the populations. Nevertheless, there are still opportunities to gain experience from each other. For example, Japan’s swift rollout of the Three Cs, a strategy quickly adopted in the United States and worldwide, represents how solid public health strategy and communications can yield immediate public acceptance and save lives without the need for a stringent government mandate. In this case, Japan’s Three Cs advised its population to avoid closed, poorly ventilated spaces; crowded places; and close-contact settings. Conversely, U.S. legal authorities can serve as a model for how to build public health and emergency management structures that build preparedness and response capabilities.

Centering Cultural Factors in Public Health Response Strategy

Several Japanese officials and experts spanning multiple sectors commented on the intended and unintended role of shame in Japanese society and its influence on the COVID-19 response. Reasons for the persistence of shame ranged. Some cited the fact that Japan is a relatively homogenous population making the pressure to conform intense while others simply attributed it to longstanding cultural norms. For better or for worse, shame clearly effected many facets of Japan’s COVID-19 response and individual attitudes and behaviors.

Furthermore, experts provided historical context to explain Japan’s present-day public health and medical lens during infectious disease outbreaks, adding that the same mental framework may apply to neighboring nations like China and Korea. According to experts, in the mid-19th century,
Japan opened its ports to U.S. trade and with this came the influx of infectious disease. The police were responsible for handling infected persons and their families, as well as evacuation. The Ministry of Health, Labour and Welfare’s (MHLW) creation also add context to Japan’s public health origins and outlook. Japan designed the early iteration of MHLW to improve the health of soldiers, and many of its national hospitals were former army or navy hospitals. These vital details, when paired with current attitudes reported by Japan’s experts, suggest a shared memory of perceived criminality associated with infectious disease and military-state controlled hospital care that persists and interacts with other cultural undercurrents such as shame, perfectionism, conformity, and rule-following.

This may help unfold the Japanese people’s modern-day relationships with medical providers and government institutions during COVID-19. Under Japan’s healthcare systems, the doctor-patient relationship takes precedent for chronic illnesses such as diabetes, with no interference from insurance companies as experienced in the U.S. Individuals from all socioeconomic backgrounds essentially have unfettered access to medical care and the Japanese people appear to be quite comfortable with this dynamic, for example shared decision-making between the patient and doctor. The paradigm shifts when we include infectious disease outbreaks into the equation. Infectious disease law introduces government institutions into that relationship and may trigger associations from Japan’s past. Some experts indicated a connection between this shift and PCR testing, case reporting, and even attributing cause of death at the local level. Still other Japanese experts assert that Japan does not politicize bureaucracy as it is in the United States. Essentially, the people of Japan trust that the government works on their behalf.

A powerful desire for perfectionism and a sense of exceptionalism, paradoxically, were just as pervasive a theme as shame. Multiple experts elaborated on this, sharing that the Japanese population views themselves as a hygienic society that is honest and diligent about the flu. Widely accepted face mask use in Japan during COVID-19 is an example of the interplay between the two major cultural phenomena present in Japan (exceptionalism and shame) and how they create rule-following within the population. According to experts, Japanese people used face masks long before COVID-19 and it was clear when walking the streets of Tokyo that most people would continue. Experts described the Japanese people going about their daily lives and being able to go
outside because of the mass acceptance of masks that rendered mandates unnecessary and afforded them great autonomy in comparison to other places in the world. All of this is in stark contrast to what occurred in the United States, where face mask compliance was a source of contention for many and noncompliance with state and local mandates was widespread.

Social responsibility was also a palpable driver of behavior and decision-making on both a micro and macro scale in Japan. This theme manifested in the personal choices of individuals (such as the cultural custom to prioritize the elderly that resulted in many refraining from visiting loved ones of advanced age), as well as the behaviors of stakeholders in COVID-19 response. For example, one expert explained that Japan did not equip its preparedness and response infrastructure to counter such a massive emerging infectious disease outbreak as COVID-19 and that Japan’s system is obscure. In the absence of a clearly defined role, this expert found himself, along with his colleagues, acting out of a sense of responsibility rather than based on a predetermined plan or governing framework. Similar examples came up in discussions repeatedly and across industries.

Absent many of the formal public health preparedness and response structures in the U.S., the Japanese people simply behaved in accordance with their culture to follow the rules, trust in their public systems, and conform. In an unprecedented pandemic driven by human behaviors, such as to wear a mask or to not wear a mask, the cumulative actions of the population as governed by Japan’s cultural makeup was paramount. Case rates aside, this SEED trip demonstrated that as public health practitioners, it is easy take culture for granted. At worst, we consider culture in the aftermath of an event and at best we identify it as something to account for in preparedness. However, Japan’s pandemic success, despite organizational and legal authority challenges, makes it clear to not only account culture, but also it is a critical driver of success. If we fail to center on sociocultural factors, even the most well-devised strategies can fall flat.

Future Collaboration and Leadership in Public Health Response

My experience as a SEED delegate provided me with fresh perspectives on how to utilize public health practice in a response context, as well as a greater understanding of Japan’s relationship with the U.S. At the time of my visit, Japanese officials and experts were working towards developing their own CDC-like body that would serve a similar function as the CDC in the United
States. This will better equip Japan’s central government to coordinate and function within clearly defined roles. Furthermore, having parallel structures could allow the U.S. and Japan to leverage potential organizational synergies when the next threat arises. Deepening relationships with likeminded countries such as Japan will play a significant role in the road ahead.

Ms. Morrell wrote in her personal capacity. The views and interpretations expressed by the author are solely her own.

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