

Part III Best practices and challenges

Chapter 7

National and local governments

A tight competition between national and local government leaders hampers efforts at crisis management because the potential gap in the interests of each of the parties makes it difficult for them to cooperate with each other. On the other hand, such competition is to be embedded in a society that pursues decentralization of administrative powers, and leaders must consider how to promote cooperation with the parties with which they compete. In this chapter, we examine from this perspective crisis management at multiple levels in dealing with the novel coronavirus.

We will first examine the effort to build systems for infection control, mainly in the medical field, as well as medical care for COVID-19 patients. In building systems for early detection of infection through public health centers, isolation of patients and containment of infection at nursing care facilities, as well as treatment of patients with severe symptoms, the built-in mechanism for cooperation between national and local governments was quite significant. Prompt responses by local authorities in Japan's outlying regions – one of the best practices – were examples of such cooperation functioning as intended. We then review the national and local governments' calls on people/local residents to act in response to COVID-19 – mainly the requests for them to voluntarily stay home and refrain from nonurgent outings when the infection was spreading. In this respect, competition between leaders of local governments to pursue stronger and more proactive measures made it difficult for the national government to adjust such efforts.

It is not easy to bind the actions of political leaders by laws or action plans on issues that attract political attention. But since these decisions involve restricting private rights and significantly affecting people's daily lives, it is all the more important to clarify in advance the division of functions among the national and local governments as well as experts.

1. Crisis management at multiple levels

1.1. Local governments as frontline bodies in combating infectious diseases

What attracted people's attention in the effort to contain COVID-19 infections was that not just the national government, but local governments, in particular governors

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of prefectures, took on frontline roles in combating the pandemic. The novel coronavirus tends to become a serious problem in urban areas – where a large population is concentrated – as observed in the cases of Wuhan, China, where the outbreak first spread, the Lombardy region of Italy, and New York, which was thrown into a critical situation by the infection. And it was the heads of local governments that were on the frontlines of the fight against the disease in these areas. Since the disease spreads through people's contacts with others, authorities covering the local area respond first to the outbreak, their leaders taking command.

Local governments also play an important role in Japan's measures against infectious diseases. Under the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases (Infectious Diseases Control Law), national and local governments are required to cooperate with each other in order to “comprehensively and promptly execute” measures to prevent an infectious disease in view of the circumstances in each area (Article 3, Clause 2). While a significant portion of the task is put in the hands of prefectural governors, including infection surveillance, restricting the movements of the infected, and building a system for medical care of the patients, the national government's function is mainly to set a basic strategy to fight against the disease and provide necessary technical and fiscal support for local governments.

It is the public health centers (*hokensyo*) across the country that actually deal with patients of infectious diseases and suspected cases. As bodies in charge of public health, public health centers are set up in 20 major cities designated by government ordinance, 60 other “core” cities, five other municipalities (Otaru, Machida, Fujisawa, Chigasaki, Yokkaichi), Tokyo's 23 special wards – as well as in roughly each of the 334 “secondary medical areas” specified by the medical care plans managed by prefectural governments. There are 335 public health centers run by prefectures, while each of the above-mentioned cities has one such facility, except for the city of Fukuoka, which has seven public health centers under its jurisdiction. Previously, public health centers were tasked primarily with preventing and coping with tuberculosis, and the success of that mission led to cuts in the number of public health centers and their personnel in a wave of administrative reforms from the 1990s. In some areas, the focus of the public health centers' gradually shifted from infectious diseases to community health care as the weight of elderly care increased with the aging of Japan's population.¹

In addition to the Infectious Diseases Control Law, the Act on Special Measures for Pandemic Influenza and New Infectious Diseases Preparedness and Response – which eventually set the framework of the measures to combat COVID-19 – also gives prefectural governors broad powers, ranging from the adjustment of appropriate measures to steps for preventing spread of the infection and securing the medical care system in case a state of emergency is declared. Given such powers, the governors occasionally try to make autonomous decisions while following the government's basic policy.

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The national government, meanwhile, is in charge of national-level crisis management, which in the case of the COVID-19 crisis included the operation of chartered flights to repatriate Japanese from Wuhan, the initial border control measure in response to the outbreak aboard the Diamond Princess, tasks that involve international relations such as developing medicine and vaccines for the novel coronavirus, requesting the closure of schools nationwide, and declaring the state of emergency. The national government takes on the function of a headquarter for crisis management efforts nationwide, while prefectural governments and public health centers are primarily responsible for the actual measures to combat the infectious disease. Since a large portion of the measures to fight the infectious disease rested with prefectural governments from the outset, crisis management against COVID-19 was pursued at different (or multiple) levels by the national and prefectural governments simultaneously, and thus emerged the need for both parties to mutually cooperate and adjust their efforts.

1.2. Establishment of decision-making led by politicians and the rise of prefectural governors

Since the Meiji Era, Japan has long had a centralized power structure, under which local authorities were to follow the command and supervision of the national government. Decentralization of administrative powers made some progress from the 1990s, but merely granting powers to prefectural governments would not enable them to proactively put crisis management in their hands. Nevertheless, some prefectural governors took noteworthy actions in response to COVID-19, and behind this move are underlying changes in Japanese politics since the political reforms of the 1990s. One of those changes is the further shift to decision-making driven by politicians at the national level.²

In the second administration of Prime Minister Shinzo Abe, opaque policy adjustments between government ministries receded into the background, and politicians and bureaucrats close to the prime minister, supported by the Cabinet Secretariat and the Cabinet Office with substantially upgraded staffing, increasingly made top-down policy decisions. And in the response to COVID-19, Health, Labor and Welfare Minister Katsunobu Kato and Yasutoshi Nishimura, minister in charge of COVID-19, put together the government's policies based on information gathered from various bodies, as those include bodies were preoccupied with dealing with their respective missions – the Cabinet Secretariat's Assistant Chief Cabinet Secretary Office (“situation office”) coping with the operation to repatriate Japanese nationals from Wuhan on chartered flights, the health ministry tackling the outbreak aboard the Diamond Princess, the Office for influenza response of the Cabinet Secretariat (and the Office of COVID-19 control that took over from it) in amending the special measures act, and the Office of the Headquarter for Japan's Economic Revitalization preparing the economic package to contain the damage from the pandemic.

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Also, between the national and local governments, many of the decisions over COVID-19 were made at the political level, instead of the routine bureaucratic channels. When the governors, prompted by concern over the spread of infection, made direct demands to the political leaders, the Cabinet ministers who received such demands were required to make a response. Local politicians sometimes give positive evaluation for the national government responsive to the demands from prefectural governments, and occasionally the national government did more than what the governors expected. For example, Kanagawa Governor Yuji Kuroiwa and Tottori Governor Shinji Hirai, who served as deputy chiefs of the National Governors' Association headquarters on COVID-19, expressed their appreciation that Kato and Nishimura accepted a proposal adopted by the governors in an online conference of the association.³

Previously, it often took a year – starting with a budget request – for most of the prefectures' demands to be accepted by the national government,⁴ but this time, the national government is believed to have made a response at the initiative of the politicians while bypassing the bureaucracy. As a consequence, some Cabinet ministers drew public attention for their political initiatives, along with some governors who made various proposals – including the idea that came under criticism to shift the start of the school year to September.

The COVID-19 response also exposed competition among political leaders, including some prefectural governors. In the government's response to the pandemic, Prime Minister Abe, Ministers Kato and Nishimura, as well as Chief Cabinet Secretary Yoshihide Suga came to the fore, while there were few occasions for other national-level politicians to draw public attention. On the other hand, people closely watched what the governors said as the leaders who took direct charge of the COVID-19 response in their respective prefectures – and often compared them with each other. The governors were even rated on the basis of data on infections and the medical service system in their prefectures.⁵ For example, Kanagawa Governor Kuroiwa candidly acknowledged that, aware of the severe criticism against his prefectural government, he wavered at the response of his counterparts in Tokyo and Osaka to the crisis.⁶ It would be impossible for governors not to be conscious of each other even as they tried to concentrate on their own duties.

In terms of comparison, many would agree that the governors who drew the most public attention were those of the two big metropolitan areas of Tokyo and Osaka. The personal characters of the two governors and their strong public communication skills might have been essential for getting public attention, but it should not be ignored that there were some partisan factors at play. Tokyo Governor Koike was seeking re-election in July, while Osaka Governor Yoshimura had a local referendum scheduled in the fall on his party's bid for administrative reorganization of the prefecture and the city of Osaka. In such a circumstance, they proceeded with crisis response in potential tension with the Liberal Democratic Party, the governing party in the Diet that also had a large influence over local elections.

2. Infection control and medical care system

2.1. Early-stage detection of the infected through virus tests

When the scale of infection is not so large, local governments respond in more or less the same way to an infectious disease. As is often observed in a relatively small city, the basics of controlling an infectious disease, when the number of infected patients is still limited, will be for the public health centers and other local bodies to contain the disease by detecting infections in the early stage through broad testing and by isolating those who test positive and their close contacts.

Wakayama Prefecture, which had to deal with COVID-19 in the initial phase of the domestic outbreak, and other local governments should be applauded for their efforts to prevent the spread of infection by building a testing system that included tracking down people who had been in close contact with the infected. Of course, the methods built on the past efforts to prevent the spread of tuberculosis functioned in combating the novel coronavirus, and the measures led by the team set up at the health ministry to deal with infection clusters also proved effective. The method to identify and examine large-scale clusters based on research about the traits of the new virus was significant from the perspective of the early detection of infected patients.

The early-stage detection of the infection and prompt isolation of the virus carriers by public health centers owed a lot to the designation of the novel coronavirus as an equivalent of the Category II infectious disease under the Infectious Diseases Control Law as early as February 1. That made it possible to recommend hospitalization of patients and suspected patients (and asymptomatic carriers of the virus beginning on February 14) under the law even as much of the details about the disease remained unknown. Such a recommendation enabled hospitalization of patients at public expense, thus lowering the hurdle for their isolation. Although the measure was later blamed as the cause for raising the number of hospitalized patients and hampering economic activities, it did help the public health centers serve their functions.

Local governments that managed to contain the infection in the early phase of the outbreak utilized the public health centers' power for active epidemiological investigation to hold large numbers of tests that far exceeded the number of patients and took mandatory measures, including hospitalization, to isolate those infected. Wakayama Prefecture, where the governor vowed to make "excessive" effort to contain the infection,⁷ implemented thoroughly the basic measure of identifying patients and terminating the link of infection by widening the scope of the epidemiological investigation. In an extreme case of such effort, Shimane Prefecture in July tested more than 600 people after finding one asymptomatic carrier. While Japan came under repeated criticism for its insufficient testing capacity, there were some examples of the heads of

local governments where the number of infected patients was small exercising political leadership to make the most of active epidemiological investigation to contain the disease.

But unlike the active epidemiological investigation, there were difficulties in dealing with suspected cases, such as people with fever whose possible infection routes were not necessarily clear. It was the “consultation centers for returnees and contact persons” (COVID-19 consultation centers) that dealt with these suspected cases. People who suspected an infection were told to first contact those centers, which then referred them to medical institutions with sections dedicated to seeing such outpatients. The consultation centers and the hospitals handling those outpatients were required to effectively screen suspected cases to prevent a sudden surge in the number of patients from overwhelming the capacity of medical institutions designated for dealing with infectious diseases. However, criticism erupted that the screening criteria – having a fever of 37.5 degrees or higher for at least four days continuously – was too prohibitive, and that calls to the consultation centers would not connect because of the manpower shortage there, therefore the callers could not even be screened.

These bodies for screening suspected cases were set up on the basis of a clerical notification from the health ministry by following the government's action plan for dealing with pandemic influenza. But there is criticism that such bodies were created before the act on special measures for the pandemic influenza and new infectious diseases was revised to deal with COVID-19, and thus legal matters for combating the novel coronavirus were not yet clearly sorted out.⁸ It was likely difficult for such bodies, which were not necessarily guided under the strong leadership of prefectural governors, to establish a testing regime by mobilizing the resources of private-sector medical institutions and medical professionals.⁹

2.2. Building a system for treating patients with serious conditions

It was known from the initial stage of the COVID-19 outbreak that most of the infected patients suffer from mild symptoms while a relatively small number fall into a serious condition – and that the severity of this disease varies by age groups. Many of the serious cases that resulted in death were elderly patients, and it was important to build a system to secure treatment for patients – mainly those of advanced age – who had developed severe symptoms.

The first obstacle was the recommendation for hospitalization of those infected with the virus under the Infectious Diseases Control Law. Since COVID-19 was designated as an infectious disease equivalent at least to the Category II disease under the law, hospitalization was recommended for all infected people, including those with mild symptoms or asymptomatic carriers. Due to the shortage of hospital beds, however, it was difficult to accommodate all the people who tested positive for the virus at medical

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institutions designated under the law for treating patients of infectious diseases. This problem was recognized from the time Kanagawa Prefecture dealt with the outbreak aboard the Diamond Princess in the initial phase of the crisis. Led by its DMAT (disaster medical assistance team), the prefecture divided patients from the cruise ship into three groups – patients with serious conditions, those with medium-level symptoms and those with either mild or no symptoms. It concentrated on the treatment of the first two groups at high-level medical institutions and priority hospitals in the area, respectively, while patients with mild or no symptoms were recommended to stay either at their homes or lodging facilities as their health conditions were monitored. Kanagawa Governor Kuroiwa, who served as deputy chief of the COVID-19 headquarters for the National Governors' Association, is also said to have proposed such a system to health minister Kato and Gaku Hashimoto, senior vice minister for health.¹⁰

Beginning in early February, the health ministry started routing infected people with mild or no symptoms to an accommodation other than the designated medical institutions. On March 1, the ministry's COVID-19 headquarters disclosed a new policy for securing an adequate number of hospital beds to accommodate COVID-19 not only at designated hospitals but also other institutions. While allocating those beds as a priority for patients with serious symptoms of the disease and a high risk of falling into a serious condition such as the elderly, those with mild or no symptoms were, in principle, to rest at home.

However, the ministry came under criticism for this rule when some cases surfaced in which people resting at home suffered a sudden deterioration in their condition. Therefore, the rule was amended in April to say that those with mild or no symptoms should basically stay at lodging facilities prepared by prefectural governments, and prefectures of urban areas with a substantial concentration of COVID-19 cases proceeded to prepare lodging capacity for those patients.

As they addressed the problem of accommodation for people with mild or no symptoms, the authorities had greater difficulty in securing treatment for patients in serious condition, due chiefly to the shortage of facilities reserved for infectious disease patients. Privately-run hospitals tend to decline to provide special beds for treating infectious diseases, which requires expensive facilities for isolation of patients in depressurized spaces and other special equipment – while those beds are unprofitable because the occupancy rate is normally low. As a result, hospitals run by local governments, as well as those operated by public service corporations including the Japanese Red Cross Society and the Saiseikai welfare organization, play important roles in maintaining such capacity. But even the public hospitals have been forced to cut back on unprofitable beds for infectious disease patients amid the fiscal crisis from the 1990s, with their combined numbers falling from 9,716 in 1996 to 1,758 in 2019.¹¹ The number is far from adequate even when beds for tuberculosis patients are converted for use by patients of other infectious diseases.

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The number of hospital beds for infectious diseases is set for each of the tertiary medical areas (or each prefecture) mainly based on the combined number of such beds at existing medical institutions designated for infectious diseases in the area, while the number of beds for tuberculosis treatment depends on the number of tuberculosis patients. Neither of their numbers are set on a population basis. As a result, prefectures with metropolitan areas – where there is a fear that an infectious disease will spread widely – have extremely low numbers of hospital beds for infectious diseases in proportion to their population.

In an emergency medical care system, in the case of an infectious disease outbreak, each of the prefectures is to decide on the use of normal hospital facilities other than those for infectious diseases – in the infection prevention plans that they create in line with the national government's basic guideline, the action plan based on the special measures act on pandemic influenza and new infectious diseases, as well as the medical services plans that take those into account. In the case of a large-scale outbreak like COVID-19, it was not assumed in the first place that the designated medical institutions alone would deal with all the patients. Whether these measures such as converting normal medical facilities for treating patients of infectious diseases would be carried out according to the plan depended a great deal on the prefectural government's continuous cooperation and communication with stakeholders at local medical institutions.¹²

At the peak of the first-wave infections of COVID-19, only 19 out of the nation's 47 prefectures could provide sufficient hospital beds for the infected number, and beds were in short supply especially in urban areas of the country. In Tokyo, it was only in May that more than the 2,950 beds specified in advance under its medical care plan were secured.¹³ According to Kyoto University professor Kengo Soga, who examined the number of COVID-19 patients with serious symptoms anticipated in each prefecture and the number of hospital beds secured for their treatment, prefectures that had relatively severe assumptions about the number of patients with serious conditions – closer to those assumed by Hokkaido University professor Hiroshi Nishiura, a member of the government's expert panel – had a hard time securing enough beds to match the number. On the other hand, prefectures that were able to secure beds for the anticipated number of patients with serious conditions tended to keep their estimates of patients relatively low in the first place. The situation was particularly serious in prefectures like Kanagawa and Chiba, which had difficulties securing beds to match despite underestimating the number of patients. Things were not as bad in the big metropolitan areas like Tokyo, Osaka and Aichi, but those prefectures still had trouble securing enough beds to accommodate patients with serious conditions.

In developing a medical care system focusing on seriously ill patients, another key is to prevent infection in elderly people, who have a higher risk of suffering from grave symptoms, and local governments have an important role to play in this respect – since nursing care facilities that accommodate large numbers of elderly residents are basically under the supervision of municipalities. At those facilities, general measures have been taken to prevent infections based on the revised manual by the health ministry,

as in the efforts to protect residents from infection with seasonal flu and novel coronavirus.

In addition, a notification issued by the health ministry on February 24 called on workers at those facilities to wear masks and perform extensive alcohol disinfection in the facilities, and said it was “desirable” to restrict visits to residents except for urgent ones in order to shut off external routes of infection.¹⁴ Professor Estevez-Abe of Syracuse University points out that curbs on visits to residents of elderly care homes from the early stage of the pandemic contributed to Japan’s success in keeping its COVID-19 deaths much lower than in other countries.¹⁵ But masks and alcohol disinfectants were in short supply for nursing care facilities until April, as the health ministry put priority on securing such supplies for medical institutions even as it called on prefectural and municipal governments to release their stockpile of such equipment.

People infected with the novel coronavirus at nursing care homes – both residents and care workers – were hospitalized in principle. Overall, the spread of COVID-19 infections at nursing care facilities for the elderly in Japan was deemed to have been contained, but there were several outbreaks of infection clusters at such facilities that claimed a large number of lives. In one such case at the Barato Acacia Heights facility in Sapporo, a total of 71 residents were infected with 12 of them dying. Those infected at the facility were rejected by local hospitals on the grounds of a shortage of beds, leaving many of them to die without being hospitalized.

The city of Sapporo said it would arrange for medical care at the facility for patients who could not be hospitalized. However, not enough medical care was provided and measures to control infections were insufficient. The case was eventually put under control after the health ministry dispatched a DMAT team to manage infections at the facility and arrange for hospitalization of the infected residents. The Hokkaido Prefectural Government and the city also accepted caregivers from the Association of Geriatric Health Services Facilities as extra help to address the situation, which contributed to preventing the spread of infection.¹⁶

3. Calling for voluntary action by the public/local residents

3.1. Efforts to subdue infection through self-quarantine

When the number of patients is expanding to a degree in which early detection and containment of the infection become difficult, people engaging in self-quarantine to voluntarily stay home and curb economic activities – on the assumption that an unspecified large number of the public have already been infected – holds the key to combating an infectious disease. Efforts for early detection/isolation of infected patients and building a system for their medical care, when the number of infections is still small,

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is assumed to be completed within the borders of prefectures, cities, towns and villages. On the other hand, broad cooperation involving national as well as local governments is required in asking the public/local residents to self-quarantine – because large numbers of people daily cross local government borders to visit large urban centers.

The first cases of large-scale self-quarantine in combating COVID-19 were the national government's requests for voluntary restraint on organizing large events and closing schools nationwide (see Part II, Chapter 3). Local governments were involved as the parties responsible for running schools. In its clerical notification issued on February 25, the Education, Culture, Sports, Science and Technology Ministry noted that a school could be closed even when none of its students had been infected. In Hokkaido, where infections of schoolchildren had already been reported, the prefectural government requested the closure of all schools across the prefecture the following day. On February 27, Ichikawa, Chiba Prefecture, and the cities of Osaka and Sakai in Osaka Prefecture followed suit. Amid such moves by some local governments, Prime Minister Abe made the decision on the evening of that day to request a nationwide closure of schools.

Local governments, which set up and run most schools, faced a difficult choice – they had to quickly decide whether to close schools as requested during this period just ahead of graduation ceremonies. According to the education ministry, roughly half of local governments closed schools in their jurisdiction beginning the following Monday of March 2, while 30 percent shut down schools from March 3 or 4. More than 95 percent of local governments eventually closed schools as requested, but roughly 70 percent of them kept up after-class care for schoolchildren and after-school club activities. The requests were not followed in some regions, including Shimane Prefecture, where the local high schools were kept open and eight of its 19 municipalities decided against closing schools.

Closing schools would not only result in depriving children/students of education opportunities but could potentially impose a heavy burden on their parents. There was indeed criticism against the national government calling for a uniform closure of schools across the country. While Prime Minister Abe made the request for the closure of schools, the government decided at the March 20 meeting of its COVID-19 response headquarters not to extend its request for the nationwide closure, leaving it up to each local government and other authorities when to reopen schools. As a growing number of local governments and other school managers started to resume classes in mid-March, the education ministry started issuing guidelines for local boards of education on March 24 about reopening schools – basically leaving the matter up to the talks between the parties that ran the schools and prefectural governments. As a consequence, schools were reopened in April in some regions, including Tottori Prefecture, on the grounds that COVID-19 infections were not widespread in those areas.¹⁸

After the nationwide closure of schools was requested in the early phase of the outbreak, the next tool employed for self-quarantine was requests for people to stay home and voluntarily restrict their movements. Hokkaido, which experienced an increase in

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local infection ahead of other prefectures, was the first to take such a step. Immediately after the cluster team was set up at the health ministry on February 25, an official from the National Institute of Infectious Diseases was dispatched to Hokkaido. Upon advice from a member of the government's expert panel that it needed to take measures to reduce people-to-people contacts, Hokkaido Governor Naomichi Suzuki declared on the evening of February 28 a three-week state of emergency for the prefecture, calling on local residents to voluntarily stay home and department stores and other retail businesses to close their stores over the following weekend.¹⁹ As a result, on March 19 – at the end of the state of emergency – the expert panel determined that the measure had been effective in containing the infection in Hokkaido to a certain degree.

As fears over an escalation of the infection were reignited after people across the country – increasingly tired of self-restraint – went out in large numbers in mid-March, the health ministry, based on data compiled by its cluster team, informally alerted Osaka Governor Hirofumi Yoshimura and Hyogo Governor Toshizo Ido on March 19 to the possibility of an “overshoot,” or an explosive jump in infections, and proposed requesting voluntary restraint on nonurgent travel in and out of the two prefectures for the following three weeks. In response, Yoshimura, speaking to media reporters later in the day, requested that people voluntarily refrain from travel between Osaka and Hyogo. But if this request was made based on Article 45 of the revised act on special measures on pandemic influenza and new infectious diseases, which cleared the Diet on March 14, a state of emergency should have been declared by the national government before that. Yoshimura said he was aware that the request amid people's growing fatigue over self-restraint was being made in the absence of a state of emergency declaration.²⁰

Meanwhile, Governor Ido of Hyogo Prefecture also decided to call on people to refrain from travel to and from Osaka – though he expressed displeasure that the Osaka governor limited the call for travel restraint to that with Hyogo without consulting him in advance. As a result, Osaka and Hyogo prefectures – which both belong to a large metropolitan area where significant numbers of people travel daily – made a rather “extralegal” decision²¹ without necessarily sharing policy.

An even stronger message was sent out by the Tokyo Metropolitan Government. Also alerted to the risk of a surge in infections based on data from the health ministry's cluster team, Tokyo Governor Yuriko Koike said on March 25 – the day after the decision was made to postpone the Tokyo Olympic Games to 2021 – a “lockdown” might have to be introduced unless no action was taken to slow down the growth in infection, and this statement raised the prospect of restricting private rights, which was not provided for even under the revised special measures act. On the following day, Koike appealed to the governors of four neighboring prefectures to cooperate in jointly requesting people to refrain from nonurgent travel. Unlike the Osaka and Hyogo prefectures, the prefectural governors in the greater Tokyo area cooperated with each other in making such a request.²² Still, the legal authority of their request was similarly left vague.

3.2. Declaration and lifting of the state of emergency

Following the revision to the act for special measures on pandemic influenza and new infectious diseases, the government launched its COVID-19 headquarters as provided for under the act on March 26. After Tokyo, Osaka and Hyogo prefectures issued requests for people's voluntary restraint on travel, the government began exploring the declaration of a state of emergency, while carefully explaining that it could not enforce a "lockdown" under the laws of this country (see Part II, Chapter 4)

As speculation intensified that the national government would declare a state of emergency on April 7, the Tokyo Metropolitan Government compiled a draft on April 5 of its emergency measures that it had prepared from late March – and gave briefings to each of the political parties in the metropolitan assembly the following day. The draft included not only a call for people to voluntarily stay home, but also an effective request for business operators to close based on the special measures act, Article 24, Clause 9 (for curbing the use of facilities, which would have been possible without a state of emergency).. But while the metropolitan government weighed and summed up a set of criteria as to the sectors and conditions subject to the business suspension request based on Article 11 of the ordinance to implement the special measures act – and briefed the metropolitan assembly – it was not necessarily in sufficient communication with the national government over the issue. The national government became aware of some inconsistencies with the metropolitan government just as it was updating the basic outline of its COVID-19 measures. The metropolitan government then put on hold the announcement of its emergency measures on April 6, saying it was "in talks" with the national government over the content of the draft.

Surprised by the metropolitan government's sudden announcement, in updating the basic outline of COVID-19 measures on April 7, the national government inserted a phrase that bound the discretion of local governments in measures taken to contain the infection following the declaration of a state of emergency. In short, a request would be first made under Article 45, Clause 1 of the special measures act for voluntary restraint in people's movements, and then would come the request for restricting the use of facilities by businesses based on Article 24, Clause 9. When prefectural governments introducing their own emergency measures issue requests/instructions for restricting the use of facilities based on Article 45, Clause 2 to 4, they were required to "consult with the national government and consult expert opinion if necessary" as well as take the step only after reviewing the effects of the "stay home" request for people.²³ Based on this updated outline of its COVID-19 measures, the Prime Minister's Office strongly urged the metropolitan government to rethink its plan to effectively call on local businesses to close the moment the state of emergency was declared.

Negotiations between the Prime Minister's Office and the metropolitan government were hampered by their differences over whether some sectors such as

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barbers and restaurants/bars should be asked to close, and the matter was eventually left to a political settlement between Yasutoshi Nishimura, minister in charge of COVID-19 affairs, and Tokyo Governor Koike. Under the emergency measures finally announced by the metropolitan government, the call for businesses to close was made under the act's Article 24, Clause 9, instead of the act's Article 45, Clause 2, and the list of targeted sectors was slightly amended from the original plan. Other prefectures that also introduced their own emergency measures would similarly follow the government's updated basic outline.

An important question in effectively requesting business operators to close is whether compensation will be provided for the lost business opportunities – because many proprietors would not agree to closing without such compensation. The Tokyo Metropolitan Government, equipped with abundant fiscal resources, announced on April 15 that it would offer payouts for small and medium-size businesses that cooperated with its requests for closing or shortening business hours – ¥500,000 for a proprietor running one outlet and ¥1 million for those each running two or more. The National Governors' Association kept in step with the national government and was cautious toward making requests for businesses to close in the absence of a provision for compensation. But in the wake of the announcement by the Tokyo Metropolitan Government, neighboring Kanagawa Prefecture made the request (for the same sectors as in Tokyo) and offered up to ¥300,000 in compensation.²⁴ Such a payout was eventually to be financed by a total of ¥1 trillion in temporary grants for regional revitalization featured in the national government's emergency economic package. Even as the government denied offering direct compensation linked to losses from suspended business, this grant money was used to provide a lump-sum payment to proprietors that agreed to close, and many other prefectures tapped into the grants to support those businesses.

Provisions under Article 45, Clause 2 of the special measures act came under the spotlight once again when the refusal of some business operators, such as pachinko parlors, to comply with the request to close was widely reported by the media. On April 24, based on the opinion of its COVID-19 expert panel, Osaka Prefecture began publicly disclosing the names of outlets that kept operating, based on the act's Article 45, Clause 2. Governor Yoshimura indicated that he would resort to a stronger measure of instructing the businesses to close, but that plan was withdrawn as all outlets agreed to close by April 30. Eventually, 21 prefectures including Osaka disclosed the names of outlets whose operators defied the business suspension request based on the provisions of Article 45, Clause 2, while five prefectures – Chiba, Kanagawa, Niigata, Hyogo and Fukuoka – took the steps of instruction and disclosure of names based on Clause 3 of Article 45.²⁵

As the infection was gradually controlled, the timing of lifting the state of emergency became a major issue. Ahead of May 6, when the measure was originally set to expire, the expert panel on May 4 recommended extending the state of emergency, and the Prime Minister Abe said it was being extended through May 31. But both the ruling and opposition parties, economic organizations and the National Governors' Association urged the government to present a numerical criterion for making the decision to lift the

state of emergency (see Part II, Chapter 5).

Meanwhile, Osaka Prefecture, in the May 5 meeting of its COVID-19 headquarters, disclosed its own idea for lifting its business suspension requests based on a set of criteria called the “Osaka model,” which used such factors as the number of patients with unidentified infection routes, the ratio of people testing positive for the virus, and the occupancy ratio of hospital beds for COVID-19 patients in a serious condition, and put it to use beginning May 8 upon hearing the opinions of experts. Kyoto (May 12), Hokkaido (May 13) and Hyogo (May 14) prefectures followed suit in announcing their own criteria for easing and lifting the requests to curb business activities that they had issued under the state of emergency. In a spat with Osaka Governor Yoshimura on Twitter, Nishimura, the minister in charge of COVID-19, maintained that the issue of numerical criteria for easing the business suspension requests belonged to each prefecture (Part II, Chapter 5), but then the national government came under fire for not disclosing its numerical criteria for lifting the state of emergency, which gave an authority for the business suspension requests the prefecture made. In the face of such criticism, the government finally announced criteria in updating its basic COVID-19 action policy on May 14, and the state of emergency was lifted across the country on May 25.

4. Best practices and challenges

As was explained in this chapter, Japan's system of combating infectious diseases has a built-in mechanism for cooperation among various parties including the central government, prefectures and municipal authorities, hospitals, nursing care facilities as well as many other private-sector businesses (See Table 1).

At each stage of the fight against an infectious disease – from early detection and isolation of infected patients to building a medical care system and request for self-quarantine – the parties involved are required to share a common objective and work together to achieve the goal, even at a cost that may not appear to match the benefits. The system depends on the cooperation of medical professionals who hold tests amid the fear of an unknown virus, hospitals that secure beds for treatment of patients in a serious condition, and private-sector businesses that agree to close in order to contain the infection. What is also essential is the cooperation of local governments that persuade those parties into joining the fight against the virus and procure the necessary supplies and resources.

Efforts where such cooperation functioned well should be hailed as best practices. Such efforts include the early detection and isolation of infected patients that made full use of active epidemiological investigation in the nation's outlying regions, as well as containment of the spread of infection at nursing care homes for the elderly. In such endeavors, extra efforts by the people involved in routine measures against seasonal

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infectious diseases are believed to have led to success.

Table 1: Cooperation in each field and duty

Field	Duty	Organization mainly in charge	Partner organizations
Early detection and isolation of patients	Categorizing as designated infectious disease	Government (health ministry)	
	Active epidemiological investigation	Public health centers (prefectures)	Hospitals
	Consultation services for returnees and contact persons	Public health centers (prefectures)	Government, hospitals and testing institutions
Response to patients with serious symptoms	Securing hospital beds for the seriously ill	Prefectures	Hospitals
	Response to asymptomatic carriers and those with mild symptoms	Prefectures	Government, lodging facilities
	Isolation of nursing care facilities	Municipalities	Government, prefectures and nursing care facilities
Self-quarantine	Nationwide school closures	Municipalities	Government and prefectures
	“Stay home” request	Prefectures	Government and other prefectures
Declaring a state of emergency	Request for closing shops	Prefectures	Government, other prefectures and private-sector businesses
	Creating numerical criteria	Prefectures	Government and other prefectures

On the other hand, it is difficult to expect the full cooperation of private-sector hospitals that independently manage their institutions. “Consultation centers for returnees and contact persons” (COVID-19 consultation centers) that dealt with these suspected cases suffered from poor preparation and coordination, and they came under fire that they did not serve the expected function of screening suspected cases. Particularly in large metropolitan areas, lack of an adequate information infrastructure made it difficult to share COVID-19 data kept at public health centers separately run by prefectures, major cities and special wards, adding to the confusion among such bodies.

Crisis management efforts pursued at multiple levels can threaten the foundation of cooperation in combating an infectious disease emergency. While many governors primarily involved in the activities of the National Governors’ Association emphasized a posture of cooperation with the national government, it was the outlier governors of

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Tokyo and Osaka who heavily influenced crisis management as COVID-19 infections expanded over the period from March to May. While the national government maintained a restrained and conservative position over increasing tests for the virus, requesting businesses to close based on provisions of the special measures act, and restarting business activities, the top leaders of large metropolitan areas tended to be more aggressive, and their decisions gradually influenced the governors of other prefectures. Behind such moves lies the competition among the top leaders of local governments, and it is difficult to stop the governors, conscious of what their peers are doing, from trying to outbid each other by pursuing policy measures that achieve more tangible results. Even before the government declared a state of emergency, governors of some prefectures had already taken steps that effectively requested people's self-quarantine. It followed that the Tokyo Metropolitan Government attempted to urge businesses to close the moment the state of emergency was declared.

As a result, the national government – while maintaining its basic strategy of first asking for people's self-quarantine and then, after reviewing the effects of the measure, urging businesses to close – was effectively forced to condone a more flexible application of Article 24, Clause 9 of the special measures act than had been stipulated. The government, counting on cooperation by the prefectures, tried to use its power of comprehensive adjustment under Article 20 of the special measures act to influence the decisions made by governors. The special measures act also provided for a stronger measure for the government – the power to give instructions to prefectural governors under its Article 33. But exercising that power might damage the democratic legitimacy of a governor publicly elected to office, and entailed the risk of the national government getting all the blame if the attempt ended in failure. In fact, Nishimura, minister in charge of the COVID-19 response who dealt with the negotiation with the Tokyo Metropolitan Government, said he respected the governor's discretion and “never thought of issuing an instruction or considered such action as necessary.”²⁶

The governors who negotiated with the national government over conditions for restraining economic activities and lifting the restrictions had significant trouble on their part in terms of cooperation with neighboring local governments. There is no effective system in the nation's large metropolitan areas to cooperate across prefectural or municipal borders, and it is extremely difficult to integrate their decision making or information management.

Prefectures neighboring the large metropolises of Tokyo and Osaka – such as Kanagawa, Saitama, Kyoto and Hyogo – have within their borders major designated cities that are inevitably under the strong influence of Tokyo and Osaka. The governors who are less influential in those designated cities have therefore tended to put more energy on areas in their prefectures other than those major cities. Governors of these prefectures put priority on early detection and isolation of infected patients in combating an infectious disease in their areas, and such a posture may become inconsistent with demands for a stronger measure calling for self-quarantine broadly across a large metropolitan area. One example of this was seen in the gap in statements made by the governors of Osaka and

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Hyogo – both belonging to the same metropolitan area – which caused a slight confusing message to the public.

The response to COVID-19 exposed the need to clarify authority and responsibility in dealing with infectious diseases. The built-in mechanism for cooperation among the parties involved in combating an infectious disease indeed resulted in some best practices in the fight against the novel coronavirus. However, there are limitations to people's extra efforts to cope with an emergency under the constraints of limited resources. The case of the Barato Acacia Heights nursing home in Sapporo shows how things could develop into a critical situation once resources run out. Extra effort and cooperation by the people involved may help get through the initial phase of an emergency, but when resources run short, an expert body with the authority and responsibility for dealing with an infectious disease will be required to provide effective support.

This holds true for the crisis management efforts made at multiple levels – such as by the national and local governments. Ambiguities over authority and responsibility create room for competition by politically intervening with the issue at hand. In combating an infectious disease, it is imperative to establish a stable system that is detached from political competition by delegating professional risk assessment to an accountable expert body, and to learn from the practices to make improvements for the future.

Notes

1. Kengo Soga, "Infectious disease control as seen from data – Health care and medical system: the gap among the 47 prefectures in the response to COVID-19" (Chuokoron Vol. 134, issue No.8, Chuokoron-Shinsha, July 2020)
2. See, for example, Izuru Makihara, "The mystery of Abe's 'dominant grip on power' " (Asahi Shinsho, 2016) and "Rebuilding politics on the verge of collapse – administrative reform for Japan in the 21st century" (Kodansha Gendai Shinsho, 2018)
3. Yuji Kuroiwa, "Correct the ambiguous relationship between the national government, prefectures and municipalities – Will the criticism of the government by governors Koike and Yoshimura fix the problem?" (Chuokoron Vol. 134, issue No.8, Chuokoron-Shinsha, 2020); Shinji Hirai "Inconspicuous but steady efforts – No need for performance in the response to the infectious disease" (Chuokoron Vol. 134, issue No.8, Chuokoron-Shinsha, 2020)
4. Above-mentioned article by Hirai, page 35
5. Such "ratings" were also frequently published in weekly magazines like Shukan Bunshun, Shukan Post and FLASH.
6. Above-mentioned article by Kuroiwa, page 30
7. The governor made the statement in an interview by Nikkan Gendai, which released the video of the interview. Nikkan Gendai "Wakayama Gov. Yoshinobu Nisaka talks about the Wakayama model" (August 3, 2020) <https://moment.nikkan-gendai.com/videos/28561>
8. Akira Imai, "Response to novel coronavirus and local autonomy – the 'Japan model' and rule of law" (The Jichi-Soken, issue No. 501, 2020) <http://jichisoken.jp/publication/monthly/JILGO/2020/07/aimai2007.pdf>
9. One of the reasons behind the "clogged" system of PCR tests was the shortage of personal protective equipment such as gloves and masks, which led to an aversion among some medical professionals to be involved in the testing work (according to an interview with a senior Cabinet Secretariat official on August 25, 2020), and it is believed that the situation at the time made it difficult for officials to exert

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strong leadership to mobilize staff for the tests amid such an aversion. And although a direct causal link is not made clear, it is suggestive that in Hokkaido, where the infection initially spread as it took time for local authorities to develop the testing system with the “returnees and contact persons consultation centers” at its core, the number of infections began to decline after officials resorted to active epidemiological investigation at the end of February (according to an interim review of the COVID-19 response in Hokkaido).

10. Above-mentioned article by Kuroiwa, page 26-33
11. Shuhei Ito, “Visualized collapse of the medical care system – Why was it so fragile?” (Sekai, July 2020, Iwanami Shoten)
12. Miku Ishibashi, “Prescription for shortage of hospital beds is reorganization of beds and cooperation – Did the regional medical care plan make the response to COVID-19 difficult?” (May 28, 2020)
https://www.dir.co.jp/report/research/policy-analysis/humansociety/20200528_021568.html
13. Ibid.
14. A health ministry official in charge of the issue emphasized the importance of this notification (interview with a senior health ministry official).
15. Margerita Estevez-Abe, “The unknown factor behind the ‘success’ of Japan’s COVID-19 response – Nursing care facilities” (Newsweek, July 16, 2020)
<https://www.newsweekjapan.jp/stories/world/2020/07/post-93979.php>
16. Interview with a senior health ministry official
17. The Education, Culture, Sports, Science and Technology Ministry, “About the situation of temporary closure of schools and securing places for children to be” (2020)
https://www.mext.go.jp/a_menu/coronavirus/index_00005.html
18. The above-mentioned article by Hirai
19. Naomichi Suzuki, “Speaks out on the 150 days of solitary fight against novel coronavirus” (Bungeishunju, Vol.98, issue No.8, 2020)
20. Hirofumi Yoshimura, “Collapse of the medical care system is within the range of expectations” (Bungeishunju, Vol.98, issueNo.5, 2020)
21. Ibid.
22. Yuriko Koike, “Answers all the questions” (Bungeishunju, Vol.98, issue No.5, 2020)
23. But according to the special measures act, the scope of requests for cooperation under Article 24, Clause 9 is limited, and temporary business closures is not necessarily anticipated (according to the research group on countermeasures on pandemic influenza and new infectious diseases, 2013). It can be said that the request for business closure based on Article 24, Clause 9 utilized an exceptional provision in the government’s plan of action on the pandemic influenza and new infectious diseases. See the points made in a blog post by Yasushi Iwamoto “The price of inappropriate request for voluntary restraint on business”
<http://iwmtys.blog.jp/archives/1077941994.html>
24. Above-mentioned article by Kuroiwa
25. COVID-19 response headquarters, “Report on the measures taken under the declaration of the state of emergency over novel coronavirus” (June 2020)
https://corona.go.jp/news/pdf/kinkyujitaisengen_houkoku0604.pdf
26. Interview with Yasutoshi Nishimura, minister in charge of the COVID-19 response (September 15, 2020)