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COVID-19 and Japan's Long-Term Care System

Margarita Estévez-Abe and Hiroo Ide

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Authors

Margarita Estévez-Abe PhD (Maxwell School of Citizenship and Public Affairs, Syracuse University) and Hiroo Ide PhD (Institute for Future Initiatives, The University of Tokyo).

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Corrections and comments are welcome at info@ltccovid.org. This document was last updated on February 27, 2021 and may be subject to revision.

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1. Key points

- Despite being the most aged society in the world and having a high population density, Japan maintained low rates of deaths from COVID-19.
- Japan locked down long-term care facilities (LTCFs) during the first months of the pandemic, several weeks earlier than in Europe and the United States. This helped protect the most vulnerable elderly population from infection risks.
- The well-established protocols of prevention and control of communicable diseases such as influenza and tuberculosis in LTCFs proved to be effective in containing transmission of SARS-COV-2. The rate of compliance with the protocols has been high.
- The Japanese government response to the pandemic has been primarily a routine bureaucratic response. The presence of public authorities exclusively devoted to the oversight of LTCFs contributed to swift institutional responses.
- The presence of effective channels of communication between the public authorities and LTCFs contributed to the swift implementation of government guidelines.
- The national government's unwillingness to make PCR tests widely available to LTCFs and the population at large has been a major obstacle in ensuring safety of residents in LTCFs and users of other LTC services. Japan has almost solely relied on lengthy lockdowns of LTCFs. This is not an ideal solution to a prolonged pandemic.
- The Governmental campaign offer subsidies for domestic tourism (GoToTravel campaign) and eating out in restaurants (GoToEat campaign) led to the worst spikes in viral transmission during the final quarter of 2020
- The pandemic has revealed the most vulnerable aspects of the Japanese LTC system. In particular, two characteristics of the Japanese LTC system have proved to be highly vulnerable to transmission of SARS-COV-2: Japan's reliance on daycare and homecare services and the large number of LTC facilities that provide both residential and non-residential care services.

2. Introduction

Japan's initial response to COVID-19 was similar to that of the United States. The government had very limited testing capacity and took little action to procure Personal Protection Equipment (PPE). Yet, while the US government has scaled up its testing capacity rapidly since

April 2020, Japan has failed to do so. Even to this day (February 27, 2021), Japan only conducts 14 tests per thousand people.¹ In spite of this, the number of deaths has remained very low. Only 1,295 deaths were reported by the end of August 31, 2020.² This number is remarkably lower than other countries with large elderly populations. This is all the more surprising, given that COVID-19 causes more severe symptoms in older people. In Europe, people aged 80 years and older constitute more than 50% of the death toll from this virus (WHO, 2020). Japan has the largest share of vulnerable adults 80 or older (8.9% of the total population in 2019).³

Japan also stands out for the low mortality rate in Long-Term Care Facilities (LTCFs) compared to both European countries and the United States. We think that Japan's decision to lockdown LTCFs as early as mid-February may have contributed to lowering the number of deaths. This lockdown decision was less a political decision than the reflection of well-established routine protocols of prevention and control of contagious diseases such as the flu. This early lockdown not only saved lives but provided the Japanese government with ample time to plan and implement new measures to contain the new corona virus.

Notwithstanding these initial successes, the Japanese national political leaders failed to use this extra time wisely. On July 22, 2020, the national government started a campaign to encourage domestic travel and eating out at restaurants (GoToTravel and GoToEat campaigns). It further expanded the eligibility rules and the generosity of travel-related subsidies on October 1, 2020. The number of deaths began to increase dramatically in the final quarter of 2020. This third wave of the pandemic has been the worst. Mr. Nakagawa, President of the Japanese Medical Association, attributes the surge in the rates of infection and hospitalization to the governmental campaign to encourage trips.⁴ Anzai and Nishiura (2021) provide further evidence in support of this claim. Clusters of infections in long-term care facilities and hospitals continue to occur. That said, the overall number of deaths due to COVID-19 remains small relative to European and North American countries. As of February 12, 2021, cumulatively, 6,847 deaths have been reported.

This report will provide information not only about Japan's initial success in containing the spread of infection into long-term care facilities, but also identify various problems that persist despite the relatively small numbers of deaths.

¹ <https://ourworldindata.org/grapher/full-list-daily-covid-19-tests-per-thousand?tab=table&time=2020-02-18>.

² The data come from the Japanese Government official COVID-19 statistics updated by the Ministry of Health, Labour and Welfare: <https://www.mhlw.go.jp/stf/covid-19/kokunainohasseijoukyou.html>

³ Japanese Government Statistics Office. “高齢者の人口” (The elderly population)

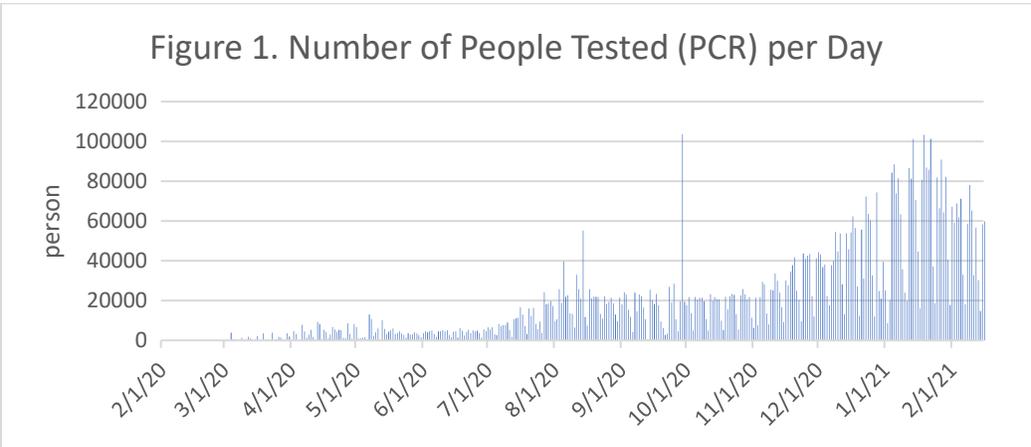
<https://www.stat.go.jp/data/topics/topi1211.html>, accessed January 14, 2021.

⁴ “感染増、GoTo トラベルが「きっかけ」日本医師会長 (President of the Japan Medical Association says GoToTravel triggered the rise in infections),” Asahi Newspaper, November 18, 2020. <https://www.asahi.com/articles/ASNCL5VLMNCLUTFL00Q.html>

3. Impact of COVID19 on long-term care users and staff

3.1. Number of positive cases in population and deaths

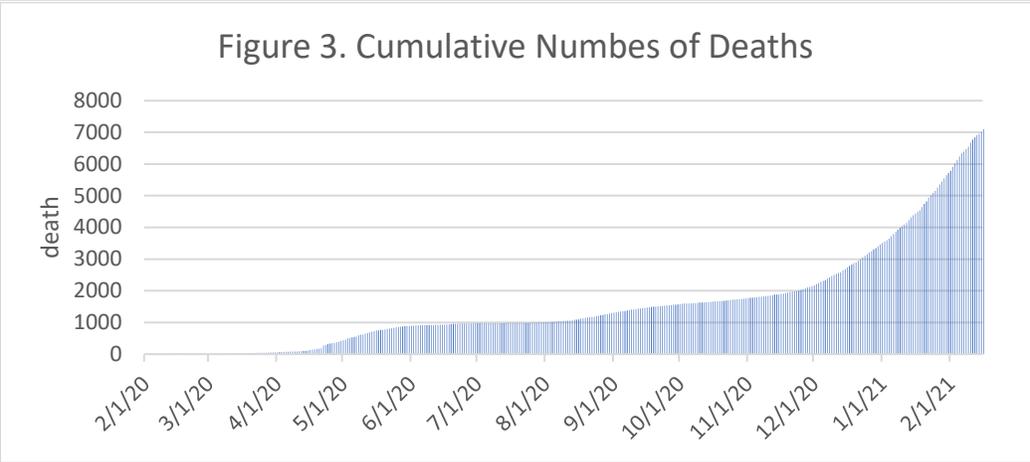
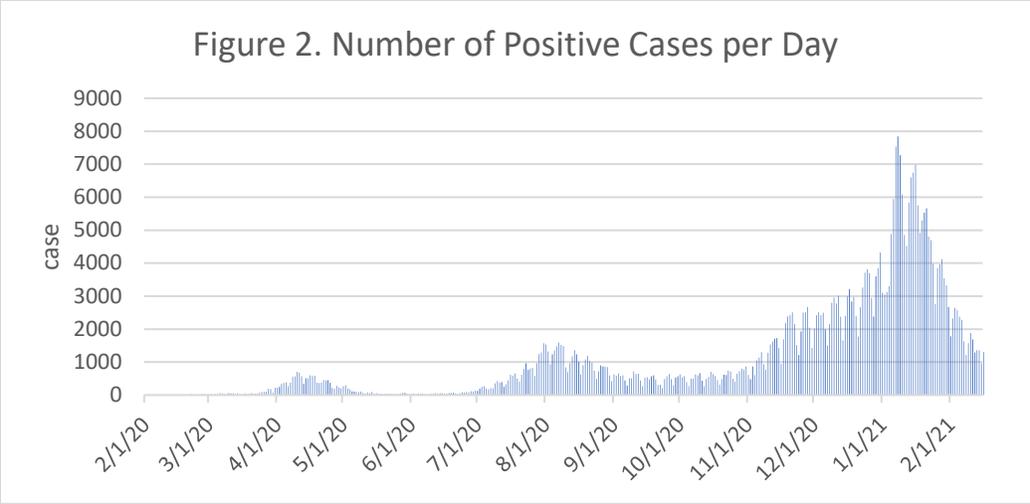
According to the Japanese Ministry of Health, Labour and Welfare (MHLW hereafter), the number of COVID-19 positive cases and deaths totalled 409,624 and 6,847, respectively, as of February 12, 2021.⁵(Japan’s population is currently 125.6 million.⁶) We can identify three waves of the pandemic in Japan. The first wave was from late February through to the end of May, 2020. The second was from late June through to the end of September 2020. The third wave began in the mid-October 2020 through to February 2021. Most of the deaths have occurred during the third wave. During the third wave, the positivity rate of the PCR tests has risen to about 10% suggesting a need for more tests.



Source for Figures 1, 2 & 3: Data compiled by the Ministry of Health, Labour and Welfare, Government of Japan, <https://www.mhlw.go.jp/stf/covid-19/open-data.html>

⁵ the Japanese Government official COVID-19 statistics updated by the Ministry of Health, Labour and Welfare, <https://www.mhlw.go.jp/stf/covid-19/kokunainohasseijoukyou.html>

⁶ Preliminary counts of population of Japan, the Statistics Bureau of Japan, <https://www.stat.go.jp/data/jinsui/new.html>



A word of caution is necessary here. It is very likely that Japan is under-counting the numbers of positive cases and deaths given the extremely small number of tests conducted so far (7 million tests cumulatively since the beginning of the pandemic through to February 12, 2021). The National Institute of Infectious Diseases (NIID) estimates that anything from 1,408 to 15,538 excess deaths may have occurred from January 1 to September 30 in 2020, using the EuroMOMO algorithm, and 1,209 to 9,744 when using the Farrington algorithm adopted by the US Centers of Disease Control and Prevention.⁷ The highest level of excess deaths during this period was recorded in August. Unfortunately, the latest estimates by the NIID only cover the period until the end of September. We suspect that the number of excess deaths in Japan will have risen sharply during the third wave of the pandemic as it also happened elsewhere. As we note at the end of this report, the Japanese government authorities have been very slow to

⁷ NIID. “我が国における全ての死因を含む超過死亡の推定 (Estimated Excess Mortality Including All Deaths in Japan),” December 2020. <https://www.niid.go.jp/niid/ja/from-idsc/493-guidelines/10070-excess-mortality-20dec.html>

publish relevant data. That said, compared to Europe and the United States, the number of Japan's excess deaths is definitely much lower.

3.2. Population level measures to contain spread of COVID-19

The Law on Special Measures for New Influenza (implemented in 2012) was modified in March 2020 in order to allow the government to extend its applicability to SARS-COV-2. This law grants the national government the authority to declare an emergency and authorizes the forty-seven prefectural governments to implement specific measures to prevent and control infections. However, not every prefectural government has jurisdiction over the public health agencies (*hokenjo*), which are the frontline agencies tasked with monitoring any outbreak of contagious diseases. In areas of Japan with a high population density, Special Cities Designated by Ordinance have jurisdiction over public health agencies. In one of our interviews, Kanagawa Prefecture Government officials told us that this jurisdictional gap stripped them of direct access to data gathered by public health agencies. It is worth noting that Japanese prefectural governments are dependent on grants provided by the national governments. Therefore, even when prefectural governments have the authority to act independently, their fiscal reliance on the national government magnifies the influence of the national government. The 2012 Law stipulates that the national government's role is to subsidize prefectural counter-measures. However, in reality, the national government chooses what to subsidize or not. The Abe administration, which was in place during the first and second waves of the pandemic, legislated two supplementary budgets in April and June. The first supplementary budget introduced included specific budgetary assistance programs for different types of LTC providers as well as subsidies for prefectural governments.⁸ But most of the funds went into national economic measures such as campaigns to encourage domestic tourism and economic rescue packages (Teraoka 2020).⁹

The Abe administration took a number of specific actions. On February 27, 2020, the Prime Minister issued an order to close down all elementary and high schools. On March 5, he restricted travel from China and South Korea. On April 1, 2020, he decided to distribute two cloth masks to every domicile in Japan. (The distribution process was completed by June, 2020). On April 7, 2020, the government declared an emergency in seven prefectures including Tokyo. On April 30, the parliament approved the Abe administration's first supplementary budget, which contained some funding for the purchase of personal protective equipment.

Prime Minister Abe pledged to ramp up the number of PCR tests but did not carry through with this promise. No significant increase in the number of tests occurred during his administration, which ended on September 19, 2020 (see Figure 1). Japan remains committed to the policy advocated by the US Centers of Disease Control and Prevention in the early days of the

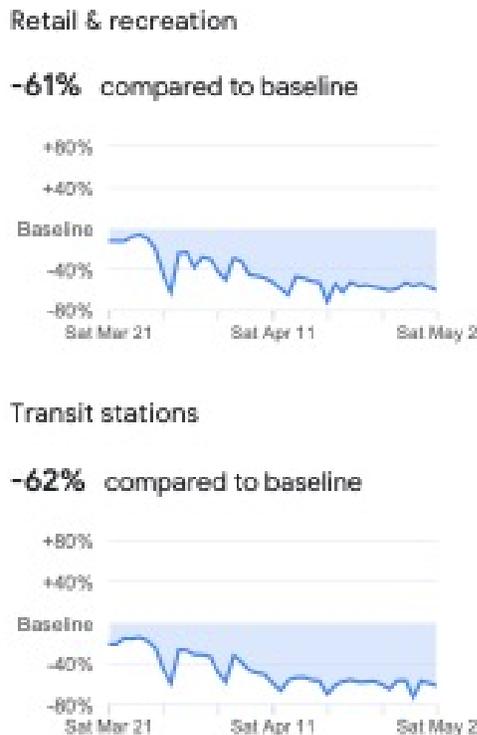
⁸ “令和2年度厚生労働省補正予算案（参考資料）（The plan for the 2020 MHLW supplementary budget, reference document),” <https://www.mhlw.go.jp/content/10900000/000621170.pdf>

⁹ The Suga Administration, another LDP administration that succeeded Abe's, introduced yet another third supplementary budget in December 2020 (Nakajima 2021).

pandemic: limited eligibility for free PCR tests. The majority of people who do not qualify have to pay for a test out of pocket in a private clinic or forego any testing. In Japan, prefectural public health agencies are tasked with contact-tracing and finding hospital beds for those who have severe COVID-19 symptoms. The desire not to overburden this system is often mentioned as one of the reasons why the Japanese government has never expanded the eligibility for free PCR tests.

Some prefectural governments (such as Wakayama) are conducting more tests than others. The rules about what to do with positive cases and people who are suspected of infection also vary from one prefecture to another. That said, most prefectures have rented hotel rooms and use them to offer room and board to residents who have tested positive as a way of isolating and monitoring them.

Figure 4. Reduction in People’s Mobility between March 21 and May 2, 2020



Source: Google COVID-19 Community Mobility Report

Japan has never implemented a strict lockdown in any of its forty-seven prefectures. However, citizens modified their behavior to a significant degree immediately after the emergency declaration. Figure 4 shows that the usage of public transportation declined by 50% and visits to areas of retail and recreation declined by more than 60% after the government declared an emergency in Tokyo (with no mandatory local lockdown). Additionally, when compared to Europe and North America, the usage of face masks in Japan was high even before the onset of

the pandemic. Typically, during the flu season and pollen season, people use face masks.¹⁰ One area in which the Japanese public authorities has succeeded from very early on is in educating citizens about the risk of aerosol transmission of SARS-COV-2. On March 1, 2020, the Minister of Health, Labour and Welfare started a campaign emphasizing the importance of avoiding the three C's (non-ventilated Confined space, Crowds and physical Closeness).¹¹

As of mid-February, 2021, Japan has not yet begun vaccination. The government has, however, conducted a trial run in Kawasaki City to plan the best logistical approach. The government document (dated February 15, 2021) suggests the following order of priority vaccination¹² : (i) medical, ambulatory and other personnel who are routinely in close contact with COVID-19 patients or people suspected of infection (4 million people); (ii) those who are 65 and older (36 million); (iii) people with comorbidities (8.7 million); (iv) personnel in residential elderly care facilities (2 million); and (v) those who are 60-64 years of age (7.5 million). The low priority assigned to personnel in the long-term care sector is noticeable. As this report will explain, the Japanese older people who live with their family rely heavily on non-residential LTC care such as daycare and homecare services. The government vaccination plan, however, says nothing about the personnel in these segments of the LTC sector and unpaid family care givers.

3.3. Rates of infection and mortality among long-term care users and staff

Unfortunately, the Japanese Government only provides the total numbers of positive cases and deaths from SARS-COV-2. No information concerning the breakdown by sex, age, place of infection and death is publicly available. For this reason, reliable data are scarce. This section thus only reports rough estimates.

Japan recorded relatively few deaths in its LTCFs. According to a report by a news agency, which contacted every prefectural government to obtain the number of deaths as results of infection in long-term-care facilities, only 14% of COVID-19-related deaths could be attributed to LTCFs as of May 8 (Kyodo News Service, 2020). Less than 0.01% of LTCF residents died of COVID-19 in Japan compared to 0.4% in Germany, 5.3%, in Britain, and 6.1% in Spain around that time (Comas-Herrera, Zalakain et al. 2020). According to the Tokyo Medical Association, the rate of cluster infection in LTCFs was 0.0017% as of July 5 (the Tokyo Medical Association, 2020).

The Japanese Government does not publicly provide any data on the number of LTC facilities with positive cases, number of cases per affected facilities, breakdowns of positive cases for residents and staff, etc. Even, Professor Oshitani, an academic member of the scientific team advising the Prime Minister on SARS-COV-2, has had to create his own dataset using newspaper

¹⁰ See <https://yougov.co.uk/topics/international/articles-reports/2020/03/17/personal-measures-taken-avoid-covid-19>

¹¹ In Japan, this was referred to as three M's (Mippei—confined space, Misshu—crowded space, and Missetsu—physical closeness).

¹² MHLW. "新型コロナワクチン優先接種についての検討案 (Tentative plan for Vaccination Priorities), Document dated February 15, 2021 available online <https://www.mhlw.go.jp/content/000739377.pdf>

reports on infection clusters. According to the professor's presentation on January 8, 2021, there were 807 clusters of infections that included five or more positive cases in December 2020. 361 (45%) of these facilities, were hospitals, elderly care facilities and other residential facilities for people in need of supervision and assistance; and the rest were restaurants and other recreational facilities, schools and workplaces. However, hospitals and care facilities account for only 61% of positive cases (8,191 out of 13,252 individuals) suggesting that clusters in medical and care facilities tend to affect more people. (Note that the number of deaths would be a fraction of the number of positive cases.¹³)

Unfortunately, Professor Oshitani's data only cover the month of December and do not distinguish hospitals from LTCFs, nor breakdown LTC providers by type. Therefore, we have had to examine the names of LTC providers with positive cases, which were reported in newspapers during the whole duration of the pandemic until February 12, 2021. The list includes 785 LTC providers and elderly assisted living facilities that provide elderly care and medical facilities.¹⁴ Of these 785 facilities, we could identify (based on the name of the facility) at least 303 LTC providers that supplied daycare or home-care services. In Japan, many nursing homes also provide daycare services on the side. As a consequence, our estimate is likely to be underreporting the number of day care providers with positive cases (i.e. it could be much greater than 303). We have compiled our own dataset of infection clusters in elderly care facilities covering the period from January through to the end of September 2020 on the basis of reports by the four major national newspapers. Based on our reading of the newspaper reports, the majority of the reported case involved a few positive cases and no deaths. However, there were also LTC facilities and providers where more than forty staff members, patients/users and their family members tested positive. Two major routes of infection were: (i) older users of daycare service or rehabilitative services infecting other users and care workers; and (ii) care workers contracting the virus outside of the facility and infecting their co-workers.

Let us present a representative case of how a large cluster of infections can emerge among users of daycare services. On April 8, 2020, an 80 year-old user of daycare services in Miyoshi City (Hiroshima Prefecture) tested positive to SARS-COV-2.¹⁵ This woman (let's call her Patient 0) was using four different service providers. In one facility that provided services to Patient 0, twenty users, three homecare workers, three of their family members and a friend also tested positive. At the second facility that serviced Patient 0, a user who shared the same care worker with Patient 0 tested positive.¹⁶ 325 people suspected of direct and indirect exposure to Patient

¹³ “新型コロナウイルス感染症対策分科会 第21回(the 21st meeting of the sub-group on counter-measures for COVID-19)” <https://www.cas.go.jp/jp/seisaku/ful/bunkakai/corona21.pdf>

¹⁴ “Long-Term Care Database on COVID-19 outbreaks,” <https://kaigodatebase.com/outbreak/7978/>

¹⁵ “新型コロナ介護施設クラスター広島三次利用者家族ら29人 (A COVID-19 cluster forms in a LTC facility in Miyoshi City, Hiroshima. 29 users and their families are infected)” (*Yomiuri Shimbun*, April 13, 2020 (Osaka, evening version))

¹⁶ “新型コロナ三次クラスター29人に、介護施設利用者ら120人検査へ (Miyoshi City Cluster infects 29 people. 120 LTC service users and others to be tested),” *Mainichi Shimbun*, April 14, 2020. (Hiroshima version).

0 were tested. Overall, 39 people tested positive in four facilities associated with Patient 0.¹⁷ During this incident, of 84 daycare and homecare service providers in Miyoshi City, 76 of them voluntarily halted or reduced service provision from the fear that the virus was being transmitted via non-residential LTC services.¹⁸ On April 24, 2020, upon confirming no more positive cases, the Hiroshima Prefectural Government notified Miyoshi City that all services could be resumed.¹⁹

4. Brief background to the long-term care system

Most of Japan's LTC services are covered by its public long-term care insurance (LTCI) introduced in 2000 (Campbell and Ikegami 2000). Japan's LTCI—which is administered by municipal governments—is operated independently of the medical insurance system and subsidizes non-medical benefits-in-kind including residential (long-term and short-term) day care services, care services at the users' home as well as home improvements so that older citizens can continue to live in their homes safely (MHLW, 2017). When an insured person requires services, the municipal government evaluates and determines the level of care to be covered by LTCI. Insured persons then can contract any service provider of choice within the municipality and pay a 10% co-payment. The remaining 90% of the service cost is reimbursed directly to the service providers by the municipal LTCI. The LTCI, however, does not cover room and board. LTCF residents have to pay for the cost out of pocket. The funding for LTCI takes the following form: 50% from mandatory insurance contributions from all residents aged 40 years and older; 25% from the national government; and 12.5% each from the prefectural and municipal governments. Each municipality sets the insurance rates on the basis of the insured residents' income levels.

While the municipal governments are the administrators of the system, LTCI is a nationally regulated system. The menu of services and pricing is set by the Ministry of Health, Labour and Welfare (MHLW) and hence is standardized across the country. Furthermore, the MHLW sets the rules over who can operate as service providers and imposes specific requirements on the provision of services such as minimum levels of accommodation, care worker/resident ratio, the number of medical and trained care staff, nutritionists and physical therapists. MHLW requires municipal and prefectural governments to update their long-term care service plans every three years. Municipal and prefectural governments make decisions over licensing of care providers in ways that are compatible with their plans.

The Japanese national LTC regulatory framework distinguishes seven categories of residential LTCFs as detailed in Table 1. There are five facilities that are specifically licensed to provide

¹⁷ “クローズアップ 広島・三次市 4月の教訓 介護施設、休業連鎖防げ(Close-up: Lessons from the April Cluster in LTC sector in Miyoshi City, Hiroshima, how to prevent another chain of infections), *Mainichi Shimbun*, November 27, 2020 (Tokyo Morning version).

¹⁸ “三次の介護施設 再開可能の見解 県市に通知 (The LTC facility in Miyoshi City reopens. The Prefecture notifies the City).” *Yomiuri Shimbun*, April 26, 2020 (Osaka morning version).

¹⁹ Ibid.

long-term care to their residents. In contrast to the United States, where for-profit facilities dominate the residential LTCF sector, non-profit facilities dominate this sector in Japan. The most vulnerable elderly population—those who require most nursing and medical care and those with the fewest economic means—are in non-profit facilities. For-profit assisted living facilities have been increasing in number in recent years. Some of these for-profit facilities provide luxury living arrangements for older people. Generally speaking, these facilities cater to the more independent and hence less vulnerable population. They cannot provide LTC services to their residents unless they are specially licensed by the respective prefectural governments to do so. Even in that instance, facilities in this category have to contract external licensed LTC service providers should their residents need nursing care. Those for-profit elderly facilities that are licensed to provide LTC services constitute the sixth category in Table 1. All those for-profit assisted living facilities that are not licensed to provide LTC services fall into the seventh category.

**Table 1. Different Types of Residential LTC Services in Japan
(Differentiated according to Residential/Non-Residential Service Types, Eligibility Status for Coverage by Long-Term Care Insurance)**

Category	Description	Provider type	Number facilities	Number of residents / users	
Eligible for coverage by the Long-Term Care Insurance	(i) Special nursing homes	Residential facilities that provide non-medical nursing care for elderly who require highest level of LTC.	Non-profit 95.5%	8,234	545,735
	(ii) Long-term care health facilities	Facilities that provide nursing care to elderly who are undergoing rehabilitation with the goal of returning home	Non-profit 95.1%	4,337	334,212
	(iii) LTC medical facilities	Hospitals that provide medical care to elderly patients requiring nursing care A new legal category similar to (iv)	Non-profit 96.7%	245	15,085
	(iv) Sanatorium medical facilities and	Hospitals that provide medical care to elderly patients requiring nursing care	Non-profit 86.9% Local governments 5.7%	833	30,250
	(v) Social welfare facilities for elderly citizens	Social welfare residential facilities for elderly who find it difficult to live at home due to non-age-related disabilities, lack of economic means and/or family support	Non-profit 56.8% Local governments 42.4%	5,262	145,047

Not Eligible for LTCI	(vi) For-profit LTCFs	For-profit elderly assisted living facilities specifically licensed to contract out LTC services for their residents	For-profit firms 82.8% Non-profit 13.7%	4,629	242,662
	(vii) Assisted living	For-profit elderly assisted living facilities specifically NOT licensed to provide LTC services to their residents	Mostly for-profit	10,558	473,280

Sources: MHLW 2019a for (i)~(iv); WHLW 2019b for (v); (vi) is estimated from MHLW 2019b and PwC Consulting 2020; and Deliberation Council on Social Security System 2020 for (vii).

Japan stands out for its large formal non-residential LTC sector (Table 2). Unlike many European countries, Japan offers no cash benefits to citizens who require nursing care or to family carers. The Long-Term Care Insurance only covers licensed professional LTC services. There are two kinds of LTC services: day care services and home care services. Many daycare service providers also accommodate overnight stays. In 2014, 7.8% of those 65 or older used day care in Japan. In Germany and Sweden, respectively, only 0.4% and 0.6% of elderly used day care (Theobald et al. 2018).

Table 2. Non-Residential LTC Services

Category		Number of users	
Non-Residential	LTCI-Eligible	(viii) Day Care Services	1,077,609
		(ix) Home Care Services	971,432

Sources: MHLW, 2019a.

In Japan, many residential elderly care facilities also provide daycare services on the side. Non-profit residential facilities are allowed to set up for-profit operations to provide daycare and home care services. Because providers of daycare services and home care services deal with so many more different users than residential facilities, this business model increased the risk of viral transmission during the pandemic.

4.1. Whole sector measures

Under the existing legal framework, the task of assisting long-term-care facilities fell upon both prefectural and municipal governments. However, as this section demonstrates, the most important counter-measure has been the pre-existing routine protocols of prevention and control of contagious diseases implemented in LTC facilities. Fortunately for Japan, the routine protocols and high rates of compliance kept the virus at bay during the early months of the pandemic.

The Japanese government did not introduce any specific new measures upon the arrival of the new corona virus. They relied on the pre-existing routine protocols for prevention and control already in place. When Japan introduced its Long-Term Care Insurance in 2000, it also introduced the guidelines for prevention and control of contagious diseases for LTCFs. The Bureau of Health and Welfare for the Elderly in MHLW together with disease prevention and control specialists within the same ministry have routinely upgraded these guidelines. All licensed LTCFs are required to establish committees consisting of different types of employees

to review and familiarize themselves with the latest prevention protocols. During the annual influenza season, residential LTCFs are accustomed to monitoring updates on influenza and other outbreaks issued from the prefectural public health offices in their area. They then determine the level of prevention and control measures to adopt. For this reason, even before the pandemic, the use of face masks has been the norm. Moreover, residential LTCFs were accustomed to requiring visitors to sanitize their hands and wear face masks during a regular flu season. They were also used to isolating their residents by restricting visitors if the flu outbreak worsened.

From the very beginning of the pandemic, the awareness about potential infection risks in elderly care facilities was high in Japan. Following the WHO's alert about the new corona virus, the sections within MHLW that were in charge of residential facilities including LTCFs and orphanages, etc. immediately issued multiple communications to all residential facilities telling them to be alert and adhere to the prevention and control protocols. As early as on January 29, the Bureau of Health and Welfare for the Elderly within the MHLW contacted their counterparts in local governments. The Bureau requested that they alert the LTCFs in their jurisdictions about the new corona virus (MHLW, 2020b). On February 13, MHLW issued another notification to all relevant departments in prefectures and large cities. The Ministry wanted them to ensure that LTC facilities and service providers in their jurisdiction followed the protocols for prevention of communicable diseases (MHLW, 2020c). The first case of infection in the LTC sector was a staff worker who tested positive on February 22, 2020. This served to further raise the urgency to prevent the virus from entering LTCFs. On February 24, MHLW issued two sets of counter-measures against SARS-COV-2—one for residential LTC facilities and the other for community-based LTC service providers. Basically, MHLW ordered residential facilities to lockdown. When it comes to community-based LTC service providers, MHLW's recommendation boiled down to scaling down day services and shifting to homecare services.

As explained in the previous section, although the overall legal framework of the LTC sector is determined by MHLW at the national level, the actual licensing and regulation over the sector takes place at the prefectural and municipal levels. The 2012 Law on Special Measures for New Influenza, which applied to SARS-COV-2, places primary responsibility for action on prefectural governments. As a result, the pandemic increased the importance of the role of elderly care departments in prefectural governments. Nonetheless, MHLW continued to issue announcements and notices to local governments and LTC providers. The regulations over the LTC sector being national regulations, any changes had to come from MHLW. In its attempt to reach out to individual providers, MHLW would rely on national associations of LTC providers to disseminate information to their members (Estévez-Abe and Ide, forthcoming). Many of communications from MHLW concerned the latest regulatory changes, clarifications and information on the pandemic-related measures.

The national government's decision to restrict access to PCR tests has made the task of keeping LTC facilities safe a lot harder. Without widely accessible testing, it has been very difficult for LTC facilities to detect and contain SARS-COV-2 more effectively. MHLW officially recognized the need for swift testing in LTC facilities in April, 2020. However, the national government did

not recommend preventive testing. Testing of all residents and staff were to be conducted only in the event of a worker or a resident being confirmed as a positive case.

A few prefectural governments and municipal governments have marshalled their resources to conduct tests at LTC facilities regardless of the presence of any positive cases (e.g. Wakayama Prefecture, Setagawa Ward in Tokyo). In the absence of any financial commitment and the necessary regulatory changes from the national government, these efforts faced obstacles. It took the rise in the number of infections in LTC facilities during the third wave of the pandemic for the national government finally to agree to subsidize the costs of tests that LTC facilities had arranged on their own.²⁰ This policy shift did not take place until November 19, 2020.

The national government emphasized economic assistance to LTC providers. The three supplementary budgets (passed in April and June 2000 and January 2021) combined provided the Medical and Welfare Service Agency with 1.6 trillion yen (roughly 16 billion US dollars) so that the agency could dispense no-interest no-collateral emergency loans to medical and LTC facilities. Such a measure was critical to maintain the service capacity of medical and LTC sectors in a country where most of the providers were not private organizations.

4.2. Care homes (including supported living, residential and nursing homes, skilled nursing facilities)

4.2.1. Prevention of COVID19 infections

Two measures stand out. One is the reliance on the pre-existing protocols of prevention and control as discussed earlier. The other is Japan's early decision to lockdown residential facilities.

On February 24, the MHLW stepped up its warning and issued a notification to all residential social welfare facilities and LTCFs, which included the following specific guidelines for: (1) how to report COVID-19 incidents to the authorities; (2) cleaning and sterilizing; (3) identification of probable infected residents and staffs; (4) handling of residents and staff suspected of infection; and (5) restrictions of visitors and delivery personnel.²¹ According to the interviews that we have conducted, some LTCFs were already in a full or semi-lockdown mode due to seasonal flu outbreaks in January and February—a routine prevention and control protocol (Estévez-Abe and Ide, forthcoming). This timing may have inadvertently protected many LTCFs in Japan. After the MHLW issued a notice about restricting any visits to residential LTCFs, the rest of the LTCFs went into lockdown. LTCFs, which were well-practiced in the protocol to isolate their residents from visitors, responded immediately.

²⁰ The Taskforce on Counter Measures against the New Coronavirus, MHLW. “高齢者施設等への重点的な検査の徹底について (Importance on testing at Elderly Facilities),” a notice dated November 19, 2020. <https://www.mhlw.go.jp/content/000696766.pdf>

²¹ MHLW, 社会福祉施設等（入所施設・居住系サービスに限る）に於ける感染拡大防止のための留意点 (Precautions for prevention of infection outbreaks in social welfare facilities (for residential facilities),” a notice dated February 24, 2020. <https://www.mhlw.go.jp/content/10900000/000599388.pdf>

In contrast to Japan, lockdowns of LTCFs came weeks later in European countries and the United States and only after large clusters of infections and deaths had already occurred. Italy, the first European COVID-19 hotspot, waited until early March; the United States until mid-March; and Britain, Germany and many others waited even longer (Comas-Herrera, Ashcroft & Lorenz-Dant 2020).

The compliance with the protocols within the facilities categorized as (i) ~ (v) had been high even before the pandemic (Estévez-Abe and Ide, forthcoming). A survey of for-profit residential facilities (i.e. supported living facilities) conducted in April 2020 found that 90% of them had taken measures to prevent and control viral transmissions such as using face masks and hand hygiene (washing and sterilization with alcohol). The majority of them asked their residents not to go out of the facility. Many facilities even restricted their staff's exposure to people outside of their workplace and immediate family (LIFULL senior Ltd., 2020).

Although the government continued to encourage virtual family visitations online, as of October 15, 2020, it granted individual LTCFs more leeway to decide to reopen for family visits. Unfortunately, this timing coincided with the rise of the third wave of infections.²²

4.2.2. Controlling spread once infection is suspected or has entered a facility

The government guidelines for prevention and control of contagious diseases specify the routine protocols. Even before the pandemic, residents suspected of contagious infection such as the flu were to be isolated in a single room away from the rest of the residents. The same routine with some modifications was applied to cases suspected of SARS-COV-2 infection.

Residential LTC facilities were required to contact the local public health agency immediately and isolate those residents suspected of SARS-COV-2 infection in single rooms. When that was not feasible, they were required to put them in a room with someone else who was suspected of being exposed to the virus. Frequent ventilation of rooms in addition to all the other hygiene practices were recommended.²³

In theory, the MHLW recommended that older residents who tested positive were to be transferred to hospitals (MHLW notice dated April 7, 2020).²⁴ However, a major bottleneck in Japan has been the unwillingness of private hospitals to take in COVID-19 patients. Local

²² MHLW. “社会福祉施設等における感染拡大防止のための留意点について（その2 一部改正）Precautions for prevention of outbreaks in social welfare facilities, part 2-modeified),” dated October 15, 2020.

<https://www.mhlw.go.jp/content/000683520.pdf>

²³ MHLW. “社会福祉施設等における感染拡大防止のための留意点について（その2）(Precautions for prevention of outbreaks in social welfare facilities, part 2),” dated April 7, 2020.

<https://www.mhlw.go.jp/content/000619845.pdf>

²⁴ Ibid.

prefectural public health agencies were tasked to find hospital beds for patients who tested positive in government-administered free PCR tests, but they lacked any authority to impose patients on unwilling private hospitals. That meant that the treatment of COVID-19 patients fell upon a small number of public hospitals. Delays in hospitalization of infected residents have been responsible for large clusters of infections in LTC facilities. Indeed, this is how the first major outbreak occurred in a nursing home in Hokkaido, which infected 90 people and led to 11 deaths at the facility.²⁵

After experiencing a few major clusters of infection in LTCFs, the national government began to pay more attention to the shortage of PPE, difficulty of transferring residents to hospitals and the need to test residents and workers broadly in facilities that had positive cases. The national government also set up a scheme to dispatch epidemiologists and certified nurses for consultation and training to LTCFs upon request. Prefectural governments were to create and coordinate such systems within their jurisdictions.²⁶

4.2.3. Managing staff availability and wellbeing

All those LTC providers eligible for reimbursements from the LTC social insurance are required to comply with specific national staffing guidelines set by MHLW. As the regulating agency, MHLW became concerned about potential staffing shortages that outbreaks could cause in LTCFs. Hence, as early as February 17, 2020, the ministry communicated to LTC providers to cooperate with the prefectural governments if they received a request to send care workers to the affected facilities.²⁷

Prefectural governments were tasked with the actual planning and implementation of specific pandemic measures including responding to staffing shortage. The first national supplementary budget passed on April 30 included subsidies to cover the prefectural governments' administrative costs of liaising with LTC providers and creating solutions to address staffing shortages. The Kanagawa prefectural government, where we conducted interviews, had launched a personnel dispatching system on May 26, 2020. On June 20, MHLW sent an announcement to prefectural governments sharing the experiences of Yamanashi, Toyama and Hyogo Prefectures, which had implemented new personnel dispatching systems, as a way of assisting other prefectural governments.²⁸

²⁵ 保健所は「施設で看取って」、感染者が続々死亡。関係者証言 (The local public health agency asked the affected nursing home to look after their sick patients until the end. Numerous deaths from COVID-19. People with knowledge testified),” Yomiuri Shimbun, May 24, 2020 (online). <https://www.yomiuri.co.jp/national/20200524-OYT1T50066/>

²⁶MHLW, “高齢者施設における新型コロナウイルス感染症発生に備えた対応などについて (on the measures in the event of COVID-19 outbreak in elderly facilities),” a notice sent to prefectures and autonomous cities on June 30, 2020. <https://www.mhlw.go.jp/content/000645119.pdf>

²⁷ National Association of Nursing Homes lists all three MHLW notices addressing potential staffing shortages in different types of facilities on their website: https://www.yurokyo.or.jp/news_detail.php?c=3&sc=11&id=2579

²⁸ See footnote 26.

As for the management of care workers' wellbeing, the national second supplementary budget (passed on June 12, 2020) included funds to set up counselling services for care workers. In August 2020, the Association of Elderly Health Facilities started to offer such services. However, to this day, we are not aware of any government-sponsored surveys of care workers.

The national government has also decided to pay hardship bonuses to care workers ranging from roughly 50,000 to 200,000 yen (\$500 ~ \$2000) depending on the worker's exposure to residents and service users.²⁹

4.2.4. Provision of health care and palliative care in care homes during COVID-19

Residential facilities eligible for LTCI reimbursements—LTC types (i) to (vi) continue to offer care.

4.3. Community-based care

As presented in the overview of the LTC system, the Japanese formal LTC care sector relies heavily on day care and homecare services. Partly because of the nature of the service, daycare service providers could not resort to “lockdowns” as residential facilities have done. For fear of infecting users, many daycare service providers simply suspended their services.

According to a survey conducted by the National Federation of LTC Service Providers in April 2020, 82% of day care service providers reported losing business income due to suspension or reduction in services (National Federation of LTC Service Providers 2020). MHLW's position as of February was that day service providers facing an outbreak should suspend their services and refer their users to homecare service providers.³⁰ The ministry noted that prefectural and city governments in Special Cities Designated by Ordinance had the authority to suspend services.³¹ That was easier said than done as many home service providers also scaled back their services. The aforementioned survey also reports that many users and their families canceled services for fear of contagion. By April and May, MHLW had become aware of the economic problems facing non-residential LTC providers, and the policy focus shifted to economic assistance to get them back in full operation. The second supplementary budget passed in June 2020, therefore,

²⁹ MHLW, “「介護サービス事業所・施設等における感染症対策支援事業等及び職員に対する慰労金の支給事業」について (Extra payments for counter-infection measures for residential and non-residential LTC service providers and their employees), https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000121431_00144.html

³⁰ MHLW, “社会福祉施設等（入所施設・居住系サービスを除く）に於ける感染拡大防止のための留意点 (Precautions for prevention of outbreaks in social welfare facilities (except for residential facilities),” a notice dated February 24, 2020. <https://www.mhlw.go.jp/content/000601686.pdf>

³¹ MHLW, “社会福祉施設などの利用者に新型コロナウイルス感染症発生した場合などの対応について (Measures in the event of infections among users of social welfare facilities, etc.),” a notice dated February 18, 2020. <https://www.mhlw.go.jp/content/000601680.pdf>

included economic assistance programs for LTC service providers so that they could resume services.³²

(For-profit assisted living facilities for older people are not licensed to provide LTC services on their own. Even when they are licensed to provide LTC, they need to contract licensed homecare service providers.)

4.3.1. Measures to prevent the spread of COVID19 infection

There has not been much in the way of effective prevention measures. Most of the day care providers, whose users tend to have dementia, resorted to scaling down their services. The national government recommended replacing daycare services with home services. However, it is not clear if that has been an effective alternative. Unlike residential facilities, which are overseen by physicians and nurses and have special committees to implement prevention and control measures, home services are delivered in individual homes. This makes it very difficult for home service providers to control the environment. These difficulties exposed the vulnerability of a large swath of Japan's LTC sector as captured by the experience of Miyoshi City in Hiroshima Prefecture (detailed in Section 3.3).

The second supplementary budget (June 2020) includes new subsidies for non-residential LTC providers to hire outside experts for recommendations on how to improve prevention and control measures. The budget also partially reimburses LTC providers for the cost of PPE and other necessary modifications of their work environment.

4.3.2. Measures to compensate for potential reductions in services

The second supplementary budget (June 2020) introduced subsidies to help homecare service providers restart their service provision. This segment of the LTC sector was economically most hard hit by the pandemic. It was also the sector whose service was vital for so many families. Aside from economic assistance to LTC providers, there have been no assistance programs to families in need.

4.4. Impact on unpaid carers and measures to support them

As mentioned earlier, a large number of older people in Japan rely on day care and home care services. Many older people live with their family members who combine their own unpaid care with care provided by professionals. Because it was much harder to prevent and control the virus, there has been no policy to support unpaid carers.

³² See footnote 26.

4.5. Impact on people living with dementia and measures to support them

There are on-going studies which are yet to be published. According to one survey conducted jointly by the Japanese Geriatrics Society and Hiroshima University, 78.7% of care providers reported that people with dementia suffered from further declines in their cognitive abilities when day care and home care services were suspended. 38.1% of them also noted the emotional, physical and economic toil on family members who were burdened with extra care as a result of the suspension of professional care services.³³

5. Lessons learnt so far

5.1. Short-term calls for action

- Testing of LTC workers and users is necessary in order to prevent and control infections.
- Japanese LTCFs relied too heavily on lockdowns as the principal measure to contain the spread of the virus. Anecdotally, we hear a lot of cases of elderly residents experiencing cognitive and physical deterioration. Surveys to investigate the severity of the negative effect of lockdowns and research into how to reverse those effects are urgently needed.
- Many families have suspended using homecare and daycare services for fear of contagion. The pandemic exposed unpaid family care givers and paid professional care workers to emotional and economic hardships. Surveys to investigate the effects of the pandemic on different types of care givers as well as the older service users are urgently needed.
- The Japanese Government stands out for its inability to gather and/or process basic pandemic-related information. For instance, it takes Japan months before publishing weekly mortality data. There are no government data on the number of positive cases in LTCFs or among users of daycare and homecare services. The Government seems to be partly aware of its failure here. The supplementary budgets have provided funding for constructing a data-sharing system among hospitals, municipalities and national ministries so that the Government can better monitor the changes in the number of COVID-19 patients in real time. This is a welcome change. But a task such as collecting the number of positive cases in LTCFs should not be so difficult in a country like Japan where the regulatory system over LTC sector is hierarchically organized. Since information travels very effectively from top to bottom (from MHLW to individual

³³Press release from Hiroshima University dated July 30, 2020. https://www.hiroshima-u.ac.jp/system/files/147360/20200730_pr01.pdf

LTCFs), requiring reporting of positive cases from bottom to top should be doable without creating any complicated system.

5.2. Longer term policy implications

The pandemic has revealed the most vulnerable aspects of the Japanese LTC system. In particular, two characteristics of the Japanese LTC system have proved to be highly vulnerable to transmission of SARS-COV-2. One is Japan's reliance on daycare and homecare services. The other is the large number of LTC facilities that provide both residential and non-residential care services. Because one user may be using services from multiple providers, these characteristics dramatically increase the number of people potentially exposed to the same infected user or care worker. (This report has discussed a care home in Hiroshima, where 380 people were tested after their indirect exposure to one infected user.). Prevention and control in daycare and home services are much more challenging, and Japan has found no viable solution. Given the fact that the Japanese government plans to expand the community care (daycare and homecare) over residential care, the government has to come up with a much more effective counter-pandemic strategy.

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