The impact of COVID-19 on older persons

Japan country analytical brief 2020 in review

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Highlights

- The number of infections of COVID-19 in Japan increased sharply for the first time at the end of March due to the holiday season and many people traveling, especially to foreign countries.
- At the start of the spread of COVID-19 infection, the government requested that the people perform basic actions to prevent disease transmission, avoid the "3Cs" (closed spaces, crowds, and conversations in close proximity), promote teleworking, and stagger commuting, and introduced counter-cluster measures in order to decrease disease transmission. Subsequently, in October, the government identified "5 situations" that increase the risk of infection and announced specific measures to the people to avoid those situations. The Governor of Tokyo Metropolitan City introduced "5 small" suggestions (meeting in small groups, using small plates, short time for gathering, talking in a small (low) voice, and frequent ventilation) for meal gatherings.
- To prevent an increase in the number of infections during the holidays from the end of April to the beginning of May, the government declared a state of emergency on April 7th, and requested the people to refrain from going out.
- After introduction of the state of emergency, the number of new infections decreased drastically; however, it subsequently increased again in July and August. By late October, the number of confirmed positive cases had increased substantially. On 21st November 2020, 2,508 cases were reported, the highest number recorded as of 25th November 2020.
- More than 90% of deaths related to COVID-19 occurred in individuals aged 60 year and older.
- Due to the higher risk of developing severe symptoms after infection, the older individuals decreased their activities, and many long-term care facilities were suspended, or enforced restricted visiting. Concern about the declining health condition of older persons is increasing.
- The number of positive cases of seasonal influenza has been much lower than in previous years. Influenza may have been prevented by the actions taken to prevent COVID-19.

Changes in national COVID-19 situation

The first confirmed case of coronavirus disease (COVID-19) in Japan was reported on January 16th; thereafter only a few new cases were reported until mid-February. On February 15th, new positive cases per day exceeded 10 for the first time,[1] excluding infections on a cruise ship named "Diamond Princess." Because March is traditionally "graduation trip" season in Japan, many college/university students go abroad during this period. Consequently, at the end of March, approximately 40% of new infections were from those who came from abroad. The government's Expert Meeting on control of COVID-19 expressed a "high probability of the expansion of infection."[2] The number of new positive cases increased sharply at the end of March, and the first peak of 708 cases per day was reached on April 10th. After the government introduced the state of emergency on April 7th, the number of new positive cases dropped drastically; however, in July, the number increased again, and the second peak was recorded on July 31st with 1,574 cases, followed by August 7th with 1,595 cases. In August, the trend of new positive cases shifted downward; this was possibly caused by people avoiding high-risk areas such as night clubs at the request of the prefectural government and behavior changes of the population according to the National Institute of Infectious Diseases (NIID).[3] The number of new cases fluctuated between 200 and 750 until the end of October.[4] On October 22nd, the NIID reported that the number of new COVID-19 cases has remained unchanged, perhaps illustrating competition between "increasing factors" and "decreasing factors." Increasing factors were that people's desire to return to usual life and revitalize their activities, and decreasing factors included the high-risk situation of infection becoming clear, and people starting to refrain from visiting high-risk places and high-risk behaviors. In the case of cluster infections, the people involved in the cluster could utilize past experience to take prompt and effective actions.[5]

In the early stage of infection, the disease was spread among the younger generation and in urban areas. However, on April 1st, the Expert Meeting mentioned that cases found in hospitals, elderly and welfare facilities, returnees from graduation trips abroad, participants of evening meetings, and groups of choirs and dancers – not only in the young generation but also among the middle-aged and older generations – were sources of clusters.[6] After the state of emergency, by August, infection mainly spread among the younger generation, differing from the situation before the state of emergency, and the ratio of hospitalized or severely ill patients remained low.[7] The proportion of cases among middle-aged and older persons increased during March and April; however it decreased in June and July and rose again in August. In the period between August 26th and September 1st, the proportion of cases among those aged >60 years was 25%.[8] At the end of September, the number of new infected people has been increased, again, and proportion of infection among middle-aged and older persons became higher than those in June and July.[9]

Infection frequently occurred in hospitals and long-term care facilities after the peak of the epidemic from March to May; however, since late June, large-scale infections in hospitals and long-term care facilities have decreased in the metropolitan areas and the NIID found that this was due to early detection and prompt measures to prevent an outbreak.[10]

In late October, the trend of the number of new positive cases continued to increase. On 18th November 2020, the number of new cases per day exceeded 2,000 cases for the first time. The number of serious cases also increased. According to the available data from the Health ministry on 10th November 2020, at least 25% of hospital beds designated for COVID-19 patients in Tokyo, Osaka and Okinawa were in use. Infection among those aged 60 years and older was also spreading. During the week of 11th November, 22.2% of the new cases were among those aged 60 years and older.[11] The infection clusters were found at diverse places, such as entertainment areas in local cities, places where people eat/drink together, offices and other work locations, communities of foreigners, medical facilities, and welfare facilities.[12] The government identified "5 situations" that increased the risk of infection: "Social gatherings with drinking alcohol, long feats in large groups (the risk of infection is increased by eating and drinking in a large group of people, for example, 5 or more people, because in groups you have to talk louder and droplets of saliva spread more often), conversation without a mask, living together in a small limited space, and switching locations" [13] (for example, taking a work break, taking off a mask to smoke). The government requested the people to avoid these 5 situations. Also the Governor of Tokyo Metropolitan City posited "5 smalls": meeting in small groups, using small plates to avoid sharing food with one big plate, gathering within a small time (less than one hour), talking in small (low) voice, and frequent ventilation.[14]

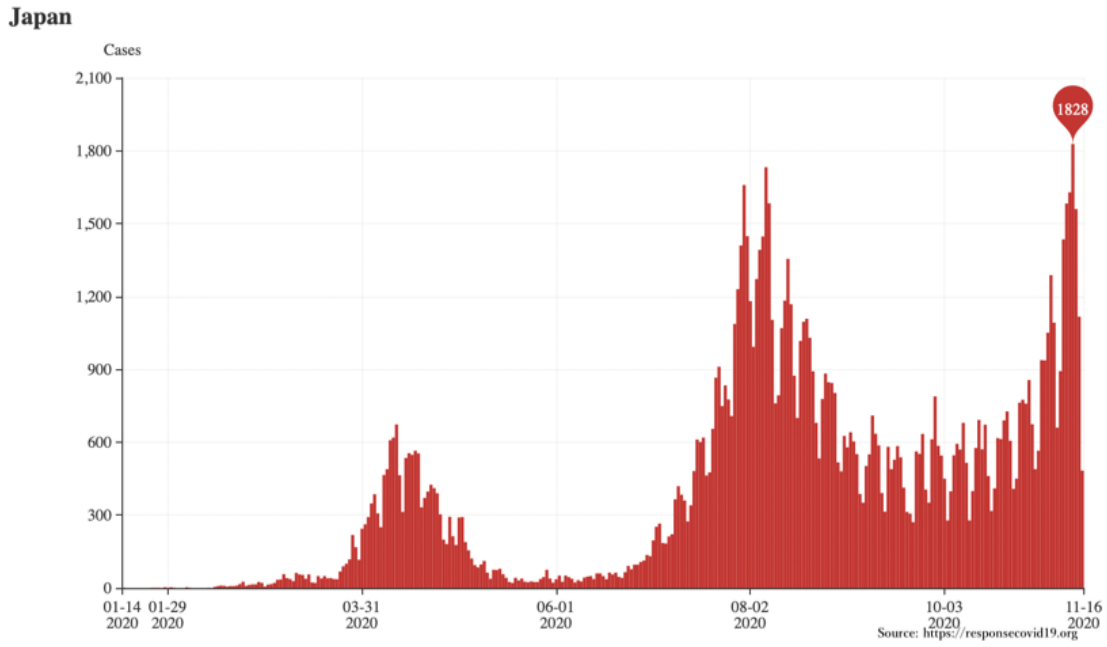
COVID-19 trends are illustrated in the tables and chart below:

Table 1: Changes in the number of new positive tested cases are as follows: [1 4 8]

Jan. 16	First confirmed positive tested case, with the total number of cases being 1.
Feb. 3	A cruise ship named "Diamond Princess" arrived in Yokohama and was quarantined at the port, and the crew and passengers were tested. As of February 18th, 531 cases (14.3% of all individuals on board on February 5th) were confirmed.[15]
Feb. 15	The number of new positive cases exceeded 10 for the first time, with 12 cases recorded.
Mar. 27	The number of new positive cases exceeded 100 for the first time, with 104 cases recorded.
Apr. 10	The number of new positive cases reached the first peak with number of 708 confirmed cases, and then the number of new positive cases decreased by mid-June.
Jun. 28	The number of positive cases exceeded 100 again and continued to increase.
Jul. 29	The number of positive cases exceeded 1000 for the first time, with 1242 cases recorded.
Jul. 31 Aug. 7	The second peak of the number of positive cases was recorded July 31st (1574) and August 7th (1595). After the second peak, the trend tended downward; however, after the middle of September the number fluctuated between 200 and 750 new cases per day.
Oct. 25	The number of new positive cases per day in this period was stable between 200 and 750, and the latest number as of October 25th was 488.
Nov. 12	The number of new positive cases increased, and exceeded the second peak with 1623 cases.
Nov. 21	The third peak was recorded with 2508 positive cases.

Source: Open Data, Ministry of Health, Labour and Welfare, accessed 27 October 2020; COVID-19 Japan Anti-Coronavirus Dashboard. Stop COVID-19, accessed 27 October 2020; and Coronavirus Disease (COVID-19) Situation Report in Japan. Tokyokeizai Online, accessed 27 October 2020.

Figure 1: Number of Confirmed Cases[16]



Source: Japan Data, 2020 Response COVID-19, accessed 13 November 2020.

Table 2: Changes in the situation of accumulated positive cases are as follows;[1 4 8]

Feb. 22	Accumulated positive cases exceeded 100, with 117 cases, which was 20 more than that on the previous day.
Mar. 21	Accumulated positive cases exceeded 1000, with 1015 cases.
Apr. 18	Accumulated positive cases exceeded 10,000, with 10,534 cases.
Jul. 7	Accumulated positive cases exceeded 20,000, with 20,132 cases.
Jul. 26	Accumulated positive cases exceeded 30,000, with 30,426 cases.
Aug. 4	Accumulated positive cases exceeded 40,000, with 41,118 cases.
Aug. 11	Accumulated positive cases exceeded 50,000, with 50,080 cases.
Aug. 21	Accumulated positive cases exceeded 60,000, with 60,664 cases.
Sep. 4	Accumulated positive cases exceeded 70,000, with 70,540 cases.
Sep. 24	Accumulated positive cases exceeded 80,000, with 80,098 cases.
Oct. 14	Accumulated positive cases exceeded 90,000, with 90,204 cases.
Oct. 31	Accumulated positive cases exceeded 100,000, with 100,762 cases.
Nov. 11	Accumulated positive cases exceeded 110,000, with 111,336 cases.
Nov. 17	Accumulated positive cases exceeded 120,000, with 120,443 cases.
Nov. 22	Accumulated positive cases exceeded 130,000, with 132,081 cases.

Source: Open Data, Ministry of Health, Labour and Welfare, accessed 27 October 2020; COVID-19 Japan Anti-Coronavirus Dashboard. Stop COVID-19, accessed 27 October 2020; and Coronavirus Disease (COVID-19) Situation Report in Japan. Tokyokeizai Online, accessed 27 October 2020.

Table 3: Accumulated number of deaths at the end of month, and number of deaths by month

Month	Accumulated number of deaths at the end of month	Number of deaths by month
January	0	0
February	5	5
March	56	51
April	415	364
May	892	528
June	973	445
July	1,010	565
August	1,295	730
September	1,570	840
October	1,765	925
November*	2,000	1,075

*As of November 24th.

Table 4: Changes in the number of deaths are as follows; [1 4 8]

Feb. 14	First COVID-19 related death recorded, with the total number of deaths being 1.
Mar. 11	Accumulated number of deaths exceeded 10 for the first time, with 12 deaths.
Apr. 13	Accumulated number of deaths exceeded 100 for the first time, with 102 deaths.
May 8	The daily number of deaths reached a peak with 49 deaths.
Jul. 28	Accumulated number of deaths reached 1,000.
Nov. 24	Accumulated number of deaths reached 2,000.

Source: Open Data. Ministry of Health, Labour and Welfare, accessed 27 October 2020; COVID-19 Japan Anti-Coronavirus Dashboard. Stop COVID-19, accessed 27 October 2020; and Coronavirus Disease (COVID-19) Situation Report in Japan. Tokyokeizai Online, accessed 27 October 2020.

Table 5: As of November 18th, the number of positive cases and deaths by age was as follows; [1 4 8 12]

Age Groups (years)	Population*[17]	Number of Positive Cases**	Number of Deaths**	Number of Positive Cases by Age Groups/ All Positive Cases	Number of Positive Cases / Population	No. of Death by Age Groups/ All Deaths	Number of Deaths / Population	Case Fatality Rate
≧80	11,462	7,391	1,092	6.23%	0.06%	59.03%	0.01%	14.77%
70-79	16,106	7,885	490	6.65%	0.05%	26.49%	0.00%	6.21%
60-69	15,719	9,537	178	8.04%	0.06%	9.62%	0.00%	1.87%
50-59	16,149	15,313	62	12.91%	0.09%	3.35%	0.00%	0.40%
40-49	17,977	17,254	20	14.54%	0.10%	1.08%	0.00%	0.12%
30-39	13,593	20,299	6	17.11%	0.15%	0.33%	0.00%	0.03%
20-29	11,852	31,550	2	26.59%	0.27%	0.11%	0.00%	0.01%
10-19	10,932	6,608	0	5.57%	0.06%	0.00%	0.00%	0.00%
≦10	9,611	2,800	0	2.36%	0.03%	0.00%	0.00%	0.00%
Unknown		1,507	7					

*Final estimation as of May 1st and not including foreign residents.
** The numbers may include foreigners.

Source: Open Data. Ministry of Health, Labour and Welfare, accessed 27 October 2020; COVID-19 Japan Anti-Coronavirus Dashboard. Stop COVID-19, accessed 27 October 2020; Coronavirus Disease (COVID-19) Situation Report in Japan. Tokyokeizai Online, accessed 27 October 2020; and "5 situations" that increase the risk of infection. Ministry of Health, Labour and Welfare, accessed 26 November 2020.

In September each year, the Health ministry reports on the seasonal influenza situation. This year, the reported cases of influenza were much lower than in previous years. For example, during the first and second week of September, the cases of influenza usually record at between several hundred to 2,000. In contrast, in the first and second week of September of this year, the reported number of influenza infections was only 3 and 4 cases, respectively. The official health minister attributed this drastic decrease to the action taken to prevent COVID-19, such as washing hands and wearing masks.[18] Even during 9th to 15th November, only 23 cases of influenza were reported. According to the National Institute of Infectious Diseases (NIID), usually, 1,000 – 5,000 cases are reported during the same period every year. Even so, the trend of infections is different from year to year, and it is still important to pay attention to the potential risk of influenza.[19]

Situation of older persons

Health and care

As of October 21st, the number of deaths related to COVID-19 in individuals aged ≧60 years was 1,576, and more than 90% of deaths have occurred in individuals aged ≧60 years.[20] Regarding the deaths at long-term care facilities related to COVID-19, according to a report from the Japan Agency for International Cooperation (JICA) published in May 2020, the rate of ageing (percentage of the total population aged ≧65 years) positively correlates with the number of deaths due to COVID-19. However, the number of deaths is lower than the estimated number from the model presented in the JICA report. In addition, the ratio of elderly facility resident deaths due to COVID-19 to all deaths caused by COVID-19 was approximately 14%.[21]

In February, the government called special attention to the higher risk of COVID-19-related complications and deaths in older persons and those with underlying diseases, and requested preparation of appropriate medical care for them. In addition, the government had identified importance of avoiding 3Cs, and requested that people to voluntarily refrain from going out.[22] For example, on May 7th, the mortality rates in Japan were 2.5% for people in their 60s, 6.8% for those in their 70s, and 14.8% for those in their 80s.[23]

This higher risk for older persons affected the application for certification of long-term insurance. In Japan, based on the universal long-term care insurance system for the people aged ≧40 years, older persons who need support for their daily lives need to apply for national long-term care certification. However, according to a survey, older persons worried about being infected by those who conduct the outreach assessments, and stopped applying for the certification. In the period from March to May, applications had decreased by more than 20% in 31 cities and by over 30% in four municipalities compared to the previous year.[24]

In addition, during the state of emergency, facilities such as day-care were requested to consider suspending or temporarily restricting their use, and to limit outings and overnight stays of inpatients and users, in areas where infection is prevalent.[25] According to the data of the Health ministry, as of April 20th, 909 long-term care service providers (858 are day-care and 51 are home-visit services) were temporarily suspended from providing services due to the increased risk of COVID-19 posed to older persons.[26] Consequently, older persons engaged in self-restraint from contacting other people, and as the self-distancing period began to lengthen, concern grew about the effects of avoiding exercise and interaction with others on older persons' physical and mental health.[27] [28] [29]

Clusters of cases in nursing homes have been reported in several prefectures in Japan.[30] A research group collected data on cluster cases in Japan from January 16th to May 9th, and they found that the number of clusters in long-term care hospitals and facilities was significantly smaller than those in other groups of facilities, such as general medical/welfare facilities and non-medical/welfare facilities. However, the cluster sizes (case numbers within a cluster) in long-term care hospitals/facilities were larger than those in non-medical/welfare facilities.[31]

When a cluster occurs at a nursing home or care facility, the local public health center organizes a temporary medical team consisting of nurses working at the facility, infectious disease doctors from nearby hospitals, the Disaster Medical Assistance Team (DMAT) members, and primary care doctors and nurses. Patients are usually cared for the nursing home or care facility, but the medical staff collaborate closely with hospitals caring for COVID-19 patients, and, if needed, patients are promptly relocated to them. The medical staff share their experiences through online conferences at the grassroots level. Furthermore, the government has recently initiated funding support for nursing homes and care facilities to obtain essential personal protective equipment (PPE) and extra salaries for staff members.[32]

Income security

There are no income security measures designated especially for older persons in Japan; however, the government introduced the first and second supplementary budgets in response to COVID-19 and older persons can apply for or become a target of those measures. These include cash payments of 100,000 yen per person, housing security benefit, emergency small amount fund/general support fund, reduction/exemption of social security insurance, and payment deferral of tax and utility changes. Furthermore, for those who are employers, including the self-employed and employees, grants, subsidies, and loans were provided to employers to maintain employment and their businesses.[33]

The details of the government's first and second supplementary budget for FY2020 to respond to COVID-19 are as mentioned below.

One of the stimulus measures for the economy (namely, support in the form of discounts and vouchers) was started on 22nd July for travel; 1st October for food services, and 30th October for events. However, because the number of new COVID-19 cases rose in late October, the government suspended the incentive program for travelling to Osaka and Sapporo, where infections were spreading rapidly. Furthermore, Prime Minister Suga asked the prefectural governors to consider suspending "Go To Eat" discount coupons.[34] [35]

On April 7th, the government took a cabinet decision on the supplementary budget bill for FY2020, and revised it on April 20th as follows:

Emergency Economic Measures for Response to COVID-19: 117 trillion yen (approximately 1.1 trillion USD)[36] [37]

1) *Measures to prevent the spread of infections and to build medical treatment structures*
    - *Counter-cluster measures: doubling the Polymerase Chain Reaction (PCR) capacity to 20,000/day, reinforcing public health centers*
    - *Medical care for patients with severe symptoms: increase in beds from 28,000 to 50,000, securing 15,000 ventilators*
    - *Facilities for patients with mild symptoms to stay: securing hotels and other public facilities*
    - *Research and development of therapeutic medication and vaccines*
    - *Avigan (medicine expected to be effective): increasing its production preparing the stockpile up to 2 million doses*
2) *Measures to support businesses*
    - *Real interest-free unsecured loans*
    - *Improved loan conditions: allowing recurring debts to be refinanced as interest free loans*
    - *Deferment of the payments of national taxes and social security premiums without collateral and penalties (amounting to 26 trillion yen)*
3) *Cash payments: approximately 15 trillion yen*
    - *Cash payment of 100,000 yen each to all residents in Japan: 12.9 trillion yen*
    - *Cash payments of 2 million yen each to micro-, small-, and medium-sized businesses and 1 million yen each to individual business owners: 2.3 trillion yen*
4) *Demand of stimulation measures, looking ahead to the phase after the containment of outbreaks*
    - *Support in the form of discounts and vouchers: tourism, transport, food services, and event industry*

Second Supplementary Budget: Total scale is 31,911.4 billion yen[38]

1) *Enhancing the employment adjustment subsidy: 451.9 billion yen*
2) *Enhancing financial support: 11,639.0 billion yen*
    - *Loan to micro-, small-, and medium-sized business: 8,817.4 billion yen*
    - *Loan to major corporations: 452.1 billion yen*
    - *Providing capitals: 2,369.2 billion yen*
3) *Establishing rent support grant for SMEs: 2,024.2 billion yen*
4) *Supporting medical treatment providers: 2,989.2 billion yen*
    - *emergency comprehensive support grant for novel coronavirus disease: 2,237.0 billion yen, of which medical care: 1,627.9 billion yen, long-term care: 609.1 billion yen*
    - *Distribution of medical masks to medical institutions: 437.9 billion yen*
    - *Development of medicine and vaccines: 205.5 billion yen*
5) *Other supports: 4,712.7 billion yen*
    - *Expanding of "Special Allocation for Revitalization to Cope with COVID-19": 2,000.0 billion yen*
    - *Additional payments to low-income single parent households: 136.5 billion yen*
    - *Enhancing the subsidy program for sustaining business: 1,940.0 billion yen*
    - *Others: 636.3 billion yen*
6) *Contingency funds for COVID-19: 10,000.0 billion yen*
7) *Transfer to the Special Account for the National Debt Consolidation Fund (interest payment): 96.3 billion yen*
8) *Reduction in previously approved expenses (annual allowance of the members of the Diet): -2.0 billion yen*

Social issues

The requirement for social/physical distancing raises an issue during evacuation procedure. During the rainy and typhoon seasons between July and September, several floods occurred and people living in the flooded areas needed to be evacuated to evacuation centers. In Japan, there are so-called "welfare evacuation centers" that have barrier-free facilities and qualified staff for those who need special assistance during evacuation, including older persons. In many cases, the local nursing home is designated as the welfare evacuation center; however, they restricted visitors due to COVID-19. In other cases, the need for social/physical distancing meant that evacuation centers were filled to capacity sooner and some evacuation centers could not accept all evacuees.[39] [40]

The problem related to heat stroke during summer has also become an issue. Because many people are wearing masks, the situation might worsen this year. According to the Fire and Disaster Management Agency, 8,388 people were taken to the hospital because of heat-related illnesses in July, an increase of 50% compared to that in July 2019.[41] Older persons are one of the most vulnerable groups for heat-related illnesses. Between 2013 and 2017, approximately half of the patients who were taken to hospital due to heat-related illnesses were aged ≧65 years[42] and 58.5% of the total number of patients were aged ≧65 years.[43]

General wellbeing

After the spread of infection of COVID-19, the isolation of older persons became an issue of well-being. Many care facilities and nursing homes were restricting visits to their facilities to prevent the spread of COVID-19, and residents, therefore, could not meet their families. Families of older persons with dementia were especially worried that the long isolation period would cause them to forget their family members.[44] Isolation was also a concern for older persons cared for at home and the family care workers. For example, an infected person with mild symptoms should stay at a hotel for the designated quarantine period; however, they do not want to stay at the hotel because they are worried about and care for their older parents at home.[45] Happiness is an important component of older persons' health.[46] To prevent the negative impact of stay-at-home measures, some facilities and nursing homes have begun to utilize IT tools, such as video calls, and introduced prevention measures such as glass barriers to allow older residents to communicate with their families without the risk of infection. IT tools may be one of the solutions, and a study shows that the interaction through telephone, mailing, letters, etc. may reduce the risk of incidence of depression compared to older persons who have no interaction.[47]

Responses

After confirmation of the first case of COVID-19, the government, including the national institute, introduced guidelines to respond to COVID-19, and provided them to local governments.

In February, the Headquarters for Novel Coronavirus Disease Control published "Basic Policies for Novel Coronavirus Disease Control" and, in its first version, mentioned that COVID-19 seemed not to be airborne infections, but people were infected in certain circumstances, such as talking to many people at close distance in unventilated spaces, and they called attention to the fact that there was a possibility of infection even without coughing or sneezing. They asked companies to promote teleworking and staggering of commuting, and requested that people to rethink the necessity of hosting public events. They also shifted the use of PCR tests for the confirmation of diagnosis necessary to treat pneumonia patients who required hospitalization. They requested local governments to conduct an active epidemiology survey in order to identify clusters. They requested patients with mild flu-like symptoms to stay at home unless otherwise specified, and to seek medical care after consulting the call center or a family doctor if their conditions changed. They also asked the public to act with due consideration to the human rights of patients and those involved in the infection control activities.[22]

On February 16th, the Prime Minister established a Novel Coronavirus Expert Meeting in order to get the advice for introducing further countermeasures for COVID-19. The meeting was held and a press conference was conducted afterward to report the results of the meeting, which still occurs periodically.[48]

In March, the government revised the "Basic Policies for Novel Coronavirus Disease Control", and stressed the importance of minimizing the impact on society and the economy, and started taking

economic and employment measures. The Basic Policies showed the importance of strengthening the testing system by utilizing local and private institutions, and asked the people for self-restraint in avoiding the 3Cs.[49]

On April 7th, because the risk of development of pneumonia by COVID-19 was considerably higher than that of seasonal influenza, and since cases with unknown infection routes increased and medical systems were stretched, the government declared a state of emergency in 7 prefectures until May 6th.[50] The state of emergency was expanded to all prefectures on April 16th,[51] because the long national holidays were scheduled from the end of April to the beginning of May, and all prefectures needed to further efforts to prevent the spread of infection during the holidays.[52] On May 4th, the government decided to extend the period of the state of emergency until May 31st,[53] with the aim of accelerating existing measures and to reduce the contact among people by 70% at a minimum or 80% ideally.[54] On May 14th, the government announced the guidelines for lifting the state of emergency, and explained that the decision to lift the state of emergency came after comprehensive consideration and it relied heavily on 3 points: epidemiological trend, medical capacity, and surveillance system. [55] In accordance with the guidelines, the state of emergency, the state of emergency was lifted in all prefectures but 8 prefectures on May 14th. The state of emergency was lifted in 3 more prefectures on May 21st, and in the last 5 prefectures on May25th.

In March, the Expert Meeting explained the attributes of COVID-19, introduced counter-cluster measures,[56] and asked people to avoid the 3Cs (closed spaces with poor ventilation, crowded with many people, and conversations and vocalization in close proximity).[57]

Table 4: The main guidance and guidelines to be published for the response to COVID-19 are as follows:

Jan. 21[58]	The "Response to Novel Coronavirus Infection and Measures for Active Epidemiological Investigation in Patients with Novel Coronavirus (nCoV) Infection (tentative version)" was updated, and the "Guidelines for Active Epidemiological Investigation in Patients with Novel Coronavirus (nCoV) Infection (tentative version)" (was updated on January 28th) was prepared as a response to COVID-19. This guideline shows the framework of response in order to be able to conduct genetic tests for COVID-19 infection under Article 15 of the Infectious Disease Law.
	The National Institute of Infectious Diseases (NIID) published the guidance of sample collection and transportation for conducting administrative inspections.
Jan. 22	The NIID assumed that detecting all cases is unrealistic. The NIID also recommended taking appropriate measures for suspected cases and mild symptoms cases, including isolation at home.[58]
Jan. 23	The NIID sent reagents to conduct conventional PCR tests to local health institutions.[59]
Jan. 24	The "Manual for Collection and Transportation of samples from suspected Cases of 2019-nCoV (Novel Coronavirus) infection" was published. [59]
	The PCR test system at the NIID changed to a real-time PCR method from the conventional PCR method, which was introduced at an earlier phase of the response. [60]
Jan. 22	The NIID assumed that detecting all cases is unrealistic, again and basic infection control measures such as cough etiquette and hand hygiene are important.
Jan. 30 - 31	The NIID allocated regents for the real-time PCR method to public health institutions and quarantine stations.[59]
Feb. 1	The government named COVID-19 a "designated infectious disease" under the Infectious Disease Law and a "quarantine infectious disease" under the Quarantine Act. Under these laws, the Government was able to hospitalize patients with suspected or confirmed infection, use public funds to cover the related medical expenses, and conduct medical examinations, tests, and so forth for quarantine purposes.[59]
Feb. 3	The Health ministry published a notification "Handling of Discharge from Hospital and Restrictions on Work Attendance of COVID-19 Patients under the Act on the Prevention of Infectious Disease and Medical Care for Patients with Infectious Diseases" for response to COVID-19 patients and asymptomatic carriers.[60]
Feb. 6	The "Guidelines for Active Epidemiological Investigation in Patients with Novel Coronavirus Infection (Tentative Version) was published for the purpose of preparation for healthcare centers to promptly conduct active epidemiological investigation by the NIID.[61]

Source: Evaluation of the Current Situation of Novel Coronavirus Infection, and Development of Surveillance and Medical Systems in Japan. National Institute of Infectious Diseases, 31 January Update and 7 February Update; Guidelines for Active Epidemiological Investigation in Patients with Novel Coronavirus Infection (Tentative Version), National Institute of Infectious Diseases, accessed 6 February 2020.

Endnotes

1. Open Data. Ministry of Health, Labour and Welfare, accessed 27 October 2020.

2. Expert Meeting on Control of the Novel Coronavirus Disease Control Analysis and Recommendations of the Response to the Novel Corona Virus (COVID-19) (April 1, 2020) (Excerpt). Ministry of Health, Labour and Welfare, 1 April 2020.

3. Current Situation of Infection, September 1st, 2020. National Institute of Infectious Diseases,18 September 2020.

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