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# What can the social care sector in England learn from Japan's experience during Covid-19 and its efforts towards recovery and resilience?

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# 1 Introduction

This case study is part of a wider study entitled the 'Social Care COVID Recovery & Resilience' project, which aims to bring together learning from scientific evidence and other countries to support the social care sector in England in recovering from the Covid-19 pandemic and becoming more resilient towards future shocks and changes.

Based on the priorities identified for the social care sector in England in a previous part of the project (Curry and others, 2023), in this case study we look specifically at what the social care sector in England can potentially learn from the Japanese experience during Covid-19 and Japan's efforts towards recovery and resilience. We focus on potential lessons from Japan related to:

- preparedness
- accountability
- communications
- workforce
- funding
- care home infrastructure.

Learning from other countries does not necessarily imply that the country we are learning from has got everything right – it can be quite the opposite. During the Covid-19 pandemic, all long-term care systems encountered serious challenges and countries faced them with different care systems and structures. The different responses to shared challenges provide rich case studies from which to learn.

This case study has been compiled through a desk review and interviews with key stakeholders, in collaboration with Japanese experts.

After this introductory chapter we give an overview of the Japanese long-term care system (Chapter 2). This is followed by a concise account of Japan's response to the Covid-19 pandemic within this sector, drawing on a more comprehensive 'living report' compiled between 2020 and 2023 (Estévez-Abe

and Ide, 2023) (Chapter 3). We then present an analysis of the Japanese experience during the pandemic and lessons learnt (Chapter 4). We conclude with a discussion on why the insights we found are particularly relevant for the English social care sector (Chapter 5).

## Why focus on Japan?

Our in-depth study of the experience of the English social care system during Covid-19 (Curry and others, 2023) identified a variety of underlying issues that need to be addressed in order to build resilience. Japan's long-term care system appeared to function well through Covid-19 and has also recovered rapidly as the pandemic has waned. Although there has been some mortality within long-term care settings and service delivery was affected to some extent, the impact was lesser than in many other countries. There are features of the Japanese long-term care insurance system that appear to lend it resilience and several of those features are relevant to a number of the weaknesses we identified in the English care system.

## Areas of focus that have relevance for England

- **Preparedness**: Japan's extensive experience of disaster management meant that its plans in long-term care ahead of Covid-19 were well developed. What was in place before Covid-19 and did this preparedness work facilitate an effective response to Covid-19? What can England learn from this?

- **Accountability**: How well did the clear accountability structures that are a feature of Japan's system function during Covid-19?

- **Communication**: What channels of communication were in place in the Japanese long-term care system before Covid-19? How well did they function during Covid-19? Did they facilitate the response?

- **Highly trained workforce**: Did the highly trained and educated nature of the workforce assist with the Covid-19 response?

- **Funding and finance**: How did the stability of funding over time, with mechanisms to get emergency support directly to providers, help with the response?

- **Care home infrastructure**: How well set up were residential homes for managing and preventing infection spread?

In the chapters that follow we explore those features that have most relevance for England and that could hold potential learning. We have not sought to present a comprehensive account of the Japanese experience during Covid-19 nor have we attempted to provide a comparative analysis of performance between Japan and other countries. For more details on Japan's response to Covid-19 and the impact of Covid-19 in Japan, please refer to Estévez-Abe and Ide (2021b).

## Our approach

This case study was developed in collaboration with two consultants, one of whom was based in Japan (Ide Hiroo), and the other who has written extensively on the long-term care insurance system and Covid-19 in Japan (Margarita Estévez-Abe). Information was initially gathered through a desk review of available documents and published literature, building on an initial LTCCovid report (Estévez-Abe and others, 2023). The England-based colleagues reviewed a draft report and noted key areas of interest that resonated with themes that emerged from our report on the Covid-19 experience in England. These areas of interest formed the basis of further exploration through interviews and primary documents in Japanese, with the aim of identifying potentially relevant lessons for England. Our enquiries were not limited to positive lessons but also sought to identify where challenges had been faced during the approach taken.

The consultants carried out seven interviews with a number of different experts, policy-makers and system leaders in Japan in July 2022. More details are available in the Appendix.

# 2 Overview of the Japanese long-term care system

Japan has a relatively generous and comprehensive long-term care insurance system that was established in 2000 in response to concerns about a rapidly ageing population, levels of unpaid care and high rates of hospitalisation. The system, which is funded via a mix of compulsory social insurance and general taxation, provides care and support mainly for the population aged 65 and over (only those aged 40–64 who have a limited range of age-related conditions are eligible). Care and support are not completely free at the point of use but individuals are protected against catastrophic costs and there is a high level of transparency and clarity about what level and type of care people can expect (Campbell and others, 2015). Unlike some other systems (for example, Germany, on which the Japanese model was based), people eligible for care are not entitled to direct cash payments – instead, all care in Japan is provided in-kind. Much of the system is run to nationally set frameworks that offer consistency but also allow for some flexibility at a local level.

The Ministry of Health, Labour and Welfare has overall responsibility for the long-term care insurance system. The same ministry also oversees the health insurance system and wider policy on employment and welfare. Social insurance payments from the 40–64 working-age population are collected nationally from earnings and distributed to municipal governments. Municipalities set and collect premiums from the population aged 65 and over, who pay the premiums from their pensions. Municipalities contract with providers and hold market-shaping duties. Prefectural governments (Sasaki, 2014), which oversee public health, provide regional oversight and registration of providers, and offer support and some data monitoring. Prefectural and municipal governments are also required to update their long-term care service plans every three years.

A national eligibility assessment provides consistent access across the country and is blind to unpaid care, income, wealth and type of need. Once assessed as needing care, individuals are assigned to a need level and assigned a commensurate notional personal budget. These budgets are set nationally. A care manager assists people assessed as eligible in choosing care providers to meet their needs and regularly reviews their needs (Tamiya and others, 2011). On accessing services, the individual is expected to contribute to costs out of pocket – this contribution is means-tested and ranges from 10% to 30% of the cost, with the poorest able to apply for exemptions (MHLW, 2022). Individual out-of-pocket contributions are capped so that even those with the highest needs do not face catastrophic costs (Rhee and others, 2015).

There is a thriving competitive provider market in home and community care, with providers from state, non-profit and for-profit sectors. The growth of residential care provision has been strictly controlled in line with national policy ambitions to limit reliance on institutional care, partly to contain costs and partly in anticipation of a drop in demand beyond the baby-boom population (Hayashi, 2015). Providers of care are paid according to a nationally set fee schedule, which is negotiated and agreed every three years (Ikegami and Anderson, 2012). However, alongside the national fee schedule, municipal governments have some flexibilities to adapt payments to attract providers that meet local population needs. Because prices are set, providers compete largely on quality and reputation. There is an inspection regime but it largely seeks to maintain minimum levels of quality rather than to drive improvement (Hiraoka, 2014).

Japan's population is ageing and shrinking rapidly. Concerns over long-term affordability led to the government reducing the generosity of the system in 2005 (Curry and others, 2018). Efforts to contain growing costs have continued since (Ikegami, 2019) and although the system was largely financially stable going into the Covid-19 pandemic, there were ongoing concerns about long-term affordability (OECD, 2020). Japan, as a nation, runs with comparatively high levels of public debt (World Population Review, 2025). Workforce shortages were also of great concern before Covid-19, with projections that vacancies would grow (Tsukada, 2021) – it was predicted that Japan would have a shortage of 320,000 care workers by 2025, reaching 690,000 by 2040 (Estévez-Abe and others, 2023). Difficulties in recruitment and

retention are fuelled by low pay and perceived low value of care work, despite generally high levels of qualifications and training (Curry and others, 2018).

In an attempt to increase numbers of care workers, the Japanese government has introduced a number of schemes to attract overseas workers. These have had a modest impact to date (Tsukada, 2021).

# 3 The experience of the Covid-19 pandemic in Japan

At wider population level, the Japanese government's Covid-19 response was rapid and focused on educating the population on the 3Cs (avoid closed space, crowded space and close contacts). There was rapid and widespread uptake of the recommendations by the general public which likely limited community spread of Covid-19. Public awareness in Japan was potentially helped by the media coverage of the Diamond Princess cruise ship which experienced rapid transmission of Covid-19 in February 2020 while anchored in Japan. On 20 February 2020, over half the world's known cases of Covid-19 outside China were among passengers on the ship and much was learnt about the virus and how it spread (Baraniuk 2020; Emery et al 2020). The population adopted near-universal mask wearing before this was an official requirement, aided by the established practice of wearing masks during the flu and allergy seasons (Estévez-Abe and Ide, 2021b).

Japan's extensive experience of disaster management also meant that the country had established and well-practised protocols for crisis response. Its relatively recent history of tuberculosis (TB) outbreaks (Katsuda and others, 2015) also meant that its emergency protocols were more appropriate for combatting the asymptomatic spread of a virus (Estévez-Abe and others, 2023). In contrast, in most Western countries, most preparedness had focused on influenza.

Care home lockdowns were also a common practice for managing flu and many homes were already closed to visitors for the season so there was no delay in putting measures in place. The country also swiftly shut down its international borders and kept them shut for far longer than Western nations. Consistent with the care system's underlying principles of promoting wellbeing and independence, during Covid-19, efforts were made to maintain

social connections and ongoing prevention activities. A website providing links to activities in and outside the home was constructed, aimed at keeping people active and preventing frailty.

Although mortality is a blunt measure of success that does not reflect other impacts, Japan's low rates suggest that its approach to infection control was largely successful during the first two years of Covid-19. Rates did rise, however, in 2022 but remained below UK rates, possibly because the virus was largely contained until the population was widely vaccinated. Vaccination of the older population was swift (Nomoto and others, 2022). At the point that infections rose in the community, the dominant variant was Omicron, which, generally, is milder than previous variants. The impact on health, care and wider society of rising infections was limited in the early waves compared with the experience in England and many other European nations. Concern about mortality, however, did begin to be raised in the Japanese media in early 2023 (NHK World-Japan, 2023).

# 4 Lessons from Japan

## Lesson 1: Preparedness

**Infection prevention and control protocols were well developed, resourced and embedded in long-term care facilities before Covid-19, allowing measures to be put in place swiftly.**

### Why we focused on preparedness

As outlined in our report on the social care sector in England (Curry and others, 2023), one of the factors that shaped the response to Covid-19 in social care in England was limited preparedness for a crisis in the sector. National preparedness plans and prior pandemic simulations did not routinely include social care and there were no requirements for individual care organisations to have infectious disease or crisis response protocols in place. One key exercise that did look at social care identified a number of recommendations to address weaknesses within the system, but few were subsequently addressed by government. As a result, when Covid-19 struck, new guidance about infection prevention and control (IPC), discharge procedures and other elements of pandemic management had to be drafted, issued, communicated and implemented. This required care staff and managers to quickly become familiar with and trained up in various aspects of the crisis response. In contrast, Japan was extremely well prepared for a crisis on this scale. Its approach to embedding emergency protocols holds relevant learning for England.

### What was in place before the pandemic and how did it work during Covid-19 in Japan?

Japan's history of natural disasters and relatively recent experience with TB outbreaks meant it had well-practised protocols for disaster management in general. There was also a well-resourced regional support infrastructure,

in the form of prefectural-level public health bodies, to facilitate the swift implementation of procedures. But what really stands out about Japan in the Covid-19 context is the fact that IPC protocols in long-term care facilities had been well established, regularly updated and, importantly, *used* since guidelines were introduced in 2000 with the new long-term care insurance system.

When the long-term care insurance system was implemented in 2000, all long-term care facilities – the majority of which were run by state-owned medical, social welfare or non-profit organisations at the time, although the number of for-profits has increased since (Legislative Council Secretariat, 2023) – were required to have mandatory IPC committees involving different types of employees, medical and non-medical, who meet every three months and familiarise themselves with the latest protocols (Abe and Kawachi, 2021). A pre-Covid-19 survey revealed that these committees did indeed meet frequently – almost half bi-monthly and 90% several times a year (Estévez-Abe and Ide, 2022). Practices such as mask wearing for staff and visitors, isolating residents suspected of having contagious infections and suspending visits and social events were already in place for other infectious diseases. Care homes were accustomed to closing their doors to visitors during flu outbreaks. In fact, when the pandemic started, many long-term care facilities were already in semi-lockdown due to seasonal flu outbreaks and they simply extended the existing lockdown, which may have contributed to reducing the risk of Covid-19 entering and spreading within the facilities (Estévez-Abe and Ide, 2022).

Because of the level of preparedness and the existence of well-practised protocols, individual long-term care facilities were able to quickly put in place appropriate measures for controlling and preventing infection spread. There was no need for new, unfamiliar guidance and thus no need to retrain staff in new skills and concepts. There was also no need for facilities to wait for external instruction to click into crisis management mode.

Alongside the long-term care system, the health system was similarly prepared and that ensured long-term care facilities were supported. Once the national government had classified Covid-19 as the highest level of contagious disease, a number of protocols were immediately actioned. One of those involved having designated hospitals for infected individuals. Because only

certain hospitals accepted Covid-19-positive patients, the majority of other hospitals were able to carry on with business as usual, ensuring that most health services for everyone (including people using long-term care services) were largely maintained. This was in part enabled by the low rate of infection throughout most of the pandemic and the relatively high bed base in the Japanese hospital sector (OECD, 2023). Prefectural-level public health bodies were key to coordinating the response across health and social care. These so-called '*hokenjos*' were the first point of contact for people infected with Covid-19 and *hokenjos* were tasked with testing, isolating and hospitalising positive cases. They were also responsible for sending food packages to those isolating at home. Interviewees remarked that the *hokenjo* that covered their area worked well to begin with but became overwhelmed when infection numbers rose (I2).

Preparedness arrangements worked well during the crisis and very few changes were made as a result. One significant change, however, was that the government introduced a requirement in 2021 that all providers, including in-home care providers, should have a business continuation plan to further strengthen preparedness for future crises, such as natural disasters or another pandemic. Municipalities have been providing support for organisations to develop these plans. The existing payment mechanisms were used to ensure compliance with this requirement (see Lesson 5 in this chapter for more on payment and funding). Interviewees commented that the templates provided by government for this have been helpful but that home care providers have in general been slower than residential care providers in implementing them. The municipal government representatives that we spoke to are actively supporting them to develop adequate plans (I4).

### Pandemic preparedness – learning points from Japan

- Having embedded, well-developed and well-practised preparedness arrangements and IPC procedures and plans put the Japanese long-term care system in a strong position from which to manage Covid-19.

- Individual long-term care facilities had very clear requirements to fulfil around preparedness and these had been enforced through regulation and inspection.

- Although each long-term care facility had the responsibility for developing and implementing emergency preparedness plans, municipalities had a clear responsibility and the capacity to support them to do so.

- Clear emergency response plans in health also helped to manage the impact of Covid-19 within long-term care, ensuring that people within long-term care facilities were still able to access health provision.

- Japan continues to learn from experience and has taken concrete steps to further strengthen its preparedness and to ensure consistency across all care providers in the sector.

## Lesson 2: Accountability

**Clarity over accountability and governance enabled the system to click into crisis management without the need for additional structures.**

### Why we focused on accountability

Our research into the English experience of social care during the early months of Covid-19 found there was considerable confusion among stakeholders about responsibilities within the sector (Curry and others, 2023). The split of accountability between national and local government, and across central government departments and arm's-length bodies, led to confusion and delay in the response. For example, this lack of clarity was evident when it came to personal protective equipment (PPE) procurement and distribution for the sector as well as with asymptomatic testing. While the confusion had a tangible impact on the handling of the crisis in England, the lack of clarity over responsibilities is an ongoing issue in ordinary times and has the potential to undermine future resilience. Japan provides a contrasting example of how pre-existing clarity over governance and accountability before the pandemic enabled the long-term care system to switch almost seamlessly into crisis mode when Covid-19 hit and to continue to run effectively.

## What was in place before the pandemic?

Similar to England, responsibility for long-term care spans local and national government but has an additional tier with regional governments, known as prefectures. What stands out in Japan is that responsibilities are very clearly demarcated and, within clear national frameworks, there are high levels of local and organisational autonomy.

As set out in Chapter 2, the national Ministry of Health, Labour and Welfare sets out the regulations, eligibility, menu and specifications of services and standardises pricing across the country through a national fee schedule. Relative to England there is a high degree of consistency across the country, although with growing demand, disparities have increased and some variation in access and cost is now evident (Masui and others, 2021). Municipalities have responsibility for running the system within the frameworks set by national government. They contract with providers, undertake eligibility assessments and assign care managers who support people to choose care packages to suit their needs. Municipalities also operate as insurers, setting the premiums for people aged 65 and over, which gives them some flexibility over revenue and establishes their democratic accountability (40- to 64-year-olds contribute to the system via social insurance payments, which are collected nationally and allocated to municipalities). Prefectures play a coordinating, oversight and support role, for instance coordinating training across municipalities (which are numerous and relatively small), approving provider licences and stepping in in cases of complaint or dispute (for example, over eligibility) (Tsutsumi, no date).

## How accountability structures operated during Covid-19 in Japan

This clarity of responsibilities appeared to lend the system resilience in the face of the Covid-19 crisis, and the layer of governance at regional level with prefectures provided coordination support and monitoring to municipalities. However, as discussed later, the slightly ambiguous status of prefectures, which rests somewhere between regional arms of national government and autonomous bodies, led to some tensions as the pandemic wore on.

The response to Covid-19 in long-term care in Japan was rapid and the pre-existing clarity of roles and responsibilities meant that individual providers, municipalities and prefectures were able to implement crisis

protocols without needing to wait for national guidelines, permission or diktats. Unlike many other countries, Japan did not need to set up a specific taskforce or additional governance structures to support the long-term care sector to cope with Covid-19. The national Ministry of Health, Labour and Welfare issued notifications and warnings about Covid-19 but decisions about when, and if, to shut long-term care facilities were very much taken at a local level (Estévez-Abe and Ide, 2021a). Interviewees indicated that municipalities and providers felt empowered to implement Covid-19 management measures early and there was a rapid and relatively smooth adoption of emergency IPC protocols. Where there was variation in how prefectures and municipalities performed, one interviewee representing the Ministry attributed this mainly to the relative number of Covid-19 cases, although factors such as the capacity of medical facilities and the decisions of individual governors/mayors did play a role as well (I1).

During Covid-19, prefectural governments were responsible for formulating and implementing specific measures and acted as conduits of information and mechanisms for shared learning. Interviewees reported confidence in the competence of leaders at prefectural level and that regional level of support and oversight appears to have been an asset at the point of crisis. Public health bodies (*hokenjos*), which operate at a regional level (typically each prefecture has a number of *hokenjos*, which typically cover 300,000 people), also played a key role in the Covid-19 response. In ordinary times, *hokenjos* (Katsuda and others, 2011) monitor contagious diseases and vaccinations and have a specific role in TB management and prevention. The *hokenjos'* expertise in carrying out contact tracing, as established through their TB management, was considered to be a strength in their role in managing the early stages of Covid-19 (Okazawa and Suzuki, 2020). Once the national government had classified Covid-19 as the highest level of contagious disease, *hokenjos* implemented existing protocols, which involved extending their regular responsibilities. Long-term care accountability structures are hierarchical and streamlined with agencies exclusively focused on care and this clarity of accountability aided effective communication (Estevez-Abe and Ide 2021a). As per the existing protocols, *hokenjos* became the first point of contact at that regional level – anyone with symptoms contacted the *hokenjos*, which arranged testing and, if positive, hospitalisation. However, according to interviewees, in one municipality, that role (and automatic hospitalisation

of infected individuals) became impractical as infection rates climbed and prefectures had to set up additional call centres.

For the most part, the different levels of governance operated smoothly during Covid-19 and helped to facilitate the response. However, some interviewees who operate at prefectural level described some tensions between the role of the national government and the autonomy of prefectures as the pandemic wore on. For instance, the national government had classified Covid-19 as the most contagious virus but, as time went on, some prefectures wanted to scale back their support to something more akin to what would be provided for a seasonal epidemic. Prefectures have the freedoms to do this, but interviewees were concerned that such reductions would not be received well by the public in the absence of a national reclassification of Covid-19.

**We want the national government to change the designation of the new coronavirus. For instance, Kanagawa Prefecture has scaled down its efforts to contact trace and collect epidemiological data, and simply asks its residents to report infection by means of an app. We want to do what Kanagawa has done, but we are afraid that our residents might perceive it negatively as a reduction of the level of governmental services/commitment. Hence we want the national government to make a decision by changing the designation of the new coronavirus as a most contagious virus to something akin to seasonal epidemics.** (I3)

Furthermore, as Covid-19 cases increased, there were some tensions around funding for Covid-19-specific programmes that were only partly funded by national government. In the words of one prefectural official "we think that the national government should pick the whole cost, since this is a national policy" (I3).

One weakness that was identified by interviewees in the Japanese governance of the system was the lack of a legal framework to monitor the number of Covid-19 infections and related deaths in long-term care facilities. While prefectural governments were able to use existing communication channels to gather information on infections, the lack of a systematic data collection

approach was seen to be a limitation in managing the response in real time by the officials we spoke to and they noted that the government did "not try to change the status quo" (I1). The official just quoted noted that the experts' council that was tasked by the cabinet office to review the Covid-19 response said in their final report in June 2022 that the lack of data was "a serious shortcoming" (I1). The lack of systematic data meant that there was a limit to the scientific analysis of infection spread and understanding of why certain facilities had outbreaks but others did not.

## Accountability – learning points from Japan

- Clarity over accountability arrangements within long-term care enabled a swift response to Covid-19 in the initial stages, with every level of the system clear about their powers and responsibilities.

- That clarity of accountability meant that high levels of local autonomy facilitated a rapid and seamless response by individual provider organisations.

- A regional tier of government lent a layer of support and oversight that helped with the coordination of the response. However, ambiguity over the autonomous status of prefectures became a source of tension when rising cases put pressure on resources.

- Well-prepared and highly skilled public health centres (*hokenjos*) played a vital role in infection management, drawing on their experience of managing TB. However, they were not sufficiently resourced to handle the volume of cases that began to emerge.

- The lack of a mature and systematic data collection regime was an impediment to the coordination and implementation of the response and limited the scientific analysis of infection spread and factors facilitating it.

# Lesson 3: Communications

**Established two-way communication channels between all levels of government and with providers facilitated the response.**

## Why we focused on communications

At the point at which Covid-19 infections started to spread in England, there were few established two-way channels of communication between different parts of the social care sector. Central government had no easy mechanism to directly communicate with individual providers and communication between the Department of Health and Social Care and local government was patchy. The social care provider sector is vast and complex, with some contracting directly with councils, others being commissioned by the National Health Service (NHS) and others dealing solely with self-funders and thus not necessarily well known to councils. Some councils had good knowledge of their provider sector and had established communication and data collection processes, but this was very variable. The social care provider sector in England is diverse and has numerous umbrella membership bodies representing different, overlapping segments. Not all organisations belong to one. It was, therefore, difficult for government to get necessary messages directly to providers. And, equally, it was difficult for providers to get their messages or calls for help to central government. There was also confusion among providers about which central body they should be contacting for what. This further complicated matters and slowed down the response.

Japan's pre-existing, established routes of communication appeared to be a strength in its response. Despite a different context, there are elements of its communication structures that could hold lessons for England.

## What was in place before the pandemic?

Japan had established communication mechanisms between providers of care and local, regional and national government embedded before Covid-19 struck. The clear accountability arrangements, as described above, created the structures that enabled these communication channels. The system of

payment (see more later) that underpins long-term care provision in Japan means that in order to access reimbursements for state-funded care (on the whole, the majority of people accessing care do so via the municipalities because a large proportion of costs for those eligible are covered by long-term care insurance with only a 10-30% copayment required (dependent on income) (MHLW n.d)), providers need to contract with municipalities and also need to be registered with prefectures. This means that there is an established channel of communication to almost all providers (a small proportion remain outside the state-reimbursed system). Additionally, there is a very clear demarcation between which services health insurance pays for and which are paid for by long-term care insurance. As a result, there was not the complexity that exists in England where a single provider might simultaneously have clients paid for by the NHS, their local council and individuals themselves. Very few providers in Japan service only self-funders and so almost all have some sort of relationship with their local municipality. What is less clear in the Japanese system is how the voices of service users are heard and fed into decision-making.

High levels of membership of officially recognised trade associations was another factor that aided effective communication between providers and government. The trade association for for-profit nursing homes in particular played a crucial role. The association was implemented by national government to enable better communication with, and oversight of, the sector. The association acts as an intermediary between the government and provider organisations and has a formal status in law, which specifies a range of duties, from providing guidance to members, to resolving complaints and providing training to employees of members. The association, in turn, is subject to supervision by the Ministry of Health, Labour and Welfare.* Membership of a trade association is not compulsory for providers but there is a strong incentive for them to join. Providers are required to adhere to strict regulatory and legal guidelines, such as minimum staffing levels, and trade associations play an intermediary role, soliciting documentation from members and working with authorities to ensure compliance (Estévez-Abe and Ide, 2021a). Interviewees from a municipality told us that they had regular monthly meetings with their local trade associations before Covid-19 (I2). One

* Act on Social Welfare for the Elderly (Act no. 133 of 1963), Articles 30 and 31. (www.japaneselawtranslation.go.jp/en/laws/view/3930/en).

interviewee from a prefecture reflected that in their area, trade associations also had a good relationship with medical associations and were in regular contact before and during Covid-19 (I4).

## How communications operated during Covid-19 in Japan

These established communication channels linking all levels of decision-making with providers facilitated the rapid dissemination of information and swift distribution of assistance. Because channels and mechanisms were already established and operational, there was no delay in communications between government and providers and no need to create new forums.

This became vital during Covid-19 when the situation was frequently changing. Routine communications included monthly meetings where the needs of providers could be collated and then reported by the trade association to municipalities or the prefecture. During Covid-19, communication increased, with some municipalities reporting daily contacts with long-term care providers who were facing problems. Communication was in both directions, with the Ministry of Health, Labour and Welfare distributing guidance and announcements, and bottom-up requests coming from providers for support. Trade associations undertook frequent surveys of the challenges faced by providers and the support needed, and municipal, prefectural and national government used that information to adapt the response. In addition to the regular long-term care-specific channels of communication, long-term care facilities were clear about how to contact and seek support from the regional public health bodies (*hokenjos*) through which all Covid-19-positive cases were handled (as explained above).

Interviewees commented on how municipalities in their area made efforts to work together to share information between them to reduce the burden of information requests on providers, many of whom operate across multiple municipalities.

**We also share information with other cities and municipalities. Some of the LTC [long-term care] providers in our jurisdiction also operate in other administrative units. So we try to coordinate with other municipalities in order not to cause confusion and inconveniences to our providers.**
(I2)

## Communications – learning points from Japan

- Having established channels of communication already built into the everyday workings of the system meant that, when Covid-19 hit, there was already a flow of information and no need to form new trusting relationships and ways of working from scratch in the heat of the crisis.

- The clarity of the underlying accountability meant there was a level of clarity to the flow of information.

- Having provider representative bodies that have a formally recognised (albeit not statutory) role within the system appeared to have been helpful in ensuring the regular and trusted communication of information between the front line and policy-makers.

- Coordination and sharing of information across municipalities helped to reduce the burden on providers that operate across different jurisdictions.

- One area that is not clear within the Japanese system is how the voices of service users are heard and incorporated in policy decision-making.

# Lesson 4: Workforce

**A highly qualified workforce and low levels of insecure contracts facilitated the Covid-19 response. Regional personnel-dispatching systems also helped support long-term care facilities.**

## Why we focused on workforce

Structural weaknesses within the social care workforce in England had a substantial impact on the effectiveness of the Covid-19 response in the country and, in some instances, the characteristics of the workforce were not sufficiently accounted for in wider Covid-19 policy. For instance, a key factor in England was the fact that insecure zero-hours contracts are widespread in the sector, which meant that wider policy on isolation was problematic for staff who had variable access to occupational sick pay. High numbers of vacancies also created pressures for providers, who struggled to cover sickness absences (Curry and others, 2023). Japan suffers from its own workforce challenges that are not dissimilar to those in England but there are points of learning from the Covid-19 experience in Japan that hold some potential learning.

## What was the workforce situation before the pandemic?

Although, like England, Japan faces challenges around a shortage of care workers, fuelled in part by relatively low pay and perceived low social value of care work, there are some distinct characteristics of the workforce in Japan that proved to be advantageous during Covid-19. First, the Japanese long-term care workforce has high levels of qualifications with stringent requirements to join the workforce and for ongoing training. Second, there is relatively low use of unstable (that is, zero-hours) contracts, which means that most staff have access to sick pay and stable employment.

In addition, there is also a high level of knowledge and oversight of the long-term care workforce built into the long-term care system's governance structures. The regional level of government – the prefectures – are tasked with monitoring infections as well as registering and regulating providers, which includes strict monitoring of staff ratios. And there are regular reviews of remuneration in the sector (Ping and Oshio, 2023).

## How workforce structures and processes held up during Covid-19

Interviewees reflected that the high baseline levels of education of the Japanese long-term care workforce meant that the workforce was generally quick and confident in effectively adopting more stringent IPC processes and understanding PPE protocols. However, while the high levels of training have been seen as positive, interviewees expressed concern that the high levels of qualification required to work in the long-term care system in Japan are exacerbating recruitment difficulties, particularly making it difficult to recruit workers from other countries, despite recent efforts to attract migrant workers.

Interviewees also mentioned that the stability of employment and access to sick pay enabled staff to isolate, helped to contain the spread of the virus and aided the retention of staff. The impact on staff of coping with Covid-19 infections was recognised by government and a fund was set up for counselling services for care workers and some hardship bonuses were paid to staff. However, these were limited to staff directly affected by infections in the facilities they worked in. In 2021, remuneration for the long-term care workforce was revised to reflect changes in the cost of living and increase the attractiveness of working in the sector as part of a wider economic stimulus package (Kyodo News, 2021). However, pay in the care sector still lags behind pay in others and wage increases have not kept pace with inflation, resulting in high numbers of leavers (Sekine, 2023).

The high level of knowledge and oversight of the workforce within the system allowed for flexible deployment of staff, which was helpful in moments of crisis. Prefectures were responsible for responding to staffing shortages and had good oversight of not only where outbreaks of Covid-19 were occurring but also where providers were experiencing staffing pressures. Where long-term care facilities were struggling to safely staff services, prefectures were able to redeploy special dispatch teams to assist – this was an approach pioneered by three prefectures and their experience was communicated to other prefectures by national government (Estévez-Abe and Ide, 2021b). A national fund to support prefectures in their Covid-19 response was put in place in April 2020. Any additional costs involved in employing additional staff were covered by prefectures from this fund so providers were not financially penalised for outbreaks. This approach was essential in ensuring that providers were adequately supported to continue to deliver safe services and that staff were not too stretched during outbreaks (I1).

### Workforce – learning points from Japan

- Generally high levels of education among the workforce and stringent mandatory training meant the workforce was able to quickly and confidently adapt to changing requirements around infection prevention and control (IPC). However, high requirements for entry into the workforce are exacerbating an already difficult recruitment challenge.

- Limited use of unstable employment contracts gave the workforce a level of resilience in the face of sickness and isolation policy and helped to contain the spread of infection.

- Regional oversight of the workforce, along with good knowledge of who works in the sector, became a powerful tool in targeting support to places that needed it.

- Japan continues to struggle with high vacancy rates and a shortage of care workers, exacerbated by wages not keeping pace with inflation or other industries, and it does not have a long-term strategy for addressing these issues.

## Lesson 5: Funding

**Stability of funding and pre-existing mechanisms for allocating funds offered certainty and stability during the crisis.**

### Why we focused on funding

A strong theme that emerged from the research in England was that funding going into social care before the pandemic was insufficient for sustained investment and improvement in services. A tendency to rely on sporadic injections of cash into the system had not offered certainty and stability to providers or councils and so, going into the Covid-19 pandemic, the system was very fragile, with few reserves and little financial resilience. Emergency funding was provided and was crucial to maintaining services but that took some time to reach the front line and has now come to an end. However,

legislation was passed in 2022 in the form of the Health and Care Bill to enable direct payments to providers in times of crisis (Curry and others, 2023). Japan's funding system offers a different approach that provides certainty and stability as well as flexibility in normal times as well as during crises.

## What was in place before the pandemic?

Japan's long-term care insurance system is funded via a mix of nationally raised social insurance premiums levied on workers aged 40 and over, employers and pensioners, general taxation and user fees. The national funding approach pools risk and there are high levels of clarity over needs assessment and benefits.

Providers are paid according to a fee schedule that is set nationally, with some local flexibility allowed. The fee schedule is negotiated by providers, municipalities and government and set every three years. Importantly, fees are future-looking and so aim to take account of likely cost pressures over the forthcoming three years. Before Covid-19, the system of provider payments with high levels of clarity and transparency over fees had helped to offer providers certainty and therefore enabled investment in infrastructure. This meant that, on the whole, care homes were modernised (see Lesson 6 on care home infrastructure for more on this).

## How funding structures and processes helped support the sector during Covid-19

During Covid-19, this pre-existing financial architecture proved helpful in sustaining services, although there was some instability in the early months before emergency funding was allocated. For instance, a national subsidy was put in place to cover providers' extra costs (for example, for PPE or hiring additional staff) but interviewees reported that it initially only covered a limited number of items and had to be widened. Once adapted, interviewees reported that it was possible to get financial support to providers quickly.

Providers of day services were particularly badly hit in the first months of the pandemic as they reduced or suspended business due to restrictions around social mixing and people choosing to avoid group settings. This financially impacted 82% of providers (Amagasa and others 2020). This was a particular

concern within the sector as day care services play a significant role in the Japanese system in terms of maintaining wellbeing and social connections and providing respite. By April 2020, emergency funding had been approved and was quickly distributed to providers via the established payment mechanism. Despite this, around 118 providers did exit the market by the end of 2020.

The flexible structure of the payment system helped to mitigate further instability in the market by supporting day care providers to change their business models. The national government was able to modify the fee schedule to allow special payments to day care providers to adapt and provide in-home care to clients who could no longer use their facility-based service. This was seen as a very positive development by provider interviewees who otherwise would have had to close their doors. It also meant that once infections fell, providers were able to resume day care services relatively seamlessly. Interviewees indicated that the government is now considering permanently allowing day care providers to provide home care services.

The payment system has also been used to incentivise providers to adhere to certain requirements. For instance, the Ministry of Health, Labour and Welfare increased reimbursements to care homes that took in Covid-19-positive patients who had been discharged from hospital. Later on in the pandemic, when the requirement to produce business continuity plans was introduced, interviewees reported that the payment mechanism was again used to enforce compliance as emergency Covid-19 funding was not accessible unless the plan had been developed.

### Funding – learning points from Japan

- Adequate and sustainable funding for the sector as a whole means it had a relatively stable and thriving provider market going into the Covid-19 pandemic.

- A national system of payment with specified fees for defined services that are set every three years offers certainty to providers, service users and municipalities. There were some delays as this was adapted to enable wider financial support but, once adapted, it allowed for rapid allocation of emergency funding straight to providers.

- Having an established payment mechanism for providers built in flexibility to allow for services to adapt and survive in the face of potential closures. This ensured that the market did not suffer extensive disruption during or in the wake of Covid-19.

- The system of direct reimbursements to providers was also a useful tool in incentivising them to take in people discharged from hospital and to develop business continuity plans.

## Lesson 6: Care home infrastructure

**Investment in the physical infrastructure meant residential care facilities were better able to manage infections.**

### Why we focused on care home infrastructure

One of the more controversial moments in the early English response to Covid-19 was the decision to rapidly discharge thousands of people from hospital and into care homes without testing them for Covid-19. While the impact of that policy decision has been found, in subsequent research, to be relatively small compared with all other sources of infections in care homes, the evidence suggests that at least some care home outbreaks were caused, partly caused or intensified by discharges from hospital (SAGE 2022). The decision to discharge to care homes rapidly without testing may have been taken without a full understanding of the ability of care homes to successfully isolate people with suspected or confirmed Covid-19 infections.

Throughout the pandemic, guidance was issued to care homes requiring them to isolate or 'cohort' (that is, group together) symptomatic or infected residents. While in theory that was an appropriate and workable approach in clinical settings such as hospitals, the care home estate in England is not well designed for such levels of infection control. The majority of care homes have not been purpose-built and a large proportion remain unmodernised, with few en-suite facilities. Japan's physical estate, in contrast, is comparatively modern and Japan is now reflecting on how to better prepare care homes for

IPC in future. It holds interesting learning for England as it considers creating a more resilient system.

## Japan's care home infrastructure before the pandemic

Japan's residential care estate is, in general, made up of purpose-built facilities. This is partly as a result of Japan's susceptibility to natural disasters and its consequent tendency to construct buildings with an anticipated lifespan of only 20–30 years (Berg, 2017). But it is also a result of long-term investment in facilities. Care home construction costs are financed separately by government and not via fee reimbursement from the insurance system. Private rooms in nursing homes became the norm in all new homes from the 1990s and, since 2002, all new nursing homes have had to meet certain standards, which include requirements to be organised as small-scale living units (with at most 10 people per unit), all with private rooms, inspired by the Scandinavian model (Ikegami and others, 2014; Nishino and others, 2024).

Care homes must meet specific design criteria in order to be accredited by a prefecture (this is a prerequisite of provision). In fact, structural design – along with strict staffing ratios – is the main marker of quality in the system, with only limited monitoring of outcome or process measures (although there has been growing interest in these elements during the last few years) (Igarashi and others, 2020). Therefore, building design regulations play a very significant role in system management.

While criteria do not require every room to have en-suite facilities, there are stringent requirements around the maximum number of people who can share a room or a communal living space (E-GOV, no date). There is also a clear demarcation of public, semi-public, semi-private and private spaces (Nishino and others, 2024). In order to comply with building and fire safety regulations, many facilities provide open balconies (or verandas) or are at ground level and have direct outside access (Hong Kong Legislative Council Secretariat, 2023; Yamaguchi and others, 2023). Many care homes also have family accommodation rooms (Yamaguchi and others, 2023).

Furthermore, the design of facilities is intended to facilitate provision of medical care should the condition of a resident suddenly change. It is mandatory, for instance, for care homes to have a medical clinic or room

within the facility and to have an established system of cooperation with medical institutions (Hong Kong Legislative Council Secretariat, 2023).

## How infrastructure facilitated the Covid-19 response in Japan

The pre-existing design of nursing homes, along with the stringent IPC policies and procedures (see Lesson 1 on preparedness), likely helped with the management and containment of Covid-19 once infections entered the homes. An analysis comparing deaths in nursing homes in Japan versus those in the United States observed that mortality in Japan was 14% compared with 35% in the US homes, although the case fatality rate was similar at approximately 16% (up to 2021). The authors of the paper surmise that a number of factors, including IPC plans and staffing ratios, impacted that result. They also concluded that the size and structure of Japanese nursing homes played a part: Japanese nursing homes are, on average, smaller than those in the United States (69 beds compared with 106) and regulations dictate that each unit within a nursing home has no more than 10 beds (Abe and Kawachi, 2021).

A study of how care homes implemented Covid-19 measures in Japan found that most facilities were able to easily comply with at least two of the '3Cs measures' as the architectural design facilitated good ventilation and reduced the risk of a space being crowded. The organisation of most care homes in small units facilitated the implementation of cohorting, with simple physical separations added. When a unit had a positive case, this was closed and staff used the verandas to access the unit from the outside. Where available, family accommodation rooms could be used by staff who were prepared not to return to their homes to avoid passing infections to family members. The study also observed very high compliance with IPC measures by staff (Yamaguchi and others, 2023).

As a result of both Covid-19 but also in response to natural disasters, Japan is now considering how to ensure care homes are resilient in the face of future crises. It is moving towards requiring all new homes to have single-use rooms complete with toilet and shower. One consideration is also to require all rooms to have external access (for example, via a veranda). Such facilities are also better able to facilitate safe visiting. In addition, external access is seen as an advantage in the case of an earthquake.

## Care home infrastructure – learning points from Japan

- Sustainability of funding has enabled long-term investment in physical infrastructure. This put residential facilities in a strong position from which to manage infection spread.

- Stringent design regulations ensured that care homes were not overcrowded, were well ventilated, and had built-in medical facilities.

- An absence of measures of quality aside from structural regulations makes measuring outcomes, process and experience more difficult.

- Japan is learning from the Covid-19 experience and actively exploring ways to make care homes even more resilient in the face of future crises.

# 5 Discussion: what can England learn from Japan's Covid-19 experience?

Japan's pandemic response in long-term care has not been without its challenges and, like many countries, it has struggled to prevent the spread of infection in care homes, albeit later in the pandemic than most. But, while its response was not flawless, there were certain features of the pre-existing system that lent it resilience and put it on a stronger footing from which to manage the crisis than some other systems. It is some of these features that offer potential lessons for England as it, too, reflects on how to build a more resilient system post-Covid-19. In this chapter we discuss how these features could potentially translate to an English context and what further considerations would be needed to ensure they are a success.

Going into the pandemic, Japan's extensive experience of disaster management stood it in good stead for managing the Covid-19 crisis. While England is unlikely to require the same level of preparedness for natural disasters, there is some relevant learning to be drawn from Japan. Some of that is in how embedded IPC policies were across the sector as a matter of course. This meant that, while some new guidance was required as new information about the Covid-19 came to light, Japan was starting from a place where there were established precautionary measures that were well practised and could be implemented swiftly and there was a basic level of training and awareness among staff around IPC, which made adapting to new Covid-19 guidelines easier. Clearly, cultural context and social norms differ between England and Japan, and the ease with which Japanese care homes could lock down, ban visits and enforce mask wearing is one way in which there is divergence. English policy-makers, therefore, will need to ensure that providers have IPC plans that balance the need to prevent infection spread with the rights

of residents and their families. Support to providers to do this will be crucial and defining where responsibility lies for ensuring the preparedness of the sector is vital. Given that a majority of care providers in England are small and medium-sized enterprises (Department for Business and Trade 2024), many with limited back-office capacity, coordinating the development of policies and procedures would offer efficiencies.

Much of the resilience and effectiveness of Japan's preparedness plans stem from the clarity of accountability and communication that is hard-wired into the system. This, in turn, is supported by established mechanisms for distributing funding and a sustainable financing regime. True local autonomy in a context of adequate funding and an ability to swiftly get support to providers appear to have assisted in the rapid response and containment of infection. While it is neither realistic nor desirable to try to implement an exact copy in an English context, there is much to reflect on from an English policy point of view.

The Japanese system appears to balance national frameworks and regulations with local autonomy relatively successfully. Stakeholders in England were clear that a shift to a very hierarchical, centrally run system of social care would not be desirable, emphasising that care needs to be rooted in local communities. However, there was a consensus that greater understanding about where responsibilities lie in all parts of the system would help build resilience not just in times of crisis but also in ordinary times. If such clarity were established, there may be less need to create new structures and forums from scratch and thus expedite any crisis response in future.

The long-term sustainable financing of the system in Japan had, in the years running up to the pandemic, enabled investment in infrastructure, which meant that the residential facilities where infection spread was a risk were largely modernised and better able to implement additional IPC measures than the ageing estate that characterises much of care home provision in England. The long-term sustainable funding also offers certainty to municipalities and providers alike so that, while there was some instability in the market at the very beginning of the pandemic, there was less dependence on emergency funding and for the most part the provider market has survived the pandemic with relatively few casualties. For England to confidently withstand another future crisis (be it a pandemic, an extreme weather event

or other political/economic upheaval), serious thought needs to be given to how to offer sufficient financial certainty to enable active investment in physical infrastructure and in alternative forms of provision to the traditional congregate setting, which is so vulnerable to infection spread. Interestingly, Japan's care home building standards were driven primarily by a concern to improve people's quality of life, learning from Scandinavian evidence, rather than by IPC considerations, suggesting that the model of small-scale homes with small units and private rooms may be desirable from both a quality of life and an IPC point of view.

An interesting feature of the Japanese governance structure is the presence of a regional layer in the form of prefectures. In the pandemic scenario, this layer of governance appeared to lend a helpful layer of support and coordination for local areas and providers alike. The ability to deploy emergency dispatch teams was one concrete example of this support. Similarly, the regional-level public health authorities that spanned multiple municipalities also provided a clear single point of contact for all in the system. There may be scope within existing English structures (perhaps at integrated care system level or Association of Directors of Adult Social Care regional level) to create a layer of governance that would be well placed to provide additional support and coordination at a time of crisis. The form that this layer may take and its exact function would need to be given careful thought to ensure it is not simply an added layer of bureaucracy (also noting the reticence to create a hierarchical system, alluded to above). One point of learning from Japan is that the prefectural level of government appears to suffer from a slight ambiguity in its status – while theoretically autonomous, prefectures do also operate as regional arms of the national government. English policy-makers would be wise to avoid any such ambiguity if new formal structures were to be implemented. Where a regional layer of governance could play a crucial role is in supporting and coordinating preparedness efforts. As noted above, much of the provider sector in England lacks the capacity to develop individual preparedness plans and so there is value in preparedness plans being developed at a regional level. Being clear where responsibility for this work lies will be crucial in determining its success.

Regular and established channels of communication also emerged as a key source of resilience within the Japanese system during Covid-19. In England, much progress was made during the pandemic in establishing lines of

communication, dialogue and input between different parts of the system. It is important that this learning is not lost but harnessed to ensure that these things are maintained during ordinary times, and can be stepped up further in times of crisis. The size and complexity of the English provider market makes communication difficult, but established umbrella bodies already provide a conduit for communication and could be further cemented within ongoing government channels. One weakness in the Japanese system that England would need to avoid is the lack of clear channels for service user voices to be heard within decision-making forums at all levels of government. It may be an oversight within this project that this did not emerge or it may be the case that the user voice is not embedded in the system. Provider organisations are an important part of the system and need to be heard but they do not speak for all service users and it is important their voices are heard too. There needs to be careful thought among policy-makers as well as social care system leaders and providers about to how best to ensure representative voices are heard on an ongoing basis, particularly as integrated care systems develop and seek to deliver integrated care.

Lessons can also be drawn around creating a resilient workforce. While Japan has by no means cracked the workforce challenge, its workforce going into the pandemic appeared to be in a more robust state than its English counterparts. One key observation is the relatively limited use of zero-hours contracts within the Japanese system, which meant many of the challenges faced in England around isolation and staff movement were avoided. Serious consideration needs to be given to how England can ensure terms and conditions build resilience for the future. High levels of training and qualifications were another feature of the Japanese workforce that lent resilience in some ways (that is, ease of training in new IPC procedures) but have created long-term challenges over recruitment as requirements pose barriers to entry to the sector for many. As England develops its skills framework for care workers, it will be important to avoid creating such unintended consequences. Consideration could be given to whether some mandatory IPC training should be required for workers and how that could be rolled out and enforced. There may be potential to combine that with regular induction training, but it will be important that the mechanisms for monitoring and enforcing this are clear.

Examining the performance of other systems during Covid-19 highlights a wealth of valuable learning that could be worthy of consideration in England.

That is not to say that everything that is observed in Japan should or could be adopted and, indeed, some of the experiences suggest some initiatives should be actively avoided. The complexity and nuance of implementing initiatives from one context in another one should also not be underestimated.

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# Appendix: Methodology used for the Japanese case study

This case study was developed iteratively, to ensure that the focus was responsive to key policy and practice questions that would be relevant to the English context, and in particular the experiences of the social care sector during the Covid-19 pandemic.

The first step was a desk review (conducted alongside other countries), as part of a wider *International Living Report on Covid-19 and Long-Term Care*, which was incrementally built as new scientific evidence and policy reports became available between 2020 and 2023 (Comas-Herrera and others, 2023).

By contrasting the experiences of a large number of countries with the key issues and structural and systemic factors identified as relevant to the English social care sector's experience during the pandemic (Curry and others, 2023), we identified the four countries where we would conduct in-depth case studies. The case studies were carried out in the following four steps in each country:

- desk review and country report
- identification of the key lines of enquiry
- semi-structured interviews with key stakeholders
- case study draft.

## Desk review and country report

Team members initiated a draft 'country report for Japan' using a common outline for all countries (as per the LTCcovid *International Living Report*), and key reports and papers on the Japanese long-term care system and

the experience of the Covid-19 pandemic. The consultant, Dr Margarita Estévez-Abe (who had authored key reports and papers on the experience of the long-term care system in Japan during the Covid-19 pandemic), reviewed and expanded the draft. The team reviewed the draft, noted questions for clarification and any further information needed and started to identify 'key lines of enquiry' to be further explored through interviews.

## Key lines of enquiry for Japan

Following the desk review and Japanese 'living' report, key lines of enquiry were developed for Japan in consultation with the Japanese expert. These lines of enquiry were selected on the basis of interesting developments in the case study and their potential lessons for England.

The key lines of enquiry for the Japanese case study were as follows:

1 Preparedness: was Japan's care system sufficiently prepared for a pandemic? How was learning from previous shocks embedded? Are there plans to further strengthen preparedness for the future?

2 Accountability: how clear were lines of accountability within the LTC system at the time covid-19 struck? Did these structure help or hinder the response? Did additional infrastructure have to be established to aid the response?

3 Communication: were there established channels of communication between different levels of government, care providers and people drawing on care services? How effective were these channels during covid-19?

4 Workforce: were there pre-existing characteristics of the workforce that helped or hindered the pandemic response? Were any changes made to the workforce to help manage Covid-19?

5 Funding: was extra funding provided to the sector to help it weather covid-19? If so, how were funds directed to providers? Was there pre-existing infrastructure that helped ensure funding reached providers?

6 Care home infrastructure: how prepared were residential care facilities to manage infection spread? Were there any features of care homes that helped or hindered them in limiting infection spread?

## Semi-structured interviews

The consultant conducted seven interviews during the first and second week of July 2022.

The interviewees and their roles were as follows:

- one official based in the Ministry of Health, Labour and Welfare (Health and Welfare Bureau for the Elderly) (I1)
- two Yokohama City officials in the Department of Health and Welfare Bureau (one in the Eldercare Facility Section and one in the Health and Safety Section) (I2)
- three Shizuoka Prefecture government officials – two based in the Department of Health and Welfare, Contagious Diseases Counter-Measures Bureau, New Coronavirus Counter-Measures Planning Section and one from the Welfare and Longevity Bureau, Welfare Guidance Section (I3)
- one manager at a long-term care provider in Chiba Prefecture. (I4)

## Case study drafting process

The project team compiled the summary of interview findings in English and organised them into lines of enquiry relevant to the Japanese context. Feedback and input from the Japanese expert were solicited to clarify interpretations of the findings and to obtain additional information where necessary. As part of the process, the Japanese expert took part in a webinar discussing the Japanese experiences of responding to Covid-19 in the long-term care system and potential lessons learnt (see CPEC and Nuffield Trust, 2023).

## Limitations of the case study

- Public officials seemed to be "not very forthcoming on measures that had not gone well" (feedback from our Japanese experts).
- It was difficult to analyse a high-level summary of the interviews, which also had to be translated.
- It was not always clear how effective a measure was, and in what ways, as data was not readily available.
- There were differences in defining phases of the pandemic across countries (e.g. defining different 'waves' of infection).

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