7 From Pneumonia to Pragmatism

The Role of the WHO in Japan During Public Health Emergencies

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Abstract

Over the past three decades, Japan has faced multiple public health crises. This chapter examines the role of the World Health Organization (WHO) in the formulation of Japan's responses to the SARS, MERS, and COVID-19 public health crises. During these crises, the WHO was used as a neutral and scientific source of information and thus managed to influence Japan's responses. However, trust in the organization has faltered due to its connection with China. Japanese policymakers have questioned the neutrality of the organization. This chapter shows that the importance of the WHO in Japanese policymaking has declined and will continue to do so as long as the organization's neutrality is doubted, and as long as its advice and guidelines conflict with Japan's domestic agenda.

Keywords: Japan, World Health Organization (WHO), public health crises, domestic policymaking, national agenda, COVID-19

Introduction

This chapter examines the role of the World Health Organization (WHO) in the formulation of Japan's responses to the SARS, MERS, and COVID-19 public health crises. During these crises, the WHO was used as a neutral and scientific source of information, and thus managed to influence Japan's responses. However, trust in the organization has faltered due to its connection with China. Japanese policy makers have questioned the neutrality of the organization. This chapter argues that Japan has pragmatically balanced

declining trust in the organization with domestic policy aims, with these aims often taking precedence. It shows that the importance of the WHO in Japanese policymaking has declined and will continue to do so as long as the organization's neutrality is doubted, and as long as their advice and guidelines conflict with Japan's domestic agenda.

Although the scale of the SARS, MERS, and COVID-19 crises cannot be compared, the ways in which Japan has organized its national response to these three crises have followed similar patterns. During public health crises the Japanese cabinet establishes an *ad hoc* task force to formulate containment policies. Those policies directly related to health are implemented by the Ministry of Health, Labour, and Welfare (MHLW), while policies related to international traffic of people and goods are implemented by the Ministry of Foreign Affairs (MOFA) and the Ministry of Justice. The main scientific research centre in Japan dealing with emerging infectious diseases is the National Institute of Infectious Diseases (NIID). The NIID is tasked with cooperating with other national institutes and international organizations, and it reports back directly to the MHLW (NIID 2018). Informed officials at the MHLW are consequently involved in policy making through cooperation with the cabinet and parliamentary questioning in the Japanese National Diet.

The analysis in this chapter relies on official parliamentary records published during the three public health crises. I have included Diet meetings and MHLW public documents from 1 November 2002 to 31 July 2003 (SARS), 1 April 2014 to 31 December 2015 (MERS), and 1 December 2019 to 31 May 2020 (COVID-19) in the data set. I have collected records of the National Diet meetings from the National Diet database (National Diet Library n.d.).

Japan and the World Health Organization

The 2003 SARS outbreak

SARS was first identified in November 2002 in southern China, evolving into a global outbreak between February and July 2003 (WHO 2003, 81). Twenty-six countries were eventually affected and by 31 December 2003 there were 8096 infections and 774 fatalities (WHO 2015). The outbreak lasted several months and according to the WHO was eventually subdued as a 'result of monumental efforts on the part of governments and health care staff, supported by a well-informed and cooperative public' (WHO 2003a, 218).

The WHO issued a global alert concerning ‘cases of atypical pneumonia’ on 12 March (WHO 2003b), with these later being identified as SARS. After this alert, regional quarantine stations in Japan started sending out information to medical institutions and the national Japan Medical Association about the possibility of a new infectious disease entering Japan.¹ In the following months, travellers were warned of the risk of infection before departure, while incoming passengers from mainland China, Hong Kong, Taiwan, and Canada were required to report their health status and have their body temperature measured. Visitors from these countries and regions were also asked to self-quarantine for ten days after arrival (MHLW 2001, National Diet 2003b).

In response to the alert, the MHLW started formalizing patient reporting and collecting information concerning the infrastructural capacities of medical institutions (i.e. private rooms, negative pressure rooms; National Diet 2003c, National Diet 2003i).² Over the course of the SARS outbreak both the incumbent administration, under the leadership of then-Prime Minister Koizumi Junichirō (former Minister of the MHLW 1996-1998), and the MHLW, consistently deferred to the standards and guidelines of the WHO in their response (National Diet 2003f).³

In late March 2003, the MHLW’s leading expert, Takahara Ryōji (1947-2013), was called for questioning in the House of Representatives of the National Diet, Japan’s main legislative body. He confirmed that the MHLW had implemented a standardized patient reporting system that followed the WHO’s guidelines. He also frequently stated that Japanese laboratories, including the NIID, had engaged in cooperation with the WHO and research institutions abroad (National Diet 2003i, National Diet 2003j). Takahara used the information that he had obtained from this cooperation with these institutions to inform the cabinet and members of parliament about the nature of the SARS virus. He clarified, for example, that human coronaviruses are the cause of SARS, and he repeatedly emphasized the

1 Quarantine stations are tasked with regulating incoming goods and passengers that pose a risk to public health. For an overview of Japan’s quarantine stations, see: https://www.mhlw.go.jp/english/policy/health-medical/health/dl/contact_list_jqs.pdf.

2 In March 2003 there were 22 negative pressure rooms nationwide equipped to deal with SARS patients.

3 The MHLW officially stated that the WHO, together with UNAIDS, formed the two main pillars of Japan’s international cooperation efforts in battling infectious diseases. See: MHLW, White Paper Heisei 15, page 346. In parliament, Minister of State Ōgi Chikage also stated that ‘we will do our utmost to implement the domestic and international manuals designated by the WHO [...] so that we can continue to have no cases in Japan.’

importance of the WHO's criteria in reporting new infections (National Diet 2003c, National Diet 2003).

Despite the testimony given by Takahara, members of the National Diet remained critical. They argued that the decentralization that had been carried out in previous years, especially under the Koizumi administration, had led to a *laissez-faire* approach to governance that extended to public health policy. They said this meant that during the SARS crisis local health institutions, such as quarantine stations, had to contact the MHLW on their own initiative when they faced possible cases of SARS (National Diet 2003a). In fact, local governments were tasked with creating their own responses when they encountered outbreaks of infection (National Diet 2003b). The responses from these local governments were therefore formulated on a case-by-case basis (National Diet 2003a). There were no clear national guidelines for the back-and-forth chain of command that was required when these responses were being formulated, further increasing the amount of time it took these local governments to respond to outbreaks of infection.

It was seen how officials relied on the WHO for information. This led to calls to set up a permanent, centralized, national task force that could allow Japan to deal with pandemics itself, instead of principally relying on the WHO (National Diet 2003b, National Diet 2003d). However, despite these calls, the MHLW instead set up an *ad hoc* task force (National Diet 2003b). As part of this task force, an emergency system remained in place during the SARS crisis (MHLW 2001). This emergency task force was dissolved once the immediate threat from SARS came to an end.

During the SARS crisis it became clear that Japan was not equipped to deal with a major outbreak (National Diet 2003a). Tokyo, for example, only had ten locations that were equipped to deal with SARS patients, despite it being the most populous metropolitan area in the world. The MHLW focused primarily on information distribution, rather than implementing concrete changes to Japan's medical infrastructure (MHLW 2001). There was no system in place to regulate the quarantining of incoming passengers, which essentially made this a voluntary procedure (National Diet 2003b). Consequently, opposition politicians continued to be critical of the lack of a streamlined national response and clear guidelines (National Diet 2003a).

The SARS crisis also incited fears about contaminated food crossing into Japan (National Diet 2003a, National Diet 2003g, National Diet 2003e). This was because of the way SARS came shortly after the world had encountered outbreaks of bovine spongiform encephalopathy, which is better known as mad cow disease. During the SARS crisis, Takahara was called in to parliament a second time. As with his earlier position, he deferred to the

WHO and argued there was ‘no epidemiological evidence that contact with objects or animals [had] led to human infection with SARS’ (National Diet 2003g). Despite the way that sceptical opposition politicians called for stricter import regimes to avoid the entry of contaminated food, the cabinet supported Takahara’s position. It used the conclusions reached by the WHO which Takahara had cited to justify its decision to keep import restrictions out of its response (National Diet 2003g, National Diet 2003h). Because the initial outbreak of SARS was located in China, which was and remains Japan’s largest trade partner, an import blockade would have had disastrous consequences for the economy.

In fact, Japan made a gesture of goodwill during the SARS crisis by providing support to China. It sent out health experts and around eighteen million yen worth of medical supplies and instruments. This was despite a significant cooling of the bilateral relationship being seen at this time, which was the result of Koizumi’s growing assertiveness, and some would argue hostility, towards China (Lam 2005). For a short period between April and May 2003, the SARS crisis dominated the bilateral relationship between the two countries (Przystup 2017). However, political distrust of China persisted. This was compounded by the way that Taiwan was excluded from the WHO as a result of China’s interference, something which led to questions in Japan about the effectiveness of the WHO (National Diet 2003a). Distrust of China extended beyond the opposition in the Diet. For example, the Deputy Minister of the MHLW, Kimura Yoshio, suggested that the officially reported number of people infected in China did ‘not reflect reality’ (National Diet 2003g). However, restrictions on trade with China were blocked by the ruling cabinet. Bilateral lines of communication were eventually opened with the affected nations and regions, including Taiwan, to circumvent the WHO’s limitations (National Diet 2003i). This indicated how Japan’s response was pragmatic when its domestic needs superseded the limits of the WHO’s collaborative framework.

The 2014–2015 MERS threat

MERS was discovered in 2012 (WHO 2019). There have been several different outbreaks of the virus affecting twenty-seven countries and leading to 2442 infections and 842 fatalities between 2012 and May of 2019 (Donnelly et al. 2019). The MERS outbreak among medical personnel in Saudi Arabia in 2014, although not leading to the WHO declaring an international public health emergency, did lead the WHO to make several emergency preparedness announcements directed at all member states (WHO 2014, WHO 2014a, WHO

2014b). In response, in Japan the MHLW started sending out information to medical institutions in a similar way to that which it had done during the SARS crisis. Reporting of possible cases was formalized and a regional approach to decision-making was adopted (MHLW 2014). In short, in Japan the MERS response was a continuation, if not a duplication, of the SARS response.

In July 2014, the incumbent cabinet, under Prime Minister Abe Shinzō, officially designated MERS as an infectious disease under the Act on Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases, which had been published in 1998 (MHLW 2014a). This designation of MERS meant that anyone entering Japan from an affected country who had a heightened body temperature, or who had been in contact with a confirmed MERS patient, had to report to the local quarantine station upon landing. Passengers who had visited any of the affected countries were also required to self-declare at the quarantine station upon arrival in Japan (MHLW 2017, National Diet 2015b). Those under suspicion of infection were required to take a PCR test (MHLW 2014b). The information concerning MERS symptoms, signalling, and which countries were affected, was taken from WHO reports (MHLW 2014c).

Throughout 2014, the MHLW mainly followed WHO guidelines in its response to MERS, following the International Health Regulations (IHR, for details see the introduction of this volume) that had been established in 2005 (National Diet 2015b). In a way similar to the response to the 2003 SARS crisis, the cabinet and the MHLW continued to focus on information distribution (National Diet 2014a).

Policy makers became increasingly alarmed following a major outbreak of MERS which occurred in South Korea in June 2015 (Park and Munroe 2015). This outbreak, which was labelled as a ‘superspreading event’, saw a single MERS patient infecting dozens of other people in the space of a few weeks (Kupferschmidt 2015, 1183). The WHO reviewed the incident and blamed it on a number of factors including South Korea’s lack of medical expertise, its inadequate infection control measures, its admission of too many foreign visitors, as well as the practice of so-called ‘doctor shopping’ where patients visit various medical facilities in search of the right physician (WHO 2015a, National Diet 2015b). As a result of this, in the same month as the outbreak occurred in South Korea, the WHO released a risk assessment regarding MERS. This concluded that the outbreaks of MERS did not qualify as an international public health emergency (National Diet 2015b, WHO 2015b).

This announcement by the WHO was picked up in the Japanese National Diet. Its view that South Korea failed in its response to MERS was taken over *ad*

verbatim by both the incumbent administration and the opposition (National Diet 2015b). However, due to South Korea's geographic proximity and its popularity as a tourist destination, worries remained about the virus 'slipping through the cracks' and crossing into Japan (National Diet 2015c). As a result, the Ministry of Foreign Affairs established contact with the health authorities in South Korea in order to gain insight into the movement of people suspected of infection. However, information about non-Japanese patients could not be collected through these means (National Diet 2015c) and could also not be obtained through the WHO. A general consensus formed in Japan that the information provided by the WHO was insufficient, particularly because this information did not track the movement of specific cases across borders and so made it difficult to prevent possible outbreaks (National Diet 2014).

Under these circumstances, the head of the MHLW's Health Bureau, Shinmura Kazuya, was called into parliament to clarify Japan's response to MERS. Restating the need for a regional approach, Shinmura attempted to solidify the existing status quo amid rising fears of a possible outbreak (National Diet 2014). Critical members of the opposition argued that the current approach would be insufficient in quelling a major outbreak, pointing to Japan's lack of medical infrastructure and local experts (National Diet 2015b). For example, Okamoto Mitsunori, the former Deputy Minister of the MHLW, called the response a 'just-in-time' game (National Diet 2015c).

Members of the opposition questioned the cabinet and the MHLW about Japan's capacity to treat patients and its transportation capabilities. Referring to an October 2014 survey, the Deputy Minister Nagaoka Keiko stated that 87, out of 141 municipalities in Japan, had a total of 206 vehicles for transporting patients. For the other 54 municipalities, local networks had been established with fire departments and local governments to provide emergency transportation (National Diet 2015). Whether this number was sufficient to deal with a national outbreak was not discussed.

The head of the MHLW's Health Bureau, Shinmura, also said that there were 300 medical institutions with 1500 beds available for infected patients, and said that he believed this to be adequate (National Diet 2015b). However, he was forced to acknowledge the shortage of infectious disease experts in Japan, which had been a chronic issue for years. The National Center for Global Health and Medical Research had previously tried to educate more local experts, to no avail (National Diet 2014a). Consequently, the incumbent Minister of the MHLW, Shiozaki Yasuhisa, was also forced to acknowledge the shortage. He confirmed that in June 2015 only 1232 doctors were certified by the Infectious Diseases Society of Japan as specialists, a number well below national standards (National Diet 2015).

There had been attempts to increase the number of experts in Japan by sending more people abroad through the WHO framework to gain experience in infectious diseases (National Diet 2014a, National Diet 2014). The concurrent outbreak of Ebola in Africa had been an opportunity to do so. However, instead of focusing on domestic policy goals and the MERS response, the cabinet viewed the Ebola outbreak as an opportunity to position itself as a regional leader. As a result, Japan mostly postured and sent few experts abroad, despite the fact that it was trying to 'train a large number of experts in infectious diseases' (National Diet 2015b). In the end, neither Japan's domestic shortcomings nor the limitations of the WHO's global information network were properly addressed during the MERS outbreaks seen in 2014.

The 2020 COVID-19 pandemic

The first case of COVID-19 in Japan was discovered on 14 January 2020 (MHLW 2020). Since then, the government has taken different steps to contain its spread, including information campaigns, public emergencies, and travel restrictions. The first concrete measure was taken on 21 January, when the Japanese government enacted travel restrictions for the Wuhan region of China where COVID-19 was first seen. At the time of writing, the pandemic has not been contained in Japan, so new measures continue to be taken. The Japanese government's decisions have been influenced considerably by international guidelines set by the WHO. However, Japan's approach has not been consistent. Domestic priorities have led policymakers to adopt a pragmatic approach in which the WHO's guidelines are used to legitimize various new policies, even when these policies are contradictory.

The then-Prime Minister Abe Shinzō was first questioned about Japan's COVID-19 response during discussions in the House of Representatives on 23 January 2020. During this questioning, Abe made reference to the emergency risk assessment meetings held by the WHO in order to argue for strengthened quarantine measures and for the need to prepare the national healthcare system (National Diet 2020l). However, few measures were taken in the early stages of the pandemic. Even though a combination of factors resulted in this slow response to COVID-19, criticism was aimed at Abe for prioritizing the Tokyo 2020 Olympic and Paralympic Games over addressing the newly emerging infectious disease (Kingston 2020).

The Tokyo 2020 Games were eventually postponed in late March. Whether the Games had a direct effect on Japan's lagged response remains debatable. Nevertheless, the fact remains that the cabinet was slow to implement concrete steps to address COVID-19. For example, in early 2020 Katō

Katsunobu, then Minister of the MHLW stated only that the cabinet would 'continue to monitor the situation in Japan on a daily basis'. He consistently referenced the decision by the WHO to refrain from designating the disease an emergency and the government's compliance with WHO guidelines (National Diet 2020d). The initial assessment of COVID-19 by the WHO, and its decision to refrain from designating the disease as a public health emergency of international concern (PHEIC), legitimized the incumbent cabinet's restrained response during the first weeks of the pandemic (WHO 2020, National Diet 2020r).

From 20 January 2020, the MHLW started publicly reporting on COVID-19 via their website. However, these reports contained updates on the development of the disease rather than practical policies (MHLW 2020a). As well as their criticism about the lack of an immediate response, throughout January and February, members of the Diet also criticised this limited flow of information to the public. Diet members questioned the government's ability to counter unreliable information about COVID-19, or what was labelled an 'infodemic' in reference to the WHO's public warning against the spread of inaccurate information without a scientific basis (National Diet 2020n, WHO 2020a).

Surprisingly, some of this early criticism came from within the ruling party. One member of the Liberal Democratic Party (LDP) openly questioned why no permanent administrative body had been set up. They asked why it was necessary for a new task force to be formed during each public health crisis. Pressed on the matter, the Minister of the MHLW at the time, Katō, acknowledged the deficiencies of the (regional) approach that the MHLW had taken during earlier public health threats. He stated that the government was setting up a new collaborative framework with the NIID and relevant agencies and ministries to formulate a national response (National Diet 2020d). However, on 31 January, in response to the WHO's official designation of COVID-19 as a public health emergency of international concern (or PHEIC; WHO 2020b), another emergency task force was established to address the developing pandemic (National Diet 2020f). Although set up under the auspices of the National Security Council, a cabinet-led body charged with national security issues, the task force dealing with the pandemic was established separately, in stopgap fashion. The establishment of this task force therefore continued the practice of creating *ad hoc* emergency task forces to deal with public health emergencies (National Security Council 2020).

The announcement by the WHO that COVID-19 was a public health emergency of international concern (PHEIC) hastened Japan's designation of

the virus as an infectious disease (National Diet 2020f, National Diet 2020u). This enabled the Japanese government to enact the Infectious Disease Law in order to implement pandemic policies. Nevertheless, the expert meeting that would serve as the scientific basis for the national approach was held on 14 February. According to the former opposition leader Saitō Renhō, who was head of the Constitutional Democratic Party, this was a month and a half too late (National Diet 2020g). In fact, no concrete and coordinated national policy was formulated. The central government effectively delegated responsibility for the containment of infections to prefectural and municipal governments, without providing a national framework for local governments to fall back on, something which left national coordination in a fractured state (Van der Veere 2020). This lack of central governance coincided with decreasing public trust in the WHO, further debilitating an already fragile COVID-19 response.

Only a few days after the WHO announced that COVID-19 was a PHEIC, Watanabe Shū (Constitutional Democratic Party of Japan) publicly expressed doubts about the neutrality of the WHO. Referencing an article from the French newspaper *Le Monde*, he asked Katō what his opinion was on the possibility that the WHO had refrained from designating COVID-19 in this way because of pressure from China. He went as far as to suggest that the WHO Director-General Tedros Adhanom Ghebreyesus was under strong Chinese influence because of the fact that his home country of Ethiopia had hosted a Chinese-built African Union building and had long been the recipient of major Chinese investments. Katō, in turn, refused to engage with the subject, falling back on the need for international cooperation (National Diet 2020s, National Diet 2020h).

Generally, officials from the various ministries, in particular the MHLW and MOFA, as well as cabinet members, refrained from answering critical questions concerning the WHO. The WHO's guidelines consistently served as justification for many of the policies implemented in later months. The MHLW obtained its information primarily from WHO reports, particularly data concerning the spread of COVID-19 in China (National Diet 2020n, National Diet 2020w).

The estimate made by the WHO about COVID-19's incubation period also led Japan to adopt a fourteen-day quarantine rule (National Diet 2020t). This quarantine measure was then adopted for passengers of the Diamond Princess Cruise ship (National Diet 2020o). Passengers were locked on the ship for weeks while government workers attempted to track and trace the spread of the virus among them only to catch it themselves due to a lack of proper protective measures and without proper government support.

When Katō was asked by Saitō why passengers were eventually allowed to disembark despite the potential health risk, he cited passenger complaints and a ‘certain amount of evidence and professional judgement’, rather than relying on factual evidence (National Diet 2020g).

The Japanese government was heavily criticized by several countries, the media, and the WHO, for its mishandling of the case (National Diet 2020o, National Diet 2020v, Rich and Yamamitsu 2020). Nevertheless, Katō repeatedly stated that the WHO’s guidelines were being followed and that the occurrence of four new infections among MHLW staff was simply ‘unfortunate’ (National Diet 2020p). The case of the Diamond Princess exemplifies the way in which the WHO’s advice and guidelines served as justification for specific measures, even when this required a flexible interpretation of these guidelines.

The cabinet and Ministry of Foreign Affairs (MOFA) set up stringent travel bans, ignoring the WHO Director General’s public warning that widespread travel bans were not necessary (Nebehay 2020). The director of the Immigration Department and Immigration Control Office attempted to justify the travel bans by arguing they were a direct result of the way the WHO had designated COVID-19 a PHEIC (National Diet 2020m), even while the WHO publicly criticized this policy (Nikkei 2020).

The issue of nationwide closure of schools also illustrates the pragmatic approach that Japan has taken to following the WHO guidelines. While cabinet members claimed that the WHO advocated a ‘multi-sectoral approach’ that justified closing schools, members of the opposition pointed to a lack of evidence that schools formed clusters for infections and argued that transmission from children to adults had yet to be confirmed (National Diet 2020g). LDP representative Koga Yūichirō later used the same ‘evidence’ to challenge claims that children were less of an infection risk, pointing to the way in which the coronavirus spread mainly among households (National Diet 2020). In fact, the WHO had recommended school closures, whilst also stating that this was a ‘political choice’. Although members of the opposition in the Diet pointed this out, Abe was consistent in deferring to the recommendation as a legitimate reason for closing schools (National Diet 2020b).

However, this pragmatic approach to following WHO guidelines had to be balanced with a growing distrust of the WHO in Japan. In early March 2020, the WHO announced that South Korea, Italy, Iran, and Japan were considered its ‘greatest coronavirus concerns’. This announcement touched a nerve among Japanese politicians, especially as China was left out of the list (Nebehay 2020a). There were immediate calls for the WHO

Director-General Tedros to resign as he was seen as 'unfit' for his position. One ruling party member openly questioned why Japan was contributing so much to the WHO and buying so little influence, while in contrast China was 'able to exert a huge amount of influence with a small amount of money' (National Diet 2020j).

Although the cabinet and officials attempted to refrain from directly criticizing the WHO, this was not always successful. One high official let slip that he believed that Tedros had shown China too much consideration (National Diet 2020v), while Deputy Prime Minister and Minister of Finance Asō Tarō went a step further by calling the WHO a 'suspicious organization', saying there were calls to rename it the 'Chinese Health Organization' (National Diet 2020i). Unsurprisingly, there was little resistance in the National Diet to subjecting the WHO to an independent review, a resolution pushed by Japan during the 73rd World Health Assembly in May 2020. The only issue that split the ruling party from the opposition was the timing of the review: during or after the pandemic (National Diet 2020c).

The issue of Taiwan's participation in the WHO gradually became a symbol of these concerns. In 2016, following the election of the anti-Beijing Tsai administration in Taiwan, China successfully pressured the WHO into barring Taiwan's participation in the World Health Assembly, the organization's annual meeting. This remained the situation at the start of the COVID-19 pandemic (Kassam 2020). Although 29 countries petitioned for Taiwan's participation as an observer during the assembly in May 2020, it was still unable to join. Japan took the public position that 'there should be no geographical gaps in global health' and continued lobbying, although with little effect (National Diet 2020c). In the Japanese National Diet this was interpreted as a lack of Japanese influence and also seen as an indication of a strong Chinese presence in the WHO (National Diet 2020e, National Diet 2020k).

The Japanese government is therefore actively lobbying for high positions within the WHO to increase its influence (National Diet 2020i, National Diet 2020q). This is not to say that Japan has little sway over the WHO. The Abe administration already enjoyed a strong relationship with the WHO before the pandemic. Abe published an opinion piece in the *Washington Post* co-authored with Tedros arguing that 'all nations should have universal health care' (Abe and Ghebreyesus 2019). In early February 2020, Abe also boasted about the fact that Japan had already dispatched health experts via the WHO to countries with fragile medical systems (National Diet 2020t). Moreover, the WHO immediately granted an MHLW request that cases related to the Diamond Princess cruise ship were listed separately from Japanese domestic cases in WHO global communications (National

Diet 2020v). Despite the WHO's initial criticism of Japan's approach to the pandemic, when Japan complained about its inclusion in the 'greatest coronavirus concerns' list, these complaints gained a prompt exhortatory response from the WHO, Tedros, and the UN Secretary-General António Guterres (National Diet 2020a).

Nevertheless, the distrust of the WHO persisted. As Kokuba Kōnosuke, the incumbent Chief Secretary of the LDP, remarked, 'Japan should not only rely on the WHO,' but should strengthen its own capabilities in countering emerging infectious diseases (National Diet 2020v). The ruling cabinet was forced to balance its reliance on the WHO and an increasing distrust of the organization. It did this by exerting pressure wherever the WHO's information directly contradicted domestic policies. The cabinet largely refrained from criticizing the WHO and its information, while also agreeing with the general talking points produced by the opposition (questioning the WHO's neutrality and mentioning Chinese influence, Taiwan, and the independent review). In this way, the cabinet was able to rely on the WHO to justify domestic policies while also not directly contradicting the increasing distrust expressed in the National Diet.

Conclusion

Japan has been confronted with several public health emergencies over the course of the 21st century. One consistent factor during each outbreak was the role of the WHO as a mechanism for providing information and guidelines. However, the distrust of China seen during the SARS crisis became a distrust of the WHO's neutrality during the COVID-19 pandemic. It was already clear during the 2014-2015 MERS outbreak that there were domestic shortcomings in Japan's ability to handle such infectious diseases, including a chronic deficit of local experts on infectious diseases, and also that there was a limit to the information the WHO could provide. However, unrelated domestic priorities often took precedence over responding to the public health threats, leaving these issues unaddressed. Japan's eventual decision to bypass the WHO's information network during the MERS outbreak, by directly establishing contact with Taiwan and other affected countries and regions, further weakened the WHO's standing in public health policy making.

This prioritization of the domestic agenda became apparent once again during the COVID-19 pandemic. The WHO's guidelines and information were not followed strictly, but used pragmatically, and only when they coincided with domestic policy goals. The continued reliance on *ad hoc*

task forces in all three public health emergencies covered in this chapter, despite calls for a permanent one, is a clear example of this prioritization. Moreover, the distrust of China, and by extension the WHO, worsened over the course of the COVID-19 pandemic. This worsening distrust is evidenced by the pragmatism with which Japan followed WHO guidelines. It is also symbolized by Japan's support of Taiwan's participation in the World Health Assembly and calls for an independent review of the WHO's functioning. In conclusion, the WHO's importance in Japan's policy making has declined since the SARS crisis in 2003. It will continue to decline unless the WHO's guidelines and advice coincide with Japan's domestic agenda, and unless policy makers are assured of its neutrality.

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