# Rehabilitation in Japan: An Overview

By: Jane E. Myers and Ryosuke Matsui

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## Abstract:
An overview of rehabilitation services for disabled persons in Japan is provided, based on the observations of an American World Rehabilitation Fund fellow. A description of Japan's unique culture, demography, and history provides a framework for understanding its rehabilitation programs. Both community and institutional services are discussed, along with issues and trends for rehabilitation in Japan.

## Article:
To most westerners, Japan is a mysterious and somewhat romantic land, as far away from the United States as it is different. The senior author of this article, under the auspices of a fellowship from the World Rehabilitation Fund, visited Japan for seven weeks in the summer of 1983 to study its services and programs for disabled persons. The visit was hosted by the co-author, along with Professor Yoko Kojima of Japan Women's University.

Japan is a unique and complex nation, and a visitor to Japan must recognize and respect the complexities of Japanese society and culture. It is virtually impossible to understand their treatment of disabled persons without first developing an appreciation of Japan's unique culture, demography, and history. An important precursor to this discussion is, therefore, a definition of rehabilitation terms as used in Japan.

## Definitions
Much of the confusion that results for an American trying to understand rehabilitation in Japan is due to the differing meaning of commonly used terms. This confusion is only partly due to the old adage that "much is lost in the translation." Interestingly, the Japanese language does not include a word for "rehabilitation," so the English word is used. The lack of such a word in the Japanese language reflects the relatively new historical development of the field, and permits many Japanese to state that their country lacks a unified profession of rehabilitation.

In Japan, the word "rehabilitation" brings to mind an instant image of medical services, while rehabilitation in the U.S. is defined somewhat comprehensively as "the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable" (National Council on Rehabilitation, 1943, in Bitter, 1979, p.3). While a full range of rehabilitation services are available in Japan, general discussions of rehabilitation presuppose a medical services focus.

In the U.S., "welfare" has a somewhat negative connotation and evokes images of public assistance, poverty, charity, and dependency. In Japan, "welfare" has a much more broad, positive and literal meaning; it refers to promoting the well-being or welfare of Japanese citizens. Welfare incorporates medical care, social security, social welfare services, and allied human services (Kojima, 1983). Most of what Americans call rehabilitation services are provided by Japan's social welfare agencies. Social welfare caseworkers, trained in social work, perform the functions of U.S. rehabilitation counselors.

The terms disability, impairment, and handicap are differentiated in English usage, and these terms have distinct meanings in both the United States and the United Nations. Although the Japanese accept these distinctions, in

their language all three terms are represented by one word, shogai. Obviously, translations of shags' from Japanese to English can be variable and confusing if the exact meaning is not clarified. Moreover, when discussing disabled people in Japan, it is important to be clear as to which disabled people are meant. Different laws have been promulgated and some different services exist for those who are physically handicapped and those who are mentally retarded. But since a law for the welfare of mentally ill persons does not exist, limited services are available to them.

Disabled persons are evaluated, registered, and given a handbook that identifies them as having one of six levels of impairment, with level one being the most severe. The six levels are linked directly to the type and extent of services that disabled persons may receive. For example, persons having a disability classified as level one may receive all necessary medical services, including hospitalization, surgery, and follow-up, prosthetics, transportation assistance, housing modifications, and purchase of equipment such as typewriters and adapted appliances to enable them to live more independently. Persons having a disability classified as level six may be eligible only for limited medical care or medications.

## Demography and Culture

Isolated by oceans, Japan's four major and almost 4,000 minor islands comprise a total area about the size of Montana. Approximately one-fifth of the land area is usable for the 119 million inhabitants. Japan ranks seventh in the world in total population, and fourth in population density. Its life expectancies of 78.9 years for women and 73.5 for men are the highest in the world. Japan's population is also aging more rapidly than that of any other country.

Among free world economies, the standard of living in Japan is second only to the U.S. A per capita income of $8,870 (compared to $11,535 in the U.S.) reflects the fact that almost all Japanese are middle class. Overall, the unemployment rate is less than 2%, aided by a customary lifetime employment policy among major employers (Japan Institute of Labor, 1982). Property values are high, especially along the coast from Tokyo to Hiroshima, where three-fourths of the population resides.

Japan has a rigorous and effective educational system. Students attend school six days a week, eleven months per year. The literacy rate exceeds 99%. Children educated since World War II take English each year beginning in junior high school. By the time of high school graduation, almost all students can read and many can understand oral communication in the international language (e.g. English), though far fewer are able or willing to speak English fluently.

Due to its long history of geographic isolation, Japan remains genetically and culturally homogeneous. Cultural values such as honesty, loyalty, and efficiency are uniformly ingrained, aided by the close proximity and compact living space that are realities of Japanese life.

One of the most significant and most visible aspects of Japanese culture is its socialization and orientation to the group. General concern and respect for others is reflected in the low crime rate, the absence of graffiti, and the preservation of, as well as pride in, public properties. The extended family network, while slowly eroding as the population migrates to the cities, still reflects a variety of deep, complex cultural mores that preserve the essential nature of a mass conforming, mutually caring society. Disabled and aged persons continue to be cared for mainly within the family. According to the Ministry of Health and Welfare, only 7.4% of all disabled persons live in single person households, while 46.4% live in nuclear families and 32.6% in three generation extended families (R. Matsui, personal communication, September 5, 1983). Thus, Japan's need for nursing homes and other types of custodial care facilities is less than that of the U.S.

An estimated 3% of Japan's population is disabled, compared to 10% in the U.S. This figure may be low because some families still hide their disabled members due to fear of negative societal attitudes (Kojima, 1983). A survey conducted by the Ministry of Health and Welfare in 1980 revealed that approximately 2,000,000 persons were physically disabled. This includes 57% having various disabilities, 17% visually

disabled, 16% with auditory handicaps, and 10% having internal disorders (Izawa & Matsui, 1983). Internal disorders are increasing most rapidly (an increase of 297% between 1970 and 1980). Physical disabilities increase with age; 60.9% of all physically disabled persons are over age 50 and 41.7% are over age 60 (Japanese Society for Rehabilitation of the Disabled [JSRD], 1980). The customary retirement age of 55, which is only recently changing to age 60, leaves many older disabled individuals out of the labor force. The three leading causes of death and major contributors to disability among older workers are cancer, stroke, and heart disease, in descending order of prevalence. This prevalence is exactly opposite to the situation in the U.S., where the order of the three major diseases is heart disease, stroke, and cancer.

When physically disabled persons are classified by level, levels one and two, (i.e., the most severely handicapped persons) comprise 10.8 and 15.7% of the disabled population, respectively. The percentage in levels three to six are 12.5, 17.8, 15.3, and 12.5%; 15.4% are classified as unknown. Persons having multiple disabilities are classified as levels one and two. In addition, an estimated 356,300 persons are mentally retarded. Of these, 43,700 are institutionalized, while 312,600 reside at home, of whom 170,900 are over age 18 (Ministry of Health and Welfare, 1979). There is no registry for mentally ill persons; however, Kojima (1983) estimated that 1.4 million Japanese have mental illness.

The employment rate of the general population in Japan is 68.8% and the rate for physically disabled persons is now 54% (JSRD, 1980; Kulkarni, undated).

The quota system, initiated in 1960 and revised in 1966 and 1976, has resulted in an increase in the percent of employed physically handicapped persons from 39.3% in 1965 to 44.1% in 1970 to the current 54% (Kulkarni, undated). The number of self-employed disabled persons exceeds that found in the general population. In 1973, 45.7% of the physically disabled population compared to 31.1% of the non-disabled population was self-employed. By 1981, these figures had become 35.1% and 17.4% respectively, indicating that the number of self-employed disabled persons is now twice as much as the number of self-employed nondisabled persons. The authors were unable to locate similar statistics for mentally retarded and mentally ill persons.

Employer attitudes have been a major barrier to employment of disabled persons, with notable improvements made since 1981. Japan, as a nation, supported the 1981 International Year of Disabled Persons. A massive publicity campaign was successful in making the entire population aware of, and more favorably inclined toward, the needs of disabled people. Japan has one congressman who represents the needs of disabled individuals in the Diet (congress). He was reelected in the last national election, held in June, 1983, with strong support from both disabled and nondisabled constituencies. This action is symbolic of the recent trend of Japanese consciousness toward improving the welfare and well-being of disabled persons.

## History, Legislation and Administrative Structure

In many ways, the historical development of rehabilitation services in Japan paralleled that of the U.S. until World War II. The first related legislation, enacted in the late 1800's, provided monies for persons in emergency situations, including disabled individuals. The earliest attempts to rehabilitate disabled persons were aimed at soldiers disabled during World War I (Kojima, 1978). Rehabilitation programs in Japan became firmly established and began to grow after World War II as part of major national reconstruction efforts. The United States system was used as a model; however, it was modified to suit Japan's needs. In contrast to the U.S., where new legislation is drafted by members of Congress and their aides, new legislation in Japan is actually written by the Ministry that will be responsible for its implementation. This procedure eliminates possible confusion over the difference between the intent of a piece of legislation and its impact.

The first piece of rehabilitation legislation passed after the war was the 1949 Law for the Welfare of the Physically Handicapped. Additional laws were passed and subsequently amended, so that today rehabilitation measures are carried out under the auspices of some 18 major laws (Government of Japan, 1980). Kojima (1978) succinctly and accurately described the overall system as follows:

> Today... no single and unified rehabilitation legislation exists, but a group of specialized rehabilitation laws are independently meeting the multidimensional needs of the disabled under three major administrative channels, the Ministry of Health and Welfare, the Ministry of Education, and the Ministry of Labor by having an independent budget and vertical administrative structure (p.9).

The various programs operated by the three ministries are implemented through governmental and quasigovernmental agencies on three levels. First is the national level, second the prefectual or state level, and last the local level. Japan has 47 prefectures and 10 major cities having equal status to each prefecture.

The Ministry of Education administers a variety of programs aimed at the education of handicapped children. Compulsory education for blind and deaf children (in special schools) was implemented in 1948. Separate schools were developed for children who were mentally retarded, orthopedically impaired, and otherwise health impaired (JSRD, 1980). Children were not required to enter these schools until 1979, nor were local governments required to establish such schools until that time.

The Ministry of Health and Welfare (i.e., Koseisho) was established in 1948 and is responsible for the administration of several major laws (Kojima, 1978), including the following: the Child Welfare Law (1947), the Daily Life Security Law (1950), the Law for Aid to War Wounded and Sick Retired Soldiers and War Bereaved (1952), the Law for Welfare of Physically Handicapped Persons (1949), The Law for Welfare of Mentally Retarded Persons (1960), and the Fundamental Law for Counter Measures for Mentally and Physically Handicapped Persons (1970).

The Koseisho serves three main functions (Koseisho, 1981); namely, to render health and medical services, to provide social welfare services, and to administer social insurance programs.

The Social Welfare Bureau, one of nine in the Koseisho, was established "to improve and promote the daily life and well-being of...marginal families, aged, and physically handicapped" (Koseisho, 1981, p.26). Some of the major functions of this bureau include payment of public assistance, providing loans to low income families, providing institutional care for aged persons and home helpers for families of aged persons, arranging free medical care for older persons, and providing "medical care and rehabilitation training for the physically handicapped (blind, deaf/mute, physically handicapped...etc.) as well as providing such rehabilitation facilities and helpers who assist those handicapped" (Koseisho, 1981, p.26).

The Rehabilitation Division within the Social Welfare Bureau is responsible for providing welfare services to physically handicapped persons. These welfare services include medical treatment; provision and/or repair of prosthetic appliances; rehabilitation examination and counseling (including in-home service for severely disabled persons); promotion of sports events; encouraging the participation of community members in rehabilitation activities (i.e., training volunteers in braille typing and finger spelling); various in-home, chore, and attendant care services; providing subsidies for remodeling cars; and payment of costs associated with rehabilitation training. A variety of rehabilitation centers and facilities for physically handicapped persons are part of this bureau's service delivery system. The Koseisho also operates institutions for the care of mentally retarded children and adults, national homes for blind persons, and the National Rehabilitation Center for the Disabled. The latter center, established in 1979, is one of two national centers developed as a result of major legislation. The second is still under construction at this time.

The Ministry of Labor also operates a variety of programs for disabled individuals. The major laws related to these programs are the Workmen's Compensation Accident Compensation Law (1947), the Employment Security Law (1947), and the Physically Handicapped Persons Employment Promotion Law, passed in 1960 and significantly amended in 1976. The 1960 law established a quota for employment of handicapped persons as a moral obligation of employers. The 1976 amendment made this a legal obligation with specified quotas by type of industry (Izawa & Matsui, 1983).

The Ministry of Labor is directly responsible for some 473 local Public Employment Security Offices. In addition, the Ministry sponsors two quasigovernment agencies that have direct relevance to the needs of handicapped persons. First is the Employment Promotion Projects Corporation (EPPC) which oversees the quota system, collects levy monies amounting to some 18 billion yen annually ($75,000,000), and administers grants from these levy monies to employers who hire above the quota. Other programs of this corporation include the following: establishment and operation of basic and advanced vocational training centers, institutes, and colleges; providing loans for the modification of homes and worksites for disabled people; providing financial assistance for training, daily living, and transportation; assisting in coordinating retraining and new job placements to prevent unemployment among disabled workers; and establishing and operating vocational evaluation and counseling centers for disabled persons (EPPC, undated).

The National Association for Employment of the Handicapped, a second quasigovernment agency operated under the auspices of the Ministry of Labor, conducts a variety of activities to promote employment opportunities for handicapped persons. These activities include offering training programs for employers and other individuals to help them better understand the needs of disabled persons, conducting research and demonstration programs for the vocational development of disabled persons, sponsoring annual national as well as international skill contests for disabled persons (Ambilympics), conducting an ongoing mass education campaign for employment of disabled persons, organizing overseas study tours and international exchange programs concerning the employment of disabled persons, and administering the National Vocational Rehabilitation Center (National Association for Employment of the Handicapped, 1982).

### The Rehabilitation Process, Japanese Style

Each of the three ministries described above provides important services to facilitate the rehabilitation of disabled persons. In the United States, the state-federal system is designed so that one vocational rehabilitation counselor is responsible for facilitating and monitoring the progress of disabled individuals toward vocational and personal independence. In Japan, such a system does not exist. Rather, the progress of a client through the standard rehabilitation process -- e.g., referral, evaluation, planning, medical services, counseling, training, job placement, successful case closure -- becomes the responsibility of many agencies. Realistically, interagency coordination is not always optimum. The involvement of each agency may be clarified by relating them to the rehabilitation process as defined in the U.S.

New referrals come through the hospitals or (and eventually, anyway) local offices of the Ministry of Health and Welfare. The latter offices send disabled persons to the Consultation Centers for the Physically Handicapped, of which there is one per prefecture. These centers use a team evaluation to determine the nature and extent of the disabilities and services needed. The centers provide counseling; medical, psychological, and vocational evaluation; prescriptions for prosthetic appliances; and a mobile counseling service for homebound persons (Koseisho, 1981). Each physically disabled person then receives a handbook that indicates the nature of his or her condition and specifies which of the six levels of severity is represented. This level is linked directly to the services they may receive. All required medical and restorative services are provided through the Ministry of Health and Welfare, including payment for prosthetic appliances.

Prevocational evaluation follows medical restoration (when needed) and may last up to one year. Intensive evaluation in a residential facility is the usual procedure. When the disabled individual is ready for vocational training and/or placement, he or she may be referred to any number of facilities, some of which are operated through the Ministry of Health and Welfare and others through the Ministry of Labor. In either case, both training and sheltered employment may be provided. If the individual is able to live and work in the community, the Public Employment Security Offices and Vocational Evaluation and Counseling Centers (both Ministry of Labor) will provide assistance with job placement.

Those adults who have mental retardation are sent either to rehabilitation centers for mentally retarded persons, of which there are 373, or to workshops for mentally retarded persons which number 137 (Ministry of Health and Welfare, 1979). Services for mentally ill persons are less readily available, and include primary hospital

care, although three rehabilitation centers for mentally ill persons have been established. Community clinics for mental health services are rare. A law for the welfare of mentally ill persons does not exist, as do laws for the welfare of physically handicapped, mentally retarded, and aged persons. Consequently, services for mentally ill persons are limited and primarily institutional in nature.

### Community vs. Institutional Services

Virtually all rehabilitation services in Japan prior to 1967 were provided in institutional settings. Those disabled persons who were not fortunate enough to be accepted in a residential facility did not have access to rehabilitation services elsewhere. Today only 3% of all disabled persons are served in institutional settings, while 97% receive care through various public and private community agencies. The greater attention devoted in this discussion to describing institutional settings should not be misinterpreted. Not only are such settings easier to observe and study, there is general consensus that the quality of care received in them is exceptional. There are many different kinds of institutions and they offer a greater variety and intensity of services than may be found in a community agency.

### Community Services

The majority of community rehabilitation services are offered through the prefectural governments, under the auspices of the Ministry of Health and Welfare. In 1979, there were 1,156 local welfare offices (each serving approximately 100,000 persons), and over 13,000 general caseworkers and 20,000 additional staff (Koseisho, 1981).

The following eight major services are provided to disabled persons through the local welfare offices: (a) day care programs for children under age six; (b) small community-based sheltered workshops and work activity centers with a capacity of 10 to 20 clients (both physically and mentally handicapped); (c) home health/ attendant care services; (d) allowances for severely handicapped persons designated as levels one and two, and also pensions for disabled persons who live in their own homes; (e) prosthetics, orthotics, and daily life appliances including beds, typewriters, tape recorders, electric toothbrushes, and so forth, as well as training in their use when needed; (f) cash grants for driver's licenses, driver's training, and remodeling of cars and homes; (g) volunteer leadership development, including training part-time and volunteer workers in braille translation and reading services, as well as training in finger spelling; and (h) sporting events and recreational activities that are both athletic and therapeutic. Medical care and subsidies for medical expenses are also provided by the welfare offices. A respite care service is available to provide temporary care and emergency protection to disabled persons, who will then return to live with their families.

Elimination of environmental barriers is a major objective of the welfare program. The Model City Welfare Plan, developed in 1973, resulted in the designation of 53 "model cities for the disabled," the goal of each being "to help develop physically and attitudinally accessible communities..." (Kojima, 1981, p.28). Improvements in the physical environment include the elimination of curbs and lowering of sidewalks, placing built-in braille tiles in sidewalks and train stations, and improving access to public buildings, elevators, restrooms, and so on. Public transportation services are being modified to include buses with lifts, and disabled persons are eligible for a 50% discount on the Japan National Railway.

A system of sport centers for disabled persons and their families is being developed, with the goal of having at least one in each prefecture and in each of the major cities. A model facility visited by the authors included an Olympic size swimming pool, bowling lanes modified for use by blind persons, an archery range, and numerous other components. Programs available include such diverse activities as swimming lessons, wheelchair basketball, therapeutic play, and socialization activities.

A voluntary peer counselor system has been developed and in 1974 included some 6,830 counselors for disabled persons (JSRD, 1980). These persons are active advocates for disabled individuals and assist them in numerous ways to meet their daily living needs. They assist in the social education of both disabled persons and their families. Numerous cultural and adult education courses are available in the communities.

Vocational services available for disabled persons living in the community include subsidized training, evaluation, counseling, and assistance with job placement. The Employment Promotion Projects Corporation has established one Vocational Evaluation and Counseling Center in each prefecture to provide evaluation, counseling, and job referral for people who have difficulty finding jobs. Each of the 47 centers has specialized staff to work with physically and mentally disabled individuals. Employers are subsidized for work site modifications to accommodate disabled workers and for their initial employment, making use of levy monies accumulated through the Employment Promotion Law for the Physically Handicapped. Loans and grants are available to employers to make employee housing accessible, as well as to build gymnasiums and leisure facilities.

It is obvious from this discussion that both vocational and independent living services are available at the community level in Japan. Moreover, when questioned, government officials unanimously indicate that every disabled individual in Japan who needs a service receives it -- including home modifications, purchase of typewriters for communication, and purchase of corning top stoves to avoid burns. The Japanese, however, are critical of their community services. While they would not downplay the importance of community services, they tend to believe that quality rehabilitation services are provided primarily in their "institutions." Community rehabilitation services are considered to be in a developmental and underdeveloped state (I. Maruyama, personal communication, September 6, 1983).

### Institutions

A major semantic problem arises when discussing institutions in Japan, because the word actually is a misnomer. Ichiro Maruyama, Special Administrator for Rehabilitation Services in the Ministry of Health and Welfare, describes them simply as "special places where special care and services are provided" (I. Maruyama, personal communication, September 6, 1983). Disabled persons in these facilities are separated from the mainstream of society. The treatment they receive, though, is both separate and superior.

Most of Japan's rehabilitation facilities are residential at this time; however, the situation is beginning to change. Separate facilities exist to treat persons who are mentally retarded, those having various physical disabilities, persons who are mentally ill, and those who are aged. The services provided in the "special places" varies, but generally includes: custodial care, activities of daily living, prevocational evaluation and training, vocational training, and sheltered employment. Most of these services are provided in welfare institutions (e.g., those facilities funded through the Ministry of Health and Welfare), but a number of the facilities providing evaluation, vocational training, and sheltered employment come under the auspices of the Ministry of Labor. In virtually all cases, there is an expressed desire for the clients to become as fully independent, self-sufficient, and self-supporting as possible.

Custodial care services, as they exist in the U.S., are not readily found in Japan. Even the most severely disabled persons are approached with a philosophy of maximizing independent functioning in all areas. The traditional Japanese virtue of patience lends itself to a high quality of care, along with an ability of the staff to accept very small and gradual improvements over a period of years. Involvement, especially in social and group activities, is stressed for all clients. A typical nursing home, for example, may be expected to have educational and craft classes, as well as numerous clubs to pursue interests such as ham radio operation and chess or the favorite Japanese game of "go." Residents are allowed a variety of personal items, and rooms tend to have the casual atmosphere of college dormitories rather than the sterile aura of a hospital. Persons requiring intensive medical care can expect to have a long-term stay in a hospital and, while there, will receive a full gamut of medical care services.

Training in activities of daily living (ADL) is a basic service of Japanese residential care institutions. For children, this may begin with toilet training and even this activity may be a long-term process. As an administrator stated, toilet training is stressed initially because without it the disabled person cannot be fully human and independent (K. Nakamura, personal communication, September 4, 1983). Caring for one's possessions (including washing and folding clothing) is part of each client's training. Mobility, cooking,

shopping, personal care, communication, and other independent living skills are taught. Social interaction skills are stressed, resulting in few (if any) antisocial behavior problems among the clients. Cultural activities are a part of the ADL training. In the psychiatric rehabilitation facilities, flower arranging and tea ceremony, (two traditional Japanese arts) are used as therapy.

Prevocational evaluation and training may last as long as two years. The evaluation is conducted by a rehabilitation team, including medical, allied health, and social work personnel. Training includes continued functional development in independent living skills, driver's training, and occupational courses. The latter are provided primarily to determine vocational competence. At the conclusion of the training, some clients may be ready for work, while others may require further vocational training.

The vocational rehabilitation/training centers in Japan vary in terms of capacity, duration, and type of training. There is a definite orientation to preparation for skilled jobs and high technology industries. Some of the more commonly available training programs are: watch and clock repair; electric appliance repair; tailoring; dress making; architectural drafting; plate making; printing; shoe making; wood, metal, and/or ceramic arts and crafts; business accounting; word processing and clerical services; manufacture and repair of prosthetic and orthotic appliances; radio and television repair; metallurgy; mechanics; and computer programming. Severely visually impaired persons are trained in massage, acupuncture, and moxibustion (another healing art using herbs and intense heat), as well as in the use of braille typewriters and Optacon machines. Some of the centers have computer printers using braille output to facilitate computer programming training for persons who are blind.

Many of the vocational rehabilitation centers also offer sheltered employment. Even with high levels of skill, many of Japan's disabled citizens still have difficulty obtaining competitive employment due to negative employer attitudes. Therefore, they live and work in sheltered environments. The clients basically are free to come and go as they choose. (This really is not so different from the larger society, where major employers provide company housing for their employees.) Some of these facilities are referred to as "welfare factories." These are not training facilities (though clients do undergo on-the-job training in specific work tasks) but are work facilities that employ disabled persons. Clients are paid for their work (about $335 per month), though at a lower rate than would be found in a competitive work setting. These factories have contracts with public and private businesses and industries to provide services that range from assembling microelectronic circuits to transcribing tapes of judicial proceedings.

The number of sheltered workshops in Japan has increased from 106 in 1970 to 447 in 1981 (Izawa & Matsui, 1983). The underlying philosophy in these workshops is that they should be a step toward competitive employment. In actuality, most clients referred to the workshops remain in them; the majority are over 40 years of age and vocational opportunities for them are limited (Izawa & Matsui, 1983). A large number of work activity centers exist at the local or community level. These are operated voluntarily, without government funds, and have a capacity of 10 to 20 clients. They are considered to provide few and unstructured rehabilitative experiences.

The total number of welfare facilities, including rehabilitation facilities and sheltered workshops for physically handicapped and for mentally retarded persons, is shown in Table 1 (which was taken from publications by the Koseisho [1981, p.10] and the Government of Japan [1980, p.11]. As can be seen from this table, there are 549 facilities for physically handicapped persons and 577 for mentally retarded persons. The total capacity for physically handicapped persons (23,652) is much lower than for those who are mentally retarded (40,098). Most of the clients served in these facilities are levels one and two in severity. Virtually none are levels five or six. Potential changes in the current workshop structure are being considered for reasons discussed below.

Table 1
Welfare Facilities for Physically Handicapped
And Mentally Retarded Persons in Japan

| Types of Institutions | Number | Capacity |
|---|---|---|
| **I. Physically Handicapped** | | |
| Rehabilitation Center for the Orthopedically Handicapped | 52 | 2,413 |
| Rehabilitation Center for the Blind | 13 | 1,510 |
| Rehabilitation Center for the Deaf and Mute | 4 | 193 |
| Rehabilitation Center for the Handicapped in Heart, Lung and Kidney | 22 | 1,160 |
| Nursing Home for the Severely Physically Handicapped | 37 | 2,690 |
| Sheltered Workshop for the Physically Handicapped | 75 | 4,085 |
| Sheltered Workshop for the Severely Physically Handicapped | 63 | 3,943 |
| Welfare Factory for the Physically Handicapped | 18 | 990 |
| Workshop for Prosthetic Appliances | 31 | |
| Braille Library | 70 | |
| Braille Publication Center | 10 | |
| Home for the Blind | 33 | 718 |
| Welfare Center for the Physically Handicapped | 32 | |
| **II. Mentally Retarded** | | |
| Rehabilitation Facilities | 428 | 32,500 |
| Sheltered Workshops | 89 | 6,215 |
| Dormitories | 60 | 1,383 |

## Issues, Trends, and Future Plans

Confucius suggested that all people look in a mirror three times each day for the purpose of self-evaluation. Japanese culture, heavily influenced by Confucianism, places a high value on continual self-examination and striving for improvement. Some of the rapid progress that they have made since the 1940's, and especially since the 1960's, may in fact be attributed to their honesty in facing social and institutional problems. Japanese

professionals freely discuss the issues that they are facing in rehabilitation, and continually examine the perceived strengths and shortcomings of their rehabilitation system. They are extremely open to feedback and input from persons outside their country. Some of the more broad and critical issues faced by Japan today are discussed in this section.

The changing demography of Japan is creating demands for change in rehabilitation programs. Japan's population is aging rapidly, and the problems of older disabled persons loom large. Industrial and automobile accidents, improvements in medical care that enable disabled persons to remain alive, and other factors are resulting in increasing numbers of severely disabled persons. There is also a greater diversity of types of disabling conditions, and services for multiply handicapped individuals are becoming increasingly important.

Developing needed services is complicated by Japan's fragmented service delivery structure. Operating under multiple laws through numerous public, private, and voluntary agencies results in a lack of coordinated services. Thus, both duplications in services and gaps in needed services are likely to occur (Kojima, 1981). An antecedent explanation for this lies in the fact that many of Japan's rehabilitation programs were adopted on a piecemeal basis, rather than with an overall concept in mind (Izawa & Matsui, 1983).

Desired changes are sought in both institutional and community services. There is a movement toward smaller facilities and more community integration of disabled persons. Japan is studying the U.S. independent living rehabilitation (ILR) movement and is seeking ways to implement ILR concepts. The development of group living homes and work activity centers are evidence of the increasing attention being given to promoting community living for disabled persons.

In contrast to other nations, notably the U.S., Japan's major problem in developing rehabilitation services has not been economic. With little money devoted to defense, expenditures for social and rehabilitative programs have been relatively large. The total allocation for all social security programs in the fiscal year 1980 was 39,595 billion yen, representing 19.6% of the national budget. The amount that is spent for social programs may be expected to decrease in the future, as pressure from other nations contributes to increased spending for defense, creating substantial needs for adjustment in the service delivery system.

Rather than finances, societal attitudes have proven to be the major problem faced by rehabilitation programs in Japan. The massive campaign initiated during the IYDP created significant changes, but problems of this scope cannot be resolved in only one year. The negative attitudes of many employers toward hiring disabled workers are a reflection of the overall societal climate. An added complication is the lifetime employment system. Employers may fear hiring disabled persons because of the possibility that they will be unproductive workers, yet will remain on the company payroll until reaching retirement age.

The quota system certainly has helped to alleviate unemployment among the disabled population of Japan. That system is not without its problems, however, and the Ministry of Labor is seeking ways to improve the system. Although the quota system does not apply to small employers (those having less than 657 employees), large employers evaluate the economic realities of hiring disabled persons versus paying the levy for not doing so, and often opt to pay the levy to avoid expenses for work site modifications (1. Seto, personal communication, July 24, 1983). Alternately, they often choose to hire less severely disabled individuals. Individual advocacy and information efforts with employers could help alleviate problems in this area, if staff were available to do so.

Lack of trained staff is a major issue facing Japan's rehabilitation system. Few universities have classes in vocational rehabilitation and no graduate training programs are available in this subject area. What training does occur is conducted on an inservice, short-term basis. Designing training programs is further complicated by the lack of a rehabilitation profession. The various types of rehabilitation services are "never performed by a single agency but are conducted part by part in a variety of agencies..." (Kojima, 1978, p.31). Japan looks with interest at vocational rehabilitation counselors (such as those found in the U.S.), but is hindered in developing such

trained professionals by a system that lacks both the types of jobs and vacancies to utilize these personnel on a level commensurate with their training.

## Conclusion

In the 39 years since the end of World War II, Japan has done what no other nation in recorded history has done. The rest of the world has watched in amazement as this island nation developed from a fairly unknown and isolated country into a major industrial power. Numerous explanations for this uniquely Japanese phenomenon have been written (Vogel, 1979).

The character and culture of the Japanese people is, of course, largely responsible (Benedict, 1946; Doi, 1973). Several notable characteristics which apply to the present discussion are: (a) their ability to be almost brutally honest in appraising their society, culture, and institutions; (b) their willingness to invest financial and human resources in studying examples from other nations; and (c) their ability to adapt the best examples from other countries to suit the unique needs of Japan.

The Japanese are faced with rapid changes and with the challenge to be proactive as well as reactive. They are aware of the strengths and shortcoming of their rehabilitation programs and are dealing head-on with a number of important issues, many of which are shared in common with other nations. Based on their history, tenacity, and numerous strengths, there can be no doubt that they will make rapid, significant progress in dealing with these issues. Through continual self-examination, they will continue to grow as a people and as a nation. Perhaps the time has come for the rest of the world to learn by example -- to study Japan as they have studied us, and to adapt their best techniques in order to improve our own rehabilitation programs.

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Jane E. Myers, Ph.D., CRC, NCC, is Director of Rehabilitation Counselor Education at Ohio University in Athens, Ohio, USA.
Ryosuke Matsui, M.Ed., is Senior Program Officer of the National Institute for Employment of the Handicapped, a quasigovernmental affiliate of the Ministry of Labor, Tokyo, Japan.