Al-Gatami, Munira Abdulwahab

A PLAN FOR IMPLEMENTING A MODEL NATIONAL REHABILITATION PROGRAM: TASK ANALYSIS, ORGANIZATION DESIGN, AND PROSPECTIVE EVALUATION METHOD, WITH SPECIAL REFERENCE TO THE STATE OF KUWAIT

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A PLAN FOR IMPLEMENTING A MODEL NATIONAL REHABILITATION PROGRAM: TASK ANALYSIS, ORGANIZATION DESIGN, AND PROSPECTIVE EVALUATION METHOD, WITH SPECIAL REFERENCE TO THE STATE OF KUWAIT

by

Munira Al-Gatami

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As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Munira A. Al-Gatami

entitled A PLAN FOR IMPLEMENTING A MODEL NATIONAL REHABILITATION PROGRAM: TASK ANALYSIS, ORGANIZATION DESIGN, AND PROSPECTIVE EVALUATION METHOD, WITH SPECIAL REFERENCE TO THE STATE OF KUWAIT

and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

	5/15/86 Date
Marlene M Bruce	May 15, 1986 Date
James E. Organist	May 15, 1986 Date
	Date
	Date

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

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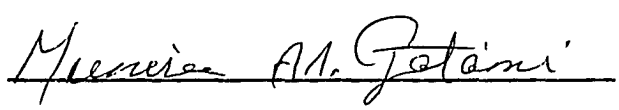
SIGNED: 

To the memory of my father and brother,

and to my mother and sisters

in gratitude for their patience and support.

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ABSTRACT

The central problem of this study is to identify and develop a model for the administration of rehabilitation services to the handicapped which can be applied to identify needed services in any country, such as Kuwait. The method used in developing the model entailed obtaining basic information about how selected nations administer services for the handicapped through

1. Published sources and reports;
2. Unpublished material;
3. Interviews of selected officials responsible for the handicapped.

The review of the literature consists of two parts. Part one reviews organizational strategies:

1. The engineering strategy;
2. The behavioral strategy;
3. The systems strategy.

The second part focuses on rehabilitation services in the eight countries selected for this study. These are discussed in the order of their difference from the State of Kuwait: the United States, the United Kingdom, Denmark, Japan, Yugoslavia, Thailand, Kenya, and finally Kuwait. Each is discussed in the following terms:

1. Overview
2. History of Rehabilitation Services
3. Structure of Service Delivery System
4. Legislation of Rehabilitation Services

The study was preceded by an analysis of tasks organized within the framework of the International Classification Matrix Model with a view to establishing an approach to prospective evaluation. A matrix can be defined as a rectangular array of elements arranged in rows and columns; the matrix used in this study was formulated on the basis of information and data collected in the eight selected countries in terms of

a. General Cultural/Social Orientation Pattern
   (i. "ascriptive/traditional," ii. "mixed"
   and iii. "achievement-oriented/innovative")
b. Degree of Cultural Materialism
c. Cultural Attitudes Toward the Handicapped
d. Percent of Population Classified As "Handicapped"
e. Per Capita Income
f. General National Political Orientation
g. General National Administrative Structure
h. Degree of Bureaucratization
i. Types of Delivery Service.

This study classifies nations for the purposes of general evaluation of their approaches to national administration of services for the handicapped and application of these approaches to a specific country, Kuwait.

CHAPTER 1

INTRODUCTION

"Rehabilitation has traditionally supplied the form in which a society restored the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable" (Townsend, 1966).

Each society has adapted an organizational framework for such restoration within which rehabilitation services are carried out through different departments of the government and through nongovernmental agencies. Many countries are trying to develop comprehensive programs that will convert as many as possible of their handicapped and disabled into relatively active, self-dependent, and productive members of their communities. The Report of the Interregional Expert Meeting of Social Welfare Organization and Administration, 1967, states that

> each nation must develop its own pattern of organization. This, however, should be the result of a conscious study within each country of those organizational patterns most likely to contribute to the implementation of policy and the attainment of objectives. The development of a comprehensive government, comprising legislation, political and executive leadership and administrative efficiency in catering for the social needs of all the people can thus be made possible. (p. 3)

Technological advances, both within and outside rehabilitation, have developed to the point where applications of emerging accountability patterns appear feasible and can be seen in terms of this study as the development of new structures for rehabilitation organizations. Dowd and Emerner (1978) state that

> Medical science. . .is capable of keeping people almost indefinitely on the very borderline of life and death. Our ability to prolong life has become so great that we are now forced to decide when we will refuse to prolong it. . .in the past few decades, medical science has produced an ever-increasing population of disabled persons. (p. 35)

As organizations have grown in size and complexity, top administrators have often encountered difficulty making decisions about the most effective use of resources because of the increase in complexity of societal demands, organizational structures, and environmental contingencies. What is needed is some unified organizational structure, together with the kind of accountability which can be plainly formulated. Clear purpose in the planning and decision-making that determine the organizational structure must be evident. An effective national rehabilitation system is needed. Struthers and Miller (1981) state that "as demands for accountability in government programs increase, efforts to make the processes more rational and more explicit have intensified. The rehabilitation enterprise is no exception to this general trend." (p. 165)

Rehabilitation administrators in Kuwait have been exploring the feasibility of identifying and detailing a model as a tool for more efficient planning and more effective decision-making. They are faced with an ever-increasing need to respond to inquiries about financial need, use of personnel, organizational structure, and program effectiveness. Carnes (1979) states that

> Current and proposed innovations in the U.S. rehabilitation delivery system resulting from pressure from increasing numbers of clients, expanded standards of eligibility, difficulties in obtaining funding, and shortages of trained personnel certainly do resemble significant aspects of the European systems. . . . The rationale behind most, if not all, of these innovations is the promise of increased efficiency and reduced costs. (p. 188)

This study investigates theoretically how a national system for rehabilitation services may be formulated on the basis of international experience. In organizational design, it proceeds by analysis of tasks in a matrix framework and establishes an approach to prospective evaluation. Its purpose is to develop an International Classification Matrix analysis for a general model of services for the handicapped. The general model is then applied to one nation, Kuwait.

Problem

The central problem is that of identifying or formulating a generic model for administrative services to the

handicapped that will coordinate all different rehabilitation services at the national level. This model will be applied to the State of Kuwait with the aim of determining its effectiveness in identifying a coordinated national rehabilitation services program for that country.

Assumptions

For the purpose of this study, the following assumptions have been made:

(1) An effective model can provide a means for coordinating rehabilitation services for any nation.

(2) Such a model, developed for one country, could be of value to other countries.

(3) The Government of Kuwait is open to considering such a model for administering all the rehabilitation services necessary for the welfare of disabled persons.

Limitations

The following are some of the limitations encountered in the development of this study:

(1) Very little literature deals with such models in any generic meaning of the word.

(2) Because this is a theoretical, methodological study, it cannot provide any very detailed illustration of the idea proposed.

Definition of Terms

The following are definitions of terms within the context of their use in this study:

Disability: Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. (World Health Organization, United Nations, 1983, p. 3)

Equalization of opportunities: The process through which the general system of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, cultural and social life, including sports and recreational facilities, are made accessible to all. (World Health Organization, United Nations, 1983, p. 3)

Handicap: is therefore a function of the relationship between disabled persons and their environment. It occurs when they encounter cultural, physical, or social barriers which prevent their access to the various systems of society that are available to other citizens. Thus, handicap is the loss or limitation of opportunities to take part in the life of the community on an equal level with others.

(World Health Organization, United Nations, 1983, p. 3)

Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or function. (World Health Organization, United Nations, 1983, p. 3)

Rehabilitation: A goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment. (World Health Organization, United Nations, 1983, p. 3)

Total Rehabilitation: Wright (1980) defines total rehabilitation as "the fullest possible restoration of the individual in all of life areas." The concept of total rehabilitation in this study forms the goal wherein multiple services are pooled to help the disabled person. These services include health, education, social welfare, vocational training, employment, and others difficult to coordinate with one another and with the community at large.

CHAPTER 2

REVIEW OF THE LITERATURE

The review of literature relevant to this study is presented in this chapter in two sections. The first section focuses on theoretical literature on administrative organizational structure. The second section focuses on a review of the overview, history of rehabilitation services, structure of service delivery system, and legislation of rehabilitation services in the eight selected countries.

Part 1

Administrative Organizational Structure

This study concerns, first, the development of a national model for administering rehabilitation services and, second, the application of this model in developing a national rehabilitation system for the State of Kuwait. This portion of the review of the literature, relating to the first point, will focus on different approaches to organizational design. Vollmer (1968) classifies the main approaches as follows. A summary of his generalizations about them appears in Figure 1.

	THEORETICAL ANTECEDENTS	FOCUS OF THE DESIGN	ROLE OF THE DESIGNER	TYPICAL OUTPUTS OF THE DESIGN PROCESS	STRATEGY IS MOST APPROPRIATE FOR:
ENGINEERING STRATEGY	Weber, Taylor, and drawing on industrial engineering and operations analysis	Organizational structuring and evaluation, with particular emphasis on operational goals	Primarily as an expert consultant to top management	Documents, such as organization charts, job descriptions, and PPB plans and memoranda, etc.	Authoritarian organizations
BEHAVIORAL STRATEGY	Lewin, Rogers, and drawing on the behavioral sciences	Organizational diagnosis and implementation of change, with particular emphasis on maintenance goals	Primarily as a social technician working with different organizational levels	Procedures for discussion, team building, conflict resolution, etc.	Voluntary or employee-centered organizations
SYSTEMS STRATEGY	Drawing on all of the above, combined in terms of systems theory	Emphasizing all of the above	Primarily as a professional in a relation to organizational clients	A mixture of documents and procedures	Changing, complex, high technology organizations

SOURCE: Vollmer, 1968.

FIGURE 1. Three Strategies of Organizational Design

The Engineering Strategy

The "engineering" strategy entails the design of an organizational mechanism from outside. This theory originates in the work of the German social scientist Max Weber (1946), who stressed "objectivity" in organizational analysis and also described the essentials of the "bureaucratic rationale" for organization as including the following:

(1) a clearcut division of labor into job positions along the function line,

(2) a hierachy of managerial positions structured into a pyramid of increasing generality of authority over subordinate positions,

(3) work activities governed by a consistently applied system of formal and informal rules generated from organizational practice (that is, precedent),

(4) impersonality in the performance of job requirements (for example, an employee is fitted to the characteristics of a job, rather than vice versa),

(5) a career progression that provides for entrants at the bottom level to move upward through a hierarchy of positions as they acquire increasing experience at each level.

The "engineering" strategy received its most direct support initially from the "scientific management" works of Taylor (1896), Fayol (1930), Gulick (1937), Urwick (1937), and others. The planning, programming, and budgeting (PPB) system of management, used widely in federal and local government and in the private sectors during the 1960s and 1970s, used the "engineering" strategy of organizational structure.

The Behavioral Strategy

The behavioral strategy seeks to change organizations (and hence "redesign" them) by changing the behavior of individuals within an organizational structure. This strategy pays more attention to building individual commitment and enhancing individual participation than it does to the efficient and effective attainment of a set of operational goals defined by top management. It is therefore more of an "inside-out" approach to organizational design or redesign, tending to place greater emphasis on organizational <u>maintenance</u> and organizational <u>development</u> than on productivity. As a strategic variable, Warren Bennis (1966) has pointed out, this approach considers such items as "human collaboration and conflict, control and leadership,

communication between hierarchial ranks," and "management and career development."

Vollmer (1966) indicates that many practitioners of this strategy in the field now known as "organizational development" trace their origins to such Gestalt psychologists, clinical psychologists, and social psychologists as Kwot Lewin, Carl Rogers, and Abraham Maslow, all of whom predicated their theories on the assumption that human beings are more or less "self-actualizing" animals, who seek to develop their capabilities to the fullest extent in all organizational environments. Organizations will fail if they do not provide a favorable environment for such self-actualization, these theorists believe.

In accord with this point of view, it is a fundamental error for an organizational designer ("change agent" is the term commonly used) to intervene actively in making changes: His or her role is to draw changes out of the analysis provided by the members of the organization themselves. Thus, Elliot Jawues states ("designer" has been substituted for "change agent" or "social scientist" acting in this role),

> It is our conviction that [the designer] working in a collaborative role rather than a technocratic one will achieve the best results; and it is our goal to achieve such a role. One might roughly differentiate collaboration as doing things <u>with</u> people, as opposed to technocracy as doing all things to people. (1961, p. 163)

An account of the initial steps in the behavioral approach to organizational design is provided by Shepard (1965) (again, "designer" has been substituted for "change agent").

> (1) In contrast to the engineering strategy, the behavioral strategy focuses on (a) the diagnosis of organizational problems and (b) the implementation of organizational change, rather than on the structuring and the evaluative elements of organizational design.
>
> (2) The diagnosis and implementation of organizational design in the behavioral approach takes place as the designer plays essentially what might be described as a "social technician" role.
>
> (3) The problems that are identified in this kind of diagnostic procedure are most likely to involve "process."
>
> (4) The implementation of design changes is likely to start immediately in the teams ("temporary systems") formed to diagnose organizational problems.
>
> (5) The products of the behavioral strategy are procedures for building new patterns of interpersonal relationships. (pp. 1136-37)

The Systems Strategy

Social and management scientists who have experienced failures in both the engineering strategy and the behavioral strategy have tended to turn toward a mixed strategy that includes joint consideration of technological, structural, and interpersonal variables, an approach that can be called a "systems strategy" of organizational design and change. Thus, William F. Whyte (1964) has written,

> in a work organization, the activities people carry on are strongly influenced by the technology, the flow of work, the formal distribution of tasks and the location of individuals in the formal structure of the organization. This structuring of activities, in turn, will strongly influence which people come together in interaction, how frequently, and for how long a period. (p. 185)

In a more critical vein, O'Connel (1964) has also pointed to the deficiencies of attending only to behavioral factors in what he calls "the conversion approach," which also considers economic and structural variables. Similarly, Leavitt (1969) classifies organizational components into task, structure, technology, and people, pointing out that "these four are highly interdependent--so that change in any one usually results in compensatory (or retaliatory) change in other." Blake and Mouton (1964) use a six-phase approach, including preliminary "management development" activities, "laboratory seminar training," and team

development followed by four "organization development" activities:

a. intergroup development,

b. organizational goal setting,

c. goal attainment,

d. stabilization.

Organizations must be concerned with renewal processes if they are to be effective, efficient, and relevant. The literature reveals that some writers see staff development as a "laundry list" of tasks or activities. Others recognize a relationship between learning as a process and staff development as activities to develop that process. A model can provide a coordinated concept to be applied to each component of the organizational operation.

Part 2

Profiles of Selected Countries

The following provides a review of information about relevant literature, history, and legislation gathered during personal visits in more than a score of foreign nations. Eight of these nations were selected to be examined in depth: the United States of America, the United Kingdom, Denmark, Japan, Yugoslavia, Thailand, Kenya, and

Kuwait. These eight countries were selected for the following reasons:

(1) The United States is included because of its comprehensive rehabilitation services, as well as its federal and state structures.

(2) The United Kingdom was selected because of its heavy industrialization together with its experience in establishing the first Ministry for the Disabled as a coordinated model for services.

(3) Denmark is included because of its extensive social welfare system, advanced technology, and emphasis upon individual freedom.

(4) Japan was selected because of its vast industrialization and extensive technology.

(5) Yugoslavia was chosen because its central political planning provides an example of a socialist government system in contrast with the governments of the other targeted countries. This system in some ways provides a source of leadership and guidance.

(6) Thailand was chosen because it is a developing country in contrast with the well-developed country of Japan in the Far East.

(7) Kenya may serve as an example of administrative pattern trying to reach handicapped persons in the rural communities.

(8) Kuwait provides the basis for contrast with the other target countries in terms of philosophies, legislation, and the history of administrative structures for rehabilitation services for disabled persons.

The examination of rehabilitation systems in these countries considered the degree to which these systems would satisfy the need of the disabled people in the State of Kuwait. Such a review was accomplished to help identify or formulate or modify a system that will improve the delivery and the efficiency of rehabilitation services in Kuwait.

A review of the literature reveals that the developed and highly industrialized countries, like the United States, the United Kingdom, and Denmark, have also achieved the greatest development in most of the above categories. These account for more than one-third of the countries studied. Countries like Japan and Yugoslavia fall into the middle range in terms of development, and Thailand and Kenya are found at the lower end of the matrix. Kuwait, although surprising in its development, falls into the middle to low range because of a large number of immigrants.

The United States of America

Overview. The area of the United States is 3,615,000 square miles, and, as of 1980, its estimated total population was over 226,545,805 (American Statistics Index, 1985). It is a highly industrialized nation, with a per capita income in 1984 of $10,887 (Economic Indicators, 1985). The Digest of Data on Persons with Disabilities, published by the National Institute of Handicapped Research (1984), reports that "close to 44 million persons, or more than one-fifth of the civilian noninstitutionalized population in 1979, are estimated to have one or more impairments. Of these, 9.9 million had two or more impairments." (p. 4)

History of Rehabilitation Services. Rehabilitation activities in the United States are provided through a variety of public and voluntary programs. In the United States, as in most countries in Western Europe, central responsibility for the development and implementation of nation-wide programs of health, social security, and human development services, including programs for children, youth, families, the aged, and disabled persons, rests with one central government agency: the Department of Health and Human Services. (See Figures 1 and 2)

The review of the literature shows that the United States federal rehabilitation agency has undergone several changes in name and administrative affiliation since 1920.

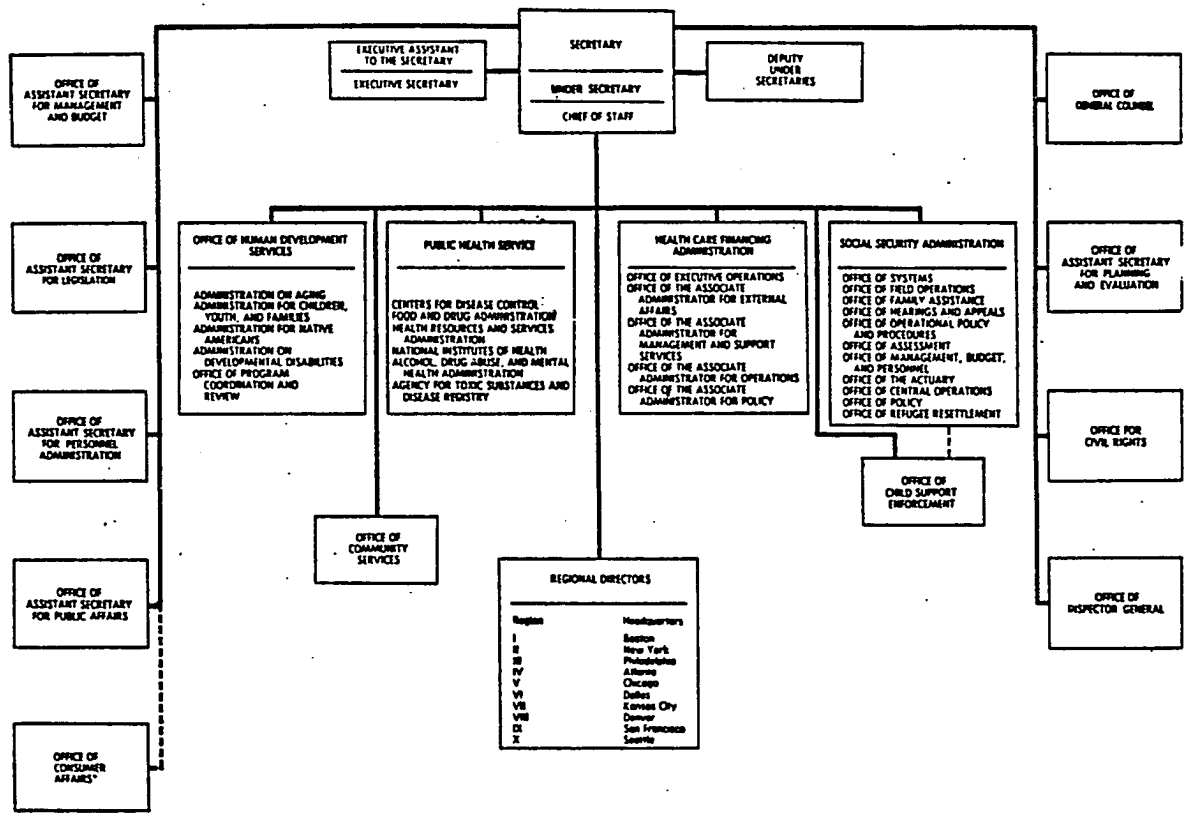

FIGURE 2. Department of Health and Human Services (U.S.)

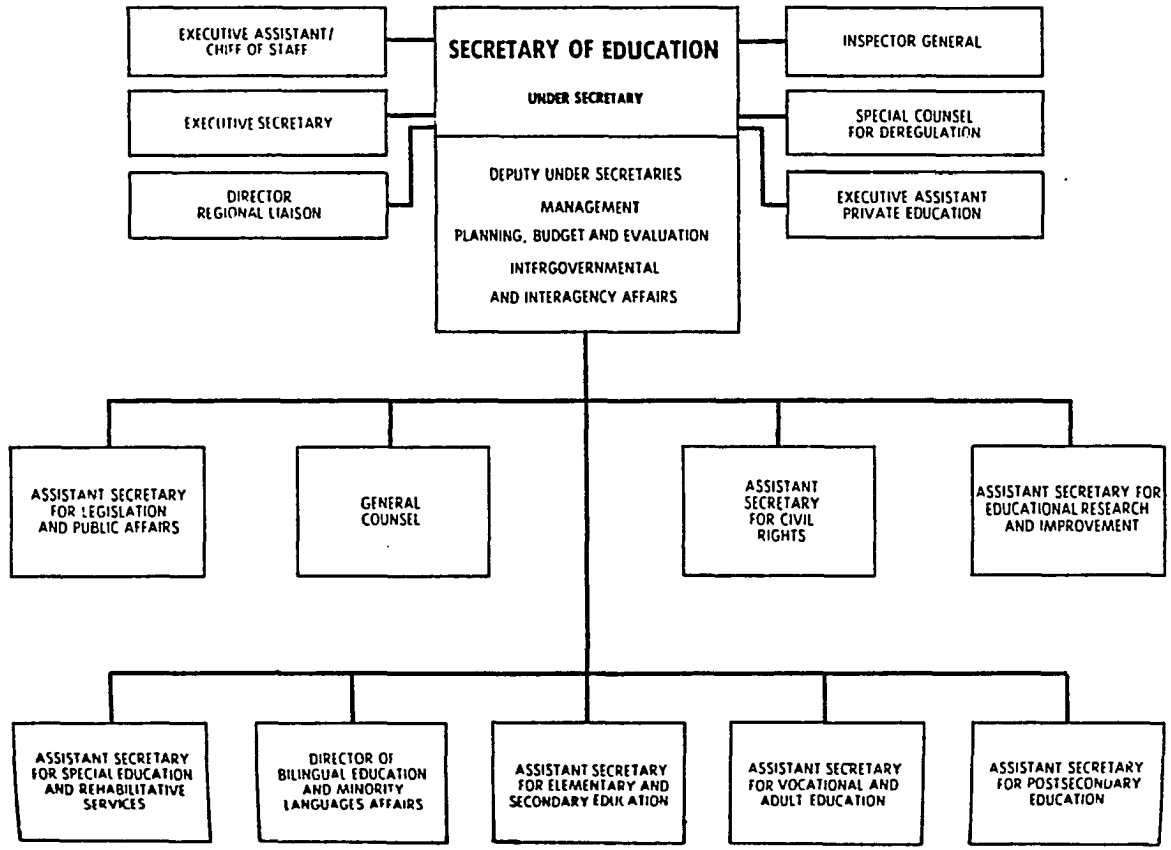

FIGURE 3. Department of Education (U.S.)

Wright (1980, pp. 179-180) summarizes its history as follows:

> Initially (1920) civilian vocational rehabilitation was administered (along with veterans rehabilitation) by the Federal Board for Vocational Education. In June, 1933, President Roosevelt transferred function of the Federal Board to the Department of Interior; there the Secretary of the Interior in October, 1933, placed the administration of vocational education and vocational rehabilitation programs in the U.S. Office of Education. Then, in 1939, Roosevelt established the Federal Security Administration (FSA), to which the U.S. Office of Education was transferred along with Vocational Rehabilitation Services as a component. The Office of Vocational Rehabilitation (OVR) was created in September, 1943, as an agency of the FSA, but not under the Office of Education. OVR, along with other human services, was moved into the new U.S. Department of Health, Education, and Welfare (HEW) when it was established in 1953. In January, 1963, OVR was designated the Vocational Rehabilitation Administration (VRA) and the Director of OVR became the Commissioner of VRA reporting directly to the HEW secretary. In August, 1967, the Social and Rehabilitation Services (SRS) was established within HEW with five major divisions, including the Rehabilitation Services Administration--formerly the VRA (Mary Swatzer, who had previously headed first OVR and then VRA since 1951, retired as the first Administrator of SRS in 1970). In the mid-1970s, various administrative changes culminated in the dissolution of SRS and resurrection of RSA as an agency separate from Social Services.

In 1980, the federal rehabilitation agency and its related programs were placed in the U.S. Department of Education (U.S. DOE) that had been established by a 1979 Act of Congress. This action completed a full circle of federal rehabilitation administration aegis from education to health and other human services and then back to education. The original association was with vocational education while the

new relationship is with special education (i.e., U.S. DOE, Office of Special Education and Rehabilitation Services).

Structure of Service Delivery System. The American rehabilitation system is based on a goal that is "vocational" in the broadest sense of the term: to assist a rehabilitant to perform adequately in a productive role (Gellman, 1973). The emphasis thus falls on the capacity of the disabled for productive employment.

The system is structured as a network of rehabilitation agencies (public and voluntary, national and local) and major service systems (health, welfare, manpower, and education) that relate to the special needs of individuals who are disabled. The rehabilitation system is structured by the state-federal civilian rehabilitation program.

The public program of rehabilitation in the United States is composed of a central federal office in Washington, D.C., and ten regional offices throughout the United States. In addition to providing most of the funding for rehabilitation services, the federal agency offers guidance to states in program implementation by interpreting legislation and monitoring state-operated programs. "There are 56 state rehabilitation agencies. . . . There are also 28 separate state rehabilitation agencies for the blind." (Bitter, 1979, p. 6)

In the United States the public agencies influence the operating policies and programs of collaborating

agencies at the local level through government grants and the purchase of service contracts. The administration of services to individuals who are disabled is conducted by the state rehabilitation agencies. Also, the United States rehabilitation system is based on active casefinding; an individualized plan of service developed with the client; a coordinated and goal-oriented service approach; the use of multidisciplinary teams; and follow-through for optimal and sustained life adjustment. In the mid-1960s a number of major comprehensive state-wide planning projects were undertaken by the states and funded partially or totally by the federal government, among them planning for the mentally ill, the mentally retarded, health, education, and vocational rehabilitation services.

Legislation of Rehabilitation Services. A brief summary of the most important federal legislation relevant to rehabilitation is provided by Wright (1980, pp. 156-7):

> 1917 - Public Law (PL) 64-347--VOCATIONAL EDUCATION ACT (SMITH-HUGHES ACT). Created the Federal Board for Vocational Education to administer federal vocational education grants to the states through state boards for vocational education.
>
> 1918: PL 65-178--SOLDIERS REHABILITATION ACT (SMITH-SEARS ACT). Authorized the Federal Board for Vocational Education to administer a national vocational rehabilitation service to disabled Veterans of World War I.
>
> 1920: PL 66-236--CIVILIAN REHABILITATION ACT (SMITH-FESS ACT). Provided vocational rehabilitation services to people "disabled in industry and otherwise state boards for vocational education; services were to be administered under the Federal

Board for Vocational Education. Signed into law by President Wilson, June 2, 1920.

1921: PL 67-47--VETERANS BUREAU ACT. Established the Veterans Bureau as an independent agency with a director responsible to the President. The veterans rehabilitation program moved out of the Federal Board for Vocational Education Administration.

1933: PL 73-2--VETERANS ADMINISTRATION ACT. Reorganized the Veterans Bureau and designated this federal agency as the Veterans Administration.

1935: PL 74-271--SOCIAL SECURITY ACT. Provided permanent authorization for the civilian vocational rehabilitation program and increased its budget. Established these federal programs: unemployment compensation, old age insurance, child health and welfare services, crippled children services, and public assistance to the aged, the blind, and to dependent children.

1943: PL 78-16--WORLD WAR II DISABLED VETERANS REHABILITATION ACT (WELSH-CLARK ACT). Provided vocational rehabilitation for disabled veterans of World War II.

1943: PL 78-113--VOCATIONAL REHABILITATION ACT AMENDMENTS (BARDEN-LAFOLLETTE ACT). Extended public rehabilitation eligibility to include the emotionally disturbed and mentally retarded, expanded service to include physical restoration, removed ceiling on appropriation.

1944: PL 78-346--SERVICEMEN'S READJUSTMENT ACT KNOWN AS THE "GI BILL." It provided for the education and training (tuition and subsistence) of men and women whose education or career was interrupted by military service.

1945: PL 79-176--JOINT CONGRESSIONAL RESOLUTION FOR A NATIONAL EMPLOYMENT OF THE PHYSICALLY HANDICAPPED (NEPH) WEEK. Established an annually observed NEPH week. Passed in August, 1945, Truman changed it to President's Committee on Employment of the Physically Handicapped in 1952; Kennedy changed it to President's Committee on Employment of the Handicapped in 1962.

1954: PL 83-565--VOCATIONAL REHABILITATION ACT AMENDMENTS (CHILL-BURTON ACT). Provided the basis for future expansion through greater financial support, research and demonstration grants, professional preparation grants, state agency expansion and improvement grants, and grants to expand rehabilitation facilities.

1965: PL 89-333--VOCATIONAL REHABILITATION ACT AMENDMENTS. Accelerated the expansion and improvement of services by allotting 75 percent federal funds to the state agencies, funding state-wide planning for growth, additional provisions for rehabilitation facilities.

1970: PL 91-517--DEVELOPMENTAL DISABILITIES SERVICES AND FACILITIES CONSTRUCTION ACT. Provided broad responsibility to states for planning and implementing a comprehensive program of services to retarded, epileptic, cerebral palsied, and other neurologiclly impaired people.

1973: PL 93-112--REHABILITATION ACT. Placed strong emphasis on expanding services to the more severely handicapped by giving them priority. It also provided for affirmative action in employment (Section 504) by federal contractors and grantees.

1978: PL 95-602--AMENDMENTS TO THE REHABILITATION ACT OF 1973. Authorized the long-sought expansion of rehabilitation to include "Independent Living" as an objective and established the National Institute of Handicapped Research. Provided employer incentives for training and hiring disabled people. These Amendments extended the Rehabilitation Act for four years, over $1 billion was authorized for 1979 with substantial increases through the 1982 fiscal year.

A detailed description of legislation dealing with the handicapped, which is beyond the scope of this study, can be found in the summary of selected legislation relating

to the handicapped, 1980-82 and 1983-84, published by Schmidt for the United Nations.

The United Kingdom

Overview. The United Kingdom lies off the northwest coast of the European continent, separated from it by the English Channel, the Strait of Dover, and the North Sea. At the closest point, England is 35 kilometers (27 miles) from France. Its capital and largest city is London. Covering an area of 244,046 square kilometers (94,226 square miles), the United Kingdom had a population in 1980 estimated at 55.9 million, projected to grow by 1986 to 56.4 million. The predominant religion is Christianity. The government, a democratic constitutional monarchy, is headed by the queen (chief of state) and the prime minister (head of government). The per capita income in 1982 was $6,309. Its economy is based on industry (24.8 percent), trade (27.0) percent), and agriculture (2.2 percent). (U.S. Government Printing Office, 1984)

History of Rehabilitation Services. Rehabilitation of the disabled in Great Britain is sponsored both by the government and by voluntary organizations. The number of the disabled is estimated at 4,368,000, 7.8 percent of persons aged 16 years and above living in private households (International Research Journal, 1982). The following is a

summary of the history of rehabilitation services from the report of U.S. Department of HEW, 1964, pp. 188-92.

> Until World War II, rehabilitation in Great Britain was largely the responsibility of the private agencies, working usually in collaboration with the local public authorities and some of the Government departments. The first training school for the blind was established in 1791, and in 1868 the Royal National Institute for the Blind was founded as a coordinating agency for blind welfare. The National Institute for the Deaf was an equivalent function in its own field. . . .
>
> During World War II, there was a large increase in the number of orthopedic beds to care for military and civilian casualties. The Ministry of Health required all hospitals to expand their facilities for physical rehabilitation and to set up occupational therapy departments. Vocational training and employment of the disabled made rapid advances.
>
> In 1941, an Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons was established under the Chairmanship of the Parliamentary Secretary to the Ministry of Labour and National Service and, as a result of the committee's recommendations, the Disabled Persons (Employment) Act of 1944 was passed, which made provision for the Industrial Rehabilitation and the Resettlement of the Disabled. Another interdepartmental committee recommended other legislation which resulted in the following acts of Parliament:
>
> The National Insurance Act, 1946, provided insurance benefits for disabled persons unfit to work.
>
> The National Insurance Industrial Injuries Act, 1946, superseding the Workmen's Compensation Act, provided benefits and pensions for those injured or contracting a prescribed disease while at work.
>
> The National Health Service Act, 1946, and the National Health Service (Scotland) Act, 1947, provided for free medical and hospital treatment for everyone including medical rehabilitation, where

necessary, and the supply of surgical and other appliances.

The National Assistance Act, 1948, provided financial assistance for the destitute and, in addition, empowered local authorities to extend to sighted disabled persons the comprehensive welfare services and sheltered employment facilities that they had already been obliged to provide for the blind.

Special education and training of handicapped children was provided for under the Education Act, 1944, and the Scottish Education Act. 1946. . . .

The Disabled Persons (Employment) Acts, 1944 and 1958, enable the Minister of Labor to make provision to enable persons handicapped by disablement to obtain employment or work on their own account suited to their age, qualifications, and experience.

An experienced placement officer, specially selected and trained for the work of resettlement and known as the Disablement Resettlement Officer (DRO), is in post either full-time or part-time at each of the Ministry's local employment exchanges. . . .

An important feature of the British rehabilitation system is the Industrial Rehabilitation Units (IRU), operated by the Ministry of Labor. . . .

Residential courses of industrial rehabilitation for the blind are provided by voluntary organizations, the Ministry of Labor contributing the cost. . . .

Free courses of vocational training are provided for persons who need special help in order to obtain work suited to their age, experience and general qualifications; for example, those who have not been able to acquire a skilled trade or who need to change their trade later in life. Courses in nearly 40 different trades are available in the 13 Government training centers run by the Ministry of Labor. . . .

Placement in employment of disabled persons is effected through the cooperative efforts of the disablement resettlement officers, employers and labor unions, and their representation on Disablement Advisory Committees. These committees form a

> link between local employment offices and local industry. . . .
>
> There are three types of organizations providing sheltered employment for disabled persons: (1) Reemploy Ltd., (2) approved voluntary undertakings and (3) local authorities, either directly or an agency with approved voluntary undertakings. . . .
>
> Special services for children include the provision of a School Health Service which examines children for any form of mental or bodily disability and of special schooling for children who need it. Many handicapped children are able to get the educational treatment they need in the ordinary schools. Local authorities, however, must provide special educational treatment when needed for handicapped pupils who are blind, partially sighted, deaf, partially deaf, educationally subnormal, epileptic, maladjusted, suffering from speech defects, physically handicapped, and delicate.

Structure of Service Delivery System. The Chronically Sick and Disabled Act was aimed to improve services and fuller lives for the disabled. (This will be further reviewed in the following section.) Section one of the Act required local authorities to inform themselves of the number and the needs of disabled persons resident in their areas and to publish information about available services. Through this Act were created the local authority social services departments. Hilditch (1961) states that "this new department, [which] became operational in April 1971 and henceforth has become the major aspect of the statutory personal social services. . ." (p. 30)

The next act to provide specific benefits to disabled persons was the National Health Service Act of 1946, which enabled local authority health departments to provide

any medical benefits for the after-care of patients in their own homes. Then the new Welfare Department came into being under the National Assistance Act of 1948. The power of "promoting welfare" went much further than the Disabled Persons Employment Act of 1944 had provided. Under the terms of the new Act, employability was seen as a social as well as an economic concept. Between 1957 and 1964, both the Department of Health and the Department of Welfare were giving the same benefits to disabled people.

The next act to provide arrangements for promoting the welfare of mentally disordered persons was the Mental Health Act of 1959.

In 1968, the Seebohm Committee proposed that medical and welfare services should be under a department, and so in 1969, the Department of Health and Social Security was formed.

The Chronically Sick and Disabled Persons Act was passed in 1970. The aim of this bill, enthusiastically supported by all parties, was clear enough to provide a far-reaching codification of help for disabled people. At the time the Act was passed, the services envisioned were the concern of four different departments of central government: the Department of Health and Social Security, the Department of Education and Science, the Department of the Environment, and the Department of Employment and Productivity. They involved traffic, sanitary, planning, housing, and

educational authorities, as well as the health and welfare departments of local authorities.

Mr. Alfred Morris, Private Member of the House of Commons who introduced the bill, became the first Minister for the Disabled in 1974, coordinating all the departments involved in services for the disabled people. Another important act introduced in the same year, the Housing Act of 1974, provided adaptations for the homes of individuals who are disabled.

Legislation of Rehabilitation Services. In the United Kingdom, the major law is the Chronically Sick and Disabled Persons Act 1970, which provides most of the help offered to disabled citizens. Before this act, Walker stated that "Britain has been slow to recognize the right of people with disabilities to become full members of the community especially in comparison with other countries such as the USA. . ." (1981, p. 1)

Topliss and Gould (1981) state:

> The first real legislative recognition of the special needs created by disability came late in the nineteenth century with the passing of the Elementary Education (Blind and Deaf Children) Act 1893. This was followed in 1899 by an Act facilitating special educational provision for mentally subnormal children, and the Education Act 1918 which required local education authorities to make special educational provision for all handicapped children who needed it and who were not so severely mentally subnormal as to be judged incapable of benefit.

> After 1918 the major concern with handicapped people shifted from disabled children to focus on the needs of the thousands of crippled ex-servicemen. In 1919 Government legislation set up training centres for the war disabled, in order to retrain them in suitable skills to enable them to obtain civilian employment, and incentives were offered to employers to recruit a proportion of their work force from disabled ex-servicemen. An Act of 1920 extended these facilities to blind civilians.
>
> The economic recession of the 1920s and 1930s not only largely defeated the purpose of the above measure, leaving many disabled unemployed, but also meant that no further provision was made for disabled people until the Second World War had started.
>
> In 1941, faced with an acute shortage of labour for the war industries since all the fit young men had been conscripted into the armed forces, the retraining facilities were extended to all civilian disabled.
>
> Towards the end of the war, in 1944, the Disabled Persons' (Employment) Act was passed, establishing assessment opportunities and industrial rehabilitation and retraining services for all disabled people who were judged to have employment potential, irrespective of the cause or circumstances of their disability. After this piece of legislation, which was reviewed in 1957 and was reported to be operating in a generally satisfactory manner, little more was done specifically for disabled people until the Chronically Sick and Disabled Persons Act, 1970. (pp. 77-78)

The Chronically Sick and Disabled Persons Act 1970 is "an Act to make further provision with respect to the welfare of chronically sick and disabled persons, and for connected purposes" (20 May 1970). There are 29 sections of the Act listed under the following headings:

Welfare and housing

Premises open to the public

University and school buildings

Advisory committees, etc.

Provisions with respect to persons under 65.

Miscellaneous provisions (Gutherie, 1981, p. 19)

Topliss and Gould (1981) state:

> the Chronically Sick and Disabled Persons Act, which amounted to an official acceptance of the fact that society has a duty towards its disabled citizens, has helped to change the attitudes both of able-bodied people towards their disabled fellows and of disabled people towards themselves and their legitimate aspirations. (p. 143)

Another important act, the Housing Act of 1974, provided adaptations for the homes of individuals who are disabled. In 1976, the Chronically Sick and Disabled Persons Act of 1970 was amended for the following reasons: (1) The volume of demand was far greater than anticipated, (2) more rigid criteria were being employed, and (3) the consumer's legal position was less than clear vis-a-vis appropriate services.

Denmark

Overview. Denmark, one of the Scandinavian countries, located strategically at the mouth of the Baltic Sea, has an area of 43,076 square kilometers (16,632 square miles), divided into 14 counties. Its population, 5.11 million in 1983, grew between 1980 and 1983 at an annual rate of 0.06 percent. In 1969, the proportion of

handicapped people in the population was 6.9 percent. About 97 percent of the population is Christian. The government is a constitutional monarchy, the constitution having been ratified on June 5, 1953. The executive branch is headed by the queen (chief of state) and the prime minister (head of government); the legislature is a unicameral parliament (Folkeling); the judicial branch consists of an appointed Supreme Court. Political life in Denmark is orderly and democratic.

Since World War II, the Danish economy has been characterized by industrial expansion and diversification and by continued dependence on foreign trade; exports and imports each account for about 35 percent of the gross national product. The economy expanded by 25 percent in 1984 on the strength of investments in North Sea oil and gas development. Per capita income is $11,018. The average inflation rate during the last five years has been 10.8 percent (U.S. Government Printing Office, 1984).

History of Rehabilitation Services. Rehabilitation Services in Denmark were first developed through private initiative and later subsidized by public funds. As in most of the economically and industrially developed countries, the case of individuals who are disabled in Denmark was first developed through private initiative, and later on subsidized by public funds. Compared to other countries,

Denmark has been a leader in providing services for its handicapped. U.S. HEW, 1964, p. 48, mentions that

> . . .in 1807, an institute for the deaf and dumb was established by the Government; in 1811, a voluntary charitable organization was set up for the blind; in 1816, the first treatment for the mentally ill in contrast to custodial institutions was put in operation, and 1855, the first institution for mental defectives was established. The care of epileptics was started in the mid 1890's, and in 1898, an institute for speech defectives was set up by the Government.
>
> The largest and oldest institution for the disabled is the Society and Home for Cripples. The society was founded in 1872. . .

Structure of Service Delivery System. Change occurred between 1976 and 1980, when the central government's responsibility shifted to the county and local authorities. The purpose of this shift was to make local and regional authorities directly responsible to all citizens in their respective fields.

The Danish Central Council for the Handicapped was established in 1980 to coordinate services for individuals who are disabled. It is made up of representatives from private organizations serving individuals who are handicapped and from central, county, and local authorities, including representatives from the ministries responsible for housing, regional planning, traffic, education, and employment. In 1980, Denmark abolished special legislation concerning individuals who are disabled and therefore placed

them on an equal footing with other citizens. But a special law regarding adult education for individuals who are disabled has been adopted which provides for the possibility of special consideration for the needs of people with handicaps. (See Figure 3)

The report from the Ministry of Social Affairs (1985, pp. 2-3) notes the establishment of

> special bodies (councils) for each area where the organizations of the disabled were represented and had a democratic right to negotiate with the responsible governmental bodies and co-determination as regards the development within the area.
>
> Whereas general social assistance in Denmark was traditionally placed under the responsibility of the local authorities, the central government has played an important direct role in the provision of economic, educational, vocational and social measures for the disabled.
>
> In the period 1976-1980 the responsibility for the service of the disabled was delegated from central government to the county and local authorities. The basis for such a delegation of responsibility was created by the carrying out of the local government reform in 1970 which secured local and regional units of a more efficient size and gave them the necessary legal, administrative and financial basis. The purpose of this delegation was to make local and regional authorities direct responsible to all citizens in their respective fields.
>
> A co-ordination of the efforts made by the county and local authorities. . .on the administration of social and certain health matters. . .the Central Council for the Handicapped is made up of representatives from the handicap organizations an from central, county and local authorities. There are furthermore representatives from the competent ministries responsible for housing, regional planning, traffic, and training/education and employment.

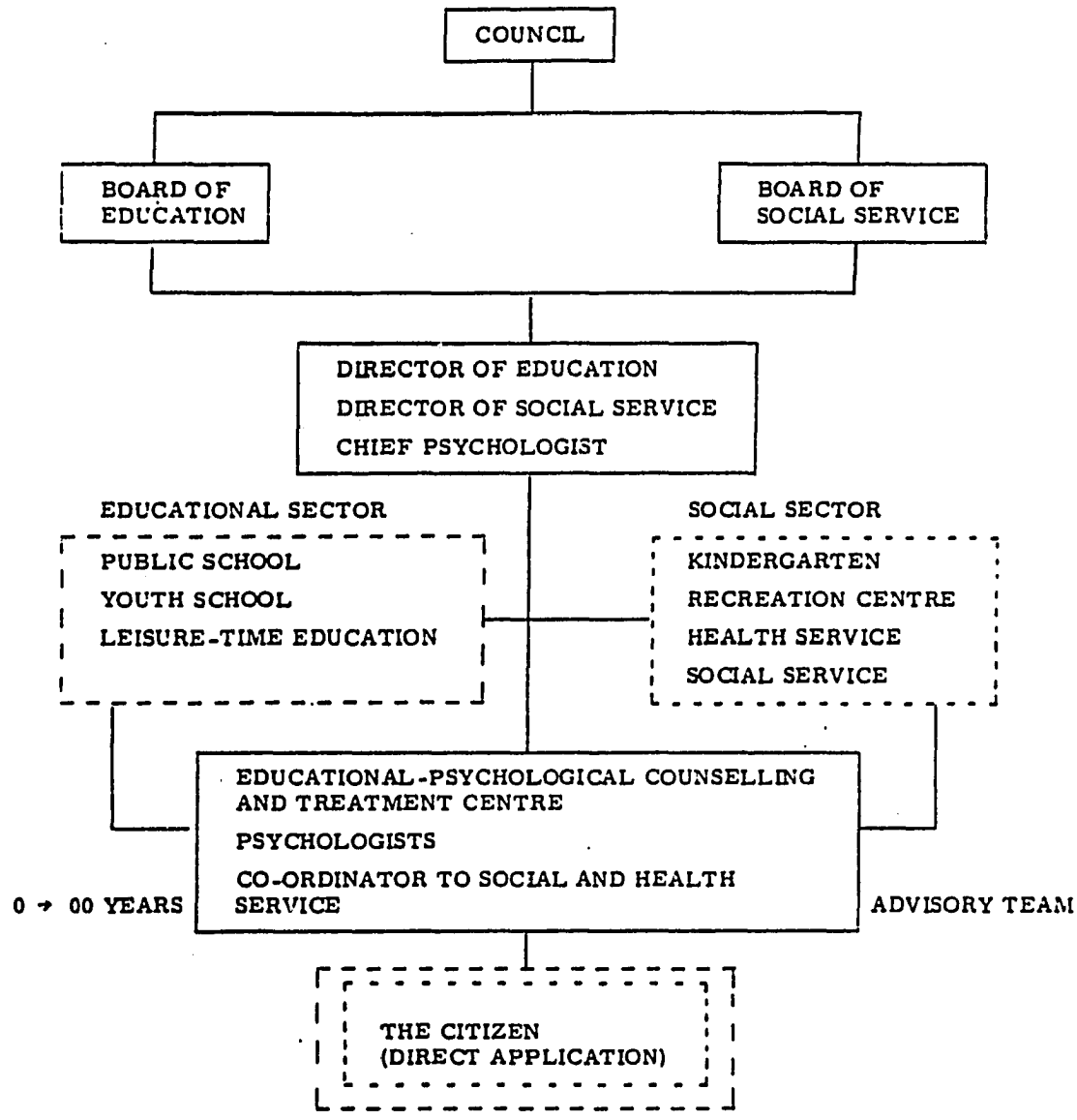

FIGURE 4. Denmark (Kariebo Model)

Legislation of Rehabilitation Services. The following summary of legislation comes from the report of Ministry of Social Affairs, 1985, pp. 1-10:

> The constitutional basis for Denmark's legislation on the disabled is contained in subsection 2 of section 75 of the Constitution, which reads as follows:
>
> Any person unable to support himself or his dependants shall, where no other person is responsible for his or their maintenance, be entitled to receive public assistance provided that he shall comply with the obligations imposed by Statute in such respect.
>
> On the basis hereof and as a general trend in the social and economic development of the last 100 years, Denmark has developed her social legislation, inclusive of legislation on the rights of the disabled based on the principles of the welfare state on equality and participation in social life.
>
> The legislation on the disabled originates in the general legislation on maintenance, education and treatment which has at times been supplemented by special statutes concerning individual groups of disabled. Especially the Public Assistance Act of 1933, which was supplemented by special statutes on the conditions of the blind, the deaf and the hard-of-hearing, and the mentally disabled respectively.
>
> This governmental responsibility was codified in the Public Assistance Act of 1933 and was also laid down in the special statutes for the deaf and the hard-of-hearing (act of 1950), the blind (act of 1956), and the mentally handicapped (act of 1959). A somewhat wider perspective for rehabilitation was introduced by the Rehabilitation Act of 1960. The governmental administration of these acts were handled by the Ministry of Social Affairs and the special administrative units falling under that Ministry, as from 1970 the Board of Social Welfare.
>
> In 1980 the responsibility for the service for the disabled was delegated from the central to the local and regional authorities. This shift has been recognized as a successful step towards facilitating the integration of the disabled in society. Another

> step forward is the general acknowledgement of the fact that matters relating to disablement should be attended to in the sector where they arise and should not automatically belong under the social welfare authorities, but e.g. by the housing sector, the traffic sector, the education sector etc as the case may be.

Japan

Overview. Japan, a chain of rugged islands, lies in an area 3,200 kilometers (2,000 miles) long off the east coast of Asia, with an area of 377,765 square kilometers (145,856 square miles). Its population, estimated in 1985 at 120,301,000, is growing at an annual rate, as of 1983, of 0.67 percent. Of the population, 92 percent practice Shintoism or Buddhism. Japan, subdivided into 41 prefectures, has a parliamentary government. It is a constitutional monarchy operating within the framework of a constitution that became effective on May 3, 1947. Sovereignty, previously embodied in the emperor, is now vested in the Japanese people, and the emperor is defined as the symbol of the State. Executive power is vested in the cabinet, composed of the prime minister and ministers of state. Japan is one of the most politically stable of all post-war democracies.

Japan has few natural resources, and only 19 percent of its land is suitable for cultivation. But its industrial leadership and technicians, together with its intelligent

and industrious work force, have resulted in a highly industrial economy that ranks with the economics of the countries of North America and Western Europe. In 1984, its real growth rate was 5.5 percent, and its per capita income was $10,266 (U.S. Government Printing Office, 1984).

History of Rehabilitation Services. Rehabilitation in Japan started very late compared to the United States and Europe except for facilities for individuals who are visually and aurally handicapped, which were started in 1879. Facilities for the physically handicapped started through the cooperative efforts of citizens in 1921. Most organizations for individuals who are disabled were established after 1945. Most of the laws affecting the disabled, such as the Social Welfare Law, the School Education Law, and the Child Welfare Law, were enacted after World War II.

This delay occurred because of Japanese attitudes, as Nihei (1985) points out: "Vocational training and vocational education facilities were established for the disabled, in 1928. At that time in Japan, there was strong discrimination and prejudice against disabled persons, and the available facilities were barely sustained." (pp. 12-13.) Kojima (1983) notes the dramatic changes thereafter:

> Since 1945 the whole welfare legal system and attitudes toward social welfare were completely reformed, which gave birth to various new organizations for the disabled. Unfortunatley, there is no precise information available on how many agencies and groups serve the disabled in Japan at the

> present time. Organizations which have a nationwide network, such as the National Parents' Union Union for Crippled Children, All Japan Parents' Association for the Mentally Retarded, and the National Federation of Organizations for the Physically Handicapped total more than 100 (p. 34).

Structure of Service Delivery System. Public administration for the advancement of individuals who are disabled and the maintenance of their welfare is now required under the various laws that establish the welfare, education, and labor divisions of government. Kojima (1983) states that "provision for respect of the disabled as individuals, however, is specified by the Constitution of Japan" (1946) on the same basis as that "for other citizens" (p. 52).

Government is organized in Japan on three levels: the national level; the 57 prefectural levels; and the local levels. Kojima (1983) makes the following distinctions among them:

> Each level has organization functioning according to national law. Welfare services called for by the Law for the Welfare of the Physically Handicapped and the Law for the Welfare of the Mentally Retarded are provided through these governmental organizations. The legal responsibility of the national government and the local governments are clearly prescribed. For instance, Article 3 of the Law for the Welfare of the Physically Handicapped provides that the national government and the local public bodies must carry out necessary measures in order to give rehabilitation assistance to disabled persons. The national government bears the final administrative responsibility for the rehabilitation of the disabled, including the establishment of such basic social resources as the National Center for the

> Handicapped, and discharges its legal duty by entrusting the provision of services for disabled people to the governors and mayors in local areas (p. 57).

Most of the costs of rehabilitation services at the local level are paid from national government subsidies. For facility construction, half the cost is subsidized by national government funding; and for some services, 80 percent of the cost is borne by the national government.

The ministries and agencies that bear the cost of services for individuals who are disabled are the Ministry of Health and Welfare, the Ministry of Labor, and the Ministry of Education, with some services implemented through the Ministry of Construction and the Ministry of Transport. In order to coordinate the policies of these five ministries, a National Council to Plan Countermeasures for Mentally and Physically Disabled Persons has been organized within the Prime Minister's office. This agency includes within its membership representatives of the Ministry of Finance, as well as experienced scholars and experts from outside government circles. (Kojima, 1983, p. 57) (See Figure 4)

In 1980, the International Year for Disabled Persons (IYDP), the National Council assumed the additional role of Special National Committee for IYDP and added to its membership fifteen representatives from business organizations,

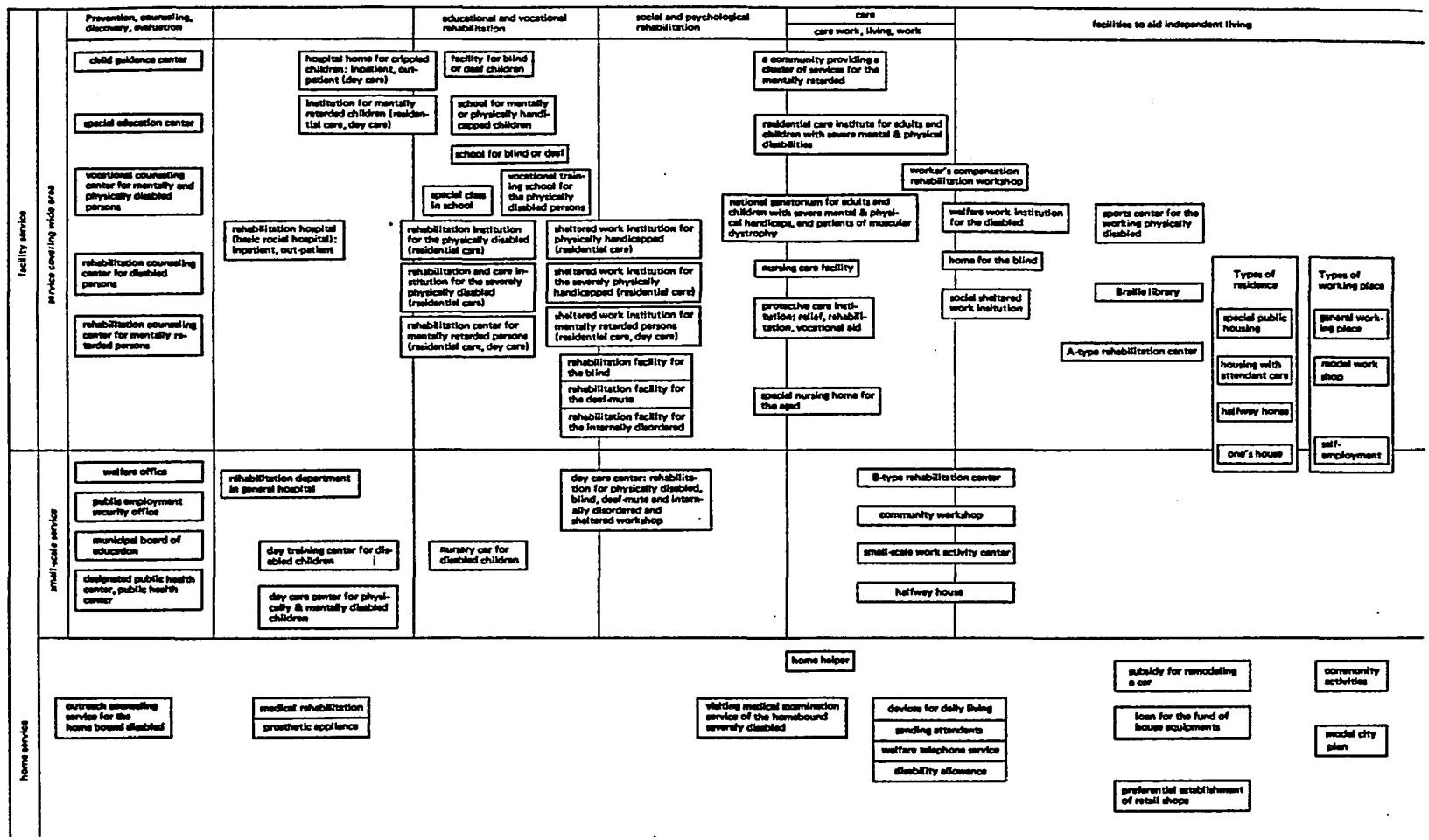

FIGURE 5. Japan Organization Structure

the mass media, labor groups, and nongovernmental organizations that provide rehabilitation services. In all, this committee has 60 members. Kojima (1983) states that:

> Although such broad representation within a government agency raises the possibility of a lack of uniformity or consistency in policies, the formation of this council has contributed greatly to the promotion, refinement, and coordination of policies since its establishment in 1970 (p. 59).

At the interministry level, this committee holds both general and subcommittee meetings. Meanwhile, other public administrative agencies relating to individuals who are disabled hold day-to-day coordinating and policy-planning sessions under the leadership of the Ministry of Health and Welfare.

After the International Year of Disabled Persons, the Japanese government drew up a "long-term National Plan of Action" concerning measures for individuals who are disabled in Japan. To implement this plan and to ensure better coordination among the concerned ministries, a government headquarters for countermeasures for individuals who are disabled was established in 1982, led by the prime minister. Members of the headquarters include the ministers of two ministries and the vice ministers of twelve. Following the long-term plan, each ministry promotes its measures

for closer coordination within the government (Kojima, 1983, p. 59).

Legislation of Rehabilitation Services. According to Kojima (1983),

> In Japan there exists no single comprehensive rehabilitation act, as may be found in Europe and America. Instead, a number of laws dealing with specific life crises surround the disabled person like a folding screen. As the number of intake agencies for systems and services increases, disabled persons and their families, often without mobility of their own or specialized knowledge of social resources, are lost in a jungle of services and overwhelmed by fragmented aid systems to the extent that they may even fail to receive services to which they are entitled.
>
> In the highly bureaucratic society of today, social workers with broad knowledge of available social resources and lawyers with expertise in the field of welfare have to join in partnership with disabled persons to assure the rights of the disabled. They must assume an advocacy role in order to help the disabled person select the service best fitted to meet a given need. At the same time, government ministries must be sensitive to the voice of disabled persons and seek to familiarize users with legislation applicable to their needs (p. 54).

Kojima (1983) summarizes laws concerning welfare for the disabled as follows:

Basic Laws
1) Constitution of Japan (1946)
2) Fundamental Law for Education (1947)
3) Fundamental Law for Countermeasures Concerning Mentally and Physically Handicapped Persons (1970)

Laws for Welfare of Disabled Children
1) Child Welfare Law (1947)
2) Child-Rearing Allowance Law (1965)
3) Maternal and Child Health Law (1965)
4) Law Concerning Special Rearing Allowances for Handicapped Children (1966)

Laws for Special Education
1) School Education Law (1947)
2) Law Concerning Encouragement of Enrollment in Schools for the Blind, Schools for the Deaf, and Schools for the Handicapped (1954)

Laws for Welfare of Disabled Persons
1) Law for the Welfare of Physically Handicapped Persons (1949)
2) Law for the Welfare of Mentally Retarded Persons (1960)
3) Law for Special Aid to Wounded and Sick Retired Soldiers (1963)
4) Mental Health Law (1950)

Laws for Social Security and Pension
1) Daily Life Security Law (1950)
2) Employees' Pension Law (1944)
3) National Pension Law (1959)

Laws for Employment and Work Accident
1) Employment Security Law (1947)
2) Workmen's Accident Compensation Insurance Law (1947)
3) Physically Handicapped Persons' Employment Promotion Law (1960)
4) Employment Countermeasures Act (1966)
5) Vocational Training Law (1969)

In Japan, the task of the Council for Countermeasures for Mentally and Physically Handicapped Persons is to coordinate the activities of eleven ministries serving the disabled, such as the Ministries of Health and Welfare, of Finance, of Transport, of Housing, of Education, and of Labor. The council must improve communication between government ministries and bureaus and, through the implementation of concrete programs, attempt to coordinate activities and fill in gaps existing between administrations. Because the structure of the legislation for the disabled is so fragmented in Japan, the Council's coordinative function is necessary to integrate existing diverse services (p. 54).

Yugoslavia

Overview. Yugoslavia's area is 256,409 square kilometers (99,000 square miles); its population in 1981 was

estimated at 22.4 million, growing at an annual rate of one percent. The population comprises clearly defined ethnic groups: Serbs (36 percent), Croats (20 percent), Bosman Muslims (9 percent), Macedonians (6 percent), Slovenes (8 percent), Albanians (8 percent), Montenegrin Serbs (3 percent), Hungarians (2 percent), Turks (0.5 percent). Religions represented are Eastern Orthodox, Roman Catholic, and Muslim.

A federal republic, Yugoslavia attained independence on December 1, 1918, and its constitution was ratified in February 1974. The single political party is the League of Communists of Yugoslavia. The executive branch of the government consists of the president (chief of state, rotated annually from among the collective body) and the premier (head of government and president of the Federal Executive Council for a four-year term). The legislature is a bicameral assembly (308 delegates), with an executive arm in the form of the Federal Executive Council (cabinet). The judicial branch contains the Constitutional Court and the Federal Supreme Court. Administratively, Yugoslavia is divided into six republics and two autonomous provinces.

Agriculture accounts for 13 percent of the economy, and industries for 37 percent. The annual growth rate of the economy in 1981-82 was 2.2 percent. The per capita

income in 1981 was $2,300. (U.S. Government Printing Office, 1984)

History of Rehabilitation Services. A summary of current rehabilitation efforts is provided by the following material from Rehabilitation of the Disabled in Fifty-One Countries (U.S. Department of HEW, 1964, pp. 216-217):

> In many countries programs for the disabled have been established first by voluntary effort and support but such is not the case in Yugoslavia. There has been some social assistance for the blind and deaf, however, since the mid-1800's. It was in 1950 with the passage of the Social Insurance Act, that the first provisions for services to the disabled were established on a nationwide scale. In 1956, improved procedures were adopted under a revision of the Social Insurance Law. The services of medical rehabilitation were provided then and are still provided by the national health institutions while vocational rehabilitation is under the Institute of Social Insurance and the Department of Labor.

Structure of Service Delivery System. Various organizations and institutions throughout Yugoslavia provide rehabilitation services to individuals who are handicapped. The Federal Institute for Rehabilitation in Belgrade provides leadership in the development and delivery of services. Its objectives are to establish national standards for treatment and training; to establish a new Speciality of Physical Medicine and rehabilitation as graduate training in several universities; to provide continuous training for medical and technical personnel; and to establish total rehabilitation programs in each Republic, integrating the

medical, educational, vocational, and social aspects of rehabilitation. (U.S. Department of HEW, 1964, p. 217)

Other centers have followed the Belgrade center; by 1957, centers had been established in Zagreb, Lijublizana, Banja-Luka, and other locations. As the nation-wide program has taken shape, a rehabilitation department has been established in the Secretariat of Public Health. A federal rehabilitation committee has also been established to advise the national program and to cooperate with international organizations.

Rehabilitation facilities in Yugoslavia are numerous. Most are located in areas where nature has provided hot springs, used as centers for convalescence and recovery. (U.S. Department of HEW, 1964, p. 218)

Thailand

Overview. Thailand, situated in Southeast Asia, has an area of 514,000 square kilometers (198,500 square miles), divided into four general regions. Its estimated population in 1981 was 48.3 million, with an annual growth rate of 2.1 percent. The predominant religion (95.5 percent) is Buddhism; 4 percent of the population is Muslim.

A politically democratic constitutional monarchy, with a constitution ratified in December 1978, Thailand is governed by a king (chief of state), a prime minister (head of government), and a bicameral national assembly. The

judicial branch contains three levels of courts. Administratively, the country is divided into 73 provinces, which are subdivided into 642 districts.

Thailand's economy consists of 24 percent agriculture, 12 percent natural resources, and 27 percent industry. It is growing at an annual rate (1975-80) of 6.8 percent. The per capita income in 1981 was $758. (U.S. Government Printing Office, 1984)

"In 1976, a sampling survey of disabled persons was conducted in the Northeastern Region of Thailand. . . .it was found that 5 per cent of the sampled population were disabled. . ." Report on Welfare and Services for the Disabled, Department of Public Welfare, Ministry of the Interior (1985, p. 2).

History of Rehabilitation Services. In the past, there were a large number of organizational/agencies from both public and private sectors which were involved in social welfare and development areas in Thailand. The fact that these organizations worked separately led to confusion and duplication of work programs and activities. According to the Report on Welfare for the Disabled, Department of Public Welfare, Ministry of the Interior (1985, p. 1),

> The welfare assistance for the disabled persons in Thailand has been given for many years according to religious principles. The problems of disablement has been realized since World War II as the increasing number of disabled persons due to battle and industrial expansion. The development of assistance

has been mostly organized among voluntary and non-governmental agencies during the early period of time. For Government sector the Department of Public Welfare, Ministry of Interior has taken responsibility for the disabled persons no later than its origination in 1941. In compliance with the Beggary Control Act B.E. 2484 (A.D. 1941), the beggars who are disabled and dependent are to stay in the institution. First of all, the major idea of welfare assistance is to provide them shelter, food and necessary things for living as well as to prevent them from begging. Chronologically, the services for them has been developed into rehabilitation, vocational training and employment aspects. In addition to welfare services for which the Department of Public Welfare provides, other governmental organiza-organizations such as the Department of Medical Services, the Department of General Education, the Department of Labour as well as non-governmental agencies are responsible.

Structure of Service Delivery System. The following summary of the departments concerned with the delivery of services comes from the Report on Welare and Services for the Disabled, Department of Public Welfare, Ministry of the Interior (1985, p. 1):

> The Department of Public Welfare, Ministry of the Interior
>
> The department runs services of welfare and social rehabilitation for the disabled namely, vocational training, sheltered workshop programme and institutional care. Apart from these services, the department undertakes therapeutic treatment in collaboration with the Department of Medical services, Ministry of Public Health. There are eight institutions under the auspices of the Department of Public Welfare.
>
> The Department of Medical Services, Ministry of Public Health
>
> The department is responsible for medical care, medical rehabilitation and prosthetic and orthotic appliances. These services are provided by six public hospitals, mostly in Bangkok except one in the northern region.

The Department of Labour, Ministry of Interior

The department undertakes the employment for the disabled and takes responsibility of their Workmen's Compensation Fund for the Disabled who had industrial accidents.

The Department of General Education, Ministry of Education

The department provides special education at the primary level. Moreover, the Division of Special Education also organizes course of training for special education and help to supply teachers with special education to schools which are run by other departments or private organizations. (See Figure 5)

Legislation of Rehabilitation Services. In 1941 the Department of Public Welfare was in compliance with the Beggar Control Act, which provides that individuals who are disabled and the destitute beggars who are convicted by law are confined in institutions:

> The Department of Public Welfare has taken the responsibility for the disabled since its inception in 1940. In compliance with the Beggar Control Act B.E. 2484 (A.D. 1941), the disabled and the destitute beggars who are convicted by law are confined in the institution. Originally, the objective of assistance was only to provide them with shelter, food and other necessities in order to prevent them from begging. However, the services for them have been developed into that of welfare and rehabilitation namely; institutional care, vocational training and employment aspects. Apart from these services, the Department has also provided therapeutic treatment for the discharged mental patients in collaboration with the Department of Medical Services, Ministry of Public Health. There are presently 8 welfare institutions for disabled persons operated by the Department of Public Welfare. . . . Since there is not any measurement to protect the disabled persons at present, it is very important to enact the legislation to protect the rights of the disabled. The draft of Rehabilitation for the Disabled Act has been prepared. This draft of Act has been proposed by the National Committee on Rehabilitation for the Disabled which one of its jobs is to

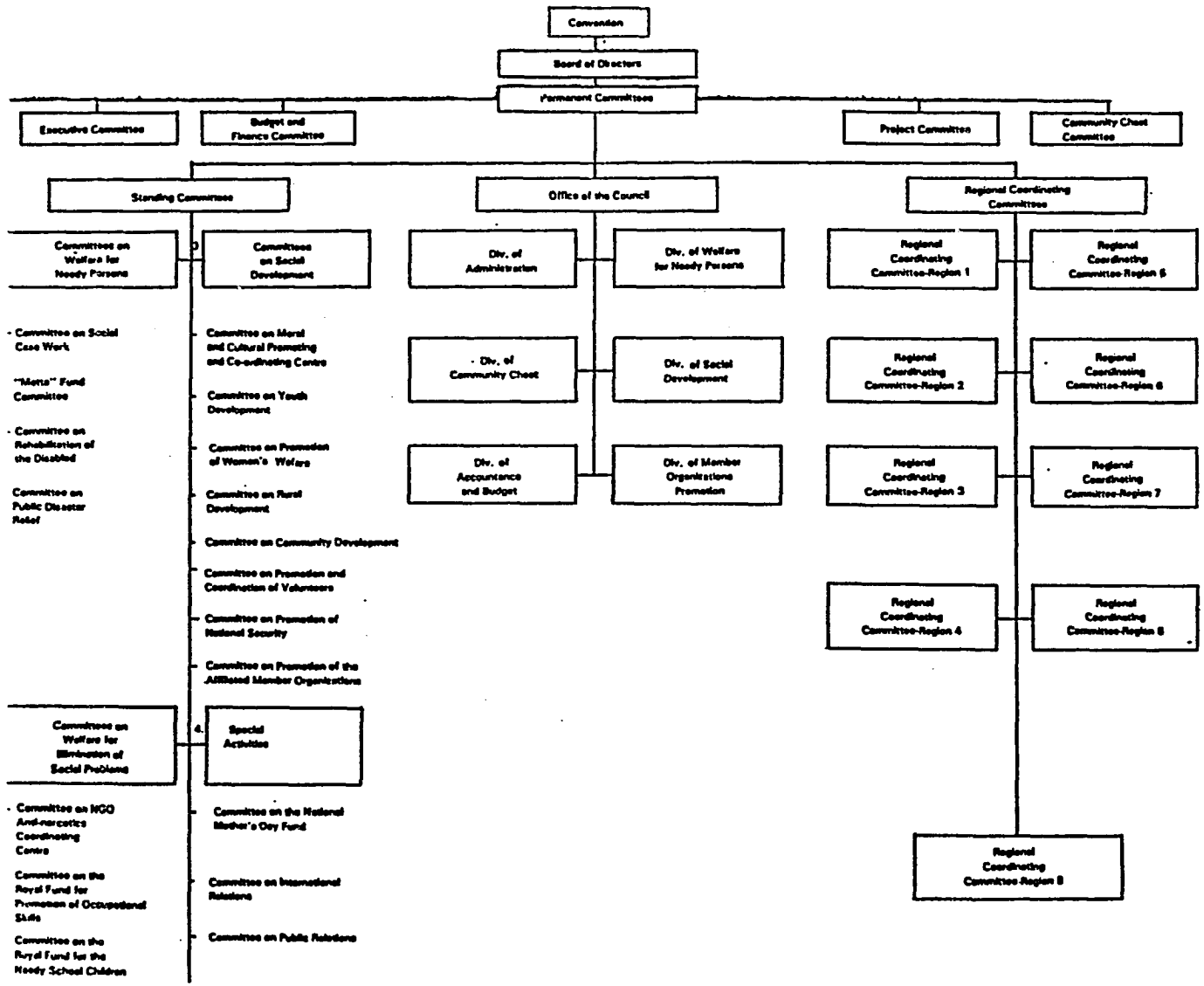

FIGURE 6. Thailand Organization Structure

> initiate and accelerate the promotion of the disabled's activities in order to encourage them as social contribution and their rights are assured. The Registered disabled can obtain the welfare services and will be protected in accordance with the Act. (Welfare and Services for the Disabled, the Department of Public Welfare, Ministry of the Interior (1985, pp. 1, 4).

Kenya

Overview. Kenya, bounded by Ethiopia, the Sudan, Tanzania, Uganda, Lake Victoria, Somalia, and the Indian Ocean, is 582,646 square kilometers (224,960 square miles) in area. Its population, estimated in 1983 at 19.7 million, is growing at an annual rate (1983 estimate) of 4.1 percent. The religions represented include indigenous beliefs (26 percent), Protestant (38 percent), Roman Catholic (28 percent), and Muslim (6 percent).

Kenya is republic, having gained independence on December 12, 1963; its constitution dates from 1963. It is governed by a president (chief of state and head of government) and a national assembly (parliament). Administrative subdivisions include 40 rural districts, joined to form seven rural provinces.

The economy comprises natural resources (wildlife, land, agriculture, 33 percent); industry (13.3 percent), and trade (16 percent). The annual growth rate of the economy in 1983 was 3.9 percent; the per capita income was $309. (U.S. Government Printing Office, 1984)

History of Rehabilitation Services. There are 1.5 million handicapped persons in Kenya (Department of Social Services, 1981), representing about 13.3 percent of the total population. The state of individuals who are handicapped was described in a conference paper at the Department of Social Services, Ministry of Cultures and Social Services, 1981, as follows:

> In the past, disabled persons were pushed aside, neglected, and sometimes hidden from view. The impairment with which a child or an adult was afflicted was seen as a terrible curse or omen. Sometimes as an inescapable punishment of sins committed by the fore-parents. In some cases, not only did the disabled persons suffer from community reproval but also the entire family. As a result of this no one realized the prevention or even cure was possible. Programs for disabled were, therefore, left to religious and voluntary organizations. (p. 33)

Structure of Service Delivery System. The Rehabilitation and Education of the Blind in Kenya was started by the Salvation Army in 1946. The Catholic church later followed suit and established several institutions for the blind. Years later, the Ministry of Education introduced the integration of blind with normally sighted students. In 1960, the Kenya Union of the Blind was established to achieve the following objectives:

a. To unite the blind.

b. To seek equal right, in the Kenya Community.

c. To give views to the government on matters affecting blind when required to do so or when need arises.

d. To organize issues affecting the blind (that is, education, recreation, trades, employment, travel, cooperatives, etc.).

e. To raise funds to achieve the foregoing objectives. (Report of the Department of Social Services, 1981, p. 43)

The Ministry of Health has recently emphasized the prevention of disabling conditions caused by certain communicable diseases. An expanded program of immunization, started in 1980, tries to ensure that all children are immunized against common childhood diseases, among them tuberculosis, measles, polio, and tetanus, all of which can leave behind permanent mental or physical damage. Besides disability prevention, the Ministry of Health is interested in rehabilitation and in the integration of individuals who are disabled into society. (The Report of The Department of Social Services, 1981, p. 50) listed the following services:

> Physiotherapy (concerned with assessment, treatment, and prevention of disorders of human movement).
>
> Occupation Therapy (concerned with assessment, treatment, and prevention of disability through specific use of activities like industrial art, recreation, etc. in order to achieve maximum function and independence).
>
> Orthopedic Technology (deals with construction and fabrication of artificial limbs and other

orthosis for substatution of the loss of a body part).
Dental Technology (concerned with construction of dental prosthesis, that is, false teeth, etc.).
Speech Therapy (concerned with disorders of human communication).

The central governmental institution in Kenya is the Department of Social Welfare in the Ministry of Culture and Social Services. Before 1974, the Department was in the Ministry of Cooperative and between 1974 and 1980, in the Ministry of Housing. The Department is headed by a Director of Social Services, accountable to the permanent secretary of the Ministry. It is responsible for youth development (that is, crafts training in village polytechnics), community development (that is, guidance for rural self-help projects), vocational rehabilitation, and adult education. Other ministries concerned with social welfare are the Ministries of Labour (National Social Security Fund) and of Home Affairs (which provides approved schools for juvenile delinquents) (U.N. Report on Administration of Social Welfare, 1985, p. 19) The Ministry of Culture and Social Services, through the Division of Vocational Rehabilitation in the Department of Social Services, is extending services to the rural areas through the expansion of Rural Vocational Rehabilitation Centers. The Special Education Section, the responsibility of the Ministry of Basic Education, maintains through annual grants and provision of teaching staff both special schools and special units in regular schools for

handicapped children with learning disabilities (Report from the Department of Social Services, 1981, p. 36).

A great variety of voluntary agencies, 123 in all, have concerned themselves with social welfare in Kenya. Coordination of voluntary efforts at the national level is often carried out by the National Council of Social Services in Kenya. All responsible branches of government are usually represented at this council. (U.N. Report on Administration of Social Welfare, 1985, p. 20)

Vocational rehabilitation services reach only a very small proportion of the number of individuals who are disabled, and these very few appear to find employment. Various possible reasons for this situation were suggested by the Report from the Department of Social Services (1981, p. 46), including unsuitable criteria for admission to programs, insufficient and low-caliber training staff, unsuitability of the courses for the labor market, and the virtual absence of any effective employment.

The report also noted with concern that one of the major obstacles to successful rehabilitation of individuals who are disabled is the negative attitude of both disabled and able-bodied persons toward individuals who are disabled. This attitude may arise from ignorance and guilt. Quite often the parents of a disabled person will go to great lengths to hide their child, for they have superstitious beliefs about the causes of disabilities. Such an attitude

causes individuals who are disabled themselves to suffer psychologically, acquiring feelings of self-hatred and alienation and thus having no motivation to improve their destiny. Of paramount importance, therefore, is a change of attitude on the part of all those concerned, among them parents, communities, schools, and the government. Once a change of attitude has occurred, individuals who are disabled will make the appropriate physical and psychological adjustments required for leading a normal life in an integrated society. (p. 13)

This change cannot be achieved without legislation. The government of Kenya is planning to enact legislation aimed at providing protection to individuals who are disabled and ensuring that their rights are protected and their needs met.

Kuwait

Overview. Kuwait is one of the Arabic countries in the Middle East, located in the northeastern corner of the Arabian Peninsula, bounded on the north and west by Iraq, on the south by Saudi Arabia, and on the east by the Arabian Gulf. Its area is 17,818 square kilometers (about 6,880 square miles) divided into five counties. Its population in 1983 was 1,550,000, and its annual growth rate from 1975 to 1980 was 7 percent (including immigration). The predominant religion is Islam (95 percent). A constitutional monarchy,

Kuwait gained independence from Great Britain on June 19, 1961, and ratified the Constitution in 1962. Politically, Kuwait is democratic, with an executive branch presided over by the Amir (head of state), a legislative National Assembly, and judicial courts established in 1959.

Kuwait has enormous oil wealth in relation to its population, producing a per capita gross income of more than $16,500 in 1981. The government has sponsored many social welfare, public works, and development plans, financed with oil revenues, surpassing the social programs of the Scandinavian countries in scope and paternalism. Among the benefits provided by the government are retirement income, marriage bonuses, housing loans, virtually guaranteed employment, free medical services, and education at all levels for Kuwaitis. Foreign nationals residing in Kuwait obtain some but not all the welfare services. For instance, the right to own stock in publicly traded companies, real estate, or majority interest in a business is limited to Kuwait citizens.

Industry in Kuwait consists of several large export-oriented petrochemical units, three oil refineries, and a range of small manufacturers. It includes large water dis-distillation plants, as well as ammonia desulfurizing, fertilizer, brick, block, and cement plants. Plans for expansion and modernization include major projects in oil

refining, petrochemicals, electricity, water supply, highway construction, housing, and telecommunications.

Kuwait has been a source of economic assistance to other Arab States since 1960. (U.S. Government Printing Office, 1984)

History of Rehabilitation Services. In 1950, the Kuwait government established a system of comprehensive services for individuals who are handicapped, provided to the public free of charge through the following ministries (as summarized in the Report of Kuwait National Committee for the Year of the Disabled, 1981).

The Ministry of Public Health provides free comprehensive multidisciplinary medical care to handicapped adults and children to help them achieve their maximum level of physical independence in order to incorporate them into the community as usefully as possible. In 1958, the ministry established a small department for physical therapy, and in 1965, more departments and one large Physical, Medical, and Rehabilitation Center. In 1985, the number of physical departments increased to more than 15.

At the same time, the Ministry has as a primary goal the prevention of disability. It has developed and implemented the following programs for public education, early detection, and overall prevention:

(1) Family Planning Division;

(2) Neurology Unit;

(3) Heredity Center;

(4) Developing Medical Unit;

(5) Motherhood and Infant Care Center;

(6) Clinics Division;

(7) Specialized Diabetes Clinics;

(8) Chest Diseases and Anti-TB Clinic;

(9) Vocational Health and Anti-Industries Valuation Dimension. (pp. 32-37))

The Ministry of Education started its services in special education and vocational rehabilitation for individuals who are disabled in 1955, when it established the Light Institute for the Blind, the first in a series of Special Education Institutes. The number of these has increased with the growing number of disabled pupils in all categories due to the passage of the compulsory law in education No. 11, Year 1965 (Article 4). This law has been applied to disabled children, making it compulsory for the physically and mentally disabled to be enrolled in special schools or ordinary schools for as long as they can pursue their studies.

The Ministry of Education now includes 13 institutes with various specialities to provide educational services to the blind, the deaf, the mentally retarded, and the physically handicapped at different stages in their education. The institutes have provided all means for ensuring the success of the educational process, such as modern technical

equipment, equipment to measure defects in hearing, workshops for the production of educational aids using the most modern machines and instruments, and workshops to demonstrate artificial limbs and walking aids. Other services, all provided free, include

(1) Medical and surgical services;

(2) physiotherapy;

(3) psychological and social services;

(4) camping and recreational services;

(5) boarding sections;

(6) transportation;

(7) sheltered workshops;

(8) textbooks and aids;

(9) meals; and

(10) clothes.

Clearly, the Ministry of Education is concerned not only with the education of individuals who are disabled but also with the services to enhance their social, psychological, and medical well-being. (pp. 8-16)

The Ministry of Social Welfare and Labour provides services for the severely mentally disabled and multiply handicapped, the chronically ill, and the needy elderly through its special care facilities.

In 1965, this ministry established the Home for the Mentally Retarded, caring for 58 clients of both sexes; by the beginning of 1980, this figure had risen to 397 clients.

Work is now under way on the construction of an additional home to accommodate a similar number of clients. Furthermore, in 1974, the ministry established a home for the welfare of individuals who are handicapped, which then accommodated 57 clients but which by the beginning of 1980 housed 90 clients. An institution for the welfare of the handicapped, designed to accommodate 720 clients, was scheduled to be opened in 1982. This facility, planned according to international specifications adopted in developed states to provide welfare services to this category of people, was expected to be completed at a cost of more than 30 million dollars.

In 1961, a center for vocational rehabilitation of individuals who are handicapped was established to provide services to handicapped citizens who have lost the function of one of their senses or who are afflicted with chronic diseases requiring sustained medical treatment. Services rendered by the center involve primarily the rehabilitation of individuals who are handicapped to train them properly in occupations compatible with their remaining functional physical abilities. This training helps them acquire skills and experiences that enable them to adjust, earn their livelihood, and continue to lead their lives with dignity and integrity. In 1966, the Sheltered Workshop was established to guarantee employment for those who have not been successful in the working world, as well as to ensure

vocational supervision for such individuals and to market their productions.

The ministry also provides financial support for those families who are able to care for their own handicapped relatives at home. (pp. 22-30)

The private sector has not stood idly by with respect to the problems of individuals who are handicapped, but has in fact contributed its share toward the rehabilitation of handicapped citizens who cannot be accommodated in governmental facilities and of non-Kuwaiti citizens living in the country. Agencies for assistance include the following:

The Kuwait Handicapped Society: Although Kuwait provides its citizens with a full span of rehabilitation services for individuals who are handicapped, a group of rehabilitation professionals and concerned parents decided to go beyond governmental assistance. Working hand-in-hand with the ministries, The Kuwait Handicapped Society, funded entirely by private donations, was created in 1971 to provide services to non-Kuwaiti disabled persons. This umbrella organization promotes the active participation of individuals who are handicapped in the day-to-day operation of its activities, with the goal of independent living for its members.

The first task undertaken by the society was to provide rehabilitation and care for severely multiply handicapped children. Believing that an efficient information system is now essential in an era of new scientific and technological advances in all aspects of rehabilitation services, the society has as its next goal the establishment of an Information and Communication Center.

The Blind Society and the Kuwait Speech and Hearing-Impaired Society: The Blind Society was established in 1973; and the Kuwait Speech- and Hearing-Impaired Society was established in 1975. Both these organizations provide technical, social, and recreational facilities to their members.

The Kuwait Club for the Handicapped: In 1976, this club for the handicapped opened to offer athletic, artistic, and recreational training to its members. Last year, a team from Kuwait participated for the first time in the International Stoke-Manderville Sports Event held in England for individuals who are disabled, winning 22 medals, 12 of them gold, and receiving a "FIRST" in amateur competition. The athletes were the youngest in attendance.

The Regional Office for Mobility International: In 1978, the Kuwait Society for the Handicapped established the Regional Office for Mobility International. This facility encourages handicapped persons to enjoy the benefits of

international travel and exchange by arranging travel services for their special needs.

The State of Kuwait has striven to provide all establishments, government or private, with trained technical staff in the form of doctors, psychiatrists, sociologists, occupational therapists, physical therapists, vocational instructors, and the like, and with experts specialized in the various relevant fields. It also holds training courses and panel discussions inside and outside those establishments to ensure that the standard of performance of staff at these facilities continually improves. Also, it participates in all regional and international conferences dealing with individuals who are disabled. The State of Kuwait further observes each year a week in honor of all those engaged in the working in this field in recognition of all the efforts exerted by them in providing welfare and rehabilitation services to their clients, the handicapped.

Rehabilitation Philosophy in Kuwait: The State of Kuwait's commitment to its responsibility for the care of handicapped people stems from its social heritage and customs, including close family ties. Accordingly, the state provides various services to all categories of disabled people through both governmental and nongovernmental bodies.

Policy, based on principles consistent with those advocated by the United Nations, is aimed at achieving full

participation and equality for individuals who are disabled. Humanitarian, democratic, and economic concepts also form the basis for rehabilitation policy.

1. The humanitarian concept derives from the Islamic heritage and religion, which looks at disability as unimportant to an individual's worth as a human being. The growing sense of social responsibility manifested during Kuwait's first 30 years as an independent state has strengthened the humanitarian argument for rehabilitation. Some Islamic ideas about disability include the following:

   a. The full right of the disabled to enjoy equality, so that they may lead dignified lives without any distinction from others regardless of social position. . . .The Koran says that there are no restrictions on the blind, the lame, or the sick.
   b. The reduction of legal obligations on the disabled according to their capabilities.
   c. The requirement that every person work to the limit of his or her capabilities.

2. The democratic concept is expressed in the Kuwait constitution. Several constitutional articles spell out the duties of the state toward its citizens: its commitment to promote justice, freedom, and equality among all segments of the population; to provide security, tranquility, and equal opportunity to all citizens; to protect motherhood and

childhood; to promote the well-being of the growing generation and to safeguard it against exploitation and physical and spiritual negligence; to assist citizens at times of sickness or incapacity to work; and to provide health care, public services, preventive measures, and therapeutic medical services for the treatment of diseases and the control of epidemics.

The constitution also provides for the right of individuals who are disabled who are capable of learning to have access to education. It safeguards as well the right of every citizen to secure employment compatible with his or her physical and mental capabilities. The State of Kuwait therefore supports national, regional, and international efforts toward the rehabilitation and employment of disabled persons.

3. The economic concept is related to the democratic and humanitarian concepts in that disabled persons are viewed as productive human beings who can participate in building the national economy. This view is based on the idea that disabled persons are an integral part of society, capable of integrating themselves into all walks of life and participating in and contributing to all activities.

All forms of isolation for individuals who are disabled are rejected by the Islamic belief in both the ability of disabled persons to give and the importance of the role that can be played by such persons. Kuwait

strives, therefore, to maintain a balanced relationship between the dependence of the disabled on the state and their dependence on their families and communities while emphasizing the role that they can play in overcoming and solving their own problems.

Legislation of Rehabilitation Services. Kuwait has no special laws for individuals who are handicapped, but since 1981 (the International Year of Disabled Persons), Kuwait has established a national community of that year which was claimed by the United Nations. One of the National Committees of Kuwait was to provide a Bill of Law that applies to individuals who are handicapped. The Bill at the moment is under the consideration at the National Assembly of Kuwait.

The following is a summary of this Bill. The Bill consists of six parts:

Part One: Definitions and General Provisions

> The Handicapped: Every person who is unable, due to a disability in his physical or mental abilities, to secure for himself, in whole or in part, the ordinary necessities of life needed by a normal person. (Article 1, p. 1)
>
> Habilitation: Preparation of the handicapped--through education, training, treatment and compensational aids to maximize the utilization of his physical, mental and occupational abilities to enable him, whenever possible, to carry on his normal life. (Article 1, p. 1)
>
> The provisions of this Law shall apply to the Kuwaiti handicapped. It shall be permissible, by a decision of the Competent Minister, to apply all or part of the provisions hereof to the non-Kuwaiti

handicapped residing in the State of Kuwait. (Article 2, p. 2)

Organized and integrated services shall be rendered to the handicapped as provided for herein or in the decisions issued by the competent authorities in the following fields:

Medical
Social
Educational
Rehabilitation
Housing and Transportation
Labour and Employment

It is permissible, by a decision of the competent Minister and after the approval of the High Council for the Disabled to establish new services or cancel such old ones as may be discovered through pursuing the problem of disablement and the methods of encountering same. (Article 3, pp. 2-3)

Part Two: Rights of the Handicapped

The handicapped person shall enjoy his political and civil rights in conformity with his physical and mental abilities pursuant to the certificate issued in this respect by the Ministry of Public Health.

The State shall provide medical services to the handicapped to relieve his disability and put an end to it. It shall also provide to him medical habilitation and nursing in an integrated and suitable manner to his respective condition.

The State shall provide proper opportunities of education and habilitation to the handicapped according to his respective condition. It shall endeavour to advance same up to the University level and shall also provide to him the training programs necessary for the carrying on of his normal life.

The State shall provide day-care to the handicapped and set up centers of habilitation and rehabilitation, sheltered workshops and accommodation houses, if necessary.

The State shall provide residences for the handicapped who meet the conditions of enjoying the governmental housing in accordance with a certain priority and at a rate to be determined under a

decision issued by the High Council for the Disabled, in the areas where the Public Housing Authority is carrying out building activities.

The State's competent authorities shall comply with the international specifications for buildings, supermarkets entrances, recreational houses, means of public transport and all places where the handicapped are expected to visit.

The competent authority shall determine the cases that require providing care to the handicapped at home and amidst his environment out of care for his family and community ties.

The subsidy established under the General Assistance Law, shall be applicable to the handicapped with an added percentage of 25%.

The Ministry of Public Health shall endeavour to study the causes of disability during the period of pregnancy, delivery and post-delivery and shall provide the preventive services therefrom through securing compulsory immunization requirements or other means. It shall also endeavour to take the measures and actions necessary for the limitation of same. (Articles 4-12, pp. 3-5)

Part Three: Habilitation and Assimilation In the Society

The State shall provide habilitation and rehabilitation for the handicapped. It shall absorb the expenses thereof and shall also grant periodic bonuses to the parties that perform such duties whether individually or in cooperation with the State's competent authorities.

The State shall further pay a rehabilitation bonus to the handicapped during the habilitation period in accordance with the rules and procedures laid down by the High Council.

The competent Minister shall issue a decision of the conditions of acceptance of the handicapped at the habilitation centres and the period thereof. The Minister may exempt some cases from such conditions. The handicapped who passes the habilitation course successfully shall be granted the occupational habilitation certificate.

The Governmental and Private Parties that employ or recruit (50) workers at least shall engage a number, not less than 2% of the total personnel, of the occupationally rehabilitated handicapped, in such jobs as may suit their respective activities. The competent authorities shall endeavour to have the occupationally qualified handicapped persons join the jobs consistent with their qualifications.

The State shall subsidize the rehabilitation and compensational tools and aids required for the handicapped.

The State shall obligate the Commercial Companies to market the Compensational and rehabilitation devices and equipment of the handicapped through the establishment of the margin of such companies. (Articles 13-17, pp. 6-7)

Part Four: The High Council for the Disabled

A High Council for the Disabled shall be set up under the chairmanship of the Competent Minister and membership of the following persons:

1. Undersecretary of the Ministry of Social Affairs & Labour
2. Undersecretary of the Ministry of Public Health
3. Undersecretary of the Ministry of Education
4. Undersecretary of the Ministry of Planning
5. Undersecretary of the Ministry of Public Works
6. Undersecretary of the Ministry of Housing
7. Undersecretary of the Ministry of Communications
8. Director General of Kuwait Municipality
9. Representative of the Kuwait Society for the Care of the Handicapped
10. Representative of the Kuwait Chamber of Commerce & Industry
11. Director of the Technical Office

The Competent Minister may invite other members, whenever required.

The Competent Minister shall, after approval of the High Council, issue an internal regulations that cover:

A. The Council's functional administrative and financial rules.

B. The Council's Personnel Regulations without prejudice to the provision of Articles 5 and 38 of the Civil Service Law.
C. The Rules necessary for the progress of work at the Council and the exercise of its functions.

The High Council shall be concerned with the formulation of the general policy for the care and habilitation of the handicapped. It shall, inter alia be concerned with the following:

1. Passing of the plans for executing the general policy towards the care of the handicapped and pursuing the reports relating to the execution thereof.
2. Formulating the regulations and procedures relating to the execution of the State's obligations provided for herein in respect of the handicapped.
3. Formulating the rules and regulations governing the determination of the basic requirements for the care and rehabilitation of the handicapped.
4. Proposing the laws and regulations relating to the care and rehabilitation of the handicapped.
5. Naming the members of the Technical Office.
6. Approving the proposed annual budget and closing account.
7. Accepting the unconditional contributions and donations as well as determining the means of expending of same.
8. Formulate the rules and regulations governing the managing and investing of the funds of the handicapped, as required.
9. Passing the annual plan of participation in the international conferences, seminars and forums as well as exchanging of expertise and information in the area of providing care and rehabilitation to the handicapped.

The revenues of the High Council shall consist of:

1. The Government's annual financial subsidy
2. Other grants, testamentary funds and contributions as well as any other revenues approved by the Council.

The High Council for the Disabled shall form a technical office reporting to the Competent Minister consisting of the Director of the Technical Office and membership of a minimum of three experts who

shall be specialized in the care and rehabilitation of the handicapped. The Council shall set out how the office shall exercise its functions and the method of work therein.

The Technical Office shall be responsible for studying the matters falling within the functions of the High Council and whatever recommendations it deems fit, follow up the implementation of any decisions passed by the High Council as well as carry out the following functions:

1. Organizing the central register of the handicapped and maintain the medical, social and educational information relating to them. It shall also complete the process of classifying the handicapped.
2. Proposing the policy and conditions of acceptance of the handicapped at the Special Education Schools, Institutions and the Handicapped Rehabilitation Centres in the State.
3. Providing advice in respect of the equipment and devices of rehabilitation and compensational devices.
4. Proposing the educational programs for Schools of the handicapped as may suit their physical and mental abilities and help develop and advance such abilities.
5. Supervising the employment of the handicapped and ascertain the allocation of the proportions prescribed for them herein in the jobs and positions of both the public and private sectors. It shall also supervise the consistency of the work entrusted to them as well as of getting reasonable wages.
6. Proposing the jobs in which the handicapped shall have priority in agreement with the Civil Service Commission and the Representative of the Commerce and Industry Sector.
7. It shall prepare and implement plans for the publicity awareness campaigns with a view of changing the trends of the public opinion towards the rights of the handicapped and the basis of cooperating with them as members in the society.
8. Passing the annual plan to encourage the researches and studies relating to the

limitation of the factors leading to disablement and rehabilitation.

9. Approving the internal regulations for work progress at the Authority and the Personnel Regulations.
10. Taking any other action which would guarantee the implementation of the objectives provided for herein.
11. Proposing an annual budget for expending therefrom on the activities and executing the functions of the High Council. (Articles 18-23, pp. 7-12)

Part Five: Penalties

Without prejudice to any severer penalty prescribed under another law, the Employer or the Person In Charge thereof, shall be punished by imprisonment for a period not exceeding six months and a fine not exceeding two hundred Kuwaiti Dinars or by one of these penalties, if he refuses to employ a handicapped person once he has been nominated by the Competent Ministry for employment therewith in accordance with the provisions of this Law.

Any person who undertakes the care of a handicapped person, regardless of the source of such undertaking in accordance with the provisions of the law, shall be punished by imprisonment for a period not exceeding three months and a fine not exceeding one hundred Kuwaiti Dinars, or by one of these penalties if he neglects in the carrying out of his duties or in taking the action necessary for carrying out such duties, without prejudice to any severer penalty provided for by the Penal Law if such negligence results in what may necessitate the imposition of the penalty. (Articles 25-25, pp. 12-13

Part Six: Concluding Provisions

The Competent Minister shall issue the decisions necessary for the execution hereof.

The Ministers shall, each in so far as he is concerned, execute the provisions of this Law and shall be put into operation as of the date of its publication in the Official Gazette. (Articles 26-27, pp. 13-14)

Information from the eight countries studied suggested that higher developed countries like the United States, the United Kingdom, and Denmark have a long history of legislation affecting individuals who are handicapped and already offer a full range of rehabilitation services. In countries like Japan, Yugoslavia, and Kuwait, where legislation is more recent, such services are only now emerging. The least developed countries, Thailand and Kenya, lack both adequate legislation and adequate services. Most of their work lies ahead of them.

CHAPTER 3

METHODOLOGY

Introduction

The central problem of this thesis is that of identifying and detailing a model for the administration of services to the handicapped which is both general enough to make useful the best of international experience and specific enough to allow application to a specific country that has quite particular characteristics. This problem must be resolved, and the function of the present chapter is to develop the appropriate scholarly methods for doing so.

Methods

The method included in developing a basic model for administering rehabilitation programs which could be applied to differing countries included 1) review of existing models of organization structures and 2) obtaining information on how nations currently administer services for individuals who are handicapped and classifying this information per an international matrix classification.

Obtaining Basic Information on How Nations Administer Services for Individuals Who are Handicapped

The methods used in developing a basic model for administering rehabilitation programs which can be applied to differing countries include:

1. reviewing existing models of organizational structures;
2. obtaining information about how nations usually administer services for the handicapped and classifying the information per the International Classification Matrix.

Published Sources and Reports

Sources. Most of the published sources above consist of records and reports of statistical data gathered by census referred to as socioeconomic, such as the census of the number of individuals who are handicapped in the population, and data on per capita income. Other studies detail the psychological impact of attitude toward individuals who are handicapped, the political situation, and the administration of services to the handicapped in the eight countries selected for this study. These sources include governmental and nongovernmental agencies, the United Nations, international organizations, and others.

Selected governmental and nongovernmental sources include, for example,

U.S. Department of Education

Digest of Data on Persons with Disabilities (June 1984)

U.S. Department of Health, Education, and Welfare

Vocational Rehabilitation Administration (1964)

Rehabilitation of the Disabled in Fifty-One Countries.

Comparability and Credibility. Some of the published sources used in this study specify that the census reports are either mostly estimated or, in some countries, not available. Problems associated with the various data collection methods include undercounting, overcounting, and misclassification. Comparisons across countries and of subgroups within countries will be used in Chapter 4.

Particular Problem of Quantitive Data.

1. Census data are collected infrequently, usually every ten years; therefore, most of the data are not very recent and are only estimated.
2. Most of the census data may not include the institutionally disabled population; in other words, sometimes only the noninstitutionalized population is covered. (Chanie, 1983, p. 26).
3. In Kuwait, for example, data include duplicated names, because many kinds of information were used and lists of registered disabled persons

were repeated by the governmental and non-governmental agencies. The data cover only the institutionalized handicapped.

4. In the developing countries, the number of disabled may likely appear smaller than the real size of the population for the following reasons:
   (a) families may hide disabled persons, because of shame or because they are of marriageable age;
   (b) some disabled do not have visible disabilities, or their disabilities have not been diagnosed.

Unpublished Materials Obtained Through Personal Correspondence.

Feasibility Due to Author's Status. During the last ten years, the author corresponded with and contacted many professional groups working in rehabilitation in national and international circles, experts at the United Nations, and other key persons around the world, receiving a great amount of information in the form of reports, conference papers, and letters. A great deal of this information was collected and used in this study after being crosschecked against other information to achieve balance among organizations known to have different viewpoints.

Other sources of unpublished materials were the doctoral dissertations accepted by the Association of Research Libraries.

Networks and Kinds of Officials Contacted. During the last ten years, the author traveled in the target countries and had the opportunity to meet with people in high positions in their governments. Because of the author's position in the government of Kuwait, as well as the fact that she has held two international positions, from 1975-1979 as Vice President of Mobility International in London and now as Vice President of Rehabilitation International for 1984-1988, New York, she has visited most of the countries in an official capacity to take part in office meetings and conferences. These positions have helped her to increase the network of contacts with many professional groups.

Interviews with Selected Officials for Handicapped Services

Feasibility Due to Author's Status and Activities. During the author's travels in the target countries, she conducted interviews with key representatives from governmental and private rehabilitation programs, among them government ministers; members of parliament; legislators; political professional groups; medical, educational, and welfare officers; and leaders of groups of disabled persons.

The interviewing was unstructured and nondirective, its aim to reveal the subject's specialized role in, experience of, and knowledge about the rehabilitation world. Interviews lasting from one to several hours were conducted on site in the offices or facilities, so that statements would be viewed in the work context. The content of each interview focused mostly on the following areas: socio-economic, cultural, political, and administrative structures.

Interviews with National Officials. Interviews were completed by the author with national leaders in the United States, the United Kingdom, Denmark, Japan, Yugoslavia, Thailand and Kenya, as well as with officials of the United Nations, for background and related information required within this study. A list of the persons interviewed, by state, appears in Appendix A.

Language. Most interviews were conducted in Arabic or English. Interpreters were used in those countries where Arabic or English was not spoken.

Rapport. The key to effective interviewing was establishing good rapport. Most of the interviewees had met the author many times, and most are colleagues and friends who share the same status as the author. Also, the author

has extensive experience meeting and interviewing key persons in rehabilitation fields.

Defensiveness. Because of good rapport, the author encountered very little defensiveness during the interviews.

Classifying Nations for Purposes of General Evaluation of Approach to National Administration of Services for the Handicapped and for Application to Specific Country: The International Classification Matrix

The amount of potential information about all the countries and their approaches to administration for the various services for several kinds of handicapped persons is so immense as to practically defy understanding. To cope with this problem, the following International Classification Matrix was developed (as shown in Table 1).

Eight selected countries are discussed in the order of their difference from the State of Kuwait, starting with the most different. Comparisons are drawn in terms of the International Classification Matrix in the order of the following categories:

a. General Cultural/Social Orientation Pattern
b. Degree of Cultural Materialism
c. Cultural Attitude Toward Handicapped
d. Percent of Population Classified As "Handicapped"
e. Per Capita Income
f. General National Political Orientation

TABLE 1. International Classification Matrix

CLASSIFICATION BY COUNTRIES

Dimensions

a. General Cultural/
Social Orientation
Pattern
i. Ascriptive/Traditional (one third of cases go in this category)
ii. Mixed-Attributes (only one third will be classified in this category)
iii. Achievement/Innovative (one third of cases go in this category)

b. Degree of Cultural
Materialism
i. High
ii. Medium
iii. Low

c. Cultural Attitude
Toward Handicapped
i. Positive
ii. Mixed
iii. Negative

d. Percent of
Population
Classified as
"Handicapped"
i. High
ii. Medium
iii. Low

e. Per Capita Income
i. High
ii. Medium
iii. Low

f. General National
Political
Orientation
i. High Democracy/"polyarchy"
ii. Mixed Democratic/Non Democratic
iii. Non-democratic (totalitarian or monarchist)

g. General National
Administrative
Structure
i. Unitary (no real authonomy)
ii. Mixed (some elements of unitary system but also some federal characteristics)
iii. Federal system

h. Degree of
Bureaucratization
i. High
ii. Medium
iii. Low

i. Range of Services
i. High
ii. Medium
iii. Low

g. General National Administrative Structure

h. Degree of Bureaucratization

i. Range of Services

Basic Dimensions of International Classification Matrix

General Cultural/Social Orientation Pattern. In rehabilitation, social integration is viewed as the active participation of handicapped persons in the mainstream of community life. That is, individuals who are handicapped have the right to and use of the so-called normal services of society, for example, health care, school, employment, housing, and cultural and recreational activities. Kallio, in his paper to the Rehabilitation International Congress in Lisban. Lisban, (1984) defined the term "culture" as a

> broader term than a 'society,' for example, which is used technically to describe an organized group of people interacting in a structural system and carrying out the activity necessary to produce and sustain life. Culture refers to the behavioral contents of this society. Culture can be divided into a series of activities with specific need satisfaction functions. Family, education, economic, politics and religion are the most familiar. These activities satisfy such basic needs as producing and raising children, training them to be members of society, organizing administration and defining the meaning of life (p. 74).

This description of the concept of culture provides the context for understanding and viewing the relation among the

handicapped person, his or her physical environment, and his or her cultural background.

Many obstacles remain in achieving optimal integration of individuals who are handicapped into their communities, because the purpose of rehabilitation is to increase independence for individuals who are handicapped, and this goal depends on the environments in which they live. In culturally well-developed countries, technology and instructional care are also well-developed, and yet only in recent years has integration, which had been neglected, improved. In contrast, in the developing countries of Asia and Africa, especially in the rural areas where the handicapped are most prevalent, the extended family system and the lack of facilities for broader social integration are visible. These countries, especially those with economic resources like Kuwait, are reversing this pattern, however. They are following the footsteps of the developed countries and, because of the expertise coming from the developed countries, we now see more institutional facilities being established.

Degree of Cultural Materialism. The degree of cultural materialism in a country is influenced by the attitudes of economic, political, religious, and social organizations. This study reveals clearly that interactions occur among material considerations such as the availability of equipment and aids and the degree of accessibility in the

community and in private homes, which influence the living conditions of the handicapped. Cultural materialism changes from country to country. The lower or more negative the attitude in any country, the greater the lack of material assistance for individuals who are handicapped, whereas the higher or more positive the attitude, the greater the provision for the needs of handicapped.

Cultural Attitudes Toward the Handicapped. The review of the literature reveals that attitudes toward individuals who are handicapped differ from period to period and from country to country. They vary also from culture to culture. We might ask, what is an attitude? "Attitude," one of the most common terms in social psychology, refers to an emotional outlook toward something. Triandis (1972) defines attitudes as follows:

> Attitudes are beliefs associated with affective state, predisposed action, so that a person's attitudes include (a) an affective component (how he feels about an attitude object), (b) a behavioral component (what he intends to do with or to the attitude object), and (c) a cognitive component (what beliefs he has about the attitude object). (p. 14)

To understand attitude toward individuals who are handicapped, we must view it as an enduring system consisting of a belief component, a feeling component, and an acting or behavioral component. Beliefs, emotional responses, and action tendencies are learned and acquired, largely as the result of influences of cultural standards and values,

religion, societal philosophy, motivation, and psychosocial and environmental factors. Attitudes refer directly to a value system and correlate with age, sex, social status, and ethnicity.

One's beliefs with respect to the target of the attitude may be factually accurate or distorted by misinformation or stereotyped thinking. One's feelings toward the target may reflect liking and attraction or dislike and repulsion. One's manifested actions involve either approaching or avoiding the target of the attitude.

The behavioral component does not always correspond to the belief system and feeling response, so that what people think is often not congruent with what they feel and what they do. This discrepancy has very important implications for the chief agents of attitudinal change--the professionals, service providers, employers, policy makers, educations, parents, and the media--and for individuals who are disabled themselves.

Percentage of Population Classified As "Handicapped". The number of individuals who are handicapped was arrived at through the available existing census and survey data on handicapped persons in the target countries. Census and survey data were examined for their scope, coverage, reliability, availability, and degree of dissemination in the countries. As noted earlier, problems

associated with the data collection methods are under-reporting, overcounting, and misclassification.

Per Capita Income. "Per capita" is a Latin term meaning 'for each person' (literally 'by head'). Thus, per capita income means the amount of income per person, calculated by dividing the total income of a group by the number of individuals it comprises" (Dictionary of Business and Economics, 1984, pp. 248-9).

National per capita income figures may reflect variations in natural resources and history. For instance, McClelland (1961) states that Walkins and Hager (1956) estimated that the average per capita income in the United States for 1953 was $1,908, whereas in Kuwait the average per capita income was $2,500, and ask, "Are we to conclude that Kuwait is more economically advanced or developed than the United States?" (p. 83) They go on to say,

> Thus it is because we are implicitly thinking in terms of capacity to produce modern material culture that we find it somewhat absurd to think of Kuwait as more developed than the United States. . . Kuwait may be able to purchase more such goods in per capital terms than the United States, but until it can produce and service them we do not think of it as an economically developed country in the sense that the United States is. (p. 84)

Thirty-three years have passed since this comparison, which was drawn when Kuwait, oil-rich, was in its beginning years. Not enough time had elapsed for an undeveloped country to develop. Thus, it was not a fair comparison. Nowadays, Kuwait has changed a great deal economically and has

developed remarkably in the provision of services for individuals who are handicapped.

General National Political Orientation.

> The term "political" comes from the Greek polis, which referred to the central and organization of life of the city-state-Aristole in his Politics (Book I) called Man "a political animal by nature," meaning that to be human is to want to live in civilized, orderly, and human relations with one's fellows in the state. . . . Political philosophy is concerned with the problems that men have about government, considered in its relation to their own lives and welfare (Colliers Encyclopedia, 1985, p. 216).

The eight countries in this study were selected both because of personal preference and in order to include different varieties of national political systems. Seven of these countries have different types of democratic government, and one is communist.

General National Administrative Structure. Elements used to fill out a picture of the general administrative structure in each country included the organization and administration of rehabilitation services at the national, subnational, and local levels of government, the role of nongovernmental and subsidiary agencies, coordination and decentralization, legislation and finance, as well as current trends and issues in rehabilitation administration.

Degree of Bureaucratization. The Dictionary of Modern Politics by Robertson (1985) summarizes "bureaucratization" as follows:

> Max Weber and many later social theorists have argued that modern political systems are becoming increasing similar; they are all undergoing a process of increasing 'bureaucratization.' According to this theory, the especial suitability of bureaucratic forms of administration for running complex and large-scale organizations makes the development of a bureaucratic state essential, regardless of official ideologies. One famous theory, derived from Weber, the 'convergence thesis,' claims that even such apparently opposed systems as the USA and the USSR are growing increasingly alike as bureaucracy takes over. The special characteristics that are held to maintain bureaucracy supreme include its control and storing of information (magnified by the bureacrat's 'everything on paper' ethic) and its concentration of specialist and expert skills. In addition, professional administrators, loyal to each other and the administrative system rather than any political party or group, are able to form a united front against any political decision-maker, whether he be a democratically elected cabinet minister or member of the Politburo. The thesis is a very hard one to test, since the presumed secrecy and confidentiality of the bureaucratic ethic would allow little evidence of manipulation to emerge if it were in fact rife. At a less sinister level, the idea that the state is becoming more and more bureaucratic is undoubtedly true: as increasing areas of social and economic life have been taken over by the state, huge administrative machines have necessarily been created, which do tend to develop a dynamic of their own (pp. 26-27).

Range of Services. The review of the literature reveals that most of the countries studied, especially the United States, the United Kingdom, and Denmark, have a full range of services for all types of individuals who are

handicapped. Bitter (1979, p. 214) lists some of the more frequently used resources in rehabilitation in the United States, for example:

1. medical consultation
2. physical medicine
3. ophthalomology
4. neurology
5. psychiatry
6. physical therapy
7. occupational therapy
8. orthotics and prosthetics
9. rehabilitation nursery
10. dentistry
11. speech therapy
12. audiological service
13. comprehensive rehabilitation centers
14. psychological and social resources
15. education-vocational resources
16. placement resources
17. voluntary community organizations
18. social security disability insurance
19. comprehensive employment and training program
20. work incentive programs
21. developmental disability assistance
22. special education-rehabilitation programs.

Components of Each Dimension. Each country arrayed in the matrix has been ranked according to its level of development within each dimension. The countries have then been grouped roughly into thirds: high, middle, and low.

General Cultural/Social Orientation Pattern. General cultural/social orientation falls into three patterns: (i) ascriptive/traditional; (ii) mixed; (iii) achievement-oriented/innovative. Table 2 groups the countries into these categories.

i. Ascriptive/Traditional

In general, the "ascriptive" culture is more traditional in that it evaluates people on the basis of family background, status, and similar criteria. Young (1959) states that

> until the civil service reforms the greater part of society was governed by nepotism. In the agricultural world which predominated until well on into the 19th century, status was not achievable by merit, but ascribed by birth. Class by class, status by status, occupation by occupation, sons followed faithfully in the footsteps of fathers, and fathers as faithfully behind grandfathers. People did not ask a boy what he was going to be when he grew up; they knew he was going to work on the land like his ancester before him. For the most part there was no selection of jobs; there was only inheritance. Rural society (and its religion) was family writ larger (p. 19).

This study shows that developing countries are characterized by ascriptive and traditional patterns. The countries included in this category are Kenya and Thailand.

TABLE 2. General Cultural/Social Orientation Pattern

Predominant General Pattern	COUNTRIES							
	USA	UK	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
Ascriptive/Traditional						X	X	
Mixed-Attributes				X	X			X
Achievement/Innovative	X	X	X					

ii. Mixed-Attributes

Three of the countries studied have a mix of traditional with innovative attitudes and thus have been able to adapt more quickly to the demands of modernization: Japan, Yugoslavia, and Kuwait. In these countries the gap between the rich or upper classes and the lower classes has been narrowed through social programs that promote social change as a result of changes in the economy, in competition, and in education.

McClelland (1961) states that "political and economic leaders. . .are of key importance in nearly all walks of life in the Middle-East" (p. 413). Education has weakened the power of the family. Still, some families are powerful and prominent in the government, for example, in Kuwait. The government holds a mixture of key people, some of them appointed on their merit and others appointed because of their status.

iii. Achievement/Innovative

According to Young (1959), the "achievement"-oriented culture or society must be very innovative because it relies on what the individual can do, based, for instance, on test scores at the secondary education level. Further, Young states, "Today we frankly recognize that democracy can be no more than aspiration, and have rule not so much by the people as by the cleverest people, not an aristocracy of birth, not a plutocracy of wealth, but a true

meritocracy of talent" (pp. 18-19). Meritocracy, as Young points out, is based on "equality of opportunity." We can observe this situation in the United States, which has no aristocracy, if we identify equality with advancement according to merit.

Degree of Cultural Materialism. The components of cultural materialism vary among countries, as does the quantity of materials used in rehabilitation services for individuals who are handicapped. One third of the countries, which are also those with the highest per capita income, rank high in the matrix classification: the United States, the United Kingdom, and Denmark. The rapidly developing countries, which also have high per capita income, fall in the middle third: Japan, Yugoslavia, and Kuwait. The lowest third have the smallest per capita income and therefore the fewest materials for use in rehabilitation: Thailand and Kenya. (See Table 3.)

Cultural Attitude Toward Handicapped. Attitudes shift over time. For example, in most of the countries before the 1970s, little was written about attitudes, and that little revealed that the disabled were treated as objects of charity. But the change has been remarkable since the 1970s; in most of the developed countries, individuals who are disabled are now viewed as having rights--civil, human, constitutional, and statutory. The change of attitude has helped to promote employment of

TABLE 3. Degree of Cultural Materialism

	COUNTRIES							
Pattern	USA	UK	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
High	X	X	X					
Medium				X	X			X
Low						X	X	

disabled persons as productive citizens and thus to promote economic development and growth.

This study shows that the developed countries like the United States, the United Kingdom and Denmark are now aware of and responsive to the needs of individuals who are handicapped. These attitudes are less developed in Japan, Yugoslavia, and Kuwait, and they are least developed in Thailand and Kenya. (See Table 4.)

Percent of Population Classified As "Handicapped".

As Table 5 shows, the developing countries like Kenya and Yugoslavia having a high percentage of handicapped citizens. The percentage is smaller in the United States, the United Kingdom and Thailand, and lowest in Japan, Denmark, and Kuwait. The percentage for Kuwait is very small because only individuals who are handicapped in institutions were counted.

Per Capita Income. Most countries are trying to take major measures, in terms of their domestic situations, to meet their needs, but their ability to do so is affected by their economic development. Their economies were assessed according to per capita income.

The per capita income in Kuwait, the United States, and Denmark is higher than in the United Kingdom and Japan.

TABLE 4. Cultural Attitude Toward the Handicapped

	COUNTRIES							
Attitude	USA	UK	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
Positive	X	X	X					
Mixed				X	X			X
Negative						X	X	

TABLE 5. Percent of Population Classified As "Handicapped"

	COUNTRIES							
Percentage	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
High	10-17%				35%		12.7%	
Medium		7.9%	6.9%			5%		
Low				2.4%				0.4%

It is lowest in Yugoslavia, Thailand, and Kenya. (See Table 6.)

General National Political Orientation. Dahl (1971) states that "the development of a political system that allows for opposition, rivalry, or competition between a government and its opponents is an important aspect of democratization." He goes on to say that ". . .the two processes--democratization and the development of public opposition--are not, in my view, identical." (p. 1). Then he lists some requirements for a democracy:

1. Freedom to form and join organizations;
2. Freedom of expression;
3. Right to vote;
4. Right of political leaders to compete for support. (p. 3)

The countries that fit within Dahl's definition of democracy are the United States, the United Kingdom, Denmark, and Japan. Those which fall partially within the definition are Thailand, Kenya, and Kuwait. Yugoslavia differs completely from Dahl's standards; he classifies it as a "one-party regime" socialist government. (See Table 7.)

The democratic or partially democratic countries have two types of political system. The first, monarchy, includes Japan (headed by an emperor), England and Denmark (headed by queens), Thailand (headed by a king), and Kuwait (shiekdoms). The second type of democratic government, the

TABLE 6. Per Capita Income

	COUNTRIES							
Income	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
High	$11,876		$11,012					$16,500
Medium		$6,309		$10,266				
Low					$2,300	$0,758	$0,309	

TABLE 7. General National Political Orientation

	COUNTRIES							
Orientation	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
Highly Democratic	X	X	X	X				
Mixed Democratic/ Non-democratic						X	X	X
Non-democratic (totalitarian)					X			

republic, includes the United States of America and Kenya. Both the monarchy and the republic have a system of one or more parties; for instance, the United States has two parties, and the United Kingdom has four. Only Kuwait has no party system; there the members of parliament are elected solely on their political point of view and contributions to the community.

General National Administrative Structure. Countries are grouped in terms of similar patterns of administrative evolution, levels of industrialization, and socio-economic systems, rather than by regions defined along strictly geographical lines.

A unitary structure with no real autonomy below the federal level exists in Thailand, Kenya, and Kuwait. A structure mixing some elements of the unitary system with some federal characteristics occurs in the United Kingdom, Japan and Yugoslavia. The federal system is fully developed in The United States and Denmark (as shown in Table 8).

Degree of Bureaucratization. Yugoslavia, Kenya, and Thailand have very elaborate bureaucratic structures. The degree of bureaucratization is lower in the United Kingdom, Japan and Kuwait, and lowest in the United States and Denmark (as shown in Table 9).

Types of Delivery Services. In order to analyze any country in terms of rehabilitation services, one must look through a review of the literature to the range of services

TABLE 8. General National Administrative Structure

	COUNTRIES							
Structure	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
Unitary (no real autonomy for provinces)						X	X	X
Mixed (some element of unitary system, some of federal system)		X		X	X			
Federal	X		X					

TABLE 9. Degree of Bureaucratization

	COUNTRIES							
Degree	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
High						X	X	X
Medium				X	X			
Low	X	X	X					

offered. The top three countries, the United States, the United Kingdom, and Denmark, have as many as thirty types of services; the middle third, Japan, Yugoslavia, and Kuwait, offer between ten and twenty types of services; the lowest third, Thailand and Kenya, have a range of services between one and ten. In addition, scores have been assigned for the quality of services: the top third were X 3; the middle third, X 2; and the lowest third, X 1. Thus,

Number of Services X High (X 3)

Number of Services X Middle (X 2)

Number of Services X Fair or Low (X 1)

Suppose that a country has ten types of services and their quality is rated high, or 3; the score for quality of service will thus be 10 X 3 = 30. If a country has, say, twenty types of services and their quality is only fair (1), its score will be 20 X 1 = 20, and so it will be placed lower than the country with fewer services. (See Table 10.)

Analyzing the Results of the International Classification Matrix Analysis for a General Model of National Administration of Services for the Handicapped

Common Patterns Among the Nations Analyzed

The administration of services for individuals who are handicapped in the eight countries shows some common

TABLE 10. Range of Services

	COUNTRIES							
Range	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
High	X	X	X					
Medium				X	X			X
Low						X	X	

patterns. Certain issues and problems are common to most of these countries.

Patterns of Integration. The review of the literature indicates that attitudes change from period to period. For example, most countries have "come out of the closet" in accepting individuals who are handicapped, and individuals who are handicapped are now guaranteed rights through many laws and constitutional statutes. The United Nations' declaration of the International Year for Disabled People (IYDP) in 1981, which followed the United Nations' declaration of the rights of disabled persons in 1975, with the aim of "full participation and equality," was expected to give further encouragement to the development of disability rights, according to Walker and Townsend (1981, p. 2), Thompson (1981, p. 2), asks, "What are the aims of the IYDP? The underlying theme is full participation and equality." The United Nations set out five principal objectives, among them

i) helping disabled people in their physical and psychological adjustment to society.

ii) promoting all national and international efforts to provide full services. (Thompson, 1981, p. 2.)

Further development has occurred in the integration of the disabled, backed up by the prominent activities of the IYDP, as well as by the United Nations Decade of Disabled Persons, 1983-1992. The World Programme of Action

concerning individuals who are disabled was adopted by The United Nations General Assembly at its 37th regulation session on 3 December 1982, the Charter for 80s of Rehabilitation International:

> The Charter of the 80s is a statement of consensus about international priorities for action during the decade 1980-1990. The Charter of the 80s was drafted by the Rehabilitation International World Planning Group. It was adapted by the Assembly of the Rehabilitation International and is presented by the world as a major contribution to the United Nations International Year of Disabled Persons. (1981 Rehabilitation International)

Administrative Patterns. The administration of rehabilitation services in most countries is scattered among many and different departments, among them Health, Education, Social Welfare, Labor and Employment, Housing, Agriculture, and even Interior and Veterans, as well as many private and volunteer organizations. Most of the countries are now trying to plan some kind of national bodies to coordinate their services.

Main Foci of Variation Among Countries. According to the view of McClelland (1961), "mankind is engaged over space and time in a variety of social cultural 'experiments' which involve different methods of economic, political, religious or social organization." Throughout this study the following variations among the eight selected countries

have been noted, particularly between the developed and the developing countries.

General Cultural/Social Orientation Pattern. McClelland (1961) notes,

> For example, in Parson's terminology, developed countries are characterized by the prevalence of achievement norms, universalism and specificity, whereas underdeveloped countries are characterized by ascriptive norms, particularism and diffuseness. That is, in developed countries people are evaluated in terms of what they can do (achieved status) rather than in terms of who they are (ascribed status); anyone is at least ideally able to compete for any job (universalism), rather than being permitted only to do particular jobs as in a caste system (particularism); and the relationship of one man to another is typically more specific, or limited to the labor contract, rather than diffuse as in a traditional society where economic relationships are tied intimately to all sorts of other relationships involving kinship, political, religious and other social structures. (pp. 16-17)

An important characteristic of the social structure is the view of individuals who are handicapped, which differs between the modern industrialized societies and the traditional societies. The developed countries are well organized, with established vocational training and updated technology. The developing countries, in contrast, still lack technology and adequate training, and individuals who are handicapped, for the most part, are denied employment or given poor jobs.

Degree of Cultural Materialism. The developed countries appear determined to make their handicapped work hard to increase their ability to meet their own material

needs, whereas the developing countries like Thailand and Kenya stress material needs less and place a positive and strong value on religious practices, such as prayer, and noneconomic activities.

Cultural Attitude Toward Handicapped. The countries that have a social structure which stresses "achieved" versus "ascribed" status reflect positive attitudes toward individuals who are handicapped, whereas the countries which stress "ascribed" status reflect negative attitudes.

Percent of Population Classified As "Handicapped". For the developed countries, it was easy to obtain data about individuals who are handicapped through national statistical offices and census bureaus. Information about disability issues is less readily available in the developing countries.

The number of individuals who are handicapped is greater in the developing countries. Many factors are responsible for the rising number of disabled persons. The following factors are listed by the United Nations (1983, pp. 12-13).

> (a) Wars and the consequences of wars; and other forms of violence, destruction, poverty, hunger, epidemics, major shifts in population;
> (b) A high proportion of overburdened and impoverished families; overcrowded and unhealthy housing and living conditions;
> (c) Populations with a high proportion of illiteracy and little awareness of basic social services or of health and education measures;
> (d) An absence of accurate knowledge about disability, its causes, prevention and treatment; this

includes stigma, discrimination and misconceived ideas on disability;
(e) Inadequate programmes of primary health care and services;
(f) Constraints, including a lack of resources, geographical distance, physical and social barriers, that make it impossible for many people to take advantage of available services;
(g) The channelling of resources to highly specialized services that are not relevant to the needs of the majority of people who need help;
(h) The absence or weakness of an infrastructure of related services for social assistance, health, education, vocational training and placement;
(i) Low priority in social and economic development for activities related to equalization of opportunities, disability prevention and rehabilitation;
(j) Industrial, agricultural and transportation-related accidents;
(k) Natural disaster and earthquake;
(l) Pollution of the physical environment;
(m) Stress and other psycho-social problems associated with the transition from a traditional to a modern society;
(n) The imprudent use of medication, the misuse of therapeutic substances and the illicit use of drugs and stimulants;
(o) The faulty treatment of injured persons at the time of a disaster, which can be the cause of avoidable disability;
(p) Urbanization and population growth and other indirect factors.

Per Capita Income. For all the countries on which data are available, the developed countries have higher economic growth than the developing countries. McClelland (1961) argues that the reason that a developing country "is so good and remains slow in its economic development is because its population is increasing so rapidly that it is difficult for the rate of capital formation to surpass it" (p. 28). This statement supports the data on per capita income in the eight countries, which reveal the developed

countries to have higher per capita income than the developing countries.

General National Political Orientation. In developed countries with democratic governments, through developed political and social action, individuals who are disabled gain significant rights to participate in their societies. The developing countries are only beginning to organize citizens' groups, such as parents' associations and organizations of disabled persons, which can influence the local governmental bodies.

General National Administrative Structure. The administration of services for individuals who are handicapped in the eight countries shows some common patterns. Certain issues and problems are common to most of these countries.

The administration of rehabilitation services is scattered among many and different departments, among them Health, Education, Social Welfare, Labor and Employment, Housing, Agriculture, and even Interior and Veterans, as well as many private and volunteer organizations. Most of the countries are trying to plan some kind of national bodies to coordinate their services.

Coordination in the administration of rehabilitation services is a priority issue in the eight countries covered by this study. The problems of horizontal coordination among the many governmental and nongovernmental departments

dealing with rehabilitation matters are sometimes complicated by conflicting political interests and the lack of coherent legislative provisions. The problems of vertical coordination occur among governmental agencies at the central, subnational, and local levels.

In Kuwait, lack of coordination among the ministries involved with rehabilitation has led to overlapping and duplication of projects, resulting in wasted resources and failure to deliver services to all the populations. All these problems arise because no adequate administrative machinery exists for coordination.

Since 1981, the Year of the Disabled, most of the countries have established national coordination bodies like committees or councils, but these may not have been used since. National coordination plans cover all stages of planning in making and executing information among agencies about rehabilitation matters.

The United Kingdom in 1974 tried to establish a special Ministry of the Disabled to coordinate all the services for individuals who are disabled. This ministry was headed by Mr. Alf Morries when the conservative government was replaced by labour administration. With the return of the government in 1979 to a conservative administration

came the end of the first Ministry for the Disabled in the United Kingdom.

Two related issues of rehabilitation administration are those of decentralization versus centralization and of inadequate services to the disadvantaged in remote or rural areas. In Kuwait, Kenya, and similar countries, rehabilitation programs are conceived in the capital by the central government without due regard to the rehabilitation needs and cultural peculiarities of the local areas, for example, the Bedouin population in the desert and the Bushmen in Kenya. Decentralization of services is necessary to overcome this problem. Kenya is starting to plan decentralized community rural services.

Highly decentralized systems can be seen in Denmark and the United States where most of the services go down to the local levels, thus reducing costs and improving efficiency.

Most countries in this study, especially the developing countries, are deficient in their training of technical and administrative personnel, to run rehabilitation programs. Training is necessary in administration and management at all levels of the hierarchy. Technical personnel must also be trained in all fields and all types of disability to fit the needs of local and rural situations. Programs in Kuwait, Kenya, and Thailand very often lack trained personnel or are poorly staffed. Kenya and Thailand

have particular problems in the rural areas, where communication is difficult and the great indencety of the population.

Degree of Bureaucratization. Other related issues of rehabilitation administration are those of decentralization versus centralization and of inadequate services to the disadvantaged in remote or rural areas.

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Highly decentralized systems can be seen in Denmark and the United States, where most of the services are delivered at the local levels, thus reducing costs and improving efficiency.

Types of Delivery Services. The developing countries lack services for individuals who are handicapped, including vocational assessment and guidance as well as vocational training, placement, and follow up. Sheltered employment is also needed in the rural areas. The reasons

for lack of service include limited funding and technology and lack of staff training.

Most countries in this study, especially the developing countries, are deficient in their training of technical and administrative personnel, to run rehabilitation programs. Training is necessary in administration and management at all levels of the hierarchy. Technical personnel must also be trained in all fields and all types of disability to fit the needs of local and rural situations. Programs in Kuwait, Kenya, and Thailand very often lack trained personnel or are poorly staffed. Kenya and Thailand have particular problems in the rural areas, where communication is difficult and where the great indencety of the population.

There is a need to study and examine the methods and curricula of professional personnel training programs. This process, however, is beyond the scope of this study.

Conclusion

In review, to analyze the data collected, the International Classification Matrix was developed. This matrix appears to provide a means of classifying the major dimensions impacting administration of rehabilitation services within the countries selected for this study. The matrix also provides a means for identifying types of services that need to be developed and presents at least a general model for such analysis.

CHAPTER 4

RESULTS

The author undertook this study in order to identify and develop a generic model for administrative services to the handicapped that would coordinate all different rehabilitation services at the national level and that could be applied to any country to provide recommendations for developing a national program of rehabilitation services. The methodology included a review of existing models of organizational structure, obtaining information about how countries currently administer services to individuals who are handicapped, developing a means of classifying this information, and analyzing the data.

The results of this study differ substantially from those of other studies in their total thrust. Most of the reports have accepted as fact the official statements from the target countries and/or rehabilitation organizations with respect to their operations at various functional levels. In addition, some of the writings are very old and outdated, such as Rehabilitation of the Disabled in Fifty-One Countries (1964) and the material in Carnes (1979) and others which deals narrowly with rehabilitation. Carnes, for example, compares the functions of rehabilitation

counselors in the United States only with similar functions in European system. Finally, literature about the developing countries, for example, Thailand, Kenya, and Kuwait, is limited or nonexistent. Studies and raw data about these countries are also limited in terms of their general cultural and social situations, cultural attitudes toward individuals who are handicapped, and legislation.

The methodology used here indicates that countries, and systems to provide rehabilitation within countries, differ considerably, but in general, most of the countries are trying somehow to establish a national administrative system to coordinate rehabilitation services. This effort was emphasized greatly during the interviews with the key persons in all eight target countries: the United States, the United Kingdom, Denmark, Japan, Yugoslavia, Thailand, Kenya, and Kuwait. In-depth interviews were conducted with representatives from government agencies, professional groups, medical, educational, and social welfare leaders, voluntary programs, and organizations of the disabled. The validity of the information was assured by cross checking statements, balancing informant viewpoints, and collecting reams of documents after the scheduled informal interviews (usually conducted in a work situation). Numerous facilities were visited, and "raw data" documents beyond official handouts were obtained. Material, updated during the several years

of data-gathering, indicated that official releases correlated highly with much of the previously published literature.

The main results of this study of the selected eight countries draw upon the information thus gathered. The study presents the theoretical system for rehabilitation services formulated on the basis of this international experience. It analyzes the data gathered, organized within a matrix framework, and establishes an approach to prospective evaluation. The model developed, the International Classification Matrix, was formulated on the basis of information from both published and unpublished sources which addressed the situations of the eight countries studied in terms of their cultural, social, economic, political, and administrative characteristics, as well as the types and quality of the rehabilitation services they offer. In conclusion, the International Classification Matrix is acceptable in identifying and detailing a model for the administration of services to the individuals who are handicapped which is both general enough to make useful the best of international experience and specific enough to allow application to a specific country that has quite particular characteristics.

Table 11 shows the International Classification Matrix model as developed.

Discussion

In this section, the International Classification Matrix model will be applied to the State of Kuwait and the Evaluation Criteria (See Appendix B) will be applied to identify and recommend changes within Kuwait. (See Table 12.)

a. General Cultural/Social Orientation Pattern

Kuwait is classified in terms of general cultural/social orientation as M = Mixed--meaning that the newly emerging achievement-oriented/innovative pattern is still mixed with this ascriptive/traditional pattern. Evaluation criteria developed from the International Classification Matrix suggest that rehabilitation service have developed most fully in those countries where tolerance of individual differences, including those of individuals who are handicapped, is fullest. Such tolerance leads to a willingness to integrate the handicapped into the full range of human activities. In these terms, Kuwait has not yet achieved the ideal cultural/social pattern. The influx of immigrants, who are often ignorant and illiterate, creates an unstable cultural base. Widespread efforts to educate the whole population about physical and mental disabilities

TABLE 11. International Classification Matrix

	CLASSIFICATION BY COUNTRIES							
Dimensions	U.S.A.	U.K.	DENMARK	JAPAN	YUGOSLAVIA	THAILAND	KENYA	KUWAIT
a. General Cultural Social Orientation Pattern								
b. Degree of Cultural Materialism								
c. Cultural Attitude Toward Handicapped								
d. Percent of Population Classified as "Handicapped"								
e. Per Capital Income								
f. General National Political Orientation								
g. General National Administrative Structure								
h. Degree of Bureaucratization								
i. Range of Services								

TABLE 12. International Classification Matrix Applied to Kuwait

	CLASSIFICATION BY KUWAIT
Dimensions	KUWAIT
a. General Cultural Social Orientation Pattern	M
b. Degree of Cultural Materialism	M
c. Cultural Attitude Toward Handicapped	Mix
d. Percent of Population Classified as "Handicapped"	H
e. Per Capital Income	H
f. General National Political Orientation	M
g. General National Administrative Structure	H
h. Degree of Bureaucratization	H
i. Range of Services	M

H = High, M = Medium

are necessary to create the requisite climate of tolerance. (See Figure 7.)

b. Degree of Cultural Materialism

In terms of cultural materialism, Kuwait is classified as M, falling in the middle range. The evaluation criteria are based on the conclusion that those countries which are advantaged in terms of money and technology are most likely to have sophisticated rehabilitation services. Although Kuwait has plenty of money, it lags in technological development. Teachers need to be brought into the country, and students need to be sent abroad for study, in order to train personnel in the use of technological devices to assist individuals who are handicapped. (See Figure 8.)

c. Cultural Attitude Toward Handicapped

Attitudes toward individuals who are handicapped in Kuwait are not documented in any study. But the author's experience in the field reveals great changes in the last 15 years. People now nearly accept individuals who are handicapped, because of the continuous education and information about the handicapped provided by the Kuwait Handicapped Society. Kuwait is classified in the mixed range. (See Figure 8) Also, people are more educated in general. And Islam has a great impact on the people in Kuwait. As White (1980) notes,

> The Mohammedans looked at the disability more objectively. In the ninth century they established

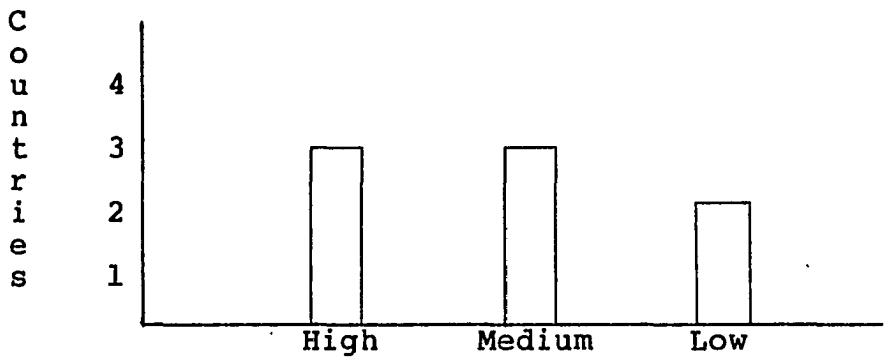


Figure 7. General Cultural Social Orientation Pattern

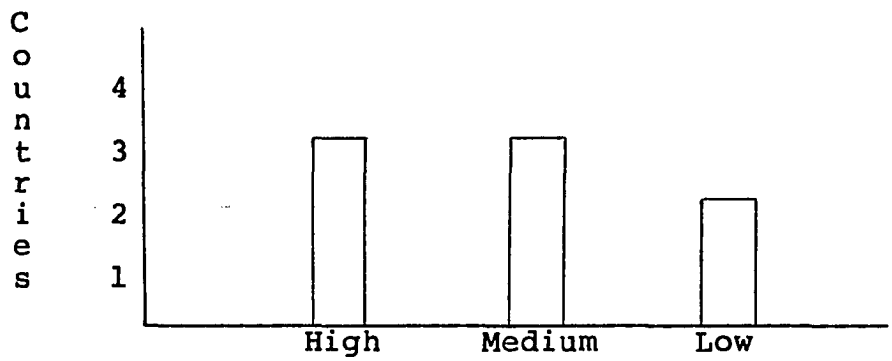


Figure 8. Degree of Cultural Materialism

> a hospital in Baghdad that provided treatment as dictated by the best scientific knowledge of the day. It is reported that there was a hospital in Cairo where people with all kinds of disorders received free treatment. When discharged, they were given money to meet their needs until they could go back to work again. (p. 119)

d. Percent of Population Classified As "Handicapped"

The percentage of Kuwait's population classified as "handicapped" is rated H = High. (See Figure 9) Facts relating to diability in Kuwait are not well documented, however. A survey is needed to determine the number and types of disability in the country because of the number of persons with diabilities is growing. The causes of the increases in impairment include a high accident rate and the large number of immigrants with a high proportion of illiteracy and little awareness of basic social services. The data collected by such a survey should be used for future classification and planning of rehabilitation services, and to help modify the environment and make it more accessible to individuals who are handicapped.

e. Per Capita Income

Kuwait's per capita income is classified as H = High (See Figure 10); in fact, it has the highest per capita income of all the countries studied. Jobs must be created which guarantee high income to individuals who are handicapped, as well as the able-bodied, through courses and training provided to meet the needs of all the different types of disabled persons. More training centers are

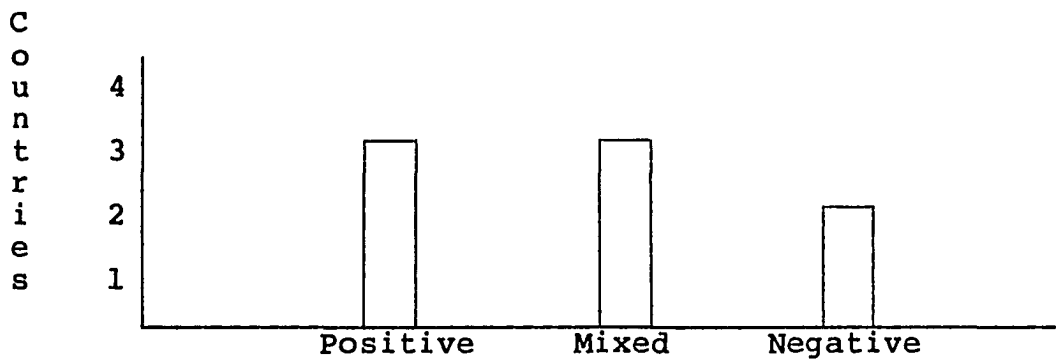


Figure 9. Cultural Attitude Toward the Handicapped

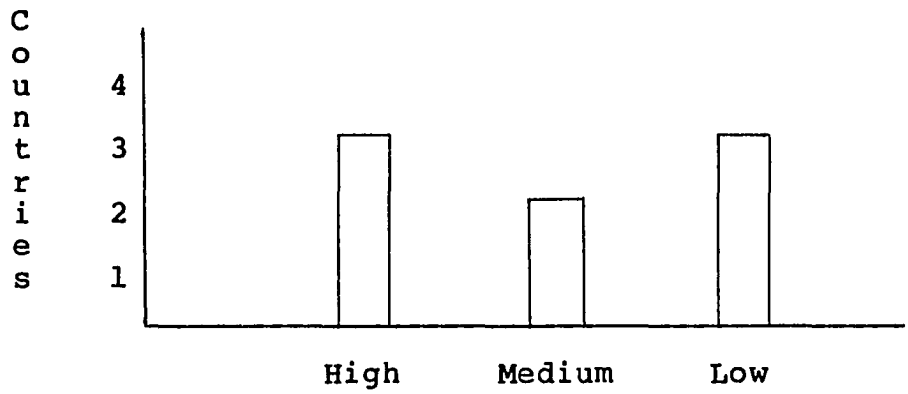


Figure 10. Percent of Population Classified As "Handicapped"

essential, and the existing ones need to regulate and modify their programs. These measures are necessary in order to guarantee accessibility in education at schools and the university and to achieve the goal of "full participation and equality." The disabled should receive all available opportunities in their communities--homes, education, employment, and the like--to ensure freedom of movement in their daily living environments.

f. General National Political Orientation

Kuwait is classified as a monarchial democracy. With the democratic concept in Kuwait (See Figure 11), individuals who are handicapped have been represented through their organizations and have helped to suggest to the government suitable solutions to their needs. The need remains for increasing the participation of the mentally retarded and for using the resources available to develop and improve the conditions of this population.

g. General National Administrative Structure

Kuwait is classified as Low in the Federal types of administration. It is centralized types of administration. (See Figure 12) The administration of services in Kuwait is carried out under different ministries, and they lack a coordinating body that should have the support of the

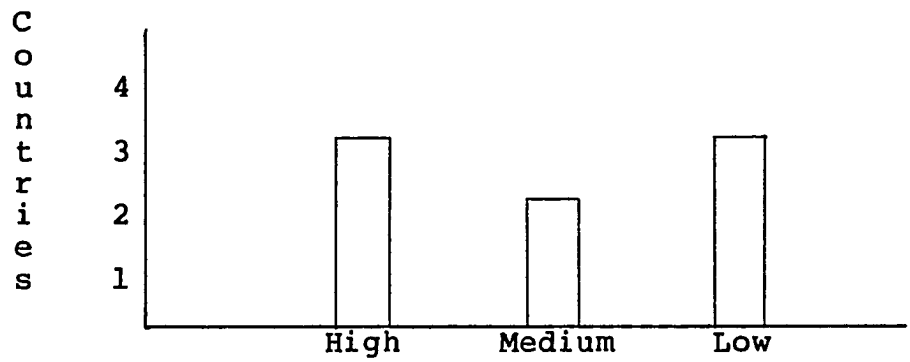


Figure 11. Per Capita Income

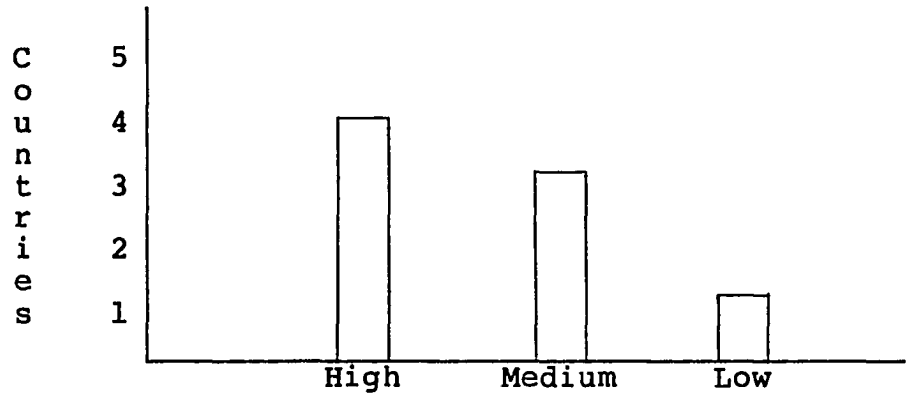


Figure 12. General National Political Orientation

appropriate ministries. The coordinating body would need to be developed.

h. Degree of Bureaucratization

Kuwait's classification is H, which means a high degree of bureaucratization. (See Figure 13)

The Kuwait administration has a rigid bureaucratic structure from "top to bottom." Administration for the national rehabilitation program will be greatly facilited at all levels (local, regional, and national) by the national rehabilitation council, whose major function is to ensure that rehabilitation is carried out as a continuous and coordinated process.

i. Range of Services.

In terms of number and quality, Kuwait's services for individuals who are handicapped are classified as M, falling in the middle range. (See Figure 14) In view of Kuwait's positive economic situation, expansion of the range of services and improvement of their quality should be feasible.

Based on a review of Kuwait's rankings on the International Classification Matrix (See Table 13), the following measures should be implemented to enhance delivery of rehabilitation services to individuals who are handicapped in Kuwait:

a. The general social/cultural orientation should be shifted, through education, to increase the full

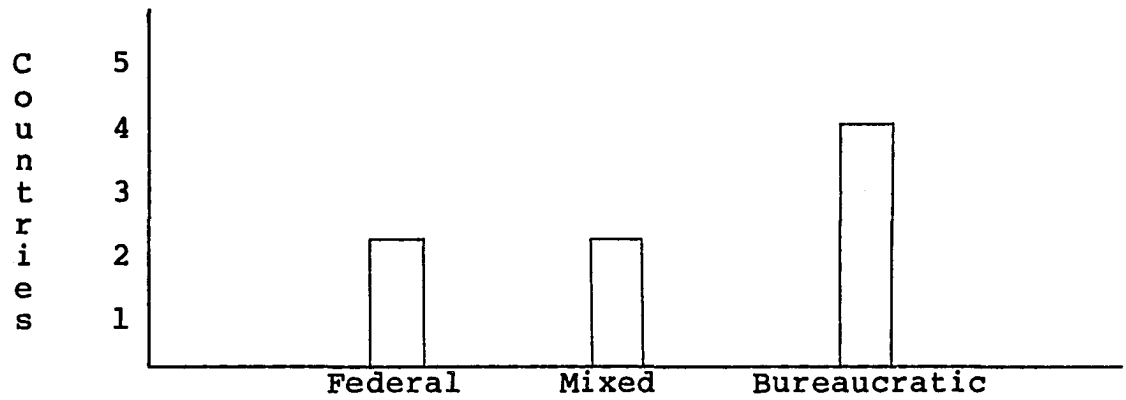


Figure 13. General National Administrative Structure

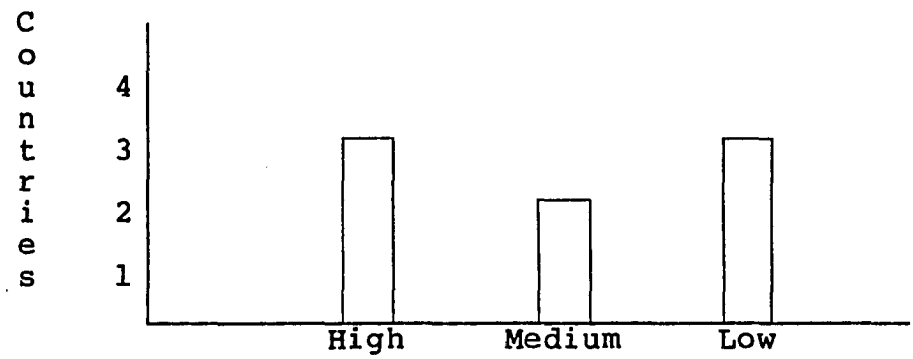
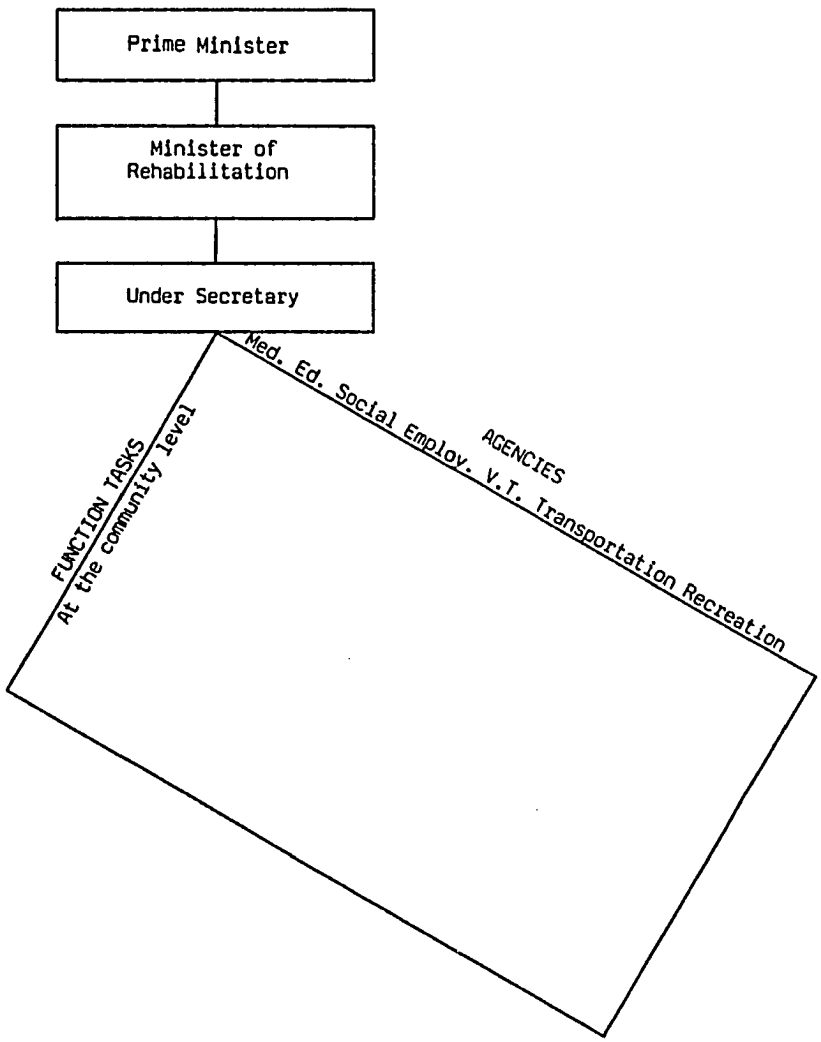


Figure 14. Degree of Bureaucratization

TABLE 13. The Matrix Model For Administration



integration of disabled persons into all aspects of society.

b. Rehabilitative technological devices, and the training of personnel to use them successfully, should be acquired.

c. Educational measures should be continued to encourage acceptance of the handicapped by the general population.

d. Both medical and social measures should be taken to decrease the accidents and illnesses leading to disability.

e. Individuals who are handicapped should be provided the training necessary to enable them to earn incomes comparable to those of their able-bodied peers.

f. The democratic policies that permit individuals who are handicapped to participate in decision-making that affects them should be extended to the mentally retarded.

g. A coordinating body should be developed to oversee the different ministries involved in delivering services to individuals who are handicapped.

h. Administration of services should be distributed among all levels of government, regional and local as well as national.

i. The range and quality of the rehabilitation services delivered should be increased.

The coordinating council should aim to create a central board, with an executive body, and a national rehabilitation project. The board would be composed of individuals and representatives of the following groups:

1. The authorities and bodies directly concerned with rehabilitation (for example, the ministries of health, education, social welfare, labor, community development, transportation, finance, and planning)
2. Employers' and workers' organizations.
3. Organizations of individuals who are disabled and voluntary organizations.
4. Persons especially qualified to serve by reason of their knowledge of and concern with the rehabilitation of individuals who are disabled.

To prevent duplication of effort, a coordinating body comprising all the voluntary organizations and a representative of the national council should be set to work at the local level.

The administrative responsibilities of the national council include coordination of services, policy-making, planning, budgeting, standard-setting, research, fund-raising, and the creation of ad hoc technical committees to examine specific aspects of rehabilitation. Wherever

possible, the council should be prepared to decentralize its work and delegate its responsibilities to local and regional committees.

The council should pay attention to the importance of widespread and sustained publicity in all available media to announce the aim and purposes of rehabilitation. The humane, social, and economic value of rehabilitation should be regarded as an important element in any national rehabilitation program.

The national board should be set up with the support of the appropriate ministries in order to produce a comprehensive plan of rehabilitation services. This plan will organize services for individuals who are handicapped on the basis of a matrix model, shown in Table 13, consisting of two functions: (1) agencies, including medical, education, social, planning, vocational training, employment, housing, transportation, and recreation; and (2) tasks such as prevention, detection, special education of the mentally retarded, budgeting, income support, equipment, special linics for mothers and children. The tasks are organized in the sub-areas of community and neighborhood, and the specialized functions of professional care lie in the agencies.

The responsibilities of the board should include the following:

1. Medical rehabilitation.
2. A vocational program which includes assessment of the disabled person's work potential, opportunity for training, and placement where possible in competitive employment.
3. Alternative work programs in cooperatives, sheltered workshops, and home-bound employment.
4. Educational facilities for those children unable to adjust to the regular school system, and upgraded programs for young adults who have missed earlier educational opportunities.
5. Support services for the families of individuals who are disabled.
6. Provision to meet the housing needs of individuals who are disabled.
7. Provision for individual transportation facilities.
8. Removal of architectural barriers.
9. Financial security, whether through employment or assistance from the government or other agencies.
10. Opportunity for spiritual growth.
11. Financial assistance for aids and equipment.
12. Training facilities for rehabilitation personnel.
13. Research programs.

Planning these various services will be related to budgetary resources, available staff, and buildings. In the first three years of operation, the minimum aim should be to plan for the establishment and full operation of some or all of the following services:

1. Identification and registration of individuals who are disabled in the country.
2. Establishment of a ministerial department of rehabilitation.
3. Creation of a national rehabilitation council.

In conclusion, the International Classification Matrix has been used to create a general model of, and evaluation criteria for, rehabilitation services. This model has then been applied specifically to the State of Kuwait to assess the current condition of rehabilitation services there and to recommend changes in them for the future.

CHAPTER 5

CONCLUSION

This chapter contains a summary of the study, based on results obtained, and recommendations for further research.

A review of the literature indicates that, to date, no consistent theoretical model has been developed which can be applied in many different countries to create a coherent system of rehabilitation services for individuals who are physically and mentally disabled. This study generates such a model, in the form of an International Classification Matrix, through examining the rehabilitation systems of eight countries, chosen for their widely differing degrees of development: the United States, the United Kingdom, Denmark, Japan, Yugoslavia, Thailand, Kenya, and Kuwait.

Through a review of the literature, written communications, and personal interviews, the author collected data in the following areas:

a. General Cultural/Social Orientation Pattern
b. Degree of Cultural Materialism
c. Cultural Attitude Toward Handicapped
d. Percent of Population Classified As "Handicapped"
e. Per Capita Income

f. General National Political Orientation

g. General National Administrative Structure

h. Degree of Bureaucratization

i. Range of Services

These data were used to rank each country according to whether it was highly developed in a given area, only moderately developed, or relatively undeveloped.

The outcome of this analysis is the formulation of a model, together with a set of evaluation criteria, which can be applied to any country to assess its current situation in terms of rehabilitation for individuals who are handicapped and determine needed changes. In this study, the model was applied specifically to the State of Kuwait.

Analysis of the International Classification Matrix formulated by this study suggests that a national rehabilitation system can best be developed in an environment that exhibits certain characteristics. The country should have an innovative cultural/social climate tolerant of the innate differences among human beings. It should be materially advantaged in terms of both money and technology, with a high per capita income. The general population should be willing to accept individuals who are handicapped as full human beings and to accord them representation in all aspects of society. The government should be democratic, with a

multilevel administrative structure and a minimum of bureaucratization.

Finally, it should be willing and able to deliver all necessary medical, educational, social, and vocational services.

Application of this general model to Kuwait reveals that Kuwait already meets some of the necessary conditions but lags behind in others. In particular, the responsibility for creating and delivering rehabilitation services is too widely scattered to be efficient. To correct this problem, this study concludes that a national coordinating council ought to create an administrative board, made up of representatives of all public and private groups concerned with individuals who are handicapped. The responsibility of this board would be to develop and oversee all elements of rehabilitation in Kuwait: medical, social, educational, vocational, financial, and research.

Recommendations

The results of this study suggest the following area for further research:

1. The model needs to be examined further for theoretical consistency.
2. The model needs to be field-tested in various countries.

APPENDIX A

Person's Interviewed

The following key persons were interviewed, listed under their countries.

The United States

Mr. N. Acton, Chairman, Council of World Organizations, interested in the handicapped and past Secretary General of Rehabilitation International, New York.

Ms. B. Duncan, Director of Information, Rehabilitation International, New York.

Mrs. S. Hammerman, Secretary General, Rehabilitation International, New York.

Dr. M. Gianimi, First Director, U.S. National Institute for the Handicapped Research, Washington, D.C.

Mrs. S.S. Parrino, Vice President, North America of Rehabilitation International, New York.

Mr. E.V. Roberto, Department of Rehabilitation, State of California.

Mr. F.R. Seton, Treasurer, Rehabilitation International, New York.

The United Kingdom

The Hon. B. Caslle, M.P. of European Parliament, and past Minister of Health in the Labour Government (1974-1979).

Dr. P. Evans, Department of Child Development and Education, London.

Mr. D. Gulture, Founder of the National Fund for Research Into Crippling Diseases and currently Director of Child-to-Child Programme in the Institute of Child and Health, London.

Mr. A. Lamlly, General Secretary, Mobility International, London

Mr. D. Lancaster-Gayer, Director, Cerebral Palsy Overseas, London.

Mr. A. Lorren, President, Cerebral Palsy International, London.

The Rt. Hon. A. Morris, M.P., first Minister for Disabled in the Labour Government (1974-1979)

Denmark

Mr. E. Gerg, International Coordinator, Danish National Board of Social Welfare, Copenhagen.

Mr. B. Marson, past President, Mobility International, London.

Japan

Mr. R. NiHei, National Hospital Rehabilitation Center for the Disabled, Tokyo.

Mr. M. Ryosuke, Assistant Professor, Institute of Vocational training, Tokyo.

Mr. K. Tetsuro, Vice President, Japanese Society for Rehabilitation of the Disabled, and Managing Director, National Association for Employment of the Handicapped, Toyko.

Dr. N. Tsuyama, Professor Emeritus (orthopedics), University of Tokyo, and Vice President for Asia and Pacific, Rehabilitation International.

Yugoslavia

Dr. Korshic, Clinical Center, Ljubjana.

Dr. M. Rill-Cerbornikov, Thalassotherapia, Opatija.

Dr. J. Stjepan, Director, Institute for Treatment and Rehabilitation, Opatija.

Dr. Tonic Zora, Minister of Health.

Dr. M. Vesel, Director, Institution of Rehabilitation, Ljubljana.

Thailand

Prof. P. Auychai, President, The Council on Social Welfare of Thailand.

Mr. A. Intupui, Vice President, The Council on Social Welfare of Thailand.

Mr. M.K. Siddiqui, Statistics Division, Economic and Social Commission for Asia and the Pacific, Bangkok.

Kenya

The Hon. S.K. Meetto, M.P., Assistant Minister for Culture and Social Services, Chairman.

Mrs. A.B.N. Wandera, Principal Vocational Officer, Chief Executive Officer, Nairobi.

United Nations

Mr. M. Chamis, Consultant on Disability Statistics, Demographic and Social Statistics Branch, United Nations Statistical Office, New York.

Mr. H. Gulbrandan, Programme Officer, Rehabilitation International/UNICEF, Technical Support Program, New York.

Mr. S.I. Niwa, Chief, Vocational Rehabilitation Branch, International Labour Organization, Geneva.

Ms. L.S. Shahani, Assistant Secretary General for Social Development and Humanitarian Affairs, Vienna.

APPENDIX B

Evaluation Criteria

a. General Cultural/Social Orientation Pattern

In the ideal, a country should see that individuals who are disabled are incorporated into general social and cultural patterns through a variety of measures, such as integration of services throughout general public facilities. In this way, individuals who are disabled will be incorporated into the mainstream of society and should participate fully in the activities of the socio-cultural system of the community of which they are a part. Such inclusion can be achieved through improving accessibility and eliminating physical and social barriers.

b. Degree of Cultural Materialism

The rehabilitation of individuals who are disabled and their integration into the society are closely linked to the government's and society's willingness and ability to allocate resources, income, and social benefits and services to individuals who are handicapped population group.

c. Cultural Attitude Toward Handicapped

Attitude and behavior often lead to the exclusion of individuals who are handicapped from social and cultural life. A review of the literature reveals little available knowledge about how individuals who are disabled are placed

within different cultures, a point that in turn determines attitudes and behavioral patterns.

In the ideal, a country will undertake studies focusing on the social and cultural aspects of disability. These will help planners of rehabilitation services to understand the relationships between individuals who are nondisabled and disabled in different cultures. The results of such studies will help them to analyze the problems involved and plan programs and rehabilitation services accordingly.

d. Percent of Population Classified As "Handicapped"

In the ideal, a country will strive to see that the number of individuals who are disabled is lowered. The number of disabilities in the world today is estimated at 500 million; thus, at least one person out of ten is disabled by physical, mental, or sensory impairment, and at least 25 percent of any population is adversely affected by the presence of disability (United Nations, 1983, p. 11). A country should take appropriate measures for the prevention of impairment and disability, coordinating programs of prevention at all levels of society. These measures should include a community-based primary health care system that reaches all segments of the population, particularly in the rural areas and urban slums (United Nations, pp. 26-27).

e. Per Capita Income

Many persons with disabilities are denied employment. In the ideal, a country will develop various programs

and take measures to create jobs for individuals who are disabled. These should include sheltered and production workshops, subsidies for employers who train for future employment, and widened employment opportunities for individuals who are disabled, so that their economic situations will be improved.

f. General National Political Orientation

Individuals who are handicapped should have the right to participate in their societies. This participation can be achieved through political and social actions. Individuals who are disabled should establish organizations that influence governmental bodies, agencies, and the community and serve as a focal point for communication and coordination to mobilize resources and initiate action.

g. General National Administrative Structure

Most of the countries studied are trying to establish a national rehabilitation administration system that would coordinate all the agencies in charge of services for individuals who are handicapped. In the ideal, each country should organize a committee that aims to create a central board, with an executive body to administer the national rehabilitation program. If this national committee is set up with the support of authorities, the administration of the national rehabilitation program will be greatly facilitated at all levels: local, regional, and national.

h. Degree of Bureaucratization

Most of the countries studied have a rigid bureaucratic structure from "top to bottom." In the ideal, a country should establish a comprehensive organization. Sutherland (1977) states that what is needed is

> a comprehension--and models--of alternative organizational structures since the hierarchial bureaucratic organizational modality is not really suitable to nonmechanical missions. Specifically, we must analyze and develop the theory of matrix organization and its more complex successor, the reticular modality (where traditional lines of authority and responsibility become replaced by sets of 'adhocratic' plastic networks). (p. 104)

Therefore, the national committee should coordinate all the service through an ad hoc committee for the rehabilitation services.

i. Range of Services

The countries should try to establish all types of services for individuals who are handicapped and should try to create a quality type of service, and to use the resources wisely and in a rational way. The developing countries face not only limited resources, but also limited technology and trained personnel.

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