

Definition and Categorization of Disability in Taiwan: A Historical Review

TASING CHIU | KAOHSIUNG MEDICAL UNIVERSITY
HSIAO-YU SUN | NATIONAL SUN YAT-SEN UNIVERSITY

The assessment of disability in Taiwan has changed historically from being part of the bureaucratic legal authority of China, to being medicalized to some extent under Japanese colonialism, and then more fully in post-War Taiwan under Chinese Nationalist Party rule. The most recent trend has been toward de-medicalization due to social awareness and activism as well as the gradual application of international standards based on more variegated criteria. Impairment in traditional Chinese societies was categorized mainly for the purposes of measuring criminal punishment, taxation and compulsory labor. During Japanese colonization, disability statistics were used as a point of comparison with Western data, and the results were taken as a reference point in formulating local health policies. After the Chinese Nationalist Government arrived in Taiwan, disability measures became a key criterion of social welfare assessment. In 2007, accommodating international trends and steady growth in the government's health budget, Taiwan started to adopt the World Health Organization's International Classification of Functioning, Disability and Health (ICF) as the basis for disability estimation and need assessment. This study uses ancient records and secondary sources to review the ways in which disability has changed over the course of Taiwan's history.

Keywords: disability, classification, welfare policy, ICF, Taiwan

The policies and practices for evaluating people with disabilities in Taiwan have changed extensively over the past centuries. When Taiwan was ruled by China's Qing empire from 1684 to 1895, the policies adopted to deal with people with disabilities were thus shaped by the traditional Chinese legal system. Those who were deemed disabled were issued different civil rights and responsibilities according to their varying categories of impairment. In 1895, Taiwan was ceded to Japan by the Treaty of Shimonoseki. The Japanese colonial government ordered a thorough investigation of impaired bodies in Taiwan, and gradually employed medical examinations in cooperation with numerous institutions for the screening of invalid bodies in order to make comparisons with Western statistics and formulate local health policies. Taiwan was handed back to the Republic of China upon Japan's defeat in World War II. By the mid-twentieth century, physical examinations came to be accepted as a definitive act of medical authority, and as a legitimate means of allocating social welfare and services. However, by the end of the century, this medical examination system came to be questioned and challenged. Social awareness of the historical exclusion of impaired bodies has now reached the ruling institutions of Taiwan, where customary policies and practices are being reconsidered and even renounced and a new system for evaluating disability in practice is gradually being set up. This study will use ancient records and secondary sources to review, first of all, the ways in which disability has changed historically in Taiwan, and, secondly, the sociopolitical relations and cultural contexts that have shaped and defined disability in these different historical periods.

Traditional Legal System (1684 to 1895)

The categorization of physical and mental impairment in traditional Chinese societies had been specified in legal codes since the sixth century, and this classification system remained steadfast for more than one thousand years in China. When Taiwan was ruled by China's Qing empire (1684-1895), the policies adopted to deal with people with disabilities were shaped by the traditional Chinese legal system. The Chinese legal system divided impaired bodies into three categories according to the degree of seriousness of Ji ("illness"): Can-ji means incomplete or deficient, Fei-ji, useless or worthless, and Du-ji, serious or critical. According to the Qing Dynasty era legal book of codes (Shen [1740] 2000, p. 724), Can-ji indicates partial physical dysfunction, such as losing one finger but with the hand still capable of

holding things. Fei-ji indicates a physical dysfunction serious enough to disable physical action, such as losing one hand, losing one leg, one blind eye, dwarfism, deafness and muteness, dementia, psychiatric illness, or lame footedness. Du-ji indicates physical or mental functions too severely impaired to cure or function, such as complete blindness, loss of two limbs, loss of one limb with one eye blind, mania, or paralyzing leprosy.

Categorization and investigation of physical impairment in traditional Chinese societies were mainly used as a basis for deciding taxation, compulsory labor, and criminal punishment; children, women and the elderly, however, were not evaluated in this way (Campbell and Lee 2002). The official method of assessment was largely based on the identifiable appearance of an individual's impaired body, aided by interviews conducted in the neighborhood for confirmation. Therefore, when local officials had difficulty in judging whether a person of concern was disabled, they might ply the local elderly and children for answers, or make a personal visit to the person's neighborhood for confirmation (Chiu 2011). For disabled males categorized as Fei-ji or Du-ji, no taxation was imposed, while those under Can-ji were partially taxed. Ordinary people aged from 16 to 60 were required to provide military and state services, but disabled persons were exempted from these obligations, though they were also disqualified from attending official exams and earning a state salary.

Nineteenth century Taiwan had an assortment of burgeoning charity associations, such as nursing homes, chastity homes, bone burial associations, and cram schools, all of which provided assistance to disadvantaged people. But none of these organizations was designed specifically for disabled persons. People with disabilities did not get preferential treatment or the same amount of relief as the elderly, women or children, unless they could prove they were unable to live on their own and had no way to receive help. Qing Dynasty Law decreed that poor citizens over 60 or under 15, and youngsters with a disability as well as lone old women with no one to rely upon, were allowed to buy salt at the salt fields on a daily basis for resale (Lu and Wu [1835] 2009, p. 414). If these folks were unable to make a living on their own and had no family to take care of them, the responsibility for their welfare fell on the shoulders of governmental officials. The rules also stated that in the case of lone widows and disabled persons of Du-ji or Fe-ji who were unable to survive on their own, and the poor without relatives to depend on, local officials who should have adopted them but didn't "shall be corporeally punished with 60 whips by cane"; moreover, officials who failed to provide disabled persons with food and clothing "shall be charged with

corruption” (Shen [1740] 2000, p. 218). However, begging for a living was a main survival tactic for the poor in traditional society, since the allowance for the poor was usually not sufficient. Yet the beggars needed official authorization in order to beg, and one condition for permission was bodily impairment (Chiu 2014).

Interrogation of or forced confession from a disabled person who broke the law was prohibited, and the sentence for their criminal actions would usually be waived or mitigated (Shen 1740/2000, p. 61, 1006). For example, a felon would be banished to the wild frontier, but if the felon was a Fei-ji, the sentence could be mitigated to a fine. A murderer would be sentenced to death, but if the murderer was a Du-ji, the higher court might consider mitigating the sentence into a fine. The magistrate might also look into the actual conditions of individual cases to reach a balance between the law and reasonability. For instance, a mentally disordered murderer who would ordinarily have received a life sentence might, if the convicted person had elderly parents in need of care, be released contingent upon an official examination proving the person was cured. If the same individual committed another murder after being released, the culprit would then have to be put behind bars for good, while the person’s family members and involved officials would all be equally punished (Hao 2002). Furthermore, if a mentally ill person was not reported to the officials by relatives or neighbors, and committed suicide or murder due to lack of proper care, relatives or neighbors would be jointly held responsible and punished accordingly. If the relatives or neighbors had reported to the officials, but the responsible officials failed to closely watch the reported person, then the officials would be punished upon the person’s suicide or injury to others. In short, the control and care of disabled persons in traditional Chinese societies were through a network of relatives and neighborhood watch systems.

Preferential treatment to Du-ji persons in the traditional laws, however, was not exactly the same as the “liability competence” of modern criminal laws. For instance, the criteria for impaired bodies were based on the perpetrator’s official status at the time of the incident’s “occurrence” rather than his or her actual physical or mental condition at the time of the “incident.” Therefore, even if the suspect’s mental condition was normal at the time of the “incident” and he or she was fully capable of understanding and in control of one’s behavior, being a Du-ji at the time of the incident’s “occurrence” would make the suspect eligible for sentence waiving or mitigation. The gender of mentally disabled persons also made a difference (Qian 2014). For instance, a mentally ill husband sentenced to custody for

killing his wife might be reinvestigated after being cured and released; but, under the same scenario, a female would probably be imprisoned for life even if she were deemed cured. Apparently, in traditional Chinese societies, impairment was only one of the many features of identity, rather than a critical or major component. Put in other words, the “core values” of the law stood on multiple standards, and under the legal framework, it was necessary to refer to civil norms and identity features of individual cases, so as to select concrete and appropriate legal values.

Beginning of Medicalization (1895-1945)

Taiwan was under Japanese rule after the First Sino-Japanese War, as per the Treaty of Shimonoseki of 1895. Among the first major programs that the Japanese initiated in Taiwan was a population census which was indispensable in the subsequent management of the colonial subjects (Chen 1984). At that time, Western countries had various categories for investigating disability through population census. Italy in 1881, for example, investigated four categories: blind, deaf, mute, and retarded; Russia in 1897 had four categories: blind, deaf, mute and insane; the Netherlands in 1889 and Germany in 1890 had three categories: blind, deaf, and mute; Hungary in 1890, England in 1891, Norway in 1885, Denmark in 1890, and Portugal in 1890 had categories of the blind, deaf, mute, psychosis (or madness) and retarded. The U.S., France and Austria investigated psychiatric disability but revoked it in 1900. Since the census system established by the Japanese colonial government was designed to be compared with the data from western countries on the one hand, and to facilitate the formulation of health policies on the other hand, the “First Temporary Taiwan Census” conducted in 1905 covered all five “*bu-gu*”, meaning lacking or imperfect, categories: the blind, deaf, mute, retarded, and insane (Chiu 2011). The census revealed a total of 22,636 disabled persons; 75 out of every 10,000 persons were designated disabled (52 blind, 13 deaf and mute, 7 retarded and 3 insane). Western countries seldom looked into the causes of disability; instead, they at most divided disabled persons into congenital and acquired. For example, Norway divided disability in this way after the age of 4, while Germany did so after the age of 2. As for the temporary census of Taiwan conducted in 1905, the causes of disability were divided into three categories: congenital, illness, and injury. If two or more infirmities existed, the cause would be given for each (Chiu 2013). The investigation was conducted mainly by hygiene policemen through house-to-

house visits. For the categorization of those who were not visibly disabled, conducting neighborhood interviews was crucial to making a final judgment. Based on these investigations, the Japanese colonial government launched medical and public health reforms in the early 1900s.

According to the 1905 census of Taiwan, 75% of the bodily or mental defects came from disease, 24% were congenital, and 8% were a result of injury (The Committee of the Formosan Special Census Investigation 1909, 123). The Japanese colonial government attributed the cause of congenital deaf-mutes and idiots to marriage between close kin. As for post-natal impairments, it was believed that the majority of the diseases were related to the inefficiency of medical aid and poor hygiene habits (The Committee of the Formosan Special Census Investigation 1909, 123). Infectious diseases, such as trachoma, influenza, smallpox and measles could lead to blindness. Due to the lack of proper medical aid, people with eye diseases were seldom completely cured. Given this, Japanese colonizers established institutes for research and prevention of infectious diseases as part of their initial medical activities (Chin 1998). Progress in medical knowledge and public health measures had important impacts on endemic and epidemic diseases and mortality at this period (Liu and Liu 1997; Liu 2002, 2004). Infectious diseases were thus brought under control in the late colonial period, and the Japanese colonial government stopped disabilities investigation after 1930s.

As early as 1891, a Western priest, William Campbell, had already set up a school for the visually impaired in Taiwan. However, it was not until 1915, when the Japanese colonial government added a “vocally impaired department” to the school, that it became a complete educational institution for both the blind and the mute. Notably, it was during a time with no mandatory schooling and, as a result, very few blind and mute kids attended the school (Chiu 2015). In 1921, the Taiwan Governor promulgated an ordinance requiring that the “mentally ill, moron, retarded, disabled adult and children” receive education befitting their situation or be adopted into appropriate homes. Nevertheless, till the end of Japanese colonial rule, Taiwan’s special education was still limited to only a few students with visual or hearing impairment, and educational facilities for mentally or physically disabled children had yet to be established (Otomo 2007).

Before Japanese rule, as noted earlier, Taiwan already had many charity organizations that had been set up by wealthy business people or the educated elite to provide the poor with food, clothing, medical care, child birth and nursing, elderly sponsorship, and burial assistance. Their help targeted the needs of Can-ji and Fe-ji persons, the injured and sick, the

elderly and weak, and the young and vulnerable: i.e., mainly those dependent on others for survival. These relief charities all espoused “enlightenment” ideals premised on their moral qualifications, and their primary goal was to control and stabilize the social order (Leung 1997). In 1920, to stem the rise of Taiwanese nationalism and resistance against Japanese rule, the colonial government started to implement measures similar to the new Japanese domestic social welfare policy (Otomo 2007). This new type of social welfare upheld the slogan of “improved life quality,” trying to break “superstitions” as well as old customs and living patterns as part of their effort to integrate Taiwan into “modernized” living styles. In 1921, the Taiwan Governor promulgated the “Taiwan Income Tax Amendment,” announcing that households with disabled members would be entitled to a tax exemption. However, with the onset of the Sino-Japanese War in 1937, social welfare gradually became part of war compensation. In sum, the categorization and statistics of Taiwan’s people with disabilities were basically used as a reference for formulating the colonial government’s health policies and making comparisons with western statistics. Few new institutions for the disabled people were set up in this period.

Extension of Medical Assessments (1945-2007)

Following the end of World War II, the Republic of China, led by the Chinese Nationalist Government, became the governing polity of Taiwan. After losing control of mainland China following the Chinese Civil War, the Chinese Nationalist Government fled to Taiwan in 1949 and transplanted the Mainland social systems to Taiwan. Nevertheless, many aspects of the governing knowledge and systems established by Japanese colonial rulers were left in place, including the bureaucratic system, school education, economic facilities, and even the household registration system (Yao 2006). Starting from 1950, laborers were required to present a diagnosis certified by a public hospital or health institution, or by a licensed physician, in order to apply for the “disability compensation” from labor insurance. And in 1953, it was stipulated that an individual with physical disability or incurable illness should not be a candidate for the provincial assembly’s legislator position. As for whether the “physical disability” needed a physician’s endorsement, it depended on the severity of the illness; if it was easily identifiable, the disability could be directly confirmed; otherwise a physician’s assessment (e.g. on mental incompetence) was required. In 1969, minor corrections were

made to regulations on “Standard for Mental Incompetence or Physical Disability: Health Certificate of Public Servant Candidate,” which classified “physical disability” as the loss of two lower limbs and prohibited such individuals from running for national legislator, though they were still able to run for provincial or local legislator and representative positions.

The Nationalist Government’s early social welfare was aimed at the military, public servants, education practitioners, and labor workers, and subsequently extended to physical impaired subsidiaries. Medical disability assessments had by that time become an essential requirement. The regulations stipulated that application for preferential treatment should have a disability diagnosis certificate issued by a public hospital (clinic) or a private general hospital. Disabled person and his/her travel companion then had to show their IDs to purchase tickets at a preferential price. From the 1950s onwards, the medical system and educational policies in Taiwan were influenced greatly by developments in America. With the outbreak of the Korean War, the China Aid Act and the Chinese-American Joint Commission on Rural Reconstruction were started with the aim of ensuring that Taiwan would not succumb to Communist forces (Chiu 2015). Under the Chinese Nationalist government, medical assessment extended to all professional occupations and local representatives and legislators, and they all had to go through the clearly defined standard of physical assessments to be eligible for their positions. Indeed, medical assessment was extensively adopted but with different emphases. For those who applied for welfare grants or subsidies, the medical assessment was to highlight “abnormal” physical conditions; however, assessments involving civil rights (such as education and job employment rights) were employed to verify the applicant’s “normal” physical condition. As such, both society at large and the institutions of social services gradually came to regard disabled people as “defective” in some way (Drake 2001). The expanding scope of control over “normal” bodies led to greater exclusion of disabled persons from either attending school or applying for a job.

In 1980, the term *Can-zhang*, meaning “incomplete and defective”, was used in the first disability-related law in Taiwan, the *Can-Zhang Welfare Act*, which commenced a full-scale medical disability assessment, and a disability identification card was also issued (Chang 2007). This marked the first massive mobilization of medical personnel in conducting disability identification, which then categorized the handicapped into six groups: visual and hearing handicaps, hearing or balancing handicaps, vocal or linguistic handicaps, physical handicaps, intellectual inadequacy, and multiple

handicaps. The categorization was then used as a basis for cash and welfare grants. Full-scale disability assessment projects started with neighborhood officials initiating investigations to establish a disability registration of the local population. The information gathered would then be sent to local special education teachers, public hospital doctors and nurses, and public health clinics for comprehensive re-assessment (Chiu 2011). After a comprehensive disability list was established, individual cases were subsequently handled by public hospitals, clinics and rehabilitation institutions for individual assessment and the issuing of certification of diagnosis. The Can-Zhang Welfare Act substantially expanded the scope and categories of disability, and the number of disabled persons, alongside the aging populations, saw a constant rise. However, this law included no regulations or concrete policies, and thus did not lead to the realization of disability rights.

On July 15, 1987, the Nationalist Government ended 38 years of martial law. Political space for civil rights advocacy thus opened up, and various groups for the disadvantaged established. The handicapped welfare movement gained great support from the public beginning at this time (Hsiao 1997; Wang 2007). Numerous disability rights-related issues were subsequently brought up, such as accessibility to public facilities and public transportation, restrictions on college entrance examinations and employment discrimination. In order to realize these goals, the first nationwide welfare advocate group, the League of Enabling Associations (LEA), was established in 1990 and effectively increased bargaining power with the state (Wang 2007). The Can-Zhang Welfare Act was amended in the same year and extended its application to include facial impairment, “human vegetable,” Alzheimer’s, and autism. Another major revision was the disability employment quota, which was the first institutional protection of employment for disabled people in Taiwan. In the 1990s, social welfare advocacy organizations began to increase their efforts in lobbying and building linkages with government agencies and legislators. With the advocacy efforts of Non-Profit Organizations (NPOs), newspaper narratives gradually changed from charity to citizens’ rights (Chang 2007). In 1997, a revision of this law, renamed Shen-Xin Zhang-Ai-Zhe (meaning people with mental and physical disabilities) Protection Act was passed. The budget for the social welfare of disabled people also increased significantly. This act added chronic mental illness, stubborn (difficult-to-cure) epilepsy, and other rare diseases to the disability welfare list. As disability categories and their scope continued to be extended, the number of disabled persons also grew. In 1980, there were over twenty thousand disabled people (1.1% of the total population); by 1997

the count had increased to fifty thousand plus (2.3% of the total population); and by 2007 the count had exceeded one million (4.4% of the total population).

Implementation of ICF (2007 to present)

Unlike the charity-oriented NPOs in the past, the new disability rights movement organizations have mainly been organized by disabled people, advocating for breaking down social-structural barriers and contesting the disability politics in the public sphere (Chang 2015). The amendment of the Disability Rights Protection Act in 2007 adopted WHO's International Classification of Functioning, Disability and Health (abbreviated as ICF) for the disability and demand assessment. The purpose of this new framework is to form links between disability evaluation, needs assessment and social welfare services, in order to promote the participation of people with disabilities (Chiu et al. 2013). Given this framework, impairments of body functions and structures no longer necessarily constituted disability; instead, it was now judged to be a result of interactions among a person's body functions and structures, activities and participation, environmental factors, and personal factors. These interactions are explained as follows: (1) the body functions and structures are interpreted through changes in the physiologic system or anatomy; (2) the activities and participation describe the individual's capability status and participation performance; (3) the environmental factors include products and technologies, natural environment and artificial transformation, supports and relationship, attitudes, service policy, etc.; (4) the personal factors include gender, race, age, living style, customs, temperament, social background, education, occupation, past and current experiences, personality types, individual's psychological advantages, and other personal traits (Chiu 2011). Therefore, disability must be evaluated and identified collaboratively by professional teams consisting of medical personnel, social workers, and professionals of special education and career consultation (Chiu and Chen 2015). While the government considers ICF as a tool to identify disabled persons and to assess their welfare needs to pursue "distributive justice," the NGOs expect to use the ICF to alter the widespread prejudice and discrimination against people with disabilities for the purpose of "formal justice" (Hung 2012).

However, this de-medicalization of the assessment has caused lots of disputes. The ICF system appeals to both personal and contextual factors, but

since being put into practice, it has encountered some uncertainties (Yen et al. 2012). First of all, it is far too time-consuming to try to observe a person's performance in various daily life situations, especially activities performed outside the household. Secondly, it is quite challenging for interviewers to be consistent in evaluating the degree of difficulty of action or behavior. Moreover, attitudinal or environmental factors are difficult to quantify and standardize. Finally, even though these variables can still create reliable measurements to a certain degree, the interviews may still face a more difficult task; namely, how to put together data collected from different viewpoints and integrate them into effective indexes for the disability assessment (Nagi 1964). Furthermore, a full-scale adoption of ICF would dramatically increase disabled populations and, consequently, greatly burden the government financially. The professionals who heatedly debated this issue in Taiwan eventually reached a consensus that medical institutions would remain the one and only authority for disability assessment. The assessment procedure was boiled down to two steps: medical institutions conduct disability assessment and then they send the final report of verification to the local Social Bureau or District Office, who issues a 'disabled person' ID card. The city and county authorities will follow up and then organize professional teams to conduct the demand assessment, based on the factors of disability categories, disability degree, household financial status, care service needs, household living requirements, social participation and anticipation. Certainly, bodily impairment may still be a necessary and sufficient condition to be counted as a disabled person; in other words, the applicant must go through a medical assessment to prove the existence of "body structure impairment or dysfunction" to be eligible for the application of social welfare and disability benefit (Teng et al. 2013). In sum, although de-medicalization has occurred to some extent over the last decade, the incorporation of ICF standards was only able to gain a tenuous foothold, as the medical establishment has recently managed to reassert a central role in demarcating disability in Taiwan.

Conclusion

Disability and its official classification provided the rationale and authority for the management of disabled persons. In the pre-modern era, the classification was made for administrative purposes consistent with the society's cultural and political values. In the nineteenth century, the

assessment of “disabled bodies” shifted to a different system of assessment which was mainly conducted by medical professionals. Disability conceptualized in this way had direct implications for treatments, interventions, and preventions. In short, in the modern era, what counts as disability has come to be based on “the medical model” of impairment, which is used to sort out the eligibility of applicants for social welfare and the allocation of available resources. Assessing disability by medical examination meets the desire of societal leaders and the majority of citizens for a seemingly reliable, scientific measurement. As Zola (1991, 306) noted, “what is measurable is somehow more real, more valid, more objective.” The history of the assessment of disability in Taiwan has changed from having a basis in Chinese society’s cultural and political values to increasingly being based on medicalized moral values, with contestation between forces of medicalization and de-medicalization in recent times. Currently, the tide is shifting back to a medical model, in response to the latest complexities challenging the assessment of social welfare and disability benefits. Medical examination once again is being viewed as more real, valid, and objective. Nevertheless, the struggles in Taiwan to find a balance between the traditional, more socially dynamic concept and means of assessing disability, and the westernized medical model, in addition to contending global concepts and assessments of disability, will no doubt continue. Moreover, we can expect to see new agendas for disability emerge as the 21st Century moves forward amid changing sociopolitical and cultural relations that will redefine disability and shape who counts and what counts as disabled or disability.

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TASING CHIU is currently the professor of Department of Medical Sociology and Social Work at Kaohsiung Medical University. He is a sociologist of disability with subsidiary interests in blindness, and his research has focused on blindness as well as disability. He is also the editor-in-chief of *Taiwanese Journal for Studies of Science, Technology and Medicine*. Recent publications include "A Tactile Turn: Exhibition Ideas of Kojiro Hirose" (2016), "The Movement and Relocation of the Blind in Taiwan during Japanese Colonial Period" (2015), "Braille, Amma and Integration: The Hybrid Evolution of Education for the Blind in Taiwan, 1870s-1970s" (2014), and "Who Are the Blind? Assessment, Categorization, and the Making Up of the Blind in Modern Taiwan" (2013). Address: No.2 Ln.437 Ben-Guan Rd. Niao-Sung, Kaohsiung 833, Taiwan [E-mail: tasingchiu@gmail.com]

HSIAO-YU SUN is currently the professor of Department of Foreign Languages &

Literature at National Sun Yat-sen University. She teaches disability studies, literary criticism, and life writing. Her interests in research include Buddhist psychology, disability studies, and theories of subjectivity. Among her publications are *Disability Studies & Life Writing: Disabled Women's Gender/Sex, Body/Politics, & Aesthetics/Politics*, "Demystifying the Fantasies of Normalcy: A Foucauldian Study of the Construction of Disability in the Nineteenth Century", "From Passing to Masquerade and Performance", and so on. Address: 70 Lienhai Rd., Kaohsiung 80424, Taiwan [E-mail: hsiaosun@mail.nsysu.edu.tw]