PROGRAM ISSUE REVIEW

DEFINING THE DEVELOPMENTALLY DISABLED POPULATION

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PREFACE

This paper is one in a series prepared under HEW, Rehabilitation Services Administration, Office of Human Development Services, Grants of National Significance #54-P-71220/2-01 (FY 1978) and #54-P-71220/2-02 (FY 1979) on pertinent issues in planning, advocacy, administration monitoring and evaluation in the Developmental Disabilities Formula Grant Program.

During Fiscal Year 1978, the following topics were addressed through developmental disabilities state plan analysis:

- Prevalence of the Developmental Disabilities
- Rates of Prevalence of the Developmental Disabilities
- Characteristics of the Developmentally Disabled
- Developmentally Disabled Population Service Needs
- Approaches to Developmental Disabilities Service Needs Assessment
- Characteristics of Developmental Disabilities State Planning Councils
- Designs for Implementation

During Fiscal Year 1979, analysis of most identified issues will be based on state plan analysis augmented by the contributions of state program and council, special project and UAF personnel to provide clarification and examples of unique approaches to Developmental Disabilities Program activities. These issues and data reviews are designed to be responsive to the new mandates of Title V of PL 95-602 (Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978):

- Gaps and Barriers in the Developmental Disabilities Service Network
- Goals and Objectives of the Developmental Disabilities Program
- Developmental Disabilities Service Utilization
- The Relationship of Developmental Disabilities Program Activities to Gaps and Barriers
- Monitoring and Evaluation in the Developmental Disabilities Program
- Coordination and Case Management in the Developmental Disabilities Program
- Child Development Activities
- Social-Developmental Services
- Community Alternative Living Arrangements
- Potential Impact of Title V, PL 95-602, on DD Program Plan Year Activities
- Impact of the Developmental Disabilities Program
- Defining the Developmental Disabilities Population
- An Analytical Review of Title V of PL 95-602
- An Analytical Review of Changes in the Rehabilitation Act of 1973

The contributions of many persons in the field of developmental disabilities have enhanced examination of these topics. Paper development was conducted by:

Irwin Schpok, Project Director
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This paper was developed in response to the immediate need of states to implement the modified definition of developmental disabilities contained in PL 95-602. It was done in the absence of regulatory guidelines or prior state program experience with this definition. As such, its meaningful completion would not have been possible without the contributions of a number of people working in the field of developmental disabilities.

EMC Institute wishes to extend special appreciation to the following staff of the "Study of the Impact of Changing the Definition of Developmental Disabilities" at Morgan Management Systems, Incorporated, Columbia, Maryland:

Solomon Jacobson, Project Director

Elinor Gollay, Principal Investigator

Karen Lapidus Batterton, Program Consultant

During Fiscal Year 1979, the impact study will examine, in detail, both the characteristics and the implementation of the new definition. The support and constructive contributions of the staff of this project have helped tremendously in the effort to produce a preliminary publication on the definition which we hope is both timely and practical.

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The suggestions, explanations and questions provided by these people have enabled EMC to develop a more practical examination of the modified definition and the decisions required for its implementation.

INTRODUCTION:

DEFINING THE DEVELOPMENTALLY DISABLED POPULATION

This Issue Paper, one in a series prepared by EMC Institute, examines the definition of developmental disabilities mandated by PL 95-602, and attempts to provide some considerations for practical implementation.

The functional definition of PL 95-602 is almost word-for-word the definition recommended by the Task Force on the Definition of Developmental Disabilities. It mandates a radical departure from the direction of the original Developmental Disabilities Program, which concentrated on persons with mental retardation, cerebral palsy, epilepsy, autism and related conditions. The new definition broadens the range of impairments which may be covered by the program, while specifically limiting program activities to those persons with functional limitations in three or more areas of major life activity.

The modified definition provides only broad considerations for determining who is included in the population. Further specification of the definition is therefore needed in order to implement this definition. While decisions on such specifications might be one area for discussion in program regulations, this paper is based on the assumption that regulations for PL 95-602 will not provide further specification of the definition, and that such specification will be left to individual state Developmental Disabilities Programs.

This paper provides a detailed examination of the definition, identifies some specific potential issues in implementation and suggests some preliminary means for dealing with these issues at the state and local levels.

THE NEW DEFINITION

In order to review the PL 95-602 definition of developmental disabilities in a meaningful way, it is necessary to define our terms. "Disability," "handicap," "condition," "impairment," and probably other terms are often used interchangeably. Much has been written about this problem although no means for standardizing the usage of these terms among human service professionals has yet been developed. For the purposes of this paper, explanations of the terms "condition," "disability," and "functional limitation" are given on Table 1. These terms provide a hierarchy of effects on an individual which are useful In analyzing the new definition.

In the context of the terms on Table 1, then, it is possible to identify what the PL 95-602 definition says about the developmentally disabled. The components of the PL 94-103 and PL 95-602 definitions are compared on Table 2.

From examination of Table 2, it becomes clear that, while the "conditions" criterion has been expanded by PL 95-602, both the "degree of disability" and "degree of functional limitation" criteria in the new legislation place strong emphasis on the fact that the new definition includes only the more severely affected individuals.

The components of the new definition are examined In more detail in the paragraphs below.

Basic Disability Characteristics

A developmental disability is a "severe, chronic disability." This phrase merely re-emphasizes other provisions of the definition.

Condition

A developmental disability results from a physical or mental impairment or a combination of both. This criterion eliminates the disability-specific language of PL 94-103 and opens the program to all severely disabled people, a further criterion which will be discussed below under "Substantial Functional Limitations."

The Task Force on the Definition of Developmental Disabilities intended this criterion to encompass all neurological, sensory, biochemical, intellectual, cognitive and affective impairments. It should be remembered that most conditions will not result in a severe, chronic disability which meets the other criteria of the definition.

Table 3 lists some characteristics of those conditions which are most likely to have major representation in the new definition. The list is not all-inclusive; it simply provides a working basis for identifying conditions

TABLE 1

DEFINITIONS

(Severity refers to the degree of impairment, disability or handicap)

CATEGORY	DESCRIPTION	STRATEGIES FOR ALLEVIATION	DISCUSSION
CONDITION*	Residual limitation resulting from congenital defect, disease or injury	Devices or medical care, Training the individual	When condition is mild, disability or handicap may not exist. The Vocational Rehabilitation Survey of the Comprehensive Needs Study found a minimal relationship between diagnostic label and severity of handicap. Different people react differently to a given condition: similar conditions may result in different disabling or handicapping condition or functional limitations. Most people with conditions experience no limits on their ability to perform in society. A diagnostic label does not imply disability or handicap, but it does stereotype people. A given level of impairment can result in different degrees of disability or handicap, for reasons other than the condition itself: age, education, motivation, family or environmental or attitudinal barriers.
DISABILITY	Inability or limitation in performing roles and tasks expected of an individual within a social environment, resulting from an impairment	Training the individual, devices or medical care and/or changing the environment	Need to look at the disabled person in terms of the whole person, not the disability alone, to determine what the person can do. Disabling conditions exist in different areas of life. For example, some disabled people can use transporation, while others are severely limited by transportation.
FUNCTIONAL LIMITATIONS	Functional limitations describe the components of a disability, i.e., inability to meet age-specific expectations in certain performance areas, resulting from a disability **	Training the individual, devices or medical care and/or changing the environment	Environments as well as conditions can cause functional limitations.

* From Report of the Comprehensive Needs Study, Urban Institute, 1975, pp. 21-38, 771-772, 776

** From Final Report on the Definition of Developmental Disabilities, Task Force on Developmental Disabilities, October, 1977

TABLE 2

DEFINITIONS OF DEVELOPMENTAL DISABILITIES

CRITERION	PL 94-103 DEFINITION	PL 95-602 DEFINITION
Degree of Disability	"a disability of a person which...	"a severe, chronic disability of a person which...
Conditions Included in Definition	"is attributable to mental retardation, cerebral palsy, epilepsy, or autism; "is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons; or "is attributable to dyslexia resulting from a disability described above;"	"is attributable to a mental or physical impairment or combination of mental and physical impairments;"
Degree of Handicap	"... constitutes a substantial handicap to such person's ability to function normally in society."	"...results in substantial functional limitations in 3 or more of the following areas of major life activity: self care receptive and expressive language, learning mobility self-direction capacity for independent living economic self-sufficiency
Need for Services		"and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."
Age of Onset	"originates before such person attains age 18;"	"is manifested before the person attains age 22;"
Duration of Disability	"has continued or can be expected to continue indefinitely;"	"is likely to continue indefinitely;"

TABLE 3

A PARTIAL LIST OF IMPAIRMENTS FOR POTENTIAL INCLUSION IN THE POPULATION

IMPAIRMENT	DESCRIPTION	ETIOLOGY	INTERVENTION-TREATMENT	AGE OF ONSET	CHRONICITY	PREVALENCE	FACTORS WHICH MITIGATE DEGREE OF DISABILITY: PRESENCE OF NORMAL I.Q.	PERSONAL MOTIVATION	FAMILY INCOME LEVEL	DIAGNOSIS - IDENTIFICATION	MAY BE MIS-DIAGNOSED AS
Childhood Psychosis [1]	An impairment in the mental or emotional functioning - deviating from the expected norms of behavior.	Organic or physical syndromes; Psychological trauma	Intense therapies required over long periods; Family therapy	4 - 7 years	Yes for some; can be for others if untreated	Too disparate	No	No	Yes	Only most severe cases identified early; Clinical training boxes in diagnosis	Learning disabled or Mentally retarded
Emotional Disturbance [1,2]	As above except children so labeled in this category showing symptoms of learning disabilities.	Organic or physical syndromes; Psychological trauma	History of treating symptoms - inadequate services; Need for coordination of Ed-Health & other agencies	School-age	Yes for some; can be for others if untreated	Too disparate	No	No	Yes	Same as above; Often mis-diagnosed	Learning disabled or Mentally retarded
Mental Illness [1,3]	An impairment in the mental or emotional functioning - deviation from the expected norms of behavior.	Organic or physical syndromes; Psychological trauma	Drugs and anti-depressants successful in mainstreaming effort but controversial as are some therapeutic efforts.	From childhood on	Yes	20 million in U.S; 215,373 institutionalized in '74	No	Sometimes	Helps, but not as much as expected	Often mis-diagnosed; Sometimes causes are physical illnesses; Most severe are identified; Diagnosis inadequate	Mentally retarded or criminal
Mental Retardation [1,4]	Significantly sub-average general intellectual functioning which is associated with impairment in adaptive behavior	Organic or physical assault to central nervous system - pre- or post-natal or at birth - severe brain damage - toxicity	Early stimulation, training - prescriptive treatments; Physical & occupational therapies; Normalization	Birth or injury; Manifests at different ages	Yes	2.8% of U.S. population	Not applicable	No - motivation may be geared to I.Q. level	Yes	Usually diagnosed early; In some rural areas, diagnosis may come later; Evaluation instruments have been improved	Mentally ill or criminal
Muscular Dystrophy [1]	Neuromuscular disease with progressive degeneration of the skeletal or voluntary musculature of the body; Five types; Duchenne is usually fatal	Genetic - progressive degeneration of the musculature of the body	No successful treatment for Duchenne type; Helpful therapies, no cure	Duchenne type: 2-10 yrs; Varying ages for other types	Yes	200,000 of U.S. population	Yes	No	No	Same as above except this serious disabling disease is usually diagnosed early everywhere; Diagnosis more difficult with milder types	Milder types-arthritis or other similar diseases
Osteogenesis Imperfecta (tarda - mild form) [1,3]	A crippling, incapacitating, disfiguring disorder of connective tissue with fragile, brittle bones	Uncommon genetic defect, deformities, brittle bones and deafness	No known treatment or cure	Birth or later in life	Yes	Estimate: 10,000 - 30,000 of U.S. population	No	No	Yes	Severity of disease leads to early diagnosis	-
Spina Bifida [1]	A birth defect in which the vertebrae fail to develop around spinal cord	Congenital birth defect; Malformation of the central nervous system 4th & 6th week of pregnancy	Immediate surgery to enclose exposed spinal cord; 8 out of 10 need brain shunts; Need supportive therapies and orthopedic treatments	Birth	Yes	12,000 such children born each year	Yes	Yes	Yes	Early diagnosis due to severity of disease	-
Tourette's Syndrome [1,3]	A movement disorder which causes erratic, involuntary spasmodic muscular movements	Organic dysfunction of central nervous system - involuntary movements of body parts	Does not respond to medication treatment	Between 2 & 15 years	Yes	Undetermined Could be more than 1,000 cases, total	Yes	No	No	Lack of familiarity with disease causes such mis-diagnosis	Emotional and psychological disorders
Blindness or Severe Visual Impairment [1]	A serious impairment in visual acuity	Retinal disease; Glaucoma, cataracts; Prenatal factors, overuse of oxygen at birth, trauma and infectious diseases	Surgery for cataracts & detached retina but most impairment of vision is irreversible; Education & training, & treatment of dev. lag is offered	Birth or injury	Yes	500,000 of U.S. population legally blind	Yes	Yes	Yes	Early diagnosis in usual cases of blindness at birth; Varies with severity and cause	-
Deafness [1]	A whole or partial loss of the sense of hearing	Experts believe that 30-40% of deafness is of unknown etiology; Prenatal infections & poor brith procedures	Micro-surgery for restoration of conduction deficiences; Use of antibiotics has reduced prevalence rate as has use of precautions at birth	Prelingual-birth to 3 years; Prevocational-to age 19 yrs	Yes	2,000,000 of U.S. population lack sufficient hearing to understand speech	Yes	Yes	Yes	Somewhat slow in milder cases - causes developmental lag; Often undetected at birth	Mentally retarded

TABLE 3 (cont'd)

A PARTIAL LIST OF IMPAIRMENTS FOR POTENTIAL INCLUSION IN THE POPULATION

IMPAIRMENT	DESCRIPTION	ETIOLOGY	INTERVENTION-TREATMENT	AGE OF ONSET	CHRONICITY	PREVALENCE	FACTORS WHICH MITIGATE DEGREE OF DISABILITY: PRESENCE OF NORMAL I.Q.	PERSONAL MOTIVATION	FAMILY INCOME LEVEL	DIAGNOSIS - IDENTIFICATION	MAY BE MIS-DIAGNOSED AS
Huntingdon's Disease [1,3]	A degenerative disorder of the central nervous system, usually fatal	Inherited, degenerative disorder causing the death of nerve cells in 2 areas of the brain - motor & mental	No known treatment	Genetic disorder present at birth (25 or so); Childhood form: 12-14 yrs	Yes Fatal	Estimate: 10,000 to 14,000; May be 3 to 4 times as many	No	No	No	Diagnosis is often confused until disease has progressed for long periods; Physicians not familiar with disease	Multiple sclerosis; Parkinson's disease; Epilepsy; Emotional disorders
Learning Disabled [1,2] and Minimal Brain Dysfunction [1,2] (medical model)	The inability to learn, to perceive and/or to read, by accepted methods, despite normal or above-normal I.Q. As above, except that assault to the brain, depending on severity and area involved, may cause functioning retardation symptoms	Central nervous system damage; Causes can't always be found - pre-natal infections, birth injuries, post-natal trauma, i.e. jaundice (high bilirubin count); Sometimes genetic	Perceptual training; Physical & occupational therapy; Medical control of hyperactivity & allergies; Individual ed. programming presently inadequate; Professionals becoming more knowledgable	Birth or Trauma	Yes	Severe: up to 10% of total school-age population	Yes	Yes	Yes	Mostly mis-diagnosed on first evaluation - often not identified until eight years old - missing high-risk infants	Mentally retarded; Socially & emotionally disturbed
Cerebral Palsy [1]	Spasmodic whole or partial paralysis due to cerebral lesion	Central nervous system damage, and causes listed directly above	Early stimulation, physical therapies; Individual treatments inadequate; Ed. programs, vocational training, normalization	Birth or trauma	Yes	.10% of U.S. population	Yes	Yes	Yes	For severe cases, diagnosis is fairly early; for mild C.P. diagnosis is poor - referrals difficult	Mentally retarded
Epilepsy [5]	A convulsive disorder of the central nervous system due to abnormal electrical discharges of brain cells	Central nervous system damage; Genetic	Medication, neuro-surgery; Special education sometimes required; Vocational programming	Birth or trauma	Yes	1.0% of U.S. population	Yes	Yes	Yes	Improving diagnostic procedures - parents tend to wait out seizures fearing labelling	M.R. L.D.
Autism [6]	Severe disorders of behavior & communication	Thought to be emotionally caused - changes in etiology due to research - may be a biochemical problem or brain damage	Medication for control; Behavior modification programs; Training & therapy; Education programming	Birth	Yes	.03% of U.S. population	Yes	No	Yes	Severity usually aids early identification, but not always - some ident. later when poor behavior patterns are already in place	M.R.

[1] Abt Associates, Inc., Background Materials for the Second Meeting of the National Task Force on the Definition of Developmental Disabilities, Cambridge, Massachusetts, April 1977.

[2] Pennsylvania Association for Children with Learning Disabilities

[3] The White House Conference on Handicapped Individuals, May 23-27, 1977, Volume One: Awareness Papers, Washington, D.C.

[4] American Association on Mental Deficiency, Manual on Terminology & Classification

[5] National Epilepsy Foundation of America

[6] National Society for Autistic Children

which are likely to be most prevalent in the new population. Table 3 also attempts to highlight some over-riding problems in the diagnosis and treatment of these conditions; while also not the final word, these descriptions may be of some assistance to councils and planners in identifying state-specific problem areas.

Age of Manifestation

A developmental disability must be manifested before a person is 22 years old. That is, it must interfere with a person's development before that age.

A child with a severe, chronic disability may not be able to acquire basic life skills through the same processes used for and by an unimpaired child. Emphasis is on habilitation, to assist the child or adult to develop basic life skills which he or she never had, and to improve skills not adequately developed.

Adults, as well as children, may acquire disabilities which result in substantial functional limitations. Except for the severe problems caused by some cases of trauma and progressive disease, the disabilities which result from adult-onset conditions are usually mitigated by the fact that the adult has already mastered most living skills during his or her unimpaired developmental period. While the adult individual who is disabled after age 22 may have lost some skills as a result of the disability, or other skills, such as job skills, may no longer be useful to the person, rehabilitation usually takes advantage of some basic life skills and attitudes which the adult has acquired in previous years.

Thus the limit on age of manifestation makes the distinction between a disability which is present during the developmental period, and interferes with development, and a disability which occurs after normal development has taken place.

Duration

A developmental disability is "likely to continue indefinitely."

The intent of this criterion is to focus the program on persons for whom the duration of disability is uncertain or is likely to be life-long. Thus, a child with a severe case of rheumatic fever, which is a time-related disease, would not be considered developmentally disabled (although residual effects of severe illness could lead to a developmental disability).

On the other hand, "indefinite" is not necessarily life-long or even decades in extent, particularly if intervention is prompt and responsive to the developmental needs of the individual.

Substantial Functional Limitations

The PL 95-602 definition of developmental disabilities specifies that a person with a "severe, chronic disability" must have "substantial functional limitations" in at least three of the following major life activities in order to qualify as developmentally disabled:

- self-care
- receptive and expressive language
- learning
- mobility
- self-direction
- capacity for independent living
- economic self-sufficiency

According to the Definition Task Force, a disability is "substantial" if an individual has functional limitations in three or more of the above areas.

Table 4 contains a working definition of each of the major life activities and lists some potential activities which may be considered under each of the seven major areas.

Note that some activities shown on Table 4 are components of more than one major life activity, and limitations in a person's ability to perform such component activities will affect that person's ability to perform more than one major life activity.

Several things should be remembered when reviewing functional limitations of an individual:

- An individual's limitations are likely to change over time, depending upon environment and services/treatment received (or not received). A person may not experience substantial functional limitations at all points throughout his or her lifetime.

- This discussion does not recognize motivation, an individual variable which can enable a person to overcome what would otherwise be substantial functional limitations.

- In most instances, the presence of functional limitations must be verified by a comprehensive evaluation of the individual, and not by services being received or objectives specified on an individual habilitation plan. We stress this distinction because, in some states, some service providers tailor individual plans to available services, not to what the clients need. For example, a child who requires

TABLE 4

COMPONENTS OF THE SEVEN MAJOR LIFE ACTIVITIES *

ACTIVITY	DEFINITION OF ACTIVITY	POTENTIAL COMPONENTS OF ACTIVITY **
Self-care	Daily activities which satisfy personal needs for food, hygiene, safety and appearance.	Eating: mastication and swallowing drinking use of utensils Hygiene: eliminating washing and bathing, including hair personal care during menstruation Immediate personal safety: use of implements (knives, pins, appliances, etc.) [orientation in environment; specifically, conduct around open flame, vehicles, traffic, inedible and caustic substances, etc.] Grooming: dressing (including use of buttons, shoe laces, etc.) hair and nail care
Learning	Changes in an individual's behavior or perception; the process which results in such changes.	Cognition: [perception (recognition and integration of sensory information)] understanding of perceived information Conception: perception of relationships among pieces of information reasoning use of abstract thought as well as perceived information Memory [Time concept & attention span] [Orientation in the environment] Academic & other educational skills

*From a review of Performance Measures of Skill and Adaptive Competencies in the Developmentally Disabled, Individualized Data Base, UCLA-Neuropsychiatric Institute Research Group, Pomona, California, 1978.

**Components which appear in brackets are components of more than one major life activity:[ ]

TABLE 4 (Continued)

COMPONENTS OF THE SEVEN MAJOR LIFE ACTIVITIES *

ACTIVITY	DEFINITION OF ACTIVITY	POTENTIAL COMPONENTS OF ACTIVITY **
Mobility	Ability of the individual to negotiate distance using his or her own power or a personally controlled device.	Locomotion Ambulation Gross motor coordination: balance walking, sitting, rolling, etc. Fine motor coordination: dexterity (precision movements) Eye/hand coordination (a feature of fine and/or gross motor coordination)
Self-direction	Ability of the individual to manage his or her personal and social behavior.	Self-concept Adaptivity and constructivenss of behavior [general responsiveness] [responsiveness to instructions] [orientation in environment] Social, recreational and cultural involvement
Economic Self-Sufficiency	Financial resources are available to meet both basic life support needs of the individual and his or her recreational needs.	income or support vocational status & skills pre-vocational skills
Receptive & Expressive Language	Ability to understand language of others; ability to communicate ideas through language. Language may be spoken, written, sign language or other gesturing.	[perception, particularly aural/visual perception] range of groups who can understand individual's communication: family, friends, instructors, acquaintances, strangers. [general responsiveness] [responsiveness to instructions]
Capacity for Independent Living	Ability to maintain a full and varied life in the community with little or no regular outside intervention in the living situation.	money management: budgeting & purchasing leisure-time activities: recreational, cultural, social & personal

*From a review of Performance Measures of Skill and Adaptive Competencies in the Developmentally Disabled, Individualized Data Base, UCLA-Neuropsychiatric Institute Research Group, Pomona, California, 1978.

**Components which appear in brackets are components of more than one major life activity:[ ]

TABLE 4 (Continued)

COMPONENTS OF THE SEVEN MAJOR LIFE ACTIVITIES *

ACTIVITY	DEFINITION OF ACTIVITY	POTENTIAL COMPONENTS OF ACTIVITY **
Capacity for Independent Living (continued)		community skills: using transportation & telephone locating & using stores, recreational facilities, institutions (including libraries, police, etc.) and other resources. sexual & legal awareness housekeeping: health & safety activities food preparation & storage care of personal possessions family: role in family child care skills

*From a review of Performance Measures of Skill and Adaptive Competencies in the Developmentally Disabled, Individualized Data Base, UCLA-Neuropsychiatric Institute Research Group, Pomona, California, 1978

**Components which appear in brackets are components of more than one major life activity:[ ]

education assistance may be placed in a regular classroom if a school district does not have the specific resources required by that child. Yet the fact that the child has been "mainstrearned" does not mean that a functional limitation does not exist; indeed, it may be aggravated by the pressures of the classroom situation.

Service Needs

A developmental disability reflects a person's need for a combination and sequence of services which are of life-long or extended duration and are individually planned and coordinated. A person with functional limitations in three or more of the major life activities is likely to need a variety of assistance to overcome those limitations. The intent of this criterion is to re-emphasize the complex and multiple nature of the needs of all developmentally disabled people.

On Table 5, functional limitations are discussed in terms of the external assistance (services) which may be needed by the person as a result of these limitations, and the support or lack of support offered by the person's total environment.

It should be noted here that, while defining the developmentally disabled population in terms of functions avoids the use of often demeaning labels, a person's disability must be identified so that it can be treated. Such treatment is essential for the amelioration of a functional limitation. For example a child with a severe heart condition which is amenable to surgery may experience a considerable increase in mobility in and receptivity to the environment if surgery is performed; it may enhance functioning in other areas of the child's life. Thus services must treat the disability (where possible) as well as assist in coping with functional limitations.

Services for the developmentally disabled must be individually planned and coordinated. It is not enough to note that several persons have the same disability or that several persons have the same functional limitations, and then create a service component which will treat them all equally. The nature and source of both limitations and disability(s) as well as other factors in the person's life, such as the family situation, must determine the person's needs and service objectives, and such a course of services can only be determined and executed through individual evaluation and programming.

TABLE 5

POTENTIAL LIMITATIONS IN MAJOR LIFE ACTIVITIES *

ACTIVITY	POTENTIAL LIMITATIONS	OTHER FACTORS
Self-care	Regular assistance is required in eating or drinking, and/or hygiene and/or assuring the individual's immediate personal safety.	Some individuals may be able to perform self-care to some extent but not to an extent that satisfies social demands, e.g., the ability to distinguish between the back or front of clothing, or the use of specific eating utensils, or partial control of eliminations. Such limitations might also limit a person's mobility in society. Ability to perform self-care may be inhibited by limitations in learning, self-direction and/or mobility.
Learning	Requires aids and techniques in learning which require environments other than those usually assumed to be adequate, including: • in the home or day care center, structured developmental play activities are needed, specific to the child's disability, rather than semi- or un-structured play. • in school, some instruction needs to take place in a sheltered classroom rather than in the mainstream.	Limitations in learning may be affected by limitations in receptive/expressive language activities. Limitations in learning can inhibit the ability to perform all other major life activities. Limitations in learning may also be affected by an inappropriate match between the learning environment and an individual's needs, including lack of appropriate guidance and positive feedback.
Mobility	Regular assistance or use of devices is required for life-support, locomotion, ambulation or mobility in the community.	Mobility may be severely limited if available transportation and community facilities are not accessible. Mobility may also be inhibited by limitations in learning, self-direction and self-care (safety, hygiene).

*Based on EMC Institute review of the major life activities

TABLE 5 (Continued)

POTENTIAL LIMITATIONS IN MAJOR LIFE ACTIVITIES *

ACTIVITY	POTENTIAL LIMITATIONS	OTHER FACTORS
Self-direction	Requires regular counseling or supervision in dealing with self or group; requires behavior modification to achieve self-restraint, social interaction, self-respect or other adaptive behavior.	Severe limitations in learning activities may inhibit a person's ability to learn changes in behavior. Frustrations with limitations in other life activities may create or aggrevate limitations in self-direction. Behavior may be influenced by the response of the environment; e.g., what is adaptive in the community may not be adaptive in an institution.
Economic Self-Sufficiency	Insufficient income or support for a person's (family's) basic and recreational needs.	A person's contributions to his or her economic sufficiency may be limited by problems in other major life activities; such a limitation may magnify other problems if the person views such economic contributions as important. May be limited by employer attitudes toward specific disabilities.
Receptive & Expressive Language	Requires some use of interpreters or devices to communicate to the individual and/or others.	May affect learning activities. May be inhibited by limitations in learning self-direction and/or mobility.
Capacity for Independent Living	Requires daily assistance for maintaining a full life in the community and/or in decisions about money management, housekeeping and related activities.	The capacity for independent living may be decreased by community attitudes and acceptance of the visibly disabled. Substantial functional limitations in any other major life activity may inhibit an individual's capacity for independent living.

*Based on EMC Institute review of the major life activities

CREATING A WORKING DEFINITION

In order to make the transition to the mandates of PL 95-602 the council must create a working definition of its target population - a definition which the council can use in reorganizing its membership, in planning and in performing its role as a systems advocate. This working definition is actually composed of several "definitions" which represent increasingly specific target groups.

It may be useful to think of the total population of the state as a triangle, as shown on Figure 1. This triangle includes all handicapped and non-handicapped people in the state. It includes service providers and administrators, legislators and the general public, all of whom the council will attempt to affect through its public awareness efforts, influencing, and other activities. Within the handicapped population, council and developmental disabilities program activities focus on progressively more specific and smaller groups of people. These activities and their target groups dictate four major areas of decision for the developmental disabilities council in developing its working definition:

1. the role of the council as systems advocate;

2. council membership and representation;

3. state plan development;

4. the focus and accountability of DDSA-funded services.

In terms of Figure 1, decisions about the working definition begin with a recognition of the needs of all handicapped people - the largest target group within the council's working definition - and end with a small specifically-defined group of developmentally disabled people who will receive certain demonstration or pilot services from the Developmental Disabilities Program. These four areas of council decision which are needed to develop a working definition are discussed in the paragraphs below.

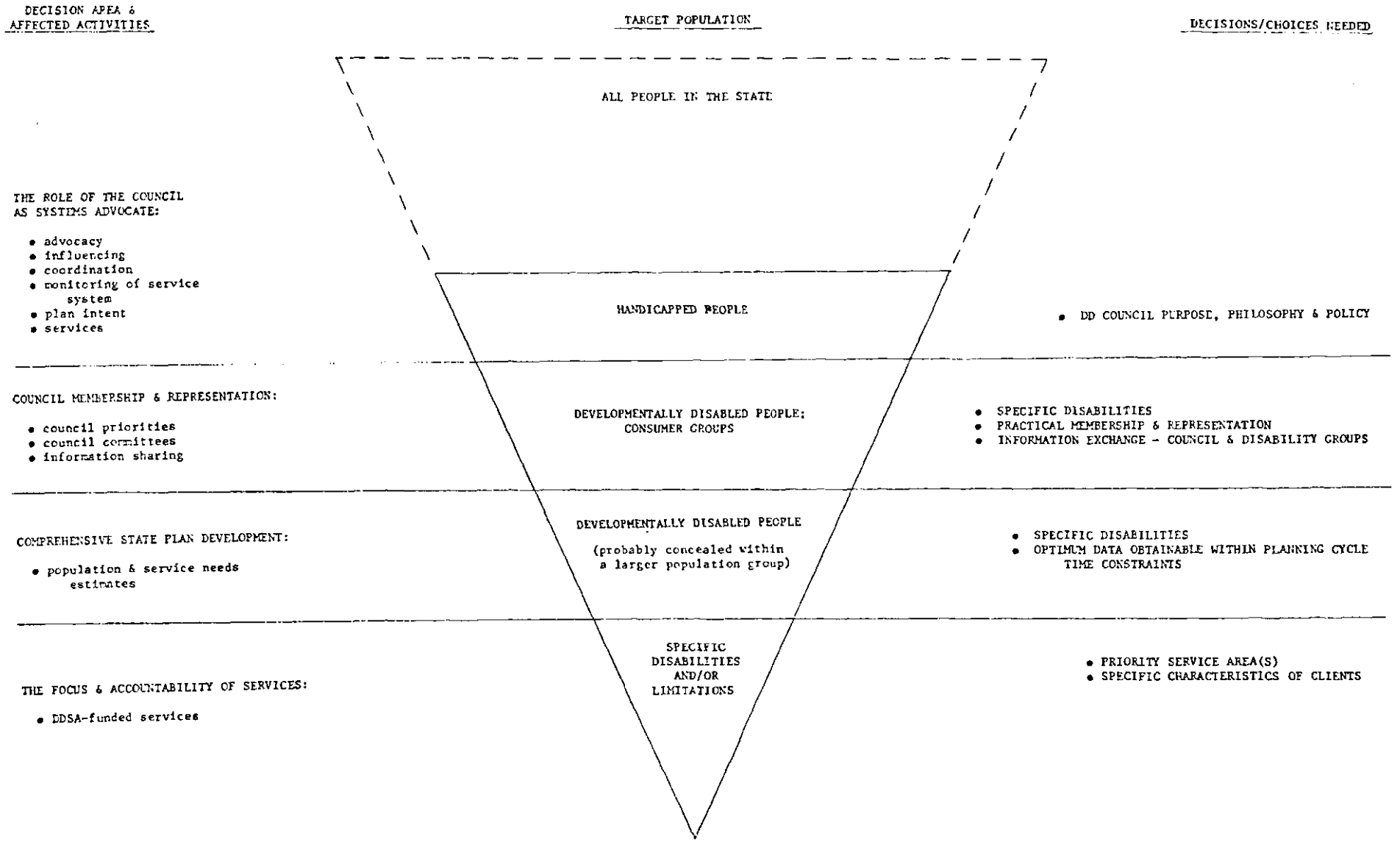
1. The Role of the Council as Systems Advocate

One decision which the Council should make concerns the scope of its advocacy activities and its allegiance to other groups which advocate for the handicapped.

Since its inception, the State Developmental Disabilities Council has been unique among federal human service entities. Individually and collectively, its members are mandated to be systems advocates - to secure beneficial changes in the whole service system rather than benefits to an individual client on a piecemeal basis. In many states, given the small allotments of the Developmental Disabilities Program, this is the only viable means by which the council can secure appropriate services for large numbers of developmentally disabled people

FIGURE 1

DEVELOPING A WORKING DEFINITION OF THE DEVELOPMENTALLY DISABLED POPULATION



in the state. Other programs, such as Comprehensive Services for Independent Living 1 and Title XX, make provision for services to the severely handicapped. In at least some states, the council may need to concentrate on securing guarantees of the appropriateness and availability of these existing or proposed services, rather than becoming redundant as a service grantee. In order to secure such guarantees, a council will need to concentrate on its systems advocacy role.

However, providers and legislators often think of human service program benefits in terms of services provided. In hearings in the spring of 1978 on HR 11764, members of the House Sub-committee on Health and the Environment repeatedly questioned the value of council advocacy activities because such activities did not represent direct services to clients.2 The benefits of systems advocacy - such as an increase in service coordination, or the passage of specific legislation for the developmentally disabled - are sometimes hard to measure and may not become apparent for several years. Services, on the other hand, are something that legislators and providers can understand, because they can see services in action.

The onus is on the council and the Developmental Disabilities Program to get results under PL 95-602. It has already been pointed out that the state Developmental Disabilities Program allotment is too small to allow the council to impact heavily on the statewide service network through gap-filling alone. Therefore, if the state council and the Developmental Disabilities Program are to continue to be recognized as a means for securing appropriate services for developmentally disabled persons, the council must become a visible, acknowledged advocate, one which achieves documented, beneficial changes in the service system.

This creates an apparent problem for the council: under PL 95-602, the developmentally disabled will still represent only a small proportion of the handicapped. Yet the broad-based support needed to accomplish major changes may not be forth-coming if the council always concentrates solely on the developmentally disabled.

Few advocate groups and spokespersons are concerned strictly with the developmentally disabled. A consumer organization may focus on its most severely handicapped members, but the council cannot expect such organizations to concentrate exclusively on the needs of the substantially functionally limited clients who became disabled before age 22. Blindness and epilepsy, for example, strike many people during adulthood. The council cannot expect such groups to push specifically for rights and services for the developmentally disabled segments of their population, unless the council also acknowledges that most handicapped people have common issues and problems.

[1] Title VII of the Rehabilitation Act of 1973, added to the Act by PL 95-602. This Title authorizes a wide range of services designed to increase the independence of the most severely disabled, to the point where they can become eligible for regular Vocational Rehabilitation services. As this paper goes to press, this program is expected to be more modest in scope than originally assumed because of the President's austere budget.

[2] Hearings before the Sub-committee on Health & the Environment of the Committee on Interstate & Foreign Commerce" on HR 11764, April 4 & 5, 1978. See particularly pp 377-378.

It is also critical for the council to consider the whole handicapped population when dealing with providers. Most generic service providers do not deal just with developmentally disabled persons. An agency cannot be expected to coordinate services just for the developmentally disabled; it may be impossible for the council to only monitor services to the developmentally disabled when the same services are provided to a wider group of people; the state legislature will not always enact mandates solely for the developmentally disabled. In its own sphere, then, the council will also have to consider the wider needs of handicapped people, if developmentally disabled people are to benefit.

This, then, may be the council's first area of decision - a reworking of its purpose, philosophy and policy to embrace the new definition and the need for broad-based cooperation and support in addressing the concerns of handicapped people.

The council must work with these broader concerns in order to become more visible and to promote solidarity with other groups on major issues. In this way, a wide variety of groups can pool their experience, contacts and resources on common issues, to become a single, united voice instead of many small voices which only address these issues from positions of special interest.

If the council supports the concerns of all handicapped people in its advocacy activities, then consumer groups may be more ready to support the council on problems which are specific to developmentally disabled people.

2. Council Representation and Composition

The state council should remain a body which is workable both in size and cost. In large states with numerous advocacy groups or identified potential consumer representatives, all or most relevant disabilities may not have a seat on the council, given the need to maintain a workable size. However, the council should identify the full developmentally disabled population for which it acts as an advocate, and should attempt to find some mechanism to ensure that all developmental disabilities have representation on the council. Such representation is needed to assure that the council knows the problems faced by all developmentally disabled groups.

To satisfy both requirements for council effectiveness - compliance with the law and adequate representation - the council may wish to make several decisions before it attempts to reorganize its composition:

a. Identification of Disabilities and/or Groups

First, the council can identify specific conditions which are most likely to result in a developmental disability. The purpose of such a list is to identify major constituents of the population. The council should avoid attempts to develop a list of all possible conditions which might conceivably result in a developmental disability; such a list would probably require considerable research to develop. Addiitonally, the council should exercise caution in specifying conditions which will be excluded, since exclusions not only have negative connotations but may also be inaccurate in specific cases.

The working list of conditions, once developed, should not be considered final. It can be expanded at any time if other consumers or members of other disability groups request inclusion.

When it identifies the major disabilities which comprise its population, the council also has a basis on which it can focus its systems advocacy and planning activities on the major needs and problems of that population, which are likely to be common to most or all developmentally disabled people.

b. Development of Membership Guidelines

As a second step, the council must establish membership guidelines. Potential points to consider in establishing these guidelines are:

- optimum council size (large councils are more costly to maintain; individual members on such councils may also feel that their concerns and input get lost in the crowd);
- the extent to which potential members are knowledgeable in the areas of state-federal program operations, the state legislative process, and related areas;
- the relative prevalence of the various disabilities;

- the willingness of consumers to participate on the council;

- allowance in the council budget for the cost of special arrangements and assistance needed by potential consumer members.

c. Communication with Other Groups

The council must establish a practical mechanism to obtain input from other groups or persons, and to provide feedback on council deliberations and actions to other representatives of the developmentally disabled. This may be a paperwork mechanism; or the council may find ways to more directly involve non-members in council activities. For example, several councils include non-members on council committees, so that such people can have more direct input to council activities. Such participation also provides excellent training for future council members.

d. Orientation

As a final step, the council must set up a comprehensive orientation program for members and for chosen representatives of non-member groups.

As the council is going through this process, it should work closely with the P & A system to ensure that both bodies agree on the characteristics of the developmentally disabled population. Cooperation is also essential because the P & A system should be one of the council's resources for identifying persistent problems in the service network which can be alleviated through systems advocacy efforts on the part of the council.

Within states, there are many state organizations of handicapped persons that should be contacted for nominations as well as treatment centers, special education and rehabilitation centers. Councils will need to maintain a listing of such nominees or it will be difficult to maintain a knowledgeable 50% consumer membership and representation.

3. Comprehensive State Plan Development

The intent of the comprehensive developmental disabilities state plan is to address the specific needs of the developmentally disabled and the common issues of all handicapped persons which the council will address in cooperation with other advocacy groups. The intent of the plan is therefore a direct outcome of decisions made in the decision areas discussed above.

Plan content concerning the magnitude and characteristics of the developmentally disabled population is likely to be represented by numbers. As with the PL 94-103 definition of a developmental disability, data are probably not kept in a form which allows the state planner to Identify all developmentally disabled people; as in previous fiscal years, available population data are likely to be estimates. This includes council data on the number of developmentally disabled people needing a given service and the agency data on the number of developmentally disabled people receiving such services.

The detail of plan data is still likely to depend on 1) the quality of available data on the disabled population of a given state, and 2) the time-cost benefits of refining available data to more nearly approximate the developmentally disabled population of a state.

The important points for the council to remember are:

- rough needs estimates can be made by identifying the types of needs which are likely to correspond to functional limitations in each of the seven areas of life activity (see Table 5);

- the population data in the plan are rough estimates, not an actual identification of the number of developmentally disabled people in the state. The data is useful for planning purposes, and council members and planners simply need to be aware of the extent to which the data really represents (or masks) the developmentally disabled target population.

This decision area may be one for the council staff rather than the council itself. The placement of the line representing the "plan development" decision area on Figure 1 was made arbitrarily to illustrate the relative size of the population affected by this decision area; the actual size of the population (placement of the line) may vary greatly from state to state, depending on the quality of data available in each state.

Some unabridged data on overall functional limitations, by state, are given as an appendix to this paper. While these data do not represent a definitive analysis relevant to the new definition, they do represent one type of data source which may prove useful as a starting point for developing data for the plan.

4. The Focus and Accountability of Developmental Disabilities Program-Funded Services

Even if its advocacy role is strengthened, as suggested above, the council may still find it necessary to develop pilot and demonstration projects in order to stimulate specific new or improved services.

On one hand, accountability in Developmental Disabilities Program pilot and demonstration projects should be simplified, since the. definition has now quantified functional limitations (three or more).

On the other hand, there is a possibility that service projects will become so locked into the functional limitations criterion in the push for accountability that clients will obtain decreased benefits. Some areas of consideration for the council are:

- the effect of the definition on services for immediate intervention, such as hotlines and the P & A system. Can these services be denied clients in an emergency situation because they are not substantially functionally limited (even assuming that providers of such services could be expected to ascertain whether such a client meets the criterion)?

- In rural areas, it may not be economically feasible to establish certain services, such as transportation or group homes, specifically for the "substantially functionally limited," if there are few clients who would use the service in a given area. It may not even be appropriate if some degree of integration with society is desired for the disabled. If DDSA-funded services open their doors to the non-developmentally disabled, however, how can the council account for whether DDSA funds are going to the target group?

When the council has reached the point in its comprehensive planning process where it can begin to talk about services and service activities, the council will need to consider two decisions:

- The service priority area(s) which will be the initial focus of the comprehensive plan, based on service gaps, previous program activities and the problems and special needs of the new developmentally disabled population;

- Guidelines to assist DD service grantees to maintain accountability within the new definition (Who is developmentally disabled? What are the seven areas of major life activity?).

At this line of decision (see Figure 1), the council is addressing itself primarily to that target group of the developmentally disabled population for which pilot or demonstration services will be funded by the Developmental Disabilities Program.

However, it should be remembered that "service activities" within a priority area do not refer merely to client services; service activities also refer to coordination and other systems advocacy which may require a focus on all handicapped people, not just the developmentally disabled, in order to be effective.

It should also be noted that some model services, such as specialized transportation, may serve a wider population than just the developmentally disabled. Not only are some services with a wider clientele more sensitive to the normalization principle; they may require a wider clientele in order to remain cost-effective. When such pilot services are supported partially by DD funds, grantees will require guidelines on how to demonstrate that the intended DD population is also being reached. To further ensure accountability in such services, the council should become more involved in regular project monitoring.

Summary

The above discussion concentrates on four major decisions of increasing specificity which the DD council and its staff can consider in implementing the new definition mandated by PL 95-602. The intent of this discussion was to provide initial considerations for councils which are beginning to address the issues surrounding the new definition. As such, it is not definitive. Individual states are likely to develop other processes and focuses for a working definition, based on their own philosophies and interpretations of PL 95-602. This discussion does suggest that, whatever direction the council decides upon, a working definition should be based upon decisions which allow the council to fulfill its membership requirements, plan for its broader population and achieve support for its activities from an even wider range of advocates for the handicapped.

ISSUES IN IMPLEMENTATION

The size of the developmentally disabled population is not expected to increase signficantly under the new definition; but the focus of the Developmental Disabilities Program must shift to consideration of the multiplicity of treatment problems, architectural and environmental requirements, and other effects of the broadened range of developmental disabilities, and in some cases, of all handicapped. The scope of long-range goals and plan year objectives must be broadened to encompass the needs of the broader population. The new definition requires the council to take a broader approach to any activities relating to implementation of Section 504; it requires re-working of strategies in public awareness and agency/legislative influencing; it implies a need for new design criteria for DDSA service projects; it suggests a need for closer council examination of more than just the mandated state programs (transportation, for example); it may require re-design of some personnel training programs.

Actual implementation of the functional definition may unearth problems specific to state and local systems which cannot be projected at this time. However, at least five major issues are likely to appear to some extent:

- publicizing the new definition;
- the timing of implementation;
- responsiveness to clients' service needs;
- impact on state legislation;
- competition among consumer groups.

These issues are examined in the paragraphs below.

Publicizing the New Definition

Confusion may result among people outside of the council - state legislators, key program figures, and segments of the public - who have been the target of lobbying, influencing and public education campaigns on behalf of the developmentally disabled population as defined by PL 94-103. The degree of confusion among these people will likely depend upon how specific any reference.to the developmentally disabled has been in the past - and upon how quickly the council reaches these people with a succinct explanation of the new mandates of the Developmental Disabilities Program. Note that, if the full council participates in development of a working definition, that definition will presumably be acceptable to and understandable by participating state-federal programs.

The Timing of Implementation

There is a good possibility that a three-year comprehensive plan for services for the developmentally disabled will be required by the end of Fiscal Year 1979. Given the clearance procedures in most states, this means that most councils would have to start now to develop a plan so that a final draft would be ready between May and July. If a council is just beginning to be involved now in developing a working definition and upgrading its membership and representation, how can it hope to have a knowledgeable body of members in time to provide input to this comprehensive plan?

New members and representatives may not be available in time to participate in plan development this year. However, as part of its drive for nominations, councils can also solicit information on service needs, gaps and barriers from the groups which it contacts. Those states which have regional councils or which hold regional public forums on needs and problems can utilize these mechanisms to solicit information pertinent to planning for the wider range of disabilities.

Just as it is not necessary for the council to develop an exhaustive "laundry list" of disabilities included in the new definition, it is not necessary to document every last problem now. The largest and most pressing problems are likely to be repeated by a number of disability groups; these are the problems that the council will probably wish to address in its Fiscal Year 1980 plan. Any glaring oversights can always be added later by submitting an amended implementation plan.

Responsiveness to the Needs of the Population

One benefit to clients of the new definition is the use of functional limitations to delineate a developmental disability, which avoids the danger of labeling an individual - which may have in turn locked that individual into a certain set of services and a certain position in society. And because the functional limitations pertain to all developmental disabilities, their use tends to ease pressures to set up separate categorical services for the mentally retarded, the blind, and so on.

On the other hand, state programs and providers also need to be aware of the danger of emphasizing the description of functional limitations to the point where no real attempt is made to identify the specific disability or its underlying cause (etiology), in which case treatment and services may be inappropriate. A functional limitation in a given area does not identify an individual's underlying problem. A child may have trouble walking because of a central nervous system defect, because of defects in the middle ear, because of a malformed hip, or because of improperly fitted shoes. Using the same treatment in all four cases will not help all four children equally cope with the problem; indeed, if inappropriate "treatment" is given, the problem may not be treated at all and may even grow worse. Thus, under PL 95-602, the Individual Habilitation Plan (IHP) becomes even more important as a tool for obtaining appropriate services.

A comprehensive evaluation, including use of a validated developmental assessment tool, should be used to establish the basic problems and needs of the individual.

A number of assessment tools exist by which the evaluation specialist can pinpoint functional levels. However, in the past children have been misplaced because of testing problems and such misplacements often hinder rather than help the child, creating more functional problems than existed prior to placement. There is a need to know what is causing the functional deficit if the condition - rather than the symptom - is to be treated.

For some situations in the Developmental Disabilities Program, a cursory evaluation based on the components of the seven areas will be required. For actual treatment, however, the underlying source of substantial functional limitations must be diagnosed, and addressed as part of the client's IHP.

When an individual program plan is being developed, the client's functional limitations can be looked at In terms of needs which are common to other clients as well. At this point, when individual objectives have been developed for the client, it becomes appropriate to ask whether a given service will achieve the intended objectives. If the answer is yes, then the service is appropriate and responsive to the client's needs. The question must be asked, however; a service is not responsive if it merely happens to address a certain functional limitation or if it is the only service which exists.

Impact on State Legislation

The transition from the old to the new definition will also affect existing state governmental institutions; for example, the many mandates that have been enacted by state governments in recent years to give added authority to the council and to the Developmental Disabilities Program. This transitional issue is also likely to affect other areas of state law.

The council and its staff should review existing state laws and guidelines to determine what changes are needed to update state mandates to conform with PL 95-602. Cooperation with P & A system staff on this activity is imperative.

This problem may place some states in an unfortunate situation. State legislative changes may be necessary to bring affected state developmental disabilities programs and councils into compliance with PL 95-602; and the legislative process is often slow. A state program which is out of compliance past federally mandated deadlines, due to lack of state legislative support, cannot receive its federal Developmental Disabilities Formula Grant Program funds. To avoid interruption in state operations, the appropriate regional General Counsel may have to be consulted by a state which finds itself in this position.

Competition Among Consumer Groups

Even while assessing the needs for changes as a result of the new definition, the program must assure that the groups which it has served in the past do not get lost in the shuffle. Conversely, there is great potential, within the council and in services, for hostile competition between the "old guard" and consumer organizations which are newly part of the program under the PL 95-602 definition. Councils and administering agencies and their staffs must be cognizant of this potential and seek ways to ensure cooperation rather than competition.

The executive committee of the council may set the tone for cooperation with additional disability groups by re-stating the council's mandate to represent all developmentally disabled people: the law must be accepted as the law, and the council has no choice but to shift philosophically and programmatically.

Further, the leadership should be certain that the council, once it has reorganized, does maintain representation of all groups of developmentally disabled people, either through participation on council committees and task forces or through some other means of exchange. The council should be sure that staff also seek input from all groups whenever this might be necessary.

Finally, if the council carefully examines the reasons why gaps exist in services, it is likely to find that the same problems and barriers plague most developmentally disabled people who seek services: lack of program expansion funds, lack of trained or sensitized program personnel, contradictory or obstructive regulations and administrative procedures, and so on — the same problems which plagued services for the developmentally disabled under PL 94-103, and which cannot be solved by the Developmental Disabilities Program through service granting to meet the needs of any one disability group. The council must demonstrate, for all council members and representatives, the need for the council to address its broader mandates as one group. To do this, the council should carefully examine the "why" behind gaps in services when developing its Fiscal Year 1980 comprehensive state plan; the answers are likely to reinforce the policy that all groups are going to have to work together if the program is to accomplish its goals.

APPENDIX

APPENDIX

DATA ON LIMITATIONS IN ACTIVITY

In 1969, 1970 and 1971, the U.S. Public Health Service conducted Health Interview Surveys (HIS) of the civilian non-institutionalized population of the United States. The data produced by this effort examines, among other things, the extent to which the population experiences limitations in activity as a result of chronic conditions.

These data do not represent the developmentally disabled population within each state. They are given here because they are sensitive to different amounts of limitation, and may provide the planner and the council as advocate with a concept of the larger functionally limited population of which the developmentally disabled population is a part. The developmental disabilities cannot be identified in these data for two reasons:

1. The data do not distinguish between people who became disabled before age 22 and those who became disabled as adults;

2. The data do not distinguish limitations in different major life activities as defined by PL 95-602. It is reasonable to assume that persons who cannot carry on major activity experience limitations in at least three areas, but the data are not specific enough to identify the substantially functionally limited among the other two groups of people who experience limitations.

The following four pages are excerpts from "State Estimates of Disability and Utilization of Medical Services: United States, 1969-71," DHEW Publication No. (HRA)77-1241, and include Table 1 from the report and a narrative discussion of the terms used in that table.

The term "synthetic" is used on the table because these estimates were not derived directly from survey results. The introduction to the publication explains the difference as follows:

> The underlying model for the synthetic method requires that the distribution of a health characteristic not vary between populations of States except to the extent that States vary in demographic composition. It is assumed that the prevalence rate of a given disease in persons in State A will be the same in State B if the composition of the persons in each state is similar with regard to age, sex, race, family income, family size, place of residence, and industry of the head of the family.

Terms Relating to Disability

Disability. — Disability is the general term used to describe any temporary or long-term reduction of a person's activity as a result of an acute or chronic condition.

Chronic activity limitation. — Persons are classified into four categories according to the extent to which their activities are limited at present as a result of chronic conditions. Since the usual activities of preschool children, school-age children, housewives, workers, and other persons differ, a different set of criteria is used for each group. There is a general similarity between them, however, as will be seen in the following descriptions of the four categories:

1. *Persons unable to carry on major activity for their group* (major activity refers to ability to work, keep house, or engage in school or pre-school activities)

   Preschool children:
   Inability to take part in ordinary play with other children.

   School-age children:
   Inability to go to school.

   Housewives:
   Inability to do any housework.

   Workers and all other persons:
   Inability to work at a job or business.

2. *Persons limited in amount or kind of major activity performed* (major activity refers to ability to work, keep house, or engage in school or preschool activities)

   Preschool children:
   Limited in amount or kind of play with other children, e.g., need special rest periods, cannot play strenuous games, or cannot play for long periods at a time.

   School-age children:
   Limited to certain types of schools or in school attendance, e.g., need special schools or special teaching or cannot go to school full time or for long periods at a time.

   Housewives:
   Limited in amount or kind of housework, e.g., cannot lift children, wash or iron, or do housework for long periods at a time.

   Workers and all other persons:
   Limited in amount or kind of work, e.g., need special working aids or special rest periods at work, cannot work full time or for long periods at a time, or cannot do strenuous work.

3. *Persons not limited in major activity but otherwise limited* (major activity refers to ability to work, keep house, or engage in school or preschool activities)

   Preschool children:
   Not classified in this category.

   School-age children:
   Not limited in going to school but limited in participation in athletics or other extra-curricular activities.

   Housewives:
   Not limited in housework but limited in other activities such as church, clubs, hobbies, civic projects, or shopping.

   Workers and all other persons:
   Not limited in regular work activities but limited in other activities such as church, clubs, hobbies, civic projects, sports, or games.

4. *Persons not limited in activities* (includes persons whose activities are not limited in any of the ways described above)

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
ALABAMA					
Total	3,380	86.5	13.5	6.8	4.1
Age					
Under 45 years	[1] 2,379	93.7	5.8	2.9	0.8
45 - 64 years	679	76.9	23.8	13.1	7.0
65 years and over	322	54.3	48.2	22.7	22.2
Family income					
Less than $5,000	1,154	81.2	23.0	11.3	9.2
$5,000 or more	2,227	92.6	9.4	4.9	1.8
ALASKA					
Total	266	91.5	8.3	4.2	1.5
Age					
Under 45 years	[2] 224	94.3	5.2	2.6	0.5
45 - 64 years	35	80.4	20.1	11.0	4.5
65 years and over	7	55.0	47.6	20.6	19.7
Family income					
Less than $5,000	40	85.3	16.0	7.4	5.3
$5,000 or more	226	93.3	7.0	3.6	0.9
ARIZONA					
Total	1,726	87.8	12.2	6.2	2.6
Age					
Under 45 years	[3] 1,222	93.9	5.6	2.7	0.5
45 - 64 years	346	80.0	20.7	11.6	4.0
65 years and over	158	57.7	44.6	21.4	15.7
Family income					
Less than $5,000	379	78.4	23.2	11.5	7.0
$5,000 or more	1,346	91.0	9.2	4.8	1.4
ARKANSAS					
Total	1,894	85.4	14.8	7.5	4.6
Age					
Under 45 years	[4] 1,277	93.6	5.9	2.9	0.8
45 - 64 years	395	75.9	24.9	13.7	7.6
65 years and over	222	54.9	47.5	22.9	21.2
Family income					
Less than $5,000	719	78.7	25.0	12.5	9.8
$5,000 or more	1,176	92.2	9.3	4.9	1.7

[1] Figure for under 17 years 1,189; for 17-44 years 1,190.
[2] Figure for under 17 years 118; for 17-44 years 106.
[3] Figure for under 17 years 614; for 17-44 years 609.
[4] Figure for under 17 years 629; for 17-44 years 648.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
CALIFORNIA					
Total	19,373	87.9	12.1	6.2	2.5
Age					
Under 45 years	[5] 13,661	93.8	5.7	2.8	0.5
45 - 64 years	3,980	80.8	19.8	11.2	3.7
65 years and over	1,731	57.9	44.5	21.6	15.4
Family income					
Less than $5,000	3,574	77.5	24.3	12.1	7.3
$5,000 or more	15,799	90.9	9.5	4.9	1.5
COLORADO					
Total	2,135	88.3	11.7	6.0	2.3
Age					
Under 45 years	[6] 1,553	93.8	5.8	2.8	0.5
45 - 64 years	400	80.8	19.8	11.4	3.5
65 years and over	182	57.9	44.4	21.9	15.0
Family income					
Less than $5,000	437	77.9	23.2	11.8	6.6
$5,000 or more	1,699	91.2	8.8	4.6	1.3
CONNECTICUT					
Total	2,970	89.6	10.5	5.6	2.3
Age					
Under 45 years	[7] 2,033	95.5	4.9	2.4	0.5
45 - 64 years	663	83.5	18.2	9.6	2.9
65 years and over	274	60.2	38.1	19.1	14.7
Family income					
Less than $5,000	369	77.0	22.8	12.0	7.4
$5,000 or more	2,601	91.6	8.8	4.7	1.6
DELAWARE					
Total	535	88.5	11.4	5.9	2.8
Age					
Under 45 years	[8] 388	94.0	5.5	2.7	0.6
45 - 64 years	103	80.8	19.7	11.3	4.5
65 years and over	43	57.8	44.4	21.8	18.8
Family income					
Less than $5,000	93	78.8	23.1	11.8	8.4
$5,000 or more	442	91.4	9.1	4.8	1.7

[5] Figure for under 17 years 8,228; for 17-44 years 7,372.
[6] Figure for under 17 years 734; for 17-44 years 819.
[7] Figure for under 17 years 958; for 17-44 years 1,075.
[8] Figure for under 17 years 188; for 17-44 years 200.

DERIVED FROM THE PHS HEALTH INTERVIEW SURVEY, 1969-71.

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971 — Con.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
KANSAS					
Total	2,178	88.0	12.0	6.5	2.6
Age					
Under 45 years	[17] 1,487	95.0	5.2	2.6	0.6
45 - 64 years	436	81.2	18.5	11.1	3.4
65 years and over	256	58.6	40.4	21.4	13.3
Family income					
Less than $5,000	506	75.9	24.4	13.2	6.9
$5,000 or more	1,672	92.1	8.4	4.5	1.9
KENTUCKY					
Total	3,150	86.4	13.6	7.0	3.8
Age					
Under 45 years	[18] 2,175	93.6	5.9	2.9	0.7
45 - 64 years	636	77.7	23.0	13.0	6.1
65 years and over	338	56.8	45.5	22.8	18.8
Family income					
Less than $5,000	1,029	78.4	23.3	11.9	8.3
$5,000 or more	2,121	91.2	9.1	4.8	1.7
LOUISIANA					
Total	3,578	87.4	12.6	6.4	3.7
Age					
Under 45 years	[19] 2,603	93.8	5.7	2.8	0.8
45 - 64 years	674	77.3	23.4	12.9	6.8
65 years and over	302	54.4	48.0	22.6	22.2
Family income					
Less than $5,000	1,159	82.7	21.3	10.6	8.4
$5,000 or more	2,419	92.8	9.2	4.8	1.8
MAINE					
Total	966	88.3	11.7	6.2	2.9
Age					
Under 45 years	[20] 657	95.4	5.0	2.5	0.5
45 - 64 years	200	81.1	18.5	10.7	4.1
65 years and over	109	58.7	39.6	20.3	14.8
Family income					
Less than $5,000	222	75.9	23.4	12.1	7.8
$5,000 or more	744	92.0	8.2	4.4	1.4

[17] Figure for under 17 years 707; for 17-44 years 780.
[18] Figure for under 17 years 1,063; for 17-44 years 1,112.
[19] Figure for under 17 years 1,324; for 17-44 years 1,279.
[20] Figure for under 17 years 328; for 17-44 years 331.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
MARYLAND					
Total	3,813	88.6	11.3	5.9	2.8
Age					
Under 45 years	[21] 2,735	94.1	5.4	2.7	0.6
45 - 64 years	786	80.9	19.6	11.1	4.6
65 years and over	292	57.9	44.2	21.6	18.9
Family income					
Less than $5,000	586	78.6	23.5	11.9	8.8
$5,000 or more	3,227	91.3	9.3	4.9	1.8
MASSACHUSETTS					
Total	5,570	88.8	11.2	5.9	2.6
Age					
Under 45 years	[22] 3,778	95.4	5.0	2.5	0.5
45 - 64 years	1,177	82.8	16.8	9.9	3.2
65 years and over	615	59.9	38.5	19.5	14.5
Family income					
Less than $5,000	871	75.7	23.9	12.5	7.8
$5,000 or more	4,699	91.5	8.9	4.7	1.7
MICHIGAN					
Total	8,762	89.6	10.4	5.5	2.2
Age					
Under 45 years	[23] 6,292	95.3	4.9	2.5	0.4
45 - 64 years	1,752	82.3	17.5	10.3	3.3
65 years and over	718	58.1	40.8	20.3	14.8
Family income					
Less than $5,000	1,321	76.7	23.8	12.3	7.6
$5,000 or more	7,441	92.6	8.1	4.4	1.3
MINNESOTA					
Total	3,745	88.9	11.1	6.0	2.3
Age					
Under 45 years	[24] 2,634	95.2	5.0	2.5	0.5
45 - 64 years	726	81.7	18.0	10.9	3.1
65 years and over	385	58.9	40.0	20.8	13.5
Family income					
Less than $5,000	720	75.4	24.2	13.0	7.0
$5,000 or more	3,025	92.1	8.0	4.3	1.2

[21] Figure for under 17 years 1,301; for 17-44 years 1,434.
[22] Figure for under 17 years 1,774; for 17-44 years 2,004.
[23] Figure for under 17 years 3,069; for 17-44 years 3,223.
[24] Figure for under 17 years 1,311; for 17-44 years 1,324.

DERIVED FROM THE PHS HEALTH INTERVIEW SURVEY, 1969-71.

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971 -- Con.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
DISTRICT OF COLUMBIA					
Total	732	87.4	12.5	6.6	3.8
Age					
Under 45 years	[9]522	93.7	5.9	3.2	0.9
45 - 64 years	148	79.4	21.2	11.9	6.1
65 years and over	61	54.8	47.6	22.1	22.6
Family income					
Less than $5,000	173	84.5	21.1	10.4	8.5
$5,000 or more	559	92.7	10.7	5.8	2.7
FLORIDA					
Total	6,622	85.2	15.0	7.6	4.6
Age					
Under 45 years	[10]4,209	93.8	5.7	2.8	0.7
45 - 64 years	1,450	78.8	21.8	12.1	5.7
65 years and over	963	57.1	45.1	21.4	20.1
Family income					
Less than $5,000	1,780	75.1	27.4	13.5	10.9
$5,000 or more	4,842	90.0	10.7	5.6	2.4
GEORGIA					
Total	4,462	87.7	12.3	6.3	3.4
Age					
Under 45 years	[11]3,257	93.8	6.7	2.9	0.8
45 - 64 years	848	77.7	23.0	12.6	6.6
65 years and over	356	55.7	46.6	22.9	20.2
Family income					
Less than $5,000	1,250	81.2	22.0	11.1	8.4
$5,000 or more	3,212	92.4	9.0	4.7	1.7
HAWAII					
Total	715	89.4	10.5	5.3	2.7
Age					
Under 45 years	[12]538	94.5	5.0	2.7	0.5
45 - 64 years	136	81.6	18.9	10.5	4.5
65 years and over	42	49.3	53.7	21.5	25.9
Family income					
Less than $5,000	91	84.8	22.9	10.2	9.7
$5,000 or more	625	94.6	9.4	4.9	1.9

[9]Figure for under 17 years 212; for 17-44 years 310.
[10]Figure for under 17 years 2,020; for 17-44 years 2,189.
[11]Figure for under 17 years 1,575; for 17-44 years 1,682.
[12]Figure for under 17 years 268; for 17-44 years 270.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
IDAHO					
Total	769	87.8	12.2	6.4	2.5
Age					
Under 45 years	[13]500	93.9	5.6	2.7	0.5
45 - 64 years	143	80.0	20.7	11.9	3.9
65 years and over	66	56.2	44.1	22.6	13.9
Family income					
Less than $5,000	160	77.1	23.8	12.3	6.5
$5,000 or more	541	91.2	8.6	4.5	1.2
ILLINOIS					
Total	10,919	88.9	11.1	5.9	2.4
Age					
Under 45 years	[14]7,550	95.2	5.0	2.5	0.5
45 - 64 years	2,310	82.2	17.5	10.4	3.2
65 years and over	1,059	58.7	40.3	20.3	14.2
Family income					
Less than $5,000	1,794	76.9	23.9	12.5	7.4
$5,000 or more	9,125	92.1	8.7	4.7	1.4
INDIANA					
Total	5,125	89.2	10.8	5.8	2.2
Age					
Under 45 years	[15]3,644	95.2	5.1	2.5	0.6
45 - 64 years	1,015	81.8	17.9	10.6	3.4
65 years and over	466	58.6	40.4	20.8	13.8
Family income					
Less than $5,000	881	76.0	24.2	12.9	7.2
$5,000 or more	4,244	92.4	8.1	4.4	1.2
IOWA					
Total	2,787	88.0	12.0	6.5	2.5
Age					
Under 45 years	[16]1,892	95.1	5.1	2.5	0.5
45 - 64 years	562	81.4	18.4	11.2	3.2
65 years and over	332	58.8	40.1	21.2	13.1
Family income					
Less than $5,000	628	74.9	24.8	13.5	7.0
$5,000 or more	2,159	91.9	8.3	4.5	1.2

[13]Figure for under 17 years 259; for 17-44 years 241.
[14]Figure for under 17 years 3,596; for 17-44 years 3,954.
[15]Figure for under 17 years 1,735; for 17-44 years 1,909.
[16]Figure for under 17 years 933; for 17-44 years 961.

DERIVED FROM THE PHS HEALTH INTERVIEW SURVEY, 1969-71.

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971 – Con.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
MISSISSIPPI					
Total	2,191	86.2	13.9	7.0	4.5
Age					
Under 45 years	[25] 1,555	93.6	5.9	2.9	0.9
45 - 64 years	423	75.3	25.6	13.8	8.2
65 years and over	213	53.4	49.0	22.9	23.2
Family income					
Less than $5,000	920	83.6	21.5	10.5	8.7
$5,000 or more	1,270	93.3	9.6	5.0	1.9
MISSOURI					
Total	4,586	87.6	12.4	6.6	2.9
Age					
Under 45 years	[26] 3,084	95.0	5.2	2.6	0.5
45 - 64 years	958	80.3	19.4	11.3	4.0
65 years and over	545	57.8	41.1	21.2	14.1
Family income					
Less than $5,000	1,131	76.2	24.6	13.0	7.6
$5,000 or more	3,455	92.2	8.7	4.7	1.4
MONTANA					
Total	679	87.5	12.6	6.5	2.7
Age					
Under 45 years	[27] 474	93.9	5.6	2.7	0.5
45 - 64 years	137	79.8	20.8	11.9	3.9
65 years and over	68	58.1	44.3	21.8	15.0
Family income					
Less than $5,000	153	76.6	24.8	12.5	7.2
$5,000 or more	527	91.0	9.1	4.8	1.4
NEBRASKA					
Total	1,455	88.0	11.9	6.5	2.5
Age					
Under 45 years	[28] 990	95.1	5.2	2.6	0.5
45 - 64 years	294	81.3	18.4	11.2	3.3
65 years and over	171	58.9	40.0	21.3	13.0
Family income					
Less than $5,000	349	76.5	23.4	12.7	6.5
$5,000 or more	1,106	91.9	8.4	4.6	1.3

[25] Figure for under 17 years 821; for 17-44 years 734.
[26] Figure for under 17 years 1,467; for 17-44 years 1,617.
[27] Figure for under 17 years 236; for 17-44 years 238.
[28] Figure for under 17 years 483; for 17-44 years 507.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
NEVADA					
Total	476	88.9	11.0	5.6	2.2
Age					
Under 45 years	[29] 348	93.9	5.6	2.7	0.5
45 - 64 years	98	80.6	20.0	11.1	4.0
65 years and over	30	58.2	44.1	21.0	15.8
Family income					
Less than $5,000	76	77.6	23.6	11.3	7.5
$5,000 or more	400	91.2	8.7	4.6	1.2
NEW HAMPSHIRE					
Total	723	89.1	10.9	5.7	2.5
Age					
Under 45 years	[30] 510	95.3	5.0	2.5	0.5
45 - 64 years	138	82.4	17.2	10.1	3.3
65 years and over	75	59.2	39.1	19.7	14.9
Family income					
Less than $5,000	124	75.2	24.1	12.4	7.9
$5,000 or more	599	92.0	8.2	4.3	1.4
NEW JERSEY					
Total	7,041	89.3	10.9	5.7	2.5
Age					
Under 45 years	[31] 4,783	95.6	4.8	2.4	0.4
45 - 64 years	1,577	83.0	16.7	9.8	3.3
65 years and over	681	59.5	38.8	19.4	15.0
Family income					
Less than $5,000	963	76.7	23.5	12.2	8.0
$5,000 or more	6,078	97.8	8.9	4.8	1.6
NEW MEXICO					
Total	994	88.6	11.4	5.8	2.4
Age					
Under 45 years	[32] 748	93.8	5.7	2.7	0.6
45 - 64 years	177	78.9	21.8	12.2	4.6
65 years and over	70	56.9	45.5	22.1	15.8
Family income					
Less than $5,000	283	81.6	19.5	9.6	5.7
$5,000 or more	712	91.8	8.9	4.3	1.1

[29] Figure for under 17 years 181; for 17-44 years 187.
[30] Figure for under 17 years 242; for 17-44 years 267.
[31] Figure for under 17 years 2,254; for 17-44 years 2,519.
[32] Figure for under 17 years 393; for 17-44 years 355.

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971 — Con.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
NEW YORK					
Total	17,956	88.6	11.4	6.0	2.8
Age					
Under 45 years	[33] 12,020	95.4	5.0	2.5	0.5
45 - 64 years	4,015	82.4	17.3	10.1	3.6
65 years and over	1,921	59.1	39.2	19.5	15.3
Family income					
Less than $5,000	3,128	77.0	23.3	12.0	8.0
$5,000 or more	14,828	91.7	9.1	4.9	1.7
NORTH CAROLINA					
Total	4,040	87.4	12.6	6.4	3.5
Age					
Under 45 years	[34] 3,560	93.7	5.8	2.9	0.8
45 - 64 years	374	77.6	23.1	12.8	6.6
65 years and over	406	55.9	46.4	22.6	20.3
Family income					
Less than $5,000	1,417	80.4	22.4	11.3	8.5
$5,000 or more	3,623	92.1	9.0	4.7	1.7
NORTH DAKOTA					
Total	597	88.5	11.5	6.3	2.4
Age					
Under 45 years	[35] 416	95.1	5.1	2.5	0.5
45 - 64 years	120	80.4	19.3	11.9	3.5
65 years and over	61	59.6	39.4	21.0	12.6
Family income					
Less than $5,000	167	79.7	20.2	11.1	5.4
$5,000 or more	430	92.1	8.1	4.5	1.2
OHIO					
Total	10,504	89.1	10.9	5.8	2.3
Age					
Under 45 years	[36] 7,381	95.2	5.0	2.5	0.4
45 - 64 years	2,158	82.3	17.7	10.4	3.3
65 years and over	965	53.4	40.5	20.4	14.4
Family income					
Less than $5,000	1,726	76.4	24.1	12.6	7.4
$5,000 or more	8,778	92.2	8.4	4.5	1.3

[33]Figure for under 17 years 5,561; for 17-44 years 6,459.
[34]Figure for under 17 years 1,688; for 17-44 years 1,872.
[35]Figure for under 17 years 216; for 17-44 years 200.
[36]Figure for under 17 years 3,530; for 17-44 years 3,851.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
OKLAHOMA					
Total	2,480	86.1	13.9	7.2	3.9
Age					
Under 45 years	[37] 1,674	93.0	5.9	2.9	0.7
45 - 64 years	570	78.3	22.3	12.0	5.8
65 years and over	286	56.2	46.0	22.9	19.3
Family income					
Less than $5,000	733	76.3	26.1	13.3	9.6
$5,000 or more	1,747	91.4	9.2	4.8	1.7
OREGON					
Total	2,061	87.2	12.8	6.6	2.7
Age					
Under 45 years	[38] 1,417	93.7	5.8	2.8	0.5
45 - 64 years	432	80.3	20.3	11.4	3.9
65 years and over	211	57.8	44.6	21.9	15.1
Family income					
Less than $5,000	425	74.7	26.5	13.2	8.0
$5,000 or more	1,636	90.6	9.3	4.9	1.4
PENNSYLVANIA					
Total	11,627	88.4	11.5	6.1	2.8
Age					
Under 45 years	[39] 7,702	95.4	5.0	2.5	0.5
45 - 64 years	2,706	81.9	17.7	10.3	3.7
65 years and over	1,219	58.7	39.5	19.7	15.4
Family income					
Less than $5,000	2,069	75.5	24.7	12.8	8.5
$5,000 or more	9,558	91.9	8.9	4.8	1.6
RHODE ISLAND					
Total	905	88.4	11.6	6.1	2.8
Age					
Under 45 years	[40] 596	95.4	5.0	2.5	0.5
45 - 64 years	209	82.5	17.1	10.0	3.4
65 years and over	101	59.1	39.2	19.7	15.0
Family income					
Less than $5,000	163	75.5	24.0	12.3	8.1
$5,000 or more	743	91.4	8.9	4.8	1.6

[37]Figure for under 17 years 791; for 17-44 years 883.
[38]Figure for under 17 years 657; for 17-44 years 760.
[39]Figure for under 17 years 3,631; for 17-44 years 4,071.
[40]Figure for under 17 years 294; for 17-44 years 311.

DERIVED FROM THE PHS HEALTH INTERVIEW SURVEY, 1969-71.

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971 — Con.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
SOUTH CAROLINA					
Total	2,496	87.6	12.3	6.3	3.5
Age					
Under 45 years	[41]1,828	93.7	5.8	2.9	0.8
45 - 64 years	483	77.2	23.5	12.8	7.0
65 years and over	186	54.9	47.5	22.9	21.2
Family income					
Less than $5,000	784	82.4	20.8	10.3	8.1
$5,000 or more	1,713	93.5	9.0	4.7	1.6
SOUTH DAKOTA					
Total	649	87.8	12.2	6.7	2.6
Age					
Under 45 years	[42]444	95.0	5.2	2.6	0.6
45 - 64 years	131	79.7	20.0	12.1	3.8
65 years and over	74	58.8	40.1	21.7	12.6
Family income					
Less than $5,000	209	79.2	20.7	11.4	5.5
$5,000 or more	440	92.2	8.1	4.5	1.2
TENNESSEE					
Total	3,865	86.6	13.5	6.9	3.8
Age					
Under 45 years	[43]2,684	93.6	6.9	2.9	0.8
45 - 64 years	800	77.5	23.2	12.9	6.5
65 years and over	382	56.1	46.1	22.6	19.8
Family income					
Less than $5,000	1,188	79.2	23.6	11.9	8.8
$5,000 or more	2,677	91.7	9.4	4.9	1.8
TEXAS					
Total	10,901	87.6	12.3	6.4	3.3
Age					
Under 45 years	[44]7,818	93.8	5.7	2.8	0.7
45 - 64 years	2,122	78.9	21.7	12.3	5.6
65 years and over	961	56.9	45.4	22.5	19.0
Family income					
Less than $5,000	2,855	79.4	22.6	11.5	8.1
$5,000 or more	8,046	91.6	9.0	4.7	1.6

[41] Figure for under 17 years 818; for 17-44 years 818.
[42] Figure for under 17 years 227; for 17-44 years 218.
[43] Figure for under 17 years 1,270; for 17-44 years 1,414.
[44] Figure for under 17 years 3,784; for 17-44 years 4,035.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
UTAH					
Total	1,044	89.1	10.8	5.5	2.1
Age					
Under 45 years	[45]797	93.9	5.7	2.7	0.5
45 - 64 years	169	80.9	19.6	11.2	3.4
65 years and over	78	57.9	44.4	22.0	14.8
Family income					
Less than $5,000	191	78.2	22.9	11.6	6.3
$5,000 or more	853	91.7	8.2	4.2	1.1
VERMONT					
Total	437	88.9	11.1	5.9	2.7
Age					
Under 45 years	[46]310	95.3	5.1	2.5	0.5
45 - 64 years	82	81.2	18.3	10.6	4.0
65 years and over	45	58.5	39.8	20.3	15.0
Family income					
Less than $5,000	97	76.6	22.7	11.7	7.6
$5,000 or more	340	92.4	7.8	4.2	1.3
VIRGINIA					
Total	4,425	87.8	12.1	6.2	3.3
Age					
Under 45 years	[47]3,176	93.9	5.6	2.8	0.7
45 - 64 years	887	79.1	21.5	12.0	5.8
65 years and over	361	56.3	46.0	22.1	20.3
Family income					
Less than $5,000	988	79.4	23.6	11.8	9.2
$5,000 or more	3,439	91.9	9.2	4.8	1.7
WASHINGTON					
Total	3,208	87.9	12.1	6.2	2.5
Age					
Under 45 years	[48]2,302	93.9	5.7	2.7	0.5
45 - 64 years	636	81.1	19.5	11.1	3.5
65 years and over	300	57.9	44.5	21.7	15.2
Family income					
Less than $5,000	585	75.4	26.0	13.0	7.7
$5,000 or more	2,713	90.8	9.2	4.8	1.3

[45] Figure for under 17 years 395; for 17-44 years 402.
[46] Figure for under 17 years 153; for 17-44 years 157.
[47] Figure for under 17 years 1,510; for 17-44 years 1,666.
[48] Figure for under 17 years 1,090; for 17-44 years 1,213.

DERIVED FROM THE PHS HEALTH INTERVIEW SURVEY, 1969-71.

Table 1. Synthetic estimates of the percent of persons with limitation of activity due to chronic conditions by degree of limitation according to selected characteristics: United States, 1969-1971 – Con.

Geographic area and characteristic	Population in thousands	Not limited in activity	Limited in activity	Limited in amount or kind of major activity	Unable to carry on major activity
WEST VIRGINIA					
Total	1,738	86.1	13.9	7.2	3.9
Age					
Under 45 years	[49]1,170	93.6	6.9	2.8	0.7
45 - 64 years	382	77.8	22.9	12.9	6.1
65 years and over	187	56.4	45.9	22.6	19.5
Family income					
Less than $5,000	540	76.9	24.8	12.5	9.1
$5,000 or more	1,198	91.1	9.2	4.8	1.6
WISCONSIN					
Total	4,365	88.8	11.1	6.0	2.4
Age					
Under 45 years	[50]3,049	95.2	5.0	2.5	0.5
45 - 64 years	857	82.0	17.7	10.6	3.2
65 years and over	449	58.7	40.2	20.6	13.9
Family income					
Less than $5,000	788	74.9	24.8	13.1	7.4
$5,000 or more	3,567	92.0	8.2	4.4	1.3
WYOMING					
Total	325	87.7	12.3	6.4	2.5
Age					
Under 45 years	[51]226	93.9	5.6	2.7	0.5
45 - 64 years	69	80.7	19.9	11.7	3.4
65 years and over	31	57.6	44.8	22.1	15.2
Family income					
Less than $5,000	74	77.4	23.7	12.0	6.8
$5,000 or more	251	90.9	9.0	4.8	1.2

[49]Figure for under 17 years 563; for 17-44 years 607.
[50]Figure for under 17 years 1,505; for 17-44 years 1,543.
[51]Figure for under 17 years 114; for 17-44 years 112.

DERIVED FROM THE PHS HEALTH INTERVIEW SURVEY, 1969-71.

NOTES