

Introduction

In the 2007 Iowa Health Fact Book, state-wide data relating to health outcomes, social and health behaviors, and health care resources are presented, generally at the county level. The data have been compiled in this book, but were collected using different methodologies by various organizations and reporting mechanisms. We encourage readers who would like to use these data to learn about the data collection processes and data definitions from those responsible for collecting the information. The use of U.S. Census data to compute adjusted rates, sparse data concerns, data groupings, data definitions, and use of ranks are described in the Fact Book Conventions section of this Introduction.

The second section, Healthy Iowans 2010 Leading Indicators, outlines the major public health mortality concerns in Iowa and provides both baseline values and target values. Current levels have been included to show the progress toward those goals. Demographics are provided in the third section, listing county-specific population estimates in Iowa for the years 1997 – 2006. These population totals drive the calculation of crude and age-adjusted rates in later sections.

The remaining ten sections provide valuable information on a variety of aspects of the health of Iowans. The Health and Social Behaviors section tracks behaviors affecting our health, including the 2006 Iowa Adult Tobacco Survey. The Prenatal and Infant Health section covers information regarding infants, but also the well-being of their mothers during pregnancy. The Infectious Diseases section focuses mainly on sexually transmitted diseases, although other infectious disease data are presented as well. The Cancer Incidence and Mortality section provides both crude and age-adjusted rates for selected major types of cancer. The Injury Mortality section reveals both crude and age-adjusted rates for certain causes of mortality, such as motor vehicle deaths and deaths caused by firearms. Closely related is the Youth Injury Mortality section, providing the same type of data but restricted to individuals aged less than 20. The last mortality section, Other Mortality, lays out crude and age-adjusted rates for mortality not caused by cancer or the causes listed in the previous two sections. A component of a good health care system is adequate capacity of both facilities and health care providers. The Health Care Providers chapter shows counts and crude rates of various types of providers across the state. The Health Care Facilities chapter details counts and crude rates for a variety of types of facilities. The final section of the book, entitled Environmental Health Indicators, focuses exclusively on the testing of blood lead poisoning of children in Iowa.

Fact Book Conventions

Layout

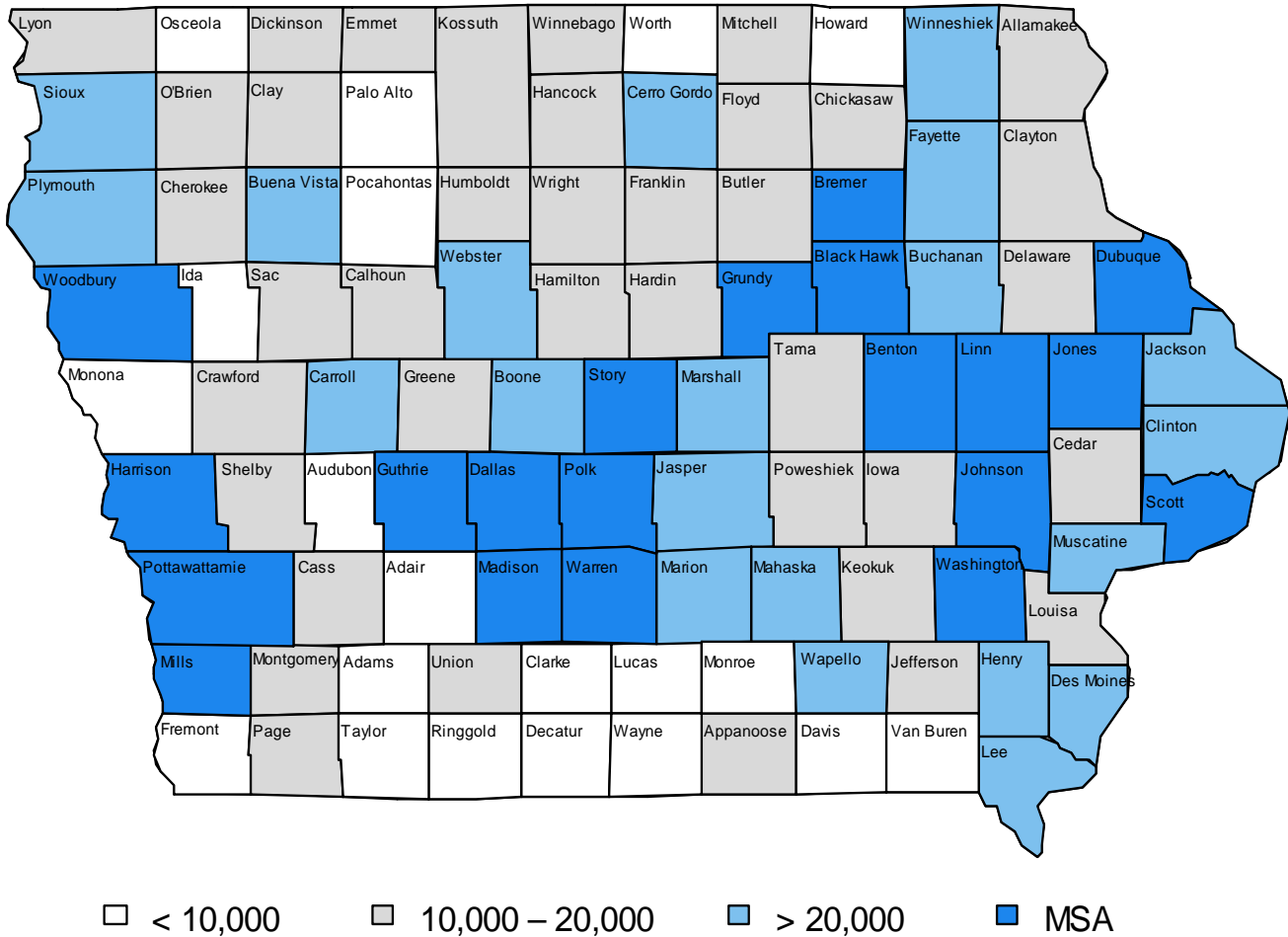
The time interval covered differs across the data items, mainly due to differences in data availability. Where reasonable and possible, county-specific data are presented. When it is not presented in that format, it is either because the data were too sparse (that is, a relatively small number of counties with non-zero counts) or they were not available at the county level. Since many of the data items presented would be expected to vary with county population size, the counties have been organized into groups based on their county population size. Both crude and age-adjusted population rates are presented when reasonable, which also facilitates comparisons across counties. For data items in which historical counts earlier than those presented in this book are available, line graphs showing time trends by county grouping are presented as well.

Four County Groupings

An MSA (Metropolitan Statistical Area) county is defined by the U. S. Census Bureau as a central city along with the counties economically and socially connected to it. Each MSA must have one city with at least 50,000 inhabitants or a Census-defined urbanized area with a total metropolitan population of at least 100,000 (75,000 in New England). Under the year 2000 standards, rural counties may be included in an MSA if at least 25 percent of the workers who live in the county work within the central county or counties (that is, the county or counties containing the urban core of 50,000 or more population) of the MSA. A county can also be included if at least 25 percent of the jobs in the county are filled by workers living in the central counties of the MSA. This definition was updated following the 2000 Census resulting in many newly classified MSA counties.

There were twenty counties defined by the U. S. Census Bureau as MSA from the 2000 Census. For the seventy-nine other counties, using the 1997-2006 average county population, there were 20 counties with less than 10,000 residents, 38 counties with 10,000 to 20,000 residents and 21 counties with 20,000 to 50,000 residents. See the map on the following page to identify the counties in each group.

County Group Based on 1997-2006 Average Population



Small Numbers

If the number of county-specific events in a health outcome table was less than five, we masked the count by replacing it with an asterisk (*) to protect subject confidentiality. However, all numbers are included in the computations needed for the line graphs and other charts accompanying the health outcomes tables, which summarizes data over a larger number of people. If only one value in a county grouping is masked with an (*), then we do not report the grouping total, only a range of possible values.

Population Standard

The Year 2000 Estimated United States Standard Million Population from the United States Census Bureau has been used for adjustment purposes.

Adjustment Calculations

Both crude and age-adjusted rates have been calculated and presented in many of the data tables. Crude rates for an entity (e.g., county) are the number of events of a health outcome divided by the population at risk in the county. The age-adjusted rates used in this book are a weighted average of the age-specific rates from the targeted population (e.g., county), where the weights are the proportions of persons in the corresponding age groups of a standard population. As stated above, the Year 2000 United States population was used as the standard population. If data only represent one age group then the age-adjusted rate is identical to the crude rate and thus not reported (e.g., Live Births).

There are no hard and fast rules as to when one should use either the crude or the adjusted rate for comparisons. A few guidelines can, however, be noted. A crude rate for a county reflects the disease or mortality burden for a county and may be useful to the health policy makers in the county. If a county has a relatively high proportion of elderly and the disease is associated with older individuals, crude rates will reflect that higher burden due to greater numbers of elderly. The age-adjusted rate is also useful as a county comparison index, but after putting both counties on the same playing field with respect to the age distribution in each. These rates have been adjusted to the same standard population, so the effect of differing age distributions in two counties is eliminated before the comparison is made. Hence, both are useful descriptive indices of diseases, but with differences in interpretation.

Ranks

The county rank represents the ranking of the county among the 99 counties of Iowa, with a rank of “1” given to the county with the largest rate and “99” to the county with the smallest rate. In general, ranks were presented for a data table when no counts in the table were less than five; i.e. when there were no very small numbers.

Maps

State maps were created to present the data for Health Care Providers and Health Care Facilities instead of tables. The number in the county represents the 2007 count. The crude rates were calculated from the estimated 2006 county population. These rates were grouped into four categories of approximately twenty-five counties each and shaded on the map. If a county rate fell on the border between two categories, it was shaded using the smaller region.