GLOSSARY OF TERMS, TECHNICAL NOTES, AND FAQS
2022 County Health Rankings State Reports

Glossary of Terms

Health equity: Assurance of conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustice, and providing resources according to need.

Health inequity: Differences in health factors or outcomes that are systematic, avoidable, unnecessary, unfair, and unjust.

Health disparities: The numerical or statistical differences in health outcomes, such as mortality rate differences. Reducing and ultimately eliminating disparities in health and its determinants of health is how we measure progress toward health equity.

Technical Notes

- Figures 1 and 2 depict each county as a single, semi-transparent circle. Counties with very similar values are displayed as overlapping circles having greater color saturation. Similarly, circles representing states may be overlapping in Figure 4.
- The state and national values for childcare cost burden represent the median of counties within the state and nation, respectively.

FAQs

How does CHR&R select evidence-informed solutions?

Evidence-informed solutions are supported by robust studies or reflect recommendations made by experts. To learn more about our evidence analysis methods, visit What Works for Health.

How does CHR&R rank counties?

To calculate the ranks, we first standardize each of the measures using z-scores. Z-scores allow us to combine multiple measures because the measures are now on the same scale. The ranks are then calculated based on weighted sums of the measure z-scores within each state to create an aggregate z-score. The county with the best aggregate z-score (healthiest) gets a rank of #1 for that state. The aggregate z-scores are graphed next to the maps for health outcomes and health factors on pages 5 and 6 to show the distribution of the values that contribute to the rank. To see more detailed information on rank calculations please visit Our Methods section in **Explore Health Rankings** at: countyhealthrankings.org.

How did the 7% benchmark for childcare affordability originate?

The Department of Health and Human Services published a 2016 update to rules and regulations for the Child Care and Development Fund (CCDF) program, which helps cover childcare costs for children from low-income households. The updated rules established a federal benchmark for an enrolled family's childcare co-payments not to be considered affordable if costs exceed 7% of household income. The benchmark has since been applied outside of the context of the CCDF program to indicate that low- and middle-income families should not spend more than 7% of their income on childcare for it to be considered affordable.

**County Health
Rankings & Roadmaps**

Building a Culture of Health, County by County

How does CHR&R define county levels of urbanization?
We define levels of urbanization as: Rural (non-metropolitan counties with less than 50,000 people); Smaller Metro (counties within a metropolitan statistical area (MSA) with between 50,000 and 1 million people); Large Suburban Metro (non-central fringe counties within an MSA with more than 1 million people); Large Urban Metro (central urban core counties within an MSA with more than 1 million people).

How does CHR&R define racial and ethnic groups?
We recognize that "race" or "ethnicity" are social categories. Society may identify individuals based on their physical appearance or perceived cultural ancestry, as a way of characterizing individuals' value. These categories are not based on biology or genetics. A strong and growing body of empirical research provides support for the fact that genetic factors are not responsible for racial differences in health factors and very rarely for health outcomes.

We are bound by data collection and categorization of race and ethnicity according to the U.S. Census Bureau definitions, in adherence with the 1997 Office of Management and Budget standards. Our analyses also do not capture those reporting more than one race, of "some other race", or who do not report their race. This categorization can mask variation within racial and ethnic groups and can hide historical context that underlies health differences.

How does CHR&R define gender?
We recognize that while the terms "gender" and "sex" are often used interchangeably, they do not represent the same concept. Sex is generally assigned at birth based on observed anatomy, while gender is a social construct wherein certain tendencies or behaviors are assigned by society to labels of masculine or feminine. We know that neither gender nor sex are binary constructs and that people living intersectional identities (e.g., transgender women) experience compounding power differentials, which are not captured in a binary delineation between men and women.