



Research Report

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2023 National Survey of Health Attitudes

Description and Top-Line Summary Data

This publication has completed RAND's research quality-assurance process but was not professionally copyedited.

For more information on this publication, visit www.rand.org/t/RRA3303-1.

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Published by the RAND Corporation, Santa Monica, Calif.

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About This Report

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led a pioneering effort to advance a Culture of Health that is rooted in equity, with a “future where everyone has a fair and just opportunity to achieve their fullest health and wellbeing.” Together with RAND, RWJF initially developed an approach to operationalizing and measuring that vision (Chandra et al., 2016, Plough et al., 2015). RWJF has further evolved its efforts to transform institutions and systems to advance health, health equity, and wellbeing, with a strong emphasis on addressing structural racism and promoting the narrative that health is a right, not a privilege.

In support of this effort, RAND continues to work with RWJF to advance understanding of American public mindset and attitudes towards health, health equity, and wellbeing through multiple streams of work including a periodic survey described in this report. RAND researchers worked with RWJF to design and field the National Survey of Health Attitudes to provide insight and perspective on how people in the United States think about, value, and prioritize health and consider issues of health equity. The survey was first fielded in 2015, and an updated version was fielded in 2018. This report provides a brief overview of the current 2023 survey development and content, providing a top-line summary of descriptive statistics. The report complements the overview of the 2015 survey described in the RAND report *Development of the Robert Wood Johnson Foundation National Survey of Health Attitudes* (Carman et al., 2016), and its subsequent topline *2018 Survey of National Health Attitudes: Description and Top-Line Summary* (Carman et al., 2019) and is organized similarly for consistency. A companion set of longitudinal surveys during the COVID-19 pandemic was fielded between 2020 and 2021 and is further described in four top-line reports, *COVID-19 and the Experiences of Populations at Greater Risk* (Carman et al., 2020-2021).

Researchers from RAND and RWJF jointly conducted the research reported here; the report is intended for individuals and organizations interested in learning more about public attitudes towards health, health equity, structural racism, and wellbeing. This work continues to inform national dialogue about approaches and investments to improve population health and wellbeing. As such, the report should be beneficial to a range of national, state, and local leaders across a variety of sectors that contribute to health. This research was supported by the Robert Wood Johnson Foundation.

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RAND Social and Economic Well-Being is a division of RAND that seeks to actively improve the health and social and economic wellbeing of populations and communities throughout the world. This research was conducted in the Community Health and

Environmental Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as infrastructure, science and technology, industrial policy, community design, community health promotion, migration and population dynamics, transportation, energy, and climate and the environment, as well as other policy concerns that are influenced by the natural and built environment, technology, and community organizations and institutions that affect wellbeing. For more information, email chep@rand.org.

Acknowledgments

We appreciate reviews of Scott Keeter (independent) and Kirsten Becker (RAND). We also thank the survey participants, who offered their perspectives on health and wellbeing issues in the United States.

Summary

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led a groundbreaking effort to advance a Culture of Health that is rooted in equity, with a “future where everyone has a fair and just opportunity to achieve their fullest health and wellbeing.” Together with RAND, RWJF initially developed an approach to operationalizing and measuring that vision (Chandra et al., 2016, Plough et al., 2015). Today, RWJF’s efforts have built on that work, but now with a stronger focus on approaches to transforming institutions and systems by addressing structural racism and promoting the narrative that health is a right, not a privilege.

RAND researchers have been working with RWJF to capture public perspective on these topics, designing and fielding the National Survey of Health Attitudes (NSHA) to provide insight and perspective on how people in the United States think about, value, and prioritize health and consider issues of health equity. The survey was first fielded in 2015, and an updated version was fielded in 2018. This report provides a brief overview of the 2023 survey development and content, and then a top-line summary of descriptive statistics. The report complements the overview of the 2015 survey described in the RAND report *Development of the Robert Wood Johnson Foundation National Survey of Health Attitudes* (Carman et al., 2016), and its subsequent topline *2018 Survey of National Health Attitudes: Description and Top-Line Summary* (Carman et al., 2019) and is organized similarly for consistency. A companion set of longitudinal surveys during the COVID-19 pandemic was fielded between 2020 and 2021 and is further described in four top-line reports, *COVID-19 and the Experiences of Populations at Greater Risk* (Carman et al., 2020-2021).

The questions in the 2023 survey uniquely capture aspects of American mindset about health, health equity, structural racism, and wellbeing in ways that are not present in other surveys. This version of the NSHA can be viewed in three main sections: (1) individual health experiences, perspectives, and knowledge (making health a shared value); (2) health equity perspectives; and (3) community wellbeing, including climate views and barriers to community engagement. Insights from the surveys referenced above, including this one, have established a baseline and set of cross-sectional pulse checks on where the American public is regarding their recognition of social determinants of health, their understanding of health inequities including structural racism, their willingness to address those inequities and their indication of who in society should be responsible for solving health inequities.

As with prior NSHA instruments, we designed this survey to measure constructs that could not be assessed using existing data. In some cases, existing data were out of date or collected only in small samples that were not nationally representative. Where possible, we used questions drawn from available survey instruments including prior versions of the NSHA or the aforementioned COVID-19 surveys. However, in some cases, we had to modify existing

questions or develop new questions because we needed to delve further into issues of race and health equity as well as community wellbeing, where survey questions did not exist.

Using methods comparable to those used in the 2018 survey, we collected data via the RAND American Life Panel (ALP) and the KnowledgePanel (administered by Ipsos). Both panels are nationally representative internet panels whose members are recruited via probability-based sampling methods. Both provide computers and internet connections for respondents who do not have them at the time of panel recruitment. Both compensate respondents for their participation. Both panels collect demographic information about respondents separately and provide this information with each data set. We fielded the same survey instrument in both panels. The resulting survey contains 37 questions, some with subquestions or multiple parts. The median length for survey completion was between 19 and 20 minutes.

The two survey efforts combined resulted in a final total sample of 5,620 completed surveys: 1,570 from the ALP and 4,050 from the KnowledgePanel. Each panel brings distinct benefits. With the ALP, we can link responses to a very rich set of background variables collected through other surveys, as well as to responses collected in the 2015 and 2018 National Survey of Health Attitudes. On the other hand, the KnowledgePanel provides a significantly larger sample size. We used a raking algorithm to create weights to match the distribution of characteristics in our sample as closely as possible to the distribution of characteristics of the population from the 2022 Current Population Survey (U.S. Census Bureau, 2022). We weighted each sample to the CPS 2022 first. Then, we combined the two samples and matched the distribution of characteristics of the pooled sample to the distribution of the CPS. In other words, our weighting procedure treated observations from the two panels as equivalent. We combined the results from the two panels and calculated weights to make the combined panel representative of the population. Because the overall sample size of our survey is large, 5,620 respondents, the margin of error (MOE) for the full sample ranges from 0.32 percent to 3.33 percent, for proportions near 0 percent and 50 percent, respectively. For the ALP subsample, the MOE ranges from 0.51 percent to 5.01 percent. For the KnowledgePanel subsample, the MOE ranges from 0.38 percent to 4.07 percent. As were done with prior NSHA, we have not adjusted the MOEs to reflect design effects.

This report describes detailed top-line results for each of the questions included in the survey and sociodemographic characteristics of the sample. The weighted results are presented separately for each panel sample and for the total.

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Chapter 1. Motivation for the Survey

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led a field-changing effort to advance a Culture of Health that is rooted in equity, with a “future where everyone has a fair and just opportunity to achieve their fullest health and wellbeing.” RWJF and RAND initially developed an approach to operationalizing and measuring that vision (Chandra et al., 2016, Plough et al., 2015). Today, RWJF’s efforts have brought that work forward but with a stronger focus on approaches to transforming institutions and systems by addressing structural racism and promoting the narrative that health is a right, not a privilege.

As part of advancing a health and wellbeing narrative that centers equity, RAND and RWJF have been examining where the American public is with respect to mindset and attitudes about health and the factors that drive inequity. This work has been key to understanding current health perspectives and values and how the general public views investments and choices to improve health and health equity. One component of this effort has been the development of the National Survey of Health Attitudes (NSHA), initially fielded in 2015 (Carman et al., 2016) and 2018 (Carman et al., 2019). This report provides a brief overview of the 2023 survey development and content, and then a top-line summary of descriptive statistics. It is organized similarly to the earlier reports for consistency. A companion set of longitudinal surveys during the COVID-19 pandemic was fielded between 2020 and 2021 and is further described in four top-line reports, *COVID-19 and the Experiences of Populations at Greater Risk* (Carman et al., 2020-2021). Insights from these surveys informed the development of the 2023 NSHA.

In this chapter, we provide the underlying motivation for key 2023 survey concepts. Chapter 2 provides more detail on the survey domains and the conceptual framework for the NSHA. Additional detail on the NSHA is provided in earlier reports (Chandra et al., 2016; Carman et al., 2016; Carman et al., 2019).

Brief Overview of Core Survey Concepts

As noted earlier, there are three sections of the 2023 NSHA: (1) individual health experiences, perspectives, and knowledge (making health a shared value); (2) health equity perspectives; and (3) community wellbeing perspectives, including climate views and barriers to community engagement. Ultimately, the NSHA primarily focuses on three core tenets of building a Culture of Health in America- making health a shared value, advancing health equity, and supporting greater community and collective wellbeing- with the goal of improved national health, wellbeing, and equity. Additional detail on this is provided in various reports, including older technical volumes (Chandra et al., 2016) and newer vision statements (Besser, 2024).

Making health a shared value

One of the key tenets of a Culture of Health is *making health a shared value* (Chandra et al., 2016, Plough et al., 2015). This tenet or concept is a primary focus of the survey described in this report. In prior work (Chandra et al., 2016; Chandra et al., 2016), we identified three drivers for understanding and measuring this concept: (1) mindsets and expectations (how the American public views health and wellbeing, and investments in this area), (2) sense of community (whether and how people feel connected to their communities, which relates to the ability to have shared health values), and (3) civic engagement (interest in promoting or advocating for health and wellbeing topics). As such, this survey focuses on individual and community values, expectations, and civic engagement around health, emphasizing the importance of achieving, maintaining, and reclaiming health as a shared priority. The argument is that achievements in making health a shared value will fuel a greater sense of community, an increased demand for healthy places and practices, and a stronger belief that individual actions can make a difference in the wellbeing of others.

Views on health equity and structural racism

The COVID-19 pandemic, the events of 2020, and the shift in national conversations about race and racial equity have underscored the importance of understanding public knowledge and attitudes about racism, and specifically the role of structural racism in influencing health, social, and economic outcomes. Given RWJF's continued centering of equity in its vision for a thriving future (Besser, 2024) plus increased interest in the role of equity in health outcomes (e.g., in Healthy People 2030) employed by health departments and communities and evident in national health policy (CDC, 2024), a continued emphasis in the NSHA was critical.

For the NSHA 2023, the research team built on insights gained from the RWJF-RAND Sentinel Communities Project, an effort to capture how communities are promoting a culture of health (Warren May et al., 2022; Chandra et al., 2018), and prior NSHA and COVID-19 surveys referenced earlier (Carman et al., 2021; Towe et al., 2018) to inform the evolution of concepts in this area as well as the maintenance of items that were included in those prior surveys. Namely, key themes that emerged from those analyses that we sought to examine in the NSHA 2023 included:

- How people viewed equity in general and how they defined the concept broadly and for health specifically;
- The extent to which the public saw racism as a topic to be addressed in the U.S.;
- The role that individuals believed race and structural and systemic racism to play in health outcomes and the existence of health inequity; and
- The extent to which the public saw addressing health equity as a societal benefit or not.

Perspectives on community and collective wellbeing

Measuring wellbeing and understanding the determinants of wellbeing and how they interact is an increasing area of emphasis globally, including the direct measurement of experienced wellbeing (e.g., Kahneman et al., 2004; Abdallah et al., 2017). Several nations now include measures of subjective wellbeing in official statistics, including Canada, the United Kingdom, and many others. In the U.S., the National Academy of Sciences established a panel on Measuring Subjective Wellbeing in a Policy Relevant Framework (2013), which provided a template for how subjective data can be leveraged. Through RWJF's expanded vision on supporting human thriving (Besser, 2024), the focus on wellbeing has grown. While there are more enduring efforts to measure happiness (e.g., Seattle, Bhutan), or surveys that assess individual wellbeing (e.g., the World Happiness Report) and some national movement to have country level, wellbeing indicators (e.g., in the OECD), these efforts rarely assess and embed wellbeing at the community level, blending both objective (e.g., community assets that promote wellbeing) and subjective data (e.g., how a person views community wellbeing).

Wellbeing comprises both individual and community dimensions. Individual wellbeing can be defined as the extent to which people experience happiness and satisfaction and are realizing their full potential. New Economics Foundation defined individual wellbeing as “the dynamic process that gives people a sense of how their lives are going, through the interaction between their circumstances, activities and psychological resources or mental capital.” Community wellbeing is the combination of social, economic, environmental, cultural, and political conditions identified by individuals and their communities as essential for them to flourish and fulfill their potential (Wiseman and Brasher, 2008). In recent years, wellbeing has broadened to include a more explicit call-out for civic wellbeing (e.g., Santa Monica Civic Wellbeing Index), to include policies, laws, and governance that oversee the investment in wellbeing promoting goods and services. Further, there is growing interest in the notion of collective wellbeing, building on principles of community resilience and community allostatic load (Chandra et al., 2018), defined by Chandra et al. (2023) as:

- The interconnection between human and place wellbeing (e.g., the environment and natural ecosystem; how people experience place based on factors such as history, collective joy, collective trauma, etc.)
- The ties between people and people, people and places, and people and institutions (i.e., more community network and relationship-based)
- The connection between systems that advance wellbeing, such as those that foster economic inclusion with those that support health
- Choices and investments a community or nation make to benefit groups and populations, particularly with a future generations focus.

Given these gaps, and the fact that capturing perspectives on community and collective wellbeing is rare, the NSHA 2023 endeavored to test relevant items.

Road Map for This Report

This report describes the latest results from the NSHA 2023. Additional survey analyses will be presented elsewhere, including in peer-reviewed journal articles in development. Prior reports and articles are posted here: <https://www.rand.org/well-being/community-health-and-environmental-policy/projects/culture-of-health.html>

As noted earlier, this report draws heavily on the report written to describe the 2015 and 2018 surveys (Carman et al., 2016, 2019), for consistency over time.

Chapter 2. Survey Overview

As described in Chapter One, there are three sections of the 2023 NSHA: (1) individual health experiences, perspectives, and knowledge (making health a shared value); (2) health equity perspectives; and (3) community wellbeing perspectives, including climate views and barriers to community engagement. The prior NSHA in 2015 and 2018 covered a variety of topics, including views regarding social determinants of health and disparities, change agents and action on health, health status and experiences, views of the role of government, general views on equity and health equity, and priorities for health relative to other social issues.

The 2023 survey included many of the same domains but had a stronger focus on health equity perspectives including views on race, structural racism, and health equity; and perspectives and experiences of community wellbeing. These were included for three reasons: 1) a stronger focus on these topics for RWJF (Besser, 2024); 2) insights gained from the 2018 NSHA (Towe et al., 2018) and the aforementioned COVID-19 surveys (Carman et al., 2020-2021) on American views on structural racism and health (Nelson et al., 2022; Carman et al., 2021), which highlighted the challenges of Americans recognizing the impact of racism on health; and 3) themes that have emerged from the RWJF-RAND Sentinel Communities Project (Warren May et al., 2021; Chandra et al., 2018), which showcased how an orientation towards health and wellbeing can be advanced or impeded by community choices and public sentiment.

Survey Design Process

Our survey design process included four steps. First, we identified new or revised constructs to include in the 2023 survey, as well as content that could be omitted from the 2018 survey instrument. In doing so, we continued to draw on findings noted above, such as broader stakeholder-engagement efforts undertaken as part of the larger Culture of Health development (Acosta et al., 2016; Martin et al., 2017), sentinel communities efforts in which RAND has been studying community perspectives on a health, health equity, and wellbeing for over seven years (Chandra et al., 2018), and the COVID-19 surveys that we fielded in 2020 and 2021 (Carmen et al., 2020-2021). Second, we reviewed relevant literature and surveys to identify potential measures and survey questions, with specific focus on newer measures that may be used on race, the connection between structural racism, health, and health equity as well as community wellbeing. During structured research team meeting discussions, we reviewed findings from steps one and two. Third, we conducted focus groups around a subset of measures that we were considering for this 2023 survey. Fourth, we tested a few survey items with an Omnibus survey instrument periodically used by RWJF as well as conducted cognitive interviewing with a set of survey items.

Selection of Key Constructs to Measure

In updating the survey, we began by reviewing our last National Surveys of Health Attitudes, fielded in 2015 and 2018 as well as the COVID-19 surveys (2020-2021). The 2018 NSHA, in particular, produced important insights about the public’s views, but we wanted to deepen our investigation of health sentiments, values, and views on health equity. We selected key constructs to continue to measure, and others to drop from the survey. Further, the COVID-19 surveys (Carman et al., 2020-2021) surfaced concepts related to what race and equity meant to the American public that we wanted to interrogate further in the 2023 NSHA.

We also considered what changes we would expect to see in the United States as progress is made toward building a Culture of Health. For instance, what would people in the United States say about health? What would they prioritize post COVID-19 and the U.S. events around race from 2020?

Table 2.1 documents the theoretical framework of outcomes and domains that we used in 2018 and continued to use initially to develop the 2023 survey content. The table outlines five key expectations to track over time with the survey. In other words, we wanted to represent the changes we expect to see among adults in the United States if the nation is moving toward a Culture of Health. We also developed a series of measurement domains representing question areas to assess progress toward these expectations. Note that some measurement domains are associated with more than one expectation. In the 2023 survey, we continued to focus on these five expectations, but downplayed these two domains based on our prior survey work and the interests in 2023: health relative to other social issues and priorities, and willingness to pay for community health. We also added a stronger emphasis on race and equity, and thus added a domain under Expectation #4 (underlined).

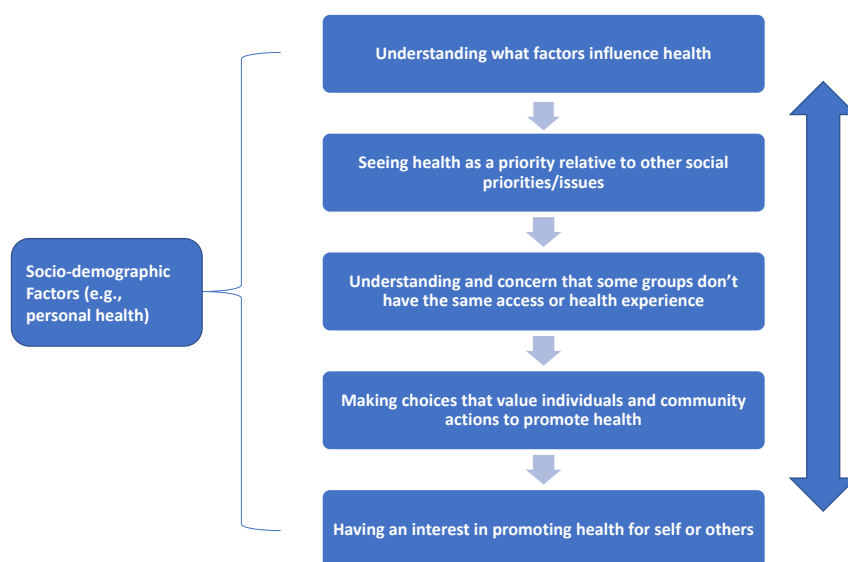
Table 2.1. Domains to Measure Whether We Are Moving Toward a Culture of Health

Expectations to Track Over Time. In a Culture of Health, more U.S. adults would:	Domains What are the types of things we need to know to assess whether this expectation is being met?
1. Appreciate that health is influenced by personal, family, and community health broadly, as well as by a variety of factors (social determinants of health) that include more than genetics, health care, and personal health behaviors	<ul style="list-style-type: none"> • Social determinants of health and disparities • Government roles, including levels of government in health promotion, illness care, etc. • Change agents and action on health • Health relative to other social issues and priorities (less a focus in 2023) • Perceptions of the role of personal responsibility
2. Value and prioritize individual, family, and community health and wellbeing	<ul style="list-style-type: none"> • Health status and experience with health and importance/value of health for individuals, family, and community • Health relative to other social issues and priorities • Perceptions of the role of personal responsibility

Expectations to Track Over Time. In a Culture of Health, more U.S. adults would:	Domains What are the types of things we need to know to assess whether this expectation is being met?
3. Take action regularly to promote personal and community health and wellbeing	<ul style="list-style-type: none"> • Community wellbeing/health—quality of own community health, interest in investing in community wellbeing, willingness to pay (less a focus in 2023), etc. • Change agents and action on health
4. Understand and value health equity as a goal and work toward this goal through the activities of individuals and institutions	<ul style="list-style-type: none"> • General views on equity and health equity, solidarity, health care as a right, and a right to health promotion services, amenities, etc. • <u>Views on diversity, race, racism, and equity</u>
5. Experience less burdened interactions with health systems based on better system integration and coordination of care	<ul style="list-style-type: none"> • Expectations of the system • Health status and experience with health and importance/value of health for individuals, family and community

We also developed a flow chart (Figure 2.1) that describes the likely progression of attitudes that we would expect to see if America is moving toward a Culture of Health. We note that this is not always a linear model, as some changes in views and attitudes may be larger than others and that there may be feedback in the model. Further, we note that sociodemographic factors, such as one’s health, age, education, or income, may moderate these relationships.

Figure 2.1. Proposed Progression of the Health Attitudes of Adults in the United States in a Culture of Health



Finally, we remained interested in understanding how people think about health equity. In our survey crafting and review of potential questions, we considered two dimensions of equity: *equity of what and equity for whom*. *Equity of what* refers to the outcomes or determinants that people believe should exhibit equity—for example, equity of social determinants of health, access to care, or outcomes, such as life expectancy, chronic conditions, and overall health. *Equity for whom* refers to the groups that are considered when thinking about equity; some might be concerned about equity based on income, others race and ethnicity or urban-rural geographies. We continue to use the RWJF definition of *health equity* as a starting point for our questions:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups. (Braveman et al., 2017)

Literature Review

In our prior topline reports (Carman et al., 2019), we described an extensive literature review on drivers for making health a shared value. At that time, we scanned several databases, including PubMed, Google Scholar, JSTOR, EBSCO Academic Search Premier, the New York Academy of Medicine’s Grey Literature Report, and SAGE Publications. Key search terms included the following:

- *value & wellbeing*
- *value & health interdependence (or social and physical influences on health)*
- *value & community metrics*
- *opinions of government spending on health*
- *opinions on government spending priorities*
- *personal political sentiment on government spending priorities*
- *U.S. opinions on health policy*
- *equal opportunity sentiment*
- *opinions on equal health opportunity*
- *willingness to pay for health, health investment, or wellbeing*
- *wellbeing and government spending*
- *society and empathy*
- *government influence on health*

At that time, we also searched Roper’s iPoll database, which archives public opinion survey questions dating back to 1935. This allowed us to draw on historical surveys archived in iPoll and identify additional constructs and survey questions. Search terms for survey questions in iPoll included the following:

- *health care & right/s*

- *health & guarantee*
- “*make enough time life*” (for health vs. other priorities) (topic = any)
- *investment children* (topic = health)
- *local government* (excluding *pensions*) (topic = health)
- *referral* (topic = health)
- *health* (topic= religion)
- *safety net* (topic = health)
- *priorities* (topic = government)
- *government individual* (topic = health)
- *spirituality* (topic = health)
- *sense* (e.g., perception) (topic = health)
- *levels of government* (topic = government)
- *personal experience* (topic = health)
- *experiences* (topic = health)

To inform the survey design of 2023, we re-ran these key words, to see if there was an updated literature and/or survey items. We added the following terms to our iPoll review along with the above items, given the areas of 2023 survey emphasis:

- *equity* (topic=any)
- *equity* (topic=health)
- *racism* (topic=any)
- *racism* (topic=health)
- *wellbeing*
- *community health*

As we had done in prior toplines, we abstracted data, surveys, and concepts from the review. In addition, we reviewed surveys, concept scales, and model questionnaires previously known to the team. This includes a survey administered by Lake Research Partners, a firm commissioned by RWJF to conduct structural racism message testing for the Foundation’s communications efforts on the topic.

Table 2.2 lists surveys that we identified through this process that contributed to the design of this survey. We reviewed each survey for items that would align with our foci noted earlier: (1) individual health experiences, views, and perspectives (making health a shared value); (2) health equity perspectives including views on race and health equity; and (3) perspectives and experiences of community wellbeing.

Table 2.2. Surveys Reviewed During 2023 Survey Development

Survey	Developer (Citation)	Most Recent Year of Survey
America’s Health Priorities during COVID-19	Cook J, Pittaoulis M, Gilchrist K, Alderfer J, Sapia M. 2022	2020
American Health Values Segmentation Study	NORC (NORC, 2023)	2023
American Fragmentation Initiative	American Communities Project (2023)	2023
American National Election Studies Time Series Study	American National Election Studies (American National Election Studies, 2020)	2020
American Time Use Survey	U.S. Bureau of Labor Statistics (U.S. Bureau of Labor Statistics, 2022)	2022
Behavioral Risk Factor Surveillance Survey (BRFSS)	Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 2022)	2022
Better Life Index	Organisation for Economic Co-operation and Development (Organisation for Economic Co-operation and Development, undated)	2023
COVID-19 and the Experiences of Populations at Greater Risk	RAND, Carman et al. 2020-2021	2021
Current Population Survey	U.S. Census Bureau (U.S. Census Bureau, 2022)	2022
European Social Survey European Research Infrastructure Consortium	European Social Survey (European Social Survey, 2022)	2022
Evercare Survey of the Economic Downturn and Its Impact on Family Caregiving	National Alliance for Caregiving (National Alliance for Caregiving and United Healthcare, 2009)	2009
Fair In Health Care?	Julia Lynch and Sarah E. Gollust (Lynch and Gollust, 2009)	2007
FICA Spirituality Assessment Tool	Tami Borneman, Betty Ferrell, and Christina M. Puchalski (Borneman, Ferrel, and Puchalski, 2010)	2010
General Social Survey	NORC (NORC, 2022)	2022
Health Reform Monitoring Survey	Urban Institute (Holahan and Long, 2022)	2022
Tracking Health Survey	Pew Research Center (Pew Research Center, 2023)	2023
iPoll database	Various (iPoll, undated)	Various dates 1937–2023
Measuring Community Engagement	International City/County Management Association (Institute for Local Government, 2015)	Not applicable
National Health Interview Survey	Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 2023)	2023
National Social Life, Health, and Aging Project Wave 2 Survey	NORC (NORC, 2021)	2021
Personal Health Assessment	Wellness Forum Health (Wellness Forum Health, 2017)	Not applicable
Personal Health Experience Scale	Alyssa T. Brooks et al. (Brooks et al., 2013)	2013
Sense of Community Index	Community Science (Chavis, Lee, and Acosta, 2008)	Not applicable

Survey	Developer (Citation)	Most Recent Year of Survey
Structural Racism Messaging	Lake Research Partners (2023)	2023

NOTE: Items shown as not applicable either were not collected in nationally representative surveys or were in a concept phase.

When specific measures were not available, we identified core concepts that we wanted to capture based on literature underlying that concept, particularly in the three foci noted earlier. We then organized these findings in a measurement list to identify where we had robust measures and where there were concepts not addressed by existing measures. The list included a measure description, the scales associated with that measure, whether data were currently available for that measure, the unit of analysis, and the source of the data for the measure.

Research Team Meetings

We conducted a series of meetings as a collective team with researchers from RAND and RWJF to discuss survey content. We held regular meetings to review the survey content, examining whether and how measures identified or newly developed mapped to the domains of interest. We rated measures on their relative face and content validity. If we were using existing measures, we looked at available psychometric properties, including reliability and construct validity, though the latter was often not available for these survey items. If we created items de novo, we tried to adhere as closely as possible to the source information where available. When it was not, we discussed different wording options over several weeks, asking individual team members to offer wording options for team review and comment.

Focus Groups

We worked with Atkins Research, Inc. to conduct two focus groups by trained moderators to explore how potential respondents may understand some new items that the research team was exploring in two topic areas: health equity views and the role of government in community health. We held two, in-person focus groups, with a racially/ethnically diverse sample of adults ages 18-64. Participants were randomly assigned to one of two focus groups (n=12 each. Total n=24), though we ensured each group had participants across the age range and each group had membership from white, Black/African American, Hispanic/Latino, and Asian/Pacific Islander groups. The groups also were mixed across the income categories, including participants, who earned less than \$30K/year to \$100K+/year. To encourage participation across diverse subgroups, the moderator ensured that each participant had time to respond to questions. We note that the focus groups did not include those over 64 years, which is limitation for the inputs received.

For each survey question reviewed, we asked questions to the group to get their reaction to the question item and then probed on issues, such as:

- Are the questions and response options interpreted to mean what we intend;
- Are any questions difficult to understand;
- Are any response options difficult to use (or certain options do not seem to fit or apply);
- Are the order of questions making sense to you; and
- Is there is anything else that you think will pose a challenge to respondents.

Testing of Survey Items: Omnibus and Cognitive Interviewing

There were two tests conducted to pilot the survey questions. The first pilot was conducted in May 2023 with the Omnibus sample of AmeriSpeak (a statistical survey of the American population led by NORC and a survey that had a relationship with RWJF). RAND tested these survey items related to:

- Reasons for life expectancy differences by race/ethnicity
- Ease of engaging different levels of government and the American people to improve health
- Role of government in health
- Confidence in one's community to act on behalf of health
- Actions that would be effective to improve health and wellbeing
- Perspectives on the magnitude of climate change and its relationship to health

With the exception of the confidence in one's community to act on behalf of health, most items were retained in the final 2023 instrument. The goal of this testing was to catalogue the distribution of respondent answers to these questions and review if there was any severe missingness on any item. On both levels, most questions performed well for further use.

In the second test, we conducted cognitive interviews to examine how people interpreted the questions. The purposes of the cognitive interviews were to (1) explore whether the items were comprehensible, (2) understand how respondents interpreted the items, and (3) ensure that the item content and wording were appropriate. We interviewed a convenience sample of twelve people across communities in Pittsburgh, Los Angeles, and Washington, D.C. Four respondents were Black/African American, 3 were White, 2 were Hispanic/Latino and 3 were Asian American/Pacific Islander. The sample was diverse in age, did not have a background in health research, and had either a high school or college degree. The interviews noted where questions were unclear, particularly items that we were newly trying on equity perspectives. We rewrote items and returned to those interviewees to check understanding before finalizing for the 2023 survey.

As an additional step before fielding, we compared the survey screen by screen in both the RAND American Life Panel (ALP) format and the KnowledgePanel format. KnowledgePanel also ran a pilot test with the first 100 respondents to check completion and any survey errors.

Survey Content

Chapter Three provides the text for each question included in the survey. Table 2.3 maps the domains shown in Table 2.1 to survey questions and source. This allows for a mapping from the underlying theoretical constructs that we were interested in measuring to the resulting survey.

Table 2.3. Mapping Survey Questions to Key Survey Concepts

Summary of Question	2023 Question Number	Expectations (numbers map to Table 2.1)	Domain
Individual experience of wellbeing/life appraisal	Q1	2,5	Health status, experience with health
Individual experience of health	Q2	2,5	Health status, experience with health
Individual experience of chronic disease	Q3	2,5	Health status, experience with health
Experience with disability for self or other, caregiving	Q4-7	2,5	Health status, experience with health
Health insurance	Q8	2,5	Health status, experience with health
Religiosity/spirituality	Q9	2,5	Experience with health
Views on diversity	Q10	4	Views on diversity, race, racism, and equity
Government role in health	Q11	1	Government roles
Success narratives in U.S.	Q12	4	Views on diversity, race, racism, equity
Views of minority experiences	Q13	4	Views on diversity, race, racism, equity
Views on racism	Q14-15, Q25	1	Views on diversity, race, racism, equity
Views of wellbeing of people in U.S.	Q16	2	Health values for community
Equity and health	Q17	4	General views on equity and health equity
Poor choices vs. outside control	Q18	1	Social determinants of health, Health relative to other social issues and priorities, Perceptions of the role of personal responsibility
Influence of physical/social on health	Q19	1	Social determinants of health
Government role in fighting opioids and obesity	Q20a,20b	1	Government roles

Summary of Question	2023 Question Number	Expectations (numbers map to Table 2.1)	Domain
Differences by race, income	Q21, 22	4	General views on equity and health equity
Role of systemic racism	Q23	4	Views on diversity, race, racism, equity
Reasons for health inequities	Q24	1, 4	Social determinants of health; general views on equity and health equity
Life expectancy- closing inequities benefits	Q26	3,4	Community wellbeing/Health, General views on equity and health equity
Role of actors to change health, and barriers to change	Q27-28	3	Change agents/action
How to make change for equity	Q29	3,4	Changes agents/action; general views on equity and health equity
Understanding equity	Q30-31	4	General view on equity and health equity
Rating of community wellbeing status	Q32-33	2,5	Health status and experience with health and importance
Community engagement for health and other social issues	Q34	4	Willingness to act for health
Barriers to action	Q35	3	Change agents/action
Views of climate change and community health	Q36	1	Social determinants of health

The full wording of survey items is noted in the final chapter with the descriptive tables.

Survey Length

The resulting survey contained 37 questions, some with subquestions or multiple parts. The median time to complete the survey was between 19 and 20 minutes.

Randomization

To avoid potential order effects, we randomized the order of some questions within modules. We randomized the order of subitems on Q36. For one question set, we used a split sample and fielded slightly different wordings or different questions to different survey respondents (Question 20A and 20B).

Survey Sample

We collected data via the ALP and the KnowledgePanel. Both panels are nationally representative internet panels recruited via probability-based sampling methods. Both provide computers and internet connections for respondents who do not already have them. Both panels collect demographic information about respondents separately and provide this information with each data set. Respondents in both panels are paid a modest amount for their participation. The content of the survey conducted in each panel was identical. Although there were small differences in the formatting used on the screen across the two panels (for example, the standard background colors used for the panels differs), the presentation was very similar. The two survey efforts combined resulted in a final total sample of 5,620 completed surveys. We fielded the survey in the ALP because of the rich historical data collected through that panel that can be linked to new data collection. These historical data include not only the previous survey that we ran in the ALP in 2015, but also any other surveys previous run in the ALP including the 2018 NSHA. However, to boost sample size, we also conducted the survey in the KnowledgePanel. In our sampling, we specifically requested an oversample of Black and Hispanic respondents, and a greater draw of Asian American, Native Hawaiian and Pacific Islander participants where possible, given interest in analyses by race/ethnicity and the survey content areas on the topics of health equity and structural racism.

RAND American Life Panel

The ALP began in 2003. All data from the ALP are made publicly available and can be linked, allowing researchers to make use of data collected in other surveys fielded in the ALP. Panel members have been recruited via address-based sampling and random digit dialing and include an oversample of vulnerable populations. The vulnerable-population oversample draws from geographic areas with lower per capita incomes and larger proportions of native Spanish speakers. All panel members update demographic data from the ALP quarterly. Additional information about the panel is available from the ALP (RAND, undated).

Our sample was limited to panel members who had participated in our 2015 survey, and all panel members who had participated in that survey and were still active in the ALP were invited to participate in the 2023 survey. This resulted in a sample of 2,033 panel members being invited to participate in this survey, and 1,570 (77.2 percent) completed the survey.

We fielded this survey from November 27 through December 19, 2023. The ALP survey was left open for respondents longer than the KnowledgePanel survey to maximize the number of respondents who responded to the 2015 survey.

Note that our sample from the ALP is not representative of individuals in the youngest age group (age 18 to 24). This is because only respondents from the ALP who had participated in our 2015 survey were invited to participate in the 2023 survey. The KnowledgePanel sample was not restricted in this way.

Finally, the ALP sample allows for longitudinal analysis for those who completed 2015, 2018 and 2023 surveys.

KnowledgePanel

The KnowledgePanel is administered by Ipsos. Panel members have been recruited via address-based sampling and random digit dialing. Additional information is available from Ipsos (Ipsos, undated).

We fielded this survey from November 27 through December 8, 2023. We invited a sample of 6,557 panel members to participate in this survey, and 4,050 (61.8 percent) completed the survey.

The KnowledgePanel sample does not allow for longitudinal analysis like the ALP, but rather is constructed as standalone or cross-sectional data.

Combining Sample Data

We combined data from the ALP and KnowledgePanel, as we did in 2015 and 2018. To assess the appropriateness of combining these data, we took several steps. First, we took care to ensure that the implementation of the survey in the two panels was the same. Both panels displayed the questions in the same order, implemented randomization in the same way, and kept the general format of each screen similar to ensure comparability. Second, in prior surveys and again in 2023, we compared responses across the two surveys. To test the feasibility of combining the two samples, we investigated whether there were systematic differences between responses to the two surveys, after controlling for demographic characteristics, and found no meaningful differences. Third, in 2015 and 2018, we investigated differences by device (i.e., participation via a desktop/laptop or smartphone). We did not identify any systematic biases across the two surveys by device type. As a result, we pooled the two panels for final analyses, a method that we pursued also in 2023 given that sample selection was not different. This report presents the responses from each panel separately, as well as the combined responses.

Weighting

To make the sample representative of the overall population, we used weighting, a statistical adjustment. To create weights to match the distribution of characteristics in our sample as closely as possible to that of the population from the 2022 Current Population Survey (CPS), we used a raking algorithm, following the methods described in Deming (1943) and Deville, Särndal, and Sautory (1993). We aimed to match population proportions on interactions of gender and race and ethnicity, gender and education, and gender and age, as well as household income interacted with household size. To calculate the weights, we combined the two samples and matched the distribution of characteristics of the pooled sample to the distribution of the CPS. In other words, our weighting procedure treated observations from the two panels as equivalent. In the top-line tables in Chapter Three, we also present the results from each survey with the weights calculated

separately for each subsample. For example, the ALP results present the results if the data from the ALP alone were weighted to match the CPS. We have not adjusted these weights to reflect how the panelists were originally recruited to the panels.

Sample Description

Our total sample includes 5,620 respondents. The weighted sample is representative of the noninstitutionalized adult population across all 50 states and the District of Columbia. Table 2.4 compares the weighted and unweighted characteristics of our sample with the characteristics of the CPS.

Table 2.4. Comparison of the Survey Sample and the Current Population Survey

Characteristic	Combined ALP and KnowledgePanel (%)		2022 CPS
	Unweighted	Weighted	
Gender			
Male	48.4	48.7	47.9
Female	51.6	51.3	52.1
Race or ethnicity*			
Non-Hispanic white	50.4	61.9	59.2
Non-Hispanic black	20.0	12.1	11.7
Hispanic	21.6	19.9	18.9
Non-Hispanic, Asian/Pacific Islander	5.7	4.2	7.5
Non-Hispanic, other	2.3	1.9	2.8
Education			
Less than high school	6.9	9.6	10.3
High school	21.9	29.5	29.2
Some college	29.0	26.2	26.3
College graduate	42.2	34.7	34.1
Age, in years			
18–24	5.4	11.4	10.5
25–44	26.8	34.3	35.2
45–64	35.7	32.3	32.2
65+	32.0	22.1	22.1
Income, in dollars			
Less than 10,000	3.5	4.8	3.9
10,000 to 24,999	7.9	9.5	10.6
25,000 to 49,999	17.3	20.8	20.6
50,000 to 74,999	18.6	18.0	17.9
75,000 to 99,999	13.0	13.2	13.7

Characteristic	Combined ALP and KnowledgePanel (%)		2022 CPS
	Unweighted	Weighted	
100,000 or more	39.7	33.7	33.3
Household size, in number of residents			
1	20.3	15.1	13.7
2	39.4	35.1	32.3
3	16.6	19.7	19.1
4	13.1	16.3	18.3
5	6.0	7.7	9.3
6	2.7	3.5	4.1
7	1.1	1.3	1.6
8	0.4	0.5	0.8
9 or more	0.4	0.6	0.8

NOTE: We present all results as percentages.

*While we weighted data to the panel information by race/ethnicity, we primarily use the self-report Q37 (race/ethnicity) data in the topline summary (see Chapter 3).

Margin of Error

We calculated the margin of error (MOE) based on the 95-percent confidence interval. If a study was repeated 100 times, the 95-percent confidence interval would contain the true value 95 percent of the time. The MOE is a function of the sample size and the measured proportion, with the smallest MOE for proportions near 0 percent or 100 percent and the largest MOE for proportions near 50 percent. Because the overall sample size of our survey is large, 5,620 respondents, the MOE for the full sample ranges from 0.32 percent to 3.33 percent, for proportions near 0 percent and 50 percent, respectively. For the ALP subsample, the MOE ranges from 0.51 percent to 5.01 percent. For the KnowledgePanel subsample, the MOE ranges from 0.38 percent to 4.07 percent. We have not adjusted the MOEs to reflect design effects.

Limitations

This research has several limitations. First, we drew our sample from two panels. Although we identified no significant differences in responses across the two panels when controlling for demographic differences, we might not be able to discern from the social and demographic profiles of the sample every underlying difference regarding attitudes and perspectives. Second, many respondents used smartphones to respond to the survey. Although both the ALP and KnowledgePanel have optimized their formatting for smartphones, some of our survey items had tables, which asked the respondent to rate many different things on one screen. These tables can be difficult for respondents using smartphones, and we cannot be sure of the device effect or influence on those questions specifically. Third, we adjusted the data to account for differences

in demographic characteristics between our sample and the CPS, but we did not adjust the data for the differential probabilities of selection that (in addition to calibration) cause design effects. A design effect is an indicator of the impact of sample design and weighting on the effective sample size of the survey. Our adjustment might underestimate the size of the design effect since we do not have sufficient information on geographic clustering and secondary recruitment details. This information is not available from the ALP and KnowledgePanel.

Access to the Data

In the summer of 2024, the combined data set with weights will be made available through RWJF's Health and Medical Care Archive at the Inter-University Consortium for Political and Social Research at the University of Michigan as the RWJF National Survey of Health Attitudes. We have provided this access to prior NSHA surveys.

Chapter 3. Top-Line Summary Data

This final chapter presents the top-line survey results from the ALP and KnowledgePanel samples in 2023 as well as the combined sample. For each question in the survey, we present the text as it was presented to survey respondents. We have weighted each panel separately according to the algorithm described in Chapter Two to make results representative of the U.S. population. For example, the ALP results present the results if we weighted the data from the ALP alone to match the CPS. We also weighted the combined results to match the CPS. After the main survey questions, we present the survey respondents weighted demographic characteristics.

We report the percentage of respondents who chose not to answer each question and label this as missing. None of the questions included a “don’t know” option, but one question on type of health insurance included a “not sure” option.

In the interest of parsimony, the following tables do not present the MOE for each question. As described in Chapter Two, we calculated the MOE based on the 95-percent confidence interval. Because the overall sample size of our survey is large, 5,620 respondents, the MOE for the full sample ranges from 0.32 percent to 3.33 percent, for proportions near 0 percent and 50 percent, respectively. For the ALP subsample, the MOE ranges from 0.51 percent to 5.01 percent. For the KnowledgePanel subsample, the MOE ranges from 0.38 percent to 4.07 percent. We have not adjusted the MOEs to reflect design effects. For these tables, we report to one decimal point.

All results are presented as the percentage of respondents selecting each answer.

1. Assume the ladder is a way of picturing your life. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst life for you. On which step of this ladder would you say you personally feel you stand at this time? Please select one number only – 0 is the worst possible life for you, 10 is the best possible life for you.



Sample	0	1	2	3	4	5	6	7	8	9	10	Missing
ALP (n=1,570)	0.1	0.4	0.5	1.9	5.5	6.2	10.7	30.9	28.6	10.1	5.1	0.0
Knowledge Panel (n = 4,050)	0.6	1.1	2.4	3.8	5.6	12.0	12.9	20.5	24.9	9.9	6.1	0.3
Total	0.6	1.1	2.3	3.7	5.5	11.2	12.9	21.0	25.6	10.5	5.4	0.3

SOURCE: Cantril Ladder.

2. Would you say that in general your health is excellent, very good, good, fair, or poor?

Sample	Excellent	Very good	Good	Fair	Poor	Missing
ALP (n = 1,570)	8.5	35.6	38.4	12.9	4.6	0.0
KnowledgePanel (n = 4,050)	8.8	34.0	38.1	15.7	3.0	0.5
Total	9.1	34.2	37.8	15.4	3.0	0.5

SOURCE: BRFSS Healthy Days/HRQOL-4 questions (Centers for Disease Control and Prevention, 2009).

3. Do you personally currently have one or more chronic health conditions (e.g., diabetes, asthma, depression)?

Sample	Yes	No	Missing
ALP (n = 1,570)	57.8	42.2	0.0
KnowledgePanel (n = 4,050)	48.5	51.0	0.5
Total	48.5	51.0	0.5

SOURCE: RAND.

4. Are you limited in any way in any activities because of physical, mental, or emotional problems?

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	25.8	74.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	26.2	73.3	0.5
Total	27.1	72.4	0.5

SOURCE: CDC Division of Human Development and Disability.

Sometimes people take care of others who are ailing or who have health needs. For example, these may include elderly relatives, family members with disabilities or chronic disease, friends, or neighbors. (Please don't include those who you take care of for pay)

5. Has the poor health of another person affected your life on an ongoing basis for any extended period of time in your life?

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	22.2	77.8	0.0
KnowledgePanel (<i>n</i> = 4,050)	24.8	74.6	0.6
Total	26.0	73.4	0.6

SOURCE: Adapted from Personal Health Experience Scale (Todaro et al 2013).

6. Have you ever had financial problems because of a health issue for yourself and/or to help others dealing with a health issue?

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	22.0	78.0	0.0
KnowledgePanel (<i>n</i> = 4,050)	20.9	78.3	0.8
Total	21.1	78.2	0.7

SOURCE: RAND.

7. In a typical month, how often, if ever, do you help others who are ailing or who have health needs, with their daily activities?

Sample	Daily	Several Times a Week	About Once a Week	2–3 Times a Month	Once a Month	Never	Missing
ALP (<i>n</i> = 1,570)	9.7	6.8	6.4	9.0	16.1	52.0	0.0
Knowledge Panel (<i>n</i> = 4,050)	8.7	7.5	5.7	7.7	13.9	55.6	1.0
Total	9.1	7.7	6.1	8.3	15.1	52.8	0.9

SOURCE: American Time Use Survey (U.S. Bureau of Labor Statistics, 2014), revised by RAND.

8. The next question asks about your health insurance or health coverage plans. In answering this question, please exclude plans that pay for only one type of service (such as nursing home care, accidents, family planning, or dental care) and plans that only provide extra cash when hospitalized. Are you currently covered by any of the following types of health insurance or health coverage plans?

Insurance through a current or former employer or union (of yours or another family member's). This would include COBRA coverage

Sample	Covered	Not Covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	53.5	35.6	9.1	1.7
KnowledgePanel (<i>n</i> = 4,050)	51.2	41.5	5.9	1.4
Total	50.7	41.8	5.9	1.6

Insurance purchased through an exchange or marketplace, such as Healthcare.gov or [state exchange of state where respondent lives]

Sample	Covered	Not Covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	9.5	77.9	10.5	2.1
KnowledgePanel (<i>n</i> = 4,050)	9.5	81.2	7.1	2.3
Total	9.7	80.7	7.1	2.4

Insurance purchased directly from an insurance company (by you or another family member) excluding coverage purchased through an exchange or marketplace, such as Healthcare.gov or [state exchange of state where respondent lives]

Sample	Covered	Not Covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	10.6	77.9	9.7	1.8
KnowledgePanel (<i>n</i> = 4,050)	10.7	79.9	7.1	2.4
Total	10.7	79.8	7.1	2.5

Medicare, for people 65 and older, or people with certain disabilities

Sample	Covered	Not covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	25.2	67.0	7.3	0.5
KnowledgePanel (<i>n</i> = 4,050)	25.1	68.2	4.4	2.3
Total	25.6	67.9	4.5	2.1

Medicaid, Medical Assistance (MA), the Children’s Health Insurance Program (CHIP) or any kind of government-sponsored assistance plan based on income or a disability [Medicaid name of state where respondent lives]

Sample	Covered	Not Covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	15.9	74.3	7.6	2.2
KnowledgePanel (<i>n</i> = 4,050)	15.7	76.8	5.1	2.4
Total	16.1	76.1	5.2	2.6

TRICARE or other military health care, including VA health care

Sample	Covered	Not Covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	5.4	85.0	7.8	1.8
KnowledgePanel (<i>n</i> = 4,050)	5.2	87.4	4.8	2.6
Total	5.4	86.9	5.0	2.7

Indian Health Service

Sample	Covered	Not covered	Not sure	Missing
ALP (<i>n</i> = 1,570)	1.4	89.0	7.3	2.3
KnowledgePanel (<i>n</i> = 4,050)	0.8	92.6	4.2	2.4
Total	0.9	92.2	4.3	2.5

Any other type of health insurance coverage or health coverage plan

Sample	Covered	Not Covered	Not Sure	Missing
ALP (<i>n</i> = 1,570)	11.8	77.7	8.9	1.6
KnowledgePanel (<i>n</i> = 4,050)	8.5	82.1	6.7	2.8
Total	8.9	81.5	6.8	2.7

SOURCE: Health Reform Monitoring Survey Q8, 2017 (Holohan and Long, 2018).

If the respondent indicated that they had no source of insurance, they were asked Q8a:

8a. Does this mean you currently have no health insurance or health coverage plan?

Sample	I do NOT have health insurance	I HAVE some kind of health insurance	Missing
ALP (<i>n</i> = 37)	80.6	19.4	0.0
KnowledgePanel (<i>n</i> = 246)	79.4	7.3	13.4
Total	79.8	7.4	12.8

SOURCE: Health Reform Monitoring Survey Q8, 2017 (Holohan and Long, 2018).

9. How would you rate the importance of religion and/or spirituality in your life on a scale from: 1 (Not at all important) to 5 (very important)?

Sample	1 (not at all important)	2	3	4	5 (very important)	Missing
ALP (<i>n</i> = 1,570)	19.9	9.0	19.1	17.3	34.7	0.0
KnowledgePanel (<i>n</i> = 4,050)	21.0	10.9	17.5	15.6	33.9	1.0
Total	19.7	11.2	18.0	15.4	34.8	0.9

SOURCE: Modified by RAND from FICA scale.

Now we ask some questions about your views of the United States.

10. The United States has a diverse population, with people of many different races, ethnicities, religions, and backgrounds. Do you think this diversity makes the country much stronger, moderately stronger, neither stronger nor weaker, moderately weaker, or much weaker?

Sample	Much stronger	Moderately stronger	Neither stronger nor weaker	Moderately weaker	Much weaker	Missing
ALP (<i>n</i> = 1,570)	30.8	23.4	33.3	9.6	2.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	30.9	26.9	29.4	8.0	3.9	1.0
Total	31.1	26.9	29.1	8.3	3.8	0.9

SOURCE: PRRI, 2021.

11. Which statement comes closer to your views, even if neither is exactly right?

Sample	Government should do more to solve problems and help meet the needs of people	Government does too many things better left to businesses and individuals	Missing
ALP (<i>n</i> = 1,570)	70.9	29.0	0.1
KnowledgePanel (<i>n</i> = 4,050)	64.5	34.5	1.0
Total	65.2	34.0	0.9

SOURCE: Lake Research Partners and RWJF.

12. Which statement comes closer to your views, even if neither is exactly right?

Sample	What's great about the U.S. is that everyone has the opportunity to succeed if they work hard.	Right now, for many people in the U.S., just working hard is not enough to get ahead.	Missing
ALP (n = 1,570)	37.0	63.0	0.0
KnowledgePanel (n = 4,050)	36.9	62.3	0.8
Total	36.5	62.8	0.7

SOURCE: Lake Research Partners and RWJF

13. Which statement comes closer to your views, even if neither is exactly right?

Sample	Minorities who cannot get ahead in this country are mostly responsible for their own condition.	Minorities face greater obstacles to economic success than white people.	Missing
ALP (n = 1,570)	38.7	60.8	0.4
KnowledgePanel (n = 4,050)	41.8	57.0	1.2
Total	40.9	58.0	1.1

SOURCE: Lake Research Partners and RWJF

Please indicate whether you agree or disagree with the following statement:

14. Racism is mostly in the past.

Sample	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Missing
ALP (n = 1,570)	5.3	15.6	26.1	53.1	0.0
KnowledgePanel (n = 4,050)	6.8	18.6	30.5	43.4	0.6
Total	6.4	18.6	30.1	44.3	0.6

SOURCE: Lake Research Partners and RWJF.

15. Discussing race divides us rather than unites us.

Sample	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Missing
ALP (n = 1,570)	23.5	33.4	21.8	21.3	0.0
KnowledgePanel (n = 4,050)	18.2	30.5	29.0	21.0	1.4
Total	18.6	30.7	28.7	20.7	1.2

SOURCE: RAND.

Next, we ask questions about health in the United States.

16. How would you rate the wellbeing of most people living in the United States?

Sample	Excellent	Very Good	Good	Fair	Poor	Missing
ALP (<i>n</i> = 1,570)	0.3	6.7	42.2	36.2	14.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	1.2	9.3	45.2	36.0	7.6	0.7
Total	1.2	9.0	44.5	36.6	8.1	0.7

SOURCE: RAND and Metropolitan Group.

17. How much more, if anything, needs to be done to ensure everyone has an equal opportunity to be healthy in the United States?

Sample	Nothing More	A Little More	A Lot More	Missing
ALP (<i>n</i> = 1,570)	10.3	25.6	64.0	0.0
KnowledgePanel (<i>n</i> = 4,050)	12.9	30.6	55.0	1.5
Total	12.4	30.0	56.2	1.3

SOURCE: RAND and RWJF.

18. Which statement comes closer to your views, even if neither is exactly right?

Sample	The biggest reason people in America become unhealthy is because they make poor choices that affect their health.	The biggest reason people in America become unhealthy is because things outside of their control affect their health.	Missing
ALP (<i>n</i> = 1,570)	63.8	36.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	60.3	37.5	2.1
Total	60.8	37.5	1.7

SOURCE: Pew Research Center, 2012. Revised by RAND.

19. Here is a list of some things that may affect people's health and wellbeing. Please rate each on a scale from 1 to 5 where 1 means it has no effect on health, and 5 means it has a very strong effect.

A. Access to affordable healthcare

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.3	5.6	15.7	16.8	59.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.0	4.9	20.9	19.9	49.9	1.4
Total	2.9	4.9	19.1	19.9	51.9	1.2

B. Having a job

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	3.0	1.0	19.0	21.7	55.3	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.3	3.6	20.1	27.4	43.8	1.8
Total	3.2	3.4	19.4	27.0	45.5	1.5

C. Stress

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	0.9	1.7	15.8	21.4	60.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	2.1	3.4	19.5	24.7	48.3	2.0
Total	2.0	3.1	18.3	24.7	50.3	1.7

D. Knowledge about health

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	1.3	2.8	27.6	26.7	41.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	2.2	5.3	30.4	28.7	31.4	2.1
Total	2.1	4.9	28.0	29.5	33.7	1.7

E. Neighborhood options for healthy food and exercise

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.7	6.7	26.1	22.8	41.7	0.0
KnowledgePanel (<i>n</i> = 4,050)	5.1	8.6	29.7	24.6	30.1	2.0
Total	4.8	8.5	28.4	25.4	31.2	1.7

F. Having health insurance

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.5	5.3	15.7	14.6	61.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	2.6	3.6	16.4	23.1	52.1	2.1
Total	2.5	3.6	15.5	22.6	54.1	1.7

G. Smoking

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.0	2.0	10.3	14.7	70.8	0.0
KnowledgePanel (<i>n</i> = 4,050)	2.2	2.0	9.3	12.1	72.0	2.3
Total	2.2	2.2	9.4	12.0	72.3	1.9

H. Amount of social support

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	3.3	11.0	34.6	26.6	24.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.6	8.5	34.4	26.1	24.0	2.4
Total	4.3	8.5	33.5	27.5	24.3	1.9

I. Personal health practices (other than smoking)

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	0.7	0.6	13.2	30.1	55.4	0.0
KnowledgePanel (<i>n</i> = 4,050)	1.9	1.6	17.2	29.8	46.7	2.8
Total	1.8	1.5	15.8	30.0	48.7	2.2

J. Physical environment such as clean air or water

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	1.4	5.3	14.7	29.2	49.4	0.0
KnowledgePanel (<i>n</i> = 4,050)	2.9	5.0	22.1	25.3	42.2	2.5
Total	2.6	4.8	20.2	25.9	44.5	2.1

K. Genetic makeup inherited from parents

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.1	5.2	28.9	28.0	35.7	0.1
KnowledgePanel (<i>n</i> = 4,050)	2.8	6.8	31.8	30.6	25.8	2.3
Total	2.9	6.5	30.5	30.7	27.5	1.9

L. Income

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.7	7.2	19.0	31.3	39.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.1	6.3	25.8	27.8	34.8	2.2
Total	3.0	6.4	24.6	28.9	35.2	1.9

M. Community safety

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.9	8.6	30.2	28.2	30.1	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.8	9.9	33.1	25.9	24.7	2.5
Total	3.7	9.3	32.1	27.3	25.5	2.1

N. Housing quality

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.2	5.3	29.6	31.2	31.8	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.9	9.1	32.9	27.3	24.3	2.6
Total	3.7	8.6	31.7	28.5	25.5	2.1

O. Education

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.5	8.3	30.1	24.8	34.3	0.1
KnowledgePanel (<i>n</i> = 4,050)	4.2	7.5	29.9	27.5	28.6	2.3
Total	3.9	7.3	28.6	28.4	29.9	1.9

P. Where a person lives

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	2.5	6.2	35.3	24.6	31.4	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.9	9.2	32.8	27.6	24.4	2.2
Total	3.7	8.8	31.6	28.9	25.1	1.9

Q. Race/ethnicity

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	13.8	11.6	36.3	21.1	17.1	0.1
KnowledgePanel (<i>n</i> = 4,050)	13.0	15.1	34.1	17.6	17.9	2.3
Total	12.7	14.6	33.0	19.0	18.7	2.0

R. Examples set by people around you

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (<i>n</i> = 1,570)	3.2	5.2	36.5	26.3	28.7	0.0
KnowledgePanel (<i>n</i> = 4,050)	5.8	10.2	33.2	26.7	22.3	1.9
Total	5.2	9.5	32.1	28.0	23.7	1.6

SOURCE: Robert and Booske, 2011; revised by RAND and NORC.

Question 20 is administered via split sample.

20A. As of 2022, more than 40% of American adults were obese. Which of the following levels of government do you think could do the most (e.g., through policies, programs, laws, and regulations) to help reduce the number of American adults who are obese? (Select one only)

Sample	Local governments	State governments	Federal governments	No government can lower this number	Missing
ALP (<i>n</i> = 764)	13.0	19.0	21.8	46.2	0.0
KnowledgePanel (<i>n</i> = 2,020)	12.4	14.2	22.1	49.4	1.8
Total	12.4	15.3	22.4	48.5	1.6

SOURCE: RAND and RWJF.

20B. In 2022, 8 percent of American adults had a substance use disorder (e.g., alcoholism, addiction to opioids). Which of the following levels of government do you think could do the most (e.g., through policies, programs, laws, and regulations) to help reduce the number of American adults who have a substance use disorder? (Select one only)

Sample	Local governments	State governments	Federal governments	No government can lower this number	Missing
ALP (<i>n</i> = 806)	19.8	26.4	27.4	26.4	0.0
KnowledgePanel (<i>n</i> = 2,030)	21.7	26.7	20.3	29.0	2.3
Total	21.2	27.0	21.6	28.4	1.9

SOURCE: RAND and RWJF.

21. When African Americans need health care, do you think it is easier or harder for them to get the care they need than it is for White Americans, or is there not much of a difference?

Sample	Easier	Not Much of a Difference	Harder	Missing
ALP (<i>n</i> = 1,570)	5.2	43.4	51.2	0.1
KnowledgePanel (<i>n</i> = 4,050)	5.8	51.5	41.4	1.4
Total	6.0	49.7	43.0	1.3

SOURCE: NORC and RAND.

22. When low-income Americans need health care, do you think it is easier or harder for them to get the care they need than it is for those who are better off financially, or is there not much of a difference?

Sample	Easier	Not Much of a Difference	Harder	Missing
ALP (<i>n</i> = 1,570)	8.2	19.5	72.3	0.0
KnowledgePanel (<i>n</i> = 4,050)	9.2	23.5	66.1	1.3
Total	9.2	22.8	66.9	1.1

SOURCE: NORC and RAND.

23. Systemic racism refers to policies and systems that reinforce racial discrimination and unfair treatment of some groups, such as where people get to live or who gets bank loans. This type of racism can be so embedded in the institutions and practices of society that it can still exist even if individuals don't want to discriminate.

For the following question, please indicate how much you agree or disagree with this statement.

One of the main reasons that people of color (e.g., African Americans, Latinos) have poorer health outcomes (e.g., higher rates of diabetes, more deaths from coronavirus (COVID-19)) than whites is systemic racism.

Sample	Strongly Agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Missing
ALP (<i>n</i> = 1,570)	22.5	20.2	33.3	7.1	16.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	15.7	23.8	28.2	11.6	19.0	1.7
Total	16.7	24.3	28.0	11.1	18.5	1.5

SOURCE: RAND and RWJF.

24. African Americans living in the U.S. are more likely to experience poor health outcomes compared to Whites, such as obesity and diabetes. The next statements are about the possible reasons for these differences. Please indicate if you strongly disagree, somewhat disagree, neither agree or disagree, somewhat agree, or strongly agree with the following statements. Choose one response per row.

A. African Americans tend to be less healthy than whites because of their health behavior choices.

Sample	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Missing
ALP (<i>n</i> = 1,570)	15.0	29.5	29.9	9.5	16.0	0.0
KnowledgePanel (<i>n</i> = 4,050)	12.6	30.5	34.5	12.8	8.5	1.1
Total	13.0	31.1	33.7	12.9	8.3	1.0

B. African Americans tend to be less healthy than whites because of discrimination they face in the health care system.

Sample	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Missing
ALP (<i>n</i> = 1,570)	20.3	29.2	22.0	11.2	17.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	11.6	26.5	27.6	15.0	18.2	1.1
Total	12.3	27.0	27.3	14.8	17.7	0.9

C. African Americans tend to be less healthy than whites because of conditions of the neighborhoods they live in.

Sample	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	23.5	39.2	25.7	5.1	6.5	0.0
KnowledgePanel (n = 4,050)	15.2	40.4	29.7	7.8	5.7	1.1
Total	15.9	40.5	29.0	7.8	5.9	1.0

D. African Americans tend to be less healthy than whites because of policies and laws that have made it more difficult for generations of African Americans to be healthy.

Sample	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	19.8	22.6	25.2	11.6	20.8	0.0
KnowledgePanel (n = 4,050)	14.4	20.7	29.4	15.0	19.3	1.2
Total	14.8	20.8	29.2	14.9	19.3	1.0

SOURCE: NORC, American Health Values Survey.

25. Racism is a major public health crisis.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	35.5	27.4	20.0	17.0	0.1
KnowledgePanel (n = 4,050)	21.0	33.5	24.2	19.6	1.7
Total	22.3	33.7	23.1	19.3	1.6

SOURCE: RAND and RWJF.

26. Closing gaps in lifespan between groups of people living in the U.S., such as those who are White or Black, could have the following benefits for the country. How important is each of these potential benefits for the country?

A. Improve America's standing in the world by making it a healthier nation.

Sample	Not important	Somewhat important	Very important	Missing
ALP (n = 1,570)	8.1	49.3	42.5	0.0
KnowledgePanel (n = 4,050)	9.4	50.3	39.1	1.2
Total	9.0	48.9	41.0	1.1

B. Make the country more resilient because people would be healthier and better able to deal with challenges.

Sample	Not important	Somewhat important	Very important	Missing
ALP (<i>n</i> = 1,570)	6.8	44.9	48.3	0.0
KnowledgePanel (<i>n</i> = 4,050)	6.3	51.4	41.0	1.3
Total	6.2	48.9	43.8	1.1

C. Make the U.S. a more fair and equitable country.

Sample	Not important	Somewhat important	Very important	Missing
ALP (<i>n</i> = 1,570)	10.4	29.1	60.5	0.1
KnowledgePanel (<i>n</i> = 4,050)	11.7	36.2	50.8	1.3
Total	11.3	35.1	52.5	1.1

D. Help the government spend less on health care so that more could be spent dealing with other challenges such as improving public education, reducing homelessness, or reducing the nation's debt.

Sample	Not important	Somewhat important	Very important	Missing
ALP (<i>n</i> = 1,570)	16.2	50.1	33.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	15.9	48.8	33.9	1.4
Total	15.1	48.3	35.3	1.2

SOURCE: RAND and RWJF.

27. How effective do you think each of these actions would be to help ensure everyone (regardless of race, income, etc.) in the U.S. has an equal opportunity to be healthy?

A. More well-funded government programs to support health.

Sample	Very effective	Somewhat effective	Not effective	Missing
ALP (<i>n</i> = 1,570)	41.3	44.6	14.1	0.0
KnowledgePanel (<i>n</i> = 4,050)	34.5	44.8	19.1	1.5
Total	35.5	45.0	18.1	1.4

B. More private sector engagement in efforts to improve health.

Sample	Very effective	Somewhat effective	Not effective	Missing
ALP (<i>n</i> = 1,570)	34.2	53.4	12.4	0.0
KnowledgePanel (<i>n</i> = 4,050)	26.9	55.8	15.7	1.6
Total	27.5	56.2	14.8	1.4

C. More funding for non-profits working to improve community conditions to support health.

Sample	Very effective	Somewhat effective	Not effective	Missing
ALP (<i>n</i> = 1,570)	40.1	49.2	10.8	0.0
KnowledgePanel (<i>n</i> = 4,050)	34.4	52.0	11.9	1.7
Total	36.0	50.9	11.6	1.5

D. More activity on the part of community members, community organizations, and coalitions to improve community conditions that support health.

Sample	Very effective	Somewhat effective	Not effective	Missing
ALP (<i>n</i> = 1,570)	45.9	46.2	7.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	33.5	54.2	10.5	1.8
Total	36.0	52.6	9.9	1.6

E. Policy changes to address barriers faced by some groups based on race, income, etc.

Sample	Very effective	Somewhat effective	Not effective	Missing
ALP (<i>n</i> = 1,570)	46.0	37.7	16.3	0.0
KnowledgePanel (<i>n</i> = 4,050)	36.0	43.1	19.1	1.8
Total	37.4	42.7	18.4	1.5

SOURCE: RAND and RWJF.

28. How easy or difficult would it be to do each of the following so that everyone (regardless of race, income, etc.) has a chance to be as healthy as possible?

A. Create the will on the part of political leaders to address the issue.

Sample	Very easy	Somewhat easy	Somewhat difficult	Very difficult	Missing
ALP (<i>n</i> = 1,570)	9.3	15.0	46.5	29.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.1	16.8	46.0	30.4	2.7
Total	4.3	16.4	46.1	30.9	2.3

B. Create the will on the part of general American public to address the issue.

Sample	Very easy	Somewhat easy	Somewhat difficult	Very difficult	Missing
ALP (<i>n</i> = 1,570)	9.4	19.4	51.3	19.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.6	22.9	50.2	19.4	2.8
Total	4.7	23.2	49.8	19.9	2.4

C. Address systemic racism as an underlying cause of this issue.

Sample	Very easy	Somewhat easy	Somewhat difficult	Very difficult	Missing
ALP (n = 1,570)	11.0	15.9	34.1	38.8	0.3
KnowledgePanel (n = 4,050)	5.8	14.3	39.7	35.7	4.5
Total	6.3	13.9	39.3	36.8	3.8

SOURCE: RAND and RWJF.

29. Which statement comes closer to your views about what needs to be done to ensure all Americans have an equal opportunity to be healthy, even if neither is exactly right?

Sample	U.S. laws and institutions need to be rewritten and redesigned because they do not adequately support the health of all people living in the US	Any changes that are necessary to support the health of all people in the US can be made by enforcing current laws and working within the current institutions	Missing
ALP (n = 1,570)	57.5	42.5	0.1
KnowledgePanel (n = 4,050)	51.4	47.1	1.5
Total	52.5	46.1	1.4

SOURCE: RAND and RWJF.

30. When people talk about making things “equitable” in a community, what do you think that means for how resources are shared across groups (e.g., by neighborhood, by race)? I think it means (select one)...

Sample	Every group gets an equal amount of resources	Every group gets equal access to resources	Every group gets the resources they need based on whether they experienced discrimination in the past	Other	Missing
ALP (n = 1,570)	16.7	58.5	19.3	5.5	0.0
KnowledgePanel (n = 4,050)	14.8	59.4	16.2	6.6	2.8
Total	14.5	60.1	16.5	6.6	2.4

SOURCE: RAND and RWJF.

31. Here are some statements about creating ‘equitable communities.’ For each one, please indicate how much you agree or disagree.

A. It’s impossible to make a community equitable without taking resources from some groups and giving them to other groups.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	15.8	39.6	27.3	17.3	0.0
KnowledgePanel (n = 4,050)	15.4	38.4	29.8	14.7	1.7
Total	15.7	38.1	29.6	15.2	1.4

B. Making a community more equitable would involve giving some groups things they don't deserve.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	8.6	32.6	28.0	30.7	0.1
KnowledgePanel (n = 4,050)	12.0	29.6	34.4	22.2	1.9
Total	11.7	28.6	34.0	24.2	1.6

C. If a community becomes 'equitable', the community will thrive, and everyone will win and be taken care of.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	29.0	39.6	21.3	10.1	0.0
KnowledgePanel (n = 4,050)	21.3	46.0	19.7	11.3	1.8
Total	22.6	45.4	19.4	11.1	1.5

D. Making a community more equitable means addressing the history of discrimination that has affected some groups more than others.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	30.8	35.1	18.3	15.7	0.0
KnowledgePanel (n = 4,050)	24.3	38.6	19.9	15.4	1.8
Total	25.3	38.3	19.8	15.1	1.5

SOURCE: RAND and RWJF

We next ask about the community in which you live.

32. How would you rate the wellbeing of the community in which you live?

Sample	Excellent	Very good	Good	Fair	Poor	Missing
ALP (n = 1,570)	6.4	37.5	36.8	16.0	3.3	0.0
KnowledgePanel (n = 4,050)	9.1	35.6	37.7	14.1	3.0	0.5
Total	8.9	34.8	38.3	14.2	3.3	0.5

SOURCE: RAND and Metropolitan Group.

33. Please rate the extent to which the following statements are true about the community in which you live.

A. Everyone in my community has access to needed health care and services.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	7.3	40.2	41.8	10.8	0.0
KnowledgePanel (n = 4,050)	8.7	34.9	43.3	11.0	2.0
Total	9.0	34.4	43.8	11.2	1.7

B. Everyone in my community can access healthy foods at affordable prices.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (<i>n</i> = 1,570)	14.4	47.1	31.3	7.1	0.0
KnowledgePanel (<i>n</i> = 4,050)	15.7	39.8	32.6	10.0	1.9
Total	16.0	39.9	32.5	10.1	1.5

C. Everyone in my community has access to safe drinking water.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (<i>n</i> = 1,570)	3.6	18.1	29.9	48.4	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.1	16.6	33.6	43.8	1.8
Total	4.2	16.3	34.1	43.9	1.5

D. My community has safe outdoor places to walk and be physically active.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (<i>n</i> = 1,570)	3.4	18.4	38.0	40.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.9	22.8	33.2	37.2	1.8
Total	5.1	22.2	33.4	37.7	1.6

E. My community has decent and affordable housing available for everyone.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (<i>n</i> = 1,570)	31.6	38.6	23.9	6.0	0.0
KnowledgePanel (<i>n</i> = 4,050)	23.9	43.7	23.5	6.6	2.3
Total	24.5	43.7	23.5	6.5	1.8

F. My community has public transportation, sidewalks for walking, and bike lanes available so people don't always have to rely on cars.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (<i>n</i> = 1,570)	16.6	34.4	25.7	23.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	18.4	36.2	27.5	15.9	2.0
Total	18.2	35.9	27.4	16.9	1.6

G. My community celebrates diversity.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (<i>n</i> = 1,570)	9.9	46.4	32.1	11.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	13.6	41.9	31.1	10.3	3.0
Total	13.7	41.5	31.1	11.1	2.5

H. My community hosts community-wide celebrations that represents all community members.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	18.1	38.4	30.0	13.4	0.0
KnowledgePanel (n = 4,050)	18.5	35.2	29.1	14.6	2.6
Total	18.4	35.4	29.0	15.2	2.1

I. There is a high level of trust among members of my community.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	11.8	44.4	33.4	10.4	0.0
KnowledgePanel (n = 4,050)	13.6	45.5	31.5	6.8	2.5
Total	13.3	45.4	32.2	7.1	2.0

J. Members of my community help and support each other, especially in times of need.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	9.5	40.4	38.2	11.8	0.1
KnowledgePanel (n = 4,050)	10.0	42.1	34.9	10.5	2.6
Total	9.6	41.5	35.5	11.2	2.2

K. Members of my community know each other.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	12.2	57.1	24.4	6.3	0.0
KnowledgePanel (n = 4,050)	13.4	53.4	25.9	4.8	2.5
Total	12.8	52.8	27.0	5.4	2.0

L. Members of my community are willing to work together to improve health.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	20.1	51.1	24.1	4.7	0.0
KnowledgePanel (n = 4,050)	15.8	53.0	23.6	4.7	2.9
Total	15.3	52.8	24.5	5.0	2.4

M. Members of my community have a say in budgets and policy decisions.

Sample	Not at all	Somewhat	Mostly	Completely	Missing
ALP (n = 1,570)	28.6	47.3	18.9	5.2	0.0
KnowledgePanel (n = 4,050)	24.7	49.8	18.5	4.0	3.0
Total	24.8	49.4	18.7	4.7	2.5

SOURCE: RAND Developed.

34. There are many activities that a person could do to influence their community. During the past year have you:

A. Served as an elected appointee or official.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	4.4	95.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.5	93.9	1.6
Total	4.9	93.7	1.4

B. Voted for or against a candidate for public office because of his/her position on a health problem or issue.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	41.3	58.7	0.0
KnowledgePanel (<i>n</i> = 4,050)	30.9	67.2	1.9
Total	33.5	64.9	1.6

C. Voted for or against a candidate for public office because of his/her position on issues such as education, public safety, or community funding.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	60.7	39.3	0.0
KnowledgePanel (<i>n</i> = 4,050)	45.2	52.9	2.0
Total	48.3	50.1	1.7

D. Contributed time or money to an organization working to pass a health policy or law at the local, state, or national level.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	19.0	81.0	0.0
KnowledgePanel (<i>n</i> = 4,050)	11.5	86.6	1.9
Total	13.7	84.7	1.6

E. Lobbied or advocated for a health-related cause in your community.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	14.1	85.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	12.4	85.6	1.9
Total	13.8	84.5	1.7

F. Attended a civic meeting or worked with neighbors to fix community problems.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	17.0	83.0	0.0
KnowledgePanel (<i>n</i> = 4,050)	14.2	83.6	2.2
Total	16.5	81.6	1.9

G. Volunteered with an organization working to improve the health and wellbeing of those in your community.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	21.2	78.7	0.1
KnowledgePanel (<i>n</i> = 4,050)	16.7	81.2	2.0
Total	18.2	80.0	1.8

H. Donated money, goods, or resources to an organization improving the health and wellbeing of those in your community (e.g., food, clothing drive).

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	62.6	37.4	0.0
KnowledgePanel (<i>n</i> = 4,050)	47.2	50.5	2.4
Total	50.2	47.8	2.0

I. Helped a neighbor who was struggling.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	52.4	47.5	0.1
KnowledgePanel (<i>n</i> = 4,050)	45.0	53.0	2.0
Total	46.5	51.7	1.8

J. Supported local businesses.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	84.3	15.7	0.0
KnowledgePanel (<i>n</i> = 4,050)	75.9	22.0	2.1
Total	77.1	21.2	1.8

K. Participated in a community-wide event.

Sample	Yes	No	Missing
ALP (<i>n</i> = 1,570)	49.1	50.9	0.0
KnowledgePanel (<i>n</i> = 4,050)	40.9	56.7	2.5
Total	43.1	54.8	2.1

SOURCE: Harvard School of Public Health, 2011; Civic Health Index. Revised by RAND.

35. Whether or not you have taken action to improve health in your community, many people face barriers to getting involved. Thinking about the following statements, please rate the extent to which you think this has been a barrier for people in your community (not a barrier to a major barrier).

A. People don't know how to get involved or where to start.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (<i>n</i> = 1,570)	6.4	10.1	36.1	32.7	14.6	0.0
KnowledgePanel (<i>n</i> = 4,050)	7.4	11.8	44.2	21.0	13.3	2.3
Total	7.0	11.8	43.3	22.3	13.6	1.9

B. People don't think their involvement will really make a difference in changing the health of the community.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (<i>n</i> = 1,570)	4.7	13.4	32.3	31.3	18.3	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.8	8.6	37.5	28.0	18.4	2.7
Total	4.5	8.6	36.1	29.6	19.0	2.2

C. People have offered suggestions in the past, but nothing happens as a result.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (<i>n</i> = 1,570)	6.3	17.4	41.0	21.2	14.1	0.0
KnowledgePanel (<i>n</i> = 4,050)	5.3	11.9	44.3	21.9	13.6	3.1
Total	5.2	12.4	42.8	22.6	14.4	2.6

D. People are focused on other issues.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (<i>n</i> = 1,570)	2.9	17.5	35.9	28.0	15.7	0.0
KnowledgePanel (<i>n</i> = 4,050)	3.6	6.9	40.0	28.3	18.1	3.1
Total	3.5	7.9	38.0	29.7	18.3	2.6

E. People don't have time or energy.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (<i>n</i> = 1,570)	10.2	10.0	30.7	25.9	23.2	0.0
KnowledgePanel (<i>n</i> = 4,050)	4.2	7.5	35.7	28.6	21.3	2.8
Total	4.4	8.0	34.3	29.3	21.7	2.4

F. People are worried about intimidation or threats by others in the community.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (n = 1,570)	25.5	21.6	26.9	15.3	10.6	0.0
KnowledgePanel (n = 4,050)	20.0	21.7	32.0	13.9	9.4	3.0
Total	20.2	22.5	30.5	14.2	10.0	2.5

G. People assume others will take care of it.

Sample	1 (Not a barrier at all)	2	3	4	5 (Major barrier)	Missing
ALP (n = 1,570)	10.3	5.4	28.0	26.7	29.5	0.0
KnowledgePanel (n = 4,050)	3.7	6.3	31.9	29.4	26.0	2.8
Total	3.7	6.5	29.9	29.9	27.7	2.3

SOURCE: RAND and RWJF.

Note items in Q36 are randomized/

36. The next few questions are about climate change. How much do you agree or disagree with each of the following statements?

A. Climate change impacts health.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	44.3	35.1	10.9	9.7	0.0
KnowledgePanel (n = 4,050)	34.3	35.4	14.8	14.0	1.4
Total	35.6	35.3	14.6	13.2	1.3

B. Climate change is harming/will harm my community.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	35.3	32.6	19.0	13.0	0.0
KnowledgePanel (n = 4,050)	28.1	35.9	18.0	16.4	1.6
Total	29.0	35.1	18.2	16.1	1.5

C. Businesses should do more to address climate change.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	39.5	36.6	13.8	10.1	0.0
KnowledgePanel (n = 4,050)	33.5	33.1	15.7	15.9	1.7
Total	34.2	33.8	15.4	15.0	1.6

D. Communities should do more to address climate change.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	35.8	36.3	16.5	11.4	0.0
KnowledgePanel (n = 4,050)	32.6	35.5	14.9	15.5	1.6
Total	32.4	36.0	15.1	15.0	1.5

E. The government should do more to address climate change.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	44.7	29.7	12.2	13.2	0.3
KnowledgePanel (n = 4,050)	43.4	25.6	12.0	17.2	1.7
Total	42.9	26.4	12.4	16.7	1.6

F. Climate change is just one of the challenges our society faces. We can't spend all of our time on it.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	18.6	38.7	28.8	13.8	0.1
KnowledgePanel (n = 4,050)	23.8	40.6	22.2	11.3	2.1
Total	23.2	39.8	23.1	12.1	1.8

G. Our current policies and law as written are doing enough to address climate change.

Sample	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Missing
ALP (n = 1,570)	11.8	26.8	25.9	35.4	0.1
KnowledgePanel (n = 4,050)	14.3	25.9	29.8	28.0	2.1
Total	14.1	25.8	29.5	28.7	1.8

SOURCE: RAND and RWJF.

For the last question, we ask about your family background.

37. What is your race or ethnicity? Select all that apply and enter additional details in the spaces below. Note you may report more than group.

Sample	White	Hispanic or Latino	Black or African American	Asian	American Indian or Alaska Native	Middle Eastern or North African	Native Hawaiian or Pacific Islander
ALP (n = 1,570)	68.2	21.1	14.1	3.0	2.2	0.2	1.2
KnowledgePanel (n = 4,050)	67.2	18.6	13.2	5.5	1.9	0.7	0.4
Total	67.2	19.2	13.4	4.8	2.1	0.6	0.4

SOURCE: Recommended OMB change to Census 2030, ratified by National Academy committee on topic.

For **white** respondents, subgroups are below. Data are presented for combined sample only.
(n = 3,777)

Subgroup	%
German	42.8
Italian	10.3
Irish	32.8
Polish	11.3
English	47.3
French	12.0
Other	26.6

For **Hispanic or Latino** respondents, subgroups are below. Data are presented for combined sample only.
(n = 1,079)

Subgroup	%
Mexican or Mexican American	65.1
Salvadoran	2.8
Dominican	4.4
Puerto Rican	12.1
Cuban	3.7
Colombian	3.2
Other	14.5

For **Black or African American** respondents, subgroups are below. Data are presented for combined sample only.
(n = 753)

Subgroup	%
African American	85.3
Nigerian	3.7
Jamaican	4.2
Ethiopian	0.9
Haitian	4.2
Somali	0.7
Other	8.3

For **Asian** respondents, subgroups are below. Data are presented for combined sample only.
(*n* = 270)

Subgroup	%
Chinese	30.5
Vietnamese	6.3
Filipino	20.8
Korean	8.2
Asian Indian	19.6
Japanese	10.7
Other	10.0

For **Native American or Alaska Native** respondents (*n* = 118), 77.6% of sample offered tribal affiliation. Each tribal affiliation is under n=3, but largest group reported is Cherokee (n=19)

For **Middle Eastern or North African** respondents, subgroups are below. Data are presented for combined sample only.
(*n* = 34)

Subgroup	%
Lebanese	19.9
Syrian	22.5
Iranian	7.1
Moroccan	16.4
Egyptian	12.4
Israeli	21.4
Other	31.8

For **Native Hawaiian or Pacific Islander** respondents, subgroups are below. Data are presented for combined sample only.
(*n* = 22)

Subgroup	%
Native Hawaiian	37.3
Tongan	0.9
Samoan	11.6
Fijian	0.9
Chamorroan	0.9
Marshallese	5.5
Other	32.6

Other respondent demographics

Respondents by Age Group, in Years

Sample	18 to 24	25 to 44	45 to 64	65+
ALP (<i>n</i> = 1,570)	0.0	44.9	33.0	22.1
KnowledgePanel (<i>n</i> = 4,050)	10.9	35.0	32.0	22.1
Total	11.4	34.3	32.3	22.1

Respondents by Gender

Sample	Male	Female
ALP (<i>n</i> = 1,570)	48.7	51.3
KnowledgePanel (<i>n</i> = 4,050)	48.7	51.3
Total	48.7	51.3

Respondents by U.S. Region

Sample	Northeast	Midwest	South	West
ALP (<i>n</i> = 1,570)	21.9	20.4	33.2	24.4
KnowledgePanel (<i>n</i> = 4,050)	16.8	21.5	38.5	23.1
Total	16.7	20.9	38.5	23.9

Respondents by Education Level

Sample	Less Than High School	High School	Some College	College Graduate
ALP (<i>n</i> = 1,570)	6.1	33.0	26.2	34.7
KnowledgePanel (<i>n</i> = 4,050)	9.5	29.7	26.2	34.7
Total	9.6	29.5	26.2	34.7

Respondents by Marital Status

Sample	Married or Living with a Partner	Separated	Divorced	Widowed	Never Married
ALP (<i>n</i> = 1,570)	59.5	0.8	9.7	4.2	25.8
KnowledgePanel (<i>n</i> = 4,050)	51.0	1.7	10.1	4.1	33.2
Total	51.0	1.6	10.0	4.2	33.2

Respondents by Number of Household Members

Sample	1	2	3	4	5	6	7	8	9 or more
ALP (<i>n</i> = 1,570)	15.1	35.1	24.1	14.4	7.5	2.5	0.8	0.1	0.3
KnowledgePanel (<i>n</i> = 4,050)	15.1	35.1	19.6	16.6	7.8	3.3	1.2	0.5	0.6
Total	15.1	35.1	19.7	16.3	7.7	3.5	1.3	0.5	0.6

Respondents by Level of Family Income, in Dollars

Sample	Less Than 10,000	10,000–24,999	25,000–49,999	50,000–74,999	75,000–99,999	100,000 or More
ALP (<i>n</i> = 1,570)	6.9	12.4	15.7	18.0	13.2	33.7
KnowledgePanel (<i>n</i> = 4,050)	4.5	9.5	21.0	18.0	13.2	33.7
Total	4.8	9.5	20.8	18.0	13.2	33.7

Respondents' Work Status

Sample	Yes, currently employed	No, not currently employed
ALP (<i>n</i> = 1,570)	69.2	30.8
KnowledgePanel (<i>n</i> = 4,050)	60.8	39.2
Total	60.1	39.9

Abbreviations

ALP	RAND American Life Panel
BRFSS	Behavioral Risk Factor Surveillance System
CPS	Current Population Survey
MOE	margin of error
NSHA	National Survey of Health Attitudes
RWJF	Robert Wood Johnson Foundation
SCI	Sense of Community Index

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