

ICPSR 37633

National Survey of Health Attitudes, [United States], 2018

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User Guide

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National Survey of Health Attitudes Data Guide

2015 and 2018

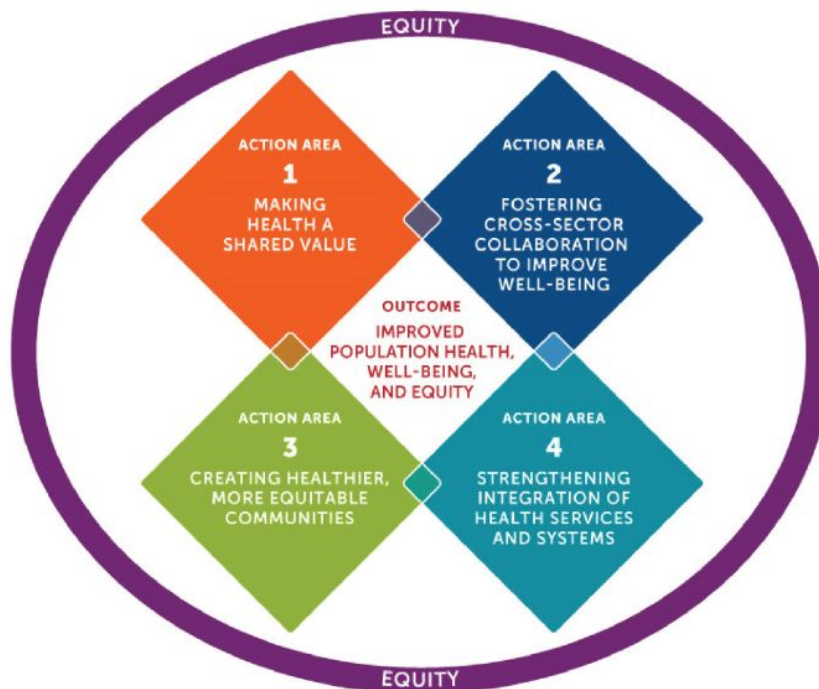
I. Introduction

About the Guide

This Data Guide is an overview of the [2015](#) and [2018](#) National Survey of Health Attitudes (NSHA) [United States] surveys with additional instructions for accessing the datasets. You can download it to your computer from the Health and Medical Care Archive ([HMCA](#)). NSHA users should refer to the 2015 [Final Report](#) (PDF) and 2018 [Final Report](#) (PDF), which provides greater detail on the topics discussed below.

Culture of Health Framework

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led the development of a pioneering national action framework to advance a "culture that enables all in our diverse



society to lead healthier lives now and for generations to come." Accomplishing these principles requires a national paradigm shift from a traditionally disease and health care-centric view of health toward one that focuses on well-being. Recognizing that paradigm shifts require intentional actions, RWJF worked with RAND researchers to design an actionable path to fulfill the [Culture of Health \(CoH\)](#) vision. The result was a framework consisting of four action areas, drivers within action areas, and a measurement strategy. A central piece of this work is the development of a

measurement strategy to assess constructs underlying a CoH. Many of the CoH measures were existing measures and were included in the set of CoH measures. For the RWJF's Culture of

Health action areas, data were available to guide the RWJF and RAND's work except for action area one, making health a shared value. Data for this action area was limited, particularly in the driver of mindset and expectations. The NSHA collects data on public perceptions of health as a shared value. These were the first principles of a CoH that RWJF identified. The RAND team was tasked with defining, operationalizing, and identifying measures for the CoH vision. They started with the ten underlying principles supporting the CoH framework:

1. Good health flourishes across geographic, demographic, and social sectors.
2. Attaining the best health possible is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible.
4. Business, government, individuals, and organizations work together to build healthy communities and lifestyles.
5. Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health.
6. No one is excluded.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. Keeping everyone as healthy as possible guides public and private decision making.
10. Americans understand that we are all in this together.

RWJF worked with RAND researchers to design an actionable path to fulfill the CoH vision. Figure 1.1 illustrates the action framework originally published by RWJF in 2015. It comprises four action areas: core areas across which investment and activity are needed to activate and cultivate a CoH broadly. Within each action area, there are drivers that indicate where the nation needs to accelerate change within those action areas specifically. These action areas and drivers work toward the outcome area of a CoH: improved population health, well-being, and equity. The outcome area is the key result of activities in each action area. More detail about the Action Framework and associated drivers and measures can be found in *Building a National Culture of Health* (Chandra et al., 2016) and *Moving Forward Together* (Plough et al., 2018).

About the Data

The NSHA is a survey that RWJF and RAND analysts developed and conducted as part of the foundation's CoH strategic framework. The foundation undertook this survey to measure critical constructs that were not measured in other data sources. Thus, the survey was not meant to capture the full action framework that informs CoH, but rather just selected measure areas. The questions in the surveys primarily addressed the action area *making health a shared value* by measuring the attitudes, values, and beliefs of a representative sample on issues related to the CoH. In 2018, the researchers fielded an updated version that included many of the same questions but added some new constructs of interest as part of the broader CoH effort. The surveys cover 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 in health, general views on equity and health equity, community well-being, and priorities for health relative to other social issues.

The initial motivation to develop and field the RWJF National Survey of Health Attitudes was to capture aspects of action area one, making health a shared value. The survey was used to collect data for three of the 35 national Culture of Health measures. All measures are associated with the action area making health a shared value. Although the survey offers more than these three measures to capture health attitudes and perspectives that will be key to the Culture of Health in future analyses, the researchers highlight the construction of those three measures here, as they align with 35 Culture of Health measures. Other information about the Culture of Health, including the Action Framework, details of all 35 national measures, technical reports, and additional information can be found at www.rwjf.org/cultureofhealth. A list of available documents and data files is available below.

Table 1. List of Available Documentation and Data Files for the 2015 survey

PART NUMBER	FILENAME	FILE DESCRIPTION
0001	37405-0001-Questionnaire.pdf	English version of the survey instrument
0001	37405-0001-Questionnaire-Spanish.pdf	Spanish version of the survey instrument
0001	37405-0001-Codebook-ICPSR.pdf	Describes the contents, structure, and layout of the ICPSR curated data collection
0001	37405-0001-Report.pdf	Final Report published by RWJF

Table 2. List of Available Documentation and Data Files for the 2018 survey

PART NUMBER	FILENAME	FILE DESCRIPTION
0001	37633-0001-Questionnaire-English.pdf	English version of the survey instrument
0001	37633-0001-Questionnaire-Spanish.pdf	Spanish version of the survey instrument
0001	37633-0001-Codebook-ICPSR.pdf	Describes the contents, structure, and layout of the ICPSR curated data collection
0001	37633-0001-Codebook-PI.pdf	PI description of the contents, structure, and layout of the data collection
0001	37633-0001-Report.pdf	Final Report published by RWJF

II. Methodology

The survey design process included four steps. First, the researchers reviewed relevant literature and surveys to identify potential measures and survey items and to understand the underlying concepts related to these drivers. Second, they conducted a series of meetings as a collaborative team with RAND staff, RWJF, and NORC at the University of Chicago to discuss survey content. The NSHA focused on capturing individual values about health and well-being and how they relate to personal behaviors. Third, they drew on findings from broader stakeholder-engagement efforts undertaken as part of the more extensive CoH development. Lastly, they conducted cognitive testing and a brief pilot test of the survey before fielding the survey.

Sample

For the 2015 survey, the researchers collected data through the American Life Panel (ALP) and the KnowledgePanel from GfK Custom Research (now part of Ipsos) via probability-based sampling methods. The surveys were administered between March 13, 2015 through April 14, 2015. The two survey efforts combined resulted in a final total sample of 11,555 completed surveys, 3,407 from the ALP and 8,148 from the KnowledgePanel.

In 2018, the panel members for the ALP and the KnowledgePanel were similarly recruited via probability-based sampling methods. The surveys were fielded from July 11, 2018 through July 24, 2018. The two survey efforts combined resulted in a final total sample of 7,187 completed surveys, 2,479 from the ALP and 4,708 from the KnowledgePanel. The sample for the ALP survey was limited to panel members who had participated in the 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 2018 survey.

Note that the sample from the 2018 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 the 2015 survey were invited to participate in the 2018 survey. The KnowledgePanel sample was not restricted in this way. The 2018 ALP survey was left open for respondents longer than the 2018 KnowledgePanel survey to maximize the number of respondents who responded to the 2015 survey.

III. Data Elements

Variables

The 2015 survey contained 22 questions and the 2018 survey contained 34 questions, both containing sub-questions or multiple parts. Variables are constructed with the question number and an abbreviation of the question being asked. For example, question 1, which asks about access to affordable health care, is listed as “Q01_ATAHC”. Several variables in the 2018 data contain missing values of 999 and -2. However, these values do not have any cases.

Demographics data comes from panel-side data collection. These demographic variables have all been harmonized and use classifications that are consistent across both surveys. The information includes age, gender, education, marital status, household size, family income, employment, and ethnicity.

Weights

The weighted samples represent the non-institutionalized adult population across all 50 states and the District of Columbia. To make the sample representative of the overall population, the researchers used weighting, a statistical adjustment. A raking algorithm following the methods described in Deming (1943) and Deville, Särndal, and Sautory (1993) was used to create weights to allow users to align the distribution of sample characteristics to the distribution of characteristics of the population from the 2014 and 2018 Current Population Survey (CPS) [U.S. Census Bureau]. Sample proportions were aimed to match on interactions of gender and race and ethnicity, gender and education, gender and age, household income interacted with household size, and an indicator for metropolitan or nonmetropolitan areas. To calculate the weights, two samples were combined and matched with the distribution of characteristics of the pooled sample to the distribution of the CPS. In other words, the weighting procedure treated observations from the two panels as equivalent. The researchers have not adjusted these weights to reflect how the panelists were originally recruited to the panel. The calculation of weights follows the standard weighting procedure used by the ALP, more information is available in Pollard and Baird 2017.

Combining Data from Two Samples

The researchers combined data from the ALP and KnowledgePanel. To assess the appropriateness of combining these data, they took several steps. First, they 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, they compared responses across the two surveys. The demographic characteristics of the survey respondents differ, primarily because the ALP's oversample of vulnerable populations, so the overall responses in the two panels differ as one would expect. To test the feasibility of combining the two samples, the study team assessed systematic differences between responses to the two surveys, after controlling for demographic characteristics, and found no meaningful differences. Finally, differences in mode of survey were assessed. Although both panels were conducted over the Internet, a respondent might have used a computer, tablet, or smartphone to respond to surveys. No systematic bias across the two surveys by mode were found to be present. As a result, a decision was made to pool the two panels into one. More information on the variable summaries for each individual panel can be found in *Chapter Three: Top-Line Summary Data* of the final reports. .

IV. How to Obtain Data and Documentation Files

ICPSR Public-Use Data

The NHSA surveys are available for public-use. Public-use data, which constitute the majority of ICPSR's holdings, are those for which disclosure risk to research participants and of confidential information is minimal. When necessary, ICPSR protects respondent confidentiality by removing, masking, and/or collapsing variables in the deposited data to produce a public-use version of the dataset.

ICPSR Restricted-Use Data

The NHSA surveys have a restricted-use data set that can be accessed following our application process. Restricted-use data are distributed in cases when removing potentially identifying information would significantly impair the analytic potential of the data, or in cases where data contain highly sensitive personal information and cannot be shared as a public-use file. In these circumstances, ICPSR provides access to a restricted-use version that retains the confidential data but requires controlled conditions for accessing them. Access is only granted following an application process during which researchers agree to follow strict legal and electronic requirements for maintaining data confidentiality. More information on accessing restricted data at ICPSR can be found [here](#).

First Steps Toward Obtaining Your Analytic File

Before downloading the data or beginning analysis, it is important for the user to become familiar with the NSHA Final Reports (PDF) and Questionnaires (see Table 1 and 2). This documentation provides technical support to users of the data. ICPSR is committed to preserving the archival holdings of HMCA in perpetuity.

Downloading Data and Documentation from HMCA

The datasets and documentation are made available through RWJF's Health and Medical Care Archive (HMCA) within the Inter-University Consortium for Political and Social Research at the University of Michigan.

Researchers interested in downloading analysis-ready data and documentation files can do so free of charge through the [HMCA website](#). In order to download data, you will need to [create an account](#). Data is available in four formats: SAS, SPSS, STATA, and R. Raw ASCII data are also provided with accompanying setup (syntax) files. Documentation is provided in PDF format. To download the NSHA data and/or documentation, researchers must agree to the [Terms of Use](#). If requesting access to the restricted-use data, an application will have to be processed and reviewed. Once approved, the data will be sent in the mode selected in your application. To download the public-use files, select the [Data & Documentation](#) tab. Click on the Download tab drop-down menu and choose the data format you would like to download.

To review the study information on the study homepage without downloading files directly, log in to your MyData account and select the preview icon for any public-facing documentation such as a Codebook or User Guide. To review variables of interest, select the [Variables](#) tab next to the **At A Glance** and **Data & Documentation** tabs to begin searching for keywords or variables of interest. This study page has online analysis capabilities available to members only by using the Survey Documentation Analysis (SDA) feature. To take advantage of this tool, log in to your MyData account and select **Analyze Online** next to the **Download** tab at the top of the study home page.

VI. Learn more

Citing Data

It's important to **cite data right**. Proper citation ensures that research data can be discovered, reused, replicated for verification, credited for recognition, and tracked to measure usage and impact.

Citing data is straightforward. Each citation must include the basic elements that allow a unique dataset to be identified over time including author, title, distributor, date, version, and persistent identifier (such as the Digital Object Identifier, Uniform Resource Name URN, or Handle System).

For more help with citations, please visit the [ICPSR resource page](#) on citing data.

Publications Based on Data

Users of ICPSR data are required to send us bibliographic citations for each completed manuscript or thesis abstract. This allows us to provide funding agencies with essential information about use of archival resources and facilitates the exchange of information about the research activities of principal investigators.

Email bibliography@icpsr.umich.edu to submit citations for inclusion in our Bibliography.

Additional Resources

- [HMCA Website](#)
 - [HMCA FAQs](#)
- [ICPSR Abbreviated bibliography of NSHA-based publications](#)
- Questions regarding this Data Guide or NSHA data files? Email [HMCA](#).

Acknowledgments

This Data Guide was prepared by [MASKED BY ICPSR] using NSHA documentation. It was developed for the Health and Medical Care Archive (HMCA), a project supported by the Robert Wood Johnson Foundation (RWJF). HMCA is housed within the Inter-university Consortium for Political and Social Research (ICPSR).

VII . References

1. Carman, Katherine Grace, et al. "Development of the Robert Wood Johnson Foundation National Survey of health attitudes." Santa Monica: RAND Corporation (2016).
2. Carman, Katherine Grace, et al. "2018 National Survey of Health Attitudes." Santa Monica: RAND Corporation (2019).