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

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Final Report

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SOCIAL AND ECONOMIC WELL-BEING

2018 National Survey of Health Attitudes

Description and Top-Line Summary Data

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Preface

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led a pioneering effort to advance a Culture of Health that “enables all in our diverse society to lead healthier lives, now and for generations to come” (Plough et al., 2015). Together with the RAND Corporation, RWJF developed an Action Framework and selected 35 measures to advance these goals. The Action Framework and measures were selected as a means of defining, operationalizing, and measuring the United States’ progress toward this goal.

As part of the work to track progress in building a Culture of Health, 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 2018 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 is organized similarly for consistency. Other information about the Culture of Health vision, including the Action Framework and measure detail, technical reports, and other information, can be found at www.cultureofhealth.org (RWJF, undated).

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 about a Culture of Health. Given that RWJF is focused on using the Action Framework and measures to catalyze a national dialogue about approaches and investments to improve population health and well-being, 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 sponsored by the Robert Wood Johnson Foundation and conducted within RAND Social and Economic Well-Being. Anita Chandra led this research study with a large, diverse team of RAND researchers. Questions about the report can be directed to Chandra@rand.org.

RAND Social and Economic Well-Being is a division of the RAND Corporation that seeks to actively improve the health and social and economic well-being 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, 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 well-being. For more information, email chep@rand.org.

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Summary

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led a pioneering effort to advance a Culture of Health that “enables all in our diverse society to lead healthier lives, now and for generations to come” (Plough et al., 2015). Together with the RAND Corporation, RWJF developed an Action Framework and selected measures to advance these goals. The Action Framework and 35 measures were selected as a means of defining, operationalizing, and measuring the United States’ progress toward this goal.

This report describes the 2018 RWJF National Survey of Health Attitudes, which RWJF and RAND researchers developed and conducted as part of the foundation’s Culture of Health vision. This survey was designed to measure whether the views and perceptions of a nationally representative sample of people living in the United States are aligned with the ideas set forth in the Action Framework, including drivers of health and well-being and the role of health equity. An earlier version of this survey was conducted in 2015. In 2018, we fielded an updated version that included many of the same questions but added some new constructs that were of interest as part of the larger Culture of Health effort. This 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). Other information about the Culture of Health, including the Action Framework, details about all 35 national measures, technical reports, and other information, can be found at www.cultureofhealth.org (RWJF, undated).

The questions in the 2018 survey were intended to measure the attitudes, values, and beliefs of a representative sample on issues related to the Culture of Health. The survey covers 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.

In particular, the survey was fielded to collect data for three of the Culture of Health measures. 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. However, in some cases, we had to modify existing questions or develop new questions because there is limited work that captures the health values, particularly outside of health care. The resulting survey contained 34 questions, some with subquestions or multiple parts. The median time to complete the survey was between 18 and 19 minutes.

Using methods comparable to those used in the 2015 survey, we collected data via the RAND American Life Panel (ALP) and the KnowledgePanel (which was administered at the time by GfK Custom Research but has since been sold to Ipsos). Both panels are nation-

ally 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 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. 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 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 2018 Current Population Survey (U.S. Census Bureau, 2018). We combined the results from the two panels and calculated weights to make the combined panel representative of the population. We calculated the margin of error based on the 95-percent confidence interval. The margin of error for the full sample ranges from 0.35 percent to 1.35 percent, for proportions near 1 percent and 50 percent, respectively.

This report describes three measures created from these survey data that are part of the 35 national Culture of Health measures (described in more detail at www.cultureofhealth.org [RWJF, undated]). These measures are whether respondents (1) recognized the influence of social and physical factors on health, (2) valued investment in community health, and (3) had a sense of community or community connection. We were unable to identify any existing surveys that explicitly addressed the first two measures, which are critical constructs in the Culture of Health Action Framework. As a result, we developed new items to measure these constructs. For the third measure—a sense of community or community connection—a validated survey instrument existed, but it had not been measured in a national survey prior to our 2015 survey. Results from the 2018 survey indicated that 36.5 percent of adults recognized a strong or very strong influence of social and physical factors on health, 28.3 percent did not consider investment in community health a top priority, and 11.1 percent reported strong sense of membership in their community and 19.4 percent reported a strong emotional connection to their community.

This report concludes with 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.

Acknowledgments

We appreciate reviews of Scott Keeter (independent) and Kirsten Becker (RAND). We thank Larry L. Bye, Alyssa Ghirardelli, and Angela Fontes from NORC at the University of Chicago for their contributions to the survey design process. We also thank the survey participants, who offered their perspectives on health and well-being issues in the United States.

Abbreviations

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

Introduction to Culture of Health

Since 2013, the Robert Wood Johnson Foundation (RWJF) has led a pioneering effort to advance a Culture of Health that “enables all in our diverse society to lead healthier lives, now and for generations to come” (Plough et al., 2015). Together with the RAND Corporation, RWJF developed an Action Framework and selected measures to advance these goals. The Action Framework and 35 measures were selected as a means of defining, operationalizing, and measuring the United States’ progress toward this goal. This report describes the 2018 RWJF National Survey of Health Attitudes, a survey that RWJF and RAND researchers developed and conducted as part of the foundation’s Culture of Health vision. This survey was designed to measure whether the views and perceptions of a nationally representative sample of people living in the United States are aligned with the ideas set forth in the Action Framework.

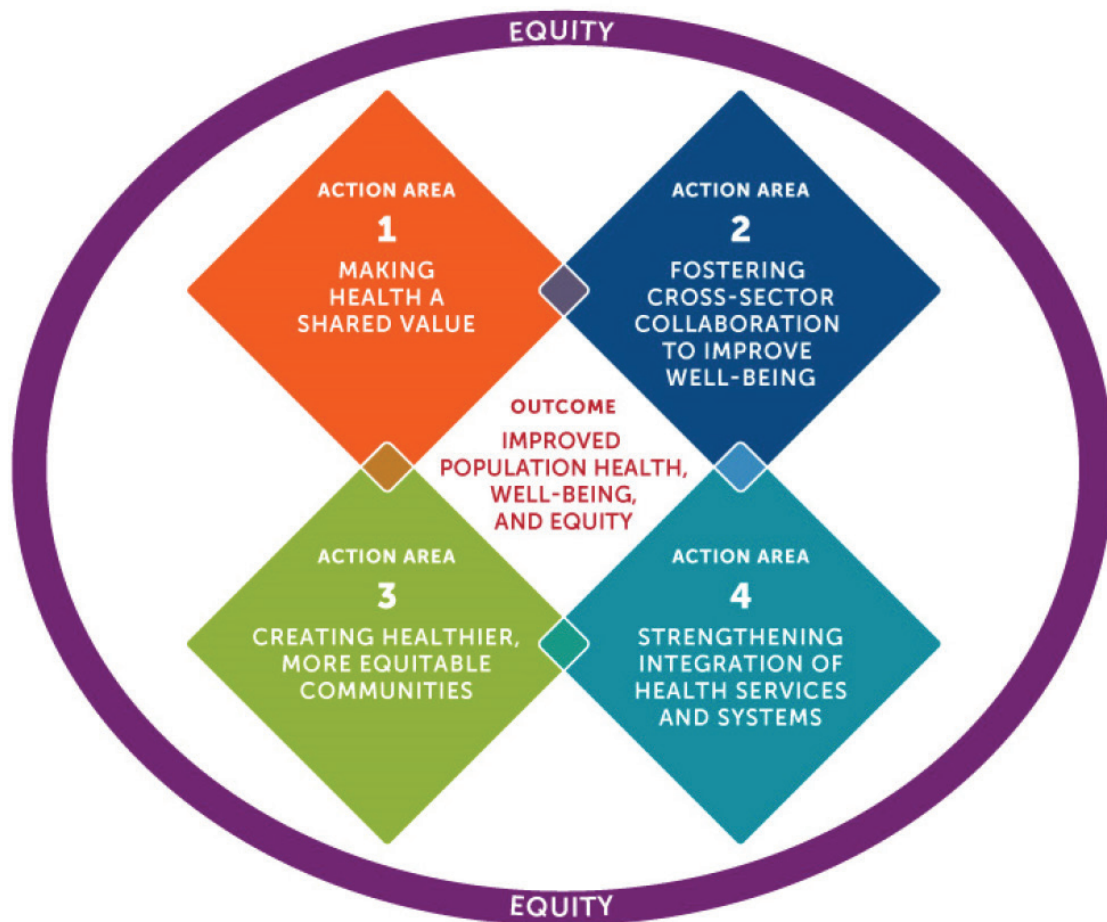
In this chapter, we provide an introduction to the Culture of Health Action Framework. Fulfilling the principles set forth in the Action Framework requires a national paradigm shift from a traditionally disease- and health care–centric view of health toward one that focuses on well-being. Recognizing that paradigm shifts require intentional actions, RWJF worked with RAND researchers to design an actionable path to fulfill the Culture of Health vision. The result is a framework consisting of four interconnected action areas, drivers within each action area, and a set of illustrative measures to track the United States’ progress in building a Culture of Health. RWJF published the framework in 2015 (Plough et al., 2015), and RAND published an associated technical report in 2016 (Chandra et al., 2016). Figure 1.1 illustrates the Action Framework.

Brief Overview of the Action Framework and Measurement

The Action Framework comprises four *action areas*: core areas across which investment and activity are needed to activate and cultivate a Culture of Health 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 Culture of Health: *improved population health, well-being, and equity*. The outcome area is the key result of activities in each action area. We briefly outline each action area below. The detailed literature reviews that motivated the selection and development of these areas are described in the earlier referenced technical report (Chandra et al., 2016).

Action Area 1 in the Action Framework calls for *making health a shared value*. This action area is the primary focus of the survey described in this report. We identified three drivers for this action area: (1) mindsets and expectations (how the American public views health and

Figure 1.1
Culture of Health Action Framework



SOURCE: Robert Wood Johnson Foundation.

well-being, 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 well-being topics). Action Area 1 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. Achievements in this action area 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 well-being of others.

Action Area 2 concerns *fostering cross-sector collaboration to improve well-being*. It highlights the need for true collaboration and integration of assets to promote health across traditional health, social, business, economic, and environmental infrastructures. Action Area 2 involves understanding how the systems that support individual and population health operate and how they could be improved and coordinated to operate more effectively. This action area includes three drivers: the number and quality of partnerships, the investment in partnerships, and the policies that support partnership and collaboration.

Action Area 3 involves *creating healthier, more equitable communities*. It focuses attention on the need to support residents of all communities to reach their best possible health potential by leveraging the resources of the social and physical environments in which they live, learn, work, and play. By drawing on the value placed on health (Action Area 1, *making health a shared value*) and on cross-sector partnerships for well-being (Action Area 2, *fostering cross-sector collaboration to improve well-being*), strategies in Action Area 3 will capitalize on people's opportunities for healthy choices. This action area includes three drivers: the built and physical environment, the social and economic environment, and related policies and governance that support healthier communities.

Action Area 4 focuses on *strengthening the integration of health services and systems*. This action area ensures individuals' access to high-quality, efficient, and integrated systems of public health, health care, and social services that can meet the health needs of a diverse U.S. population across the life span and across the "health span" (i.e., from sick to well). Action Area 4 emphasizes general access to and equal opportunity for health care, public health, and social services as essential contributors to health and well-being. Further, it addresses the system-level balance and integration and changes that must occur in public health and health care to create an efficient, interdependent system of health and social services. This action area includes three drivers: access to care, consumer experience, and balance and integration of health services.

At the intersection of these four action areas in Figure 1.1 is the outcome of a Culture of Health: *improved population health, well-being, and equity*. We expect to see improvements in access to care and population health outcomes, economic benefits, and indicators that well-being and productivity are flourishing within all demographic, social, and geographic populations. As a result, we also expect that changes in these outcomes will reinforce the value of health and health care, increasing the value people place on health for all in the United States, and the importance of multisector partnerships and changes to achieve the value proposition. In this sense, the action and outcome areas of the Culture of Health Action Framework are fully interactive.

Within each action area, we selected measures to provide further insight into the definition of the action areas and drivers and to provide examples of guidance in operationalizing the action areas. Over time, these measures can help assess the United States' progress toward this goal. Whenever possible, we drew from existing data, but, in many cases, we found either that previous research had not considered these concepts or that nationally representative data have not been collected.

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).

Road Map for This Report

This report describes the latest results from a series of national surveys called the RWJF National Survey of Health Attitudes, which was designed to assess particular constructs underlying Action Area 1: *making health a shared value*. Surveys were fielded in 2015 and 2018. As described above, where possible, we drew from existing data for the Culture of Health measures. However, in the context of making health a shared value, there were large gaps in our

understanding of the perspectives of individuals living in the United States. This survey was developed to address these gaps.

This survey included questions drawn from previous work and new questions developed to measure concepts not previously considered in the literature. These constructs were originally developed and measured in a 2015 survey, described in Carman et al. (2016). In 2018, we developed and fielded an updated survey containing these measures and a variety of new questions, to track changes over time and to address a new set of related questions.

In addition to describing the survey development for the 2018 survey, this report also provides the survey top-line data but does not provide analyses of trends or other analyses of subpopulations. Those findings will be presented elsewhere, including in peer-reviewed journal articles in development and on the Culture of Health website that RWJF maintains (www.rwjf.org/cultureofhealth [RWJF, undated]). As noted earlier, this report draws heavily on the report written to describe the 2015 survey (Carman et al., 2016), for consistency over time.

Survey Overview

We developed the 2015 survey and our updated 2018 survey to understand national perspectives related to the Culture of Health, with a primary focus on the action area *making health a shared value*. To understand the extent to which health is a shared value among adults in the United States, data about attitudes and values are needed. In many cases, these data were not available at the national level. Thus, primary data collection was needed. We identified the three areas where there were particular gaps, and a central goal of this survey was to measure the following for the action area *making health a shared value*: whether respondents (1) recognized the influence of social and physical factors on health, (2) valued investment in community health, and (3) had a sense of community or community connection. The survey also included other items related to the outcome of well-being, primarily to test items and to explore correlates of mindsets and expectations.

The survey 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, community well-being, and priorities for health relative to other social issues.

Survey Design Process

Our survey design process included four steps. First, we identified new or revised constructs to include in the 2018 survey, as well as content that could be omitted from the 2015 survey instrument. In doing so, we drew on findings from broader stakeholder-engagement efforts undertaken as part of the larger Culture of Health development (Acosta et al., 2016; Martin et al., 2017). Second, we reviewed relevant literature and surveys to identify potential measures and survey questions. Third, we conducted a series of meetings as a collective team with RAND staff, RWJF, and NORC at the University of Chicago to discuss survey content. Fourth, we conducted cognitive testing and a brief pilot test of the survey.

Selection of Key Constructs to Measure

In updating the survey, we began by reviewing our last National Survey of Health Attitudes, fielded in 2015. The 2015 survey 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.

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?

Table 2.1 documents the theoretical framework of outcomes and domains that we used to develop the 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, particularly in Action Area 1, *making health a shared value*. 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.

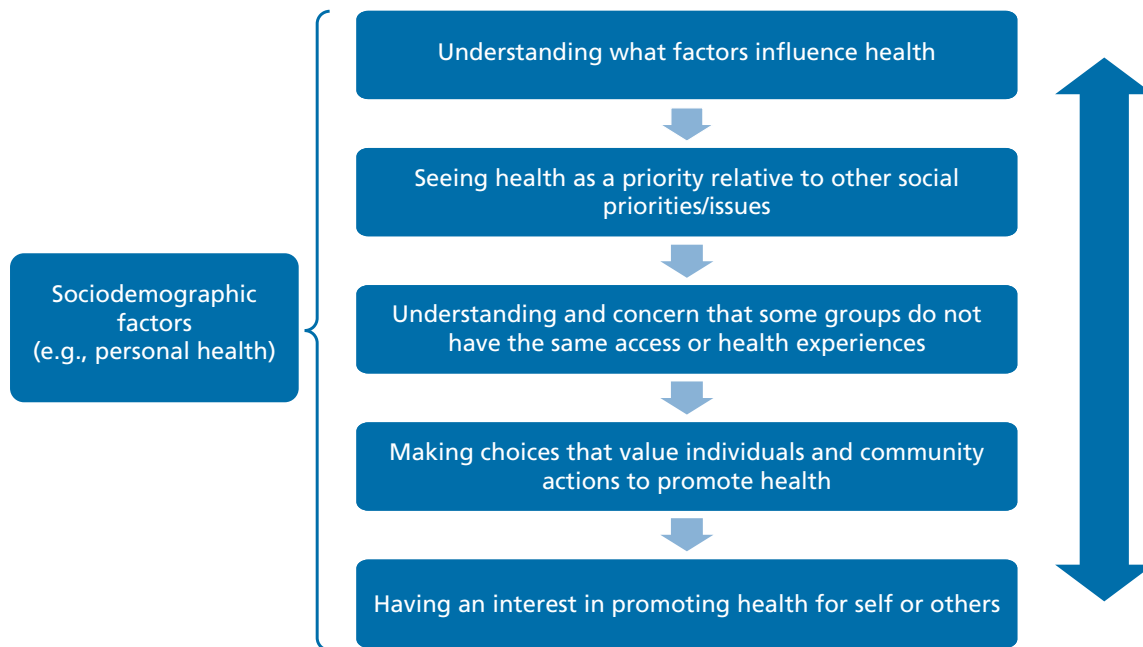
We also developed a flow chart (Figure 2.1) that describes the likely progression of attitudes that we would expect to see if America is moving toward a Culture of Health. We note that this is not always a linear model, as some changes in views and attitudes may be larger than other and that there may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

Finally, we were particularly interested in understanding how people think about health equity. 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

Table 2.1
Domains to Measure Whether We Are Moving Toward a Culture of Health: Assessing Action Area 1, Making Health a Shared Value

Expectations to Track <i>Over time in a Culture of Health, more U.S. adults would:</i>	Domains <i>What are the types of things we need to know to assess whether this expectation is being met?</i>
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	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 Perceptions of the role of personal responsibility
Value and prioritize individual, family, and community health and well-being	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
Take action regularly to promote personal and community health and well-being	Community well-being/health—quality of own community health, interest in investing in community well-being, willingness to pay, etc. Change agents and action on health
Understand and value health equity as a goal and work toward this goal through the activities of individuals and institutions	General views on equity and health equity, solidarity, health care as a right, and a right to health promotion services, amenities, etc.
Experience less burdened interactions with health systems based on better system integration and coordination of care	Expectations of the system Health status and experience with health and importance/value of health for individuals, family, and community

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



income, others race and ethnicity or urban rural geographies. We used 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, p. 1)

Literature Review

We reviewed literature to identify any current nationally representative data related to the three drivers for making health a shared value. If such data were not available, we worked to identify survey instruments addressing these concepts.

Topics searched included social and physical influences on health (e.g., peer, family, neighborhood, and workplace drivers of health); values related to national and community investment for health and well-being; behaviors around health and well-being, including civic engagement on behalf of health; and the role of community engagement and sense of community in relation to health attitudes and values. We also considered research and perspectives on relationships between the concepts, such as political sentiment and health interdependence or well-being and a sense of community. For the literature review, 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 & well-being*
- *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 well-being*
- *well-being and government spending*
- *society and empathy*
- *government influence on health.*

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 & rights*
- *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 this survey design, we abstracted data, surveys, and concepts from the review. In addition, we reviewed surveys, concept scales, and model questionnaires previously known to the team. 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 the *making health a shared value* action area, with a particular but not exclusive focus on the mindsets and expectations driver.

When specific measures were not available, we identified core concepts that we wanted to capture based on literature underlying the three drivers. We then organized these findings in a measurement list to identify where we had robust measures and where there were concepts in the Action Framework not addressed by existing measures. The list included a measure

Table 2.2
Surveys Reviewed During Survey Development

Survey	Developer (Citation)	Most Recent Year of Survey
America's Health Agenda: Priorities and Performance Rating Survey	Harvard School of Public Health (Harvard School of Public Health, 2011)	2011
American Health Values Segmentation Study	NORC (NORC, 2015)	2015
American National Election Studies Time Series Study	American National Election Studies (American National Election Studies, 2009)	2012
American Time Use Survey	U.S. Bureau of Labor Statistics (U.S. Bureau of Labor Statistics, 2014)	2014
Behavioral Risk Factor Surveillance Survey (BRFSS)	Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 2009)	2014
Better Life Index	Organisation for Economic Co-operation and Development (Organisation for Economic Co-operation and Development, undated)	2015
Current Population Survey	U.S. Census Bureau (U.S. Census Bureau, 2018)	2013
European Social Survey European Research Infrastructure Consortium	European Social Survey (European Social Survey, 2014)	2014
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 Spiritual Assessment Tool	Tami Borneman, Betty Ferrell, and Christina M. Puchalski (Borneman, Ferrel, and Puchalski, 2010)	2010
General Social Survey	NORC (NORC, 2016)	2014
Health Reform Monitoring Survey	Urban Institute (Holahan and Long, 2018)	2017
Health Tracking Survey	Pew Research Center (Pew Research Center, 2012)	2012
iPoll database	Various (iPoll, undated)	Various dates 1937–2017
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, 2019)	2017
National Social Life, Health, and Aging Project Wave 2 Survey	NORC (NORC, 2014)	2014
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

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

description, the scales associated with that particular measure, whether data were currently available for that measure, the unit of analysis, and the source of the data for the measure.

Some of the surveys reviewed did not provide data that would fit the selection criteria of the Culture of Health measures. As described in *Moving Forward Together* (Plough et al., 2018), the measures compendium located at www.rwjf.org/cultureofhealth (RWJF, undated), and in Chandra et al. (2016), two of the criteria for the selection of Culture of Health measures across all action areas were that that recent data are available and that the data are nationally representative. Some surveys were fielded many years ago, and up-to-date data were not available. Other measures were not collected in nationally representative surveys, or survey instruments were only in the concept phase (listed in Table 2.1 as “Not applicable”). When data meeting these criteria were not available, we included or adapted measures for the RWJF National Survey of Health Attitudes to obtain more-recent data. For concepts for which no previous data or survey instruments were available related to making health a shared value, we developed new items in this survey.

Research Team Meetings

We conducted a series of meetings as a collective team with researchers from RAND, RWJF, and NORC at the University of Chicago to discuss survey content. NORC is conducting related research, including developing a complementary study, the American Health Values Segmentation Study, that has a different purpose—to create a typology related to Culture of Health values (Bye and Ghirardelli, 2016). The RWJF National Survey of Health Attitudes focused on capturing individual values about health and well-being and how they relate to personal choices and behaviors, as well as community expectations. Although the surveys had different purposes, some questions were developed together to allow for future comparisons across the two data sets. Thus, we used the meetings to find items that we could both field while avoiding unnecessary redundancies that might lengthen our surveys.

We held regular meetings to review the survey content, examining whether and how measures identified or newly developed mapped to the action area overall and to the drivers of interest. We rated measures on their relative face and content validity. In some cases, we discussed modifications or adaptations to the item to better align with our Culture of Health Action Framework and drivers. If we could use 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.

Pilot Test

There were two tests conducted to pilot the survey questions. The first pilot was conducted in December of 2017 with ten *nonresearch* staff at RAND representing three races/ethnicities and both genders. Participants were divided into two focus groups of five people, and the testing consisted of (1) participants completing a handwritten version of the survey (the order of questions was different for each focus group) and (2) a qualitative question-and-answer session for participants to provide feedback on the survey. In the discussion, participants were asked the following questions:

- What do you think this survey is about?
- What did you find confusing or hard to answer?
- What did you find relevant to the present state of things in the United States?
- What are your thoughts on the flow, order, and length of the survey questions?
- What do you suggest as possible questions to cut considering the goal of the survey?

Results were used to inform further survey development.

In the second pilot test, we conducted five 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 five people from lower-income neighborhoods in Pittsburgh. Most of the interviewees were African American, and they were diverse in age, did not have a background in health research, and had either a high school or college degree. The interviews suggested that particular questions about health interdependence and value on well-being were unclear. We rewrote items and returned to those interviewees to check understanding.

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.

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. For survey questions that were included in our 2015 survey, we also include the question number from the previous survey.

Survey Length

The resulting survey contained 34 questions, some with subquestions or multiple parts. The median time to complete the survey was between 18 and 19 minutes.

Randomization

To avoid potential order effects, we randomized the order of some questions within modules. We randomized the order of subquestions for Questions 1, 14, 15, and 17. For some questions, we used a split sample and fielded slightly different wordings or different questions to different survey respondents (Questions 6, 8a, 8b, 11, and 13). We also randomized receipt of a follow up to Question 16. More details about the randomization are provided in Chapter Three.

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

Table 2.3
Mapping Survey Questions to Key Survey Concepts

Summary of Question	2018 Question Number	2015 Question Number (if applicable)	Expectations (numbers map to Table 2.1)	Domain
Influence of physical/social on health	Q1	Q1	1	Social determinants of health
Ranking influence of physical/social on health	Q1_extra		1	Social determinants of health
Valuing investments in community health	Q2-Q6	Q7-11	3	Community well-being/health
Ranking valuing investments in community health	Q7		3	Community well-being/health
Society's role	Q8	Q12	4	Equity/solidarity
Education vs. health	Q9		1 and 2	Health relative to other social issues
Health care as a right	Q10		1 and 2	Health relative to other social issues
Poor choices vs. outside control	Q11	Q6_1	1	Social determinants of health, Health relative to other social issues and priorities, Perceptions of the role of personal responsibility
Government role	Q12	Q5	1	Government roles
Government role in fighting opioids and obesity	Q13a, Q13b		1	Government roles
Differences by race, location, income	Q14a–Q14d		4	Equity/solidarity
Life expectancy low vs. high income	Q15a, Q15b		4	Equity/solidarity
Government roles in various areas	Q16		1 and 2	Health relative to other social issues
Sense of community measure	Q17	Q13A-L	3	Community well-being/Health
Sense of community health	Q17	Q13M-P	3	Community well-being/Health
How groups impact health of community	Q18		1	Social determinants of health, Health relative to other social issues and priorities, Perceptions of the role of personal responsibility
Actions to influence government	Q19	Q21	3	Change agents/action
Barriers to action	Q20		3	Change agents/action
Health status	Q21		2 and 5	Health status and experience with health and importance
Religion and spirituality	Q22		2 and 5	Health status and experience with health and importance
Impact of others health	Q23		2 and 5	Health status and experience with health and importance

Table 2.3—continued

Summary of Question	2018 Question Number	2015 Question Number (if applicable)	Expectations (numbers map to Table 2.1)	Domain
Chronic health conditions Q24			2 and 5	Health status and experience with health and importance
Financial burden of health care	Q25		2 and 5	Health status and experience with health and importance
Are you a caregiver?	Q26	Q15	2 and 5	Health status and experience with health and importance
Discrimination due to health	Q27		2 and 5	Health status and experience with health and importance
Regular source of health care	Q28, Q28a		2 and 5	Health status and experience with health and importance
Health insurance	Q29		2 and 5	Health status and experience with health and importance
Health care professionals	Q30		2 and 5	Health status and experience with health and importance
Confidence to manage health conditions	Q31		2 and 5	Health status and experience with health and importance
Time in community	Q32		2 and 5	Health status and experience with health and importance
Community trauma	Q33		2 and 5	Health status and experience with health and importance
Live in other country	Q34		2 and 5	Health status and experience with health and importance

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 7,187 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. However, to boost sample size, we also conducted the survey in the KnowledgePanel.

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 Corporation, 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 2018 survey. This resulted in a sample of 2,858 panel members being invited to participate in this survey, and 2,479 (86.7 percent) completed the survey.

We fielded this survey from July 11 through August 30, 2018. 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 2018 survey. The KnowledgePanel sample was not restricted in this way.

KnowledgePanel

At the time of the study, KnowledgePanel was administered by GfK, but it has since been sold to Ipsos. It was formerly known as the Knowledge Networks Panel and was administered by Knowledge Networks. 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 July 11 through July 24, 2018. We invited a sample of 8,675 panel members to participate in this survey, and 4,708 (54.3 percent) completed the survey.

Combining Sample Data

We combined data from the ALP and KnowledgePanel. 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 2015, 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, 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 2018 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 2018 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 and household income interacted with household size, as well as an indicator for metropolitan or nonmetropolitan areas. To calculate the weights, we combined the two samples and matched the distri-

bution 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 panel.

Sample Description

Our total sample includes 7,187 respondents. The weighted sample is representative of the non-institutionalized 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.

Margin of Error

We calculated the margin of error (MOE) based on the 95-percent confidence interval. If a study were 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, 7,187 respondents, the MOE for the full sample ranges from 0.35 percent to 1.35 percent, for proportions near 1 percent and 50 percent, respectively. For the ALP subsample, the MOE ranges from 0.57 percent to 2.18 percent. For the KnowledgePanel subsample, the MOE ranges from 0.41 percent to 1.68 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, our survey contained several large tables—for example, for Question 1, 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 devices' affect 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 geo-

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

Characteristic	Combined ALP and KnowledgePanel		2018 CPS
	Unweighted	Weighted	
Gender			
Male	46.2	48.2	48.2
Female	53.8	51.8	51.8
Race or ethnicity			
Non-Hispanic white	71.1	64.0	64.0
Non-Hispanic black	9.3	11.8	11.8
Hispanic	13.3	17.1	15.9
Non-Hispanic, all other races	6.3	7.0	8.2
Education			
Less than high school	5.8	9.2	11.1
High school	22.3	30.9	29.0
Some college	31.0	28.4	28.4
College graduate	40.9	31.5	31.5
Age, in years			
18–24	3.5	8.4	12.0
25–44	25.9	37.6	33.9
45–64	42.5	34.0	34.1
65+	28.1	20.1	20.1
Income, in dollars			
Less than 10,000	3.5	4.9	5.7
10,000 to 24,999	11.8	13.7	13.1
25,000 to 49,999	21.1	23.5	23.9
50,000 to 74,999	18.7	19.1	19.0
75,000 to 99,999	12.8	12.7	12.3
100,000 or more	32.1	26.1	26.1
Household size, in number of residents			
1	20.8	14.8	14.8
2	40.0	34.4	34.4
3	15.7	19.6	19.1
4	12.6	16.1	16.8
5	6.2	8.7	8.6
6	2.8	3.8	3.6
7	1.2	1.6	1.5
8	0.3	0.4	0.6
9	0.2	0.2	0.2
10	0.2	0.3	0.2
11	0.04	0.05	0.1
12	0.01	0.02	0.04

NOTE: We present all results as percentages.

graphic clustering and secondary recruitment details. This information is not available from the ALP and KnowledgePanel. Fourth, to pilot test the survey, we were only able to conduct a limited number of cognitive interviews in one geographic area and with a relatively homogeneous group. However, many survey questions were derived from other sources. Furthermore, all pilot interviews suggested that the survey was well understood by participants.

Access to the Data

In the summer of 2019, 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.

Culture of Health–Specific Measures

As described earlier, the initial motivation to develop and field the RWJF National Survey of Health Attitudes was to capture aspects of the action area *making health a shared value*. Then, we specifically used the survey 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 Culture of Health in future analyses, we highlight the construction of those three measures here, as they align with our set of 35 Culture of Health measures. More information about each measure is available at www.rwjf.org/cultureofhealth (RWJF, undated). Table 2.5 summarizes which questions we used for each measure.

All of the three Culture of Health measures are based in Action Area 1, described earlier. We summarize each below.

Recognized Influence of Physical and Social Factors on Health: Percentage of Adults, 18 Years and Older, in Strong Agreement That Health Is Influenced by Peers, Neighborhood, and the Broader Community

Understanding community members' health attitudes and expectations will inform where community engagement and information processes should start to catalyze community health action. We calculated the measure using six of the items from Question 1, which read, "Here is a list of some things that may affect people's health and well-being. Please rate each on a scale

Table 2.5
Survey Questions Used for Each Culture of Health Measure

Measure	Relevant Question
Recognized influence of physical and social factors on health	Q1: E, H, J, M, P, S
Valued investment in community health	Q2–Q6
Sense of community (community connection)	Q17 A–F and G–L

from 1 to 5 where 1 means it has no effect on health and 5 means it has a very strong effect.” The six items included are

- E: neighborhood options for healthy food and exercise
- H: amount of social support
- J: physical environment such as clean air or water
- M: community safety
- P: where a person lives
- S: examples set by people around you.

A person’s overall score is the average across the six items. We then grouped respondents into three categories based on their average summative score on the value of health interdependence: very weak or weak agreement (average score 1 to 2.9); moderate agreement (average score 3 to 3.9); or strong or very strong agreement (average score 4 to 5). We then calculated the proportion of respondents who fall into each category. Our top-line measure indicated that 36.5 percent reported strong or very strong value placed on health interdependence. Nearly half (48.2 percent) were in the moderate category, and 15.3 percent in the weak category.

Value Investment in Community Health: Percentage of Adults, 18 Years and Older, Interested in How Their Communities Invest in Well-Being Signaling a Broader Expectation for Well-Being

This measure provides insight on the current landscape of public opinion and attitudes regarding community investment in health and well-being. We calculated this measure using Questions 2 through 6, which asked respondents whether they thought that various policy measures to improve health and well-being should be a top priority, important but not a top priority, or not a priority at all for communities. The policy measures were

- Q2: making sure that the disadvantaged have an equal opportunity to be healthy
- Q3: making sure that healthy foods are for sale at affordable prices in communities where they are not
- Q4: making sure that there are safe, outdoor places to walk and be physically active in communities where there are not any
- Q5: making sure that there is decent housing available for everyone who needs it
- Q6: making sure that there are bike lanes, sidewalks for walking, and public transportation available so that people do not have to always rely on cars. *Or* making sure that there is public transportation, sidewalks for walking, and bike lanes available so that people do not have to always rely on cars.

For Question 6, we split the sample into two equal groups, with half receiving the first wording and half receiving the second wording. Respondents were more likely to report these items were a top priority with the second wording that emphasized public transportation over bike lanes.

We then counted how many of these possible policies each respondent rated a top priority. The measure reports the percentage of the respondents who considered each value of these to be a top priority: 28.3 percent said that none of these was a top priority, 17.4 percent thought that one was a top priority, 18.1 percent considered two to be top priorities, 14.1 percent con-

sidered three top priorities, 11.8 percent considered four top priorities, and 10.0 percent indicated that all policies were top priorities.

Sense of Community (Community Connection): Aggregate Score on Two Subscales of the Sense of Community Index—Emotional Connection to Community and Sense of Belonging to Community (Membership)

We developed this measure using an existing battery of questions designed to measure emotional connection to one's community and sense of membership in the community. Question 17 of the survey asked this. Additional information about the existing index is available in Chavis, Lee, and Acosta, 2008. The Sense of Community Index (SCI) reveals how community members feel about their communities—whether they feel they belong and whether they can count on people in their communities. Previous research has found that the SCI is linked to whether people get involved, whether they have better satisfaction with their health care, and whether they engage in healthy behaviors, such as exercise and good diet (Chavis, Lee, and Acosta, 2008).

For our measure, we separately calculated a score for each of the two subscales. Each scale contains six questions. We measured the membership subscale with items A through F of Question 17. The emotional-connection subscale consists of items G through L of Question 17. Each item asks respondents to indicate how well the statement represents how they feel about their communities on a scale from 0 to 3, where 0 is not at all well, 1 is somewhat, 2 is mostly, and 3 is completely. We averaged the score for each subscale and grouped respondents into three categories of sense of community: weak (score between 0 and 0.9), moderate (score between 1 and 1.9), or strong (score between 2 and 3). We found that 30.6 percent reported a weak emotional connection, 50.1 percent a moderate emotional connection, and 19.4 percent a strong emotional connection, 45.7 percent reported a weak sense of membership, 43.2 percent a moderate sense of membership, and 11.1 percent a strong sense of membership.

Top-Line Summary Data

This final chapter presents the top-line survey results from the ALP and KnowledgePanel samples in 2018, 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 present the unweighted demographic characteristics so that readers can see the original survey sample composition before we applied weighting procedures. This can aid other users of the survey data, who might apply other weighting approaches in their analyses.

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.

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. The MOE for the full sample ranges from 0.35 percent to 1.35 percent, for proportions near 1 percent and 50 percent, respectively. For the ALP subsample, the MOE ranges from 0.57 percent to 2.18 percent. For the KnowledgePanel subsample, the MOE ranges from 0.41 percent to 1.68 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, except where noted in Question 16.

Recognized Influence of Physical and Social Factors on Health

Q1. Here is a list of some things that may affect people's health and well-being. 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.

Note on randomization: The order of Questions 1A–1T was randomized for each respondent.

A. Access to affordable healthcare

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	2.2	5.0	19.7	22.4	49.9	0.8
KnowledgePanel (n = 4,708)	3.4	4.9	19.0	27.6	44.8	0.4
Total	3.2	4.6	18.4	26.7	46.5	0.5

B. Having a job

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	3.9	5.2	24.1	32.8	33.0	1.0
KnowledgePanel (n = 4,708)	4.9	7.2	29.8	32.1	25.6	0.4
Total	4.7	6.9	28.6	32.4	26.8	0.6

C. Stress

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	1.2	1.8	8.6	26.1	61.4	1.0
KnowledgePanel (n = 4,708)	1.9	1.8	12.3	30.3	53.1	0.5
Total	1.9	1.8	12.1	29.6	54.0	0.7

D. Knowledge about health

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	1.0	3.6	20.1	36.5	38.0	0.7
KnowledgePanel (n = 4,708)	2.9	4.5	23.3	36.0	32.8	0.5
Total	2.5	4.4	22.9	36.2	33.4	0.6

E. Neighborhood options for healthy food and exercise

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	6.8	7.7	26.4	32.3	25.8	1.1
KnowledgePanel (n = 4,708)	4.9	9.7	30.5	30.9	23.6	0.4
Total	4.8	9.3	29.8	31.7	23.8	0.6

F. Having health insurance

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	2.4	4.9	16.0	25.2	49.3	2.3
KnowledgePanel (n = 4,708)	5.2	5.7	20.5	26.4	41.7	0.5
Total	4.6	5.5	19.6	26.3	43.3	0.7

G. Smoking

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	2.9	2.1	8.1	12.4	72.0	2.4
KnowledgePanel (n = 4,708)	5.3	1.7	7.0	13.0	72.7	0.3
Total	4.8	1.8	7.0	13.5	72.3	0.6

H. Amount of social support

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	5.8	10.8	29.0	33.1	19.3	2.0
KnowledgePanel (n = 4,708)	6.6	11.9	35.7	29.2	16.3	0.4
Total	6.0	11.6	34.4	30.1	17.2	0.6

I. Personal health practices (other than smoking)

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	2.9	1.6	11.8	29.5	51.7	2.5
KnowledgePanel (n = 4,708)	2.5	2.1	13.3	30.7	51.0	0.3
Total	2.4	2.0	13.3	30.6	51.2	0.6

J. Physical environment such as clean air or water

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	1.3	1.7	12.2	28.8	53.8	2.2
KnowledgePanel (n = 4,708)	2.0	2.4	16.1	30.3	48.8	0.4
Total	1.9	2.2	15.3	30.2	49.7	0.6

K. Genetic makeup inherited from parents

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	5.3	4.9	19.7	37.1	30.7	2.4
KnowledgePanel (n = 4,708)	3.5	4.5	23.7	34.3	33.6	0.4
Total	3.6	4.5	23.4	34.4	33.3	0.7

L. Income

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	4.0	6.3	22.0	35.0	32.1	0.6
KnowledgePanel (n = 4,708)	4.4	7.8	29.0	31.5	26.9	0.4
Total	4.2	7.5	27.8	32.2	27.8	0.5

M. Community safety

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	5.0	10.8	27.4	32.3	23.8	0.6
KnowledgePanel (n = 4,708)	5.0	11.3	32.6	30.7	20.0	0.5
Total	4.8	11.1	31.7	31.3	20.5	0.6

N. Housing quality

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	3.3	7.2	30.0	34.3	24.0	1.1
KnowledgePanel (n = 4,708)	4.3	9.4	32.9	31.6	21.2	0.5
Total	4.1	8.9	32.5	32.4	21.3	0.7

O. Education

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	5.9	6.8	25.7	34.4	24.8	2.4
KnowledgePanel (n = 4,708)	6.0	10.0	29.5	32.0	22.2	0.4
Total	6.0	9.4	29.1	32.5	22.4	0.6

P. Where a person lives

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	4.1	8.6	31.9	33.3	19.8	2.2
KnowledgePanel (n = 4,708)	4.7	8.6	33.7	33.1	19.5	0.4
Total	4.5	8.7	33.3	33.6	19.3	0.6

Q. Personal religion/spirituality

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	18.1	20.2	25.0	21.3	14.8	0.7
KnowledgePanel (n = 4,708)	17.6	17.8	29.8	19.5	14.9	0.4
Total	17.2	18.3	29.2	19.9	14.9	0.5

R. Race/ethnicity

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	18.3	17.8	32.6	18.7	10.5	2.1
KnowledgePanel (n = 4,708)	16.7	17.6	35.2	19.7	10.3	0.4
Total	16.8	17.3	35.0	19.7	10.5	0.6

S. Examples set by people around you

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	6.9	10.8	28.9	34.2	18.3	0.9
KnowledgePanel (n = 4,708)	6.9	11.3	34.2	30.0	17.1	0.4
Total	6.6	11.3	33.4	31.0	17.2	0.5

T. Access to wellness technologies (Fitbit, trackers etc.)

Sample	1 (No Effect)	2	3	4	5 (Very Strong Effect)	Missing
ALP (n = 2,479)	16.6	25.5	30.1	16.6	9.1	2.1
KnowledgePanel (n = 4,708)	16.1	26.7	31.9	15.5	9.3	0.4
Total	15.8	26.2	32.0	16.1	9.3	0.6

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

Q1_extra. You said the following items have a very strong effect on health and well being. Of these which do you think has the strongest impact?

	ALP (n = 2,479)	KnowledgePanel (n = 4,708)	Both Surveys
No items were selected as having a very strong effect	5.8	10.5	10
Smoking	14.3	18.5	17.8
Personal health practices (other than smoking)	13.2	15.2	14.1
Access to affordable health care	12.2	10.2	10.8
Stress	12.5	9.6	9.9
Genetic makeup inherited from parents	7.2	8.2	7.9
Having health insurance	7.6	5.8	6.4
Physical environment such as clear air or water	5.5	4.7	4.9
Knowledge about health	3.9	3.7	3.9
Income	4.5	2.6	3.1
Personal religion/spirituality	2.2	2.6	2.5
Having a job	3.7	1.9	2.0
Education	1.7	1.8	1.7
Neighborhood options for healthy food and exercise	0.4	1.5	1.3
Examples set by people around you	1.0	0.9	0.9
Housing quality	1.7	0.6	0.6
Amount of social support	0.7	0.4	0.5
Where a person lives	0.5	0.5	0.5
Community safety	0.2	0.4	0.4
Race/ethnicity	0.6	0.3	0.4
Access to wellness technologies (Fitbit, trackers etc.)	0.1	0.0	0.1
Refused	0.5	0.1	0.2

SOURCE: RAND.

NOTE: Approximately 7 percent of respondents reported only one item in Question 1 as having a very strong effect on health. We include those individuals' responses when calculating the percentage who reported each item had the strongest effect. For example, individuals who reported in Q1 that only smoking had a very strong effect on health are combined with those who reported in Q1_extra that smoking had the strongest effect on health.

Valued Investment in Community Health

In the following section, we list goals that some people think are important for communities in the U.S. For each, indicate whether you think it should be a top priority, important but not a top priority, or not a priority at all for communities. In these statements, when we refer to “communities,” we mean all communities not just your own.

Should the following be a top priority, important but not a top priority, or not a priority at all for communities?

Q2. Making sure that the disadvantaged have an equal opportunity to be healthy

Sample	Top Priority	Important but Not Top	Not a Priority at All	Missing
ALP (n = 2,479)	51.5	45.8	2.2	0.5
KnowledgePanel (n = 4,708)	42.5	51.7	5.3	0.5
Total	44.7	50.1	4.7	0.6

SOURCE: American Health Values Segmentation Study (NORC, 2015).

Q3. Making sure that healthy foods are for sale at affordable prices in communities where they are not

Sample	Top Priority	Important but Not Top	Not a Priority at All	Missing
ALP (n = 2,479)	49.1	46.8	3.6	0.5
KnowledgePanel (n = 4,708)	43.5	49.3	6.7	0.5
Total	44.5	48.7	6.2	0.6

SOURCE: American Health Values Segmentation Study (NORC, 2015).

Q4. Making sure that there are safe, outdoor places to walk and be physically active in communities where there aren't any

Sample	Top Priority	Important but Not Top	Not a Priority at All	Missing
ALP (n = 2,479)	35.3	59.7	4.5	0.5
KnowledgePanel (n = 4,708)	36.3	56.8	6.4	0.5
Total	36.3	57.0	6.1	0.5

SOURCE: American Health Values Segmentation Study (NORC, 2015).

Q5. Making sure that there is decent housing available for everyone who needs it

Sample	Top Priority	Important but Not Top	Not a Priority at All	Missing
ALP (n = 2,479)	48.6	45.6	5.3	0.5
KnowledgePanel (n = 4,708)	42.9	48.8	7.8	0.5
Total	44.2	47.9	7.4	0.5

SOURCE: American Health Values Segmentation Study (NORC, 2015).

Q6. Making sure that there are bike lanes, sidewalks for walking and public transportation available so that people do not have to always rely on cars*or***Making sure that there is public transportation, sidewalks for walking, and bike lanes available so that people do not have to always rely on cars***Note on randomization: Half of the sample received the first wording and half received the second.¹*

Sample	Top Priority	Important but Not Top	Not a Priority at All	Missing
ALP (n = 2,479)	24.2	62.2	13.0	0.5
KnowledgePanel (n = 4,708)	23.5	60.5	15.4	0.6
Total	23.3	61.1	15.0	0.6

SOURCE: RAND.

¹ Respondents were 3 percentage points more likely to endorse this statement as a top priority when public transportation was listed first than when bike lanes were listed first.

Q7. You said the following programs are a top priority. Of these which would you consider to be the highest priority? Of these which would you consider to be the lowest priority?

Respondents were asked to consider all items listed as a top priority. They selected the lowest and highest priorities among those. If more than 3 were selected as a top priority, they were also asked to rank the remaining items. This resulted in a full ranking of all items that were considered a top priority.

A. First highest top priority

Sample	Making sure that the disadvantaged have an equal opportunity to be healthy.	Making sure that healthy foods are for sale at affordable prices in communities where they are not.	Making sure that there are safe, outdoor places to walk and be physically active in communities where there aren't any.	Making sure that there is decent housing available for everyone who needs it.	Making sure that there are sidewalks for walking, bike lanes, and public transportation available so that people do not have to always rely on cars.	Missing
ALP (n = 1,875)	41.2	19.4	7.4	27.0	4.1	0.7
KnowledgePanel (n = 3,189)	35.1	22.9	10.8	25.7	4.7	0.8
Total	36.6	21.9	10.3	26.1	4.3	0.8

B. Second highest top priority

Sample	Making sure that the disadvantaged have an equal opportunity to be healthy.	Making sure that healthy foods are for sale at affordable prices in communities where they are not.	Making sure that there are safe, outdoor places to walk and be physically active in communities where there aren't any.	Making sure that there is decent housing available for everyone who needs it.	Making sure that there are sidewalks for walking, bike lanes, and public transportation available so that people do not have to always rely on cars.	Missing
ALP (n = 1,426)	46.9	23.7	10.3	13.8	1.9	3.4
KnowledgePanel (n = 2,347)	20.1	26.2	16.1	26.9	9.5	1.1
Total (n = 3,773)	29.1	26.0	13.9	22.4	7.3	1.3

C. Third highest top priority

Sample	Making sure that the disadvantaged have an equal opportunity to be healthy.	Making sure that healthy foods are for sale at affordable prices in communities where they are not.	Making sure that there are safe, outdoor places to walk and be physically active in communities where there aren't any.	Making sure that there is decent housing available for everyone who needs it.	Making sure that there are sidewalks for walking, bike lanes, and public transportation available so that people do not have to always rely on cars.	Missing
ALP (n = 943)	55.7	16.8	11.2	5.2	6.0	5.0
KnowledgePanel (n = 1,522)	13.3	25.8	23.5	20.6	15.8	1.1
Total (n = 2,465)	27.2	22.9	19.8	15.6	12.9	1.6

D. Fourth highest top priority

Sample	Making sure that the disadvantaged have an equal opportunity to be healthy.	Making sure that healthy foods are for sale at affordable prices in communities where they are not.	Making sure that there are safe, outdoor places to walk and be physically active in communities where there aren't any.	Making sure that there is decent housing available for everyone who needs it.	Making sure that there are sidewalks for walking, bike lanes, and public transportation available so that people do not have to always rely on cars.	Missing
ALP (n = 561)	7.9	20.5	38.0	7.4	23.3	2.9
KnowledgePanel (n = 882)	6.1	13.8	42.9	9.2	25.3	2.8
Total (n = 1,443)	6.4	14.6	42.4	9.2	24.3	3.2

E. Fifth highest top priority

Sample	Making sure that the disadvantaged have an equal opportunity to be healthy.	Making sure that healthy foods are for sale at affordable prices in communities where they are not.	Making sure that there are safe, outdoor places to walk and be physically active in communities where there aren't any.	Making sure that there is decent housing available for everyone who needs it.	Making sure that there are sidewalks for walking, bike lanes, and public transportation available so that people do not have to always rely on cars.	Missing
ALP (n = 245)	5.7	8.7	21.0	5.4	52.7	6.5
KnowledgePanel (n = 399)	10.4	11.5	24.3	10.2	38.9	4.7
Total (n = 644)	9.0	10.6	23.5	8.7	42.7	5.5

SOURCES: RAND and RWJF.

Q8. Please indicate how much you agree or disagree with each statement.

Note on randomization: For Q8a and Q8b, half of respondents saw the phrase “an equal opportunity” and half saw “a fair and just opportunity.”²

A. Our society needs to do more to make sure that everyone has [‘an equal’/‘a fair and just’] opportunity to succeed

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	4.3	9.7	16.2	28.6	40.5	0.6
KnowledgePanel (n = 4,708)	5.6	8.8	23.9	30.6	30.5	0.6
Total	4.9	8.9	22.8	30.1	32.6	0.7

SOURCES: Feldman (1988) is the source for the survey instrument that was last fielded in American National Election Studies (2009, 2013), revised by RAND.

B. Our society needs to do more to make sure that everyone has [‘an equal’/‘a fair and just’] opportunity to be healthy

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	3.1	4.2	13.9	31.6	46.5	0.6
KnowledgePanel (n = 4,708)	4.2	6.5	21.0	30.4	37.3	0.6
Total	3.6	6.0	19.9	30.4	39.4	0.7

SOURCES: Developed by NORC, revised by RAND.

C. It is best for society if people are as concerned about the needs of others as they are about their own needs

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	2.7	7.0	18.6	34.7	36.3	0.6
KnowledgePanel (n = 4,708)	3.6	6.0	23.3	35.5	30.9	0.6
Total	3.3	6.1	22.7	35.1	32.1	0.7

SOURCE: Developed by NORC.

² For Q8a, respondents were approximately 2 percentage points more likely to select “somewhat agree” and 2 percentage points less likely to select “somewhat disagree” when the question said “a fair and just opportunity” relative to “an equal opportunity.” These differences are small but statistically significant. There was no statistically significant difference for Q8b.

D. It would be unfair if some people had more of an opportunity to be healthy than other people

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	6.5	11.1	21.3	27.7	31.4	2.0
KnowledgePanel (n = 4,708)	7.2	9.7	28.8	23.9	29.7	0.6
Total	6.9	9.8	27.4	24.7	30.5	0.8

SOURCE: Developed by NORC, revised by RAND.

Q9. Please indicate if you agree or disagree with the following statements.***A. Health is like education—just like all children have access to public education from K–12, all children should have access to a basic level of health care***

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	1.6	2.7	7.4	23.4	64.2	0.7
KnowledgePanel (n = 4,708)	2.7	2.8	14.2	25.6	53.8	0.8
Total	2.4	2.9	13.0	25.2	55.7	0.9

B. A good education is a building block for the future

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	1.1	1.6	4.3	21.6	70.8	0.7
KnowledgePanel (n = 4,708)	1.7	1.3	10.1	25.0	61.1	0.8
Total	1.5	1.4	9.3	24.3	62.6	0.8

C. Good health is a building block for the future

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	0.8	4.2	9.0	28.3	57.0	0.7
KnowledgePanel (n = 4,708)	1.5	1.7	13.4	32.4	50.1	0.8
Total	1.3	2.0	12.7	31.8	51.4	0.8

D. Good health is a result of the choices you have made

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	1.2	8.5	15.1	39.9	34.6	0.7
KnowledgePanel (n = 4,708)	2.3	5.7	20.7	39.6	30.9	0.8
Total	2.1	6.4	19.4	39.9	31.3	0.9

E. Being educated is a result of the choices you have made

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	2.9	11.9	17.2	35.9	31.5	0.7
KnowledgePanel (n = 4,708)	3.1	9.1	24.1	35.5	27.3	1.0
Total	3.1	10.0	22.4	35.8	27.6	1.0

SOURCE: RAND

Q10. Do you agree or disagree with the following statement? “It is the obligation of the government to ensure that everyone has access to health care as a fundamental right.”

Sample	Strongly Disagree	Somewhat Disagree	Neither Agree Nor Disagree	Somewhat Agree	Strongly Agree	Missing
ALP (n = 2,479)	18.5	14.0	15.1	20.1	31.6	0.6
KnowledgePanel (n = 4,708)	16.2	12.4	17.6	21.2	31.8	0.8
Total	16.4	12.4	17.5	20.9	32.0	0.8

SOURCES: RAND and RWJF.

Q11a. For the pair of statements below, indicate whether the FIRST statement or the SECOND statement comes closer to your own views—even if neither is exactly right.Note on randomization: Half of the sample saw Q11a and half saw Q11b.³

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 (n = 1,226)	64.6	34.4	0.9
KnowledgePanel (n = 2,319)	68.9	29.4	1.7
Total	68.0	30.4	1.6

SOURCES: Health Tracking Survey (Pew Research Center, 2012); revised by the RAND team to reflect health.

³ Respondents were 13.6 percentage points more likely to choose personal factors in Q11b than poor choices in Q11a.

Q11b. Which of the following is the biggest reason that people in America become unhealthy?

Sample	Personal Factors	External Factors	Missing
ALP (n = 1,253)	83.0	16.2	0.8
KnowledgePanel (n = 2,389)	80.5	17.8	1.7
Total	80.1	18.3	1.6

SOURCES: RAND and RWJF.

Q12. When it comes to U.S. government spending on health and health care, if you had to balance that spending between helping people get and stay healthy and taking care of people when they get sick, how would you do it?

Sample	More on Getting and Keeping People Healthy	More on Taking Care of People When They Get Sick	Equal Between the Two	Missing
ALP (n = 2,479)	37.7	9.3	52.2	0.9
KnowledgePanel (n = 4,708)	33.2	11.2	54.7	0.9
Total	33.6	10.9	54.5	0.9

SOURCES: America's Health Agenda: Priorities and Performance Rating Survey (Harvard School of Public Health, 2011); revised by NORC and RAND.

Q13a. Recent research shows that as of 2018, more than one-third of American adults are 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?*Note on randomization: Half of the sample saw Q13a and half saw Q13b.*

Sample	Local Governments	State Governments	Federal Governments	No Government Can Lower This Number	Missing
ALP (n = 1,226)	22.8	11.7	19.3	45.6	0.5
KnowledgePanel (n = 2,319)	15.7	14.8	16.6	51.1	1.7
Total	16.5	14.7	17.3	49.8	1.7

SOURCES: RAND and RWJF.

Q13b. Recent research shows that in the past year, 8% 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?

	Local Governments	State Governments	Federal Governments	No Government Can Lower This Number	Refused
ALP (n = 1,253)	22.6	22.7	23.1	30.7	0.9
KnowledgePanel (n = 2,389)	21.1	21.3	20.9	34.9	1.7
Total	21.6	22.3	20.9	33.7	1.6

SOURCES: RAND and RWJF.

Note on randomization: The order of Questions 14a–14d was randomized for each respondent.

Q14a. 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 (n = 2,479)	9.9	49.7	39.7	0.7
KnowledgePanel (n = 4,708)	9.4	55.7	34.0	0.9
Total	9.2	54.6	35.3	0.9

SOURCES: NORC and RAND.

Q14b. When Latinos 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 (n = 2,479)	9.9	49.4	39.9	0.8
KnowledgePanel (n = 4,708)	11.7	51.9	35.4	0.9
Total	11.2	51.3	36.5	1.0

SOURCES: NORC and RAND.

Q14c. 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 (n = 2,479)	18.1	18.1	63.2	0.6
KnowledgePanel (n = 4,708)	12.4	23.7	63.1	0.7
Total	12.9	22.8	63.5	0.8

SOURCES: NORC and RAND.

Q14d. When Americans living in rural communities 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 live in urban areas, or is there not much of a difference?

Sample	Easier	Not Much of a Difference	Harder	Missing
ALP (n = 2,479)	5.0	33.5	60.9	0.6
KnowledgePanel (n = 4,708)	4.4	37.8	57.0	0.7
Total	4.6	37.0	57.6	0.8

SOURCES: NORC and RAND.

Q15a. In the U.S. today, people with lower incomes live on average 7.5 years less than people with higher incomes. What do you think are the top three reasons why this is the case? (Select three options)

The following tables each list percentage of respondents who selected each item as a top three reason for longer life expectancy.

Access to a good education

Sample	Not Selected	Selected
ALP (n = 2,479)	83.4	16.6
KnowledgePanel (n = 4,708)	85.0	15.0
Total	84.6	15.4

Access to health care

Sample	Not Selected	Selected
ALP (n = 2,479)	51.5	48.5
KnowledgePanel (n = 4,708)	49.1	50.9
Total	49.3	50.7

Access to health insurance

Sample	Not Selected	Selected
ALP (<i>n</i> = 2,479)	58.3	41.7
KnowledgePanel (<i>n</i> = 4,708)	56.7	43.3
Total	56.5	43.5

Community environment

Sample	Not Selected	Selected
ALP (<i>n</i> = 2,479)	79.6	20.4
KnowledgePanel (<i>n</i> = 4,708)	81.3	18.7
Total	80.8	19.2

Discrimination

Sample	Not Selected	Selected
ALP (<i>n</i> = 2,479)	90.9	9.1
KnowledgePanel (<i>n</i> = 4,708)	91.9	8.1
Total	91.7	8.3

Economic resources/how much money they have

Sample	Not Selected	Selected
ALP (<i>n</i> = 2,479)	53.4	46.6
KnowledgePanel (<i>n</i> = 4,708)	52.7	47.3
Total	52.3	47.7

Genetics (someone's biological makeup)

Sample	Not Selected	Selected
ALP (<i>n</i> = 2,479)	85.1	14.9
KnowledgePanel (<i>n</i> = 4,708)	83.4	16.6
Total	84.0	16.1

Health information they have

Sample	Not Selected	Selected
ALP (<i>n</i> = 2,479)	83.7	16.3
KnowledgePanel (<i>n</i> = 4,708)	82.0	18.0
Total	82.4	17.6

Luck

Sample	Not Selected	Selected
ALP (n = 2,479)	94.9	5.1
KnowledgePanel (n = 4,708)	95.0	5.0
Total	95.1	4.9

Personal choices and behavior

Sample	Not Selected	Selected
ALP (n = 2,479)	47.7	52.3
KnowledgePanel (n = 4,708)	49.1	50.9
Total	49.7	50.3

Treatment by society of those with low incomes

Sample	Not Selected	Selected
ALP (n = 2,479)	83.7	16.3
KnowledgePanel (n = 4,708)	84.9	15.1
Total	84.9	15.1

Other

Sample	Not Selected	Selected
ALP (n = 2,479)	96.0	4.0
KnowledgePanel (n = 4,708)	96.6	3.4
Total	96.4	3.6

SOURCE: RAND.

Q15b. Would you be willing or unwilling to do each of the following to address the gap in life expectancy between lower and higher income people?

A. Pay more in taxes

Sample	Very Willing	Somewhat Willing	Neither Willing Nor Unwilling	Somewhat Unwilling	Very Unwilling	Missing
ALP (n = 2,479)	11.5	19.2	22.1	17.4	27.5	2.3
KnowledgePanel (n = 4,708)	8.2	18.5	27.1	16.7	27.7	1.8
Total	9.2	19.1	26.2	16.3	27.5	1.7

B. Donate to a charity working to address this issue

Sample	Very Willing	Somewhat Willing	Neither Willing Nor Unwilling	Somewhat Unwilling	Very Unwilling	Missing
ALP (n = 2,479)	15.9	36.9	25.5	10.9	8.5	2.3
KnowledgePanel (n = 4,708)	11.1	35.0	31.9	10.5	9.6	1.9
Total	12.5	35.4	30.2	10.5	9.5	1.9

C. Volunteer with a community organization that is working to address this issue

Sample	Very Willing	Somewhat Willing	Neither Willing Nor Unwilling	Somewhat Unwilling	Very Unwilling	Missing
ALP (n = 2,479)	19.3	38.0	23.0	9.5	7.9	1.1
KnowledgePanel (n = 4,708)	13.5	32.2	33.5	10.3	8.8	1.8
Total	15.3	33.3	31.3	10.2	8.3	1.6

D. Vote for a candidate who will address this issue

Sample	Very Willing	Somewhat Willing	Neither Willing Nor Unwilling	Somewhat Unwilling	Very Unwilling	Missing
ALP (n = 2,479)	38.0	21.4	21.9	5.8	10.6	2.3
KnowledgePanel (n = 4,708)	30.6	23.0	28.2	6.1	10.5	1.6
Total	33.0	22.3	26.5	6.2	10.5	1.6

SOURCES: RAND and RWJF.

Q16. Indicate who you think should play a bigger role in providing these services, the government or the private sector (businesses and nonprofits)? Slide the dot to left to indicate that you think the government should play a bigger role and to the right to indicate that the private sector should play a bigger role. If you place the dot all the way to the left that indicates that the government should provide these services, and the private sector should not be involved at all. If you place the dot all the way to the right that indicates that the private sector should provide these services and the government should not be involved at all. Any point in the middle indicates that each should play some role.

These questions were answered on a visual slider scale that ranged from 0 to 100. A zero indicates that the government should provide these services, while 100 indicates that the private sector should provide these services. The tables below present the mean value across respondents.

Transportation including highways, roads, buses, trains, and subways

Sample	Number of Respondents	Mean
ALP	2,342	34.6
KnowledgePanel	3,637	37.0
Total	5,979	35.6

Neighborhood safety and security

Sample	Number of Respondents	Mean
ALP	2,355	39.2
KnowledgePanel	3,287	41.8
Total	5,642	41.0

Job training programs

Sample	Number of Respondents	Mean
ALP	2,357	47.7
KnowledgePanel	2,874	52.8
Total	5,231	51.1

Health care services

Sample	Number of Respondents	Mean
ALP	2,369	38.5
KnowledgePanel	3,167	39.6
Total	5,536	38.9

Elementary and high school education

Sample	Number of Respondents	Mean
ALP	2,370	33.6
KnowledgePanel	3,297	32.7
Total	5,667	32.4

Parks and recreation services

Sample	Number of Respondents	Mean
ALP	2,374	35.3
KnowledgePanel	3,113	38.3
Total	5,487	37.4

Housing

Sample	Number of Respondents	Mean
ALP	2,364	43.3
KnowledgePanel	2,943	46.9
Total	5,307	45.7

Food safety in restaurants

Sample	Number of Respondents	Mean
ALP	2,378	36.7
KnowledgePanel	3,107	36.1
Total	5,485	36.5

SOURCES: RAND and RWJF.

Q17. The following statements about community refer to your neighborhood. How well do each of the following statements represent how you feel about this community?—not at all, somewhat, mostly, or completely.

A. I can trust people in this community

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	13.4	39.6	35.9	9.1	1.9
KnowledgePanel (n = 4,708)	13.2	41.1	37.0	7.4	1.2
Total	13.7	40.4	36.7	7.6	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

B. I can recognize most of the members of this community

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	25.0	42.1	22.3	7.2	3.4
KnowledgePanel (n = 4,708)	30.5	40.8	21.9	5.6	1.2
Total	29.4	40.7	22.3	6.0	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

C. Most community members know me

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	33.7	38.7	17.1	8.3	2.1
KnowledgePanel (n = 4,708)	37.4	38.4	17.8	5.1	1.3
Total	36.0	38.4	18.4	5.5	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

D. This community has symbols and expressions of membership such as clothes, signs, art, architecture, logos, landmarks, and flags that people can recognize

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	33.9	31.9	20.9	10.0	3.4
KnowledgePanel (n = 4,708)	40.3	32.0	19.5	7.0	1.2
Total	39.0	32.1	19.9	7.4	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

E. I put a lot of time and effort into being part of this community

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	30.0	42.5	17.5	6.7	3.4
KnowledgePanel (n = 4,708)	35.8	41.7	15.9	5.3	1.3
Total	34.3	41.7	16.7	5.6	1.7

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

F. Being a member of this community is part of my identity

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	37.0	34.2	18.0	7.4	3.3
KnowledgePanel (n = 4,708)	37.0	35.4	19.2	7.3	1.1
Total	36.7	35.2	19.0	7.5	1.5

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

G. It is very important to me to be a part of this community

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	20.8	38.7	24.7	13.8	2.0
KnowledgePanel (n = 4,708)	22.8	39.4	26.9	9.7	1.3
Total	22.3	38.9	26.5	10.7	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

H. I am with other community members a lot and enjoy being with them

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	34.6	38.5	16.7	6.9	3.3
KnowledgePanel (n = 4,708)	38.5	38.2	17.1	5.1	1.2
Total	37.4	38.0	17.5	5.5	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

I. I expect to be a part of this community for a long time

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	18.3	27.8	30.8	19.7	3.4
KnowledgePanel (n = 4,708)	15.6	32.7	32.7	17.7	1.2
Total	16.2	31.4	32.3	18.4	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

J. Members of this community have shared important events together, such as holidays, celebrations, or disasters

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	25.1	33.9	27.6	11.5	1.9
KnowledgePanel (n = 4,708)	26.7	37.9	25.1	9.0	1.3
Total	26.0	37.4	25.7	9.4	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

K. I feel hopeful about the future of this community

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	13.4	32.1	38.0	14.6	1.9
KnowledgePanel (n = 4,708)	13.8	36.5	36.4	12.1	1.2
Total	13.9	35.6	36.5	12.5	1.5

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

L. Members of this community care about each other

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	11.7	41.9	34.4	8.7	3.4
KnowledgePanel (n = 4,708)	13.5	45.6	32.4	7.4	1.2
Total	13.3	44.7	32.5	8.0	1.6

SOURCE: Sense of Community Index (Chavis, Lee, and Acosta, 2008).

NOTE: The order of Questions 17A–17P was randomized for each respondent.

M. My community can work together to improve its health

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	16.3	40.2	30.4	11.0	2.0
KnowledgePanel (n = 4,708)	18.5	44.0	28.6	7.7	1.3
Total	18.4	42.5	29.2	8.3	1.6

SOURCE: RAND.

NOTE: The order of Questions 17A–17P was randomized for each respondent.

N. My community has the resources to improve its health

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	19.2	35.0	32.0	10.6	3.3
KnowledgePanel (n = 4,708)	19.7	38.6	31.1	9.4	1.3
Total	20.2	37.3	31.1	9.8	1.6

SOURCE: RAND.

O. My community works together to make positive change for health

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	31.0	40.7	19.3	5.7	3.3
KnowledgePanel (n = 4,708)	30.9	42.6	20.3	5.0	1.2
Total	31.0	42.0	20.1	5.2	1.6

SOURCE: RAND.

NOTE: The order of Questions 17A–17P was randomized for each respondent.

P. I know my neighbors will help me stay healthy

Sample	Not at All	Somewhat	Mostly	Completely	Missing
ALP (n = 2,479)	47.4	30.9	13.8	5.9	2.0
KnowledgePanel (n = 4,708)	46.2	34.0	14.9	3.6	1.2
Total	46.6	33.1	14.8	4.0	1.6

SOURCE: RAND.

NOTE: The order of Questions 17A–17P was randomized for each respondent.

Q18. This question is about how different groups or organizations impact the health of your community. For each, please indicate what impact (positive, negative, or no impact) this group has on the health of your community. If the impact is both positive and negative, please indicate whether the overall impact is more positive or negative.

A. People living in my community

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	1.9	8.9	38.2	37.7	10.6	2.7
KnowledgePanel (n = 4,708)	2.5	9.3	47.8	31.5	7.2	1.7
Total	2.6	9.4	45.1	33.2	7.8	2.0

B. Local businesses

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	1.9	6.7	37.7	40.6	10.5	2.7
KnowledgePanel (n = 4,708)	1.5	8.0	46.3	35.3	7.0	1.9
Total	1.6	8.2	44.2	36.4	7.5	2.2

C. Local law enforcement

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	3.3	8.2	29.8	39.3	16.7	2.7
KnowledgePanel (n = 4,708)	2.3	7.5	41.6	34.7	11.7	2.1
Total	2.6	7.5	39.8	35.6	12.3	2.2

D. Local organizations that provide health services (e.g., health care, public health)

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	2.1	5.3	25.2	43.5	21.2	2.7
KnowledgePanel (n = 4,708)	1.9	5.9	36.8	39.8	13.8	1.8
Total	2.0	5.6	34.8	40.6	15.0	2.1

E. Local organizations that provide other social services (e.g., food assistance, job training) such as faith based orgs, nonprofits

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	3.5	4.4	24.8	45.3	19.3	2.7
KnowledgePanel (n = 4,708)	2.0	6.2	36.7	39.1	14.2	1.7
Total	2.1	6.0	34.5	40.0	15.4	2.0

F. Local government

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	6.4	8.3	35.4	37.3	9.9	2.7
KnowledgePanel (n = 4,708)	3.7	9.6	45.8	33.2	5.8	1.9
Total	4.0	9.6	44.0	33.8	6.5	2.2

G. State government leaders

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	6.8	13.2	41.3	29.9	6.2	2.7
KnowledgePanel (n = 4,708)	5.9	12.4	51.7	23.8	4.3	1.9
Total	6.1	12.9	49.5	24.8	4.5	2.2

E. Federal government leaders

Sample	Very Negative	Somewhat Negative	No Difference	Somewhat Positive	Very Positive	Missing
ALP (n = 2,479)	9.7	14.4	42.0	25.0	6.1	2.8
KnowledgePanel (n = 4,708)	8.6	13.4	53.2	19.4	3.4	2.0
Total	9.1	13.9	51.1	19.9	3.8	2.2

SOURCES: RAND and RWJF.

Q19. There are many activities that a person could do to influence government decisions about health issues. During the past year have you . . .**A. 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 (n = 2,479)	46.0	51.4	2.6
KnowledgePanel (n = 4,708)	38.0	59.8	2.3
Total	40.1	57.5	2.4

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

Sample	Yes	No	Missing
ALP (n = 2,479)	57.5	39.9	2.6
KnowledgePanel (n = 4,708)	49.2	48.5	2.2
Total	50.7	47.0	2.4

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

Sample	Yes	No	Missing
ALP (n = 2,479)	26.4	70.9	2.6
KnowledgePanel (n = 4,708)	15.8	82.0	2.2
Total	18.2	79.4	2.4

D. Lobbied or advocated for a health-related cause in your community. (This may include signing a petition, calling a public official, disseminating information via social media, participating in demonstrations)

Sample	Yes	No	Missing
ALP (n = 2,479)	28.0	69.4	2.6
KnowledgePanel (n = 4,708)	18.1	79.5	2.3
Total	20.6	76.9	2.5

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

Sample	Yes	No	Missing
ALP (n = 2,479)	26.2	71.2	2.6
KnowledgePanel (n = 4,708)	19.1	78.6	2.4
Total	21.2	76.4	2.5

F. Ever served as an elected appointee or official

Sample	Yes	No	Missing
ALP (n = 2,479)	11.8	85.6	2.6
KnowledgePanel (n = 4,708)	6.8	90.7	2.5
Total	7.8	89.7	2.5

SOURCES: America's Health Agenda: Priorities and Performance Rating Survey (Harvard School of Public Health, 2011) (revised), and CPS Civic Engagement Supplement (U.S. Census Bureau, 2018); adapted by RAND and RWJF.

Q20. 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.

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 (n = 2,479)	7.0	11.9	32.2	24.1	22.0	2.8
KnowledgePanel (n = 4,708)	8.5	9.9	39.5	23.9	16.1	2.1
Total	7.8	10.0	38.1	24.1	17.6	2.4

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 (n = 2,479)	6.5	9.5	25.4	31.8	24.1	2.8
KnowledgePanel (n = 4,708)	5.5	7.9	33.6	28.7	22.2	2.2
Total	5.2	8.1	32.1	29.5	22.7	2.4

C. People offer suggestions but only those coming from certain groups or individuals are addressed

Sample	1 Not a Barrier at All	2	3	4	5 Major Barrier	Missing
ALP (n = 2,479)	7.1	12.0	34.6	24.4	19.1	2.8
KnowledgePanel (n = 4,708)	7.4	11.4	40.8	23.9	14.3	2.2
Total	7.1	11.5	39.4	24.5	15.1	2.4

D. There are other issues people care more about

Sample	1 Not a Barrier at All	2	3	4	5 Major Barrier	Missing
ALP (n = 2,479)	4.9	9.6	30.1	28.8	23.8	2.8
KnowledgePanel (n = 4,708)	4.7	7.2	38.3	29.2	18.2	2.4
Total	4.6	7.7	36.8	29.6	18.8	2.6

SOURCES: RAND and RWJF.

Q21. 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 = 2,479)	10.5	37.5	33.6	13.4	2.5	2.5
KnowledgePanel (n = 4,708)	10.3	36.0	36.7	12.6	3.2	1.2
Total	10.2	36.7	35.7	12.7	3.2	1.5

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

Q22. How would you rate the importance of the following items on a scale from: 1 (Not at all important) to 5 (Very important)?

A. Religion and/or spirituality in your life

Sample	1 Not at All Important	2	3	4	5 Very Important	Missing
ALP (n = 2,479)	18.2	9.5	15.3	15.5	38.8	2.8
KnowledgePanel (n = 4,708)	18.2	9.9	19.4	16.5	34.5	1.5
Total	17.7	9.7	19.1	16.3	35.3	1.9

SOURCES: RAND and RWJF.

B. Religion and/or spirituality in the choices you make about health

Sample	1 Not at All Important	2	3	4	5 Very Important	Missing
ALP (n = 2,479)	29.3	11.8	19.4	16.2	20.5	2.8
KnowledgePanel (n = 4,708)	27.7	12.0	24.0	15.2	19.6	1.5
Total	27.5	11.9	23.6	15.1	20.1	1.9

SOURCES: FICA Spirituality Assessment Tool scale item (Borneman, Ferrell, and Puchalski, 2010), revised by RAND.

Q23. Has the poor health of another person affected your life on an ongoing basis for any extended period of time?

Sample	Yes	No	Missing
ALP (n = 2,479)	46.0	51.5	2.5
KnowledgePanel (n = 4,708)	34.8	63.7	1.5
Total	37.8	60.4	1.8

SOURCES: Personal Health Experience Scale (Brooks et al., 2013), revised by RAND.

Q24. Do you personally currently have one or more chronic health conditions (e.g., diabetes, asthma, depression)?

Sample	Yes	No	Missing
ALP (n = 2,479)	37.3	60.0	2.7
KnowledgePanel (n = 4,708)	34.1	64.0	1.9
Total	35.0	62.9	2.1

SOURCE: RAND.

Q25. Have you ever had financial problems because of a health issue for yourself and/or others?

Sample	Yes	No	Missing
ALP (n = 2,479)	31.1	66.3	2.6
KnowledgePanel (n = 4,708)	23.2	75.1	1.7
Total	24.8	73.2	1.9

SOURCE: RAND.

Q26. 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) 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 (n = 2,479)	14.6	9.1	8.2	10.5	19.9	35.0	2.6
KnowledgePanel (n = 4,708)	8.7	8.4	6.5	8.2	12.2	54.6	1.6
Total	9.8	8.9	7.3	9.1	13.8	49.3	1.9

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

Q27. Have you ever personally experienced discrimination or been treated unfairly because of an ongoing health issue or condition or because of disability?

Sample	Yes	No	Missing
ALP (n = 2,479)	15.2	82.3	2.5
KnowledgePanel (n = 4,708)	12.0	86.4	1.5
Total	13.2	85.0	1.8

SOURCES: RAND and RWJF.

Q28. Is there a place that you usually go to when you are sick or need advice about your health?

Sample	Yes	There Is No Place	There Is More Than One Place	Don't Know	Missing
ALP (n = 2,479)	68.7	9.0	13.1	6.8	2.5
KnowledgePanel (n = 4,708)	65.4	9.8	14.2	9.1	1.4
Total	65.7	9.5	14.3	8.9	1.7

Q28a. If YES: What kind of place do you go to most often—a clinic, doctor’s office, emergency room, or some other place?

Sample	Clinic or Health Center	Doctors Office or HMO	Hospital Emergency Room	Hospital Outpatient Dept.	Some Other Place	I Don’t Go to One Place Most Often	Don’t Know	Missing
ALP (n = 2,170)	24.9	66.7	3.2	0.9	2.7	1.1	0.5	0.0
KnowledgePanel (n = 3,918)	21.6	68.4	2.5	1.8	2.7	2.1	0.7	0.2
Total	22.7	67.5	2.6	1.7	2.7	2.0	0.7	0.1

SOURCE: National Health Interview Survey (Centers for Disease Control and Prevention, 2019).

Q29. 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 (n = 2,479)	55.9	34.6	5.8	3.7
KnowledgePanel (n = 4,708)	51.9	41.2	5.5	1.4
Total	51.6	40.6	5.7	2.1

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 (n = 2,479)	12.5	74.4	8.0	5.1
KnowledgePanel (n = 4,708)	9.6	82.0	7.0	1.4
Total	10.3	79.8	7.3	2.6

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 (n = 2,479)	12.7	73.6	8.0	5.7
KnowledgePanel (n = 4,708)	11.3	79.6	7.5	1.5
Total	11.9	77.4	7.8	2.8

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

Sample	Covered	Not Covered	Not Sure	Missing
ALP (n = 2,479)	24.0	62.9	8.1	5.0
KnowledgePanel (n = 4,708)	25.1	67.6	5.9	1.4
Total	24.8	66.0	6.6	2.5

[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 (n = 2,479)	14.1	72.4	8.3	5.2
KnowledgePanel (n = 4,708)	13.9	77.9	6.8	1.4
Total	14.5	75.5	7.2	2.7

TRICARE or other military health care, including VA health care

Sample	Covered	Not Covered	Not Sure	Missing
ALP (n = 2,479)	6.8	79.5	8.6	5.1
KnowledgePanel (n = 4,708)	7.2	84.5	6.8	1.4
Total	7.2	82.7	7.4	2.7

Indian Health Service

Sample	Covered	Not Covered	Not Sure	Missing
ALP (n = 2,479)	2.9	83.1	8.4	5.6
KnowledgePanel (n = 4,708)	2.2	89.1	7.2	1.5
Total	2.4	87.0	7.6	2.9

Any other type of health insurance coverage or health coverage plan

Sample	Covered	Not Covered	Not Sure	Missing
ALP (n = 2,479)	8.1	75.3	10.8	5.8
KnowledgePanel (n = 4,708)	7.3	83.2	8.0	1.5
Total	7.5	80.9	8.7	2.9

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 Q29a:

Q29a. 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 (n = 2,479)	57.8	23.5	18.8
KnowledgePanel (n = 4,708)	62.7	30.2	7.1
Total	60.9	29.8	9.4

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

Q30. Are you or a close family member a medical doctor, nurse, or other health care professional? (Check all that apply)

	Yes, I am.	Yes, a close family member is.	No	Missing
	Selected	Selected	Selected	
ALP (n = 2,479)	9.3	20.5	69.1	2.6
KnowledgePanel (n = 4,708)	6.9	16.4	76.0	1.7
Total	7.3	17.6	74.5	1.9

SOURCE: RAND.

NOTE: Because respondents were asked to select all that apply, the total may sum to more than 100 percent.

Q31. How confident are you that you can:

Manage any health problems you have

Sample	Not Confident at All	Not Too Confident	Somewhat Confident	Very Confident	Missing
ALP (n = 2,479)	3.5	8.0	48.4	37.5	2.6
KnowledgePanel (n = 4,708)	4.5	11.2	51.4	31.4	1.5
Total	4.6	10.5	50.7	32.4	1.8

Prevent health problems in the first place

Sample	Not Confident at All	Not Too Confident	Somewhat Confident	Very Confident	Missing
ALP (n = 2,479)	3.8	14.5	57.3	21.9	2.6
KnowledgePanel (n = 4,708)	5.0	15.1	57.9	20.2	1.8
Total	4.9	14.9	57.6	20.6	2.0

SOURCE: American Health Values Segmentation Study (NORC, 2015), revised by RAND.

Q32. How long have you lived in your community?

Sample	Less Than 5 Years	5 to 9 Years	10 to 19 Years	20 or More Years	Missing
ALP (n = 2,479)	24.6	13.8	19.4	39.6	2.6
KnowledgePanel (n = 4,708)	22.4	14.9	24.3	37.1	1.2
Total	22.3	14.8	23.6	37.7	1.6

SOURCES: RAND and RWJF.

Q33. While you have lived in your current community, has the community experienced a major stressful event like a natural disaster, economic challenge like a plant closure, major incident of community violence?

Sample	Yes	No	Missing
ALP (n = 2,479)	28.1	69.4	2.5
KnowledgePanel (n = 4,708)	23.9	74.6	1.6
Total	25.0	73.2	1.9

SOURCES: RAND and RWJF.

Q33a. If yes: As a result of this event, were you temporarily or permanently displaced from your home or community?

Sample	Yes	No	Missing
ALP (n = 2,479)	11.3	80.5	8.2
KnowledgePanel (n = 4,708)	13.6	79.7	6.6
Total	13.4	79.2	7.4

SOURCES: RAND and RWJF.

Q34. Have you ever lived outside the country for a year or more?

Sample	Yes	No	Missing
ALP (n = 2,479)	11.7	85.8	2.5
KnowledgePanel (n = 4,708)	11.8	86.7	1.5
Total	11.8	86.5	1.7

SOURCES: RAND and RWJF.

NOTE: Respondents who answered yes were asked to list the name of the country (or countries) they have lived in.

Survey Respondent Demographics

Both panels collect demographic information about respondents separately and provide this information with each data set. This section presents the survey respondents' unweighted demographic characteristics.

Respondents by Age Group, in Years

Sample	18 to 24	25 to 44	45 to 64	65+
ALP (<i>n</i> = 2,479)	0.6	20.3	46.5	32.7
KnowledgePanel (<i>n</i> = 4,708)	5.0	29.0	40.4	25.6
Total	3.5	25.9	42.5	28.1

NOTE: 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 2018 survey. The KnowledgePanel sample was not restricted in this way.

Respondents by Race and Ethnicity

Sample	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian or Pacific Islander	Non-Hispanic All Other Races
ALP (<i>n</i> = 2,479)	71.5	9.8	13.8	2.7	2.3
KnowledgePanel (<i>n</i> = 4,708)	70.9	9.1	13.0	3.5	3.5
Total	71.1	9.3	13.3	3.2	3.1

Respondents by Gender

Sample	Male	Female
ALP (<i>n</i> = 2,479)	43.4	56.6
KnowledgePanel (<i>n</i> = 4,708)	47.6	52.4
Total	46.2	53.8

Respondents by U.S. Region

Sample	Northeast	Midwest	South	West	Unknown
ALP (<i>n</i> = 2,479)	17.6	18.0	34.4	28.4	1.5
KnowledgePanel (<i>n</i> = 4,708)	18.7	22.1	36.3	22.9	. ^a
Total	18.3	20.7	35.7	24.8	0.5

^a The period indicates true 0 (rather than a number that has been rounded down to 0.)

Respondents by Education Level

Sample	Less Than High School	High School	Some College	College Graduate
ALP (<i>n</i> = 2,479)	2.7	11.5	35.6	50.2
KnowledgePanel (<i>n</i> = 4,708)	7.5	28.0	28.5	36.1
Total	5.8	22.3	31.0	40.9

Respondents by Marital Status

Sample	Married or Living with a Partner	Separated	Divorced	Widowed	Never Married
ALP (<i>n</i> = 2,479)	58.5	2.7	16.5	6.7	15.6
KnowledgePanel (<i>n</i> = 4,708)	67.0	1.4	10.0	4.6	17.0
Total	64.1	1.9	12.3	5.3	16.5

Respondents by Number of Household Members

Sample	1	2	3	4	5	6	7	8	9	10	11	12
ALP (<i>n</i> = 2,479)	24.7	40.3	14.0	10.6	6.0	2.6	0.9	0.4	0.2	0.1	0.1	0.0
KnowledgePanel (<i>n</i> = 4,708)	18.8	39.8	16.7	13.6	6.4	3.0	1.3	0.2	0.1	0.2	. ^a	. ^a
Total	20.8	40.0	15.7	12.6	6.2	2.8	1.2	0.3	0.2	0.2	0.0	0.0

^a The period indicates true 0 (rather than a number that has been rounded down to 0.)

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> = 2,479)	2.8	14.2	23.6	21.7	11.2	26.3
KnowledgePanel (<i>n</i> = 4,708)	3.8	10.6	19.8	17.0	13.6	35.2
Total	3.5	11.8	21.1	18.6	12.8	32.1

Respondents' Work Status

Sample	Working as a Paid Employee	Working Self- Employed	Not Working— on Temporary Layoff	Not Working— Looking for Work	Not Working— Retired	Not Working— Disabled	Not Working— Other
ALP (<i>n</i> = 2,479)	46.4	8.0	0.8	3.5	29.9	6.0	5.4
KnowledgePanel (<i>n</i> = 4,708)	51.6	7.9	0.4	4.9	24.3	4.2	6.8
Total	49.8	7.9	0.5	4.4	26.2	4.8	6.3

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