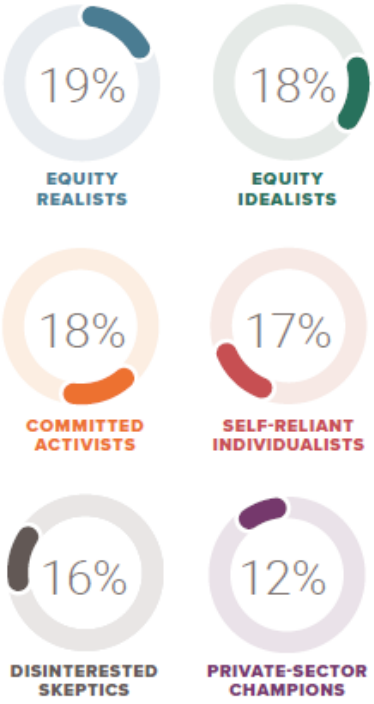
www.norc.org | info@norc.org December 2022

American Health Values Survey and Typology: Race-Ethnic Differences

Alyssa Ghirardelli, Petry Ubri, Praveen Karunatileka, Erin Tanenbaum, and Larry Bye

NORC at the University of Chicago conducted the American Health Values Survey (AHVS) for the Robert Wood Johnson Foundation in 2016 and 2020. The survey focused on health values and beliefs among U.S. adults, including social equity and solidarity values, perceptions about the existence of health care disparities, impact of social and environmental factors on health, government involvement in health, and health-related civic engagement. NORC used the data from the AHVS to create typologies in 2016 and 2020, classifying U.S. adults into six segments or typology groups based on their health values and beliefs (Figure 1).

Figure 1. The Six National Typology Groups in 2020



Typology Group Differences

The typology group most supportive of population health and health equity, **Committed Activists,** are strong believers in equal opportunity for success, and acknowledge the existence of race-ethnic and income-based health care disparities, and the role of social and environmental factors in influencing health. Two other supportive typology groups, **Equity Idealists**[1] and **Equity Realists**,[2] differ from the Committed Activists largely because they do not agree on the importance of the social and environmental factors in health and existence of health care disparities. The two typology groups less supportive of population health, **Self-Reliant Individualists** and **Disinterested Skeptics**, are skeptical on issues related to health equity. **Private Sector Champions** are aligned in some cases, but are conflicted about the role of government in health and would prefer that the leadership for healthy communities come from the private sector.[3]

This brief describes differences in typology groups, health values, and beliefs among different race-ethnic populations.

[1] Equity Advocates in 2016 were renamed in 2020 as Equity Realists to reflect key changes in values that distinguished them from the prior typology group.
[2] Health Egalitarians in 2016 were renamed in 2020 as Equity Idealists to reflect key changes in values that distinguished them from the prior typology group.
[3] More information on the profiles of these groups is included in the 2020 AHVS II Report and the accompanying brief.

Race-Ethnic Populations Leaned Toward Support More than Skepticism in 2020

We analyzed the 2020 AHVS data to examine the typology groups by race-ethnic populations (see Table 1). The figure shows the percentage of the typology groups within each race-ethnic population.

Table 1. Percentage of Typology Groups among Race-Ethnic Populations in 2020

	White	Black	Hispanic/ Latino	Multi-racial	Asian/NHOPI	AI/AN
Committed Activists	12	38	24	17	20	8
Equity Idealists	19	12	16	15	19	26
Equity Realists	19	22	22	19	21	12
Private-Sector Champions	11	15	12	12	11	16
Self-Reliant Individualists	20	7	14	20	18	7
Disinterested Skeptics	19	7	12	17	11	31

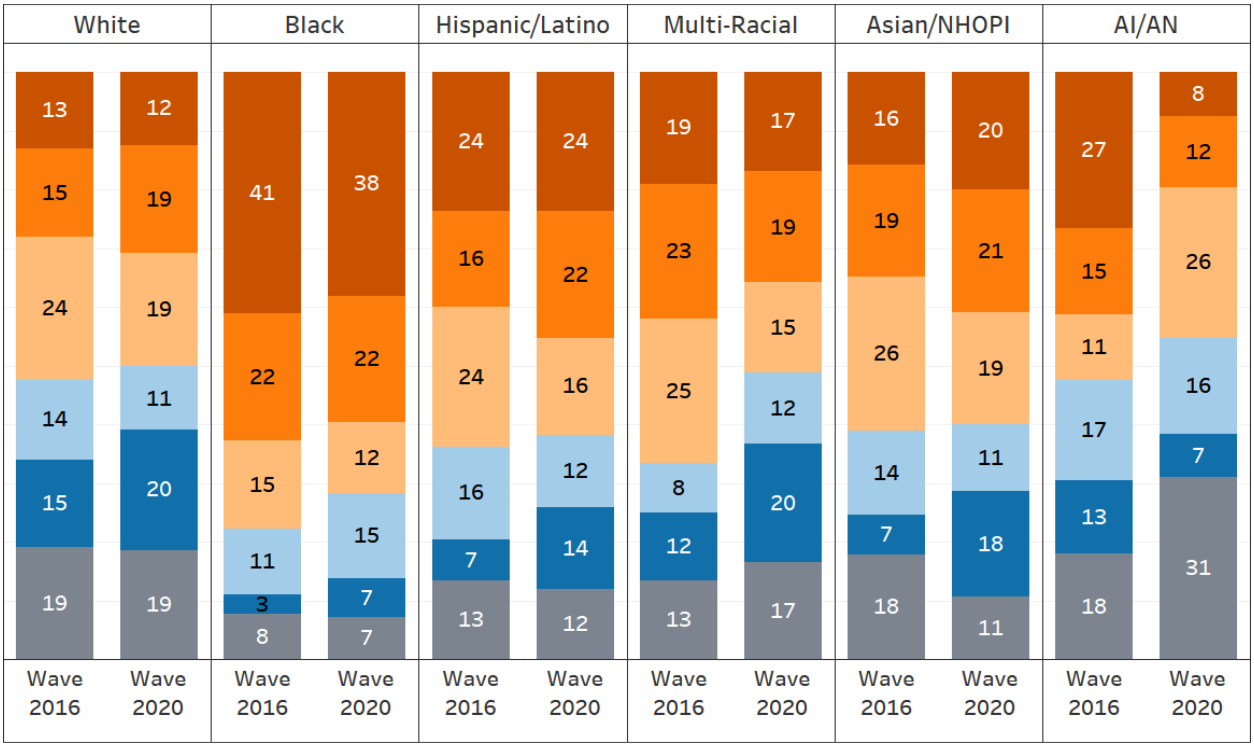
The populations are ordered based on their size in the sample from the largest to the smallest. Race-ethnic population naming conventions are: Non-Hispanic (NH) White populations as White, NH Black or African American populations as Black, Hispanic with another race or no other race as Hispanic/Latino, NH Asian, Native Hawaiian, and Other Pacific Islander populations as Asian/NHOPI, NH American Indian/Alaskan Native populations as AI/AN, and NH individuals of two or more races as Multi-racial. See Table 2 in Analysis Methodology at the end of the brief for sample sizes and additional information.

- Over 70% of Black persons fell into one of the three supportive typology groups, the highest of any race-ethnic population. Black persons had the highest number of Committed Activists (38%). They also had the fewest skeptical typology groups, with only 7% falling into Self-Reliant Individualists and 7% into Disinterested Skeptics.
- Nearly two-thirds of Hispanic/Latino persons fell into one of the three supportive typology groups. Nearly a quarter (24%) were in Committed Activists and 22% in Equity Realists.
- The majority (60%) of Asian/Native Hawaiian and other Pacific Islander (NHOPI) persons fell into supportive typology groups; 21% in Equity Realists and 20% in Committed Activists.
- Half of Multi-racial persons (51%) were in supportive typology groups. However, 20% fell into a skeptical typology group, the Self-Reliant Individualists.
- White persons were evenly split between supportive (50%) and skeptical/conflicted typology groups; most fell into the Self-Reliant Individualists (20%) followed by Disinterested Skeptics (19%), and another even split between Equity Idealists (19%) and Equity Realists (19%).
- Although the number of American Indian/Alaska Native (AI/AN) persons in the sample was too small to confidently speak to differences (n=41), to honor their participation, we have reported descriptive findings. A majority (54%) fell into the skeptical/conflicted typology groups in 2020. AI/AN persons had the highest percent of Disinterested Skeptics (31%) among all populations.

Skeptical and Conflicted Typology Groups Grew in Size from 2016 to 2020 across All Race-Ethnic Populations, with the Highest Increases among Multi-racial Persons

Figure 2 presents the differences in typology groups from 2016 to 2020, by race-ethnicity. The warm colors (orange, red) represent the supportive groups and the cool colors (dark blue, grey) represent the skeptical groups. Light blue represents the conflicted group of Private-Sector Champions.

Figure 2. Typology Groups Within Race-Ethnic Populations in 2016 and 2020[b]



- In both 2016 and 2020, majorities of U.S. adults fell into one of the three supportive typology groups with 57% falling into supportive typology groups in 2016 and 55% in supportive groups in 2020.
- However, there were shifts from supportive to skeptical or conflicted typology groups from 2016 to 2020 across all race-ethnic populations, with the largest shift among Multi-racial persons. Skeptical and conflicted typology groups grew among Multi-racial persons from a combined 33% in 2016 to 49% in 2020.
- The race-ethnic population with the single largest shift in a typology group was Asian/NHOPI persons, with an increase from 7% to 18% in Self-Reliant Individualists.
- Hispanic/Latino persons also had relatively large shifts with a drop from 24% to 16% in Equity Idealists and an increase from 7% to 14% in Self-Reliant Individualists.
- The percentage of skeptical and conflicted typology groups also increased from 22% to 28% among Black persons and from 48% to 55% among AI/AN persons.

Key Health Values and Beliefs among Race-Ethnic Populations

This section compares survey data across race/ethnic populations on individual questions in the survey that explore health equity, disparities in access to care, and perceptions of the effects social and environmental factors have on health. Statistical comparisons were conducted using t-tests to identify statistically significant differences between race-ethnic populations and all other respondents within each wave for specific survey items.

EQUITY VALUES AND BELIEFS

Disparities in health are rooted in race-ethnic inequities.[a] Exploring differences in health values and beliefs by race-ethnicity can provide insights to understand the potential factors and relationships that lead to disparities in access, quality, and outcomes.

Black and Hispanic/Latino Persons Reported Strong Views on Health Equity and Equal Opportunity to Succeed Compared to Other Race-ethnicities

Health Equity:

- Seventy-nine percent of Black persons strongly agreed with the statement *"our country should do whatever is necessary to make sure everyone has an equal opportunity to be healthy"* compared to all other race-ethnic populations (56%). However, this gap shrank in 2020 as more of all other race-ethnic populations (60%) strongly agreed with the idea of health equity while the percent of Black persons who strongly agreed did not change.
- Differences between Hispanic/Latino persons and other race-ethnic populations were not as large, with 66% strongly agreeing with the statement on health equity compared to 57% of all other populations of Non-Hispanic persons in 2016 and, in 2020, 70% of Hispanic/Latino persons compared to 61% of Non-Hispanic persons in 2020.
- White persons were less likely to strongly agree with health equity beliefs compared to all others (57% of White persons versus 72% all other populations in 2020; and 53% versus 68% in 2016).

Equal Opportunity:

- More Black persons (71%) strongly agreed with the statement *"our country should do whatever is necessary to make sure that everyone has an equal opportunity to succeed"* compared to all other race-ethnic populations (48%) in 2020, with similar differences in 2016 (72% Black persons versus 45% all others, a 27-percentage point difference).
- More Hispanic/Latino persons (59%) strongly agreed with this statement in 2016, compared to 46% of Non-Hispanic persons. The gap shrank slightly in 2020 with more Non-Hispanic persons who strongly agreed with the statement (59% Hispanic/Latino persons compared to 49% Non-Hispanic persons in 2020).
- More (60%) Asian/ NHOPI persons also strongly agreed with the statement compared to 51% of all other race-ethnic populations in 2020.
- Fewer White persons strongly agreed with this statement, though differences between White persons and other race-ethnic populations decreased from 2016 to 2020 (41% vs 62%, 2016; 45% vs 62%, 2020).

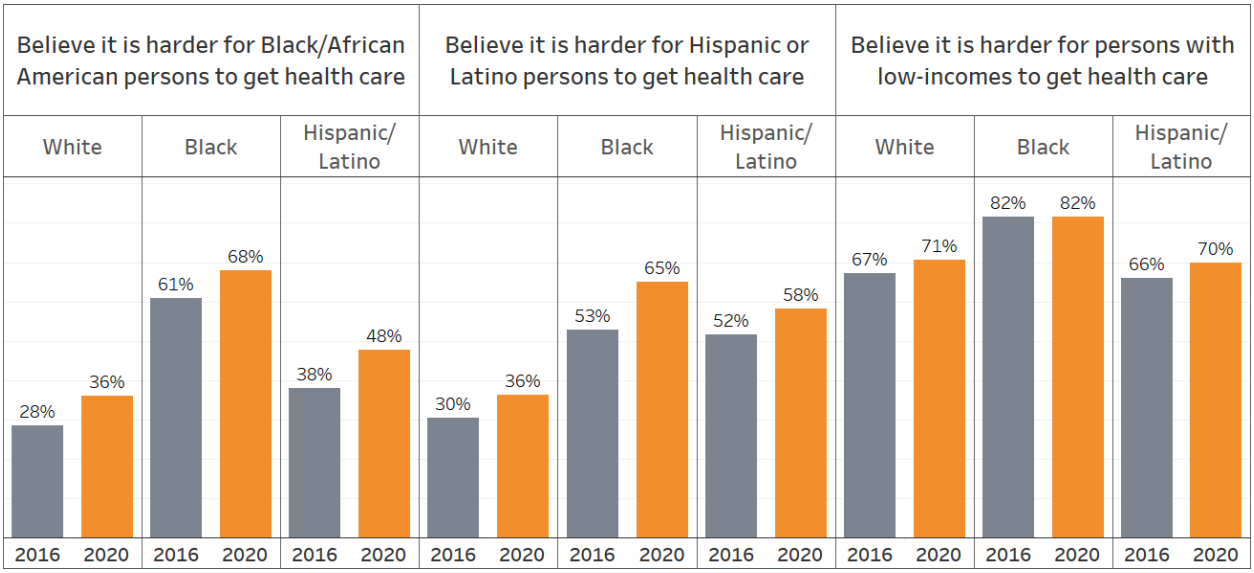
PERCEIVED DISPARITIES IN ACCESS TO HEALTH CARE

There are documented disparities in access to care by race-ethnicity. Black, Hispanic/Latino, and AI/AN persons often have less access to and use of care, including lower health insurance coverage and lack of a usual doctor or provider as compared with White persons.[b] The AHVS asked respondents whether it was easier or harder for Black/African American or Hispanic/Latino persons to get the care they need than for White Americans, and for those with lower incomes compared to those who are better off financially.

Black and Hispanic/Latino Persons Perceived the Existence of Disparities in Access to Health Care More Frequently than Other Race-Ethnic Populations

Figure 3 shows increases from 2016 (grey) to 2020 (orange) in beliefs that it is harder for Black persons, Hispanic or Latino persons and those with low incomes to get the health care they need. However, among Black persons, the perception of disparities in access to care for low-income Americans among did not change between the two waves of the survey.

Figure 3: Beliefs about Disparities in Access to Health Care among White, Black and Hispanic/Latino Persons, 2016 and 2020



- More White, Black and Hispanic/Latino persons believe that persons with low incomes have a harder time getting the health care they need than it is for Black/African American persons or those who are Hispanic/Latino. Higher numbers of Black persons believe disparities in health care exist among all these populations.
- More than half of Hispanic/Latino persons believed in the existence of health care disparities for Hispanic/Latino persons. In 2020, nearly half of Hispanic/Latino persons (48%) believed it was harder for Black/African American persons to access health care.
- Less than a third of White persons believed in health care disparities for African American (28%) or Hispanic/Latino (30%) persons in 2016. In 2020, just over a third (36%) believed it is harder for African American or Hispanic/Latino persons to get the health care they need.

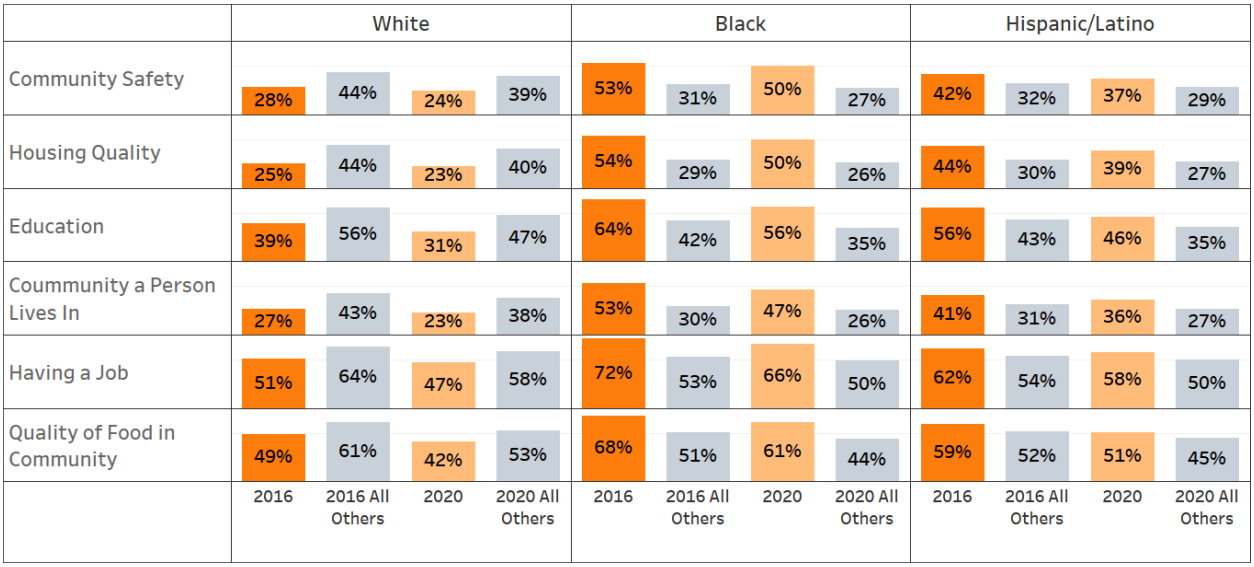
IMPORTANCE OF SOCIAL AND ENVIRONMENTAL FACTORS ON HEALTH

Evidence suggests that social and environmental factors (e.g., employment, education, housing food security) play a major role in health outcomes.[c,d] The AHVS asked respondents how strong of an effect having a job, education, quality of food available in the community, housing quality, community safety, and the community a person lives in, have on people's health.

Belief in the Strong Effects of Social and Environmental Factors Decreased Across Race-Ethnic Populations from 2016 to 2020

Figure 4 shows decreases in beliefs that certain factors have a strong effect on health from 2016 to 2020 among White, Black, and Hispanic/Latino persons (orange bars) compared to all other populations (grey bars).

Figure 4: Beliefs that Social and Environmental Factors Have a Strong Effect on Health among White, Black and Hispanic/Latino Persons, 2016 and 2020



Statistical comparisons were conducted using t-tests to identify statistically significant differences between race-ethnic populations and all other respondents within each wave and across waves.

Differences among Race-Ethnic Populations:

- The starkest differences in beliefs about the effects of social and environmental factors on health (> 20-percentage points) were among Black and Hispanic/Latino persons compared to all others (grey bars) for community safety, housing quality, education, and the community a person lives in.
- Other social and environmental factors, having a job, and the quality of food available in the community, also showed differences, but they were smaller (< 20-percentage points).

Other Key Findings: Perceived Discrimination in the Health Care System

Nearly a third (31%) of Black persons strongly agreed that Black/African American populations tended to be less healthy than White populations due to discrimination in the health care system, compared to only 16% of all other race-ethnic populations in 2020. More than a third (34%) of Black persons also believed this tendency to be less healthy was due to the conditions of the neighborhoods they live in, compared to about a quarter (27%) of all other race-ethnic populations.

Summary

Most race-ethnic populations include a majority of individuals who fall into three typology groups which are supportive of population health and health equity promotional efforts in the U.S., Committed Activists, Equity Idealists and Equity Realists. However, the proportion falling into skeptical or conflicted typology groups, Self-Reliant Individualists, Disinterested Skeptics, and Private-Sector Champions, increased from 2016 to 2020 for all groups. We found race-ethnic differences in specific health values and beliefs related to the importance of health equity and general equality of opportunity, existence of disparities in access to care and the effects of social and environmental determinants on health. Black and Hispanic/Latino persons more often strongly agreed with statements about the importance of health equity, existence of race/ethnic-based disparities in access to care and the strong effects of social and environmental factors on health; White persons were less likely to agree with these statements. There were across-the-board increases in the perceived existence of disparities in access to care from 2016 to 2020. On the effects of social and environmental factors on health, there were significant decreases over time in the proportion of those believing in strong effects of these factors across the race-ethnic populations.

Additional Resources

Visit rwjf.org or everyfamilyforward.org for additional resources.

Topline Tables of Race-Ethnic Differences

The topline data tables provide percentages for each response option for all survey questions from both wave 1 and 2 surveys as well as information about statistical significance.

Comprehensive Report: Findings from the AHVS (2020)

The report describes the survey methodology, 2020 AHVS findings, and changes over time since 2015-2016.

Key Trends from Wave 1 to Wave 2 of the AHVS

This report highlights key trends over the two waves of the survey as well as findings on new issues explored only in the wave 2 survey in 2020.

Analysis Methodology

Respondents were categorized into race-ethnic categories based on analysis of raw, unweighted data of available race/ethnic categories within the 2016 and 2020 AHVS samples. NORC created the final race-ethnic groups for analysis based on information from a variety of sources and subject-matter experts familiar with challenges presented by race-ethnic category designations. The final race-ethnic categories were determined to be Non-Hispanic, White; Non-Hispanic, Black or African American; Hispanic/Latino of Any Race or Without a Race; Non-Hispanic, Two or More Races (Multi-Racial); Non-Hispanic, Asian or Native Hawaiian or Pacific Islander (Asian/NHOPI); and Non-Hispanic, American Indian or Alaska Native (AI/AN). Additionally, NORC examined the differences between 2016 and 2020 in the Hispanic category and the Non-Hispanic, Multi-Racial category by examining the sample source (Amerispeak versus address-based sample) and mode (online, paper/pencil or phone) of respondents. This allowed NORC to identify more complete race-ethnic categories and respondents for additional subgroup analysis. Per consultation with subject matter experts and due to small sample size, the following analytic decisions were made:

- The NHOPI category was combined with the Asian category to create the Non-Hispanic, Asian or Native Hawaiian or Pacific Islander (Asian/NHOPI).
- Respondents that selected two or more and three or more races were combined into the Non-Hispanic, Two or more races (Multi-racial) category.
- Non-Hispanic, AI/AN respondents were included in descriptive tables given interest in ensuring the AI/AN population is represented, even if the sample size is low. However, the AI/AN population was not included in statistical chi-square testing due to small sample size.
- Respondents that selected "Other" as their race and no or non-response (Don't Know, Skipped, Refuse) to Hispanic identity and respondents who gave a non-response for race and Hispanic identity were not included in the analysis.

T-tests were conducted to identify statistically significant differences between race-ethnic populations and all other respondents within each wave for specific survey items using the same dichotomization of responses created for both 2016 and 2020 in the segmentation analysis. T-tests were also used to identify differences between each race-ethnic population across the two years of the survey in 2016 and 2020.

Table 2 presents sample sizes for the race-ethnic populations reported in this study which are for comparison purposes. In this brief, we refer to Non-Hispanic, White populations as White, Non-Hispanic Black or African American populations as Black, Non-Hispanic, Asian, Native Hawaiian, and Other Pacific Islander populations as (Asian/NHOPI), American Indian/Alaskan Native populations as AI/AN, and Non-Hispanic individuals of two or more races as Multi-racial. We also refer to those of Hispanic or Latino/Latina ethnicity as Hispanic/Latino (with any other race or without a race if only Hispanic was selected), acknowledging that the use of Latinx as a term for inclusivity has not been widely accepted by the population[e]. The order of the groups is based on their relative sizes with the largest group presented first, followed by the group with the next largest sample size, and so on, for each of the figures presented.

Table 2: Sample Sizes of Race/Ethnic Categories, by AHVS Survey Year

Race/Ethnic Categories	2016		2020	
	n= 10,207	Percent	n= 8,023	Percent
Non-Hispanic, White	7,468	73	5,591	70
Non-Hispanic, Black or African American	1,073	11	826	10
Hispanic/Latino of Any Race or Without a Race	854	8	981	12
Non-Hispanic, Two or More Races (Multi-racial)	421	4	309	4
Non-Hispanic, Asian or Native Hawaiian and Other Pacific Islander (Asian/NHOPI)	340	3	267	3
Non-Hispanic, American Indian or Alaska Native (AI/AN)	51	1	49	1

Due to small sample size, the AI/AN population was included in descriptive visuals given interest in ensuring the AI/AN population is represented, even if sample sizes are low, but excluded from analyses due to small sample size. Additional Note: Percentages presented in this brief may differ slightly from percentages in the Race-Ethnicity Topline Tables. Respondents who selected Don't Know, Refused, Missing/Blank for race-ethnicity were included in the Topline Tables, but excluded from analysis for this brief.

American Health Values Survey 2016 and 2020 Methodology

The American Health Values Survey was first conducted in 2016 (Wave 1) with the goal of developing a typology based on U.S. adult health values and beliefs. The original AHVS questionnaire from 2016 was developed after an extensive literature review, the convening of a technical expert panel, focus group research, and cognitive testing. As noted in the brief, the survey examined values and beliefs related to a wide variety of health and health equity promotional issues facing the nation. In 2020, the study was conducted again (Wave 2) to assess whether change had taken place in the values and beliefs as well the structure of the typology. In 2020, a few new measures were added to the questionnaire. To deal with the additional survey length, about one half of the final items were asked of half of the sample (n=4,069) and the other one half of items were asked of the other half of the sample (n=4,192).

The data collection period for Wave 1 was from June 2015 through February 2016 and for Wave 2, from December 2019 through July 2020. For both waves, each a separate cross-sectional sample, data was collected using a multi-mode survey design. For each wave two samples were used, an address-based list sample (ABS) and the NORC probability-based survey panel, AmeriSpeak. The Wave 1 dataset from both samples included a total of 10,574 respondents. There were 6,789 respondents from the ABS group and 3,785 from the AmeriSpeak group. The number of respondents by mode for the Wave 1 dataset included:

- Web-based: 5,304
- Telephone interview: 2,001
- Self-administered questionnaire: 3,269

The Wave 2 dataset from both the samples included a total of 8,261 respondents. There were 4,552 respondents from the ABS group and 3,709 from the AmeriSpeak group. Below is the number of respondents by mode in the Wave 2 dataset:

- Web-based: 5,576
- Telephone interview: 609
- Self-administered questionnaire: 2,076

The survey data for each wave were weighted to account for non-response and imbalances in important respondent characteristics (age, sex, race, education, and region). The weights were then normalized to allow for comparison of the two waves.

To develop the typology of U.S. adults following each survey wave, k-means cluster analytical methods were used. K-means is a frequently used classification approach (Maibach, Maxfield, Ladin &Slater, 2014) that seeks to identify a set of mutually exclusive segments based on the input variables. In our case the input variables were all measures of values/beliefs and not measures of demographic or other characteristics. In k-means, randomly selected cluster centroids are selected, and observations are partitioned into k clusters based on each observation's distance from the cluster mean (centroid), with the goal of identifying an optimal solution where the observations within each cluster are similar and the difference between the cluster means is greatest. New typologies were developed after each wave using these same methods. The overall process was standardized to ensure that we could validly assess change over time in the resulting typologies.

Acknowledgements

Support for this publication was provided by a contract from the Robert Wood Johnson Foundation.

References

[a] https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

[b] https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-coverage-and-access-to-and-use-of-care/

[c] U.S. Department of Health and Human Services O of DP and HP (ODPHP). Social Determinants of Health. Healthy People 2030. Accessed December 12, 2021. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

[d] Manatt P& P. Medicaid's Role in Addressing Social Determinants of Health.; 2019. Accessed December 12, 2021. https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-inaddressing-social-determinants-of-health.html

[e] Latinx Used by Just 3% of U.S. Hispanics. About One-in-Four Have Heard of It. | Pew Research Center

ABOUT NORC

NORC at the University of Chicago is an independent research organization headquartered in downtown Chicago with additional offices on the University of Chicago's campus, the DC Metro area, Atlanta, Boston, and Sacramento. NORC also supports a nationwide field staff as well as international research operations. With clients throughout the world, NORC collaborates with government agencies, foundations, educational institutions, nonprofit organizations, and businesses to provide data and analysis that support informed decision-making in key areas, including health care, education, economics, crime, justice, and energy. NORC's decades of leadership and experience in data collection, analysis, and dissemination—coupled with deep subject matter expertise—provide the foundation for effective solutions.