American Health Values Survey and Typology: Urban and Rural Differences

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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).

**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 In both 2020 and 2016 a majority of U.S. adults fall into the three supportive groups. The structure of the typologies are similar at both points in time.

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.
This brief describes differences in typology groups, health values and beliefs, between U.S. adults residing in urban and rural portions of the country.

We analyzed the 2020 AHVS data to examine how the typology groups are distributed in both urban and rural communities. Information about the urban and rural assignments are provided at the end of this brief in a description about our methodology. Figure 2 below presents the differences in the relative sizes of the typology groups among adults living in urban and rural communities from the 2020 survey.

**Figure 2. Percentage of Typology Groups among Urban and Rural Communities in 2020**

- In 2020, the majority (56%) of U.S. adults in urban settings fell into three typology groups supportive of health and health equity promotion (the Committed Activists, Equity Realists and Equity Idealists depicted in yellow in Figure 2). While the relative percentages for each of those groups was different in rural settings, these supportive groups still collectively made up the largest group of rural adults (48%).

- The remainder of U.S. adults fell into two skeptical groups (Disinterested Skeptics and Self-Reliant Individualists shown in Figure 2 in grey) and another with conflicted views, the Private-Sector Champions (Figure 2 in orange). The proportion of Private Sector Champions in both rural and urban settings was similar (12% versus 13%), but rural adults were more likely to fall into the skeptical groups (40% versus 32%).

- Compared to the proportions for each group on a national basis (as shown in Figure 1), urban adults were more similar to the national sample in 2020 than rural adults. Similar proportions urban adults were supportive of health and health equity promotion (55% in the national sample versus 56% of urban adults), skeptical (33% versus 32%), and conflicted (12% in both the national and urban samples).
**Skeptical Typology Groups Grew in Size from 2016 to 2020 among Rural Communities**

Figure 3 presents the differences in typology groups from 2016 (Wave I) to 2020 (Wave II), by urban and rural communities. The grey bars represent the percentage of individuals falling into each of the typology groups who live in urban areas and the orange bars, those living in rural areas.

**Supportive Typology Groups in Urban and Rural Communities**

As shown in Figure 3, support for health and health equity promotion has been broad in both urban and rural America. In 2016 (Wave I), 58% of adults living in urban areas fell into the three supportive groups, Committed Activists, Health Egalitarians and Equity Advocates; in 2020 (Wave II), 56% of urban adults fell into the three supportive groups. In rural America, the proportions of the three supportive groups were slightly smaller, yet still sizeable—51% in 2016 and 48% in 2020. Two of the three supportive groups, Committed Activists and Equity Advocates (2016)/Equity Realists (2020) were largest in urban portions of the nation. The other supportive group, Health Egalitarians (2016)/Equity Idealists (2020) were largest in rural portions of the nation.

**Skeptical/Conflicted Typology Groups in Urban and Rural Communities**

Skepticism grew in rural America, from 2016 (Wave I) to 2020 (Wave II): the percentage of rural adults falling into the two skeptical groups, Self-Reliant Individualists and Disinterested Skeptics, increased from 32% in 2016 to 40% in 2020. These two groups are also more common in rural than urban America. So too is the conflicted, Private-Sector Champions group, however, this group shrank from 2016 to 2020 among both urban and rural areas. The group that changed the most in size over time was the Self-Reliant-Individualists, which increased in size in both urban and rural areas between 2016 and 2020.
Similarities and Differences in Health Values and Beliefs

While the previous section compared the typologies, this section compares the specific health values and beliefs of urban and rural adults. Overall, we found both similarities⁴ and differences between urban and rural groups. Key similarities include a shared sense of moral obligation to care for others and an embrace of social equity and solidarity values. Urban and rural groups were also similar in their level of health-related civic engagement and belief in collective efficacy (a shared belief that working together can create positive results).

Key differences include urban adults being more likely to acknowledge the existence of health care disparities; to ascribe race/ethnic disparities in health outcomes to systemic causes; and to support government action in health. Details about these group comparisons are presented below. This section also notes important shifts from 2016 to 2020.

SIMILARITIES IN URBAN AND RURAL AREAS

Social Equity/Solidarity Values:

- Urban and rural adults in both years were equally likely to believe in health equity (society should ensure an equal opportunity to be healthy), solidarity (people should be as concerned about the needs of others as they were about their own needs) and equal opportunity (everyone should have an equal opportunity to succeed).

Collective Efficacy:

- Urban and rural adults were also equally likely to believe that people in their communities could work together to make it a healthier place to live.

Health-related Civic Engagement:

- Both urban and rural adults were equally likely to be civically engaged in health.

Self-Efficacy for Health:

- Both reported similar self-efficacy for medical care seeking and managing medical conditions.

Beliefs about the Role of Government in Health:

- Adults in both groups in 2020 also believed that the government should ensure health equity and healthcare as a matter of right.⁵ These data were only collected in the 2020 survey.

Moral Obligation:

- Both urban and rural adults believed in moral obligations to help the poor, sick, and old and show compassion to others.⁵

Inequality of Income and Opportunity:

- Adults in both groups believed that income inequality was a serious societal issue that should be addressed.

Beliefs about the Role of Government in Areas Outside Health:

- Adults in both groups believed that government should address income inequality. They also agreed that the government should ensure an equal opportunity to succeed.⁵

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⁴ Similarities were defined as those variables where there were no statistically significant differences between groups.

⁵ These data were only collected in the 2020 survey.
Health Care Disparities:
- Both groups were equally unlikely to believe in urban and rural health outcome disparities.\(^5\)

Health Outcomes Disparities
- Both groups believed that low-income people’s reduced lifespan is an important problem that they were willing to address.\(^6\)

**DIFFERENCES IN URBAN AND RURAL AREAS**

Health Care Disparities:
- In both years, urban adults were much\(^7\) more likely to believe in racial/ethnic and income-based health care disparities.

Health Outcomes Disparities
- In 2020, urban adults were more likely to ascribe racial/ethnic health outcome disparities to systemic causes.\(^6\)

Importance of the Social Determinants of Health:
- In 2020 urban adults’ belief in the importance of the social determinants of health relative to rural adults was mixed – they were more likely to believe that quality of food, community of residence, and community safety affected health, less likely to believe that housing had an impact, and equally likely in terms of employment and education.

Beliefs about the Role of Government in Health:
- Urban adults in both years were more likely to say that the government needed to do more on health, should make health and healthy communities top priorities, and assume responsibility for building healthy communities at the local level.

Inequality of Income and Opportunity:
- Urban adults were less likely to believe that all groups in the U.S. have an equal opportunity to succeed.\(^6\)

Importance of Personal Health:
- Urban adults in both years were more likely to prioritize personal health in daily living, but measures within the disease prevention and medical care seeking domains were mixed. For example, urban adults were more likely to engage in exercise and weight maintenance, but not limiting portions and stress reduction.

Self-Efficacy for Health:
- Urban adults in 2020 were more likely to report higher levels of disease prevention self-efficacy.

Trust in Science and the Health Care System:
- Conversely, rural adults in 2016 and 2020 were much\(^8\) less likely overall to report trust in science.

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\(^5\) These data were only collected in the 2020 survey.
\(^6\) On average, 16% of rural adults in both years did not believe in racial/ethnic or income-based disparities, compared to 11% of urban adults.
\(^7\) On average, 59% of rural adults did not trust in science versus 57% of urban adults.
CHANGES FROM 2016 TO 2020

Key findings include increases among both groups from 2016 to 2020 in the embrace of health equity as well as support for government action in health. There were also declines for both groups in the importance of the social determinants of health, belief in the existence of race/ethnic- and income-based health care disparities, trust in science and the health care system and in self-efficacy for health.

Social Equity/Solidarity Values:
- Both urban and rural adult’s belief in the importance of health equity increased from 2016 to 2020. Urban adults’ belief in the importance of equal opportunity for success increased, but their belief in social solidarity decreased.

Collective Efficacy:
- Urban adults’ belief in collective efficacy dropped from 2016 to 2020.

Health Care Disparities:
- Both urban and rural adults were more likely to see racial/ethnic and income-based health care disparities in 2020.

Importance of the Social Determinants of Health:
- Both groups’ beliefs in social determinants of health decreased from 2016 to 2020.

Beliefs about the Role of Government in Health:
- Both groups support for government involvement in health increased substantially in 2020.

Health-related Civic Engagement:
- Urban adults’ civic engagement rose overall from 2016 to 2020. Both groups were much more likely to vote based on health issues in 2020.

Importance of Personal Health
- Urban adults’ engagement in some preventive health behaviors and care-seeking behaviors dropped in 2020, but others increased.

Self-Efficacy for Health:
- Urban adults’ care-seeking, medical condition management and disease prevention self-efficacy decreased in 2020. Among rural adults’, care-seeking and disease prevention self-efficacy also dropped, with the latter decreasing substantially.

Trust in Science and the Health Care System:
- Both groups in 2020 were less likely to trust in science and the health care system.

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9 From an average of 53% of rural adults in 2016 to 63% in 2020 and from 61% for urban adults in 2016 to 70% in 2020.
10 From 31% to 40% for rural adults and from 33% to 53% for urban adults.
11 From 41% to 31%
Similarring and Differences in Other Descriptive Characteristics

We explored urban and rural differences in trusted sources of health information; interest in religion and spirituality; political characteristics; health status, health insurance coverage, and system use; and other demographic characteristics. Variables exploring trust in various sources for health information, importance of religion and attendance of religious services were only added in 2020.

**URBAN AND RURAL COMPARISONS**

**Trusted Sources for Health Information:**
- Rural and urban adults were equally likely to trust health information from health provider groups, public health agencies, foundations, scientists/researchers, neighborhood/civic groups, network TV and radio, MSNBC, USA Today, and PBS/NPR, as well as social change groups like Action for Healthy Kids and the Center for Food Safety.
- However, both urban and rural adults were also equally likely to distrust corporations, social media influencers, and both local and national elected officials for the same type of information.
- Urban adults were more likely to trust environmental groups, the Democratic Party, CNN, Wall Street Journal, and the New York Times, but not Fox News Channel. Rural adults were more likely to trust Fox News, religious leaders, and the Republican Party.

**Interest in Religion/Spirituality:**
- Rural adults were more likely to put a great deal of effort into prayer and meditation in 2016, and to say that religion was very important to them and to attend weekly religious services in 2020.

**Political Characteristics:**
- Both groups in 2016 and 2020 were equally likely to be registered voters. However, rural adults in 2016 were more likely to always vote. In both years of the survey, they were more likely to identify as Republicans and conservative, while their urban counterparts were more likely to identify as Democrats and moderate or liberal.

**Health Status:**
- Rural adults were more likely to report having at least one chronic disease condition and to be functionally impaired and much more likely to smoke in both years and to be functionally impaired in 2020 but were just as likely to be overweight or obese as urban adults.

**Health Insurance Coverage:**
- Urban and rural adults were alike in terms of having health insurance coverage, but urban adults were more likely in both 2016 and 2020 to have private insurance.

**Health System Use:**
- Urban adults were more likely in 2020 to report having a usual source of care, but rural adults were less likely in 2016. There was no difference within years in terms of recent check-ups.

**Other Demographics:**
- Rural adults in both 2016 and 2020 were more likely to be White, older, and high school graduates. Urban adults in both years of the survey were much more likely to be highly educated and more likely to earn higher incomes.

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12 An average of 47% rural adults in both years compared with 39% of urban adults.
13 An average of 26% rural adults in both years compared with 20% of urban adults.
14 An average of 24% rural adults in both years compared with 39% of urban adults were likely to have at least a Bachelor’s degree.
CHANGES FROM 2016 TO 2020

Health Status:
• Urban adults were less likely to report being overweight or obese in 2020 than in 2016.

Health Insurance Coverage:
• There was a decrease between 2016 and 2020 in the number of urban adults with private insurance.

Health System Use:
• Urban adults were less likely to report a recent check-up in 2020 and more likely to report a usual source of care than in 2016.

Summary

A slightly larger proportion of urban adults fell into the three typology groups supportive of population health and health equity promotional efforts in the U.S., Committed Activists, Equity Idealists and Equity Realists. However, the proportion of rural adults falling into the supportive typology groups is very sizeable. The share of adults in the skeptical groups, Self-Reliant Individualists and Disinterested Skeptics, increased from 2016 to 2020 among adults in both rural and urban communities.

We found some important urban and rural differences in specific health values and beliefs. Urban adults were less likely than rural adults to believe that all groups in the U.S. society have an equal opportunity to succeed. However, they more often strongly agreed with statements about the existence of race/ethnic-based disparities in access to care and the strong effects of social and environmental factors on health; while rural adults were less likely to agree with these statements. Urban adults were also more likely to ascribe race/ethnic disparities in health outcomes to systemic causes; and to support government action in health.

In terms of trusted sources of information on health, urban adults were more likely to trust environmental groups, the Democratic Party, CNN, Wall Street Journal, and the New York Times, but not Fox News Channel. Rural adults were more likely to trust Fox News, religious leaders, and the Republican Party.

Overall, while there are urban and rural differences in the health values and beliefs of U.S. adults, there are also many similarities. Large proportions of adults in both urban and rural America are supportive of efforts to promote population health and health equity. As a result, it is important for advocates and activists to not ignore either in their planning and outreach efforts.
Additional Resources
Visit rwjf.org or everyfamilyforward.org for additional resources.

Topline Tables of Urban and Rural 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.

Urban and Rural Analysis Methodology
Respondents were categorized as urban or rural using Rural Urban Commuting Area (RUCA) codes, a widely used metric developed by the U.S. Department of Agriculture. It defines the difference between rural and urban by classifying U.S. census tracts based on area population density, urbanization, and daily commuting patterns. RUCA codes make use of the same theoretical framework developed by the Office of Management and Budget (OMB) to create county-level metropolitan statistical areas. Codes were assigned based on the respondent’s residential census tract.

- **Urban:** RUCA Codes 1-3 – Metropolitan areas with populations of at least 50,000, with differing levels of commuting (10-30%)
- **Rural:** RUCA Codes 4-10 – Small cities, towns, and rural areas with populations of less than 49,999, regardless of commuting

If a survey respondent’s census tract could not be determined, RUCA codes were assigned using ZIP code (2016 only). Urbanicity was mean imputed for some Wave 1 respondents (n = 178), who neither had a valid residential census tract nor a valid ZIP code assigned.

T-tests were used to identify statistically significant differences between rural/urban respondents in each wave for survey item using the same dichotomization of responses used for both Waves 1 and 2. Pooled t-tests were used to identify differences between respondents by group across waves.
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.

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