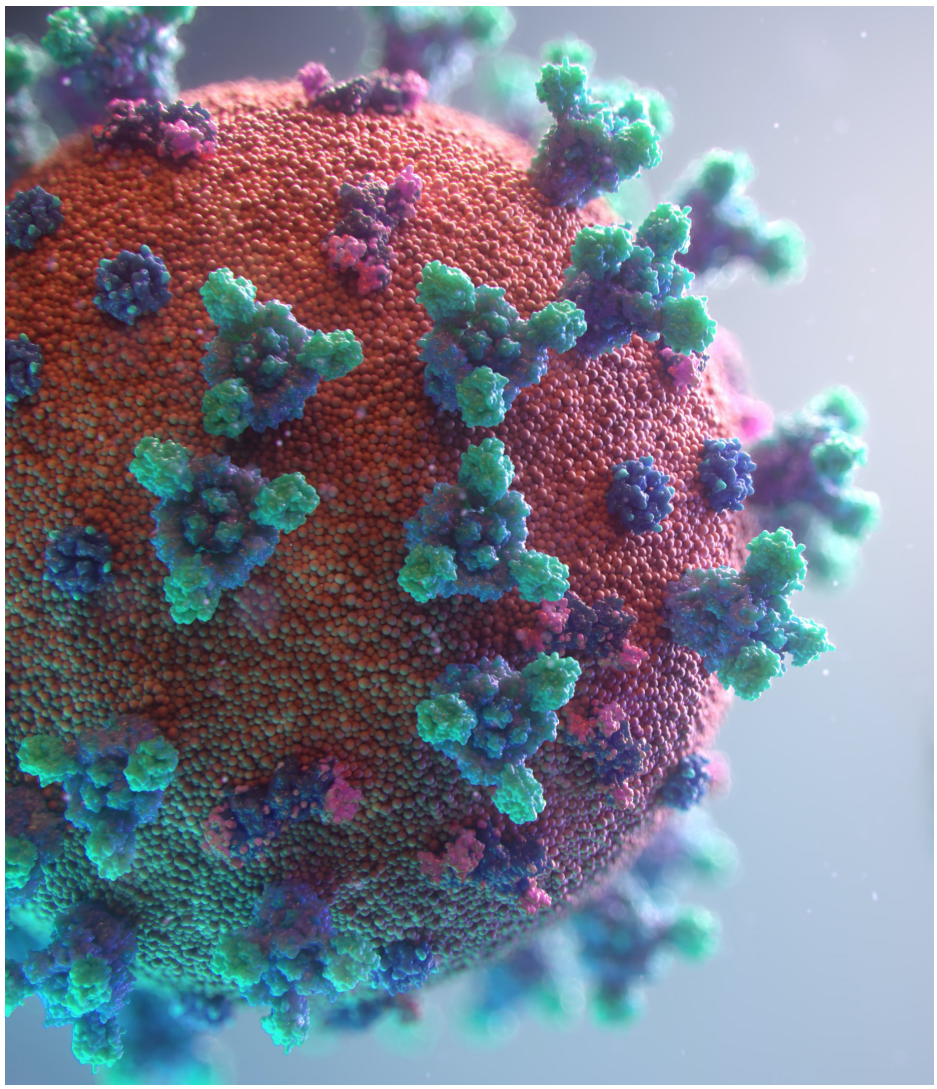
UHERO

THE ECONOMIC RESEARCH ORGANIZATION
AT THE UNIVERSITY OF HAWAIʻI

UHERO PUBLIC HEALTH REPORT

Hawaiʻi's Health and Wellbeing Journey Over Time — Monitoring Equity and Access

MAY 21, 2025



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Hawaiʻi's Health and Wellbeing Journey Over Time — Monitoring Equity and Access

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Executive Summary

The UHERO Rapid Health Survey is a statewide longitudinal study offering one of the most comprehensive real-time assessments of health equity in Hawai‘i. Launched in 2022, the survey has completed four major waves, with the most recent concluding in December 2024. It tracks over 2,000 adults and provides disaggregated data on physical and mental health, healthcare access, food security, housing, and employment. The findings highlight growing disparities that call for coordinated, equity-driven policy action.

Key Findings:

- **Worsening Self-Reported Health:** Only 40% of adults rated their health as excellent or very good in December 2024—a decline from 44% in mid-2023 and 83% reporting good or better health the year before. Among Native Hawaiian and Pacific Islander (NHPI) respondents and those below the poverty line, excellent/very good ratings dropped from 40% to 23% in just 18 months.
- **Mental Health Burden Remains High:** 31% of respondents reported symptoms of depression, and 4% reported severe depressive symptoms. Rates were highest among young adults (18–34), NHPI, Filipino, and low-income groups. Notably, 10% of low-income individuals reported severe depressive symptoms.
- **Escalating Barriers to Mental Healthcare:** The proportion of adults missing needed mental health care rose sharply—from 5% in mid-2023 to 22% by late 2024. Among young adults aged 18–34, the rate jumped to 39%. This trend was consistent across all racial and income groups.
- **Persistent Food Insecurity:** Nearly 30% of adults reported low or very low food security, with the burden disproportionately affecting NHPI, Filipino, and low-income groups. Among those living near or below the poverty line, only 33% were food secure.
- **Widespread Healthcare Access Barriers:** Provider availability (79%) and cost (49%) were the most cited barriers to physical healthcare. In mental healthcare, 68% reported barriers to therapy, 50% to psychiatrists, and 31% to urgent care services.

An interactive dashboard accompanies this report, enabling policymakers and stakeholders to explore trends across demographic subgroups and survey waves. This dataset and dashboard offer critical infrastructure for timely, equity-centered public health planning and response across Hawai‘i.

Next Steps and Policy Recommendations: Strengthening Health Equity in Hawai‘i

The UHERO Rapid Health Survey reveals widening disparities in health, access to care, and basic needs like food and housing—particularly among Native Hawaiian, Pacific Islander, Filipino, Hispanic, and low-income communities. These inequities are not isolated; they stem from systemic barriers that demand coordinated, equity-driven action. Addressing them requires targeted investments in community-based mental health services, culturally competent healthcare providers, and expanded access to both primary and dental care—especially in underserved rural and outer islands.

To build a more resilient and equitable Hawai‘i, we must also tackle the structural roots of health disparities. This means investing in affordable housing, strengthening local food systems, creating pathways to stable employment, and sustaining real-time data systems like the UHERO Rapid Health Survey to guide public policy. Above all, we must ensure that solutions are developed and implemented in partnership with communities most affected. Building a healthier Hawai‘i is not only a policy imperative—it is a shared responsibility.

Introduction

The UHERO Rapid Health Survey was launched in 2022 to provide timely, community-informed data during public health emergencies such as COVID-19. It has since evolved into one of Hawai'i's only real-time, longitudinal tracking systems for health equity. This system captures dynamic changes in health, healthcare access, and social determinants among more than 2,000 adults statewide.

Our initial UHERO Public Health Report (June 2022): Health Effects and Views of COVID-19 in Hawai'i examined the widespread impact of the pandemic on mental health, food security, and long-COVID. The second UHERO Public Health Report (January 2023): Vaccination Booster Uptake Lags as COVID Impact Reach Widens documented persistent mental health challenges, ongoing cases of long-COVID, and its cascading effects on employment and economic security. The third UHERO Public Health Report, *Shaping Health in Hawai'i: The Influences of Poverty, Housing, and Food Insecurity (July 2023)*, emphasized that stable housing, access to nutritious food, and economic security are not peripheral concerns but core determinants of health. It called for integrated policy solutions to address these root causes and reduce health disparities across the state. Findings from the Rapid Health Survey have also informed and been used for comparison in other major efforts, including the Maui Wildfire Exposure Study and a recent study highlighting how food insecurity is a major driver of mental health challenges in Hawai'i.

This fourth major report presents data collected between March and December 2024. It offers a detailed snapshot of health status, healthcare access, mental health, and food security among Hawai'i residents, disaggregated by age group, race/ethnicity, and income level. Specifically, we present findings for three age groups (18–34, 35–64, and 65+), five self-identified racial/ethnic groups (Native Hawaiian or Pacific Islander, Filipino, Other Asian, White, and Other Race/Ethnicity), and three income categories (below/near poverty, ALICE, and middle/high income). ALICE stands for Asset Limited, Income Constrained, Employed—households that earn above the federal poverty level but still cannot afford the basic cost of living in Hawai'i. This group often struggles to meet everyday needs despite holding one or more jobs. Income classifications are based on federal poverty thresholds and the United for ALICE framework, which identifies households that are Asset Limited, Income Constrained, and Employed.

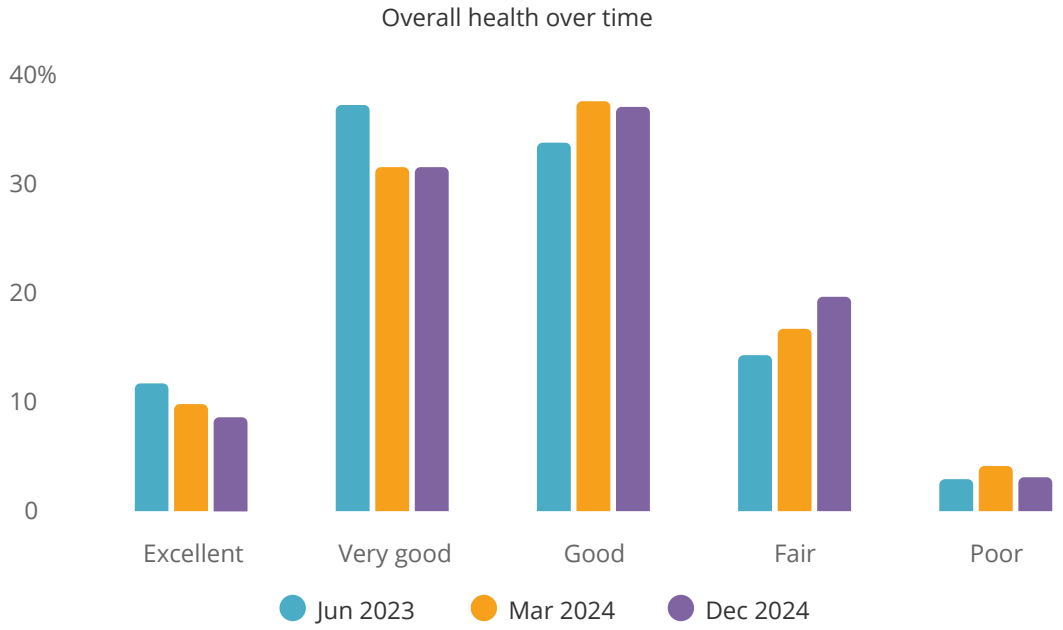
To complement this report, we are launching an interactive public dashboard that allows users to explore the data in greater depth. The dashboard enables community members, researchers, and policymakers to examine health and well-being indicators by demographic and socioeconomic breakdowns.

While this report is descriptive and does not infer causality, its strength lies in its longitudinal scope, demographic granularity, and policy relevance. Our goal is to support equity-driven policy reforms, improve access to care, and strengthen the social foundations of health across the state.

Overall health status

As of December 2024, 77% of people rate their health as good or better, compared to 83% in June 2023. This shift from higher to moderate health ratings is observed across most demographic groups, with notable declines among Native Hawaiian and Pacific Islander (NHPI) and individuals living below or near the poverty line. Adults aged 35 to 64 continue to report the lowest levels of excellent or very good health, while older adults continue to rate their health less negatively.

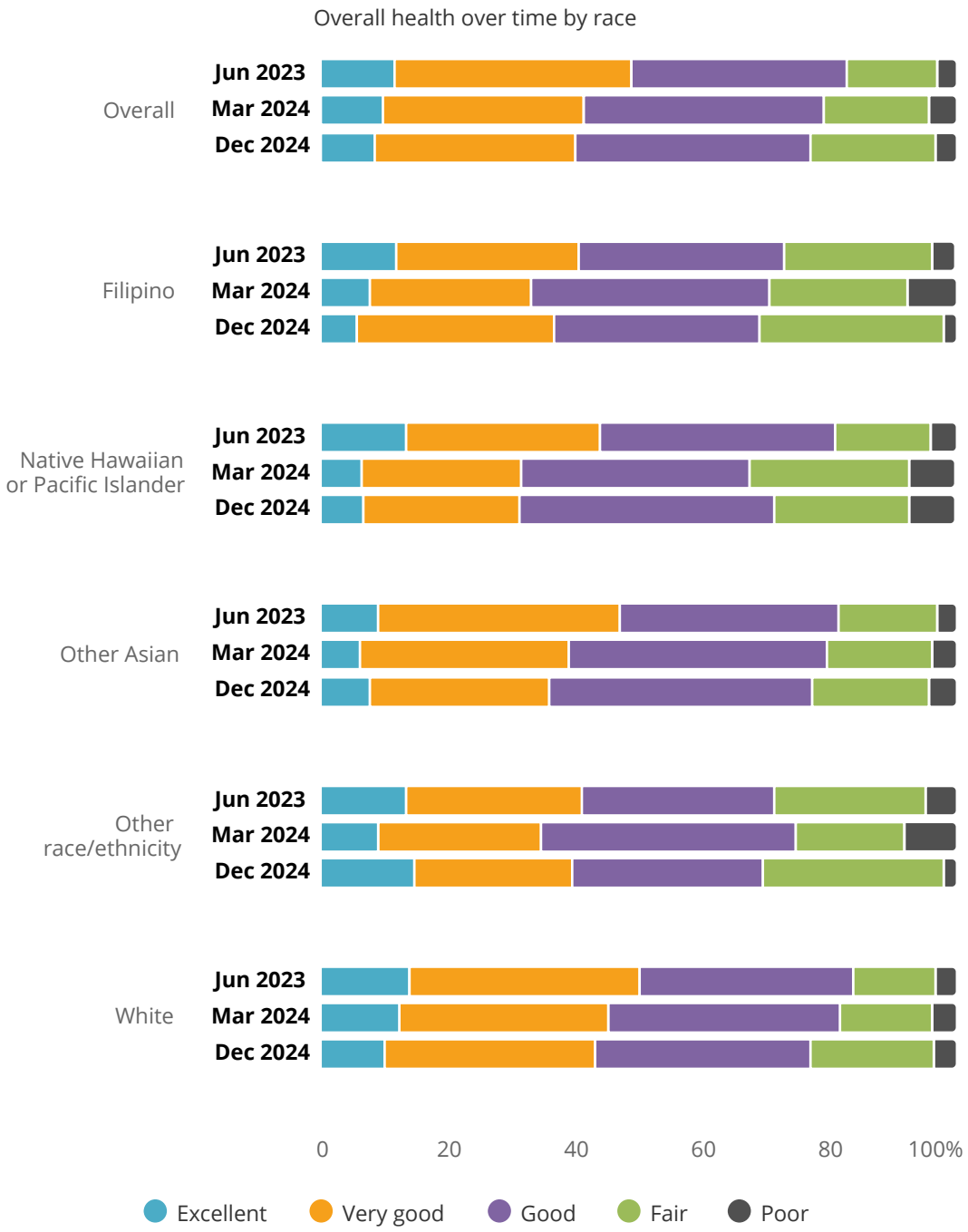
Participants were asked to rate their overall health on a scale ranging from poor to excellent. As of December 2024, about 40% of respondents reported their health as excellent or very good, although this has declined over the past 18 months (see figure below). Overall, self-reported health status has shifted from higher to more moderate categories: from 83% of respondents rating their health as excellent, very good, or good in June 2023, to 79% in March 2024, and down to 77% in December 2024. The percentage reporting fair or poor health has risen from 17% to 23% over this same period.



Data on overall health was collected from wave 3 onwards.

Adults aged 35-64 consistently reported the lowest rates of excellent/very good health compared to other age groups (see charts on the UHERO Rapid Survey Dashboard). Our December 2024 survey suggests that 36% of respondents aged 35-64 rate their health as excellent or very good. This is compared to 46% of respondents aged 18-34 and 43% of respondents aged 65 and older. Interestingly, respondents 65 and older, despite likely facing more health issues, consistently rate their health less negatively. This is possibly due to different perceptions of aging or reluctance to report health concerns. Over time, we observe the same general trend across all age groups: a gradual shift from higher to moderate self-assessments of health.

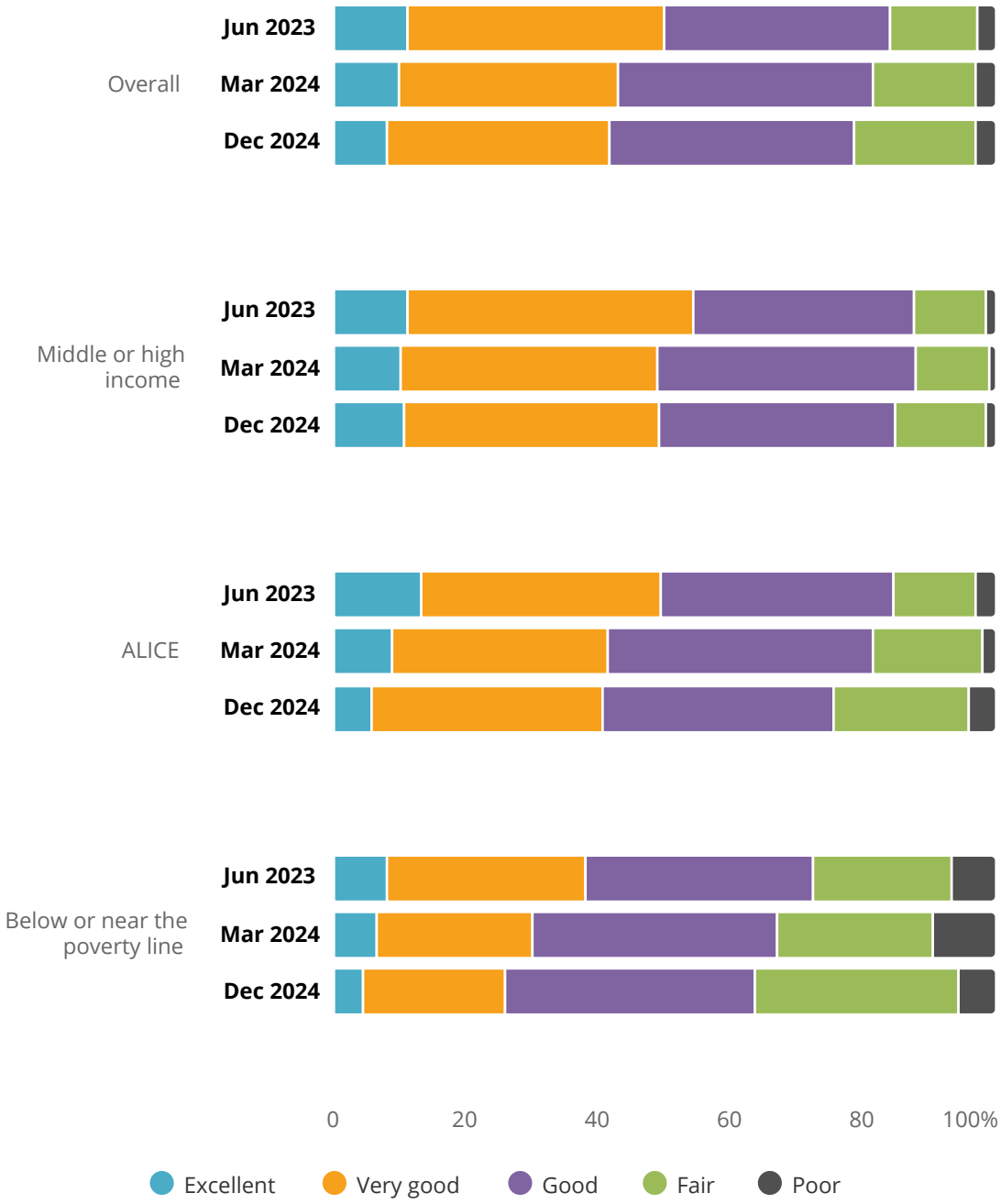
The figure below shows that, as of December 2024, there are significant disparities in health status across racial and ethnic groups. Filipinos (31%), NHPIs (29%), and respondents of other races/ethnicities (30%) reported higher rates of poor/fair health compared to White (23%) and non-Filipino Asian respondents (23%). Over time, the moderate decline in health status seems to have affected all groups. However, NHPI and non-Filipino Asian respondents show particularly notable declines in reports of excellent or very good health. Between June 2023 and December 2024, the share of NHPI respondents reporting excellent or very good health declined from 44% to 31%, the largest decline among all racial/ethnic groups. The share of Non-Filipino Asian respondents reporting excellent/very good health fell from 47% to 36% during the same period.



Data on overall health was collected from wave 3 onwards.

Income seems to play a major role in perceived health. Respondents living below or near the poverty line consistently reported worse health outcomes, including lower rates of excellent/very good health and higher rates of poor/fair health (see charts on the UHERO Rapid Survey Dashboard). Our most recent data suggest that only 23% of respondents living below or near the poverty line perceive their health as excellent or very good. Meanwhile, 50% of ALICE and 55% of middle- or high-income respondents reported excellent or very good health. Over time, the shift away from excellent/very good health ratings towards more moderate ratings seems to appear across all income groups. There is a notably steep decline in health ratings for respondents below or near the poverty line. In June 2023, the share of respondents in this group reporting excellent/very good health was 40%. By December 2024, this decreased to 23%.

Overall health over time by poverty



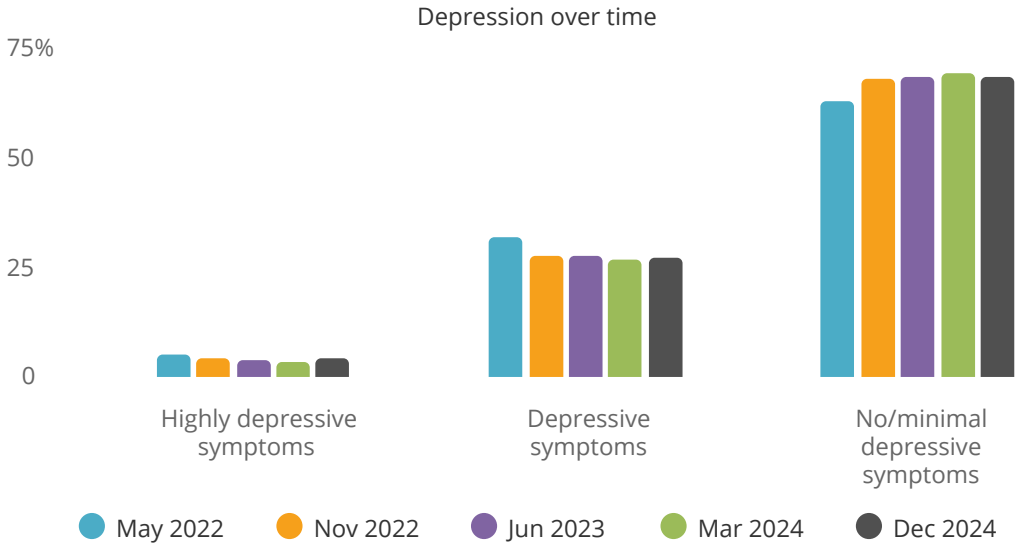
Data on overall health was collected from wave 3 onwards.

Mental Health

Depression

Over the past two and a half years, nearly one in three adults in Hawai'i have reported symptoms of depression, based on responses to the 10-item Center for Epidemiologic Studies Depression Scale (CES-D), a widely used screening tool that assesses the frequency of depression-related symptoms over the past week. Scores range from 0 to 30, with 10–20 indicating depressive symptoms and scores above 20 indicating severe depressive symptoms. As of December 2024, 27% of respondents reported depressive symptoms (CES-D score 10–20), while 4% reported highly depressive symptoms (score >20). These figures reflect a gradual improvement from May 2022, when 32% of respondents reported depressive symptoms and 5% reported highly depressive symptoms. While the decline in symptom prevalence has been modest, the trend has stabilized since mid-2023.

Mental health indicators suggest a consistent improvement across survey waves. The proportion of adults reporting no or minimal depressive symptoms (CES-D score <10) increased from 63% in May 2022 to a peak of 70% in March 2024, before slightly decreasing to 69% in December 2024. Simultaneously, the share of respondents experiencing depressive symptoms declined from 32% to 27%, and those with highly depressive symptoms dropped from 5% to 4%. These changes indicate a modest but steady improvement in population-level mental health outcomes in Hawai'i since 2022.

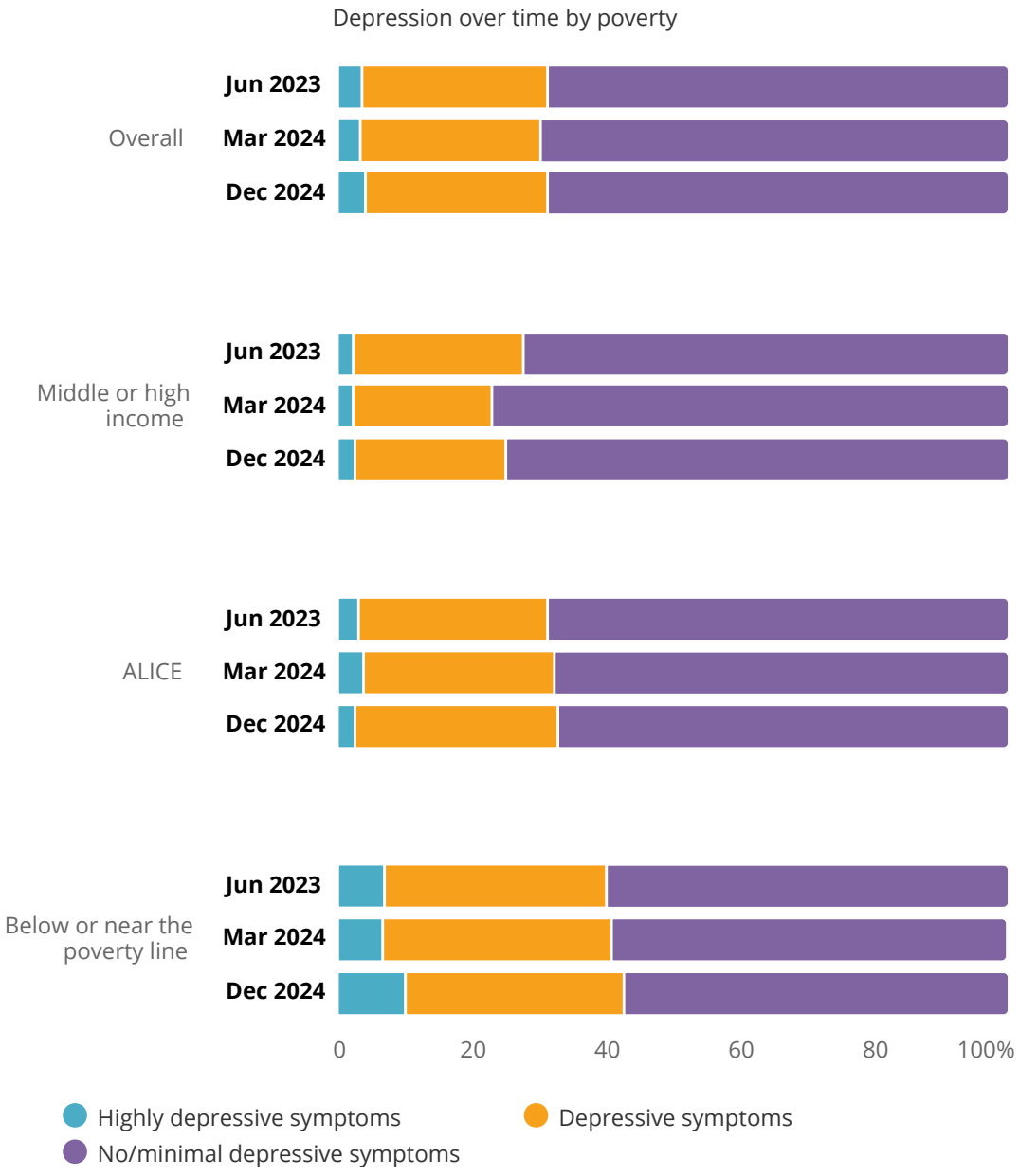


Depression was evaluated with a screening tool (Center for Epidemiological Studies-Depression scale, CES-D) that measures the frequency of various depression-related symptoms over the past week. A total score of 10-20/30 indicates symptoms of depression, while >20/30 suggests highly depressive symptoms.

When disaggregated by age, older adults (65+) consistently reported the highest levels of mental well-being and the lowest prevalence of depressive symptoms. As of December 2024, 80% of adults aged 65 and over reported no or minimal depressive symptoms, compared to 64.8% among those aged 35–64 and 62% among those aged 18–34 (see charts on the UHERO Rapid Survey Dashboard).

The prevalence of highly depressive symptoms remained low among older adults, fluctuating only slightly from 1% in June 2023 to 2% by December 2024. In contrast, young adults (18–34 years) exhibited the highest burden of severe depressive symptoms, with rates at 6% in June 2023, dipping to 4% by December 2024. Among adults aged 35–64, severe symptom prevalence remained relatively stable, but increased slightly to 5% by December 2024.

Filipino, NHPI as well as Latinx, Black and Native American ("other race/ethnicity") respondents continued to report elevated rates of both depressive and highly depressive symptoms compared to the overall population (see charts on the UHERO Rapid Survey Dashboard). As of December 2024, only 57% of Latinx, Black, and Native American ("other race/ethnicity") respondents, 61% of Filipinos, and 61% of NHPI reported no or minimal depressive symptoms—each below the overall average of 69%. Notably, the mental well-being of NHPI respondents showed a decline over time, with no/minimal symptom rates dropping from 69% in June 2023 to 61% in December 2024. Rates of highly depressive symptoms were also disproportionately higher in these populations. Six percent of Filipinos and 5% of Latinx, Black, and Native American ("other race/ethnicity") reported highly depressive symptoms in December 2024.



Depression was evaluated with a screening tool (Center for Epidemiological Studies-Depression scale, CES-D) that measures the frequency of various depression-related symptoms over the past week. A total score of 10-20/30 indicates symptoms of depression, while >20/30 suggests highly depressive symptoms.

Individuals living below or near the poverty line continued to report the highest levels of depressive burden. As of December 2024, 33% of this group experienced depressive symptoms, and 10% reported highly depressive symptoms—the highest across all income brackets (see figure

above). These rates remain persistent over time, even slightly increasing since June 2023. Only 57% of low-income respondents reported no or minimal depressive symptoms, compared to the overall average of 69%.

Similarly, rates of highly or moderately depressive symptoms also persist over time. In December 2024, 30% reported depressive symptoms, while 3% reported highly depressive symptoms. By contrast, 75% of individuals in middle- or high-income households reported no or minimal depressive symptoms, reflecting a stable and enduring pattern of better mental well-being across all survey waves.

We also note that the dashboard and previous reports include other mental health metrics, including self-esteem and suicidal ideation, which are excluded from this report for brevity.

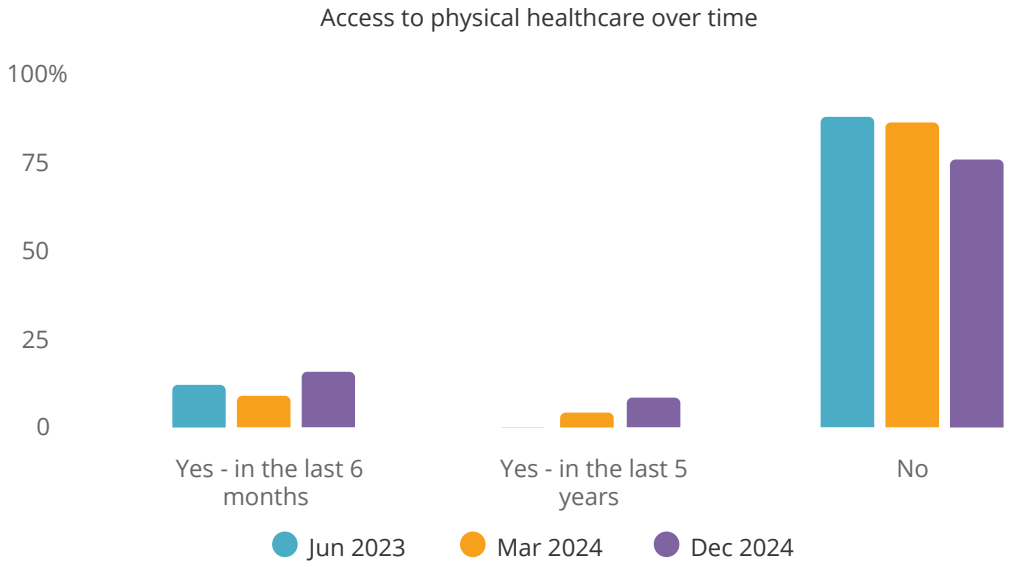
Healthcare Experiences

Access to Healthcare

15% of respondents delayed physical healthcare and 22% missed needed mental healthcare in December 2024—both increased from June 2023. Access issues were highest among younger individuals, ALICE households, and Latinx, Black, and Native American respondents. Barriers to mental healthcare have worsened sharply and are now affecting all demographic groups.

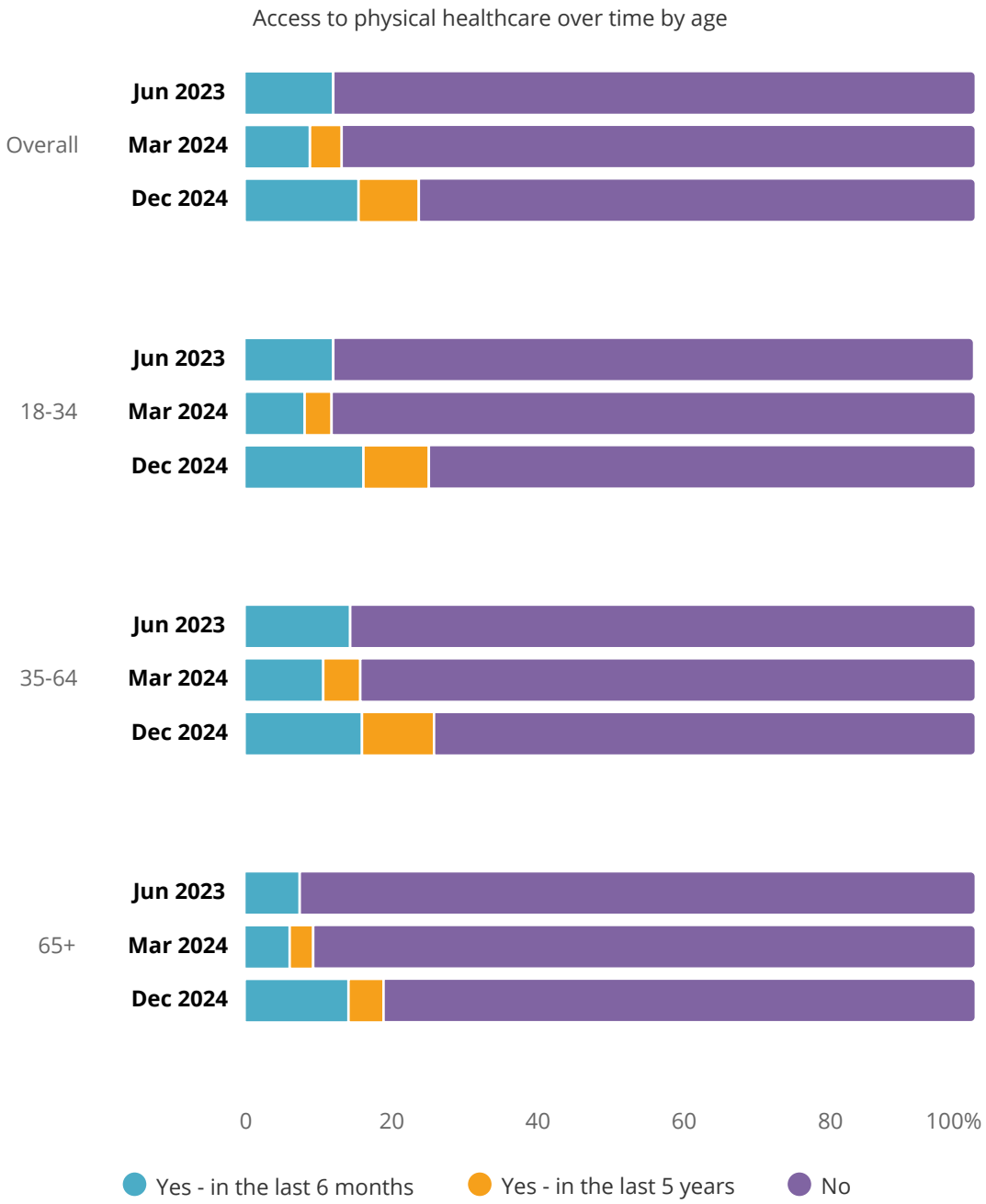
Physical Healthcare

15% of respondents reported having to delay or forgo needed physical healthcare in the last six months (see figure below). In previous surveys, the share of respondents reporting healthcare access issues ranged between 9% and 12%.



Data on access to physical healthcare was collected from wave 3 onwards. The "Yes - in the last 5 years" category is not available in wave 3. Therefore, "No" in wave 3 includes anyone who has not experienced barriers to healthcare in the last six months.

The figure below shows that younger groups consistently reported more trouble with physical healthcare access than older people. Reported access to physical healthcare slightly worsened in the last 1.5 years.



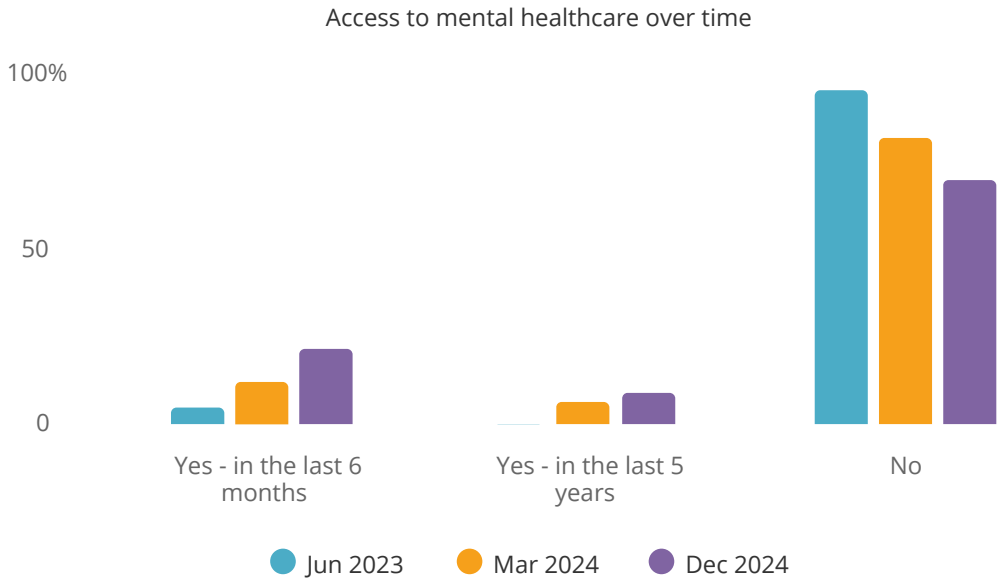
Data on access to physical healthcare was collected from wave 3 onwards. The "Yes - in the last 5 years" category is not available in wave 3. Therefore, "No" in wave 3 includes anyone who has not experienced barriers to healthcare in the last six months.

Participants across all racial groups reported an increase in delayed or foregone physical healthcare in the past year and a half (see charts on the UHERO Rapid Survey dashboard). Latinx, Black and Native American respondents ("other race/ethnicity") reported both the highest level and the largest increase in healthcare access issues.

Poverty and ALICE status were major drivers of healthcare access, with substantially higher rates of having to forgo or delay healthcare in both groups compared to middle and high-income individuals (see charts on the UHERO Rapid Survey dashboard).

Mental Healthcare

About 22% of respondents report missing out on needed mental healthcare in the last six months (see figure below). There has been a large increase in this metric, up from 5% in June 2023. Notably, respondents from all demographic groups (including income, age, and racial identity) reported similar issues with healthcare access, suggesting that barriers to healthcare access are affecting the entire population.

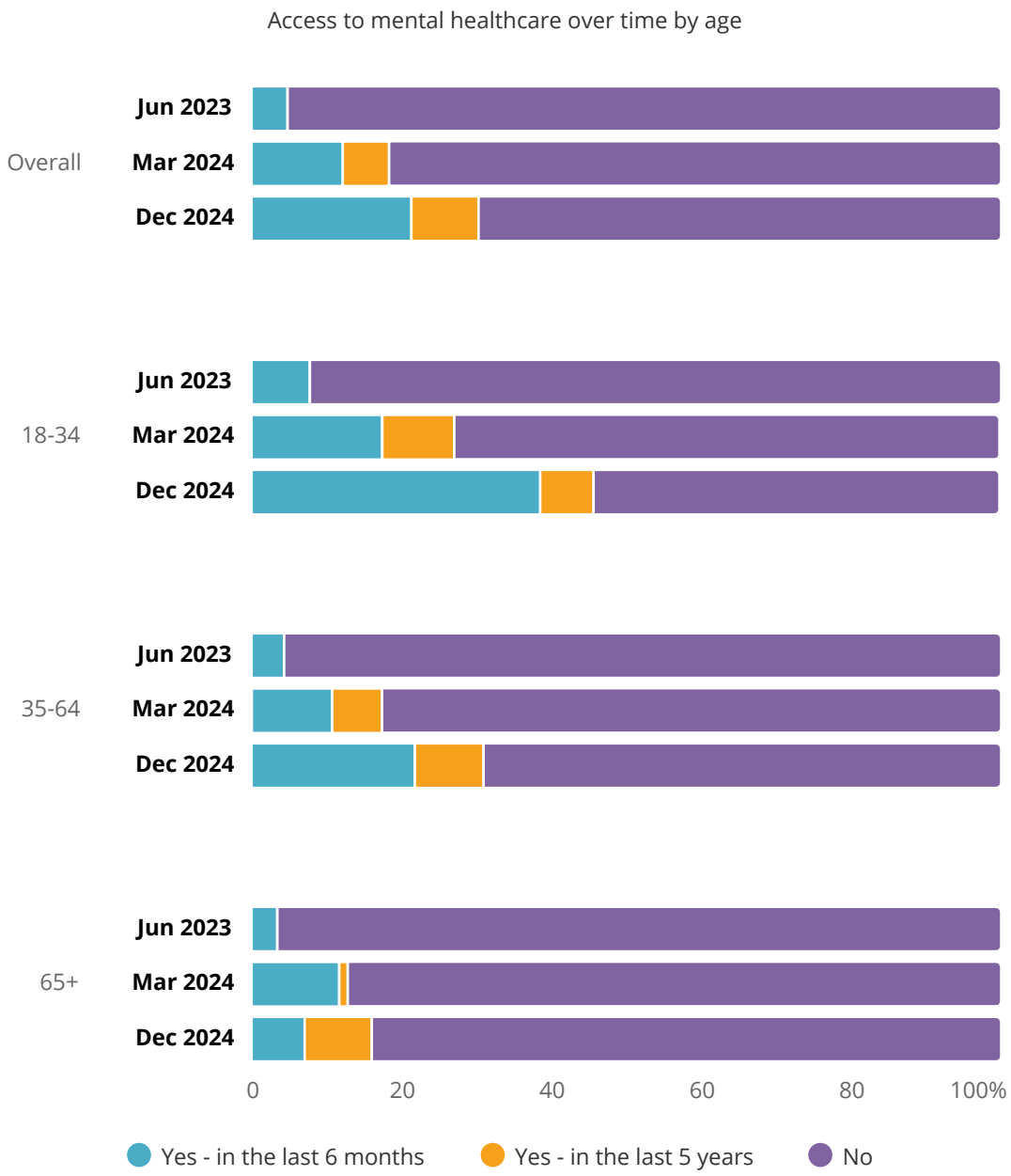


Data on access to mental healthcare was collected from wave 3 onwards. The "Yes - in the last 5 years" category is not available in wave 3. Therefore, "No" in wave 3 includes anyone who has not experienced barriers to healthcare in the last six months.

Consistent with prior trends, the younger groups reported higher rates of experiencing issues with mental healthcare access compared to the older individuals. Access to mental healthcare has dramatically worsened from June 2023 to December 2024 across all age groups, but especially people under 65. In June 2023, 8% of respondents between 18 and 34 years reported access issues for mental healthcare compared to 39% in December 2024 (see the figure on the next page).

Participants across all racial groups reported an increase in delayed or foregone mental healthcare between June 2023 and December 2024 (see charts on the UHERO Rapid Survey Dashboard). Similar to physical healthcare access, Latinx, Black, and Native American respondents ("other race/ethnicity") have both the highest rates and largest increase in experiencing mental healthcare access issues.

Heightened difficulties accessing mental healthcare are also pervasive across all income groups over the last 1.5 years. Respondents from ALICE households report most likely missing out on needed mental healthcare at 30% compared to 17% of middle and high-income individuals (see charts on the UHERO Rapid Survey Dashboard).



Data on access to mental healthcare was collected from wave 3 onwards. The "Yes - in the last 5 years" category is not available in wave 3. Therefore, "No" in wave 3 includes anyone who has not experienced barriers to healthcare in the last six months.

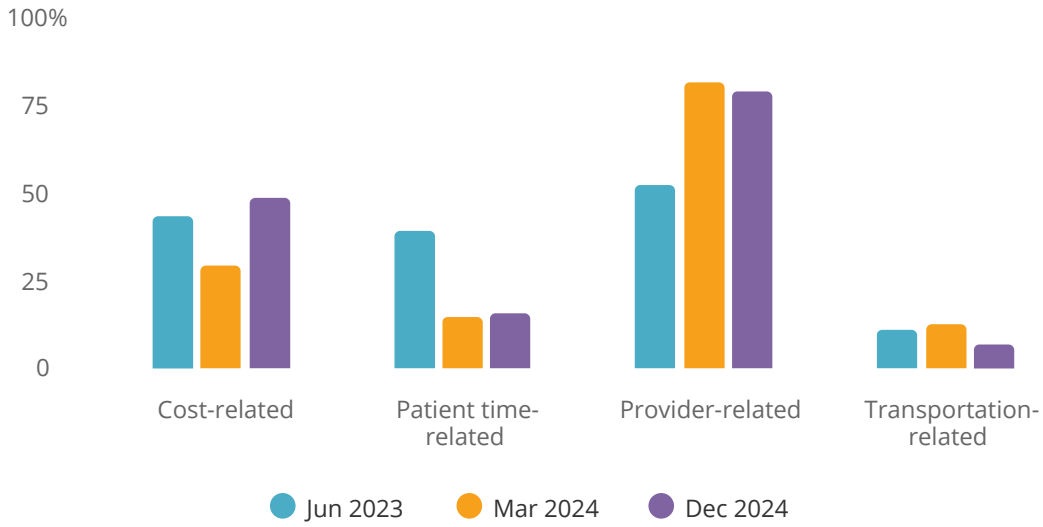
Barriers to Access

Provider availability and cost are the top barriers to care, especially for low-income and marginalized groups. Physical healthcare faces more provider issues, while affordability remains the biggest hurdle for those with fewer resources.

Physical Healthcare

The primary barriers to accessing physical healthcare are related to providers and cost— e.g., unavailable appointments, limited hours, lack of necessary accommodations, high out-of-pocket costs, and insurance coverage. A staggering majority of the respondents (79%) highlighted challenges linked to providers, while nearly half (49%) experienced cost-related hurdles. Transportation-related barriers, such as providers being too far away or a lack of suitable transportation options, were reported more often for physical healthcare than for mental healthcare.

Barriers to physical healthcare access over time



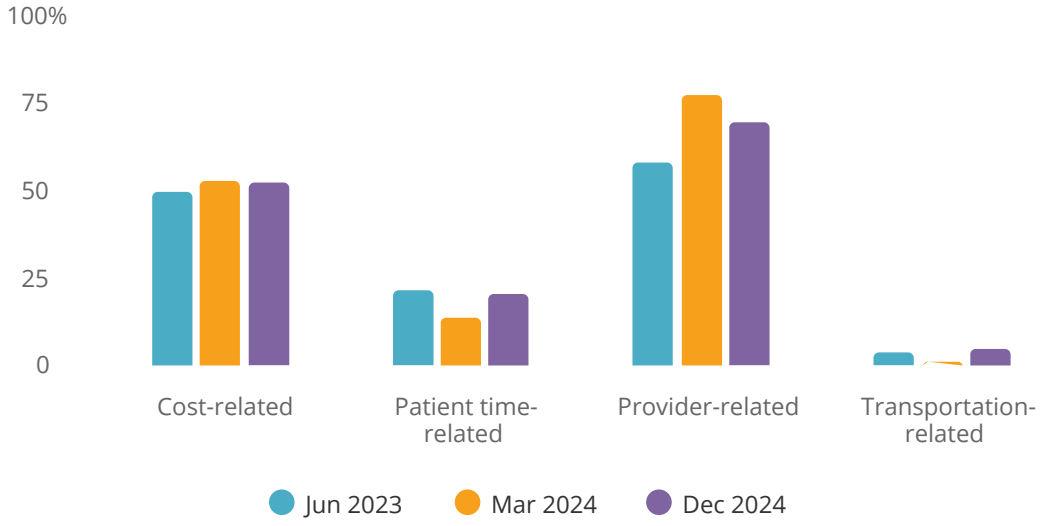
This data represents the barriers reported by all respondents who selected that they experienced issues with physical healthcare access. Data on barriers to physical healthcare was collected from wave 3 onwards. For wave 3, the data is based on access issues within the last six months. For waves 4 and 5, it reflects access issues within the last five years.

Younger and middle-aged respondents (18-34 and 35-64 years) consistently reported higher rates of cost and patient-time related barriers than older people aged 65 and over. Cost-related barriers are disproportionately affecting Latinx, Native American and Black respondents ("other race/ethnicity"), and are more prevalent among middle and high income people (see charts on the UHERO Rapid Survey Dashboard).

Mental Healthcare

The patterns observed regarding barriers to accessing physical healthcare also emerged in the mental healthcare space. The most commonly reported barriers to mental healthcare were also related to providers (70%), followed by cost (52%) and time (21%) and transportation-related (5%) barriers (see figure below).

Barriers to mental healthcare access over time



This data represents the barriers reported by all respondents who selected that they experienced issues with mental healthcare access. Data on barriers to mental healthcare was collected from wave 3 onwards. For wave 3, the data is based on access issues within the last six months. For waves 4 and 5, it reflects access issues within the last five years.

As with barriers to physical healthcare, cost-related barriers are much more common among younger respondents aged 18 to 34 at 69% compared to 52% for the overall sample. Across all age groups, provider-related barriers were reported more frequently for physical healthcare than mental healthcare. Mirroring the patterns we see for barriers to physical healthcare, cost-related barriers also consistently affect Latinx, Black, and Native American respondents ("other race/ethnicity") more frequently across survey waves, and cost-related barriers were also more common among respondents living in households below the poverty line across all survey waves (see charts on the UHERO Rapid Survey Dashboard).

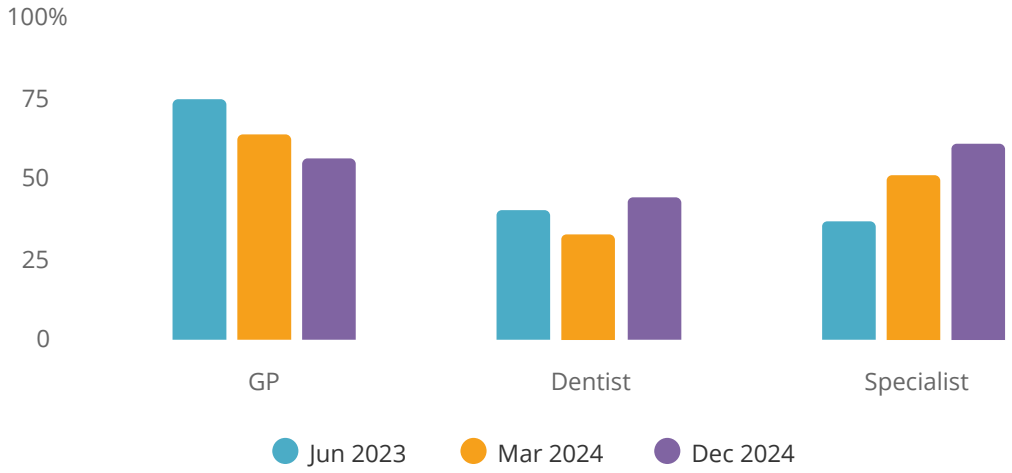
Types of services affected by barriers

Among respondents who reported barriers to physical healthcare, 61% struggled to access specialists, 57% had difficulty seeing a GP, and 44% faced challenges with dental care. For mental healthcare, 68% encountered barriers to therapy, 50% to psychiatrists, and 31% to urgent mental care.

Physical Healthcare

Approximately 57% of the respondents reported that they had problems accessing GP services, which is considerably lower than about 75% of such reports in June 2023. Access to dental services have worsened slightly, but access to specialist services have significantly deteriorated—up to 61% from 37% in 2023 (see figure below).

Types of physical healthcare services affected by access issues over time

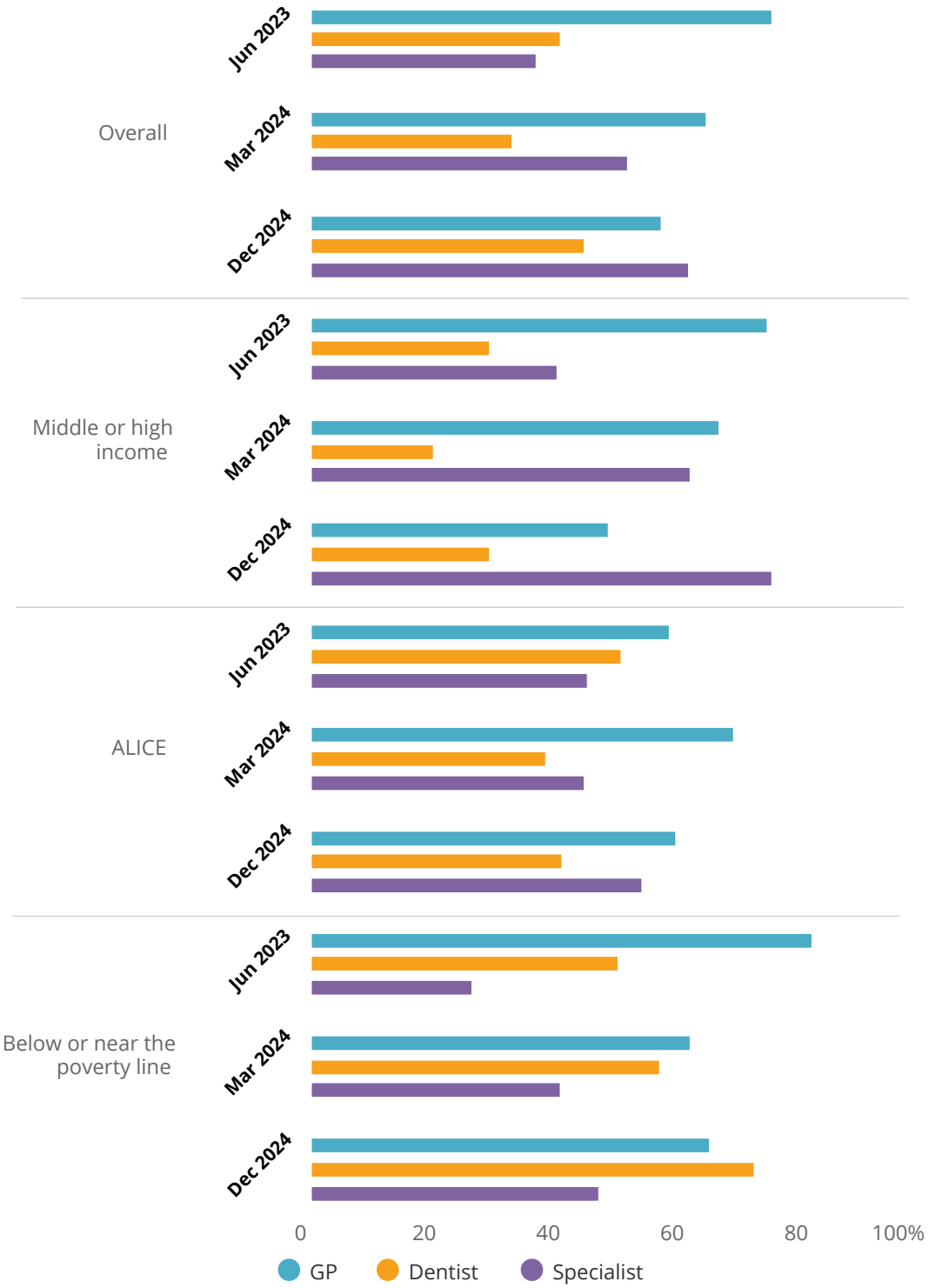


This data represents the share of respondents who had issues with accessing GP, dentist and specialist services out of all respondents who reported issues with physical healthcare access. Data on types of physical healthcare services affected by access issues was collected from wave 3 onwards. For wave 3, the data is based on access issues within the last six months. For waves 4 and 5, it reflects access issues within the last five years.

Nearly 84% of the youngest group (18-34) reported having problems with accessing GP services (see charts on the UHERO Rapid Survey Dashboard). Both respondents aged 35 to 64 and 65 and over noted significant improvements in the same area, with rates of barriers to primary care falling to 56% for the 35-64 years group and to 36% for the 65+ years group. Access to specialists generally worsened over the last 1.5 years for all age groups, ranging between 60% for individuals aged 18-34 and 69% for people aged 65 and over. Moreover, access to GP services improved, but barriers to specialist care worsened across all race groups over the last 1.5 years (see charts on the UHERO Rapid Survey Dashboard).

The most pronounced differences among income groups exist for access to dental and specialist services (see figure below). Barriers to dental care are larger for people from households below the poverty line. This may be because of the substantial out-of-pocket costs for dental care, especially without dental insurance. Conversely, middle and high income people report higher rates of issues with accessing specialist services. It is possible that lower income individuals are less likely to seek specialist care in the first place.

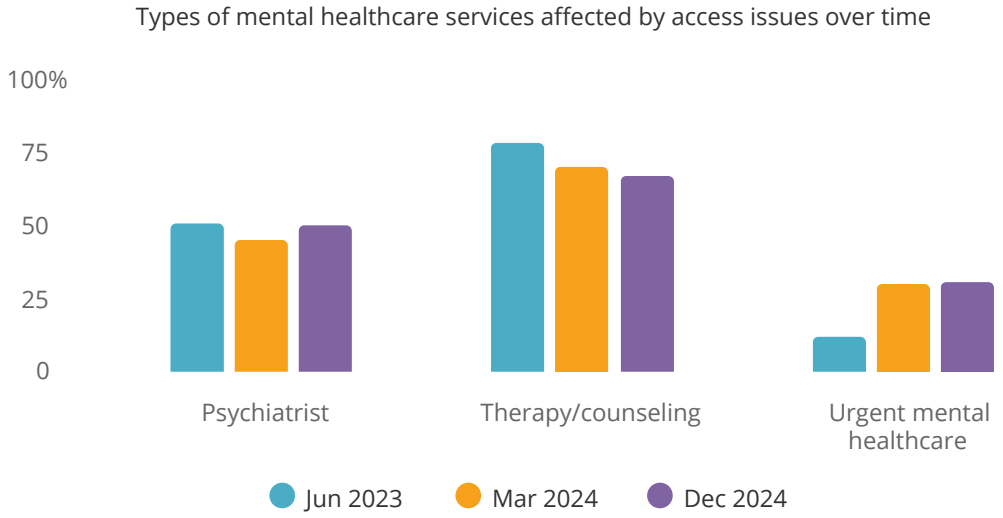
Types of physical healthcare services affected by access issues by poverty



This data represents the share of respondents who had issues with accessing GP, dentist and specialist services out of all respondents who reported issues with physical healthcare access. Data on types of physical healthcare services affected by access issues was collected from wave 3 onwards. For wave 3, the data is based on access issues within the last six months. For waves 4 and 5, it reflects access issues within the last five years.

Mental Healthcare

Regarding mental healthcare, 68% of respondents experienced barriers to accessing therapy or counseling, 50% reported barriers to accessing psychiatrists, and 31% faced challenges with urgent mental healthcare (see figure below). Notably, the data suggest some improvement in accessing therapy or counseling over time, down from 79% in June 2023 to 68% in December 2024. However, barriers to seeing psychiatrists and urgent mental healthcare have remained similar or increased over the same period.



This data represents the share of respondents who had issues with accessing psychiatrist, therapy/counseling and urgent mental healthcare services out of all respondents who reported issues with mental healthcare access. Data on types of mental healthcare services affected by access issues was collected from wave 3 onwards. For wave 3, the data is based on access issues within the last six months. For waves 4 and 5, it reflects access issues within the last five years.

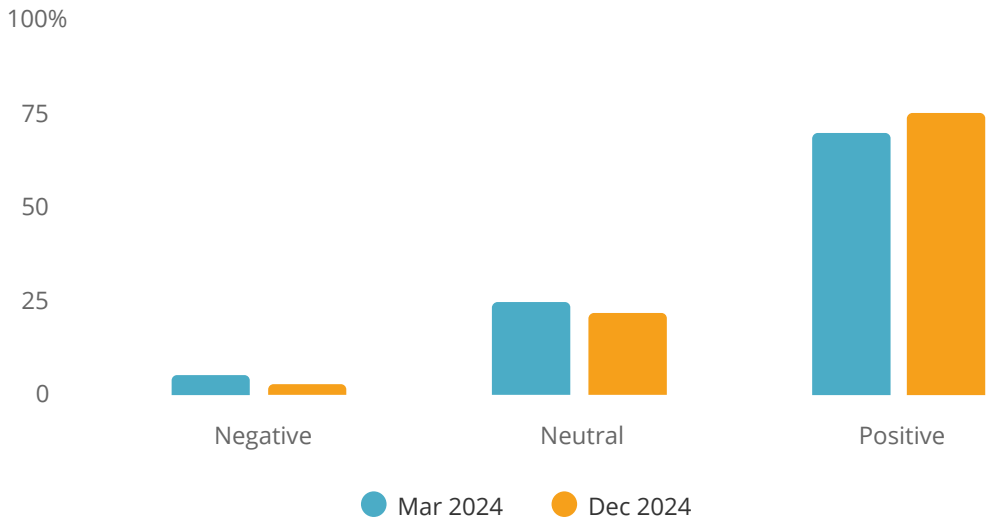
The most robust difference across age groups affects urgent mental healthcare. Younger respondents aged 18-34 report substantially higher rates of barriers to accessing urgent mental healthcare at 48% in December 2024. Similarly, barriers to urgent mental healthcare are consistently most common among NHPI and Latinx, Black and Native American respondents ("other race/ethnicity"). Respondents from households below the poverty line also report barriers to access to urgent mental healthcare more frequently across most survey waves. Between-group differences by age, race/ethnicity and poverty status are less clear for access to psychiatrists and therapy/counseling services. More data will need to be collected to establish consistent trends across groups see charts on the UHERO Rapid Survey Dashboard).

Satisfaction with healthcare services

About 3 out of 4 respondents reported positive experiences at their last GP visit. Younger respondents aged 18-34 reported much lower rates of positive experiences at just above 50%. Similarly, positive experiences are less common among Latinx, Black, and Native American respondents. Filipinos and people living in households below or near the poverty line reported outright negative experiences at higher rates.

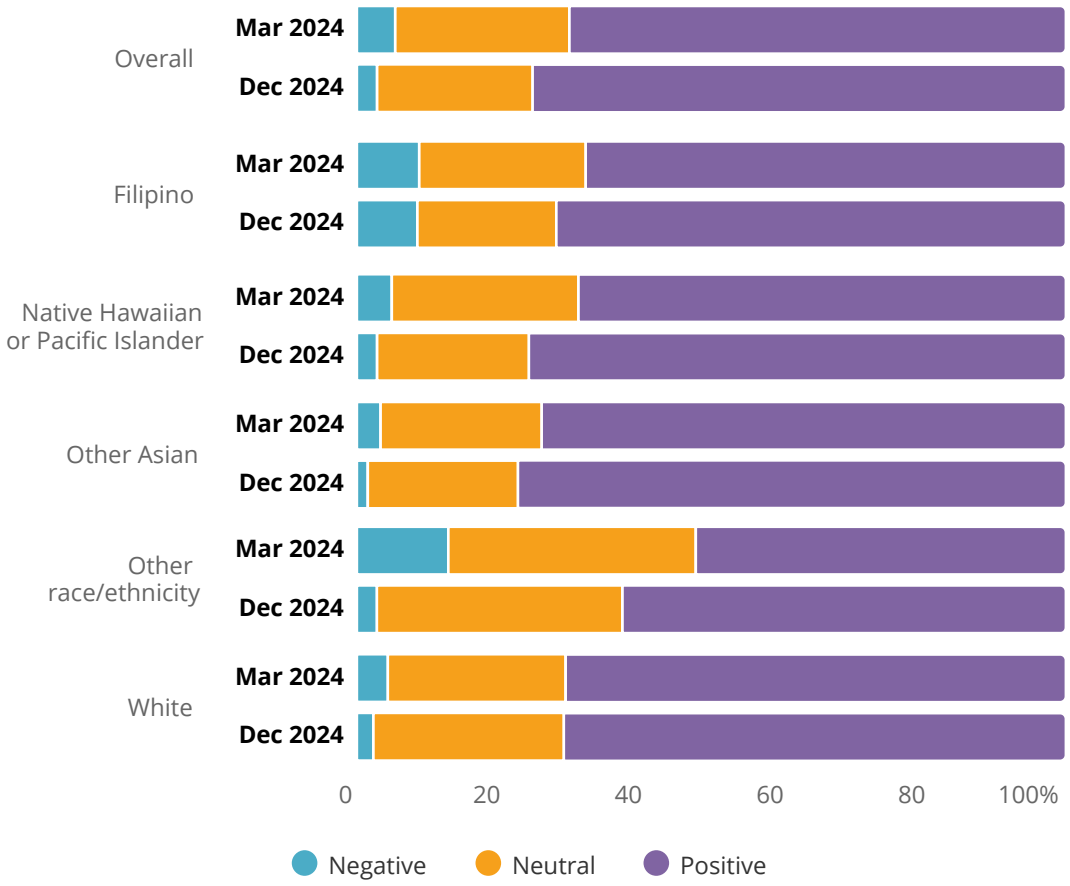
Participants were asked to evaluate their experience during their most recent visit with a general practitioner (GP) or family doctor using a scale from 0 to 10, where 0 represented the worst possible experience and 10 the best. These responses were grouped into three categories: negative (0–3), neutral (4–7), and positive (8–10). As the figure below shows, 75% of respondents rated their experience as positive, and only 3% of respondents reported negative experiences. This reflects an increase in reported positive experiences from 70% in March 2024.

Satisfaction with healthcare services over time



Data on satisfaction with healthcare services was collected for respondents' last GP visit on a scale from 0 (worst possible experience) to 10 (best possible experience). "Positive" represents scores from 8-10, "Neutral" corresponds to 4-7 and "Negative" to 0-3. This data was collected from wave 4 onwards.

Satisfaction with healthcare services by race



Data on satisfaction with healthcare services was collected on a scale from 0 (worst possible experience) to 10 (best possible experience). "Positive" represents scores from 8-10, "Neutral" corresponds to 4-7 and "Negative" to 0-3. This data was collected from wave 4 onwards.

Younger respondents aged 18 to 34 were less likely to report a negative experience with their healthcare provider than older respondents. 53% of younger adults rated their last primary care visit positively, compared to 74% among those aged 35-64 and 87% among those aged 65 and older (see charts on the UHERO Rapid Survey Dashboard). It is important to note that the current analyses are based on self-reported, subjective experiences, and older respondents may be more lenient in their assessments.

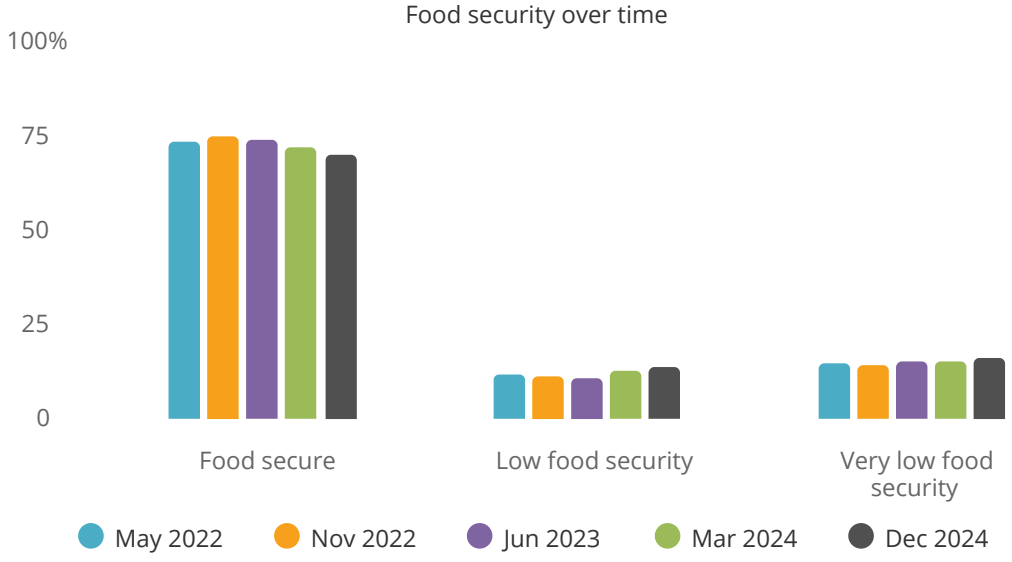
The figure above shows that Latinx, Native American and Black respondents ("other race/ethnicity") have much lower rates of positive experiences at 63%.

Disparities across income levels in provider satisfaction are evident. In the most recent survey wave, 67% of respondents living below or near the poverty line reported a positive experience, compared to 71% of those in ALICE households and 82% in middle- or high-income households (see charts on the UHERO Rapid Survey Dashboard).

Food security

More than a quarter of respondents have low or very low food security, with minimal changes over time. NHPI, Filipino, and Latinx, Black, and Native American respondents reported higher-than-average rates of food insecurity. More than half of respondents who earn incomes below the poverty line are affected by food insecurity and they are more than twice as likely to have very low food security.

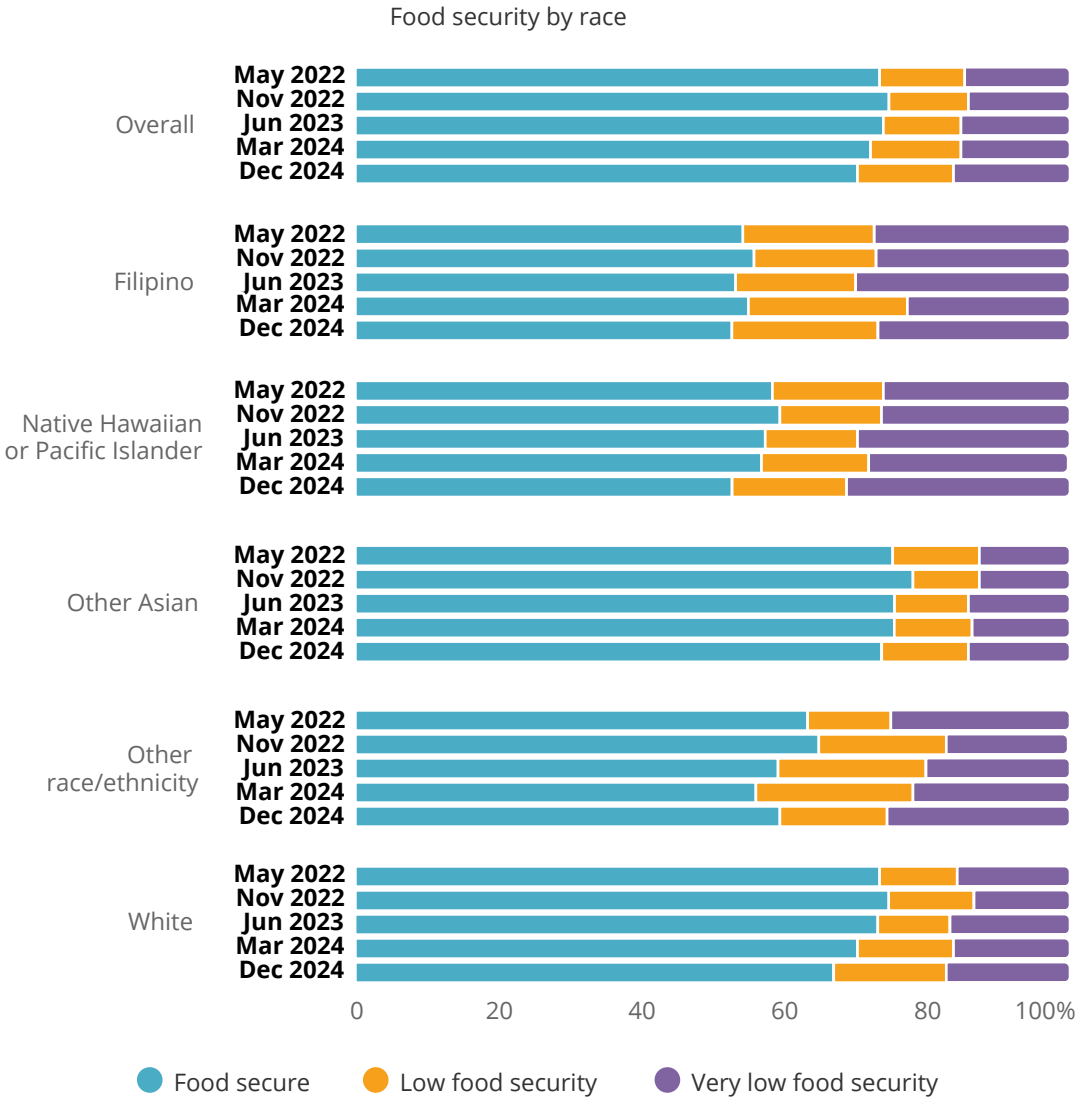
We measured food insecurity using the Six-item Food Security Scale developed by the National Center for Health Statistics (NCHS), with scores ranging from 0 to 6. Scores between 0 and 1 are categorized as food secure, scores between 2 and 4 as low food security and scores between 5 and 6 as very low food security. This scale identifies households that struggle to afford sufficient, nutritious food. Tracking these measures over time shows a consistent share of respondents classified as having low or very low food security. Since May 2022, rates of food insecurity have varied slightly ranging from 25% to 28% with approximately 30% of respondents considered food insecure in December 2024.



Food insecurity was evaluated with a screening tool (National Center for Health Statistics Food Security Scale). Scores of 2-4 indicate "Low food security" and scores of 5-6 correspond to "Very low food security".

Respondents aged 65 and older have the highest rates of food security at about 90% across all survey waves (see charts on the UHERO Rapid Survey Dashboard). This compares to roughly 60% of respondents in the 18-34 age group and roughly 70% of respondents in the 35-64 age group. As with other metrics, part of this difference may be related to the lower rates of poverty among older participants in the survey cohort. For the 18-34 and 65 and over age groups, rates of food security appear relatively stable over time. The share of respondents in the 35-64 age group struggling with food security increased over time. In May 2022, 27% of respondents in this age group were considered to have low or very low food security. By December 2024, this figure had increased to 35%.

The figure below shows that NHPI and Filipino as well as Latinx, Native American and Black ("other race/ethnicity") respondents tend to have consistently lower rates of food security compared to the other racial/ethnic respondents. In December 2024, only 53% of NHPI and Filipino respondents and 60% of Latinx, Native American and Black respondents ("other race/ethnicity") were food secure. In contrast, 67% of White and 74% of non-Filipino Asian respondents were food secure in our most recent survey wave. While White respondents have seen slight decreases in food security over time, these rates seem generally consistent across multiple survey waves.



Food insecurity was evaluated with a screening tool (National Center for Health Statistics Food Security Scale). Scores of 2-4 indicate "Low food security" and scores of 5-6 correspond to "Very low food security".

As expected, respondents living below or near the poverty line are much less likely to be food secure. In addition, rates of food security in this vulnerable group seem to have further decreased since June 2023. The share of respondents at or near poverty that were food secure in December 2024 was 33%, a decrease from 47% in June 2023 (see charts on the UHERO Rapid Survey Dashboard). Respondents in the ALICE group have also experienced a slight decrease in food security. In June 2023, 73% of respondents in this group were food secure. By December 2024, this share decreased to 66%. The share of food insecure individuals in the middle- and high-income group remained stable at around 87%.

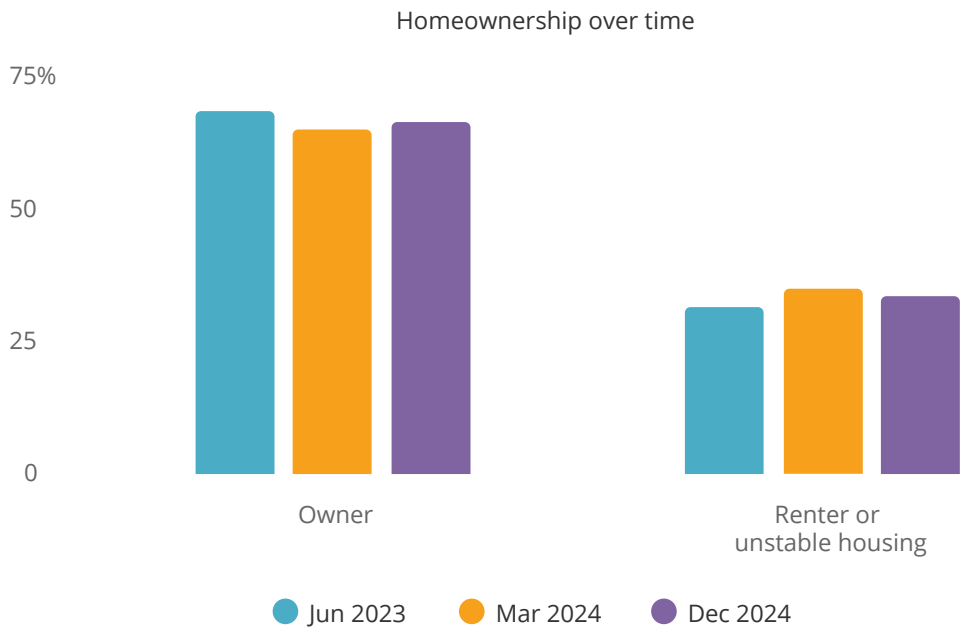
Homeownership

Across the UHERO Rapid Survey waves that collected housing data (June 2023 onward), approximately one in three respondents reported living in rental or unstable housing. This figure has remained relatively consistent across the three waves surveyed, indicating ongoing housing instability for a substantial portion of the population.

Homeownership rates are significantly lower among respondents with lower incomes. Those living below the poverty line are far more likely to rent or report unstable housing conditions compared to middle- or high-income households. In particular, NHPI, Filipino, and Latinx, Black, or Native American respondents ("other race/ethnicity") report higher-than-average rates of rental or unstable housing, reinforcing broader patterns of housing insecurity and systemic disparities in wealth accumulation and homeownership opportunities.

In contrast, respondents aged 65 and older are much more likely to own their homes. This likely reflects long-term tenure, generational wealth, and housing purchases made prior to Hawai'i's more recent spikes in housing costs. For younger adults and middle-aged respondents, barriers to homeownership—including affordability, credit access, and lack of intergenerational support—remain prominent challenges.

The housing trends reflected in the survey underscore the intersection of race, income, and age in shaping access to stable housing, and highlight the urgent need for equity-informed housing policy and investment to expand pathways to ownership and reduce instability among vulnerable populations.



Data on homeownership was collected from wave 3 onwards.

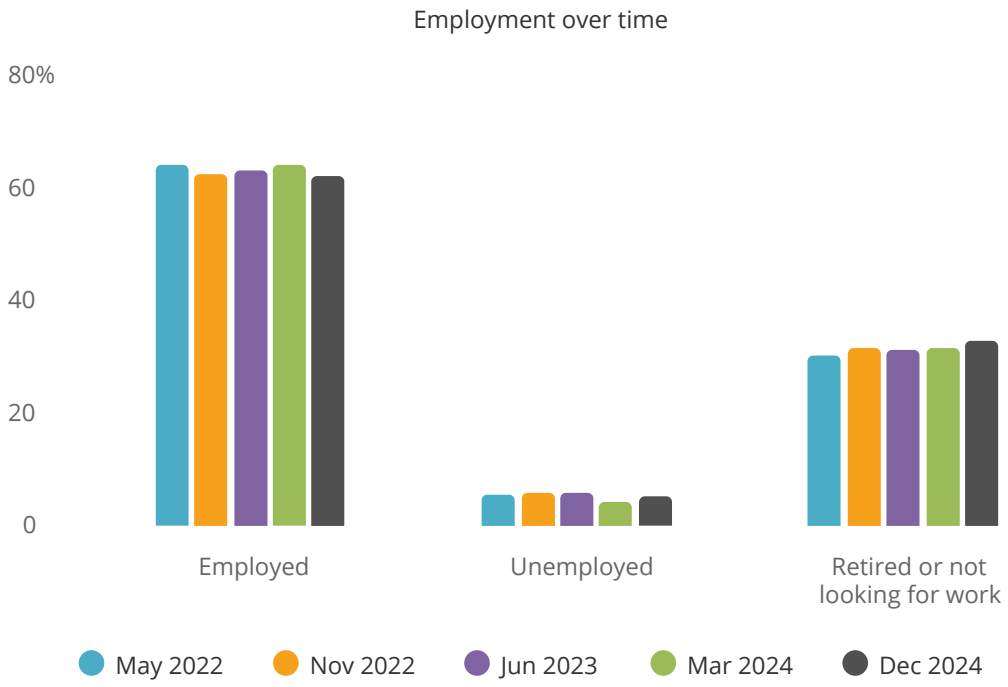
Employment

Employment patterns across demographic groups in the UHERO Rapid Survey reveal important disparities. Respondents who identify as Filipino or as Latinx, Black, or Native American ("other race/ethnicity") report higher-than-average rates of employment across survey waves, suggesting strong labor force participation among these groups. However, these same populations also experience elevated levels of economic hardship and healthcare access barriers, indicating that employment does not necessarily equate to financial security or well-being.

Unemployment is highest among younger adults (ages 18–34), who are more likely to report being out of work compared to those aged 35–64. This trend may reflect transitional life stages such as education, job searching, or unstable employment conditions that affect younger respondents disproportionately. Higher unemployment in this age group is also closely correlated with increased rates of poverty and food insecurity, as observed across other indicators in the survey.

Additionally, a larger-than-expected share of ALICE households report being retired or not currently seeking employment. This may reflect a mismatch between income and cost of living, where individuals in financially constrained households are unable to maintain or re-enter the workforce due to caregiving responsibilities, health limitations, or lack of access to supportive services such as transportation or elder care.

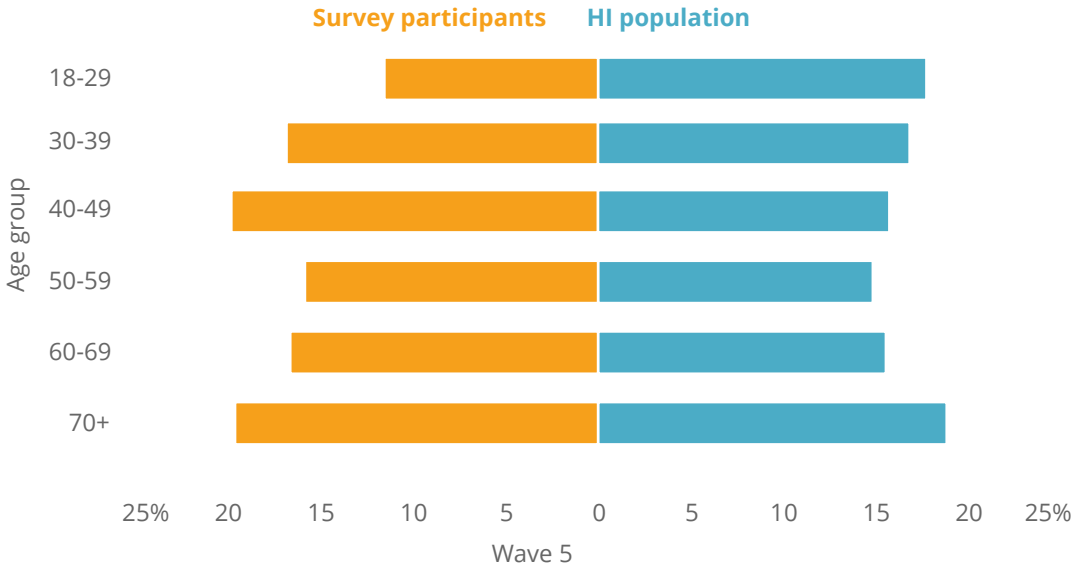
Taken together, these employment trends reinforce the complex intersection between labor force status, age, race/ethnicity, and household income, and suggest that employment alone is not a sufficient buffer against health or economic vulnerability. These findings underscore the need for equity-focused workforce and social policies that better support Hawai'i's diverse populations across life stages.



Characteristics of the Survey Participants

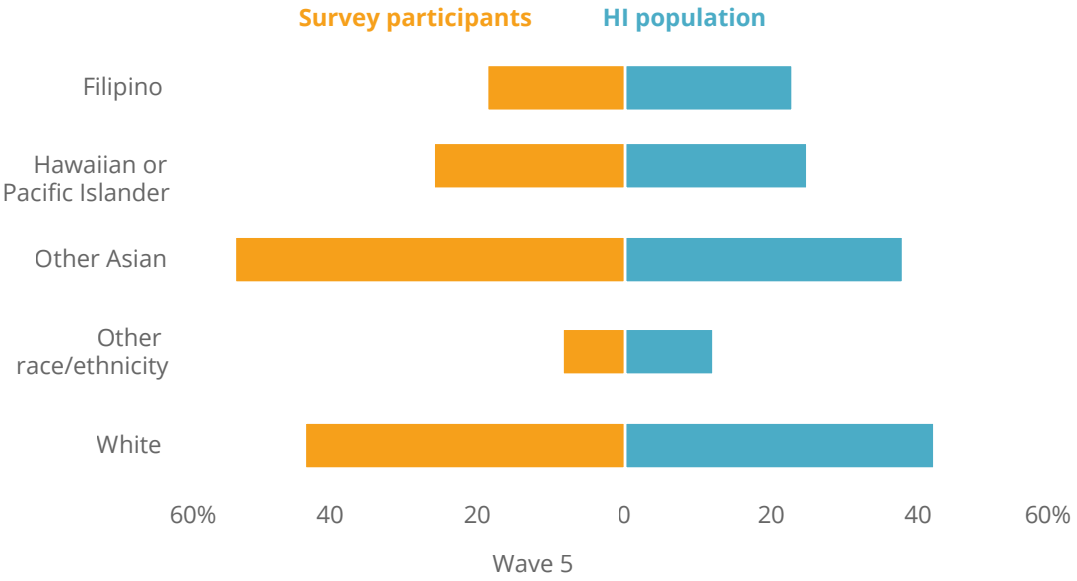
Age

The sample includes individuals 18 years and over. The age distribution of the weighted sample is similar to the overall Hawai'i population, particularly for individuals older than 60 years old. In our survey, about 36% of respondents were 60 or older compared to 34% in the overall population. Individuals in their 40s and 50s were slightly overrepresented. About 36% of our respondents were between 40 and 59 years old, compared to 31% in the general population. In contrast, our cohort has relatively fewer younger individuals between 18 and 29 years (12%) than in the general population (18%).



Race/Ethnicity

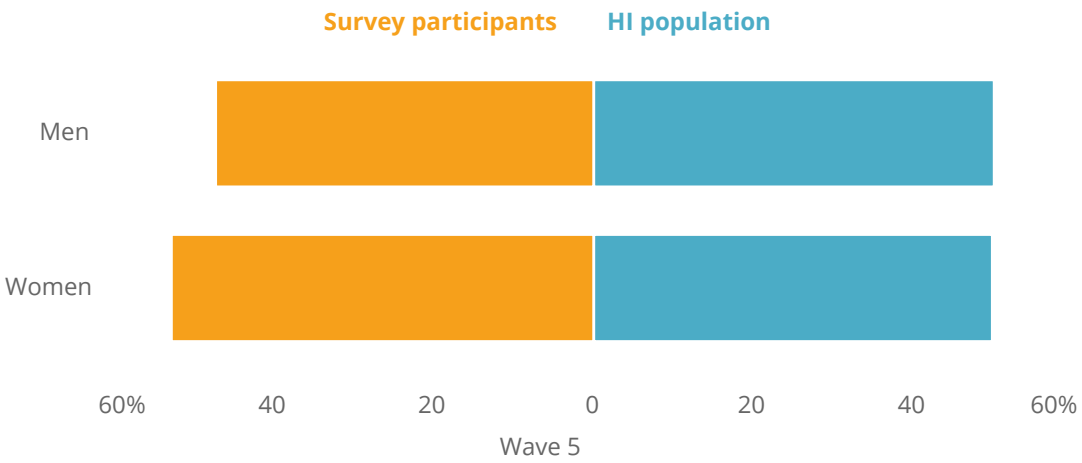
Respondents' racial identities are categorized as Native Hawaiian or Pacific Islander (NHPI), Filipino, other Asian, White, and "other race/ethnicity" (Black, Native American, and/or Latinx). The sample includes 26% NHPI, 19% Filipino, 53% non-Filipino Asian, 43% White, and 9% Black, Native American, and/or Latinx participants. The racial distribution of the weighted survey sample is similar to the Hawai'i population, with a somewhat higher share of non-Filipino Asian respondents and fewer people who identify with one of the other race/ethnicity groups.



"Other race/ethnicity" includes Latinos, Black and Native American people.

Gender

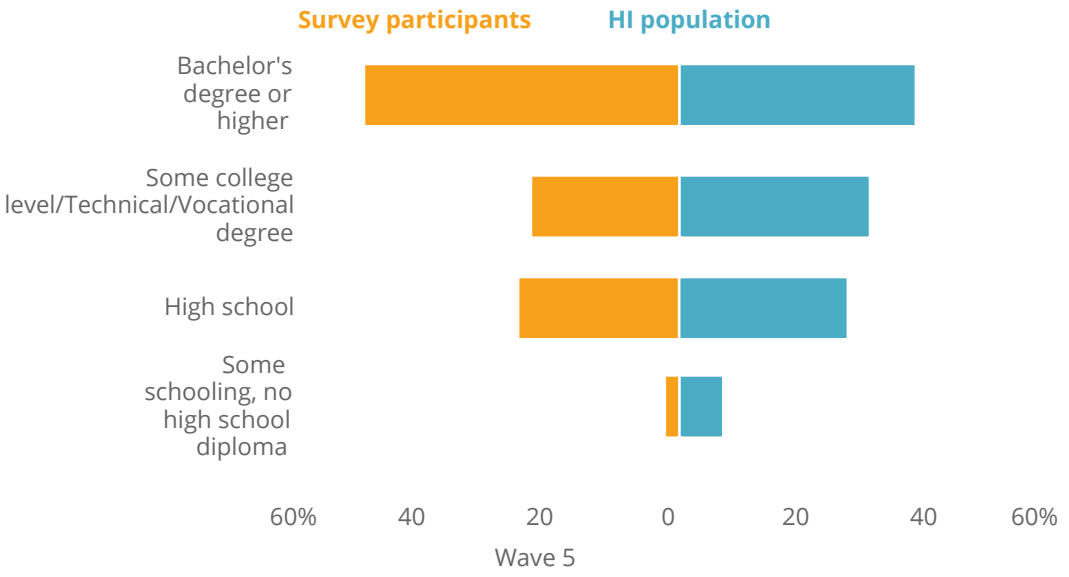
Similar to state levels, about 53% of respondents of the weighted sample identified as women and about 47% identified as men. The survey sample also included about 1% of respondents who identify as non-binary or other genders. Unfortunately, the Census Bureau does not collect data on non-binary gender for comparison.



The survey cohort currently includes <1% people of other genders. Since the Census Bureau does not collect data on non- binary genders, this data is not displayed here.

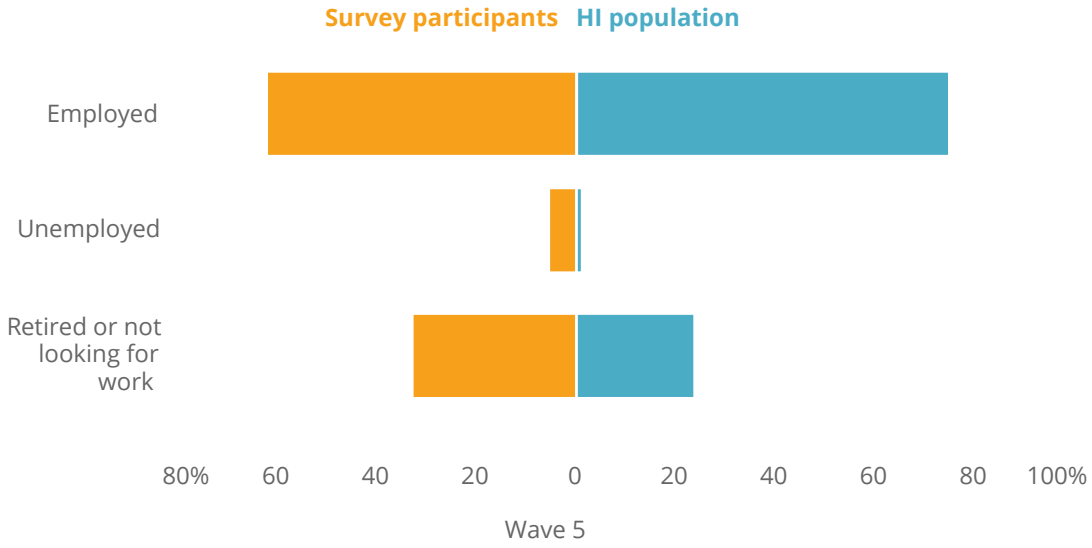
Education

Nearly half of the survey participants (49%) hold a bachelor's degree or higher, compared to 37% in the general Hawai'i population, suggesting a more highly educated sample of people relative to the state population. One in five individuals (20%) reported having some college, technical, or vocational education, and about 25% reported having a high school diploma. About 2% reported having some schooling, but no high school diploma.



Employment

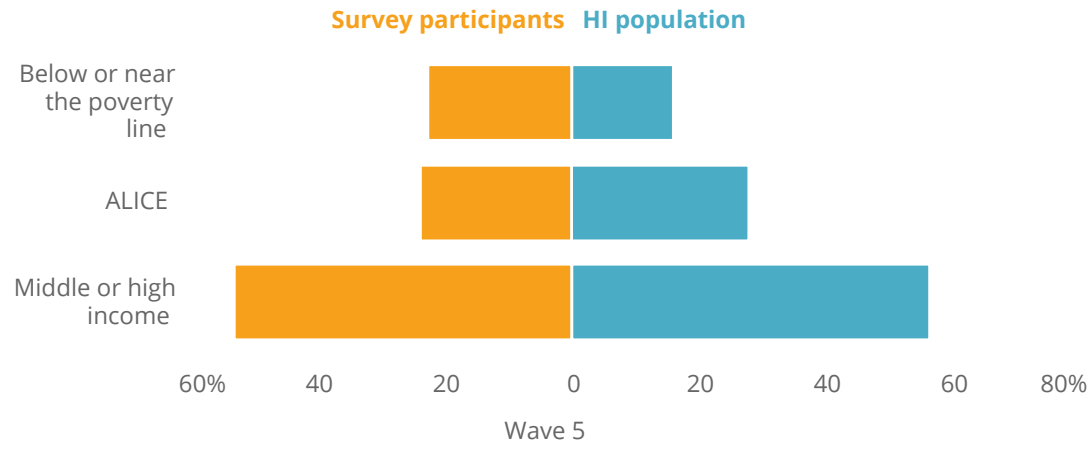
This sample represents a lower proportion of respondents who are employed than state estimates. About 62% of respondents in this sample were employed compared to 75% in the overall population. Around 5% of respondents were unemployed, compared to less than 2% statewide. Around one-third (33%) of respondents were retired or not looking for work compared to about one-fourth (24%) in the state.



Poverty

Poverty status in this survey is determined using federal guidelines that account for household size and annual income, following thresholds established by the U.S. Department of Health and Human Services. ALICE (Asset Limited, Income Constrained, Employed) status is based on the ratio of income to the cost of household essentials as determined by the United for ALICE research group. Respondents are categorized into three income groups: those below or near the poverty line, those classified as ALICE, and those with middle or high income. The ALICE threshold reference data is from 2022 while waves 3-5 of the survey data were collected in 2023 and 2024, which may influence the reliability of comparisons over time.

In our sample, 53% of households reported earning middle or high income, about 23% have incomes below or near the poverty line, and 23% reported living in an ALICE household. The poverty status distribution of the weighted sample is similar to the overall Hawai'i population, with a somewhat higher share of people living in households below the poverty line and fewer ALICE households in the survey.



Data on poverty was collected from wave 3 onwards.

Methodology

Data collection and analysis methods

The UHERO Rapid Health Survey was originally developed to support public health decision-making in Hawai‘i during the COVID-19 pandemic. Since its inception, the survey has evolved to capture a broader range of data on health outcomes, healthcare experiences, and social determinants of health across the state.

The survey is based on a convenience sample of more than 2,000 adult Hawai‘i residents, forming a longitudinal cohort that allows for repeated observation over time. To date, five survey waves have been conducted: May 2022, November 2022, June 2023, March 2024, and December 2024. Sample sizes for each wave range from approximately 1,100 to 2,200 participants, with 1,135 respondents completing the most recent wave in December 2024.

Participants receive a $20 gift card as compensation for their time. The survey is administered online and is available in multiple languages, including English, Spanish, Mandarin, Ilocano, and Tagalog. Community organizations throughout the state assist with recruitment to help ensure diverse representation.

To improve the representativeness of the findings, survey responses are weighted to align with the demographic profile of Hawai‘i’s adult population. Weighting adjustments are made based on age, gender, and educational attainment using iterative proportional fitting (also known as raking). This method repeatedly adjusts survey weights until the sample distribution closely matches statewide population benchmarks for the selected variables.

Limitations

As with any survey-based research, several limitations should be acknowledged. First, all responses are self-reported and may be influenced by social desirability bias. Some participants may underreport or overreport certain health behaviors, outcomes, or socioeconomic conditions—particularly when these are sensitive or stigmatized topics, such as mental health. These biases may vary across demographic groups.

Second, while the sample provides broad coverage across islands, age groups, and most racial and ethnic populations, it tends to be more highly educated than the general population in Hawai‘i. This could introduce bias into certain estimates. However, the survey data have been weighted by age, gender, and education using iterative proportional fitting to help mitigate this issue and improve representativeness.

Finally, this report is based on descriptive analyses and does not imply causal relationships. While the findings identify important patterns and disparities, they do not establish direct cause-and-effect links between variables.

Despite these limitations, we believe this report provides some of the most timely and comprehensive data currently available on health outcomes, healthcare access, and social determinants of health in Hawai‘i. The insights offered here are intended to inform evidence-based policymaking, resource allocation, and community-driven solutions.

Acknowledgments

We are deeply grateful to the Hawai‘i Community Foundation for its support, which made the development of this report and dashboard possible. Additional funding was provided by the State of Hawai‘i under award number 41895 through the Coronavirus State Fiscal Recovery Fund, for the project titled *Data Infrastructure and Analysis for Health and Housing Program and Policy Design – Response to Systemic Economic and Health Challenges Exacerbated by* COVID-19. This funding supported both data collection and the development of this report.

We also recognize the contributions of the Pacific Alliance Against COVID-19 (PAAC), whose staff provided essential support for data collection and analysis. PAAC's efforts, funded by the National Institutes of Health RADx-UP Initiative (U54MD007601-34S2 and OT2HD108105-02), focused on reaching underserved areas across the state. These efforts expanded access to COVID-19 testing and empowered communities through educational outreach and public health service connections, including through AHARO Community Health Centers.

The views expressed in this report are those of the authors and do not necessarily reflect the official positions of the State of Hawai‘i, the NIH, or other funders.

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