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Primary care usage among adults with self-reported hypertension – United States, 2023

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Abstract

Background: Approximately half of US adults have hypertension, with only 1 in 4 having it controlled. Regular visits to primary care can assist with managing hypertension. We estimated the number of US adults aged ≥18 years with self-reported hypertension reporting primary care visits within the last year.

Methods: Using the 2023 National Health Interview Survey (NHIS) we identified respondents who reported a hypertension diagnosis. Among this population we calculated the percentage and numbers who reported primary care visits in the last year by select demographic and socioeconomic covariates.

Results: Our analytical sample of 10,953 US adults with self-reported hypertension represented 81.9 million adults nationally. Overall, 91.6% (95% CI: 90.7%, 92.3%) of US adults with self-reported hypertension reported primary care visits in the last year, representing 75 million nationally. Adults aged 18–44 years had the lowest proportion of visits to primary care by age, 82.3% (95% CI: 79.0%, 85.3%). Males (90.1%, 95% CI: 88.8%, 91.3%) were less likely than females (93.1%, 95% CI: 92.1%, 94.0%) to report visits. Among those with no insurance coverage, only 79.8% (95% CI: 75.3%, 83.8%) reported primary care visits in the last year.

Conclusion: Over 90% of US adults with self-reported hypertension reported a primary care visit in the previous year, representing important opportunities to manage hypertension.

Keywords

hypertension; control; primary care; prevention; access to care; insurance

Introduction

Hypertension's health and economic burdens in the United States (US) are large, prompting attention to improved hypertension management.¹ Approximately half (120 million) of US

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adults have hypertension -- systolic blood pressure ≥ 130 mm Hg, diastolic ≥ 80 mm Hg, or take antihypertensive medication.^{2,3} In 2021, the annual medical cost for people with hypertension was approximately \$3000 higher than for those without.⁴ National medical costs among individuals with hypertension account for an estimated \$131 billion in annual health care expenditures.⁵

Hypertension control is key to addressing the health and economic burdens associated with high blood pressure. Effective control of hypertension significantly reduces the risks of all-cause mortality and of cardiovascular disease (CVD), with similar benefits observed across patient populations.⁶ Access to primary care can support hypertension awareness and control.⁷ Within primary care, team-based care, where physicians, nurses, and pharmacists coordinate care can enhance hypertension management and support patients in achieving hypertension control.⁸

However, only one in four US adults with hypertension meets current American Heart Association (AHA)/American College of Cardiology guidelines for hypertension control.^{3,9,10} Leveraging existing engagement in and increasing access to primary care settings are critical to improving hypertension control and subsequent health outcomes.^{1,7,11} To quantify opportunities for managing hypertension, this study estimates the percent and number of U.S. adults with hypertension reporting primary care visits within the past year.

Methods

Data Source

We used data from the 2023 National Health Interview Survey (NHIS) sample adult interview. NHIS is a cross-sectional, nationally representative multistage probability sample survey of civilian, noninstitutionalized US adults aged ≥ 18 years administered annually by the National Center for Health Statistics (NCHS).¹²

Study Population

Our study sample included adults aged ≥ 18 years with self-reported hypertension defined as respondents reporting that they had ever been told they had high blood pressure by a medical professional.

Outcome variables

Our primary outcome of interest was reporting a primary care visit within the past year. This outcome was constructed from three questions in which respondents indicated when they last saw a doctor, if that was a primary care visit, and how long it had been since that visit. A primary care visit was defined as one that “typically includes: blood pressure, cholesterol, and blood sugar checks, height and weight measurements, and vaccinations. The doctor or other health professional may also discuss topics related to your health.”

We also examined usual place of care for adults aged ≥ 18 years reporting hypertension. Respondents were asked “Is there a place that you usually go to if you are sick and need health care?”. Respondents not responding “no” were asked, “What kind of place do you go to most often: a doctor’s office or health center; an urgent care center or clinic in a drug

store or grocery store; a hospital emergency room; a VA Medical Center or VA outpatient clinic; or some other place?” “Some other place” which was combined with “Does not go to one place most often” and respondents who reported no usual place of care into a single “no regular place of care” category.

Covariates

Results were disaggregated by selected covariates. We categorized race and ethnicity as Hispanic, non-Hispanic (NH) Black, NH White, or NH Asian, and NH Other (including NH American Indian or Alaska Native [AI/AN], AI/AN and any other group, and Other single and multiple races). Hispanic ethnicity included all races; other racial categories represent only non-Hispanic ethnicity. Age was categorized as 18-44, 45-64, and ≥ 65 years. We reported outcomes by sex and combined sex and age group. Urban-rural status was based on residential location using a modified 2013 NCHS Urban-Rural Classification Scheme for Counties. Locations were classified as large central metro, large fringe metro, medium and small metro, or nonmetropolitan. Insurance coverage was categorized as no coverage, private insurance, Medicare/Medicaid, or other insurance. We categorized educational attainment as: less than high school graduate, high school graduate or GED, associate’s degree or some college, and bachelor’s degree or higher. Finally, we constructed a history of CVD variable by combining respondents who reported that they had been told by a healthcare provider that they had a heart attack, stroke, angina, or coronary heart disease.

Analysis

Overall and by each covariate, we calculated the proportions and 95% confidence intervals (CI) for reporting primary care visits in the past year and usual place of care. We also calculated national estimates for the numbers of adults with self-reported hypertension who did and did not report primary care visits in the previous year. We used chi-squared tests to test for differences between the proportion reporting primary care visits for each covariate. All analyses used survey weights and clusters as defined by NCHS to represent non-institutionalized US adults aged ≥ 18 years.¹² Results were suppressed using the NCHS standards for presenting proportions.¹³

Analyses were conducted in R 4.1.0 (R Core Team, Vienna, Austria) using the Survey package.¹⁴ This analysis of publicly available, deidentified data did not require institutional review board approval.

Results

The 2023 NHIS adult sample included 29,522 respondents. Of these, 11,094 (37.6%) respondents reported hypertension. Among those with hypertension, 141 respondents had missing data for at least one covariate, leaving a final analytic dataset of 10,953 respondents with self-reported hypertension, representing 81.9 million US adults.

Overall, 91.6% of adults with self-reported hypertension (95% CI: 90.7%, 92.3%), representing 75.0 (95% CI: 72.6, 77.5) million adults, reported a primary care visit in the past year (Table 1). Approximately 6.9 million (95% CI: 6.3, 7.5) adults with self-reported hypertension did not report primary care visits in the previous year. The percentages

reporting primary care visits varied by race and ethnicity ($p < 0.01$). The highest proportion of adults with self-reported hypertension reporting primary care visits in the past year was NH Black adults (93.3% [95% CI: 91.2%, 95.0%]) and the lowest was among Hispanic adults (88.5% [95% CI: 85.4%, 91.1%]).

Age and sex were both associated with primary care visits in the past year. Adults aged 18–44 years with self-reported hypertension reported the lowest percentage of primary care visits (82.3%, 95% CI: 79.0%, 85.3%); approximately 2.5 million (95% CI: 2.1, 2.9) adults in this age group with hypertension did not have a primary care visit in the previous year. Males (90.1%, 95% CI: 88.8%, 91.3%) were less likely than females (93.1%, 95% CI: 92.1%, 94.0%) to report a primary care visit ($p < 0.0001$). When disaggregated by both sex and age, males aged 18–44 years had the lowest percentage of primary care visits (78.8%, 95% CI: 74.2%, 82.9%), compared to both females of the same age (86.9%, 95% CI: 82.7%, 90.4%) with $p < 0.05$ and males aged ≥ 65 years (96.0%, 95% CI: 94.9%, 96.9%) with $p < 0.0001$. Both age and sex specific age were associated with primary care visits.

Urban-rural status ($p = 0.09$) and educational attainment ($p = 0.55$) were not associated with primary care visits in the previous year. By insurance, adults with self-reported hypertension with no health insurance coverage had the lowest percentage of primary care visits in the last year (79.8%, 95% CI: 75.3%, 83.8%), equivalent to 2.2 million (95% CI: 1.9, 2.5) adults with hypertension nationally without a primary care visit. Adults with Medicare/Medicaid had the highest proportion of primary care visits (94.8%, 95% CI: 93.7%, 95.7%). Reported primary care visits varied by history of CVD ($p < 0.0001$). 94.8% (95% CI: 93.2%, 96.0%) of those with a history of CVD had a primary care visit in the past year, compared to 91.1% (95% CI: 90.2%, 91.8%) of those without this history.

Most adults with self-reported hypertension reported receiving usual care in a doctor's office or health center (86.5%, 95% CI: 85.5%, 87.3%), with the lowest percentages among those with no insurance coverage (61.3%, 95% CI: 55.4%, 67.2%) (Supplemental Table 1). Notably, approximately 1 in 20 adults with self-reported hypertension (4.9%, 95% CI: 4.3, 5.4) reported receiving usual care in an urgent care center or drug or grocery store clinic. Among adults aged 18–44 years, this value was 1 in 10 (9.9%, 95% CI: 8.2, 11.7). 10.5% (95% CI: 8.6, 12.4) of adults ages 18–44 years reported no regular place of care or some other place of care.

Discussion

In this nationally representative study, $>90\%$ of US adults with self-reported hypertension reported a primary care visit in the past year. This engagement with primary care offers numerous advantages, including better management of chronic conditions including hypertension, potentially improving cardiovascular health outcomes and reducing long-term healthcare costs.^{1,7} Primary care visits are opportunities to reinforce heart healthy behaviors and lifestyle modifications, initiate or titrate medication, and connect patients with healthcare and community resources.¹¹ However, approximately 6.9 million US adults with self-reported hypertension did not see a primary care provider in the past year. These gaps highlight opportunities to support hypertension management in the US.

Most US adults with self-reported hypertension reported both a primary care visit in the previous year and a usual source of care. However, approximately 42.6 million adults aware of their hypertension status do not have their it under control.¹⁵ The healthcare visits reported in this study represent opportunities for managing hypertension in tandem with other chronic conditions and risk factors. Clinicians can follow hypertension treatment guidelines to drive hypertension control. For instance, the Million Hearts Hypertension Control Change package, Second Edition¹⁶ and AHA's Target BP initiative¹⁷ present process improvements for outpatient settings seeking to optimize hypertension control. Clinically, effective hypertension management is facilitated by prioritizing hypertension control (including establishing systems to support home-based blood pressure monitoring), implementing team-based care, and aligning treatment protocols to ensure recommended lifestyle modifications, medications, and timely follow-up are consistent and guideline-based.¹⁸

However, almost seven million adults with self-reported hypertension did not report a primary care visit in the past year. Likewise, almost 15% of adults did not report a usual place of care in a doctor's office or health center. Hypertension management often requires multiple clinical visits, virtual or in-person, to monitor lifestyle modification, titrate medications, and support medication adherence,^{9,19} underscoring the importance of sustained primary care relationships. These essential processes are not suited for one-time visits to urgent care facilities or clinics in drug or grocery stores, as reported by 4.9% of adults.

The highest percentages of adults with self-reported hypertension without a usual place of care were among those without health insurance. Addressing barriers to care, including lack of insurance, limited awareness of low-cost health care, transportation challenges, and poorly coordinated care may improve access to primary care among these groups and serve as a critical first step towards improving hypertension management.^{18,20}

Our findings among adults aged 18-44 years, especially young men, are troubling as poor cardiovascular health in this age group can be disabling and deadly.¹ Ensuring continuity of care in the transition from pediatric to adult care may improve medical engagement for young adults.¹¹ Young adults are more likely to have uncontrolled hypertension partly because lifestyle modifications may be insufficient as standalone strategies and medication initiation may be delayed.¹⁰ Community and workplace-based health initiatives, including workplace blood pressure monitoring, can provide opportunities to engage with young adults, identify those at high risk, and link them to appropriate care.²¹

Limitations

This analysis is subject to several limitations. First, hypertension was self-reported and blood pressure thresholds were likely homogenous. Approximately 60% of US adults with hypertension are aware of their diagnosis.² Our values may therefore underestimate total numbers of individuals with hypertension engaged in primary care. Simultaneously, we may overestimate proportions for visiting primary care as those aware of their hypertension diagnosis may be more likely to visit primary care. Secondly, NHIS does not include hypertension control data. However, as only one-quarter of US adults with hypertension

have it controlled² and control requires ongoing management, our results still represent opportunities. Thirdly, we excluded 1.3% of respondents because of missing data. Finally, in 2023 NHIS' response rate was 47.0%, potentially biasing results.¹²

In conclusion, millions of US adults with self-reported hypertension are engaged with primary care, representing millions of potential opportunities to improve hypertension control. Leveraging these primary care contacts through evidence-based strategies, team-based care, and systems-level interventions can support hypertension control efforts and advance national hypertension control goals.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Disclaimer:

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Table 1: Characteristics of US adults aged ≥18 years with self-reported hypertension, and proportion and nationally weighted counts of those who reported a primary care visit within the previous year, United States, 2023.

Category	N (%)	Reporting a primary care visit in the last year (%) (95% CI) ²	p-value ¹	Number reporting a primary care visit in the last year (in millions) (95% CI) ²	Number NOT reporting a primary care visit in the last year (in millions) (95% CI) ²
Overall	10,953 (100)	91.6 (90.7-92.3)		75.0 (72.6-77.5)	6.9 (6.3-7.5)
Race			<0.01		
Hispanic	1,210 (11.0%)	88.5 (85.4-91.1)		9.8 (8.7-10.9)	1.2 (0.9-1.4)
NH Asian	422 (3.9%)	90.2 (84.6-94.3)		3.7 (3.2-4.3)	0.4 (0.2-0.6)
NH Black	1,558 (14.2%)	93.3 (91.2-95.0)		11.1 (10.0-12.1)	0.9 (0.7-1.2)
NH White	7,511 (68.6%)	91.8 (90.8-92.7)		48.8 (46.8-50.8)	4.2 (3.8-4.7)
NH Other	252 (2.3%)	Suppressed		Suppressed	Suppressed
Age in years			<0.0001		
18-44	1,360 (12.4%)	82.3 (79.0-85.3)		11.7 (10.9-12.6)	2.5 (2.1-2.9)
45-64	3,682 (33.6%)	90.5 (89.0-91.8)		29.3 (27.9-30.7)	3.0 (2.6-3.3)
≥65	5,911 (54.0%)	96.2 (95.5-96.8)		34.0 (32.7-35.3)	1.4 (1.2-1.6)
Sex			<0.0001		
Male	5,201 (47.5%)	90.1 (88.8-91.3)		37.5 (35.9-39.1)	4.1 (3.6-4.6)
Female	5,752 (52.5%)	93.1 (92.1-94.0)		37.5 (36.1-39.0)	2.8 (2.4-3.1)
Male sex only - Age in years			<0.0001		
18-44	703 (6.4%)	78.8 (74.2-82.9)		6.3 (5.7-6.8)	1.7 (1.3-2.0)
45-64	1,896 (17.3%)	89.7 (87.7-91.4)		15.4 (14.4-16.4)	1.8 (1.5-2.1)
≥65	2,602 (23.8%)	96.0 (94.9-96.9)		15.8 (15.0-16.7)	0.7 (0.5-0.8)
Female sex only - Age in years			<0.0001		
18-44	657 (6.0%)	86.9 (82.7-90.4)		5.5 (4.9-6.0)	0.9 (0.7-1.1)
45-64	1,786 (16.3%)	91.4 (89.3-93.2)		13.9 (13.1-14.7)	1.2 (0.9-1.4)
≥65	3,309 (30.2%)	96.4 (95.5-97.2)		18.2 (17.3-19.1)	0.7 (0.6-0.9)
Urban/Rural status			0.09		
Large metro	3,007 (27.5%)	91.1 (89.2-92.6)		21.2 (19.5-22.9)	2.1 (1.8-2.5)
Fringe metro	2,446 (22.3%)	90.4 (88.5-92.1)		18.1 (16.2-20.0)	1.8 (1.4-2.1)

Category	N (%)	Reporting a primary care visit in the last year (%) (95% CI) ²	p-value ¹	Number reporting a primary care visit in the last year (in millions) (95% CI) ²	Number NOT reporting a primary care visit in the last year (in millions) (95% CI) ²
Small and medium metro	3,478 (31.8%)	92.1 (90.7-93.3)		23.1 (20.9-25.3)	2.1 (1.8-2.4)
Non-metropolitan	2,022 (18.5%)	93.2 (91.5-94.6)		12.6 (11.7-13.6)	0.9 (0.7-1.1)
Insurance Status			<0.0001		
No coverage	356 (3.3%)	79.8 (75.3-83.8)		2.2 (1.9-2.5)	1.1 (0.9-1.3)
Privately insured	5,320 (48.6%)	91.1 (89.8-92.3)		39.0 (37.3-40.7)	3.7 (3.3-4.2)
Medicare/Medicaid	4,368 (39.9%)	94.8 (93.7-95.7)		28.0 (26.8-29.3)	1.6 (1.3-1.8)
Other	909 (8.3%)	91.1 (85.6-94.9)		5.9 (5.3-6.4)	0.5 (0.3-0.6)
Educational Attainment			0.55		
Less than high school	1,205 (11.0%)	91.1 (88.4-93.3)		9.7 (8.8-10.5)	0.9 (0.7-1.1)
High school graduate or GED	3,086 (28.2%)	90.7 (89.0-92.3)		21.8 (20.7-23.0)	2.1 (1.8-2.5)
Associate's degree or some college	3,244 (29.6%)	92.0 (90.4-93.4)		22.5 (21.4-23.6)	2.0 (1.-2.3)
Bachelor's degree or higher	3,418 (31.2%)	92.2 (90.7-93.5)		21.0 (20.0-22.1)	1.8 (1.5-2.1)
History of CVD			<0.0001		
No History of CVD	6271 (57.2%)	91.1 (90.2 – 91.8)		63.2 (61.0-65.3)	6.2 (5.6-6.8)
History of CVD	4682 (42.8%)	94.8 (93.2-96.0)		11.9 (11.1-12.7)	0.7 (0.5-0.8)

¹ P-values represent the results of a chi-squared test between the covariate and reporting a primary care visit.

² Values are weighted according to the survey design.

NH – non-Hispanic, CVD – cardiovascular disease (defined as respondents told by a healthcare provider that they had a heart attack, stroke, angina, or coronary heart disease)