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Heterogeneous Effects of Blood Pressure Screening

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DISCUSSION PAPER SERIES

IZA DP No. 16767

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JANUARY 2024

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ABSTRACT

Heterogeneous Effects of Blood Pressure Screening

This is the first study that investigates the heterogeneous effects of blood pressure (BP) screening on subsequent changes in BP in a high-income country. We use data from clinical health assessments carried out in 2010 (baseline) and 2014 (follow-up) as part of a nationally-representative longitudinal study on ageing in Ireland. We employ a Regression Discontinuity Design (RDD) by comparing outcomes at follow-up on either side of the BP cutoff that separates normal to abnormal BP at baseline. We find that the BP screening reduces BP at follow-up among those who at baseline do not report a previous hypertension diagnosis, with larger and more precisely estimated effects for males, middle-age individuals (as opposed to older individuals) and individuals without public health insurance coverage. However, we find no effects when we include in the analysis individuals who at baseline report a previous hypertension diagnosis. Overall, our analysis suggests that the effectiveness of the screening likely depends on whether the information on the outcome of the screening provided to individuals is new to them or not.

JEL Classification: C21, I12, I18

Keywords: health screening, hypertension, blood pressure, undiagnosed individuals, non-communicable diseases, regression discontinuity design, ireland, high-income country

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1 Introduction

Hypertension, or high blood pressure, is the principal risk factor for cardiovascular disease (CVD) (Stanaway *et al.*, 2018), which in turn is the largest contributor to the global burden of disease (Vos *et al.*, 2020). According to recent estimates (Zhou *et al.*, 2021a) every year around 8.5 million deaths worldwide are attributable to hypertension. Globally, 34% of men and 32% of women aged 30 to 79 suffer from this condition. However, hypertension is often undetected, with many individuals suffering from this condition not experiencing noticeable symptoms. Awareness rates around the globe are low, with only around 49% of men and 59% of women with hypertension being aware of their condition (Zhou *et al.*, 2021b).

In Ireland, around 38% of men and 27% of women aged 30 to 79 suffer from hypertension. Only 48% of men and 54% of women suffering from this condition are aware of their hypertension status (Zhou *et al.*, 2021b). Ireland has the lowest hypertension awareness rates of all high-income English speaking countries.¹ For women, the hypertension awareness rate is also the lowest in Europe. For men, it is the third lowest, after Albania (28%) and Estonia (47%) (Zhou *et al.*, 2021b). Awareness of hypertension is a crucial first step for individuals to seek care and achieve long lasting blood pressure (BP) control. Early detection is vital to prevent complications. Once hypertension is detected, there are two well-established strategies to lower BP: lifestyle interventions, such as salt reduction, healthy diet, moderate alcohol consumption, smoking cessation, and regular physical exercise, and drug treatment (Williams *et al.*, 2018).

The finding that around half of adults with hypertension in Ireland are unaware of their condition leads to the natural question of whether hypertension screening can be effective at increasing awareness and in turn at lowering BP and reducing hypertension prevalence rates in Ireland. Addressing this question is particularly important in the Irish context for at least two reasons. The first reason is that Ireland is the only western European country without universal coverage for primary care, with approximately 58% of the population paying the full out-of-pocket cost of a general practitioner (GP) visit (OECD *et al.*, 2019). Still, GPs play a key role in the Irish health care system as most often they are the first point of call for interactions with the health service. GPs provide a wide range of services in relation to diagnosis, treatment, and management of health problems, and act as gatekeepers for secondary care (Ma *et al.*, 2020). The second reason is that in Ireland there is no national programme for CVD risk assessment similar to those in place in countries such as Belgium, Germany, Luxembourg, and Switzerland

¹These include Australia, Canada, Ireland, New Zealand, the United Kingdom and the United States of America.

(Murphy *et al.*, 2016).

With this background in mind, this paper investigates whether hypertension screening leads to changes in BP using data from the first (2010) and third (2014) waves of The Irish Longitudinal Study on Ageing (TILDA) (Whelan and Savva, 2013). TILDA is a nationally representative sample of community-dwelling individuals aged 50 or older in Ireland and their partners of any age. One unique feature of TILDA is that each respondent is offered an in-depth health assessment which is carried out by a trained and qualified nurse. The health assessment is carried out at baseline (wave 1), and again 4 years later (wave 3). Respondents' systolic blood pressure (SBP) and diastolic blood pressure (DBP) are measured at both baseline and follow-up. At the end of the assessment, the nurse who has undertaken the assessment provides feedback to the respondent on whether his/her measured BP is normal (below a BP cutoff) or abnormal (above a BP cutoff). The cutoff that separates normal to abnormal BP is 140 mmHg for SBP and 90 mmHg for DBP.

We follow the literature (Chen *et al.*, 2019; Ciancio *et al.*, 2021; Dai *et al.*, 2022; Kämpfen *et al.*, 2023; Pedron *et al.*, 2022; Sudharsanan *et al.*, 2020; Zhao *et al.*, 2013) and estimate the causal effect of hypertension screening on BP using a Regression Discontinuity Design (RDD) approach. Effects are estimated by comparing outcomes at follow-up on either side of the BP cutoff at baseline. The design allows causal impact to be estimated in the absence of explicit randomisation. Causal identification relies on the assumption that respondents in a narrow range around the cutoff that separate the normal to the abnormal BP range are similar on average in both observed and unobserved characteristics such that an outcome would evolve smoothly and continuously through the cutoff if no such cutoff were to exist. Any discontinuity in the outcome at the cutoff can then be attributed to the causal effect of crossing the normal BP range cutoff.

Following Chen *et al.* (2019), Ciancio *et al.* (2021), and Sudharsanan *et al.* (2020), we employ a unidimensional RDD in the first instance. With this approach, we estimate treatment effects which are frontier-specific —systolic or diastolic—. However, this approach has a number of limitations, primarily a substantial reduction in both information and statistical power due to the exclusion of a sizeable number of observations in each unidimensional RDD. To address the limitations of the unidimensional approach, we then follow Pedron *et al.* (2022) and Kämpfen *et al.* (2023), and adopt a binding-score RDD strategy, which essentially relies on a centering approach that leverages the changes in treatment status at both systolic and diastolic BP cutoffs simultaneously. Given the high rates of hypertension unawareness in Ireland, the main

focus of our analysis are on undiagnosed individuals, i.e., individuals who at baseline do not report a previous hypertension diagnosis. For completeness, we also carry out a comparative analysis for the entire sample of TILDA respondents with valid BP measurements at baseline and follow-up. The entire sample includes individuals who at baseline either report (32.7%) or do not report (67.3%) a previous diagnosis of hypertension.

The results of our analysis show that screening reduces BP among undiagnosed individuals. Estimates are large and precisely estimated. To illustrate, estimates from the binding-score RDD approach show that individuals at the cutoff experience a drop in SBP of 5.3 mmHg (p -value=0.027) relative to individuals just below the cutoff. A similar effect on SBP is estimated from the discontinuity at the systolic frontier (-5.5 mmHg, p -value=0.062) and at the diastolic frontier (-6.1 mmHg, p -value=0.113). Effects on DBP are sizable as well: individuals just above the cutoff experience a decrease in DBP that ranges between 3.2 mmHg (p -value=0.044) and 4.3 mmHg (p -value=0.022). However, these effects do not translate into a statistically significant decrease in the probability of being hypertensive at follow-up. For the full sample that includes both diagnosed and undiagnosed individuals, we find no evidence that screening reduces BP four years later. Estimated effects are consistently negative, but they are imprecise and not close to conventional levels of statistical significance.

We also document important heterogeneity effects among undiagnosed individuals with larger effects for males, middle-aged respondents (as opposed to older respondents), and individuals who are not eligible to public health care. For instance, when considering the SBP frontier only, undiagnosed males experience a drop in SBP and DBP of about 8.3 mmHg (p -value=0.043) and 6.7 mmHg (p -value=0.009), respectively. The corresponding drops for females are much smaller (-2.2 mmHg and -0.8 mmHg, respectively) and not precisely estimated (p -value=0.630 and p -value=0.774, respectively). Even larger differences emerge when focusing on the effects of the screening on middle-aged vs older adults. Along the SBP frontier, middle-aged individuals just above the cutoff have lower SBP (-12.9 mmHg, p -value=0.002) and DBP (-10.1 mmHg, p -value<0.001) at follow-up relative to those just below the cutoff. In contrast, screened older adults just above the cutoff do not experience any change in their BP characteristics. Our analysis does not reveal any heterogeneity by educational attainment.

This paper contributes to various strands of the literature. First, existing evidence on the effects of BP screening is mixed and clear differences emerge between High-Income Countries (HICs) and Low- and Middle-Income Countries (LMICs). While studies from HICs such as Germany (Pedron *et al.*, 2022) and the United Kingdom (Rodriguez-Lesmes, 2021) find that

BP screening does not have any effect on BP at follow-up, studies from LMICs such as Malawi (Ciancio *et al.*, 2021), South Africa (Sudharsanan *et al.*, 2020), and China (Chen *et al.*, 2019) conclude that BP screening does reduce BP at follow-up. Knowledge and awareness of hypertension status is typically lower in LMICs than in HICs (Lloyd-Sherlock *et al.*, 2014; Mohanty *et al.*, 2021, 2022), suggesting that (low) awareness is likely a key determinant of the effectiveness of BP screening. Our study from Ireland shows that among undiagnosed individuals—and thus likely to be unaware of their condition—, BP screening leads to improvements in BP characteristics that are consistent with evidence from LMICs (Chen *et al.*, 2019; Ciancio *et al.*, 2021; Sudharsanan *et al.*, 2020). This is in line with the literature that documents that health information and news have no impact if irrelevant or useful only for a short period of time (Ciancio *et al.*, 2024).

Our second contribution is that we document heterogeneous effects of BP screening by key socio-demographic groups. Previous research in Ireland has shown that, compared to women and older adults, men and middle-aged adults are less likely to use health care services and preventive care (Barry *et al.*, 2009; Central Statistics Office, 2016). Existing evidence from Ireland has also shown that public patients have more healthcare utilisation (especially more GP visits) than private patients, even when differences in health needs between the two groups of patients are accounted for (Ma and Nolan, 2017). The analysis of this paper indicates that those who typically have fewer interactions with the healthcare services, i.e., men, middle-aged adults, and those without public health care eligibility, are more likely to benefit from the BP screening. Our third contribution is that compared to most previous studies the information provided to respondents in TILDA is closer to how it would be provided in an actual screening programme. This is because in TILDA BP is measured by trained and qualified nurses who provide oral and written feedback to the respondents at the time of the screening.

The remainder of this paper is structured as follows. Section 2 provides a description of the institutional setting, the data and the variables employed in the analysis. Section 3 presents the econometric specifications and Section 4 presents the results. Section 5 concludes.

2 Context and Data

2.1 Institutional setting

Ireland remains the only western European country without universal coverage for primary care, with eligibility to public health care varying according to residency, age, and socioeconomic status. Residents with an income below a defined threshold or with certain medical conditions (32 % of the population in 2021 according to [OECD *et al.* \(2021\)](#)) are eligible for a Medical Card, which provides access to primary care and hospital services free of charge and medicines with limited co-payments. Some other population groups (10 % of the population) have access to a GP Visit Card that covers GP charges but does not cover the costs of medicines or hospital fees. The income thresholds for the GP visit card are 50% higher than for the full medical card ([Ma and Nolan, 2017](#)). In 2015, automatic eligibility for a GP visit card was extended to all children under 6 years of age, and all those aged 70+ ([Connolly *et al.*, 2023](#)). In 2023, it was extended to children aged 6 and 7. The remaining population (58%), who hold neither a Medical Card nor a GP Visit Card, must cover the costs of accessing GP services themselves ([OECD *et al.*, 2021](#)). Costs per GP visit are about EUR 40-65 ([OECD *et al.*, 2019](#)).

In Ireland there is no national programme for CVD risk assessment similar to those in place in countries such as Belgium, Germany, Luxembourg, and Switzerland ([Murphy *et al.*, 2016](#)). In 2019, a Chronic Disease Management (CDM) Programme was introduced for the management and treatment of specified chronic diseases, including cardiovascular disease. This programme provides additional funding for GPs for the management and treatment of the specified chronic diseases. However, only two groups of people can avail of the programme. The first group consists of those with full public eligibility for GP services, i.e., those with a medical or GP visit card. The second group consists of those already diagnosed with specified chronic diseases.

2.2 Sample

The data used in this paper come from The Irish Longitudinal Study on Ageing (TILDA), which is a nationally representative sample of community-dwelling individuals aged 50 or older in Ireland and their partners of any age ([Kearney *et al.*, 2011](#); [Whelan and Savva, 2013](#)). The survey collects detailed information on the economic, health, and social aspects of the respondents' lives in a series of data collection waves once every two years. The study is

harmonised with other international longitudinal studies of ageing, including the Health and Retirement Study (HRS) in the US, the Survey of Health, Ageing and Retirement in Europe (SHARE), and the English Longitudinal Study on Ageing (ELSA).

In TILDA, data are collected via computer-aided personal interviewing (CAPI), a self-completion questionnaire (SCQ) which is designed to collect more sensitive information and a nurse-led clinical health assessment in a dedicated health centre. If unable or unwilling to travel to the dedicated health centre, respondents are offered a shorter, modified assessment in their own home. BP is measured in all assessments, whether carried out in the dedicated health centre or in the respondent’s home. All assessments are carried out by qualified and trained nurses.

In this paper, we use data collected in the health assessments carried out in wave 1 (2010) and wave 3 (2014) (Donoghue *et al.*, 2018).² The benchmark sample consists of undiagnosed individuals for whom we have valid BP measurements at both assessments in wave 1 and wave 3 ($N=2,752$). Undiagnosed individuals are those who at wave 1 interview answered “No” to the question “*Has a doctor ever told you that you have high blood pressure or hypertension?*”.³

2.3 Blood pressure (BP) screening and study protocol

BP is measured by a nurse according to a standard protocol. After a period of rest, a digital automated oscillometric BP monitor with an arm cuff (22-42 cm) is used to measure BP in one arm, at heart height, while the respondent is seated comfortably in an upright position. BP is recorded twice while seated with a timed interval of 1 minute between readings. The mean systolic and diastolic readings are obtained from these two measurements (Murphy *et al.*, 2016).

At the end of the health assessment, TILDA respondents receive feedback on a number of possible health issues, including BP.⁴ The feedback sheet is given to respondents by the nurse who has carried out the assessment. Respondents are notified about the reference range of normal BP and the interpretation of their measured BP, which is given as “normal” —less than 140/90 mmHg for systolic and diastolic, respectively—, or “abnormal” otherwise.⁵ The nurses

²The third health assessment, originally planned for 2020, was postponed until wave 6 (2022) due to the occurrence of the Covid-19 pandemic. Data from wave 6 are not available to us.

³The full sample that we use for our comparative analysis includes 4,093 respondents, of whom around 32.7% ($N=1,341$) report a previous doctor diagnosis of hypertension.

⁴They also receive information on their measured height and weight, bone density and visual acuity.

⁵The feedback form for the health assessments conducted in the dedicated TILDA health centre and at home can be found in Appendix Figures A.1 and A.2, respectively. Note that the abnormal BP range for people with diabetes is different (135/85 mmHg for systolic and diastolic, respectively). Our benchmark sample

are trained to deal with abnormal results and respond to any queries relating to the results that a respondent has received. If there is uncertainty or concern on the part of the nurses, they are instructed to contact the TILDA Health Assessment Manager to discuss the matter further. Participants are also noted that those with undesirable results may be at higher risk of some diseases and may wish to consider appropriate lifestyle changes. Participants with high BP are also recommended to have their BP checked again by their own doctor (Kenny *et al.*, 2010).

2.4 Outcome variables

Our outcomes of interest are derived from BP measurements. We consider four outcome variables. The first two capture changes in mean SBP and mean DBP, respectively, between baseline and follow-up. The third outcome variable captures changes in mean arterial pressure (MAP), which is a time-weighted average of the arterial pressure over the whole cardiac cycle (Kundu *et al.*, 2017).⁶ The fourth outcome variable is indicator of hypertension derived from those measurements, $1(\text{mean SBP} \geq 140 \vee \text{mean DBP} \geq 90)$.

2.5 Descriptives

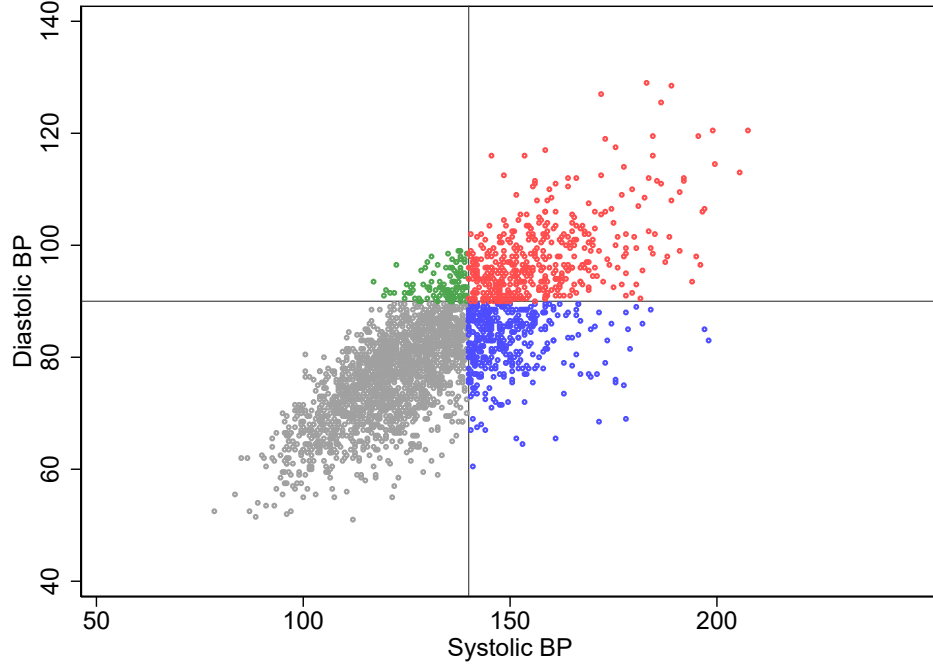
Figure 1 is a scatter plot of the mean DBP measurements against the mean SBP measurements at baseline for undiagnosed respondents. Respondents with a mean DBP of at least 90 mmHg or a mean SBP of at least 140 mmHg are outside the normal range. Blue dots correspond to respondents who have (only) SBP outside the normal range. Green and red dots correspond to individuals with diastolic (only) and both systolic and diastolic BP outside the normal range, respectively. Grey dots correspond to individuals who will serve as controls in our causal identification strategy.

Descriptive statistics of baseline characteristics (top panel), outcome variables (middle panel), and control variables (bottom panel) are presented in Table 1. The top panel of Table 1 shows that the mean SBP and DBP at baseline are equal to about 131 and 82 mmHg,

therefore excludes individuals ($N = 104$, or 3.64% of the sample) who at baseline report a previous diabetes diagnosis. In the results section, we show that our results are robust to the inclusion of these individuals.

⁶MAP is calculated as follows: $MAP = DBP + 1/3(SBP - DBP)$ (DeMers and Wachs, 2019). The cardiac cycle is the period of time that begins with contraction of the atria and ends with ventricular relaxation. The period of contraction that the heart undergoes while it pumps blood into circulation is called systole. The period of relaxation that occurs as the chambers fill with blood is called diastole. SBP and DBP are indicators of changes in blood flows through the blood vessels. However, they do not provide information on cardiac output, which is the amount of blood the heart pumps in one minute. In contrast, MAP does provide information on cardiac output. MAP has been shown to be an independent predictor of CVDs (GE HealthCare, 2023).

Figure 1: Scatter plot of the systolic and diastolic BP at baseline – undiagnosed individuals



Notes: $N=2,752$. The x-axis (y-axis) shows average systolic (diastolic) BP at baseline. Blue, green, and red dots identify respondents who are above the systolic (only), diastolic (only), and both systolic and diastolic thresholds (systolic = 140 mmHg, diastolic = 90 mmHg). Grey dots identify respondents who are below both thresholds at baseline. The sample includes only individuals who at baseline do not report a previous hypertension diagnosis.

respectively. Mean MAP is equal to 98 mmHg. Daytime MAP between 96 mmHg and 104 mmHg is usually indicative of stage-1 hypertension and values above 104 mmHg correspond to stage-2 hypertension (Melgarejo *et al.*, 2021). About 30.2% of respondents have a mean SBP at or above the 140 mmHg threshold, that is outside the normal range (blue and red dots in Figure 1). This compares to 20.2% of respondents with a mean DBP at or above the respective 90 mmHg threshold (green and red dots in Figure 1). On the basis of the comparison of the mean SBP and DBP with the respective thresholds, a total of 34.4% of respondents can be classified as hypertensive. The middle panel of Table 1 shows that BP characteristics of TILDA respondents remain stable over time, as on average SBP, DBP, and MAP change by 0.1, -1.1, and -0.6 mmHg between baseline and follow-up, respectively. At follow-up, around 32.6% of respondents can be classified as hypertensive, compared to 34.4% at baseline. The bottom panel of Table 1 shows that 55% of the overall sample are female and the average age is equal

Table 1: Descriptive statistics – undiagnosed individuals

	Mean	Std. dev.	p10	p90	Obs
<i>Baseline characteristics</i>					
SBP	131.331	18.769	109	156	2752
DBP	81.178	10.865	67.5	95.5	2752
MAP	97.895	12.677	82.667	114.333	2752
Hypertension ^a	0.344	0.475	0	1	2752
Above SBP cutoff	0.302	0.459	0	1	2752
Above DBP cutoff	0.202	0.402	0	1	2752
<i>Outcomes</i>					
Change in SBP	0.140	16.607	-19.5	19.5	2752
Change in DBP	-1.084	10.153	-13.5	10.5	2752
Change in MAP	-0.676	11.581	-14.667	12.667	2752
Hypertension ^a	0.326	0.469	0	1	2752
<i>Controls (at baseline)</i>					
Female	0.550	0.498	0	1	2752
Age	60.751	8.003	51	73	2749
Age above 80	0.027	0.161	0	0	2749

Notes: SBP, DBP, and MAP stand for systolic blood pressure, diastolic blood pressure, and mean arterial pressure, respectively. ^a: Hypertension is a dichotomous variable that = $\mathbb{1}(\text{Mean DBP} \geq 90 \vee \text{Mean SBP} \geq 140)$. The cutoff for SBP is 140 and the cutoff for DBP is 90. The sample excludes individuals who at baseline report a previous diabetes diagnosis. p10 and p90 correspond to the 10th and 90th percentiles, respectively. Descriptive statistics including those who at baseline report a previous hypertension diagnosis are reported in Appendix Table B.1.

to 60.8 years old. Around 2.7% of the respondents are aged 80 or older.⁷

Appendix Table B.1 shows corresponding descriptive statistics for the entire sample, which includes both diagnosed individuals, i.e., individuals who at baseline report a previous hypertension diagnosis, and undiagnosed individuals, i.e. individuals who at baseline do not report a previous hypertension diagnosis. Differences between diagnosed and undiagnosed individuals are investigated in Appendix Table B.2. The results of Appendix Tables B.1 and B.2 indicate that many individuals who had been diagnosed with hypertension by a doctor before joining the TILDA study do not have their BP under control. The results of Table B.2 show that around 55.1% of individuals previously diagnosed with hypertension are considered as hypertensive at the time of wave 1 screening according to BP measurement. This compares to 34.4% among undiagnosed individuals. The drop in BP at follow-up is larger among diagnosed individuals as compared to undiagnosed individuals. This suggests that the rate of improvement

⁷Age of the respondents in TILDA is capped at 80. In our econometric specification, we therefore include a dichotomous variable that takes the value 1 if a respondent is aged 80 or older, and 0 otherwise, in addition to controlling for our continuous measure of age.

between baseline and follow-up is higher among diagnosed individuals. The last column of Table B.2 shows the p -values resulting from testing the difference in means between diagnosed and undiagnosed individuals. Means of the variables considered are all statistically different between the two groups, except in the % of females.

3 Econometric specifications

We use a regression discontinuity design (RDD) to estimate effects on outcomes of receiving BP measurements that are outside the normal ranges. Causal identification relies on the assumption that respondents in a narrow range around the cutoff that separate the normal to the abnormal BP ranges are similar on average in both observed and unobserved characteristics such that an outcome would evolve smoothly and continuously through the threshold if no such cutoff were to exist. Any discontinuity in the outcome at the cutoff can then be attributed to the causal effect of crossing the normal BP range cutoffs.

We observe respondents ($i = 1, 2, \dots, n$) whose BP is measured two times ($t = 1, 2$) at baseline. For each respondent, we have two measurements each of SBP (s_{ti}) and DBP (d_{ti}), from which we compute the mean \bar{s}_i and \bar{d}_i . Normal ranges for SBP and DBP are below 140/90 mmHg. The Health Centre Assessment feedback form filled in by the nurse reports the respondent's mean SBP \bar{s}_i and DBP \bar{d}_i , as well as the normal range. If the respondent's BP is outside the normal ranges, this would be pointed out to the respondent by the nurse.

3.1 Unidimensional RDD

Most previous RDD evaluations of hypertension screening estimate treatment effects either at only one threshold or separately at the systolic and diastolic thresholds using unidimensional RDD (Chen *et al.*, 2019; Ciancio *et al.*, 2021; Dai *et al.*, 2022; Kämpfen *et al.*, 2023; Rodriguez-Lesmes, 2021; Sudharsanan *et al.*, 2020; Zhao *et al.*, 2013). This is also one of the strategies we adopt. This strategy estimates frontier-specific treatment effect —systolic or diastolic—. To ensure that treatment status (but nothing else) differs on each side of the respective cutoff (140 mmHg for systolic and 90 mmHg for diastolic), respondents who cross the other threshold must be excluded from the sample used for unidimensional RDD. The scope of exclusion encompasses respondents who surpass both cutoffs, as failing to do so would render the crucial continuity assumption required for identification implausible.

The effect of crossing the 140 mmHg systolic cutoff, τ_s , is estimated along the frontier

defined by that threshold and below the DBP threshold, $F_s = (\bar{s}_i = 140, \bar{d}_i < 90)$. The corresponding effect of crossing the DBP cutoff, τ_d , is estimated along the respective diastolic frontier, $F_d = (\bar{d}_i = 90, \bar{s}_i < 140)$. These effects are defined as follows:

$$\begin{aligned}\tau_x &= \lim_{\bar{x}_i \downarrow c_x} \mathbb{E}[Y_i(1) \mid \bar{x}_i] - \lim_{\bar{x}_i \uparrow c_x} \mathbb{E}[Y_i(0) \mid \bar{x}_i] \\ &= \mathbb{E}[Y_{1i} - Y_{0i} \mid \bar{x}_i = c_x]\end{aligned}\tag{1}$$

where Y_{1i} and Y_{0i} are potential outcomes for respondents right above and right below the cutoff, respectively, and $c_x \in \{c_s, c_d\} = \{140, 90\}$ is the relevant cutoff.

We employ non-parametric estimation techniques to derive these effects. We use local linear regression along with triangular weights generated by kernel functions centered at the threshold. This weighting method assigns greater weights to observations close to the cutoff. To determine the bandwidths of observations on either side of the cutoff, we use the Mean Square Error (MSE) optimal bandwidth selector to set the bandwidths that can differ on each side of the threshold (Calonico *et al.*, 2014a,b, 2015). To calculate standard errors, we employ the heteroskedasticity-robust plug-in residuals variance estimator (Calonico *et al.*, 2017; Kolesár and Rothe, 2018).

The unidimensional RDD approach has significant drawbacks, primarily involving a substantial reduction in both information and statistical power due to the exclusion of a substantial number of observations in each unidimensional RDD. Additionally, the effects identified using this method are frontier-specific and do not reflect the overall average effect on individuals categorized based on their SBP or DBP. To address these limitations, we adopt an alternative strategy that leverages the changes in treatment status at both thresholds simultaneously. This approach allows us to utilize observations from all four quadrants of Figure 1, mitigating the drawbacks associated with the unidimensional approach.

3.2 Binding-score RDD

Binding-score RDD (Reardon and Robinson, 2012) is a centering approach (Wong *et al.*, 2013) that creates a single running variable from the two assignment variables, \bar{s}_i and \bar{d}_i , by reducing the dimensions over which treatment is determined from two to one. This technique has already been used to evaluate hypertension screening in South Africa and Germany (Kämpfen *et al.*, 2023; Pedron *et al.*, 2022). This approach is particularly appealing in the case of BP screening because the two assignment variables \bar{s}_i and \bar{d}_i are in the same measurement units (mmHg),

which simplifies the interpretation of both the significance and scale of the estimated effects.

In order to create a single running variable from the two assignment variables, we first center \bar{s}_i and \bar{d}_i relative to their respective thresholds $\bar{x}_{i,c} = \bar{x}_i - c_x$ with $x = \{s, d\}$. To ensure similar scale in the two variables, we standardize each centered variable on its standard deviation $\bar{x}_{i,c}^{std} = \bar{x}_{i,c} / sd_x$.

We can then calculate the maximum distance of these two standardized and centered assignment variables away from their respective cutoff (0), $r_i = \max(\bar{s}_{i,c}^{std}, \bar{d}_{i,c}^{std})$. r_i corresponds to the new running variable and is the basis of our unidimensional RDD to estimate the effect of the BP screening on BP characteristics at follow-up. Any individuals with $r_i \geq 0$ has BP characteristics, either SBP or DBP, outside the normal range. The discontinuity at the cutoff 0 is estimated in the same fashion as the unidimensional RDD (Eq. 1), that is:

$$\begin{aligned} \tau_r &= \lim_{r_i \downarrow 0} \mathbb{E}[Y_{1i} | r_i] - \lim_{r_i \uparrow 0} \mathbb{E}[Y_{0i} | r_i] \\ &= \mathbb{E}[Y_{1i} - Y_{0i} | r_i = 0] \end{aligned} \quad (2)$$

Although still a local average effect, τ_r is not as local as τ_x for $x = \{s, d\}$. τ_r is an overall average treatment effect at the frontier running along the two thresholds. By incorporating data from all four quadrants as delineated by these thresholds, including individuals above both the SBP and DBP cutoffs (red dots in Figure 1), there is a gain in power, as well as external validity, compared with the unidimensional approach. In implementing the binding-score approach, we select the same estimator (local linear regression), kernel function, optimal bandwidths, and standard error estimator as for unidimensional RDD.

3.3 Identification assumptions

The two empirical strategies above rely on the assumption of imprecise control over the assignment variables. In other words, they rely on the assumption that there is no sorting around the two thresholds. We test the validity of this assumption by examining histograms of the SBP and DBP assignment variables and conducting density tests (McCrary, 2008). Figure C.1 in the Appendix show that there appears to be no discontinuity in the densities of the running variable when considering r_i , \bar{s}_i , and \bar{d}_i as running variables.⁸ The heat plot of the joint density of SBP and DBP also gives no evidence that suggests any manipulation of recorded BP along

⁸This holds true as well in the various subsamples of main interest we consider in our analysis (undiagnosed males, undiagnosed middle-aged respondents, and undiagnosed individuals without any public health insurance).

these two dimensions (Appendix Figure C.2).⁹ Finally, unidimensional RDD and binding-score RDD estimates do not show any discontinuity in the predetermined variables we consider in our analysis at the thresholds (Appendix Table B.3).¹⁰

4 Results

Table 2 shows estimates of the discontinuities in the outcome variables —change in SBP, DBP, MAP, and the probability of being hypertensive at follow-up— at the BP cutoffs used to determine BP values outside the normal range at baseline.¹¹ Column 1 presents estimates derived from the binding-score RDD strategy, while Columns 3 and 5 show estimates of the unidimensional RDD using the systolic and diastolic frontier, respectively.

The results of the binding-score approach indicate that undiagnosed individuals at the cutoff experience a large drop in SBP of 5.3 mmHg (p -value=0.027) relative to undiagnosed individuals right below the cutoff. A similar effect is estimated from the discontinuity at the systolic frontier (-5.5 mmHg, p -value=0.062) and at the diastolic frontier (-6.1 mmHg, p -value=0.113). Similar patterns emerge for changes in DBP and MAP, where large and precisely estimated effects are observed. Individuals at the cutoffs experience a drop in MAP at follow-up ranging between about 4.1 mmHg (binding-score, p -value=0.021) and 4.9 mmHg (systolic frontier, p -value=0.019). It is worth noting that these effects are surprisingly consistent across the three different estimation strategies, although they are less precise when considering the diastolic frontier only, probably because of the lower number of treated individuals (green dots in Figure 1). However, these effects do not translate into a statistically significant drop in the probability of being hypertensive at follow-up (last row of Table 2).¹² Corresponding discontinuity plots of these effects are presented in Appendix Figure C.6.

Appendix Table B.5 shows estimates of the discontinuities in the outcome variables for the entire TILDA sample, which also includes individuals who at baseline report a previous diagnosis of hypertension. The results of Table B.5 show that the decrease in BP experienced by diagnosed and undiaogonsed individuals at the cutoff is smaller than the decrease in BP

⁹Corresponding heatplots for undiagnosed males,undiagnosed middle-aged respondents, and undiagnosed inviduals witouth public health insurance can be found in Appendix Figures C.3, C.4, and C.5, respectively.

¹⁰Again, as shown in Appendix Table B.3, this holds in the various subsamples we consider in our analysis.

¹¹Note that these results are derived using a sample that do not include individuals who at baseline report a previous diabetes diagnosis. Appendix Table B.4 show that the results presented in this section are very robust to not imposing this restriction.

¹²Note that in order to assess whether changes in BP translate into changes in the probability of being hypertensive, we derive treatment effects on hypertension using the optimal sample from the MAP analysis.

experienced by undiagnosed individuals only at the cutoff. To illustrate, the results of the binding-score approach show that for the entire sample, SBP decreases by about -1.5 mmHg (p -value=0.404), as compared to -5.3 mmHg (p -value=0.027) for undiagnosed individuals. Drops in DBP and MAP are of similar magnitude to drops in SBP. Moreover, none of the effects of the binding-score approach are statistically significant at conventional levels. The results of unidimensional RDD at the systolic frontier show that individuals at the cutoff consistently experience a larger drop in BP characteristics relative to those just below the cutoff, although once again none of these effects is precisely estimated. Estimates from the diastolic frontier are positive and far from being remotely statistically significant.¹³

Taken together, the results of Table 2 and Table B.5 seem to suggest that screening is effective at lowering BP only among individuals who are unaware of their high BP at the time of screening. One can argue that the feedback provided by the nurse to unaware individuals carries information that is new to the individual and in turn stimulates a change in behaviour and an improvement in BP. As similar effects are not found when diagnosed individuals are included in the sample, which suggests that awareness of hypertension status dilutes somehow the overall effectiveness of the BP screening.

4.1 Heterogeneous effects of BP screening

Results in the previous section show that BP screening is effective at lowering BP at follow-up only among respondents who at baseline do not report a previous hypertension diagnosis. In this section, we document important heterogeneity in these effects across key demographic characteristics, more specifically sex, age, educational attainment, and public health insurance coverage. Figure 2 shows the estimated results for these subgroups by considering a specification that includes linear local polynomials and the set of predetermined control variables. In Figure 2, results derived from the binding-score RDD strategy are displayed in blue. Results derived from the systolic frontier and diastolic frontier are presented in green and red, respectively. Appendix Tables B.8–B.15 show the corresponding estimates.

Our analysis shows that when considering the change in SBP, DBP, and MAP, BP screening appears to be effective for males but not for females. For instance, when considering the SBP frontier only (in green), undiagnosed males experience a drop in SBP and DBP of about

¹³Results presented in Table 2 are derived from a specification that employs local linear regressions and controls for sex and age. Appendix Table B.6 show that these results are robust to local linear regression specifications that do not include any controls and to specifications that use local quadratic regressions instead of linear ones. Appendix Table B.7 shows that the null findings when including individuals who at baseline report a previous hypertension diagnosis are also robust to various econometric specifications.

Table 2: Effects of BP screening among undiagnosed individuals

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
Change in SBP	-5.299** (0.027)	1067	-5.523* (0.062)	761	-6.105 (0.113)	470
Change in DBP	-3.245** (0.044)	994	-4.291** (0.022)	711	-3.061 (0.263)	736
Change in MAP	-4.111** (0.021)	990	-4.890** (0.019)	724	-4.173 (0.162)	596
Hypertension ^a	-0.045 (0.671)	990	-0.097 (0.426)	724	-0.041 (0.773)	596

Notes: ^a: Hypertension is a dichotomous variable that = $\mathbb{1}(\text{Mean DBP} \geq 90 \vee \text{Mean SBP} \geq 140)$ at follow-up. Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local linear regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. All estimates are from specifications that control for age (including a dichotomous variable for age 80 and above) and sex. Corresponding results from specifications without controls, and/or using local quadratic regression are presented in Appendix Table B.6.

8.3 mmHg (p -value=0.043) and 6.7 mmHg (p -value=0.009), respectively. The corresponding effects for females are much smaller (-2.2 mmHg and -0.8 mmHg, respectively) and not precisely estimated (p -value=0.630 and p -value=0.774, respectively). This patterns holds when considering MAP and the probability of hypertension, and is robust to using the binding-score RDD (in blue) and to considering treatment when crossing the diastolic frontier only (in red).

Even larger differences in the effects of the screening emerge when distinguishing between middle-aged and older adults. The cutoff between the two groups is defined by the median age in the sample. Along the SBP frontier (in green), middle-aged individuals just above the cutoff have lower SBP (-12.9 mmHg, p -value=0.002) and DBP (-10.1 mmHg, p -value<0.001) at follow-up relative to those just below it. Older adults just above the cutoff do not experience any changes in their BP characteristics. Differences between the two groups are again very similar when considering changes in MAP instead of SBP and DBP and robust to using the binding-score RDD or the diastolic frontier only strategies. Interestingly, our analysis does not reveal any heterogeneity by educational attainment. We define an individual as highly educated if the highest level of education attained is a leaving certificate or higher¹⁴ (58% of the sample), and lowly educated otherwise (42% of the sample). Moreover, the effects of the BP screening appear large and statistically significant when considering individuals without public

¹⁴“Higher” includes diploma/certificate, primary degree, or postgraduate/higher degree.

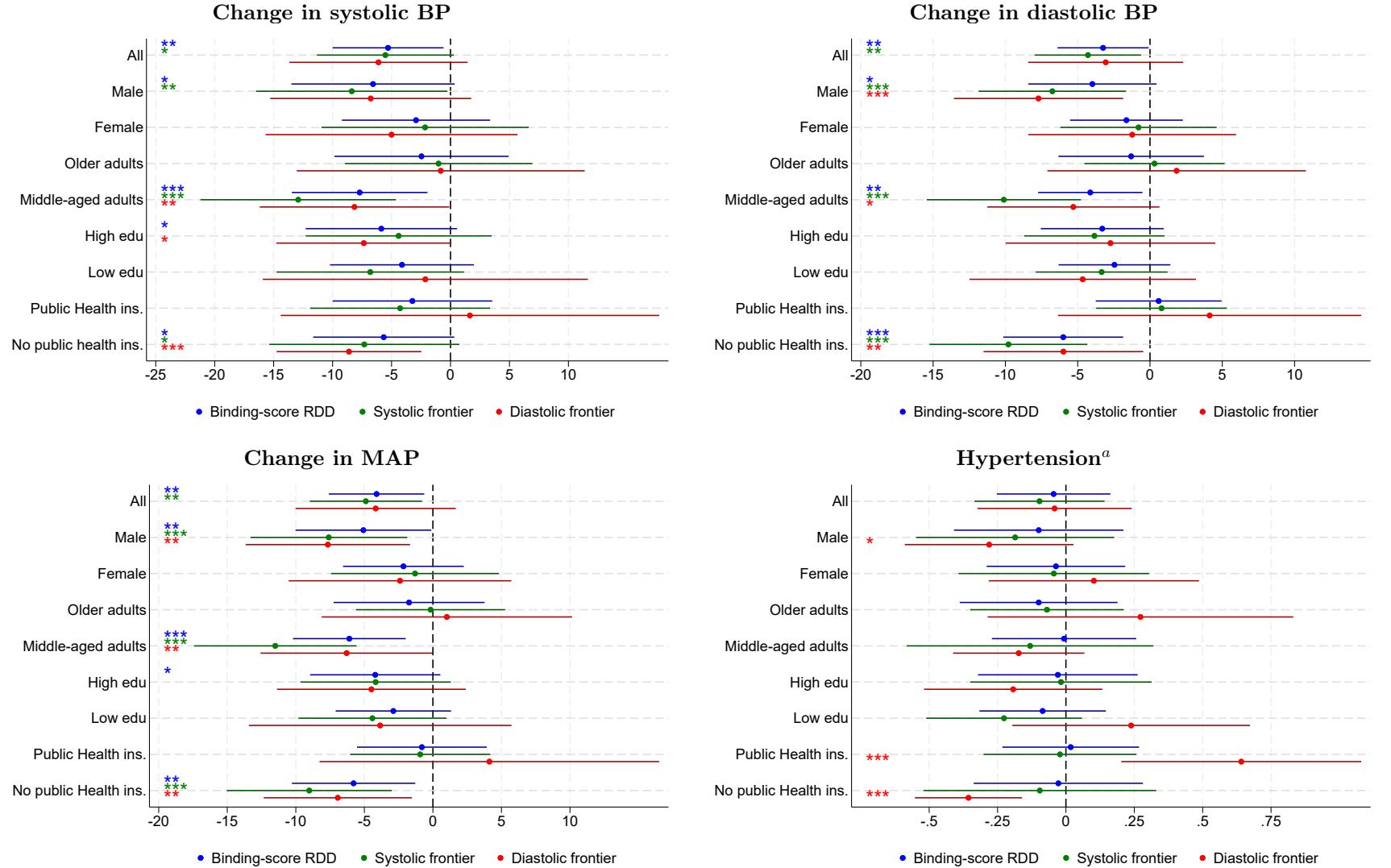
health insurance coverage (65% of the sample).¹⁵ In contrast, such effects are not detected when considering individuals with such health insurance (34% of the sample).¹⁶

Appendix Tables B.8 for males, B.9 for females, B.10 for middle-aged respondents, B.11 for older respondents, B.12 for respondents with lower educational attainment, B.13 for respondents with higher educational attainment, B.14 for individuals with public health insurance coverage, and B.15 for individuals without public health insurance coverage show that our results are robust to local linear regression specifications that do not include any controls, or to specifications that use local quadratic regressions instead of linear ones.

¹⁵We consider someone as having a public health insurance coverage if that person has a Full Medical Card or a GP Visit Card.

¹⁶We obtain non-credible estimates for the effects of BP screening on the probability of having hypertension when considering the DBP frontier and individuals with public health insurance coverage. This is due to the small sample size and the small variation in the outcome close to the frontier.

Figure 2: Heterogeneous effects of BP screening among undiagnosed individuals



Notes: ^a: Hypertension is a dichotomous variable that = $\mathbb{1}(\text{Mean DBP} \geq 90 \vee \text{Mean SBP} \geq 140)$ at follow-up. Centering (blue), systolic-frontier (green), and diastolic-frontier (blue) RDD estimates obtained from local linear regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. Standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. Estimates are derived using undiagnosed individuals at baseline. Details of these results, along with their corresponding estimates from local quadratic regressions are presented in the Appendix. Results for males, females, middle-aged individuals, older adults, individuals with low education, individuals with high education, individuals with public health insurance coverage, and individuals without public health insurance coverage are presented in Appendix Tables B.8, B.9, B.10, B.11, B.12, B.13, B.14, and B.15, respectively.

5 Discussion and conclusion

To the best of our knowledge, this is the first study that investigates the heterogeneous effects of BP screening in a HIC. Using a large and nationally representative sample of older adults living in Ireland, we show that BP screening does not improve the BP characteristics of screened individuals four years after the screening on average. However, we find precise and consistent effects among individuals who at baseline do not report a previous hypertension diagnosis. More specifically, we find improvements in systolic and diastolic BP at follow-up among undiagnosed individuals who at baseline have BP outside the normal range. The results of the binding-score RDD approach indicate that improvements in SBP and DBP are about 5.3 mmHg and 3.2 mmHg, respectively. The binding-score RDD approach determines treatment based on both crossing the systolic and diastolic BP frontiers that define the normal/abnormal range. Results are similar in magnitude when considering both frontiers separately, although they are less precise when the analysis is restricted to the diastolic frontier only. We then show that there exists important heterogeneity in these effects, with larger and more precisely estimated effects for undiagnosed males ($\Delta SBP = -6.6$ mmHg, $\Delta DBP = -4.0$ mmHg), middle-age individuals ($\Delta SBP = -7.7$ mmHg, $\Delta DBP = -4.1$ mmHg), and individuals without public health insurance coverage ($\Delta SBP = -5.6$ mmHg, $\Delta DBP = -6.0$ mmHg). These effects are similar in magnitude, although somewhat lower, to those estimated in LMICs (Chen *et al.*, 2019; Ciancio *et al.*, 2021; Sudharsanan *et al.*, 2020).

Overall, our results show that BP screening improves BP characteristics only among individuals who at baseline do not report a previous diagnosis of hypertension and thus are likely unaware of their condition. This suggests that the health information provided to individuals through the screening might trigger a health response only if that information is new to the respondent. Our study also illustrates the importance of the quality of the health information provided to respondents, as well as the importance of the way the information is conveyed (MacKian, 2003; Zhang, 2014). Our study uses data from TILDA, which has four clear advantages over other large-scale surveys employed in previous studies that looked at the effects of hypertension screening. The first advantage is that BP is measured by trained and qualified nurses as part of a very comprehensive health assessment. In many previous studies, BP is measured by field workers (Ciancio *et al.*, 2021; Sudharsanan *et al.*, 2020). Measurements taken by nurses as opposed to field workers might be less prone to errors, which in turn might reduce the probability of false positive and false negative discovery. The second advantage is

that in TILDA the health assessment feedback is provided to the respondent by the nurse who undertakes the assessment. The feedback and recommendations provided by a nurse might be more credible, trustworthy and persuasive than feedback and recommendations provided by a field worker (Binder *et al.*, 2020; Hsu, 2023; Woods *et al.*, 2017). Respondents who are unaware of their hypertension status and who are notified by a professional healthcare worker that their BP is high might take this warning more seriously and in turn might be more inclined to change health-related behaviour.

The third advantage is that in TILDA the feedback is given to respondents directly after the assessment. This is in contrast to some previous studies such as Pedron *et al.* (2022) where the feedback is given through a letter that is sent to respondents about two weeks after the BP measurements are taken. Immediate feedback might result in better outcomes and corrective behaviours as compared to delayed feedback (Kulik and Kulik, 1988; Metcalfe *et al.*, 2009). The fourth advantage is that in TILDA respondents are clearly informed that they “may be at higher risk of some diseases” if their BP measurements are outside the normal range. This is in contrast to some previous studies which provide less assertive feedback to respondents with abnormal BP measurements (Rodriguez-Lesmes, 2021).¹⁷ Evidence shows that the content of the information provided and its framing matter to a great extent (Gonzalez *et al.*, 2005; Wankar *et al.*, 2015; Wu *et al.*, 2012). The clear and unambiguous feedback given to TILDA respondents is likely to have lower cognitive load of information processing, which might facilitate changes in behaviours by lowering the cognitive effort of making “a good decision” (Gonzalez *et al.*, 2005).

In a nutshell, in contrast to most previous studies on BP screening, in TILDA BP screening is performed by *trained and qualified nurses*, who provide *credible and assertive warnings* to respondents whose BP is outside the normal range *directly after the health assessment*. All combined, these factors might explain why our study is the first to show that BP screening is effective in improving the BP characteristics of undiagnosed respondents living in a HIC. We also argue that our results are policy relevant as the screening provided in TILDA is closer to how it would be provided in an actual screening programme, both in terms of measurements (performed by health care professionals) and feedback (provided again by health care professionals at the time of the screening).

¹⁷For example, the statement given to respondents in the English Longitudinal Study on Ageing (ELSA) with BP measurements outside the normal range reads as follows: “Your blood pressure is a bit high today. Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure. You are advised to visit your GP within 3 months to have a further blood pressure reading to see whether this is a once-off finding or not” (Rodriguez-Lesmes, 2021).

Our result that the screening lowers BP among undiagnosed individuals without public health insurance coverage, but not among undiagnosed individuals with public health insurance coverage, deserves further attention. This result is perhaps surprising because individuals without public health insurance coverage face a higher price of medical care and therefore might have less opportunity to respond to the information provided to them at the time of screening. One possible explanation for our finding is that those without public health insurance cover and with BP above the normal range are less likely to believe that they are a “type I error” than those with cover. Those with cover likely have had more access to primary health care and their BP measured before baseline. More frequent interactions with health care providers should increase the likelihood of someone knowing their BP levels. Receiving a warning in TILDA knowing that previous BP measurements were in the normal range might make respondents more likely to believe that the TILDA measurements are a one time off BP measurements and that there is no reason for concern. One can argue that those without cover have less basis for such judgement and are therefore more likely to take the TILDA BP measurement seriously.

Several limitations should be acknowledged. First, while we do find an improvement in BP characteristics for some subgroups of the population, we cannot draw clear conclusions on the mechanisms leading to improvements in BP four years after the screening. In the follow-up survey of TILDA (wave 3), respondents are asked whether in the last two to four years they have been diagnosed with hypertension by a doctor. If their answer is affirmative, then they are also asked whether they are currently taking medication for hypertension¹⁸ and whether they have put in place lifestyle changes (e.g., diet, exercise, etc.) to control their BP.¹⁹ We show in Appendix Table B.17 that BP screening does not have any positive effect on these outcomes (i.e., doctor diagnosis, self-reported medication, and lifestyle changes) for undiagnosed individuals. The screening also does not have any positive effect among undiagnosed males, undiagnosed middle-aged adults, and undiagnosed individuals without public health insurance coverage. One major limitation of this analysis is that the two questions on self-reported medication and lifestyle changes are asked only to respondents who report a diagnosis of hypertension in the last two to four years. It is possible that individuals changed their lifestyle after the TILDA screening without having been diagnosed with hypertension by a

¹⁸Note that at the end of the interview, interviewers also ask respondents to show them the medications they are currently on. Interviewers ask to see medication packages to transcribe the correct medication names. Up to 20 medications are recorded per participant. We also investigate the effects of the screening on the probability of being currently on hypertensive medication based on this alternative measure of medication. More details are presented in Appendix Tables B.16 and B.17.

¹⁹Descriptive statistics of these variables are presented in Table B.16.

doctor. Unfortunately, behavioral changes adopted by respondents who have not received a recent diagnosis of hypertension are not captured in our analysis. Therefore, while our results are robust to various sample selection and econometric specifications, we cannot draw clear conclusions on how exactly individuals achieve improvements in their BP characteristics four years after the screening.

Second, by design, the method used in our study uncovers treatment effects that are very local. Effects correspond to changes in BP characteristics among individuals who are at the treatment threshold and not elsewhere on the BP characteristics distribution. Third, there is evidence of possible selective attrition in our analysis. Surprisingly, we find that individuals right above the BP cutoffs are more likely to participate in the follow-up survey than those right below it. However, we discuss and show in Appendix D that even under extreme assumptions about the BP characteristics of those not participating at follow-up, we still obtain effects that are consistent with the effects reported in our main analysis. We are therefore confident that our main conclusions are not driven by selective attrition.

Overall, our study shows that population screening does appear to be effective among those who prior to the screening are unaware of their hypertension status but ineffective when those who are aware of their hypertension status are also screened. The null effect of the screening program on average does not necessarily mean that it is not cost-effective: if the health benefits of improving BP characteristics of males, middle-aged adults, and individuals without public health insurance coverage outweigh the cost of such screening program, then it might still make financial sense to implement it.

Acknowledgments: Researchers interested in using TILDA data may access the data for free from the following sites: Irish Social Science Data Archive (ISSDA) at University College Dublin <http://www.ucd.ie/issda/data/tilda/>; Interuniversity Consortium for Political and Social Research (ICPSR) at the University of Michigan <http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/34315>.

References

- Barry, M., van Lente, E., Molcho, M. et al (2009). *SLAN 2007: Survey of lifestyle, attitudes and nutrition in Ireland: mental health and social well-being report*. Royal College of Surgeons in Ireland.
- Binder, A., Naderer, B. and Matthes, J. (2020). Experts, peers, or celebrities? The role of different social endorsers on children’s fruit choice. *Appetite*, **155**, 104821.
- Calonico, S., Cattaneo, M.D. and Titiunik, R. (2014a). Robust data-driven inference in the regression-discontinuity design. *The Stata Journal*, **14**(4), 909–946.
- Calonico, S., Cattaneo, M.D. and Titiunik, R. (2014b). Robust nonparametric confidence intervals for regression-discontinuity designs. *Econometrica*, **82**(6), 2295–2326.
- Calonico, S., Cattaneo, M.D. and Titiunik, R. (2015). rdrobust: An R package for robust nonparametric inference in regression-discontinuity designs. *R Journal*, **7**(1), 38–51.
- Calonico, S., Cattaneo, M.D., Farrell, M.H. et al (2017). rdrobust: Software for regression-discontinuity designs. *The Stata Journal*, **17**(2), 372–404.
- Calonico, S., Cattaneo, M.D. and Farrell, M.H. (2018). Coverage error optimal confidence intervals for local polynomial regression. *arXiv preprint arXiv:1808.01398*.
- Cattaneo, M.D., Jansson, M. and Ma, X. (2018). Manipulation testing based on density discontinuity. *The Stata Journal*, **18**(1), 234–261.
- Cattaneo, M.D., Jansson, M. and Ma, X. (2020). Simple local polynomial density estimators. *Journal of the American Statistical Association*, **115**(531), 1449–1455.
- Central Statistics Office (2016). Women and men in Ireland 2016 - health. Technical report, Central Statistics Office.
- Chen, S., Sudharsanan, N., Huang, F. et al (2019). Impact of community based screening for hypertension on blood pressure after two years: regression discontinuity analysis in a national cohort of older adults in China. *BMJ*, **366**, 14064.
- Ciancio, A., Kämpfen, F., Kohler, H.P. et al (2021). Health screening for emerging non-communicable disease burdens among the global poor: Evidence from sub-Saharan Africa. *Journal of Health Economics*, **75**, 102388.
- Ciancio, A., Kämpfen, F., Kohler, H.P. et al (2024). Surviving bad news: health information without treatment options. *University of Pennsylvania Population Center Working Paper (PSC/PARC)*, 2024-102.
- Connolly, S., Keegan, C., O’Malley, S. et al (2023). *Extending eligibility for general practitioner care in Ireland: Cost implications*. Economic and Social Research Institute.
- Dai, T., Jiang, S., Liu, X. et al (2022). The effects of a hypertension diagnosis on health behaviors: A two-dimensional regression discontinuity analysis. *Health Economics*, **31**(4), 574–596.
- DeMers, D. and Wachs, D. (2019). *Physiology, mean arterial pressure*. StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan. PMID: 30855814.
- Donoghue, O.A., McGarrigle, C.A., Foley, M. et al (2018). Cohort profile update: the irish longitudinal study on ageing (tilda). *International journal of epidemiology*, **47**(5), 1398–1398l.
- GE HealthCare (2023). Taking the mystery out of MAP measurements. https://clinicalview.gehealthcare.com/article/taking-mystery-out-map-measurements#_ftn5. Online; accessed 17 November 2023.
- Gonzalez, C., Dana, J., Koshino, H. et al (2005). The framing effect and risky decisions: Examining cognitive functions with fmri. *Journal of Economic Psychology*, **26**(1), 1–20.
- Horowitz, J.L. and Manski, C.F. (1998). Censoring of outcomes and regressors due to survey nonresponse: Identification and estimation using weights and imputations. *Journal of Econometrics*, **84**(1), 37–58.
- Horowitz, J.L. and Manski, C.F. (2000). Nonparametric analysis of randomized experiments with missing covariate and outcome data. *Journal of the American statistical Association*, **95**(449), 77–84.

- Hsu, C.W. (2023). Who and what messages are more suitable for health ads: the combined influence of endorsers and message framing on visual attention and ad effectiveness. *Aslib Journal of Information Management*.
- Kämpfen, F., Gómez-Olivé, X., O'Donnell, O. et al (2023). Effectiveness of population-based hypertension screening: A multidimensional regression discontinuity design. *UCD Centre For Economic Research Working Paper Series 23/20*.
- Kearney, P.M., Cronin, H., O'Regan, C. et al (2011). Cohort profile: the Irish longitudinal study on ageing. *International journal of epidemiology*, **40**(4), 877–884.
- Kenny, R.A., Whelan, B.J., Cronin, H. et al (2010). *The design of the Irish longitudinal study on ageing*. The Irish Longitudinal Study on Ageing (TILDA).
- Kolesár, M. and Rothe, C. (2018). Inference in regression discontinuity designs with a discrete running variable. *American Economic Review*, **108**(8), 2277–2304.
- Kulik, J.A. and Kulik, C.L.C. (1988). Timing of feedback and verbal learning. *Review of Educational Research*, **58**(1), 79–97.
- Kundu, R., Biswas, S. and Das, M. (2017). Mean arterial pressure classification: a better tool for statistical interpretation of blood pressure related risk covariates. *Cardiology and Angiology: An International Journal*, **6**(1), 1–7.
- Lee, D.S. (2002). Trimming for bounds on treatment effects with missing outcomes. *National Bureau of Economic Research Cambridge, Mass., USA, Working Paper NO. 51*.
- Lloyd-Sherlock, P., Beard, J., Minicuci, N. et al (2014). Hypertension among older adults in low-and middle-income countries: prevalence, awareness and control. *International journal of epidemiology*, **43**(1), 116–128.
- Ma, Y. and Nolan, A. (2017). Public healthcare entitlements and healthcare utilisation among the older population in Ireland. *Health Economics*, **26**(11), 1412–1428.
- Ma, Y., Nolan, A. and Smith, J.P. (2020). Free GP care and psychological health: Quasi-experimental evidence from Ireland. *Journal of Health Economics*, **72**, 102351.
- MacKian, S. (2003). A review of health seeking behaviour: problems and prospects. *Health Systems Development Programme*.
- McCrary, J. (2008). Manipulation of the running variable in the regression discontinuity design: A density test. *Journal of Econometrics*, **142**(2), 698–714.
- Melgarejo, J.D., Yang, W.Y., Thijs, L. et al (2021). Association of fatal and nonfatal cardiovascular outcomes with 24-hour mean arterial pressure. *Hypertension*, **77**(1), 39–48.
- Metcalfe, J., Kornell, N. and Finn, B. (2009). Delayed versus immediate feedback in children's and adults' vocabulary learning. *Memory & cognition*, **37**(8), 1077–1087.
- Mohanty, S.K., Pedgaonkar, S.P., Upadhyay, A.K. et al (2021). Awareness, treatment, and control of hypertension in adults aged 45 years and over and their spouses in India: A nationally representative cross-sectional study. *PLoS Medicine*, **18**(8), e1003740.
- Mohanty, S.K., Upadhyay, A.K., Shekhar, P. et al (2022). Missed opportunities for hypertension screening: a cross-sectional study, India. *Bulletin of the World Health Organization*, **100**(1), 30.
- Murphy, C., Kearney, P., Shelley, E. et al (2016). Hypertension prevalence, awareness, treatment and control in the over 50s in Ireland: evidence from the Irish longitudinal study on ageing. *Journal of Public Health*, **38**(3), 450–458.
- OECD, on Health Systems, E.O. and Policies (2019). *Ireland: Country Health Profile 2019*. OECD.
- OECD, on Health Systems, E.O. and Policies (2021). *Ireland: Country Health Profile 2021*. OECD.
- Pedron, S., Hanselmann, M., Burns, J. et al (2022). The effect of population-based blood pressure screening on long-term cardiometabolic morbidity and mortality in Germany: A regression discontinuity analysis. *PLoS Medicine*, **19**(12), 1–18.

- Reardon, S.F. and Robinson, J.P. (2012). Regression discontinuity designs with multiple rating-score variables. *Journal of research on Educational Effectiveness*, **5**(1), 83–104.
- Rodriguez-Lesmes, P. (2021). Estimating the gains of early detection of hypertension over the marginal patient. *PLoS One*, **16**(7), 1–18.
- Stanaway, J.D., Afshin, A., Gakidou, E. et al (2018). Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks for 195 countries and territories, 1990–2017: a systematic analysis for the global burden of disease study 2017. *The Lancet*, **392**(10159), 1923–1994.
- Sudharsanan, N., Chen, S., Garber, M. et al (2020). The effect of home-based hypertension screening on blood pressure change over time in south africa: A home-based hypertension screening intervention in south africa resulted in important reductions in systolic blood pressure for women and younger men. *Health Affairs*, **39**(1), 124–132.
- Vos, T., Lim, S.S., Abbafati, C. et al (2020). Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the global burden of disease study 2019. *The Lancet*, **396**(10258), 1204–1222.
- Wankar, T.J., Syahlani, S.P. and Haryadi, F.T. (2015). Combined effect of message framing and endorser credibility on buying interest of yoghurt product. In *International Seminar on Tropical Animal Production (ISTAP)*, pages 629–633.
- Whelan, B.J. and Savva, G.M. (2013). Design and methodology of the irish longitudinal study on ageing. *Journal of the American Geriatrics Society*, **61**, S265–S268.
- Williams, B., Mancia, G., Spiering, W. et al (2018). 2018 practice guidelines for the management of arterial hypertension of the European Society of Cardiology and the European Society of Hypertension. *Blood Pressure*, **27**(6), 314–340.
- Wong, V.C., Steiner, P.M. and Cook, T.D. (2013). Analyzing regression-discontinuity designs with multiple assignment variables: A comparative study of four estimation methods. *Journal of Educational and Behavioral Statistics*, **38**(2), 107–141.
- Woods, C.B., James, E.L., Baxter, S. et al (2017). Celebrity? Doctor? Celebrity doctor? Which spokesperson is most effective for cancer prevention? *Teaching Medicine and Medical Ethics using Popular Culture*, pages 71–98.
- Wu, W.Y., Linn, C.T., Fu, C.S. et al (2012). The role of endorsers, framing, and rewards on the effectiveness of dietary supplement advertisements. *Journal of Health Communication*, **17**(1), 54–75.
- Zhang, Y. (2014). Beyond quality and accessibility: Source selection in consumer health information searching. *Journal of the Association for Information Science and Technology*, **65**(5), 911–927.
- Zhao, M., Konishi, Y. and Glewwe, P. (2013). Does information on health status lead to a healthier lifestyle? evidence from China on the effect of hypertension diagnosis on food consumption. *Journal of health economics*, **32**(2), 367–385.
- Zhou, B., Perel, P., Mensah, G.A. et al (2021a). Global epidemiology, health burden and effective interventions for elevated blood pressure and hypertension. *Nature Reviews Cardiology*, **18**, 785–802.
- Zhou, B., Carrillo-Larco, R.M., Danaei, G. et al (2021b). Worldwide trends in hypertension prevalence and progress in treatment and control from 1990 to 2019: a pooled analysis of 1201 population-representative studies with 104 million participants. *The Lancet*, **398**(10304), 957–980.

Online Appendix

A Additional materials

Figure A.1: Feedback form received at health assessment center

Participant Name:			
Date of Assessment:			
TEST	FINDING	REFERENCE RANGE	INTERPRETATION
BLOOD PRESSURE	MMHG	LESS THAN 140/90 MMHG LESS THAN 135/85 IN PEOPLE WITH DIABETES	
WEIGHT	kg (st lbs)		
HEIGHT	cm (ft ")		
HEEL BONE ULTRASOUND	T Score	+2 to -1 = NORMAL -1 to -2.5 = REDUCED -2.5 and below = MAY INDICATE OSTEOPOROSIS BUT NEEDS FURTHER ASSESSMENT	
VISION LOGMAR	Right Eye: Left Eye:	0.2 to -0.3 = NORMAL 1.0 to 0.2 = REDUCED	Right Eye: Left Eye

NOTES

The interpretation of findings is based on information from previous studies linking these factors with health risk. Participants with undesirable findings may be at higher risk of some diseases, and may wish to consider appropriate lifestyle changes (e.g. stopping smoking; reducing dietary intake of salt, meat and other sources of animal and other "saturated" fats; increasing physical activity). Some advice leaflets are available from reception. Participants with high blood pressure levels may also wish to have their blood pressure checked again by their own doctor. Please note that local GPs are not part of the TILDA study therefore the normal charge for a consultation with your doctor will apply.

Figure A.2: Feedback form received at home

Participant Name:			
Date of Assessment:			
TEST	FINDING	REFERENCE RANGE	INTERPRETATION
BLOOD PRESSURE	_____ MMHG	LESS THAN 140/90 MMHG LESS THAN 135/85 IN PEOPLE WITH DIABETES	
WEIGHT	____kg		
HEIGHT	____ cm		
BLOOD RESULTS WILL FOLLOW BY POST			

NOTES

Participants with high blood pressure may be at a higher risk for heart disease and may wish to consider appropriate lifestyle changes (e.g. stopping smoking; reducing dietary intake of salt, meat and other sources of animal and other "saturated" fats; increasing physical activity). Participants with high blood pressure levels may also wish to have their blood pressure checked again by their own doctor. Please note that local GPs are not part of the TILDA study therefore the normal charge for a consultation with your doctor will apply.

B Additional Tables

Table B.1: Descriptive statistics, including those who at baseline report a previous hypertension diagnosis

	Mean	Std. dev.	p10	p90	Obs
<i>Baseline characteristics</i>					
SBP	134.676	19.593	111	160.5	4093
DBP	82.431	11.180	68.5	96.5	4093
MAP	99.846	13.089	83.667	116.667	4093
Hypertension ^a	0.412	0.492	0	1	4093
Above SBP cutoff	0.368	0.482	0	1	4093
Above DBP cutoff	0.241	0.428	0	1	4093
<i>Outcomes</i>					
Change in SBP	-0.547	18.016	-22.5	21	4093
Change in DBP	-1.567	10.799	-15	11	4093
Change in MAP	-1.227	12.457	-16.5	13.333	4093
Hypertension ^a	0.384	0.486	0	1	4093
<i>Controls (at baseline)</i>					
Female	0.550	0.498	0	1	4093
Age	61.945	8.317	52	74	4087
Age above 80	0.034	0.181	0	0	4087

Notes: SBP, DBP, and MAP stand for systolic blood pressure, diastolic blood pressure, and mean arterial pressure, respectively. ^a: Hypertension is a dichotomous variable that = $\mathbb{1}(\text{Mean DBP} \geq 90 \vee \text{Mean SBP} \geq 140)$. The cutoff for SBP is 140; the cutoff for DBP is 90. Descriptive statistics excluding those who at baseline report a previous hypertension diagnosis are reported in Table 1 in the paper. The sample excludes individuals who at baseline report a previous diabetes diagnosis.

Table B.2: Differences between diagnosed and undiagnosed individuals

	<i>Diagnosed individuals at baseline</i>			<i>Undiagnosed individuals at baseline</i>			<i>Difference</i>
	Mean	Std. dev.	Obs	Mean	Std. dev.	Obs	Diag. vs Undiag.
<i>Baseline characteristics</i>							
SBP	141.541	19.466	1341	131.331	18.769	2752	0.000
DBP	85.002	11.379	1341	81.178	10.865	2752	0.000
MAP	103.849	13.014	1341	97.895	12.677	2752	0.000
Hypertension ^a	0.551	0.498	1341	0.344	0.475	2752	0.000
Above SBP cutoff	0.506	0.500	1341	0.302	0.459	2752	0.000
Above DBP cutoff	0.322	0.467	1341	0.202	0.402	2752	0.000
<i>Outcomes</i>							
Change in SBP	-1.957	20.544	1341	0.140	16.607	2752	0.001
Change in DBP	-2.557	11.960	1341	-1.084	10.153	2752	0.000
Change in MAP	-2.357	14.023	1341	-0.676	11.581	2752	0.000
Hypertension ^a	0.503	0.500	1341	0.326	0.469	2752	0.000
<i>Controls (at baseline)</i>							
Female	0.550	0.498	1341	0.550	0.498	2752	0.991
Age	64.397	8.415	1338	60.751	8.003	2749	0.000
Age above 80	0.049	0.215	1338	0.027	0.161	2749	0.000

Notes: SBP, DBP, and MAP stand for systolic BP, diastolic BP, and mean arterial pressure, respectively. ^a: Hypertension is a dichotomous variable that = $\mathbb{1}(\text{Mean DBP} \geq 90 \vee \text{Mean SBP} \geq 140)$ at follow-up. The cutoff for SBP is 140; the cutoff for DBP is 90. High BP/hypertension diagnosis is based on the question: “Has a doctor ever told you that you have high BP or hypertension?”. Out of the 4,093 respondents for whom we have valid BP measurements in wave 1 and wave 3, 1,341 (32.76%) report at baseline a previous hypertension diagnosis. The last column shows the results (*p*-values) of tests for the difference (means) in respondent’s characteristics between diagnosed and undiagnosed individuals.

Table B.3: Tests for threshold discontinuities in predetermined variables

	Female (1)	N (2)	Age (3)	N (4)	$\mathbb{1}(\text{Age} \geq 80)$ (5)	N (6)
<i>Undiagnosed individuals at baseline</i>						
Unidimensional RDD - Systolic frontier	-0.013 (0.851)	1343	-1.781 (0.211)	809	0.033 (0.373)	1215
Unidimensional RDD - Diastolic frontier	-0.114 (0.315)	708	-0.184 (0.908)	741	-0.000 (0.987)	384
Binding-score RDD	-0.059 (0.306)	1942	-1.812* (0.082)	1614	0.016 (0.563)	1602
<i>Undiagnosed males at baseline</i>						
Unidimensional RDD - Systolic frontier			-2.850 (0.125)	466	-0.089 (0.149)	451
Unidimensional RDD - Diastolic frontier			0.169 (0.942)	408	-0.012 (0.463)	276
Binding-score RDD			-1.983 (0.173)	803	-0.078 (0.130)	676
<i>Undiagnosed middle-aged individuals at baseline</i>						
Unidimensional RDD - Systolic frontier	-0.126 (0.235)	733	0.035 (0.967)	752		
Unidimensional RDD - Diastolic frontier	-0.083 (0.530)	648	0.509 (0.576)	557		
Binding-score RDD	-0.142* (0.078)	1056	-0.137 (0.818)	1106		
<i>Undiagnosed individuals without public health insurance</i>						
Unidimensional RDD - Systolic frontier	-0.134 (0.174)	712	-0.654 (0.630)	548	0.025 (0.192)	274
Unidimensional RDD - Diastolic frontier	-0.250* (0.096)	510	-1.836 (0.209)	401	^a	
Binding-score RDD	-0.185** (0.023)	1024	-0.990 (0.319)	1005	0.004 (0.736)	610

Note: RDD estimates using predetermined variables –sex and age– as outcome variables. $\mathbb{1}(\text{Age} \geq 80)$ is a dichotomous variable that takes the value 1 if age is equal or greater than 80. Estimates obtained from local linear regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. ^a: not enough variability in the sample to estimate the effects.

Table B.4: Effects of BP screening including individuals with a prior diagnosis of diabetes

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
<i>Change in systolic BP</i>						
Linear	-4.718** (0.039)	1169	-5.094* (0.075)	824	-5.710 (0.130)	483
Linear with controls	-4.615** (0.041)	1157	-4.529 (0.103)	861	-5.486 (0.144)	522
Quadratic	-5.690** (0.035)	1659	-5.751* (0.066)	1391	-6.190 (0.139)	869
Quadratic with controls	-5.561** (0.037)	1674	-5.330* (0.079)	1453	-5.702 (0.169)	917
<i>Change in diastolic BP</i>						
Linear	-3.064** (0.047)	1076	-3.681** (0.037)	781	-3.444 (0.162)	947
Linear with controls	-3.099** (0.046)	1075	-4.008** (0.026)	758	-2.982 (0.223)	1012
Quadratic	-3.705** (0.043)	1604	-4.628** (0.032)	1128	-3.451 (0.214)	1229
Quadratic with controls	-3.727** (0.043)	1599	-4.846** (0.026)	1096	-3.172 (0.253)	1262
<i>Change in MAP</i>						
Linear	-3.746** (0.027)	1080	-4.302** (0.031)	774	-4.189 (0.127)	698
Linear with controls	-3.745** (0.026)	1087	-4.258** (0.031)	781	-3.953 (0.151)	742
Quadratic	-4.698** (0.020)	1573	-4.905** (0.033)	1204	-4.141 (0.179)	1028
Quadratic with controls	-4.719** (0.019)	1559	-4.811** (0.036)	1204	-3.933 (0.204)	1108
<i>Hypertension</i>						
Linear	-0.028 (0.782)	1080	-0.076 (0.520)	774	-0.002 (0.987)	698
Linear with controls	-0.020 (0.847)	1087	-0.063 (0.589)	781	-0.008 (0.956)	742
Quadratic	-0.032 (0.772)	1573	-0.093 (0.462)	1204	0.002 (0.991)	1028
Quadratic with controls	-0.022 (0.844)	1559	-0.078 (0.529)	1204	0.003 (0.986)	1108

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. Control variables include age (including a dichotomous variable for age 80 and above) and sex. These estimates are based on a sample that includes individuals who at baseline report a previous diabetes diagnosis but excludes individuals who at baseline report a previous hypertension diagnosis.

Table B.5: Effects of BP screening on outcomes, including individuals who at baseline report a previous hypertension diagnosis

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
Change in SBP	-1.478 (0.404)	2161	-1.722 (0.466)	1332	1.314 (0.696)	804
Change in DBP	-1.654 (0.130)	2115	-2.197 (0.124)	1292	1.642 (0.448)	931
Change in MAP	-1.566 (0.199)	2147	-2.086 (0.200)	1271	1.540 (0.530)	864
Hypertension ^a	-0.026 (0.710)	2147	-0.050 (0.576)	1271	0.134 (0.290)	864

Notes: ^a: Hypertension is a dichotomous variable that = $\mathbb{1}(\text{Mean DBP} \geq 90 \vee \text{Mean SBP} \geq 140)$ at follow-up. Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local linear regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. *p*-values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. All estimates are from specifications that control for age (including a dichotomous variable for age 80 and above) and sex.

Table B.6: Effects of BP screening — robustness checks

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
<i>Change in systolic BP</i>						
Linear	-5.343** (0.028)	1059	-6.138** (0.045)	733	-6.277 (0.108)	432
Linear with controls	-5.299** (0.027)	1067	-5.523* (0.062)	761	-6.105 (0.113)	470
Quadratic	-6.497** (0.023)	1566	-6.615* (0.052)	1192	-7.032 (0.101)	797
Quadratic with controls	-6.499** (0.022)	1538	-6.141* (0.064)	1226	-6.661 (0.119)	846
<i>Change in diastolic BP</i>						
Linear	-3.174** (0.047)	1045	-3.945** (0.032)	739	-3.567 (0.191)	737
Linear with controls	-3.245** (0.044)	994	-4.291** (0.022)	711	-3.061 (0.263)	736
Quadratic	-4.273** (0.028)	1484	-5.099** (0.025)	1081	-3.725 (0.225)	1084
Quadratic with controls	-4.473** (0.022)	1446	-5.320** (0.020)	1048	-3.333 (0.282)	1122
<i>Change in MAP</i>						
Linear	-4.062** (0.023)	991	-4.927** (0.019)	717	-4.401 (0.139)	596
Linear with controls	-4.111** (0.021)	990	-4.890** (0.019)	724	-4.173 (0.162)	596
Quadratic	-5.241** (0.013)	1480	-5.642** (0.022)	1113	-4.558 (0.170)	897
Quadratic with controls	-5.315** (0.012)	1447	-5.577** (0.023)	1113	-4.242 (0.207)	948
<i>Hypertension</i>						
Linear	-0.050 (0.639)	991	-0.111 (0.368)	717	-0.029 (0.851)	596
Linear with controls	-0.045 (0.671)	990	-0.097 (0.426)	724	-0.041 (0.773)	596
Quadratic	-0.050 (0.667)	1480	-0.145 (0.276)	1113	-0.032 (0.845)	897
Quadratic with controls	-0.044 (0.703)	1447	-0.130 (0.326)	1113	-0.039 (0.802)	948

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. Control variables include age (including a dichotomous variable for age 80 and above) and sex. These estimates exclude individuals who at baseline report a previous hypertension diagnosis.

Table B.7: Effects of BP screening including individuals who at baseline report a previous hypertension diagnosis — robustness checks

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Change in systolic BP</i>						
Linear	-1.561 (0.384)	2136	-1.954 (0.417)	1293	1.437 (0.679)	753
Linear with controls	-1.478 (0.404)	2161	-1.722 (0.466)	1332	1.314 (0.696)	804
Quadratic	-1.441 (0.503)	2775	-2.182 (0.417)	2075	1.071 (0.780)	1246
Quadratic with controls	-1.383 (0.521)	2726	-1.968 (0.461)	2072	1.251 (0.738)	1305
<i>Change in diastolic BP</i>						
Linear	-1.707 (0.120)	2118	-2.143 (0.132)	1293	1.704 (0.429)	933
Linear with controls	-1.654 (0.130)	2115	-2.197 (0.124)	1292	1.642 (0.448)	931
Quadratic	-1.820 (0.214)	2427	-2.444 (0.155)	1800	1.678 (0.470)	1701
Quadratic with controls	-1.819 (0.214)	2430	-2.477 (0.151)	1768	1.483 (0.535)	1645
<i>Change in MAP</i>						
Linear	-1.597 (0.195)	2123	-2.126 (0.193)	1272	1.584 (0.524)	866
Linear with controls	-1.566 (0.199)	2147	-2.086 (0.200)	1271	1.540 (0.530)	864
Quadratic	-1.580 (0.318)	2538	-2.273 (0.231)	1871	1.711 (0.523)	1500
Quadratic with controls	-1.584 (0.316)	2495	-2.232 (0.240)	1868	1.609 (0.544)	1599
<i>Hypertension</i>						
Linear	-0.027 (0.713)	2123	-0.045 (0.617)	1272	0.147 (0.260)	866
Linear with controls	-0.026 (0.710)	2147	-0.050 (0.576)	1271	0.134 (0.290)	864
Quadratic	-0.006 (0.947)	2538	-0.043 (0.657)	1871	0.169 (0.206)	1500
Quadratic with controls	-0.006 (0.945)	2495	-0.045 (0.643)	1868	0.161 (0.212)	1599

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. Control variables include age (including a dichotomous variable for age 80 and above) and sex.

Table B.8: Effects of BP screening on undiagnosed males

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Change in systolic BP</i>						
Linear	-6.971* (0.054)	522	-9.402** (0.028)	332	-7.460* (0.074)	265
Linear with controls	-6.571* (0.063)	533	-8.374** (0.043)	347	-6.768 (0.120)	265
Quadratic	-8.629** (0.039)	736	-11.572** (0.021)	498	-9.336** (0.038)	400
Quadratic with controls	-7.916* (0.050)	763	-10.325** (0.035)	509	-9.187** (0.039)	416
<i>Change in diastolic BP</i>						
Linear	-4.026* (0.075)	566	-6.600** (0.011)	315	-7.689*** (0.010)	332
Linear with controls	-3.986* (0.078)	567	-6.752*** (0.009)	305	-7.711*** (0.010)	332
Quadratic	-6.272** (0.018)	703	-8.005*** (0.008)	449	-9.543*** (0.002)	494
Quadratic with controls	-6.319** (0.018)	692	-8.268*** (0.006)	449	-9.236*** (0.002)	494
<i>Change in MAP</i>						
Linear	-5.341** (0.037)	532	-7.848*** (0.008)	305	-7.763** (0.010)	289
Linear with controls	-5.071** (0.045)	539	-7.596*** (0.009)	309	-7.661** (0.012)	296
Quadratic	-7.213** (0.015)	707	-9.254*** (0.007)	447	-9.608*** (0.002)	472
Quadratic with controls	-6.931** (0.017)	709	-9.045*** (0.008)	463	-9.340*** (0.002)	472
<i>Hypertension</i>						
Linear	-0.120 (0.469)	532	-0.214 (0.261)	305	-0.303** (0.039)	289
Linear with controls	-0.099 (0.529)	539	-0.186 (0.316)	309	-0.281* (0.075)	296
Quadratic	-0.124 (0.471)	707	-0.214 (0.306)	447	-0.278* (0.089)	472
Quadratic with controls	-0.103 (0.530)	709	-0.193 (0.340)	463	-0.296* (0.076)	472

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for age (including a dichotomous variable for age 80 and above).

Table B.9: Effects of BP screening on undiagnosed females

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>		
		N	Sys front.	N	Dia front.
	(1)	(2)	(3)	(4)	(5)
					N
					(6)
<i>Change in systolic BP</i>					
Linear	-3.085 (0.340)	616	-2.520 (0.581)	399	-4.793 (0.382)
Linear with controls	-2.925 (0.362)	615	-2.158 (0.630)	399	-4.997 (0.359)
Quadratic	-4.010 (0.295)	874	-4.823 (0.325)	743	-3.921 (0.518)
Quadratic with controls	-4.036 (0.292)	871	-4.459 (0.356)	745	-3.975 (0.513)
<i>Change in diastolic BP</i>					
Linear	-1.577 (0.427)	640	-0.925 (0.737)	393	-1.301 (0.718)
Linear with controls	-1.630 (0.413)	638	-0.790 (0.774)	393	-1.228 (0.738)
Quadratic	-2.813 (0.296)	808	-1.902 (0.581)	635	0.238 (0.957)
Quadratic with controls	-2.935 (0.280)	781	-1.852 (0.598)	616	0.628 (0.890)
<i>Change in MAP</i>					
Linear	-2.186 (0.331)	616	-1.539 (0.623)	399	-2.453 (0.560)
Linear with controls	-2.150 (0.339)	615	-1.303 (0.677)	399	-2.399 (0.563)
Quadratic	-3.248 (0.258)	810	-2.062 (0.567)	703	-1.519 (0.748)
Quadratic with controls	-3.372 (0.243)	801	-1.773 (0.624)	683	-1.232 (0.799)
<i>Hypertension</i>					
Linear	-0.032 (0.802)	616	-0.051 (0.775)	399	0.122 (0.565)
Linear with controls	-0.037 (0.777)	615	-0.044 (0.803)	399	0.102 (0.602)
Quadratic	-0.021 (0.892)	810	-0.007 (0.971)	703	0.148 (0.503)
Quadratic with controls	-0.027 (0.862)	801	-0.003 (0.985)	683	0.145 (0.488)

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. *p*-values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for age (including a dichotomous variable for age 80 and above).

Table B.10: Effects of BP screening on middle-aged undiagnosed individuals

	<i>Binding-score RDD</i>	<i>Unidimensional RDD</i>				
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Change in systolic BP</i>						
Linear	-7.300** (0.013)	618	-13.064*** (0.002)	317	-8.540** (0.046)	332
Linear with controls	-7.704*** (0.009)	612	-12.918*** (0.002)	332	-8.147** (0.047)	332
Quadratic	-10.214*** (0.004)	845	-14.863*** (0.002)	563	-10.461** (0.020)	596
Quadratic with controls	-10.416*** (0.003)	841	-14.213*** (0.003)	588	-10.127** (0.021)	596
<i>Change in diastolic BP</i>						
Linear	-3.950** (0.032)	697	-10.074*** (<0.001)	277	-5.471* (0.073)	386
Linear with controls	-4.130** (0.025)	686	-10.108*** (<0.001)	277	-5.302* (0.081)	386
Quadratic	-6.842*** (0.005)	816	-10.793*** (<0.001)	491	-6.172* (0.056)	640
Quadratic with controls	-6.960*** (0.004)	827	-11.025*** (<0.001)	486	-5.963* (0.064)	676
<i>Change in MAP</i>						
Linear	-5.745*** (0.006)	594	-11.605*** (<0.001)	263	-6.536** (0.045)	332
Linear with controls	-6.094*** (0.004)	594	-11.497*** (<0.001)	271	-6.289** (0.050)	332
Quadratic	-8.133*** (0.002)	807	-12.663*** (<0.001)	499	-7.561** (0.027)	596
Quadratic with controls	-8.274*** (0.001)	807	-12.634*** (<0.001)	497	-7.328** (0.030)	632
<i>Hypertension</i>						
Linear	-0.001 (0.992)	594	-0.119 (0.610)	263	-0.166 (0.168)	332
Linear with controls	-0.007 (0.959)	594	-0.131 (0.570)	271	-0.173 (0.159)	332
Quadratic	0.003 (0.987)	807	-0.134 (0.543)	499	-0.179 (0.150)	596
Quadratic with controls	-0.009 (0.954)	807	-0.136 (0.535)	497	-0.183 (0.140)	632

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age.

Table B.11: Effects of BP screening on older undiagnosed individuals

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Change in systolic BP</i>						
Linear	-2.424 (0.516)	538	-1.511 (0.711)	430	-1.190 (0.846)	251
Linear with controls	-2.462 (0.514)	517	-1.015 (0.802)	420	-0.830 (0.894)	253
Quadratic	-2.496 (0.567)	702	-1.730 (0.716)	585	-1.046 (0.886)	374
Quadratic with controls	-2.290 (0.596)	702	-1.249 (0.788)	585	-0.958 (0.897)	363
<i>Change in diastolic BP</i>						
Linear	-1.338 (0.602)	458	0.264 (0.915)	423	2.680 (0.551)	263
Linear with controls	-1.303 (0.612)	458	0.312 (0.900)	419	1.841 (0.686)	239
Quadratic	-2.095 (0.510)	591	-1.983 (0.572)	465	2.592 (0.653)	350
Quadratic with controls	-1.972 (0.533)	595	-1.840 (0.598)	464	2.494 (0.672)	326
<i>Change in MAP</i>						
Linear	-1.800 (0.521)	482	-0.365 (0.895)	440	1.855 (0.685)	314
Linear with controls	-1.740 (0.536)	474	-0.167 (0.952)	433	1.019 (0.827)	281
Quadratic	-2.360 (0.493)	618	-1.787 (0.630)	503	1.321 (0.820)	374
Quadratic with controls	-2.200 (0.519)	618	-1.517 (0.678)	503	0.947 (0.875)	349
<i>Hypertension</i>						
Linear	-0.117 (0.434)	482	-0.091 (0.540)	440	0.278 (0.334)	314
Linear with controls	-0.100 (0.498)	474	-0.069 (0.628)	433	0.273 (0.339)	281
Quadratic	-0.117 (0.496)	618	-0.104 (0.570)	503	0.326 (0.308)	374
Quadratic with controls	-0.096 (0.566)	618	-0.077 (0.660)	503	0.338 (0.304)	349

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. *p*-values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age (including a dichotomous variable for age 80 and above) and sex.

Table B.12: Effects of BP screening on undiagnosed individuals with low level of education

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
<i>Change in systolic BP</i>						
Linear	-4.152 (0.191)	593	-6.887* (0.097)	382	-1.030 (0.884)	156
Linear with controls	-4.118 (0.186)	598	-6.801* (0.093)	393	-2.133 (0.762)	153
Quadratic	-5.291 (0.178)	803	-8.563* (0.076)	559	-2.743 (0.718)	292
Quadratic with controls	-5.500 (0.158)	790	-8.308* (0.076)	568	-3.163 (0.679)	309
<i>Change in diastolic BP</i>						
Linear	-2.434 (0.217)	624	-3.047 (0.179)	464	-4.432 (0.266)	255
Linear with controls	-2.455 (0.213)	624	-3.343 (0.151)	451	-4.653 (0.244)	255
Quadratic	-3.354 (0.203)	782	-5.105 (0.131)	497	-4.431 (0.310)	467
Quadratic with controls	-3.430 (0.194)	759	-5.096 (0.135)	480	-4.367 (0.324)	478
<i>Change in MAP</i>						
Linear	-2.859 (0.186)	641	-4.309 (0.120)	414	-3.418 (0.485)	185
Linear with controls	-2.885 (0.179)	630	-4.412 (0.110)	414	-3.847 (0.431)	197
Quadratic	-4.092 (0.154)	781	-6.302* (0.082)	518	-3.710 (0.487)	360
Quadratic with controls	-4.194 (0.142)	771	-6.148* (0.085)	514	-3.567 (0.507)	381
<i>Hypertension</i>						
Linear	-0.092 (0.450)	641	-0.238 (0.108)	414	0.306 (0.167)	185
Linear with controls	-0.085 (0.470)	630	-0.226 (0.119)	414	0.238 (0.282)	197
Quadratic	-0.098 (0.507)	781	-0.294* (0.093)	518	0.315 (0.167)	360
Quadratic with controls	-0.090 (0.533)	771	-0.277 (0.107)	514	0.250 (0.272)	381

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age (including a dichotomous variable for age 80 and above) and sex.

Table B.13: Effects of BP screening on undiagnosed individuals with high level of education

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
<i>Change in systolic BP</i>						
Linear	-5.709* (0.090)	584	-4.985 (0.236)	388	-8.199** (0.028)	430
Linear with controls	-5.866* (0.073)	583	-4.401 (0.274)	397	-7.349* (0.052)	430
Quadratic	-6.159* (0.098)	891	-5.854 (0.197)	708	-9.301** (0.020)	718
Quadratic with controls	-6.445* (0.080)	874	-5.617 (0.192)	742	-9.119** (0.021)	735
<i>Change in diastolic BP</i>						
Linear	-3.392 (0.127)	510	-3.848 (0.122)	405	-2.521 (0.490)	468
Linear with controls	-3.302 (0.128)	549	-3.841 (0.121)	402	-2.735 (0.460)	467
Quadratic	-4.225* (0.099)	818	-4.877 (0.101)	601	-3.988 (0.322)	690
Quadratic with controls	-4.311* (0.088)	820	-4.580 (0.117)	629	-3.915 (0.339)	689
<i>Change in MAP</i>						
Linear	-4.157* (0.092)	514	-4.290 (0.131)	388	-4.669 (0.183)	430
Linear with controls	-4.206* (0.082)	542	-4.176 (0.136)	402	-4.485 (0.202)	459
Quadratic	-5.061* (0.069)	831	-5.207 (0.105)	626	-5.997 (0.114)	718
Quadratic with controls	-5.131* (0.063)	826	-4.917 (0.116)	660	-5.872 (0.124)	717
<i>Hypertension</i>						
Linear	-0.027 (0.860)	514	-0.005 (0.977)	388	-0.170 (0.362)	430
Linear with controls	-0.029 (0.843)	542	-0.018 (0.915)	402	-0.193 (0.247)	459
Quadratic	-0.054 (0.741)	831	0.065 (0.733)	626	-0.183 (0.357)	718
Quadratic with controls	-0.059 (0.713)	826	0.036 (0.843)	660	-0.206 (0.256)	717

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age (including a dichotomous variable for age 80 and above) and sex.

Table B.14: Effects of BP screening on undiagnosed individuals with public health insurance coverage

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
<i>Change in systolic BP</i>						
Linear	-3.628 (0.302)	516	-5.019 (0.200)	447	1.981 (0.811)	121
Linear with controls	-3.233 (0.349)	521	-4.276 (0.272)	442	1.647 (0.841)	121
Quadratic	-4.434 (0.319)	632	-4.770 (0.330)	532	4.415 (0.661)	221
Quadratic with controls	-3.839 (0.382)	636	-4.077 (0.394)	538	4.319 (0.661)	237
<i>Change in diastolic BP</i>						
Linear	0.365 (0.870)	518	0.664 (0.774)	448	4.306 (0.440)	160
Linear with controls	0.600 (0.787)	506	0.799 (0.729)	443	4.125 (0.441)	147
Quadratic	-0.642 (0.825)	611	0.625 (0.834)	539	5.437 (0.363)	334
Quadratic with controls	-0.365 (0.898)	614	0.807 (0.785)	538	4.841 (0.433)	333
<i>Change in MAP</i>						
Linear	-0.938 (0.702)	525	-1.290 (0.618)	451	3.097 (0.620)	129
Linear with controls	-0.803 (0.740)	527	-0.926 (0.723)	448	4.120 (0.515)	129
Quadratic	-1.951 (0.538)	621	-1.507 (0.641)	554	4.832 (0.490)	288
Quadratic with controls	-1.509 (0.627)	625	-1.150 (0.721)	555	5.773 (0.415)	297
<i>Hypertension</i>						
Linear	-0.020 (0.879)	525	-0.045 (0.752)	451	0.665** (0.013)	129
Linear with controls	0.018 (0.890)	527	-0.022 (0.879)	448	0.641*** (0.004)	129
Quadratic	-0.088 (0.580)	621	-0.089 (0.586)	554	0.720*** (0.009)	288
Quadratic with controls	-0.039 (0.801)	625	-0.057 (0.724)	555	0.685*** (0.004)	297

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. *p*-values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age (including a dichotomous variable for age 80 and above) and sex.

Table B.15: Effects of BP screening on undiagnosed individuals without public health insurance coverage

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
<i>Change in systolic BP</i>						
Linear	-5.590* (0.068)	632	-7.759* (0.064)	360	-8.516*** (0.006)	648
Linear with controls	-5.662* (0.064)	624	-7.313* (0.076)	375	-8.609*** (0.006)	624
Quadratic	-6.652* (0.054)	966	-8.770* (0.057)	663	-9.651** (0.011)	709
Quadratic with controls	-6.777** (0.049)	959	-8.323* (0.066)	660	-9.694** (0.011)	708
<i>Change in diastolic BP</i>						
Linear	-5.884*** (0.005)	545	-9.655*** (<0.001)	299	-6.042** (0.031)	656
Linear with controls	-5.997*** (0.005)	539	-9.791*** (<0.001)	299	-5.988** (0.034)	656
Quadratic	-7.310*** (0.003)	845	-10.096*** (0.001)	562	-7.231** (0.019)	773
Quadratic with controls	-7.466*** (0.002)	819	-10.265*** (0.001)	542	-7.112** (0.022)	772
<i>Change in MAP</i>						
Linear	-5.703** (0.013)	545	-9.161*** (0.003)	308	-6.934** (0.011)	656
Linear with controls	-5.785** (0.012)	544	-9.019*** (0.003)	306	-6.937** (0.012)	656
Quadratic	-7.055*** (0.007)	875	-9.493*** (0.005)	583	-8.067*** (0.009)	709
Quadratic with controls	-7.175*** (0.006)	874	-9.372*** (0.005)	583	-7.992** (0.010)	737
<i>Hypertension</i>						
Linear	-0.026 (0.867)	545	-0.122 (0.573)	308	-0.358*** (<0.001)	656
Linear with controls	-0.028 (0.860)	544	-0.096 (0.660)	306	-0.356*** (<0.001)	656
Quadratic	-0.047 (0.761)	875	-0.157 (0.440)	583	-0.359*** (0.008)	709
Quadratic with controls	-0.045 (0.770)	874	-0.137 (0.499)	583	-0.365*** (0.007)	737

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age (including a dichotomous variable for age 80 and above) and sex.

Table B.16: Descriptive statistics of mechanisms measured at wave 3 among individuals who at baseline do not report a previous hypertension diagnosis

	<i>Undiagnosed</i>			<i>Undiagnosed males</i>			<i>Undiagnosed middle-aged adults</i>			<i>Undiagnosed without public health ins.</i>		
	Mean	Sd	N	Mean	Sd	N	Mean	Sd	N	Mean	Sd	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Diagnosed	0.149	0.356	3746	0.172	0.377	1677	0.131	0.338	2304	0.121	0.327	2307
Medication	0.112	0.316	3746	0.131	0.337	1677	0.086	0.280	2304	0.085	0.280	2307
Antihypertensive	0.088	0.283	3746	0.123	0.329	1677	0.046	0.210	2304	0.059	0.236	2307
Antihypertensive (broader def.)	0.211	0.408	3746	0.265	0.442	1677	0.126	0.332	2304	0.141	0.348	2307
Lifestyle changes	0.047	0.212	3746	0.050	0.218	1677	0.049	0.215	2304	0.048	0.213	2307

Notes: Sample descriptive statistics of the variables we use to explore potential mechanisms measured at wave 3. “Sd” stands for standard deviation and N corresponds to the number of observations. Columns (1)-(3) are based on the entire sample of undiagnosed respondents, and columns (4)-(6) are based on undiagnosed males. Columns (7)-(9) and (10)-(12) are based on undiagnosed middle-aged individuals and undiagnosed individuals without public health insurance, respectively. “Medication” corresponds to a question in which *diagnosed* respondents (at wave 3) are asked whether they are currently taking any medication for hypertension. Moreover, at the end of the interview, interviewers ask respondents to show them the medications they are currently on. “Antihypertensive” is a variable that takes the value one if a respondent shows the interviewer a medication that is specifically designed for hypertension. “Antihypertensive (broader def.)” is a variable that takes the value one if a respondent shows the interviewer a medication that is specifically designed for hypertension, as well as medications that have been shown to improve BP characteristics but that were not designed exclusively to treat hypertension.

Table B.17: Effects of BP screening on mechanisms measured at wave 3

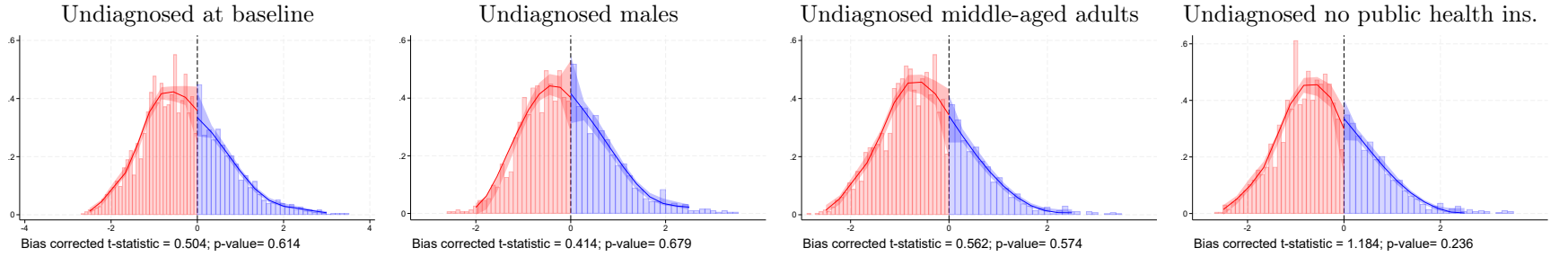
	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Undiagnosed individuals at baseline</i>						
Diagnosed	-0.144** (0.041)	1105	-0.127 (0.119)	814	-0.187** (0.016)	667
Medication	-0.130** (0.042)	1105	-0.131* (0.080)	814	-0.148** (0.035)	667
Antihypertensive	-0.011 (0.843)	1105	-0.012 (0.865)	814	-0.040 (0.269)	667
Antihypertensive (broader def.)	-0.001 (0.986)	1105	0.025 (0.785)	814	-0.130* (0.061)	667
Lifestyle changes	-0.012 (0.742)	1105	0.015 (0.702)	814	-0.062 (0.143)	667
<i>Undiagnosed males at baseline</i>						
Diagnosed	-0.246** (0.046)	597	-0.221 (0.113)	344	-0.350*** (0.005)	329
Medication	-0.256** (0.025)	597	-0.248** (0.046)	344	-0.307** (0.011)	329
Antihypertensive	-0.043 (0.692)	597	-0.053 (0.673)	344	-0.065 (0.384)	329
Antihypertensive (broader def.)	0.059 (0.623)	597	0.094 (0.500)	344	-0.153 (0.194)	329
Lifestyle changes	-0.024 (0.610)	597	-0.039 (0.507)	344	-0.071 (0.191)	329
<i>Undiagnosed middle-aged individuals at baseline</i>						
Diagnosed	-0.083 (0.299)	667	0.015 (0.877)	311	-0.173* (0.070)	371
Medication	-0.046 (0.422)	667	-0.006 (0.913)	311	-0.113 (0.128)	371
Antihypertensive	0.005 (0.886)	667	0.005 (0.918)	311	-0.066 (0.122)	371
Antihypertensive (broader def.)	0.034 (0.620)	667	0.087 (0.265)	311	-0.164** (0.035)	371
Lifestyle changes	-0.050 (0.278)	667	0.024 (0.577)	311	-0.094 (0.155)	371
<i>Undiagnosed without public health insurance at baseline</i>						
Diagnosed	-0.111 (0.236)	601	-0.049 (0.675)	343	-0.133* (0.045)	716
Medication	-0.084 (0.275)	601	-0.063 (0.537)	343	-0.074 (0.185)	716
Antihypertensive	0.051 (0.481)	601	0.019 (0.857)	343	-0.037 (0.221)	716
Antihypertensive (broader def.)	-0.023 (0.826)	601	0.021 (0.882)	343	-0.112 (0.069)	716
Lifestyle changes	0.000 (0.999)	601	0.065 (0.140)	343	-0.035 (0.350)	716

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age (including a dichotomous variable for age 80 and above) and sex. These estimates include only undiagnosed. “Medication” corresponds to a question in which *diagnosed* respondents (at wave 3) are asked whether they are currently taking any medication for hypertension. Moreover, at the end of the interview, interviewers ask respondents to show them the medications they are currently on. “Antihypertensive” is a variable that takes the value one if a respondent shows the interviewer a medication that is specifically designed for hypertension. “Antihypertensive (broader def.)” is a variable that takes the value one if a respondent shows the interviewer a medication that is specifically designed for hypertension, as well as medications that have been shown to improve BP characteristics but that were not designed exclusively to treat hypertension.

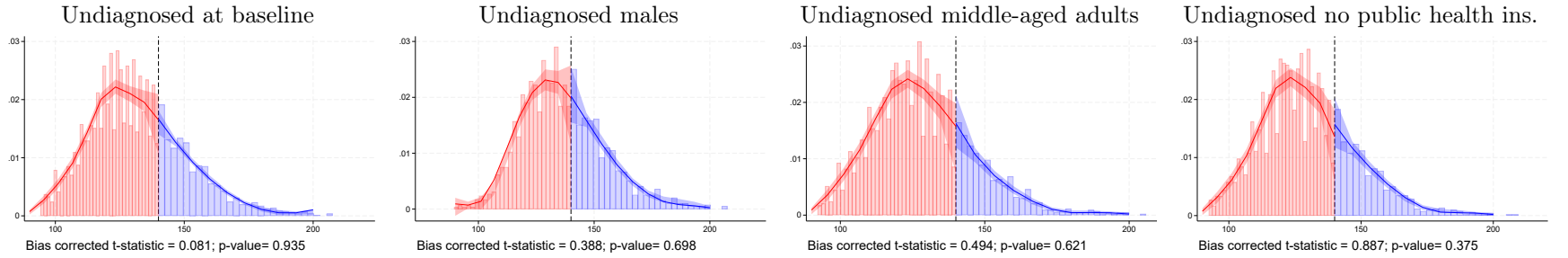
C Additional Figures

Figure C.1: Histograms and tests of threshold discontinuities in running variables

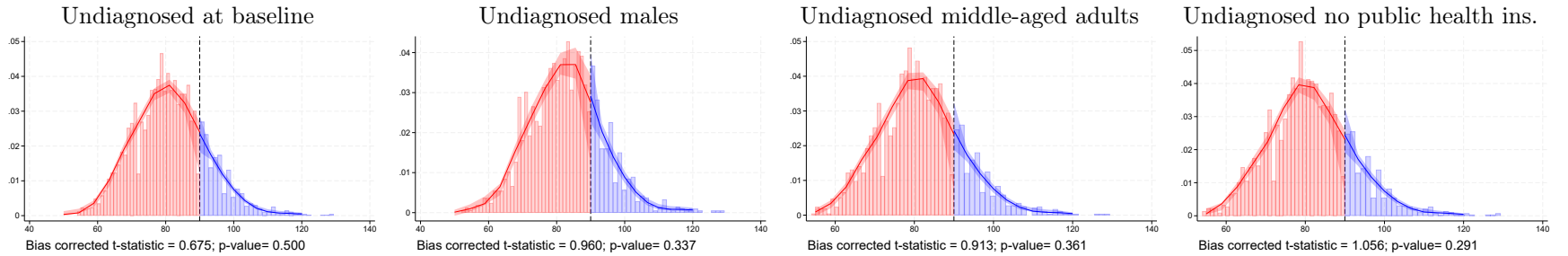
A) Binding-score RDD



B) Unidimensional RDD - Systolic frontier

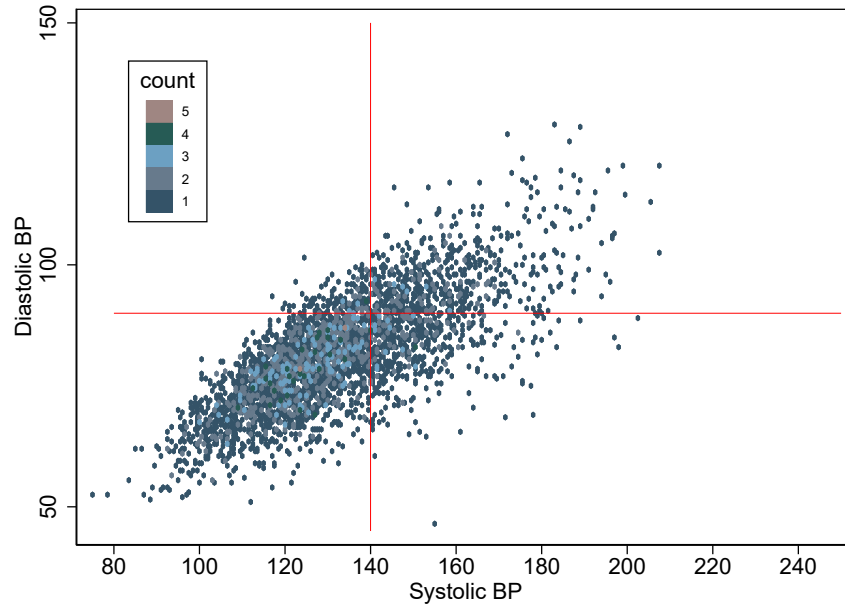


C) Unidimensional RDD - Diastolic frontier



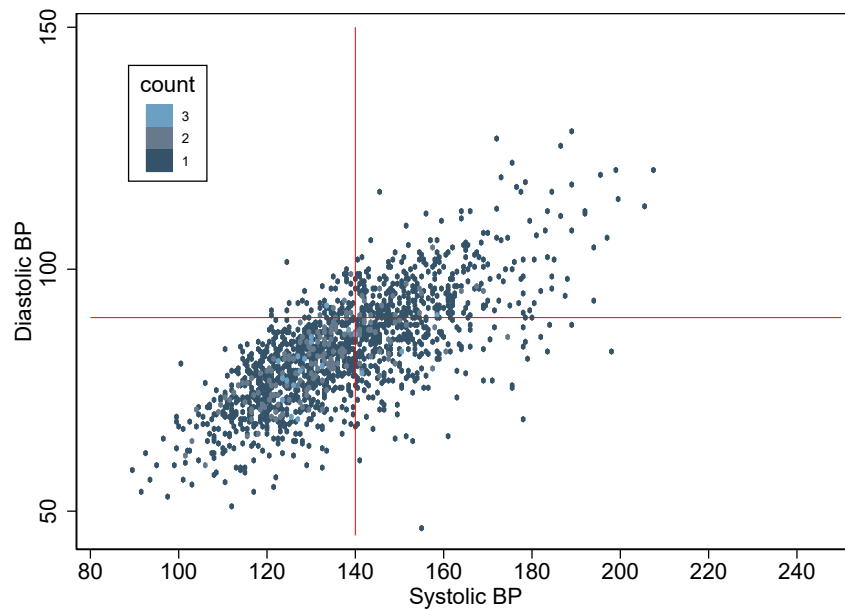
Notes: Plots exclude respondents who at baseline report a previous diagnosis of hypertension. Plots in column 2 are derived using males who were not diagnosed at baseline. Plots in column 3 are derived using middle-aged individuals who were not diagnosed at baseline. All plots show there is no statistically significant discontinuity in either running variables at the respective threshold (0 for centering (Panel A), 140 mmHg for systolic BP (Panel B) and 90 mmHg for diastolic BP (Panel C)). These RDD plots are generated using third order polynomial, triangular weights, and a different optimal bandwidth on each side of the threshold (based on the MSE of each density estimator separately) (Calonico *et al.*, 2015, 2017, 2018; Cattaneo *et al.*, 2018, 2020). Below each RDD plot is the bias-corrected t-statistic and corresponding p -value for test of no discontinuity at the threshold (McCrary, 2008).

Figure C.2: Joint density of the running variables – heat plot for undiagnosed individuals at baseline



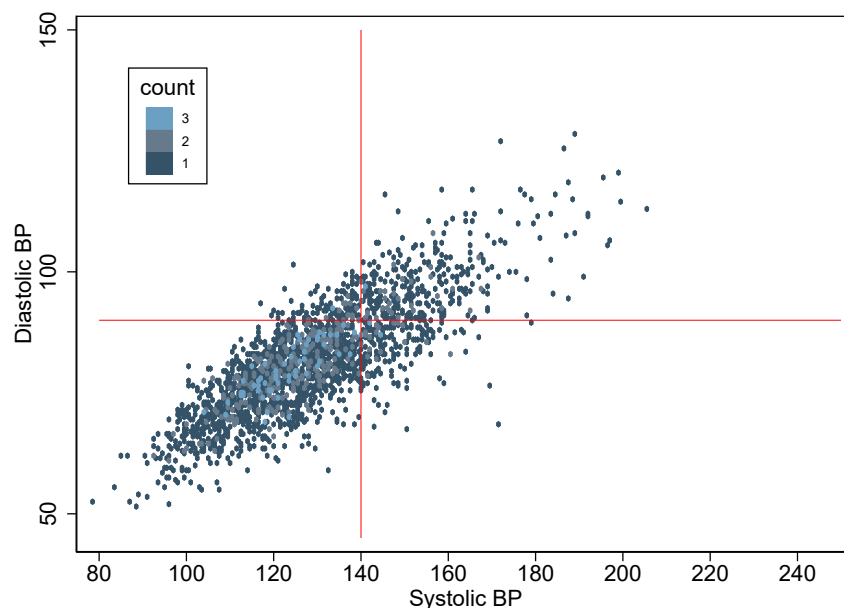
Notes: $N = 2,752$. x-axis (y-axis) shows average systolic (diastolic) BP at baseline. The red lines identify treatment assignment thresholds (140 mmHg for systolic and 90 mmHg for diastolic).

Figure C.3: Joint density of the running variables – heat plot for undiagnosed males at baseline



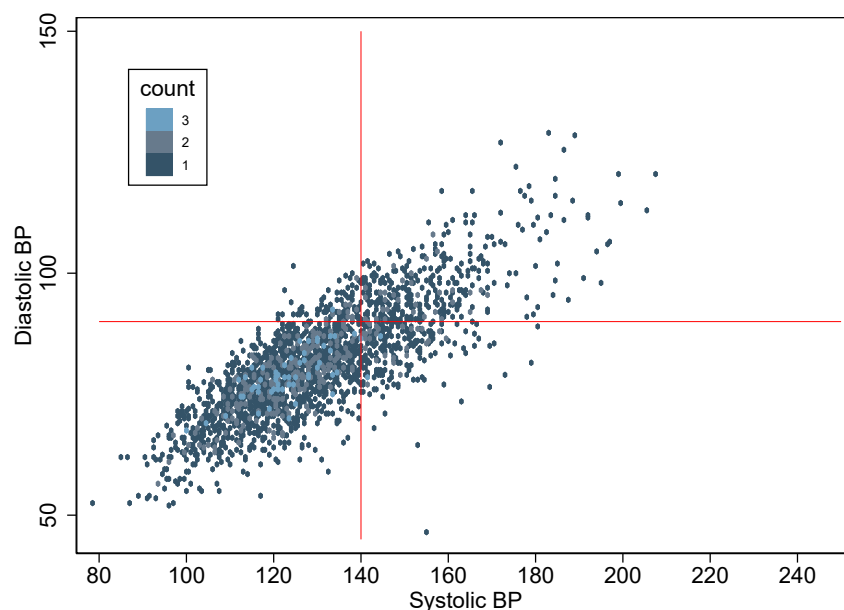
Notes: $N = 1,238$. x-axis (y-axis) shows average systolic (diastolic) BP at baseline. The red lines identify treatment assignment thresholds (140 mmHg for systolic and 90 mmHg for diastolic).

Figure C.4: Joint density of the running variables – heat plot for undiagnosed middle-aged individuals at baseline



Notes: $N = 1,602$. x-axis (y-axis) shows average systolic (diastolic) BP at baseline. The red lines identify treatment assignment thresholds (140 mmHg for systolic and 90 mmHg for diastolic).

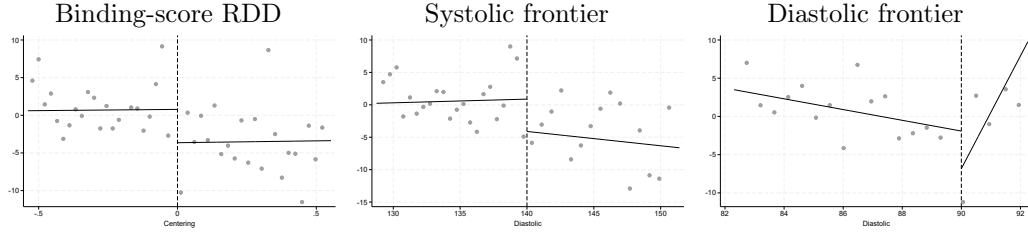
Figure C.5: Joint density of the running variables – heat plot for undiagnosed individuals without public health insurance at baseline



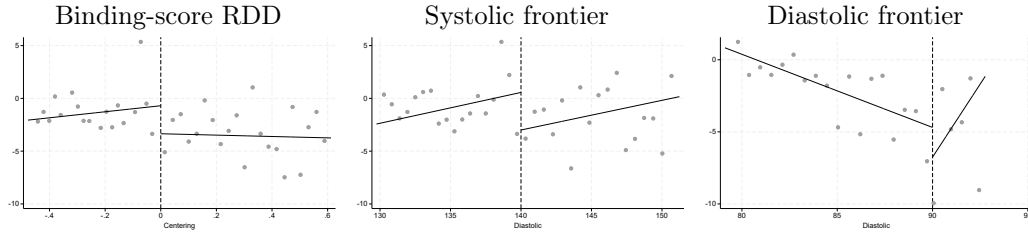
Notes: $N = 2,826$. x-axis (y-axis) shows average systolic (diastolic) BP at baseline. The red lines identify treatment assignment thresholds (140 mmHg for systolic and 90 mmHg for diastolic). This plots include individuals who were not diagnosed with high BP at baseline and who did not have public health insurance.

Figure C.6: Discontinuity plots for undiagnosed individuals at baseline

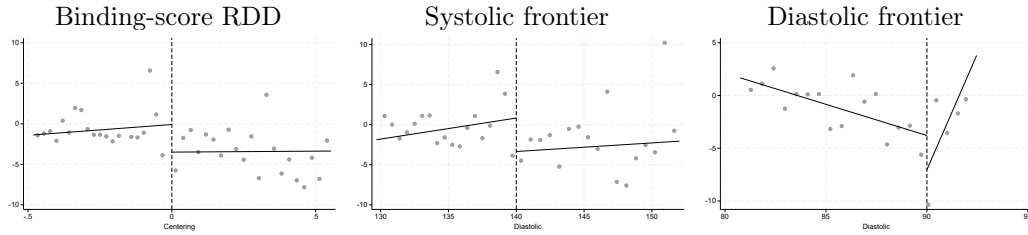
A) Change in systolic BP



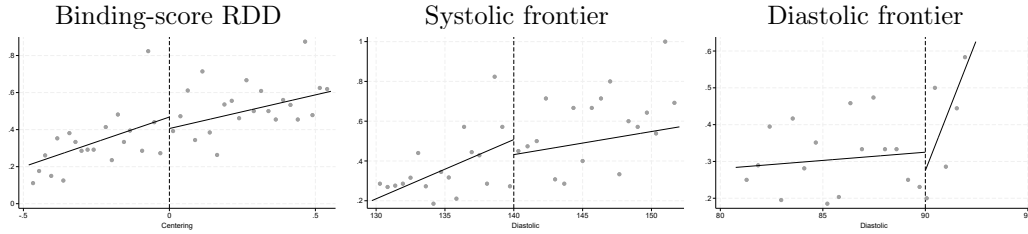
B) Change in diastolic BP



C) Change in MAP



D) Hypertension



Notes: Plots of average outcomes conditional on the running variable(s). For these plots, we use local linear regression, triangular kernels, and the MSE optimal bandwidth selector. Each dot is the mean of the respective outcome in a given bin. We use optimal bins obtained with variance evenly-spaced method using spacing estimators (Calonico *et al.*, 2014a,b, 2015, 2017). In all plots, we control for sex and age (including a dichotomous variable for age 80 and above).

D Attrition

There appears to be selective attrition in our sample. Out of the 3,596 undiagnosed individuals with valid BP at baseline, 2,752 have valid BP measurements at follow-up, and 844 have not (23.47%). Surprisingly, Table D.1 shows that having a systolic BP above the normal range increases the probability of being in the sample by about 13-15% point. When combining both SBP and DBP to estimate the effects of having abnormal BP at baseline on the probability of being in the sample at follow-up, we again obtain a positive effect of about 11-12% point, although this effect is statistically significant only at 10% level.

To assess the extent to which this selective attrition can influence our results, we bound our treatment effects by assigning BP characteristics to individuals missing at follow-up. More specifically, akin to Lee (2002) and Horowitz and Manski (1998, 2000), we implement a simulation exercise in which we first predict our outcome variables using the observations available, then impute the values of outcome variables for attrited individuals based on their individual characteristics, allowing these predictions to be different on both sides of the cutoffs. We then add a positive or negative penalty to the predicted outcomes for attrited individuals above the thresholds, with penalties equal to 0.25, 0.5, 1, 2, and 3 standard deviations above or below the values of the predicted outcomes. For instance, when considering the effects at the systolic frontier, and restricting the sample to the one optimally derived in our benchmark analysis, the average predicted change in SBP for the treated individuals is equal to -5.098 mmHg and the standard deviation is equal to 3.139. Imposing a positive penalty of 3 standard deviations implies that attrited individuals who have abnormal SBP at baseline experience on average an increase in SBP of about +4.318 mmHg at follow-up ($+4.318 = -5.098 + 3 \times 3.139$). Relative to the average predicted drop of 5.098 mmHg in SBP, assuming an average increase in SBP of 4.318 mmHg for attrited individuals is extreme as there is a priori no reason to believe that such large differences in the effects across these two groups exist.²⁰ We finally estimate our RDD models including in our sample the attrited individuals whose BP characteristics were imputed with positive or negative penalty. Our simulations show that our results are very robust to selective attrition, irrespective of the “direction” of this selection.

Tables D.2, D.3, D.4, and D.5 present the results of these simulations when considering SBP, DBP, MAP and the probability of being hypertensive at follow-up, respectively. Naturally, if attrited individuals whose BP at baseline were above the threshold have better BP characteristics at follow-up—in the sense that the drop is larger for them—, then the overall effects of the screening increases. This can be seen in the first panel of the four tables where we assume that the drop in the outcome variables for each treated attrited individuals is 0.25, 0.5, 1, 2, and 3 standard deviations larger than the average values of treated individuals in observed samples.

Reassuringly, our benchmark results hold when we assume that treated attrited individuals have worse BP characteristics at follow-up as compared to treated individuals for whom we have valid BP measurement at follow-up. Indeed the second panel of Tables D.2, D.3, D.4, and D.5 show that our results are robust even to extreme assumptions about the BP characteristics of the treated attrited individuals. Naturally, the drop in BP characteristics at the threshold decreases as the penalty on the imputed BP characteristics increases, but the overall effects remain rather constant and precisely estimated. For instance, our benchmark analysis shows a drop in SBP of about 5.3 mmHg (p -value=0.027) for undiagnosed individuals at baseline when considering our binding-score approach (see Table 2). When we impose a penalty of +0.25 standard deviation in the

²⁰The average predicted change in SBP for untreated individuals is equal to +1.087 mmHg.

Table D.1: Effects of BP screening on the probability of follow-up

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
	(1)	N (2)	Sys front. (3)	N (4)	Dia front. (5)	N (6)
Linear	0.105* (0.067)	1623	0.128** (0.048)	1155	0.043 (0.731)	517
Linear with controls	0.106* (0.056)	1597	0.141** (0.021)	1215	0.045 (0.714)	566
Quadratic	0.114* (0.085)	2266	0.137* (0.053)	2040	0.020 (0.874)	1390
Quadratic with controls	0.123* (0.053)	2285	0.148** (0.032)	1924	0.023 (0.855)	1387

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age. These estimates include only undiagnosed individuals. The outcome variable is a dichotomous variable that takes the value 1 if a respondent has a valid BP measure at follow-up and 0 otherwise.

SBP characteristics of individuals that were above the threshold at baseline but for whom we do not have BP measurements at follow-up, the effect of the screening remain large and precisely estimated, at -5.03 mmHg (p -value=0.006) (Table D.2). These effects appear large and precisely estimated even in the extreme case where we increase the penalty to up to 3 standard deviations above the SBP average value of the treated group that we observe in our sample ($\beta = -4.19$, p -value=0.023). This results hold true for our four outcome variables and for the three empirical strategy we put in place (binding-score, systolic frontier, and diastolic frontier).

Overall, our simulation exercise shows that selective attrition is unlikely to explain the sizable and precisely estimated effects of the screening. We show that even in the extreme cases where attrited individuals above the cutoff have much worse BP characteristics at follow-up relative to those for whom we have valid BP measurements at follow-up, we still obtain statistically significant large improvement in BP characteristics at follow-up for those who are at the cutoffs that determine normal vs abnormal BP range.

Table D.2: Effects of BP screening on change in SBP, robustness checks to selective attrition

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Attrited individuals with better BP characteristics at follow-up</i>						
-0.25 × Std. dev.	-5.188*** (0.004)	1335	-5.645** (0.014)	961	-4.945* (0.060)	517
-0.5 × Std. dev.	-5.270*** (0.004)	1335	-5.784** (0.012)	961	-5.242** (0.045)	517
-1 × Std. dev.	-5.440*** (0.003)	1351	-6.066*** (0.008)	942	-5.838** (0.025)	517
-2 × Std. dev.	-5.767*** (0.001)	1358	-6.634*** (0.004)	942	-7.034*** (0.007)	517
-3 × Std. dev.	-6.101*** (0.001)	1358	-7.201*** (0.002)	942	-8.228*** (0.002)	517
<i>Attrited individuals with worse BP characteristics at follow-up</i>						
+0.25 × Std. dev.	-5.026*** (0.006)	1311	-5.367** (0.019)	961	-4.353 (0.104)	517
+0.5 × Std. dev.	-4.948*** (0.006)	1311	-5.229** (0.022)	961	-4.058 (0.133)	517
+1 × Std. dev.	-4.794*** (0.008)	1311	-4.954** (0.031)	961	-3.471 (0.209)	517
+2 × Std. dev.	-4.494** (0.014)	1311	-4.412* (0.055)	961	-2.198 (0.450)	530
+3 × Std. dev.	-4.187** (0.023)	1294	-3.874* (0.095)	961	-0.615 (0.842)	530

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age. These estimates include only undiagnosed individuals. The outcome variable is change in SBP. The specification includes linear trends on both sides of the cutoff and our usual set of control variables.

Table D.3: Effects of BP screening on change in DBP, robustness checks to selective attrition

	<i>Binding-score RDD</i>			<i>Unidimensional RDD</i>		
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Attrited individuals with better BP characteristics at follow-up</i>						
-0.25 × Std. dev.	-3.431*** (0.007)	1161	-4.397*** (0.003)	841	-2.389 (0.197)	848
-0.5 × Std. dev.	-3.464*** (0.006)	1172	-4.467*** (0.002)	841	-2.643 (0.152)	848
-1 × Std. dev.	-3.533*** (0.005)	1172	-4.601*** (0.002)	841	-3.159* (0.087)	848
-2× Std. dev.	-3.670*** (0.004)	1197	-4.847*** (0.001)	846	-4.244** (0.025)	848
-3× Std. dev.	-3.816*** (0.002)	1225	-5.109*** (0.001)	859	-5.449*** (0.006)	848
<i>Attrited individuals with worse BP characteristics at follow-up</i>						
+0.25 × Std. dev.	-3.361*** (0.008)	1161	-4.258*** (0.004)	822	-1.887 (0.315)	848
+0.5 × Std. dev.	-3.325*** (0.009)	1145	-4.190*** (0.005)	822	-1.637 (0.388)	848
+1 × Std. dev.	-3.253** (0.011)	1121	-4.052*** (0.006)	822	-1.145 (0.555)	848
+2× Std. dev.	-3.120** (0.015)	1121	-3.783** (0.011)	822	-0.190 (0.927)	852
+3× Std. dev.	-2.967** (0.021)	1104	-3.506** (0.020)	809	0.751 (0.736)	852

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age. These estimates include only undiagnosed individuals. The outcome variable is change in DBP. The specification includes linear trends on both sides of the cutoff and our usual set of control variables.

Table D.4: Effects of BP screening on change in MAP, robustness checks to selective attrition

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Attrited individuals with better BP characteristics at follow-up</i>						
-0.25 × Std. dev.	-4.340*** (0.002)	1121	-4.882*** (0.003)	841	-3.636* (0.074)	612
-0.5 × Std. dev.	-4.392*** (0.002)	1121	-4.957*** (0.002)	841	-3.854* (0.057)	612
-1 × Std. dev.	-4.482*** (0.001)	1145	-5.111*** (0.002)	846	-4.292** (0.033)	612
-2 × Std. dev.	-4.685*** (0.001)	1161	-5.421*** (0.001)	846	-5.170** (0.011)	612
-3 × Std. dev.	-4.886*** (<0.001)	1172	-5.734*** (0.001)	846	-6.049*** (0.004)	612
<i>Attrited individuals with worse BP characteristics at follow-up</i>						
+0.25 × Std. dev.	-4.236*** (0.002)	1121	-4.733*** (0.004)	841	-3.155 (0.125)	625
+0.5 × Std. dev.	-4.184*** (0.003)	1121	-4.660*** (0.004)	841	-2.852 (0.168)	625
+1 × Std. dev.	-4.080*** (0.004)	1104	-4.513*** (0.006)	841	-2.303 (0.273)	625
+2 × Std. dev.	-3.867*** (0.006)	1104	-4.214** (0.010)	841	-1.316 (0.550)	625
+3 × Std. dev.	-3.659*** (0.010)	1091	-3.899** (0.018)	841	-0.389 (0.867)	625

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. p -values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age. These estimates include only undiagnosed individuals. The outcome variable is change in MAP. The specification includes linear trends on both sides of the cutoff and our usual set of control variables.

Table D.5: Effects of BP screening on the probability of being hypertensive, robustness checks to selective attrition

	<i>Binding-score RDD</i>		<i>Unidimensional RDD</i>			
		N	Sys front.	N	Dia front.	N
	(1)	(2)	(3)	(4)	(5)	(6)
<i>Attrited individuals with better BP characteristics at follow-up</i>						
-0.25 × Std. dev.	-0.039 (0.446)	1789	-0.020 (0.767)	1409	-0.005 (0.954)	553
-0.5 × Std. dev.	-0.044 (0.383)	1789	-0.024 (0.723)	1409	-0.011 (0.903)	553
-1 × Std. dev.	-0.055 (0.274)	1817	-0.031 (0.637)	1409	-0.024 (0.786)	553
-2 × Std. dev.	-0.078 (0.121)	1844	-0.047 (0.481)	1401	-0.051 (0.572)	553
-3 × Std. dev.	-0.099** (0.046)	1882	-0.064 (0.351)	1401	-0.078 (0.392)	543
<i>Attrited individuals with worse BP characteristics at follow-up</i>						
+0.25 × Std. dev.	-0.028 (0.590)	1766	-0.012 (0.859)	1409	0.004 (0.963)	553
+0.5 × Std. dev.	-0.022 (0.667)	1766	-0.008 (0.905)	1409	0.009 (0.922)	553
+1 × Std. dev.	-0.011 (0.825)	1749	-0.000 (0.998)	1409	0.018 (0.841)	553
+2 × Std. dev.	0.010 (0.851)	1724	0.015 (0.817)	1422	0.037 (0.689)	553
+3 × Std. dev.	0.032 (0.552)	1709	0.031 (0.645)	1422	0.055 (0.558)	553

Notes: Centering (column 1), and frontier-specific RDD estimates (systolic frontier in column 3 and diastolic frontier in column 5) obtained from local regression, with triangular kernels and optimal bandwidths on each side of the threshold using the MSE optimal bandwidth selector. *p*-values in parentheses derived from standard errors that are heteroscedasticity-robust with * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$. N is the effective number of observations used in estimation. We control for sex and age. These estimates include only undiagnosed individuals. The outcome variable is the probability of being hypertensive. The specification includes linear trends on both sides of the cutoff and our usual set of control variables.