RESPOND MALAYSIA
Centre for Translational Research & Epidemiology (CenTRE)
Faculty of Medicine, Universiti Teknologi MARA, Sungai Buloh Campus
Selangor, Malaysia

Acknowledgement: Professor Dr Martin Mckee, Chief Investigator and RESPOND team
London School of Hygiene and Tropical Medicine

RESPOND

Responsive and Equitable HealthSystems - Partnership on Non-Communicable Diseases

POLICY BRIEF

APRIL 2022

01 Addressing the strengths and the gaps in the current policies on health systems with regards to Hypertension

02 A Vibrant management of Hypertension Catering to Low-Income Group

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Level 4, Academic Building, Faculty of Medicine,
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Sungai Buloh Campus, 47000, Sungai Buloh, Selangor,
Malaysia.
Tel : +603 6126 7461
Fax : +603 6126 7479
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ABOUT US

RESPOND project started in 2017 with three main objectives;
(1) Research on access to hypertension care
(2) Capacity building
(3) Impact and communication.

RESPOND Quantitative MY team:

Principal Investigator
Dr Nafiza Mat Nasir

Team Members
YBhg. Prof Dato' Dr Ahmad Ibrahim
Assoc Prof Dr Farnaza Ariffin
Assoc Prof Dr Mohamad Rodi Isa
Dr Mazapuspavina Md Yasin
Dr Azlina Ab Razak
Fadhlina Ab Majid

In memory the late YBhg. Prof Emeritus Dato' Dr Khalid Yusoff

APRIL 2022

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CENTRE FOR TRANSLATIONAL RESEARCH
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FACULTY OF MEDICINE
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FOREWORD

Responsive and Equitable Health Systems—Partnership on Non-Communicable Diseases, RESPOND project provides knowledge to overcome health system barriers in optimizing the management of hypertension in Malaysia and Philippines. In addition, this knowledge can be used to improve policies in the management of chronic diseases.

This project is a partnership between Universiti Teknologi MARA (UiTM) Malaysia, University of the Philippines (UP Manila) and the London School of Hygiene & Tropical Medicine (LSHTM) United Kingdom. RESPOND project used quantitative method to understand the barriers to hypertension control faced by the low-income households over 12-18 months. The data captured the respondents' lived experience in dealing with hypertension.

This is to generate analytical and methodological insights of relevance to Malaysia and the Philippines, and other low- and middle-income countries seeking to implement patient-centred and pro-poor responses to the growing burden of non-communicable disease (NCD).

POLICY BRIEF

Addressing the strengths and the gaps
in the current policies on health systems
with regards to Hypertension

01

BACKGROUND

Hypertension has been described as a silent killer. The National Health and Morbidity Survey Malaysia (NHMS, 2019) reported that the overall prevalence of hypertension among adults in Malaysia was 30%. It is one of those ailments which caused high economic burden. Yet, if properly managed with the necessary therapy, the cost to the economy can be substantially reduced. Hypertension is a non-communicable disease (NCD) which would creep on individual without being noticed. When one realises it, it is often too late. But if one gets diagnosed early enough, the medical facilities and technology to manage it is widely available. Managing the disease effectively also calls for lifestyle and behavioural change. This proves to be the biggest challenge dealing with hypertension.

Figure 1: Blood pressure taking of a respondent

The strategy that is widely adopted involves the following key steps: creating awareness through effective communication, facilitating early diagnosis, appropriate management and prescribing and monitoring the patients.

Over the years, there have been efforts worldwide to proactively establish the gaps in the above measures, so that the necessary actions can be taken to address the weaknesses in the health system. This has been the subject of a 2-country study under the name RESPOND which was internationally funded. Managed under the auspices of the London School of Hygiene & Tropical Medicine (LSHTM), the study looked at the challenges for the low-income group of the population in managing hypertension in both Malaysia (B40) and the Philippines.

The findings of the study will be shared with the relevant authorities and stakeholders in the country for policy considerations. This policy brief is looking at the current available policies towards hypertension healthcare deliveries within the health system and how the results from this study can enhance these policies.

Figure 2: House visit

THE RESEARCH

Figure 3: Data collection

The Responsive and Equitable Health Systems-Partnership on Non-Communicable Diseases (RESPOND) research aimed to assess the disease burden among hypertensive individuals in the low-income B40 group in Malaysia. The study also aimed to identify the respondent's perception of their health in relation to their chronic disease illnesses among the hypertensive adults. Data for analysis was obtained from this internationally funded RESPOND study.

The low-income communities (B40, income < RM3,855, based on 2014 criteria) were selected in the rural and urban areas in four peninsular states (Selangor, Kelantan, Perak and Johor) in 2018 and 2019. Following a multistage sampling approach, communities in each stratum were selected according to the probability proportional to size and identified based on national census data by community and administrative registers.

Figure 4: House visit

The households were randomly selected using ‘randomizer.org’. Eligible individuals were those aged between 35 – 70 years old, and self-reported or identified as hypertensive at screening. This was based on a self-reported history of hypertension diagnosis or identified as hypertensive during blood pressure screening.

A survey using validated questionnaires was conducted. The questionnaire was administered by trained personnel. This consisted of socio-demographic data, information on housing characteristics, socio-economic characteristics of households and respondents, and hypertension-related care experiences, practices, knowledge and attitudes. Informed consent was taken.

Data analysis was conducted using SPSS version 28.0.

HIGHLIGHTS OF THE RESEARCH FINDINGS

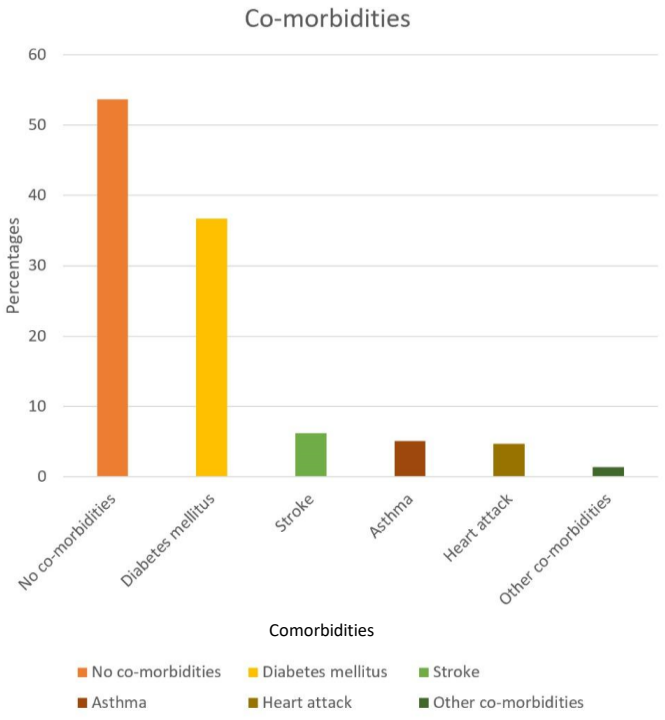

Figure 5: Respondents' comorbidities

A total of 611 respondents were involved in this study. Most of them were between 50-59 years-old (33.9%). Out of those, 162 (26.5%) were males and 449 (73.5%) were females. The median duration of hypertension for male was 5.00 (IQR: 7.27) years and 5.00 (IQR: 7.00) years for females.

The respondent's mean blood pressure was; systolic blood pressure (SBP) of 147.42 mmHg (SD:22.92) and mean diastolic blood pressure (DBP) of 90.21 mmHg (SD:14.31). Out of respondents who are known hypertensive, the controlled blood pressure (BP < 140/90 mmHg) was 41.9% (n=375).

The study found that about half of the hypertensive individuals in low income households in Malaysia had at least one comorbidity, with diabetes mellitus is the most prevalent comorbidity. It is reported that diabetes mellitus was the highest (36.7%) among other comorbidity, followed by stroke (6.2%), asthma (5.1%) and heart attack (4.7%). Other comorbidities were 1.4% and 53.7% of the respondent

has no other comorbidity.

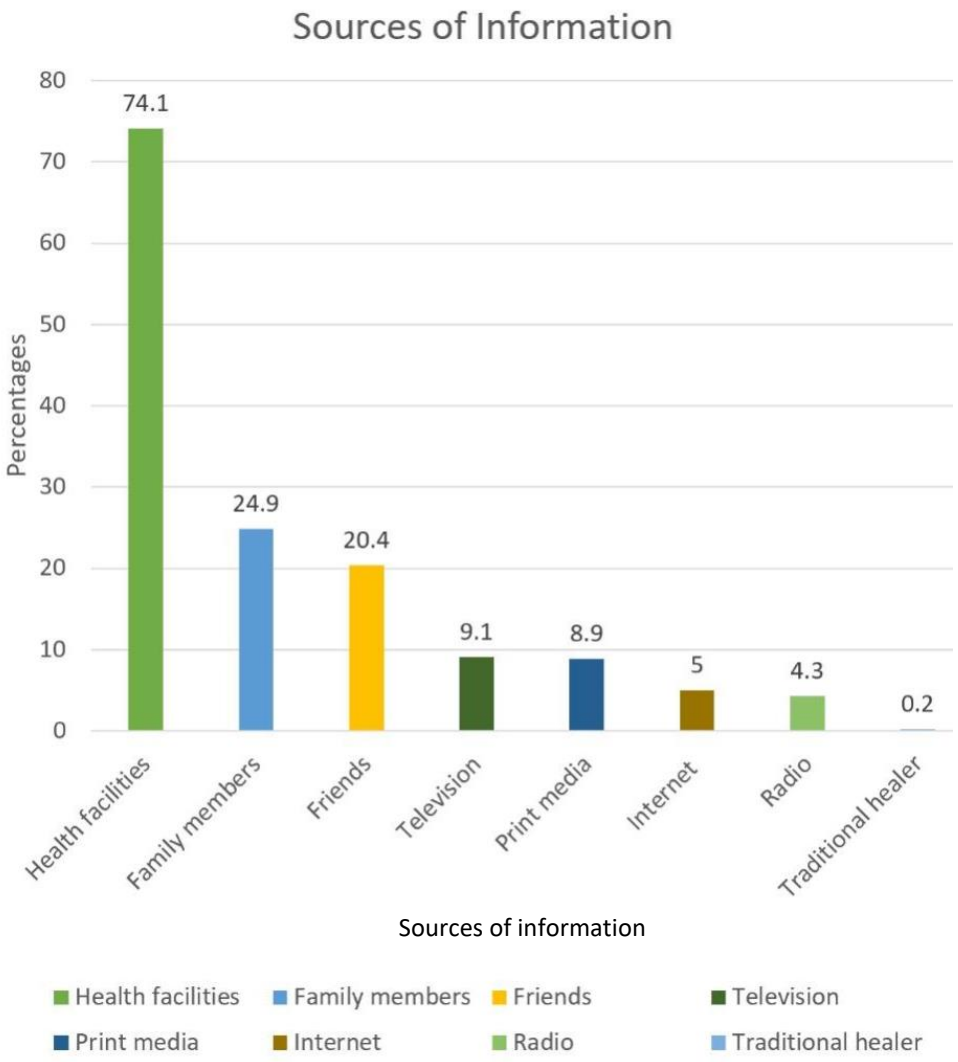

Figure 6: Respondents' Sources of Information

On the sources of information about hypertension, the respondents received information mainly from the health facilities (74.1%), followed by family members (24.9%) and friends (20.4%).

The study also found that TV (9.1%), print media (8.9%), internet (5.0%) and radio (4.3%) and traditional healers 0.2%) are other identified sources of information. Therefore, the suggestion is for the media to play a more active role in disseminating accurate information regarding hypertension to the general public to encourage health self-awareness.

Figure 7: Respondents' source of information.

Regarding the information dissemination via social media, the Ministry of Health has an official website, facebook page, twitter and instagram account that is updated regularly.

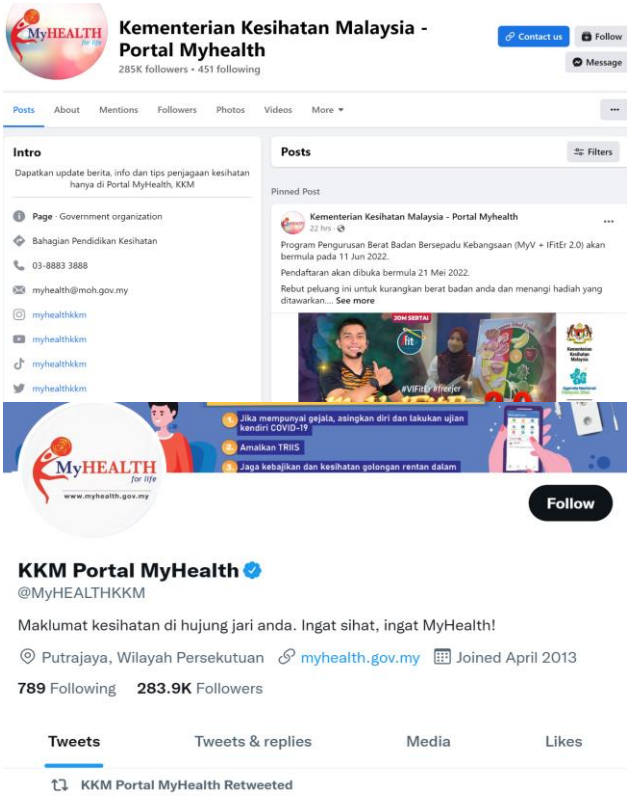

Figure 8: Ministry of health information dissemination website.

Figure 9: Respondents' areas of living.

In the 2010 census, it was found that the digital literacy rate for Malaysian citizens aged from 5 to 69 years old reached more than 45% in every state. The computer literacy rate in urban and rural areas were 68.6% and 42.1% respectively.

There have been numerous national ICT policies developed by the government including National Information Technology Agenda (NITA) and the National Strategic ICT Roadmap. Access to digital gadgets, internet broadband or WIFI, digital literacy skills is important for the user to access information.

Although there have been policies that involved patient health awareness programmes, this may not reach the target population who are unaware of their health needs or have other priorities over their health for example financial.

However, this requires its own financial resources and initiatives. This may pose a challenge for the B40 community.

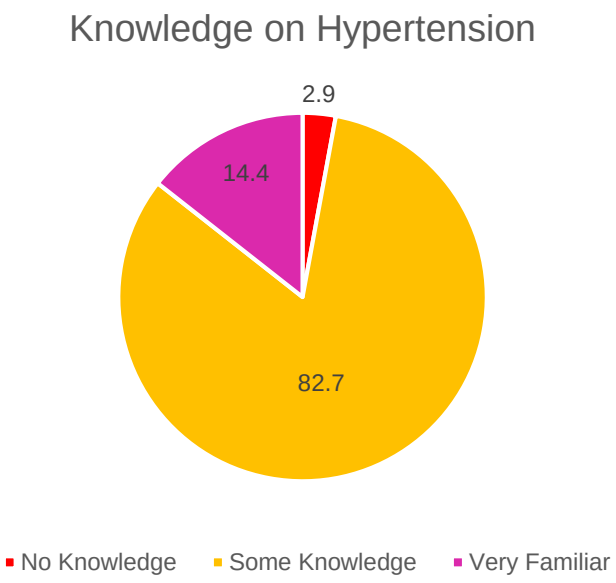

Figure 10: Respondents' Knowledge on Hypertension

Hypertension is a leading contributor to the global burden of disease, and this is undeniable. Previous studies have revealed that the control of hypertension is still low in Malaysia, especially in low-income household B40 groups. Despite only 2.9% of respondents reported has no knowledge on hypertension, 82.7% had some knowledge and 14.4% were very familiar with it.

Majority knew that hypertension could lead to stroke (90.8%). A fifth thought it could cause cancer (19.0%) and 54.7% did not know whether hypertension can cause cancer. This is a misconception because hypertension does not cause cancer but is a risk for stroke, heart disease and chronic kidney disease. Most knew that hypertensive patients are often asymptomatic (70%) and recognize that they should continue taking their medication despite feeling well (69.9%).

Although 65.6% of the respondents rated their health as poor, but 94.4% did not perceive themselves as having a long-term illness. Hence, there is a discrepancy between these two facts.

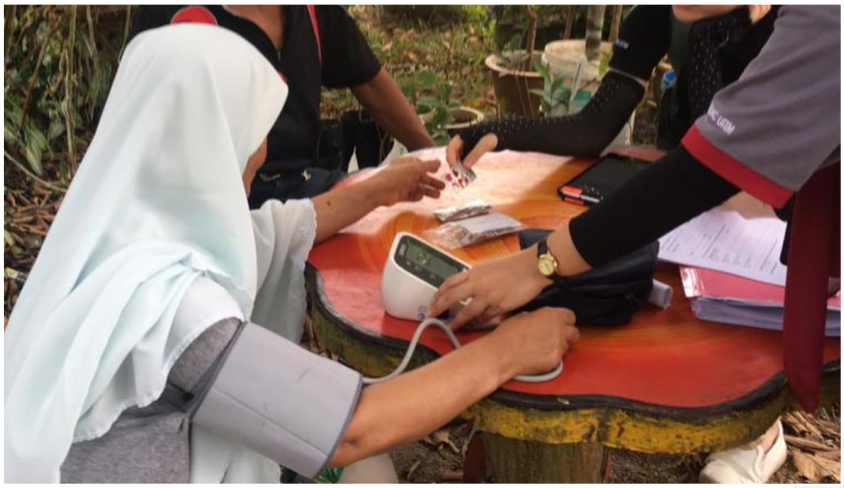

Figure 11: Respondents' blood pressure measurement.

Patients knew about factors that can reduce blood pressure such as taking modern medication (72.2%), losing body weight (61.1%), reducing stress (77.8%), performing physical exercise (77.89%), and salt-intake reduction (77.8%).

Regarding the effectiveness of traditional complementary medicine (TCM) in controlling blood pressure, 20.8% thought that 'sometimes it was effective' and 'sometimes it was ineffective', 22.7% thought it was 'effective', 23.8% thought it was 'ineffective', and 32.7% 'do not know'. There is a need to address the misconception regarding TCM in hypertension.

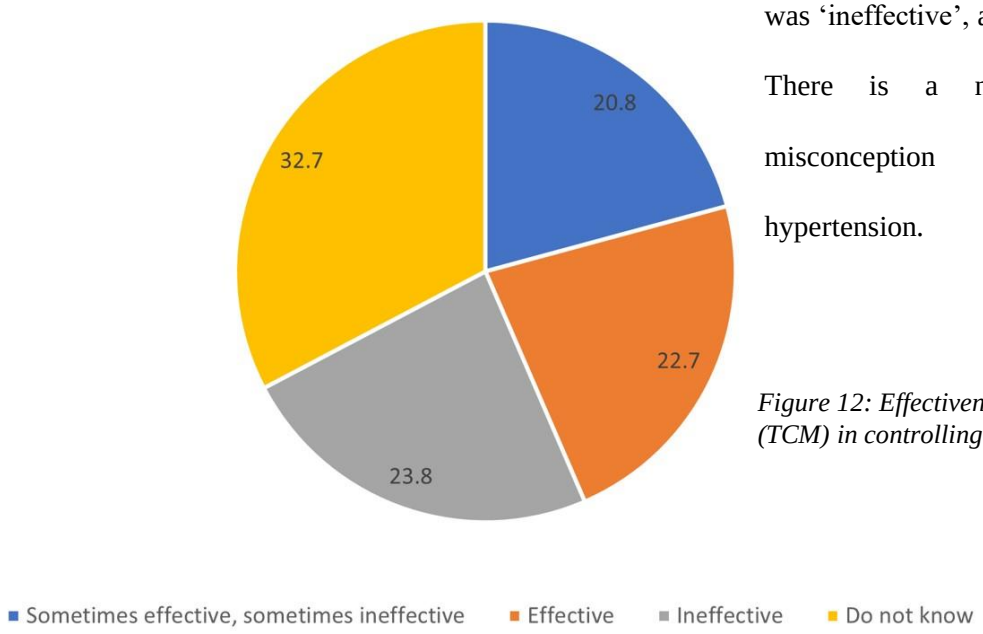

Figure 12: Effectiveness of Traditional Medicine (TCM) in controlling blood pressure

Figure 13: RESPOND team meeting with respondents' representatives

The results showed there is strength in the health equity of the country. The study showed there was consistency in terms of access to the health system between the urban and rural B40 population.

This was further testimony to the fact that the health policy, which for example prescribed having a health facility in the 25km radius, has worked well.

Figure 14: RESPOND visits

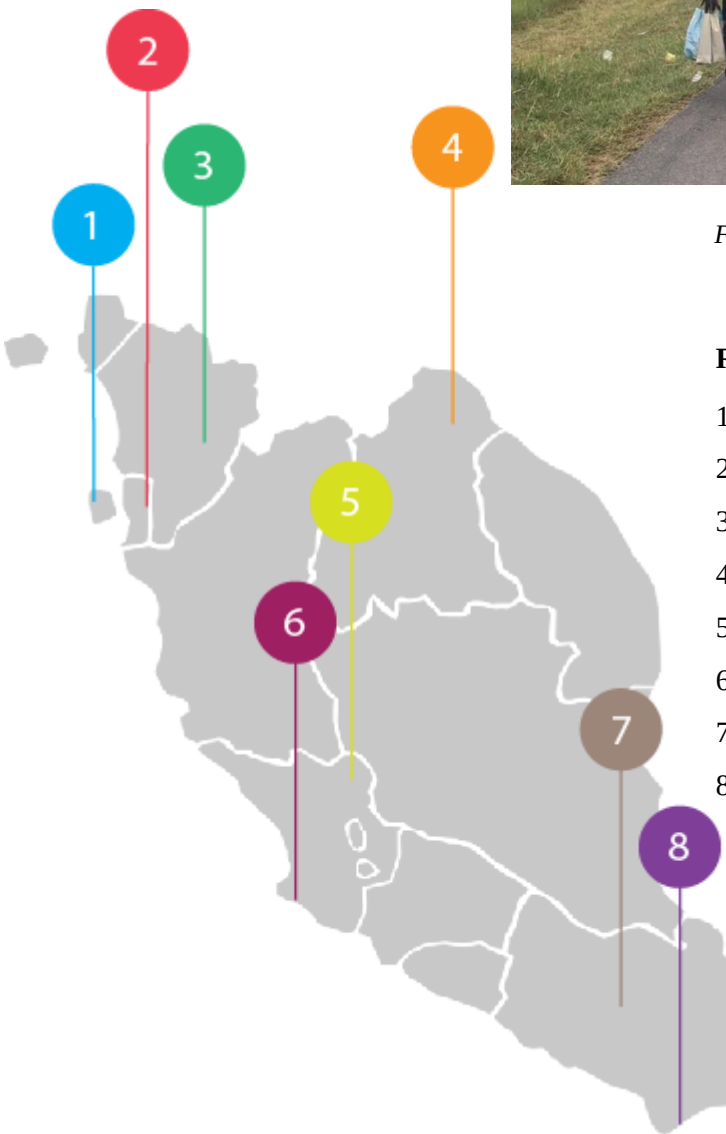

Figure 15: RESPOND sites

RESPOND sites:

1. KADUN Teluk Bahang, PULAU PINANG
2. KADUN Seberang Jaya, PULAU PINANG
3. Bachok, KELANTAN
4. Kota Bharu, KELANTAN
5. Gombak, SELANGOR
6. Kuala Langat, SELANGOR
7. Kulai, JOHOR
8. Johor Bahru, JOHOR

CURRENT POLICIES

Malaysia has solid established policies and national plans particular in non-communicable diseases with various policy documents for example Ministry of Health 2016 National Strategic Plan for Non-Communicable Disease (NSP-NCD) 2016-2025.

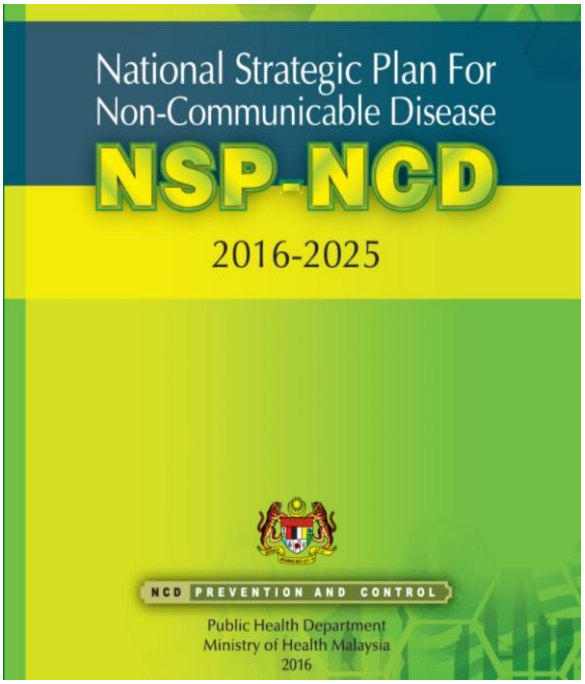

Figure 16: National Strategic Plan for Non-Communicable Disease (NSP-NCD) – 2016-2025

In this national strategic plan, there are action plans and initiatives such as:

2.1. National Strategic Plan for Tobacco Control 2015-2020.

2.2. Policy Options to Combat Obesity in Malaysia 2016-2025.

2.3. Salt Reduction Strategy to Prevent and Control NCD For Malaysia 2015-2020.

2.4. National Strategic Plan for Active Living 2016-2025.

2.5. National Action Plan: Prevention and Harmful Use of Alcohol 2013-2020.

2.6. National Strategic Plan for Cancer Control Program 2016-2020.

2.7. Strengthening Chronic Disease Management at Primary Care Level through the Enhanced Primary Health Care (EnPHC) Initiative.

This policy consist of 5 objectives of NSP-NCD 2016-2025:

Objective 1: To strengthen national capacity, leadership, governance, multi-sectoral action and partnerships to accelerate country response for the prevention and control of NCDs.

Objective 2: To reduce modifiable risk factors for NCDs and underlying social determinants through creation of health-promoting environments.

Objective 3: To strengthen and orient health systems to address the prevention and control of NCDs and the underlying social determinants through people-centred primary health care and universal health coverage.

Objective 4: To promote and support national capacity for high-quality research and development for the prevention and control of NCDs.

Objective 5: To monitor the trends and determinants of NCDs and evaluate progress in their prevention and control.

The policy also includes strengthening chronic disease management at Primary Care level through the Enhanced Primary Health Care (EnPHC) Initiative.

Following the above national strategic plan, the NSP-NCD 2016-2025 is in line and includes several other relevant action plans and initiatives:

5.1. National Plan of Action for Nutrition of Malaysia (NPANM) III 2016-2025

5.2. National Strategic Plan for Tobacco Control 2015-2020

5.3. Policy Options to Combat Obesity in Malaysia 2016-2025

5.4. Salt Reduction Strategy to Prevent and Control NCD For Malaysia 2015-2020

5.5. National Strategic Plan for Active Living 2016-2025

5.6. Malaysia Alcohol Control Action Plan 2013-2020

5.7. National Strategic Plan for Cancer Control Program 2016-2020

5.8. Strengthening Chronic Disease Management at Primary Care Level through the Enhanced Primary Health Care (EnPHC) Initiative.

5.9. KOmuniti Sihat PEmbina Negara (KOSPEN) initiative

The KOSPEN initiative was launched in 2014 and it stands for Komuniti Sihat Pembina Negara. This initiative stems from a strong need to empower the Malaysian population to take more responsibility for their own health status. The program involves several stakeholders including creating trained health volunteers, who will function as “agents of change” or health enablers. These are people living within a community who are trained to facilitate healthy living practices. Also, the program aims to empower the community to adopt and practice healthy lifestyles such as healthy diet, active living, smoke-free, weight management and routine community NCD risk factor screening.

The Ministry of Health (MOH) is currently collaborating with the Ministry of Rural and Regional Development (through the Department of Community Development or KEMAS) in implementing KOSPEN in rural areas and collaborating with the Department of National Unity and Integration (through Rukun Tetangga) for urban and sub-urban areas.

Figure 17: KOSPEN Initiative

In 2018, the government announced a document called Shared Prosperity Vision 2030. This is a commitment to make Malaysia a nation that achieves sustainable growth along with fair and equitable distribution, across income groups, ethnicities, regions and supply chains.

Figure 18: Shared Prosperity Vision 2030

Figure 19: The B40 household

Shared Prosperity Vision 2030 defined by this document is the following: Shared Prosperity Vision 2030 is a commitment to make Malaysia a nation that achieves sustainable growth along with fair and equitable distribution, across income groups, ethnicities, regions and supply chains. The commitment is aimed at strengthening political stability, enhancing the nation's prosperity and ensuring that the *'rakyat'* are united whilst celebrating ethnic and cultural diversity as the foundation of the nation state. This includes the vision to eliminate poverty and manage the bottom 40% (B40) households including the vulnerable and marginalized groups. A general boost of economic growth will inevitably lead to an equitable distribution of wealth that will improve the standard of living and quality of life.

POLICY GAPS

Admittedly, current policies as described above have to some extent improved hypertension management among the B40 group in Malaysia. But this study has highlighted some gaps in implementation which need attention. Closing the identified gaps would further enhance the policies.

One gap concerns the awareness among the B40 group of the existence of the policies that are mentioned above and how these policies can be accessed by them. This includes the quality of the information which has been disseminated to the B40 group.

Many are not fully aware of the details in terms of the seriousness of the diseases, health self-empowerment and access to their privileges towards healthcare services. Such poor awareness about the long-term implications of hypertension, a high percentage of the B40 population has perceived that hypertension is not a serious ailment. This would complicate the efforts to effectively manage the disease among the group.

Another gap is in the effectiveness of the communication channel. This study identified that the common practice in getting the health information is through their visit to the health clinics. Information may be received from doctors, nurses and other healthcare providers. In view of this, it is suggested that more training of healthcare providers for effective communication with patients be implemented. Also, in instances where there are irregularities of health visits, the information obtained has been incoherent.

CONCLUSION

The RESPOND study has unveiled some gaps in the implementation of the current policies on hypertension management for the B40 group in Malaysia. There is a need to further improve the quality of such information, as well as enhance the mode of communication to the group. This would further improve the understanding about the long-term nature and the seriousness of the disease. A review of the current policies is proposed in order to further the management of hypertension in the country, especially among the B40 group.

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Exploring the Digital Landscape in Malaysia. ISBN 978-967-12284-4-9.

POLICY BRIEF

A Vibrant management of Hypertension Catering to Low-Income Group

02

BACKGROUND

Inclusivity is adopted as a key principle in all the country's development plans, where no group will be marginalised. These principles apply and are not limited to any group. The B40 group, which is described as poor and economically vulnerable, has been a major target. The lack of a comprehensive social safety net affects such vulnerable groups.

According to the Bank Negara Malaysia (BNM) annual report in 2017, almost half of Malaysians could not afford to spend RM1,000 in case of emergency. This indicates that the rakyat, especially the B40 group, are not able to save enough money for emergency needs. This is due to the relatively higher household expenditure compared to income growth. The broad classification of the B40 household income group creates difficulty for

Figure 1: House visit

the Government to determine the types of assistance required for households. In addition, databases on the recipients that are provided by the various ministries and agencies are not fully integrated, resulting in inclusion and exclusion errors.

This has led to the Government's assistance and incentives not reaching the intended target groups. Malaysia has a strong policy that includes many programmes to improve health particularly hypertension for the B40. What has been found lacking is the implementation and evaluation of the policy. The system to convey information to the B40 group needs improvement.

Hypertension has been described as a silent killer. It is one of those ailments which can cost the economy heavily. Yet, if properly managed with the necessary therapy, the cost to the economy can be substantially reduced. In 2019, the NHMS reported that the overall prevalence of hypertension in adults in Malaysia was 30%. Hypertension is non-communicable which would creep on you without being noticed. When one realises it, it is often too late. But if one gets diagnosed early enough, the medical technology to manage it is already widely available. Managing the disease effectively also calls for lifestyle and behavioural change. This proves to be the biggest challenge dealing with hypertension.

The strategy that is widely adopted involves the proper management of hypertension which includes facilitating early diagnosis, appropriate prescribing of the anti-hypertensive agents and adhering to the treatment dynamics including constant monitoring. Over the years, there have been national efforts to proactively establish the gaps in the management of hypertension such as the development of the Clinical Practice Guidelines (CPG) so that the necessary actions can be taken to address these weaknesses. This has been the subject of a 2-country study under the name RESPOND which was internationally funded.
Managed under the auspices of
the London School of

Hygiene & Tropical Medicine (LSHTM), the study looked at the challenges for the low-income group of the population in managing hypertension in both Malaysia (B40) and the Philippines.

The findings of the study will be shared with the relevant authorities in the country for policy considerations. This policy brief is directed towards the creation of a vibrant policy of an inclusive health system which caters to the low-income group down with hypertension.

The study looked at the challenges for the low-income group of the population in managing hypertension in both Malaysia (B40) and the Philippines.

The findings of the study will be shared with the relevant authorities in the country for policy considerations. This policy brief is directed towards the creation of a vibrant policy of an inclusive health system which caters to the low-income group down with hypertension.

THE RESEARCH

Figure 3: Data collection

There are exists evidence globally to show the occurrence of health equity disparities in chronic health conditions, particularly hypertension, between localities. Good urban road network amenities have a positive influence on the spatial distribution of health service facilities. Hypertension is also a leading contributor to the global burden of disease in most countries. Past studies revealed that the control is still low in Malaysia especially among the low-income household (B40 group).

In Malaysia, four in ten adults aged ≥ 30 years old have hypertension. It is therefore important that information about hypertension needs to be delivered clearly to the affected group, as part of a programme of awareness creation.

This research aimed to identify the treatment seeking dynamics and access to health care among the B40 Hypertensive patients in Malaysia, comparing urban and rural localities. Data for analysis was obtained from the internationally funded Responsive and Equitable Health Systems-Partnership on Non-Communicable Diseases (RESPOND) study.

Figure 3: House visit

The low-income communities (B40, income < RM3,855; 2014) were selected in the rural and urban areas in four peninsular states (Selangor, Kelantan, Perak and Johor).

Following a multistage sampling approach, communities in each stratum were selected according to the probability proportional to size and identified based on national census data by community and administrative registers.

The households were randomly selected using 'randomizer.org'. Eligible individuals were those aged between 35 – 70 years old, and self-reported or identified as hypertensive at screening. This was based on a self-reported history of hypertension diagnosis or identified as hypertensive during blood pressure screening.

A survey using validated questionnaires was conducted. The validated questionnaire was administered by trained personnel. This consisted of socio-demographic data, information on housing characteristics, socio-economic characteristics of households and respondents, and hypertension-related care experiences, practices, knowledge and attitudes. Informed consent was taken.

Data analysis was conducted using SPSS version 28.0.

HIGHLIGHTS OF RESEARCH FINDINGS

A total of 611 respondents were involved in this study, comprising 162 (26.5%) males and 449 (73.5%) females with a mean age of 58.87 (±7.92SD) years old. The respondents with existing hypertension were 84.8% and the newly diagnosed were 15.2%. The median duration of hypertension for male was 5.00 (IQR: 7.27) years and 5.00 (IQR: 7.00) years for females.

The respondents' mean systolic blood pressure (SBP) was 147.42 mmHg (SD:22.92) and the mean diastolic blood pressure (DBP) was 90.21 mmHg (SD:14.31). This was comparable between urban and rural.

The characteristics of age, gender, marital status, level of education and employment between urban and rural were comparable.

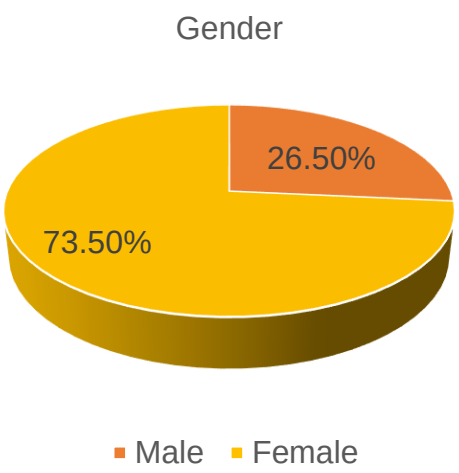


Figure 4: Gender

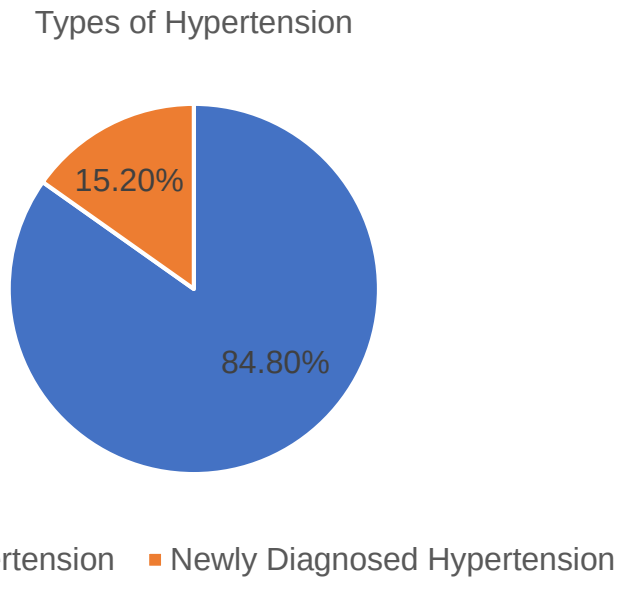


Figure 5: Types of Hypertension

The study found that most of the respondents were diagnosed at the clinic and health centre (72.4%), treated by general practitioners or non-specialist physicians (88.2%). The majority were treated in the government sector (86.1%).

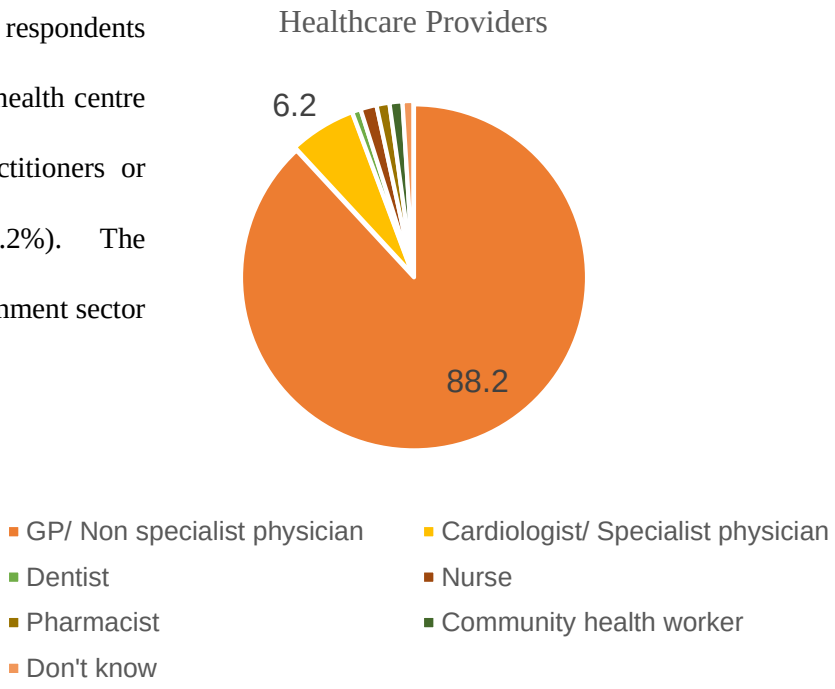


Figure 6: Healthcare Providers

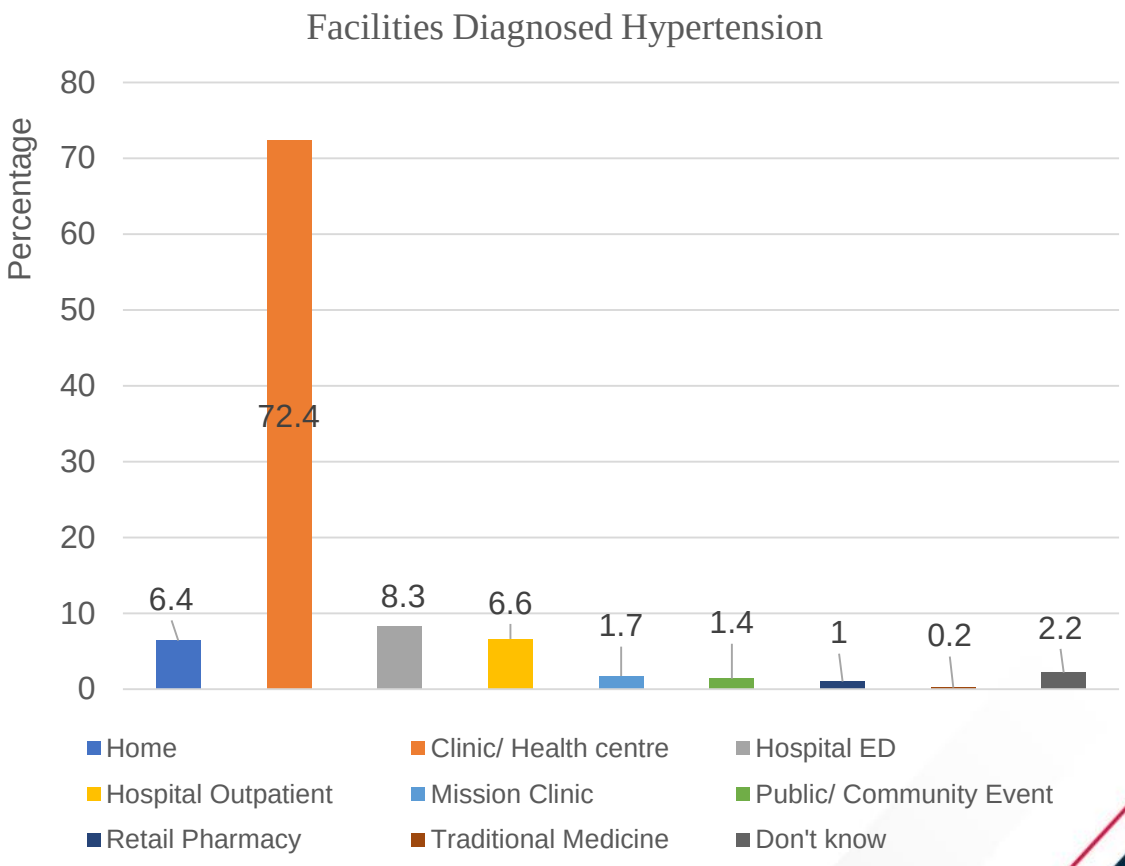
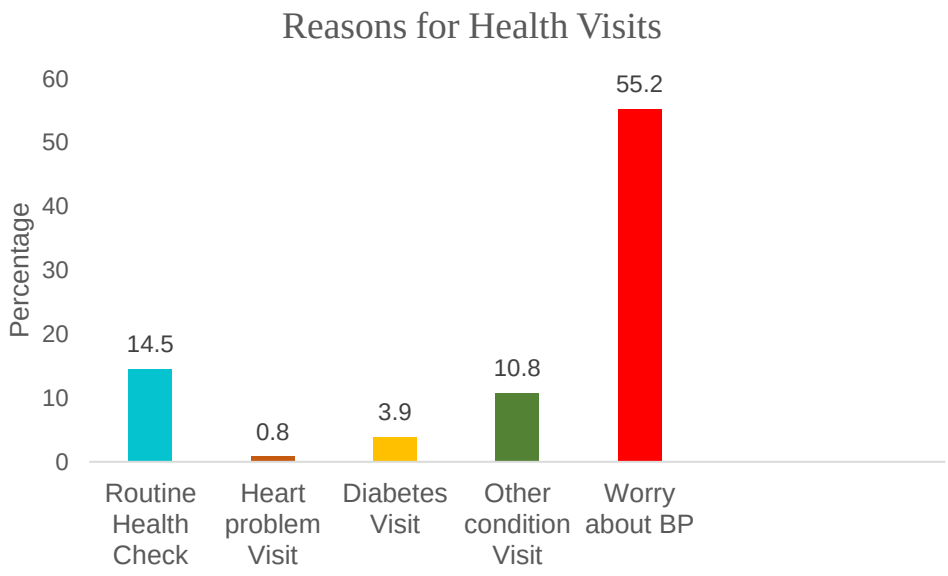


Figure 7: Facility Diagnosed Hypertension

The main reasons for their visit to the health facility were due to their worry about their blood pressure and the relevant symptoms (55.2%), followed by routine health check-up (14.5%) and 12.4% were incidentally found to have high blood pressure following a presentation of acute ailments.

The health care providers and facilities were chosen because they were nearby and convenient (85.3%). Most of the respondents felt that their health issues were resolved (52.7%) and fairly satisfied (64.7%) with the care received.

Figure 8: Reasons for Health Visits



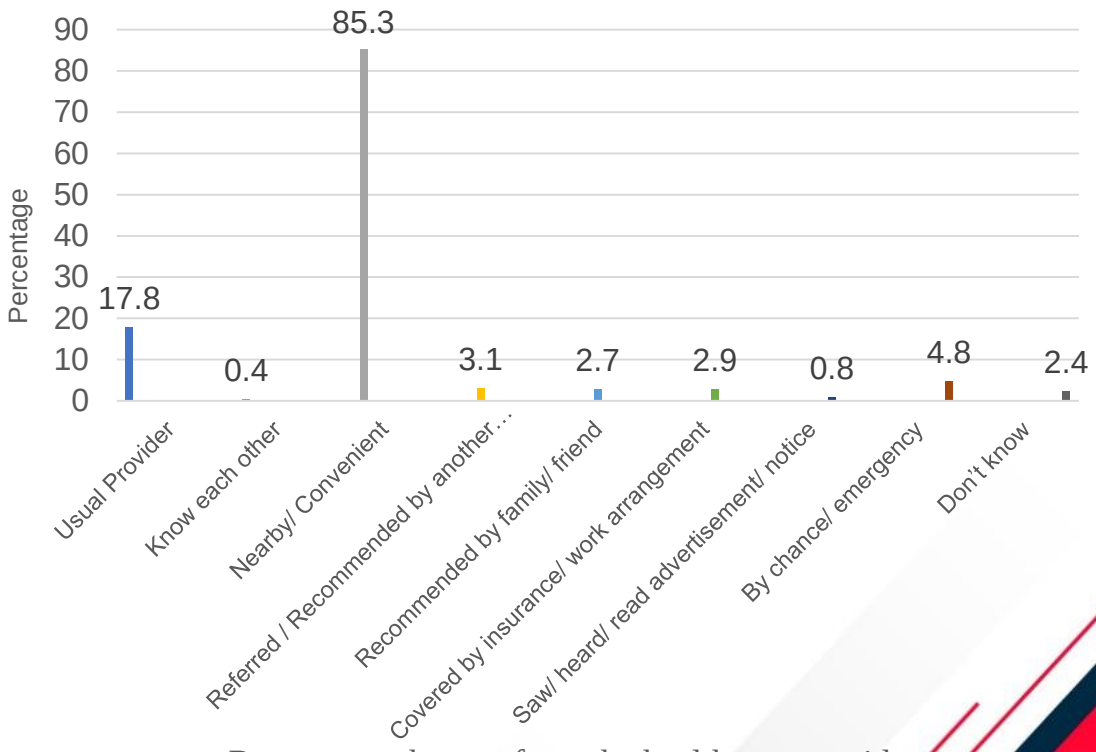


Figure 9: Reason sought care from the Healthcare Providers

The study found that the majority of respondents were prescribed modern medication (54.3%) and only 13.2% took traditional medication. Upon diagnosis, most of them were advised by the healthcare provider on dietary change (76.0%), weight reduction (65.4%), increase their physical activity (68.5%), to reduce stress (69.8%), to return to follow-up visit (58.5%) but only 34.6% were advised to obtain a blood pressure measuring device.

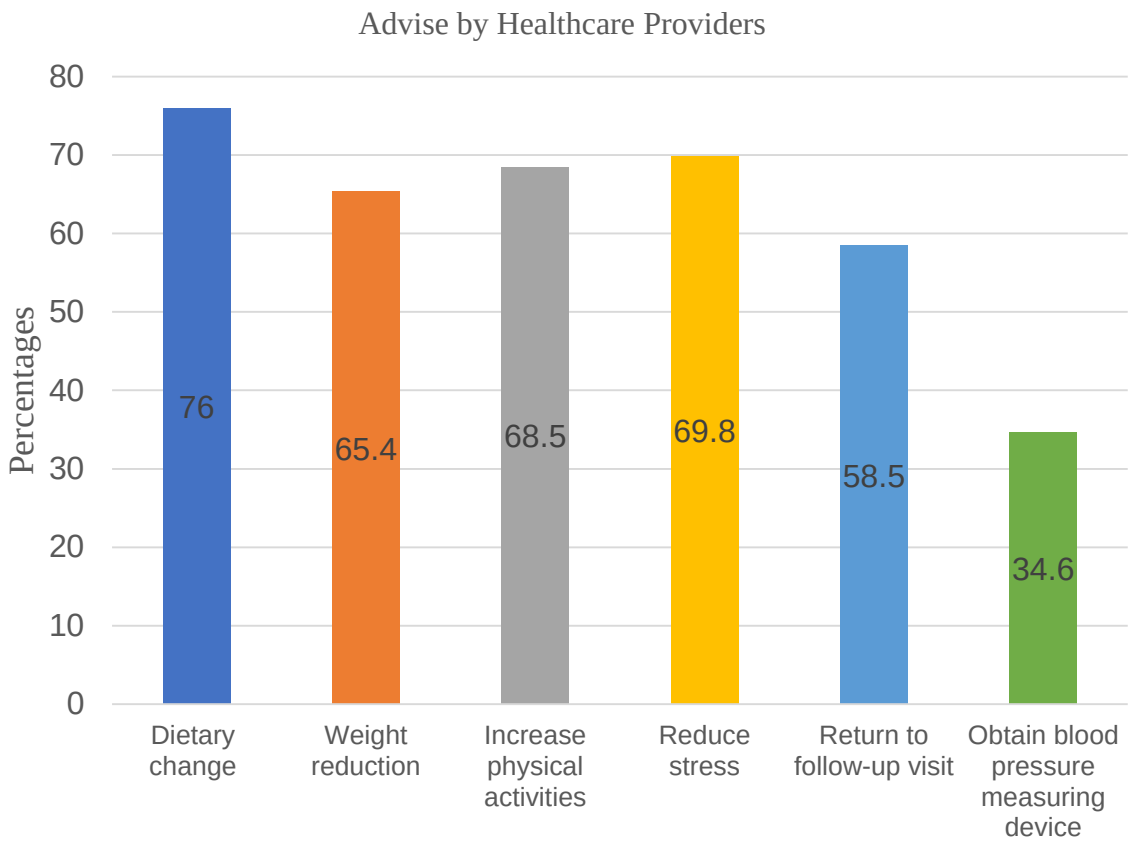


Figure 10: Advise by Healthcare Providers

Majority of the respondents spent ≤ RM1 (64.8%) on their hypertensive management.

The anti-hypertensive medicines prescribed were comparable between urban (86.5%) and rural (91.4%). The most prescribed was calcium channel blocker (CCB) (urban:37.4% vs rural:38.4%) followed by ACE-Inhibitor (urban:16.8% vs rural:16.1%) and beta blocker (urban:8.9% vs rural:10.7%). Majority received their medication from the clinic/ health centre (urban: 86.8% vs rural:77.1%) and the majority adhered to their medications in the past 12 months (urban:98.7% vs rural:99.1%).

Figure 11: Respondents Interviewed by RESPOND team

This study highlights the health equity across localities among lower-income groups with hypertension in Malaysia. The stakeholder's engagement outreach efforts are equal across localities to improve health services related to hypertensive control.

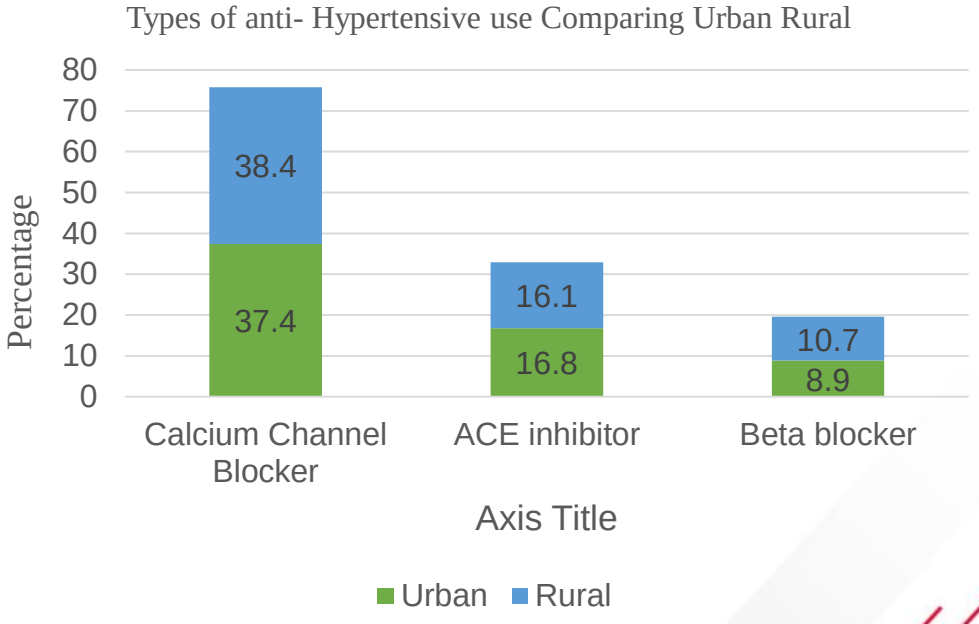


Figure 12: Types of anti-Hypertensive Use Comparing Urban Rural

CURRENT POLICIES

1. In 2019, the government introduced a health care scheme for the B40 group (PeKa B40) through the Malaysian Ministry of Health (MOH). PeKa B40 aims to improve access to health services, reducing the cost-of-living burden and improving the well -being of the people. This initiative emphasizes on non-communicable diseases and focuses on the intertwining of cooperation between the public and private sectors, more so at the level of primary health care. PeKa B40 is offered to Malaysians who are in the lowest 40% household income, known as the B40 group.

2. There are four benefits of PeKa B40 that include health screening, health aid, completing cancer treatment incentive and transport incentive.

Figure 13: Pamphlet on Peka B40

Beneficiaries of Subsistence Assistance (BSH) and their spouses and those who are 40 years of age and older, are automatically eligible to join PeKa B40. No special registration is required to join PeKa B40.

CURRENT POLICIES (cont)

3. The government has focused on strengthening primary health care. The number of health clinics increased steadily from 2011 to 2016. In 2016, we had a total of 2863 public health clinics. In 2020 we had 2889 which includes health clinics, rural clinics and flying doctors' service. There are also 230 mobile clinic teams.

4. The government has also invested in subsidising the healthcare provision. This includes a fee of minimum RM1 per registration at a government health facility. This is inclusive of all treatment received in one visit. The fee is waived for government servants and pensioners, children, students from government school, students from public university and those with disability (OKU).

5. The Ministry of Health has developed a clinical practice guideline for the management of hypertension that is constantly updated every 5 years. This is used by the healthcare providers in their clinical practice.

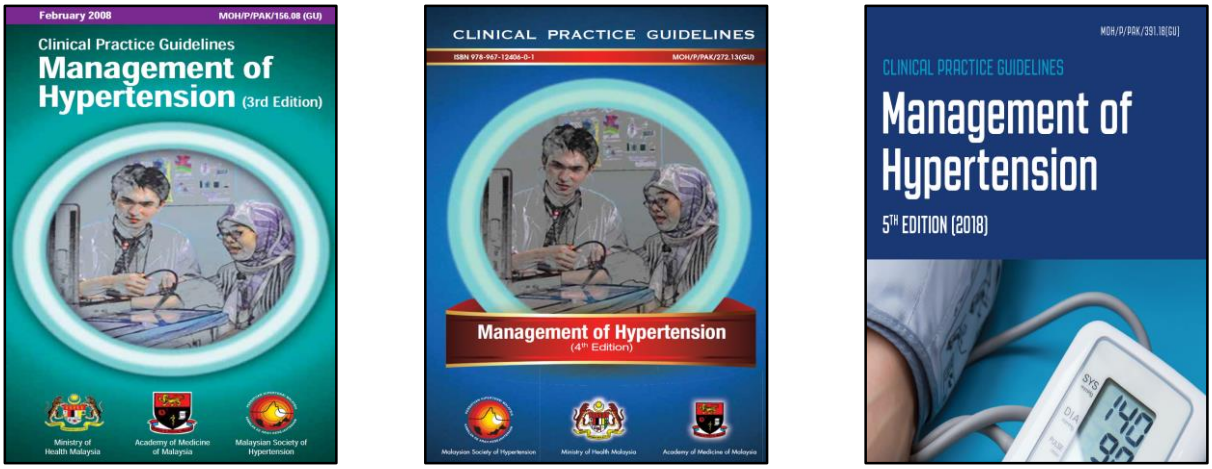


Figure 14: Malaysian Clinical Practice Guidelines in the Management of Hypertension the 3rd, 4th and 5th Edition

CURRENT POLICIES (cont)

6. The government policy also includes increasing the number of Family Medicine Specialists (FMS) in the health clinics. In 2020, the number of FMS had increased to 546 specialists. The MOH also aims to distribute the specialists equally among urban and rural clinics. The clinics that have a FMS will receive A-list medications that will benefit the patients.

7. A regular clinical audit is conducted on hypertension management to identify the strengths and weaknesses within the clinic.

Pakar perubatan keluarga di Malaysia masih rendah

| | 26 Mac 2022

Listen

KUALA LUMPUR - Jumlah pakar perubatan keluarga (FMS) di negara ini masih rendah berbanding keperluan sebenar iaitu seorang pakar untuk setiap 50,000 populasi berbanding nisbah ideal seorang pakar untuk setiap 4,000 populasi.

Ketua Pengarah Kesihatan Tan Sri Dr Noor Hisham Abdullah berkata, sehingga Disember 2021, terdapat hanya 924 pakar dalam bidang itu di negara ini, termasuk 625 orang yang sedang berkhidmat di 397 klinik kesihatan Kementerian Kesihatan Malaysia (KKM).

Figure 15: News on the need of Family Medicine Specialist in the country.

POLICY GAPS

The current policies mentioned above shows that there are already in place the scheme to support hypertension management among the B40 group in Malaysia. However, some gaps in implementation need attention.

The facilities for diagnosis and management of hypertension are adequate. The medicines available and prescribed are according to established medical standards. However, the weakest link is between knowledge and action, compliance towards medication and adopting healthy lifestyle among the B40 hypertension patients themselves. In fact, healthy lifestyle should be promoted and implemented at all times and for all peoples. Although the B40 are aware of these lifestyle changes, the incorporation of these changes in their daily life requires action.

Government policy could include town planning that can increase physical activities, exercise facilities at low income housing areas, covered walkways to and from public transport, using stairs (where appropriate).

Figure 16: Respondent's residence

Figure 17: Plan of Action Ministry of Health Malaysia

There is a need to strengthen the policy to motivate behavioural change among the hypertensive patients in the B40 group.

CONCLUSIONS

The RESPOND study has provided compelling evidence that Malaysia has in place robust health policies to address the needs of the B40 group in managing hypertension. Implementing the policies has been identified as a key challenge. One aspect of implementation is the poor adoption of the prescribed treatment dynamics. Lifestyle change to support the recommended medical therapy has been identified as a major stumbling block to better hypertension management. Policy makers need to revisit the action plan on diagnosis and treatment dynamics to further improve hypertension management among the B40 group.

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