

Letters

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Hypertension in Pakistan: time to take some serious action

Hypertension is counted as the major cause and most important factor in the development of cardiovascular diseases worldwide.¹ However, even in the presence of efficacious antihypertensive agents and intensive research data, large numbers of patients in actual clinical practice still suffer with uncontrolled hypertension. Studies indicate that control rates vary according to various countries and geographic regions.^{2,3} Even though, the rate of awareness towards hypertension is quite prominent from 62% in Australia to 72% in US, the control rates are quite discouraging as with 24% and 35% respectively. In the South Asian region, the scenario is more threatening as China reported only 8% control rates and India with 6% in management of hypertension.⁴ At present, it is estimated that about 1 billion people worldwide have hypertension (>140/90 mmHg), and this number is expected to increase to 1.56 billion by 2025.⁵

A similar scenario is seen in Pakistan. The National Health Survey of Pakistan estimated that hypertension affects 18% of adults and 33% of adults above 45 years old. In another report, it was shown that 18% of people in Pakistan suffer from hypertension with every third person over the age of 40 becoming increasingly vulnerable to a wide range of diseases. It was also mentioned that only 50% of the people with hypertension were diagnosed and that only half of those diagnosed were ever treated. Thus, only 12.5% of hypertension cases were

adequately controlled.⁶ Some remote areas like Balochistan, there is a paucity of data but the control rate is likely to get even worse.

In Pakistan, health units range from basic health units (BHUs) to tertiary referral centres. The BHUs cover around 10 000 people, whereas the larger rural health centres (RHCs) cover around 30 000 to 450 000 people. Primary health centre (PHC) units comprise both BHUs and RHCs. The Tehsil Headquarters Hospital (THQ) covers the population at sub-district level.⁷ Utilisation of these units is generally low due to the lack of services and facilities available, uncooperative staff, and inaccessibility. Just 33% of the population has access to health facilities in an area with a 5 km radius⁸ that becomes worse as many areas of Pakistan are covered with mountains and hills. This place is a huge burden on District Headquarters Hospital (DHH) as a vast number of population have no choice other than to move there for treatment. As a result this increases, specifically, the work load of the health facility team, and in general, total expenditures. Even though the Ministry of Health in Balochistan has re-strategised by appointing more doctors, pharmacists, and supporting staff, and increasing the medical and technical budgets of the said hospitals, there is hardly any change seen regarding awareness, control or management of hypertension in particular.

The issues on hand are underlining the predisposing factors (such as little or no knowledge of hypertension, non-compliance to the treatment regimen, inability of follow-ups, and financial constraints) and the need to find a solution as soon as possible.⁹ The scenario is quite disturbing and requires an effective, radical, but immediate plan in order to increase the control rate of

hypertension in the Pakistani population. The consequences are no doubt alarming and can lead to unnecessary casualties or the development of further cardiac diseases, thus placing an additional burden on the health system, patients, and, as a result, on society itself.

One option is perhaps to initiate an awareness programme for physicians, pharmacists, and patients. Introduction of generic medicines, availability, and promotion are another prominent space available. Increasing financial budgets and facilities could improve the problem but may be impossible in the light of current political and social unrest. It is time that the patient should be extensively involved in developing the concept of 'this is your health so you must get involved'. This is achievable only if a 'pharmacist' status in hospital is accepted as 'drug counselor' by the healthcare system. Being the custodian of drugs, pharmacists play a vital role in educating the patients regarding hypertension, drug use, medication adherence, mentioning and reporting adverse drug reactions, and thus reducing the chances of uncontrolled hypertension rates. During the past 4 years, 350 pharmacists have been appointed by the Ministry of Health, Government of Balochistan in various health-providing centres and it is now time to utilise the full potential of these experts. Pharmacists have to come out of the traditional circle of dispensing, drug supply, and record keeping and to move on the areas that are pharmacist owned. The interaction with patients needs improvement, as they must be educated about their condition, the factors affecting their health, and in what matters they can improve. This is only possible if the pharmacist is involved in the process. Even though at present it seems challenging, a little help from the

physicians and regulatory bodies can play a vital role in achieving this goal. It is now time to stop promises and to start practices in order to achieve the premium health status that will be beneficial for all.

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REFERENCES

1. Kannel WB. Blood pressure as a cardiovascular risk factor. *J Am Med Assoc* 1996; **275**(20): 1571–1576.
2. Kearney PM, Whelton M, Reynolds K, *et al*. Global burden of hypertension: analysis of worldwide data. *Lancet* 2005; **365**(9455): 217–223.
3. Kearney P, Whelton M, Reynolds K, *et al*. Worldwide prevalence of hypertension: a systematic review. *J Hypertens* 2004; **22**(1): 11–19.
4. Sailesh M, Norm RCC. Hypertension management: time to shift gears and scale up national efforts. *Hypertension* 2009; **53**(3): 450–451.
5. Sarafidis PA, Li S, Chen SC, *et al*. Hypertension awareness, treatment, and control in chronic kidney disease. *Am J Med* 2008; **121**(4): 332–340.
6. Anonymous. 18% population suffering from hypertension. *The Daily Times*. http://www.dailytimes.com.pk/default.asp?page=story_28-3-2005_pg7_32 (accessed 11 May 2010)
7. Azhar S, Hassali MA, Ibrahim MI, *et al*. The role of pharmacists in developing countries: the current scenario in Pakistan. *Hum Res Health* 2009; **7**: 54.
8. WHO. *Health system profile*. Egypt: Regional Health System Observatory, 2006.
9. Hashmi SK, Afridi MB, Abbas K, *et al*. Factors associated with adherence to anti-hypertensive treatment in Pakistan. *PLoS One* 2007; **2**(3): e280.

DOI: 10.3399/bjgp10X502182

Incapacity certification

I was delighted to read the April Focus in the *BJGP*.¹ The new more positive approach to certification of incapacity is to be welcomed. Starting in 1947, whenever I issued a 'certificate' I gave an expected duration of incapacity. This enabled both patient and employer to anticipate 'return to full function'. It also

led the patient to realise that they had a duty to 'get better'. My patients always knew I was not a soft touch for extended sloth.

PS. I still feel strongly at 90.

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REFERENCE

1. Jones R. Challenges to advocacy in primary health care. *Br J Gen Pract* 2010; **60**(573): 234.

DOI: 10.3399/bjgp10X502191

Automated electronic reminders and primary prevention of cardiovascular disease

Holt *et al* present interesting data on the effect of automated electronic prompts on primary prevention of cardiovascular disease.¹

Their results support recent anecdotal observations I made while trying to achieve the yearly cardiovascular disease (CVD)/coronary heart disease (CHD) QOF targets for one of the local practices in Fulham.

It is interesting to see these observations corroborated by a well conducted randomised controlled trial.

In contrast to the EMIS software used in their study, our practice uses VISION software that has a built in CVD/CHD risk calculator based on the Framingham risk equation applied to the most recent risk factor measurements.

Each patient's CVD/CHD risk is immediately visible in the lower left-hand corner of the computer screen. Clicking on the reported risk score releases a pop-up window containing the risk calculator and recent measurements of risk factors such as smoking, cholesterol, and blood pressure, presenting the opportunity to address unmet QOF targets and control clinical parameters.

Translating identified risk and appropriate interventions into improved clinical outcomes is the bigger challenge, and one clear potential implication from Holt *et al*'s study is that high QOF CVD/CHD scores may not necessarily result in reduction in cardiovascular event rates.

The reasons for this are not clear and are probably multifactorial, however, poor patient understanding of CVD/CHD risk and risk reduction is contributory and can be partly addressed by using the CVD/CHD risk calculator interactively during consultations.

This can be done by demonstrating to the patient how his or her risk can increase or decrease with positive or negative changes in the measurements of clinical parameters. Therefore, the CVD/CHD risk calculator can also be a powerful tool used to build therapeutic relationships and improve understanding of CVD/CHD risk and what it means for each patient on a personal level.

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REFERENCE

1. Holt TA, Thorogood M, Griffiths F, *et al*. Automated electronic reminders to facilitate primary cardiovascular disease prevention: randomised controlled trial. *Br J Gen Pract* 2010; **60**(573): 251–256.

DOI: 10.3399/bjgp10X502209

Near-patient testing holds most promise for acute conditions

We welcome the editorial by Professor Khunti on near-patient testing in general practice.¹ He states that quality assurance is of utmost importance if near-patient testing is to be successfully implemented in general practice. We fully agree on this point. Moreover, he correctly concludes that near-patient testing has a number of potential benefits beyond patient satisfaction, although the