

# Council's Corner: Hypertension Issues - a personal view



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### The will to control hypertension

*('The spirit is willing, but the flesh is weak')*

It remains discomfiting and almost hard to believe that, in this day and age, blood pressure (BP) control still remains woefully inadequate worldwide. We would expect that with all the advances in hypertension treatment and control, we would attain more success in lowering the blood pressure to <140/90 mm Hg in a more substantial percentage of the hypertensive population.

The stats stare us in the face like a predator eyeing its prey. Less than one of eight hypertensive individuals has controlled BP. In high-income countries, wherein it can be rightfully presumed that the big majority of the population has access to adequate healthcare and cost-effective antihypertensive medicines, control rate is less than 20%. Even in the relatively high-risk hypertensive population with two or more cardiovascular risk factors, awareness and treatment rates are <50%; and control rate is still very low at 15%. (Chow CK. *JAMA*. 2013; 310:959-968)

This brings to mind Jesus Christ's admonition to his apostles in the Garden of Gethsemane: "The spirit is willing, but the flesh is weak." Just like the 12 dedicated and loyal apostles who could not hold their heavy eyes from closing and dozing off instead of vigilantly keeping watch for the angry mob and arresting soldiers, the modern-day apostles involved in hypertension prevention and control have all the earnest intentions to stem the tide of elevated BP, yet find themselves seemingly battle-fatigued and weary to sustain all programs and interventions necessary in hypertension prevention and control.

The intention to control high BP on the part of the physicians and healthcare providers, the governments and policy makers, and certainly the people with elevated BP may not be wanting; but the *will* to do whatever it takes to attain it still leaves much to be desired. A goal of better BP control is not a far-fetched dream. Success stories in hypertension prevention and control offer excellent models which other countries can aim to duplicate. The Canadian experience has shown that hypertension control can be increased by almost 500% in a little over 25 years; from 13.2% in 1992 to 64.6% in 2009. This was clearly an offshoot of improved awareness (from 56.9% to 82.5%) and treatment (from

34.6% to 79%). (McAlister FA. *CMAJ*. 2011; 183:OL1007-1013)

### Physician inertia

In surveys, physicians are quick to blame poor patient adherence and ineffective antihypertensive medicines as causes for the inadequate control of their patients' high BP, but research data suggest otherwise. Therapeutic or clinical inertia on the physicians' part is reflected by the low use of combination treatments (<5% in low income nations) when it is well known that combination treatment is required in at least two-thirds of hypertensive patients to reach BP goal of <140/90 mm Hg. The use of combination treatment in low middle income, upper middle income and high income countries is also dismally low, ranging from 12.95% to 15.65%. (Chow CK. *JAMA*. 2013; 310:959-968)

In a BP-control project study in Spain, treatment modification or revision of initial antihypertensive prescription was only done in 15.4% of hypertensive patients treated by primary care physicians. In 84.6%, there was no effort to titrate the medicine prescribed, change it, or use combination treatment. A high 85% rate of physician inertia has been shown in several other European countries. (Wang YR. *Arch Intern Med*. 2007; 167:141-147)

Although BP control rates are expectedly higher in regular clinical practice (20%-30%), and even higher in randomized clinical trials (40%-60% in VALUE and ASCOT), some degree of physician or investigator inertia is suggested by the observation that more than one third of the patients enrolled in the trials, whose BPs remained uncontrolled, were still taking their initial antihypertensive regimen with no uptitration in the doses.

### Multisectoral political will

It cannot be argued that prevention and control of

hypertension is complex, and has to be approached via a multisectoral collaboration. A strong multisectoral *political will* is necessary so governments, policy-makers, as well as various health workers, professional organizations like the ISH, the private sector and individuals with hypertension can work in unison, as a team, to increase BP control.

For control of hypertension and other noncommunicable diseases the government should strengthen its primary healthcare services. A simple device is all that is needed to diagnose hypertension. Even non-physicians can be trained to help in sustained massive screening programs to increase awareness and treatment, which should translate to better control rates later on. With simple risk-assessment instruments and a modicum of training, these volunteers can also preliminarily identify those who are at risk for cardiovascular events. When resources are low, this is one way to get a bigger bang for the buck.

One best-practice that can be duplicated is the training of health volunteers in the community who go from house to house to check the BPs of everyone in the household. We recently brainstormed on this idea in our local hypertension society, in support of Prof. Neil Poulter's and ISH 'marching orders' to increase hypertension awareness. We calculated that if we have 300 of these dedicated volunteers going house-to-house and screening 100 adults/day for 22 days a month, in a year's time, close to 8,000,000 adults could be screened. Around 2 million hypertensive individuals could be identified. If this is done as a continuing program, with an expected multiplier effect, hypertension awareness can increase to 80% in 10 years' time with an achievable doubling of control rate. Duplicate this all around the world, and we should be able to achieve our global 25/25 hypertension and cardiovascular disease (CVD) vision; that is, a 25% reduction in premature deaths due to high BP and CVD by the year 2525.

Needless to say, population-directed interventions and other preventive approaches should be implemented. This may require legislative assistance; hence, a whole-of-government approach is vital to enlist the support of all government branches and agencies. Many countries, particularly in upper middle income and high income countries have already strengthened their public education campaigns and surveillance systems to increase awareness to hypertension and other cardiovascular risk factors, and improve management and control. There must be a *collective effort* to do the same in low income and low middle income countries as well.

## Patient must will it, too

On the patients' side, the lack of will to detect and control high BP can be reflected in the low motivation to have their BP checked, with the misconception that asymptomatic individuals cannot have a potentially serious hypertension. All it takes is a few minutes to find out if one is hypertensive or not, but taking the initiative to spare those few minutes seems to be a tall order for many. A strengthened will to curb hypertension can make people take the initiative to have their BPs checked, and for those who are diagnosed to be hypertensive, this can translate to better treatment adherence, more health-promoting activities and more active participation in managing one's hypertension. This attitudinal shift in paradigm can certainly impact favorably on the control of high BP and prevention of complications for individual hypertensive patients, and for the entire population as a whole.

The academe and professional organizations such as ISH can pitch in their share by helping primary healthcare physicians and non-physician health workers particularly in low- and low-middle-income countries in drafting treatment guidelines which are not mere 'cut-and-paste' recommendations from foreign guidelines, but are truly suited for the country, addressing specific issues in a real-world setting. More country- or region-specific clinical practice guidelines can ensure an individualized approach to hypertensive patients and encourage more apt utilization of treatment guidelines, preventing under- or over-translation of guideline recommendations and other clinical trial findings in real-world practice.

National and local professional cardiovascular organizations, together with the rest of civil society can also help convince their respective policy-makers and governments to increase allocation of resources for hypertension and CVD control programs, particularly primary healthcare approaches. A strong-willed health leadership is imperative to effectively execute population-based integrated approaches—addressing cultural norms and practices that promote unhealthy behaviors and misconceptions about hypertension, providing a more enabling environment for healthy lifestyle practices, and correcting disparities in healthcare.

In summary, envisioning a much better awareness, treatment and control rate for hypertension worldwide is a daunting, but achievable aspiration. Wishful thinking? An attitudinal paradigm shift may be the missing component that can set on fire our collective fervor to attain this vision. If there's a will, there's a way. If we truly muster the will to do it, committing to do whatever it takes to achieve it, then there is certainly a way.

-Rafael Castillo