KERATAN AKHBAR 24/05/2026 (Ahad)

The Star M/S 6, 16

No training, no licence

Protection officers must attend mandatory course by 2028

By RAGANANTHINI VETHASALAM
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The Star EXCLUSIVE

PETALING JAYA: Radiation Protection Officers (PPS) at licensed healthcare premises must attend a mandatory training course as part of the requirement for applying for an operating licence.

Health director-general Datuk Dr Mahathar Abd Wahab said in a circular dated March 31 that all existing registered personnel at [illegible] premises must attend the Radiation Protection Officers (Medical) course before Jan 1, 2028.

"This requirement applies to all government and private medical facilities under the Atomic Energy Licensing Act 1984 (Act 304)," the circular said.

Dr Mahathar said this came about after a previous circular was reviewed, and based on feedback and discussions during the 9th Meeting of the Radiation Advisory Committee held in February.

"All new government and private medical facilities must ensure the PPS appointed have attended the course as a requirement for applying for an operating licence," he said.

Prospective candidates are also required to attend physical courses at training centres accredited by the Health Ministry according to the risk categories of the service.

> "This requirement applies to all government and private medical facilities."
>
> Datuk Dr Mahathar Abd Wahab

Existing personnel and prospective candidates must attend the Phase 1 course before a stipulated deadline, failing which they will be required to go through the full course and sit for an examination.

"Each government and private medical facility is only permitted to send one candidate to attend training throughout the implementation of Phase 1," he said.

There are three categories of training.

Category 1 is the high-risk one and involves premises possessing either radioactive materials, therapeutic radiation generators as well as radiation generators utilising radioactive materials such as positron emission tomography-computed tomography (PET-CT) and/or single photon emission computed tomography (SPECT).

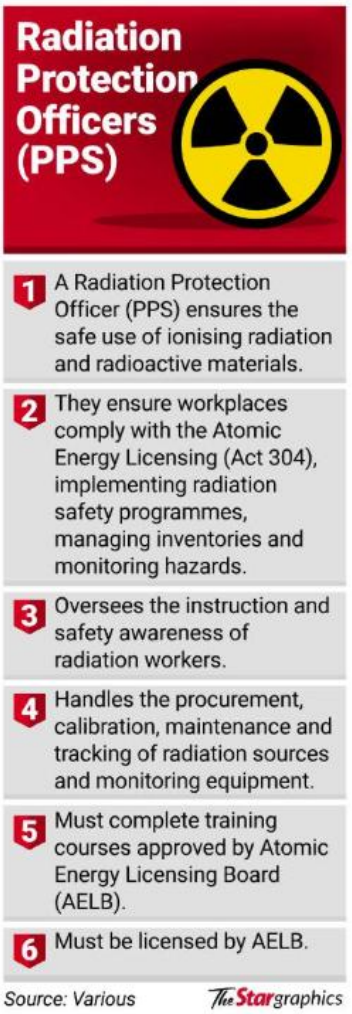
Moderate-risk facilities come under Category 2. These are premises possessing fluoroscopy-type radiation generators and/or computed tomography units for diagnostic purposes.

Category 3 is the low-risk one. It involves premises with diagnostic radiation generators other than those in Category 1 and Category 2. It includes apparatus for dental and veterinary purposes such as general radiography, intra-oral, cone beam computed tomography (CBCT) and mammography.

A PPS manages the technical aspects, procedures and radiation protection measures in hospitals or clinics.

All government and private healthcare premises that possess radiation apparatus for medical purposes are required to employ one or more qualified and competent PPS.

For a person to be appointed as a PPS, he or she must have the relevant theoretical training, both technical and non-technical, as approved by the Atomic Energy Licensing Board, covering practical radiation protection and regulatory requirements with respect to the irradiation facility for which they are appointed.



Concerns over cost and time impact on GPs

PETALING JAYA: While healthcare practitioners acknowledge the importance of training courses for Radiation Protection Officers (PPS), they are concerned about the impact on private general practitioners (GPs).

Malaysian Medical Association (MMA) president Datuk Dr Thirunavukarasu Rajoo said MMA does not dispute the importance of radiation safety standards in medical facilities.

"However, we have serious concerns about how this policy will be implemented on the ground, and its impact on the sustainability of GP practices across Malaysia.

"The majority of GPs in this country are solo practitioners. Any new compliance requirement lands entirely on that one person, and by extension, on their patients," he said.

The PPS in a GP clinic, which is typically the doctor or sole radiographer, must attend mandatory in-person training. Existing registered facilities have until Jan 1, 2028, to comply under the sunset clause, with course fees ranging from RM600 to RM799.

However, any GP wishing to set up a new clinic with X-ray facilities after Jan 1, 2028, faces a significantly higher barrier – full certification is required before licence application and at a cost of RM1,530 to RM2,400.

"This is before a single patient has been seen and before any income has been earned. It is a serious disincentive to expanding access to X-ray services, particularly in underserved areas," said Dr Thirunavukarasu.

Sustainability impact: Dr Thirunavukarasu (left) says any compliance requirement lands entirely on the GPs while Dr Shanmuganathan says private clinics are already facing rising overheads.

The policy, he said, adds a new compliance layer on top of an already strained workforce situation without any corresponding measure to address the problem of radiographer supply.

He argued that the six-hour course for low-risk diagnostic facilities, which covers general X-ray and dental, can be delivered fully online.

"The MMA is also concerned that this requirement could be taken advantage of by commercial interests. The Health Ministry must ensure training providers do not treat a mandatory government requirement as a commercial opportunity.

"The Health Ministry must regulate approved training provider fees to ensure they are reasonable and transparent," he added.

Dr Thirunavukarasu said the MMA had already formally engaged with Bahagian Kawalselia Radiasi Perubatan about these concerns.

"We urge the Health Ministry to mandate fully online delivery for Category 3 training, regulate training provider fees, review the one-candidate restriction and address the radiographer shortage as part of this policy.

"Policy must support the sustainability of frontline GP practices. A compliance burden that is costly and logistically demanding does not improve safety. It simply reduces access to care," he added.

Concurring with the MMA, Federation of Private Medical Practitioners' Associations Malaysia (FPMPAM) president Dr Shanmuganathan Ganeson said their reservations are mainly about cost implications.

"PPS play an important role in ensuring compliance with radiation safety standards, monitoring protection measures, maintaining records, coordinating staff training, and liaising with regulatory authorities," he said.

"Larger hospitals and radiology centres have already established radiation safety structures in place, but smaller private facilities, including dental and GP-associated imaging services, may face additional compliance obligations relating to training timelines, staffing and certification."

Dr Shanmuganathan said private clinics are already facing rising overheads, including staff salaries, rental, utilities, digital compliance requirements, indemnity coverage, and other regulatory obligations.

"The requirement for Radiation Protection Officers carries both manpower and training costs. Dedicated officers may earn salaries of RM3,000 and above, while certification courses can range from several hundred ringgit for short programmes to more than RM2,000 for full certification training.

"The FPMPAM fully supports the importance of radiation safety and proper governance. However, consideration should be given to ensuring that compliance pathways remain practical and affordable, particularly for lower-risk facilities such as small diagnostic premises and dental clinics," added Dr Shanmuganathan.

Caught between care and claims

By GERALDINE TONG
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REJECTED or delayed insurance claims are not just administrative disputes between insurers and policyholders.

There is a third stakeholder in the process: doctors. Because such incidents can directly affect how quickly patients receive treatment or, in some cases, whether they receive it at all.

Malaysian Medical Association (MMA) president Datuk Dr Thirunavukarasu Rajoo says there is a concerning trend of patients being denied, delayed and turned away from treatment due to insurance claim disputes.

"We don't have a national [illegible] or rejected claims. That is itself a problem.

"What we do have are consistent reports from doctors in private practice, and the pattern is worrying," he says.

According to him, doctors frequently find themselves caught between patient care and insurance processes, particularly when guarantee letters are delayed or disputed.

"When a guarantee letter is rejected or delayed and the patient is waiting or getting worse, the doctor still has to act.

"Duty of care doesn't pause for an insurer's decision," he says.

In some emergency situations, he says doctors have proceeded with treatments despite uncertainty over whether the claims will eventually be paid.

This pattern cannot continue, he says, adding that the MMA is calling on Bank Negara Malaysia to require data on rejection rates, dispute frequencies and settlement timelines to be reported, analysed and acted on.

Mind the gap: One problem is our lack of a national registry for rejected claims. — FAIHAN GHANI/The Star

Internally, the MMA has already tried to do something about this.

"In 2019, we proposed a formal grievance mechanism for exactly these issues.

"That became the HPPSC (Healthcare Partners Protocol and Solutions Committee) – bringing together doctors, hospitals, insurers, takaful operators and third-party administrators, with the Health Ministry and Bank Negara as observers."

For the patients, rejected or delayed claims often create immediate financial and emotional strain, he says.

"Self-pay means finding money fast – loans, borrowing from family, delaying the procedure."

Patients who cannot afford private healthcare may instead turn to public hospitals, where waiting periods can be significantly longer depending on the urgency of the condition.

"A patient waiting for a hernia repair or joint replacement can wait months.

"He is in pain. His condition can worsen.

"What was elective becomes an emergency.

"That was preventable. The only thing that stopped timely treatment was money," says Dr Thirunavukarasu.

The doctor is also affected, he adds, because when they see such patients, they know the delay was caused by a coverage dispute and not clinical necessity.

"That stays with you."

As such, he says, the impact extends beyond finances.

With the base medical and health insurance and takaful (MHIT) framework being prepared for roll out, *The Star* previously reported that while the MMA supports the intent behind the plan, it also warned that affordability reforms must not come at the expense of treatment quality, specialist access or patient flexibility.

Meanwhile, Dr Thirunavukarasu acknowledges that confusion over claims often stems from exclusions involving pre-existing, congenital or hereditary conditions, particularly when someone fails to fully disclose their medical histories during the application process.

However, he argues that people do this because they fear insurers will impose exclusions or higher premiums.

"The fear is not unreasonable.

"It is a direct response to how some insurers have priced and structured their products.

"Insurers are in the business of covering risk. That is what they are paid to do.

"A product designed to avoid anyone with a real medical history is not insurance; it is premium collection from the healthy," he says.

While the MMA's stance is to advise everyone to declare everything when they buy a policy, he questioned the insurance industry on whether their products are accessible to Malaysians with health conditions or only to those unlikely to ever claim.

"Policy language must also be written for the policyholder, not the insurer's legal team. That has to change," he adds.

Many consumers across all education levels do not fully understand their policies, but this is not purely a consumer problem, says Dr Thirunavukarasu.

"These are complex products, and the consequences only become clear at the worst possible moment.

"The licensed financial planner must do more than sell. They must sit with the client, explain what is covered, what is not, and what to do when a claim arises.

"You cannot sell on benefits and hide behind fine print when the claim comes in."

Crucial **collaboration**

A clinician's perspective on public-private sector knowledge-sharing for Malaysia's healthcare future.

By DR KULJIT SINGH

IN the wake of the Middle East crisis and its potential to further drive up medical costs, the question for me, as a practising physician, is no longer whether the public and private healthcare sectors should collaborate, but how we can do so in a way that is truly meaningful for patients in this environment.

We have taken an important step forward with the establishment of the Joint Ministerial Committee for Private Healthcare Costs (JMCPHC). Led by the Health [illegible] Finance ministries, the committee brings together private hospitals, insurers, and academia to collaboratively address the challenge of medical inflation.

In addition, initiatives such as the Hospital Services Outsourcing Programme enable public healthcare patients to access care in private facilities when needed, helping to ease capacity constraints while maintaining continuity of care. The Healthcare Partners Protocol & Solutions Committee (HPPSC), established as a joint multistakeholder platform, complements these efforts by addressing common issues related to medical claims and guarantee letter processes, allowing stakeholders to identify root causes of issues, develop practical solutions, and promote greater transparency across the private healthcare financing ecosystem.

While these are strong examples of what structured collaboration can look like in practice, from where I stand, we are only scratching the surface of what is possible.

For many years, Malaysia's public and private healthcare systems have operated side by side, each doing what it does best. The public sector plays a critical role in ensuring access and equity, but often faces significant financial pressure. The private sector, on the other hand, has had to prioritise efficiency and innovation, while facing the challenge of remaining sustainable.

The next step is not to blur roles, but to connect them more meaningfully. While the JMCPHC addresses private healthcare costs, the public healthcare system, still the foundation of national care, requires urgent focus and strengthening, especially given the world's current political and economic climate.

One of the most practical ways to do this is through meaningful knowledge-sharing between the public and private healthcare sectors – and a key area where this can make an immediate difference is procurement.

In private hospitals, procurement has evolved out of necessity. Without a close eye on procurement, the sustainability of private hospitals would be a challenge. We rely heavily on data, demand forecasting, and close vendor management to keep costs under control while maintaining quality. Far from being merely theoretical ideas, these are operational practices that are tested daily, and refined continuously, and as such, there is real value in sharing these approaches more systematically with the public sector. I believe the public sector can truly benefit from adapting these practices for its own context.

Another area that deserves more attention is what we might call non-clinical value-based outcomes.

As clinicians, we are trained to focus on clinical outcomes, and rightly so. But patients experience healthcare in a much broader way. Waiting time, ease of getting an appointment, clarity of billing, and how well we communicate all shape their overall experience. These factors may not appear in a medical chart, but they matter to patients. For example, reducing waiting times through better scheduling, improving access to preferred doctors, or ensuring patients understand their bills upfront can significantly improve trust and satisfaction.

In private healthcare, we have invested heavily in tracking and improving these metrics, often using real-time dashboards and patient feedback. Done well, the focus on non-clinical value-based outcomes would represent a meaningful investment in improving the everyday experience of patients within our public healthcare system.

There is an opportunity here to share what has worked, adapt it thoughtfully, and scale it where appropriate without losing sight of clinical quality or equitable access for the public sector.

Of course, none of this happens automatically, and trade-offs are inevitable. But we cannot allow that to stall progress indefinitely. At some point, we have to move forward with intent.

I remain optimistic that the first step is establishing a common baseline, where public-private sector knowledge-sharing allows us to identify what works, adopt best practices, and collectively troubleshoot the areas that remain challenging.

The Association of Private Hospitals of Malaysia has expressed strong support for the JMCPHC, and that alignment is encouraging. But as with many good initiatives, the real challenge lies in execution. And this is achievable.

The HPPSC is an example of how this can be translated into practice by bringing stakeholders together to address real, operational challenges and drive meaningful improvements in the healthcare financing ecosystem. Building on the example of HPPSC, for similar efforts to succeed, it is essential that all parties engage from a position of openness, trust, and transparency.

If we are serious about moving forward, three things need to happen.

First, knowledge-sharing must be institutionalised, not left to informal exchanges, but supported through structured platforms, joint working groups, and pilot projects.

Second, incentives need to be aligned. Both public and private stakeholders should be working towards outcomes that benefit the system as a whole.

Third, we must be willing to scale what works. Too often good ideas remain as small pilot projects. We need a pathway to expand successful models quickly and responsibly.

At the end of the day, healthcare reform is often described as a policy issue. From a clinician's perspective, coordination can address that issue, especially seeing that we do not lack expertise or capability in Malaysia.

I believe the foundation is already in place. The real question is whether we build on it with intent and urgency, or allow it to remain a well-intentioned idea that never quite reaches its full potential.

Datuk Dr Kuljit Singh is president of the Association of Private Hospitals Malaysia. The views expressed here are solely his own.

The Sun M/S 3

'Bill must effectively improve welfare of elderly'

PETALING JAYA: Malaysia's upcoming Senior Citizen Bill must deliver real protection for the elderly by tackling pressing issues such as elder abuse, financial insecurity, healthcare access, mental health support and long-term care services, said The Alliance for a Safe Community chairman Tan Sri Lee Lam Thye.

He said the proposed legislation is timely and crucial as Malaysia moves steadily towards becoming an ageing nation and welcomed the government's move to table the Bill in the next Parliament meeting next month.

"This is a crucial step towards safeguarding the rights and welfare of older persons. Many senior citizens today continue to face neglect, abandonment, loneliness, rising living costs, poor healthcare access and social isolation, with some left without adequate family support or protection systems.

"We hope the government will ensure that the final legislation is not merely symbolic but truly effective in improving the quality of life, dignity, independence and wellbeing of senior citizens throughout the country.

Lee also stressed the need for stronger mechanisms to protect elderly individuals from physical, emotional and financial abuse.

"At the same time, senior citizens should not be viewed as a burden to society.

"They are valuable members of the nation who have contributed significantly to the country's development through their experience, sacrifices and wisdom," he said.

Lee added that the legislation should encourage stronger family and community responsibility in caring for the elderly while promoting active ageing and greater participation of senior citizens in society.

"Malaysia must prepare itself comprehensively for the demographic changes ahead to avoid facing a major social and healthcare crisis in the future."

Lee also stressed the importance of comprehensive consultations with senior citizens' groups, healthcare professionals, social welfare experts, NGOs, caregivers, and community leaders before the Bill is finalised.

He said such engagement is necessary to ensure the law is practical, inclusive and capable of addressing the real needs faced by elderly individuals from different backgrounds and communities.

The Women, Family and Community Development Ministry announcing on Thursday it is pushing to table the long-awaited Senior Citizens Bill at the upcoming Parliament meeting, although its progress remains subject to final procedural clearance and continued review by the Attorney General's Chambers. – *BY* ***QIRANA NABILLA MOHD RASHIDI***

GENEVA DIVIDEND

Turning global health resolutions into national realities

The World Health Organisation recognises Malaysia's national digital tools, most notably MySejahtera, as world-class case studies for pandemic management. NSTP PIC

MALAYSIA'S presence at the 79th World Health Assembly in Geneva last week was to ensure that the global mandates forged there translate into tangible benefits for every Malaysian.

Two years ago, Malaysia signalled leadership in the digital frontier, with the World Health Organisation recognising its digital tools, most notably MySejahtera, as world-class case studies for pandemic management.

It proved that Malaysia is no longer merely a rule-taker in global health, but also an active rule-maker.

This momentum accelerated last year when we took over as Asean chair. We made history by spearheading the first-ever Integrated Lung Health Resolution at the global level.

While the Geneva plenary sessions provide the stage for global consensus, the bilateral meetings held on the sidelines are where the heavy lifting of healthcare reform truly happens.

DR DZULKEFLY AHMAD

Looking back on 2024 and 2025, these meetings were highly productive. We forged ties with Indonesia on genomic mapping, Oman on digital surveillance, and opened doors for our specialists to provide training to nations like the Maldives.

We also initiated a crucial dialogue with Brunei on "pooled procurement" for rare disease medications, which has now matured into a regional priority.

This year, we are elevating this strategy with a specific hit list. Our engagement with Spain is a calculated move to solve a chronic national bottleneck: organ donation and transplant rates.

Spain holds the gold standard in this field, and by seeking to adapt its operational model we aim to transform our transplant system and shorten the agonising wait for thousands.

Simultaneously, our dialogues with Singapore, Vietnam and Bangladesh are about building a "regional shield".

We are moving beyond health security rhetoric to establish data-sharing frameworks and digital health interoperability.

This ensures that Malaysia remains the anchor of the Asean health agenda, fostering a regional ecosystem that is resilient against cross-border health threats.

Our mission in Geneva also marks a significant milestone with the global showcase of our National Blueprint for Behavioural Sciences.

We are shifting the state's role to "designing". By understanding that human choices are often governed by the path of least resistance, we are using choice architecture to make healthy living the default option.

This is the backbone of our "War on 5S" strategy, targeting sugar, smoke, salt, stigma and sedentary lifestyles.

Malaysia is also expanding leadership into integrated eye health.

It is an extraordinary fact that Malaysia is regarded as a global benchmark in this field, particularly for the quality and volume of cataract operations.

In Geneva, we co-hosted the Global Summit for Eye Health alongside partners like Nigeria and Antigua. While they led the formal representation, Malaysia's role was one of "hosting the standard".

The work we began in previous years on "pooled procurement" is now culminating in the Asean Declaration on Rare Diseases — towards a framework where nations can negotiate drug prices and share diagnostic expertise.

Finally, the recognition by the Medicines Patent Pool (MPP) serves as a powerful testament to our medical sovereignty.

The MPP has selected Malaysia as a global case study for leadership in national HIV response, specifically in navigating patent landscapes to secure affordable, life-saving drugs.

During our mission in Geneva, we championed the "Economics of Health for All" narrative.

Our progress over the last three years shows a consistent plan: from establishing digital leadership to spearheading global resolutions and acting on them.

The writer is Malaysia's health minister

The Borneo Post M/S 4

Unimas, CMUH unite healthcare specialists to tackle obesity challenges

KUCHING: Medical experts and healthcare practitioners from diverse disciplines gathered at a health symposium titled 'The Metabolic Tsunami: Modern Strategies for Root-Cause Obesity Management', jointly organised by Universiti Malaysia Sarawak (Unimas) and China Medical University Hospital (CMUH), to address the growing obesity epidemic.

Unimas Faculty of Medicine and Health Sciences dean Prof Dr Asri said the half-day symposium reflected the university's commitment to fostering interdisciplinary discussions as well as the importance of multidisciplinary collaboration in tackling obesity and metabolic diseases.

"Usually, programmes such as this are organised by industry players or single disciplines with the intention of furthering their own objectives," he said.

"But if we want to talk about tackling obesity, it is about getting everyone from different disciplines together, which is why we have this platform where we bring in surgeons, nutritionists, psychologists and physicians to talk about obesity."

According to Dr Asri, more than 50 per cent of Malaysians are currently classified as overweight, while approximately 24 per cent fall within the obesity category, with a body mass index (BMI) exceeding 30.

"As mentioned earlier by (MUH Taiwan International Center superintendent) Prof Dr Chih-Kun Huang, about five years ago Taiwan was also facing obesity issues.

"The number of obesity cases in Taiwan was very high, but they have successfully mitigated the problem, so we need to learn success stories from other countries," he said.

Meanwhile, Dr Huang hailed the symposium as signifying the strong partnership between CMUH and Unimas in advancing international academic and healthcare collaboration.

"I firmly believe that through this kind of sustainable exchange, innovative concepts and shared expertise, we can strengthen regional healthcare as well as improve the quality of life of communities across Asia," he said.

Also present at the event was Ling-Ying Wu, director of the Taipei Economic and Cultural Office in Malaysia.

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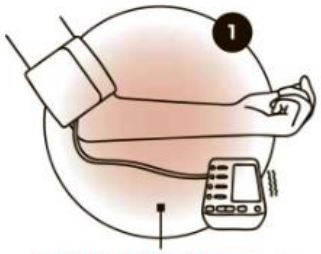
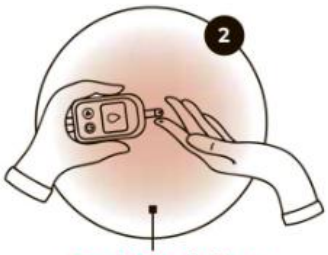


Dua daripada tiga rakyat Malaysia berusia 60 tahun ke atas mempunyai tekanan darah tinggi (hipertensi)



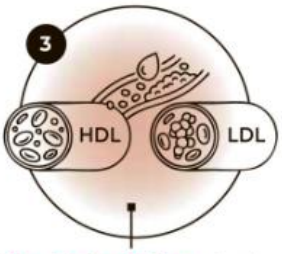
Dua daripada lima rakyat menghidap diabetes

Krisis sakit sebelum tua

Malaysia berdepan krisis kesihatan membimbangkan apabila semakin ramai rakyat hidap penyakit tidak berjangkit (NCD) seperti diabetes, hipertensi, jantung, kolesterol tinggi, kanser dan buah pinggang kronik pada usia muda, sekali gus mewujudkan fenomena 'sakit sebelum menua' yang menjejaskan produktiviti dan menekan sistem kesihatan awam.

EKSKLUSIF

Oleh Alzahrin Alias dan Ercy Gracella Ajos → *Nasional* 4



Tiga daripada lima rakyat berhadapan kolesterol tinggi

Tiga daripada 10 rakyat mengalami kemurungan

Sumber: Kajian Tinjauan Kebangsaan Kesihatan dan Morbiditi (NHMS) 2025

Separuh peserta jalani saringan Peka B40 hidap satu NCD

Kuala Lumpur: Separuh daripada rakyat yang menjalani saringan kesihatan menerusi program PeKa Sihat (Peka B40) di bawah Kementerian Kesihatan (KKM) dikesan menghidap sekurang-kurangnya satu penyakit tidak berjangkit (NCD) sebelum memasuki usia emas.

NCD merujuk kepada penyakit seperti diabetes, hipertensi, jantung, kolesterol tinggi, kanser dan buah pinggang kronik.

Ketua Pegawai Eksekutif ProtectHealth Sdn Bhd (ProtectHealth), Wan Mohd Hazwan Wan Mohd Najib, berkata berdasarkan data 2025, anggaran 46 peratus individu yang menjalani saringan kesihatan di bawah program PeKa Sihat dikesan mempunyai sekurang-kurangnya satu NCD baharu didiagnosis.

Katanya, ia menunjukkan semakin ramai rakyat berdepan masalah kesihatan kronik pada usia lebih muda sebelum mencapai usia tua, sekali gus berpotensi menjejaskan jangka hayat sihat rakyat di negara ini.

"Sekiranya tidak dikawal, NCD memberi kesan produktiviti tenaga kerja melalui peningkatan ketidakhadiran kerja akibat penyakit kronik, penurunan produktiviti kerana kesihatan terjejas serta beban kewangan kepada sistem kesihatan dan majikan.

Wan Mohd Hazwan

"Ini akan menyebabkan kos rawatan meningkat berbanding jika penyakit dikesan dan dikawal pada peringkat awal, malah jangka hayat umur sihat rakyat Malaysia boleh menurun.

"Ini akan memberi kesan langsung kepada ekonomi dan kemampanan sistem penjagaan kesihatan awam," katanya.

Laporan Pertubuhan Kesihatan Sedunia (WHO) pada 2022 menunjukkan, 74 peratus daripada jumlah kematian di Malaysia disebabkan oleh NCD dengan majoriti membabitkan individu berusia antara 35 hingga 64 tahun.

Wan Mohd Hazwan berkata, tahap kesedaran rakyat terhadap kepentingan saringan kesihatan rendah walaupun kerajaan menyediakannya secara percuma.

Katanya, hanya 1.9 juta daripada 7.1 juta rakyat yang layak menjalani saringan kesihatan menerusi PeKa Sihat sehingga 30 April 2026, menggunakan perkhidmatan itu.

"Hanya 27 peratus mendapat manfaat PeKa Sihat berbanding yang layak. Ia membimbangkan walaupun kerajaan memperuntukkan RM80 juta tahun ini untuk rakyat menikmati saringan kesihatan PeKa Sihat," katanya.

Wan Mohd Hazwan berkata, peningkatan kes NCD merangkumi faktor seperti gaya hidup yang tidak aktif, kurang kesedaran kesihatan, tekanan hidup dan kesihatan mental serta pengambilan makanan tinggi gula, lemak dan garam.

‘Sakit sebelum menua’ gugat sistem kesihatan

EKSKLUSIF

Peningkatan penghidap NCD, penyakit mental usia muda berisiko jejas produktiviti

Oleh Alzahrin Alias dan Ercy Gracella Ajos
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Kuala Lumpur: Malaysia berdepan ancaman krisis kesihatan membimbangkan apabila semakin ramai rakyat menghidap penyakit tidak berjangkit (NCD) pada usia muda, sekali gus mewujudkan fenomena ‘sakit sebelum menua’ yang boleh menjejaskan produktiviti negara dan menekan sistem kesihatan awam.

Peningkatan kes NCD, isu kesihatan mental, obesiti dan tekanan hidup bukan sahaja mengurangkan kualiti hidup rakyat tetapi turut berisiko memperlahankan pertumbuhan ekonomi negara.

Ramai yang mendapatkan rawatan selepas penyakit pada tahap serius, menyebabkan kos rawatan meningkat dan produktiviti kerja merosot.

Ia diburukkan dengan situasi Malaysia yang bergerak ke arah negara menua menjelang 2030 apabila 15 peratus daripada populasinya berumur 60 tahun dan ke atas.

Melalui beberapa kajian dikumpulkan *BH*, wujud persoalan kritikal mengenai tekanan terhadap sistem kesihatan awam, struktur perlindungan sosial dan produktiviti pasaran buruh.

Kajian Tinjauan Kebangsaan Kesihatan dan Morbiditi (NHMS) 2025 mendapati, dua daripada tiga rakyat Malaysia berusia 60 tahun ke atas mempunyai tekanan darah tinggi (hipertensi), tiga daripada lima orang berhadapan kolesterol tinggi, dua daripada lima orang menghidap diabetes manakala tiga daripada 10 rakyat mengalami kemurungan.

Penyakit ini kebiasaannya bermula dari usia 40-an atau 50-an sebelum meningkat ke tahap yang kronik selepas tempoh persaraan.

Dr Muhammad Adil

Kadar saringan kesihatan yang masih rendah dan budaya menangguhkan rawatan turut menjadi cabaran utama.

Data Laporan *Patient Voices Malaysia: Making Healthcare Clearer and More Connected* oleh *Economist Impact* menunjukkan, hampir keseluruhan rakyat Malaysia pernah menangguhkan rawatan kesihatan atas faktor kos, komitmen kerja dan keutamaan keluarga, menyebabkan penyakit hanya dikesan pada peringkat lebih serius.

Antara faktor utama penangguhan rawatan termasuk kebimbangan menjadi beban kepada keluarga dari segi kewangan atau penjagaan (28 peratus), komitmen kerja (19 peratus) dan mendahulukan keperluan anak berbanding diri sendiri (18 peratus).

Berdasarkan data terkini ProtectHealth, anak syarikat Kementerian Kesihatan (KKM), hanya 27 peratus daripada 7.1 juta rakyat Malaysia layak menggunakan perkhidmatan PeKa Sihat (Peka B40) walaupun ia percuma sepenuhnya.

Peka Sihat adalah inisiatif kerajaan bagi meningkatkan akses golongan B40 kepada penjagaan kesihatan, terutama aspek pengesanan awal NCD.

Kajian Alpro Health menunjukkan, satu daripada dua pekerja berisiko mengalami keletihan melampau atau *burnout* akibat tekanan kerja semakin meningkat.

Kajian itu mendapati, sekitar 49 peratus responden berisiko tinggi *burnout*, lebih 57 peratus pekerja mengalami tekanan psikologi tinggi, manakala 46 peratus berdepan tekanan fizikal ketara dalam menjalani tugasan harian.

Data Pertubuhan Kesihatan Sedunia (WHO) menganggarkan kemurungan dan keresahan menyebabkan kehilangan kira-kira 12 bilion hari bekerja setiap tahun di seluruh dunia.

Pertubuhan Buruh Antarabangsa (ILO) dalam laporan global 2026 menganggarkan risiko psikososial di tempat kerja menyumbang kepada lebih 840,000 kematian setahun dan kerugian ekonomi, bersamaan kira-kira 1.37 peratus daripada Keluaran Dalam Negara Kasar (KDNK) global.

Kesihatan tenaga kerja susut

Pakar melihat fenomena ‘sakit sebelum menua’ ibarat ‘bom jangka’ demografi yang boleh menjejaskan produktiviti negara jika tidak ditangani lebih awal.

Pakar Perubatan Kesihatan Awam, Kuliah Perubatan, Universiti Islam Antarabangsa Malaysia (UIAM), Prof Madya Dr Muhammad Adil Zainal Abidin, berkata Malaysia bagai berlumba dengan masa berikutan kemerosotan tahap kesihatan tenaga kerja sebelum usia persaraan yang semakin membimbangkan.

Hanya 27 peratus daripada 7.1 juta rakyat Malaysia yang layak menggunakan perkhidmatan PeKa Sihat walaupun ia percuma. (Foto hiasan)

Katanya, keadaan itu bukan sahaja meningkatkan kos rawatan kesihatan negara, malah menyebabkan kehilangan modal insan kritikal ketika negara berdepan cabaran populasi menua dan penyusutan saiz tenaga kerja masa depan.

Situasi itu, jelasnya, lebih membimbangkan apabila digabung dengan kadar kesuburan rendah yang menyebabkan saiz keluarga semakin kecil, sekali gus melemahkan sistem sokongan tradisional dalam keluarga.

“Apabila saiz keluarga mengecil, sistem sokongan tradisional iaitu anak menjaga ibu bapa akan runtuh.

“Jika generasi kecil ini turut berdepan masalah kesihatan atau tekanan kewangan akibat kos rawatan keluarga, produktiviti negara boleh terjejas secara menyeluruh.

“Saringan awal NCD seperti diabetes, hipertensi dan penyakit jantung perlu dianggap sebagai insurans produktiviti untuk negara supaya pekerja kekal sihat dan mampu menyumbang kepada ekonomi dalam tempoh lebih panjang, terutama golongan berusia antara 45 hingga 55 tahun yang memiliki pengalaman serta kemahiran tinggi.

“Apabila pekerja mahir mengalami komplikasi seperti strok atau perlu menjalani dialisis, negara kehilangan tenaga kerja berpengalaman yang sepatutnya memindahkan kemahiran kepada generasi muda,” katanya.

Muhammad Adil berkata, pendekatan kesihatan awam perlu beralih daripada konsep *sick care* kepada *healthcare* dengan penekanan kepada pencegahan dan pengesanan awal.

Saringan awal, katanya, mampu mengurangkan kes kecemasan di hospital, sekali gus membolehkan sumber manusia dan kewangan negara disalur kepada usaha pemerkasaan kesihatan dan pencegahan penyakit.

Metro Ahad M/S 37, 38

ANCAMAN PSIKOSOSIAL

Gangguan mental bukan hanya beri kesan kepada ekosistem di tempat kerja, malah di luar pekerjaan

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Keselamatan dan kesihatan di tempat kerja sering tertumpu kepada ancaman bahaya seperti bahan kimia, mesin dan kebisingan.

Bagaimanapun, terdapat satu lagi elemen bahaya perlu diberi keutamaan iaitu ancaman psikososial.

Ancaman atau bahaya psikososial merujuk kepada gangguan mental yang bukan hanya memberi kesan kepada ekosistem di tempat kerja, malah di luar pekerjaan.

Menurut Doktor Kesihatan Pekerjaan dan Ketua Pegawai Eksekutif Pusat Psikologi Jiwadamai, Dr Hasnor Safwan, gangguan mental seperti tekanan dan kemurungan antara bahaya psikososial paling ketara membabitkan golongan pekerja.

"Bilangan rakyat Malaysia mengalami tekanan dan kemurungan sudah berganda sejak sekian tahun. Namun masih ramai pekerja mendiamkan diri kerana stigma dan rasa takut hilang pekerjaan.

"Data Tinjauan Kesihatan dan Morbiditi Kebangsaan (NHMS) 2023 mendapati, 4.6 peratus rakyat dewasa berumur 16 tahun ke atas (kira-kira satu juta orang) mengalami kemurungan.

"Angka ini berganda daripada 2.3 peratus pada 2019 dan lebih membimbangkan, lebih kurang separuh daripada responden NHMS yang mengalami kemurungan ini turut melaporkan fikiran untuk mencederakan diri atau berasakan 'lebih baik mati'," katanya.

KERAP cuti sakit juga dilihat gejala awal. - Gambar janaan AI

Tambah Dr Hasnor, tekanan bukan lagi sekadar tekanan emosi, sebaliknya ia membabitkan isu keselamatan dalam dunia pekerjaan.

"Gangguan kecil pada tumpuan, daya membuat keputusan atau masa tindak balas pekerja, boleh berakhir dengan kemalangan.

"Contoh, jika seorang pemandu treler tidak tidur kerana tekanan, kesannya kepada keselamatan jalan raya setara dia memandu dalam keadaan mabuk.

"Kerana itu kesihatan mental pekerja bukan lagi soal 'baik untuk ada', ia adalah soal kesihatan dan keselamatan pekerjaan," katanya.

Menurut beliau, penting kepada pekerja dan majikan mendapat gambaran mengenai gejala awal jika individu berkaitan mengalami masalah tekanan atau kemurungan di tempat kerja.

> 38

DARI MUKA 37

RAMAI TAKUT JUMPA OHD

Salah faham menyebabkan kebimbangan status mental dimaklumkan kepada majikan

SARINGAN awal perlu dalam menangani isu kesihatan mental pekerja. - Gambar janaan AI

Kata Dr Hasnor, petanda awal boleh dilihat menerusi perubahan tingkah laku mereka.

"Antaranya menunjukkan reaksi emosi tertekan walaupun selepas bercuti.

"Selain itu, sukar tidur atau letih setiap kali bangun. Mereka juga mudah marah, hilang sabar atau menangis tanpa sebab.

"Akhirnya, mereka sukar memberi tumpuan, lupa pada tugas selain lambat membuat keputusan," katanya.

Kata Dr Hasnor, jika simptom itu berlarutan sehingga menjejaskan prestasi kerja, sebaik-baiknya pekerja terbabit dirujuk kepada Doktor Kesihatan Pekerjaan (OHD) dan Ahli Profesional Kesihatan Mental.

"Ramai pekerja takut berjumpa OHD dan Profesional Kesihatan Mental kerana bimbang status mental mereka akan dimaklumkan kepada majikan. Ini adalah salah faham.

> Bilangan rakyat Malaysia mengalami tekanan dan kemurungan sudah berganda sejak sekian tahun. Namun masih ramai pekerja mendiamkan diri kerana stigma dan rasa takut hilang pekerjaan
>
> **DR HASNOR**

"Maklumat kesihatan mental adalah data peribadi sensitif di bawah Akta Perlindungan Data Peribadi 2010 (Akta 709).

"Ahli profesional hanya akan memaklumkan kepada majikan dalam bentuk bahasa fungsi. Contoh, 'memerlukan jadual kerja yang stabil selama enam minggu' tanpa mendedahkan diagnosis kecuali dengan kebenaran bertulis pekerja.

"Penilaian OHD memberi tumpuan pada fungsi kerja, iaitu sejauh mana simptom menjejaskan keupayaan pekerja menjalankan tugas dengan selamat dan berkesan, bukan pada label diagnosis," katanya.

Tambah pakar itu lagi, lebih baik menangani gejala awal daripada ia dibiar berlarutan.

"Bagi masalah ringan hingga sederhana seperti 'burnout' awal, gangguan penyesuaian atau kebimbangan ringan, ia cukup dengan merujuk kepada ahli psikologi klinikal selain tidak membabitkan pengambilan ubat.

"Tetapi untuk simptom yang lebih berat atau memerlukan diagnosis lanjut dan rawatan farmakologi, barulah dirujuk kepada psikiatri. Dalam banyak kes, kedua-duanya bekerja serentak," katanya.

Terdapat juga keperluan mendesak andai pekerja menunjukkan gejala berat bagi gangguan kepada kesihatan mental mereka.

"Dalam kes tertentu, jika terdapat gejala yang serius, langkah segera perlu diambil.

"Gejala terbabit seperti pekerja berkaitan meluahkan idea atau rancangan untuk mencederakan diri, atau pernah ada sejarah cuba mencederakan diri.

"Malah, pekerja yang berdepan tekanan atau kemurungan, berhalusinasi atau kehilangan pegangan dengan realiti juga perlu dirujuk segera.

"Paling serius jika mereka menunjukkan tingkah laku tidak terkawal hingga membahayakan diri atau orang lain," katanya.

Selain itu, Dr Hasnor menggesa majikan atau organisasi mematuhi garis panduan Pertubuhan Kesihatan Sedunia (WHO) 2022 yang dengan jelas menekankan pencegahan.

Antaranya, mengurangkan punca tekanan di tempat kerja sebelum pekerja jatuh sakit, ia termasuk beban kerja yang munasabah, jadual yang dapat diramal, kepimpinan yang menyokong dan budaya yang menghormati.

Pekerja juga perlu mengamalkan disiplin diri dengan menjaga waktu tidur, menghadkan komunikasi kerja di luar waktu, memelihara hubungan keluarga, bersenam dan tidak takut bercakap dengan rakan sekerja atau pakar apabila beban mula berat.

Kesihatan mental bukan kelemahan. Ia adalah tanggungjawab bersama pekerja, majikan dan sistem kesihatan pekerjaan negara.

INFO

BILA PERLU JUMPA AHLI PROFESIONAL?

- Tekanan, kebimbangan atau kemurungan lebih daripada dua minggu
- Tidur terganggu secara berterusan
- Kesilapan kerja yang tidak biasa dilakukan atau hampir terbabit kemalangan
- Kembali bertugas selepas cuti sakit berkaitan mental
- Dirujuk daripada penilaian PRisMA tempat kerja kecergasan


MENGENDALI mesin juga perlu melepasi saringan tahap kesihatan mental. - Gambar janaan AI