

Gold, golf and pharmacy in the Gulf

Having recently revisited the country of his birth, **Sultan Dajani** tells of developments in the United Arab Emirates



Sultan Dajani

According to legend, when a gazelle cried in the Abu Dhabi desert, an oasis was born and this became known as Al-Ein

Visitors to the Gulf who expect year round sunshine, white beaches, undulating desert sands, world class shopping, diverse cuisines, live entertainment and an unlimited range of recreational pursuits are rarely disappointed. For those in love with carats of the gold variety, the Gulf is paradise. This is where you will find 22-carat gold about a third cheaper than the 18-carat versions in the UK. And haggling in English is expected.

The United Arab Emirates (UAE) is a federation of seven states, which include Abu Dhabi and Dubai. Dubai is cosmopolitan but Abu Dhabi is the only place to be if you want to play golf in the footsteps of Faldo, Montgomery and other golfing heroes — the World Golf Sand Championships were held there recently. But do not expect to find any greens. There are only browns and you need an artificial grass mat to tee off. However, no course is without the requisite 19th hole!

Development

The federation was formed in 1971. Under the presidency of Sheikh Zayed Bin Sultan Al

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Nahayan, the UAE has made gargantuan architectural, structural and economic achievements, through ambitious vision and having the resources to realise this. There have been similar unrelenting advances in societal aspects, too. This includes a burgeoning health care system. When I visited Abu Dhabi recently I hardly recognised the place. Admittedly, I had only just started walking when my family left, but it would be just as unrecognisable had we left only 10 years ago. I am glad to say that the place has changed for the better.

Although Abu Dhabi is the capital of the federation, Dubai is considered the commercial hot-bed of the Middle East. Served by more than 200 shipping lines and with airline links to over 130 cities, it is the gateway to a billion people whose annual market value is estimated at almost £70bn per annum.

Here, the pharmaceutical market is about 4 per cent greater than the global average and, because Dubai has an open market with no exchange controls, quotas or trade barriers, it is easier to do business. The UAE is a launch-pad to the Middle East and Africa so it is not surprising that a great deal of importance is placed on the Middle Eastern health market. This is reflected by the region playing host to one of the busiest and most comprehensive health conferences in the world: the Arab Health Conference.

Now in its 28th year and held in Dubai, the Arab Health Conference is considered to be a

vital showcase for many new products and innovative services. Hosting 1,500 exhibitors and involving 25 countries it is no wonder that it has become so renowned and is reputed to be the breaking ground for many new companies. Furthermore, the conference acts as a forum for exchanging ideas and facilitating the development of health care through five areas, namely “medlab” (clinical testing), pharmaceuticals, dentistry, international health services and hospital design and interiors.

In addition, work to build a health care city in Dubai is currently under way. This is to become the region’s centre of excellence for specialist medical services, medical education, life science research and technology leveraged health care services. Dubai Healthcare City will have the capacity to accommodate 15 million visitors each year and, all being well, should be completed in five years. The first four buildings of phase I are to be inaugurated on Christmas day this year.

Apart from having fewer resource problems than other countries, the main advantage the UAE has is that, as a new country, it starts with a clean slate — unlike the NHS in the UK, it does not have to make the best out of an old system and is not embedded in any particular culture. Materials are new and the processes are not over burdened. Ongoing expansion of hospitals, laboratories, medical research centres and specialist medical facilities will make the ideals of equity and choice attainable.

However, in a land of plenty sometimes logic can be in short supply. For example, the health care available to the large migrant manual labour workforce is expensive and choice is a luxury. So, many who fall ill are forced to return to their place of origin for treatment — an anathema to any civilisation that wishes to become a first class society. To overcome this problem, a workable national health insurance scheme is being developed.

Pharmacy, UAE style

The practice of pharmacy in hospitals, as in the UK, varies significantly between institutions, especially in their relationships with the community (eg, the services they commission from primary care). The American Hospital in Dubai was the first hospital to be accredited by the American Society of Health-system Pharmacists (ASHP) and the Joint Commission for International Accreditation (JCIA). For example, all intravenous medicines are prepared in accordance with the latest ASHP and JCIA standards. Medicines are distributed to patients on the wards in “unit dose systems”. This means that for each ward round the medicines for each patient are individually packaged. The pharmacy staff at the American Hospital are also responsible for preparing total parenteral nutrition.

Pharmacists deliver the required discharge medicines to patients, provide medicines management information and answer any queries. Medication errors and adverse drug

reaction are all reported and all the necessary procedures are in place relating to alerts, correcting errors and educating hospital staff in order to prevent such incidents reoccurring. Other work includes evaluation of antibiotic use, data collection, formulation, producing pharmacy and therapeutic committee bulletins and the performance improvement committee with recommendations for corrective action (eg, risk assessment). All these activities are documented.

Many hospitals in the UAE work collaboratively with Ajman University’s college of pharmacy, where education and training manuals are prepared to ensure high quality training for preregistration trainees. Pharmacy staff are requested to keep up to date with new information through continuing education. Continuing professional development is not practised and long-distance learning is not part of the educational landscape.

However, the American Hospital is one of the better examples of hospital pharmacy. In the UAE, pharmacists are looked at in much the same sense as technicians are in the UK because their skills remain untapped. There is little consistency of service, no inspectors and no official ethical guidance document. It is also surprising to learn that part-time post-graduate qualifications are not as esteemed as the full-time equivalent. This is reflected in terms of responsibilities given.

Nevertheless, progress is being made. The UAE may be a long way from pharmacist pre-

scribing, pharmacist-run medicines management clinics and electronic patient records but, if as much energy is devoted to public health as it is to engineering, it will catch up quickly and could soon become a world leader.

The UAE’s open market (apart from Dubai, which opted out) is regulated by the Directorate of Drug Control in co-operation with the General Secretariat of Municipalities. This is a valuable measure because the market attracts numerous pharmaceutical products and food supplements and, therefore, needs to be regulated. Under the personal control of the director, Easa Bin Jakka Al Mansoori, the drug control department issues guidance to protect patients while also encouraging the highest quality pharmaceutical services in the Emirates.

Future plans for pharmacy include:

- Developing a financially independent agency for the control of medicines and medical devices
- A pharmacy board to oversee the professional side of pharmacy
- More resources for inspection and enforcement
- More UAE nationals to qualify and work as pharmacists
- A transparent legal mechanism for enforcing the powers given to drug control in the 1983 law and, ideally, a modernised law and legislature for medicines and pharmacy

How NHS prescribing was restricted

In this article, **Peter Homan**, explains how the limited list was introduced by the Government in 1984

Just over twenty years ago, on 8 November 1984, the Government delivered a bombshell: patients would, from 1 April 1985, no longer be allowed an almost unlimited range of medicines on their NHS prescriptions. Prescribing would be restricted to a “limited list”. By doing this, the Government hoped to save £100m a year.

Up to this point it had been possible for GPs to prescribe a wide range of proprietary medicines on an NHS prescription. This included many household names, such as Benlyn expectorant, Actifed compound linctus and Senokot granules. Although over-the-counter packs were available, these medicines could not be advertised to the public and dispensing was usually from large “prescription only packs”. The size of pack on which payment would be made was controlled and stated in the Drug Tariff.

But it was not only proprietary products that would be affected by the limited list proposal. It would also be forbidden to prescribe

standard British National Formulary medicines such as Gee’s Linctus, Mist Expect and Potassium Bromide and Nux Vomica Mixture.

The restrictions

Several categories of drug were affected. Patients would be restricted to a choice of five antacids, two laxatives, one inhalation, six antitussives, five analgesics (for mild to moderate pain), eight vitamin preparations, one “tonic and bitter” and three benzodiazepines (in the “sedatives and tranquillisers category”), of which none was a proprietary product. There was, however, to be no restrictions in other therapeutic groups. The Secretary of State, Norman Fowler, decided to allow until 31 January 1985 for consultation.

Kenneth Clarke, the health minister at the time, had made it known that he thought pharmacists were under-used and that this measure would give them a greater role in the treatment of minor ailments through counter prescribing. Frank Dobson (the then shadow health minister) told *The Pharmaceutical Journal* (17 November 1984, p597) that he was critical of the proposal that doctors should lose their right to prescribe brand

name drugs altogether in selected areas. He said it was possible that there was a limited number of patients for whom the brand name drug was better than the generic.

Pharmacy responds

Pharmacy’s reactions were mixed. The then President of the Pharmaceutical Society, Hopkin Maddock, condemned the Government’s bureaucratic approach and considered the problems of administering the new system to be “clearly boundless”. However, the Society welcomed the Department of Health’s recognition of the pharmacist’s role in advising patients on the treatment of minor ailments. Alan Smith of the Pharmaceutical Services Negotiating Committee, welcomed the switch to generics but warned that there might be a problem with dead stock in dispensaries.

Peter Dodd of UniChem did not believe that the Government would go ahead in relation to Distalgic and was worried about wholesalers being left with unsaleable stock. Tim Astill of the National Pharmaceutical Association pointed out what he considered important omissions: senna, folic acid and vitamin B₁₂.

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There was, of course, much anger in the pharmaceutical industry. Many of the large drug companies had high profile prescription products, such as Distalgesic (Lilly), Valium and Mogadon (Roche), and Equagesic (Wyeth). The Association of the British Pharmaceutical Industry declared its "implacable opposition" and said it would "fight tooth and nail".

Over the following weeks there was much debate. Members of the Society had their say in the letters pages of *The Journal* and the activities of various pharmaceutical bodies were reported in great detail. The ABPI began a campaign in the medical press against this "stupid and dangerous" proposal. The Guild of Hospital Pharmacists also strongly disagreed with limited list prescribing.

The PSNC raised further issues, which included:

- Would there be compensation for dead stock?
- Could an NHS prescription be treated as a private prescription?
- Who would pay for a disallowed item dispensed in error?

It also expressed concern that the list affected drugs that were considered essential by the World Health Organization. In addition, the limited list would be unfair to people who could not afford disallowed preparations, particularly the elderly.

By mid-January, it had been confirmed that an FP10 could not be dispensed as a private prescription. Only the pharmacist would be responsible for a disallowed item and it would not be acceptable to supply a disallowed item and charge the difference between its price and that of an allowed item. And there was no way round the list. For example, when asked whether a GP could order a medicine by writing the ingredients, such as codeine phosphate 8mg, paracetamol 500mg and caffeine 3mg, for Solpadeine, the answer from the Minister of Health was an emphatic "no".

In February 1985, *The Journal* featured the Society's comments on the provisional limited list. For each therapeutic group the Society discussed the preparations proposed, their suitability and their limitations. It also suggested additions to the list. In discussing the nature of a list, the following appeared: "Any limited list would need to be a black list, ie, it would need to include the names and product licence numbers of all products not approved for prescribing in the NHS." The Society also proposed a "white list". This was a list of approved products, under category headings (such as "antacid") to indicate the groups being limited. Comments on how this would be administered followed.

Two lists

The Society's proposal for two lists was accepted and, at the beginning of March 1985, the white list and the black list were published in *The Journal*. The white list was a revised version of the original provisional list.



"Prescription-only packs" of Panadol and Panadeine Co.

Comment in *The Journal* was that it was "better but still bad". It now contained 20 antacids, 26 laxatives, 35 analgesics, 22 cough and cold remedies, two bitters and tonics, 44 vitamins, and 14 benzodiazepine sedatives and tranquillisers. This time a number of proprietary medicines were included. The black list of disallowed items ran to 24 columns.

Later in March *The Journal* included a pull-out supplement: "The limited list — a special guide". The black list now ran to 26 columns. This increased again, to 28 columns, in October, when an updated guide was published. Instructions in October's guide were: check the white list. If the product is on it dispense the prescription. If not on the white list, check the black list. If the product is not on the black list dispense the prescription.

Impact on patients

How would the patients react? Would there be rioting in the pharmacies? One company thought that difficulties would arise and launched a training session for all chemist counter staff. A video was produced which featured various scenarios of patients, reactions when they found out that they could not have their usual prescribed medicine. They promoted the limited list as a challenge and an opportunity. By sympathetic and informed counselling, not only would patients be reassured but, possibly, more patients would bring their prescriptions to that friendly pharmacy. Product knowledge would be essential and the pharmacist should be ready to spring into action.

Outcome

In the event, 1 April 1985 was an anticlimax. *The Journal* of 6 April bore the headline "It was quiet: almost too quiet". The number of prescriptions presented on Monday morning were well down on the immediately preceding weeks. Doctors had been well informed

and most had told their patients of the changes. Patients had stock-piled disallowed products.

A further quote from *The Journal*: "It was possible that the preparatory action of some pharmacists resulted in a smooth April Fool's Day. Mr E. P. Moffitt had spent time over the past few weeks consulting with local doctors within a small mining community in Northumberland where his pharmacy is situated. The advanced discussions with the doctors had resulted in 120 prescriptions being presented on Monday morning, and they were all written correctly; that in itself was unusual, said Mr Moffitt."

Something else happened on 1 April 1985 — the prescription charge was raised from £1.60 to £2.00 per item. In fact, the only reported complaint of the day was of a patient in Oxted, Surrey, who was "horrified" at the rise and stormed out of the pharmacy, leaving the prescription behind.

The limited list was responsible for the introduction of "co-" products. For example, Distalgesic tablets were blacklisted but the generic version was allowed. To avoid the prescriber having to write "dextropropoxyphene HCl 32.5mg, paracetamol 325mg", the formula was shortened to "co-proxamol". Other abbreviations for products quickly followed, including co-codamol, co-amilofruse and co-danthrusate.

The numbers of prescriptions diminished but there was an upturn in the sales of over-the-counter sales of proprietary medicines, certainly in cough remedies.

Changes in the limited list and correspondence about it continued for many months. Week after week, more items were added to the black list. Any new proprietary medicine (within the limited list categories) was added. Some (eg, Mucodyne) were deleted and others, such as Asilone, were added. Now updates to the two lists are published monthly.