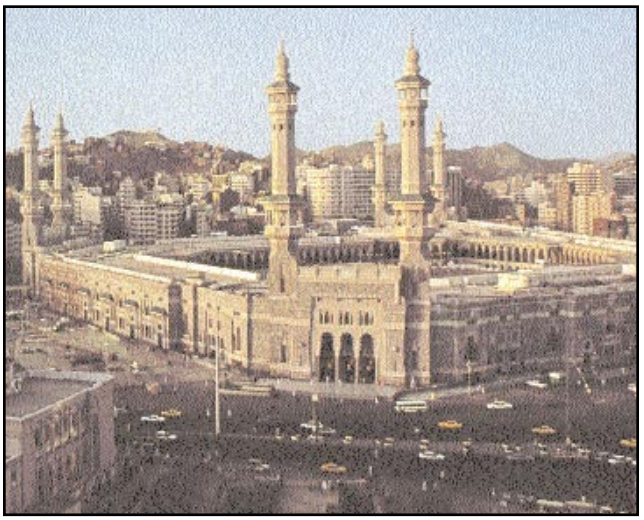
A Pharmacist's Experiences in Saudi Arabia

Andrew E. Simor

In our most recent federal election, in November 2000, there was some discussion of the future of health care in Canada, including the possibility of a "two-tiered system" and its effect on universal access, a hallmark of the Canadian system. In 2001, our front cover will feature pictures to illustrate the stories of Canadians who have volunteered or worked in health care in other countries.



In Saudi Arabia, it is said that all roads lead to Mecca. In the picture above, the road leads to the Haram Mosque, one of the many mosques in Islam's holiest city. In the summer of 1993, Allan Mills, currently Clinical Coordinator of Pharmacy Services at Baycrest Centre in Toronto, Ontario, began a 3-year work term in Saudi Arabia. In this, our second report, Allan describes health care in Saudi Arabia.

Long known as an historically rich but otherwise empty quarter of the Arabian peninsula, the Kingdom of Saudi Arabia has become the wealthiest country in the Middle East. Over the past half century, the area has undergone significant economic and sociologic change due to the enormous amount of oil that is pumped from beneath the desert each day. One such change has been the development of a health-care system where none existed 50 years ago. In the summer of 1993 my wife and I went to work in this exotic location and stayed for a 3-year period.

The 2 cities in which we worked, Tabuk and Jeddah, represent opposite extremes of the Arabic experience. Jeddah is an ancient port city rich in tradition, with a large resident population and an influx of millions of visitors during the annual pilgrimage to Mecca and Medina. Tabuk is smaller and more prototypically Arabic, with a greater population of nomadic Bedouins and far less contact with the Western world. The population of the kingdom is relatively young and experiencing significant changes in lifestyle because of modernization and industrialization. These factors have contributed to an exploding birth rate, a very high rate of trauma from motor vehicle accidents, and a significant increase in cardiac disease and diabetes. For example, the prevalence of glucose intolerance or diabetes (or both) in Saudi women 51 to 60 years of age has been reported to be as high as 59%.[1]

The 2 hospitals where I worked were relatively modern facilities, having been built within the previous 15 years to serve members of the Saudi military, the Royal family, and their dependents. The health-care system in Saudi Arabia is tiered, with public hospitals, military hospitals, and hospitals serving the Royal Family receiving different amounts of funding. In the larger commercial centres there are also numerous private hospitals for those who are ineligible for treatment in the military hospitals but who want, and are wealthy enough to afford, a higher standard of health care than the public hospitals can deliver. In many ways the funding structure of the hospitals is a mixture of the Canadian and American health-care systems. The Government of Saudi Arabia, as a central payer, hires international agencies to run hospitals on a for-profit basis. The agencies in turn hire administrative, health-care, and support staff for their hospitals. Hospital organization and structure is based on the norm in the country of origin of the administrative staff, with English generally being the working language.

A pharmaceutical care approach was relatively new when I went to Saudi and, although not discouraged,

continued on page 16

was not completely understood or encouraged. The dispensing workloads were significantly less than in Canadian hospitals, which allowed greater time for clinical involvement. There was some degree of curiosity when I started to participate in medical rounds, but this soon dissipated, and my contributions were welcomed and acted upon and came to be expected. Since the clinical staff members were from all regions of the globe, we encountered a variety of approaches, drug names, and health-care beliefs. This diversity required all members of the team to appreciate that the protocols, guidelines, and beliefs used in local hospitals in their own countries held little value — evidence from the literature took precedence. At times, this led to conflict, but overall it encouraged everyone to reassess their practice patterns and to review the level of support for their treatment decisions. At the same time, technical advances were highly regarded. Significant investment was put into computerization, unit dose, IV additive programs, and, in Jeddah, direct physician order entry.

Being able to work in and experience an area of the world that few people get to visit was an experience I will never forget. I believe my experiences there have caused me to question, review, and finally appreciate the Canadian health-care system and the advantages of living in a country such as ours.

Reference

1. Al-Nuaim AR. Prevalence of glucose intolerance in urban and rural communities in Saudi Arabia. Diabet Med 1997;14:595-602.

Allan Mills, PharmD, is Clinical Coordinator, Pharmacy Services, Baycrest Centre, and Assistant Professor, Faculty of Pharmacy, University of Toronto, Toronto, Ontario.