Review Article

Funding the Clinical Pharmacist: A United States-United Arab Emirates Comparison of Hospital Staffing, Pay, Career Opportunities and Policy Reform

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Abstract

Background: Hospital-based clinical pharmacy is increasingly central to medication safety, antimicrobial stewardship and multidisciplinary care. However, the presence of licensed pharmacists does not guarantee funded bedside positions, protected clinical time or equitable remuneration. The United States (US) and United Arab Emirates (UAE) offer contrasting financing and labor-market arrangements.

Objective: To compare clinical pharmacy service integration, mechanisms financing clinical pharmacist posts, healthcare workforce capacity and compensation, and to propose actionable UAE reforms.

Methods: Targeted narrative synthesis of government labor statistics, healthcare regulatory documents, US reimbursement policy, peer-reviewed practice surveys and outcome studies, and clearly labeled UAE recruitment-platform salary signals available by 1 November 2026. This was not an exhaustive systematic review.

Findings: The US Bureau of Labor Statistics reported 325,200 pharmacist jobs in 2025, 32% in hospitals, and a May 2025 median pharmacist wage of US$67.75/hour; these are occupational, not clinical-specialist, data. The 2024 ASHP hospital survey reported clinical services for most inpatients in over 75% of responding hospitals but had a 16.7% response rate. US positions are primarily supported through institutional budgets financed by hospital payments, with additional limited medication-management billing, selected outpatient pharmaceutical margins and value-based programs. The UAE counted 175 hospitals in 2023; Abu Dhabi's 2022 workforce plan described an overall pharmacist oversupply but did not measure clinical specialist unemployment. UAE law sets no general minimum salary, although an AED 6,000 monthly floor applies

to Emirati private-sector workers from 2026. Unofficial UAE salary samples suggest potentially low clinical pharmacist remuneration but are not representative national estimates.

Conclusions: UAE policy should distinguish licensed pharmacist supply from required clinical pharmacist full-time equivalents (FTEs), establish transparent staffing and pay intelligence, link clinical pharmacist services to accredited care requirements and payer financing, and evaluate job creation and patient outcomes in a staged pilot.

Keywords: clinical pharmacy; hospital pharmacists; United Arab Emirates; United States; workforce planning; financing; remuneration; patient safety; health policy; pharmacy labor market.

1. Introduction

Clinical pharmacy involves direct responsibility for optimizing pharmacotherapy, preventing medication-related harm, assessing treatment responses and supporting prescribers and patients. It relies on pharmacist access to the medical record, sufficient time for clinical review, a defined scope of practice and multidisciplinary accountability. The question of whether a health system employs clinical pharmacists is therefore separate from the question of how many individuals hold clinical pharmacist licenses. [1]

The US is frequently viewed as a mature hospital clinical pharmacy market because pharmacists routinely support specialty services, join medical rounds and operate within institutional protocols. [1] Yet the US model is not based on universal independent pharmacist billing. Most hospital clinical pharmacists are salaried employees whose positions must be justified within budgets financed by inpatient case payments, insurer contracts and institutional revenue. [2,3] Even in the US, limited direct reimbursement and competition for approved positions remain substantial constraints. [4-6]

The UAE presents a different policy problem. It has rapidly expanded healthcare capacity and established a legally articulated clinical pharmacy scope [7-9], while public occupational data do not consistently distinguish dispensing pharmacists from ward-based clinical specialists, vacancies from licensed supply, or clinical service time from pharmacy operating hours. [10,11] The policy hypothesis considered here is that a market may simultaneously have many licensed clinical pharmacists, limited funded clinical specialist positions and undertreated medication safety risks. This is a plausible structural mismatch, not a verified national unemployment statistic.

This review therefore asks how US health systems finance and sustain clinical pharmacy jobs; what can be established about the UAE hospital market, hiring and pay; and which legal, reimbursement and workforce interventions the Department of Health (DoH), labor authorities, employers and payers could reasonably implement without treating unverified employment claims as settled facts.

2. Methods and evidence hierarchy

A targeted narrative review and policy analysis was conducted using primary regulator publications (US Centers for Medicare & Medicaid Services [CMS], Bureau of Labor Statistics [BLS], Department of Labor [DOL], American Hospital Association [AHA], CDC, UAE federal portals, Department of Health - Abu Dhabi and Dubai Health Authority), indexed peer-reviewed papers, and publicly available salary snapshots. Searches focused on clinical pharmacy staffing, inpatient payment,

pharmacist-delivered services, hospital financing, UAE hospital counts, salary law, pharmacist salaries and workforce planning. Documents were checked for effective dates and denominators where available; the evidence cutoff was 1 November 2026.

Priority was given to government counts and law for hospital numbers, employment and statutory wages; peer-reviewed surveys and intervention studies for practice coverage and outcomes; and recruitment platforms only as nonrepresentative market signals. The synthesis is narrative: it did not undertake comprehensive database retrieval, dual screening, formal risk-of-bias scoring or meta-analysis. Salary observations were not weighted into a pooled UAE mean. The analysis does not infer individual vacancy rates from numbers of hospitals or regulatory licenses.

3. US clinical pharmacy employment and service structure

3.1. Scale and distribution of positions

AHA reported 6,100 US hospitals in its February 2026 Fast Facts release, based on the 2024 annual hospital survey. [12] BLS estimated 325,200 pharmacist jobs in 2025; 32% were in hospitals and 37% in pharmacies and drug retailers. [13] Applying the rounded hospital share to the occupational total yields approximately 104,000 hospital pharmacist jobs, an illustrative calculation rather than a published count of clinical specialists. Hospital pharmacist jobs include medication distribution, sterile compounding oversight, informatics, management and direct clinical work.

In the ASHP 2024 national hospital survey, over 75% of responding hospitals reported routine clinical pharmacy services for a majority of inpatients. Services were reported in medical-surgical areas (73.3% of hospitals), critical care (68.5%), oncology (56.9%), cardiology (48.5%), infectious diseases/antimicrobial stewardship (48.1%) and emergency departments (46.5%). Independently prescribing pharmacists were reported in 18.5% of hospitals. These are hospital-level responses, not percentages of inpatients receiving a specialist assessment, and the 16.7% survey response rate limits national representativeness. [1]

The 2026 US hospital pharmacy leadership survey illustrates what established positions can look like: participating leaders reported a median of 30 clinical pharmacist FTEs at their flagship hospitals, but the self-selected institutional sample is not a population benchmark. The same study found that only about one-third of requested new clinical FTEs were approved in the prior year. US positions are numerous relative to the UAE, but their sustainability is contested rather than guaranteed. [4]

3.2. Why employers fund clinical pharmacy posts

An inpatient hospital usually pays for pharmacists through an operating budget, not by issuing a separate bill for every bedside medication review. Under Medicare's inpatient prospective payment system, most acute-care inpatient stays generate a hospital payment based on Medicare Severity Diagnosis-Related Groups (MS-DRGs), with adjustments. The hospital must allocate such revenues, alongside other payer receipts, to nursing, physicians, diagnostics, medications, pharmacy and overhead. If pharmacy services lower avoidable harm, improve drug use or protect quality, they may justify a service line or FTE budget even when there is no stand-alone pharmacy fee. [2,3]

Directly attributable external payments are selective. Medicare Part D plans are required to provide medication therapy management (MTM) programs for eligible beneficiaries and identify relevant service resources and remuneration. For some outpatient settings, CMS allows pharmacists to act as auxiliary personnel delivering services incident to eligible

physician/nonphysician practitioner services, subject to applicable supervision, scope-of-practice and coding restrictions. Neither mechanism should be portrayed as a universal pathway through which every hospital clinical pharmacist directly bills Medicare. State Medicaid and commercial payers may use different arrangements. [2,5,6]

Some qualifying US safety-net institutions participate in the 340B Drug Pricing Program, which permits discounted eligible outpatient medication purchases and may support broader institutional services depending on organizational choices and lawful program use. The program is not a dedicated federal clinical pharmacist salary subsidy, does not apply to all hospitals, and should not be treated as the principal source of hospital-wide staffing. Pharmacy residency education and training can be supported by institutional budgets and, where eligible and properly documented, Medicare cost-reporting arrangements; ASHP identifies both the opportunity and ongoing funding disallowance disputes. [14,15]

The employer business case is strengthened by a documented safety contribution. In a landmark US ICU evaluation, pharmacist participation in rounds was associated with a fall in preventable medication-order adverse drug events from 10.4 to 3.5 per 1,000 patient-days (66% relative reduction). This historical single-center intervention should not be translated directly into a universal UAE return on investment. More recent financing analysis notes that even when pharmacists generate potential cost avoidance, those savings may accrue to different parts of the health system and never appear as cash in the pharmacy department budget. [2,16]

Clinical pharmacist staffing is also supported by service expectations. The CDC hospital antimicrobial stewardship framework calls for leadership commitment, resources and pharmacy expertise; 97% of participating acute-care hospitals reported implementing all seven Core Elements in 2024. Implementation reporting is not evidence that each institution has an adequate dedicated FTE, but it demonstrates how an explicit service requirement can create a reason for health systems to invest in pharmacist expertise. [17]

Table 1. Mechanisms sustaining US clinical pharmacy services and their transferability

Mechanism	US financing logic	Potential UAE application / caution
Hospital operating budgets	Pharmacist labor embedded in care delivery financed by case-based or insurer payments.	Budget explicit clinical service FTEs; do not require one pharmacist fee per intervention.
Medication-management payments	Part D MTM; limited incident-to and payer-specific outpatient services.	Pilot paid medication-review packages with participating payers; respect local scope and tariffs.
Quality, risk and value	Lower adverse events, medication waste, readmissions or length of stay can influence business case.	Measure validated outcomes; distinguish modeled cost avoidance from realized budget savings.
Outpatient pharmacy margins / 340B	Eligible drug pricing and service-line margins can cross-support programs.	Not directly transferable; UAE payment and procurement rules differ.
Residency/education funds	Institutions and certain cost-reporting avenues support postgraduate training.	Fund accredited training as paid positions, not unpaid substitute labor.

4. UAE capacity: hospital growth does not equal clinical pharmacist job creation

4.1. Hospital and licensing figures

The Federal Competitiveness and Statistics Centre reported 175 hospitals across the UAE in 2023 (56 governmental and 119 private) and 18,497 hospital beds. [7] The Dubai Health Statistical Yearbook separately reported 57 licensed hospitals and 5,372 healthcare facilities of all types in Dubai in 2024. [8] The DoH website describes more than 65 hospitals in Abu Dhabi in its current sector overview. [18] These refer to different dates and classification schemes and should not be added together or interpreted as a synchronized 2026 hospital census.

Dubai's 2024 yearbook counted 66,070 licensed healthcare workforce members, with pharmacists representing approximately 10%. This corresponds arithmetically to approximately 6,600 pharmacists in Dubai's licensed workforce, but the statistic includes pharmacists outside inpatient clinical services and does not determine the number of ward-based clinical pharmacists or unemployed job seekers. A city with thousands of licensed pharmacists and dozens of hospitals can still have a limited clinical specialist labor market if specialist roles are neither defined nor funded. [8]

4.2. Evidence for oversupply - and the key distinction

The DoH Abu Dhabi Health Workforce Masterplan 2022 explicitly reported an overall oversupply of pharmacists and described more than 4,000 pharmacists licensed in the workforce, with 70% concentrated in the Abu Dhabi region and lower regional distribution in Al Dhafra. This is important official evidence of a supply-versus-need imbalance for the general pharmacist category at the time of the plan. However, it does not establish a current 2026 unemployment rate, the number of qualified clinical specialists seeking work, or the number of vacant authorized clinical positions. [10]

DoH's 2026 Emiratisation and Medical Education Priorities classified the broad category of pharmacy in Priority 3, and its methodology explicitly states that 2022 workforce distribution had changed and updated planning was necessary. The Priority 3 classification relates to training and national workforce priorities; it must not be misconstrued as a conclusion that a clinical pharmacist-led ICU or antimicrobial stewardship service has adequate staffing. [11]

Consequently, the strongest defensible interpretation is an occupational mismatch: a potentially saturated general pharmacist licensing market alongside insufficient publicly visible measures of specialty FTE demand, paid vacancies and patient-facing clinical coverage. Direct claims of nationwide clinical pharmacist unemployment, a hiring freeze across hospitals, or a fixed clinical pharmacist-to-hospital ratio cannot be supported from these published sources.

4.3. Legal recognition has advanced faster than financing evidence

Abu Dhabi's 2024 hospital accreditation standard requires inpatient pharmacy leadership by a qualified licensed clinical pharmacist and a pharmacy operating policy specifying required staff numbers and skill mix. Its separate 2024 pharmacist scope of practice describes inpatient and clinical functions, including collaborative practice arrangements with physicians within stipulated requirements. At federal level, Article 74 of Federal Decree-Law No. 38 of 2024, effective 2 January 2025, recognizes clinical pharmacy services in licensed treatment establishments in partnership with the treating physician and provides defined possibilities for modifying medication treatment plans after diagnosis, subject to protocols and restrictions. [9,19,20]

These are substantive regulatory advances. They do not, by themselves, require a specific number of independently budgeted ward-based clinical pharmacist posts per hospital, or establish that an insurer reimburses every specialist intervention.

A facility may satisfy a governance expectation with a limited number of individuals while leaving much of its potential inpatient demand unserved; the extent of any such implementation gap requires hospital-level assessment rather than assumption. [9,19,20]

In a 2024 UAE national survey of 342 hospital pharmacy practitioners, 120 respondents (35.09%) reported performing medication reconciliation for fewer than five patients per week. The study identified knowledge, training and implementation barriers. It supports concern about inconsistent deployment of clinical functions, although it does not itself measure the number of funded clinical pharmacist positions or prove unemployment. [21]

Table 2. Verified capacity indicators and interpretive limitations

Metric	Published figure	What it does and does not establish
US hospitals (AHA 2026 edition; FY2024)	6,100	Size of US hospital system; not specialist pharmacist headcount. [12]
US pharmacist jobs (BLS 2025)	325,200; 32% in hospitals	Occupational positions, not exclusive clinical pharmacist roles. [13]
UAE hospitals (FCSC 2023)	175; 119 private / 56 government	Dated national hospital census; not present vacancies. [7]
Dubai hospitals (DHA 2024)	57	Emirate subset; different year from federal total. [8]
Dubai licensed workforce (2024)	66,070; ~10% pharmacists	Not a count of clinical specialists or unemployed pharmacists. [8]
Abu Dhabi masterplan (2022)	Overall pharmacist oversupply described	All-pharmacist workforce planning; outdated for 2026 and not specialist-specific. [10]

5. Remuneration: legal minimum wages are not professional salary benchmarks

5.1. United States: minimum wage versus pharmacist occupational pay

The BLS May 2025 national median pharmacist wage was US$67.75/hour (approximately US$140,910 annually), and the median annual wage for pharmacists in hospitals was US$157,290. These estimates cover pharmacists across roles and workplaces, not a separately surveyed US clinical pharmacy specialist occupation. Comparisons to the UAE therefore require occupational caution and adjustment for hours, benefits, taxes and purchasing power. [13,22]

5.2. UAE: lack of a general floor, existing labor protection and selective national rule

The official UAE Government platform states that UAE labor law does not prescribe a general minimum salary, although wages and contract compliance are regulated, and the Wage Protection System (WPS) monitors timely payments. From 1 January 2026, MoHRE set a minimum monthly salary of AED 6,000 for Emirati employees in the private sector, with a transition deadline for earlier employees. This nationality-specific requirement is not a universal minimum for expatriate clinical pharmacists and is not a profession-specific salary grid. Therefore, it is inaccurate to say that salary payment is wholly "unregulated"; the more accurate critique is the absence of an enforceable clinical pharmacist-specific remuneration floor for the workforce as a whole. [23,24]

Under the UAE general private-sector working-hours framework, ordinary hours are up to eight per day or 48 per week, with sectoral and individual exceptions. A monthly salary should only be converted to an hourly equivalent after specifying actual contractual paid hours, excluding unrecorded overtime and recognizing differences between basic pay and total allowances.

For illustration, 48 hours per week implies approximately 208 hours per month; at 40 hours per week, approximately 173.3 hours per month. Neither conversion constitutes an official UAE hourly minimum wage. [25]

5.3. What public salary observations can establish

Two current recruitment-platform snapshots demonstrate a reason to investigate compensation but not a trustworthy national salary average. Naukrigulf displayed AED 5,613 monthly from 133 self-reported clinical pharmacist salaries when accessed for this review; Indeed displayed AED 4,500 monthly based on only three reported clinical pharmacist salaries (updated August 2026). A publicly indexed hospital pharmacist vacancy advertised AED 4,000-5,000 per month in Abu Dhabi, but its post was for a broadly defined pharmacist rather than a verified specialist-level clinical pharmacist position. These platforms are subject to self-selection, role-label ambiguity, low sample numbers and unknown employer mix. Other recruitment advertisements offer substantially higher amounts, reinforcing that a single figure cannot characterize the profession. [26-28]

The transparent implication is not that every UAE clinical pharmacist earns AED 4,500-5,613, but that publicly visible pay can be low relative to specialist training and that a regulator-grade salary distribution is unavailable in the reviewed sources. The country would benefit from confidential employer payroll reporting and stratified median, 10th/25th percentile and hourly compensation analyses by title, clinical setting, licensing level, emirate and sector. [23,26-28]

Table 3. Legal wage floors and observed salaries: do not equate them

Indicator	United States	United Arab Emirates
Statutory general wage floor	Federal US$7.25/hour, higher in many states. [22]	No general statutory minimum salary. [23]
Special rule	No nationwide minimum specifically for clinical pharmacists.	Emirati private-sector workers: AED 6,000/month from Jan 2026; not a universal pharmacist floor. [24]
Government pharmacist pay statistic	US$67.75/hour national median for all pharmacists (May 2025). [13]	No directly comparable nationwide official clinical pharmacist hourly series located.
Recruitment-platform signals	Not used in place of BLS occupational series.	Naukrigulf AED 5,613/month (n=133); Indeed AED 4,500/month (n=3). [26,27]
Illustrative hourly equivalent at 48h/week	Not applicable to BLS reported hourly statistic.	AED 27.0/hour (AED 5,613/month) or AED 21.6/hour (AED 4,500/month); NOT statutory rates. [25-27]

6. Why clinical pharmacy jobs may be underfunded in the UAE

First, specialist labor can remain a hidden cost center when a hospital's pharmacy budget is organized around drug procurement, dispensing and distribution rather than separately costed patient-facing care. A clinical pharmacist who prevents an adverse drug event may benefit the patient and insurer without creating a recognizable billing line for the pharmacy

department. This structural challenge also exists in the US, but the US has a longer institutional tradition of staffing and documenting these roles and a more diverse set of payer and service-line mechanisms. [2,3,5,6,20]

Second, a license and a clinical pharmacist title do not create paid posts. The workforce must be mapped by full-time equivalent and actual patient-facing assignments: one licensed pharmacist employed in distribution and occasionally consulted on clinical questions is not equivalent to one fully allocated critical-care or antimicrobial stewardship specialist.

Without separate occupational classifications, hospital workforce planners may incorrectly infer sufficient capacity from the much larger pool of general pharmacists. DoH's published general oversupply finding makes this classification issue especially important. [9,10,19,20]

Third, governance requirements may not consistently translate into protected clinical service hours. A policy requiring a clinical pharmacist to lead an inpatient pharmacy service should be operationalized through documented coverage models, medication-risk stratification, clinical privilege boundaries and audit trails. Fulfilling leadership requirements does not necessarily assure daily unit-level pharmacotherapy input for the sickest patients. This is a hypothesis suitable for DoH audit rather than an allegation about any named hospital. [19,20]

Fourth, specialty training, job classification and payer design may be misaligned. The unified professional qualification framework differentiates the clinical pharmacist licensing title from general pharmacist pathways, and Abu Dhabi already has a pharmacy residency example. However, hospitals still need budget authorization and recognized specialist career ladders; more trainees alone may worsen labor-market pressure if clinical jobs and protected salaries do not expand. [10,15,20,29]

Finally, limited public vacancy, compensation and service-coverage data may make fair recruitment scrutiny difficult. Salary observations from commercial sites are neither payroll audits nor measures of wage-law violation. DoH, MoHRE and professional employers can remedy this informational gap through anonymized workforce and pay surveillance that follows privacy and labor law. [10,23,26,27]

7. Proposed policy reforms for Abu Dhabi and the wider UAE

7.1. A DoH-led clinical pharmacy workforce registry and staffing standard

DoH should use its licensing and accreditation authority to establish a clinical pharmacy workforce dashboard recording, by hospital and service line, licensed title, employed FTE, clinical FTE, ward coverage hours, vacancy posts, recruitment time, attrition, and residency capacity. Reporting should distinguish pharmacotherapy specialists from dispensing/operations pharmacists and distinguish current employment from license eligibility. A confidential baseline would allow publication of aggregate data without exposing individual wages or personnel files. [10,11,19,20]

After risk stratification, DoH should consider progressive minimum service-coverage expectations for higher-risk areas (intensive care, antimicrobial stewardship, oncology, anticoagulation, renal medicine, emergency and discharge transitions). Instead of an arbitrary national ratio, staffing should reflect patient acuity, occupied beds, medication complexity, prescribing volume, service hours and verified specialist competency. A pilot could test advisory ranges, for example specialty unit coverage with an assigned clinical pharmacist during defined clinical hours, before binding numbers are set. [1,17,19,20]

7.2. Convert recognized scope into funded, documented work

DoH and hospital associations should specify structured clinical activities tied to hospital accreditation and JAWDA-style quality reporting: high-risk medication review within 24 hours of admission, admission/discharge medication reconciliation, vancomycin/aminoglycoside therapeutic drug monitoring, antimicrobial prospective audit and feedback, anticoagulation protocol review and documented stewardship outcomes. Coverage denominators should be patients eligible and patients reviewed, rather than raw recommendation counts alone. The 2024 legal scope and accreditation standards provide a foundation for this implementation step. [9,19-21]

Hospital management should provide electronic documentation templates, access to necessary laboratory information, written collaborative protocols and explicit competency-based delegation, without exceeding the scope of federal law or independent medical diagnosis limitations. A dedicated clinical FTE should not be silently reassigned to dispensing work without remeasuring coverage and risk. [9,20]

7.3. A UAE clinical pharmacy remuneration and employment framework

The Ministry of Human Resources and Emiratisation (MoHRE), in coordination with DoH, the Dubai Health Authority, the Ministry of Health and Prevention, employers and worker representatives, should commission an independent confidential salary and vacancy survey. It should report basic wage, allowances, total compensation, contracted and actual hours, night and weekend premiums, seniority, degree, clinical residency, board certification, hospital type, emirate, nationality and sector. Disaggregation must prevent small-cell identification and avoid assumptions that all clinical pharmacists have identical responsibilities. [23-27]

A profession-specific salary floor or enforceable grade structure should be considered only after legal, economic and impact assessment. DoH can set clinical competence and staffing expectations within its remit; changes to labor-law wage minima should be pursued with the authorities legally empowered to act. Interim measures could include wage-transparency requirements in job advertisements, standardized clinical specialist job titles, independent salary reference ranges, recognition of relevant qualifications, and monitoring through existing WPS and labor complaint channels. These measures need not imply that existing employers violate current law. [22-25]

7.4. Reimbursement and investment cases for clinical pharmacist work

DoH and private/government payers should pilot explicit payments or contracted service bundles for high-risk pharmacist interventions within lawful clinical scope. Candidate packages include structured medication reconciliation at care transitions, complex-polypharmacy reviews, pharmacist-supported chronic disease medication optimization, antimicrobial stewardship for high-use hospitals and high-alert medication monitoring. Contracts could combine a funded base FTE or per-episode service fee with modest quality incentives. Payers should specify accountability, documentation, physician collaboration, eligibility and safeguards against double billing. The US Medicare MTM and selected incident-to experience offers design lessons but is not a plug-and-play reimbursement template. [2,5,6,9,20]

Hospitals should evaluate incremental staffing against measured endpoints: medication-related harm, preventable adverse drug events, antimicrobial days of therapy, guideline adherence, readmissions, avoidable ICU days, patient satisfaction, therapeutic target attainment and validated cost measures. Hypothetical cost avoidance should be reported separately from

realized budget savings and net new reimbursement; transparent evaluation will improve credibility with finance executives. [2,4,16,17]

7.5. Responsible workforce development and job creation

DoH's existing Tawteen and health workforce initiatives can be aligned with specialty service development, including postgraduate training, mentor-protected positions, internal clinical ladders and structured conversion of operational roles into clinical positions where safe and appropriate. Planning must protect service quality for all patients while respecting Emiratisation policy and fair recruitment standards. The first expansion phase should concentrate on under-covered, high-risk clinical activities rather than incentivizing indiscriminate graduation volumes. [10,11,29,30]

Table 4. Suggested policy action plan and accountability

Time horizon	Lead stakeholders	Action	Measurable deliverable
0-6 months	DoH Workforce + hospital regulators + MoHRE	Audit pharmacy title, clinical FTE, posted vacancies, time-to-fill, actual hours and anonymized compensation.	Baseline hospital-by-hospital denominator; public aggregate dashboard.
6-18 months	DoH + hospital groups + payers	Pilot minimum specialist coverage and two reimbursable medication-safety service bundles in 15-20 hospitals.	Protected clinical FTEs, reviewed patient coverage, documented outcomes, independent audit.
6-18 months	MoHRE + DoH + employer and worker representatives	Study compensation spread; publish specialty title definitions and voluntary wage guidance.	Salary report by credential, sector, role and hours; wage transparency adoption.
18-36 months	DoH + federal stakeholders + insurers	Scale proven services and evaluate staffing and legally viable wage-floor proposals.	FTE growth, turnover, quality outcomes, net program costs and equity indicators.

8. Illustrative staffing-and-budget pilot (not a UAE workforce estimate)

A feasible evaluation could recruit 20 diverse hospitals, assigning two additional protected clinical pharmacist FTEs in each to high-risk patient services, generating 40 new paid positions. A second scenario would add four FTEs per hospital, or 80 posts. Using an explicit hypothetical monthly salary of AED 20,000 per FTE, the respective annual base salary costs would be AED 9.6 million and AED 19.2 million. These figures exclude benefits, annual leave backfill, insurance, education, systems costs and shift coverage. AED 20,000 is a modeling input, not an assertion about current average UAE pay and not a proposed legal salary floor. [19,26,27]

The pilot should use prospectively defined baseline, matched comparator units where feasible, independent medication harm adjudication, a pre-specified financial evaluation and 12-month workforce retention follow-up. FTE targets would be revised after measuring patient complexity and hospital capacity. Its purpose is to learn whether budgeted clinical care can improve outcomes and stable employment, not to project the entire UAE job market from a single pilot.

9. Discussion

The US demonstrates that clinical pharmacist positions can be maintained at scale when multidisciplinary care models, sustained institutional budgets, established specialty training and specific quality obligations reinforce one another. However, it would be inaccurate to claim that US clinical pharmacy is universally reimbursed at individual service level, that its salaries are protected by a pharmacist-specific statutory minimum, or that no US hospital struggles to secure additional posts. In fact, recent US pharmacy finance literature and a 2026 administrator survey document continuing pressure on FTE approval and direct reimbursement. [1,2,4,22]

In Abu Dhabi and the wider UAE, the most credible concern is not simply "too many pharmacists" or "too few hospitals." It is that broad pharmacist workforce supply, specialist clinical demand, funding arrangements and employer wage-setting are not publicly mapped onto one another with sufficient precision to plan careers or assure patient coverage. The DoH 2022 oversupply finding and 2026 updated priority framework establish that workforce balancing is an acknowledged policy issue. The 2024 accreditation/scope framework and 2025 federal legislation create practical levers for moving from recognition to supported service delivery. [9-11,19,20]

Professional remuneration matters for safety because pay and career stability influence retention, willingness to undertake specialized training and the continuity of complex clinical services. Yet an assertion that all UAE wages are "uncontrolled" would neglect existing labor-law duties, WPS monitoring, private-sector citizenship-specific wage rules and employer contractual obligations. The policy gap is best framed as limited specialty-specific wage protection and transparency. Creating pay standards without a complementary source of hospital funding could inadvertently suppress jobs, so payer reform and targeted staffing expectations should be developed together. [2,23,24,26,27]

Policy transfer also requires caution. The UAE has a different hospital size distribution, insurance structure, employment composition and legislative environment. Clinical pharmacist contributions should be valued in patient outcomes and risk-adjusted service provision, not merely compared with US job counts or dollar wages. DoH could act as a regional pilot regulator while MoHRE and national professional organizations develop workforce protections and national comparability. [7-9,19,23,30]

10. Limitations

This is a narrative synthesis using accessible primary government/regulatory sources, selected research and online salary indicators, not a systematic review. No UAE-wide registry of employed and unemployed clinical pharmacists, funded clinical specialist vacancies, hiring-freeze prevalence, or standardized remuneration by job title was identified in the reviewed sources; absence in this review is not proof that no agency collects such information. The DoH oversupply finding is from a 2022 workforce planning document and should not be extrapolated to November 2026 without updated data. US hospital survey response rates are low, BLS occupational wages do not isolate clinical specialists, and UAE salary websites use nonrandom volunteer or job advertisement samples. Dollar and dirham figures are not adjusted for taxation, purchasing power or benefits. The proposed staffing and compensation reforms are policy recommendations, not currently binding legal requirements.

11. Conclusion

A sustainable UAE clinical pharmacy workforce requires more than recognition of advanced practice or an expanding hospital sector. It requires paid patient-facing posts, credible staffing expectations, transparent and fair compensation, institutionally supported career pathways, and funding arrangements that reward measurable patient safety. The United States supplies transferable examples of embedding pharmacists in hospital operating models and selected medication-management payment streams, but also warns that clinical benefit alone does not automatically fund jobs. The Department of Health - Abu Dhabi, labor and workforce authorities, healthcare employers, insurers and professional organizations should jointly measure the gap between licensed pharmacist supply and funded clinical service demand, pilot financially viable staffing models, and strengthen wage transparency and employment quality. These policies would permit a genuinely evidence-based response to concerns over underemployment, limited recruitment and low specialist pay in the UAE.

Policy message to regulators

For the Department of Health - Abu Dhabi: operationalize the existing legal scope and hospital accreditation requirements through a risk-adjusted clinical pharmacist staffing and outcomes framework; publish aggregated clinical FTE, vacancies and service coverage; and test payer-supported high-risk pharmacotherapy services.

For MoHRE and national workforce stakeholders: commission a confidential profession-specific wage and job-market census; develop transparent clinical-specialist grades and legally sound pay safeguards; monitor actual hours and contracted wages; and link advanced training investments to paid positions and career progression.

Declarations

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