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The Hon. Mark Butler MP
Minister for Health and Aged Care
House of Representatives
Parliament House
CANBERRA ACT 2600

Email: minister.butler@health.gov.au

Dear Minister Butler

RE: Concerns Regarding Pharmacist Driven Urinary Tract Infection (UTI) Treatment

1. Barriers to access and timely access to treatment of UTI

50 % of women will experience a painful UTI and 5% of men. Professional bodies understand that it is unacceptable that patients have to wait for the diagnosis and treatment of this condition and the delay in treatment can result in avoidable hospitalisation.

It is a fact that UTIs affect women more than men. The diagnosis of this infection requires the assessment of the classic symptoms of painful urination, increased frequency of urinating and in some cases blood in the urine. It has detrimental effects for the patient and in the course of diagnosis, management and treatment can result in the loss of working days with a significant social cost. It is also very clear that a percentage of UTIs will progress to a more serious infection of the kidneys which can result in the need for hospitalisation.

The presentation of a classic UTI is not uniform. The symptoms may NOT be present in some cases – in patients with diabetes, there maybe no burning or stinging during urination; in patients with a neurological condition or in the elderly, the only symptoms can be a change in behaviour or cognition. There is also the very real possibility that the symptoms of a classic UTI may NOT be due to an infection. Frequency and burning on urination can be seen in cases of kidney stones, bladder cancers, interstitial cystitis (non-infective bladder condition), cancers in the pelvis, fistulae (connection between bladder or urethra and vagina or bowel) or foreign body reaction (e.g., eroded mesh).

Therefore, this condition, so easily diagnosed when there is no knowledge to exclude other diagnoses, can result in significant harm if poorly or inadequately assessed. This can increase the burden of disease in the community, increase the risk of unnecessary hospitalisation due to treatment delay.

The barriers to access in the management of UTI relies on the ability to access a medical professional to assess and investigate. The urine would need to be tested for infection and identify the responsible bacteria. Based on the antibiotic susceptibility (which can change between communities and evolve over time), the appropriate antibiotic can be used which would also need to be assessed based on the patient's allergy profile and other medications.

Therefore, the access would need to be assisted in the form of increasing the presence of community healthcare services – GPs, specialist nurses – which will require time, thought and care.

Easier access to urine results, increasing education around access to results in My Health Record and empowerment of community GPs would need to be supported.

The risks to the community not only include the delayed diagnosis of mores serious, possibly malignant conditions, missed diagnosis of UTIs due to lack of typical symptomatology, but also poor antibiotic stewardship by overuse of antibiotics generating multi-resistant UTIs.

2. The applicability of implementing Queensland's UTI community pharmacy service

The Queensland experience has been reviewed by the Australian Medical Association-AMAQ (response to QH consultation on autonomous pharmacist prescribing of antibiotics for UTI – July 2022). The review outlined significant issues within this pilot:

- 15% of 185 doctors surveyed provided care for patients with complications following their treatment by a pharmacist.
- Inappropriate or ineffective antibiotics were utilised in 30% of the complications noted
- 8 patients required hospitalisation due to serious or life-threatening infection
- Three male patients were treated for UTI though the trial was only for "uncomplicated cystitis in non-pregnant women"
- Misdiagnosis of UTI – pregnancy, kidney stones, large pelvic tumour, ruptured ovarian cyst missed

The AMA-Q has vehemently opposed the implementation of antibiotic prescribing by pharmacists based on the findings demonstrated above. It would be clear that these findings would also be highly likely throughout Australia. The attempt to deliver accessible care needs to be tempered with the responsibility of ensuring the care is not dangerous, to the detriment of the community and increasing healthcare burden in an already overstretched system.

3. Other considerations

- Financial conflict of interest

It would be a natural consideration in this case. Increasing the remit of pharmacies, there is the increased ability to monetise the prescription of antibiotics. There is a direct financial benefit in doing so. It is difficult to separate this consideration here.

- Lack of definitive diagnosis

The prescription of an antibiotic requires clear assessment of infection, causal organism, resistance patterns and patient factors – co-morbidity, history of resistance to antibiotics, allergies, medication, red flag risk factors. This is an active and thoughtful process. The administration of a prescription is also a thoughtful process. Consideration of concomitant medications and allergy history would be part of that assessment. There is a distinct difference in the approach and process in both of these actions. Blurring the line between them severely erodes the ability to support antibiotic stewardship and support of patient safety. As medical practitioners we are well aware of the emergence of multi-resistant organisms as the cause of bacterial infection and sepsis, leading to increased rates of severe septicaemia and even death. The greatest risk factor for this is the indiscriminate use of antibiotics which will most likely occur with this proposed model of care to treat urinary symptoms which may or may not be an infection.

- Privacy and maintaining health records

Discussing the symptoms attributable to a UTI is deeply personal. It would have to be undertaken in a private setting with clear documentation and entry into the patient's health record so that any issues such as poor response to antibiotic, resistance and concomitant illness can be assessed. The breakdown of this process can result in misdiagnosed and delayed diagnoses, already demonstrated in the study by AMA-Q. The need for a complete and thorough patient health record is clear. What remains unclear is how this can be supported by the administration of antibiotics in a fragmented manner with no assessment or evaluation.

o Safety

The assessment and identification of a sick patient requires healthcare knowledge and practice. It is unsafe and unfair to expect the pharmacist to be able to identify the sick patient and implement management. The patient who is clearly about to deteriorate significantly can present in a variety of ways. This is where algorithms and checklists are unhelpful as it does not convey the complexity of assimilating the patient in front of the clinician and the baseline assessment tools – temperature, heart rate, respiratory rate and blood pressure. It would be unreasonable to expect a healthcare professional who has undertaken no clinical study to be able to deliver this level of care. It is unsafe for the patient as alternative diagnoses may be missed including malignancies and other acute surgical conditions that could mimic urinary infections.

We stand with the AMA-SA, AMA-Q and Royal Australian College of General Practitioners (RACGP) to oppose the motion to implement unsupervised antibiotic prescribing authority to pharmacists. We support caring for our community and our patients. We support excellent governance and clinical care standards. We support equitable delivery of healthcare and the need to be thoughtful and thorough in the consideration and implementation of measures to improve healthcare access. If this response rate is applied to the many health service access needs, we may actually be making gains on healthcare provision in a resource limited landscape. We recognise the need for patients to obtain an assessment and treatment in a timely fashion, and our nursing colleagues and pharmacists can be part of the solution in a collaborative model, but unsupervised prescribing by pharmacists alone without a formal medical assessment cannot be supported.

Yours sincerely

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