AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
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31 January 2023

Ms Jayne Stinson
Chair
Select Committee on Access to Urinary
Tract Infection Treatment
GPO Box 572
Adelaide SA 5001

E: scuti@parliament.sa.gov.au

Dear Ms Stinson

Re: Select Committee on Access to Urinary Tract Infection Treatment – Call for Submissions

On behalf of the Australian Medical Association in South Australia (AMAA(SA)), thank you for the opportunity to provide a submission to the Select Committee on Access to Urinary Tract Infection (UTI) Treatment, so that we may outline the reasons our members argue strongly against any expansion of pharmacy prescribing that might include prescribing medicinal treatments for UTIs.

Consistent with the views of the Pharmaceutical Society of Australia, AMA(SA) considers the separation between dispensing and prescribing activities to be critical, and that pharmacist-prescribing requires 'adequate checks and balances and auditing to ameliorate conflict-of-interest risk'.

It is our belief that the introduction of pharmacy prescribing for UTIs in South Australia would jeopardise patient safety by encouraging pharmacists to work as de facto GPs with a fraction of the training and experience necessary to provide care. At the same time, pharmacists have a financial and business incentive to prescribe antibiotics that may be unnecessary, ineffective or even unsafe for treatment of patients' conditions. We are concerned that patients will have little or no opportunity to discuss their symptoms and medical histories in private, which may lead them to withhold details critical to accurate diagnoses and safe, effective treatment and care.

Our argument is outlined below, according to the terms of the review.

1. Barriers facing sufferers of Urinary Tract Infections (UTIs) in gaining timely access to treatment

We recognise that the crisis in funding general practice and Medicare has led to some issues in patients accessing appointments with their general practitioners (GPs) in South Australia in recent months. The ongoing impact of COVID on the heath system has also contributed to GP availability. However, our members report that South Australian women who report suspected UTI symptoms are seen as a matter of urgency, so that any so-called 'barrier' to access does not in fact exist for patients with these symptoms.

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In addition, the cost of the pharmacy consultation cannot be claimed through Medicare, and the prescribed medication cannot be recouped through the Pharmaceutical Benefits Scheme (PBS), so the pharmacy consultation creates a different but equally troublesome 'barrier to access' for many patients.

We proposed that changes to the funding of general practice to enable practices to employ nurse practitioners, who will have access to women's medical history, including previous UTIs, will be a safer option in terms of increasing access to consultations than allowing pharmacists to prescribe UTIs no access to medical histories, and few (if any) opportunities for private discussion.

2. The applicability of implementing Queensland's UTI Community Pharmacy Service in South Australia

The introduction of pharmacy prescribing in Queensland follows recent examples of the Pharmacy Guild capitalising on Queensland's one-house parliamentary system to introduce medical reforms with questionable benefit for patients but unquestionable benefits for pharmacies. In this case, the decision to allow retail pharmacists in North Queensland to diagnose and prescribe for a range of serious conditions, including UTIs, demonstrates a blatant disregard for patient safety. There was no support for the decision from doctors, including a former pharmacist who retrained as a GP.

We note that in Queensland, many medical organisations withdrew from the experiment due to the threat posed to patient safety, including through a methodology that did not meet clinical and scientific standards: there was no random controlled trial, no clinical review and no valid evaluation.

As mentioned above, we are concerned that the Queensland model failed to address how a retail pharmacy business will manage its actual conflict of interest in diagnosing/prescribing and selling. The amendments fundamentally conflict with the long-standing and essential separation of drug prescribing and selling functions, fragments care and undermines team-based, collaborative healthcare.

In regard to the UTI pharmacy prescribing experiment, the Queensland Government's own review showed that hundreds of women were harmed through not receiving the correct treatment during the pilot program:

- 65 per cent of women who took part in the UTI experiment were not contacted for follow-up, despite this being part of the protocol, meaning their safety and/or any adverse events were not known
- Of those who were followed up, at least 270 needed further treatment, either because they were misdiagnosed, suffered complications, or did not respond to treatment, possibly due to antibiotic resistance.
- 97 per cent of women who took part were sold antibiotics, whether they needed them or not
- One in two pharmacists said they would have found it difficult to charge the consultation fee without also supplying antibiotics
- The vast majority of services were delivered in cities and major regional towns in business hours, not after-hours or in rural and remote areas.

We expect that in establishing your review you have sought from Queensland Health the evidence that the experiment was successful in supporting the safe and effective treatment

of women for UTIs, and the cost-benefit analysis that provides an argument for this decision rather than other options that might improve 'timely access to treatment'.

We also expect that any pilot undertaken in South Australia do so under the standard procedures for a clinical trial, including ethics approval, evaluation and reporting, and that any such trial immediately cease if it is shown to negatively affect patient health.

3. Any other matters

The AMA(SA) rejection of pharmacy prescribing for UTIs is solely based on concerns for patient safety.

Clinical examples

Anecdotal reports of the Queensland pilot include missed diagnoses of ectopic pregnancies, sexually transmitted infections, and cervical cancer. Examples of how patient safety is at risk through pharmacy prescribing – which may miss important symptoms or diagnoses – include the following:

- An AMA(SA) Councillor and GP discussed with a senior medical colleague a series of urine samples she had undertaken to investigate what she thought were UTIs. All tests were clear. The GP recommended an appointment, during which the GP identified the inflammatory condition Lichen Planus as the explanation for her symptoms. Triggers for Lichen Planus include hepatitis C, certain pigments and chemicals, and pain relievers. It can cause severe pain and long-term sexual dysfunction. The patient said that she would have sought antibiotics from a pharmacist; these would have had no effect.

- On a weekend morning in December, the same GP saw a woman who sought an urgent appointment as the woman thought that she had a UTI. A specific history was suggestive but not conclusive of urine infection. A dipstick urine test quickly revealed that the woman did not have a UTI. (The dipstick test can determine the presence of blood, protein, sugar, white cells – found in infection – and nitrites in a graded amount.) A physical examination identified the problem as a gynecological diagnosis often seen in post-menopausal women due to a lack of oestrogen that can masquerade as a UTI. Treatment provided was of topical oestrogen cream and reassurance that she did not have a UTI.
  The woman agreed that if the opportunity had been available, she would have seen her pharmacist and accepted antibiotic treatment because she was confident that she did indeed have a UTI. A pharmacist would not have been able to conduct the appropriate, intimate physical examination.

- During the same weekend, the GP saw an older woman who has a complicated history including diabetes, weight issues, multiple medications and a past history of UTI. The woman called the GP concerned she had a UTI. With the patient's detailed history, the GP determined a UTI was likely. The GP provided an e-prescription for an antibiotic that is not the one usually prescribed for UTIs, due to the woman's medical history. A UTI was later confirmed. However, the woman's complex history means she would not have recovered with the 'standard' antibiotic and could have been very unwell. A follow-up appointment has been booked.

Repeat UTIs

Women who have had UTIs that did clear up with antibiotics may be persuaded that a quick trip to the pharmacist is preferable to waiting for a GP. However, this approach overlooks the possibility of other causes of the symptoms and complications or history of antibiotic use.

The pharmacy diagnosis or treatment can be wrong – and those women who repeatedly seek antibiotics for UTIs may be those at greatest risk of missed diagnoses of cancer or a serious STI, or pregnancy. There is no opportunity to establish proper preventative therapy and establish a treatment plan for recurrent symptoms based on existing and prior medical symptoms and conditions.

Privacy concerns

One of our concerns relates to how the pharmacy consultation will take place with adequate privacy procedures to protect the patient while ensuring she feels safe and comfortable in explaining her symptoms. Queensland Health has proposed a 'screened or private consulting area'; we reject the suggestion that a 'screened' area provides sufficient privacy for sensitive discussions about medical symptoms and sexual histories.

Women who have additional symptoms are unlikely to want to discuss them with a pharmacist and may avoid awkward conversations.

International comparisons

AMA(SA) is aware that Queensland Health pointed to 'pharmacist models of care in comparable countries'. However, as our AMA Queensland colleagues pointed out, the 'models' were not comparable.

New Zealand
Pharmacists must have a postgraduate clinical diploma or equivalent and have several years of clinical experience in a specialised area before applying for the 12-month postgraduate course.

The course involves a 250-hour practical along with an academic component.
Pharmacist prescribers must train in a specific clinical area – for example, paediatrics – and then work within their specific clinical area of practice in a hospital ward, not in a retail pharmacy.

United Kingdom
Pharmacist prescribers must have a minimum standard learning time of 26 days' worth of structured learning and a 90-hour practical. Most work in general practices.

Canada
Limited emergency prescribing and prescription extension powers in 10 of 13 provinces.
One province (Alberta) allows pharmacists to apply for additional prescribing authorisation.
All information must be relayed back to the patient's doctor. If it is a new condition, the pharmacist must refer the patient to a doctor for formal diagnosis and treatment.

The model in New Zealand does not occur in isolated community pharmacies but in an integrated model with doctors. Likewise, the United Kingdom does not permit the scope of pharmacist-prescribing permitted in the NQ Pilot. The model in Alberta lacks sufficient scientific evidence to be relied upon and incorporates far more stringent requirements for referral to a doctor and record-keeping than that included in the NQ Pilot.

Antimicrobial resistance

In Queensland, 97 per cent of pharmacists prescribed antibiotics to people presenting with UTI symptoms. Yet the World Health Organization has determined that antimicrobial resistance is one of the greatest risks to global health. One of the major concerns is resistance to certain strains of E. coli that cause UTIs. Inappropriate use and overuse of antibiotics will increase resistance, increasing the risk of a return to non-treatable infections.

Enabling pharmacists to prescribe antibiotics without reference to a patient's history undermines efforts to monitor and enforce compliance with best-practice approaches for appropriate and judicious antimicrobial use, as required in *Australia's National Antimicrobial Resistance Strategy 2020 and Beyond.*[1]

At the same time, we note the existing issues of supply of many medications in Australia, and question whether pharmacists without many years of medical training will be in the best position to offer safe alternatives if the commonly prescribed antibiotics are unavailable.

In closing, we note the recent release of a report[2] demonstrating that since a doctor's prescription has been required to access codeine – a change introduced in 2018 to increase patient safety – use of codeine has dropped by 37 per cent across Australia and between 25 and 51 per cent in Australian states and territories. With GPs responsible for monitoring codeine prescriptions, patient safety increased.

I look forward to discussing this submission with you and your Committee. Should you wish us to provide more information or clarify any issue in the meantime, please contact me via my Executive Assistant, Mrs Claudia Baccanello, on 8361 0109 or at president@amasa.org.au at any time.

Yours sincerely

Dr Michelle Atchison

BM, BS, FRANZCP, GDipArtHist

President
Australian Medical Association (SA)

[1] https://www.amr.gov.au/resources/australias-national-antimicrobial-resistance-strategy-2020-and-beyond

[2] https://www.unisa.edu.au/media-centre/Releases/2022/codeine-consumption-plunges-in-the-wake-of-tough-love/, 20 December 2022