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Issues related to Menopause and perimenopause

Senate Standing Committees on Community Affairs

Online submission

Introduction

The AMA welcomes the Senate Standing Committees on Community Affairs Inquiry: Issues into Menopause and Perimenopause. The Committee listed nine Terms of References (ToRs) for consideration. Throughout this submission, the term woman is used. The AMA acknowledge that menopause and perimenopause can affect people who do not identify as female/woman, and their needs may be particularly unique and complex. The evidence on menopause in gender-diverse individuals is difficult to source and needs more attention[1].

Menopause is a pivotal time in midlife for approximately 3 million Australian women aged between 45-64 years. Changes in the menstrual cycle due to varying levels of oestrogen (the main sex hormone) is the most reliable indicator of the menopause transition (the peri-menopause). The menopause occurs with the final menstrual period and women who have gone 12 months without a period are termed post-menopausal[2]. Menopause can also start much earlier for some women due to treatment for cancer (chemotherapy and/or radiotherapy), primary ovarian insufficiency (POI) and surgical removal of the ovaries[3].

Menopause is biologically inevitable. However, a woman's experience is highly variable. Factors including symptoms, race and ethnicity, social meanings, expectations, self-esteem, life adversity and general health impact on women in different ways. For around one in three women, the severity of symptoms at some stage of their transition to menopause will negatively impact their ability to perform

[1] https://www.healthline.com/health/transgender-menopause

[2] https://www.menopause.org.au/hp/management/menopause-basics

[3] https://www.healio.com/news/womens-health-ob-gyn/20230928/reduce-morbidity-mortality-with-hormone-therapy-for-premature-menopause

daily functions[4]. All women should have access to evidence-based support to determine the best course of action to manage symptoms and improve their health and lifestyle.

In this submission, the AMA will focus on six key issues which interchange with the nine ToRs outlined by the committee:

1) The central role GPs play in helping women to make informed decisions about their healthcare during menopause and perimenopause.

2) Access challenges for women prescribed Menopausal Hormone Therapy (MHT) medicines.

3) All women experiencing symptoms have the right to seek and receive the care they need.

4) Menopause and the workplace.

5) Funding boost for new research into menopause and perimenopause.

6) Development of a National Menopause Framework.

1. GPs play a central role in helping women to make informed decisions about their healthcare during menopause and perimenopause

Over 90 percent of Australians visit their GP every year and are the first port of call for people with questions about perimenopause and menopause. They are also the first port of call for 90 percent of people with mental health issues. GPs are trusted by patients and many have long lasting therapeutic relationships. GPs understand the patient and are best placed to provide holistic care that takes into considerations the patients' other health issues and social circumstances.

For some women, their transition to menopause can be uneventful. But for others, the experience is vastly different, suffering from prolonged or severe symptoms. Hot flushes, insomnia, anxiety and depression, fatigue, irritability, muscle aches and pains, vaginal dryness and low libido are just some of the symptoms[5]. Importantly, and under-prioritised, is that the transition to menopause and perimenopause is the optimal time to identify women at greatest risk of diabetes[6], heart disease[7], osteoporosis[8] and some cancers[9] which are well documented long-term risks. Integrated care and prevention strategies are best managed by the GP. Any given patient may benefit from referrals to gynaecology and endocrine specialist services when needed, such as for women after cancer or with contraindications to Menopausal Hormone Therapy (MHT) and when it would benefit women, and to women's health physiotherapy services for issues such as stress incontinence and dyspareunia.

[4] Davis, SR & Magraith, K. Advancing menopause care-Australia barriers and opportunities. Medical Journal Australia 2023; 218 (11): 500-502
[5] Gartoulla P, Bell RJ, Worsley R, Davis SR. Menopausal vasomotor symptoms are associated with poor self-assessed work ability. Maturitas 2016; 87:33-9
[6] Paschou et al., Diabetes in Menopause: Risks and Management. Curr Vasc Pharmacol 2019; 17(6):556-563
[7] Ryczkowska, K et al., Menopause and women's cardiovascular health: is it really an obvious relationship? Arch Med Sci 2023 v19 (2)
[8] https://www.endocrine.org/patient-engagement/endocrine-library/menopause-and-bone-loss
[9] Davis SR, Baber RJ. Treating menopause - MHT and beyond. Nature reviews Endocrinology 2022

Patient rebates have not kept pace with rising inflation, and this is a constant challenge for GPs. The current MBS structure is a barrier for GPs spending more time with patients to provide the necessary care. The AMA welcomed the introduction of a new Level E consultation item in November 2023 which covers consultations longer than 60 minutes. It is too early to determine if the introduction of Level E consultations has improved care for menopause and perimenopause.

Developed by the Women's Health Research Program in the Monash University School of Public Health and Preventive Medicine, The Practitioner's Toolkit for Managing the Menopause was revised last year in accordance with published literature[10] and has been endorsed by the International Menopause Society, Australasian Menopause Society, British Menopause Society, Endocrine Society of Australia and Jean Hailes for Women's Health. Algorithms are provided to guide the clinical assessment and care of women relevant to menopause. This Toolkit assists with the determination of menopausal status, MHT and non-hormonal treatment options for symptom relief. Additionally, clear guidelines were developed to determine when MHT might be indicated to prevent bone loss and subsequent osteoporosis in asymptomatic women. The algorithms are designed for shared decision-making with the medical practitioner and patient. Reluctance to prescribe MHT suggests this is still an area of confusion and an under-recognised challenge for medical practitioners[11]. More evidence-based information is needed regarding the potential risks of newer forms of MHT, contraindications to newer forms of MHT, and the potential benefits of MHT on symptom control, bone, and cardiovascular health. In the absence of these, the decision to offer and use MHT and its duration needs to be made by a woman and her doctor based upon her symptoms and the impact the condition is having on her quality of life. There is increasing evidence in support of Cognitive Behavioural Therapy (CBT) and Mindfulness Therapy[12] to reduce the psychological impact of hot flushes and night sweats and improve sleep. As medical practitioners are highly experienced at the provision of mental health care and strategies, they are crucial in this effective treatment modality.

2. Access challenges for women prescribed MHT medicines

Newer medicines, with more favourable side effect and adverse event profiles are available in Australia but are not listed on the Pharmaceutical Benefits Scheme (PBS). This raises serious questions regarding the affordability of new generation medicines for many women. This is partly due to outdated pricing regulations and a glaring oversight of the health needs of women.

Many MHT medications such as oestrogen patches are susceptible to supply shortages and/or discontinuation by the sponsoring pharmaceutical company. The issue of MHT medication supply shortages need to be urgently addressed by the TGA. The impact on the patient and their doctor is untenable as they spend large amounts of additional time trying to find alternatives for patients when their regular medications are unavailable. Manufacturers have provided a variety of reasons, including

[10] https://www.menopause.org.au/images/pics/ptmm/a-practitioners-toolkit-for-managing-menopause.pdf
[11] https://www.healthed.com.au/clinical_articles/mht-prescribing-anxiety-persists/
[12] Khoshbooii R et al. Effectiveness of Group Cognitive Behavioural therapy on Depression among Iranian Women around menopause. Australian Journal of Basic and Applied Sciences. 2011:5: 991-995.

shortages of raw materials, batches of the medicine not meeting Australian specifications, or logistical delays including potential impacts of global events.

3. All women who have symptoms from menopause and perimenopause seek and receive the care they need.

The lack of education and "visibility" of menopause as a public discourse is stark in many non-Western countries. As a result, many women from Culturally and Linguistically Diverse (CALD) societies ignore or downplay the discomfort associated with menopause and perimenopause[13]. There is a widespread tendency to neglect women's health issues, in general, due to a culture of normalisation of the symptoms, as 'part of being a woman' be they associated with menstruation, conception, pregnancy, childbirth, or declining ovarian reserve as occurs leading into perimenopause, menopause and beyond[14]. An Australian survey of 197 Arabic women living in Sydney revealed menopause-related symptoms were highly prevalent and severe[15]. Women reported their quality of life was negatively affected, yet they did not seek care from health professionals. Both ageism and sexism has contributed to a dismal norm. This stigma keeps women from embracing interventions that can help.

There is no clear consensus on how Aboriginal women view menopause or what influences may play a role in the development of this view due to very few published accounts[16]. In an exploratory, qualitative study (or yarning session) involving 25 Aboriginal women from the mid-west region of Western Australia, the term "change of life" was more widely recognised and signified the process of ageing, and an associated gain of respect in the local community[17]. A fear of menopausal symptoms or uncertainty about their origin was also common.

With regards to menopause, our dilemma is how we view and encourage women and our society to view and embrace it as a normal and natural phase of life, while still ensuring that women who have symptoms that significantly affect their lives seek and receive the care they need. Educating women about their menarche, reproductive and menopause life stages provide empowerment to make informed decisions about their health care. Informed and shared-decision making has been the focus of peak national and international organisations such as the Australasian and International Menopause Societies and Jean Hailes for Women's Health for many years and these principles were further reinforced in an Australian-led series on menopause, recently published in The Lancet[18].

[13] https://www.jeanhailes.org.au/news/helping-women-from-diverse-backgrounds-access-reproductive-care
[14] Bandyopadhyay et al., Accessibility of web-based health information for women in midlife from culturally and linguistically diverse backgrounds or with low health literacy ANZ J Public Health 2022, Pages 269-274
[15] Lu, J. et al. The experience of menopausal symptoms by Arabic women in Sydney. Climateric 2007 Feb;10(1):72-9
[16] https://menopausealliance.au/menopause/first-nations-women-and-menopause/#:~:text=In%20one%20study%20of%20over,rural%20Aboriginal%20women%20reported%20symptoms
[17] Jurgenson et al., Exploring Australian Aboriginal Women's experiences of menopause: a descriptive study. BMC Womens Health 2014 13, 7053

Engaging and accessible campaigns (ensuring reach includes women from culturally and linguistically diverse backgrounds, Indigenous women, women with disabilities and gender diverse people) are needed using social media, convenience advertising, short ads/ posters (with a QR code to link to a Government website). Investment into making a series of short culturally appropriate, comprehensive health education videos that could be used as a "takeaway information tool" and stored on mobile phones and social media platforms is required.

Health misinformation through social channels is highly contentious, leading to unnecessarily spending vast sums of money on ineffective and unproven alternative therapies. Complementary and herbal therapies are sometimes referred to as "natural" and may be derived from plants and other sources, mimicking the effects of prescribed body-identical hormones at unknown strengths. Some people believe that these products are safer than prescription products. These "natural products" can cause harm and can interact with prescribed medicines. Some over the counter treatments, including plant extracts, are not subject to the rigorous testing for content, safety and effectiveness that prescription treatments are subject to. Despite no clinical trial evidence, natural therapies are easily purchased and tend to be very expensive. The associated marketing is sophisticated and typically use celebrity endorsement.

4. Menopause and the workplace

Data presented by the Australian Institute of Superannuation Trustees (AIST) in their submission to Treasury (Measuring what matters: Understanding our economy and society while informing policy making) alerted to a significant economic impact attributed to menopause and early retirement[19]. Women retire 7.4 years earlier, on average, than men. In economic terms, menopause is estimated to cost Australian women $15.2 billion in lost income and superannuation for every year of early retirement. The Annual Jean Hailes National Women's Health Survey 2023 found that a quarter of Australian women (45-64 years of age) reported that symptoms attributed to menopause (experienced in the last five years) made it hard to do daily activities[20]. In the UK, it was reported that one in four women who experience menopausal symptoms considered leaving their job, with the potential loss of knowledge, experience, and talent[21].

In the UK, several attempts were made to make menopause, like pregnancy, a protected characteristic under the 2010 Equality Act[22]. While these attempts failed, more recently the Equality and Human Rights Commission released guidance suggesting that menopause symptoms could be considered a disability if disruptive enough to interfere with everyday activities, and that employers are legally obliged to make reasonable adjustments[23]. In keeping with the requirement of Australian workplaces to be inclusive, reasonable changes could include a perimenopause/ menopause policy that could be factored into health and safety risk assessments due to relevant (currently invisible) considerations, for example,

[19] https://treasury.gov.au/sites/default/files/2023-03/c2023-379612-australian_institute_of_superannuation_trustees.pdf
[20] https://www.jeanhailes.org.au/uploads/15_Research/Menopause-and-Australian-Women-FINAL_V2_TGD.pdf
[21] https://newsroom.simplyhealth.co.uk/35-million-women-have-considered-quitting-job-due-to-menopause-and-menstrual-health-symptoms/
[22] https://committees.parliament.uk/work/1416/menopause-and-the-workplace/

[23] https://www.equalityhumanrights.com

temperature regulation, the importance of ventilation and access to sanitary facilities/products. Other workplace initiatives could include flexible work environments where days could be spent working from home, beginning respectful conversations to enable reasonable adjustments such as cooling or appointing menopause 'champions' within the organisation to ensure a discrete; and knowledgeable point of contact for employees who wish to access such a support.

5. Funding boost for new research into menopause and perimenopause

There is a lack of funding for therapeutic clinical trials in perimenopause and menopause leading to poor treatment outcomes, especially in perimenopause mental health conditions. The NHMRC and MRFF need to prioritise funding toward supporting research initiatives and longitudinal studies focused on women's health during mid-life. This will provide valuable insights and data to fill existing evidence gaps.

Collaboration between government bodies, research institutions, healthcare providers, and community organisations is crucial. Establishing partnerships can facilitate data-sharing, joint research projects, and the development of targeted programs to address mid-life women's health concerns.

All research conducted needs to include diverse representation across age groups, socio-economic backgrounds, ethnicities, and geographical locations. This approach will help capture a more comprehensive understanding of the health issues faced by mid-life women, considering the diverse experiences within this demographic.

6. Call for a National Menopause Framework

Australia does not ha a National Menopause Framework and/or Action Plan. The AMA is hopeful that a National Framework will be recommended as a priority from this Inquiry. A framework will factor in the considerable social, economic and health impacts menopause can have. Depending on a woman's cultural and financial background, access to quality treatment and support for menopause and perimenopause is not equitable in Australia. A national framework needs to establish goals and timelines for change.

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