RACGP submission to

Inquiry into the issues related to menopause and perimenopause

February 2024

RACGP

Contents

Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Senate Community Affairs References Committee *Inquiry into the issues related to menopause and perimenopause*.

The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or toward a specialty career in general practice, including four out of five general practitioners (GPs) in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support GPs and their broader healthcare team to address the primary healthcare needs of the Australian population.

The RACGP's mission is **to improve the health and wellbeing of all people in Australia by supporting GPs, general practice registrars and medical students through its principal activities of education, training and research** and by assessing doctors' skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, helping GPs with issues that affect their practice, and developing standards that general practices use to ensure high-quality healthcare.

Executive summary

Menopause is a normal reproductive stage in which egg production and menstrual periods stop permanently. Menopause typically happens to people in their early 50s but may occur earlier in certain populations.[1] Menopause before the age of 45 is regarded as 'early' and before age 40 as 'premature'. [1] Most individuals (around 80%) experience symptoms of menopause. These generally do not need treatment, however for around 20–25% of people, there are severe and/ or prolonged symptoms that may require medical intervention.[1]

The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG), defines perimenopause as the time from the onset of menstrual cycle changes until one year after the final menstrual period. The menopause is the final menstrual period. The "perimenopause" or "menopause transition" is the time from the onset of menstrual cycle changes until one year after the final menstrual period**.** A woman is postmenopausal 12-months after her final menstrual period.

Despite menopause being a natural part of ageing, there can still be a huge stigma attached to it. This may impact seeking help for symptoms and openly discussing health concerns.[3] Other impacts on individuals' lives can also be attributed to menopause – many may reduce their working hours or cease work altogether due to a lack of support to manage their symptoms. Additionally, there are financial considerations from the cost of treatments and medications to manage symptoms, as well as the possible changes to work and remuneration.

a. The economic consequences of menopause and perimenopause.

A study conducted in the UK in 2019 by the Chartered Institute for Personnel and Development found that three in five people experiencing menopause – usually aged between 45 and 55, were negatively affected at work. [4]

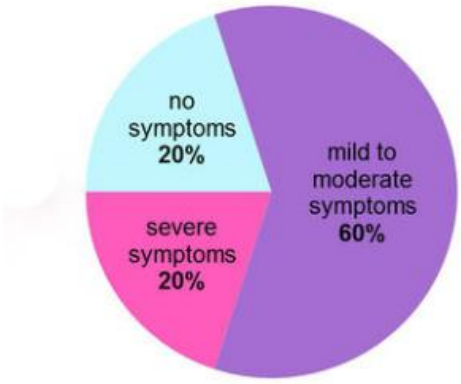
This is a concern for patients presenting for menopausal care. Patients often express concern about not coping at work which can be a major stressor due to the impact on self-esteem, finances, and sense of independence. They are often concerned about using sick leave or requesting medical certificates to take time off work. Menopausal symptoms can lead to patients retiring earlier than planned, or taking less high-powered work, leading to a loss of income and status.[5,6]

Research shows that women retire 7.4 years earlier on average than men. This results in a loss of more than $577,000 per woman. This has a huge economic impact on Australia with menopause estimated to cost Australians experiencing menopause $15.2 billion in lost income and superannuation for every year of early retirement. [6]

There is evidence that menopausal individuals often leave their place of employment as they do not feel supported. This creates a loss of corporate knowledge and increased costs for business as they need to recruit to these positions. People who remain in the workplace, but feel unsupported, often experience an increase of sick days and loss of productivity at work.[16]

b. The physical health impacts of menopause and perimenopause

Approximately 80% of menopausal individuals experience some symptoms of menopause, 60% experience mild to moderate symptoms, and 20% experience severe symptoms that interfere with their daily life.[2]



Common symptoms of menopause include[2]:

Physical Symptoms

- Vasomotor symptoms (hot flushes, night sweats), which may impact mood and quality of life
- Sleep problems – often caused by hot flushes and night sweats but also exacerbated by mood disorders, sleep apnoea and other chronic conditions such as restless leg syndrome.
- Irregular periods (perimenopause)
- Sore breasts
- Itchy, crawly, or dry skin
- Exhaustion and fatigue
- Dry vagina
- Loss of libido and painful sex
- Headaches and migraines
- Painful, aching joints due to the drop in oestrogen levels.
- Bloating
- Urinary problems
- Weight gain due to a slower metabolism
- Increased risk of osteoporosis with decreased bone density and increased fracture risk.

As a GP providing holistic care, one of the barriers to assisting in quality menopause management is having adequate time to support quality menopause care. For quality perimenopause and menopause care, longer appointments are needed. This is to adequately assess the multiple physical health impacts of menopausal symptoms but also to consider preventative care and risk screening.

Menopause occurs at a time of mid-life heath which includes an increasing risk of metabolic diseases including diabetes and cardiovascular disease, breast and bowel cancer, and osteoporosis. Many people consider that vasomotor symptoms are the main physical symptoms, but musculoskeletal and skin symptoms can also impact on physical health. Fatigue is a specific symptom, and also has a side-effect of poor sleep and nocturnal vasomotor symptoms that can impact physical health. It can also lead to decreasing exercise and increasing weight, which in turn worsens metabolic disease.

c. The mental and emotional wellbeing of individuals experiencing menopause and perimenopause.

Emotional symptoms

- Anxiety and depression – sleep disturbances due to hot flushes contribute to increased symptoms of anxiety and depression. Menopause can be a time of vulnerability for the development of clinical anxiety and depressive disorders[1]
- Feeling irritable or frustrated
- Difficulty concentrating
- Forgetfulness
- Lowered mood
- Mood swings.

Perimenopause in particular, is a time of hormonal transition and can cause worsening in mental health, motivation, concentration and cognition. Symptoms can persist when post-menopausal.

Again, GPs need appropriate time and funding to provide best care for the assessment and management of the mental and emotional wellbeing of people experiencing menopause. There is also a need for patient and practitioner education on the impact and sensitive management of the impact on cognition and memory (brain fog), and appropriate management options for mental health in this time.

Access to and costs associated with psychological and psychiatric services continue to be an ongoing issue for many mental health conditions and it can be challenging to find a mental health practitioner with a specific interest in menopausal, hormonal, and mental health.

d. The impact of menopause and perimenopause on caregiving responsibilities, family dynamics and relationships.

Menopausal symptoms, especially when not recognised or treated, can lead to relationship difficulties and even breakdown due to impact on physical and emotional wellbeing. Partners and families unaware of, or not understanding symptoms can be an issue. There are online resources, but further education and health promotion of what is normal and what is not can be helpful to partners and family members. This could be through an advertising campaign or specific educational activities for partners, carers, and families.[7]

e. The cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause.

There is a lack of culturally appropriate research in First Nations menopause perceptions and best-evidence care to guide culturally appropriate menopause clinics and management options.

Two small studies have found that there were similarities between Indigenous and non-Indigenous experiences of and symptoms of menopause. However, the authors found that the current language and health promotion around menopause used within mainstream health settings may not be appropriate for Indigenous settings. Use of more common and culturally appropriate phrases such as 'change of life' can help.

Another theme found was that menopause symptoms were often attributed to more serious and common conditions for Aboriginal patients, such as diabetes and heart disease, and that fear of complications and poor outcomes can lead to treatment avoidance.

Further research into culturally appropriate best practice menopausal care is required.[8, 9]

There is also a lack of evidence of menopause symptoms and treatment experience for the LGBTQIA+ community. There is also a need for appropriate health resources for this community.

Most of the research in the LGBTQIA+ community has focused on the menopausal experience of people who identify as lesbians. Researchers found that there is minimal difference between the number and severity of symptoms for lesbian

participants, but they were more likely to report positive feelings towards menopause and midlife sexual function. Genitourinary symptoms of menopause were noted to have a similar negative impact on sexual function.

There is less data available about menopause and midlife sexual experiences for other members of the LGBTQIA+ community.

Many of the challenges for inclusive menopause care for the LBTQIA+ community are barriers that occur when accessing healthcare in general. Some examples of challenges that can occur are:

- healthcare practitioners not understanding and expecting menopausal symptoms for trans men or non-binary patients
- need for sensitive communication around body part terms and examinations.
- gender dysphoria
- concerns and lack of knowledge about the use of menopausal hormone therapy whilst also using gender affirming hormones
- existing mental or physical health problems that may be exacerbated by fluctuating hormones.

Whether (exogenous) sex steroids influence breast cancer risk and pathogenesis in transgender people is not fully understood. It is known that sex steroids induce changes in breast tissue. A study from the Netherlands found that there was an increased risk of breast cancer was observed in transwomen who had used gender affirming hormone therapy (GAHT) compared with cisgender men, and lower risk in transmen who had used GAHT compared with cisgender women.[10, 11]

For CALD patients there is lack of easy English resources (Jean Hailes is looking to develop resources with input from Sexual Health Victora), however there are translated fact sheets available through hospitals, Jean Hailes, and government health translation pages. Again, further research is needed into menopause experience of symptoms and management for CALD communities to help guide holistic culturally appropriate menopause care in Australian primary care.

f. The level of awareness amongst medical professionals and patients of the symptoms of menopause and perimenopause and the treatments

S Davis et al (2021) found that Australian healthcare providers appeared knowledgeable about menopause, but uncertain about its management. Menopausal hormone therapy (MHT) prescription appeared limited to those with severe symptoms. They concluded that the upskilling of clinicians providing care for patients at midlife, concerning the indications for and prescribing of MHT, urgently needs to be addressed.[12] This appears to be an international issue as similar findings and conclusions were made in a European study by Rozenberg et al (2023) [13.]

Further education in recognising symptoms and signs but also a systematic evidence-based approach to management including non-drug therapy, MHT, and other management options is required at medical school, prevocational and vocational training, and post-Fellowship. This will improve knowledge of menopause care, especially in perimenopause when treatment can be withheld due to it ‘not being post-menopausal’ or the patient ‘too young’.[11]

Author Tania Glyde states:

> Along with understanding minority – and global majority – experiences of menopause, it is perimenopause specifically where much work needs to be done. Insufficient knowledge and awareness of perimenopausal symptoms remains a problem. I have heard accounts of people being told by doctors that they are too young to be in perimenopause. What is strange is that instead of accepting their patients’ experiences, some practitioners are still telling them what can and cannot be. [11]

Funding for further research into best practice menopause clinical education as well as funding for education activities for health professionals could address this gap.

Another barrier to providing appropriate medication management is that Australia has a problem with MHT supply and cost. Australia can have shortages of MHT preparations due to manufacturing and shipping delays. Many MHT products are not available on the Pharmaceutical Benefits Scheme (PBS) making them costly for some patients and can influence

the choice of preparation away from a lower risk for venous thromboembolism (blood clots in veins such as deep vein thrombosis and pulmonary embolism) and cardiovascular disease (transdermal preparations) to a cheaper but more moderate risk (such as oral preparations).

The 52 mg levonogestrol interuterine device (IUD), which can be a useful part of MHT by providing contraception, perimenopausal menstrual control, and endometrial protection, still has a low Medicare rebate for insertion in primary care. This can be a barrier to GPs to learn and provide insertion services.

g. The level of awareness amongst employers and workers of the symptoms of menopause and perimenopause.

The number of people who will experience menopause while in employment is increasing. Pre-pandemic research in the UK, showed that women over the age of 50 were the fastest growing group in the workforce.[3] The same UK study showed that the average age of retirement for women in 1986 was 60 and by 2020 this had increased to 64.3. While many of these women were highly skilled and at the peak of their careers, many of them felt forced to leave work because of menopausal symptoms, noting that menopause is not well understood or provided for in workplace cultures, policies and training[14].

As mentioned in section a), patients often note concern about not coping at work and express concern about using sick leave or asking their GP for a medical certificate due to potential lack of understanding from their employer. Employees can fear repercussions will impact their job security or career progression and so many prefer to suffer in silence.

Suggestions of how employers could make the workplace more supportive for individuals experiencing perimenopause or menopausal symptoms could include[6]:

- flexible working conditions – flexible start and finish times, working from home.
- fans
- cold drinking water available
- natural light
- free period products
- uniforms made from natural, breathable fabrics.
- more access to toilet breaks
- education of management in how to manage not just menopause, but other health issues experienced such as pelvic pain and menstruation.

h. Existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause.

The Victorian Occupational Health and Safety Act, 2004[15] includes a duty to ensure that workplace conditions and their environments do not adversely impact on health, which is important as many individuals experiencing menopause complain that their workplace environment has a negative impact on their health.

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