

## **PARLIAMENT OF AUSTRALIA SENATE INQUIRY: ISSUES RELATED TO MENOPAUSE AND PERIMENOPAUSE**

**Submission prepared by the Gynaecology Community of Practice (GCoP) for the SA Health Maternal, Neonatal & Gynaecology Strategic Executive Leadership Committee**

*Scope: Members of the Gynaecology Community of Practice are employed within the acute / public hospital sector. Therefore, the submission is limited to sections b, f and h and does not purport to be a comprehensive response from SA.*

### **b. the physical health impacts, including menopausal and perimenopausal symptoms, associated medical conditions such as menorrhagia, and access to healthcare services:**

#### **1. Symptoms, medical conditions and provision of medical services**

According to the [Australian Menopause Society](#) (AMS), approximately 20% of women will experience no physical menopausal symptoms, 60% of women will experience mild symptoms for 4-8 years, and 20% will experience severe symptoms that extend into their 60s or later. Physical symptoms include hot flushes, night sweats, joint and muscle pain, light headedness, headaches, insomnia, unusual tiredness, new facial hair, vaginal atrophy and dryness, loss of libido, dyspareunia, urinary frequency, dry skin and crawling feelings under the skin. Psychological symptoms include irritability, mood changes, depression, and anxiety and may be related to physical symptoms, including sleep deprivation.

First line support and management of menopause is, and should be, in the primary care sector. [A Practitioner's Toolkit for the Management of the Menopause](#) updated in 2023 provides evidence-based guidance for the assessment and care of women, but we are unable to comment on the extent it is used by General Practitioners (GPs) or Gynaecologists working in the community.

However, there are clinical presentations associated with perimenopause and menopause that are more complex. These include heavy menstrual bleeding, post-menopausal bleeding, premature menopause due to surgery, spontaneous premature ovarian insufficiency, oncology treatment or genetic conditions, and management of menopause following treatment for breast or ovarian cancer. It is likely that more specialised and/or multi-disciplinary management will be required for women experiencing these conditions.

Furthermore, increased rates of osteoporosis, urinary tract infections and associated morbidity, incontinence, and pelvic organ prolapse are associated with menopause, again requiring more complex surgical and non-surgical management.

#### **Recommendations:**

Provision and funding for complex menopause clinics within the public hospital system (including in regional areas), that includes increased urogynaecology medical staff, continence nurse(s), dietitians, physiotherapists and mental health practitioners.

Such clinics should have the ability to perform relevant procedures in the outpatient setting.

#### **2. Access to healthcare services**

As with most healthcare, access to specialist menopause healthcare providers is more difficult for women living in regional and remote areas, with specialist gynaecologists predominantly located in metropolitan areas, some major regional centres and as a visiting (private) medical specialist in GP or other healthcare centres. For the majority of women, this necessitates travelling to the city.

Aboriginal and culturally and linguistically diverse women and gender-diverse people may not access healthcare to remoteness, stigma, lack of awareness and an assumption that symptoms and other conditions associated with menopause are simply something 'to put up with'.

The other major barriers to access are cost for fee-for-service for people of lower socio-economic status and/or only available option, travel, investigations and treatment and lack of access to publicly funded clinics with long wait lists, general gynaecology clinics only, and lack of multi-disciplinary input within clinics. See section f.

#### Recommendations:

The Federal Government and local jurisdictions develop public awareness campaigns that include how to access services.

Options for telehealth be developed (including from major regional centres).

Options for mobile menopause services (like Breast screening and Bone Density screening) be developed.

Specific consultation with priority population groups be undertaken with subsequent actions to ensure equity of access.

Increase publicly funded multi-disciplinary clinics (as above) and investigations.

The Federal Government lobby RANZCOG and universities and/or offer additional incentives to place even greater emphasis on rurality in their selection of future medical staff and specialist gynaecologists.

#### **f. the level of awareness amongst medical professionals and patients of the symptoms of menopause and perimenopause and the treatments, including the affordability and availability of treatments:**

Awareness amongst women and health professionals was addressed above.

With most menopause management occurring in the private sector, including GPs and private gynaecologists, appointments, associated additional investigations (e.g., pelvic ultrasound scans) and potentially procedures or surgery, most women will be 'out of pocket' to some degree due to the gap payment between the Medicare benefit rebate and the service cost. Whilst there is a gap payment for GP visits, the gap for private gynaecologists is significantly more and for ultrasounds, it is frequently over \$150. This puts the price of accessing care beyond the reach of many women.

Allied health professionals are predominantly located within the private sector with associated fee for service. Even when accessing the scheme that subsidises costs with an appropriate care plan, there is frequently a gap and a capped number of visits.

Furthermore, many hormonal replacement therapies (HRT) are not covered on the PBS with additional out of pocket expenses of more than \$70 per month.

- Note: This includes Mirena® when used as a component of HRT or for women with atypical hyperplasia or endometrial malignancy where surgery is not considered an appropriate option.

Access to appropriate HRT has also been problematic with Australia-wide shortages. The AMS has updated information on their website.

Travel costs subsidised by local jurisdictional schemes are largely inadequate with overnight stays (even in basic accommodation), also incur out of pocket expenses, which is cumulative for ongoing management.

## Recommendations

The Australian Government:

- ☐ Expand the list of HRT included in the Pharmaceutical Benefits Scheme (including Mirena® with the above indications).
- ☐ Increase the MBS rebate for both GP and specialist gynaecology appointments.
- ☐ Increase the MBS rebate for pelvic ultrasound scans.
- ☐ Increase the number of allied health visits allowed with an appropriate care plan.

Increase publicly funded multi-disciplinary clinics (including in regional areas, as above) and investigations.

Where women need to travel for appointments, local jurisdictional transport schemes should have minimum rebates that more appropriately reflect market prices.

Increased affordable overnight options should be available for women and families needing to travel long distances for appointments.

Telehealth appointments should be made available wherever appropriate.

### **h. existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause:**

The GCoP is largely unaware of any specific actions for menopause in the healthcare sector in SA.

The Premier's Council for Women was established in December 2002 to provide leadership and advice to the South Australian Government in respect to the needs and interests of women through the provision of well-informed and strategic advice on policies, programs and matters of significance to women. We are unable to comment on any specific actions relating to menopause and other items in the Senate Inquiry terms of reference.

The SA Office for Women has specific policies relating to:

- ☐ Safety and Wellbeing
- ☐ Employment and Economic Status
- ☐ Leadership and Participation