About Viv Health

Viv Health is a telemedicine service for women Australian women experiencing perimenopause and menopause. It was founded in response to a service gap identified through the personal menopause experience of the medical director, Dr Louise Tulloh.

Viv health provides a new model of care for women experiencing perimenopause and menopause. Women complete a comprehensive digital form outlining their health, symptoms and concerns and then continue to a 30+ minute video or phone consultation with a doctor experienced in treating menopause. Following this they're issued a report and recommendations, e-scripts if indicated, information, resources particular to their situation and have the option of joining a membership or continue with healthcare as usual (pay as you go service fee). Membership provides ongoing appointments, asynchronous care (contact your doctor anytime), ongoing symptom monitoring and member only benefits including courses, webinars and other content related to midlife women's health and wellness.

Viv Health operates outside the Medicare-rebatable system. Currently, telehealth reproductive services attract a Medicare rebate but only if provided by a VR GP. This does not apply to other doctors working in menopause.

There are no current formal or accredited training qualifications for offering menopause care, which is delivered by GPs, endocrinologists, gynaecologists, integrative care doctors and other doctors with an interest in the area who have typically voluntarily upskilled. Whilst VRGPs attract time tired rebates for telehealth reproductive services, many, perhaps most GPs, are not comfortable or skilled at providing this type of care.

This submission will include the experience of both health care providers and experiences shared by women as their patients.

Terms of reference (b)

Physical Health Impacts

Symptoms of menopause transition
Research indicates that 80 to 85% of women will experiencing symptoms of hormonal change which will last from anywhere between four years and 12 years. 20% of women experience severely disruptive symptoms that impact them at work and in life.

Symptoms of hormonal change start even before the menstrual periods vary in length. The commonly agreed STRAW 10 classification of reproductive ageing defines early perimenopause as occurring when the menstrual period length varies by more than seven days. Symptoms of hormonal change, in particular breast tenderness, worsening PMS, flushes and sweats associated with the menstrual period, mood changes, increased frequency of headaches and generalised aches and pains have been identified to occur in

the late reproductive stage, when the period is still regular but may have changed in flow or duration.

Women are becoming increasingly aware that in their early 40s new symptoms may be attributable to hormone changes and often over-interpret any new symptoms accordingly. They naturally feel dismissed and frustrated when their healthcare practitioners have little to offer in the form of recognition, education or hormone treatment (which is complicated during this stage of reproductive life).

Hormone receptors are present in most cells of the body and therefore the symptoms can be varied, and are variably experienced between individuals, both in nature and severity. Whilst there is increased awareness of the variety of symptoms, public perception continues to identify menopause as being a bothersome time of hot flushes, sweats and sometimes irritability. While symptoms may be disruptive, they usually resolve over time as the body adapts to changing hormone levels. The duration of disturbance varies from 1-2 years to 12+ years.

We will not elaborate further on the symptoms experienced during menopause as we anticipate this will be well covered during the enquiry.

Action 1. Increase research funding into for late reproductive stage – physiology, clinical experience, management.

Long-term health impacts

The menopause has a long-term impact on the musculoskeletal system, cardiometabolic system and risk of Alzheimer's and non-Alzheimer's dementia.

Bone health
Bone loss is accelerated in the five years before and after the last menstrual period after which the rate of bone loss plateaus. Osteoporosis is a significant cause of mortality and morbidity in women. Osteoporosis is a silent disease and often only presents with a fragility fracture. Currently there is no Medicare rebate for bone density screening around the time of menopause despite the considerable cost of osteoporotic fractures to the health budget.
"The total direct cost of osteoporosis in Australia in 2017 was estimated to be $3.44 billion"
https://pubmed.ncbi.nlm.nih.gov/30615801/

Menopause hormone treatment has been shown to reduce the risk of fracture and osteoporosis when used within 5-10 years of the last menstrual period. It is indicated as a first line, anti-resorptive therapy in women identified with osteoporosis.

Nutrition and exercise in addition to general health and well-being are also important for bone health. The exercise that has been shown to improve bone health includes high impact loading, for example jumping, skipping, running for short bursts of time, and heavy resistance training, often much more than is recommended for women in midlife and beyond. Women are often under the mistaken belief that they are looking after their bones

by walking for their prescribed 150 minutes a week. In addition, falls prevention in the form of strength training, agility and balance work becomes increasingly important with age.

Action 2 - The use of menopause hormone treatment to prevent further bone loss in women identified as being at high risk of osteoporosis should be considered within five years of the last menstrual period.

Action 3 - Provide a Medicare rebate for a single screening DEXA scan between the ages of 45 and 55 so that women know where their baseline bone density is when considering the use of MHT for long term health.

Action 4 - Refine education for exercise in post-menopausal women to include high impact loading as well as heavy resistance training in addition to balance for falls prevention.

Cardiometabolic Health

The prevalence of cardiovascular disease increases in women after the menopause, independently of age. This is thought to be due to the loss of the protective effect of oestrogen on various risk factors. Women experiencing early menopause (younger than 45 years) or premature ovarian insufficiency (younger than 40 years) have long been identified as having an increased risk of developing cardiovascular disease. In addition, women experiencing negative outcomes of pregnancy, preeclampsia, gestational diabetes and those menopausal women experiencing worse vasomotor symptoms have also been identified as having an increased risk.

There is evidence that commencing MHT within the "window of opportunity" (5-10 years following their last menstrual period), reduces cardiometabolic risks - improving lipid profile, reducing insulin resistance and reducing the development of atherosclerosis.

Menopausal Hormone Replacement Therapy and Reduction of All-Cause Mortality and Cardiovascular Disease: It's About Time and Timing. Hodis

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9178928/#:~:text=Initiated%20in%20women%20%3C60%20years,lowering%20fail%20to%20do%20so.

Despite this, current guidelines do not recommend MHT for the prevention of cardiovascular disease in. However, in women experiencing early menopause, MHT until the age of average menopause in (51 years) *is* indicated for the prevention of cardiovascular disease. This would appear contradictory but there seems to be a reluctance to include CV protection as an indicator for MHT use.

Ref https://www.menopause.org.au/images/docs/2023wmd/White-Paper-final.pdf

Action 5. Provide a Medicare rebatable mid-life health check that covers hormonal health and ensure the current cardiac health check includes information about reproductive risk factors.

Dementia

Both Alzheimer's disease and non-Alzheimer's dementia are more common in women than men and have recently reached the status of the leading cause of death in women. There are very few treatment options for women experiencing dementia. Preventative lifestyle factors including regular exercise, avoidance of excessive alcohol and smoking, getting good sleep, and identifying and treating cardiometabolic risks such as high blood pressure, abnormal lipids, insulin resistance our priorities. It also seems that using menopause hormone treatment can reduce the risk of developing both Alzheimer's and non-Alzheimer's dementia when commenced within five years of the last menstrual period. The effect size is comparable to other lifestyle factors.

Systematic review and meta-analysis of the effects of menopause hormone therapy on risk of Alzheimer's disease and dementia

https://www.frontiersin.org/articles/10.3389/fnagi.2023.1260427/full

There has been controversy regarding the use of MHT and its impact on both cardiovascular events and dementia. It appears that there is a reduced risk of developing these conditions when MHT is used within the window of opportunity but after this time considered to be 10 years after the last menstrual period there is an increased risk of these conditions presumably because cells have been adapted to their low oestrogen state, no longer respond favourably to oestrogen supplementation and the risk of thrombogenesis with oestrogen supplementation in this context.

Terms of reference (c)

Mental and Emotional Well-being

Hormonal symptoms impact women's emotional health via various mechanisms including lack of sleep, increased irritability, depression, anxiety and mood swings, and compound situational stresses of mid-life including continued and emerging child rearing, caring roles for ageing parents, work and changing sense of physical self and social relevance.

Emotional disorders often start even before the period has changed and are rarely recognised by general practitioners as being hormonal in nature. They often treated with antidepressants which may be ineffective. Rates of suicide for women peak between the ages of 45 and 55 years, although it is uncertain whether this relates to increasing incidence of menopausal depression.

Action 6. Create GP education resources to highlight the nature of perimenopausal mental health and the role of hormone treatments.

Terms of reference (f)

Awareness in medical practitioners and patients

Women's expectations
Many women are becoming self-informed with the help of social media (Facebook, Instagram, tiktok) and through podcasts and books. Unfortunately, much of this information is generated via celebrities and other menopausal women inspired by their own personal experience and is not medical in nature even though medical information is being freely shared in peer-to-peer fashion.

One popular source of information amongst menopausal women is the Dr Louise Newson podcast and her balance app which generate interest for her recent book, app and clinic based in the UK. The UK health system is quite different to the Australian health system and the information that is shared is often inappropriate to our population. There is also controversial information regarding some hormones (for example testosterone) shared on this site and we are noticing many women bringing requests for these treatments to our service. There is also a gap in applying this generic hormonal information to the different reproductive stages that any individual woman may be experiencing and yet there is a pervasive expectation amongst women that hormones will treat all their unwanted symptoms. These unrealistic expectations can be quite challenging to dismantle on a background where women feel that their symptoms and experiences have been dismissed by their regular treating doctors. Many women understand the variety of unwanted symptoms that may arise in busy and stressful mid-life, are attributable to "hormones" and are expecting some form of hormone therapy to "give them their life back". This is a phrase we hear regularly, along with "my doctor dismissed me".

It is our clinic's experience that women often have numerous symptoms that they have been made aware of by using various checklists and apps available online. Whilst this would appear helpful and often is, it can also lead to hypervigilance and the development of suffering from symptoms they may not even had been aware of. Many women have expectations that all their symptoms and indeed all the issues that they may attribute to their hormones can be resolved with hormone replacement therapy, which is simply not the case, especially when the menstrual period is still largely regular. Women are reluctant to address lifestyle issues (such as excessive alcohol consumption, obesity, lack of physical activity), preferring the magic fix of hormone treatment promised by FB groups, celebrities and high-profile doctors. This viewpoint requires balance.

Practitioner competency
Many general practitioners do not have the experience, confident or time to understand the breadth of the menopausal experience, monitor symptoms, explain and educate. They may not fully understand the hormonal changes occurring during the various reproductive stages which are indeed complex, and the appropriate and safest treatments when women are seeking symptom relief.

A case in point is the exclusion of treating women with migraine using HRT. Women with migraine and aura can usually use HRT provided it is transdermal oestrogen which does not increase thrombotic risk. Another group of women that is being regularly denied the opportunity for effective hormone treatment is those who have a family history of breast cancer, even if that family history does not constitute a strong risk for them personally.

Fear of cancer seems to outweigh fear of heart disease and quality of life when it comes to healthcare professionals offering treatment, bypassing the shared decision-making process that should take place in any of these circumstances.

Doctors are also subject to biases of information – with unwarranted fear of breast cancer resulting in avoidance of hormone therapy or creating undue fear in women themselves.

Action 7. Support an accreditation process for menopausal care in Australia. The Australasian Menopause Society could be responsible for development and oversight.

Action 8. Support practitioners who are competent in providing menopause care (and accredited as above) with appropriate time-based rebates, including telehealth services.

Treatment access

Most of the women seeking care at Viv Health have used menopause supplements recommended on social media or by friends. These come at considerable expense although seem to be largely safe, if ineffective.

There have been chronic and recurrent shortages of some of the most popular and safest forms of HRT, transdermal oestrogen patches. Transdermal oestrogen patches are on the PBS but women with a uterus require a progestogen to protect the endometrial lining from endometrial cancer. The safest progesterone (Prometrium) is available as a private prescription, making the combination of patch and Prometrium expensive for the average woman. Whilst they can use progestins on the PBS (non-body identical progestogens), these have more side effects, are implicated in the increased risk of breast cancer and may be poorly tolerated by some women, aggravating mood disorders.

Women with financial restraints do not have access to optimal medical opinion nor to the safest and most effective HRT options.

Action 9. Ensure the safest treatments are on the PBS.

Terms of reference (a)

Menopause in the workplace

There is a lot of discussion regarding policy and in particular additional leave for women experiencing symptoms of menopause in the workplace. Menopause remains a threat to a woman's career progression given there are *actual* symptoms impairing performance such

as sleeplessness, irritability, fatigue and brain fog, and *perceived* impairments around the concept that menopausal women are “crazy and over the hill”.

Policies that exclude women further from the workplace eg additional leave, may not suit all women and may indeed further alienate and impair career progression. Fortunately, disruptive menopausal symptoms can be safely treated using hormone treatments for most women most of the time. This reduces the disruptive symptoms so that they can get on with effective and meaningful work and avoids the necessary policy adjustments that may appear to exclude their relevance and usefulness in the workplace.

For other workers and those with less autonomy, policies regarding leave, breaks, uniform and environmental temperatures maybe more relevant.

Summary

Perimenopause and menopause are an important timestamp in a woman's reproductive life. They mark not only a transition from fertility but also an opportunity to make decisions and take action on current and long-term health. Women should be confident in being supported within our current healthcare structure through properly qualified doctors, using affordable, effective treatments when safely possible.

Proposed actions

Action 1. Increase research funding into for late reproductive stage – physiology, clinical experience, management.

Action 2 - The use of menopause hormone treatment to prevent further bone loss in women identified as being at high risk of osteoporosis should be considered within five years of the last menstrual period.

Action 3 - Provide a Medicare rebate for a single screening DEXA scan between the ages of 45 and 55 so that women know where their baseline bone density is when considering the use of MHT for long term health.

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Action 5. Provide a Medicare rebatable mid-life health check that covers hormonal health and ensure the current cardiac health check includes information about reproductive risk factors.

Action 6. Create GP education resources to highlight the nature of perimenopausal mental health and the role of hormone treatments.

Action 7. Support an accreditation process for menopausal care in Australia. The Australasian Menopause Society could be responsible for development and oversight.

Action 8. Support practitioners who are competent in providing menopause care (and accredited as above) with appropriate time-based rebates, including telehealth services.

Action 9. Ensure the safest treatments are on the PBS.

Note – People experiencing menopause have been referred to as “women” in this submission. We appreciate not all people experiencing menopause will identify as “woman”.

HRT is used interchangeably with MHT.

Dr Louise Tulloh
MBBS FACSEP GAICD
Medical Director, viv Health