The Senate

Community Affairs References Committee

Issues related to menopause and perimenopause

September 2024

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Terms of reference

Issues related to menopause and perimenopause, with particular reference to:

a. the economic consequences of menopause and perimenopause, including but not limited to, reduced workforce participation, productivity and retirement planning;

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

c. the mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support;

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

e. the cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause, including specifically considering culturally and linguistically diverse communities and women's business in First Nations communities;

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;

g. the level of awareness amongst employers and workers of the symptoms of menopause and perimenopause, and the awareness, availability and usage of workplace supports;

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

i. how other jurisdictions support individuals experiencing menopause and perimenopause from a health and workplace policy perspective; and any other related matter.

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Abbreviations

AIST	Australian Institute of Superannuation Trustees
ALSWH	Australian Longitudinal Study on Women's Health
AMC	Australian Medical Council
AMS	Australasian Menopause Society
ASFA	Association of Superannuation Funds of Australia
CALD	Culturally and linguistically diverse
CAMs	Complementary and alternative medicines
COTA	Council on the Ageing
Equality Act	Equality Act 2010
FECCA	Federation of Ethnic Communities' Councils of Australia
FSH	Follicle-stimulating hormone
GP	General practitioner
GSM	Genitourinary syndrome of menopause
HRT	Hormone Replacement Therapy
IC	Involuntary childlessness
IVF	In vitro fertilisation
Jean Hailes	Jean Hailes for Women's Health
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual plus
LH	Luteinising hormone
MBS	Medicare Benefits Schedule
MCHRI	Monash Centre for Health Research and Implementation
MHT	Menopause Hormonal Therapy
MIPO	Menopause Information Pack for Organisations
MRFF	Medical Research Future Fund
NES	National Employment Standards
NHMRC	National Health and Medical Research Council
NSW	New South Wales
PBAC	Pharmaceutical Benefits Advisory Committee

PBS	Pharmaceutical Benefits Scheme
PMDD	Premenstrual dysphoric disorder
POI	Primary ovarian insufficiency
PPC	Prescription payment certificate
RACGP	Royal Australian College of General Practitioners
TGA	Therapeutic Goods Administration
the Act	Fair Work Act 2009
the committee	Senate Community Affairs References Committee
the Council	The National Women's Health Advisory Council
the Department	Department of Health and Aged Care
the Strategy	The National Women's Health Strategy 2020–2030
UK	United Kingdom
WGEA	Workplace Gender Equality Agency
WHI Study	Women's Health Initiative Study

List of recommendations

Recommendation 1

2.114 The committee recommends that the Department of Health and Aged Care commission research to establish a comprehensive evidence base about the impacts of menopause and perimenopause on women in Australia, including:

- **Menopause differentiated from midlife stressors;**
- **Mental health impacts of menopause; and**
- **Early menopause.**

The research should also establish an understanding of experiences for:

- **Culturally and linguistically diverse women;**
- **First Nations women;**
- **LGBTQIA+ individuals; and**
- **Women living with a disability.**

Recommendation 2

2.117 The committee recommends that the Australian Government launch a national menopause and perimenopause awareness campaign, providing information and resources for women and communities across Australia. This awareness campaign should be designed in consultation with experts and people with lived experience.

Recommendation 3

2.120 The committee recommends that, in the next review of the Australian Curriculum, the Australian Curriculum, Assessment and Reporting Authority (ACARA) consider how menopause can be expressly referenced in the menstrual health and reproductive cycles content within the Health and Physical Education learning area.

Recommendation 4

3.78 The committee recommends that the Australian Government commission research to undertake a comprehensive study to assess the economic impacts of menopause which clearly delineates the impact of symptoms of menopause on women's workforce participation, income, superannuation, and age of retirement.

Recommendation 5

3.81 The committee recommends that the Australian Government introduce reforms to allow the Workplace Gender Equality Agency (WGEA) to

re-commence data collection on the supports employers are providing, and their usage, for employees experiencing menopause and perimenopause, including specific workplace policies.

Recommendation 6

3.90 The committee recommends that the Australian Government consider amendments to Section 65 of the Fair Work Act 2009, to ensure women can access flexible working arrangements during menopause.

Recommendation 7

3.91 The committee encourages Australian workplaces develop perimenopause and menopause workplace policies in consultation with their employees.

Recommendation 8

3.92 The committee recommends that the Australian Government task the Department of Employment and Workplace Relations to undertake further research on the impact and effectiveness of sexual and reproductive health leave where it has been implemented in Australia and overseas, while giving consideration to introducing paid gender-inclusive reproductive leave in the National Employment Standards (NES) and modern awards.

Recommendation 9

4.141 The committee recommends that the Australian Government encourage the Australian Medical Council to consider explicitly including menopause and perimenopause in the Graduate Outcome Statements of the Standards for Assessment and Accreditation of Primary Medical Programs. The committee further recommends that menopause and perimenopause be included in graduate outcomes for other health professionals, including nurses and physiotherapists.

Recommendation 10

4.142 The committee recommends that the Australian Medical Council work with Medical Deans Australia and New Zealand to ensure that menopause and perimenopause modules are included in all medical university curriculums.

Recommendation 11

4.146 The committee recommends that all governments and the medical colleges work together to require and facilitate further education on menopause and perimenopause for physicians practising in the public health system across Australia.

Recommendation 12

4.147 The committee recommends that the Australian Government considers increasing funding and expand the recipient base for the delivery of incentivised continuing professional development to medical practitioners on perimenopause and menopause.

Recommendation 13

4.148 The committee recommends that the Australian Government consider how to expand the scope of practice of nurse practitioners to ensure better support for women experiencing menopause in rural and regional areas.

Recommendation 14

4.155 The committee recommends that the Department of Health and Aged Care, through the Medicare Benefits Schedule (MBS) Continuous Review, review existing MBS item numbers relevant for menopause and perimenopause consultations, including for longer consultations and mid-life health checks, to assess whether these items are adequate to meet the needs of women experiencing menopause.

Recommendation 15

4.156 The committee recommends that the Australian Government consider whether a new MBS item number or the expansion of criteria for the mid-life health check, is needed to support greater access to primary care consultations for women during the menopause transition.

Recommendation 16

4.166 The committee recommends that the Department of Health and Aged Care, including the Therapeutic Goods Administration, consider action to address the shortages of menopause hormonal therapy (MHT) in the Australian market and consider options to secure sufficient supply, including a review of the supply chains and pricing trends of MHT, with a view to enabling universal affordable access to treatment and care.

Recommendation 17

4.167 The committee recommends the Therapeutic Goods Administration continue to monitor the advertising alternative medicines and treatments in Australia and take action as appropriate. The committee further recommends the Department of Health and Aged Care consider reviewing the labelling of TGA approved medicines.

Recommendation 18

4.168 The committee recommends that the Australian Government examine options to implement a means of ensuring that MHT items are affordable and accessible, including consideration of domestic manufacturing and alternate means of subsidising costs to the consumer. Such examination should include, but not be limited to, considering ways to encourage pharmaceutical sponsors to list a broader range of MHT items, such as body identical hormone therapy products, on the Pharmaceutical Benefits Scheme to ensure appropriate access and lowered costs for all women who need it.

Recommendation 19

4.169 The committee recommends that the Pharmaceutical Benefits Advisory Committee (PBAC) reforms comparator selection during evaluation of new MHT items to include quality of life health impacts. The committee also recommends that the PBAC regards body identical hormone therapy products in a separate drug class to remove the lowest cost comparator to synthetic therapies.

Recommendation 20

4.172 The committee recommends the Australasian Menopause Society regularly review and update their guidance for medical practitioners around best practices in the treatment and management of mental health symptoms.

Recommendation 21

4.175 The committee recommends that the Australian Government work with state and territory governments to implement or leverage existing women's health facilities with multidisciplinary care, including in the public health system, to better support women during the menopause transition across Australia.

Recommendation 22

5.73 The committee recommends that organisations tasked with improving menopause care utilise learnings from international best practice.

Recommendation 23

5.74 The committee recommends that the Australian Government investigate improvements to the collection and use of data to assist with research into the experience of menopause and perimenopause, and surveillance of the outcomes of the use of MHT.

Recommendation 24

5.75 The committee recommends that the Australian Government task the National Women's Health Advisory Council to assist state and territory governments to deliver a National Menopause Action Plan which considers best practices in menopause care.

Recommendation 25

5.77 The committee recommends that the Australian Government task the Department of Health and Aged Care and the Department of Employment and Workplace Relations to monitor international best practices to ensure Australia is at the forefront of menopause and perimenopause care.

Chapter 1
Introduction

> Menopause is not an illness, and neither is it a medical condition: it is a normal component of the female life cycle; however, it is a women's health issue with social and economic consequences.[1]

1.1 From reproductive health to menopause, women's experiences are too often ignored and their concerns easily dismissed. Previous inquiries by this committee have highlighted the substandard level of care that some women may experience in their health journey.[2]

1.2 To date, menopause, despite being a natural transition for over 51 per cent of the population, has remained an area in women's health where women's voices and pain have been ignored or poorly understood. Menopause continues to be a topic that is rarely discussed and is stigmatised.

1.3 Every woman's experience of menopause is unique. For some women with debilitating symptoms, this can have a significant impact on their relationships, workforce participation and many other aspects of their lives. Other women will experience few negative impacts.

1.4 Evidence indicates that the level of awareness in the community is very low. There is limited information available, and women experience significant barriers in accessing diagnosis and treatment.

1.5 It is in this context that the committee embarked on this inquiry, seeking to explore the multitude of issues related to perimenopause and menopause in Australia and consider measures to adequately support women during this phase of their lives.

1.6 During the inquiry, the committee listened to the stories of hundreds of women, heard from academics, clinicians, businesses, public health bodies and government departments. The evidence told a compelling story that in Australia, women do not always receive adequate support to manage their symptoms, both in the health system and in their workplaces.

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[1] Affiliation of Australian Women's Action Alliances, *Submission 31*, p. 10.

[2] See, for example, Senate Community Affairs References Committee, *Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia*, May 2023; Senate Community Affairs References Committee, *Number of women in Australia who have had transvaginal mesh implants and related matters*, March 2018.

Referral of the inquiry

1.7 On 6 November 2023, the following matter was referred to the Senate Community Affairs References Committee (the committee) for inquiry and report by the first sitting Tuesday in September 2024:

> Issues related to menopause and perimenopause, with particular reference to:
>
> a. the economic consequences of menopause and perimenopause, including but not limited to, reduced workforce participation, productivity and retirement planning;
>
> b. the physical health impacts, including menopausal and perimenopausal symptoms, associated medical conditions such as menorrhagia, and access to healthcare services;
>
> c. the mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support;
>
> d. the impact of menopause and perimenopause on caregiving responsibilities, family dynamics, and relationships;
>
> e. the cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause, including specifically considering culturally and linguistically diverse communities and women's business in First Nations communities;
>
> 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;
>
> g. the level of awareness amongst employers and workers of the symptoms of menopause and perimenopause, and the awareness, availability and usage of workplace supports;
>
> h. existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause;
>
> i. how other jurisdictions support individuals experiencing menopause and perimenopause from a health and workplace policy perspective; and any other related matter.[3]

1.8 On 1 July 2024, the Senate granted an extension of time to report until 17 September 2024.[4] On 17 September 2024, the Senate granted an extension of time to report until 18 September 2024.[5]

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[3] *Journals of the Senate,* No. 77, 6 November 2023, p. 2217.

[4] *Journals of the Senate,* No. 116, 1 July 2024, p. 3555.

[5] *Journals of the Senate,* No. 133, 17 September 2024, p. 4032.

Conduct of the inquiry

1.9 Details of the inquiry were published on the committee's website and the committee invited a number of organisations and individuals to lodge submissions. The committee received 290 submissions, which are listed at Appendix 1.

1.10 The committee held seven public hearings, and one site visit, across Australia:

- 17 June 2024 – Sydney, New South Wales;
- 18 June 2024 – Melbourne, Victoria;
- 29 July 2024 – Brisbane, Queensland (including a site visit to the Menopause Centre in Greenslopes);
- 30 July 2024 – Canberra, Australian Capital Territory;
- 5 August 2024 – Adelaide, South Australia;
- 6 August 2024 – Perth, Western Australia; and
- 13 August 2024 – Canberra, Australian Capital Territory.

1.11 A list of witnesses who gave evidence at the public hearings is available at Appendix 2.

1.12 In this report, references to *Committee Hansard* are to the proof transcripts. Page numbers may vary between proof and official transcripts.

Structure of this report

1.13 This report is comprised of five chapters, as outlined below:

- This chapter sets out general information outlining the conduct of the inquiry and provides background information pertaining to perimenopause and menopause, its symptoms, health impacts and effects.
- Chapter 2 focuses on the experiences of menopause and perimenopause. It examines the lack of awareness and understanding surrounding perimenopause and menopause, in addition to social impacts and differing cultural perspectives and experiences.
- Chapter 3 discusses the impact of perimenopause and menopause on a woman's working life and its economic consequences, including retirement age, workplace promotions, and superannuation accumulation. It also investigates menopause leave and flexible working arrangements.
- Chapter 4 explores the challenges to diagnose and manage perimenopause and menopause. It examines a lack of medical awareness and training, midlife as an opportunity for preventative healthcare and potential tools that could assist in diagnosis. Additionally, the chapter outlines available treatments and their associated costs and barriers to access, alternative and complementary therapies and the advertisement and regulation of some other therapies.
- Chapter 5 investigates current federal and state government approaches to addressing issues related to menopause and perimenopause. The chapter

also explores international approaches, and considerations raised by inquiry participants for policy makers.

Acknowledgements

1.14 The committee thanks all those who contributed to the inquiry by making submissions, providing additional information, appearing at public hearings and facilitating the site visit.

1.15 In particular, the committee thanks those submitters and witnesses who shared their moving, and sometimes challenging, lived experiences with perimenopause and menopause. The committee appreciates the courage and generosity of these individuals in sharing their personal stories.

1.16 These personal testimonies have been vital in deepening the committee's understanding of the issues related to menopause and perimenopause across Australia and have helped inform the recommendations of this report, which aim to improve outcomes for women and their families, into the future.

Note on the terminology used in this report

1.17 Throughout this report, the term 'woman' or 'women' is used broadly.[6]

1.18 This report uses the term 'perimenopause'. The committee is aware that 'menopause transition' and 'post menopause' have important biological differences, which the term perimenopause can fail to capture.[7] However, to remain in line with the inquiry's terms of reference, perimenopause is used in this report to refer to both the menopause transition and the first year after menopause.

1.19 In this report, the terms 'menopause', 'menopausal' and 'perimenopause' are used broadly as terms encompassing the menopause transition and the final menstrual period for ease of readability throughout the report. However, for clarity, the specific terms and their biological implications are explained in detail below.

What is the menopause and perimenopause?

1.20 Menopause refers to a woman's final menstrual period, which is identified after one year without menstruation.[8] Perimenopause, also known as the 'menopause

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[6] These terms are used in recognition that most people who experience perimenopause and/or menopause identify as women. Notwithstanding this, the committee acknowledges that sex and gender are distinct concepts, and that perimenopause and menopause are also applicable to individuals that do not identify as women, including trans, gender-diverse and non-binary people.

[7] Professor Susan Davis, Director, Monash University Women's Health Research Program, *Committee Hansard*, 18 June 2024, p. 10.

[8] See, for example, Royal Australian College of General Practitioners (RACGP), *Submission 1*, p. 3; Monash Women's Health Research Program, *Submission 11*, p. 3.

transition',[9] refers to the phase prior to a woman's final menstrual period which commences when menstrual cycles start to vary in length by seven or more days,[10] and includes the year after the final menstrual period.[11] Submitters highlighted that as the identification of the menopause is driven by menstrual cycles, it can be more difficult to identify onset in women with irregular menstrual cycles.[12]

1.21 Several inquiry participants also noted that the perimenopause phase can last for years before reaching menopause.[13] The Australasian Menopause Society (AMS), submitted that 'perimenopause can last 4–7 years' and therefore it is 'common for women in their mid-forties to be entering perimenopause'.[14]

1.22 The Australian Academy of Health and Medical Sciences provided a useful visual for understanding the phases of the menopause transition:

Figure 1.1 Summary of the stages of menopause

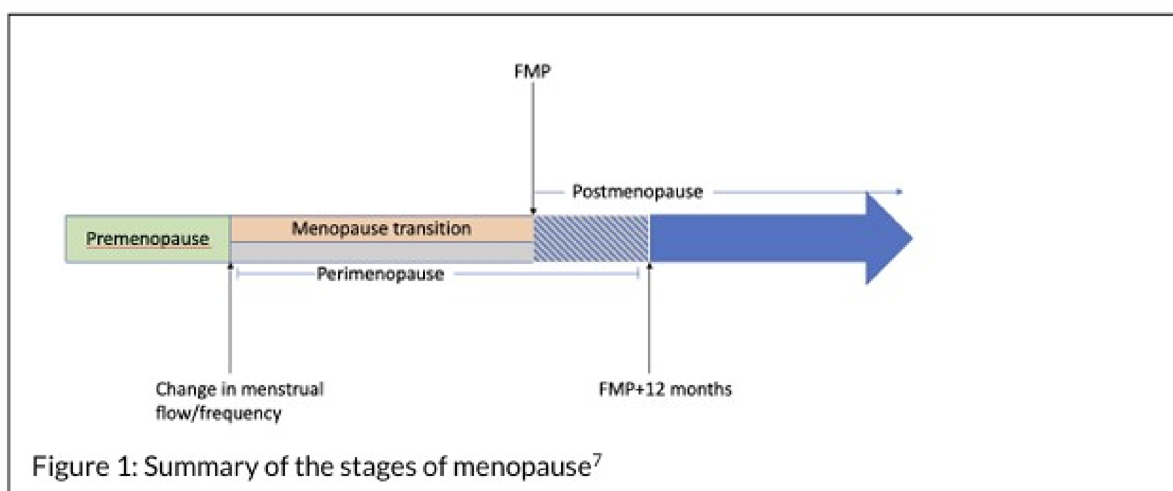

Figure 1: Summary of the stages of menopause[7]

Source: Australian Academy of Health and Medical Sciences, Submission 27, p. 4.

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9 RACGP, *Submission 1*, p. 3.

10 See, for example, Monash Women's Health Research Program, *Submission 11*, p. 3; Department of Health and Aged Care, *Submission 15*, p. 4; Organon, *Submission 24*, pp. 2–3; Dr Fatima Khan, *Submission 46*, p. 1.

11 See, for example, RACGP, *Submission 1*, p. 3; Sexual Health and Family Planning ACT, *Submission 102*, p. 3; Australian Medical Association, *Submission 115*, p. 1.

12 See, for example, Monash Women's Health Research Program, *Submission 11*, p. 3; Australian Academy of Health and Medical Sciences, *Submission 27*, p. 4.

13 See, for example, Dr Fatima Khan, *Submission 46*, p. 1; Dr Ceri Cashell, *Submission 44*, [p. 5]; Metluma, *Submission 56*, Attachment 1, [p. 10]; AIA Australia, *Submission 101*, [p. 3]; Australasian Menopause Society, *Submission 177*, p. 23; Royal Australian and New Zealand College of Gynaecologists and Obstetricians, *Submission 140*, p. 2.

14 Australasian Menopause Society, *Submission 177*, p. 23.

1.23 A number of submitters highlighted the ongoing nature and effects of menopause where it was explained that women continue to experience the impacts of menopause beyond the perimenopause period.[15]

1.24 Professor Elizabeth Hill and Ms Sydney Colussi highlighted that symptoms can still be experienced during the post-menopause phase, but often at a lower frequency or intensity.[16] Inquiry participants also noted that given Australian women's increased life expectancy, Australian women are now, on average, living more than one third of their lives in the post menopause phase.[17]

Physiological changes

1.25 Perimenopause and menopause signal a change in the body's hormonal production.[18] Estrogen, progesterone and testosterone are hormones that 'sharply' decline when a woman undergoes her final ovulation at menopause.[19]

1.26 Leading up to menopause, joint submitters Chelvanayagam, Bouse, Cotellessa, and de Lacy noted that 'the normal rise and fall of the menstrual cycle becomes chaotic in perimenopause (for around 10 years)'.[20] They elaborated that the receptors for these hormones are found throughout 'every tissue of a woman's body' and therefore fluctuations and declines in these hormones can cause 'widespread physical and mental impacts'.[21]

1.27 The Victorian Women's Trust explained the consequences of these hormonal changes, informing the committee that:

> … during late-stage perimenopause and menopause diminished oestrogen causes an increase in the levels of the hormones Follicle-stimulating Hormone (FSH) and Luteinising Hormone (LH). The brain centre that secretes these hormones, the hypothalamus, directs many bodily functions, including body temperature, sleep patterns, metabolic rate, mood and reaction to stress, so with higher levels of FSH and LH all these can be disturbed, including causing the very common hot flushes.[22]

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15 See, for example, Maridulu Budyari Gumal, *Submission 109,* p. 7; Dr Ceri Cashell, *Submission 44,* [p. 6]; Menodoctor, *Submission 39,* p. 10.

16 Professor Elizabeth Hill and Ms Sydney Colussi, *Submission 48,* p. 18.

17 See, for example, National Council of Women, *Submission 161,* p. 4; Australian College of Rural and Remote Medicine, *Submission 12,* p. 1; Menodoctor, *Submission 39,* p. 4; NSW Government, *Submission 53,* p. 3; Maridulu Budyari Gumal, *Submission 109,* p. 3.

18 See, for example, Dr Fatima Khan, *Submission 46,* pp. 1–2; Chelvanayagam, Bouse, Cotellessa, and de Lacy, *Submission 59,* p. 4; Victorian Women's Trust, *Submission 99,* p. 20.

19 Chelvanayagam, Bouse, Cotellessa, and de Lacy, *Submission 59,* p. 4.

20 Chelvanayagam, Bouse, Cotellessa, and de Lacy, *Submission 59,* p. 4.

21 Chelvanayagam, Bouse, Cotellessa, and de Lacy, *Submission 59,* p. 4.

22 Victorian Women's Trust, *Submission 99,* p. 20.

1.28 Dr Fatima Khan, a Melbourne based menopause specialist, similarly described menopause as a 'multi-organ syndrome' in which a decline in reproductive hormones 'causes symptoms affecting multiple organs including the brain, heart, bone, skin, gut, pelvic floor, bladder, etc'.[23]

Age at menopause

1.29 The Royal Australian College of General Practitioners (RACGP) outlined that people in their early 50s will 'typically' start to experience menopause, but that it can occur earlier in certain populations.[24] For example, the Australian Longitudinal Study on Women's Health (ALSWH) explained that women from African, Latin American, Asian and Middle Eastern countries typically experience menopause earlier.[25]

1.30 ALSWH went on to explain that in Australia, the average age at menopause is 51 years old.[26] The menopause transition usually starts at around 47 years of age and typical symptoms, such as hot flushes and night sweats, continue on average for seven years.[27] Menopause experienced before the age of 45 is considered 'early' and before 40 as 'premature'.[28]

1.31 The ALSWH outlined that 'age at menopause is an important indicator of future health and ageing'.[29] For example, and as further discussed below, the Monash Centre for Health Research and Implementation (MCHRI) explained that:

> … the menopause and menopause transition is a time of accelerated cardiometabolic and osteoporosis risk. These adverse impacts are even greater in women with early menopause, especially those with medically induced early menopause.[30]

Early menopause

1.32 There is a proportion of women who will experience early menopause, as a result of biological factors, medical treatments or surgical intervention.

1.33 The ALSWH indicated that the risk of experiencing biological early menopause can be increased by a range of factors, including:

- smoking;

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23 Dr Fatima Khan, *Submission 46*, p. 1.

24 RACGP, *Submission 1*, p. 3.

25 Australian Longitudinal Study on Women's Health, *Submission 35*, p. 3.

26 Australian Longitudinal Study on Women's Health, *Submission 35*, p. 3.

27 Professor Martha Hickey, *Submission 138*, p. 3.

28 RACGP, *Submission 1*, p. 3.

29 Australian Longitudinal Study on Women's Health, *Submission 35*, p. 5.

30 Monash Centre for Health Research and Implementation (MCHRI), *Submission 34*, p. 5.

- being underweight;
- never giving birth;
- infertility;
- recurrent miscarriages or stillbirth; and
- 'having a reproductive history including a first period before age 11'.[31]

Primary ovarian insufficiency and biological early menopause

1.34 The Women's Health Services Network identified that approximately 12 per cent of women experience early menopause (between the ages of 40–44 years) and/or primary ovarian insufficiency (before age 40).[32] It noted that experiences of primary ovarian insufficiency (POI) are also often difficult to diagnose and can result in delays in diagnosis and treatment.[33]

1.35 The committee heard evidence that women who experience premature menopause are at enhanced risk of developing cardiovascular disease, depression, osteoporosis and type two diabetes.[34]

1.36 POI can occur for girls who have never had a period, through to women in their teens, twenties or thirties.[35] Importantly, women with POI often have more severe menopause symptoms and psychological distress and are at a higher risk of chronic disease.[36]

Medically induced menopause

1.37 While menopause is a natural biological occurrence for all women, some women may undergo surgical and other health interventions, resulting in medically induced menopause.

Cancer treatment

1.38 Cancer Australia informed the committee that early menopause can be triggered as a result of cancer treatment, especially for breast, endometrial and ovarian

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31 Australian Longitudinal Study on Women's Health, *Submission 35,* p. 3.

32 Women's Health Services Network, *Submission 149,* p. 11.

33 See, for example, Women's Health Services Network, *Submission 149,* p. 11; Australasian Menopause Society, *Submission 177,* p. 20; Professor Roger Hart, Director, Menopause Alliance Australia, *Committee Hansard,* 6 August 2024, p. 16.

34 See, for example, Department of Health and Aged Care, *Submission 15,* p. 6; Viv Health, *Submission 5,* [p. 3]; Australian Longitudinal Study on Women's Health, *Submission 35,* p. 3; Women's Health & Equality, *Submission 113,* [p. 2].

35 Clinical Associate Professor Amanda Vincent, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard,* 29 July 2024, p. 18.

36 Clinical Associate Professor Amanda Vincent, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard,* 29 July 2024, p. 18.

cancers.[37] It explained that treatments of gynaecological and oestrogen-dependent cancers can include surgery, ovarian suppression and/or endocrine therapies, which can cause temporary or permanent menopause in women.[38] Chemotherapy and radiation are also ovarian suppressing treatments which can induce permanent menopause.

1.39 Further, evidence indicated that menopause after cancer treatment may be more severe than for those experiencing non-cancer induced menopause.[39] This parallel was also drawn by other submitters, which indicated that more women are surviving cancer now, and thus more women are experiencing early or induced menopause.[40]

1.40 Cancer Australia also noted that in addition to surgery, other treatments for gynaecological and oestrogen-dependent cancers such as 'ovarian suppression and/or endocrine therapies' can result in 'temporary menopausal symptoms or permanent menopause'.[41]

Surgically induced menopause

1.41 Surgically induced menopause occurs through the process of a bilateral salpingo-oophorectomy, where both ovaries are removed, which can trigger menopause.[42] Menodoctor, a New Zealand based specialist menopause clinic, explained that 'unlike natural menopause, there is no perimenopause phase' which results in a sudden loss of hormones and potentially more 'intense' symptoms.[43]

1.42 Submitters advised that oophorectomy can be a recommended course of treatment for women at high inherited risk of breast and ovarian cancer.[44] Some

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37 Cancer Australia, *Submission 38,* p. 1.

38 Cancer Australia, *Submission 38,* pp. 3–4.

39 See, for example, The Royal Women's Hospital Melbourne, *Submission 33,* p. 5; Australian Nursing and Midwifery Federation, *Submission 163,* p. 5; Chelvanayagam, Bouse, Cotellessa and de Lacy, *Submission 59,* p. 5; Research Australia, *Submission 98,* p. 7; Sexual Health and Family Planning ACT, *Submission 102,* p. 3; Professor Martha Hickey, *Submission 138,* p. 7.

40 See, for example, Monash Centre for Health Research and Implementation, *Submission 34,* p. 1; Professor Martha Hickey, *Submission 138,* p. 37.

41 Cancer Australia, *Submission 38*, p. 3.

42 Professor Martha Hickey, *Submission 138,* p. 35.

43 Menodoctor, *Submission 39,* p. 37.

44 See, for example, Cancer Australia, *Submission 38,* p. 3; University of Melbourne, *Submission 105,* p. 8; Professor Martha Hickey, *Submission 138,* p. 7; Australian Longitudinal Study on Women's Health, *Submission 35,* pp. 7–8.

women spoke to their experiences of having oophorectomy to treat pre-menstrual dysphoric disorder (PMDD) or endometriosis.[45]

1.43 An oophorectomy is often carried out in conjunction with a hysterectomy.[46] Surgical menopause is also associated with increased risks of cardiovascular disease, diabetes and depressive symptoms.[47]

1.44 The ALSWH raised that bilateral oophorectomy used to be 'commonly performed at the time of a hysterectomy for benign diseases to prevent ovarian cancer'; however, this is no longer recommended unless a woman has a 'high inherited risk of ovarian cancer'.[48]

Symptoms of perimenopause and menopause

1.45 Symptoms of perimenopause and menopause are highly variable, but a range of submitters noted 'common' symptoms of menopause and perimenopause include:

- vasomotor symptoms (hot flushes or night sweats);
- sleep difficulties;
- fatigue;
- muscle and joint aches/pains;
- brain fog;
- anxiety;
- depression;
- irritability;
- urogenital symptoms;
- headaches;
- low libido;
- pelvic pain;
- breast tenderness;[49]
- paresthesia;[50] and

45 See, for example, Name withheld, *Submission 215,* [p. 2]; Naomi, *Submission 196,* [p. 1].

46 Australian Longitudinal Study on Women's Health, *Submission 35*, p. 5.

47 Australian Longitudinal Study on Women's Health, *Submission 35*, p. 12.

48 Australian Longitudinal Study on Women's Health, *Submission 35*, pp. 7–8.

49 See for example, Sexual Health and Family Planning ACT, *Submission 102*, p. 3; Women's Health and Equality Queensland, *Submission 113,* [p. 2]; Australian College of Rural and Remote Medicine, *Submission 12*, p. 2; Queensland Nurses and Midwives Union, *Submission 107*, p. 5; Newson Health Group, *Submission 18,* pp. 1–2; Australian Longitudinal Study on Women's Health, *Submission 35,* p. 3; Chelvanayagam, Bouse, Cotellessa and de Lacy, *Submission 59,* p. 5; Urological Society of Australia and New Zealand, *Submission 108*, p. 2.

50 Australian Menopause Centre, *Tingling Extremities*, www.menopausecentre.com.au/tingling-extremities/#:~:text=Tingling%20extremities%20during%20menopause,-

- gum disease.[51]

1.46 Women can also experience genitourinary syndrome of menopause (GSM) which encompasses a range of genital and urinary symptoms, including discomfort, vaginal dryness, sexual and pelvic pain, urinary incontinence and prolapse.[52]

Challenges in defining symptoms

1.47 Some submitters raised that there are various issues and challenges ascribing concrete definitions of menopausal symptoms.[53] Jean Hailes for Women's Health (Jean Hailes), a female-focused health and wellbeing not-for-profit, asserted that 'attempting to define and describe a broad set of menopausal symptoms is not helpful because menopause is a biopsychosocial issue'.[54]

1.48 It elaborated that comprehensive reviews have found that the consistency of symptoms across various factors (for example culture, race and ethnicity) and 'consistency of risk factors for symptoms, found no evidence of a common menopause syndrome'.[55]

1.49 Dr Gabriela Berger and Dr Anita Peerson similarly contended that:

> There is no consensus on definitive menopause symptoms, ranging from hot flushes and night sweats to dozens of vasomotor, physical, urogenital, and psychological symptoms. … Most studies provide a snapshot of menopausal symptoms at a discrete point in time and disregard a whole of lifecycle approach.[56]

1.50 Professor Martha Hickey, the lead for menopause services at the Royal Women's Hospital, emphasised that 'uncertainty' and 'confusion' about menopause symptoms are 'major barrier[s] to evidence-based diagnosis and clinical care'. Professor Hickey highlighted that:

Tingling%20extremities%2C%20medically&text=In%20more%20mild%20cases%2C%20tingling,normal%20after%20compression%20is%20relieved (accessed 16 September 2024).

51 Dr Alistair Graham, 'Does menopause affect teeth and gums?' *Mona Vale Dental*, 11 May 2023, www.monavaledental.com.au/does-menopause-affect-teeth-and-gums/ (accessed 16 September 2024).

52 See, for example, Australian Physiotherapy Association, *Submission 10,* [p. 5]; Chronic UTI Australia, *Submission 22,* p. 1; Urological Society of Australia and New Zealand, *Submission 108,* [p. 1].

53 See, for example, Dr Gabriela Berger and Dr Anita Peerson, *Submission 52,* p. 3; Professor Martha Hickey, *Submission 138,* p. 5; Jean Hailes for Women's Health, *Submission 119,* p. 27.

54 Jean Hailes for Women's Health, *Submission 119,* p. 27.

55 Jean Hailes for Women's Health, *Submission 119,* p. 27.

56 Dr Gabriela Berger and Dr Anita Peerson, *Submission 52,* p. 3.

> Establishing what symptoms are attributable to menopause is an urgent priority. This will require systematic review of prospective studies as people transition through menopause and beyond.[57]

Unique experiences

1.51 Several submitters highlighted that the menopause and perimenopause experience is different and unique to each woman.[58]

1.52 Council on the Ageing (COTA) Australia, a peak body that represents Australians over 50, explained that changing hormone levels 'can produce different symptoms', with some women experiencing no symptoms while others can undergo moderate to severe symptoms.[59] For example, Victorian Women's Trust submitted that many women will not be 'particularly symptomatic' while others may experience 'hot flushes and night sweats, insomnia, fatigue and loss of zest' amongst other symptoms.[60]

1.53 This variability in experience and impact on an individual was also detailed by Research Australia, as it noted:

> There is enormous variation in the physical symptoms, the duration and onset of menopause and perimenopause. There is variation in the severity of symptoms, the extent to which they are debilitating for any one individual, and the impact they have on an individual's identity, self-esteem, mental health and wellbeing. There is also variability in how perimenopause and menopause interact with other diseases (chronic and acute) and the impact of lifestyle factors like diet and smoking.[61]

Health impacts and effects

1.54 The time of life at which the menopause transition occurs intersects with a time of mid-life health that includes 'an increasing risk of metabolic diseases including diabetes and cardiovascular disease, breast and bowel cancer, and osteoporosis'.[62]

1.55 Inquiry participants highlighted to the committee that menopause (including premature, early and post menopause) and its associated reduced oestrogen

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57 Professor Martha Hickey, *Submission 138*, p. 5.

58 See, for example, Gabriela Berger and Anita Pearson, *Submission 52*, p. 7; Sage Women's Health, *Submission 100*, p. 1; Australian Medical Association, *Submission 115*, p. 1; The Office for Women, *Submission 135*, p. 2; Chief Executive Women, *Submission 136*, p. 4; Australasian Menopause Society, *Submission 177*, p. 2.

59 COTA Australia, *Submission 165*, p. 10.

60 Victorian Women's Trust, *Submission 99*, p. 20.

61 Research Australia, *Submission 98*, p. 6.

62 RACGP, *Submission 1*, p. 4. See, for example, Australian Psychological Society, *Submission 6*, p. 3; Newson Health Group Limited, *Submission 18*, pp. 4–5; Australian Association of Psychologists, *Submission 21*, [p. 1].

production may increase certain health risks, most notably cardiovascular disease, diabetes, osteoporosis, some cancers and dementia across the life course post-menopause.[63]

Osteoporosis

1.56 The AMS reported that oestrogen is an important hormone for maintaining bone strength, therefore when its levels drop, 'accelerated bone loss occurs'.[64] It noted that 'the average woman loses around 10 per cent of her bone mass in the first five years after menopause', and this loss can lead to osteoporosis.[65]

1.57 Both Healthy Bones Australia and AMS outlined that early menopause is a risk factor for osteoporosis,[66] and therefore 'intervention at peri/menopause can reduce the risk of osteoporosis, fractures and morbidity'.[67]

Cardiovascular health

1.58 Perimenopause and menopause can be a time of increased risk for women in relation to cardiovascular health, with emerging risks associated with cardiovascular disease.[68] This increased risk is associated with the lower production of oestrogen.[69]

1.59 Further, the loss in oestrogen causes the body to redistribute fat from the hips to the waist.[70] The AMS explained the consequences of this fat redistribution, noting:

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[63] See, for example, Australian College of Rural and Remote Medicine, *Submission 12*, p. 2; Australian Longitudinal Study on Women's Health, *Submission 35*, pp. 3 and 10–11; Besins Healthcare, *Submission 146*, [p. 4]; Private Healthcare Australia, *Submission 155*, p. 3; The Society of Hospital Pharmacists of Australia, *Submission 3*, p. 3; Women's Health and Equality Queensland, *Submission 113*, [p. 2]; Queensland Nurses and Midwives Union, *Submission 107*, p. 5; Australasian Menopause Society, *Submission 177*, p. 2; Monash University Women's Health Research Program, *Submission 11*, p. 2.

[64] Australasian Menopause Society, *Submission 177*, p. 12.

[65] Australasian Menopause Society, *Submission 177*, p. 12.

[66] See, for example, Healthy Bones Australia, *Submission 132*, [p. 1]; Australasian Menopause Society, *Submission 177*, p. 12; Dr Roy Watson, Proxy for Chair, Gynaecology Community of Practice, Strategic Executive Committee, SA Health Maternal, Neonatal & Gynaecology Community of Practice, *Committee Hansard*, 5 August 2024, p. 36.

[67] Australasian Menopause Society, *Submission 177*, p. 12.

[68] See, for example, Maridulu Budyari Gumal, *Submission 109*, p. 3; Women's Health and Equality Queensland, *Submission 113*, [p. 2]; Jean Hailes for Women's Health, *Submission 119*, p. 6; Women's Health in the South East, *Submission 120*, [p. 11]; Avalon Family Medical Practice, *Submission 142*, [p. 4]; Australasian Menopause Society, *Submission 177*, pp. 2 and 12–13.

[69] Besins Healthcare, *Submission 146*, [p. 4]. See, for example, Department of Health Victoria, *Submission 14*, pp. 4–5; Australasian Menopause Society, *Submission 177*, pp. 2 and 12–13.

[70] Australasian Menopause Society, *Submission 177*, p. 13.

> This fat redistribution can increase the risk of metabolic syndrome, which includes obesity, high blood pressure, high blood sugar and abnormal cholesterol levels. Metabolic syndrome is associated with increased cardiovascular disease risk.[71]

1.60 The AMS also noted that 'the increase in sleep disorder at midlife can also increase cardiovascular disease risk'.[72]

1.61 Moreover, the Monash Women's Health Research Program outlined that cardiovascular disease is the leading cause of death in postmenopausal women.[73]

Diabetes and some cancers

1.62 Pertaining to diabetes, Newson Health Group Limited advised that the 'biochemical changes' that result from low oestrogen levels can cause increased insulin production by the pancreas, increased insulin resistance and increased risk of type 2 diabetes.[74]

1.63 The AMS noted that the risk of 'metabolic syndrome' also causes an increased risk in 'type 2 diabetes mellitus and many cancers, which both cause significant morbidity and mortality'.[75]

1.64 Further, the Monash Women's Health Research Program emphasised:

> Diabetes is increasing in women and the adverse outcomes conferred by diabetes are considerably greater in women than men.[76]

Neurological health

1.65 There is some evidence to suggest that women are at a higher risk of developing dementia the longer they live in the post menopause period.[77] However, certain menopause treatments, such as menopause hormonal therapy (MHT), when

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71 Australasian Menopause Society, *Submission 177*, p. 13.

72 Australasian Menopause Society, *Submission 177*, p. 13.

73 Monash Women's Health Research Program, *Submission 11*, p. 4.

74 Newson Health Group Limited, *Submission 18*, p. 5. See, for example, Avalon Family Medical Practice, *Submission 142*, [p. 4]; Private Healthcare Australia, *Submission 155*, p. 3; Australasian Menopause Society, *Submission 177*, pp. 2 and 13; RACGP, *Submission 1*, p. 4; Society of Hospital Pharmacists of Australia, *Submission 3*, [p. 3].

75 Australasian Menopause Society, *Submission 177*, p. 13.

76 Monash Women's Health Research Program, *Submission 11*, p. 4.

77 Newson Health Group Limited, *Submission 18*, p. 5. See also, for example, Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 3; Monash Centre for Health Research and Implementation, *Submission 34*, p. 22; Menodoctor, *Submission 39*, p. 35.

used within five years of the last menstrual period, may have protective qualities for brain health.[78]

Mental health impacts

1.66 Menopause can also directly contribute to adverse mental health outcomes. Dr Fatima Khan explained that cognitive difficulties, such as brain fog, and mental health challenges can be one of the first indications of menopause occurring.[79] For some women, the committee heard that menopause can induce experiences of depression or anxiety.[80]

1.67 Some submitters also discussed that the emergence of physical menopause symptoms, such as hot flushes and sleep disturbances, may exacerbate or contribute to mental health symptoms.[81]

1.68 The mental health symptoms of menopause can also have broader impacts, including loss of confidence, as well as challenges in the workplace or feeling unable to continue to perform in a professional setting.[82]

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78 Viv Health, *Submission 5,* [p. 4].

79 Dr Fatima Khan, *Submission 46,* [p. 2].

80 See, for example, Dr Fatima Khan, *Submission 46,* [p. 1]; Chelvanayagam, Bouse, Cotellessa and de Lacy, *Submission 59,* pp. 7–8; Sage Womens Health, *Submission 100,* [p. 4]; HER Centre Australia, *Submission 8,* [p. 4]; Professor Jayashri Kulkarni, Director, HER Centre Australia, Monash University, *Committee Hansard,* 30 July 2024, p. 10; Maridulu Budyari Gumal, *Submission 109,* p. 6; Women's Health in the South East, *Submission 120,* pp. 12–13.

81 See, for example, Women's Health in the South East, *Submission 120,* p. 13; Diversity Council of Australia, *Submission 133,* p. 3.

82 See, for example, Dr Keturah Hoffman, *Submission 76,* [p. 1]; Queensland Nurses and Midwives Union, *Submission 107,* p. 6; Women's Health Road, *Submission 117,* [p. 3]; UnionsWA, *Submission 152,* p. 1; Women in STEMM Australia, *Submission 154,* p. 36; Community and Public Sector Union, *Submission 158,* p. 6; Australian Nursing and Midwifery Federation, *Submission 163,* p. 5; Queensland Unions, *Submission 166,* p. 2; Health Care Consumers, *Submission 170,* p. 21.

Chapter 2
The experience of menopause and perimenopause

> I wish I knew at 30 what I know now. Perimenopause is not for old ladies and is not just hot flushes. Not knowing this before I entered this phase of life and not starting MHT [menopause hormonal therapy] when symptoms first appeared has negatively impacted my life. … I've been gaslit and misdiagnosed, had symptoms ignored and dismissed, told they're all in my head or it's stress, told to exercise, take a holiday, have a glass of wine.[1]

2.1 Throughout the inquiry, women shared their personal stories of the significant impact menopause and perimenopause have had on their lives. The stories told by submitters highlighted that, for some women, the menopause transition can involve debilitating symptoms that can affect all aspects of a woman's life. Their direct experiences reveal the difficult challenges faced by many women in Australia to access the care and support they need.

2.2 Firstly, this chapter discusses the extent to which women are unprepared and uninformed about menopause. Secondly, the chapter explores the lack of existing support and information, including for women experiencing early menopause. The chapter then discusses the social impacts of menopause and the mechanisms through which women are trying to access support.

2.3 Finally, the chapter discusses the lack of an existing evidence base relating to experiences of menopause across all socio-demographics. It also outlines the gaps in data and understanding of the experiences and impacts of menopause for First Nations women, women from culturally and linguistically diverse (CALD) communities and LGBTQIA+ individuals. The chapter concludes with the committee's view and recommendations to build a better understanding of menopause and raise awareness across the community.

Uninformed and unprepared

2.4 Many women spoke to their personal experiences of having never heard the term perimenopause, or not understanding that they could be impacted by symptoms prior to their final menstrual period.[2] As Sandy, a submitter who shared her lived experience with the inquiry, highlighted:

> I hadn't come across the term 'peri-menopause' until I was in my 40's, even then I didn't know what it meant and certainly had no idea, even when I was in the midst of it what the symptoms were.[3]

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1 Sandy, Private capacity, *Committee Hansard,* 18 June 2024, pp. 38–39.

2 See, for example, Rebecca, Private capacity, *Committee Hansard,* 18 June 2024, p. 40; Jo, *Submission 64,* [pp. 3–4]; Sandy, *Submission 75,* p. 3.

3 Sandy, *Submission 75,* p. 3.

2.5 Rebecca, who appeared at a hearing in Melbourne, further echoed this sentiment:

> Then I spoke to a girlfriend over coffee and said: 'Look, I'm really struggling at work. I just have no idea what's happening.' She said, 'Oh, maybe you're peri.' I was like, 'What? What is "peri"?' 'Perimenopause.' 'Menopause?' 'No, no—perimenopause.' I had no idea that this existed in this day and age.[4]

2.6 Further, Jill who detailed her lived experience to the committee, highlighted:

> Like many others I was familiar with menopause being referred to as the "change of life". As it turns out, what I was massively less aware of is how that change could manifest itself in reality. I was totally unprepared for the impact that menopause would have on me, my life, my family and my finances.[5]

Rapid onset and confusing symptoms

2.7 Women discussed their limited knowledge of the variety of symptoms that could be caused by the menopause transition, beyond hot flushes and night sweats.[6]

2.8 Many women emphasised that their prior knowledge of menopause meant that they expected symptoms related to hot flushes; however, symptoms that affected the whole body, for example, cognition difficulties or joint paint, were unexpected for many women.[7] Submitters to the inquiry outlined symptoms that appeared rapidly and affected all aspects of their life and were difficult to attribute to menopause.[8]

Physical symptoms

2.9 Naomi, who appeared at a hearing in Sydney, emphasised the whole of body impacts of her menopause symptoms:

> Menopause impacted my life, however, far beyond anything I thought possible. I had hot flushes, vaginal dryness, insomnia, anxiety, extreme fatigue, brain fog, joint pains, heart palpitations, increased hypertension, osteoporosis, IBS, heartburn, anger, rage, nasal congestion, rage, stress

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4 Rebecca, Private capacity, *Committee Hansard,* 18 June 2024, p. 40.

5 Jill, *Submission 224,* p. 1.

6 See, for example, Rachel, *Submission 77,* [p. 1]; Name withheld, *Submission 88,* [p. 1]; Name withheld, *Submission 125,* [p. 2]; Name withheld, *Submission 189,* [p. 1]; Jo, *Submission 242,* [p. 2]; Name withheld, *Submission 129,* [p. 1].

7 See, for example, Ms Sharon Best, *Submission 230,* p. 6; Kerry, *Submission 202,* [p. 1]; Sonia, *Submission 238,* [p. 1]; Megan, *Submission 68,* [p. 2]; Name withheld, *Submission 195,* [p. 1]; Ieva, *Submission 199,* [p. 2].

8 See, for example, Jill, *Submission 224,* p. 2; Name withheld, *Submission 220,* [p. 1]; Sandy, *Submission 75,* p. 3; Sonia, *Submission 238,* [p. 1]; Jo, *Submission 64,* [pp. 2–3]; Name withheld, *Submission 95,* [p. 1]; Name withheld, *Submission 96,* p. 2; Name withheld, *Submission 194,* [p. 2]; Megan, *Submission 68,* [p. 2].

> fractures, lethargy, apathy, rage, grief and headaches. My migraines got worse. I had night terrors—which was horrendous—and painful sex, which, given I was in a relatively new marriage, was not much fun either. The list just went on.[9]

2.10 Another private individual described similar experiences in her submission:

> I began experiencing unexplained hot flushes, night sweats, insomnia, joint pain, memory issues, mood instability (episodes of uncontrolled rage), was diagnosed with osteopenia & experienced significant weight changes… I had no understanding of what on earth was happening to my body because not one of my doctors had ever mentioned perimenopause to me throughout my 40's.[10]

2.11 Rachel, a submitter in her early 50s, stated that:

> At 48… I suddenly started to feel as if my whole body was letting me down, my eyesight one day went from perfect to, I can't read a text message. My joints were in excruciating pain, I could no longer exercise, getting up and down stairs was torturous. Every day I woke up with impending fear of doom and intrusive thoughts and I had terrible insomnia, I felt awful.[11]

Symptoms affecting mental wellbeing

2.12 Some submitters also emphasised that the first indication that something was changing in their bodies was triggered by changes to their mental and emotional wellbeing.[12]

2.13 At a hearing in Brisbane, Jennifer elaborated on her own experience:

> My perimenopausal symptoms became obvious to me, and quite debilitating, a few days after I turned 45. Just really suddenly I couldn't sleep anymore and my anxiety was through the roof. I doubted myself as a mother and in my work and I had brain fog or brain annihilation, as I like to call it, that rendered me useless at work. I couldn't focus or remember words. I stressed over things I've done for years that have never stressed me out before. And I'm really embarrassed to tell you that I raged at my family, especially at my children. But I did not miss a period. I never had irregular periods and, to this day, I have not had a hot flush.[13]

2.14 Grace, a private individual who submitted to the inquiry, emphasised the broad impact of symptoms that affected her mental wellbeing:

> As an individual my symptoms of perimenopause have significantly impacted my daily performance, primarily due to cognitive decline (brain fog), fatigue, and lack of energy. However, the most severe symptom I've

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9 Naomi, Private capacity, *Committee Hansard*, 17 June 2024, p. 44.

10 Name withheld, *Submission 125,* [p. 2].

11 Rachel, *Submission 77,* [p. 1].

12 See, for example, Name withheld, *Submission 201,* pp. 2–3; Name withheld, *Submission 194,* [p. 2].

13 Jennifer, Private capacity, *Committee Hansard*, 29 July 2024, p. 40.

> experienced is insomnia. … which greatly hindered my ability to function effectively in both my personal and professional life.[14]

2.15 Tara, a lived experience witness who appeared at a public hearing in Sydney also discussed her experience:

> In October of 2021, I began experiencing anxiety, particularly in the mornings upon waking, and one month later I had a severe panic attack during my period. I had no history of panic attacks, anxiety disorders or mental health issues and had always been an extremely high-functioning, high-achieving individual… I could not understand why I was suddenly experiencing such high levels of physical anxiety that were not linked to a direct cause.[15]

The 'sandwich generation'

2.16 The arrival of perimenopause and menopause often coincides with other challenging events that affect women during midlife. These includes care responsibilities for dependant parents and children, reaching a career peak with enhanced work pressure, relationship and family pressures and the emergence of health difficulties.[16]

2.17 As members of the so-called 'sandwich generation', submitters discussed the challenges of caring for elderly parents and dependent children at the same time as experiencing the significant physical and mental changes associated with menopause.[17] As discussed by one submitter to the inquiry:

> Women are expected to maintain job function and parenting or caring whilst struggling quietly with symptoms that may be debilitating e.g. ongoing sleep loss, brain fog, anxiety, joint pain, hot flushes and more, that may render a women unable to work or care for children.[18]

2.18 For example, Megan expressed her difficulty caring for her father while navigating through menopause:

> As the eldest daughter in my family, I am responsible to assist in life admin and activities with my aging father. At the times when I was really struggling to manage myself the added stress of caring for my father, while

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14 Grace, *Submission 240,* [p. 1].

15 Tara, Private capacity, *Committee Hansard,* 17 June 2024, p. 42.

16 See, for example, Dr Marita Long, Board Member and Victoria and Tasmania Representative, Australasian Menopause Society, *Committee Hansard,* 18 June 2024, p. 62; Department of Health Victoria, *Submission 14,* p. 7; Name withheld, *Submission 125,* [p. 2]; Dr Alexandra Murray, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard,* 18 June 2024, p. 68; Ms Cilla de Lacy, Private capacity, *Committee Hansard,* 6 August 2024, p. 27.

17 See, for example, Name withheld, *Submission 96*, p. 3; Department of Health Victoria, *Submission 14,* p. 7; Chelvanayagam, Bouse, Cotellessa and de Lacy, *Submission 59,* p. 13; Ms Laura Ricciardi, Sexual and Reproductive Health Lead, Women's Health in South East, *Committee Hansard,* 18 June 2024, p. 33; Leeanne, *Submission 73,* [p. 4].

18 Name withheld, *Submission 225,* [p. 2].

> he was going through major health problems, was overwhelming… I have struggled to maintain friendships with my closest friends, because I simply have changed and can no longer do the things I used to do.[19]

2.19 The Jean Hailes submission specified this period as the 'midlife collision', given the substantial pressures that are often placed on women at midlife including caring responsibilities, financial obligations, other health issues and work pressures.[20] The organisation elaborated that this makes it difficult to clearly isolate the causes and impacts of perimenopause:

> The many, many combinations of factors that constitute a woman's familial and social environment make it extremely difficult to understand the impact of peri/menopause alone on caregiving, family dynamics and relationships.[21]

Challenges to accessing care

2.20 The intersection with the other difficulties of midlife were also a barrier to treatment and care. The committee heard that women were often dismissed by medical practitioners as being stressed or overwhelmed due to lifestyle factors, rather than needing care.[22]

2.21 Jennifer told the committee at a hearing in Brisbane about her experiences:

> When I finally saw my GP about the insomnia, which made the bouts of anxiety even worse, I asked her if it might be perimenopause, given my age. She dismissed me and said, 'You're far too young.' I was 45. That's prime perimenopausal age. She tried to convince me that this was just the stress of midlife, that my children are quite young, my husband travels for work and basically just to suck it up. I walked out of her office scared, confused and with a prescription for a sleeping pill.[23]

2.22 The Australian Psychological Society described the occurrence of this phenomenon, noting:

> Because of a lack of awareness or recognition of symptoms, particularly in younger people, changes may be attributed to other factors such as stress or other health issues.[24]

2.23 Issues around getting a diagnosis and accessing care are further discussed in Chapter 4 of the report.

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19 Megan, *Submission 68*, p. 4.

20 Jean Hailes for Women's Health, *Submission 119*, p. 15.

21 Jean Hailes for Women's Health, *Submission 119*, p. 15.

22 See, for example, Bronwen, *Submission 249*, [p. 2]; Dr Jennifer Hacker Pearson, *Submission 239*, [p. 2]; Name withheld, *Submission 184*, [pp. 1–2].

23 Jennifer, Private capacity, *Committee Hansard*, 29 July 2024, p. 40.

24 Australian Psychological Society, *Submission 6*, p. 4.

Lack of support and information

2.24 Women shared their experience of finding that there was a complete lack of available information and support related to menopause and perimenopause.[25] Women explained how they had to rely on peer support networks and self-education through podcasts and social media to learn more and be prepared with evidence-based information.[26]

2.25 A submitter to the inquiry pointed out the overall lack of information on perimenopause in the media as well as in healthcare settings:

> As mentioned earlier, at age 47, I had not had any information on perimenopause presented to me by any health professional, through the media, through social media, or through any other medium such as TV or film, advertising, in a chemist, in the mail, in a magazine, on a blog or through a friend or family member.[27]

2.26 Another submitter also reflected on her experiences, highlighting the paucity of information available:

> Looking back, virtually all the information I had received about menopause and what to expect was word of mouth, shared from older women friends.[28]

2.27 In her submission, Sarah discussed how this lack of information was a barrier to seeking access to care:

> I had tried to research perimenopause prior to attending appointments but available information is very brief. Many reputable websites have a lot of information on menopause, and 1-2 sentences on perimenopause.[29]

Stigma and taboo

2.28 Submitters to the inquiry discussed how stigma directly contributes to a lack of awareness and understanding of menopause for women. As articulated by the Federation of Ethnic Communities' Councils of Australia (FECCA):

> Whilst menopause is a universal experience for women, it continues to be poorly understood, with taboo and stigma associated with ageing and

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25 See, for example, Bronwyn, *Submission 61*, [pp. 2–3]; Name withheld, *Submission 82*, [p. 1]; Name withheld, *Submission 203*, [p. 6]; Sonia, *Submission 238*, [p. 1]; Dr Jennifer Hacker Pearson, *Submission 239*, [p. 2]; Jodie, *Submission 241*, [p. 2]; Dr Lucy Caratti, *Submission 244*, [p. 2]; Jennifer, Private capacity, *Committee Hansard*, 29 July 2024, p. 40.

26 See, for example, Sandy, *Submission 75*, p. 3; Name withheld, *Submission 88*, [pp. 3–4]; Name withheld, *Submission 203*, [pp. 5–6]; Name withheld, *Submission 205*, [p. 1]; Jill, *Submission 224*, p. 7; Simone, *Submission 236*, [pp. 5–6]; Jo, *Submission 242*, [p. 5]; Ms Kaz Cooke, Private capacity, *Committee Hansard*, 18 June 2024, pp. 2–4; Jodie, Private capacity, *Committee Hansard*, 5 August 2024, p. 27.

27 Name withheld, *Submission 203*, [pp. 5–6].

28 Name withheld, *Submission 84*, [p. 1].

29 Sarah, *Submission 197*, [p. 2].

women's reproductive health contributing to little understanding of this natural transition point in a woman's life.[30]

2.29 This was reinforced by Ms Lisa Annese of the Diversity Council of Australia when she stated:

> It's a real risk. Women who talk openly about menopause run the risk of being scapegoated and stigmatised. I think that that is real and will happen.[31]

2.30 Further, some witnesses spoke about the importance of breaking down stigma and openly speaking about menopause:

> A lot of the services that we provide are helping workplaces to accept that there may be some stigma existing already and work out how we can break down that stigma. A lot of it comes down to communication. It comes down to having those leaders in the business stand up and talk about it openly, and we are seeing more and more of that.[32]

Education in schools

2.31 Submitters recommended the need for education regarding menopause and perimenopause to be included in the reproductive health curriculum, alongside topics such as menstruation and sexual health, to establish this as a normal element of the reproductive cycle and prepare women for this life stage.[33]

2.32 In her submission, Jo elaborated on her perspective that high school education would have changed her experience of menopause:

> Had perimenopause/menopause been taught to me in high school I would have known to expect the symptoms I experienced. At the very least I would have known that something happens before my period stop[ped] and not have felt so isolated, ill-informed, gas-lighted, and left wondering if I was going mad.[34]

2.33 A submitter remarked that introducing menopause in sexual education subjects in school would increase the awareness for both men and women.[35]

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30 Federation of Ethnic Communities' Councils of Australia (FECCA), *Submission 169*, p. 3.

31 Ms Lisa Annese, Chief Executive Officer, Diversity Council of Australia, *Committee Hansard*, 17 June 2024, p. 58.

32 Ms Grace Molloy, Chief Executive Officer and Co-Founder, Menopause Friendly Australia, *Committee Hansard*, 17 June 2024, p. 16.

33 See, for example, Name withheld, *Submission 89*, [p. 1]; Name withheld, *Submission 182*, [p. 2]; Dr Lesley Ramage, Director, Menopause Alliance Australia, *Committee Hansard*, 6 August 2024, pp. 19–20; Ms Cilla de Lacy, Private capacity, *Committee Hansard*, 6 August 2024, p. 23; Chelvanayagam, Bouse, Cotellesa and de Lacy, *Submission 59*, p. 1; Jo, *Submission 64*, [pp.3–4].

34 Jo, *Submission 64*, [p. 5].

35 Name withheld, *Submission 182*, [p. 2].

2.34 Jo also expressed the view that the current omission of menopause in the curriculum was reinforcing stigma:

> If we are willing to talk about contraception, sexually transmitted disease and childbirth with teenagers yet not talk about menopause, it just stigmatises it even further as a taboo topic, making women feel alone and isolated when they experience it.[36]

2.35 Some submitters highlighted that the United Kingdom has implemented menopause as a topic in the high school reproductive health curriculum.[37]

Raising awareness

2.36 To effectively combat stigma and taboo, inquiry participants identified the importance of implementing a comprehensive national health awareness campaign that encompasses education of the general public, as well as medical professionals.[38]

2.37 For example, Associate Professor Magdalena Simonis AM described the need for a national public awareness campaign 'to increase knowledge and literacy around this phase of life and its treatment'.[39]

2.38 The AMS recommended education of women through community programs and public awareness campaigns about the symptoms and health implications of menopause.[40]

2.39 The Royal Women's Hospital Melbourne suggested:

> A national public information and awareness campaign that promotes independent and evidence-based information about the common symptoms associated with menopause including the risks and benefits of treatments, and the opportunity it provides for healthy female ageing.[41]

2.40 It was underlined to the committee that the development of any such campaign should involve co-design with women living through menopause; as well as

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36 Jo, *Submission 64,* [p. 5].

37 See, for example, Department of Health Victoria, *Submission 14,* p. 9; Royal Women's Hospital Melbourne, *Submission 33,* p. 7; Chelvanayagam, Bouse, Cotellesa and de Lacy, *Submission 59,* p. 3.

38 See, for example, Associate Professor Treasure McGuire, Women's and Newborn Health Committee, Society of Hospital Pharmacists of Australia, *Committee Hansard,* 29 July 2024, p. 11; Menodoctor, *Submission 39,* p. 20; Samy Medical Group, *Submission 41,* p. 7; WellFemme, *Submission 111,* [p. 3].

39 Associate Professor Magdalena Simonis AM, *Submission 45,* [p. 6].

40 Dr Christina Jang, Board Director and President-elect, Australasian Menopause Society, *Committee Hansard,* 18 June 2024, p. 58.

41 Royal Women's Hospital Melbourne, *Submission 33,* p. 11.

specific initiatives for hard-to-reach groups such as First Nations women, CALD communities and individuals with poor health literacy.[42]

Women needing to be their own advocates

2.41 During the inquiry, women shared their difficult experiences in accessing appropriate perimenopause and menopause care, often resulting in the need to conduct their own research to enhance their capability to self-advocate.[43]

2.42 Many women experienced misdiagnosis and inappropriate treatment in their journey to address menopause symptoms; including being misdiagnosed with incorrect conditions, being referred to specialists unnecessarily, seeking access to MHT and being denied or being prescribed the wrong types or forms of MHT as a result of outdated understandings of prescribing guidelines.[44]

2.43 Many submitters also mentioned that they were often dismissed by doctors as being 'too young' to experience menopause; in some instances, despite being within the recognised age range of the menopause transition.[45]

2.44 Concerningly, the committee learned of the experiences of women seeking care through the health system often being prescribed anti-depressants as a first line therapy for a range of different perimenopausal symptoms rather than further investigation being undertaken.[46]

2.45 Further, when seeking help and support from general practitioners (GPs), women often discussed the limited knowledge of their healthcare providers in

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[42] See, for example, Clinical Associate Professor Amanda Vincent, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard,* 29 July 2024, p. 20; Professor Martha Hickey, *Submission 138,* p. 10; Macquarie Menopause Research Group, *Submission 150,* p. 10; FECCA, *Submission 169,* p. 6.

[43] See, for example, Janey, Private capacity, *Committee Hansard,* 17 June 2024, p. 42; Tara, Private capacity, *Committee Hansard,* 17 June 2024, p. 43; Name withheld, *Submission 195,* [p. 3]; Ieva, *Submission 199,* [p. 1]; Kerry – Peripausers, *Submission 202,* [p. 6].

[44] See, for example, Sandy, Private capacity, *Committee Hansard,* 18 June 2024, p. 38; Name withheld, *Submission 125,* [p. 2]; Name withheld, *Submission 96,* pp. 2–5; Maria, *Submission 232,* p. 1; Jo, *Submission 242,* [pp. 3–5].

[45] See, for example, Jennifer, Private capacity, *Committee Hansard,* 29 July 2024, p. 40; Maria, *Submission 232,* p. 1; Name withheld, *Submission 184,* [p. 3]; Name withheld, *Submission 188,* [p. 1].

[46] See, for example, Sonya, Private capacity, *Committee Hansard,* 17 June 2024, p. 40; Sandy, Private capacity, *Committee Hansard,* 18 June 2024, p. 37; Imogen, Private capacity, *Committee Hansard,* 18 June 2024, p. 41; Jennifer, Private capacity, *Committee Hansard,* 29 July 2024, p. 40; Felicity, Private capacity, *Committee Hansard,* 30 July 2024, p. 29; Cathy, Private capacity, *Committee Hansard,* 30 July 2024, p. 32; Karen, Private capacity, *Committee Hansard,* 6 August 2024, p. 9; Name withheld, *Submission 253,* [p. 3]; Rachel, *Submission 77,* [p. 1].

relation to perimenopause and menopause.[47] This was starkly demonstrated by Sandy's story:

> I asked my GP if it could be a symptom of menopause, and he said, 'All I learnt at med school was that menopausal women were either mad or sad.'[48]

2.46 A common theme of accessing care was that healthcare providers did not recognise the variety of perimenopausal symptoms until a woman had a hot flush or night sweats.[49] Imogen discussed the impact of this narrow view of diagnosis of perimenopause:

> It was only when the night sweats and hot flushes kicked in that my GP said the word 'perimenopause'. That was almost five years after my original symptoms presented themselves—five very frustrating years. My jigsaw became a picture of a perimenopausal woman. But five years is 1 825 days. Of those, 1 300 were working days.[50]

2.47 Sharon, a private individual who appeared at a public hearing in Brisbane, also emphasised:

> I also had idiopathic peripheral neuralgia, which is tingling hands and feet as part of the hot flashes, but the doctors were looking for other answers. They just don't have the experience.[51]

2.48 Women discussed their journey of self-education and self-advocacy, in response to the lack of knowledge and awareness of their health practitioners.[52] Mrs Rebecca Thomson, Founder of Your Menopause explained the need for a more comprehensive education for women:

> For me, the thing I think that stands out is that we need to have education—obviously, education on the medical, nursing and allied health side, but also education for women. We need to know what's going on with our bodies. We need to know what's happening to our bodies, what these symptoms are all about and also what treatments are available, so that when we go in, we can advocate for ourselves and have a partnership approach with our GPs.[53]

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[47] See, for example, Jennifer, Private capacity, *Committee Hansard,* 29 July 2024, pp. 40–41; Name withheld, *Submission 84,* [p. 1]; Name withheld, *Submission 125,* [p. 2]; Name withheld, *Submission 88,* [p. 2].

[48] Sandy, Private capacity, *Committee Hansard,* 18 June 2024, p. 37.

[49] See, for example, Name withheld, *Submission 84,* [p. 1]; Name withheld, *Submission 125,* [p. 2]; Name withheld, *Submission 88,* [p. 2]; Name withheld, *Submission 127,* [p. 1]; Name withheld, *Submission 189,* [p. 4].

[50] Imogen, Private capacity, *Committee Hansard,* 18 June 2024, p. 41.

[51] Sharon, Private capacity, *Committee Hansard,* 29 July 2024, p. 44.

[52] See, for example, Sandy, *Submission 75,* pp. 10–11; Sandy, Private capacity, *Committee Hansard,* pp. 37–38; Rebecca, Private Capacity, *Committee Hansard,* 18 June 2024, p. 40.

[53] Mrs Rebecca Thomson, Founder, Your Menopause, *Committee Hansard,* 6 August 2024, p. 14.

Early menopause

2.49 The lack of awareness and access to information was a problem that was further compounded for women who experienced early menopause as a result of cancer treatment, surgical intervention, premature menopause or primary ovarian insufficiency.

Menopause after cancer treatment

2.50 The experience of dealing with cancer treatment and early menopause was described as a double burden for patients.[54] For example, Sonya, a breast cancer survivor, emphasised the significant challenges of living through menopause as a result of her cancer treatment, detailing:

> Navigating menopause after my cancer felt harder than the cancer treatments themselves. Exhausted, and suffering a wide range of physical and psychological side effects I was frightened and unsupported by my doctors with no idea how to manage or if this was how I was going to feel for the rest of my life.
>
> I struggled daily with extreme fatigue, cognitive disruption, anxiety, severe hot flushes and horrendous night sweats, weight gain, dreadful joint pain and psychological distress, all profoundly undermining my quality of life and functioning at home and work.
>
> In ten months I had gone from being a healthy, fit, active and happy 47-year-old to feeling like a 90-year-old woman.[55]

2.51 One submitter emphasised the limited availability of support and information:

> Personally, I also found finding advice and support difficult. At times my oncology specialists did not recognise some of the symptoms I was experiencing. While menopause support organisations focused on women aged between 45 and 55 years in 'natural menopause'. In effect, I am 'too young' and in a 'different' / the 'wrong' cohort. This prompted me to pursue support elsewhere to manage my symptoms.[56]

2.52 While cancer treatment can induce menopause, it was highlighted to the committee that specialists treating patients for cancer may not have knowledge about the impacts of menopause and may overlook its impact or provide inaccurate advice on treatment options.[57]

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54 See, for example, Maridulu Budyarai Gumal, *Submission 109,* pp. 5–13; Cancer Australia, *Submission 38,* p. 5.

55 Sonya, *Submission 79,* [p. 2].

56 Name withheld, *Submission 187,* [p. 1].

57 Australasian Menopause Society, *Submission 177*, p. 14. See, for example, Professor Martha Hickey, *Submission 138,* p. 7; The Royal Women's Hospital Melbourne, *Submission 33,* p. 5; Professor Roger Hart, Director, Menopause Alliance Australia, *Committee Hansard,* 6 August 2024, p. 17.

Surgically induced menopause

2.53 As outlined in chapter one, surgically induced menopause occurs through the process of a bilateral salpingo-oophorectomy, where both ovaries are removed which triggers menopause.[58]

2.54 Janine detailed her experience of surgical menopause, specifying that '[w]ithout ovaries producing hormones, the body goes into menopause overnight. This is not a natural situation'.[59] Janine conveyed that she was not counselled on the potential impacts of surgically induced menopause and, while provided with a preventative prescription for MHT patches, was not given further information on what to expect or how to manage her menopause symptoms.[60]

2.55 Another submitter to the inquiry detailed the traumatic nature of the lack of information that she was provided with:

> I found the recovery and the surgical menopause brought about by removal of my ovaries incredibly traumatic and I was woefully underprepared for my immediate menopausal experience.[61]

2.56 Jo, a private individual who submitted to the inquiry, also discussed that she received no information on early menopause after her full hysterectomy at the age of 39 in 2009.[62] She subsequently only learned of the onset of early menopause after surgery when watching a character experience it on television last year and was then able to understand the impact of symptoms she had experienced.[63]

Primary ovarian insufficiency

2.57 One in 100 women will experience primary ovarian insufficiency (POI).[64] Given the early age at which premature menopause can occur, there can be a lack of recognition by employers and a lack of peer support,[65] as well as a higher risk of emotional distress for women experiencing it.[66]

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58 Professor Martha Hickey, *Submission 138,* p. 35.

59 Janine, Private capacity, *Committee Hansard,* 29 July 2024, p. 42.

60 Janine, Private capacity, *Committee Hansard,* 29 July 2024, p. 42.

61 Name withheld, *Submission 220,* [p. 1].

62 Jo, *Submission 254,* [p. 1].

63 Jo, *Submission 254,* [p. 1].

64 Jacqui, *Submission 71,* [p. 1].

65 Royal Women's Hospital Melbourne, *Submission 33,* p. 5. See also, for example, Jacqueline, Private capacity, *Committee Hansard,* 6 August 2024, pp. 11–12.

66 Cancer Australia, *Submission 38,* p. 4. See, for example, Jean Hailes for Women's Health, *Submission 119,* p. 16 and p. 32; Jacqui, *Submission 71,* [p. 1].

2.58 Jacqui spoke to the unique challenges of her experience of POI in terms of accessing social support:

> POI sufferers have issues such as navigating and accepting infertility, navigating relationships with younger partners (who have no understanding of menopause, no peers with partners going through menopause, busy work and young children.[67]

2.59 At a hearing in Canberra, Belinda spoke to the experience of her daughter Vienna, who had 44 appointments over four years, starting at the age of 14. She presented to multiple GPs, with 13 of the 15 identified symptoms of menopause, but was not diagnosed with POI until the age of 19.[68]

2.60 Belinda also emphasised the long-term impacts of POI for women who are diagnosed earlier in life when she commented:

> She and young women and girls like her will live with the symptoms of menopause for most of their lives. The impact on their health, relationships, fertility and overall quality of life will be vastly affected yet they receive the least research funding. Research into the long-term impact of POI, how it might be diagnosed earlier to preserve fertility, how it might be prevented is desperately needed.[69]

2.61 The issues related to diagnosis and treatment of early menopause are further explored in Chapter 4.

Social impacts

2.62 Inquiry participants spoke to the pressures that the menopause transition can place on families, relationships and women's ability to fully participate in life.[70] As emphasised by Sandy:

> Untreated symptoms affected not only my health but also my relationships with partners and children, my workplace, my finances and retirement, my aging parents and my overall quality of life. It impacts not just our physical health but our sexual, emotional and mental health as well.[71]

Family pressures

2.63 Leeanne explained the pressures felt across the whole family, beyond an individual's symptoms of menopause:

> What is not taken into consideration while the woman is suffering is the toll that it takes on the rest of the family members whether it be immediate or extended. If the mother is suddenly unable to adequately function that puts

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67 Jacqui, *Submission 71,* [p. 1].

68 Belinda, Private capacity, *Committee Hansard,* 30 July 2024, pp. 34–35.

69 Belinda, Private capacity, *Committee Hansard,* 30 July 2024, p. 36.

70 Sexual Health Victoria, *Submission 17,* p. 3. See, for example, Family Planning Alliance Australia, *Submission 103,* [p. 5]; Bronwen, *Submission 249,* [p. 3]; Name withheld, *Submission 126;* [p. 2].

71 Sandy, Private capacity, *Committee Hansard,* 18 June 2024, p. 39.

> enormous pressure on other family members for additional help at various times. The impact can be enormous financially and emotionally.[72]

2.64 Kim, a submitter who started experiencing symptoms in her mid-forties described how it directly affected her family:

> I could not sleep and the anxiety I was feeling was the ultimate challenge and was destroying my life. The final straw was when my daughter asked me "What is wrong with you?" as I was snapping at her. This broke my heart. My family were suffering as they tried to navigate and understand what was happening to their mother, partner, and sister.[73]

2.65 Carl, a private individual who spoke to his wife's experience of menopause, emphasised the broad impacts for families:

> Menopause and its consequences affect everybody. Every man has a mother who will have to cope with menopause if she lives long enough. Many men have sisters, daughters, other female relatives and friends who will experience menopause. The issue needs to be discussed more widely in our society and there needs to be more compassion shown towards women.[74]

2.66 Women were also afraid of being financially reliant or dependant on their family members or expressed gratitude and regret that they needed to be supported financially by family members.[75] As discussed by one private individual who submitted to the inquiry:

> I am concerned as I am/will be, much more reliant on my husband's earnings to support me now and in the future.[76]

Divorce

2.67 Some submitters spoke to the potential link between menopause and higher rates of divorce in midlife or noted that they had considered divorce for the first time during the period of the menopause transition. [77]

2.68 Sandy, in her submission, noted the economic impact divorce can have:

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[72] Leeanne, *Submission 73,* [p. 2].

[73] Kim, *Submission 256,* [p. 1].

[74] Carl, *Submission 78,* [p. 1].

[75] See, for example, Charlene, *Submission 69,* [p. 1]; Name withheld, *Submission 88,* [p. 2]; Name withheld, *Submission 206,* p. 2.

[76] Name withheld, *Submission 88,* [p. 2].

[77] See, for example, Megan, *Submission 68,* p. 4; Sandy, *Submission 75,* p. 5; Name withheld, *Submission 96,* p. 3; Name withheld, *Submission 207,* [p. 2]; Simone, *Submission 236,* [p. 1]; Dr Keturah Hoffman, *Submission 76,* p. 3.

> Unfortunately another financial impact that can stem from divorce and little or no superannuation can be an increasing number of women being homeless and/or below the poverty line.[78]

2.69 In her submission, Megan emphasised the struggle she and her husband faced, and recounted that many of her friends have in fact divorced as a result of the effects of menopause:

> My husband and I have struggled through the last 7 years. It has been very difficult at times, and I can absolutely understand why people divorce. I am very blessed to have a caring, supportive, and rock steady husband, but I know this is not the case for everyone, and again several of our friends have divorced or separated as a result.[79]

2.70 Another private individual also discussed the correlation between her menopause symptoms and the potential for divorce:

> For the first time in our 34 years together my husband and I have recently discussed the possibility of divorce.
>
> My husband is a good and caring person, but not educated in emotional intelligence nor intrinsically interested in women's issues, during peri menopause I have been too tired to continue to do his share of the emotional labour in our relationship and without Hormonal support I could barely do my own.[80]

Mental health impacts

2.71 The existence or emergence of mental health difficulties as a symptom of menopause was discussed as a key driver of social impacts.[81] Allison explained the comprehensive challenges she faced during the menopause transition:

> Daily, I questioned my sanity and feared early dementia as I forgot words, could not complete sentences, and failed to absorb new information. I feared my irrational behaviour would shatter my marriage.[82]

2.72 For some women, the physiological changes of the menopause transition triggered substantial mental health impacts.[83] In some cases, women detailed menopause symptoms impacting them so significantly that they lost the will to live or considered suicide.[84] A submitter discussed the extent of the impact of menopause on her mental wellbeing:

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78 Sandy, *Submission 75*, p. 5.

79 Megan, *Submission 68*, p. 4.

80 Name withheld, *Submission 207,* [p. 2].

81 See, for example, Name withheld, *Submission 253,* [p. 2]; Leeanne, *Submission 73,* [p. 2].

82 Allison, *Submission 80,* [p. 1].

83 See, for example, Jodie, *Submission 241,* [p. 2]; Elena, *Submission 246,* p. 2.

84 See, for example, Name withheld, *Submission 85,* [p. 1]; Lisa, *Submission 183,* [p. 2]; Name withheld, *Submission 220,* [p. 1]; Janine, Private capacity, *Committee Hansard,* 29 July 2024, p. 42.

> If it were not for the love of my children, I would rather have left this world behind. The thoughts of suicide are daily and yet I push through it day after day. I struggle to look after myself let alone anyone else. I am 50 per cent at capacity of who I once was in terms of functionality.[85]

2.73 The committee was also informed of the extent to which some women used alcohol to cope with these impacts of menopause and perimenopause. As highlighted in the Newson Group submission when quoting a respondent to their survey:

> I self-medicated to the point of becoming an alcoholic.[86]

Involuntary childlessness

2.74 Involuntary childlessness (IC) was raised as another social impact that had repercussions for women during menopause. The Australian Longitudinal Study on Women's Health noted that never having given birth, infertility and recurrent miscarriages or stillbirths all increase the risk of a woman's early menopause.[87] Despite the increased health risks associated with premature menopause, involuntary childlessness is not mentioned directly in the National Women's Health Strategy 2020–2030, but the Strategy does note the need to highlight gaps in care for marginalised and stigmatised cohorts.[88]

2.75 Women with lived experience explained the relationship between menopause and involuntary childlessness, where women who had wanted to have children but were unable to, had to come to terms with the permanent loss of the ability to have children. Ms Sarah Roberts of the Empty Cradle explained:

> The menopause is both the actual and symbolic end to our reproductive years, and it can coincide with the grief and transition to permanent childlessness. This can have significant physical, psychological and mental health impacts. Many women experience the menopause as both a factor in their childlessness and a source of deep grief.[89]

2.76 At a hearing in Melbourne, Catherine talked about her experiences with an 'unusual and early menopause' following the cessation of In Vitro Fertilisation (IVF) treatment after five years. She explained how difficult this phase was for women who have experienced IC:

> By its very nature, menopause is the end of the reproductive years and can signify that the battle to have that wanted child is over. That realisation and its intersection with menopause impacts IC women with varying degrees of

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85 Name withheld, *Submission 85,* [p. 1].

86 Newson Health Group Limited, *Submission 18,* p. 10.

87 Australian Longitudinal Study on Women's Health, *Submission 35,* p. 3.

88 Catherine, Private capacity, *Committee Hansard,* 18 June 2024, p. 43.

89 Ms Sarah Roberts, Counsellor, Lived Experience Advocate and Founder, The Empty Cradle, *Committee Hansard,* 29 July 2024, p. 34.

> trauma and severity. I don't think it's possible to overstate the enormous scope of these issues and the ever growing number of women that they may impact.[90]

Accessing support and information

2.77 Given the limited availability of information, women across Australia explained the mechanisms through which they had sought out information and support.

Online support groups

2.78 Submitters to the inquiry highlighted the importance of finding online support and information through groups on social media.[91] Leeanne highlighted that these groups are 'literally SAVING women's lives' as a result of providing a community of support and shared knowledge.[92]

2.79 Women explained to the committee the role that these online support groups played in their ability to learn further about the impacts of symptoms, the mechanisms for accessing care and treatment, and discussing potential avenues for better care.[93]

2.80 Participants to the inquiry also emphasised the importance of learning that they were not alone through this journey and that other women were having similar difficulties with access to diagnosis, treatment and care.[94]

2.81 The demand for these online support groups was highlighted by Naomi, who volunteers as a co-admin of a Facebook support group, noting that the online community had grown in seven years from about 2 000 people to close to 40 000 people.[95]

2.82 The rise in popularity of these online support groups was attributed to the need for peer support during an isolating journey. It also pointed to the need for readily accessible, easy to understand information relating to the varied

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90 Catherine, Private capacity, *Committee Hansard,* 18 June 2024, p. 43.

91 See, for example, Sandy, *Submission 75,* p. 3; Name withheld, *Submission 86,* [p. 4]; Name withheld, *Submission 182,* [p. 1], Naomi, *Submission 196,* [p. 2]; Name withheld, *Submission 215,* [p. 4]; Tara, Private capacity, *Committee Hansard,* 17 June 2024, p. 43; Janine, Private capacity, *Committee Hansard,* 29 July 2024, p. 42; Cathy, Private capacity, *Committee Hansard,* 30 July 2024, p. 31.

92 Leeanne, *Submission 73,* [p. 1].

93 See, for example, Jo, *Submission 242,* [p. 3]; Charlene, *Submission 69,* [pp. 2–3]; Leeanne, *Submission 74,* [pp. 1–3].

94 See, for example, Sandy, *Submission 75,* p. 3; Name withheld, *Submission 88,* [pp. 3–4]; Name withheld, *Submission 99,* [pp. 2–3]; Name withheld, *Submission 125,* [p. 2].

95 Naomi, Private capacity, *Committee Hansard,* 17 June 2024, p. 45.

presentations and impacts of the menopause transition.[96] Dr Kelly Teagle elaborated:

> … I'd say meet women where they are. Social media is where women are. They're scrolling their feeds. They're getting all of this messaging, good and bad, and if the government doesn't provide some messaging then they're going to suck up whatever they can find on the internet.[97]

2.83 However, other witnesses raised concerns about potential misinformation being shared through these groups:

> … We've already heard today that there are a lot of social media groups, one that has 39 000 members, and, as one of the people presenting today on the panel said, none of them are medically trained. I think that some things that I find—and we find generally—are very scary. These women are so desperate to try and find information that they're not getting the quality of education and the information they need about certain medicines through those sorts of groups. That group of 39 000-plus—and there are many of these groups—are trying to get information from resources that are not factual and not aligned to the quality of health care that they deserve and should be getting.[98]

Menopause cafés

2.84 Another example of the need for greater peer support for women was highlighted through the example of the emergence of menopause cafés.

2.85 Felicity Brazil, a private individual who started the first Menopause Café in Canberra, explained that menopause cafés are a mechanism of community-based support where people of all ages and genders can discuss issues related to menopause.[99]

2.86 The University of Melbourne emphasised that menopause cafés can help to reduce stigma and promote open and frank discussion.[100]

Lack of evidence

2.87 The anecdotal experiences shared by women over the course of the inquiry about the lack of available information and awareness of menopause is also reflected in the lack of a comprehensive evidence base in Australia. As emphasised by Professor Susan Davis AO at a public hearing in Melbourne:

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96 See, for example, Jo, *Submission 242,* [p. 3]; Charlene, *Submission 69,* [pp. 2–3]; Leeanne, *Submission 74,* [pp. 1–3].

97 Dr Kelly Teagle, Founder, Shareholder, Director and Principal Clinician, WellFemme, *Committee Hansard,* 30 July 2024, p. 6.

98 Ms Tania Kunda, Associate Director Marketing, Theramex, *Committee Hansard,* 17 June 2024, p. 67.

99 Ms Felicity Brazil, *Submission 225,* p. 8.

100 University of Melbourne, *Submission 105,* p. 13.

> There has been no quality, cross-sectional data about menopause collected in the last 10 years in any country in the world. We're walking blind. We don't really know collectively the voice of women.[101]

2.88 Many inquiry participants emphasised the lack of available and robust data as one of the greatest hindrances to understanding the health, social and professional impacts of menopause in Australia.[102]

2.89 In terms of assessing the impacts of symptoms of menopause, Jean Hailes conducted an analysis on the National Women's Health Survey in regards to menopause, finding that 26 per cent of midlife women (aged 45 to 64) had experienced symptoms in the last five years, that they attributed to menopause, that made it hard for them to do daily activities.[103] This report also recommended further studies be undertaken to differentiate between the true impact of perimenopause and menopause from other causes of midlife stressors.[104]

2.90 It was discussed that the collection of any evidence on the impact of menopause symptoms should be designed in a manner that delineates between symptoms and the other common challenges of midlife, to establish a clearer picture of how menopause impacts women in Australia.[105]

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[101] Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard,* 18 June 2024, p. 12.

[102] See, for example, Professor Helena Teede, Director, Monash Centre for Health Research and Implementation, *Committee Hansard,* 18 June 2024, p. 21; Ms Nicola Leaney, Medical Manager, Theramex, *Committee Hansard,* 17 June 2024, p. 67; Ms Kaz Cooke, Private capacity, *Committee Hansard,* 18 June 2024, p. 2; Name withheld, *Submission 182,* [p. 3]; Associate Professor Treasure McGuire, Women's and Newborn Health Committee, Society of Hospital Pharmacists of Australia, *Committee Hansard,* 29 July 2024, p. 11; Ms Helen Dalley-Fisher, Convener, Equality Rights Alliance, *Committee Hansard,* 30 July 2024, p. 59; Research Australia, *Submission 98,* p. 5; The Office for Women, *Submission 135,* p. 4; Chief Executive Women, *Submission 136,* p. 7; Private Healthcare Australia, *Submission 155,* p. 2; Australian Academy of Health and Medical Sciences, *Submission 27,* p. 7.

[103] Jean Hailes for Women's Health, *Submission 119,* p. 18. The full report is also available online: Jean Hailes for Women's Health, *The impact of symptoms attributed to menopause by Australian women,* www.jeanhailes.org.au/research/womens-health-survey/menopause-in-australian-women (accessed 15 August 2024).

[104] Jean Hailes for Women's Health, *Submission 119,* p. 18. The full report is also available online: Jean Hailes for Women's Health, *The impact of symptoms attributed to menopause by Australian women,* www.jeanhailes.org.au/research/womens-health-survey/menopause-in-australian-women (accessed 15 August 2024).

[105] Research Australia, *Submission 98,* p. 7. See, for example, Jean Hailes for Women's Health, *Submission 119,* pp. 11–12; Women's Health Services Network, *Submission 149,* p. 12; Australasian Menopause Society, *Submission 177,* pp. 16–17.

2.91 It was further emphasised that the collection of any data must be intersectional by capturing the experiences of diverse demographics, such as CALD women, as well.[106]

2.92 As observed in the Royal Women's Hospital Melbourne submission:

> A contributing factor is the lack of consensus about what symptoms menopause causes. Whilst symptoms such as brain fog, mood swings, anxiety and weight gain may be common, they have not been shown to be attributable to menopause. Stigma around ageing in women and a research focus on pharmacological treatments means that evidence is limited. Addressing this would help women and health professionals to better understand this life stage and aid decision-making about self-management, treatment and clinical care.[107]

2.93 The lack of data on the economic impacts of menopause is discussed specifically in Chapter 3.

The need for intersectional data and responses

2.94 Submitters pointed to the lack of data and research on the experiences of different groups within the Australian community, including women from CALD communities, First Nations women and LGBTQIA+ people.[108] As Research Australia stated in their submission:

> Understanding cultural differences in the experience of menopause is critical in a multicultural nation like Australia if we are to provide appropriate education, services and treatment for menopause and perimenopause. However, we do not have a thorough understanding of these differences in the Australian context; this includes a lack of understanding of cultural differences for First Nations communities.[109]

CALD communities

2.95 Submitters highlighted that women in different cultures can experience menopause differently. This includes age of onset, types of symptoms but also

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[106] Ms Delaram Ansari, Research, Advocacy and Policy Manager, Multicultural Centre for Women's Health, *Committee Hansard,* 18 June 2024, p. 29. See, for example, Metluma, *Submission 56,* p. 5; Australian Psychological Society, *Submission 6,* p. 4; Royal Women's Hospital Melbourne, *Submission 33,* p. 12; Besins Healthcare, *Submission 146,* [p. 9]; Australasian Menopause Society, *Submission 177,* p. 2; The Office for Women, *Submission 135 – Attachment 1,* [pp. 3–4].

[107] Royal Women's Hospital Melbourne, *Submission 33,* p. 7.

[108] See, for example, Metluma, *Submission 56,* p. 5; Australian Psychological Society, *Submission 6,* p. 4; Royal Women's Hospital Melbourne, *Submission 33,* p. 12; Besins Healthcare, *Submission 146,* [p. 9]; Australasian Menopause Society, *Submission 177,* p. 2; The Office for Women, *Submission 135 – Attachment 1,* [pp. 3–4].

[109] Research Australia, *Submission 96,* p. 6.

community perceptions of menopause and perimenopause.[110] For example, in some cultures, reaching menopause is associated with an experience of enhanced wisdom or becoming more revered.[111]

2.96 However, in the Australian context, the experiences of women from CALD communities can be mixed. FECCA pointed to the 'disturbing scarcity of research or even knowledge amongst health practitioners about how to support women from culturally and linguistically diverse backgrounds'.[112]

2.97 In explaining the knowledge that does exist in relation to culturally and linguistically diverse women accessing care, Ms Mary Ann Baquero Geronimo, Chief Executive Officer of FECCA, explained:

> With the few studies available, it's reported that migrant women follow traditions to self-manage menopause and obtain information through friends and family. When they consult a doctor, they tend to experience a lack of patient centred culturally responsive care.[113]

2.98 The Family Planning Alliance emphasised the importance of more research in CALD communities to 'help guide holistic culturally appropriate menopause care in Australian primary care'.[114]

2.99 Furthermore, the Queensland Nurses and Midwives Union also noted the intersecting factors of discrimination from healthcare providers for women from CALD communities, which can contribute to further stigma and barriers to accessing care.[115]

2.100 Sexual Health Victoria acknowledged that there are some existing translated fact sheets available for women from CALD communities.[116] However, submitters discussed the lack of easy-to-read English resources related to menopause and perimenopause, and recommended this as an area for further consideration by

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110 See, for example, Professor Gita Mishra, Private capacity, *Committee Hansard,* 29 July 2024, p. 55; Research Australia, *Submission 98,* p. 6; Dr Keturah Hoffman, *Submission 76,* p. 2; Dr Gabriela Berger and Dr Anita Peerson, *Submission 52,* pp. 3–7.

111 Professor Helena Teede, Director, Monash Centre for Health Research and Implementation, *Committee Hansard,* 18 June 2024, p. 26.

112 FECCA, *Submission 169,* pp. 2–3.

113 Ms Mary Ann Baquero Geronimo, Chief Executive Officer, FECCA, *Committee Hansard,* 30 July 2024, p. 53. See also, for example, Dr Gabriela Berger and Dr Anita Peerson, *Submission 52,* p. 4.

114 Family Planning Alliance, *Submission 103,* p. 6. In relation to the need for more comprehensive data, see, for example, Professor Gita Mishra, Private capacity, *Committee Hansard,* 29 July 2024, p. 55; Research Australia, *Submission 98,* p. 3.

115 Queensland Nurses and Midwives Union, *Submission 107,* p. 8.

116 Sexual Health Victoria, *Submission 17,* [p. 3].

the government.[117] For these resources to be effective, the importance of co-design with CALD communities was emphasised.[118]

First Nations women

2.101 In its submission, the Royal Australian College of General Practitioners (RACGP) stated that 'there is a lack of culturally appropriate research in First Nations menopause perceptions'.[119] Similarly, Dr Odette Best noted the lack of specific research and told the committee that there has been 'absolutely no Indigenous research in Australia for over a decade'.[120]

2.102 In terms of existing research, some submitters pointed to a 2014 study which indicated a lack of information and understanding of menopause amongst Aboriginal healthcare workers.[121] The study also found that the average age of onset for menopause was five years earlier than non-Indigenous women and noted that First Nations women were experiencing increased health risks.[122]

2.103 Dr Odette Best and Professor Tracey Bunda also recommended the need for inclusion of references to perimenopause and menopause in relation to the funding provided to Aboriginal Community Controlled Health Organisation services (ACCHOs).[123] Further, they explained their research that showed of 145 Aboriginal medical services in Australia, only two had outward facing information related to 'the change' available online.[124]

2.104 Submitters asserted that this lack of evidence-based data directly contributed to the absence of culturally safe and appropriate education, support and care for

117 Family Planning Alliance, *Submission 103*, p. 6.

118 FECCA, *Submission 169*, p. 6.

119 RACGP, *Submission 1*, p. 5.

120 Dr Odette Best, Private capacity, *Committee Hansard*, 29 July 2024, p. 24

121 The study referred to by submitters is: Janelle R Jurgenson, Emma K Jones, Emma Haynes, Charmaine Green and Sandra C Thompson, 'Exploring Australian Aboriginal Women's experiences of menopause: a descriptive study', *BMC Women's Health*, vol. 14, no. 47, doi.org/10.1186/1472-6874-14-47. See, for example, Queensland Nurses and Midwives Union, *Submission 107*, p. 8; Australian Medical Association, *Submission 115*, p. 2; Jean Hailes for Women's Health, *Submission 119*, p. 24; RACGP, *Submission 1*, p. 5; Australian Psychological Society, *Submission 6*, p. 4; Department of Health Victoria, *Submission 14*, p. 5.

122 Department of Health Victoria, *Submission 14*, p. 5.

123 Dr Odette Best, Private capacity, *Committee Hansard*, 29 July 2024, pp. 24–25.

124 Dr Odette Best, Private capacity, *Committee Hansard*, 29 July 2024, pp. 24–25.

First Nations women.[125] As articulated by the Family Planning Alliance Australia:

> There is currently very little research on First Nations people's experiences and perceptions of menopause, nor evidence to guide culturally appropriate and safe best practice menopause clinics and management options… Further research, consultation and co-design with First Nations communities is essential to ensure health promotion initiatives are culturally relevant, appropriate and relatable.[126]

2.105 Dr Odette Best also emphasised the need to invest in research:

> … Women's business, which is what we in the Indigenous community call this time of our lives, must be better researched and must be better resourced.[127]

LGBTQIA+ people

2.106 Inquiry participants identified the need for a greater understanding of the impacts of menopause for LGBTQIA+ people.[128] Some submitters pointed out that much of the existing research has focussed on lesbian women's experiences only but there was less data available for other members of the LGBTQIA+ community.[129]

2.107 Ms Tilly Mahoney of Women's Health in the North, emphasised the need for further research:

> For trans men and intersex, non-binary and gender-diverse people who also experience menstruation, there's a severe lack of research on experiences of ageing and menopause.[130]

2.108 Submitters also noted the importance of acknowledging that the barriers to healthcare that can exist for LGBTQIA+ people also extend to accessing menopause care.[131]

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125 See, for example, Dr Alice Fitzgerald, Board Member, Australian College of Rural and Remote Medicine, *Committee Hansard*, 29 July 2023, p. 6; Australian College of Rural and Remote Medicine, *Submission 12*, p. 4; Women's Health in the North, *Submission 36*, pp. 5–6.

126 Family Planning Alliance Australia, *Submission 103*, pp. 5–6.

127 Dr Odette Best, Private capacity, *Committee Hansard*, 29 July 2024, p. 24.

128 See, for example, Dr Emily Castell, Clinical Psychologist, Sexuality, Education, Counselling and Consultancy Agency, *Committee Hansard*, 6 August 2024, p. 1; Sexual Health Victoria, *Submission 17*, pp. 3–4; Family Planning Alliance Australia, *Submission 103*, [p. 6].

129 See, for example, RACGP, *Submission 1*, pp. 5–6; Sexual Health Victoria, *Submission 17*, pp. 3–4; Family Planning Alliance Australia, *Submission 103*, [p. 6].

130 Ms Tilly Mahoney, Coordinator, Sexual and Reproductive Health, Women's Health in the North, *Committee Hansard*, 18 June 2024, p. 30.

131 RACGP, *Submission 1*, p. 6. See, for example, Multicultural Centre for Women's Health, *Submission 148*, p. 13.

Committee view

2.109 The committee is concerned by the current lack of awareness of the impacts of menopause and perimenopause across the Australian community. Australian women want to be better informed and more empowered to approach this natural life transition. The stories shared with the committee demonstrate the unnecessary harm currently experienced by too many women across the country.

Lack of data

2.110 Considering the lack of research, data and information available, the committee notes that the personal experiences and testimonies received during the inquiry were the most powerful, compelling and important evidence to gain an understanding of the impacts of menopause on women in Australia. The committee expresses its thanks once more to the individuals who shared their stories with the committee, either through a written submission or attendance at a public hearing.

2.111 These direct experiences shared with the committee tell a concerning story of the burdens placed on women at midlife, as well as the significant impact that symptoms can have on women. It is deeply concerning that so many women are unprepared and uninformed for what is an inevitable life transition. Too few women are empowered with information that can assist them with identifying symptoms and choosing the type of supports and care that would best suit them.

2.112 Moreover, the impacts of this lack of awareness do not just affect individual women. The social impacts of menopause, including family pressures and divorce, speak to the critical need for a greater understanding of the impacts of menopause for people across the community.

2.113 The committee acknowledges that certain groups of women face additional challenges which are not currently effectively understood. It is of concern to the committee that there is a limited understanding of the specific experiences of menopause for women from CALD communities, First Nations women and LGBTQIA+ individuals. The committee received very limited evidence about the impacts of menopause on women living with a disability and is cognisant that that this gap in information should also be addressed. A comprehensive review and understanding of the experiences for these cohorts would enable policymakers to develop tailored and effective initiatives to raise awareness and provide appropriate supports.

Recommendation 1

2.114 The committee recommends that the Department of Health and Aged Care commission research to establish a comprehensive evidence base about the impacts of menopause and perimenopause on women in Australia, including:

- **Menopause differentiated from midlife stressors;**

- **Mental health impacts of menopause; and**
- **Early menopause.**

The research should also establish an understanding of experiences for:

- **Culturally and linguistically diverse women;**
- **First Nations women;**
- **LGBTQIA+ individuals; and**
- **Women living with a disability.**

Raising awareness and education

2.115 The lack of support and information related to menopause is driving women to establish their own communities of support to better educate themselves and advocate for themselves. The existence of communities of support on social media are important and the rapid increase in membership of these groups indicates that there is a high demand for information.

2.116 There is an important role for the Australian Government in building greater national awareness of menopause and perimenopause and supporting the availability of good quality information. Doing so will lessen stigma, facilitate more community understanding of the experiences of women during this time and, over time, lessen the negative social impacts experienced by women.

Recommendation 2

2.117 The committee recommends that the Australian Government launch a national menopause and perimenopause awareness campaign, providing information and resources for women and communities across Australia. This awareness campaign should be designed in consultation with experts and people with lived experience.

2.118 The committee also acknowledges that the limited availability of information on menopause appears to be exacerbated for women experiencing early menopause as a result primary ovarian insufficiency, cancer treatment or surgical menopause. More must be done to support these women, which would be assisted by understanding their unique experiences and needs.

2.119 The committee agrees that there is merit in introducing discussion about the experiences of menopause during the health and physical education component of the Australian Curriculum to normalise these experiences and better prepare young women and men for this natural phase in a woman's life. The committee is of the view that starting the conversation about menopause as early as possible in young people's education would reduce the stigma and taboo, which currently exists in the Australian community.

Recommendation 3

2.120 The committee recommends that, in the next review of the Australian Curriculum, the Australian Curriculum, Assessment and Reporting Authority (ACARA) consider how menopause can be expressly referenced in the menstrual health and reproductive cycles content within the Health and Physical Education learning area.

Chapter 3
Impact on work and the economic consequences of menopause

> The complex heterogeneity of menopause transition within the population of Australian women is reflected in the varied impacts of those symptoms on work and career. The notion of an 'average' impact is not applicable – some women will experience relatively mild symptoms that have only a minor impact on their work, while others will experience severe, debilitating symptoms that require extended breaks from the workforce.[1]

3.1 This chapter explores the economic implications associated with menopause. For some women, menopause can contribute to leaving the workforce earlier, reduced superannuation balances and enhanced financial reliance on partners or family members.

3.2 Firstly, this chapter discusses the experience of menopause at work for some women, including impacts on workforce participation, superannuation balances and hesitancy or inability to take on higher responsibility roles. It then discusses the data related to women's workforce participation.

3.3 Finally, the chapter examines potential supports available for women in the workforce including menopause-specific leave, greater flexibility and reasonable workplace adjustments. The chapter concludes with the committee's view and recommendations.

The experience of menopause at work

3.4 Inquiry participants spoke to their own personal experiences of limiting workforce participation, as they were forced to reduce hours at work, take on roles with less responsibility or, in some cases, leave the workforce altogether as a result of difficult menopause symptoms.[2] As explained in a submission to the inquiry:

> While I have supportive managers and team (who I have not told the exact reason for my absences), I fear for my future career as I may need to reduce my work to part time to cope or wonder if I may need to consider leaving the workforce earlier than planned. This has stopped me putting my hand up for career progression opportunities because I fear that I could not cope

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1 The Association of Superannuation Funds of Australia (ASFA), *Submission 144*, p. 5.

2 See, for example, Name withheld, *Submission 93*, [p. 5], Name withheld, *Submission 94*, [p. 1], Name withheld, *Submission 129*, [p. 1]; Jill, *Submission 224*, p. 2; Maria, *Submission 232*, p. 1; Jodie, *Submission 241*, [p. 2]; Name withheld, *Submission 88*, [p. 2]; Name withheld, *Submission 188*, [p. 2]; Name withheld, *Submission 207*, [p. 1].

> with the extra responsibilities and pressure while enduring the current physical symptoms.[3]

Reduced workforce participation

3.5 Some women also spoke about the impact of cognitive symptoms, such as brain fog, on their ability to recall important information, and the related impact on their professional confidence overall.[4] Naomi discussed the impacts of these symptoms on her professional and earning capacity:

> Due to the effects of menopause, including severe brain fog, hot flushes, loss of cognitive function, anxiety, and depression, my ability to perform my work was greatly impaired. I felt unwell, inefficient, and of little use to my employers. My anxiety over the errors I was making merely made things worse. I ended up leaving my job of 15 years for a much lower-level position that was less stressful, just so I could remain employed and earning an income. This reduced my earning capacity yet increased my hours. … This in turn reduced my superannuation earnings, and any potential career progression I may have been able to achieve.[5]

3.6 A mathematics teacher submitted that, due to the onset of menopause symptoms, she was forced to relinquish her full-time position for a part-time relief teaching:

> … I had to make the decision to reduce my working hours and decrease the stress load. … I started off being able to work 4-5 days per week in a relief role but have now found that I am only able to put in 2-3 days per week due to the level of fatigue I experience and the amount of time.[6]

3.7 Another submitter to the inquiry talked about the economic impact of reduced hours and the lack of flexibility of her employer:

> I put in a request to work a 9-day compressed fortnight with a letter from my GP explaining that I had severe menopause and this request was rejected. I was told by my workplace that I could consider purchasing extra leave or going part time. Neither of these options would help me because it would mean a drop in my salary which I can't afford given I pay my own mortgage and the general cost of living.[7]

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3 Name withheld, *Submission 186,* [p. 1].

4 See, for example, Dr Andrea Binks, Fellow, Australian and New Zealand College of Anaesthetists, *Committee Hansard,* 18 June 2024, p. 74; Name withheld, *Submission 95,* [p. 1]; Rebecca, *Submission 193,* [pp. 1–2]; Name withheld, *Submission 198,* [p. 1]; Ms Cilla de Lacy, *Submission 223,* p. 4; Jodie, *Submission 241,* [p. 2].

5 Naomi, *Submission 196;* [pp. 1–2].

6 Name withheld, *Submission 88*, [p. 1].

7 Name withheld, *Submission 93,* [p. 5].

The cumulative financial impacts of menopause

3.8 Beyond the immediate impacts of needing to reduce working hours, submitters to the inquiry also highlighted the cumulative impact of menopause, including increased financial reliance on their partner, lessened superannuation contributions, and the additional financial burden of accessing menopause hormonal therapy (MHT).[8] For example, a submitter explained to the committee:

> This change in working hours has significantly impacted my income and reduced the amount of super savings I will have in future. I am concerned as I am/will be, much more reliant on my husband's earnings to support me now and in the future. Financial impacts are not only confined to loss of earnings and superannuation but also from medical expenses including Drs appointments, Specialist fees and scans, that have totalled more than $3000 during this period. There is also the on-going cost of the HRT prescriptions themselves which are around $80 per month.[9]

3.9 Amanda, a woman in her early 60s, submitted that her undiagnosed and untreated symptoms led her to have limited capacity to work and live in poverty:

> … Due to the undiagnosed symptoms, and consequently lack of correct medical care, I was only able to work part-time when I was in the prime of my working life, my late thirties forties and fifties. … So as a single parent, I was forced to live in poverty and also not accrue as much super as I needed, for a decent retirement. I am now medically retired at the age of 60.[10]

Future career prospects

3.10 Other submitters to the inquiry emphasised the fears they had for future career prospects. These fears centred on their ability to maintain full time hours or apply for promotions as being dependent on effective management of their menopause symptoms and a stable supply of MHT treatment that assisted in managing the impact of symptoms at work.[11]

3.11 For example, a submitter explained how her symptoms effectively ended any chance of further career progression:

> I have been told that it is all in my mind, I have been told that every woman goes through this I should just get over it, I have been told that I am no

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8 See, for example, Sandy, *Submission 75*, p. 4; Name withheld, *Submission 96*, pp. 3–5; Name withheld, *Submission 182*, [p. 1]; Name withheld, *Submission 206*, p. 2; Name withheld, *Submission 207*, [p. 2]; Lisa, *Submission 216*, [p. 1].

9 Name withheld, *Submission 88*, [p. 2].

10 Amanda, *Submission 210*, [p. 1].

11 See, for example, Name withheld, *Submission 186*, [p. 2]; Kelly, *Submission 250*, [p. 1].

> longer up to the job and that I should settle for never progressing further in my career.[12]

3.12 An inquiry participant reflected the anxiety of women having to manage symptoms and balance financial considerations at work:

> Coming from the perspective of an individual, a single parent of a 14-year-old teen, the potential impact of my perimenopausal symptoms on my ability to maintain my Senior Management role is honestly frightening. The consequences of me not being able to work, or having to reduce the type of work I am capable of, would be catastrophic.[13]

Stigma in the workplace

3.13 During the inquiry, stigma and taboo in relation to experiencing menopause symptoms were cited as having a direct impact on women's ability to maximise workforce participation, take leave or access appropriate workplace supports.[14] As described by Ms Julia Angrisano from the Finance Sector Union of Australia:

> The discussion of menopause remains taboo, and the inability to discuss the impacts and symptoms can affect a person's self-confidence and their ability to work productively. It's vital that we increase awareness of the impact that menopause can have or is having on individual workers. The symptoms of menopause are not well known, and the culture of silence means that the impact of menopause on workers is hidden.[15]

3.14 Further, women may experience multiple layers of potential workplace discrimination through the functioning of 'gendered ageism'. As Professor Kathleen Riach explained, gendered ageism:

> … provides an important cultural backdrop to menopause as it means women may be more likely to hide menopausal experiences and symptoms for fear of being positioned as older and therefore of less relevance or importance in society due to gender-ageism stereotypes. Menopause bias also contributed to gendered ageist perceptions that mean women are

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12 Name withheld, *Submission 188,* [p. 4].

13 Name withheld, *Submission 203,* [p. 1].

14 See, for example, SheListens Collective, *Submission 13,* p. 1; Department of Health Victoria, *Submission 14,* p. 9; Royal Australian College of Psychiatrists, *Submission 19,* p. 2; Maurice Blackburn Lawyers, *Submission 20,* pp. 1–3; Aware Super, *Submission 26,* p. 2; Finance Sector Union, *Submission 29,* pp. 4 and 6; Royal Women's Hospital Melbourne, *Submission 33,* p. 6 and p. 8; Women's Health in the North, *Submission 36,* p. 5; Professor Elizabeth Hill and Ms Sydney Colussi, *Submission 48,* p. 2; Metluma, *Submission 56 – Attachment 2,* [p. 4]; Queensland Nurses and Midwives Union, *Submission 107,* p. 9; Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Submission 140,* p. 4.

15 Ms Julia Angrisano, National Secretary, Finance Sector Union of Australia, *Committee Hansard,* 17 June 2024, p. 27.

> overlooked or not considered a source of talent and development in and around the labour market.[16]

3.15 Moreover, the prevalence of menopause stigma or taboo within the workplace can directly contribute to women being reluctant to disclose experiences of troublesome symptoms, request reasonable adjustments in the workplace and can – in extreme cases – lead to departures from the workforce altogether.[17] Dr Sianan Healy from Women's Health Victoria highlighted:

> We know that researchers have demonstrated that, while there's increasing visibility in the media about menopause and perimenopause, a lot of this is focused on individual determinants and on the so-called 'debilitating syndromes', which ultimately can end up reinforcing and exacerbating the stigma that women experience, and can also contribute to those barriers to workforce participation and to people either taking lower responsibility jobs or leaving the workforce earlier.[18]

3.16 One submitter attempted to raise awareness of menopause in her workplace, but it was met by stigmatising comments from senior management:

> I was asked by one senior manager not to talk about it as it made us look like a feminist movement and workplaces had managed fine until now.[19]

3.17 This submitter also recounted the experience of another colleague's fear of speaking up because of the lack of support they would receive from their manager:

> Another lady said that she would lie about feeling unwell because her anxiety was so bad that she couldn't face work but couldn't talk to her manager so would say she had a cold or gastro rather than have the conversation around her actual menopause symptoms because she didn't feel like they would understand or support her.[20]

3.18 Dr Rebecca Mitchell of the Macquarie Menopause Research Group also explained that the limited number of older women in workplaces and senior leadership roles can further exacerbate issues of stigma, because there are limited role models who can address stigma through their working experience.[21]

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16 Professor Kathleen Riach, *Submission 162,* p. 5.

17 See, for example, Jodie, *Submission 241,* [p. 2]; Rebecca, *Submission 193,* pp. 1–2; Name withheld, *Submission 215,* [p. 1]; Amanda, *Submission 210,* [p. 1]; Jill, *Submission 224,* [pp. 1–2].

18 Dr Sianan Healy, Senior Policy, Health Promotion and Advocacy Officer, Women's Health Victoria, *Committee Hansard,* 18 June 2024, p. 33.

19 Name withheld, *Submission 247,* [p. 3].

20 Name withheld, *Submission 247,* [p. 3].

21 Dr Rebecca Mitchell, Director, Health and Wellbeing Unit and Menopause Research Group, Macquarie Business School, *Committee Hansard,* 17 June 2024, p. 56.

3.19 As elaborated by Maurice Blackburn Lawyers, workplaces have a responsibility to address stigma, noting that:

> … issues related to workforce participation, in relation to menopause and perimenopause, centre around the extent to which an employer can destigmatise these issues in the workplace. In our experience, it is in workplaces where a culture of shame exists, that women avoid discussing their needs with their employer, and in turn, this can create the issues of reduced workforce participation and productivity.[22]

The cost of menopause to the economy and women's workforce participation

3.20 This section examines the impact of menopause on the economy and workforce participation. It considers the existing data as well as gaps and research needs.

Existing studies and research

3.21 In October 2022, the Australian Institute of Superannuation Trustees (AIST) released a report that indicated that menopause costs female workers $17 billion each year in lost earnings and superannuation.[23] This research was based on an estimate of 25 per cent of menopausal women experiencing debilitating symptoms causing long term absences from work or forcing early retirement.[24]

3.22 Further, AIST research in a 2023–24 pre-Budget submission referenced Australian Bureau of Statistics data which showed that 45 per cent of women retiring under the age of 55 did so due to sicknesses, injury or disability, and that women retired, on average, 7.4 years earlier than their male counterparts.[25] It is difficult to know the proportion of these women retiring due to the impacts of menopause specifically.

3.23 AIST research also estimated that early retirement could cost women approximately $500 000 in lost salary income and over $50 000 in superannuation savings. Submitters citing this research, emphasised that the cost to the economy could amount to $15.2 billion in foregone earnings and

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22 Maurice Blackburn Lawyers, *Submission 20*, pp. 1–2.

23 See, for example, Tasmanian Government, *Submission 6*, [p. 2]; Department of Health Victoria, *Submission 14*, p. 4; Equality Rights Alliance, *Submission 37*, p. 7; Professor Elizabeth Hill and Ms Sydney Colussi, *Submission 48*, p. 2; AIA Australia, *Submission 101*, p. 5; Australian Medical Association, *Submission 115*, p. 2; The Office for Women, *Submission 135 – Attachment 1*, p. 4; Avalon Family Medical Practice, *Submission 142*, [p. 4]; RANZCOG, *Submission 140*, p. 2; Future Group, *Submission 145*, [p. 3]; SDA Union, *Submission 156*, p. 5.

24 Tasmanian Government, *Submission 6*, [p. 2].

25 Australian Institute of Superannuation Trustees, *Measuring what matters: Understanding our economy and society while informing policy making*, treasury.gov.au/sites/default/files/2023-03/c2023-379612-australian_institute_of_superannuation_trustees.pdf (accessed 21 August 2024).

superannuation annually.[26] Submitters also pointed out that this phenomenon contributes to the existing gender superannuation gap.[27]

3.24 In their submission and at a hearing, based on their research, the Association of Superannuation Funds Australia (ASFA) also explained the key impact of menopause on a woman's superannuation due time off work and reduced hours through a few illustrative scenarios:

> A woman who is 51 (on average wages for age), and who shifts from full-time to part-time work (3 days per week) for a period of four years, would have around $25,000 less superannuation at retirement (assumed retirement age of 67).
>
> A woman who is 51 (on average wages for age), and who leaves the workforce for a period of two years, would have around $30,000 less superannuation at retirement (assumed retirement age of 67).[28]

3.25 Ms Toni Brendish, Interim Chair of the Policy and Engagement Committee at Chief Executive Women gave evidence to the committee about the potential impact of menopause on the economy:

> Globally, addressing menopause could potentially contribute $120 billion to the economy, and an increase in the participation rate of five per cent of people aged 55 and over could add $48 billion to the Australian economy alone.[29]

Need for robust data

3.26 The Australian Academy of Health and Medical Sciences took issue with the methodological limitations of the AIST data, noting that the financial estimates appear to be based on two United Kingdom studies that had substantial limitations.[30]

3.27 In acknowledging that some women do experience debilitating symptoms of menopause that affect their workforce participation, some submitters identified the need for more robust data that assesses the impact of menopause symptoms on women's workforce participation specifically, as well as the other drivers of

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[26] Queensland Nurses and Midwives Union, *Submission 107*, p. 5. See, for example, Chief Executive Women, *Submission 136*, p. 5; Women's Health Services Network, *Submission 149*, p. 18; COTA Australia, *Submission 165*, p. 13; Australian Council of Trade Unions, *Submission 178*, pp. 5–6; Health Care Consumers' Association, *Submission 170*, p. 5; Dr Sianan Healy, Senior Policy, Health Promotion and Advocacy Officer, Women's Health Victoria, *Committee Hansard*, 18 June 2024, p. 33.

[27] ASFA, *Submission 144*, p. 2. See, for example, NSW Government, *Submission 53*, p. 3.

[28] Ms Mary Delahunty, Chief Executive Officer, Association of Superannuation Funds of Australia, *Committee Hansard*, 17 June 2024, p. 27.

[29] Ms Toni Brendish, Interim Chair, Policy and Engagement Committee, Chief Executive Women, *Committee Hansard*, 17 June 2024, p. 21.

[30] The Australian Academy of Health and Medical Sciences, *Submission 27*, pp. 6 and 9.

economic disadvantage for women in midlife.[31] As noted by the Australian Academy of Health and Medical Sciences:

> Whilst a growing number of women are working during their perimenopause and during their early post menopause years (menopausal stage), we need more robust data to establish whether (and if so, to what extent), being perimenopausal or postmenopausal is associated with reduced productivity or likelihood of leaving work – the availability of robust data currently limits our understanding of this issue and therefore our ability to responded [sic] appropriately, if needed.[32]

3.28 In its submission to the inquiry, Jean Hailes for Women's Health (Jean Hailes) discussed the need to understand the compounding economic disadvantage related to wage, superannuation and career opportunity losses across a woman's lifespan. [33] It also noted the need to support women's workforce participation at an earlier age, instead of just focussing on the cohort of women affected by perimenopause and menopause symptoms in isolation, referencing an ASFA research paper which:

> … showed that the gap between median super balances between women and men are the same in the 25-29 age cohort and diverge in the 30-34 age cohort (presumably due to the motherhood penalty). In other words, there is already a striking difference between the median superannuation balances by the time women enter the 40-44 age cohort, the age range after which most women enter perimenopause.[34]

3.29 Professor Susan Davis AO, Director of the Monash University Women's Health Research Program, advised the committee of its Australian Women's Midlife Years (AMY) Study, a 'nationally representative study of Australian women aged 40 to 69 years, to understand the contemporary menopausal experience'.[35]

3.30 Professor Davis flagged that whilst data collection from over 8 000 Australian women has been completed, data analysis is now being completed without any government funding. Professor Davis also emphasised the need for 'good data':

> … we need good data and we don't need a bastardisation of my data where I see a budget submission saying that 30 percent of women can't work well

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31 See, for example, Royal Women's Hospital Melbourne, *Submission 33*, pp. 3–4; Women's Health and Research Program, *Submission 11*, pp. 2–3 and 6; Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard*, 18 June 2024, pp. 8 and 11–12; Professor Helena Teede, Director, Monash Centre for Health Research and Implementation, *Committee Hansard*, 18 June 2024, p. 24; Professor Kathleen Riach, *Submission 162*, p. 2.

32 Australian Academy of Health and Medical Sciences, *Submission 27*, p. 7.

33 Jean Hailes for Women's Health, *Submission 119*, p. 35.

34 Jean Hailes for Women's Health, *Submission 119*, p. 35.

35 Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard*, 18 June 2024, p. 8; Document tabled by Professor Susan Davis AO, the Australian Women's Midlife Years (AMY) Study, [p. 1] (tabled 18 June 2024).

> because of menopause, whereas in fact our data show that only 3.3 per cent of women have poor work ability. I really want you to look carefully at the data that's being handed to you…[36]

3.31 Ultimately, submitters pointed to the difficulties of drawing conclusions on the impact of menopause symptoms on women's workforce participation without more robust data that specifies the impacts of symptoms, specifically on women's work and careers, including early retirement.[37] At a hearing in Canberra, Ms Rochelle White of the Office for Women highlighted:

> There isn't clear evidence about whether menopause is causing the uptake of paid or unpaid leave, or whether it is moving women to part-time work or to exiting the system. … We need some more research on how menopause is impacting different cohorts of women and their economic participation decisions, and the consequences for their economic security. [38]

Menopause leave

3.32 The inquiry canvassed potential ways that employers can better support employees experiencing menopause in the workplace, including existing best practices, as well as recommendations for reform. It is important to note that many submissions did not support stand-alone menopause leave, but did support using existing levers to support women in the workplace.

Reproductive leave

3.33 Some submitters were in support of the introduction of paid menopause and perimenopause leave, either as a standalone category or captured as part of a broader reproductive health leave.[39]

3.34 Inquiry participants pointed to examples of existing reproductive health leave across the private and public sectors that are proving to be effective. Most of the existing leave initiatives incorporate a broad category of reproductive leave, or menstrual and menopause leave, rather than menopause specific leave. This is

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36 Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard,* 18 June 2024, p. 8.

37 See, for example, RANZCOG, *Submission 140,* pp. 2–3; ASFA, *Submission 144,* p. 7; The Australian Academy of Health and Medical Sciences, *Submission 27,* pp. 6 and 9; Ms Patricia Sparrow, Chief Executive Officer, Council on the Ageing Australia, *Committee Hansard,* 30 July 2024, p. 60; Ms Helen Dalley-Fisher, Convener, Equality Rights Alliance, *Committee Hansard,* 30 July 2024, p. 52; Monash Centre for Health Research and Implementation, *Submission 34,* p. 3; Monash University Women's Health Research Program, *Submission 11,* p. 2.

38 Ms Rochelle White, Assistant Secretary, Social Policy and International Engagement, The Office for Women, Department of Prime Minister and Cabinet, *Committee Hansard,* 13 August 2024, p. 14.

39 See, for example, COTA Australia, *Submission 165,* p. 6; Ms Rebecca Madill and Dr Alessandra Briglia, *Submission 168,* p. 2; Australian Services Union, *Submission 173,* [p. 3]; Australian Physiotherapy Association, *Submission 10,* [p. 5]; Department of Health Victoria, *Submission 14,* p. 10; Pharmacy Guild of Australia, *Submission 32,* [p. 3]; Future Group, *Submission 145,* [p. 2].

to ensure the leave encompasses experiences across a woman's life course, such as painful menstruation, conditions such as endometriosis, and accessing reproductive healthcare services, such as in vitro fertilisation (IVF).[40]

3.35 The quantum of days and the mechanisms for reproductive leave are different across different companies. By way of example, some of the existing arrangements for reproductive leave that were shared with the committee over the course of the inquiry include:

- Future Group – Six paid days per year to manage symptoms of menopause and menstruation, available to all employees of Future Group;[41]
- Aware Super – 10 days of paid menopause leave per financial year;[42]
- CBUS – 12 days of paid menopause and menstrual leave included in the Enterprise Agreement;[43]
- ModiBodi – 10 paid days per calendar year of menstruation, menopause and miscarriage leave;[44] and
- Women's Health Matters ACT – 24 days of paid reproductive health leave per calendar year.[45]

3.36 Many of the aforementioned reproductive health leave policies are employed alongside a variety of supports, ensuring that the policy does not just provide leave in isolation. An example of one such leave policy in practice is provided below:

Box 3.1 An example of reproductive health leave in practice: Victorian Women's Trust

In 2017, the Victorian Women's Trust implemented a paid leave policy for issues related to menstruation and menopause, which saw the introduction of 12 paid days of menopause leave per calendar year.[46] The policy involves a three-tiered approach to provide support for women in the workplace experiencing challenging symptoms associated with menstruation or menopause:

- **Reasonable and practical adjustments** – when employees are experiencing symptoms but are capable of remaining at work, they can

[40] Queensland Unions, *Submission 166*, pp. 7–8.

[41] Future Group, *Submission 145*, [p. 3].

[42] Aware Super, *Submission 26*, [p. 1].

[43] Finance Sector Union, *Submission 29*, p. 11.

[44] Women's Health in the North, *Submission 36*, p. 7.

[45] Women's Health Matters ACT, *Submission 116*, p. 12.

[46] Victorian Women's Trust, *Submission 99*, pp. 37–38.

access reasonable adjustments such as resting in a quiet area or stepping out for a walk.

- **Remote work policy** – if an employee is able to work but would be more comfortable managing symptoms from home, they are able to do so through the remote work policy of the organisation.
- **Access to menstrual or menopause leave** – if an employee is unable to work due to the impact of symptoms, they are able to access a day of paid leave which does not require a medical certificate.

Since the introduction of the leave policy in 2017, the uptake has seen an average of six days of leave taken per year across the organisation.[47] The total amount of leave days utilised across the seven year period was between 36 and 37 days of leave.[48] The Victorian Women's Trust has since made the policy template available for open access on their website, and it has been accessed 8000 times.[49]

3.37 Other examples of effective implementation of reproductive leave included the implementation of 10 days paid reproductive leave for workers in the Queensland Public Service,[50] and the introduction of a reproductive health leave clause in the Victoria Public Service Agreement 2024, providing five days of paid reproductive leave to Victorian Government employees.[51]

3.38 It was also highlighted to the committee that, where menopause or reproductive leave policies have been implemented, there is often lesser uptake than anticipated.[52] For example, CBUS, as an industry super fund, put in 12 days of paid menopause and menstrual leave. Over a period of three years, and across over 700 staff, only 40 calendar days of menopause and menstrual leave were used.[53]

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47 Victorian Women's Trust, *Submission 99*, p. 37.

48 Ms Mary Crooks AO, Executive Director, Victorian Women's Trust, *Committee Hansard*, 18 June 2024, p. 46.

49 Ms Mary Crooks AO, Executive Director, Victorian Women's Trust, *Committee Hansard*, 18 June 2024, p. 47.

50 Mr Grant Burton, Assistant Secretary, Queensland Nurses and Midwives Union, *Committee Hansard*, 29 July 2024, p. 2. See, for example, Ms Jacqueline King, General Secretary, Queensland Council of Unions, *Committee Hansard*, 29 July 2024, p. 60.

51 Australian Council of Trade Unions, *Submission 178*, p. 14.

52 See, for example, Ms Christina Hobbs, General Manager, Advocacy, Future Group, *Committee Hansard*, 17 June 2024, p. 34; Ms Mary Crooks AO, Executive Director, Victorian Women's Trust, *Committee Hansard*, 18 June 2024, p. 46.

53 Ms Angela Budai, National Policy Officer, Finance Sector Union of Australia, *Committee Hansard*, 17 June 2024, p. 31.

3.39 Ms Kate Marshall, Senior National Assistant Secretary of the Health Services Union also emphasised the importance of a separate category of reproductive leave for women, noting that the burden of unpaid care work often means that women use their sick leave for caring responsibilities.[54]

3.40 Further, it was argued by Ms Delaram Ansari of the Multicultural Centre for Women's Health, that any implementation of menopause specific leave or reproductive health leave must be undertaken with an intersectional approach. She noted the:

> … structural barriers or the systemic barriers that force a lot of migrants or refugee women to the casualised workforce or the underpaid workforce, be it aged care or child care, and that sometimes don't even allow someone to be able to take time off if there is no leave policy.[55]

3.41 Menopause Friendly Australia also pointed to the fact that the Workplace Gender Equality Agency (WGEA) previously collected voluntary reporting data on action taken in the workplace in relation to menopause, including implementation of specific policies.[56] Ms Mary Wooldridge of WGEA further explained that voluntary reporting in the 2022–23 reporting period had 532 employers respond, with 65 indicating that they provided paid menopause leave.[57]

Enabling cultural change

3.42 The committee heard that an important element of the implementation of reproductive leave or menopause leave was the need to also facilitate a supportive cultural shift towards these issues within the workplace.[58] As identified by Ms Laura Ricciardi of Women's Health in the South East, summarising findings of a review of reproductive leave policies:

> … there were positive findings in terms of the impact for both organisations and the employees, but that the leave needed to be surrounded by, or ensconced within, a positive cultural framework in the organisation.[59]

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[54] Ms Kate Marshall, Senior National Assistant Secretary, Health Services Union, *Committee Hansard,* 30 July 2024, pp. 41–42.

[55] Ms Delaram Ansari, Research, Advocacy and Policy Manager, Multicultural Centre for Women's Health, *Committee Hansard,* 18 June 2024, p. 34.

[56] Menopause Friendly Australia, *Submission 147,* [p. 2] and p. 7.

[57] Ms Mary Wooldridge, Chief Executive Officer, Workplace Gender Equality Agency, *Committee Hansard,* 13 August 2024, p. 13.

[58] Ms Laura Ricciardi, Sexual and Reproductive Health Lead, Women's Health in the South East, *Committee Hansard,* 18 June 2024, p. 34.

[59] Ms Laura Ricciardi, Sexual and Reproductive Health Lead, Women's Health in the South East, *Committee Hansard,* 18 June 2024, p. 34.

3.43 It was further explained that the introduction of such leave can enable a process of destigmatisation of the experiences of menopause and perimenopause, or reproductive health issues, in the workplace where women and workplaces discuss these issues to facilitate uptake of leave.[60]

3.44 Ms Christina Hobbs of Future Group further elaborated on the identified benefits noticed within the company after the implementation of their leave policy:

> We know that women who are going through menopause, and also women who are menstruating, have reported that they feel more comfortable speaking about their symptoms because they're not applying for sick leave. Within the organisation, there's a growing acknowledgement that this isn't about sickness or illness; it's something natural. Women have reported that sense that this is a natural process, and understanding from the organisation has increased.[61]

3.45 The Victorian Women's Trust explained that this can have a clear economic benefit for companies:

> Developing positive menstrual and menopausal policies across workplaces is not simply about accommodating a perfectly natural cycle within workplace culture. It is also about maximising the talents and capacities of women in the workforce. This also goes to maximising the productivity of a workplace.[62]

Reproductive leave in the National Employment Standards

3.46 Another approach that was canvassed across the inquiry was to enshrine gender-inclusive reproductive leave in the National Employment Standards (NES) and modern awards.[63]

3.47 The NES are a framework that exist under the *Fair Work Act 2009*. The NES entitles employees, among other things, to access ten days of personal/carer's leave per year.[64] The recommendations related to paid reproductive leave were

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60 Ms Mary Crooks AO, Executive Director, Victorian Women's Trust, *Committee Hansard*, 18 June 2024, p. 46. See, for example, Ms Julia Angrisano, National Secretary, Finance Sector Union of Australia, *Committee Hansard*, 17 June 2024, pp. 33–34; Ms Christina Hobbs, General Manager, Advocacy, Future Group, *Committee Hansard*, 17 June 2024, p. 33.

61 Ms Christina Hobbs, General Manager, Advocacy, Future Group, *Committee Hansard*, 17 June 2024, p. 33.

62 Victorian Women's Trust, *Submission 99*, p. 36.

63 See, for example, Women's Health Services Network, *Submission 149*, pp. 18–19; Victorian Trades Hall Council, *Submission 164*, p. 4; COTA Australia, *Submission 165*, p. 5.

64 Queensland Council of Unions, *Submission 166*, p. 4.

specified as being recommended for Part 2-2 Division 7 of the NES and the recommendation was made for 10 days per year.[65]

3.48 Women's Legal Services Australia further explained:

> This leave would offer support to workers who are trying to start a family, or to anyone who is managing some of the complex needs of the human body, which requires different levels of attention and maintenance over the life course. … In particular, WLSA propose it would cover perimenopause, menopause, menstruation, IVF and other assisted fertility treatments, and other forms of assisted reproductive health services such as vasectomy, hysterectomy and termination of pregnancy.[66]

3.49 Other submitters, such as the Equality Rights Alliance, instead recommended that the government examine the adequacy of existing leave entitlements to cover menopause and perimenopause under the NES.[67]

Concerns with menopause specific leave

3.50 Many participants in the inquiry were not supportive of menopause specific leave and expressed concerns about a potential backlash against women in the workplace.[68] For example, Ms Thea O'Connor from Menopause at Work Asia-Pacific told the committee:

> I have quite mixed feelings on menopause specific leave. I've seen organisations where it works well and the leaders are right behind it and everyone is positive. But I think just giving leave means the workplace doesn't have to change, because you are sending women home to do it in private. Some of the surveys indicate that quite a large number of women would prefer to stay at work if they can just be given a little bit more support.[69]

3.51 At a hearing in Sydney, Ms Grace Molloy of Menopause Friendly Australia further emphasised that 'the top three things that women say would be most helpful at work don't include leave'.[70] She explained that preferred mechanisms

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65 Women's Legal Services Australia, *Submission 171,* pp. 11–12.

66 Women's Legal Services Australia, *Submission 171,* p. 12.

67 Equality Rights Alliance, *Submission 37,* p. 8. See also, for example, Women's Health Matters ACT, *Submission 116*, p. 4.

68 See, for example, Professor Gita Mishra, Private capacity, *Committee Hansard,* 29 July 2024, p. 57; RANZCOG, *Submission 140,* p. 9 and pp. 11–12; Australian College of Midwives, *Submission 157,* p. 9; Professor Kathleen Riach, *Submission 162,* p. 9; The Office for Women, *Submission 135,* p. 5; Monash University Women's Health Research Program, *Submission 11,* p. 6.

69 Ms Thea O'Connor, Founder and Director, Menopause at Work Asia Pacific, *Committee Hansard,* 17 June 2024, p. 15.

70 Ms Grace Molloy, Co-Founder and Chief Executive Officer, Menopause Friendly Australia, *Committee Hansard,* 17 June 2024, p. 15.

of management were workplace flexibility, a supportive manager and flexibility related to temperature and clothing within the workplace.[71]

3.52 Other submitters cautioned against the introduction of menopause specific leave due to the potential risk of greater stigma, and leave posing an additional barrier to workforce participation and employability in mid-age.[72] Specifically, the Chief Executive Women submission cautioned 'against the implementation of standalone "menopause leave" that risks further alienating a woman from her place of work'.[73]

3.53 It was also argued that some workers may be unwilling to disclose their menopausal status in the workplace and so there could be unanticipated challenges with uptake of this leave.[74]

3.54 Jean Hailes pointed to findings of the 2023 National Women's Health Survey, which showed that more than four in five Australian women agreed with the statement that 'some employers or co-workers would not be understanding if someone took menstrual or menopause leave'.[75] Further, seven in 10 Australian women believed employers would use menopause leave as an excuse to discriminate against women in the workplace.[76]

3.55 The inquiry also canvassed the issues faced in accessing leave or flexible working arrangements across different industries. As articulated by Dr Sarah White, Chief Executive Officer of Jean Hailes for Women's Health:

> I think it's flexibility dependent on the workplace because there will be so many things that are dependent. We often talk about this from a position of privilege, where we're talking as knowledge workers. If you're a teacher, a nurse, even a female doctor, you're not going [to] go and sit in the menopause pod or take the leave—who, then, covers your ward rounds? We have to look at some middle ground. I know it's not a definite answer, but it's about co-designing what the women in that workforce and that workplace need. It might not be leave. It might be, but it might not be.[77]

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71 Ms Grace Molloy, Co-Founder and Chief Executive Officer, Menopause Friendly Australia, *Committee Hansard*, 17 June 2024, p. 15.

72 See, for example, Monash Centre for Health Research and Implementation, *Submission 34*, p. 15; Chief Executive Women, *Submission 136*, p. 11.

73 Chief Executive Women, *Submission 136*, p. 11.

74 See, for example, Equality Rights Alliance, *Submission 37*, pp. 8–9; Jean Hailes for Women's Health, *Submission 119*, pp. 15–16; The Office for Women, *Submission 135*, p. 5.

75 Jean Hailes for Women's Health, *Submission 119*, p. 33.

76 Jean Hailes for Women's Health, *Submission 119*, p. 33.

77 Dr Sarah White, Chief Executive Officer, Jean Hailes for Women's Health, *Committee Hansard*, 18 June 2024, pp. 50–51.

3.56 Ms Mary Wooldridge of the Workplace Gender Equality Agency took a similar view, noting that there had not been enough research into the impact of menopause leave:

> The jury is still out in relation to leave. More information and evidence would be helpful on that.[78]

Flexibility in the workplace

3.57 Many participants to the inquiry outlined that in many cases, individuals experiencing difficulty with their menopause symptoms may not require specific leave. Rather, they could manage these symptoms with reasonable adjustments in the workplace, including greater workplace flexibility.[79]

3.58 Some participants to the inquiry outlined that in many cases, individuals experiencing difficulty with their menopause symptoms may not require specific leave. Rather, they could manage these symptoms with reasonable adjustments in the workplace, including greater workplace flexibility.

3.59 As asserted by one submitter, accessing workplace flexibility was critical to staying an active participant in the workforce:

> Early onset menopause disrupted my career trajectory. It had reduced workforce participation due to symptoms like fatigue, brain fog, and mood swings that affected my productivity. However, since COVID-19, the workforce has changed, and my current employment has given me the flexibility to better manage this and contribute to my full potential. I believe that I would have had to leave my position and the workforce if these arrangements were not an option.[80]

3.60 Rebecca, an individual with lived experience, told the committee at a hearing in Melbourne the extent to which flexible workplace options enabled her to participate in her workplace:

> … We have a very good flexible-workplace policy, and I thought maybe I just needed some reasonable adjustments. He was quite open—and, yes, my manager is a male. Thankfully, he was very open to the conversation. He did not make me feel uncomfortable about discussing this life transition. We did come up with a flexible work arrangement, which meant that I could work from home a couple of days a week to help with my sleeping, or, if I hadn't slept really well, at least I could lie in bed a bit longer and that type of thing.[81]

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[78] Ms Mary Wooldridge, Chief Executive Officer, Workplace Gender Equality Agency, *Committee Hansard*, 13 August 2024, p. 19.

[79] See, for example, Dr Kate Johnston-Ataata, Manager Policy, Health Promotion and Advocacy, Women's Health Victoria, *Committee Hansard,* 18 June 2024, p. 34; Ms Jacqueline King, General Secretary, Queensland Council of Unions, *Committee Hansard,* 29 July 2024, p. 64.

[80] Name withheld, *Submission 91,* [p. 1].

[81] Rebecca, Private capacity, *Committee Hansard,* 18 June 2024, p. 40.

3.61 Ms Grace Molloy, Chief Executive Officer and Co-Founder of Menopause Friendly Australia, emphasised:

> For many women, simply coming to work and saying, 'I'm having a bit of a day', is all that's needed, knowing that that will be met with understanding and support. However, creating a safe environment where everyone feels comfortable talking about menopause at work takes intentional action on the part of employers.[82]

3.62 While it was discussed that the reasonable adjustments required for a woman working in a hospital environment or school environment would differ significantly to a woman who works in an office and who can work from home, submitters pointed out that adjustments can be reasonably made across all workplaces with flexibility, a safe and supportive culture, and workplace adjustments.[83]

3.63 Suggested examples of the types of reasonable adjustments that can make a meaningful difference for employees experiencing perimenopause symptoms included:

- access to temperature regulation and ventilation;[84]
- allowing for different start times for rostered workers;[85]
- longer or more frequent breaks;[86]
- access to cool drinking water, desk fans and refrigeration;[87]
- access to uniforms made of breathable material or with short sleeves;[88]

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82 Ms Grace Molloy, Co-Founder and Chief Executive Officer, Menopause Friendly Australia, *Committee Hansard,* 17 June 2024, p. 13.

83 See, for example, Professor Jayashri Kulkarni, Director, HER Centre Australia, *Committee Hansard,* 30 July 2024, p. 14; Dr Andrea Binks, Fellow, Australian and New Zealand College of Anaesthetists, *Committee Hansard,* 18 June 2024, p. 72.

84 Ms Yumi Lee, Chief Executive Officer, Wolder Women's Network New South Wales, *Committee Hansard,* 17 June 2024, p. 46.

85 Ms Kate Marshall, Senior National Assistant Secretary, Health Services Union, *Committee Hansard,* 30 July 2024, p. 40.

86 Ms Kate Marshall, Senior National Assistant Secretary, Health Services Union, *Committee Hansard,* 30 July 2024, p. 40.

87 Ms Kate Marshall, Senior National Assistant Secretary, Health Services Union, *Committee Hansard,* 30 July 2024, p. 40. See, for example, Australian Medical Association, *Submission 115,* p. 2.

88 See, for example, RACGP, *Submission 1,* p. 7; Finance Sector Union, *Submission 29,* p. 7; Australian Longitudinal Study on Women's Health, *Submission 35,* p. 23; Associate Professor Ravani Duggan, *Submission 51,* p. 4; ACTU, *Submission 178,* p. 11; Her Health & Aesthetics, *Submission 179*, [p. 3]; Elena, *Submission 246,* [p. 7]; Ms Sarah Haynes, Industrial Officer and Equity Officer, Shop, Distributive and Allied Employees Association, *Committee Hansard,* 6 August 2024, p. 36.

- adjustments to strict rostering practices to enable toilet breaks to manage heavy bleeding or hot flushes;[89] and
- better access to toilets.[90]

Amendment of the Fair Work Act

3.64 Some submitters suggested amending Section 65 (1A) of the *Fair Work Act 2009* (the Act) as a potential way to ensuring that workplaces offer flexibility to women. Currently, Section 65 (1A) specifies the circumstances through which an employee can request a change to working arrangements, including access to flexible working arrangements.[91] These circumstances are currently listed as applicable if the employee:

- is pregnant;
- is a parent, or has the responsibility for the care of a child who is of school age or younger;
- is a carer (under the *Carer Recognition Act 2010);*
- has a disability;
- is 55 years or older;
- is experiencing family or domestic violence;
- is providing care or support to a member of the employee's immediate family, or a member of the employee's household, who requires care or support because the member is experiencing family and domestic violence.[92]

3.65 Submitters recommended that a new category should be added, which specifies symptoms of perimenopause, menopause or reproductive health as a reason for accessing flexible work under the Act.[93] Discussing the importance of this recommendation, Women's Legal Services Australia stated:

> Enshrining the right to request a flexible working arrangement based on reproductive health grounds would mean that employees feel more empowered to make a request on these grounds; have a process and rigour around making a request that extends to an ability to raise a dispute in the Fair Work Commission if their request is not accommodated; and are not just at the whim of their manager.[94]

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89 ACTU, *Submission 178,* p. 11.

90 Ms Claire King, Work Health and Safety Policy Officer, Australian Council of Trade Unions, *Committee Hansard,* 30 July 2024, pp. 38 and 40.

91 *Fair Work Act 2009,* ss. 65(1A).

92 *Fair Work Act 2009,* ss. 65(1A).

93 See, for example, Finance Sector Union, *Submission 29,* p. 12; UnionsWA, *Submission 152,* p. 4; Shop, Distributive and Allied Employees' Association, *Submission 156,* p. 4; Women's Legal Services Australia, *Submission 171,* p. 5; Community and Public Sector Union (PSU Group), *Submission 158,* p. 3; Police Federation of Australia, *Submission 176,* p. 4; ACTU, *Submission 178,* p. 2.

94 Women's Legal Services Australia, *Submission 171,* p. 10.

Enabling a supportive culture to access workplace supports

3.66 Submitters also stressed the importance of ensuring that workplaces engaged proactively with their staff to establish an environment where reasonable workplace adjustments could be requested and subsequently supported.[95]

3.67 Ms Thea O'Connor, Founder and Director of Menopause at Work Asia-Pacific, commented:

> The big issue here is that there is a lot of work to be done to raise the level of menopause literacy in our culture, and also for all workplaces to at least become menopause aware. That is going to take a multisector approach, with academics, workplace practitioners like us, doctors, allied health professionals and unions working together.[96]

3.68 The intersection of workplace culture and the need for normalisation of issues related to menopause were also discussed by Ms Yumi Lee of the NSW Older Women's Network:

> … we should not be penalising women when they have had a lifetime of experience and skills that they can offer in the workplace. We should be making it easier for them to make that contribution. It just makes economic sense as well. So the normalisation of issues related to ageing, perimenopause and menopause will go a long way to that end.[97]

3.69 Professor Helena Teede also underscored the importance of a workforce-wide approach being taken:

> I would just implore us to make sure we take a holistic approach to women across the workforce. We shouldn't just leave it [to] individual employers; we should create an expectation about the culture of a work environment that can actually support not just women but marginalised groups more broadly.[98]

Resources to support employers to support menopausal employees

3.70 Evidence to the inquiry highlighted different examples of resources that can support employers to establish supportive workplaces for workers experiencing the menopause transition.

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95 See, for example, Mr Grant Burton, Assistant Secretary, Queensland Nurses and Midwives Union, *Committee Hansard,* 29 July 2024, p. 5; Clinical Associate Professor Amanda Vincent, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard,* 29 July 2024, p. 19; Ms Helen Dalley-Fisher, Convener, Equality Rights Alliance, *Committee Hansard,* 30 July 2024, p. 55.

96 Ms Thea O'Connor, Founder and Director, Menopause at Work Asia Pacific, *Committee Hansard,* 17 June 2024, p. 14.

97 Ms Yumi Lee, Chief Executive Officer, Older Women's Network New South Wales, *Committee Hansard,* 17 June 2024, pp. 47–48.

98 Professor Helena Teede, Director, Monash Centre for Health Research and Implementation, *Committee Hansard,* 18 June 2024, p. 25.

Menopause Information Pack for Organisations (MIPO)

3.71 Co-developed by researchers and academics from Monash University, the University of Glasgow and the University of Melbourne, the MIPO is a 'free, open access suite of resources to help workplaces support menopausal transition informed by internationally recognised research'.[99]

3.72 The MIPO provides resources under two categories: menopause-sensitive policies and menopause-savvy managers. The first category includes resources such as:

- why is menopause a workplace issue;
- health check of existing policies;
- strategic decisions for menopause supportive workplaces; and
- training decisions for menopause supportive workplaces.[100]

3.73 In terms of resources to support managers to be menopause friendly, the following resources are available:

- what to expect when you are (not) expecting the menopause: A guide for managers;
- creative conversations for line managers and supervisors; and
- working through menopause transition: a collaborative tool.[101]

The MAPLE Framework

3.74 Professor Kathleen Riach also highlighted the MAPLE framework as a mechanism for supporting managers to consider reasonable adjustments within the workplace for employees experiencing the menopause transition. MAPLE stands for:

- M for microleave – including starting or finishing early, flexibility around the workplace;
- A for allyship – including managers taking on the responsibility of establishing a supportive culture for their employees to access supports, rather than the burden being placed on individual women;
- P for physical environment – including looking at how the physical environment can be adjusted to better support employees in the menopause transition;

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99 Menopause Information Pack for Organizations, *What is MIPO?* www.menopauseatwork.org/about (accessed 22 August 2024).

100 Menopause Information Pack for Organizations, *Our Free Resources*, www.menopauseatwork.org/free-resources (accessed 22 August 2024).

101 Menopause Information Pack for Organizations, *Our Free Resources*, www.menopauseatwork.org/free-resources (accessed 22 August 2024).

- L for line management – including empowering line managers to make decisions that support women to continue to have meaningful workforce participation;
- E for education awareness – including undertaking workplace specific menopause education and awareness training.[102]

Committee view

Lack of data

3.75 The committee is extremely concerned by the lack of a comprehensive evidence base that measures the impact of menopause symptoms on women's workforce participation, age of retirement, income and superannuation balances.

3.76 While there has been some work undertaken to measure the impact of menopause on women's workforce participation, the evidence does not clearly delineate the specific impacts of menopause in comparison to other factors that may contribute to women leaving the workforce at midlife. This is clearly insufficient to build a comprehensive understanding of how menopause impact women's workforce participation and earnings.

3.77 The experiences women shared with the committee indicate that for some women, menopause has had a significant impact on their career, ability to work and income. It points to the importance of developing a more robust evaluation of these issues to inform the development of policies to support women in the workplace.

Recommendation 4

3.78 The committee recommends that the Australian Government commission research to undertake a comprehensive study to assess the economic impacts of menopause which clearly delineates the impact of symptoms of menopause on women's workforce participation, income, superannuation, and age of retirement.

3.79 The committee notes that the Workplace Gender Equality Agency (WGEA) has previously collected some data related to menopause leave in the workplace, but that this reporting no longer takes place.

3.80 The committee is of the view that WGEA has a significant role to play in its data collection across leading Australian employers and is uniquely positioned to contribute to an enhanced evidence base by adding additional questions to its annual reporting. The collection of greater evidence on the existing approaches

[102] Professor Kathleen Riach, Professor of Organisation Studies, University of Glasgow and Monash University, *Committee Hansard*, 30 July 2024, pp. 66–67.

across organisations in Australia and the efficacy of these approaches will be useful to inform government policymakers.

Recommendation 5

3.81 The committee recommends that the Australian Government introduce reforms to allow the Workplace Gender Equality Agency (WGEA) to re-commence data collection on the supports employers are providing, and their usage, for employees experiencing menopause and perimenopause, including specific workplace policies.

Stigma

3.82 The committee also acknowledges that the issue of women's workforce participation being impacted by perimenopause and menopause is multi-layered and has multiple drivers. It is highly concerning that in the 21st century, the operation of stigma and taboo in the workplace is an additional barrier for women's full workforce participation. This is especially concerning as menopause is a natural phase of life that will affect more than half the population.

3.83 All employers have a responsibility to address stigma around menopause in their workplaces. Implementing organisation wide menopause policies, promoting internal awareness for employees and managers about these issues and sharing menopause-specific workplace resources can all help to address menopause stigma.

Workplace supports

3.84 The committee acknowledges that there are a variety of options available to employers to support employees, including provision of paid reproductive leave, reasonable workplace adjustments, and greater flexibility in the workplace. The committee is pleased to see the higher levels of attention being paid to this issue in workplaces across Australia and is hopeful that these initiatives will continue to develop as understanding and awareness of the impacts of menopause grow.

Menopause specific leave

3.85 In relation to paid leave, the committee heard mixed views about the benefits of introducing menopause-specific leave, with many submitters expressing the view that it would have a negative impact on their experiences in the workplace. The committee notes various forms of reproductive health leave exist across the private and public sectors.

Workplace flexibility

3.86 The committee notes that most submitters advocated for workplace flexibility and adjustments rather than the introduction of menopause-specific leave. The committee heard that, in most cases, women will only require access to

reasonable adjustments and workplace flexibility to continue to be active contributors to the economy. The committee is of the view that ensuring access to flexible work arrangements is a critical tool to ensure that all women can continue to participate in the workforce for as long as they want.

3.87 The committee notes the range of resources that have been developed to specifically support managers and employees, such as the Menopause Information Pack for Organizations and the MAPLE Framework, which provide useful information and strategies for employers and organisations.

3.88 The committee acknowledges that the current operation of the legal framework in Australia does not provide any explicit legal protections or supports for women experiencing debilitating symptoms of menopause in the workplace and considers that the suggestions made to amend Section 65 of the Fair Work Act may be a potential remedy to this.

3.89 The committee is of the view that there is merit in further evaluating the appropriateness and effectiveness of the existing legislative framework and whether changes to existing legislation, or development of new legislation, should be considered to ensure women can access flexible work arrangements when they need to.

Recommendation 6

3.90 The committee recommends that the Australian Government consider amendments to Section 65 of the Fair Work Act 2009, to ensure women can access flexible working arrangements during menopause.

Recommendation 7

3.91 The committee encourages Australian workplaces develop perimenopause and menopause workplace policies in consultation with their employees.

Recommendation 8

3.92 The committee recommends that the Australian Government task the Department of Employment and Workplace Relations to undertake further research on the impact and effectiveness of sexual and reproductive health leave where it has been implemented in Australia and overseas, while giving consideration to introducing paid gender-inclusive reproductive leave in the National Employment Standards (NES) and modern awards.

Chapter 4
Diagnosis and care

> Menopause is a gender equity issue because women's health is under-researched, research inappropriately excludes female participants, and women are chronically underserved and underdiagnosed by medicine.[1]

4.1 Over the course of the inquiry, the committee learned of the variety of barriers that can exist for patients accessing diagnosis and treatment for perimenopause and menopause symptoms.

4.2 While earlier chapters of this report canvassed the impact of menopause symptoms on individuals and families, this chapter seeks to look at the systemic drivers of the lack of diagnosis and access to treatment that are affecting Australian women.

4.3 The chapter begins with a discussion on the challenges associated with diagnosis, including a lack of medical awareness and training, difficulties accessing informed healthcare practitioners, availability and length of medical consultations, and access to potential diagnostic tools.

4.4 The chapter then discusses the matters specific to treatment options, including access and financial barriers to menopause hormonal therapy (MHT). The chapter also explores the issues associated with certain supplements and health products being marketed to women to alleviate the symptoms of menopause.

4.5 The chapter concludes with the committee's view and recommendations to improve access to diagnosis and treatment options.

Diagnosis challenges

4.6 The inquiry highlighted a range of challenges faced by Australian women in relation to getting a diagnosis of menopause and perimenopause. This included medical practitioners having a limited understanding of the variety of presentations of symptoms of perimenopause.[2]

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1 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 2.

2 See, for example, Bronwyn, *Submission 61,* [p. 2]; Name Withheld, *Submission 126,* [p. 2]; Name Withheld, *Submission 129,* [p. 1]; Name Withheld, *Submission 180*, p. 5; Ieva, *Submission 199,* [p. 2]; Kerry, *Submission 202,* [p. 2]; Name Withheld, *Submission 207,* [p. 1]; Simone, *Submission 236*, [p. 7]; Jo, *Submission 242*, [pp. 1–7]; Name Withheld, *Submission 247,* [p. 6]; Julie, *Submission 257*, [p. 2]; Ms Grace Molloy, Chief Executive Officer and Co-Founder, Menopause Friendly Australia, *Committee Hansard,* 17 June 2024, p. 13; Associate Professor Amanda Vincent, Clinical Associate, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard,* 29 July 2024, p. 18; Jill, Private capacity, *Committee Hansard,* 30 July 2024, p. 33; Dr Lucy Caratti, Private capacity, *Committee Hansard,* 6 August 2024, p. 39; Dr Antonia Hendrick, Senior Lecturer, School of Allied Health, University of Western Australia, *Committee Hansard,* 13 August 2024, p. 2.

4.7 Dr Christina Jang of the Australasian Menopause Society summarised the two key issues, namely training and time:

> Australian research has shown that many healthcare professionals have significant gaps in their knowledge and training in menopause such as failure to recognise symptoms of menopause and lack of confidence to counsel women about the benefits and risks of menopausal hormone therapy. Many simply lack the time. We can't do menopause in a 15-minute consultation.[3]

Medical training

4.8 Several medical professionals shared with the inquiry the limited education on issues related to menopause and perimenopause that they themselves had received.[4]

4.9 It was highlighted to the committee that there is a variety of existing menopause and perimenopause education in undergraduate medical degrees, as the specifics of the curricula are set by individual universities.[5]

4.10 The committee heard that medical training on menopause and perimenopause can be almost non-existent at the undergraduate level, with some medical practitioners recalling that they had only one hour on menopause during their education.[6] Dr Marita Long told the committee that:

> We have to start preparing our medical graduates for 21st-century medicine, but we're really preparing them for 20th-century medicine, where we just look at very acute conditions. Menopause isn't in the undergraduate training in any significant capacity. I taught primary care at UTAS and was asked to deliver a one-hour women's health lecture to the primary care students. I

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3 Dr Christina Jang, Board Director and President-elect, Australasian Menopause Society, *Committee Hansard*, 18 June 2024, p. 58.

4 See, for example, Dr Alice Fitzgerald, Board Member, Australian College of Rural and Remote Medicine, *Committee Hansard*, 29 July 2024, p. 6; Mr Grant Burton, Assistant Secretary, Queensland Nurses and Midwives Union, *Committee Hansard*, 29 July 2024, p. 5; Dr Louise Manning, President, Rural Doctors Association of Victoria, *Committee Hansard*, 30 July 2024, pp. 16–17; Dr Jessica Floreani, General Practitioner, AWARE Women's Health, *Committee Hansard*, 5 August 2024, p. 16; Dr Ceri Cashell, General Practitioner and Co-Owner, Avalon Family Medical Practice, *Committee Hansard*, 17 June 2024, p. 7.

5 See, for example, Dr Elaine Leung, Senior Lecturer, Medical Deans Australia and New Zealand, *Committee Hansard*, 5 August 2024, pp. 44–45; Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard*, 18 June 2024, p. 9; Professor Steve Robson, President, Australian Medical Association, *Committee Hansard*, 30 July 2024, p. 23; Dr Carmel Reynolds, Board Member, Australasian Menopause Society, *Committee Hansard*, 5 August 2024, p. 17.

6 See, for example, Dr Jessica Floreani, General Practitioner, AWARE Women's Health, *Committee Hansard*, 5 August 2024, p. 16; Dr Marita Long, Board Member and Victoria and Tasmania Representative, Australasian Menopause Society, *Committee Hansard*, 18 June 2024, p. 59; Ms Kaz Cooke, Private capacity, *Committee Hansard*, 18 June 2024, p. 2.

> chose to deliver that whole hour on the vulva because no-one is taught about the vulva. That was their whole women's health exposure in undergrad. It's not taught in undergrad, and it has to start there.[7]

4.11 Submitters called for more comprehensive menopause education across medical training institutions, particularly undergraduate medical degrees.[8]

4.12 Dr Elaine Leung recommended a change in the approach to shift the focus beyond one unit on menopause and perimenopause to an integrated focus on women's health:

> There's so much to cover in medical school. Just as there might be one lecture on perimenopause and menopause, there might only be one lecture on prostate health, for example. I really think that women's health, perimenopause and menopause should be integrated throughout the medical curriculum and throughout the program.[9]

4.13 Witnesses also pointed out that the impact of this lack of awareness was not limited just to general practitioners but extended to all doctors, as all doctors would see women experiencing menopause and perimenopause.[10] Some submitters emphasised the need for education at the post-graduate level across a range of medical specialisations.[11] For example, Dr Marita Long emphasised:

> … menopause is a transition point where women become incredibly vulnerable to chronic disease, and we're not teaching our undergraduates that. We're not teaching our graduates that. They go into postgraduate training programs and get very little teaching. And it is across every college. I would argue that there's not a college that shouldn't be touching on menopause. The surgeons, endocrinologists, medical doctors, obstetricians and gynaecologists need to know about it—it's more than just GPs.[12]

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7 Dr Marita Long, Board Member and Victoria and Tasmania Representative, Australasian Menopause Society, *Committee Hansard,* 18 June 2024, p. 59.

8 See, for example, Victorian Women's Trust, *Submission 99,* p. 45; Maridulu Budyari Gumal, *Submission 109,* p. 7; Menopause Friendly Australia, *Submission 147,* [p. 2]; Theramex, *Submission 124,* [p. 2]; Ms Yumi Lee, Chief Executive Officer, Older Women's Network New South Wales, *Committee Hansard,* 17 June 2024, p. 50.

9 Dr Elaine Leung, Senior Lecturer, Medical Deans Australia and New Zealand, *Committee Hansard,* 5 August 2024, pp. 43–44.

10 Dr Ceri Cashell, General Practitioner and Co-Owner, Avalon Family Medical Practice, *Committee Hansard,* 17 June 2024, p. 7. See, for example, Dr Christina Jang, Board Member and President-elect, Australasian Menopause Society, *Committee Hansard,* 18 Jun 2024, p. 63.

11 See, for example, Australasian Menopause Society, *Submission 177,* pp. 20–25; Women's Health Road, *Submission 117,* [pp. 4–5]; Avalon Family Medical Practice, *Submission 142,* [p. 2]; Private Healthcare Australia, *Submission 155,* p. 4; The Society of Hospital Pharmacists, *Submission 3,* [pp. 3–4]; Organon, *Submission 24,* p. 6; Sexual Health and Family Planning ACT, *Submission 102,* p. 6.

12 Dr Marita Long, Board Member and Victoria and Tasmania Representative, Australasian Menopause Society, *Committee Hansard,* 18 June 2024, p. 59.

4.14 Further, given the whole-of-body impacts of some menopause and perimenopause symptoms, inquiry participants discussed the need for menopause-specific education to enhance education and awareness across all healthcare disciplines.[13] As further elaborated by Maridulu Budyari Gumal, a Sydney based medical research organisation:

> It is essential that clinical training reflects the fact that each woman is different and there is no one-size-fits all diagnostic pathway or management strategy. Education that is easy to access and relevant to the many health professionals who interact with the women experiencing and/or being treated for the symptoms of menopause needs to be prioritised.[14]

The role of the Australian Medical Council

4.15 The Australian Medical Council (AMC) has a role in maintaining the standards for accreditation for universities that provide medical practitioner education.[15] Professor Robyn Langham AM, as representative for the AMC, explained to the committee at a hearing that the AMC is responsible for the standards for accreditation that universities must adhere to in their specific curriculums.[16]

4.16 When asked by the committee about the relevant guidance for medical schools related to menopause, Professor Langham AM informed the committee that the most relevant standard is standard number 1.13, which reads as follows:

> Apply scientific knowledge and clinical skills to care for patients across their lifespan, including as children, adolescents and ageing people, and patients in pregnancy and childbirth.[17]

4.17 Professor Langham AM explained that the accreditation standard is deliberately broad to encompass the necessary flexibility in the curriculums for individual medical schools to adapt their education based on new knowledge.[18] The

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13 See, for example, Menopause Friendly Australia, *Submission 147*, [p. 2]; Women's Health Road, *Submission 117*, [pp. 4–5]; Theramex, *Submission 124*, [p. 2]; Private Healthcare Australia, *Submission 155*, p. 4; The Australian College of Midwives, *Submission 157*, p. 2; Organon, *Submission 24*, p. 7; Affiliation of Women's Action Alliances, *Submission 31*, p. 8; Sexual Health and Family Planning ACT, *Submission 102*, p. 6; Women's Health Services Network, *Submission 149*, p. 8.

14 Maridulu Budyari Gumal, *Submission 109*, p. 7.

15 Australian Medical Council Limited, *Accreditation standards and procedures*, January 2024, www.amc.org.au/accredited-organisations/accreditation-standards-and-procedures/ (accessed 20 August 2024).

16 Professor Robyn Langham, Specialist Education Accreditation Committee and Board Director, Australian Medical Council, *Committee Hansard*, 13 August 2024, pp. 5–6 and 8–9.

17 Australian Medical Council Limited, *Standards for Assessment and Accreditation of Primary Medical Programs*, January 2024, p. 10. See also, for example, Professor Robyn Langham, Specialist Education Accreditation Committee and Board Director, Australian Medical Council, *Committee Hansard*, 13 August 2024, pp. 5–6 and 8–9.

18 Professor Robyn Langham, Specialist Education Accreditation Committee and Board Director, Australian Medical Council, *Committee Hansard*, 13 August 2024, pp. 5–6 and 8–9.

accreditation standards have also been recently updated and implemented and so will not be reviewed or updated for another six years.[19]

4.18 The committee was advised that the AMC also has a role in the oversight of continuing professional development for medical practitioners.[20]

Professional development for General Practitioners

4.19 Beyond the limited and varied undergraduate medical education related to menopause and perimenopause, the committee learned of the high burdens placed on general practitioners (GPs) when accessing training and education to upskill or specialise in menopause and perimenopause.[21]

4.20 Theramex, a pharmaceutical company, highlighted this issue by drawing attention to how few menopause specialists there are in Australia compared with the number of GPs and specialist gynaecologists. There are over 38 000 GPs and 1700 specialist gynaecologists in Australia.[22] However, there are only 877 members of the Australasian Menopause Society.[23]

4.21 Dr Sara Whitburn of the Royal Australian College of General Practitioners (RACGP) highlighted the dual impacts of cost and time on general practitioners in accessing continuing professional development:

> General practice being a small business, any time GPs are trying to educate they are doing it at a time that might impact not only on their ability to provide patient care but also on income. Though it's very important they do continuing education—it's part of our registration, and we should certainly do it—it often has to be squeezed in around making sure they're available for their community and the cost to take the time to do that education.[24]

4.22 Dr Christina Jang of the Australasian Menopause Society (AMS) emphasised the need for targeted training to be available for GPs in a variety of forms to enhance

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19 Professor Robyn Langham, Specialist Education Accreditation Committee and Board Director, Australian Medical Council, *Committee Hansard,* 13 August 2024, p. 9.

20 Professor Robyn Langham, Specialist Education Accreditation Committee and Board Director, Australian Medical Council, *Committee Hansard,* 13 August 2024, p. 5.

21 See, for example, Dr Sarah White, Chief Executive Officer, Jean Hailes for Women's Health, *Committee Hansard,* 18 June 2024, p. 52; Dr Sara Whitburn, Chair, Sexual Health Specific Interest Group, Royal Australian College of General Practitioners, *Committee Hansard,* 30 July 2024, p. 18.

22 Theramex, *Submission 124,* [p. 2].

23 Theramex, *Submission 124,* [p. 2].

24 Dr Sara Whitburn, Chair, Sexual Health Specific Interest Group, Royal Australian College of General Practitioners, *Committee Hansard,* 30 July 2024, p. 18.

uptake; including module courses, online learning and webinars, as well as in person conferences and training.[25]

4.23 Submitters contended that women's health training and further education related to menopause for GPs must be prioritised to support a more highly skilled general practice workforce.[26] It was suggested that the AMS may be the appropriate body to undertake this work, given they already facilitate a range of menopause specific continuing education opportunities on a voluntary basis.[27]

4.24 Jean Hailes for Women's Health was provided with $1.2 million by the Commonwealth Government to advertise and subsidise continuing professional development for health professionals on managing menopause.[28] Jean Hailes advised that this work will be undertaken in collaboration with the Australasian Menopause Society.[29]

Self-selecting to specialise in menopause and women's health

4.25 For medical practitioners participating in further specialisation related to menopause and perimenopause at the general practice level, the committee heard that often these practitioners seek out this further education and training on the basis of patient demand or professional interest.[30]

4.26 At a hearing in Perth, Dr Sunita Chelvanayagam, who appeared in a private capacity, explained to the committee why she opened a GP-led menopause-specific clinic:

> I have been a GP for almost 20 years, and my colleague Dr Michelle Cotellessa for almost 30. Having seen a large cohort of female patients, combined with our own lived experience, it became abundantly clear that midlife health needed a different model of care. Fifteen minutes in a regular general practice consult was simply not covering the complex and sensitive needs of women in this transitional phase.

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[25] Dr Christina Jang, Board Director and President-elect, Australasian Menopause Society, *Committee Hansard,* 18 June 2024, p. 59.

[26] See, for example, Monash Centre for Health Research and Implementation, *Submission 34,* p. 6; Bayer Australia, *Submission 30,* p. 5; Women's Action Alliance, *Submission 31*, p. 8.

[27] Dr Kelly Teagle, *Submission 111,* [p. 3]. See also, for example, Jean Hailes for Women's Health, *Submission 119,* pp. 28–29; Women's Health Services Network, *Submission 149,* p. 13.

[28] Dr Sarah White, Chief Executive Officer, Jean Hailes for Women's Health, *Committee Hansard,* 18 June 2024, pp. 49–50.

[29] Dr Sarah White, Chief Executive Officer, Jean Hailes for Women's Health, *Committee Hansard,* 18 June 2024, pp. 49–50.

[30] See, for example, Dr Jessica Floreani, General Practitioner, AWARE Women's Health, *Committee Hansard,* 5 August 2024, p. 16; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 24.

> We opened WA's first GP-led menopause-specific clinic… one year ago practically to this day. In this short time, we have seen over 2 000 patients and have grown to a practice of four GPs. The demand for specialised menopause care has been unprecedented.[31]

4.27 Often, these menopause and perimenopause specialists experience high demand for services and there are exceptionally high wait times for appointments. This is due to the lack of appropriate and effective menopause awareness and care in the broader healthcare system.[32] These practitioners are also often required to charge more for the longer consultations needed for the comprehensive model of care they provide.[33]

4.28 Dr Michelle Cotellessa, who also appeared in a private capacity, explained to the committee that 'the overheads that go with running a clinic when you're on a GP Medicare rebate mean we have to charge just to give good care'.[34]

Need for longer consultations and a holistic approach to women's mid-life healthcare

4.29 Practitioners who provided evidence to the committee highlighted the complexity that can be associated with consultations related to menopause and the subsequent requirement for longer appointments for more thorough assessment of symptoms.[35] As highlighted by Professor Steve Robson of the Australian Medical Association:

> The management of menopause and perimenopause can be complex. It needs a whole-of-person, multisystem approach that deals with the issues affecting women and acknowledges that women are affected differently and individually. There is often a significant intertwining between the physical, work, family, emotional and many other issues in their lives.[36]

4.30 At a hearing in Perth, Professor Roger Hart further emphasised that the menopause transition can be difficult to diagnose given the broad impact of symptoms across all aspects of bodily function and the fact that women often

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31 Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 24.

32 See, for example, Mrs Rebecca Thomson, Founder, Your Menopause, *Committee Hansard,* 6 August 2024, p. 14; Australasian Menopause Society, *Submission 177,* p. 14; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 24.

33 Her Health and Aesthetics, *Submission 179,* [p. 5].

34 Dr Michelle Cotellessa, Private capacity, *Committee Hansard,* 6 August 2024, p. 24.

35 See, for example, Dr Virginia French, Her Health and Aesthetics, *Committee Hansard,* 30 July 2024, p. 2; Dr Danielle McMullen, Vice President, Australian Medical Association, *Committee Hansard,* 30 July 2024, p. 18; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 24.

36 Professor Steve Robson, President, Australian Medical Association, *Committee Hansard,* 30 July 2024, p. 16.

present to general practice with one or two most pressing concerns.[37] As such, Professor Hart encouraged a holistic understanding of women's health by GPs to assist in the process of diagnosis.[38]

4.31 The fact that the severity of symptoms can be so debilitating of course means that women and their doctors will obviously spend time testing and treating for other conditions. However, both doctors and women may fail to assess the possibility that the onset of symptoms is associated with perimenopause.[39] This in turn means that women have not discussed whether MHT would be of benefit, instead of, before or with other interventions.[40]

The operation of the Medicare Benefits Schedule

4.32 A number of medical practitioners also raised the issue that the operation of the Medicare Benefits Schedule (MBS) does not incentivise the longer appointments needed to discuss and diagnose menopause symptoms.[41] Many submitters discussed the need for financial incentives for longer consultations, particularly noting that the current structure of the MBS prioritises short consultations.[42]

4.33 Whilst the government recently introduced a 60 minute consult item to the MBS, Dr Virginia French discussed that the remuneration for a one-hour consult would still result in a practitioner earning about half as much or less than

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37 Professor Roger Hart, Director, Menopause Alliance Australia, *Committee Hansard,* 6 August 2024, p. 18.

38 Professor Roger Hart, Director, Menopause Alliance Australia, *Committee Hansard,* 6 August 2024, p. 18.

39 See, for example, Dr Christabel Samy, Medical Director, Samy Medical Group Pty Ltd, *Committee Hansard,* 6 August 2024, p. 41; Associate Professor Ravani Duggan, Associate Professor, Curtin University and Sir Charles Gairdner Osborne Park Health Care Group, *Committee Hansard,* 6 August, p. 38.

40 See, for example, Dr Christabel Samy, Medical Director, Samy Medical Group Pty Ltd, *Committee Hansard,* 6 August 2024, p. 41; Dr Lucy Caratti, Private capacity, *Committee Hansard,* 6 August 2024, pp. 41–42.

41 See, for example, Dr Alice Fitzgerald, Board Member, Australian College of Rural and Remote Medicine, *Committee Hansard,* 29 July 2024, p. 4; Dr Sara Whitburn, Chair, Sexual Health Specific Interest Group, Royal Australian College of General Practitioners, *Committee Hansard,* 30 July 2024, p. 23; Sexual Health and Family Planning ACT, *Submission 102,* p. 4; Theramex, *Submission 124,* [pp. 4–5]; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 24.

42 See, for example, Professor Steve Robson, President, Australian Medical Association, *Committee Hansard,* 30 July 2024, p. 16; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 27; Besins Healthcare, *Submission 146,* [p. 7]; Women's Health Services Network, *Submission 149,* p. 15; Australian College of Midwives, *Submission 157,* pp. 5–6; Australasian Menopause Society, *Submission 177,* pp. 20–21; Dr Keturah Hoffman, *Submission 76,* [p. 4]; Women's Health Road, *Submission 117,* [p. 6]; Theramex, *Submission 124,* [p. 4–5]; Avalon Family Medical Practice, *Submission 142,* [p. 1].

another doctor who is doing 10-to-15-minute consultations.[43] Dr Kelly Teagle stressed the impact of this in dollar amounts:

> If you're turning over rapidly, seeing lots of patients, if you were bulk-billing you could earn $6 a minute. But by the time you're doing 50-minute consultations you're earning $2 or less per minute.[44]

4.34 The issue of financial renumeration acting as a disincentive to provide this more comprehensive care was also highlighted by Sexual Health and Family Planning ACT:

> The current Medicare system also incentivises short consultations. A GP conducting six 10-minute consultations would receive a Medicare rebate of $248.4/hour. This compares unfavourably to a GP doing one 45-minute consultation and one 15-minute consultation who would receive a Medicare rebate of $159.4/hour.[45]

4.35 Some submitters suggested considering a menopause specific MBS item as an option to remedy this issue;[46] with some witnesses suggesting access to the funding for the new MBS item would depend on further demonstration of training on women's health.[47]

Government reforms to the MBS

4.36 The Department of Health and Aged Care (the Department) elaborated on recent reforms to the MBS that could be of benefit to women experiencing menopause and perimenopause. These include:

- Funding in the 2023–24 Budget to include the introduction of a new MBS item for longer GP consultations of 60 minutes or more;
- Enabling GPs to refer women to allied health professionals, including psychologists, physiotherapists and dietitians to support management of menopause conditions under a GP Management Plan and Team Care Arrangement, enabling referral of five MBS rebated allied health services per calendar year;

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43 Dr Virginia French, Her Health and Aesthetics, *Committee Hansard*, 30 July 2024, p. 4.

44 Dr Kelly Teagle, Founder, Shareholder, Director and Principal Clinician, WellFemme, *Committee Hansard*, 30 July 2024, p. 4.

45 Sexual Health and Family Planning ACT, *Submission 102*, p. 4.

46 Sexual Health and Family Planning ACT, *Submission 102*, p. 4. See, for example, Multicultural Centre for Women's Health, *Submission 148*, p. 14.

47 Dr Virginia French, Her Health and Aesthetics, *Committee Hansard*, 30 July 2024, pp. 3–4. See, for example, Dr Purity Carr, Founder, Purity Health Menopause and Wellbeing Centre, *Committee Hansard*, 6 August 2024, p. 42; Dr Caroline Rogers FRACGP, *Submission 50*, [p. 1]; Women's Health Road, *Submission 117*, [p. 6].

- Patients with a chronic condition experiencing menopause may be eligible for MBS Chronic Disease Management items.[48]

4.37 Ms Louise Riley, Assistant Secretary, MBS Policy and Reviews Branch at the Department, further explained at a public hearing that the new MBS item for a 60 minute consultation will be available for nurse practitioners from 1 March 2025.[49]

4.38 Ms Leanne Boase, Chief Executive Officer of the Australian College of Nurse Practitioners explained that access to this new MBS item for nurse practitioners will enable nurse practitioners to deliver more comprehensive care, stating:

> What that means for people who want to access the care of a nurse practitioner or midwife in primary care is that they are now fully entitled to their Medicare and PBS rebates or subsidies without needing the permission of another practitioner that they may or may not be involved with to access that. It doesn't affect clinical care in any way. Nurse practitioners have always been independent practitioners, able to practise without supervision. What it does do is uncouple it from the funding, so it will improve access to care.[50]

Mid-life health check for women

4.39 Submitters discussed the potential utility of an MBS item for a women's mid-life health assessment as an opportunity for identifying menopause, as well as enabling broader discussions on preventative healthcare checks.[51]

4.40 While there is an existing MBS health assessment for a person aged 45 to 49 years old, eligibility for the rebate is dependent on a chronic disease risk. However, menopause is not currently classified as a chronic disease risk.[52] Associate Professor Madalena Simonis AM pointed out that even if menopause was included in the eligibility criteria it would not cover all women experiencing menopause symptoms as 'an estimated 60 per cent of women go through the menopausal transition before the age of 45 or after 49'.[53]

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48 Department of Health and Aged Care, *Submission 15,* p. 8.

49 Ms Louise Riley, Assistant Secretary, Medicare Benefits Schedule Policy and Reviews Branch, Department of Health and Aged Care, *Committee Hansard,* 13 August 2024, p. 25.

50 Ms Leanne Boase, Chief Executive Officer, Australian College of Nurse Practitioners, *Committee Hansard,* 18 June 2024, p. 14.

51 Besins Healthcare, *Submission 146,* [pp. 6–7]. See, for example, Dr Ceri Cashell, General Practitioner and Co-Owner, Avalon Family Medical Practice, *Committee Hansard,* 17 June 2024, p. 10; Dr Sara Whitburn, Chair, Sexual Health Specific Interest Group, Royal Australian College of General Practitioners, *Committee Hansard,* 30 July 2024, pp. 23–24.

52 Besins Healthcare, *Submission 146,* [pp. 6–7]. See also, for example, Her Health and Aesthetics, *Submissions 179,* [p. 6].

53 Associate Professor Magdalena Simonis AM, *Submission 45*, [p. 5].

4.41 Professor Susan Davis AO suggested moving away from a specified age for mid-life health check and instead employing it in response to an event, enabling a mid-life health check MBS item number to be utilised by women experiencing menopause; regardless of the age at which it occurs.[54] Further:

> The midlife health consultation happens at an age. It doesn't happen at a biological event. When you think about it, it's nonsense. If you go through menopause at 40 you've got to wait until you're 45 to have a midlife health consultation. If you have a midlife health consultation at 45 and you go through menopause at 54 it's completely irrelevant.[55]

Opportunity for preventative healthcare

4.42 Participants in the inquiry discussed the opportunities for health practitioners to engage in conversations related to preventative healthcare for women living through the menopause transition, as well as further risk screening.[56]

4.43 As outlined by the RACGP, menopause often occurs at 'a time of mid-life health which includes an increasing risk of metabolic diseases including diabetes and cardiovascular disease, breast and bowel cancer, and osteoporosis'.[57] GPs treating women for menopause and perimenopause are also often best placed to conduct mid-life health risk screening and provide preventative care and treatment.[58]

4.44 The AMS has developed a tool to assist with screening for mid-life health risks which encompasses a range of factors beyond the impact of menopause symptoms, including:

- past medical history;
- family medical history;
- breast, cervical and bowel cancer screening;
- social history;
- smoking, diet, alcohol, drugs, exercise;
- cardiovascular risks;
- bone health; and

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[54] Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard,* 18 June 2024, p. 10.

[55] Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard,* 18 June 2024, p. 10.

[56] See, for example, Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 24; RACGP, *Submission 1,* p. 4; Sexual Health Victoria, *Submission 17,* [p. 1]; Organon, *Submission 24,* p. 4; Dr Fatima Khan, *Submission 46,* [p. 2]; Family Planning Alliance Australia, *Submission 103,* [p. 1].

[57] RACGP, *Submission 1,* p. 4.

[58] Besins Healthcare, *Submission 146,* pp. 6–7.

- contraception.[59]

4.45 Ms Iwinska from the Women's Health and Equality Queensland emphasised the economic benefits of conducting these health checks, advising the committee that for every one dollar invested in healthcare prevention, the healthcare system is saved $14.80.[60]

Osteoporosis and bone density scans

4.46 A key issue raised during the inquiry was the increased risk of osteoporosis or the precursor condition, osteopenia, as a result of the lowered production of hormones during the menopause transition.[61] As explained by Healthy Bones Australia:

> Menopause is a critical period for bone health, as it is associated with a rapid loss of bone mass and strength, increasing the risk of osteoporosis and of painful, debilitating and costly fractures.[62]

4.47 Dr Roy Watson made the point that osteoporosis is a 'significant complication of menopause', and that:

> … there are around 3 800 women in Victoria alone each year who suffer a hip fracture and that the cost to the Australian healthcare system is around $1 billion per year. In addition, hip fracture carries a mortality within 30 days of eight per cent and within one year of 25 per cent.[63]

4.48 A concern identified was the challenge of accessing preventative bone density scans to diagnose osteoporosis risk or to measure a baseline of bone density, due to cost barriers.[64] As the Tasmanian Government highlighted:

> It is important to note in relation to Medicare-rebated bone density assessments, that these are only available in a very limited number of clinical

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59 Australasian Menopause Society, *Template for Menopause Consult,* 16 March 2022, www.menopause.org.au/hp/gp-hp-resources/ams-template-for-menopause-consult (accessed 26 August 2024).

60 Ms Emma Iwinska, Chief Executive Officer, Women's Health and Equality Queensland, *Committee Hansard*, 29 July 2024, p. 49.

61 Dr Roy Watson, Proxy for Chair, Gynaecology Community of Practice, Strategic Executive Committee, SA Health Maternal, Neonatal & Gynaecology Community of Practice, *Committee Hansard*, 5 August 2024, p. 36.

62 Healthy Bones Australia, *Submission 132*, [p. 1].

63 Dr Roy Watson, Proxy for Chair, Gynaecology Community of Practice, Strategic Executive Committee, SA Health Maternal, Neonatal & Gynaecology Community of Practice, *Committee Hansard*, 5 August 2024, p. 36.

64 See, for example, Australian and New Zealand College of Anaesthetists, *Submission 5*, [p. 5]; Allison, *Submission 80*, [p. 2]; Ms Sharon Best, *Submission 230*, [p. 7]; Name withheld, *Submission 253*, [p. 2]; Grace, Private capacity, *Committee Hansard*, 6 August 2024, p. 10.

> conditions, even though all postmenopausal women are at risk of osteoporosis/osteopenia.[65]

4.49 Submitters discussed that the only bone density scan that is available under the MBS has eligibility for women with certain chronic conditions, primary ovarian insufficiency or who are over the age of 70, excluding a number of other individuals who would benefit from preventative screening for their long-term health.[66]

4.50 Felicity, an individual with lived experience, called for women from 35 years of age to be eligible for subsidised bone density screening to enable any concerns to be promptly addressed.[67]

4.51 Jill, another submitter to the inquiry also highlighted:

> It is a travesty that a routine bone densitometry is not covered by Medicare until the age of 70. For a huge proportion of post-menopausal women, the damage is well and truly done by then.[68]

The barriers to diagnosis for women living in regional and remote areas

4.52 The committee heard of the additional barriers to treatment and diagnosis faced by women living in regional and remote areas.[69] It was highlighted that the issue of workforce pressure is magnified in rural areas.[70]

4.53 The difficulties accessing specialist medical care in regional and remote Australia were highlighted by one submitter:

> Access to specialist gynaecological services is difficult for rural women. There is a dearth of appropriately qualified professionals practicing rurally, and if a region is lucky enough to have a specialist, the waiting list for treatment and care can be many, many months.[71]

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65 Tasmanian Government, *Submission 7*, [p. 3].

66 Family Planning Alliance Australia, *Submission 103*, [p. 2]. See also, for example, Dr Roy Watson, Proxy for Chair, Gynaecology Community of Practice, Strategic Executive Committee, SA Health Maternal, Neonatal & Gynaecology Community of Practice, *Committee Hansard*, 5 August 2024, p. 37.

67 Ms Felicity Brazil, *Submission 225*, p. 3.

68 Jill, *Supplementary submission 224.1*, [p. 2].

69 See, for example, Mrs Joy Beames, President, Country Women's Association of New South Wales, *Committee Hansard*, 17 June 2024, p. 47; Dr Louise Manning, President, Rural Doctors Association of Victoria, *Committee Hansard*, 30 July 2024, p. 20.

70 Dr Louise Manning, President, Rural Doctors Association of Victoria, *Committee Hansard*, 30 July 2024, p. 20.

71 Name withheld, *Submission 97*, [p. 1].

4.54 Submitters recommended more telehealth options to enable women in regional and remote areas to more easily access specialist care for menopause and perimenopause.[72]

4.55 Of the specific benefits associated with telehealth appointments for women living in regional and remote areas, Dr Alice Fitzgerald of the Australian College of Rural and Remote Medicine explained:

> I think the advancements in telehealth are quite significant for populations in rural, remote and First Nations communities, especially since COVID, and we do recognise that many women, in particular, are more able to seek continuity of care via telehealth. I think the important thing to note is that telehealth shouldn't be a replacement for doctors on the ground but an adjunct for GPs and RGs working in rural areas that are particularly hard to staff. We really welcome the input from non-GP specialists and other allied health professionals, and use of telehealth in that space is really important.[73]

4.56 The committee also heard evidence about the potential for nurse-led clinics and a greater role for nurse practitioners to support women's health in regional areas:

> I can actually give you an example of an initiative that I've been involved in recently in Queensland. You might've heard about it: the women's and girls' health clinics that are being set up. They intend for those to be nurse led, and it's an interesting model. … Honestly, we talked about why they're nurse led. We know that we don't have doctors where we need them. I always say that I don't think we're going to have them everywhere we need them, nor can we possibly even have nurses everywhere we need them. We need to look at new and flexible different types of health services and new and flexible types of funding.[74]

4.57 Ms Beverly Baker, President of the National Older Women's Network New South Wales spoke to the importance of pharmacists in regional areas, noting that:

> … the pharmacy is the hub. They go there and ask [the pharmacist] before they go to the doctors. And that should be recognised and it should be built on.[75]

4.58 Mr Chris Campbell of the Pharmaceutical Society of Australia also further elaborated that there are some rural towns in Australia where 'the pharmacy is

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[72] See, for example, Mrs Danica Leys, Chief Executive Officer, Country Women's Association of New South Wales, *Committee Hansard,* 17 June 2024, p. 50; Name withheld, *Submission 186,* [p. 2].

[73] Dr Alice Fitzgerald, Board Member, Australian College of Rural and Remote Medicine, *Committee Hansard,* 29 July 2024, p. 4.

[74] Ms Leeanne Boase, Chief Executive Officer, Australian College of Nurse Practitioners, *Committee Hansard,* 18 June 2024, p. 17.

[75] Ms Beverly Baker, President, National Older Women's Network and Chair, Older Women's Network New South Wales, *Committee Hansard,* 17 June 2024, p. 51.

the only place that's providing healthcare, and it's making sure there is consistency of advice'.[76]

4.59 In response to a question on notice, the Department outlined the steps taken to provide further support to women living in regional and remote areas. These include:

- permanent implementation of MBS telehealth items for blood borne virus, sexual or reproductive health services, which can encompass menopause and peri-menopause care;
- an investment of $3.5 billion to triple the bulk billing incentive, which commenced on 1 November 2023 and applies to the most common GP consultations; and
- scaling and increasing the value of MBS bulk billing incentives for patients who live in regional, rural and remote communities.[77]

Diagnosis tools

4.60 The committee heard that there are diagnosis tools either already in use or in development that should be considered to facilitate diagnosis.

MenoPROMPT

4.61 Researchers from Monash University, in partnership with researchers from Melbourne University and the RACGP, Jean Hailes and the AMS, are in the process of developing software to assist GPs with the provision of informed and comprehensive menopause care.[78]

4.62 The MenoPROMPT tool will involve a two-pronged approach for more comprehensive menopause primary care for women by offering:

- a simple menopause assessment and decision-making tool that will be integrated into GP software, 'so that key information is immediately accessible to GPs'; and
- a pre-consultation women's health self-assessment tool, delivered by SMS, which is subsequently integrated into the women's electronic medical records.[79]

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76 Mr Chris Campbell, General Manager, Policy and Program Delivery, Pharmaceutical Society of Australia, *Committee Hansard*, 29 July 2024, p. 12.

77 Department of Health and Aged Care, response to a question on notice IQ24-000103, 13 August 2024 (received 30 August 2024).

78 Monash University, *MenoPROMPT: a co-designed, comprehensive, evidence-based program to improve the care of women at and after menopause*, www.monash.edu/medicine/sphpm/units/womenshealth/research/menoprompt (accessed 21 August 2024).

79 Monash University, *MenoPROMPT: a co-designed, comprehensive, evidence-based program to improve the care of women at and after menopause*, www.monash.edu/medicine/sphpm/units/womenshealth/research/menoprompt (accessed 21 August 2024).

4.63 The program is at the point of a pilot stage and is expected to be rolled out within the next 12 months.[80] It is also designed to be incorporated into the three most commonly used GP software programs: Medical Director, Best Practice and ZedMed.[81] Based on particular words used in the woman's self-report, GPs will be prompted to step through the Practitioner's Toolkit for Managing Menopause, as discussed below.[82]

2023 Practitioner's Toolkit for Managing Menopause

4.64 Also developed by the Monash University Women's Health Research Program, the 2023 Practitioner's Toolkit for Managing Menopause provides GPs with a comprehensive guide to identifying, treating and caring for patients experiencing the menopause transition.[83]

4.65 The toolkit provides an easy-to-understand flowchart that guides GP decision-making in assessing:

- symptoms and concerns of menopause;
- whether a patient is in the menopause transition;
- the relevant information required to query midlife women about;
- patient care considerations;
- management options and symptom treatment;
- the need for bone density assessment; and
- information on dosing of MHT and other medical treatments.[84]

80 Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard*, 18 June 2024, p. 9.

81 Document tabled by Professor Susan Davis AO, *MenoPROMPT*, [p. 2] (tabled 18 June 2024).

82 Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard*, 18 June 2024, p. 8.

83 Monash University Women's Health Research Program, *A Practitioner's Toolkit for Managing Menopause*, a-practitioners-toolkit-for-managing-menopause.pdf (monash.edu) (accessed 21 August 2024).

84 Monash University Women's Health Research Program, *A Practitioner's Toolkit for Managing Menopause*, a-practitioners-toolkit-for-managing-menopause.pdf (monash.edu) (accessed 21 August 2024).

Symptom checklists

4.66 Other tools that are assisting women to access enhanced care and diagnosis from their GPs are symptom checklists, with examples developed by the AMS,[85] Jean Hailes,[86] and the New South Wales (NSW) Government.[87]

4.67 These symptom checklists offer a tool for women to guide discussions with their GP, or to assist GPs in diagnosing the menopause transition.[88] Some witnesses to the inquiry spoke of the lack of awareness of these checklists and how it would be useful for these to be more widely utilised.[89]

MENO-D – diagnosis of mental health impacts of menopause

4.68 As discussed in Chapter 2, many women shared their experiences of mental health challenges during the menopause transition. The impacts on women's mental health and wellbeing were raised as an underreported and under addressed challenge of perimenopause diagnosis and treatment, requiring further medical education and upskilling.[90]

4.69 Professor Jayashri Kulkarni AM discussed the impact of the menopause transition on the brain and its subsequent impact on mood; including through increased presentation of menopausal depression.[91] Professor Kulkarni highlighted the impact of fluctuating hormones such as oestrogen, progesterone and testosterone affecting fluctuating production of brain chemicals including serotonin, dopamine and noradrenaline.[92]

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85 Australasian Menopause Society, *AMS Symptom Score Card*, March 2021, www.menopause.org.au/hp/information-sheets/ams-symptom-score-card (accessed 21 August 2024).

86 Jean Hailes for Women's Health, *Perimenopause and menopause symptom checklist*, www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist (accessed 21 August 2024).

87 Women NSW, *Perimenopause and menopause checklist*, 1 June 2022, www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit/symptom-checklist (accessed 21 August 2024).

88 Dr Sarah White, Chief Executive Officer, Jean Hailes for Women's Health, *Committee Hansard*, 18 June 2024, p. 53.

89 See, for example, Tara, Private capacity, *Committee Hansard*, 17 June 2024, p. 43; Dr Sara Whitburn, Sexual Health Specific Interest Group, Royal Australian College of General Practitioners, *Committee Hansard*, 30 July 2024, p. 19; Jill, Private capacity, *Committee Hansard*, 30 July 2024, p. 33.

90 See, for example, Dr Alexandra Murray, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 18 June 2024, p. 67; Australasian Menopause Society, *Submission 177*, p. 3; Viv Health, *Submission 5*, [p. 4]; HER Centre Australia, *Submission 8*, [p. 9];

91 Professor Jayashri Kulkarni, Director, HER Centre Australia, *Committee Hansard*, 30 July 2024, p. 10.

92 Professor Jayashri Kulkarni, Director, HER Centre Australia, *Committee Hansard*, 30 July 2024, p. 10.

4.70 Professor Kulkarni argued that occurrences of menopausal depression are underdiagnosed and often not clinically recognised, resulting in inappropriate treatment.[93] This was an issue that was raised in evidence by individuals who shared their experiences with the committee and talked about the incorrect prescription of anti-depressants in lieu of MHT or other menopause-specific treatment.[94]

4.71 Particularly, Professor Kulkarni emphasised the need to recognise that menopausal depression is caused by fluctuating hormone levels and thus must be treated with hormone therapy.[95] Dr Louise Newson highlighted the devastating impacts it can have, stating:

> We know suicide increases by a factor of seven in women in their late 40s, and a lot of it will be due to hormones, because we know they work as neurotransmitters.[96]

4.72 Sexual Health and Family Planning ACT discussed the importance of continued access to Mental Health Care Plans to 'enable those on the menopause journey to access psychological services'.[97]

4.73 In response to emerging trends of menopausal depression, the HER Centre Australia developed the MENO-D rating tool to assist individual patients and/or clinicians to diagnose this condition. The tool assesses the following symptoms on a sliding scale based on experiences over the past two weeks:

- low energy;
- paranoid thinking;
- irritability;
- self esteem;
- isolation;
- anxiety;
- somatic symptoms;
- sleep disturbance;
- weight;
- sexual interest;

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93 Professor Jayashri Kulkarni, Director, HER Centre Australia, *Committee Hansard,* 30 July 2024, p. 10.

94 See, for example, Sonya, Private capacity, *Committee Hansard,* 17 June 2024, p. 40; Sandy, Private capacity, *Committee Hansard,* 18 June 2024, p. 37; Imogen, Private capacity, *Committee Hansard,* 18 June 2024, p. 41; Jennifer, Private capacity, *Committee Hansard,* 29 July 2024, p. 40; Felicity, Private capacity, *Committee Hansard,* 30 July 2024, p. 29; Cathy, Private capacity, *Committee Hansard,* 30 July 2024, p. 32; Karen, Private capacity, *Committee Hansard,* 6 August 2024, p. 9; Name withheld, *Submission 253,* [p. 3]; Rachel, *Submission 77,* [p. 1].

95 Professor Jayashri Kulkarni, Director, HER Centre Australia, *Committee Hansard,* 30 July 2024, p. 10.

96 Dr Louise Newson, Founder and Menopause Specialist, Newson Health, *Committee Hansard,* 30 July 2024, p. 63.

97 Sexual Health and Family Planning ACT, *Submission 102,* pp. 5–6.

- memory; and
- concentration.[98]

Treatment options

4.74 Following the difficulties of seeking access to a diagnosis of menopause, the inquiry also highlighted the subsequent challenges of accessing appropriate, cost effective and available treatments for menopause symptoms. This section discusses Menopause Hormonal Therapy (MHT) as a treatment, the benefits of multidisciplinary menopause clinics and considers the issue of complementary and alternative therapies.

Menopause Hormonal Therapy

4.75 MHT, also known as Hormone Replacement Therapy (HRT), is a recommended treatment option for addressing problematic symptoms of menopause. MHT treatment involves replacement of the hormones that are depleted as a result of the menopause transition, including oestrogen (specifically the compound oestradiol), progesterone and also in some cases, testosterone, to treat troublesome symptoms.[99]

4.76 Oestrogen is usually utilised for treating vasomotor symptoms such as hot flushes and night sweats. It also has protective factors in preventing bone loss.[100] It is available as tablets, skin patches and gels. Vaginal oestrogen in creams, pessaries or tablets is available for vaginal dryness or dyspareunia.[101]

4.77 For women who have a uterus (i.e., have not had a hysterectomy), a progestogen is also recommended alongside oestrogen to counteract the risk of endometrial cancer from the oestrogen by itself.[102] Progestogens are most often taken orally, and micronized progesterone capsules are a form of body identical

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98 HER Centre Australia, *MENO-D: A rating scale to detect depression in menopause;* Meno-D-Rating-Scale-Sheet_HER-Centre-Australia.pdf (monash.edu) (accessed 20 August 2024).

99 Australasian Menopause Society, *Combined Menopausal Hormone Therapy (MHT)*, September 2018, www.menopause.org.au/hp/information-sheets/combined-menopausal-hormone-therapy-mht (accessed 21 August 2024).

100 Australasian Menopause Society, *Combined Menopausal Hormone Therapy (MHT)*, September 2018, www.menopause.org.au/hp/information-sheets/combined-menopausal-hormone-therapy-mht (accessed 21 August 2024).

101 Australasian Menopause Society, *Combined Menopausal Hormone Therapy (MHT)*, September 2018, www.menopause.org.au/hp/information-sheets/combined-menopausal-hormone-therapy-mht (accessed 21 August 2024).

102 The term 'progestogen' encompasses natural progesterone and synthetic preparations which act on the progesterone receptor. The phrase 'progestin' is used purely for synthetic preparations. For further information, see Australasian Menopause Society, *Combined Menopausal Hormone Therapy (MHT)*, September 2018, www.menopause.org.au/hp/information-sheets/combined-menopausal-hormone-therapy-mht (accessed 21 August 2024).

progesterone. Women who have had a hysterectomy do not require use of a progestogen.[103]

4.78 Testosterone can also be used for women experiencing negative impacts of perimenopause and menopause on their libido.[104]

4.79 A number of practitioners emphasised the 'gold standard' of combined MHT which include body identical transdermal estradiol, oral micronized progesterone and inclusion of testosterone where needed as preferrable because of their lower risk profile.[105]

4.80 Comparatively, evidence suggests that particular oral and synthetic preparations of MHT may have higher levels of risk:

> Synthetics have a higher risk of breast cancer, arterial and vascular disease compared to body identical hormones. Orals have a higher risk of arterial and vascular disease than transdermal.[106]

Fear associated with the use of MHT

4.81 In relation to the use of MHT, there are continuing concerns about the Women's Health Initiative (WHI) study in 2002. The study was designed to evaluate the role of MHT in the prevention of diseases related to aging but was concluded early, with findings that included a potentially increased risk of breast cancer associated with MHT use.[107] As explained by the Society of Hospital Pharmacists of Australia in their submission:

> The release of the Women's Health Initiative (WHI) study in 2002 on the use of hormone replacement therapy (HRT) in menopause became a catalyst for huge change in HRT use across the globe. The initial results and the proceeding media reports of increased risk of breast cancer from HRT use led to the sudden cessation of HRT in thousands of women.[108]

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[103] Australasian Menopause Society, *Combined Menopausal Hormone Therapy (MHT)*, September 2018, www.menopause.org.au/hp/information-sheets/combined-menopausal-hormone-therapy-mht (accessed 21 August 2024).

[104] Australasian Menopause Society, *Combined Menopausal Hormone Therapy (MHT)*, September 2018, www.menopause.org.au/hp/information-sheets/combined-menopausal-hormone-therapy-mht (accessed 21 August 2024).

[105] Avalon Family Medical Practice, *Submission 142*, [p. 5]. See also, for example, Dr Kelly Teagle, *Submission 111*, [p. 2]; Women's Health Road, *Submission 117*, [p. 5]; Dr Ceri Cashell, *Submission 44*, [p. 11].

[106] Avalon Family Medical Practice, *Submission 142*, [p. 5]. For further discussion on the associated risks of MHT use, see, for example, Samy Medical Group, *Submission 41*, pp. 5–6.

[107] Australasian Menopause Society, *Women's Health Initiative – Update 2013*, October 2013, www.menopause.org.au/hp/news/womens-health-initiative-update-2013 (accessed 2 September 2024).

[108] Society of Hospital Pharmacists of Australia, *Submission 3*, [p. 3].

4.82 Several submitters explained that healthcare providers, especially GPs, have a lack of confidence in prescribing, recommending and managing MHT as a form of therapy due to the WHI study findings and associated concerns about the purported increased risk of breast cancer, heart disease and stroke.[109]

4.83 The WHI study has subsequently been found to have had significant limitations in its study design and findings. This includes that the study employed a synthetic progestin which is not extrapolatable to body identical hormone treatment which is currently available on the market.[110]

4.84 At a hearing, Jill relayed her difficulties accessing MHT in the Australian medical system because of the ongoing hesitation to prescribe MHT:

> My individual experience has been that HRT is not thought of as a first-line treatment for menopause. In fact, in a medical setting, it was rarely mentioned or discussed as a viable option. You have to, basically, demand it, and that is not a good situation for the doctor or the patient. I demanded HRT and commenced taking it at the age of 61.[111]

4.85 Associate Professor Treasure McGuire also noted the WHI study contributed to the recent shortages of these products across Australia, noting that the outcomes of the WHI study 'led to a massive cessation of hormonal therapy, and this resulted over time in discontinuation of the very products we need to use'.[112]

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[109] See, for example, Associate Professor Treasure McGuire, Women's and Newborn Health Committee, Society of Hospital Pharmacists of Australia, *Committee Hansard,* 29 July 2024, p. 11; Ms Karen Castle, Policy Pharmacist, Pharmaceutical Society of Australia, *Committee Hansard,* 29 July 2024, pp. 12–13; Dr Virginia French, Her Health and Aesthetics, *Committee Hansard,* 30 July 2024, p. 7; Dr Sara Whitburn, Chair, Sexual Health Specific Interest Group, Royal Australian College of General Practitioners, *Committee Hansard,* 30 July 2024, p. 18; Dr Christina Jang, Board Member and President-elect, Australasian Menopause Society, *Committee Hansard,* 18 June 2024, p. 59; Dr Christabel Samy, Medical Director, Samy Medical Group, *Committee Hansard,* 6 August 2024, p. 39; Associate Professor Ravani Duggan and Ms Lucy Gent, *Submission 51,* p. 3; Chelvanayagam, Bouse, Cotellessa and de Lacy, *Submission 59,* pp. 11–12; Sexual Health and Family Planning ACT, *Submission 102,* p. 6; Women's Health in the South East, *Submission 120,* [p. 19]; Professor Susan Davis AO, Director, Monash University Women's Health Research Program, *Committee Hansard,* 18 June 2024, p. 8; Besins Healthcare, *Submission 146,* [pp. 8–9].

[110] See, for example, Women's Health in the South East, *Submission 120,* [p. 19]; Dr Ceri Cashell, General Practitioner and Co-Owner, Avalon Family Medical Practice, *Committee Hansard,* 18 June 2024, p. 2; Theramex, *Submission 124,* [p. 2].

[111] Jill, Private capacity, *Committee Hansard,* 30 July 2024, p. 33.

[112] Associate Professor Treasure McGuire, Women's and Newborn Health Committee, Society of Hospital Pharmacists of Australia, *Committee Hansard,* 29 July 2024, p. 11.

Costs of treatment

4.86 Many women raised the issue of the cost of MHT as a barrier to effective treatment.[113]

Pharmaceutical Benefits Scheme listing

4.87 There are a limited number of MHT products on the Pharmaceutical Benefits Scheme (PBS), with many medications and delivery methods not subsidised.[114]

4.88 Currently, some transdermal oestrogen patches are available on the PBS.[115] However, the safest form of micronized progesterone, Prometrium, is not available on the PBS.[116] Instead, the only options available on the PBS for progesterone therapy are synthetic progestins which are identified as having a higher risk profile.[117] The combined MHT medication course of Estradiol gel and Prometrium capsules is not listed on the PBS.[118] Also, AndroFemme, the testosterone product for women, is not available on the PBS.[119]

4.89 Her Health and Aesthetics elaborated that the 'safest medications are the most expensive as they are not supported by the prescription subsidy scheme'.[120] Dr Kelly Teagle of WellFemme elaborated:

> Regarding affordability of best evidence-based treatments: micronized (body-identical) progesterone has overwhelmingly proven to be the safest progestogen for MHT, but it is not subsidised under the PBS. Financially vulnerable women must instead settle for cheaper synthetic progestins that have been shown to increase breast cancer risk.[121]

4.90 Further, pharmaceutical companies spoke to the difficulties of introducing new products to be considered for listing on the PBS, given the requirement to

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113 See, for example, Name withheld, *Submission 90*, [p. 1]; Allison, *Submission 80*, [p. 2]; Name withheld, *Submission 95,* [p. 2]; Name withheld, *Submission 96,* p. 4; Name withheld, *Submission 130,* [pp. 6–7]; Rachel, *Submission 181*, p. 2; Name withheld, *Submission 189,* [p. 1]; Naomi, *Submission 196,* [p. 2]; Ms Cilla de Lacy, *Submission 223,* p. 8.

114 Tasmanian Government, *Submission 7,* [p. 3]. See, for example, Sexual Health Victoria, *Submission 17,* [p. 4]; Royal Australian College of Psychiatrists, *Submission 19,* p. 4; Monash Centre for Health Research Implementation, *Submission 34,* p. 7.

115 Viv Health, *Submission 5,* [p. 6].

116 Viv Health, *Submission 5,* [p. 6]. See, for example, Dr Ceri Cashell, *Submission 44,* [p. 14].

117 Viv Health, *Submission 5,* [p. 6]. See, for example, Dr Ceri Cashell, *Submission 44,* [p. 10].

118 Dr Caroline Rogers FRACGP, *Submission 50,* [p. 1].

119 Dr Ceri Cashell, *Submission 44,* [p. 14].

120 Her Health and Aesthetics, *Submission 179,* [p. 5].

121 Dr Kelly Teagle, *Submission 111,* [p. 2].

compete with older listed products, such as synthetic progestins, which are not comparable in production costs to body identical progestogens.[122]

Prohibitive costs

4.91 These products not being on the PBS drives a higher cost burden on women seeking the most effective and safe treatments. Dr Cashell highlighted the financial impact of accessing MHT on a regular basis, noting that the 'whole cost of HRT if you take all three hormones plus vaginal oestrogen is roughly $100 per month'.[123]

4.92 Dr Cashell further explained the real impact of these issues by sharing a story of a patient who was no longer able to afford MHT and instead asked for Valium 'because a box of 50 Valium is PBS listed and costs $15, whereas her anxiety and depression were controlled on progesterone and estradiol'.[124]

4.93 This also has implications for the quality of care that doctors are able to provide to their patients. As Dr Louise Manning of the Rural Doctors Association of Australia explained:

> Often I am having to have conversations like: 'This is what I think will be best for you. This is what I think will manage your symptoms best. But you can't afford it.' It's a real struggle. As a doctor, I find that really challenging ethically because I know that they will get better symptom management with X, Y or Z, but they literally cannot afford it. ... These people can't afford what will be better for them, because it's not currently on the PBS.[125]

4.94 Grace, a private individual who appeared at a hearing, provided an analysis of the costs associated with accessing MHT and associated healthcare:

> I'm going to share with you a list of my monthly medications, including supplements I need just to be able to function: oestrogen patches range from $21 to $35; oral progesterone, $47; vaginal oestrogen, $19; testosterone, $75; and contraceptive pills are $83 to help stop my constant heavy bleeding. This is a total of $259. Supplements: B12, $48; magnesium, $44; iron, $32; intimate cream, $23; zinc, $24; omega 3, $33; collagen powder, $59; dry eye wipes, $21; and eyedrops, $13. The total is $297.[126]

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[122] See, for example, Organon, *Submission 24,* p. 9; Bayer Australia, *Submission 30,* p. 4; Besins Healthcare, *Submission 146,* [p. 11].

[123] Dr Ceri Cashell, General Practitioner and Co-Owner, Avalon Family Medical Practice, *Committee Hansard,* 17 June 2024, p. 6.

[124] Dr Ceri Cashell, General Practitioner and Co-Owner, Avalon Family Medical Practice, *Committee Hansard,* 17 June 2024, p. 5.

[125] Dr Louise Manning, President, Rural Doctors Association of Victoria, *Committee Hansard,* 30 July 2024, p. 24.

[126] Grace, Private capacity, *Committee Hansard,* 6 August 2024, p. 10.

Shortages and discontinuation of MHT products

4.95 There are additional barriers due to current shortages of prescribed treatments, caused by a number of factors, including discontinuation of certain products from the market and manufacturing difficulties.[127]

4.96 The Department explained that there has been a global shortage of some estradiol-containing transdermal patches, including Estradot, Estraderm MX and Estalis.[128] Moreover, Climara, a transdermal estradiol patch was discontinued from the market.[129]

4.97 Author Ms Kaz Cooke conducted an online survey of almost 9000 women to inform the content of her book 'It's the Menopause'. At a hearing in Melbourne, she emphasised the range of challenges experienced by women trying to access MHT, elaborating on the experiences shared with her when writing her book:

> They are all so upset about the shortage of medications. They feel that they're held in contempt. You know, they've gone to 12 pharmacies and consider how difficult that is when you live in a regional area, to try and find this thing that they've been prescribed by a doctor. When they can't get it they're told that they can get this other thing, but it's not on the Pharmaceutical Benefits Scheme and they're spending a $1 000 to 1 500 a year on medications and other things to try and mitigate.[130]

4.98 Lynette, a community pharmacist, spoke to the impacts of MHT shortages on her practice:

> Over recent months, there has been a notable and distressing trend of menopause treatments being consistently out of stock or discontinued altogether. This scarcity of essential medications is causing undue hardship and distress to countless individuals who rely on these treatments to manage the symptoms associated with menopause. Many women are ringing multiple pharmacies daily, travelling for hours just to source their monthly prescription.[131]

4.99 At a hearing in Perth, Dr Sunita Chelvanayagam explained difficulties in providing stable and consistent patient care, and how she often needed to adjust prescriptions and care plans on the basis of stock availability.[132]

4.100 Many women shared with the committee the impacts of these shortages, including having to travel to a number of different pharmacies, needing to return to their GP to change dosage, brand or formulation and; in some

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[127] Department of Health and Aged Care, *Submission 15*, p. 13.

[128] Department of Health and Aged Care, *Submission 15*, p. 13.

[129] Department of Health and Aged Care, *Submission 15*, p. 13.

[130] Ms Kaz Cooke, Private capacity, *Committee Hansard*, 18 June 2024, p. 4.

[131] Lynette, *Submission 60*, [p. 1].

[132] Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard*, 6 August 2024, p. 27.

instances, needing to cut MHT patches against the advice of pharmacists in order to achieve appropriate relief from symptoms.[133]

4.101 A further point consistently raised with the committee was the comparison of access to MHT for women to Viagra, a medication designed for male erectile dysfunction.[134] Submitters emphasised that Viagra is available on the PBS and is readily available across the country; whereas MHT is not.[135]

4.102 The committee was also informed about the impact of localised medicine shortages in regional and remote areas, whereby MHT treatments may be more readily available in metropolitan areas, but shortages continue in rural locations.[136]

Potential remedies for MHT shortages

Domestic manufacturing of MHT

4.103 Submitters discussed considering a domestic manufacturing capability of certain forms of MHT as a potential solution to the shortage issues regarding these medications.[137] It was highlighted to the committee that AndroFemme, a testosterone treatment for women, is manufactured in Perth, Western Australia.[138]

TGA actions to remedy shortages

4.104 Participants in the inquiry emphasised the potential for the Therapeutic Goods Administration (TGA) to respond to shortages of MHT by enacting special actions to bring in different medications, as explained by Dr Christina Jang:

> … when the shortages are present, the TGA have the ability to enact special actions to bring a range of different medications in. Section 19A of the TGA [Act] allows medications which are normally not available in the country to be brought in. There is an example of that currently. It is a patch called Estramon which has been brought in from Germany. That's currently

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[133] See, for example, Clare, *Submission 74,* p. 2; Rachel, *Submission 181,* pp. 2–3; Sandy, *Submission 75,* p. 11; Name withheld, *Submission 85,* [p. 2]; Name withheld, *Submission 208*, [p. 3].

[134] See, for example, Name withheld, *Submission 90*, [p. 1]; Name withheld, *Submission 129,* [p. 1]; Name withheld, *Submission 130,* [pp. 3–4]; Sandy, *Submission 75,* p. 6.

[135] See, for example, Name withheld, *Submission 90*, [p. 1]; Name withheld, *Submission 129,* [p. 1]; Name withheld, *Submission 130,* [pp. 3–4]; Sandy, *Submission 75,* p. 6.

[136] Mr Chris Campbell, General Manager, Policy and Program Delivery, Pharmaceutical Society of Australia, *Committee Hansard,* 29 July 2024, p. 14. See, for example, Dr Louise Manning, President, Rural Doctors Association of Victoria, *Committee Hansard,* 30 July 2024, p. 20.

[137] See, for example, Professor Steve Robson, President, Australian Medical Association, *Committee Hansard,* 30 July 2024, p. 19; Dr Michelle Cotellessa, Private capacity, *Committee Hansard,* 6 August 2024, p. 27; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 27.

[138] Ms Kirstin Bouse, Private capacity, *Committee Hansard,* 6 August 2024, p. 27.

> available. That's in place of Estradot and Estraderm, which have been in short supply.[139]

4.105 In a response to a question taken on notice, the Department explained recent actions taken under Section 19A:

> From 1 January 2023 to 26 August 2024, the Pharmaceutical Benefits Advisory Committee (PBAC) considered 48 applications to list alternative brands under s19A temporarily on the PBS during shortages. Of these, 3 related to perimenopause or menopause treatments. These 3 related to different strengths of the hormone replacement therapy (HRT) medicine Estradiol (Sandoz, USA), and since 1 June 2024, this product has been available on the PBS in 37.5 microgram, 75 microgram and 100 microgram 24-hour patches. All s19A applications related to perimenopause or menopause treatments considered by PBAC during this period have been listed on the PBS.[140]

4.106 At a hearing, Associate Professor Robyn Langham AM, in her capacity as Chief Medical Adviser of the Health Products Regulation Group, explained that there are a range of additional options available to the TGA to mitigate shortages.[141] These include:

- approving overseas registered alternative products that can be imported and supplied in Australia without going through the TGA's pre-market evaluation safety quality registration;
- publishing identified shortages online based on information provided by sponsors;
- working with community service obligation deed distributors to constrain available supplies and facilitate equitable distribution of PBS listed patches; and
- where a product is particularly scarce, the TGA can issue a Serious Scarcity Substitution Instrument, but this requires a readily available substitute to be most effective.[142]

4.107 Associate Professor Langham advised the committee that the TGA is also undertaking a review of medicine shortages, including comprehensive

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139 Dr Christina Jang, Board Director and President-elect, Australasian Menopause Society, *Committee Hansard*, 18 June 2024, p. 60.

140 Department of Health and Aged Care, answer to a question on notice IQ24-000106, 13 August 2024 (received 30 August 2024).

141 Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 26.

142 Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 26.

stakeholder engagement, with a series of draft recommendations expected to be put to the Minister for Health in the coming months.[143]

The need for priority access to MHT for certain cohorts

4.108 Given the substantially increased impacts of menopause on women with primary ovarian insufficiency (POI), women who experience surgically induced menopause and those who are in early menopause due to the effects of cancer treatment, the need for a priority access scheme to MHT for these women was also highlighted during the inquiry.[144] As made clear by a private individual speaking to her daughter's experiences with POI:

> There is precedent for prioritising medication to those most in need during times of drug shortages. A recent example of this is the ability of pharmacists to prioritise of patients with diabetes to access the drug Ozempic. The ability of pharmacists to prioritise those at greatest risk of severe health consequences is a critical and ethical practice. The evidence strongly supports that young women with POI should receive similar prioritisation for HRT access.[145]

Multi-disciplinary clinics and the idea of a 'one stop shop'

4.109 In discussing potentially useful models of treatment, submitters emphasised the importance of multidisciplinary clinics that incorporate a range of different services that can contribute to a women's wellbeing during menopause; for example, physiotherapy, exercise physiology, nutrition support and other allied health services.[146]

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143 Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 13 August 2024, p. 26.

144 See, for example, Clinical Associate Professor Amanda Vincent, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard,* 29 July 2024, p. 18; Janine, Private capacity, *Committee Hansard,* 29 July 2024, p. 43; Belinda, Private capacity, *Committee Hansard,* 30 July 2024, p. 35.

145 Name withheld, *Supplementary submission 180.2*, [p. 1].

146 See, for example, Ms Emma Iwinska, Chief Executive Officer, Women's Health and Equality Queensland, *Committee Hansard,* 29 July 2024, p. 50; Ms Catherine Willis, Board Director, Australian Physiotherapy Association, *Committee Hansard,* 18 June 2024, p. 72; Ms Mirjana Jovetic, Senior Policy Adviser, Australian Physiotherapy Association, *Committee Hansard,* 18 June 2024, p. 72; Dr Richelle Douglas, Medical Director, Derbal Yerrigan Health Service, *Committee Hansard,* 6 August 2024, p. 5; Dr Lesley Ramage, Director, Menopause Alliance Australia, *Committee Hansard,* 6 August 2024, p. 21; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 25; Dietitians Australia, *Submission 104,* pp. 2–3; Ms Rebecca Madill and Dr Alessandra Briglia, *Submission 168,* p. 5.

4.110 Ms Leeanne Boase of the Australian College of Nurse Practitioners pointed out there is the option for these clinics to be nurse-led to address GP workforce shortages in certain areas.[147]

4.111 The Monash Centre for Health Research and Implementation discussed the fact that public specialist menopause services are not available in all states and territories of Australia. It recommended 'a specialised multidisciplinary menopause service (with telehealth remote access)' in each state and territory in Australia to provide specialist care and support GPs.[148]

4.112 More broadly, it was noted that there are limited existing multidisciplinary menopause clinics in the public health system. Some submitters recommended that the Australian Government support the roll out of these clinics through the public health system.[149]

4.113 Dr Sara Whitburn, in her capacity as Deputy Medical Director and Senior Medical Officer at Sexual Health Victoria, took the example of the existing pelvic pain clinics across the country as a potential model of care for the menopause clinics:

> So thinking about how the pelvic pain clinics work, I would envisage grants to set up a multidisciplinary menopause clinic that would allow you to have a longer appointment, allow to have a team looking at mental health, physiotherapy—nurse practitioners, GPs and midwives. You could allow for that access and quality care so people don't get turned away, so they do get the information they are looking for, so they do get asked around assessments and so people who are used to looking at investigations can provide that care.[150]

4.114 The NSW Government highlighted its rollout of a network of Menopause Services across NSW that will provide an escalation pathway to specialist care for people experiencing severe or complex symptoms of menopause.[151]

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[147] Ms Leanne Boase, Chief Executive Officer, Australian College of Nurse Practitioners, *Committee Hansard*, 18 June 2024, p. 14.

[148] Monash Centre for Health Research and Implementation, *Submission 34*, p. 17.

[149] See, for example, Professor Helena Teede, Director, Monash Centre for Health Research and Implementation, *Committee Hansard*, 18 June 2024, p. 23; Dr Fatima Khan, *Submission 46*, [p. 2]; Chelvanayagam, Bouse, Cotellessa and de Lacy, *Submission 59*, p. 11.

[150] Dr Sara Whitburn, Deputy Medical Director and Senior Medical Officer, Sexual Health Victoria, *Committee Hansard*, 30 July 2024, p. 48.

[151] NSW Government, *Submission 53*, p. 5. See also, for example, NSW Health, *Menopause services*, 23 October 2023, www.health.nsw.gov.au/women/Pages/menopause.aspx (accessed 25 August 2024).

Box 4.1 The Menopause Centre – a multidisciplinary menopause clinic
As part of its inquiry, the committee visited The Menopause Centre, in Brisbane. The clinic is a private clinic that offers access to a number of different specialists all housed in the same location. The Menopause Centre offers the following services:

- Endocrinology;
- Gynaecology;
- Psychology;
- Women's health physiotherapy;
- Exercise physiology; and
- Dietitian services.[152]

Alternative therapies

4.115 Some submitters told the committee that there are alternative and complementary therapies that can provide relief from menopause and perimenopause symptoms. According to Dr Gabriela Berger and Dr Anita Peerson, there are a range of alternative therapies that can provide relief, including aromatherapy, massage, yoga and acupuncture, dietary and herbal supplements and, to a lesser extent, exercise and reflexology.[153]

4.116 The ALSWH provided an overview of the uptake of alternative therapies by women in the 1946–51 cohort, between the ages of 59 and 64:

[152] The Menopause Centre, *The Menopause Centre,* 2024, www.themenopausecentre.com.au/ (accessed 25 August 2024).

[153] Dr Gabriela Berger and Dr Anita Peerson, *Submission 52,* p. 4.

- 39 per cent of menopausal women consulted a complementary practitioner (including massage therapists, naturopaths/herbalists, chiropractors/osteopaths and acupuncturists;[154] and
- 75 per cent had used at least one self-prescribed complementary or alternative medicine.[155]

4.117 The Naturopaths and Herbalists Association of Australia explained the holistic approaches used in naturopathy that can assist in supporting the management of menopause symptoms:

> Naturopaths can contribute valuable insights into lifestyle modifications, nutritional interventions, and evidence-based complementary or alternative therapies.[156]

4.118 A few submitters to the inquiry also shared their experiences of turning to naturopathy and other complementary therapies for a more holistic approach to managing their symptoms.[157] Some naturopathy practitioners also specified that they saw a number of patients after they had sought help from doctors who did not recognise their symptoms.[158]

4.119 The AMS has developed a comprehensive fact sheet outlining the various complementary medicine options for the treatment of menopause symptoms.[159] The fact sheet identifies the safe and effective complementary therapies as:

- vitamin E;
- cognitive behavioural therapy;
- hypnosis; and
- yoga.[160]

4.120 Conversely, the fact sheet also identifies a range complementary therapies which should not be used due to safety concerns and insufficient evidence:

- wild yam cream or progesterone cream;

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[154] Australian Longitudinal Study on Women's Health, *Submission 35*, pp. 19–20.

[155] Australian Longitudinal Study on Women's Health, *Submission 35*, pp. 19–20.

[156] Naturopaths and Herbalists Association of Australia, *Submission 54*, p. 4.

[157] See, for example, Kerry – Peripausers, *Submission 202*, [p. 3]; Megan, *Submission 68*, p. 3; Maria, *Submission 232*, p. 3; Bronwen, *Submission 249*, [p. 2].

[158] See, for example, Simone, *Submission 236*, [p. 6]; Ms Natasha Langovski and Ms Louise Rubic, *Submission 233*, [p. 2].

[159] Australasian Menopause Society, *Complementary medicine options for menopausal symptoms;* January 2018, www.menopause.org.au/health-info/fact-sheets/complementary-medicine-options (accessed 29 August 2024).

[160] Australasian Menopause Society, *Complementary medicine options for menopausal symptoms;* January 2018, www.menopause.org.au/health-info/fact-sheets/complementary-medicine-options (accessed 29 August 2024).

- red clover;
- omega 3 supplements;
- black cohosh;
- evening primrose oil;
- homeopathy;
- magnetic therapy; and
- bioidentical compounded hormone therapy.[161]

Marketing of alternative therapies to women

4.121 Some submitters were concerned that there are companies that market certain products to women without an established evidence base to support the claims they make.[162] In its submission, Jean Hailes explained:

> There are many, many complementary and alternative therapies being marketed to women in perimenopause and menopause that promise to 'balance hormones', reduce weight gain, "regain a youthful appearance" and lose weight. At best, these advertisements induce women to waste their money; at worst, they could cause real psychological harm by creating feelings of envy or inadequacy or affecting self-esteem and self-worth. The products themselves carry their own risks.[163]

4.122 The Monash Centre for Health Research and Implementation highlighted the issues associated with complementary and alternative medicines (CAMs):

> The use of unproven and ineffective CAMs, fuelled by misinformation on social media and the lack of counter balancing accessible evidence based information leads to a major waste of money for women and delays use of effective treatments.[164]

4.123 Ms Kaz Cooke emphasised the importance of greater regulation of the alternative therapy industry targeted at menopause, explaining:

> No agency in Australia now properly regulates the billion-dollar supplements industry. So-called 'supplements' are sold directly or by implication as health remedies and therapeutic goods. Women believe they are herbal equivalents of pharmaceutical hormone medications which will deliver the same effects. This is not true.[165]

4.124 The Australian Medical Association also pointed out that some over the counter alternative treatments:

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[161] Australasian Menopause Society, *Complementary medicine options for menopausal symptoms;* January 2018, www.menopause.org.au/health-info/fact-sheets/complementary-medicine-options (accessed 29 August 2024).

[162] Chief Executive Women, *Submission 136*, p. 7.

[163] Jean Hailes for Women's Health, *Submission 119*, p. 37.

[164] Monash Centre for Health Research and Implementation, *Submission 34*, pp. 13–14.

[165] Ms Kaz Cooke, Private capacity, *Committee Hansard*, 18 June 2024, p. 1.

> … 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.[166]

Regulation of alternative therapies

4.125 Associate Professor Robyn Langham, in her capacity as Chief Medical Adviser of the Health Products Regulation Group, outlined that there are different mechanisms for classifying different types of medicines. For example, products identified as higher risk, such as those containing hormones, must undergo a TGA evaluation of safety, quality and efficacy.[167]

4.126 Comparatively, lower risk products, such as vitamins, herbal medicines and traditional medicines are classed as listed medicines and do not require TGA pre-market approval.[168] She explained to the committee that:

> …they must be made under a licence of good manufacturing practice. They can only contain preapproved low-risk ingredients. They can only make low-risk preapproved health claims. And they must have evidence that supports the claims that they're making. They must also comply with all advertising and labelling requirements of the Therapeutic Goods Act.[169]

4.127 Further, Associate Professor Langham advised the committee that any products that are intended for oral consumption may be regulated as a food or as a medicine, depending on several factors such as the ingredients, the overall presentation and the types of claims that are being made about the product.[170]

4.128 Products for oral use that are not regulated as therapeutic goods are likely to be regulated under food legislation by Food Standards Australia New Zealand. These are different to therapeutic goods regulated by the TGA which must make a therapeutic claim, particularly:

> … a claim that they're either preventing, diagnosing, curing or alleviating a disease, an ailment, a defect or an injury or anything that's influencing, inhibiting or modifying a physiological process. Claims such as 'relieving the symptoms of menopause' would be considered a therapeutic claim,

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[166] Australian Medical Association, *Submission 115*, p. 2.

[167] Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 23.

[168] Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 23.

[169] Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 23.

[170] Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 24.

> therefore they are considered therapeutic goods and they are regulated by the TGA.[171]

4.129 When asked by the Chair of the committee if there was an indication on packaging that a product was 'TGA listed', Associate Professor Langham responded that it was not part of the TGA labelling requirements under legislation.[172]

4.130 On the issue of greater regulation for advertising of alternative therapies, Ms Tracey Lutton from the Department explained the powers of the TGA to:

- develop educational resources for social media platforms to identify problematic social media influencers, including information on lawful content and known influencer endorsements associated with particular products;
- identify advertisements that are not lawful or go against the advertising code; and
- disrupt websites advertising unlawful information and removal of information from particular platforms.[173]

4.131 The Department, in an answer to a question on notice, confirmed that in the 2023–24 financial year, over 4 800 removal requests were issued to various digital platforms, including social media platforms, for unlawful advertising of any therapeutic good.[174] Although it was not possible to delineate the data to menopause specific advertising, the Department advised a number of these removals were for complementary/herbal medicines that would have included those targeted at menopause and perimenopause treatments.[175]

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[171] Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 13 August 2024, p. 24.

[172] Associate Professor Robyn Langham, Chief Medical Adviser, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard*, 13 August 2024, p. 24.

[173] Ms Tracey Lutton, Assistant Secretary, Regulatory Compliance Branch, Health Products Regulation Group, Department of Health and Aged Care, *Committee Hansard,* 13 August 2024, p. 23.

[174] Department of Health and Aged Care, answer to a question on notice IQ24-000102, 13 August 2024 (received 30 August 2024).

[175] Department of Health and Aged Care, answer to a question on notice IQ24-000102, 13 August 2024 (received 30 August 2024).

Avoiding overmedicalisation of menopause

4.132 Some inquiry participants spoke to the need to have a balanced discourse in discussions related to menopause and perimenopause, to avoid women being fearful of entering this life phase or the further perpetuation of stigma.[176]

4.133 The Royal Women's Hospital Melbourne submission elaborated:

> Unfortunately, amongst many medical professionals, menopause has largely been pathologised and viewed as a "hormone deficiency". This is both inaccurate and potentially harmful and can lead to over-diagnosis and over-treatment. It can also create negative expectations, and those with negative expectations are more likely to report problematic symptoms.[177]

4.134 Professor Martha Hickey of the Australian Academy of Health and Medical Sciences explained:

> Menopause isn't a disease. It doesn't need a formal diagnosis as such; it's something that happens to all those born with functioning ovaries. The important thing is that those who need help get help. … It's not necessarily helpful to take the position that menopause is a disastrous event for all women, because it isn't. As with pregnancy, for example, there are a diversity of experiences.[178]

4.135 Dr Christina Jang of the AMS noted the need for accepting menopause as an important part of the process of ageing and spoke to the need to prepare women effectively:

> It's a privilege that we get there [to menopause]. It's preparing them. We don't need to say it's a disaster. I think we have to embrace it: 'This is what happens. This is how you go into it. This is what's going to happen. Stay healthy. These are the things that you can do. Be empowered and let's go forth'.[179]

Committee view

4.136 Throughout the inquiry, the committee heard from women, doctors, advocates and experts about the various barriers to diagnosis and treatment. The committee was concerned to see how arduous and expensive the journey to diagnosis and treatment can be for women who, at times, can experience debilitating symptoms.

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[176] See, for example, Jean Hailes for Women's Health, *Submission 119*, p. 22; FECCA, *Submission 169*, pp. 3–4; Health Care Consumers' Association, *Submission 170*, p. 13; Australian Psychological Society, *Submission 6*, p. 5; Royal Women's Hospital Melbourne, *Submission 33*, p. 7.

[177] Royal Women's Hospital Melbourne, *Submission 33*, p. 7.

[178] Professor Martha Hickey, Fellow, Australian Academy of Health and Medical Sciences, *Committee Hansard*, 5 August 2024, pp. 2–3.

[179] Dr Christina Jang, Board Director and President-elect, Australasian Menopause Society, *Committee Hansard*, 18 June 2024, p. 62.

Medical practitioner training

4.137 The issue of menopause training for medical practitioners cannot be underestimated. The current level of education received at medical schools is clearly insufficient. The committee was alarmed to hear that most medical students only spent an hour on the topic of menopause during their undergraduate studies given it will affect more than half the population.

4.138 The Australian Medical Council explained to the committee that there are certain accreditation standards which individual medical schools are responsible for assessing core competencies for their graduates. The committee is deeply concerned that there is no key standard that speaks specifically to women's health or menopause, which makes it difficult to ascertain the specific women's health education outcomes in the Australian medical education system.

4.139 The committee acknowledges that the Australian Government has committed $1.2 million for Jean Hailes for Women's Health to advertise and subsidise continuing professional development.

4.140 The committee is of the view that all Australian universities have a role to play in ensuring that undergraduate medical students receive appropriate information and training.

Recommendation 9

4.141 The committee recommends that the Australian Government encourage the Australian Medical Council to consider explicitly including menopause and perimenopause in the Graduate Outcome Statements of the Standards for Assessment and Accreditation of Primary Medical Programs. The committee further recommends that menopause and perimenopause be included in graduate outcomes for other health professionals, including nurses and physiotherapists.

Recommendation 10

4.142 The committee recommends that the Australian Medical Council work with Medical Deans Australia and New Zealand to ensure that menopause and perimenopause modules are included in all medical university curriculums.

4.143 The committee acknowledges that there are barriers to continuing professional development for GPs in Australia, including the costs of maintaining a practice and managing a patient load, which can mean that professional development is de-prioritised.

4.144 Further, the comparative lack of AMS accredited menopause specialists when compared to the number of GPs and specialist gynaecologists in Australia suggests that there is an even smaller number of GPs who are prioritising menopause specific professional development.

4.145 Women deserve access to medical practitioners who are informed and aware of menopause and its symptoms, and who are confident in providing advice on the best management options currently available. As such, the committee is of the view that initiatives and incentives to ensure better training of medical practitioners should be considered by the Australian Government as well as state and territory governments.

Recommendation 11

4.146 The committee recommends that all governments and the medical colleges work together to require and facilitate further education on menopause and perimenopause for physicians practising in the public health system across Australia.

Recommendation 12

4.147 The committee recommends that the Australian Government considers increasing funding and expand the recipient base for the delivery of incentivised continuing professional development to medical practitioners on perimenopause and menopause.

Recommendation 13

4.148 The committee recommends that the Australian Government consider how to expand the scope of practice of nurse practitioners to ensure better support for women experiencing menopause in rural and regional areas.

Healthcare reforms

4.149 The primary healthcare system in Australia is of the utmost importance to ensuring that Australians receive timely and effective access to diagnosis and care. Firstly, the lack of awareness and understanding in relation to the symptoms and presentations of menopause is a significant barrier to accurate diagnosis.

4.150 The committee acknowledges the important work that has taken place in building awareness and supporting GPs through tools such as MenoPROMPT, the Practitioner's Toolkit for Managing Menopause and symptom checklists. These are useful tools that can assist practitioners and patients to more effectively work through a diagnosis of menopause and perimenopause. The committee encourages further dissemination and promotion of these resources.

4.151 Menopause consultations require a comprehensive health approach and an understanding of the various facets of a woman's life that are affected. They can require a lot longer than the standard 15 minute consultation. The committee heard that that the Medicare system incentivises general practitioners to provide short appointments. This results in the GPs who are providing longer consults

and more comprehensive care, being financially disadvantaged. These GPs are often required to pass these additional costs on to their patients.

4.152 The committee welcomes the recent introduction of the 60 minute consultation. However, the committee recognises that this may not go far enough for women seeking access to menopause care or for the practitioners currently providing this care.

4.153 As explained by submitters, the committee notes that these longer consultations provide an important opportunity for preventative healthcare to avoid developing the chronic health conditions that can occur during midlife or menopause.

4.154 The committee notes that expansion of the eligibility for mid-life health check appears to be a potential option to enable greater access to comprehensive preventive care. However, more work needs to be done to determine the best mechanism for ensuring women can access the care they need during the menopause transition.

Recommendation 14

4.155 The committee recommends that the Department of Health and Aged Care, through the Medicare Benefits Schedule (MBS) Continuous Review, review existing MBS item numbers relevant for menopause and perimenopause consultations, including for longer consultations and mid-life health checks, to assess whether these items are adequate to meet the needs of women experiencing menopause.

Recommendation 15

4.156 The committee recommends that the Australian Government consider whether a new MBS item number or the expansion of criteria for the mid-life health check, is needed to support greater access to primary care consultations for women during the menopause transition.

4.157 It is clear that menopause is a period of high risk for the development of secondary health conditions, including cardiovascular disease, osteoporosis and diabetes. Prevention is a greater tool than treatment. Given women who are post menopause are at a much higher risk of developing osteoporosis than the general population, it is obvious that they should be supported to access the appropriate prevention tools.

4.158 Currently, bone density scans are only available under the Medicare Benefits Schedule (MBS) under certain circumstances, including, having certain chronic conditions, being over the age of 70 or being at high risk of primary ovarian insufficiency (POI). The committee is of the view that all women identified by their GPs as having a risk of developing osteoporosis through the menopause transition should be eligible under the MBS to access bone density scans.

4.159 The committee notes that the Department of Health and Aged Care may have a role to play in considering an extension of MBS rebate eligibility for bone density scans to women in perimenopause who are identified by their GPs as having a risk of developing osteoporosis.

Access to treatment

4.160 The barriers to accessing menopause hormonal therapy treatments in Australia are unacceptable and are having a disproportionate negative impact on too many women's lives. It is urgent to address the two key barriers to access MHT, namely high costs and supply issues.

4.161 While acknowledging the issues of global supply chain disruptions and the removal of certain products from the Australian market, it is deeply concerning that so many Australian women are unable to access the products they rely upon for their quality of life.

4.162 It is also of great concern that some of the most effective and safe products are not available on the Pharmaceutical Benefits Scheme (PBS), forcing women to choose between cost and efficacy.

4.163 The committee is of the view that the Australian Government must undertake work to ensure a more stable supply of these products. It must investigate options for the inclusion of more of the safest body identical hormone treatments onto the PBS.

4.164 It was also of great concern to the committee to learn of the disproportionate impacts and significantly increased risks for women who experience early menopause, through diagnosis of POI or through surgical menopause or side effects of cancer treatment. Given the extended period of time that these women live without natural hormone production, MHT is particularly important for them as a preventative health measure. The committee is of the view that the Australian Government should give consideration to mechanisms that may enable these women to have greater access to these treatments.

4.165 The committee acknowledges the wide variety of complementary and alternative medicines and treatments that are available in the Australian market. While some of these products are useful to support women to more effectively manage their symptoms, it is concerning that there are still too many products being marketed that may not be effective or may cause harm. The committee encourages the TGA to continue to monitor this situation in Australia and take action as appropriate. Further, to address the issue, the committee encourages the Department of Health and Aged Care to consider reviewing the labelling of TGA approved medicines. This would ensure consumers can clearly identify products that are approved by the TGA and reduce the risk of them being misled in buying food products, which have no proven efficacy in the management of menopause symptoms.

Recommendation 16

4.166 The committee recommends that the Department of Health and Aged Care, including the Therapeutic Goods Administration, consider action to address the shortages of menopause hormonal therapy (MHT) in the Australian market and consider options to secure sufficient supply, including a review of the supply chains and pricing trends of MHT, with a view to enabling universal affordable access to treatment and care.

Recommendation 17

4.167 The committee recommends the Therapeutic Goods Administration continue to monitor the advertising alternative medicines and treatments in Australia and take action as appropriate. The committee further recommends the Department of Health and Aged Care consider reviewing the labelling of TGA approved medicines.

Recommendation 18

4.168 The committee recommends that the Australian Government examine options to implement a means of ensuring that MHT items are affordable and accessible, including consideration of domestic manufacturing and alternate means of subsidising costs to the consumer. Such examination should include, but not be limited to, considering ways to encourage pharmaceutical sponsors to list a broader range of MHT items, such as body identical hormone therapy products, on the Pharmaceutical Benefits Scheme to ensure appropriate access and lowered costs for all women who need it.

Recommendation 19

4.169 The committee recommends that the Pharmaceutical Benefits Advisory Committee (PBAC) reforms comparator selection during evaluation of new MHT items to include quality of life health impacts. The committee also recommends that the PBAC regards body identical hormone therapy products in a separate drug class to remove the lowest cost comparator to synthetic therapies.

4.170 The committee notes that there is a need to educate mental health and primary health practitioners about menopause related mental health issues and hormone therapy to enable more options to be discussed with women they are treating. The committee heard that too many health practitioners are still unaware of the hormone - mental health link.

4.171 Further, the committee notes the call for more research to build an evidence base for the use of hormone therapy in mental ill health. The committee encourages the AMS and other peak bodies ensure their guidance and factsheets around the use of MHT reflect new findings, especially in the area of menopause and mental health symptoms.

Recommendation 20

4.172 The committee recommends the Australasian Menopause Society regularly review and update their guidance for medical practitioners around best practices in the treatment and management of mental health symptoms.

Multidisciplinary care clinics

4.173 The committee agrees with submitters that there is great benefit associated with menopause multidisciplinary care clinics that offer a range of specialists, as well as allied health professionals, in one location through the public health system. The committee acknowledges that the majority of menopause clinics are currently operating in the private health sector.

4.174 The committee is of the view that there is an opportunity to engage in effective primary care through the provision of public health menopause care clinics in each state and territory across Australia. The incentivisation of professional development courses and opportunities for specialisation in women's health and menopause and perimenopause would likely greatly assist with the staffing of these clinics.

Recommendation 21

4.175 The committee recommends that the Australian Government work with state and territory governments to implement or leverage existing women's health facilities with multidisciplinary care, including in the public health system, to better support women during the menopause transition across Australia.

Chapter 5
Policy directions and governmental approaches

5.1 This chapter discusses Australia's current policy directions and approaches to addressing issues related to menopause and perimenopause across various facets of society.

5.2 Firstly, this chapter examines the current policy initiatives at the federal level, led by the Department of Health and Aged Care (the Department). These include the National Women's Health Strategy 2020–2030 (the Strategy) and the work of the National Women's Health Advisory Council (the Council).

5.3 This chapter then proceeds to review the approaches taken by state governments, looking specifically at New South Wales, Victoria and Tasmania.

5.4 Lastly, this chapter illuminates approaches adopted by different international jurisdictions, drawing on examples from the United Kingdom and Spain, amongst other countries.

5.5 It then concludes with the committee's view and recommendations for the government to promote better outcomes for women experiencing perimenopause and menopause.

Australian Government initiatives

National Women's Health Strategy 2020–2030

5.6 The National Women's Health Strategy 2020–2030 (the Strategy) outlines Australia's approach to improving health outcomes for all women and girls in Australia.[1] The Strategy aims to inform targeted and coordinated action at federal and state levels.[2] The guiding purpose of the Strategy is to:

> Improve the health and wellbeing of all women and girls in Australia, [by] providing appropriate, equitable and accessible prevention and care, especially for those at greatest risk of poor health.[3]

5.7 The Strategy examines key health risks and issues for women and girls in Australia and outlines a number of factors that affect health outcomes. These are:

- biomedical factors – relating to the condition, state or function of the body, such as medically significant obesity;

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1 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6.

2 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6.

3 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 7.

- behavioural factors – relating to physical activity and healthy eating habits, including other risk factors such as smoking, tobacco, alcohol and/or illicit drug misuse;
- social factors – non-modifiable risk factors which can be genetic, such as hereditary breast cancers relating to an inherited genetic mutation;
- economic factors; and
- environmental factors – natural and built.[4]

5.8 The Strategy explores how the above factors can influence health inequities, such as access to services, health literacy, stigma and gender inequality.[5] The Department also emphasises that the Strategy recognises the unique needs of different demographics and identifies targeted interventions to improve health outcomes for priority populations.[6]

5.9 The Department uses a 'life course approach' in the Strategy to recognise the different health needs, risks and influences experienced by women at different stages in their lives, with a particular focus on the importance of investing in awareness and education, health interventions, service delivery and research to maximise physical, mental and social health.[7]

5.10 The Strategy contains specific principles and objectives to provide a framework for both the development and subsequent implementation of priorities and actions outlined in the Strategy. There are five distinct key priorities referenced in the Strategy:

- maternal, sexual and reproductive health – increase access to information, diagnosis, treatment and services for sexual and reproductive health; enhance and support health promotion and service delivery for preconception, perinatal and maternal health;
- healthy ageing – adopt a life course approach to healthy ageing; address key risk factors that reduce quality of life and better manage the varied needs of women as they age;
- chronic conditions and preventive health – increase awareness and prevention of chronic conditions, symptoms and risk factors; invest in targeted prevention, early detection and intervention; tailor health services for women and girls;
- mental health – enhance gender-specific mental health awareness, education and prevention; focus on early-intervention; invest in service delivery and multi-faceted care; and

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4 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6 and 10.

5 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6.

6 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6.

7 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6.

- health impacts of violence against women and girls – raise awareness about and address the health and related impacts of violence against women and girls; co-design and deliver safe and accessible services.[8]

Menopause in the Strategy

5.11 Menopause is mentioned in priority areas one, two and four of the Strategy. Within priority area one, 'maternal, sexual and reproductive health', there are a total of 16 actions, and two of these reference menopause. These are:

- raise community and health care provider awareness to improve visibility and diagnosis of under-recognised sexual and reproductive health conditions and reproductive risk factors; and
- strengthen access pathways to sexual and reproductive health services across the country, particularly in rural and remote areas'.[9]

5.12 Within priority area two, 'healthy ageing', there are a total of 14 actions, and one references menopause:

- support women and their health care providers to manage the effects of menopause.[10]

5.13 Within priority area four, 'mental health', there are a total of 19 actions; however, whilst the Department acknowledges that menopause is a critical life point, there is no explicit mention of menopause in these actions.[11]

Perspectives on the inclusion of menopause in the Strategy

5.14 In its submission, Besins Healthcare argued the importance of implementing a 'condition-specific national policy for menopause as it addresses the unique healthcare needs and challenges faced by women during this life stage'.[12] Besins Healthcare recommended the implementation of a national policy for menopause, given that it will assist 'awareness, research, and education and enhance the overall wellbeing of women navigating this life-stage and promoting gender-sensitive healthcare practices'.[13]

5.15 However, Besins Healthcare stated that is has been 'four years into the Strategy and there has been little tangible action taken to improving menopausal awareness and care', adding that:

> Women are accessing well-respected, non-government websites such as the Australasian Menopause Society, Jean Hailes for Women's Health and

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8 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 6.

9 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 24.

10 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 28.

11 Department of Health and Aged Care, *National Women's Health Strategy 2020–2030*, p. 35.

12 Besins Healthcare, *Submission 146*, [p. 5].

13 Besins Healthcare, *Submission 146*, [p. 5].

> Wellfemme for information about menopause but many are getting their menopause information and advice from social media, which is obviously uncontrolled and not always accurate.[14]

5.16 Some submitters argued that whilst the Strategy seeks to prioritise investment into research, there is not a clear connection between how the funding will support the implementation of the Strategy. For instance, Research Australia asserted that:

> [Although] the Strategy emphasised the importance of ongoing research, highlighting some past funding initiatives that aligned with parts of the Strategy. … it lacked any means of directing research funding to support the Strategy's goals and implementation.[15]

5.17 They expanded on this statement by saying that the 'research required to support these strategies has not progressed as intended, hampering Australia's ability to respond effectively to these critical health issues'.[16]

5.18 Some submitters suggested that the Strategy does not reach far enough so as to examine the interaction between menopause and voluntary or involuntary childlessness.[17] In its submission, The Empty Cradle contended that women who are involuntarily childless have unique and specific physical health needs at menopause and perimenopause.[18] A submitter with lived experience added that:

> The National Women's Health Strategy 2020–2030 makes no mention of childlessness. There is no question that we are an invisible demographic. … Hence the health outcomes and impact of menopause in this demographic cannot be understood without acknowledgement and research.[19]

National Women's Health Advisory Council

5.19 Established in February 2023, the role of the Council is to 'provide advice to the government on priority health issues for women and girls in Australia… including recommendations on the implementation of the Strategy'.[20] The

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14 Besins Healthcare, *Submission 146*, [p. 5].

15 Research Australia, *Submission 98*, p. 10.

16 Research Australia, *Submission 98*, p. 10.

17 See, for example, The Empty Cradle, *Submission 121*, [pp. 6–7]; Name Withheld, *Submission 130*, [p. 5]; Name Withheld, *Submission 231*, [p. 1]; Name Withheld, *Submission 235*, [p. 1].

18 The Empty Cradle, *Submission 121*, [p. 6].

19 Name Withheld, *Submission 130*, [p. 7].

20 Department of Health and Aged Care, *National Women's Health Advisory Council*, www.health.gov.au/committees-and-groups/national-womens-health-advisory-council#communiques (accessed 14 August 2024).

Council aims to 'provide a better, more targeted healthcare system for Australian women and girls, ensuring it is culturally safe and appropriate'.[21]

5.20 The Council has also established sub-committees to investigate gender bias within the healthcare system across five focus areas:

- access;
- care and outcomes;
- empowerment;
- research; and
- safety.[22]

5.21 The Council stated that there is growing evidence that shows systemic issues within healthcare delivery and medical research, resulting in women experiencing poorer health outcomes.[23] The Council mentioned that women 'disproportionately experience delayed diagnosis, overprescribing, and a failure to properly investigate symptoms'.[24]

5.22 However, the publicly available communiques of the Council do not currently have explicit references to dedicated work on issues related to menopause.[25]

5.23 Research Australia discussed the importance of having a strategic approach to menopause research, with its primary objective of improving the evidence to guide the 'prevention, diagnosis and effective treatment of the symptoms of menopause and perimenopause and provide appropriate support'.[26] As such, their submission advised that:

> The Minister should charge the Council with identifying research priorities required to achieve this objective, as part of its remit to provide advice on priority issues and progress the implementation of the Strategy.[27]

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[21] Department of Health and Aged Care, *National Women's Health Advisory Council*, www.health.gov.au/womens-health-advisory-council (accessed 14 August 2024).

[22] Department of Health and Aged Care, *National Women's Health Advisory Council*, www.health.gov.au/womens-health-advisory-council (accessed 14 August 2024).

[23] Department of Health and Aged Care, *National Women's Health Advisory Council*, www.health.gov.au/womens-health-advisory-council (accessed 14 August 2024).

[24] Department of Health and Aged Care, *National Women's Health Advisory Council*, www.health.gov.au/womens-health-advisory-council (accessed 14 August 2024).

[25] Department of Health and Aged Care, *National Women's Health Advisory Council – Communiques*, www.health.gov.au/resources/collections/national-womens-health-advisory-council-communiques?language=en (accessed 25 August 2024).

[26] Maurice Blackburn Lawyers, *Submission 20*, p. 4.

[27] Research Australia, *Submission 3*, p. 3.

National strategies on preventing and managing chronic conditions

5.24 In its submission, the Department stated that the government's national strategies focus on the prevention and management of chronic conditions, which evidence shows can be worsened by menopause.[28] These national strategies are embodied in the following plans:

- The National Strategic Action Plan for Heart Disease and Stoke;[29] and
- The National Strategic Action Plan for Osteoporosis.[30]

Health care services

5.25 The Department noted that the government supports access to general and specific healthcare and services which may be suitable for sexual and reproductive health concerns, including menopause.[31] These include:

- reforms to the Medicare Benefits Schedule (MBS) rebates, such as time-tiered items for complex conditions and referred services to consultant physicians specialising in sexual health medicine;[32]
- providing longer general practitioner (GP) consultations (up to 60 minutes) to respond to complex conditions or reproductive health matters;[33]
- expanding funding for Aboriginal Community Controlled Health Organisations to deliver culturally appropriate comprehensive primary care health services for First Nations people;[34]
- expanding access to mental health care services, which can be accessed by women experiencing menopause and perimenopause symptoms;[35]
- expanding access to translation and interpreting services;[36]
- developing the Clinical Care Standard for Heavy Menstrual Bleeding;[37] and
- expanding the remit of GP referrals to various allied health professionals including psychologists, physiotherapists and dieticians to support the management and treatment of menopausal symptoms.[38]

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28 Department of Health and Aged Care, *Submission 15*, p. 6.

29 Department of Health and Aged Care, *Submission 15*, p. 6.

30 Department of Health and Aged Care, *Submission 15*, p. 7.

31 Department of Health and Aged Care, *Submission 15*, p. 7.

32 Department of Health and Aged Care, *Submission 15*, p. 7.

33 Department of Health and Aged Care, *Submission 15*, p. 7.

34 Department of Health and Aged Care, *Submission 15*, p. 8.

35 Department of Health and Aged Care, *Submission 15*, p. 8.

36 Department of Health and Aged Care, *Submission 15*, p. 9.

37 Department of Health and Aged Care, *Submission 15*, p. 10.

38 Department of Health and Aged Care, *Submission 15*, p. 8.

Health information

5.26 The Department made clear that the government supports the provision of information and advice on sexual and reproductive health, including menopause and perimenopause, through the following programs:

- Healthdirect – a consumer health information website, app and telephone line. Healthdirect provides a range of free, trusted online resources related to menopause, including information on perimenopause, early menopause, HRT and post-menopause;[39]
- $23.5 million (GST exclusive) in funding provided to support Jean Hailes for Women's Health implement the Strategy;[40] and
- Health in My Language – providing $13.3 million in funding over three years for the delivery of the national bicultural health educator program, which provides people from CALD communities, including migrants and refugees, with opportunities to converse with trained professionals about COVID-19 and other health and wellbeing matters, such as menopause.[41]

My Health Record

5.27 The inquiry heard about the use of the My Health Record platform as a mechanism for data collection related to menopause and perimenopause, including prescribing practices related to menopause hormonal therapy.[42]

5.28 In a response to a question on notice, the Department provided the following update on the utility of My Health Record for these purposes:

> My Health Record has medication information, which can be used by individuals and their healthcare providers for healthcare services. Health information held in My Health Record is not currently available for research or public health purposes, including the use of individuals' prescription and dispense records to investigate prescribing of Hormone Replacement Therapy. My Health Record data will only be made available for these purposes when the required legislative, governance, security, privacy and technical arrangements are in place.

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[39] Department of Health and Aged Care, *Submission 15,* p. 14.

[40] Department of Health and Aged Care, *Submission 15,* pp. 14–15.

[41] Department of Health and Aged Care, *Submission 15,* p. 15.

[42] See, for example, Professor Gita Mishra, Private capacity, *Committee Hansard,* 29 July 2024, pp. 58–59; Professor Steve Robson, President, Australian Medical Association, *Committee Hansard,* 30 July 2024, pp. 25–26; Ms Alison Weatherstone, Chief Midwife, Australian College of Midwives, *Committee Hansard,* 30 July 2024, p. 50; Ms Francine Eades, Area Director, Aboriginal Health, East Metropolitan Health Service, *Committee Hansard,* 6 August 2024, p. 5; Dr Michelle Cotellessa, Private capacity, *Committee Hansard,* 6 August 2024, p. 29; Dr Sunita Chelvanayagam, Private capacity, *Committee Hansard,* 6 August 2024, p. 29; Dr Purity Carr, Founder, Purity Health Menopause and Wellbeing Centre, *Committee Hansard,* 6 August 2024, p. 41; Ms Louise Riley, Assistant Secretary, Medicare Benefits Schedule Policy and Reviews Branch, Department of Health and Aged Care, *Committee Hansard,* 13 August 2024, pp. 28–30.

> The Department of Health and Aged Care is currently working to develop a roadmap to guide a multi-year, staged implementation of research and public health use of My Health Record data.[43]

Health and medical research

5.29 The Department outlined that the government provides support for health and medical research through the Medical Research Future Fund (MRFF) and the National Health and Medical Research Council (NHMRC).[44] The MRFF funds priority driven research focusing on research translation whereas the NHMRC focuses on investigator-led research.[45] The Department stated that while no funding has been allocated specifically for research addressing menopause, from its inception in 2015 to 31 October 2023, the MRFF has invested $205.71 million (GST exclusive) in 101 grants with a focus on women's health research.[46]

5.30 Between 2020 and 2023, the NHMRC has expended:

> $23.3 million (GST exclusive) towards 41 active research projects relevant to menopause and perimenopause (of the $23.3 million, $620 946 was expended for research relating to perimenopause). Issues investigated have included a randomised controlled trial of acupuncture for post-menopausal hot flushes, thermal instability at menopause, bone loss during and after menopause, vasoactive nutrients to promote healthy ageing in postmenopausal women, and evidence and new tools to improve health after surgical menopause.[47]

5.31 The Department highlighted that the government's research into menopause and perimenopause supports a key priority of the Strategy: 'a strong and emerging evidence base'.[48] This key priority includes the objective of aligning Australian health research investment with the priority health issues affecting Australian women and girls.[49]

Approaches taken across different jurisdictions

5.32 The committee received some evidence on the state jurisdictional/level approaches. Noting that other jurisdictions may also have work underway in this domain; however, it was not brought to the committee's attention.

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43 Department of Health and Aged Care, answer to question on notice IQ24-000106, 13 August 2024 (received 30 August 2024).

44 Department of Health and Aged Care, *Submission 15*, p. 15.

45 Department of Health and Aged Care, *Submission 15*, p. 15.

46 Department of Health and Aged Care, *Submission 15*, p. 15.

47 Department of Health and Aged Care, *Submission 15*, p. 15.

48 Department of Health and Aged Care, *Submission 15*, p. 15.

49 Department of Health and Aged Care, *Submission 15*, p. 15.

New South Wales

Menopause Services Initiative

5.33 The New South Wales (NSW) Government has invested $37.35 million over four years between 2023–24 to 2026–27 for the delivery of a network of menopause services, which includes four menopause hubs and 12 referral sites across NSW.[50] The NSW Government stated that these new services will be an 'escalation pathway to specialist care for women experiencing severe or complex symptoms of menopause':

> This will complement existing services and does not replace the need for existing women's health services and the role of the general practitioner. Investment in menopause also supports a clinical group to lead the implementation of these new services and a state-wide education and awareness campaign.[51]

Menopause hubs and referral sites

5.34 The NSW Government underscored that its NSW Menopause Services will build on NSW's successful model of bone health services (called Osteoporotic Refracture Prevention services) to provide women with access to a broader range of support services, including access to allied health professionals for urinary continence management, exercise advice, nutrition and weight management advice.[52]

Menopause services model of care

5.35 The NSW Government spoke of its model of care to enable improved access to care for severe and/or complex menopause symptoms and management.[53] The new services will provide expert advice and assistance for women about:

- managing severe and complex symptoms of menopause;
- bone health for the management of osteoporosis and to prevent fractures;
- lowering the risk of cardiovascular disease and stroke;
- supporting mental health and wellbeing;
- management of weight and lifestyle; and
- managing urinary problems which may cause problems for women following menopause.[54]

5.36 The NSW Government advised it has established a number of bodies to oversee the implementation of the model of care. These include:

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50 NSW Government, *Submission 53*, p. 4.

51 NSW Government, *Submission 53*, p. 4.

52 NSW Government, *Submission 53*, p. 4.

53 NSW Government, *Submission 53*, p. 5.

54 NSW Government, *Submission 53*, p. 5.

- A clinician reference group with 77 members which provides broad clinical subject matter expertise to inform the taskforce;
- A consumer reference group of seven members which provides the consumer lived experience to inform the model of care development; and
- An Aboriginal Menopause Working Group which was established in 2023, with 27 members to understand the experience for Aboriginal communities and how the menopause initiative could improve menopause care within Aboriginal Health.[55]

MenoECHO

5.37 Launched in September 2023, MenoECHO is an online education tool facilitated by the Menopause hubs to provide case-based learning for GPs, other medical specialists, allied health, and nursing professionals.[56] The NSW Government stated that more than 500 clinicians have registered for the sessions to date and bi-monthly engagements will continue throughout 2024.[57] Moreover, the Agency for Clinical Innovation has also delivered six clinical engagement and capability development sessions in the last year from December 2023, which discussed the following topics:

- common questions;
- the consumer and primary care perspectives;
- the multidisciplinary team;
- genitourinary syndrome;
- continence; and
- the workplace.[58]

Menopause Awareness Campaign

5.38 In its submission, NSW Government highlighted that Women NSW is responsible for the development and delivery of the NSW Government's Menopause Awareness Campaign.[59] In October 2022, Women NSW commissioned focus group research to understand perceptions and awareness of perimenopause and menopause among women from diverse backgrounds and their partners.[60]

5.39 On 18 October 2022, on World Menopause Day, the NSW Government launched the Menopause Awareness Campaign to 'destigmatise experiences of perimenopause and menopause':

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55 NSW Government, *Submission 53*, p. 5.

56 NSW Government, *Submission 53*, p. 5.

57 NSW Government, *Submission 53*, p. 5.

58 NSW Government, *Submission 53*, p. 5.

59 NSW Government, *Submission 53*, p. 6.

60 NSW Government, *Submission 53*, p. 6.

> The Campaign was designed to raise awareness and encourage conversations about perimenopause and menopause, focused on three key stakeholders: communities, General Practitioners, and employers. The menopause awareness campaign is part of the NSW Government's continuing commitment to supporting women's health and wellbeing.[61]

Community campaign

5.40 To support the launch of this campaign, the NSW Government also developed tailored resources and campaigns, including:

- a Menopause Toolkit with free, reliable information which seeks to increase understanding of the symptoms of perimenopause and menopause;
- a professionally accredited GP case study-based webinar; and
- an employer campaign to assist employees and managers navigate menopause conversations in the workplace.[62]

Victoria

Women's Sexual and Reproductive Health Plan 2022–2030

5.41 According to the Department of Health Victoria, the Victorian Women's Sexual and Reproductive Health Plan 2022–2030 was developed to strengthen the sexual and reproductive health of Victorian women, girls and gender diverse people:

> The Victorian Government committed $153 million to improve health outcomes for girls and women as part of 2023/24 State Budget. We have established the first Victorian Women's Health Advisory Council that is led by women, for women, to guide reforms that will support an integrated and equitable Victorian health system.[63]

Response to the physical impacts of menopause and perimenopause

5.42 In its submission, the Department of Health Victoria pointed out that its Women's Sexual and Reproductive Health Plan 2022–2030 includes initiatives to promote positive sexual health and related screening and testing services.[64]

5.43 Cardiovascular health and cancer screening for perimenopausal and menopausal women was also identified as a health priority for the Department of Health Victoria, via the Victorian Heart Hospital.[65]

5.44 The Royal Women's Hospital and Monash Health-run menopause clinics also provide information, services and referrals for women, including those

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61 NSW Government, *Submission 53*, p. 6.

62 NSW Government, *Submission 53*, pp. 6–7.

63 Department of Health Victoria, *Submission 14,* p. 3.

64 Department of Health Victoria, *Submission 14,* p. 5.

65 Department of Health Victoria, *Submission 14,* p. 5.

experiencing menopausal symptoms after cancer.[66] Further, the Department of Health Victoria fund the National Ageing Research Institute to continue to support older women with improved health and wellbeing outcomes.[67]

Response to cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause

5.45 The Department of Health Victoria claimed that it has been a leader in destigmatising menopause and identified it as a priority in the first Victorian Women's Sexual and Reproductive Health Plan released in 2017 and again in 2022:

> The 2022–30 plan has a priority action to reduce stigma associated with perimenopause, premature menopause, and post-menopause. Our equal state, Victoria's gender equality strategy released in 2023, has a strong focus on the need for cultural change in progressing gender equality.[68]

Response to level of awareness amongst medical professionals and patients

5.46 The Department of Health Victoria has raised awareness of menopause through various channels, such as:

- Via the Royal Australian and New Zealand College of Obstetrics and Gynaecology's 'A practitioner's toolkit for managing the menopause';
- The Better Health Channel, via the Jean Hailes for Women's Health website provides information on menopause for consumers and clinicians; and
- Sustainability Victoria's Menstruation and Menopause Policy which provides support and relief to staff members who are experiencing symptoms of menstruation or menopause, including additional paid leave provisions and flexible work measures.[69]

Tasmania

5.47 The Tasmanian Government recognised that most menopause-related care is delivered in the community by GPs or by special-interest primary care services.[70]

5.48 The Tasmanian Government acknowledged that access to specialists can be variable depending on geographical location, in which there are known workforce challenges for these specialities within the state.[71] In addressing these challenges, the Tasmanian Government is, under its Equal means Equal

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66 Department of Health Victoria, *Submission 14*, p. 5.

67 Department of Health Victoria, *Submission 14*, p. 5.

68 Department of Health Victoria, *Submission 14*, p. 8.

69 Department of Health Victoria, *Submission 14*, pp. 4–9.

70 Tasmanian Government, *Submission 7*, [p. 2].

71 Tasmanian Government, *Submission 7*, [p. 2].

Tasmanian Women's Health Strategy, developing a Gender Impact Assessment process to apply a gender lens to the design and implementation of budgets, policies, programs and services:

> It is our vision that through this toolkit the needs of all women at every stage of life will be considered throughout the policy and budget cycle. The findings of the Inquiry will be valuable for enhancing the utility of the toolkit and providing guidance to agencies about the diverse impacts of menopause and perimenopause.[72]

International approaches

5.49 After a discussion of the various approaches to menopause and perimenopause care adopted by the federal government and states and territories, it is now necessary to outline international models that contrast Australia's policy landscape.

United Kingdom

5.50 Some submissions have referred to the United Kingdom (UK) Government's 2022 Parliamentary Inquiry into Menopause in the Workplace, conducted by the Women and Equalities Committee, as a model of best practice for Australia to look to.[73]

5.51 The Menopause in the Workplace final report contained 12 recommendations aimed at facilitating change and increasing support for women experiencing menopause across various facets of society: government policy, employer practices and wider societal and financial change.[74] In 2022, the UK Government published a response to the recommendations of the inquiry and accepted in principle, or in part, most of the recommendations that were made.[75]

Menopause Ambassador

5.52 One of the cornerstone recommendations that was recently implemented was the appointment of a Menopause Ambassador in 2023 (also referred to as the Menopause Employment Champion) to work on behalf of government to:

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72 Tasmanian Government, *Submission 7*, [p. 3].

73 See, for example, The Royal Women's Hospital Melbourne, *Submission 33*, pp. 10–11; University of Melbourne, *Submission 105*, pp. 15–16; The Office for Women, *Submission 135*, p. 8–9; Professor Martha Hickey, *Submission 138*, p. 14; The Australian Services Union, *Submission 173*, [p. 1].

74 House of Commons Women and Equalities Committee, *Menopause and the workplace: First Report of Session 2022–23;* 28 July 2022, https://committees.parliament.uk/work/1416/menopause-and-the-workplace/publications/ (accessed 26 August 2024).

75 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, pp. 2–19.

> … work with stakeholders from business (including small to medium enterprises), unions, and advisory groups to encourage and disseminate awareness, good practice and guidance to employers.[76]

5.53 According to the UK Government, the purpose of appointing a Menopause Ambassador is to drive forward work with employers and menopause workplace issues and to spearhead the proposed collaborative employer-led campaign.[77] The UK Government elaborated further on the role of the Menopause Ambassador:

> Key to the role will be to give a voice to menopausal women, promoting their economic contribution, and working with employers to keep people experiencing menopause symptoms in work and progressing.[78]

5.54 The Menopause Ambassador is also required to provide a six-monthly report on progress made by business, including examples of good practice.[79] In tandem with the Menopause Taskforce, measures have been put in place to ensure that employers facilitate training, processes and information so that colleagues have a better understanding of menopause and to also ensure that any policy or guidance documents be visible and well publicised.[80]

Prescription payment certification

5.55 Cost was identified as one of the main barriers to accessing hormone replacement therapy (HRT). The UK Department of Health and Social Care implemented the prescription payment certificate (PPC) amid calls from women to widen HRT's access.[81] As such, women need not pay for monthly prescriptions, but can now access their HRT via a one-off charge (equivalent of two prescriptions).[82] There are no limitations on the frequency of use of the PPC, nor the amount of HRT items it can be used for during the 12 months it is valid.[83] Since the certificate's implementation, Newson Health Group outlined that:

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76 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 12.

77 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 12.

78 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 12.

79 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 12.

80 Professor Martha Hickey, *Submission 138*, p. 14.

81 Newson Health Group, *Submission 19*, p. 14.

82 Newson Health Group, *Submission 19*, p. 14.

83 Newson Health Group, *Submission 19*, p. 14.

> Half a million women have signed up to the scheme since it was launched, with an estimated £11 million (AUD $21 million) saved by women utilising the PPC between April 2023 and January 2024.[84]

5.56 In its submission, Besins Healthcare pointed out that the UK Government noted the importance of having a suitable methodology to quantify the cost of menopause to individuals, businesses, health services and wider society:

> In three out of four countries within the UK (Scotland, Wales and Northern Ireland), prescribed menopause treatments are available to all citizens free of charge. In England, following a high-profile campaign, the Government introduced a new hormone replacement therapy prescription prepayment certificate on 1 April 2023. This reduces prescription costs for hormone replacement therapy medication in England to a total of £19.30 per year effectively reducing the cost for many women by up to 91 per cent.[85]

5.57 Dr Lucy Caratti echoed Besins Healthcare's remarks about the accessibility of HRT via the PPC in the UK, which gives patients a year's worth of HRT for under 20 pounds.[86]

UK's Equality Act 2010

5.58 The UK's *Equality Act 2010* (Equality Act) provides:

> Protection to individuals from prohibited conduct (including direct discrimination or failure to make reasonable adjustments for disabled persons), because of a protected characteristic (such as sex, disability or age) and in certain prescribed contexts (such as work, education and premises).[87]

5.59 The Equality Act does not specifically include menopause as a protected characteristic; however, employees can bring a claim of menopause-related workplace discrimination to the UK Employment Tribunal on the basis of sex, age and disability.[88]

5.60 Recommendation 12 of the Women and Equalities Committee's inquiry report recommended that:

> The Government should launch a consultation on how to amend the Equality Act to introduce a new protected characteristic of menopause, including a duty to provide reasonable adjustments for menopausal employees. This consultation should commence within six months of publication of this report. The Government's consultation response should

[84] Newson Health Group, *Submission 19,* p. 14.

[85] Besins Healthcare, *Submission 146,* [p. 15].

[86] Dr Lucy Caratti, Private Capacity, *Committee Hansard,* 6 August 2024, p. 14.

[87] Anti-Discrimination NSW, *Submission 28*, p. 5.

[88] Anti-Discrimination NSW, *Submission 28*, p. 5.

> include a review of whether the newly commenced s14 (above) has mitigated concerns about the current law.[89]

5.61 The UK Government did not accept this recommendation to amend the Equality Act on the basis that the Act itself already provides protections against unfair or unjust treatment of employees going through menopause via the umbrella of sex, age and disability.[90] The then UK Government provided an alternative approach, in that:

> A new, separate protected characteristic might include an expansion of the reasonable adjustments' duty in section 20 and schedule 21 through an expansion of the definition of disability; or expansion of age discrimination provisions as they apply to employment.[91]

5.62 Further, the UK Government added that:

> Given the importance of this legislation it is important to ensure that the policy is considered in the round to avoid unintended consequences which may inadvertently create new forms of discrimination, for example, discrimination risks towards men suffering from long-term medical conditions, or eroding existing protections. The more substantial the necessary changes to the 2010 Act are, the more likely it is that they would require a full-scale review of the Act. This could only be made as part of a wider reform of the Act. This is a major undertaking which would necessarily be some years away.[92]

5.63 In the UK, there are several examples of claims that have been made for menopause-related discrimination under the disability characteristic. For instance, in its submission, Anti-Discrimination NSW provided a detailed case study of *Lynskey v Direct Line Insurance Service Ltd:* 1802204/2022 and 1802386/2022:

Box 5.1 UK Case Study - Lynskey v Direct Line Insurance Services Ltd: 1802204/2022 and 1802386/2022

In Lynskey v Direct Line Insurance Services Ltd: 1802204/2022 and 1802386/2022, Ms Lynskey began working as a motor sales consultant in 2016 and was considered a good employee. In 2019 she began to experience menopausal symptoms including mood swings, poor concentration, and memory loss which profoundly affected her ability to retain information and her emotional stability. She was diagnosed with a hormone imbalance

89 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 18.

90 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 18.

91 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 18.

92 House of Commons Women and Equalities Committee, *Menopause and the workplace: Government Response to the Committee's First Report of Session 2022–2023*, 18 January 2023, p. 18.

> and depression in March 2020. In May 2022, Ms Lynskey resigned from her job due to the treatment she received and brought claims in the Employment Tribunal under the Equality Act which included disability, age and sex discrimination.[93]
>
> The Tribunal dismissed her complaints based on sex and age direction discrimination, however, it found that her menopausal symptoms amounted to a disability under the Equality Act and that she was treated unfavourably, based on her disability, on three occasions by her employer. Her claim was upheld and she was awarded £64 645 in compensation.[94]

5.64 In the Australian context, Maurice Blackburn Lawyers argued that the above recommendation would not be appropriate, given that it came as a response to:

> High levels of unfair dismissal cases where women of menopause age were dismissed from their employment, and where they had cited symptoms as affecting their employment. We are unaware of a similar concentration of cases in Australia.[95]

Menstrual and menopause leave

5.65 Internationally, there are several different countries that currently adopt a form of menstrual or menopause leave. For instance, Spain was the first European country to introduce laws permitting three to five days of paid menstrual leave for women with secondary disabling or incapacitating menstruations (referring to medical conditions that cause painful periods).[96]

5.66 For employees to access menstrual leave, a doctor's certificate is required and the costs to employers are met via Spain's public social security system.[97] Spain's laws were created to ensure that employees do not have to rely on personal or sick leave entitlements when unable to work.[98]

5.67 Menstrual leave entitlements, in various forms, are also available in the following countries:

- Japan;
- Indonesia;
- South Korea;

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93 Anti-Discrimination NSW, *Submission 28,* pp. 5–6.

94 Anti-Discrimination NSW, *Submission 28,* pp. 5–6.

95 Maurice Blackburn Lawyers, *Submission 20,* pp. 4–5.

96 Maurice Blackburn Lawyers, *Submission 20,* p. 4; National Tertiary Education Union, *Submission 153,* p. 5.

97 Maurice Blackburn Lawyers, *Submission 20,* p. 4.

98 Maurice Blackburn Lawyers, *Submission 20,* p. 4.

- Zambia;
- China – across five provinces; and
- Taiwan.[99]

Committee view

5.68 The evidence received throughout this inquiry has demonstrated that there is a glaring need for a range of actions to ensure that all women can continue to lead healthy and productive lives during the menopause transition. This includes raising community and health care awareness, improving access to appropriate health services and preventive care. To achieve this, the Australian Government needs to take a leadership role and ensure menopause care is recognised and prioritised.

National coordination

5.69 The committee notes that menopause and perimenopause were mentioned in three of the total five priorities of Australia's National Women's Health Strategy 2020–2030. However, of the three priorities, there were a total of 49 definitive actions, with menopause only mentioned in three of these actions. The committee is of the view that further actions are required. Further, the committee noted the evidence that there have only been minimal tangible actions taken to improve menopausal awareness and care, four years into the Strategy's implementation.

5.70 The committee notes that the Department of Health and Aged Care's submission stated that, since its inception in 2015 to 31 October 2023, the Medical Research Future Fund has invested $205.71 million (GST exclusive) in 101 grants with a focus on women's health research. However, it is disappointing that, to date, nil funding has been allocated specifically for research into menopause.

5.71 The committee recognises that the National Women's Health Advisory Council has an important role to play to ensure that the implementation of the National Women's Health Strategy 2020–2030 produces tangible health outcomes for women experiencing menopause and perimenopause across all spheres of their life.

5.72 The committee acknowledges the different approaches adopted by some of the states and territories to support women during the menopause transition. The committee sees value in building on existing states and territory initiatives. A coordinated national menopause action plan would ensure a cohesive approach to menopause care in Australia. The committee is of the view that a national plan should encompass raising awareness in the community, addressing stigma, improving access to diagnosis and treatment and encouraging initiatives to create menopause friendly workplaces.

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[99] National Tertiary Education Union, *Submission 153*, p. 5.

Recommendation 22

5.73 The committee recommends that organisations tasked with improving menopause care utilise learnings from international best practice.

Recommendation 23

5.74 The committee recommends that the Australian Government investigate improvements to the collection and use of data to assist with research into the experience of menopause and perimenopause, and surveillance of the outcomes of the use of MHT.

Recommendation 24

5.75 The committee recommends that the Australian Government task the National Women's Health Advisory Council to assist state and territory governments to deliver a National Menopause Action Plan which considers best practices in menopause care.

International approaches

5.76 The committee notes that there are a number of international models of menopause care, including initiatives in the workplace, that Australia can learn from, particularly in the UK. The committee believes some of these policy approaches should be considered within the Australian context.

Recommendation 25

5.77 The committee recommends that the Australian Government task the Department of Health and Aged Care and the Department of Employment and Workplace Relations to monitor international best practices to ensure Australia is at the forefront of menopause and perimenopause care.

Senator Penny Allman-Payne
Chair

Coalition Senators - Additional Comments

Introduction

1.1 The inquiry into issues related to menopause and perimenopause was a comprehensive and largely bi-partisan exercise that sought to hear from Australian women across the country from varied and diverse backgrounds, as well as from a broad range of business groups, medical organisations, clinicians and health practitioners involved in the employment, treatment and care of women at this stage of their life.

1.2 The committee sought to garner greater insights into the present experiences and challenges facing women presenting with perimenopausal and menopausal symptoms, the general awareness - or lack thereof - in the public sphere including general practitioners, their diagnosis and treatment methods, and various workplace arrangements for women.

1.3 The Coalition acknowledges the contribution of the many groups and individuals who appeared around the country at the various hearings as they offered up their uniquely lived experiences, insights and expertise on an experience common to all women, yet largely undiscussed, stigmatised and often misunderstood.

1.4 The inquiry examined and heard from many individuals who had lived experience with menopause and perimenopause. They shared their insights of the wide-ranging symptoms and side-effects they had undergone through their experiences.

1.5 The Coalition emphasises that a balanced approach between government oversight and private sector autonomy must be taken when developing and determining solutions. It should not impose restrictive burdens on businesses, especially small and family businesses. We should ensure that the correct steps are taken to provide greater accommodations, awareness and support for women in vocational settings during this time in their lives.

Menopause leave

1.6 The Coalition has articulated its opposition to the introduction of menopause-related leave, either as a standalone provision or as part of broader reproductive leave. The Coalition contends that decisions regarding such leave should rest with the private sector, which is in a better position to determine what measures are necessary to retain and motivate employees.

1.7 Coalition Senators note that the main advocates for menopause specific leave were trade unions, and that their position was inconsistent with what we have heard from women's groups, community groups and experts on perimenopause and menopause.

1.8 We also note and echo the widespread concern raised by various groups and individuals across the country, via both submissions and in person at the many hearings conducted, that suggested the introduction of menopause leave could inadvertently disadvantage women in the workplace.

1.9 At a public hearing in Perth, Ms Cilla de Lacy summarised her views on menopause specific leave when she stated:

> I'm actually not a supporter of menopause leave, because I don't think that it's purely necessary to use a specific type of leave for menopause. I'm worried about the impact on small businesses. I'm worried about the impact on women not being able to get jobs because 'you're a woman; you're going to need 10 days of menopause leave'. I've managed staff in the state government, and I'm staggered by the amount of personal leave they have. So it's not like leave is an issue from what I've observed.[1]

1.10 Coalition Senators share Ms de Lacy's concerns, as did many other witnesses. Menopause specific leave poses a risk to women's advancement, while not directly addressing the barriers menopause creates in the workplace.

1.11 This sentiment was echoed in the Chief Executive Women submission, when they stated:

> We caution against the implementation of standalone 'menopause leave' that risks further alienating a woman from her place of work.[2]

1.12 Associate Professor Amanda Vincent added to these concerns during a hearing in Brisbane when she said:

> I think that menopause leave per se is an issue. We don't want to make employers averse to employing women.[3]

1.13 Again, this view was further emphasised by Jean Hailes for Women's Health in their submission:

> Any menopause-focused workplace provision to support workforce participation must ensure that it does not inadvertently make it harder for women in the workplace. Again, the 2023 National Women's Health Survey provides unbiased, nationally representative data on some of the potential issues related to asking for and taking *one* potential workplace provision; menopause leave. The survey tested support for and barriers to menopause leave as this is a workplace provision being advocated and adopted by some organisations. Most Australian women were concerned that menopause leave might negatively impact the hiring, treatment, promotion and/or retention of women.[4]

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1 Ms Cilla de Lacy, Private capacity, *Committee Hansard,* 6 August 2024, p. 28.

2 Chief Executive Women, *Submission 136,* p. 11.

3 Associate Professor Amanda Vincent, Early Menopause Lead, Monash Centre for Health Research and Implementation, *Committee Hansard*, 29 July 2024, p. 19.

4 Jean Hailes for Women's Health, *Submission 119,* p. 15.

1.14 There are overwhelming concerns that employers might find it more cost-effective to hire male employees over women who may require menopause leave, potentially leading to unintended consequences that could exacerbate gender disparities in the workforce.

1.15 The pursuit of legislated leave arrangements fails to consider the various and diverse voices of women we heard during the extensive inquiry period who spoke to a range of nuanced and unique experiences of menopause and perimenopause. To attempt to quantify this with a fixed figure undermines the evidence given by the majority of women for understanding, for flexibility, and for the right support and treatment options.

1.16 Notwithstanding specific menopause or reproductive leave arrangements, it is the view of the Coalition that general leave flexibility arrangements ought to be accommodated by individual businesses, rather than being subject to direct government intervention.

Further examination of leave flexibility arrangements

1.17 It is also the opinion of the Coalition that the present committee, which has a remit that covers health and social security, is not best-placed to make detailed examinations or determinations regarding industrial relations law.

1.18 Coalition Senators agree that evidence that has come out from this inquiry points to the need for further analysis and scrutiny around how menopause interacts with Australia's workplace relations.

1.19 In their submission, The Royal Women's Hospital Melbourne, stated:

> Some Australian organisations have introduced menopause policies, mainly focusing on menopause leave, sometimes combined with other sex-specific leave purposes, such as menstrual leave. Unfortunately, there is relatively little evidence showing that these workplace adjustments actually result in improved physical or mental health for employees or improved workplace outcomes such as productivity, absenteeism or presenteeism, and this lack of evidence is proving to be a hindrance to progress.[5]

1.20 Coalition Senators agree that the lack of evidence on the effectiveness of menopause specific policies, alongside the overwhelming evidence identifying risks with such policies, makes it ill advised for this committee to make any recommendations in this space.

1.21 It is our view that while this committee, through the Chair's report, has done excellent work in identifying health specific factors regarding menopause, a reference to the Senate Education and Employment Standing Committee is appropriate in order to properly consider Australia's complex industrial relations law to recommend changes in this space.

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5 The Royal Women's Hospital Melbourne, *Submission 33*, p. 9.

1.22 Any issues that may arise in relation to workplace relations, particularly concerning menopause and perimenopause, should be referred to the Education and Employment Committee. This body would be better positioned to conduct a more detailed examination of potential legislative changes, offering a more nuanced assessment of what might be required to address any emerging challenges.

Recommendation 1

1.23 The Senate Education and Employment Standing Committee to review the adequacy of existing legal frameworks, including Section 65 of the Fair Work Act 2009, to ensure women can access flexible working arrangements during menopause.

Education and awareness

1.24 The report highlights the need for broader awareness campaigns aimed at destigmatising menopause and increasing understanding of perimenopause. Such efforts would empower women in the workplace to speak openly about their experiences, fostering an environment where concerns related to menopause are more readily discussed.

1.25 This approach could be as simple as encouraging women around mid-life to go for a menopause specific check-up much in the same way there exists prostate awareness material for men once they enter mid-life.

1.26 Moreover, by increasing public understanding, these campaigns could lead to greater acceptance and flexibility in workplace arrangements, which would ultimately support women as they navigate this phase of life.

1.27 Additionally, the Coalition agrees that modules on menopause and perimenopause should be integrated into curricula at higher education institutions, particularly in courses where such knowledge is relevant.

1.28 By embedding this education into requisite programs, future professionals would be better prepared to address the medical, social, and occupational aspects of menopause and perimenopause, thus contributing to a more informed and supportive environment for women in all sectors.

1.29 Further research should be undertaken by the Department of Health and Aged Care to deepen the understanding of menopause and perimenopause.

1.30 Such studies would provide valuable data that could inform public health policies, medical treatment guidelines, and workplace accommodations.

1.31 This research is critical for advancing the overall health and wellbeing of women during this period of their life, ensuring that their needs are adequately addressed across various sectors.

1.32 The Coalition also supports a coordinated approach in which the states and territories are supported by the Commonwealth to integrate, as part of various women's health action plans, carve-outs for menopause and perimenopause specific supports and treatments.

Menopausal hormone therapy

1.33 The Coalition stresses the importance of enhancing access to Menopausal Hormone Therapy (MHT) and other treatments. Pathways to these treatments are crucial for women experiencing severe symptoms of perimenopause and menopause, and ensuring equitable access is a key element in effectively managing the more debilitating effects of these conditions.

1.34 Further to this, there remain high barriers of cost for individuals to access MHT as a result of the therapy not being Pharmaceutical Benefits Scheme (PBS) listed.

Conclusion

1.35 The Coalition acknowledges the majority of the findings of the report are sensible and designed to increase public awareness, destigmatise, provide access to treatments and supports, and to encourage further research and foster new pathways for vocation related to menopause and perimenopause.

1.36 We, however, must be clear that we do not support any recommendations calling for changes to legislation, or to compel the insertion of menopause and perimenopause leave in Australian businesses and organisations.

1.37 As previously stated, notwithstanding the abundant evidence received during the inquiry about the general reticence to support the introduction of menopause leave due to the risk of further workplace disadvantage for women, the Coalition is of the belief that the choice and responsibility should fall on the private sector to make determinations as to whether it should include such accommodations as part of an attractive employment package.

1.38 Furthermore, the Coalition believes it is through concerted education campaigns, awareness campaigns and efforts to destigmatise and create understanding around the symptoms and effects associated with menopause and perimenopause, that better flexibility arrangements in the workplace stand the best chance of success.

1.39 The Coalition also recommends any proposed changes to legislation should be brought before the Education and Employment Committee for further, detailed scrutiny around issues specific to workplace reforms.

Senator Wendy Askew **Senator Hollie Hughes** **Senator Maria Kovacic**

Appendix 1
Submission and additional information

1 Royal Australian College of General Practitioners (RACGP)
2 Womens Wellbeing Association
3 The Society of Hospital Pharmacists of Australia
4 Australian and New Zealand College of Anaesthetists
5 Viv Health
6 Australian Psychological Society
7 Tasmanian Government
8 HER Centre Australia
9 Older Women's Network NSW
10 Australian Physiotherapy Association
11 Monash University Women's Health Research Program
12 Australian College of Rural and Remote Medicine
13 SheListens
14 Department of Health Victoria
15 Department of Health and Aged Care
16 MS Australia
17 Sexual Health Victoria
18 Newson Health Group Limited
19 Royal Australian and New Zealand College of Psychiatrists
20 Maurice Blackburn Lawyers
21 Australian Association of Psychologists
22 Chronic UTI Australia Inc
23 SPHERE
24 Organon ANZ
25 Australian College of Nurse Practitioners
26 Aware Super
27 The Australian Academy of Health and Medical Sciences
28 Anti-Discrimination NSW
29 Finance Sector Union of Australia
30 Bayer Australia
31 Affiliation of Australian Women's Action Alliances
32 The Pharmacy Guild of Australia

- 32.1 Supplementary submission

33 The Royal Women's Hospital
34 Monash Centre for Health Research and Implementation (MCHRI)
35 Australian Longitudinal Study on Women's Health
36 Women's Health in the North
37 Equality Rights Alliance

38 Cancer Australia
39 Menodoctor
40 Avanzare Consulting
41 Samy Medical Group
42 CWA Tamworth Evening Branch
43 Ms Kaz Cooke
- 2 Attachments

44 Dr Ceri Cashell
45 Associate Professor Magdalena Simonis AM
46 Dr Fatima Khan
47 Ms Suzanne Orr MLA
48 Professor Elizabeth Hill and Ms Sydney Colussi
49 Mr Liam Holt
- Attachment

50 Dr Caroline Rogers FRACGP
51 Associate Professor Duggan and Ms Gent
52 Dr Gabriela Berger and Dr Anita Peerson
53 NSW Government
54 Naturopaths & Herbalists Association of Australia
55 Sexuality Education, Counselling, Consultancy Agency (SECCA)
56 Metluma
- 2 Attachments

57 Wesnet (Women's Services Network)
58 HCF
59 Chelvanayagam, Bouse, Cotellessa and de Lacy
60 Lynette
61 Bronwyn
62 Laura
63 Julia
64 Jo
65 Julie
66 Rinelda
67 Tamar
68 Megan
69 Charlene
70 Ms Sally Mathrick
71 Jacqui
72 Ms Maree Lipschitz
73 Leeanne
74 Clare
75 Sandy
76 Dr Keturah Hoffman

77 Rachel
78 Carl
79 Sonya
80 Allison
81 Lisa
82 Name Withheld
83 Name Withheld
84 Name Withheld
85 Name Withheld
86 Name Withheld
87 Name Withheld
88 Name Withheld
89 Name Withheld
90 Name Withheld
91 Name Withheld
92 Name Withheld
93 Name Withheld
94 Name Withheld
95 Name Withheld
96 Name Withheld
97 Name Withheld
98 Research Australia
99 Victorian Women's Trust
100 Sage Womens Health
101 AIA Australia
102 Sexual Health and Family Planning ACT
103 Family Planning Alliance Australia
104 Dietitians Australia
105 University of Melbourne
106 Women With Disabilities Australia
107 Queensland Nurses & Midwives Union
108 Urological Society of Australia and New Zealand
109 Maridulu Budyari Gumal
110 Elevate Menopause
111 Dr Kelly Teagle
112 Country Women's Association of NSW
113 Women's Health and Equality Queensland
114 SA Health Maternal, Neonatal & Gynaecology Strategic Executive Leadership Committee
115 Australian Medical Association
116 Women's Health Matters ACT
117 Women's Health Road Ltd Pty
118 Menopause Experts Group (MEG) Champions Australia Submission

119 Jean Hailes for Women's Health
120 Women's Health in the South East
121 The Empty Cradle
122 Own Your Health Collective
123 Health Services Union
124 Theramex
125 Name Withheld
126 Name Withheld
127 Name Withheld
128 Name Withheld
129 Name Withheld
130 Name Withheld
131 Dr Odette Best
132 Healthy Bones Australia
133 Diversity Council Australia
134 Name Withheld
135 The Office for Women
- Attachment

136 Chief Executive Women
137 Dr Kelly Teagle, Dr Erin Morton and Dr Marina Delphin
138 Professor Martha Hickey
139 Associate Professor Erin Morton
140 RANZCOG
141 Asthma Australia
142 Avalon Family Medical Practice
143 Menopause at Work Asia Pacific
- 143.1 Supplementary submission

144 ASFA
145 Future Group
146 Besins Healthcare
147 Menopause Friendly Australia
148 Multicultural Centre for Women's Health
149 Victorian Women's Health Services Network
150 Macquarie Menopause Research Group
151 Victorian Women in Law
152 Unions WA
153 National Tertiary Education Union (NTEU)
154 Women in STEMM Australia
155 Private Healthcare Australia
156 Shop, Distributive and Allied Employees' Association (SDA)
157 Australian College of Midwives
158 Community and Public Sector Union (PSU Group)
159 AEU Federal Office

160 Northern Rivers Electrolysis
161 National Council of Women Australia
162 Professor Kathleen Riach
163 Australian Nursing & Midwifery Federation
164 Victorian Trades Hall Council
165 COTA Australia
166 Queensland Council of Unions
167 BPWA
168 Ms Alessandra Briglia and Dr Rebecca Madill
169 FECCA
170 Health Care Consumers' Association
171 Women's Legal Services Australia
172 Pharmaceutical Society of Australia
173 Australian Services Union
174 Rural Doctors Association of Australia
175 Butterfly Foundation
176 Police Federation of Australia
177 Australasian Menopause Society
178 Australian Council of Trade Unions
179 Dr Virginia French - Her Health and Aesthetics
180 Name Withheld

- 180.1 Supplementary submission

181 Rachel
182 Name Withheld
183 Lisa
184 Name Withheld
185 Ms Julie Dimmick
186 Name Withheld
187 Name Withheld
188 Name Withheld
189 Name Withheld
190 Angela
191 Science in Australia Gender Equity (SAGE Ltd)
192 Ms Imogen Crump
193 Rebecca
194 Name Withheld
195 Name Withheld
196 Naomi
197 Sarah
198 Name Withheld
199 Ieva
200 Sarah
201 Name Withheld

202 Kerry - Peripausers
203 Name Withheld
204 Name Withheld
205 Name Withheld
206 Name Withheld
207 Name Withheld
208 Name Withheld
209 Name Withheld
210 Amanda
211 Dr Erin Seeto
212 Ms Peta Dampney
213 Cathy
214 Name Withheld
215 Name Withheld
216 Lisa
217 Name Withheld
218 Name Withheld
219 Ms Jacinta Firman
220 Name Withheld
221 Ms Kristen Beck
222 Ms Katie Harris
223 Ms Cilla de Lacy
224 Jill

- 224.1 Supplementary submission

225 Ms Felicity Brazil
226 Lipoedema Australia
227 Name Withheld
228 Name Withheld
229 Name Withheld
230 Ms Sharon Best
231 Name Withheld
232 Maria
233 Ms Natasha Langovski and Ms Louise Rubic
234 Name Withheld
235 Name Withheld
236 Simone
237 Name Withheld
238 Sonia
239 Dr Jennifer Hacker Pearson
240 GRACE
241 Jodie
242 Jo
243 Name Withheld

244 Dr Lucy Caratti
- 244.1 Supplementary submission

245 JO
246 Elena
247 Name Withheld
248 Name Withheld
249 Bronwen
250 Kelly
251 Dr Ginni Mansberg
252 Name Withheld
253 Name Withheld
254 Jo
255 Louise
256 Kim
257 Julie
258 Name Withheld
259 Name Withheld
260 Name Withheld
261 Ms Chiza Westcarr
262 Rebecca
263 Cherie
264 Centre of Research Excellence on Women and Non-Communicable Diseases
265 Name Withheld
266 Name Withheld
267 Dr Kylie Dodsworth
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281 Confidential
282 Confidential
283 Confidential
284 Epilepsy Action Australia
285 So Brave

Additional Information

1 Grace Molloy, Menopause Friendly Australia, additional information on research informing Menopause Friendly Australia's workplace policy; received 18 June 2024.

2 Andrea Binks, ANZCA, additional information on the menopause toolkit developed for use by Anaesthetists; received 19 June 2024.

3 Professor Jayashri Kulkarni AM, HER Centre Australia, additional information on Research Leader in Women's Mental Health; received 30 July 2024.

4 Associate Professor Amanda Vincent, Monash Centre for Health Research and Implementation
(MCHRI), additional information on the Early Menopause Stream CRE WHiRL; received 29 July 2024.

5 Australian College of Nurse Practitioners, additional information on the inquiry's terms of reference; received 23 July 2024.

Answer to Question on Notice

1 Bayer Australia, answer to questions taken on notice, 17 June 2024 (received 2 July 2024).

2 Diversity Council of Australia, answer to questions taken on notice, 17 June 2024 (received 3 July 2024).

3 Professor Susan Davis, answer to questions taken on notice, 18 June 2024 (received 3 July 2024).

4 Macquarie University Menopause Research Group, answer to questions taken on notice, 17 June 2024 (received 4 July 2024)

5 Australasian Menopause Society, answer to questions taken on notice, 18 June 2024 (received 4 July 2024).

6 Jean Hailes for Women's Health, answer to questions taken on notice, 18 June 2024 (received 5 July 2024).

7 Victorian Women's Health Services Network, answer to questions taken on notice, 18 June 2024 (received 5 July 2024).

8 Theramex Australia, answer to questions taken on notice, 17 June 2024 (received 5 July 2024).

9 Professor Helena Teede, answer to questions taken on notice, 18 June 2024 (received 3 July 2024).

10 Professor Jayashri Kulkarni AM, answer to question taken on notice, 30 July 2024 (received 31 July 2024).

11 Chief Executive Women, answer to questions taken on notice, 17 June 2024 (received 10 July 2024)

12 Australian College of Nurse Practitioners, answer to questions taken on notice, 18 June 2024 (received 23 July 2024)

13 RACGP, answer to questions taken on notice, 30 July 2024 (received 14 August 2024)

14 Australian Medical Council, answer to questions on notice, 13 August 2024 (received 22 August 2024)

15 Dr Dani Barrington and Dr Antonia Hendrick, answer to questions on notice, 13 August 2024 (received 22 August 2024)

16 Professor Martha Hickey, answers to questions on notice, 5 August 2024 (received 23 August 2024)

17 Fair Work Ombudsman, answers to questions on notice, 13 August 2024 (received 23 August 2024)

18 SECCA, answers to questions on notice, 6 August 2024 (received 23 August 2024)

19 Office for Women, answers to questions on notice, 13 August 2024 (received 23 August 2024)

20 Menopause Alliance Australia, answer to questions taken on notice, 6 August 2024 (received 19 August 2024)

21 Department of Health and Aged Care, answers to questions on notice, 13 August 2024 (received 30 August 2024)

22 Department of Health and Aged Care, answers to questions on notice, 13 August 2024 (received 10 September 2024).

Tabled Documents

1 Document tabled by Dr Louise Tulloh at a public hearing Sydney on 17 June 2024.

2 Document tabled by Professor Helena Teede at a public hearing in Melbourne on 18 June 2024.

3 Document tabled by Professor Susan Davis at a public hearing in Melbourne on 18 June 2024.

4 Document tabled by Associate Professor Michelle Peate at a public hearing in Adelaide on 5 August 2024.

5 Document tabled by Rebecca Thomas at a public hearing in Perth on 6 August 2024.

6 Document tabled by Associate Professor Ravani Duggan at a public hearing in Perth on 6 August 2024.

Appendix 2
Public Hearings

Monday 17 June 2024

Northcott Room (Level 4)
Sydney Masonic Centre
66 Goulburn St, Sydney

Viv Health

- Dr Louise Tulloh, Medical Director

Avalon Family Medical Practice

- Dr Ceri Cashell, Co-Founder

Metluma

- Ms Georgie Drury, Co-Founder and CEO
- Dr Nicole Avard, Medical Director

Menopause Friendly Australia

- Ms Grace Molloy, CEO

Menopause at Work Asia Pacific

- Ms Thea O'Connor, Director

Chief Executive Women

- Ms Toni Brendish, Chair of the Policy and Engagement Committee and Board Member
- Ms Melanie Fernandez, General Manager, Policy, Advocacy and Communications

Association of Superannuation Funds of Australia

- Mr Andrew Craston, Director, Economics
- Ms Mary Delahunty, CEO

Future Group

- Ms Christina Hobbs, General Manager, Advocacy

Finance Sector Union of Australia

- Ms Angela Budai, National Policy Officer
- Ms Julia Angrisano, National Secretary
- Ms Rina Abbott-Jard, Delegate

Lived experience panel

- Janey, Private capacity
- Naomi, Private capacity
- Sonya, Private capacity
- Tara, Private capacity

Older Women's Network NSW

- Ms Yumi Lee, CEO
- Ms Beverly Baker, Chair of Older Women's Network NSW and National President

Country Women's Association of NSW

- Mrs Joy Beames, President
- Mrs Danica Leys, CEO

Macquarie Menopause Research Group

- Ms Kayley Zielinski-Nicolson, Research Assistant for the Menopause Research Group, Macquarie Business School
- Professor Kerry Sheman, Professor of Health Psychology, Lifespan Health and Wellbeing Research Centre
- Dr Rebecca Mitchell, Professor and Director, Health & Wellbeing Research Unit and Menopause Research Group, Macquarie Business School

Diversity Council Australia

- Ms Lisa Annese, CEO

Bayer Australia

- Mrs Monica Saba, Senior Manager, Public Affairs
- Ms Elizabeth Mary Hanley, Head of Public Affairs, Sustainability and Communications

Theramex

- Ms Tania Kunda, Associate Director Marketing
- Ms Nicola Leaney, Medical Manager

Tuesday 18 June 2024

Buckingham Room
Stamford Plaza Hotel
111 Little Collins St, Melbourne

Ms Kaz Cooke

- Author of 'It's the Menopause: What you need to know in your 40s, 50s and beyond'

Monash University Women's Health Research Program

- Professor Susan Davis AO MBBS FRACP FAHMS, Director

Australian College of Nurse Practitioners

- Ms Leanne Boase, CEO
- Ms Melanie Rose, Nurse Practitioner and Member of College

Monash Centre for Health Research and Implementation

- Professor Helena Teede AM, PhD, MBBS, FRACP, FRANZCOG, FRCOG, FAAHMS, Director

Multicultural Centre for Women's Health

- Dr Maria Hach, Director of Stakeholder Engagement and Advocacy
- Ms Delaram Ansari, Research, Advocacy and Policy Manager

Women's Health in the North

- Ms Tilly Mahoney, Coordinator, Sexual and Reproductive Health

Women's Health in the South East

- Ms Laura Riccardi, Sexual and Reproductive Health Lead

Victorian Women's Health Services Network

- Dr Kate Johnston-Ataata, Manager Policy, Health Promotion and Advocacy
- Dr Sianan Healy, Senior Policy, Health Promotion and Advocacy Officer
- Dr Katherine Keirs, Policy, Advocacy and Communications Worker

Lived experience panel

- Catherine, Private capacity
- Imogen, Private capacity
- Rebecca, Private capacity
- Sandy, Private capacity

Victorian Women's Trust

- Ms Mary Crooks, Executive Director

Jean Hailes for Women's Health

- Dr Sarah White, CEO

Australasian Menopause Society

- Dr Christina Jang, Board Director, President-Elect
- Dr Marita Long, Board Member (VIC/TAS Representative)

Butterfly Foundation

- Dr Sarah Squire, Head of Knowledge, Research and Policy

Australian Psychological Society

- Dr Alexandra Murray, Senior Policy Advisor

Australian Physiotherapy Association

- Ms Mirjana Jovetic, Senior Policy Adviser
- Ms Catherine Willis, Board Director and Senior Pelvic Health Physiotherapist

Australian and New Zealand College of Anaesthetists

- Dr Andrea Binks, Fellow

Monday 29 July 2024

Leichhardt Room
Hotel Grand Chancellor
23 Leichhardt St, Brisbane

Australian College of Rural and Remote Medicine

- Dr Alice Fitzgerald, Board Member

Queensland Nurses & Midwives Union

- Mr Grant Burton, Assistant Secretary
- Dr Belinda Barnett, Research and Policy Officer
- Ms Emily Hanna, Industrial Officer - Servicing

Pharmaceutical Society of Australia

- Ms Karen Castle, Policy Pharmacist
- Mr Chris Campbell, General Manager, Policy and Program Delivery

The Society of Hospital Pharmacists of Australia

- Mr Jerry Yik, Head of Policy and Advocacy
- Associate Professor Treasure McGuire, Member, Women's and Newborn Leadership Committee

Monash Centre for Health Research and Implementation (MCHRI)

- Associate Professor Amanda Vincent, Early Menopause Lead

Professor Tracey Bunda, Private capacity

Dr Odette Best, Private capacity

Dr Gabriela Berger, Private capacity

National Council of Women Australia

- Ms Chiou See Anderson, President / Chairperson

The Empty Cradle

- Ms Sarah Roberts, Counsellor, Lived Experience Advocate and Founder of The Empty Cradle

Lived experience panel

- Allison, Private capacity
- Carl, Private capacity
- Janine, Private capacity
- Jennifer, Private capacity
- Sharon, Private capacity

Women's Health and Equality Queensland

- Ms Emma Iwinska, Chief Executive Officer

Australian Longitudinal Study on Women's Health

- Professor Gita Mishra

SPHERE

- Professor Danielle Mazza AM

Queensland Council of Unions

- Ms Jacqueline King, General Secretary
- Ms Madina Mohmood, Industrial Women's Officer
- Mr Nate Tosh, Legislation and Policy Officer

Maurice Blackburn Lawyers

- Ms Jessica Heron, Lawyer

Tuesday 30 July 2024

Committee Room 2S3
Parliament House
Canberra

WellFemme

- Dr Kelly Teagle, Founder / Shareholder / Director / Principal Clinician

Her Health and Aesthetics

- Dr Virginia French

Menodoctor

- Dr Linda Dear, Director

HER Centre Australia

- Professor Jayashri Kulkarni AM, Director

Australian Medical Association

- Dr Danielle McMullen, Vice President
- Professor Steve Robson, President

Rural Doctors Association of Australia

- Dr Louise Manning

Royal Australian College of General Practitioners (RACGP)

- Dr Sara Whitburn, Chair – RACGP Sexual Health Special Interest Group

Lived experience panel

- Belinda, Private capacity
- Cathy, Private capacity
- Felicity, Private capacity
- Jill, Private capacity
- Vienna, Private capacity

Australian Council of Trade Unions

- Ms Claire King, Work Health and Safety Policy Officer

Australian Services Union

- Ms Dee Spink

Australian Education Union

- Ms Emma Lowe, Federal Women's Officer
- Ms Natasha Watt, Senior Vice President NSW Teachers Federation, AEU Executive Member

Health Services Union

- Ms Kate Marshall, Senior National Assistant Secretary

Australian Nursing and Midwifery Federation

- Ms Kristen Wischer, Senior Federal Industrial Officer
- Ms Annie Butler, Federal Secretary

Family Planning Alliance Australia

- Mrs Caroline Mulcahy, Chair
- Dr Sara Whitburn, Medical Director Victoria
- Ms Lisa Harrison, Nurse Practitioner Queensland

Australian College of Midwives

- Ms Alison Weatherstone, Chief Midwife
- Ms Zoe Bradfield, President

Equality Rights Alliance

- Ms Helen Dalley-Fisher, Convener

Council on the Ageing (COTA) Australia

- Ms Patricia Sparrow, Chief Executive Officer
- Ms Mary Swift, Policy and Engagement Officer

Federation of Ethnic Communities' Councils of Australia (FECCA)

- Ms Mary Ann Baquero Geronimo, CEO

Professor Kathleen Riach, Private capacity

Newson Health Group Limited

- Dr Louise Newson, Founder and Menopause Specialist

Monday 5 August 2024

Balcony Room
Parliament of South Australia
Adelaide

The Royal Women's Hospital

- Professor Martha Hickey, Women's Gynaecology Research Centre
- Associate Professor Michelle Peate, Program Leader, Psychosocial Health and Wellbeing Research

Besins Healthcare

- Mrs Lorna Elliot, Director, Corporate Affairs
- Mr Geoff Blundell, Managing Director
- Ms Tiree Bowden, Senior Product Manager, Women's Health

Aware Women's Health

- Dr Sarah Maltby, General Practitioner
- Dr Jessica Floreani, General Practitioner

Centre for Health and Wellbeing

- Dr Kylie Dodsworth, Practice Principal – General Practitioner

Dr Carmel Reynolds, Private capacity

VITAL PeriMenopause Registry

- Associate Professor Erin Morton, Chief Investigator and Lead

Lived experience panel

- Charlene, Private capacity
- Jodie, Private capacity
- Laura, Private capacity

Menopause Experts Group (MEG) Champions Australia

- Mrs Megan Hayward, Menopause Champion
- Mrs Ellen Ford, Menopause Champion

RANZCOG

- Dr Heather Waterfall, Chair, SA-NT State Committee

SA Health Maternal, Neonatal & Gynaecology Strategic Executive Leadership Committee

- Dr Roy Watson, Proxy for Chair of Gynaecology Community of Practice

Medical Deans Australia and New Zealand

- Dr Elaine Leung, Senior Lecturer, Teaching Specialist

Tuesday 6 August 2024

Wattle Room
DoubleTree Hilton Perth Northbridge
100 James St, Perth

Aboriginal Health, East Metro Health Service

- Ms Francine Eades, Area Director

Sexuality Education, Counselling, Consultancy Agency (SECCA)

- Dr Emily Castell, Clinical Psychologist

Derbarl Yerrigan Health Service

- Dr Richelle Douglas, Medical Director

Lived experience panel

- Grace, Private capacity
- Jacqueline, Private capacity
- Karen, Private capacity

Menopause Alliance Australia

- Mrs Natalie Martin, Founder and Chief Executive Officer
- Professor Roger Hart, Director
- Dr Lesley Ramage, Director

Your Menopause

- Ms Rebecca Thomson, Founder

Ms Cilla de Lacy, Private capacity

Ms Kirstin Bouse, Private capacity

Dr Sunita Chelvanayagam, Private capacity

Dr Michelle Cotellessa, Private capacity

Shop, Distributive and Allied Employees' Association (SDA)

- Ms Sarah Haynes, Industrial and Equity Officer

Unions WA

- Ms Kari Pnacek, Assistant Secretary

Samy Medical Group

- Professor Martin Samy, Chief Executive Officer
- Dr Christabel Samy, Medical Director
- Dr Purity Carr, Purity Health Owner and Principal General Practitioner

Floralia Wellness

- Dr Lucy Caratti, Integrative Medical Doctor, Women's Health, Fertility, Nutritional and Environmental Medicine

Associate Professor Ravani Duggan, Private capacity

Ms Lucy Gent, Private capacity

Tuesday 13 August 2024

Committee Room 2S3, Parliament House
Canberra

University of Western Australia School of Population and Global Health

- Dr Dani Barrington, Senior Lecturer

University of Western Australia School of Allied Health

- Dr Antonia Hendrick, Senior Lecturer

Australian Medical Council

- Adjunct Professor Robyn Langham AM, Director and Chair, Specialist Education Accreditation Committee

The Office for Women

- Ms Rochelle White, Assistant Secretary, Social Policy and International Engagement Branch

The Workplace Gender Equality Agency (WGEA)

- Ms Mary Woolridge, Chief Executive Officer

The Fair Work Ombudsman

- Mrs Rachel Volzke, Chief Counsel/Group Manager of Legal and Policy

Department of Health and Aged Care (including the Therapeutic Goods Administration)

- Mr Duncan McIntyre, First Assistant Secretary, Technology Assessment and Access Division
- Ms Louise Riley, Assistant Secretary, Medicare Benefits Schedule Policy and Reviews Branch
- Ms Belinda Roberts, Assistant Secretary, Health Equity Branch
- Adjunct Professor Robyn Langham AM, Chief Medical Adviser
- Ms Tracey Lutton, Acting Branch Head, Regulatory Compliance Branch