Inquiry into issues related to menopause and perimenopause

acnp australian college of nurse practitioners

ACNP Report in preparation for Senate Inquiry:

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THE SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

Reference Committee

Inquiry into issues related to menopause and perimenopause

The ACNP has provided this report as part of the inquiry to summarise the issues raised today and captures the work we have done to gather and present member feedback on these issues.

a. the economic consequences of menopause and perimenopause, including but not limited to, reduced workforce participation, productivity and retirement planning;
    - symptoms of menopause and perimenopause are often seen as 'normal' and not treated, even when moderate to severe and treatable. Early identification and management of symptoms can not improve quality of life, but improve overall health, including mental health. Women can stay in the workforce, lead more active and healthy lives, including in retirement
    - Women over 50 form a significant part of the workforce and should be actively contributing to their retirement planning and superannuation. Persistent, moderate or severe symptoms of menopause and perimenopause can reduce productivity, increase time away from work, affecting productivity in the short term, along with potentially delaying retirement.
    - Economic consequences can also be considered in relation to costs of treatment for women. There are increasing out of pocket costs to see a GP, even for short consults. The out of pocket fees for longer consults are more cost prohibitive.
    - In the case of a woman consulting a nurse practitioner, their out of pocket costs are likely to be higher. There are fewer rebates available to women who see nurse practitioners, specifically:
        - Lower rebates for consultations
        - Fewer medicines on the PBS – this is especially obvious in women's health. Several medicines for treatment of menopause and perimenopause are either completely excluded from the PBS, despite being safe, proven and effective, or are conditional so that NPs cannot initiate them. This means that many women are forced to pay full price for these medicines (private), and they also do not count toward their safety net. Women's health medicines are one of the bigger areas of disparity on the PBS. Often, a woman will make an appointment with a GP, if they can access one, and ask for their prescription to be re-written to access their PBS entitlement.
        - Fewer necessary tests on the MBS – Osteoporosis as one example – this is a common concern associated with menopause. If a woman sees a nurse practitioner they are not entitled to any Medicare rebate on a DEXA scan to check for osteoporosis, the have to pay the full private fee. If the DEXA is

requested by a doctor, there is a Medicare rebate. Often, to avoid the private fee, the consultation is duplicated (or repeated by a GP) so the patient can have their DEXA request re-written so they can access their Medicare entitlement. This adds cost to Medicare through the duplication, it delays the DEXA scan, and delays diagnosis and management. Presuming a GP is available and accessible.

- Weight gain is a symptom of menopause, treatment is available and accessible however nurse practitioners cannot refer anyone for a Sleep Study under Medicare to establish if sleep apnoea is an issue. Again, the service is often duplicated to access entitlements.
- Few to no gynaecologists in regional, rural and remote areas, leading to significant travel costs, delays to diagnosis and treatment, and forming a barrier to women's health care.

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

- Physical health concerns are often ignored. Fatigue, sleep disturbances, changes in menstrual bleeding patterns, night sweats, and weight gain are often attributed to menopause and dismissed.
- Sleep and rest and vitally important for good health, and leads to fatigue. Obesity and weight gain are heavily stigmatised, and also has a significant impact on health. As symptoms are dismissed, women lose confidence in raising such issues with health care providers.
- A significant proportion of GP consultations are short consultations. Menopausal symptoms require longer consultations to identify if they are associated with menopause, if there are other contributing or causative factors, and what treatment options should be considered, including pharmacological and non-pharmacological.
- A lack of opportunity for longer consultations, the experience of short consults and 'one problem at a time' approaches in some areas of General Practice, and rising out of pocket costs all impact on access to health care services for menopause and perimenopause.
- Nurses, and particularly Nurse Practitioners are often seen as the healthcare professional of choice for discussions about complex health conditions, and nurses are trusted to be empathetic, and non-dismissive. There are numerous access barriers to nurse practitioners, with people often financially penalised for their choice of provider.

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

- Mental Health issues are prevalent across the entire community, however are more likely to be ‘dismissed’ as part of ‘normal’ menopause symptoms, when they are not.
- Little to no attention is paid to the emotional wellbeing of women, or to the social supports they may or may not have. There is not usually a medical focus on these factors.

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

- menopause can impact on all activities, responsibilities and relationships. Symptoms of fatigue, sleep disturbance, weight gain, can all impact on daily activities of living.

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;

- Our members report challenges, especially in rural areas, where doctors are commonly overseas trained, there are issues with language and being able to understand.

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;

- In many cases, awareness appears to be limited. Often symptoms such as bleeding after menopause, weight gain, and fatigue are dismissed without support or education for the woman. Even when treatment is available, the attitude seems to be ‘live with it, it will go away eventually’. This attitude leads to unnecessary suffering, loss of quality of life, loss of productivity, increased visits to health services, etc.
- In other cases, there is a significant reluctance. Some doctors refuse to ‘do’ women’s health at all, others restrict the age within which they will see women, for women’s health related issues. Some restricting the age groups to under 45-50, thereby refusing to see women experiencing perimenopause or menopause at all.
- Many doctors who do offer women’s health care are not taking new patients.
- Recent announcements by the government relating to education for doctors, nurses and midwives to undergo training in menopause, and in relation to LARC insertion and removal are very welcome. We strongly recommend that outcomes are measured, including but not limited to:
  - The types of practitioners taking up the free training (we anticipate a proportionally higher number of nurse practitioners)
  - The number of practitioners and types that continue on to provide the services
  - The distribution of this workforce

- Generally, it is difficult to find high quality and accessible information for patients and their families. As health professionals, we see their resources as being just as limited as ours, if not more so,

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;

- There seems to be little awareness or support.

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

- Some currently in discussion – see i.

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

- Queensland is currently working on 4 nurse led womens health clinics, this will include management of women's health across the lifespan, as well as minor injury and illness. This will be a no cost service to consumers. Further work can be done to expand the MDT in these models, and consider a blend of mobile and fixed location clinics to ensure rural and remote people can have access. Access issues will remain in regard to PBS and diagnostic testing for consumers.
- The nurse led model is well suited to women's health. Holisitic, person centred assessment and treatment is required, seeing people, not problems. Longer consults are required, particularly for menopause and perimenopause, and time needs to be taken to listen, evaluate and educate.
- Recent federal govt. announcements in relation to training programs.

Case 1:

72 year old women with early memory loss, auto-immune arthritis admitted to hospital for pain management, for chronic pain.

Mentioned vaginal bleeding on admission, not followed up. Has mentioned it to her 2 regular GP's in 2 different clinics, and was repeatedly told it was nothing to worry about. It has been happening for 3-4 years, she brought it up with her GP when it first started, and then when she transferred to a new clinic (moved house), added it on her registration form and mentioned it to her new GP. She has never been examined by either GP, and has stopped raising it over the last 12 months after being told it is nothing to worry about so many times. It is now a matter of embarrassment for her. Contacted nurse practitioner in her home community after admission, nurse practitioner advised to insist on follow up, to include examination and ultrasound as a starting point. Advised woman bleeding after menopause is not normal.

Diagnosis: Uterine Sarcoma, some spread to lymph nodes, radical hysterectomy, chemotherapy.

Case 2:

Woman in early 50's Low Ferritin. Told it was due to irregular moderate vaginal bleeding during short follow up consult. Perimenopause. No examination or further investigations. Patient saw local nurse practitioner, investigated – positive FOBT. Requires colonoscopy for ? bowel cancer.

Many patients do, and would choose, to see a nurse practitioner, as nurses are usually seen as more trusted and interested in women's health, however people are penalised for their choice through lack of funding, and through access blocks to associated testing and medicines. NPs can prescribe these medicines, but there is no funding for the diagnostic tools to establish clinical criteria, or there is no PBS access, or it is conditional on them seeing a medical doctor first.

Case 3:

A local GP clinic has one female doctor, she is the only doctor in the practice seeing women with 'women's health' issues. The male doctors in the practice, citing cultural reasons, refer any women's health issues to her.

The practice nurse is certified to do pap smears. Up until recently, they have worked well together, until the female doctor said she is no longer seeing women over 50 for women's health issues, as they were too complex. She asked the practice nurse to take over these patients, however apart from doing their pap smears, this was out of her scope.

This is a practice I used to work in, I still provide some informal support to the practice nurse.

A nurse practitioner quote:

Most of my patients see me as they do not want to see a doctor, this is their choice. For this choice they are penalised by either having to pay privately for things that they should ultimately be entitled to under Medicare. Or go and see a doctor, which is something they are being forced to do by virtue of restrictions on access.

This report, and responses to questions on notice was prepared by Leanne Boase on behalf of ACNP, and incorporated member feedback.

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