Newson Health Group's submission to the Standing Committee on Community Affairs inquiry into issues related to menopause and perimenopause

About Newson Health Group

Newson Health Menopause and Wellbeing Centre was established in 2018 by Dr Louise Newson BSc(Hons) MBChB(Hons) MRCP FRCGP and Dr Rebecca Lewis MBBS FRCA DRCOG MRCGP in response to difficulties many women face in obtaining perimenopause and menopause treatment in the UK and is now the largest GP led menopause clinic in the world.

Our clinicians provide individualised consultations, with a holistic approach to perimenopause and menopause to women who have been unable to find the advice, support and help from their own GPs. Evidence based treatment options, both HRT and non-hormonal treatments relevant to each patient, are discussed and given to improve their symptoms and also their future health. HRT and testosterone doses and types are prescribed so the dose and type are optimised for each woman. We operate nine clinics across the UK, offering both face to face and virtual appointments to around 4,000 women from all socioeconomic backgrounds each month.

Newson Health's mission is to improve the future health of women globally. We reinvest a significant portion of profits from our clinics to fund research in hormone health and provide free perimenopause and menopause resources, including our free balance app and balance menopause website, which have been used by millions of people worldwide – about 4% of all balance app downloads are from users in Australia. Our CPD-accredited Confidence in the Menopause online education programme has been accessed more than 32,000 times globally since its launch in 2021. In addition, the Dr Louise Newson Podcast, a weekly look at all things perimenopause and menopause-related, has been downloaded some 5.7 million times; currently 24% of downloads are in Australia.

All women deserve access to individualised perimenopause and menopause care, and as a global leader in menopause care, we feel that it is important to respond to this inquiry. Below is our submission using the terms of reference set out by the inquiry exploring the scale of the issues, and actions on how to improve menopause awareness, education and care for all.

Women's hormone health worldwide is all too often overlooked, under resourced and under-funded, so this inquiry presents an opportunity to reset the dial and make for meaningful and lasting changes to improve both quality of life and health for women in Australia for generations to come.

Economic impact of perimenopause and menopause, and level of awareness amongst employers and employees, and workplace support

'It is heartbreaking to know so many of my peers of well educated, capable career women, all women over 40, have dropped out of the workplace due to symptoms which could have been eased'
(respondent to Newson Health call for evidence, 2023)

The most common symptoms of perimenopause and menopause affecting working women are memory problems, anxiety and fatigue. Other common symptoms such as low mood, poor sleep, reduced stamina, low self esteem, irritability, urinary symptoms and headaches can also affect

working women. Vasomotor symptoms (hot flushes and sweats) are not usually as common as some of these other symptoms but still affect working women too.

The average age of menopause for most is 51 (younger in some ethnic groups), precisely the age when many women are the peak of their careers with an abundance of skills and experience to offer. With the retirement age for women in Australia born after 1957 67[1], potentially decades of a woman's working life could be spent perimenopausal, menopausal and post-menopausal.

In addition, around one in 30 women will have their menopause under the age of 40 which will their clearly have a longer effect on their working lives and careers.

Yet for too long menopausal women have been faced with an impossible choice: struggle on with often debilitating symptoms or leave behind careers they have worked so hard for.

A 2021 Newson Health survey of 3,800 perimenopausal and menopausal women found crippling menopause symptoms and a lack of support are ruining women's careers, with women being forced to take time off work or even leave their jobs altogether[2].

Our findings included:

- 99% of respondents said their perimenopausal or menopausal symptoms had led to a negative impact on their careers
- 59% had taken time off work due to their symptoms. 18% were off more than eight weeks
- Reasons for taking time off included reduced efficiency (45%), poor quality of work (26%) and poor concentration (7%)
- 21% passed on the chance to go for a promotion they would otherwise have considered
- 19% reduced their hours
- 12% resigned
- 60% of women said their workplace offered no menopause support
- Only 5% had menopausal symptoms listed on their sickness certificate but over a third who had a sickness certificate issued for their menopausal symptoms had anxiety or stress documented as the reason.

Wider economic impact of menopause on the workplace

In the UK, where we are based, women of menopausal age (45-54) make up around 11% of all people in employment and 23% of all women in employment[3], while women experiencing menopausal symptoms represent the fastest growing demographic in the UK workforce, with nearly eight out of ten being in work[4]. In Australia, women aged 45 years and over comprise 17% of the ageing Australian workforce[5].

The impact of menopause is not only felt on the individual: it has ramifications throughout the workplace and on the wider economy. A 2022 economic analysis by Newson Health found that a lack of menopause awareness and support in the workplace is costing the UK economy almost £10 billion

[1] Australian Government Department of Social Services, Age Pension
[2] Newson Health (2021) Menopause symptoms are killing women's careers, major survey reveals
[3] Labour Force Survey Q2, 2021
[4] Faculty of Occupational Medicine, Guidance on menopause and the workplace
[5] Tilly, J., O'Leary, J., & Russell, G. (2013). Older Women Matter: Harnessing the Talents of Australia's Older Female Workforce. Diversity Council Australia.

($19.2 billion AUD)[6]. This figure includes the cost of women leaving their roles due to their symptoms, as well as the cost of rehiring and retraining staff, and loss of productivity.

Retirement planning

We hear on an almost daily basis from our patients and via our free balance app and social media how women are leaving the workforce early because of their symptoms (for context, our balance app has been downloaded 1.2 million times worldwide, and we have over 900,000 followers across our social media channels). The financial ramifications of these decisions need to be considered not only in the here and now, but also how it will affect a woman's financial position in retirement.

One woman told Newson Health in 2023: *'We need to ensure that women are supported during this time of their lives a time where they are contributing hugely in their careers and we need to ensure that they stay in the workplace to reach their full pension benefits.'*

An analysis by the Australian Institute of Superannuation Trustees (AIST) estimates that even if just 10% of women retired early because of menopausal symptoms, it would equate to a loss of earnings and superannuation of more than $17 billion[7]. If that figure rose to 20%, the economic loss would grow to more than $35 billion.

In addition, a 2023 analysis by Newson Health found that UK women face missing out on more than £30,000 ($58,000 AUD) in pension contributions due to their menopausal symptoms[8]. A woman in her 40s with the average projected pension pot would lose out on £1,750 ($3,370 AUD) if she took eight months of leave, the average period of time for those with serious symptoms. And a woman who subsequently reduces her hours until retirement could face a reduction of £32,000 ($58,000AUD) in savings.

What needs to be done

At Newson Health we have worked with organisations including Diageo and the Ministry of Defence as well as NHS organisations, schools and colleges to provide evidence-based information and training.

We believe every workplace needs to be menopause aware, and that starts with a robust menopause policy. This needs to include meaningful change, not a tick box exercise and a policy left to gather dust on a shelf, and one that extends far beyond a few token desk fans for hot flushes.

Such a policy should include:

- **Menopause awareness training and support**, from board level through to the wider workforce, delivered by healthcare professionals
- **Support groups for staff** – open not only to those experiencing menopause, but those with partners, relatives and colleagues going through menopause
- **Evidence-based resources for staff**, for example, links to trusted sources on workplace intranet pages and regular communications from human resources departments
- **Access to healthcare professionals trained in menopause** via occupational health or outside providers, so women can have an individualised consultation and access to evidence-based

[6] Newson Health (2022) Menopause cripples the UK economy, https://www.balance-menopause.com/news/menopause-cripples-the-uk-economy/
[7] ABC (2022), Menopause estimated to cost Australian women $17 billion a year in lost earnings, super

[8] Newson Health (2023) Menopause can cause £30,000 pension shortfall www.balance-menopause.com/news/menopause-can-cause-30000-pension-shortfall/

treatments. Hormone replacement therapy (HRT) is globally recognised as the first-line treatment for managing menopause-related symptoms. As one woman told Newson Health: *'The education of women, myself included has enabled me to seek HRT and much-needed treatment. Its enabled me to continue in my career and contribute through my tax and national insurance to the UK government.'* Another summed up the issue as: *'Middle aged women have a lot to offer the workplace – especially their accumulated knowledge and expertise and to lose this because they cannot access the appropriate treatment is damaging to the economy and simply inhumane.'*

- **Adjustments to the work environment,** such as flexible working, including time to attend healthcare appointments

Physical health impact

For generations the menopause conversation (if discussed at all) has been framed in terms of hot flushes and night sweats. But while an estimated 80% of menopausal women will experience hot flushes, the physical impact of menopause extends far beyond vasomotor symptoms. Hormone receptors are present throughout a woman's body, so when levels of oestrogen, progesterone and testosterone fluctuate and fall during the perimenopause and menopause, this often triggers a whole host of symptoms.

Symptoms include joint and muscle pains, genitourinary symptoms, heart palpitations, fatigue, oral symptoms, headaches and worsening migraines, pins and needles, tinnitus, dry and irritated skin and weight gain, in addition to numerous psychological symptoms (covered in the next section).

Lack of awareness, and failure to recognise the impact of changing hormones on physical and mental health, delays access to timely care and causes unnecessary suffering. A 2022 Newson Health survey of 5,800 perimenopausal and menopausal women found almost three quarters (74%) of respondents experienced surprising or unexpected symptoms.

Joint pain was the most common unexpected symptom (34%), followed by dry eyes (26%), heart palpitations (25%), hair issues such dryness, thinning hair and hair loss (20%), tinnitus (19%) weight gain (18%), vaginal dryness (17%), mood swings (17%) formication (14%), urinary symptoms (14%) and heartburn (10%). Words used to describe these unexpected/surprising symptoms in free text responses included 'distressing', 'debilitating' 'depressing' and 'embarrassing'. The findings suggest many respondents were unprepared for the range of symptoms associated with perimenopause and menopause.

Long-term health risks associated with menopause

Many women are not aware of the long-term health risks associated with low hormones and menopause – and of the protective benefits of HRT (to be addressed in a later section of our response). These long-term risks include:

Osteoporosis

Women have an accelerated bone loss during their perimenopause and also in the years during and after their menopause, as oestrogen (the key hormone for protecting and maintaining bone density) rapidly declines during this time. Progesterone and testosterone also build bone. Bone is breaking down at a faster rate than the body can grow new bone tissue. An estimated one in two women (who do not take HRT) over 50 worldwide will develop osteoporosis, compared to one in five men.

One in three post-menopausal women (not taking HRT) will sustain an osteoporotic fracture – which is associated with a mortality rate of around 20% in the year following the fracture which is greater that most new cancer diagnoses.

Cardiovascular disease

Cardiovascular disease (heart attacks, strokes, raised blood pressure) is the leading cause of death in women globally and their risk notably increases after menopause[9]. The risk of heart attacks is around five times higher after menopause than before, and heart disease is the leading cause of death for post-menopausal women[10][11]. This is because the hormones, especially oestrogen, are very protective on the entire cardiovascular system.

In addition, heart disease in women is often underdiagnosed, as women can present with different symptoms than men. Plus, the prognosis after a heart attack in a woman is worse than in men. Typically, women are around ten years older than men when they are first diagnosed with heart disease and this is likely to be related to the decline in hormone levels during the perimenopause and menopause[12].

Women who have a menopause at a young aged (under 40) are more likely to develop heart disease, atrial fibrillation and heart failure if they do not receive HRT.

Type 2 diabetes

The menopause is a cardiometabolic condition, meaning that biochemical changes occur in the body when oestrogen levels are low, resulting in metabolic changes occur including an increased insulin resistance, abdominal-fat occurrence, increased risk of metabolic syndrome and also increased risk of type 2 diabetes. In addition, low oestrogen levels can affect insulin production by the pancreas, which also increases future risk of type 2 diabetes[13][14].

Dementia

Worldwide, women with dementia outnumber men by nearly two to one and risk of dementia increases post menopause. It's not yet fully understood why this is the case, however there is evidence that a woman's risk of dementia is greater the longer they live in their menopause. There is also increasing evidence that women who take body identical HRT have a lower future risk of developing dementia.

What needs to be done

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[9] El Khoudary, S. R. et al. (2020), 'Menopause transition and cardiovascular disease risk: implications for timing of early prevention: a scientific statement from the American Heart Association', Circulation, 142 (25), e506–32. doi:10.1161/CIR.0000000000000912

[10] Boardman, H. et al. (2015), 'Hormone therapy for preventing cardiovascular disease in post-menopausal women', Cochrane database of systematic reviews, doi:10.1002/14651858.CD002229.pub4

[11] Lobo, R. A. et al. (2016), 'Back to the future: Hormone replacement therapy as part of a prevention strategy for women at the onset of menopause', Atherosclerosis, 254 (2016): 282–90. doi:10.1016/j.atherosclerosis.2016.10.005

[12] Anand S. S. et al. (2008), 'INTERHEART Investigators. Risk factors for myocardial infarction in women and men: insights from the INTERHEART study', European Heart Journal, 29 (7), pp. 932–40. doi: 10.1093/ eurheartj/ehn018. Epub 2008 Mar 10. PMID: 18334475

[13] Nappi, R. E., Chedraui, P., Lambrinoudaki, I., Simoncini, T. (2022), 'Menopause: a cardiometabolic transition', Lancet Diabetes and Endocrinology, 10 (6), pp. 442–56. doi.org/10.1016/S2213 -8587(22)00076 – 6

[14] 57. Slopien, R. et al. (2018), 'Menopause and diabetes: EMAS clinical guide', Maturitas, doi: 10.1016/ j.maturitas.2018.08.009

- **Better menopause education for all**: It is vital that menopause education – for both the public and for healthcare professionals at undergraduate level and through continuous professional development training – detail the full spectrum of potential symptoms, so that women can access help and treatment. As one respondent surmised: *'I wasn't mentally prepared to deal with surprising symptoms as I feel education is key. If I were more informed, I could have been more prepared.'*
- **Awareness campaigns across health and social care of menopause symptoms, and the long-term health risks** associated with low hormones: this is vital so women can recognise symptoms and access evidence-based treatment
- **Prioritising menopause when commissioning healthcare services,** including targeted menopause healthcare services so women can easily access advice and evidence-based treatment

Mental and emotional impact

Between one and two thirds of women report deterioration in mental health during the menopause transition. Perimenopause and the early postmenopausal period are associated with a 2 to 4-fold increased risk for clinical depression, and suicide rates peak in women aged 45 to 49 years[15]. If oestrogen levels are balanced with HRT, patients are likely to respond more consistently to medication, perhaps requiring lower doses or less complex regimes and ultimately enjoying better physical and mental health outcomes. With perimenopausal patients with a history of mental ill-ness, there is a danger of diagnostic overshadowing and new- onset perimenopausal symptoms being misdiagnosed as a relapse of a pre-existing mental illness. This can lead to delays in diagnosis and correct treatment. Women with schizophrenia are less likely to use HRT compared with women without psychiatric diagnosis. Clinicians should also be proactive in discussion of the perimenopause and menopause.

The mental health impact of menopause is overlooked. While the most effective treatment for mood symptoms due to hormone deficiency is HRT, many women are incorrectly antidepressants first-line for menopause-related low mood.

In Newson Health's 2022 survey of 5,800 perimenopausal and menopausal women, 96% of respondents had reported a negative change in their mood or emotions since onset of perimenopause. The most common symptoms were: feeling anxious or stressed (84%), more easily overwhelmed (79%), low or tearful (72%), angry or irritable (67%) and flat or blunted (55%).

In our survey, two thirds of women said they had sought help for their symptoms, usually from their family doctor. 19.1% had been formally diagnosed with a mood disorder, 38.5% of women had been offered antidepressants rather than HRT; 4.6% had been treated with more than two antidepressants and 13.4% women had received cognitive behavioural therapy (CBT).

Too often, women are told their symptoms are down to clinical depression and are offered and prescribed antidepressants to try to regulate and improve their moods, which often do not help or work. Feeling down, sad and upset can be very common symptoms of the menopause and perimenopause. Other psychological symptoms include feelings of low self-esteem, reduced motivation or interest in things, anxiety and panic attacks, irritability and mood swings. It is clear to see why these feelings could be mistaken for depression and perhaps, therefore, understandable

[15]BJPsych Bulletin (2023) Page 1 of 7, doi:10.1192/bjb.202 3.89

why a healthcare professional might prescribe antidepressants. Yet for too many women, this lack of understanding only delays access to first-line treatment.

Testosterone

In our clinical experience, the benefits of testosterone in the perimenopause and menopause extend beyond improving libido.

At Newson Health, we care for thousands of patients every year, and this allows us to collate a huge amount of rich data about symptoms and impact of treatments for patients.

We studied data from our clinic of 1,200 peri- and postmenopausal women prescribed transdermal testosterone for at least three months. This large retrospective cohort included women who were already taking standard HRT and scored moderate/ severe on relevant domains of the Greene Climacteric Questionnaire – a checklist used to measure menopause symptoms and assess changes in symptom severity before and after treatment.

After comparing scores before and after adding testosterone to their treatment regimen, our audit found testosterone significantly improved mood-related symptoms such as anxiety and irritability, as well as concentration and memory.

And while there was also an improvement in symptoms associated with low libido, the biggest was seen in mood and anxiety- related ones.

These results reflect what clinicians working at Newson Health and many other menopause clinics have noticed when they prescribe testosterone to women. Our study, with all the limitations that naturally come with an observational study of this kind, suggests testosterone has wide ranging benefits alongside HRT for perimenopausal and menopausal women struggling with not only low libido, but other symptoms such as low mood, anxiety, poor concentration, low energy and memory problems. More studies are required, but our findings suggest that testosterone should be considered as part of HRT for women who continue to have symptoms despite being on standard HRT.

What needs to be done

Better patient and clinician education is urgently needed to raise awareness about the psychological impact of the perimenopause and menopause, and the efficacy and safety of hormone therapy to treat mood-related symptoms.

Women and clinicians need clear information on the difference between clinical depression and menopause-related low mood to avoid inappropriate antidepressant prescribing.

As one woman told Newson Health in 2023:

The effect the HRT has had on my mood has been outstanding. I no longer feel anxious in stressful situations, my family relationships have improved and overall I am feeling calm and relaxed. I have more energy which is resulting in increased exercise. The list of changes goes on.'

More research into the effects of testosterone on mental health

Impact of menopause on caregiving, family dynamics and relationships

Caregiving and family dynamics

'Before I went on the full triage of hormones (progesterone, oestrogen and testosterone) my life was falling apart.

'I was on antidepressants as I had felt suicidal. I was inpatient and angry with my family, and I was struggling to hold down a job due to anxiety and brain fog. HRT was the ONLY thing that pulled me in the world of being human again.'

(Newson Health call for evidence 2023)

Mid-life tends to be a peak point of change for women. Women we see in clinic often speak of the difficulty of balancing careers and caregiving responsibilities, such as caring for children or older relatives, and then how struggling to cope with menopause symptoms puts an additional strain on top of these existing challenges.

Those who have children may be living with teenagers, who themselves are going through their own hormonal changes with puberty, which can put relationships under strain.

Some 12.3% of all women in Australia identify as a carer, and women represent seven out of ten primary carers (71.8%)[16]. According to the Workplace Gender Equality Agency, the peak age for a female carer in Australia 55, which is a time in life when many women may have recently transitioned out of child rearing only to assume caring responsibilities for a relative or friend[17].

A lack of menopause education and awareness through the generations can still affect family dynamics today. For example, menopause was only added to the Relationship and Sex Education curriculum in secondary schools in England in 2020, so most perimenopausal and menopausal women have never received any formal menopause education. Conversations with friends and family may be the only source of information for many. However, taboos around menopause may limit discussion resulting in lack of knowledge about symptoms and management options.

A 2022 Newson Health survey of 5,800 women found:

- Three-quarters (75%) of respondents said the menopause was never discussed in their home while growing up, 5% recalled it being discussed once, 19% discussed it occasionally and 1% said it was discussed on a regular basis.
- 34% had never discussed the menopause with their mother, 38% had occasionally, 13% once, and 12% had never discussed it.
- Women were more likely to have conversations about menopause with their children; 87% had discussed menopause with their daughters (55% 'often' and 32% 'occasionally'), and 69% of women had discussed menopause with their sons (25% 'often' and 44% 'occasionally').
- Key barriers to family menopause discussions included a lack of knowledge (45%), embarrassment (30%), lack of communication (28%), being short of time (17%) and feelings of shame (10%)[18].

Relationships

[16] Australian Bureau of Statistics, 2019, Disability, Ageing and Carers, Australia: Summary of Findings, https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release

[17] Workplace Gender Equality Agency, Gender equality and caring

[18] Newson Health (2022) The last great taboo: menopause discussions in the home and between generations https://emas2023.abstractserver.com/program/#/details/presentations/275

With the onset of perimenopause in the mid-40s, the average age of menopause at 51 and the peak time of divorce being between the ages of 45 and 55, it's long been assumed, but never proven, that the menopause has a clear and negative impact on divorce, separation and relationships.

Domestic abuse, in particular, may have an impact on severity of menopause symptoms and earlier menopause[19].

In 2022, Newson Health joined with the Family Law Menopause Project for survey to investigate the impact of menopause on relationships. More than 1,000 women who had either gone through or were currently going through a divorce took part in the poll. Findings included:

• Seven in 10 women (73%) blamed the menopause for the breakdown of their marriage.

• Worryingly, a further 67% claimed it increased domestic abuse and arguments

• Sadly, only a fifth of those women had sought support to talk about the perimenopause/menopause because at the time, they didn't think it was a contributing factor to the breakdown of their relationships.

• Almost 80% said their symptoms put a strain on their children and/or family life; only a third of all women had been offered treatment or HRT to relieve their symptoms despite it being the first line treatment.

• In contrast, 65% of those who were offered HRT said it had made a positive impact on their menopause related symptoms.

• Some 70% of those who had not received support or treatment said that if they had, it would have had a positive impact on their relationship and potentially avoided the breakdown of their marriage.

What needs to be done:

- **Greater menopause education for all ages, including school and college-age children:** Menopause is no longer a taboo subject, and that starts with education that encompasses symptoms, long-term health risks and treatments for the menopause.
- **Targeted resources for family members and partners:** This could include workplace training, information leaflets for partners and family members available in healthcare and social settings. For example, our balance website has a dedicated page for partners linking to resources

Cultural and societal factors

No two menopauses are the same, and experiences differ between women of different ethic and socioeconomic backgrounds.

For example, menopause can occur earlier in women from a non-White background. A 2022 study found that Black women have their final period an average of eight and a half months before White women[20]. The study also found Black women were 50% more likely to report hot flushes compared to White women. And 27% of Black women reported clinically significant depressive symptoms,

[19] Clin. Exp. Obstet. Gynecol. 2021 vol. 48(6), 1292-1299
[20] Harlow, S. D. et al. (2022), 'Disparities in reproductive aging and midlife health between black and white women: The Study of Women's Health Across the Nation (SWAN)', Women's Midlife Health. doi:10.1186/s40695-022-00073-y

compared to 22% of White women. In addition, preliminary research found that Black women were three times more likely to become menopausal before the age of 40[21].

Women from South Asian backgrounds tend to become menopausal earlier, at around 46 years of age. And women from South Asian backgrounds whose diets may be more plant based (containing phytoestrogens, which can stimulate them oestrogen receptors) tend to suffer from fewer hot flushes, night sweats and skin changes[22]. However, women from South Asian backgrounds more commonly report body aches, palpitations and urinary symptoms. In addition, women from South Asian backgrounds have a higher risk of cardiovascular disease, type 2 diabetes, insulin resistance, obesity and osteoporosis than the White population[23]. When they are menopausal, these risks increase further.

Women in marginalised communities, including those who speak English as a second language, homeless and prison populations, and those struggling with addiction, are overlooked when it comes to menopause care.

Many people do not realise that addictive behaviours can increase during the perimenopause and menopause. This is thought to be due to the powerful effect of the loss of sex hormones on the brain. Drinking more alcohol, taking drugs, gambling, eating disorders and gaming are all behaviours that can escalate and become out of control when hormone levels are low. In 2023, a Newson Health survey of 1,200 women found women are spending nearly £3,000 on alcohol and over-the-counter medication in a year in a bid to cope with menopause-related symptoms[24].

'I self-medicated to the point of becoming an alcoholic,' said one respondent.

'I suffered from many symptoms from the age of forty-three, including terrible night sweats, anxiety and depression. I could not cope, so I drank.'

What needs to be done

- **Wider access to evidence-based menopause care for women of all backgrounds** through dedicated clinics with trained menopause specialists
- **Tailored menopause resources for women of all ethnic and socio-economic backgrounds, and those in marginalised populations**. Every woman will go through menopause at some point in their lifetime, and women deserve information to make informed decisions. For example, we have translated a number of free resources available on the balance online library into nine languages.
- **Outreach work by healthcare professionals in marginalised communities** In addition to our translated resources, Newson Health has worked with organisations to produce information for women with learning disabilities, women living with HIV and delivering education talks to women who have experienced female genital mutilation.

[21] American Heart Association (2021), 'Early menopause linked to higher risk of future coronary heart disease', https://newsroom.heart.org/news/early-menopause-linked-to-higher-risk-of-future-coronaryheart-disease?preview=f0f8
[22] Chen, M. N., Lin, C. C., Liu, C. F. (2015), 'Efficacy of phytoestrogens for menopausal symptoms: a meta - analysis and systematic review', Climacteric, 18(2), pp.260–9. doi.org/10.3109/13697137.2014.966241
[23] Hu, D., Yu, D. (2010), 'Epidemiology of cardiovascular disease in Asian women', Nutrition, Metabolism, and Cardiovascular Diabetes, 20(6), pp.394–404. doi.org/10.1016/ j.numecd.2010.02.016
[24] Newson Health (2023) UK women spending more on alcohol a week than on their grocery shop to cope with menopause symptoms https://www.balance-menopause.com/menopause-library/uk-women-spending-more-on-alcohol-a-week-than-on-their-grocery-shop-to-cope-with-menopause-symptoms/

- **Menopause awareness training for staff working with marginalised groups,** including homeless and prison populations, so they can recognise the signs and symptoms and sinpost appropriate help

Level of awareness amongst healthcare professionals and patients

Misconceptions around HRT

HRT has been around for decades, and to this day remains the first line evidence-based treatment for managing menopausal symptoms. In the US and Europe, HRT grew in popularity over the decades, rising significantly in the 1990s. Many menopausal women took HRT, and healthcare professionals were very happy and willing to prescribe it.

But in the early 2000s, this upward trend changed. In 1993, the Women's Health Initiative (WHI) had begun a clinical trial looking at the health effects of women taking oestrogen-only or combined HRT compared to a placebo. The type of HRT used in this study contained oestrogen derived from pregnant horses' urine and a synthetic progestogen; this is very different from the body-identical HRT we now usually prescribe, which has lower risks and is very safe. And in 2002, the combined HRT part of the study was halted prematurely, due to results linking HRT with breast cancer, heart disease, stroke and blood clots.

The conclusions were then leaked to the lay and medical press without the results being properly analysed first. Yet later analysis of the data revealed the link with breast cancer was not statistically significant – in fact, oestrogen-only HRT has subsequently shown to be associated with a lower risk of developing breast cancer – but the damage was done. The notion that all types of HRT caused breast cancer was now firmly planted in the minds of women and healthcare professionals alike.

As a result, numbers of women taking HRT worldwide fell sharply. Some women are still reluctant to take HRT and healthcare professionals to prescribe it to this day due to unfounded fears from this study.

Putting the benefits and risks into perspective

However, a closer look into the WHI study found the following

• The average age of women in the study was sixty-three, yet researchers wrongly generalised their conclusions to include women entering menopause in their early 50s.

• Nearly half the participants were current or past smokers, many had had heart disease in the past, more than a third had been treated for high blood pressure, and 70 per cent were seriously overweight or obese.

• The study claimed HRT increased the risk of heart problems, but the proper analysis revealed that the risk occurred only among women who were starting it in their seventies and older.

• The investigators revised their findings five years after they were initially published and concluded that women who started HRT in the fi rst ten years following the beginning of menopause actually reduced their risk of heart disease – but this didn't make headlines either.

• Further analysis of the study showed that there was a significantly lower risk of breast cancer in women who took oestrogen-only HRT (so those women who'd had a hysterectomy in the past) and a lower risk of dying from breast cancer in women who took any type of HRT.

• The risk of breast cancer in women taking HRT with synthetic progestogen was very small and not even statistically significant.

A 2023 critical review of the WHI study concluded that 'a generation of women has been deprived of HRT largely as a result of this widely publicised misinterpretation of the data'[25].

The benefits of HRT usually far outweigh any risks, and body-identical HRT containing oestrogen in the form of 17 beta-oestradiol and micronised progesterone is extremely safe. There is no clot risk or cardiovascular risk with these natural hormones and there has never been a study showing an increased risk of breast cancer in women taking body identical HRT.

Awareness of the long-term benefits of HRT

As covered earlier in our response, low hormones during and after the perimenopause and menopause carry long-term health risks including osteoporosis, cardiovascular disease, type 2 diabetes and dementia.

By correcting the hormone deficiency, HRT will usually improve menopausal symptoms within a few months. However, little credence is given to the long-term protective effects of HRT. Not only would this improve quality of life but, as HRT is a relatively inexpensive treatment, these long-term benefits could help reduce the financial burden of treating conditions associated with low hormones.

The overall cost to Australian health system in treating these conditions among the population in Australia is enormous. For example:

- The total direct cost of osteoporosis in Australia in 2017 was estimated to be $3.44 billion[26]
- $2.3 billion was attributed to type 2 diabetes care in 2020-21[27]
- In 2020–21, an estimated 9.5% of total allocated expenditure in the Australian health system ($14.3 billion) was attributed to cardiovascular disease[28]
- In 2018–19, almost $482 million was spent on health services directly for dementia[29]

Osteoporosis

[25] Bluming A.Z., Hodis H.N., Langer R.D. (2023), ''Tis but a scratch', Menopause, doi: 10.1097/GME.0000000000002267

[26] Tatangelo, Gemma et al. "The Cost of Osteoporosis, Osteopenia, and Associated Fractures in Australia in 2017." Journal of bone and mineral research : the official journal of the American Society for Bone and Mineral Research vol. 34,4 (2019): 616-625. doi:10.1002/jbmr.3640

[27] Australian Institute of Health and Welfare, Diabetes: Australian facts https://www.aihw.gov.au/reports/diabetes/diabetes/contents/impact-of-diabetes/health-system-expenditure

[28] Australian Institute of Health and Welfare, Heart, stroke and vascular disease: Australian facts https://www.aihw.gov.au/reports/heart-stroke-vascular-disease/hsvd-facts/contents/impacts/expenditure-cvd

[29] Australian Institute of Health and Welfare, Dementia in Australia https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/population-health-impacts-of-dementia

Correcting the hormone deficiency via HRT helps to protect the bones from weakening due to lack of oestrogen and can reduce the risk of both osteoporosis and fragility fractures[30][31]. HRT is, in fact, licensed as a treatment for osteoporosis in the UK.

Type 2 diabetes

Women who take HRT have a lower future risk of developing type 2 diabetes. This is due to many beneficial effects of oestrogen, including reducing insulin resistance, improving insulin sensitivity in the liver, muscle and fat cells and insulin production in the pancreas.

Cardiovascular disease

By correcting the hormone deficiency and replacing the missing hormones, HRT helps to lower risk of heart disease in future. Oestrogen reduces inflammation in the endothelium, leading to less atheroma developing, which reduces risk of heart disease in the future. Body-identical HRT can also lower blood pressure and reduce the risk of heart failure and also atrial fibrillation occurring. Women who start HRT during the perimenopause or within ten years of the menopause have been shown to have a significantly lower risk of developing heart disease compared to women who don't take it[32][33]. Women who start taking HRT more than ten years after the menopause are also likely to have a lower future risk of heart disease, but the evidence is less robust.

Dementia

This is an emerging area of research, with more to be done.

However a 2023 meta-analysis of six clinical trials and 45 observational studies, encompassing data from more than six million women, in which women were given oestrogen-based therapy found Starting oestrogen hormone therapy during or soon after menopause could cut risk of Alzheimer's[34].

Findings from the study suggest that when started in midlife or within 10 years of menopause:

- Oestrogen therapy was associated with a 32% reduction in dementia risk
- Combined oestrogen-progestogen therapy was associated with a 23% reduction in dementia risk

When started after the age of 65:

- Oestrogen-only therapy had neutral effects
- Combined oestrogen-progestogen therapy was associated with a non-significant risk increase, largely linked to the use of synthetic progestin.

[30] Zhu L., Jiang X., Sun Y., Shu W., (2016), 'Effect of hormone therapy on the risk of bone fractures: a systematic review and meta - analysis of randomized controlled trials', Menopause, 23(4), pp. 46170. doi:10.1097/GME.0000000000000519

[31] Trémollieres F. (2019), 'Assessment and hormonal management of osteoporosis', Climacteric, 22 (2), pp. 122–6, doi: 10.1080 / 13697137.2018.1555582

[32] Maclaran K., Stevenson J. C. (2012), 'Primary prevention of cardiovascular disease with HRT', Womens Health, 8 (1) pp. 63–74. doi: 10.2217/whe.11.87

[33] Lobo, R. A., Pickar, J. H., Stevenson, J. C., Mack, W. J., Hodis, H. N. (2016), 'Back to the future: Hormone replacement therapy as part of a prevention strategy for women at the onset of menopause', Atherosclerosis, 254: pp. 282–90. doi: 10.1016/j.atherosclerosis.2016.10.005

[34] Nerattini, M. et al. "Systematic review and meta-analysis of the effects of menopause hormone therapy on risk of Alzheimer's disease and dementia." Frontiers in aging neuroscience vol. 15 1260427. 23 Oct. 2023, doi:10.3389/fnagi.2023.1260427

HRT and all-cause mortality

A prolonged period without oestrogen increases the risk of an earlier death. Clearly, lifestyle and other factors are important, but the beneficial effects of oestrogen have often been forgotten and overlooked over the past twenty years since the launch of the WHI study. A 2022 study examining whether HRT had any effect on mortality rates found that women who took combined HRT had a 9% lower risk of death from any cause than non-HRT users[35].

Affordability and availability of treatments

Despite readily safe HRT and non-hormonal interventions, over 85% of Australian women with symptoms are not receiving effective, approved therapy - a figure similar in the UK.

Several countries, including the UK and Australia, have experienced supply issues with HRT in recent years as menopause awareness increases, meaning women have struggled to access timely treatment. HRT isn't a one size fits all treatment; doses and products will vary from woman to woman, so a disruption in supply causes unnecessary anxiety and can impact women's physical and mental health.

Cost can also be a barrier. In 2023, the Department of Health and Social Care introduced a prescription prepayment certificate for HRT for women in England amid calls to widen access to HRT. Instead of paying for monthly prescriptions, women can access their HRT by paying a one-off charge the equivalent of two single prescriptions (currently £19.30 or $38 AUD). There is no limit to how many times the certificate can be used, or how many HRT items it can be used for, during the 12 months it is valid. However the certificate does not currently cover testosterone. Half a million women have signed up to the scheme since it was launched, with an estimated More than £11 million ($21 AUD) was saved by women using the PPC between April 2023 and January 2024[36].

In addition, vaginal oestrogen brand Gina was made available over the counter in the UK for the first time in 2022.

As one woman who had suffered with symptoms for nine years told Newson Health: '*The impact menopause has had on me and my family has been unexpected and life changing. Menopausal symptoms change all the time. There is no smooth path to recovery for many of us and it is important women have access to a wide variety of hormones.'*

What needs to be done

- **Greater education to debunk misinformation** on the safety of HRT
- **More long-term research** into the long-term benefits of HRT and testosterone
- **Working closely with companies** to ensure an uninterrupted supply of HRT
- **Allow women to access all forms of HRT more cheaply** to reap the benefits of symptom control and long-term positive impact on health

[35] Akter, N., Kulinskaya, E., Steel, N., Bakbergenuly, I. (2022), 'The effect of hormone replacement therapy on the survival of UK women: a retrospective cohort study 1984-2017', BJOG, 129 (6):994–1003. doi:10.1111/1471-0528.17008

[36] Department of Health and Social Care (2024), 500,000 women benefit from cheaper hormone replacement therapy