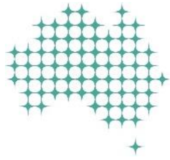

Submission to the Inquiry into Issues related to menopause and perimenopause

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The Australian Academy of Health and Medical Sciences

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Summary

The Australian Academy of Health and Medical Sciences (AAHMS, the Academy) welcomes this Senate Inquiry into the *Issues related to Menopause and Perimenopause*.

AAHMS is Australia's Learned Academy for the health and medical sciences – the impartial, authoritative, cross-sector voice. We advance research and innovation in Australia to improve everyone's health.

We are an independent, interdisciplinary body of Fellows – elected by peers for outstanding achievements and exceptional contributions to health and medical science in Australia. Collectively, AAHMS Fellows are a representative and independent voice, through which we engage with the community, industry and governments.

Our response has been informed by input from Fellows of the Academy and is focused on answering the Terms of Reference that relate to our remit and expertise. The term "women" is used for brevity, but it is important to acknowledge that some transgender men, non-binary, and gender diverse people might also experience menopause, and that transgender women might experience menopausal symptoms when decreasing or stopping hormone therapy.[1]

Our submission is focused on responding to the first point in the terms of reference (point 'a') and touches on elements for points 'g' and 'h'.

- **TOR 'a': The economic consequences of menopause and perimenopause, including but not limited to, reduced workforce participation, productivity and retirement planning.**
- **TOR '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.**
  TOR 'h': Existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause.

Key messages:

- While data are often quoted as to the adverse impact of menopause on work participation, satisfaction and capacity, there is a lack of high-quality evidence about whether perimenopause/menopause transition specifically impacts work engagement, productivity or retirement planning.
- Menopause can cause both physical and emotional difficulties at midlife, but these symptoms may not necessarily be attributed exclusively to menopause. Prevalent societal attitudes around sexism and ageism can also negatively impact older women and should be addressed.
- The critical factors(s) that may adversely affect work participation and engagement for midlife women still need to be determined. These may differ depending on the type of work.
- Robust data, from a large nationally representative, unselected, sample of women, are urgently needed. Such data would help to better understand why some midlife women are not part of the paid workforce; to differentiate between the impact of perimenopause/menopause and the impact of other midlife stressors that have economic consequences for women; and to document the impact of perimenopause/menopause alongside other midlife stressors. High quality long-term studies on women's health from midlife are needed.
- Incorrectly attributing work engagement issues to menopause risks stigmatisation and inappropriate management of the issues.

- New policies addressing the impact of menopause at work should be informed by high-quality evidence on the key economic barriers for women at midlife.
- Workplace policies should reflect the key concerns and needs of working women, including whether menopause leave is seen as a priority.
- It is important to agree on the role of the workplace in supporting women with menopause. The implementation of any workplace policies or amendments pertaining to female workers should not reinforce outdated perceptions and/or negative social attitudes about menopausal women.

Introduction

The perimenopause describes the time from the onset of menstrual irregularity to one year after the final menstrual period (the menopause), as outlined in Figure 1. During the early perimenopause menstrual bleeding problems are common. Heavy, irregular or prolonged menstrual bleeding affects >90% of women at least once and nearly 80% at least 3 times.[2] Women taking hormonal contraception may be unaware of the onset of perimenopause. Similarly, those with irregular/absent menstrual cycles, or following hysterectomy or endometrial ablation, may be uncertain about the timing of menopause.

The average age of the menopause in Australia has been reported as 51.5 years, mainly from data in women of European ancestry.[3] As the average age of menopause is lower in women of other ancestries (e.g. 49 years for Latin America[4], 46 years in India[5]) the variations in age at menopause need to be taken into consideration in the heterogeneous Australian population.

Symptoms do not reliably diagnose menopause and not all women are symptomatic. However, new onset or an increase in hot flushes and/or night sweats often indicates perimenopause (these are known as "vasomotor symptoms"). Other symptoms experienced by perimenopausal women, such as fatigue, headache, brain fog and weight gain, are not menopause specific, and may result from an array of life circumstances and other medical conditions.[6]

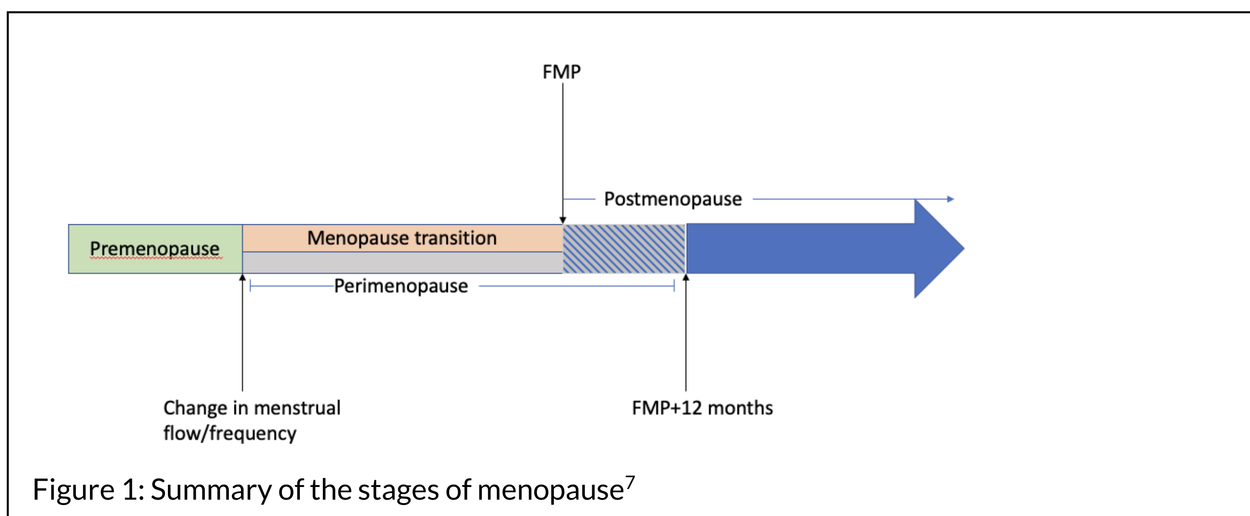

Figure 1: Summary of the stages of menopause[7]

A cross sectional study of 2,020 Australian women aged 40 to 65 years revealed:

- The prevalence of moderate to severe vasomotor symptoms to be 2.8% in premenopausal women, 17.1% in perimenopausal women, 28.5% in postmenopausal women younger than 55 years, 15.1% in postmenopausal women aged 55 to 59 years, and 6.5% in postmenopausal women aged 60 to 65 years.[8]
- Moderate to severe vasomotor symptoms are associated with lower wellbeing and moderate-severe depressive symptoms.[9,10]

Other common menopause-associated symptoms may include disturbed sleep, joint pain and vaginal dryness. Musculoskeletal pain affects some populations.

The final menstruation period, i.e. the period immediately before the menopause, occurs at an average age of 51 years old, while the perimenopause usually occurs several years earlier,

when a woman is aged 47-49 years.[6] However, there is substantial variability in the onset of these stages; although the average age at menopause in Australia is 51.5 years, an age range of 45-55 at menopause is considered normal, and up to 12% of women have their final period before they are 45 years of age.[3]

Hot flushes and night sweats start during perimenopause and are not always short-lived. A cross-sectional study showed that about 42% of Australian women aged 60-64 years continue to experience these, with about 6% describing them as moderately to severely bothersome.[8] Hot flushes may affect concentration and cause embarrassment, and night sweats often disturb sleep and impact on daytime function.

It is vital to recognise that menopause occurs at an age when multiple life stressors collide, such as responsibility for, and care of, others (children, siblings, partners, parents), work stress (e.g. greater demands or job dissatisfaction), financial stress, and personal health issues. These factors may profoundly affect work, and their effects may be exacerbated by interaction with symptoms.

Workforce, economic and productivity impacts

Contribution of midlife and older women to the workforce

As of 2020, Australian women represent almost half of the paid workforce, with increased presence as mature aged workers (i.e. those over 55 years old), a stark contrast to historical data, e.g. in 1966 women accounted for only 30% of the total workforce.[2] Women, particularly older women, constitute the great majority of voluntary workers and carers.[11] Older workers are a crucial component of the Australian workforce. The COVID-19 pandemic revealed that the majority of essential workers in health, childcare and education are women and older women are an important component of this workforce.[12] Australia has a shortage of skilled workers, particularly in healthcare, and we need strategies to attract and retain skilled older workers.

It is also worth noting that traditional "workforce participation" statistics may not accurately capture individuals engaging in the digital economy or those earning their incomes through social media platforms (e.g. YouTube and Instagram) and start-ups. An increasing number of women are engaged in such work. The number of women owning businesses is also on the rise, e.g. the McKell Institute reported that women-owned businesses now represent over 35% of all businesses, compared with 31% in the early 2000s.[13]

Impact of perimenopause/menopause on workforce participation

It is unclear whether perimenopause/menopause cause reduced workforce participation in Australia or elsewhere.

There have been examples globally of media coverage about women quitting their jobs because of menopausal symptoms. [14] However, quality evidence to support this is lacking. For example, Bupa in the UK published survey results and concluded that one million women quit their jobs because of menopause.[15] Box 1 provides further information on the nature of some such studies and how their usefulness may be limited. One such issue, for instance, is that samples in some studies are not selected to be statistically representative and can therefore be open to bias – e.g. women most bothered by symptoms that they attribute to menopause are most likely to answer these kinds of surveys, meaning the sample is not representative of the whole population of perimenopausal and postmenopausal women, and in other cases the vagueness of the questions asked renders these statistics unreliable. Similarly, the Australian Institute of Superannuation Trustees (AIST) estimated in 2022 that menopause may cost women $15.2 billion in lost earnings and superannuation.[16] This estimate appears to have been derived from UK surveys with methodological limitations (see Box 1) and the assumption that up to 25% of menopausal women experience 'debilitating symptoms that for some leads to long-term absences from work and for others forces them out of the workplace entirely'.[16] The source of this figure is not clear from the references and we are not aware of any robust Australian data showing such effects. There is no doubt that some women do leave the workforce, find they need to take long-term absences, or experience other such serious impacts, however, the data on the proportion of women to whom this applies need to be more robust to allow accurate conclusions to be drawn and appropriate measures introduced (Box 1 provides further supporting information).

A consistent message from the published literature is that work performance is not directly correlated with menopausal stage, i.e. whether a woman is premenopausal, perimenopausal or postmenopausal does not predict work productivity or work retention.[17–20]

However, having severe vasomotor symptoms has been associated with reduced work participation. The most robust data are from the UK, which showed that having severe menopausal symptoms was associated with reducing working hours (24.3% of women with severe symptoms reduced working by 5 or more hours/week vs 21.8% with no symptoms) and leaving the workforce (13.6% vs 8.5% respectively).[20] It is important that women impacted by such symptoms are adequately supported.

Impact of perimenopause/menopause on productivity

Australian data do not suggest that women have reduced productivity or plan to leave their jobs because of menopause, in fact their participation in the workforce is growing and they are playing an increasingly crucial role.[21]

In 2020, Australian midlife women were more likely to continue to work as they aged than they were in the past. For example, in 2000 the employment-to-population ratio (the number of employed women as a proportion of all women) for 50-year-old women was 70.5%, but only 53.5% for women aged 55 years. In 2020 the employment-to-population ratio for a 50-year-old woman had increased to 76.9%, but notably, the retention rate had increased considerably, such that for women aged 55 years, the employment-to-population ratio remained above 70% (71.7%).

For 65-year-old women in 2020 the employment-to-population ratio was more than three times higher (35.6%) than similar aged women in 2000 (10.0% in 2000).

Whilst a growing number of women are working during their perimenopause and during their early postmenopause 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 appropriately, if needed.[19,20,22]

A survey of 1,092 female healthcare workers in Victoria aged 40 to 73 years found no association between menopause stage and work engagement, organisational commitment, job satisfaction or work limitations. Two-thirds reported that menopause did ‘not at all’ affect their work performance, 6% that menopause ‘very much’ affected work performance and 6% that menopause ‘somewhat’ affected their work performance.[22] In particular, menopausal women did not wish to be considered a “problem group” in the workplace.

The Australian Midlife Women’s Health Study was a national cross-sectional survey of 2,020 women, of which 1,274 were in paid employment (aged 40-64 years). 1,263 of those in the sample completed a self-assessed, validated, work ability questionnaire.[23] 81.5% of these women rated their work ability as good-excellent. In concordance with the above study, only 6% rated their work ability as poor.

While menopausal stage has not been associated with work outcomes, the presence of severe menopausal symptoms (that may still occur many years post-menopause) has been associated with poorer work outcomes.

After adjustment for socio-demographic characteristics, having any vasomotor symptoms was associated with a two-fold greater likelihood of women rating their work ability as “poor-moderate”. [23] However, most of the women in this category had “moderate” work ability, which translates to the person assessing their capability for their work as satisfactory as opposed to

poor (incongruity between work demands and capability). In a longitudinal UK study of 3,109 women, unselected for menopause status, severe menopausal symptoms were associated with reducing working hours between the ages of 50 and 55 years (24.3% with severe symptoms vs 21.8% with no symptoms) and leaving work (13.6% vs 8.5% respectively).[20]

A 2023 Australian survey of more than 3,000 women reported that 64% of midlife women reported bothersome symptoms that they attributed to menopause, with 21% finding it hard to work or study, although only 7% said they had missed work or study due to these symptoms.[24] Overall, 3.8% of all those who experienced bothersome symptoms they attributed to menopause (i.e. all ages) said they missed days of work or study due to these symptoms.

Together, the available Australian and UK data suggest that some women do experience menopausal symptoms that impacts on their work.

Workplace factors that have been implicated in exacerbating the burden of menopausal symptoms at work included non-breathable uniforms, hot environment, lack of access to cool drinking water and shift work.[25]

Other factors independently associated with lower work ability included being unpartnered, obese/overweight, smoking, having carer responsibilities and having insecure housing finance.[20,23]

Impact of menopause on retirement

It is uncertain whether women retire earlier because of menopause.

On average, women spend less time in the workforce than men, largely because of absence due to parenting responsibilities. In Australia women earn 13% less than men on average, i.e. double the gender pay gap in the UK (7.7%), and retire with $136,000 (37%) less superannuation.[26,27,28] Together, these can contribute to poverty in older age.[29] The gender pay gap and less time in paid employment mean that retired women are more likely to live in poverty than retired men.[30] Consequently, midlife and older age women may find they need to remain employed because they cannot afford to retire. However, women at midlife may choose to retire from paid work for an array of positive reasons.

Box 1: Additional information on relevant studies

Relatively few studies of the effects of menopause on work are based on representative samples, many have selection bias (e.g. surveying only symptomatic women) or have not accurately identified women as being premenopausal, perimenopausal and postmenopausal. Few have included other sociodemographic or health variables. Data for women who are volunteers or carers for another person are lacking.

We outline some examples of studies below:

The UK Health and Employment After Fifty Study is a community-based cohort of people aged 50-64 years, not selected according to menopause status. It demonstrated the interaction between sociodemographic factors and menopause in working women.[31] It found that difficulty coping with menopausal symptoms in relation to work was associated with insecurity, worry about work, feeling unappreciated, and low job satisfaction. Other independent risk factors for coping at work included financial deprivation, poorer self-rated health, depression, and adverse psychosocial occupational factors but not physical demands.

The Australian Institute of Superannuation Trustees (AIST) has called on the Office for Women to measure and report on the extent to which menopausal symptoms impact women's employment and retirement decisions, and how these impact their super balances and retirement incomes.[16] The AIST estimated that menopause costs women more than $15.2 billion per year in lost earnings, but this report does not appear to provide clear data to support this claim. Notably, the report stated, *"What is unclear from this data is what role menopausal symptoms have on a woman's decision to retire and specific research needs to be undertaken by government to assess this"*. The financial estimates appear to be based on the following studies:

- **A survey by Benenden Health**, of 2,000 employees and 500 business owners, reported various findings, including that 23% of women who have been unwell as a result of the menopause have left jobs; however, the methodology used for this survey, or insights into the sample, do not appear to be available.[32]
- **A report by the Fawcett Society**, which reports on a survey commissioned by UK Channel 4 TV, undertaken by Savanta ComRes, of 4,014 UK women aged 45-55 who are currently or have previously experienced the perimenopause or the menopause.[33] The findings from this survey have major limitations:
  1. There was no formal assessment of menopause/perimenopause in the participants.
  2. There was no control group, i.e. age-matched women who had not experienced menopause.
  3. The two symptoms most commonly described as either very or somewhat difficult were difficulty sleeping (84%), and poor memory or concentration or difficulty focussing on tasks – sometimes called 'brain fog' (73%). These symptoms are not menopause specific. Without a control group these symptoms cannot be attributed to menopause
  4. Women classified as DE social grade (semi-skilled and unskilled manual occupations; unemployed and lowest grade occupations) found symptoms to be more difficult, raising a key issue of intersectionality. Those on lower incomes with less job security are more likely to work in environments that may exacerbate the burden of menopausal symptoms (shift work, uniforms. hot environments, uniforms).[34]

Bupa UK survey: conducted in 2019, the survey reported that 900,000 women leave the workforce in the UK each year because of menopause.[15] This figure comes from a market survey commissioned by Bupa UK that involved 1,000 women aged 18-70 years, i.e. it is not a survey of women in their midlife. There is very little information about the methodology used, for instance demographic information about the participants or how they were selected. It is not clear where the figure of 900,000 comes from. Further investigation, reported online, has suggested that the survey was, in fact, broader, with participants asked *'have you ever left your job because one of these events became unmanageable alongside work?'*, where 'events' included periods, fertility struggles, pregnancy and menopause.[35]

We are grateful for the contributions of our Fellows and Associate Members in developing this submission. For questions about our response, or to arrange a consultation with Fellows and Associate Members of the Academy, please contact Lanika Mylvaganam, Head of Policy (lanika.mylvaganam@aahms.org) at the Australian Academy of Health and Medical Sciences.

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