SUBMISSION

Inquiry into the Issues Related to Perimenopause and Menopause

Submission by the **Australian Physiotherapy Association**

February 2024

Authorised by:

Anja Nikolic
Chief Executive Officer
Australian Physiotherapy Association
Level 1, 1175 Toorak Rd Camberwell VIC 3124
Phone: (03) 9092 0888
Fax: (03) 9092 0899
www.australian.physio

Acknowledgement of Traditional Owners

The APA acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander Peoples today.

SUBMISSION

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

About the Australian Physiotherapy Association

The Australian Physiotherapy Association's (APA) vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy. The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 32,000 members. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

We are committed to professional excellence and career success for our members, which translates into better patient outcomes and improved health conditions for all Australians. Through our National Groups we offer advanced training and collegial support from physiotherapists working in similar areas.

SUBMISSION

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Table of Contents

SUBMISSION

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

1. Executive summary

The Australian Physiotherapy Association (APA) is pleased to contribute to the Senate Community Affairs References Committee's groundbreaking Inquiry into Issues Related to Perimenopause and Menopause (the Inquiry). We applaud the Australian Government's commitment to ending the suffering and taboo surrounding what has been called euphemistically but aptly "the change of life". In this submission, we have narrowed our focus on a number of symptoms of menopause but welcome the opportunity to present more expansive evidence to the Inquiry.

We see this Inquiry as an unprecedented opportunity to remove the stigma and shame that has been associated with the symptoms of menopause and reimagine the healthcare system to meet the complex needs of perimenopausal and menopausal women. Any reform must begin by embedding recognition of the physiological processes causing the often-debilitating symptoms, educating the sector and the community, and funding credible, evidence-based and low cost treatment pathways that address them.

As the symptoms and conditions experienced during perimenopause and menopause are finally being acknowledged and understood—no longer perceived as a woman's lot to simply put up with—so too should the effective, evidence-based health interventions that already exist to ensure they do not have to suffer.

Pelvic health physiotherapy is the first line treatment for symptoms most commonly reported as impacting quality of life, social and workforce participation and mental health, such as muscle and joint aches and pains, urinary incontinence and sexual pain.

Pelvic health physiotherapists are advanced practice professionals providing effective, individualised and group treatment. They are uniquely and highly qualified to reduce pain and discomfort and resulting withdrawal from activities of daily living caused by these symptoms, and are a critical part of the multi-disciplinary care team.

A shift towards timely evidence-based primary care interventions is critical to ensure effective outcomes, and avoid unnecessary pharmacology and costly surgeries.

While pelvic floor muscle training in individualised and group settings is a key component of pelvic health, a trusted relationship with a suitably trained physiotherapist provides women reassurance and comfort in identifying and addressing what can be highly sensitive health matters, and ensuring the continuity of care required to diagnose, treat and manage them.

We would like to see this Inquiry reshape women's health with funded access and workforce supports for pelvic health physiotherapy via Medicare, and the introduction of paid menopause leave, in addition to and as distinct from personal leave or sick leave, to enable women to attend appointments and manage their symptoms.

The APA has made a number of recommendations but accepts a number of models should be considered and are feasible with the inclusion and embedding of physiotherapy to ensure evidence-based first line and multidisciplinary approaches are adopted.

2. Recommendations

Recommendation 1	The APA calls for Medicare funding of the assessment and first-line, non-surgical pelvic health physiotherapy management of the conditions and symptoms associated with the genitourinary syndrome of menopause. This is a systemic reform combining better health outcomes for women with a reduction in costly surgeries and associated out of pocket expenses. Fund five individual physiotherapy consultations per year to enable assessment, program prescription, education and review. Fund two multidisciplinary case conferences annually. Fund 12-week physiotherapy-led group pelvic floor muscle training programs (once per week, eight participants) as prescribed by a physiotherapist to address the conditions and symptoms associated with genitourinary syndrome of menopause.
Recommendation 2	Allocate funding to PHN on a local area need basis to identify service gaps as identified in recommendation 1.
Recommendation 3	Fund access to pelvic health physiotherapy telehealth consultations to increase access to appropriate care, particularly for those in rural and regional areas.
Recommendation 4	Expand the scope and network of endometriosis and women's pain clinics to encompass women's health at all stages of life, removing remove financial and geographical barriers to affordable multidisciplinary, patient-centred care.
Recommendation 5	Recognise and grow the unique scope of pelvic health physiotherapy workforce by financially incentivising take up of advanced practice training.
Recommendation 6	Introduce requirements for paid workplace menopause leave to enable women to self-care, attend medical appointments and undertake therapy programs.

3. Introduction

For too long, the life-changing and often debilitating symptoms and conditions associated with perimenopause and menopause have been ignored, negated and dismissed – forcing women to live in pain and discomfort, and to withdraw from daily and social activities, sex and participation in the workforce.

They have faced these physiological changes and accompanying psychological impacts without access to prevention, early detection, and credible, holistic evidence-based care.

This has led to a reliance on pharmacological and costly surgical interventions, which often are not as effective as conservative management or a combined approach.

Physiotherapists have the skills, knowledge and expertise to diagnose, manage and treat a diverse range of acute and chronic health conditions and movement disorders. As members of a regulated profession, physiotherapists use clinical reasoning to determine a diagnosis and adopt the optimal treatment for each pathology presented. Physiotherapists are trained in evidence-based practice, evaluating the key issues and utilising numerous potential treatment approaches.

Advanced practice pelvic health physiotherapists are further qualified to conduct examinations and ultrasounds to diagnose and treat conditions and symptoms associated with genitourinary syndrome of menopause (GSM).

GSM encompasses a number of genital and urinary symptoms and signs associated with a decrease in oestrogen and other sex steroids leading to changes to the vulva, vagina, urethra and bladder. These include discomfort, sexual and pelvic pain, urinary incontinence and prolapse. They also address associated muscular and joint aches and pain, which have the leading reported impact on quality of life.

The symptoms of GSM can be a barrier for women to participate in exercise, a modifiable risk factor for other preventable chronic conditions.

Pelvic health physiotherapists undertake further training to develop skills specific for women's healthcare. The APA has developed and delivers courses to physiotherapists who work in the area of women's health and pelvic floor that are part of a career pathway that leads to titling and specialisation.

As movement and mobility experts, and health educators, physiotherapists take into account existing co-morbidities, personal capacity and lifestyle to address modifiable risk factors such as weight, and to maintain strength, balance and bone density, reducing the risk of osteoporosis and falls and fractures.

In Victoria, advanced practice clinics and services have been implemented in a number of areas including musculoskeletal, pain, neurosciences, continence and women's health.[1]

4. Physiotherapy-led pelvic floor muscle training

Pelvic health physiotherapists help prevent, treat and manage conditions such as pelvic floor weakness or tightness, urinary incontinence, pelvic pain and prolapse using targeted, pelvic floor muscle training (PFMT).

PFMT is a prescribed program of exercises for improving pelvic floor muscle strength, endurance, power and/or relaxation taught and monitored by physiotherapists. It is recommended as a first-line treatment for pelvic floor dysfunctions and has been found to be an effective treatment approach for postmenopausal women with GSM,[2] urinary incontinence[3] and pelvic organ prolapse.[4]

It has been demonstrated to be effective as part of individualised treatment and in follow-up physiotherapy-led group settings.

There is evidence that following individualised pelvic health physiotherapy consultations to learn PFMT, a 12-week program of once weekly physiotherapy-led PFMT as part of a group of eight women (with access to individual consultations as required) was clinically effective and reducing stigma and isolation.[5]

Stress urinary incontinence

Pelvic health and incontinence affects up to 30 per cent of women over the age of 40 with the financial cost estimated at approximately $9,014 per person (excluding the burden of disease).[6]

As a physical and social problem, stress urinary incontinence affects women's quality of life with associated shame and negative self-perception potentially leading to reduced social interaction and physical activity.[7]

Physiotherapy-led PFMT is the recommended first-line treatment for stress or mixed urinary incontinence in women. PFMT has been reported to be effective in curing or improving urinary incontinence symptoms in young, middle-aged, and older women.[8]

Evidence shows that the incidence of leakage can be reduced by 75 per cent after a 12-week course of physiotherapy-led PFMT once per week for urinary incontinence.[9]

However, without investment in funded access to pelvic health physiotherapy, surgery is frequently recommended despite serious adverse effects[10], adding costs and pressure to the healthcare system.

The average net-benefit of treating stress urinary incontinence with physiotherapy versus other approaches is estimated to be $16,814 per episode of care.[11]

Pelvic organ prolapse

Pelvic organ prolapse (POP) occurs when one or more of the pelvic organs descend into the vagina. This causes symptoms of heaviness, dragging, bulge or pressure. POP is estimated to affect more than half of women who have had a baby and becomes more common during menopause, significantly affecting their quality of life.

However, only one in five women seek medical help for their symptoms.

A suitably trained physiotherapist is able to assist in the management of POP by:

- educating lifestyle modifications to reduce symptoms such as weight loss, treating constipation, avoiding straining and heavy lifting
- teaching pelvic floor muscle training, which has a demonstrated benefit in the treatment of POP[12], individualised to the woman
- fitting vaginal pessaries to support the prolapse
- providing prolapse-friendly exercises and activities to meet national physical activity guidelines
- discussing medical options such as local oestrogen or surgical outcome rates, which are often better if pelvic floor training is commenced prior to surgery.

5. Musculoskeletal aches and pains

As oestrogen and collagen levels decline during menopause, muscular aches and pains become more prevalent and are the number one cause of decline in quality of life reported by women during this stage of life. Overall, women had higher rates of chronic pain (21 per cent) than men (17 per cent).[13]

Physiotherapy promotes improved function through movement, rehabilitation and exercise. Sedentary behaviours and low levels of physical activity are associated with chronic pain.[14] Regular physical activity

may reduce pain severity and increase the ability to perform the tasks required for daily living and recreation in those with chronic pain.[15]

Physiotherapy's scope includes weight management via exercise and health promotion. Being overweight or obese is a risk factor for developing chronic pain.[16] A higher body mass index is associated with greater joint and back pain due to the increased pressure on these areas.

Physiotherapy management is effective in reducing pain and in improving quality of life, physical functioning and depression. Physiotherapy is an effective treatment strategy for acute, chronic and neuropathic pain.

Common conditions affecting menopausal women include greater trochanteric pain syndrome (GTPS), which produces pain radiating in the lateral hip and can cause debilitating tendon pain and dysfunction. Hormone changes have a negative effect on tendons, which become thinner and more prone to rupture (tendinopathy).

Conservative management via physiotherapy and exercise are first-line interventions in the clinical management of GTPS[17] and tendinopathy. Physiotherapists diagnose and treat the conditions with targeted and graduated exercises, manual therapy and pain relieving strategies. Evidence has demonstrated that ongoing physiotherapy-led exercise is more effective in reducing tendinopathy pain than a pharmacological approach.[18]

6. The solution

Access to prevention, early intervention, diagnosis and quality care to improve function and reduce the symptoms of menopause is essential. Living with pain, discomfort and social isolation is not only debilitating to the individual; it places a significant economic burden on the nation.

Too many women are without access to prevention, early detection and quality care by highly qualified and credible healthcare practitioners. Investment in publicly funded pelvic health physiotherapy for women is long overdue and will advance health, improve care and increase value.

The APA calls for greater integration of pelvic health physiotherapists into primary healthcare. Too many women are without access to prevention, early detection and quality care by highly qualified and credible healthcare practitioners.

Women require access to specific Medicare funding and local area provision of both individualised and group physiotherapy consultations to address perimenopausal and menopausal symptoms and promote positive health-related quality of life.

Financial and geographic barriers to care must be removed and this can be achieved through the expansion of the scope and network of endometriosis and women's pain clinic to encompass a broader women's health focus and embedding advance practice pelvic health physiotherapy within them. Pelvic health physiotherapy consultations are another key mechanism to ensure access to care for women in rural and remote areas.

We must grow and support the advanced practice pelvic health physiotherapy workforce to ensure women have access to their critical care wherever they live and whatever their socioeconomic circumstance.

Introduce requirements for paid workplace menopause leave, in addition to and distinct from sick leave, in recognition that menopause is not an illness but a stage of life during which women need additional support. This leave would enable women to self-care, attend medical appointments and undertake therapy programs.

7. Conclusion

The growing awareness and openness surrounding the often-debilitating symptoms of perimenopause and menopause is encouraging. The Senate References Committee examination of this critical life stage and its impacts is an unprecedented opportunity to ensure Australian women have access to effective, evidence-based non-surgical health-care from trusted practitioners. It is time to remove the financial and geographic barriers to expert pelvic healthcare.

8. References

[1] State of Victoria (Department of Health). (2016). Advanced Practice in Allied Health. https://www.health.vic.gov.au/allied-health-workforce/advanced-practice-in-allied-health.

[2]J Mercier, M Morin, D Zaki, B Reichetzer, M Claude Lemieux, S Khalifé, C Dumoulin. Pelvic floor muscle training as a treatment for genitourinary syndrome of menopause: A single-arm feasibility study. https://doi.org/10.1016/j.maturitas.2019.03.002

3 C Dumoulin, J Hay-Smith, G Mac Habée-Séguin, J Mercier. Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women: a short version Cochrane systematic review with meta-analysis DOI: 10.1002/nau.22700

[4] S..Hagen. A randomized controlled trial of pelvic floor muscle training for stages I and II pelvic organ prolapse.. Int. Urogynecol. J. (2009)

[5] Group-Based vs Individual Pelvic Floor Muscle Training to Treat Urinary Incontinence in Older Women A Randomized Clinical Trial Chantale Dumoulin, PhD; Mélanie Morin, PhD; Coraline Danieli, PhD; Licia Cacciari, PhD; Marie-Hélène Mayrand, MD, PhD; Michel Tousignant, PhD; Michal Abrahamowicz, PhD; for the Urinary Incontinence and Aging Study Group

6 Deloitte Access Economics. The economic impact of incontinence in Australia. The Continence Foundation of Australia; 2011

[7] Johnson TM II, Kincade JE, Bernard SL, Busby-Whitehead J, Hertz-Picciotto I, DeFriese GH. The association of urinary incontinence with poor self-rate Sen I, Onaran M, Aksakal N, et al.

[8] Dumoulin C, Cacciari LP, Hay-Smith EJC. Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women. Cochrane Database Syst Rev. 2018;10(10):CD005654. doi:10.1002/14651858. CD005654.pub4

[9] The impact of urinary incontinence on female sexual function. Adv Ther. 2006;23(6):999-1008. doi:10.1007/ BF02850220 d health.J Am Geriatr Soc. 1998;46(6): 693-699. doi:10.1111/j.1532-5415.1998.tb03802

[10] Engen M, Svenningsen R, Schiøtz HA, Kulseng-Hanssen S. Mid-urethral slings in young, middle-aged, and older women. Neurourol Urodyn. 2018;37(8):2578-2585. doi:10.1002/nau.23583

[11] Qasem A, et al. (2014); Thom DH and Rortveit G (2010); Deloitte Access Economics (2011); Nous Group (2020).

12 Chunbo L, Yuping G, Bei W. The efficacy of pelvic floor muscle training for pelvic organ prolapse: a systematic review and meta-analysis, International Urogynecology Journal 27(7). OI:10.1007/s00192-015-2846-y

[13] Australian Institute of Health and Welfare. (2020). *Chronic pain in Australia*. Canberra: AIHW.

[14] Nielens H, Plaghki L. Cardiorespiratory fitness, physical activity level, and chronic pain: are men more affected than women? Clin J Pain. 2001 Jun;17(2):129-37. doi: 10.1097/00002508-200106000-00005. PMID: 11444714.

[15] Geneen LJ, Moore RA, Clarke C, Martin D, Colvin LA, Smith BH. Physical activity and exercise for chronic pain in adults: an overview of Cochrane Reviews. Cochrane Database Syst Rev. 2017 Apr 24;4(4):CD011279. doi: 10.1002/14651858.CD011279.pub3. PMID: 28436583; PMCID: PMC5461882.

[16] Okifuji A, Hare BD. The association between chronic pain and obesity. J Pain Res. 2015 Jul 14;8:399-408. doi: 10.2147/JPR.S55598. PMID: 26203274; PMCID: PMC4508090.

17 French, H., Woodley, S., Fearon, A., O'Connor, L. and Grimaldi, A., 2020. Physiotherapy management of greater trochanteric pain syndrome (GTPS): an international survey of current physiotherapy practice. Physiotherapy, 109, pp.111-120.

[18] A Grimaldi, A Fearon. Gluteal Tendinopathy: Integrating Pathomechanics and Clinical Features in Its Management. Phys Ther 2015;45(11):910-922. Epub 17 Sep 2015. doi:10.2519/jospt.2015.5829