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The medical management of menopause: A four-country comparison care in urban areas

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Abstract

Objective: To compare the medical management of menopause across urban areas in four countries which differ by level of income and degree of medicalization.
Methods: Surveys of health providers who advise women on the menopausal transition were carried out in Beirut, Lebanon ($n = 100$), Madrid, Spain ($n = 60$), Worcester, MA, U.S. ($n = 59$), and Rabat, Morocco ($n = 50$) between 2002 and 2004. Physician characteristics, hormone therapy (HT) prescribing practices, and concerns about the management of menopause were compared across countries using χ^2 and logistic regression analyses.
Results: Across sites, physicians were generally well informed about HT and thought that symptom alleviation and disease prevention were equally important. They had concerns about risks associated with HT, particularly breast cancer, and in 3 sites where the survey was conducted after the WHI (Beirut, Rabat, and Madrid) physicians changed their practices to prescribe HT less frequently, for shorter durations, or shifted to other medications. There were significant differences across sites in the recommended duration of HT, time spent talking with patients, perceived benefits of HT, tests recommended before prescribing HT, and concern about the risks associated with HT. Physicians in Madrid and Massachusetts were more likely to report that decisions about the management of menopause were difficult, but in all sites the main reason for difficulties was concerns about risks. The results also suggest discrepancies between physicians' perceptions and women's reports about the reasons why women consult at menopause.
Conclusions: Prescription patterns and perceived benefits of HT appear to reflect local medical culture rather than simply physician characteristics. The impact of the WHI study was seen in prescribing patterns and concerns about HT. Physicians in all four countries were generally well informed. Financial support: NIH 5 900 000196.

Keywords: Menopause; Hormone therapy; Physician prescribing practices; Medicalization; Lebanon; Spain; United States; Morocco

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1. Introduction

Menopause is a medicalized condition; a normal life course event that comes under the sphere of medical supervision and influence [1]. Meyer [2] argues that the medicalization of menopause began in the U.S., spread across Europe, and then to the rest of the world. The same process may now be happening to the so-called "male menopause," previously understood to be social issue, but now refashioned into a medical problem [3]. The extent to which menopause is medicalized differs across countries, and even across regions within the same country [4]. Medicalization occurs in response to the concerns and demands of patients, physician education and socialization, and commercial and market interests [5–12].

The use of estrogen replacement therapy (ERT) after menopause was popularized in the 1960s and 1970s as a means to reduce hot flashes and improve skin tone [13]. The popularity of ERT declined at the end of the 1970s because of its association with endometrial cancer [14]. Progestogen was added to the regimen to protect the uterus from cancer and, in the 1980s, hormone replacement therapy (HRT) was reconfigured as a preventative for osteoporosis [12]. HRT was recommended for use by all women in 1992 [15], and by the end of the 1990s, hormone therapy (HT) was portrayed as a preventative for coronary heart disease and dementia in addition to its FDA approved role as a treatment for vasomotor symptoms and osteoporosis.

The use of HT was dramatically called into question in 2002 when the Women's Health Initiative (WHI) was stopped due to a demonstrated increase in risk of venous thrombosis, ischemic stroke, breast cancer, and dementia among women taking HT compared to women taking placebo [16–19]. While researchers and clinicians continue to debate the details of the WHI [20–23], women around the world responded to the findings of the WHI by stopping the use of HT [24–28].

Treatment of vasomotor symptoms (i.e., hot flashes and night sweats) is the primary indication for HT. HT products are also FDA approved for treating vaginal atrophy and for preventing osteoporosis [29]. The use of HT varied across countries prior to the WHI study [30–32] and use continues to vary across countries in the wake of the WHI results. The purpose of this study was to compare the medical management of menopause, with particular emphasis on the use of HT, across four urban areas in Lebanon, Spain, the United States, and Morocco.

These four countries differ in terms of income, cost of health care delivery, risk of chronic diseases associated post-menopausal declines in levels of estrogen (e.g., cardiovascular disease) and risk of cancers associated with ERT (endometrial cancer) and HT (breast cancer) (Table 1). Of the four countries, the U.S. has the highest per capita income and the highest per capita total expenditure for health, Morocco has the lowest income and health care expenditure. In the U.S. 55% of health care expenditure comes from non-governmental sources (e.g., private insurance and out-of-pocket). This is lower than the percentage of non-governmental health care expenditure in Lebanon (73%) and Morocco (66%) but higher than non-governmental health care expenditure in Spain. Morocco has begun to implement a universal health insurance plan, but the system in place when this survey was carried out was a mixture of separate mutual insurers (e.g., for civil servants), private health insurance, and a compulsory social security system [33]. Spain, on the other hand, has had a comprehensive, single-payer national health service since 1978 (http://www.euro.who.int).

The studies presented here were carried out in the capital cities of Beirut, Lebanon; Madrid, Spain; and Rabat, Morocco; and in the urban area of Worcester, MA, U.S. (population 172,648, 2000 census). This sampling limits the generalization of results to rural areas; however, the sampling of these urban centers increases the comparability of the studies because all four areas share a high degree of access to resources including at least one medical school.

2. Methods

The Decisions At Menopause Study (DAMES) was designed as a multisite study of women's experience of menopause and the role of health providers who advise women on the menopausal transition. Women aged 45–55 were drawn from the general population in Beirut, Lebanon; Madrid, Spain; central Massachusetts, U.S.; and Rabat, Morocco [34–38]. At about the same time, surveys were administered to health care providers in the same four locations. Results from the health care provider surveys are presented here.