NSW GOVERNMENT

MAPPING OF NSW WOMEN'S HEALTH CENTRES

LITERATURE REVIEW 2017

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WOMEN'S HEALTH LITERATURE REVIEW

ACRONYMS

ALSWH	Australian Longitudinal Study of Women's Health
AIHW	Australian Institute of Health and Welfare
ANROWS	Australian National Research Organisation for Women's Safety
AWHN	Australian Women's Health Network
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
CoE	National Centre of Excellence for Women's Health
CSDH	Commission on the Social Determinants of Health
DFV	Domestic and Family Violence
IPV	Intimate Partner Violence
LHD	Local Health District
MBS	Medical Benefits Scheme
MIs	Myocardial Infarcts
PBS	Pharmaceutical Benefits Scheme
PCC	Patient-Centred Care
PHC	Primary Health Care
PHN	Primary Health Networks
SARCs	Sexual Assault Resource Centres
WGE KN	Women and Gender Equity Knowledge Network
WHO	World Health Organisation

OTHER

'Heart Foundation'	National Heart Foundation of Australia
'the Ministry'	NSW Ministry of Health

EXECUTIVE SUMMARY

BACKGROUND

Urbis was commissioned by the NSW Ministry of Health (the Ministry) to undertake a mapping study to establish a comprehensive understanding of the services provided by Women's Health Centres in NSW and their alignment with state and local priorities. This literature review was conducted to inform the research project.

Core topics for this research comprised:

- women's experience of health and the gender based vulnerabilities that influence women's health outcomes,
- the services currently available to women through the 20 Women's Health Centres in NSW,
- the models of care that are most likely to positively affect women's health outcomes.

KEY FINDINGS

Women's health and the experience of gender as a social determinant

Across the past three decades, there has been a growing recognition that women's health is influenced by a broad range of 'political, social, economic, and cultural forces' (CSDH, 2008). Referred to as the social determinants of health, this shift marked a movement away from an exclusive focus on women's reproductive functions and biology (Weisman, 1997), to a consideration of gender as a distinct determinant of women's health. Evidence collected in this literature review suggests women experience health inequities and inequalities as a direct result of their distinct gender role.

Gender-based vulnerabilities identified in the literature included:

- income inequality between men and women (Ichiro Kawachi & Kennedy, 1999)
- women's ability to access financial resources (DiGiacomo et al., 2015; Hills & Mullett, 2005)
- women's experience of violence (Krug et al., 2002), including intimate partner and/or domestic and family violence (ANROWS, 2016; DiGiacomo et al., 2015 citing Beal 2006 and UN Women 2011)
- women's capacity to play an active role in decision-making when it comes to their health and preferences for health care (Anderson et al., 2001; DiGiacomo et al., 2015)
- the devaluing of women's health concerns within the health system (Anderson et al., 2001; DiGiacomo et al., 2015), including women's experience of discrimination (Kurtz et al. 2008)
- women's level of educational attainment (Adamson et al., 2007)
- women's disproportionate role as caregivers, including caring responsibilities for a partner or elderly parent (DiGiacomo et al., 2011; Hills & Mullett, 2005).

Models for women's health care

This reframing of women's health has implications for the models of care that are most likely to positively affect women's health outcomes (including service access), as services must reflect the unique experiences that derive from women's biological differences, as well as their distinct gender roles (WHO, 2001). The literature revealed three key models that have come to influence the delivery of women's health services, including:

- **The social model of health** - "an approach to service delivery, health promotion and community development that addresses the broader determinants of health and acts to reduce social inequalities and injustices, with an emphasis on community engagement and participation and empowerment of individuals and communities" (AWHN, 2012 citing: Keleher & MacDougall 2011, p 320).
- **The primary health care (PHC) model** - seeks to achieve health equity, by addressing the "whole range of social and environmental factors that cause ill-health as well as those that sustain and create good

health" (Keleher, 2001 p 8). The model uses "a wide-ranging approach to the delivery of a comprehensive variety of health services" (Hills & Mullett, 2005 p 326), as distinct from primary care, which refers to the "medical care that is delivered at a patient's first point of contact with the health care system" (Hills & Mullett, 2005; Keleher, 2001), for example, General Practitioners.

- **Women-centred approach to care** - a women-centred approach is responsive to women's unique health needs and preferences for care. Women centred care is "gender inclusive" as it recognises the role gender plays as a social determinant of health (Hills & Mullett, 2002 p 86)

Model elements that positively impact women's health outcomes

While limited evidence was found to demonstrate a direct causal link between these models and improvements in women's health outcomes, the literature suggests some of the elements of each model align with women's preferences for care and create an enabling environment for improvements in women's health outcomes. Key elements identified in this review are summarised in the table below:

Table 1: Service elements that have been found to positively affect women's health outcomes

	Service element
1	Delivering quality care that is holistic in scope and recognises women's overall physical, mental and emotional wellbeing
2	Empowering women and promoting their participation as 'partners' in their health care
3	Providing access to female physicians
4	Facilitating inclusive care, including culturally appropriate care
5	Creating safe, private and women-friendly spaces for women to access essential health services
6	Providing opportunities for single site service provision
7	Promoting continuity of care
8	Providing access to affordable health services
9	Adopting a life course approach to women's health issues

CONCLUSION

The evidence obtained in this literature review suggests that Women's Health Centres in NSW are applying many of these elements to a greater or lesser extent. Several core themes emerged in relation to the Centres' self-reported approaches to service delivery, including:

- a focus on delivering women-centred approaches to care and empowering women to play an active role in their health care
- a holistic view of women's health, including a recognition of the social determinants of health
- the provision of a broad range of services in the one health centre – including medical and complementary health services, alternative therapies, counselling, massage, group programs, health promotion, information and referral services, legal support, advocacy, case work and outreach
- a dual focus on prevention and treatment, including health promotion, education and referral services
- a commitment to achieving health equity for women and girls
- promotion of access to affordable health care for women, including free or heavily discounted services for women.

At this stage of the mapping study, evidence was limited to a desktop review and as a result the extent to which these elements are applied by the Women's Health Centres is difficult to ascertain. A core focus of the primary research will be to understand the extent to which these elements have been effectively integrated into the service delivery models currently applied by the 20 Women's Health Centres in NSW. The research will also seek to identify other model elements that have been found to positively affect women's health outcomes.

1.1. INTRODUCTION

Urbis has been commissioned by the NSW Ministry of Health (the Ministry) to undertake a mapping study to establish a comprehensive understanding of the services provided by Women's Health Centres in NSW and their alignment with state and local priorities. This literature review was conducted to inform the research project, with a focus on women's experience of health, the services currently available to women in NSW and the models of care that are most likely to positively affect women's health outcomes.

Within Australia, a social gradient exists in the health outcomes of specific population groups (AIHW, 2016). Women in Australia experience health in unique ways, as well as face distinct health issues across their life span (NSW Health, 2013). This review begins with an overview of women's health and the gender based vulnerabilities that impact women's health outcomes. Chapter 0 then outlines the services currently available to women through the Women's Health Centres in New South Wales, as well as other jurisdictions in Australia. Select examples from international jurisdictions is considered in Chapter 1.5. The evidence regarding which service delivery models are most likely to positively affect women's health outcomes is then assessed in Chapters 1.6 and 1.7. This includes a discussion of the attributes of health services that have been found to align with women's preferences for care and create an enabling environment for improvements in women's health.

1.2. METHODOLOGY

A search for relevant literature and documents was conducted through the following databases and resources:

- a number of databases provided by EBSCO, including Academic Search Complete, SocINDEX with Full Text, Health Policy Reference Centre and Social Work Reference Centre
- Google, Google Scholar and relevant websites in Australia and overseas, including but not limited to Commonwealth, Australian state and territory health departments, websites of women's health peak bodies and organisation in Australia (e.g. Women's Health NSW and the Australian Women's Health Network) and websites reporting on health data (e.g. the Australian Institute of Health and Welfare)
- journals to access relevant peer reviews, including the Medical Journal of Australia, Australian Journal of Rural and Remote Health and the Journal of the American Medical Association.

Key search terms used in this review comprised –

- women's health
- women's health in Australia
- social determinants of health
- women's health and the social determinants of health
- women's health services
- women's health service delivery models
- feminism and women's health
- a feminist model for women's health care
- women's health and empowerment
- gender differences and health care
- gender differences and health care in Australia
- improving women's health outcomes
- women and primary health care
- women-centred care.

1.3. WOMEN'S HEALTH

1.3.1. Social determinants of health

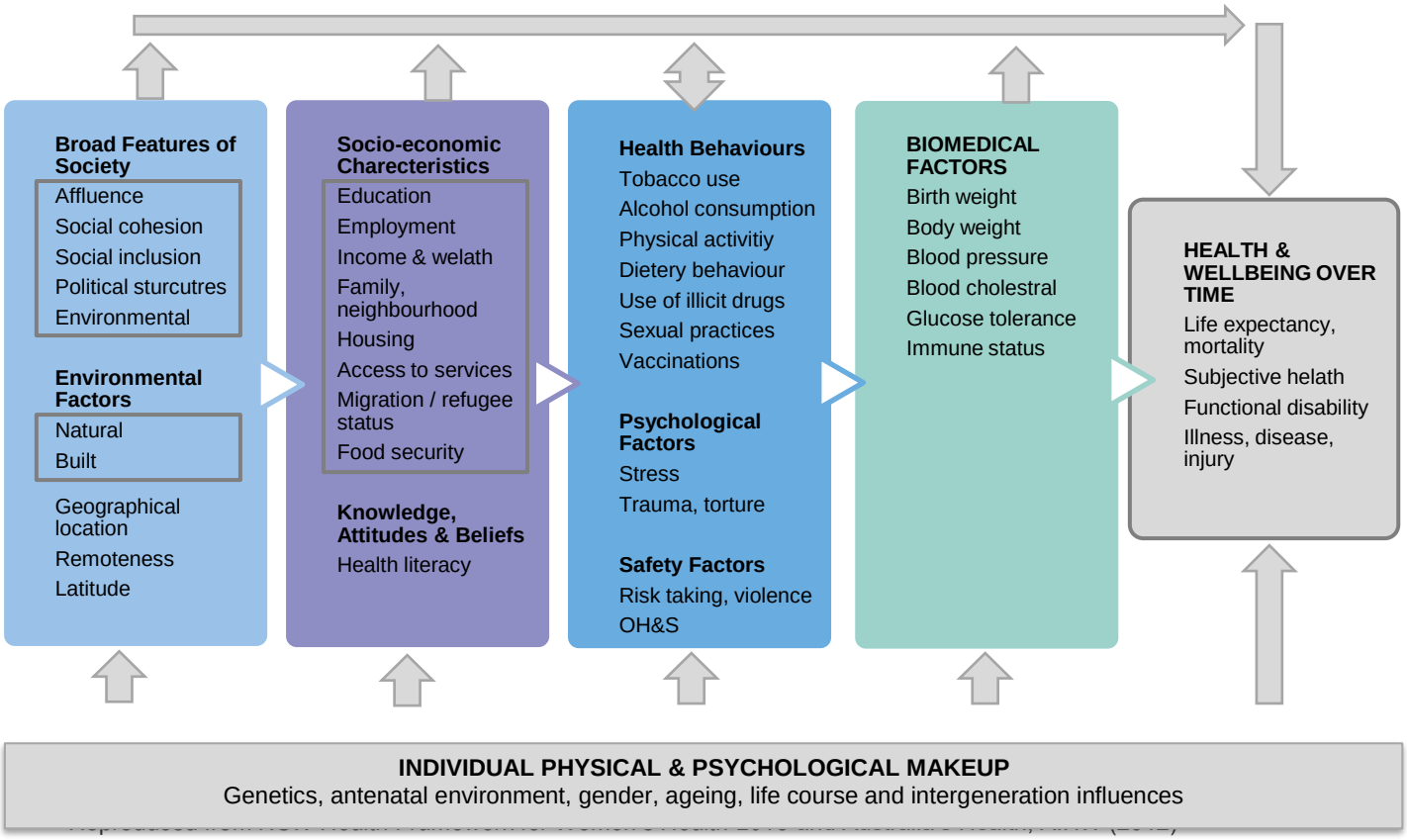
Good health is commonly defined as a "state of complete physical, mental and social-wellbeing and not merely absence of disease or infirmity" (WHO, 1948 p 1). It is now widely recognised that health is not only influenced by biological and physiological factors, but also a broad range of 'political, social, economic, and cultural forces' (CSDH, 2008). Referred to as the 'social determinants of health', these influences have been defined as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (WHO, 2017b p 1). They include a broad range of social factors, such as wealth, gender, race, political power and social inclusion (Figure 1). Significantly, the social determinants of health have been shown to contribute to health inequities between and within countries, as well as directly impact individual health outcomes (CSDH, 2008). Evidence suggests a social gradient in health has emerged, in which an individual's socioeconomic status often correlates with their experience of health or ill health (Marmot, 2007). As Marmot observes, "[w]ith few exceptions, the evidence shows that the lower an individual's socioeconomic position the worse their health" (Marmot, 2007 p 10)

In March 2005, the former Director General of WHO, Dr JW Lee, established the Commission on the Social Determinants of Health (CSDH). The CSDH was endowed with the task of drawing attention to the social determinants of health and the 'pragmatic ways' that health outcomes could be improved by focusing on the social conditions required for good health (CSDH, 2006 p 6). This framing of health as a social phenomenon was seen to reveal the complexity of health and its importance as a matter of social justice. As a direct result, the CSDH's work was grounded in a focus on health equity, which it defined as the "absence of unfair and avoidable or remediable differences in health among social groups" (WHO, 2010 p 4). One of the key implications of this framing is that efforts to improve health outcomes must rely on "more complex forms of intersectoral policy action" (WHO, 2010 p 4), as distinct from an exclusive focus on "technology-based medical care and public health interventions" (WHO, 2010 p 4). That is, services targeted at improving the health status of vulnerable target populations, including women, must not only consider the individual's biological and physiological traits, but also the social context in which health and illness occur (Germov, 2014).

While a large body of literature has focused on the impact of income inequality in influencing individuals' health outcomes (Sen & Östlin, 2008), it is important to recognise that health disparities occur along several complex and often intersecting "axes of social stratification" (Marmot, 2007 p 10). That is, a broad range of social factors impact an individual's health, for example housing, health literacy, access to services and social inclusion. This is also highlighted in the differential health status of men and women across the globe, which has been described by the WHO as "perhaps the single most pervasive and entrenched inequity" (Marmot, 2007 p 15).

Importantly, when considering the role of the social determinants of health it is important to draw a distinction between health inequality and health inequity. While health inequality refers to "the differences, variations and disparities" (I. Kawachi et al., 2002) in health outcomes of individuals and specific cohorts, health inequities are "are *avoidable* inequalities in health between groups of people" (WHO). That is, inequalities in health outcomes which "are deemed to be unfair or stemming from some form of injustice" (I. Kawachi et al., 2002).

Figure 1 – The determinants of health



1.3.2. Gender as a social determinant of health

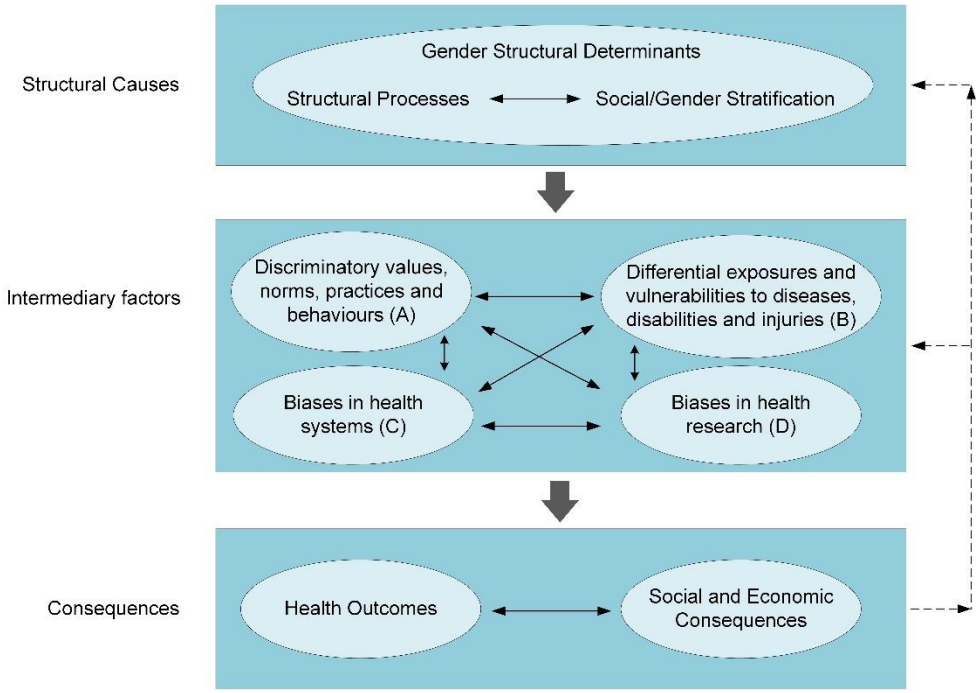
It is now widely recognised that gender is a social determinant of health (DiGiacomo et al., 2015; Hills & Mullett, 2005; Phillips, 2005). In contrast to the term sex, which refers to the 'different biological and physiological characteristics of males and females,' gender refers to the 'economic, social, political and cultural attributes and opportunities ascribed with being either female or male' (AWHN, 2012; WHO, 2013). These socially constructed characteristics influence the health status of men and women through a range of pathways, such as an individual's vulnerability to ill health, their capacity to access health services, their experience of care and ability to exert control over their health and healthcare decisions (Sen & Östlin, 2008).

The role of gender as a social determinant of health was central to the work of the Women and Gender Equity Knowledge Network (WGE KN), which reported to the WHO CSDH. In their final report to the CSDH, WGE KN presented a conceptual framework for understanding the structural and intermediary factors that contribute to health inequity (Figure 2). The structural determinants were seen to include the gender systems and relations of power that "govern how people live, and what they believe, and claim to know, about what it means to be a girl or a man" (Sen & Östlin, 2008). The intermediary factors identified included:

- discriminatory values, norms, practices and behaviours
- differential exposures and vulnerabilities to disease, disability and injuries
- biases in health systems
- biased health research (Sen & Östlin, 2008 p 3).

This framework highlights the influence of gender across the health system and beyond, and demonstrates the need for holistic responses to the health inequities between men and women (Sen & Östlin, 2008). That is, similar to the conclusion of the CSDH, intersectoral action is required (CSDH, 2008). Of particular significance to this review, this framework also highlights the need for responses that overcome the unique barriers faced by men and women when accessing health services, including the experience of discrimination and biases embedded within the health system.

Figure 2 – Framework for the role of gender as a social determinant of health



Reproduced from (Sen & Östlin, 2008 p 3).

The influence of gender on both men and women

Importantly, gender has "meaning for both men and women" (AWHN, 2012 p 7) and contributes to health inequity and inequality in all societies to a varying degree (WHO, 2013). Sen and Östlin observe that despite men commonly experiencing greater 'resources, power, authority and control,' these social benefits can also have detrimental impacts on their overall health and wellbeing. Specifically, the social benefits can be "translated into risky and unhealthy behaviours, and reduced longevity" (Sen & Östlin, 2008 p 1). At the same time, these 'gender relations of power' (Sen & Östlin, 2008 p 2) also influence women's experience of health. Despite women having a longer life expectancy than men in a number of countries, including Australia, women fall behind on a number of key health indicators. As an example, globally, women are more likely to experience depression (5.1 per cent) than men (3.6 per cent) (WHO, 2017a). Rates of hospitalisation for self-harm in Australia are also higher in women (154.4 per 100,000 population in 2010-11) than men (101.1 per 100,000 population in 2010-11) (NSW Ministry of Health, 2013). As DiGiacomo et al observe, "Women continue to experience inferior health outcomes across a number of conditions, despite human rights advances and average longevity in many developed countries as surpassing men by several years" (DiGiacomo et al., 2015 p 106). These health inequalities will be explored in depth below.

The 'interconnectedness' of sex and gender

While gender is often positioned as a distinct determinant, when considering health outcomes, Phillips (2005) suggests that sex and gender cannot adequately be examined independent of each other (Phillips, 2005). The 'interconnectedness' of biology and gender is said to be demonstrated in men and women's varying experiences of myocardial infarcts (MI), commonly referred to as heart attacks. Despite MIs being a leading cause of death among both men and women in developing countries, Phillips observes that heart disease is typically presented as a 'male affliction' (Phillips, 2005 p 13). This includes the presentation of chest pain, the most common symptom experienced by men but not women, as the "most important diagnostic clue to the presence of angina" (Phillips, 2005 p 13). Phillip's suggests that in such a case there "is no practical advantage to disentangling where sex ends and gender takes over" (Phillips, 2005 p 13)as a proper diagnosis will require health professionals to both recognise the unique symptoms experienced by women, as well as reject the dominant gender narrative that men are "the bearers" of coronary heart disease (Phillips, 2005 p 13). In response, Philips concludes "it might prove pragmatic to consider that gender encompasses both sex differences and the social constructs that give rise gender differences (Phillips, 2005 p 13).

Similar interplays are observed in the Health Foundation's Women and Heart Disease Forum Report (2011). The report points to research that indicates "women mistakenly believe that heart disease is only a male problem, with women tending to dismiss their symptoms or not seek help until their condition becomes

serious" (Heart Foundation, 2011 p 6). Additionally, focus groups undertaken with women aged 45-64, revealed a range of social determinants directly impact women's experience of cardiovascular health, including their "socioeconomic status, cultural background, health literacy, and rurality" (Heart Foundation, 2011 p 7). These social influences were seen to be a particular concern given that while men experience greater incidences of heart disease, women experience inferior health outcomes, including higher mortality rates (Heart Foundation, 2011 p 6). Coronary heart disease is the leading cause of death in women in Australia (AIHW, 2013; Heart Foundation, 2011).

In response, the Forum advocated the need for 'gender-specific' strategies, with some of the priorities identified including the need to –

- educate health professionals about the gender differences in diagnosis, prevention, treatment and rehabilitation
- increase women's access to services through a greater understanding of the barriers of health literacy, culture, inequities and the social determinants of health (Heart Foundation, 2011 p 11).

The report concluded that "a collaborative, strategic and integrated cross-sectorial approach" (Heart Foundation, 2011 p 6) is required if Australia is to see a positive change in the cardiovascular health of women in the long-term.

While it is important to acknowledge the relationship between sex and gender, and specifically their interplay, in determining women's overall health outcomes, both Phillips' article and the work of the Heart Foundation ultimately point to the distinct impacts that gender determinants can have on an individual's health. As such, it is useful to explore women's unique experience of gender as a social determinant of health.

1.3.3. Women's health and the experience of gender as a social determinant of health

The term 'women's health' has traditionally been associated with women's reproductive functions, which were seen to control women's overall health and mental wellbeing (Weisman, 1997). This focus is grounded in the "medical conceptions of women's health that emerged in the second half of the 19th century, when ideas about biological determinism and fundamental differences between the sexes were becoming prominent" (Weisman, 1997 p 180). The modern Women's Health Movement in Australia, which occurred at a similar time to movements in other countries such as the United States, challenged this view (Jamieson, 2012; Weisman, 1997)

Subsequently, a feminist critique of the male-dominated medical profession surfaced, with many individuals advocating for women to be informed and empowered to make their own healthcare decisions (Jamieson, 2012 p 30). During the 20th century there was a growing emphasis on the impact of gender on a broad range of social issues, including gender equity, women's reproductive rights, gender bias in medical research, practice and treatment, and women's access to accessible and appropriate healthcare (Jamieson, 2012). Drawing on the earlier work of Broom (1991), Jamieson observes

> "… *women were dissatisfied with medical services, critical of many of the professionals who delivered them and had a vision of a radically different society, in which women would be no longer subordinate, would be proud of their bodies and would enjoy life conditions that would enable them to be responsible for their own health and health care*" (Jamieson, 2012 p 30).

The WHO has identified some of the sociocultural barriers that prevent women from accessing health services and attaining quality health outcomes, including "unequal power relationships between men and women, social norms that decrease education and paid employment opportunities, an exclusive focus on women's reproductive roles, and potential or actual experience of physical, sexual and emotional violence" (WHO, 2017). These overarching barriers are reflected in the existing literature, which demonstrates the effects of a broad range of social determinants on women's health outcomes. Determinants identified in the literature include:

- income inequality between men and women (Ichiro Kawachi & Kennedy, 1999)
- women's ability to access financial resources (DiGiacomo et al., 2015; Hills & Mullett, 2005)
- women's experience of violence (Krug et al., 2002), including intimate partner and/or domestic and family violence (ANROWS, 2016; DiGiacomo et al., 2015 citing Beal 2006 and UN Women 2011)

- women's capacity to play an active role in decision-making when it comes to their health and preferences for health care (Anderson et al., 2001; DiGiacomo et al., 2015)
- the devaluing of women's health concerns within the health system (Anderson et al., 2001; DiGiacomo et al., 2015), including women's experience of discrimination (Kurtz et al. 2008)
- women's level of education attainment (Adamson et al., 2007)
- women's disproportionate role as caregivers, including caring responsibilities for a partner or elderly parent (DiGiacomo et al., 2011; Hills & Mullett, 2005).

In recent years, women's health has been more broadly defined as the "social conditions, illnesses and disorders unique to, more prevalent among, or more serious in women for which there are different risk factors, interventions, or strategies for women than for men" (NSW Health Department, 2000 p 11). This expanded view has implications for the models of care that are likely to be most effective for women, as services must reflect the unique experiences that derive from women's biological differences, as well as their distinct gender roles (WHO, 2001). Of particular significance to this review, one of the notable outcomes of the Women's Health Movement in Australia was the establishment of Women's Health Centres across Australia during the 1970s (Mackey & Social Policy Group, 1997). These Centres championed new approaches to women's healthcare and will be explored in greater detail below.

Social determinants of health example one: Violence and women's health outcomes

Recent research by Australian National Research Organisation for Women's Safety (ANROWs) estimates "1.4 per cent of the disease burden experienced by women aged 18 years and over in 2011 was attributable to physical/sexual IPV by a current or previous cohabiting partner" (ANROWS, 2016 p 7).

Significantly, the report observes that IPV is both "an important public health issue and social determinant of health… [suggesting] within the social determinants of a health framework, IPV can influence health directly (for example, in the form of injuries) or indirectly (through its influence on social, behavioural and biomedical factors)" (ANROWS, 2016 p 9). As an example, the report highlight the role IPV plays in influencing women's use of tobacco, as well as their decision to undertake cervical screening (ANROWS, 2016 p 7 citing; Jun et al., 2008; Loxton et al., 2009; Vos et al., 2006)

The intersection between gender and other social determinants of health was also reflected in the findings. Specifically, it was estimated the rate of burden attributable to physical/sexual IPV was "five times greater among Indigenous women than non-Indigenous women in 2011 once the effects of age were removed" (ANROWS, 2016 p 7).

Social determinants of health example two: Socio-economic status (SES) and women's health outcomes

The impact of socioeconomic status on women's health outcomes was explored in a 2013 study by Stewart Williams and Cunich et al. The longitudinal study included 12,709 women (born 1946-51), who were participants in Australian Longitudinal Study of Women's Health (ALSWH).

One of the overall findings of the research was that SES "significantly modified the effects of time on both the general and mental health of women, in favour of women with higher SES" (Stewart Williams et al., 2013 p 32). The researchers suggest "highly educated professional women in their early and mid-fifties may have reported better health in the ALSWH surveys as a result of benefiting from programs and services such as cancer screening, counselling, physiotherapy, remedial massage, and occupational health initiatives" (Stewart Williams et al., 2013).

1.4. WOMEN'S HEALTH IN AUSTRALIA

1.4.1. Women's health status in Australia

Evidence suggests women in Australia experience the social determinants of health in unique ways, as well as face distinct health issues across their life span (NSW Ministry of Health, 2013). While there have been considerable gains in women's health across the past two decades, and women in Australia currently enjoy one of the highest life expectancies in the world (Department of Health and Ageing, 2010; AIHW, 2013), inequalities remain between the health outcomes of men and women. As an example, a 2013 report found around one in eight women reported high/very high levels of psychological distress (12.8%) compared to one in eleven men (8.8%), and a significantly higher proportion of women deferred access to a GP due to cost (8.7%) compared to men (5.4%) (COAG Reform Council, 2013).

Importantly, women in Australia are not a homogenous group and there are notable discrepancies in health outcomes between different groups of women. This is particularly true for a range of population cohorts such as Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse (CALD) backgrounds and women living in rural and remote areas. As an example, the gap in life expectancy between Indigenous and non-Indigenous women in Australia is around 10 years (AIHW, 2016), while women living in rural and remote areas experience higher levels of diabetes, arthritis, high blood pressure, and asthma compared to those living in urban areas (NSW Ministry of Health, 2013 citing: AIHW, 2008)

Additionally, 'mothers residing in the lowest socioeconomic areas of Australia have been found to be 30 per cent more likely to have a low birthweight baby than those living in the highest socioeconomic areas' (AIHW, 2016 citing: AIHW, 2015). Lower 'education levels have also been linked to an increase risk of stroke' (Jackson et al., 2014; Mishra et al., 2016) and, even after adjusting for lifestyle factors, women living in remote areas have higher incidence of heart disease that those in non-remote areas (McLaughlin et al., 2013; Mishra et al., 2016). These variances highlight the complexity of health and the role that multiple social determinants can play in shaping women's health outcomes.

1.4.2. Women's health care in Australia

In 1989, Australia became one of the first countries to establish a national framework for women's health (Keleher, 2013). This framework recognised the unique impact the social determinants of health have on women in Australia and signalled a commitment to improving health equity and access to services. The Commonwealth Government remains committed to overcoming these inequities and recently reaffirmed its commitment to women's health through the *2010 National Women's Health Framework*. Drawing on evidence from the ALSWH, key government data sets and findings from public consultations, the report identified four key areas of focus:

- prevention of chronic diseases through the control of risk factors (targeting chronic disease such as cardiovascular disease, diabetes and cancer, as well as risk factors such as obesity, nutrition, physical inactivity, alcohol and tobacco consumption)
- mental health and wellbeing (targeting anxiety, depression and suicide)
- sexual and reproductive health (targeting sexually transmitted infections, screening/vaccination and fertility control)
- healthy ageing (targeting musculo-skeletal conditions, disability and dementia) (Department of Health & Ageing, 2010).

1.4.3. Women's health care in NSW

At the state level, NSW Government is also committed to improving the health status of women. In 2013, it established the *NSW Health Framework for Women's Health 2013*, which seeks to deliver services that are responsive to the needs of women and allow them to fulfil their potential (NSW Government, 2013). Adopting a life course approach, the Framework outlines key priorities across women's lifespan and includes a broad range of strategies, such as addressing domestic and family violence, promoting access to health services and providing reproductive and health prevention, screening, treatment and education (NSW Government, 2013). The framework also reflects a number of the State's health priorities including:

- building a patient-focused health system that is responsive to individuals' needs across the whole of life
- keeping people healthy and out of hospital, focusing on prevention and working with primary care providers

- devolving governance structure, service delivery and patient care as close to local communities as possible
- delivering truly integrated services and fostering a continuum of care
- providing world class clinical services with timely access and effective infrastructure
- providing a whole of society approach to health prevention and promotion
- promoting reliance on strong evidence based policy and a commitment to greater transparency and public accountability
- adoption of the CORE values of Collaboration, Openness, Respect and Empowerment (NSW Ministry of Health, 2014, 2015).

A core focus of this review is to understand the women's health services currently being delivered in the community, and the models that are most likely to keep women healthy and out of hospital.

1.4.4. Women's Health Centres in NSW

As part of its commitment to improving women's health outcomes, NSW Health currently provides $10.1 million funding each year to 20 Women's Health Centres across NSW, not including Women's Health NSW. Funding is delivered through the NGO Grants Program, and administered by the Local Health Districts (LHDs) at the local level. The first Women's Health Centre was established in Australia on International Women's Day in 1974. The Centre was developed in response to a perceived gap in "appropriate service provision for women in the mainstream health system" (Women's Health NSW, 2017), with additional Centres emerging in the following years.

Based on information provided by Women's Health NSW, the Centres aim to:

- improve the health status of women by providing a unique, holistic, woman-centred approach to primary health care
- blend medical and clinical services and a range of counselling, health promotion, education, self-help and consumer advocacy services
- provide women with the knowledge, skills and resources to enable us to take more responsibility over factors that adversely affect our health (Women's Health NSW, 2017).

As a first step in this mapping study, desktop research was undertaken to better understand the aims and services offered by the individual Women's Health Centres in NSW. Table 2 overleaf provides an overview of the current centres based on the available information, including their geographical reach, services, fee structure, vision, and governance and funding arrangements. In considering the findings outlined in this table, several core themes emerged in relation to the Centres' self-reported approaches to service delivery. These include:

- a focus on delivering women-centred approaches to care and empowering women to play an active role in their health care
- a holistic view of women's health, including a recognition of the social determinants of health
- the provision of a broad range of services in the one health centre – including medical and complementary health services, counselling, massage, group programs, health promotion, information and referral services, legal support, advocacy, case work and outreach
- a dual focus on prevention and treatment, including health promotion, education and referral services
- a commitment to achieving health equity for women and girls
- promotion of access to affordable health care for women, including free or heavily discounted services for women.

The primary data collection phase of this study will consider the extent to which these approaches are currently applied and remain dominant features of the Women's Health Centres in NSW. It will also seek to obtain further details on each of the core areas outlined in the table, including funding and governance arrangements. As an example, it was noted that some of the Women's Health Centres have listed the same governing body, The Committee of Women, which will be explored further in the review.

Table 2: Women's Health Centres in NSW

SERVICE NAME	GEOGRAPHICAL AREA SERVICED	SERVICES OFFERED													FEE STRUCTURE	VISION	FUNDING	GOVERNANCE
		COUNSELLING	MEDICAL	COMPLEMENTARY	GROUP PROGRAMS	HEALTH PROMOTION*	REFERRAL & INFORMATION	MASSAGE	LEGAL	ADVOCACY	CASE WORK	OUTREACH	OTHER					
Bankstown Women's Health Centre	Canterbury Bankstown & Holroyd LGA, St George and South West Sydney areas	X	X		X	X	X		X	X	X	X	X		Services are free or heavily discounted	An empowered community which values and supports the wellbeing of all women and their families	Bankstown Women's Health Centre	Canterbury Bankstown & Holroyd LGA, St George and South West Sydney areas
Blacktown Women's & Girls' Health Centre	Blacktown LGA, South Western Sydney, wider Sydney	X	X	X	X	X	X	X	X	X	X	X	X		Services are free or heavily discounted	Services are provided within a feministic context, including recognition of the social, environmental, economic, physical, emotional and cultural factors which influence women's health and wellbeing	NSW Ministry of Health, Western Sydney LHD Legal Aid NSW (Women's DV Court Advocacy Program)	Blacktown Women's & Girls' Health Centre

SERVICE NAME	GEOGRAPHICAL AREA SERVICED	SERVICES OFFERED													FEE STRUCTURE	VISION	FUNDING	GOVERNANCE
		COUNSELLING	MEDICAL	COMPLEMENTARY	GROUP PROGRAMS	HEALTH PROMOTION*	REFERRAL & INFORMATION	MASSAGE	LEGAL	ADVOCACY	CASE WORK	OUTREACH	OTHER					
Blue Mountains Women's Health & Resource Centre	Blue Mountains and Lithgow	X	X	X	X	X	X	X		X	X	X	X		Services are free or charged on a sliding scale	To create a community where women, regardless of their social and cultural background, age and sexual orientation, will have knowledge and control over their bodies and their lives, living freely and safely, with access to the support they need to enhance their health and wellbeing	NSW Ministry of Health, Nepean Blue Mountains LHD NSW FACS Private grants Legal Aid NSW (Women's DV Court Advocacy Program)	Management Committee
Central Coast Community Women's Health Centre Ltd	Gosford and Wyong LGAs	X	X	X	X	X	X	X	X	X		X	X		Services are free, heavily discounted or by donation	Feminist care, supporting women of all ages, backgrounds and cultures in a respectful, friendly and effective way	Central Coast Community Women's Health Centre Ltd	Gosford and Wyong LGAs

SERVICE NAME	GEOGRAPHICAL AREA SERVICED	SERVICES OFFERED												FEE STRUCTURE	VISION	FUNDING	GOVERNANCE
		COUNSELLING	MEDICAL	COMPLEMENTARY	GROUP PROGRAMS	HEALTH PROMOTION*	REFERRAL & INFORMATION	MASSAGE	LEGAL	ADVOCACY	CASE WORK	OUTREACH	OTHER				
Central West Women's Health Centre Inc.	Western NSW Local Health District	X	X	X	X	X	X	X		X	X		X	Services are free or heavily discounted	To provide a unique, holistic, women-centred preventative and treatment approach to health and well-being to empower women and children from all cultures to make informed choices throughout their lives	NSW Ministry of Health, Western NSW LHD Private grants	Volunteer Board (President, VP, Secretary, Treasurer, 3 ordinary members)
Coffs Harbour Women's Health Centre	Coffs Harbour and surrounds	X	X	X	X	X	X	X				X	X	Services are free or heavily discounted & charged on a sliding scale	Thriving and resilient women, families and communities achieved through the provision of dynamic health services to promote physical, mental and social wellbeing	NSW Ministry of Health, Mid North Coast LHD Private Grants	Voluntary Board of Governance (Chair, Deputy Chair, Secretary, Treasurer and 5 ordinary members)

SERVICE NAME	GEOGRAPHICAL AREA SERVICED	SERVICES OFFERED												FEE STRUCTURE	VISION	FUNDING	GOVERNANCE
		COUNSELLING	MEDICAL	COMPLEMENTARY	GROUP PROGRAMS	HEALTH PROMOTION*	REFERRAL & INFORMATION	MASSAGE	LEGAL	ADVOCACY	CASE WORK	OUTREACH	OTHER				
Cumberland Women's Health Centre Inc.	Parramatta Cumberland LGA, Baulkham Hills	X		X	X	X	X	X		X	X	X		X	N/A	Services are free	Empowerment of women, servicing those suffering and underprivileged with an unyielding commitment to equality, social justice and self-determination
Hunter Women's Centre	Newcastle, Lake Macquarie, Port Stephens, Lower Hunter LGAs	X			X	X	X					X	X		Services are free or heavily discounted	Women of the Hunter will have the best possible physical, emotional and psychological health and wellbeing	NSW Ministry of Health, Hunter New England LHD
Illawarra Women's Health Centre	Illawarra Region	X	X	X	X	X	X	X	X	X		X	X	Free, bulk billed, or heavily discounted, depending on the service	A society where women and girls are respected, safe and free, and achieve their full potential; where they enjoy well-being prosperity and equality, and fully participate in a local and global community	NSW Ministry of Health, Illawarra Shoalhaven LHD Federal Government - Medicare Local Government Grants Club grants Private grants Donations Fundraising	Community based board of Management (the Counsel of Women)

SERVICE NAME	GEOGRAPHICAL AREA SERVICED	SERVICES OFFERED												FEE STRUCTURE	VISION	FUNDING	GOVERNANCE
		COUNSELLING	MEDICAL	COMPLEMENTARY	GROUP PROGRAMS	HEALTH PROMOTION*	REFERRAL & INFORMATION	MASSAGE	LEGAL	ADVOCACY	CASE WORK	OUTREACH	OTHER				
Leichhardt Women's Community Health Centre	Sydney Local Health District and NSW	X	X	X	X	X	X	X	X	X	X	X	X	Free or heavily subsidized Medicare for doctors' services	Every woman has the right to affordable and effective health care	NSW Ministry of Health, Sydney LHD Grants Medicare Fee for service Donations and Sales	Skills-based Management Committee
Lismore Women's Health and Resource Centre	Lismore LGA and surrounding districts	X	X	X	X	X	X	X		X	X	X	X	Services are free or heavily discounted	Provide affordable health services to women and promote wellbeing of women and girls through feminist education and support networks	NSW Ministry of Health, Northern NSW LHD Private grants	Board of Management. Northern Rivers Women and Children's Services Incorporated
Liverpool Women's Health Centre	Liverpool LGA South Western Sydney	X	X	X	X	X	X	X	X	X	X	X		Services are free or heavily discounted	Women in South West Sydney will live free of violence, have equal rights and optimum health and play an essential and visible role in society	NSW Ministry of Health, South Western Sydney LHD Private grants	Management Committee

SERVICE NAME	GEOGRAPHICAL AREA SERVICED	SERVICES OFFERED												FEE STRUCTURE	VISION	FUNDING	GOVERNANCE
		COUNSELLING	MEDICAL	COMPLEMENTARY	GROUP PROGRAMS	HEALTH PROMOTION*	REFERRAL & INFORMATION	MASSAGE	LEGAL	ADVOCACY	CASE WORK	OUTREACH	OTHER				
Penrith Women's Health Centre	Penrith LGA	X	X	X	X	X	X	X	X	X	X		X	Services are free or heavily discounted	Our Vision is to increase the well-being of all women by providing holistic health services within a feminist, social justice view of their health	NSW Ministry of Health Nepean Blue Mountains LHD Family & Community Services Legal Aid NSW (Women's DV Court Advocacy Program) Private grants	Volunteer Management Committee
Rape & Domestic Violence Services Australia	Australia	X					X			X	X	X		Services are free	Full Stop to sexual assault, domestic and family violence	NSW Ministry of Health, Sydney LHD FacHSIA (FOR 1800RESPECT and Royal Commission) Women NSW	Board of 12 elected at the AGM

*NB: Health promotion has been defined broadly, including health education and information on wellness and disease prevention.

1.4.5. Women's health services in other Australian jurisdictions

In addition to providing an overview of Women's Health Centres in NSW, it is useful to consider the way in which women's health services are currently delivered in other jurisdictions in Australia. Evidence collected in this literature review, and presented in Table 3, suggests that a similar range of services are currently offered in other jurisdictions. Similar themes also emerged in relation to the approaches to care being adopted by the women's health services, including a holistic view of health, a women-centred approach to care and a focus on empowering women to play an active role in making health care decisions.

Table 3: Women's health services in other Australian jurisdictions

STATE	CENTRAL AGENCY/ SERVICES	FOCUS	VISION	NUMBER OF CENTRES AND COVERAGE	TYPES OF SERVICES OFFERED	FUNDING	CURRENT FRMEWORKS AND POLICY
ACT	Women's Centre for Health Matters	Community development: improving women's health and wellbeing; health promotion, aiming to ensure that women contribute to and are aware of the health choices available to them.	Women can choose and access responsive, women-focused health and wellbeing services.	ACT and surrounding region.	Health promotion, social research, community development, capacity building, information provision and education and advocacy – no direct services.	Charity organisation.	ACT Women's Plan 2016-26
ACT	ACT Women's Health Service	Services for women who have significant difficulty in accessing health services.	A service for women by women: underpinned by the values of acceptance, courage, connectedness, empathy, safety and self-determination.	Central service in Canberra and five outreach counselling and women's health services situated throughout the state.	Primary health care, women's' health checks, counselling, education, specialised medical services.	ACT Government.	
NT	Women's Health Strategy Unit	Improving Aboriginal health is NT Health's greatest challenge and they recognise tackling the underlying causes of poor health and providing health services within a primary care framework is the best approach.		The NT does not directly fund women's health centres, dedicated women's services tend to be provided through Community and Rural Health Centres, Aboriginal Health Centres.		NT Government.	Policy Framework for Northern Territory Women 2015-2020

STATE	CENTRAL AGENCY/ SERVICES	FOCUS	VISION	NUMBER OF CENTRES AND COVERAGE	TYPES OF SERVICES OFFERED	FUNDING	CURRENT FRMEWORKS AND POLICY
NT	Central Australian Aboriginal Congress (Congress)	Aboriginal community controlled health service providing comprehensive range of culturally appropriate services.	Caring for the social, emotional, cultural and physical health and wellbeing of Aboriginal people (*including Alukura Women's Health Service, an Aboriginal women-only place caring for the health of women.*	Aboriginal people living in and nearby Alice Springs, including five remote communities; Amoonguna, Ntaria (and Wallace Rockhole), Santa Teresa, Utju (Areyonga) and Mutitjulu.	Women's health checks, education and advice, breastfeeding support, family support, primary health services, specialist health services, nutrition support, information and referral, to other health and wellbeing services.	Commonwealth Government.	
QLD	QLD Women's Health Network	Based on the principles of social justice and understanding of a gendered approach to health – providing health services to marginalised communities and vulnerable women and families.	The tradition of women pursuing the health interests of women, through recognition and dignity of all women.	Three state wide services – Women's Heath QLD Wide, QLD Women's Health Network, Children By Choice and seven regional services across the state.	Community support, health promotion, early intervention and prevention.	QLD Government.	Queensland Women's Strategy 2016-2021
SA	Women's Health Service (SA)	Clinical and emotional health and wellbeing services provided by women for women in welcoming, safe and culturally respectful centres.	To support women to take control of their health and wellbeing by making their own decisions.	Two services in metropolitan Adelaide, outreach services in Hillcrest.	Primary health services, counselling, social work, education and information sessions, screening and referrals.	SA Government.	Achieving Women's Equality, South Australia's Women's Policy
TAS	Women's Health Tasmania	Run by women for women, working with Tasmanian women for better health.	Tasmanian women are informed, supported and active decision makers in their own health and wellbeing.	Centre in North Hobart, outreach services by telephone and other technologies.	Counselling, individual advocacy, primary care including nurse practitioner, support and interest groups, professional development.	TAS Government.	Tasmania's Women's Plan 2013-2018

STATE	CENTRAL AGENCY/ SERVICES	FOCUS	VISION	NUMBER OF CENTRES AND COVERAGE	TYPES OF SERVICES OFFERED	FUNDING	CURRENT FRMEWORKS AND POLICY
VIC	Women's Health Victoria	Promoting health, empowerment and equality for women underpinned by the social health model.	Women living well – healthy, empowered, equal.	Nine regional and three state-wide services.	Strategic health promotion, advocacy and direct services.	VIC Government.	Women's Sexual and Reproductive Health: key priorities 2017-2020
VIC	Jean Hailes	Not-for-profit organisation dedicated to improving the knowledge of women's health throughout the various stages of their lives, and to provide a trusted world-class health service for women.	To inspire confidence to create a healthier future for all women.	Two medical centres in metro and outer metro Melbourne.	Evidence-based information provision, education resources and trusted information, medical services, telehealth.	Australian Government Department of Health, foundations and trusts and major private donors.	
WA	Women's Health Clinical Support Programs.	Community based women's health services and regional sexual assault resource centres based on state and national policies and partnership strategies to target at-risk populations. The funded sexual assault resource centres (SARCs) provide a variety of crisis and ongoing counselling services for victims of sexual assault as well as, in some areas, therapeutic groups and health promotion activities.	Providing quality, gender specific integrated services to women, their families and their communities.	12 funded women's health centres across WA, with seven located within the metropolitan area and five rural and remote centres.	A range of services including health promotion, information, counselling and clinical support to maintain health and prevent and treat diseases affecting women.	WA State Government.	Western Australia Women's Health Strategy 2013-17

1.4.6. Implications for this Mapping Study

Based on the available information, similar themes emerged in relation to the services and approaches to service delivery currently being applied by Women's Health Centres across Australia. Core themes emerging in the review include a commitment to health equity, a women-centred approach to care and a focus on empowering women to play an active role in health care decision-making. Additionally, the diversity of services offered by the Women's Health Services indicates a holistic approach to women's health, for example primary care, counselling, health promotion and education, screening and referrals.

1.5. WOMEN'S HEALTH SERVICES INTERNATIONALLY

Within a broader international landscape, it is particularly worth noting the approaches to Women's Health adopted in Canada and the United States. Across the past two decades, both countries have introduced National Centre's of Excellence for women's health. The key insights from these two examples are outlined in Table 4 below.

Table 4: Selected women's health services internationally

COUNTRY	SELECTED EXAMPLES	OVERVIEW	FOCUS & SERVICES OFFERED	KEY INSIGHTS
United States	National Centres of Excellence for Women's Health (CoEs), established in 1996 by the Department of Health and Human Services' Office on Women's Health.	The CoEs were introduced to address the health inequities experienced by women in the United States, and to improve women's health outcomes.	The CoEs were based on a new model of integrated women's health that aims to "unite research, medical training, clinical care, public education, community outreach, and the career advancement of women in the health sciences" (Gwinner et al., 2000 p 2000). The CoEs offer a broad range of holistic health services including - primary health care, cancer care, complementary medicine, fertility services, HIV program, mental health, reproductive health care and various resource centres.	Despite their shared focus, an early study by Gwinner at al. (2000) observed that a significant lesson from the first three years of the Centre's operation was that the CoE model was "not a one-size-fits-all model" (Gwinner et al., 2000p 984). These authors observed, "although all the 15 CoEs share a common mission and set of core program components, they reflect broad geographic and cultural diversity as well as important differences in their organizational characteristics and structures. As a result of this diversity, the CoE model has had to remain sufficiently flexible to accommodate the variations" (Gwinner et al., 2000p 984). While certain models of care have emerged as effective responses to women's health, when undertaking the primary data collection for this mapping study, consideration will be given to variations based on local needs.
Canada	The Canadian Women's Health Network was established in 1993.	The Canadian Women's Health Network was established to improve the health outcomes of women and girls in Canada.	The Canadian Women's Health Network has a particular focus on women's health research, including key issues impacting women's health outcomes, health inequities and policy issues. Similar to the United States, in 1996 the Canadian Women's Health Network established four Centres of Excellence for Women's Health, in partnership with the Governments' Women's Health Contribution Program. The Centre's focus on a wide research agenda , including "themes of population health, gender as a social determinant of health, and the impact of policy" on women's health (Armstrong & Pederson, 2015 p 13).	In 2013, Canada's Federal Government ended the Women's Health Contribution Program. As a result of this reduced funding, the Canadian Women's Health Network suspended its activities in 2014. It has been suggested that this marks a "diminishing emphasis and investment in women's health" (Armstrong & Pederson, 2015 p 13) in Canada since the early 2000s.

1.6. MODELS OF WOMEN'S HEALTH CARE

The literature revealed three key models that have come to influence the delivery of women's health services, including the social model of health, the primary health care (PHC) model and a women-centred approach to care. The evidence obtained in this literature review suggests that Women's Health Centres in NSW are applying many of the principles of each these models to a greater or lesser extent. Evidence was however limited to a desktop review. As such, a core focus for the primary research will be to understand the extent to which these models are currently being applied.

1.6.1. The social model of health

The social model of health emerged in large part to the perceived deficiencies of the biomedical model and its narrow focus on disease and illness as a "malfunction of the body's biological functioning" (Germov, 2014 p 11). This view was seen to undermine the complexity of health (Germov, 2014), including the role the social determinants play in influencing health outcomes. In direct contrast, the social model of health situates the experience of disease and illness within a broader social context (Germov, 2014).

The social model has been described as, "an approach to service delivery, health promotion and community development that addresses the broader determinants of health and acts to reduce social inequalities and injustices, with an emphasis on community engagement and participation and empowerment of individuals and communities" (AWHN, 2012 citing: Keleher & MacDougall 2011, p 320). Gender has been identified as a factor influencing health equity, and one of the broader determinants of health considered under the social model (Germov, 2014). Importantly, the social model does not "deny the existence of biological and physiological aspects of disease" (Germov, 2014 p 16) or the need for medical treatment; rather, it views these factors as two of the many determinants of an individual's health.

Table 5: Elements of the social model of health

Elements of the social model of health
The social model of health encompasses the following elements: • recognition of the broad social, economic and environmental determinants of health and illness • the importance of health promotion and disease prevention • the importance of community participation in decision making • the importance of working with sectors outside of health • an understanding that equity is an important outcome of health service intervention (AWHN, 2012 p 9, citing VHA 2012).

The social model of health provides a broad framework for addressing the health inequities between men and women and "is most commonly practiced in the community and women's health sectors" (AWHN, 2012) in Australia. Its holistic approach to health and the causes of ill health is reflected in the range of services currently offered by the Women's Health Centres, including legal, advocacy, counselling, health promotion and medical services (Table 2).

1.6.2. The primary health care model

The PHC model is grounded in a social view of health. In considering this model, it is important to begin by drawing a distinction between primary health care and primary care. While the terms are often used interchangeably (Heart Foundation, 2011; Hills & Mullett, 2005; Keleher, 2001), they denote two distinct concepts. Primary care refers to the "medical care that is delivered at a patient's first point of contact with the health care system" (Hills & Mullett, 2005; Keleher, 2001). While primary care operates across a range of services, general practitioners are commonly viewed as "the heart of primary care" (Keleher, 2001 p 4). Of critical importance, primary care derives from a biomedical view of health, and is typically focused on "early diagnosis and timely and effective treatment" (Keleher, 2001 p 4) of a patient's illness or disease. While there has been an increased recognition of the role that primary care providers can play in referring patients to community and non-medical services, by definition, primary care practices "are not intended to deliver social programs" (Keleher, 2001 p 5).

Primary *health* care (PHC) on the other hand has been defined as "a wide-ranging approach to the delivery of a comprehensive variety of health services" (Hills & Mullett, 2005 p 326). While the PHC model acknowledged the role of biomedical approaches to health, it also draws attention to the social determinants of health. PHC seeks to achieve health equity, by addressing the "whole range of social and environmental factors that cause ill-health as well as those that sustain and create good health" (Keleher, 2001 p 8). The model received global recognition in 1978 through the Alma-Alta Declaration, which was the product of an International Conference on Primary Health Care jointly convened by WHO and UNICEF.

Table 6: Elements of the primary health care model

Elements
A PHC approach, as outlined in the Alma-Alta Declaration, encompasses the following elements: • responds to the social determinants of health – PHC reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities • promotes accessibility to essential care – PHC includes essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain • empowers patients and promotes participation – PHC requires and promotes maximum community and individual self-reliance and participation • requires an intersectoral and multi-disciplinary response - in addition to the health sector, PHC involves all related sectors and aspects of national and community development • adopts a holistic approach - addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly • fosters comprehensive and integrated care – PHC should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all (International Conference on Primary Health Care, 1978).

Significantly, PHC is grounded in a social view of health and the two models share a similar focus on achieving health equity. Armstrong and Clow et al. (2012) observe that the PHC model aligns strongly with many of the aims of the women's health movement, including the movement's focus on addressing health inequities and the social determinants of health, its positioning of health promotion and disease prevention as core aspects of care and its advocacy for women to be involved in the design and planning of health services (Armstrong et al., 2012 p 39). Hills and Mullett (2005) similarly highlight the alignment between PHC and the women's health movement, suggesting that the model should be the "preferred option for the delivery of women's community health service" (Hills & Mullett, 2005 p 326).

While recognising the value of PHC in addressing gender inequities, Armstrong and Clow et al. (2012) do not advocate for wholesale adoption of PHC, rather these authors recommend a women-centred approach to PHC. Drawing on the earlier work of Valssof and Moreno (2002), Armstrong and Clow et al. express concerns that originally the PHC model "was promoted without adequate consideration of gender" (Valssof & Moreno, 2002 p 1714), and some applications of the model may have perpetuated gender stereotypes, such as women's role as primary carers (Armstrong et al., 2012 p 56). In their view, a women's approach to PHC would ideally reinterpret the vision and aspirations of primary health care "through the lens of gender and gender equity" (Armstrong et al., 2012 p 57).

Similarly, while Hills and Mullet (2005) suggest that women are well served under a PHC model and that this should be the preferred model of care, they also note the importance of women-centred care. Unlike Armstrong and Clow (2012) who advocate for the reframing of the PHC model, Hills and Mullet conclude that PHC's focus on participation "should be applied to the planning of women-centred care" (Hills & Mullett, 2005 p 336). Additionally, they note the striking parallels between the two approaches, including their focus on "issues of equitable care, access, more informed decision making, greater service integration (or more holistic care), and [health] education" (Hills & Mullett, 2005 p 333).

Evidence collected in this review suggests that many of the Women's Health Centres are applying aspects of the PHC model, such as adopting a holistic view of health, demonstrating a commitment to health equity and promoting access to care. Additionally, while the PHC model emerged as a prominent model in the literature, some authors have noted that the model would be strengthened by a stronger focus on women-centred care.

1.6.3. Women-centred care model

At its core, a women-centred approach is responsive to women's unique health needs and preferences for care. Unlike patient-centred care, Hills and Mullet (2002) observe that women-centred care is "gender inclusive" as it recognises (both at a population and individual level) the role gender plays as a social determinant of health and, specifically, that "women and men are affected differently by health policy and programs" (Hills & Mullett, 2002 p 86).

Judd and Armstrong et al (2009) similarly observe a women-centred approach "explicitly acknowledges" the influence of gender and sex on women's need and preferences for care (Armstrong et al., 2012 p 56). These authors advocate for a women-centred approach to mental health care. This is based on the differences between men and women's experience of mental illness, such as the influence women's brain structures have in determining how women processes emotions, as well as social determinants such as the strong correlation between gender-based violence and mental ill-health. Up to 50 per cent of women who experience violence suffer from depression, anxiety, eating disorders and/or substance abuse (Judd et al., 2009) Judd and Armstrong (2009) conclude, that "highlighting the importance of both social and cultural influences and biological differences on health, a women-centred mental health care model encourages the development of programs and treatments to ensure that the best outcomes for women with mental health problems" (Judd et al., 2009 p 105).

Table 7: Elements of the women-centred care model

Elements of the women-centred care model
A women-centred approach to care is said to encompass the following elements: • recognises the importance of gender differences • values women's experience in defining their problems and health goals • recognises women's diversity in race, ethnicity, culture, sex preferences, education and access to health care • supports empowerment of women in their own recovery and as valued members of the community • supports women's values of caring and sharing • works to change the context of women's health problems (Hills & Mullett, 2005 p 329).

Drawing on the existing literature and evidence, Hills and Mullet (2005) suggest that benefits of a women-centred approach include:

- more effective delivery of preventative gender-specific services and increased preventative counselling services
- an integration of clinical services with research and training
- the provision of care that is coordinated, comprehensive, and easily accessible while serving diverse populations
- the identification of women's health need in the future (Hills & Mullett, 2005 p 334).

1.6.4. Impact of these models on women's health

Limited evidence was found to demonstrate a direct causal link between the implementation of these models and improvements in women's health outcomes. Given the complexity of health and the broad range of factors that influence an individual's health status, direct attribution is difficult. However, the literature suggests elements of these models align with women's preferences for care and create an enabling

environment for improvements in women's health services, which can lead to improved health outcomes at an individual and population level.

As an example, Peters (2010) found that the ability to access women-centred services, a safe environment, and continuity of care, were major concerns influencing women's decision to undertake health care screenings. These screenings were presented as of critical importance to preventive health, with Peters (2010) arguing that "routine women's health screening, using mammography and Papanicolaou (Pap) testing, is known to assist in the early detection of cancer and thereby has the potential to increase positive health outcomes for women" (Peters, 2010 p 2558). The elements that have been found to positively influence women's health outcomes will be explored below.

1.7. SERVICE ELEMENTS THAT HAVE BEEN FOUND TO POSITIVELY IMPACT WOMEN'S HEALTH OUTCOMES

Based on the literature, elements of the three models explored in this review have been found to not only align with women's preferences for care, but also create an enabling environment, which can positively impact women's health outcomes.

Three studies by DiGiacomo and Green et al (2015), Peters (2010) and Anderson and Barbara et al (2001), were particularly informative in identifying women's preferences for care. An overview of these studies and their implication for this mapping study are outlined in Table 8 below. A limitation of the literature is the focus on small qualitative studies, which provide depth of understanding with regard to women's experience but do not provide generalizable data regarding women's preferences or outcomes.

Table 9 then considers the main service elements that have been found to positively impact women's experiences of care. These service elements are mapped against the three models discussed above (the social model, PHC model and a women-centred approach to care). It should be noted that terminology used to describe models (including individual service elements) are not necessarily consistent with the terminology adopted in the table (e.g. the women's health model does not explicitly state that it is CALD health care model, however it specifies the importance of recognising women's diversity when delivering care).

The service elements are considered in light of their implications for women's health services in NSW. The impact of these elements, as well as the potential role that other model elements may play in improving women's health, will be explored during the collection of primary data, including interviews with Women's Health Centres and other stakeholders.

Table 8: Key studies for identifying women's preferences for care

Study	Overview	Implications for the Mapping Study
Developing a gender-based approach to chronic conditions and women's health: a qualitative investigation of community-dwelling women and service provider perspectives (DiGiacomo et al., 2015)	• DiGiacomo, Green, Rodrigues, Mulligan and Davidson (2015) conducted two focus groups with professional stakeholders (n = 6) and three focus groups with women community members (n = 14) to ascertain women's experiences interacting with the health system in Australia. Participants were recruited from local community health centres and other relevant health facilities across the Illawarra region. The study, which had a particular focus on chronic diseases, sought to "identify the barriers and facilitators to providing a gender-based approach to chronic conditions" (DiGiacomo et al., 2015 p 105). In considering the focus group findings, DiGiacomo et al. conclude it is 'critically important' that the health system addresses the distinct needs of women, and incorporates 'perspectives of both sex and gender' into the planning of health care services, such as using interpreters or bilingual health workers, developing culturally sensitive health programs for CALD women and "offering respect, flexibility, and responsiveness, mindful of varied contexts and complexities not amenable to population-level approaches" (DiGiacomo et al., 2015 p 113). Limitations of the study include its small sample size. The views of Aboriginal and Torres Strait Islander women and women from a CALD background who did not speak English were also not captured.	• Research by DiGiacomo and Green et al (2005) suggests that services which respond to the distinct needs of women, including the role both sex and gender play in determining women's health outcomes, are 'critically important.'
Reasons why women choose a medical practice or a women's health centre for routine health screening: worker and client perspectives (Peters, 2010)	• Peters (2010) undertook a qualitative research study of women (n = 9) and health care professionals working in Women's Health Clinics (n = 6) to better understand their perceptions of health care screening and women's experiences accessing screening services. Participants were recruited from a socioeconomically disadvantaged area of Australia, with a low uptake rate of women's health screening services. The area was also identified as one of the most culturally diverse parts of Australia. The study found that women's decisions to undertake routine health screening are "guided by three major concerns. Women are seeking a women friendly and women centred service, a safe environment and continuity of care" (Peters, 2010 p 2557). In response the study ultimately concluded "additional specialised women's health services are required to meet the needs of women" (Peters, 2010 p 2557). The findings of this study must be considered in light of the small sample size of participants.	• Evidence presented in Peters (2010) study highlights the need for women friendly and safe services, which provide consistent care for women.
A qualitative analysis of women's satisfaction with primary care from a panel of focus groups in the National Centres of Excellence in women's health (Anderson et al., 2001)	• Anderson, Barbara, Weisman, Scholle, Binko, Schneider, Freund and Gwinner (2001) conducted 18 focus groups with women (n= 137) recruited from six of the 18 National Centres of Excellence in Women's Health (CoEs) in the United States. The focus groups were designed to ascertain women's experiences and preferences for health care, including the attributes of health services they most value. After identifying the attributes of health care that women value, Anderson and Barbara et al. conclude women's health centres "should be designed for women, based on their experiences, in a format that is clinically effective and valued by patients" (Anderson et al., 2001 p 647). That is, services should be responsive to women's distinct needs and preferences for care. Similar to the other studies explored above, the main limitation of this study is the limited number of women who took part in a focus group. In the context of this review, the findings must also be read in light of the contextual differences between the United States and Australia, including differences between their health systems.	• Anderson and Green et al's (2001) provides evidence for the importance of developing health services that align with women's preferences for care and create an environment which is responsive to women's distinct needs.

Table 9: Enablers that positively impact women's health outcomes and implications for service delivery

Service elements	Overview	Implications for service delivery	Model alignment		
			SOCIAL MODEL	PHC MODEL	WOMEN-CENTRED
Quality care that is holistic in scope	Women in Anderson and Barbara et al's study (2010) viewed women's health holistically, suggesting it encompassed women's physical, mental and emotional wellbeing (Anderson et al., 2001 p 639). In keeping with this expanded definition, women expressed preferences for access to a "full range of services" (Anderson et al., 2001 p 639) that extended beyond traditional health care to include alternative or complementary treatments such as "herbal medicine, massage therapy, acupuncture and chiropractic" (Anderson et al., 2001 p 640). Women also felt the women's health service should include issues that were important to them, such as support in addressing domestic and family violence, prevention of chronic conditions and help with issues of sexuality.	Women's holistic views of health and what constitutes quality care, suggests that health centres that provide a variety of services and treatment options are likely to be valued by women - including both traditional and alternative or complementary care. The research also suggests health education is an important aspect of women's health care, and helps to empower women to feel confident in making decisions about their health.	X	X	X
Women empowerment and participation	A "prominent theme" in DiGiacomo and Green et al.'s study was "women's disempowerment and loss of voice through communication and interactions within the health system" (DiGiacomo et al., 2015 p 113). The study identified several disempowering features of health care systems including – • experiences of feeling 'dismissed or avoided' by health care professionals • the dominance of men in health professional positions • fears of being 'labelled and stigmatised' (DiGiacomo et al., 2015 p 113) Similarly, some women in Anderson and Barbara et al.'s study reported "feeling that their health concerns and experiences (e.g. symptoms) were not being taken seriously or were attributed to pyschomatic processes or stress" (Anderson and Barbara et al, 2001 p643). In direct contrast, practitioners who respected women's views and knowledge of their own health were associated with positive experiences of health care. An additional theme in Anderson and Barbara et al.'s study (2001) was women's desire to be "partners" in their own health. This included women's desire to be informed (e.g. through health education, counselling and access to detailed results of any testing), as well as empowered to play a central role in decision making. Women in Peters (2012) similarly expressed preferences to be partners in their health care, noting that "being able to ask questions and have things explained was integral to their participation in health screening" (Peters, 2010).	The studies by DiGiacomo and Green et al. (2015), Peters (2010) and Anderson and Barbara et al. (2001) suggest that valuing women's knowledge of their own health, creating an environment where women feel comfortable to ask questions and empowering women to play an active role in decision-making, all help to foster an enabling environment for improvements in women's health outcomes. This includes the ability of women to self-manage their conditions. As Anderson and Barbara et al (2001) observe, "perhaps a fundamental experience was for the patient to feel that she had been taken seriously and respected, not just listened to" (Anderson et al., 2001 p 646).		X	X

Service elements	Overview	Implications for service delivery	Model alignment		
			SOCIAL MODEL	PHC MODEL	WOMEN-CENTRED
	DiGiacomo and Green et al observed that women's comfort in asking questions typically depended on the doctor-patient rapport and individual traits (DiGiacomo et al., 2015). Older women were less likely to feel comfortable asking questions and seeking clarity during consultations, as were women from CALD background who often felt intimidated by health professionals. Notably, DiGiacomo and Green et al found instances where "women's avoidance of personal health topics meant some women often went several years without needed pain relieving treatment" (DiGiacomo et al., 2015 p 108). The impact of women not feeling comfortable to seek information and assistance, is heightened by the fact that some health professionals may wrongly believe that women with chronic conditions "have acquired expertise and capacity for self-management throughout the duration of illness" (DiGiacomo et al., 2015 p 108). As a result, women may not be equipped with the knowledge required to self-manage their health issues, with conditions progressing to acute stages.				
Access to female physicians	Research applying regression analysis to explore the influence of patient and physician gender on the delivery of patient-centred care (PCC) revealed, "the greatest amount of PCC was seen in the female patient-female physician gender dyad" (Bertakis & Azari, 2012 p 327), while the female patient-male physician dyad produced the lowest level of PCC (Bertakis & Azari, 2012). In discussing these results, researchers Bertakis and Azari observe "male physicians seeing female patients are more prone to display tension and boredom, both verbally and non-verbally, than are female physicians. This may be related to female patients longer, more complicated presentation of symptoms" (Bertakis & Azari, 2012 p 331). Bertakis and Azari (2012) also note numerous studies have shown that "a psychosocial orientated consultations (rapport building, asking questions, giving information, counselling) is highest when the physician and patient are both female" (Bertakis & Azari, 2012 p 331; Brink-Muinen et al., 2002) A recent study exploring the role of Australian nurses in general practice (Mills et al., 2012), highlighted women's preference for a "female clinician to provide their cervical screening and well women's health services" (Mills et al., 2012). The authors pointed to an earlier study by Christie and Gamble et al. (2005), which similarly found "high levels of acceptance" of female clinicians and practitioners providing pap smears. In this study, women were less likely to accept pap smears being conducted by male practice nurses, "citing personal comfort and the sensitivity of female clinicians as influencing factors" (Mills et al., 2012). Most women in Peters (2010) study also expressed a preference to have health screenings undertaken at a Women's Health Service, with four out of the nine women	Given the benefits of patient-centred care and some women's preference for female clinicians, particularly in relation certain services such as women's health screening, research suggests that providing access to female physicians is likely to be a positive feature of health services for women. Importantly, Paters (2010) notes that this has significant implications for Women's Health Clinics and female GPs in Australia, noting that women's health services are "currently stretched to capacity and cannot meet demand" (Peters, 2010).			X

Service elements	Overview	Implications for service delivery	Model alignment		
			SOCIAL MODEL	PHC MODEL	WOMEN-CENTRED
	indicating they would only participate in screenings undertaken by a female physician (Peters, 2010)				
Inclusive care, including culturally appropriate health care	DiGiacomo and Green et al. highlighted the importance of inclusive and culturally appropriate care, particularly in relation the experiences of women from a CALD background. The study revealed instances where health professionals may "erroneously assume satisfactory health literacy levels and language proficiency" (DiGiacomo et al., 2015 p 113), which can act as barrier to women's full participation and engagement with the health system. Particular challenges were identified for women from a CALD background who are ageing, including women feeling "separated or isolated due to language or socio-economic barriers" and finding it "difficult to identify with mainstream women depicted in health campaigns, thus influencing self-management" (DiGiacomo et al., 2015 p 113).	The provision of inclusive and culturally competent care is likely to be an important feature for some cohorts of women, and helps to facilitate women's full participation and engagement with the health system. While the literature in this review focused on women from a CALD background, other groups are likely to benefit from culturally appropriate care, including Aboriginal and Torres Strait Islander women.		X	X
Creation of a safe, private, women-friendly environment	Research by DiGiacomo and Green et al. found "a local women's-only health facility was perceived as a safe space" (DiGiacomo et al., 2015 p 112), noting that women from CALD background were particularly surprised to find "a service dedicated to women" (DiGiacomo et al., 2015 p 112). As one women observed, "*So it was a – a man free place. And that made a huge difference, because a lot of women who came there were women who's been beaten up by men... We got a lot of those, although we weren't funded for domestic violence – that didn't stop women coming in, you know, bruised and beaten and asking for help*" (DiGiacomo et al., 2015 p 112) Similarly, women and health practitioners in Peters (2010) study expressed 'the need to feel safe' (Peters, 2010), including cultural, emotional and physical safety. Both also identified the "major benefits a women-centred health service could have for women who had previously been the victims of sexual abuse" (Peters, 2010 p 2562). This impact is particularly significant given the negative health outcomes linked to women's experience of domestic and family violence, including "depression, anxiety, suicide, physical injury, eating disorders, STIs, cervical cancer and death" (NSW Ministry of Health, 2013 p 12), as well as the greater difficulties women from a CALD background experience accessing domestic violence services, compared to women from a non-CALD background in Australia (NSW Ministry of Health, 2013). Linked to this, Anderson and Barbara et al's study (2001) indicates "privacy is a core dimension of patient's satisfaction with health care" (Anderson et al., 2001 p 643). Privacy in this context was seen to extend to both:	DiGiacomo and Green et al.'s (2015) and Peters (2010) studies indicate the importance of facilities creating "a welcoming, comfortable, and safe environment for women" (DiGiacomo et al., 2015 p 113), including women's only facilities and/or spaces where appropriate. Similarly, research by Anderson and Barbara et al (2001) suggest that maintaining privacy is an important feature of healthcare, which is valued by women.			X

Service elements	Overview	Implications for service delivery	Model alignment		
			SOCIAL MODEL	PHC MODEL	WOMEN-CENTRED
	• the environment e.g. ensuring waiting rooms protect patient's privacy, particularly if they are required to disclose sensitive information • patient – provider interactions e.g. allowing women to remain fully clothed before any physical examination (Anderson et al., 2001 p 643). Finally, women in Peters' (2010) study were seeking "women-friendly" spaces. As one participant observed, "I just think women need to feel comfortable in a woman's environment. No men, just women" (Peters, 2010).				
Single site service provision and convenience	As a result of women's competing demands and roles, convenience emerged as a central theme in Anderson and Barbara et al.'s study (2011). Women expressed preferences for timely and prompt services, as well as access to services throughout the day. In an earlier study a health care provider noted the advantages of single site services, commenting "having a full range of services easily available is important... so that women can take care of all their medical needs – including preventative care – in as few visits as possible. Returning for multiple appointments is something that women today – whose time is already spread too thin – are unable to do" (Meade, 1997 P 4) Significantly, there is evidence that this approach can help to promote engagement with the health care system. As an example, a 2012 study undertaken in the United States (O'Malley et al., 2002), found that providing a comprehensive array of primary health services at a single site, is "likely to improve inner-city, low-income women's adherence to cancer screening recommendations" (O'Malley et al., 2002 p 144). Other factors influencing adherence included strong patient-practitioner relationships, continuity of care and coordination between service providers (O'Malley et al., 2002).	The provision of comprehensive and multidisciplinary services at a single site, not only aligns with women's holistic views of health, but also their preferences for convenience.		X	X
Continuity of care	Linked to the benefits of single service provision was a preference for continuity of care. Women in Anderson and Barbara et al's study (2001) expressed concerns a fragmented health system would interfere with the continuity of their care, including a "breakdown in communication among providers and between provider and patient" (Anderson et al., 2001 p 643).	Health services that provide continuity of care through an integrated health offering are likely to be valued by women.		X	X
Affordability of services	Anderson and Barbara et al. (2001) found that health care costs influence both women's continuity of care, as well as their access to preferred services (Anderson et al., 2001 p 641).Additionally, financial barriers related to accessing health services, including associated costs such as transport, parking and meals, were identified as concerns of women in DiGiacomo and Green et al.'s study (2015). Research from the COAG Reform Council similarly found in 2011-12 a significantly higher proportion of women deferred access to a GP due to cost (8.7%) compared to men (5.4%) (COAG Reform Council, 2013).	Providing affordable access to services will assist to remove the barriers faced by women accessing health care.	X	X	X

Service elements	Overview	Implications for service delivery	Model alignment		
			SOCIAL MODEL	PHC MODEL	WOMEN-CENTRED
Life course approach	Another theme that emerged in the literature was the need to promote a life course approach to women's health. A life course approach "investigates the effects of biological, social, and behavioural exposures during gestation, childhood, adolescence and adulthood on current and future health" (Steel et al., 2013 p 7). Importantly, this approach to care recognises the "links between health or health events through each life stage" (Steel et al., 2013 p 7), including the impact early-life events can have in influencing women's future health outcomes. In doing so, it places emphasis on the "potential for early intervention to reduce disease risk and severity… and has intuitive relevance to women's health needs" (Royal College of Obstetricians and Gynaecologists, 2011; Steel et al., 2013 p 2). As an example, a "pre-existing diagnosis with type 1 or type 2 diabetes mellitus is linked with greater risks of preterm (20–31 weeks) birth, caesarean delivery, longer antenatal and postnatal hospital stays, stillbirth and low birth-weight babies" (Steel et al., 2013 p 12). In considering the implications of a life course approach to women's health, the Royal College of Obstetricians and Gynaecologists observes, "a life course view of women's health offers a more unified and women-centred approach to health promotion, disease prevention and management with implications for long-term, cross-generational health gain" (Royal College of Obstetricians and Gynaecologists, 2011).	Services which adopt a life course approach, including an emphasis on early intervention and women's distinct needs at each life stage, are likely to create an enabling environment for improvements in women's health.			X

1.8. CONCLUSION

In response to the gender inequities between men and women, health policies and services must reflect the unique experiences of women that derive from their biological differences, as well as their distinct gender roles (WHO, 2001). The social model, PHC model and a women-centred approach to care are commonly applied and advocated for as effective models for responding to the holistic needs of women. While limited evidence was found to demonstrate their direct impact in terms of improvements in women's health outcomes, literature suggests elements of these models align with women's preferences for care, help to overcome the barriers faced by women accessing essential health services, and create an enabling environment for improvements in women's health.

Specifically, this literature review revealed nine model elements which have been found to have a positive impact on women's health and their experience of care. These are outlined in Table 10.

Table 10: Service elements that have been found to positively affect women's health outcomes

	Service element
1	Delivering quality care that is holistic in scope and recognises women's overall physical, mental and emotional wellbeing
2	Empowering women and promoting their participation as 'partners' in their health care
3	Providing access to female physicians
4	Facilitating inclusive care, including culturally appropriate care
5	Creating safe, private and women-friendly spaces for women to access essential health services
6	Providing opportunities for single site service provision
7	Promoting continuity of care
8	Providing access to affordable health services
9	Adopting a life course approach to women's health issues

The extent to which these service elements are currently applied in the 20 Women's Health Centres in NSW will be explored in the primary data collection phase of this mapping study. This phase will also focus on identifying other elements not revealed in the literature that positively impact women's health and wellbeing.

1.9. REFERENCES

Adamson, L., et al. (2007). Women's weight: Findings from the Australian Longitudinal Study on Women's Health. Australia, The University of Queensland and The University of Newcastle.

AIHW. (2013). Leading causes of death. Retrieved from http://www.aihw.gov.au/deaths/leading-causes-of-death/

AIHW. (2016). Australia's Health 2016. Canberra, Austalian Institute Institute of Health and Welfare

Anderson, R. T., et al. (2001). A qualitative analysis of women's satisfaction with primary care from a panel of focus groups in the National Centers of Excellence in women's healthlth. Journal of Women's Health & Gender-Based Medicine, 10(7), 637-647. doi:10.1089/15246090152563515

ANROWS. (2016). Examination of the burden of disease of intimate partner violence against women in 2011: Final report Australia, Australia's National Research Organisations for Women's Safety

Armstrong, P., et al. (2012). Thinking Women and Health Care Reform in Canada: International Perspectives. Toronto, Women's Press.

Armstrong, P., & Pederson, A. (2015). Women's Health: Intersections of Policy, Research, and Practice (Vol. Second Edition). Canada, Women's Press.

AWHN. (2012). Women and Health Care Reform: Position Paper 2012. Drysdale, Victoria, Australian Women's Health Network.

Bertakis, K. D., & Azari, R. (2012). Patient-Centered Care: The Influence of Patient and Resident Physician Gender and Gender Concordance in Primary Care. Journal of Women's Health (15409996), 21(3), 326-333. doi:10.1089/jwh.2011.2903

Brink-Muinen, A. v. d., et al. (2002). Do gender-dyads have different communication patterns? A comparative study in Western-European general practices. Patient Education & Counseling, 48(3), 253.

COAG Reform Council. (2013). Tracking equity: Comparing outcomes for women and girls across Australia. Canberra, Council of Australian Governments. Reform Council.

CSDH. (2006). Commission on the Soical Determinants of Health. Geneva, World Health Organisation.

CSDH. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organisation.

Department of Health & Ageing. (2010). National Women's Health Policy 2010. Canberra: Australian Government.

DiGiacomo, M., et al. (2011). Caring for Others, but Not Themselves: Implications for Health Care Interventions in Women with Cardiovascular Disease. Nursing Research & Practice, 1-5. doi:10.1155/2011/376020

DiGiacomo, M., et al. (2015). Developing a gender-based approach to chronic conditions and women's health: a qualitative investigation of community-dwelling women and service provider perspectives. BMC Women's Health, 15, 1-11. doi:10.1186/s12905-015-0264-4

Germov, J. (2014). Imagining Health Problems as Social Issues. Australia, Oxford University Press.

Gwinner, V. M., et al. (2000). Implementing a New Model of Integrated Women's Health in Academic Health Centers: Lessons Learned from the National Centers of Excellence in Women's Health. Journal of Women's Health & Gender-Based Medicine, 9(9), 979-985. doi:10.1089/15246090050200006

Heart Foundation. (2011). Women and Heart Disease Forum Report National Heart Foundation of Australia

Hills, M., & Mullett, J. (2002). Women-centred care: working collaborativelt to develop gender inclusive health policy. Health Care for Women International, 23(1), 84-97. doi:10.1080/073993302753428456

Hills, M., & Mullett, J. (2005). Primary Health Care: A Preferred Health Service Delivery Option for Women. Health Care for Women International, 26(4), 325-339. doi:10.1080/07399330590925844

International Conference on Primary Health Care. (1978). Declaration of Alma-Ata: international conference on primary health care. Alma-Ata, USSR, World Health Organisation.

Jackson, C., et al. (2014). Educational and homeownership inequalities in stroke incidence: a population-based longitudinal study of mid-aged women. Eur J Public Health, 24.

Jamieson, G. (2012). Reaching for Health: The Australian Women's Health Movement and Public Policy. Canberra, ANU E Pess.

Judd, F., et al. (2009). Gender-sensitive mental health care. Australasian Psychiatry, 17(2), 105-111. doi:10.1080/10398560802596108

Jun, H.-J., et al. (2008). Intimate Partner Violence and Cigarette Smoking: Association Between Smoking Risk and Psychological Abuse With and Without Co-Occurrence of Physical and Sexual Abuse. American Journal of Public Health, 98(3), 527-535.

Kawachi, I., & Kennedy, B. P. (1999). Women's status and the health of women and men: A view from the States. Social Science & Medicine, 48(1), 21.

Kawachi, I., et al. (2002). A glossary for health inequalities. Journal of Epidemiology & Community Health, 56(9), 647-652.

Keleher, H., . (2001). Why Primary Health Care Offers a More Comprehensive Approach for Tackling Health Inequities than Primary Care. Australian Journal of Primary Health, 7(1), 57-61.

Keleher, H., . (2013). Policy scorecard for gender mainstreaming: gender equity in health policy. Australian & New Zealand Journal of Public Health, 37(2), 111-117. doi:10.1111/1753-6405.12027

Krug, E., et al. (2002). The world report on violence and health. Geneva, World Health Organisation.

Loxton, D., et al. (2009). Inadequate cervical cancer screening among mid-aged Australian women who have experienced partner violence. Preventive Medicine, 48(2), 184-188. doi:10.1016/j.ypmed.2008.10.019

Mackey, P., & Social Policy Group. (1997). Women's Health in Australia: A Status Report. Canberra: Department of the Parliamentary Library.

Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. Lancet, 370(9593), 1153-1163.

McLaughlin, D., et al. (2013). Heart disease in women in remote Australia: urban-rural differences after adjusting for lifestyle behaviours and sociodemographic factors,. Aust N Z J Public Health, 37(90).

Meade, V. (1997). Integrating women's healthcare - serving the whole woman. The Quality Letter for Healthcare Leaders, 9(9).

Mills, J., et al. (2012). Australian nurses in general practice, enabling the provision of cervical screening and well women's health care services: a qualitative study. BMC Nursing, 11(1), 23-30. doi:10.1186/1472-6955-11-23

Mishra, G., et al. (2016). Future health service use and cost: Insights from the Australian Longitudinal Study on Women's Health (Report prepared for the Australian Government Department of Health). Australia.

NSW Health Department. (2000). Strategic Framework to Advance the Health of Women. Gladesville, NSW, NSW Health Department.

NSW Ministry of Health. (2013). NSW Health Framework for Women’s Health 2013,. North Sydney: NSW Ministry of Health.

NSW Ministry of Health. (2014). NSW State Health Plan: Towards 2021. North Sydney: NSW Ministry of Health.

NSW Ministry of Health. (2015). What is Health Reform,. Retrieved from http://www.health.nsw.gov.au/healthreform/pages/healthreform.aspx

O'Malley, A. S., et al. (2002). Adherence of low-income women to cancer screening recommendations. JGIM: Journal of General Internal Medicine, 17(2), 144-154.

Peters, K. (2010). Reasons why women choose a medical practice or a women's health centre for routine health screening: worker and client perspectives. Journal of Clinical Nursing, 19(17/18), 2557-2564. doi:10.1111/j.1365-2702.2010.03245.x

Phillips, S. P. (2005). Defining and measuring gender: A social determinant of health whose time has come. International Journal for Equity in Health, 4, 11-14. doi:10.1186/1475-9276-4-11

Royal College of Obstetricians and Gynaecologists. (2011). Why Should we Consider a Life Course Approach to Women's Health Care? UK, Royal College of Obstetricians and Gynaecologists.

Sen, G., & Östlin, P. (2008). Gender inequity in health: why it exists and how we can change it. Global Public Health, 3, 1-12. doi:10.1080/17441690801900795

Steel, A., et al. (2013). Women's health in NSW – a life course approach: an Evidence Check rapid review brokered by the Sax Institute. Australia, Sax Institute

Stewart Williams, J., et al. (2013). The impact of socioeconomic status on changes in the general and mental health of women over time: evidence from a longitudinal study of Australian women. International Journal for Equity in Health, 12(1), 25-35. doi:10.1186/1475-9276-12-25

Valssof, C., & Moreno, C. (2002). Placing gender at the centres of health programming: Challenges and limitations. Social Science & Medicine, 54.

Vos, T., et al. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. Bulletin of the World Health Organization, 84(9), 739-744.

Weisman, C. S. (1997). Changing Definitions of Women's Health: Implications for Health Care and Policy. Maternal and Child Health Journal, 1(3), 10.

WHO. Social Determinants of Health: Key Concepts. Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

WHO. (1948). WHO Definition of Health. Retrieved from http://www.who.int/about/definition/en/print.html

WHO. (2001). Mainstreaming Gender Equity in Health: The Need to Move Froward, Madrid Statement. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0008/76508/A75328.pdf

WHO. (2010). A Conceptual Framework for Action on the Social Determinants of Health (Social Determinants of Health Discussion Paper 2). Geneva.

WHO. (2013). Review of social determinants and the health divide in the WHO European Region: Final Report. Denmark.

WHO. (2017a). Depression and Other Common Mental Disorders: Global Health Estimates. Geneva, World Health Organisation.

WHO. (2017b). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/

Women's Health NSW. (2017). About WHNSW. Retrieved from http://whnsw.asn.au/about-whnsw/

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