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Review Article

Women Caregivers' Engagement With Healthcare Services for Their Personal Healthcare Needs: A Scoping Review

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The objective of this scoping review is to map the extent, range and nature of literature pertaining to women caregivers and their engagement with healthcare for their personal healthcare needs. It is estimated that 3 out of 5 people will become caregivers at some stage throughout their life, with a large percentage of women (75%) being primary carers. Family or informal care has been the subject of extensive research in the past, demonstrating the physical and emotional health risks placed on caregivers. However, little is known about how women caregivers engage with healthcare services for their own health needs, a factor that could mediate or prevent these health outcomes. Arksey and O'Malley's scoping review methodology was applied to identify relevant empirical, peer-reviewed studies across six databases: MEDLINE, PsycINFO, SocIndex, CINAHL, Web of Science and Sociological Abstracts. Searches were limited from January 2013 to May 2025. A total of 11,228 papers were screened, with 41 papers meeting the inclusion criteria for the review. Studies were primarily quantitative, with a focus on physical and mental health, and the comparison of caregiver to noncaregiver experiences. Three key categories/issues were identified in these studies: (1) a varying frequency of service use (higher, lower and no difference when compared with noncaregivers), (2) key engagement factors (with a focus on individual versus contextual factors), and (3) encounters with health professionals. Findings demonstrate that specific caregiving roles and healthcare system factors influence the way in which carers engage with healthcare services for themselves and have the potential to inform overall health outcomes through a lack of timely treatment or an increased likelihood of requiring healthcare. With women comprising the majority of caregivers, they face a heightened risk of exposure to these challenges, yet existing research overlooks their specific needs and experiences. Opportunities for new and innovative directions in research exist to address ongoing gaps and for the development of meaningful policy and intervention to support women caregivers more effectively.

Keywords: caregiver; healthcare engagement; scoping review; women

1. Introduction

Caregiving (sometimes referred to as family or informal caregiving) refers to the unpaid care work provided by members of the community who care for a family member or friend that is ageing, has a chronic health or mental health condition, or is living with a disability [1, 2]. Both in Australia and internationally a significant percentage of the population fall into this category at any one time, with recent statistics identifying between 10% and 21.3% across Australia, the UK and the US [1, 3, 4]. The nature of caregiving

itself means that people will transition in and out of this role over time, and when taking this into consideration, it is estimated that 3 out of 5 people will experience being a caregiver during their lifetime—therefore, an issue affecting a large part of the population [4].

When looking at caregiver demographics, women are over-represented. Whilst the discrepancy between the number of males and females providing care may be small when considering caregiving of any capacity, this gap becomes much larger when looking specifically at primary caregivers [4, 5]. Statistics indicate that of those identifying

as primary caregivers (providing the majority of care for an individual), women constitute around or upwards of 75% of these figures [6–8]. With caregiving already acknowledged as an important public health issue, it is therefore also one that is particularly pertinent for women and consequently justifies adopting a gendered lens when considering how to improve caregiver outcomes [5, 9].

The topic of caregiving has gained significant attention in international academic research and literature in recent decades; however, gaps remain in its focus. From a population health perspective, a strong body of evidence emphasises the influence of this role on caregivers' own mental and physical health outcomes [10–13]. Identified as a chronic stressor, caregiving has been linked with increased rates of depression, anxiety and stress-related disorders, as well as poorer physical health outcomes in general [14–16]. Despite this knowledge, it remains unclear how these adverse health outcomes influence access to healthcare services—a crucial factor in fully understanding the broader impact of caregiving on well-being. Furthermore, existing research in the caregiver field has historically come under scrutiny (over two decades ago) due to the tendency of researchers to focus on individual characteristics and interventions that do not address the broader social and healthcare structure under which caregiving takes place [7, 17]. Even as early as 1989, Steven Zarit called for new directions to be taken, as the field was saturated with 'simple descriptive studies that [were] not likely to advance the field further' [18]. Two decades on from these critiques, it remains unclear as to whether these issues have been addressed in subsequent studies, and therefore whether a greater depth of knowledge has been acquired.

The consideration of gender within caregiving research has traditionally labelled participants within a male/female binary only, overlooking individuals with other gender identities. Even with this limitation, what it does highlight is that disparities between male and female caregivers' health outcomes are evident. Research evidence indicates that women are even more disadvantaged compared to their male counterparts, with increased rates of negative experiences that see them face higher levels of stress and lower levels of reported physical and psychological health [7, 8, 15, 19]. Despite this knowledge, there is a paucity of studies that focus on the unique experiences of women only—a factor that results in their needs remaining largely invisible. Whilst caregiving as a women's health issue is not a new concept in academic literature, empirical studies to date have largely defined their caregiver populations according to the care recipient's health issue, rather than by factors pertaining to the caregiver themselves (such as gender) [8]. This has resulted in the gender imbalance within caregiving being largely overlooked in existing literature, an issue verified by feminist researchers who emphasise the continued devaluing and misrepresentation of women's perspectives in research and policy on this topic [17, 20].

The demand for care is expected to grow significantly across OECD countries within the next decade due to an ageing population and an increase in long-term care needs [2, 6, 21]. Consequently, greater numbers of women will find

themselves in caregiving roles into the future. With caregivers playing a crucial economic role by alleviating substantial pressure on existing health and social support systems (i.e., aged care, disability and mental health), the need for supporting their own health is paramount [6]. Understanding healthcare engagement is a critical aspect of this, as it has the capacity to either enhance caregivers' health outcomes or place them under further disadvantage if timely care is not obtained. Without targeted policy and program delivery specifically for women caregivers, undertaking a caring role will continue to have detrimental effects on their health outcomes, compromising their ability to care and ultimately also impacting those for whom they care for. The objective of this scoping review is therefore to identify the extent, range and nature of empirical research in accordance with the following question: 'What is known in the literature about women caregivers' engagement with healthcare services for their personal healthcare needs?' This information will give insight into women's engagement with healthcare services as a potentially crucial factor when considering women caregivers' health outcomes. It will also shed light on whether current literature has addressed previously identified gaps and therefore guide future research direction.

2. Methods

Given the broad nature of the research question, a scoping review methodology was utilised due to its relevance for mapping the extent, range and nature of research activity [22]. It also ensured that researchers adhered to a systematic process for searching and synthesising the data. Researchers followed the framework for scoping reviews originally put forward by Arksey and O'Malley and further refined by the Joanna Briggs Institute (JBI) [22, 23]. Findings were then reported according to the preferred reporting items for systematic reviews and meta-analyses (PRISMA) extension for Scoping Reviews (PRISMA-ScR) [24]. The mnemonic PCC—population, concept and context—from the JBI scoping review method was also adopted to shape the elements of the research question and eligibility criteria, as seen in Tables 1 and 2 [23].

2.1. Eligibility Criteria. A comprehensive list of inclusion and exclusion criteria is listed in Table 2. Articles were included if they focused on women informal caregivers and their access or engagement with healthcare services for their own needs. Articles were included if the sample included > 50% women carers, as preliminary searches had indicated few studies that focused only on women. The review focused on studies published within the last 12 years which were available in English (between January 2013 and May 2025) in keeping with the objective of determining the nature of current research on this topic. Limiting the review to this period ensured relevance to contemporary Western healthcare delivery and evolving caregiving dynamics within a constantly changing context. Only empirical research published in peer-reviewed journals was included.

TABLE 1: PCC—population, concept and context.

	Definition
Population	<p>Women adult caregivers (18 years and older)</p> <p>A person who provides care to those who need it within an existing relationship, such as a family member, friend or neighbour. Whilst unpaid, some may receive assistance through welfare or income support payments or other support services. Care may take place in the context of caring for a person with a chronic health condition, mental health condition, disability or due to ageing [1]</p>
Concept	<p>Engagement with healthcare services for carers' own healthcare needs</p> <p>Engagement is defined according to the concept of 'patient engagement', which encompasses levels of participation/involvement in care according to the individual desire and capabilities [25]</p> <p>Healthcare services are defined broadly in this review as encompassing all major types of healthcare across primary, secondary and hospital settings, in accordance with the AIHW [26] as follows:</p> <p>'Primary care is defined as a person's first contact with the health system and can incorporate a range of activities including health promotion, prevention, early intervention, treatment of acute conditions and management of chronic conditions. Primary healthcare is delivered in a variety of setting including general practices, community health centres and allied health practices.</p> <p>'Secondary care' is medical care provided by a specialist or facility upon referral by a primary care physician</p> <p>'Hospital' services encompass both private and public hospitals</p>
Context	Peer-reviewed, empirical studies available in English

TABLE 2: Inclusion and exclusion criteria.

Inclusion	Exclusion
<i>Population</i>	
Paper focuses on informal or family caregivers	
Papers including or focused on women caregivers	Papers focused on professional caregivers
Papers focused on caregivers over the age of 18	Papers focused only, or predominantly (over 50%) on male caregivers
Papers focused on caregivers who care for a friend or relative who has a disability, a terminal or chronic illness, mental illness or is frail aged	
<i>Concept</i>	
Paper discusses women caregivers' experiences engaging with healthcare for themselves (primary, secondary, tertiary)	Paper discusses women caregivers' experiences engaging with healthcare for the care recipient
<i>Context</i>	
Papers written or translated into English	
Peer reviewed papers presenting empirical research	
Papers published in the last 12 years (2013–2025)	Care recipient lives in permanent care facility (i.e., residential care)

2.2. Information Sources. To identify relevant sources for inclusion, the following databases were systematically searched: MEDLINE, PsycINFO, SocIndex, CINAHL, Web of Science and Sociological Abstracts. All database searches were conducted in November, 2023 and further updated in May, 2025.

2.3. Search Strategy. A systematic search strategy was developed in consultation with an expert librarian at The University of Melbourne and the authors (LKH and LCH). Table 3 outlines key search terms and synonyms which were applied across all databases, differentiated only by Boolean operator. Additional limits of English language, year of publication and peer reviewed were added on all databases excluding MEDLINE and Web of Science which did not have functionality to limit to peer-reviewed papers.

2.4. Source of Evidence Selection. Final results were collected into reference manager Endnote X9 before being imported into the screening and data extraction tool Covidence [27]. Reviewers met prior to screening to clarify the inclusion criteria, then commenced screening of a small number of papers together (approx. 20) to determine any discrepancies. Four reviewers then commenced title and abstract screening independently (Sarah Martin, Anna Bornemisza, Lyndal C. Hickey, and Louise K. Harms), with each article requiring screening by two reviewers before advancing to the next stage. Conflicts were resolved in fortnightly meetings whereby three reviewers (Sarah Martin, Lyndal C. Hickey, and Louise K. Harms) reviewed each conflict together until consensus was reached. Full-text screening then followed the same process until 41 articles were deemed eligible for inclusion in the review.

2.5. Data Charting and Items. A data extraction tool was developed by researchers (Lyndal C. Hickey and Sarah Martin) to extract key information from which synthesis could take place. One researcher (Sarah Martin) took part in the data extraction process, whilst simultaneously consulting with other researchers for clarification (Lyndal C. Hickey, and Louise K. Harms). Data items were chosen to capture an overview of key characteristics and findings, so that key categories could be identified across the body of literature. Data items included the following: study title; country, aim, study population sample size, methodology and relevant outcomes/findings. A copy of the completed chart was sent to researchers (Lyndal C. Hickey and Louise K. Harms) at completion for review and feedback. The completed chart was then used to commence the final stage of the scoping review, which involved collating, summarizing and reporting the results [22]. In order to present an overview of all the material reviewed, key findings were analysed initially by one researcher (Sarah Martin). An inductive approach was applied to identify patterns in the type of engagement with health services that was discussed. Three main categories emerged from this process: frequency of service use, key engagement factors and encounters with healthcare

professionals. These categories were then reviewed by two researchers (Lyndal C. Hickey and Louise K. Harms) according to their analysis of key findings in Supporting Table 1. The completed Supporting Table 1 is available for viewing in the online version of this article.

3. Results

3.1. Selection of Sources of Evidence. Preliminary search results yielded 17,212 articles across 5 databases, of which 5984 articles were identified to be duplicates. Almost half of these studies were excluded at title/abstract stage, as they did not include discussion on caregivers' access to their own healthcare services. 110 papers were retrieved for full-text review, from which 41 met all inclusion criteria. Figure 1 PRISMA flow diagram provides an overview of the screening process in more detail.

3.2. Characteristics of Sources of Evidence. The majority of papers ($n = 35$) were quantitative in design, with 30 cross-sectional studies [29–58] and 5 longitudinal [59–63]. There was 1 systematic review [64], 4 qualitative studies [65–68] and 1 mixed-methods study [69]. None of the papers that comprised the systematic review were found to be duplicated amongst other included studies. Almost half of the papers ($n = 19$) were published in the United States [33, 36, 37, 40–42, 49, 50, 54–56, 59, 61, 64, 66, 69], 5 from Europe [29, 32, 38, 48, 51], 9 from Australia [30, 31, 34, 53, 60, 62, 63, 65, 68], 1 from the UK [43], 3 from Japan [35, 39, 57], 1 from Ghana [52], 1 from Brazil [47], 1 from Canada [58] and 1 from Uganda [67]. The population of caregivers for each study was largely determined according to the medical condition of the care recipient, however a small number of papers ($n = 10$) defined their population according to characteristics of the caregiver, including 6 papers focusing on older caregivers [44, 50, 53, 54, 61, 63], 1 paper on African American and Latino caregivers [50], 1 paper on rural caregivers [68] and 4 papers focused only on women caregivers [31, 40, 65, 67]. Of the papers which included both male and female caregivers, the percentage of female caregivers ranged broadly from between 50% and 95% [29, 30, 32–39, 41–64, 66, 68, 69]. The majority of papers ($n = 33$) focused very broadly on engagement with both physical and mental healthcare [29, 33, 34, 37–39, 41–43, 45, 46, 57–59, 62–64, 68, 69], including 4 papers which were concerned with preventative screening practices only [35, 40, 44, 67]. Five papers looked solely at engagement with mental healthcare services [30–32, 56, 65] and two papers looked at caregivers' access to dental care [36, 55].

3.3. Synthesis of Results. Analysis of the 41 included studies in Supporting Table 1 identified three emergent categories under which key finding/outcomes can be summarised.

3.3.1. Frequency of Service Use. 29 articles examined the health service usage of caregivers. This was mostly

TABLE 3: Search strategy.

Keyword	Search strategy
Healthcare	Healthcare or "health care" or "primary care" or "health service**"
Women	Woman* or women* or female* or gender* or daughter* or sister* or mother* ("Care giv*" or caregiv* or carer*) adj3 (engag* or utilis* or utiliz* or participat* or access* or barrier* or facilitat* or support* or experience* or perspective* or perception* or attitude* or view* or need* or outcome* or help-seeking or "help seeking")
Carer engagement	

* a wildcard character that represents zero or more characters.

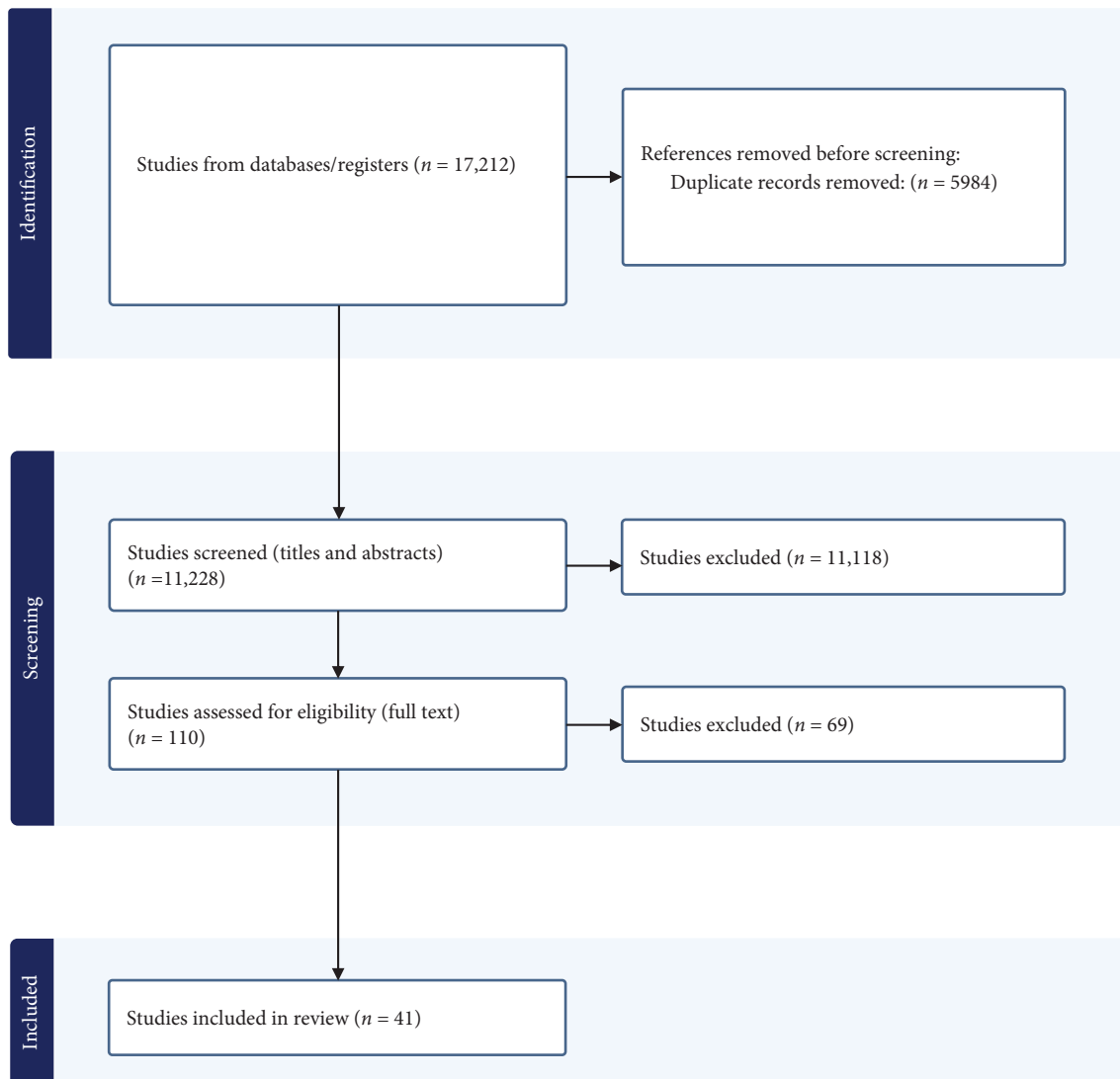


FIGURE 1: PRISMA flow diagram [28].

determined by comparison with noncaregiver control groups, followed by studies comparing caregiver groups according to different factors. Four studies did not utilize a control group. Research findings found varying results including higher usage, lower usage and no difference when compared with control groups.

Altogether, 10 papers discussed findings in relation to lower usage of healthcare services by caregivers [34, 37, 41, 43, 48, 50, 54, 61, 63, 69]. Of these, only a few

papers reported significant differences between caregiving and control groups. Musich et al. [54] reported significantly lower inpatient admissions for caregivers of older adults, compared with noncaregivers, as well as significantly lower medical and drug expenditures. In a large, nationwide survey across the US, Tingey et al. [37] found that caregivers in general exhibited a 59% increased risk for reduced access to needed healthcare. The remaining papers reported on lower usage related to barriers or difficulties accessing care,

however, did not comment on the degree of difference with control groups [34, 41, 43]. In a study of older Mexican Americans', Herrera et al. [61] found that only a smaller percentage of caregivers had visited a doctor in the last year compared with noncaregivers, and Mendez-Luck et al. [50] found that overall, African-American and Latino caregivers were less likely to have received preventive services, including vaccinations and screenings, however results varied considerably between each type of preventive service. When comparing between caregiver groups, Temple et al. [34] found that caregivers' own chronic health condition or disability resulted in lower healthcare access. Mendez-Luck et al. [50] found that older caregivers were less likely to receive preventive services; however, Nissen et al. found a likelihood of missed routine tests and GP appointments when caregivers were younger in age. As women constitute a majority of the population in these studies, results indicate that caregiving may impact women's ability to seek preventative healthcare or treatment through inpatient admissions.

By contrast, a total of 15 papers depicted caregivers' increased use of healthcare services [29, 30, 32, 38, 39, 45–47, 49, 51, 56–60, 62]. Significant increases compared with noncaregivers were reported by 5 articles, in relation to emergency room visits, hospital stays, mental healthcare and GP visits [38, 39, 47, 51, 56, 57, 60]. An article examining parents of children with haemophilia A found that caregivers were 120% more likely to have made an outpatient mental health claim or pharmacy claim, thus confirming a much higher rate of access to healthcare [49]. The remaining articles did not compare access with a non-caregiver control group, but rather looked at differences of access among groups of caregivers' themselves. These identified a positive association between higher healthcare access and factors including increased caregiving intensity; being a mental health carer; being Caucasian or non-Latino; having a chronic health condition or health issue; and being female [29, 30, 32, 45, 56, 58, 59, 61, 62]. Dementia caregivers were largely represented in this section, with 5 articles pertaining to this cohort [29, 39, 45, 47, 59]. For women who undertake a caring role, these results indicate an increased chance of accessing the GP, hospital admissions, mental healthcare or emergency care. Women caregivers who have their own health condition, care for someone with high care needs or a mental health condition, and are also more likely to utilise healthcare services.

Of all included studies, only 4 reported no difference in healthcare usage between caregivers and noncaregivers [33, 40, 42, 60]. This was in relation to receipt rates of preventive mammogram screening [40], hospitalisation rates [60] healthcare visits in the community or routine check-ups [33, 42]. Shaffer and Nightingale [42] could also not find any factors that altered this finding, which they acknowledged to be at odds with other studies.

3.3.2. Key Engagement Factors. Common factors that influenced healthcare engagement across studies were identified from both an individual and contextual perspective as seen in Table 4.

Individual factors were discussed by 20 of the studies [30–34, 36, 37, 41, 43, 45, 46, 48, 50, 52–55, 59, 64–66]. The range of factors was broad; however, some common ones were observed across multiple papers. Several [11] papers discussed the intensity of the caregiving role in relation to health status and consequent engagement with services [29, 31, 33, 34, 36, 38, 43, 50, 53, 55, 58]. Most papers associated increased caregiving intensity with poor outcomes such as less engagement with nonacute services or increased use of emergency services [29, 31, 33, 34, 55, 58]. Only one paper found increased caregiving intensity to be associated with favourable outcomes, which included a greater uptake of vaccination [50]. Two other factors that were common across multiple articles were that of cost [34, 37, 65, 66, 68] and 'attitudes to help-seeking' [31, 64–66, 68]. Cost was noted as prohibiting engagement factor by Temple et al. [34] across all points of care, particularly in relation to dental and specialist care, and Tingey et al. [37] found that carers were at a 59% increased risk for reduced access to healthcare due to cost. Studies by Mosher et al. [66] and Gilson et al. [65] provided less detailed results, simply listing cost as a relevant factor. In relation to attitudes to help-seeking, results were more in accordance with each other; however, it should be noted that two of these studies were from the same group of authors, incorporating both the caregiver and health professional perspective [31, 65]. Findings here were largely in the context of mental healthcare, whereby caregivers reported a lack of desire to access services [31, 64, 66]. This was due to both a belief that mental health professionals would be unable to help, but also a view that help-seeking was a sign of weakness [31, 65, 66]. One study by Johnston et al. [68] found that caregivers avoided accessing care due to avoiding pity or sympathy from others. Interestingly, only 3 papers reported on the association between caregivers' own health issues and healthcare engagement in their findings [34, 46, 59]. Temple et al. [34] found that caregivers with their own chronic health condition or disability were significantly more likely to encounter barriers to care, whereas Hebdon et al. [46] and Zhu et al. [59] found a significant association between caregivers' own health issues and an increased use of healthcare service access.

A fewer number of papers [9] discussed contextual factors associated with healthcare service use, as opposed to individual characteristics [30, 34, 35, 37, 41, 64–68]. The issue of cost was a re-occurring theme, given that the inter-relatedness of individual socioeconomic status and the broader economy of healthcare are hard to differentiate between [34, 37, 65, 66, 68]. Inaccessibility due to geographical location was prevalent in studies by Benyo et al. [64] and Slaboda et al. [41], noting, however, that there was no contextualisation of these results (for instance, whether they resided in urban or rural settings). One study by Hu et al. [56] noted poor service engagement for rural caregivers. Other broad policy and systemic factors included service navigation issues, availability and accessibility issues [30, 65, 68]. Finally, three qualitative studies included in this section identified and discussed the concept of social stigma and the role it played in influencing access to healthcare. This included health professionals' views that mothers of children

TABLE 4: Key engagement factors.

Factor	Type	References	Summary
Caregiving intensity	Individual	[29, 31, 33, 34, 36, 38, 43, 50, 53, 55, 58]	Higher intensity associated with poorer outcomes; one study noted positive vaccination uptake
Cost	Individual/contextual	[34, 37, 59, 60, 68]	Consistently reported as major barrier to care access
Attitudes to help-seeking	Individual	[31, 55, 58–60, 67, 68]	Reluctance to seek mental healthcare; own health not prioritised; stigma and perceptions of weakness reported
Carer's health status	Individual	[34, 46, 55]	Mixed finding: Carers' health problems linked to both barriers and increased service use
Geographic inaccessibility	Contextual	[41, 56, 58]	Location-based barriers noted
Systemic barriers	Contextual	[30, 59, 68]	Issues with service availability and navigation
Social stigma	Contextual	[59, 60, 67, 68]	Fear or judgement and stigma influenced caregivers' willingness to seek mental healthcare or preventive care

with a disability did not want to let their guard down to show they were not coping by accessing treatment, caregivers feeling a lack of validation from the broader community, as well as caregivers of cancer patients' own reflections that seeking professional support was a sign of weakness that elicited negative self-perceptions and social reactions [65, 66, 68].

3.3.3. Encounters With Health Professionals. A small number of papers [6] reported on the nature of healthcare encounters of caregivers, as well as their preferences regarding the mode of care [35, 41, 43, 51, 66, 68]. Studies by Nakamaya et al. [35] and Gavrilov et al. [51] demonstrated the positive associations between positive communication skills from health professionals and engagement with healthcare services, with a focus on the practice of interprofessional care and GP experiences, respectively. Furthermore, a study by Johnston et al. [68] discussed seeking healthcare as a means for caregivers to feel valued and acknowledged. Conversely, two papers reported on poor patient experiences: one within primary care and the other in regard to seeking mental healthcare, where caregivers held a view that mental health professionals were unable to assist [43, 66]. The final study, which encompassed caregivers across age groups (30–89 years old), found a collective desire for more accessible forms of healthcare, i.e., through the delivery of telehealth and house calls [41].

4. Discussion

This scoping review sought to map the empirical evidence base within the last decade, to respond to the question: 'What is known in the literature about women caregivers' engagement with healthcare services for their personal healthcare needs?' In doing so, it hoped to provide insight into engagement with healthcare services as a potentially crucial factor when considering women caregivers' health outcomes, as well as determine whether recent caregiving literature has addressed historically identified gaps in its' approach. This is the first scoping review to date that focuses on this aspect of caregiving. Overall, this review found 41 studies that spoke to three aspects of healthcare service engagement, including: frequency of service use, key engagement factors and encounters with health professionals.

This scoping review demonstrates that the caregiving role tends to influence the frequency of which caregivers access healthcare. This is reflected in the numerous studies that compare caregivers to noncaregiver control groups, reporting mostly either an increased or decreased use. These varied results can be interpreted in two ways—firstly, that the demands of the caring role make it difficult for caregivers to access needed care for themselves—therefore delaying or going without needed treatment, or that caregivers are experiencing increased health issues influenced by the caring role. This is in line with existing research which emphasizes caregivers lack of time to prioritise their own needs and the negative impact of caregiving on their own health and wellbeing [70–72]. Whilst results regarding frequency of

healthcare access varied significantly, making it impossible to identify recurring trends, what is apparent is that opportunity exists for healthcare professionals across disciplines to engage with carers across multiple points in the healthcare system—from primary and secondary through to tertiary care. Therefore, the development of interventions should not be limited to only one setting or avenue for delivery. Furthermore, these results also demonstrate that looking specifically at patterns of healthcare access in greater detail can reveal further insight into health outcomes of caregivers, warranting the need for further research that focuses on this aspect.

Similarly, included studies revealed broad findings in relation to key factors that influence engagement with healthcare services. Nevertheless, results highlight a tendency to focus on individual factors over contextual ones. This imbalance within the literature is problematic, as it means that interventions are developed in accordance with this, overlooking potentially critical broader contextual issues. This speaks directly to the same issues outlined by researchers over two decades ago, who criticised previous studies for ignoring the broader social and healthcare structures under which caregiving takes place [7, 17]. The fact that this remains an issue within caregiving literature is detrimental to advancing outcomes but also presents with it opportunities for new directions in research into the future. For example, further studies that focus on the healthcare professional or key stakeholders' perspective could provide important insight in broader social structures and institutions that influence caregivers' choices and opportunities. The need for this is evident from this scoping review, where 'encounters with health professionals' were found to be a key category relevant to engagement with healthcare services; however, only one paper was found to present the healthcare professional's own perspective [65]. Furthermore, Zarit's [18] previous critique of caregiving literature over two decades ago remains pertinent with the current studies identified in this scoping review, whereby there is a saturation of simple descriptive studies. Many of the included studies in this review call for more 'in depth' studies, which would likely greater inform contextual factors that influence caregivers' engagement with healthcare [29, 33, 34, 36, 38, 42, 46–51].

Although most of the included studies incorporated the experiences of both male and female caregivers, women were overrepresented in the study populations. Consequently, the findings of this scoping review are more reflective of women's caregiving experiences. However, apart from four included studies that focused on women only, the remaining did not discuss the role of gender as part of the discussion or key findings. This is problematic, as the omission of explicit language regarding a gender imbalance only serves to minimise the fact that women are overrepresented in this cohort. Furthermore, the existing body of literature fails to represent the voice of caregivers who are providing the highest level of care—primary caregivers. Only one study, by Temple et al. [34], specified a population of primary caregivers, with the remaining studies comprised of 'caregivers' in general, which may include individuals who are

undertaking a shared caregiving role. Given that higher rates of primary caregivers are female than in the general caregiving population, this results in an evidence base that is not representative of those providing the highest level of care, and therefore those who are most likely to experience adverse implications. In the small number of studies where the ‘intensity’ of the caregiving role was considered as a key engagement factor, most of these linked greater hours of caregiving with poorer outcomes in terms of healthcare service access—either by reduced engagement with non-acute services or increased use of emergency services. This itself implies a link between poorer healthcare access and increased caregiving hours, justifying the need for further research focused on primary caregivers as a population—a step which would also bring the gender imbalance within caregiving further into light. Despite the knowledge that centering women’s voices and experiences is integral to advancing research in this field, current research has not addressed this gap and therefore continues to perpetuate inequality through a lack of understanding of women’s specific needs and experiences [9, 20, 73, 74].

4.1. Limitations. The authors acknowledge several limitations pertaining to this scoping review. The nature of the research question resulted in the identification of studies whereby the issue of engagement with healthcare services was only one smaller aspect of a larger research aim and focus. This has resulted in included studies that are heterogeneous in nature, making synthesis more challenging and consequently more likely to differ between individual interpretation. The nature of this body of research also resulted in the inclusion of studies pertaining to both male and female caregivers, which was not the focus of the research question. No protocol was published or registered before completion of this scoping review, which was potentially detrimental to the transparency of methodology and the risk of duplicated studies. Restrictions placed on English language and peer-reviewed articles also resulted in publication bias and potentially missed relevant studies.

5. Conclusions

This scoping review is the first of its kind to focus on caregivers’ engagement with healthcare services for their own healthcare needs. It identified 41 studies that spoke to three aspects of healthcare service engagement, including frequency of service use, key engagement factors and encounters with health professionals. This review demonstrates that the caregiving role influences the way in which caregivers engage with healthcare services for themselves and has the potential to inform overall health outcomes through a lack of timely treatment or increased likelihood of requiring healthcare. With women comprising the majority of caregivers, they remain more vulnerable to these risks; however, existing studies neglect their unique needs and lived experience. Opportunities exist for new directions in caregiver research that centre women’s voices and that provide insight into broader structural and societal issues.

Only then can informed policy and interventions be developed that can support women caregivers’ health and wellbeing.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Conflicts of Interest

The authors declare no conflicts of interest.

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This research received no external funding.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. (*Supporting Information*)

Supporting Table 1 is the completed data extraction table which includes details of the 41 articles included in this scoping review.

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