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REVIEW ARTICLE

Older migrants, language and access to care: a qualitative systematic review

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Abstract

Population ageing and international migration are reshaping care systems and heightening the need for linguistically responsive models of support. This qualitative systematic review synthesizes evidence on how community-dwelling older migrants experience language-related barriers when accessing and using health, aged and community care. Using JBI meta-aggregation and PRISMA 2020 reporting, we identified 51 peer-reviewed qualitative studies published between 2004 and 2023, predominantly from anglophone destinations with selected North- and West-European comparators.

Four interrelated themes emerged – system, provider, societal and cultural factors – showing that language operates as a systems-level determinant of access rather than an individual 'deficit'. Barriers included inaccessible information, inadequate interpreter provision, digital exclusion and care models misaligned with cultural expectations. Enablers included peer-led supports, tailored communication, shared language with providers and opportunities for language learning. These dynamics shaped autonomy, trust and engagement, with emotional consequences when communication failed. The review also flags risks from stereotyping (*e.g.* 'happy migrant', 'exaggerating migrant') and the limits of checklist-style 'cultural competence', pointing instead to practice grounded in cultural safety and structural competence.

Findings have implications for co-designed, linguistically responsive models that integrate interpreter quality, plain-language communication, digital and health literacy supports and community infrastructure. A concise theoretical frame – migration-systems and ecological (lifecourse) – helps explain how system, provider, societal and cultural layers interact to shape communication and access. The findings predominantly reflect the contexts and literature included (English-language publications from the settings noted); future research should examine non-English scholarship and other migration systems to extend applicability.

Keywords: access to care; cultural competence; health communication; health equity; language barriers; older migrants; qualitative synthesis

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Background

Population ageing and international migration are reshaping the demographic landscape globally, creating an urgent policy and practice change for inclusive and responsive health and social care systems. Access to care is a recognized human right, embedded in ethical, legal and international frameworks (Coomans 2011; World Health Organization 2015; McLeod 2018). Language barriers remain a persistent and well-documented obstacle to equitable access to care for older migrants from culturally and linguistically diverse (CALD) backgrounds (Pandey et al. 2021). Older migrants also face intersecting barriers beyond language, including unfamiliarity with complex health systems, limited health literacy and culturally incongruent care models (Khatri and Assefa 2022; Vange et al. 2024). While language is frequently cited as a key barrier (Pandey et al. 2021), its interaction with systemic, societal and cultural factors – and their cumulative impact on care access and outcomes – remains largely unexplored.

Studies on the experiences of older migrants from CALD backgrounds frequently identify language barriers as a central challenge (Arora et al. 2018; Kobayashi and Khan 2023). Evidence also shows that this population actively adopts strategies to mitigate these barriers, such as improving proficiency in the mainstream language (L2) or relying on ethnic community networks to access information in their first language (L1) (Pandey et al. 2021). Limited knowledge of the care system and the absence of linguistically tailored information often constrain their ability to access needed services, leading to poorer health outcomes and increased safety risks (Pandey et al. 2021). The lack of health information in preferred languages impedes health literacy and discourages proactive engagement with evidence-based self-care strategies (Pandey et al. 2021). In contrast, linguistically tailored communication has been shown to enhance autonomy, trust and care outcomes (Brijnath et al. 2023; Xiao et al. 2022). Digital technologies offer promising avenues for delivering culturally adapted, in-language support, but their effectiveness depends on users' digital literacy, generational preferences and educational backgrounds.

Interpreter services are critical for bridging communication gaps; however, access remains inconsistent (Pandey et al. 2021; Khanal 2025). Older migrants, particularly those managing chronic conditions, frequently report unmet needs due to inadequate interpretation and culturally insensitive care (Hadziabdic and Hjelm 2014; White et al. 2019; Khanal 2025). These barriers contribute to delayed treatment, misdiagnoses and dissatisfaction with care.

Cross-cultural miscommunication, often rooted in stereotypes or limited cultural competence, further erodes trust. For example, older migrants may be perceived as overly agreeable ('happy migrant') or exaggerating symptoms ('exaggerating migrant') due to differing non-verbal cues (Gerber et al. 2020; Georgeou et al. 2023). Cultural norms around family involvement, fatalism and end-of-life discussions may also conflict with Western individualistic care models, leading to discomfort and disengagement (Gerber et al. 2020; Georgeou et al. 2023). These challenges reflect broader inequities in care access between migrant and non-migrant populations, with significant implications for health outcomes, quality of life and the uptake of preventive services (Kristiansen et al. 2016; Ma and Joshi 2021; Hanewald et al. 2023).

Despite a growing body of qualitative studies, there remains a lack of systematic synthesis of qualitative evidence focused specifically on language barriers and its impact

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on access to care services among older migrants. A preliminary search of the Cochrane Database, CINAHL, PubMed and PROSPERO confirmed the absence of comprehensive qualitative reviews on this topic. While individual studies are abundant, few have integrated findings to inform policy and practice.

Theoretical frameworks

First, we applied the migration-systems framework (Castles and Miller 2009), which conceptualizes language barriers in older migrants' access to care not as individual 'deficits' but as socially constructed language determinants of health embedded within the migration system. From this perspective, language barriers constitute part of the broader social determinants of health and therefore require cross-sectoral collaboration in migrant-receiving countries. Addressing these health determinants requires responses that move beyond narrow language-barrier solutions towards whole-of-system policy interventions. Such interventions should reinforce rights-based care through rights-aware interpreter policies, plain-language standards and supports for navigating digital portals. It also requires investment in community-level infrastructure, including – though not limited to – peer learning initiatives, ethno-specific hubs and digital-literacy scaffolding. In addition, effective responses depend on cross-sectoral collaboration across health, aged care, settlement, interpreting and translation, and digital-inclusion sectors (Castles and Miller 2009; De Haas et al. 2019).

We draw on migration-systems theory to situate older migrants' communication within a dynamic macro–meso–micro social system. At the macro level, integration regimes and labour markets shape the institutional availability, organization and status of interpreting and translation services. At the meso level, migrant networks, community organizations and the 'migration industry' (*e.g.* brokers and service providers) mediate older migrants' access to care services. At the micro level, clinical encounters and family roles may either enable or constrain interpretation and translation practices. This analytical lens requires researchers to examine how language barriers experienced by older migrants emerge from interactions among system-level, provider-level, societal and cultural factors, rather than from individual characteristics alone (Castles and Miller 2009; De Haas et al. 2019).

We also applied the ecological framework (Elder et al. 2003), which foregrounds a lifecourse perspective in analysing older migrants' care needs and the suitability of services to meet those needs. This framework highlights four key dimensions relevant to understanding the care needs of older migrants. First, time and place call for analysis of the historical, institutional and policy contexts shaping migration experiences. Second, linked lives emphasize the interdependence of older migrants with family members, peers, interpreters and care providers involved in health and social care delivery. Third, timing draws attention to life stage, care-giving roles and illness trajectories that influence older migrants' abilities to access and utilize care services. Fourth, agency requires consideration of the strategies, adaptations and trade-offs that older migrants – and often their care-givers – employ in navigating care systems.

Viewed through this lens, language barriers experienced by older migrants are understood as cumulative, context-embedded exposures that interact with ageing

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processes, migration histories, social relationships and coping strategies within specific social contexts. Consequently, addressing access to health and social care for older migrants with language barriers necessitates an individualized, holistic approach that accounts for both structural conditions and lived experiences.

Methods

Review question

This review addressed the question: what are the experiences of older migrants with language barriers in accessing and using care services?

Methodological approach

We conducted a qualitative systematic review using a meta-aggregation approach, following the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis (Lockwood et al. 2020). Reporting adhered to the PRISMA 2020 guidelines (Page, McKenzie et al. 2021; Page, Moher et al. 2021). The protocol was registered with PROSPERO (CRD42023491183) and amended twice, with changes documented (Chudecka et al. 2023) (see Appendix 1).

Data sources

Using the PICO framework, we defined: population – older migrants with language barriers; phenomenon of interest – accessing and using care services; context – health and aged care systems; outcome – experiences of care access and use.

Eligibility criteria

The participants were community-dwelling older migrants experiencing language barriers. For the purposes of this review, an 'older migrant' refers to an older person from a CALD background. Due to the ambiguity of nomenclature, different phrases were considered, including but not limited to 'older person', 'aged', 'from multicultural/CALD background', 'from a minority/ethnic/diverse/marginalized group', 'spoken language other than English (LoTE)'. We note that our migrant string may under-capture refugee and forced-migration populations. Implications for transferability are discussed in the limitations section.

Regarding inclusion criteria amendment in the registered protocol (Chudecka et al. 2023), the age limit was specified to include people 60 years old and older to align with the World Health Organization (WHO) definition of older people (WHO 2015). The phenomenon was experiences of accessing, navigating and using health, aged or community care services. The context was health and aged care systems in adopted countries. The study types included peer-reviewed qualitative studies in English. Mixed-methods studies were included if qualitative data specific to older migrants were extractable. The 'non-extractable qualitative data' referred to studies where qualitative findings specific to older migrants could have not been isolated or analysed independently.

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Exclusion criteria

Excluded were studies focusing on migrants aged under 60 years, lacking language-related findings, targeting only professionals or carers, or without extractable qualitative data.

Search strategy

A comprehensive search strategy was developed in consultation with a medical sciences librarian and tailored to each database. The following databases were searched between November 2023 and March 2024: MEDLINE (PubMed), SciVerse Scopus (Elsevier), Cochrane Library (Wiley), the Cumulative Index to Nursing and Allied Health Literature CINAHL (EBSCO), EMBASE (Ovid), APA PsycINFO (EBSCO) and Web of Science (Clarivate). Our seven-database strategy targeted comprehensive coverage across medicine, nursing and allied health, public health, psychology and social sciences, appropriate for a cross-sectoral care-access question.

Search terms were structured using the PICO framework (see Appendix 2). An exemplary search query used in one of the searched databases is provided in Appendix 2 to support reproducibility. Inclusion criteria amendment in the registered protocol (Chudecka et al. 2023) was for the review to include articles published in the last 20 years (2004–2023). We delimit the review to 2004–2023 for the following reasons. First, the 2002 Madrid International Plan of Action on Ageing marked a rights-based care turn in aged care research and policy (United Nations 2002). Second, the mid-2000s marked the digitalization of health systems (*e.g.* electronic health records, portals, online forms) and might have affected migrants' access to health (European Commission 2004; Office of the National Coordinator for Health Information Technology 2022; HIPAA Journal 2025). Third, migration and aged-care policy shifts in this period altered service configurations and language-support needs, including the effects of the 2004 EU enlargement on migration flows and cohorts, and ongoing reforms in Australia's aged-care system (European Commission 2009; Kahanec and Zimmermann 2010; Love 2021).

Study selection

Search results were managed using EndNote 20.6 and screened in Covidence. After removing duplicates, 1,189 records were screened independently by two reviewers. Discrepancies were resolved through discussion or a third reviewer. A total of 164 full-text articles were assessed, and 51 studies met the inclusion criteria (see PRISMA flowchart, Figure 1).

Data extraction

Data were extracted using a customized Excel tool based on the JBI QARI Data Extraction Tool. Extracted data included study characteristics, participant demographics, context, methods, language-related findings and conclusions. All data were reviewed iteratively by the research team (see Table 1).

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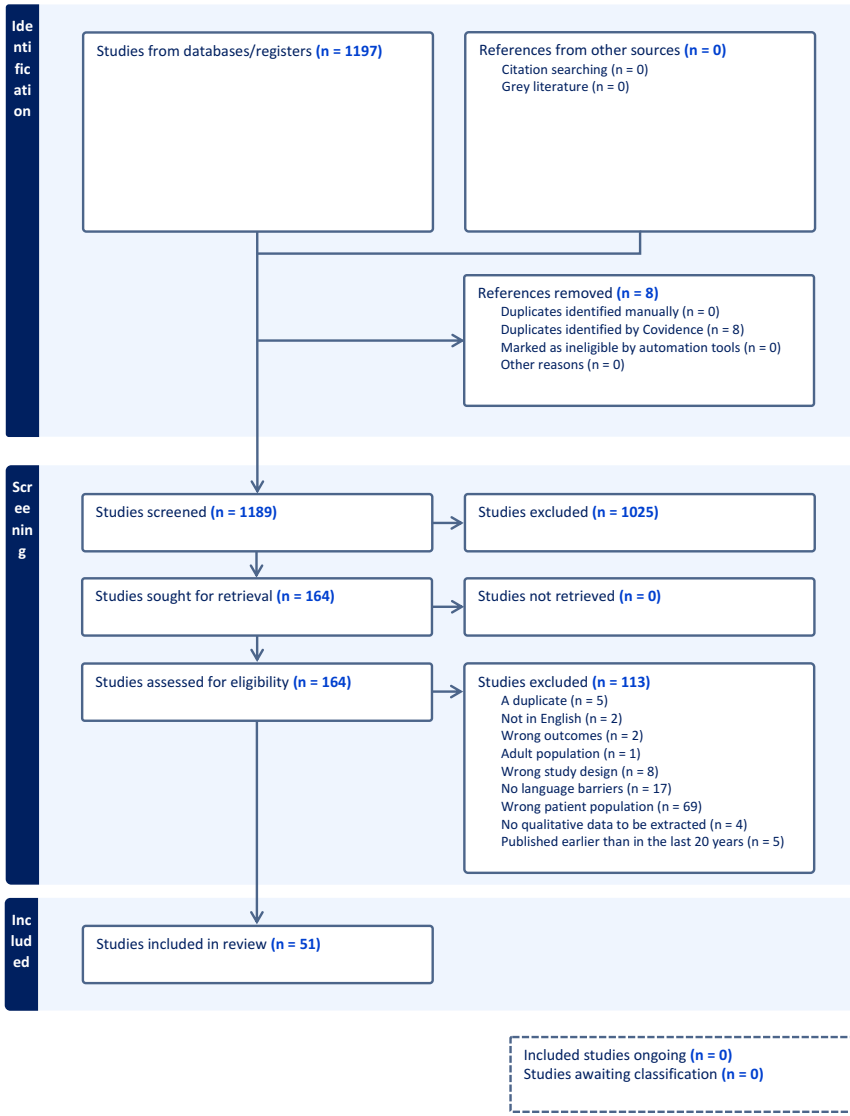


Figure 1. Review flow diagram.

Quality appraisal

Two reviewers independently assessed methodological quality using the JBI Critical Appraisal Checklist for Qualitative Research. Discrepancies were resolved by consensus or a third reviewer. Of the 51 included studies, 32 met all criteria, 11 met 9/10, and 8 met 8/10 (see Table 2).

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Table 1. Older migrants' perspectives on challenges and opportunities in accessing and using care services: a qualitative systematic review

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Arora et al. 2019 Norway	To explore the interaction of elderly Pakistani women with the health-care system and their experiences therein.	Pakistani women (n = 23) aged 48–81 years old; family carers (n = 10) aged 23–40 years old	Pakistani	Qualitative study using semi-structured in-depth interviews and a focus group	Health-care interactions often mirror participants' social standings, with language barriers and immigrant status creating ethnic boundaries.
Barenfeld et al. 2015 Sweden	To explore the comprehension of key processes and their significance for health promotion among individuals ageing within the context of migration.	Older migrants (n = 14) aged 70–83 years old; in participants' own homes	From Finland and the Balkan Peninsula	Qualitative study using in-depth interviews	The comprehension of health-promotion programmes among ageing migrants is influenced by both participants and personnel.
Barenfeld et al. 2017 Sweden	To examine the outcomes of a health-promoting programme (HPP) by exploring the experiences of participants six months post-engagement.	Older migrants (n = 12) aged 70–83 years; in participants' own homes.	From Finland or the Balkan Peninsula	Qualitative study using in-depth interviews	Assessing the personal and environmental resources of ageing migrants empowers them to address their health needs.
Blake et al. 2017 UK	To explore the individual lived experiences surrounding in-home social care provision as perceived by service users, their families and professional care workers.	Service users (n = 63) aged 18–60 years old and older; social care professionals (n = 24)	Bangladeshi, Pakistani and white British	Qualitative study using in-depth interviews and cognitive interviews; collaborative workshops	While dissatisfaction is common across all service user groups, minority ethnicity participants face specific factors.
Bruland et al. 2023 Norway	To explore the experiences of senior immigrant women participating in activities facilitated by voluntary organizations.	Older immigrant women (n = 12) aged 53–79 years old; the voluntary service centre	African, Asian	Qualitative study using semi-structured in-depth interviews	Physical activity and social relationships contribute to better self-perceived health and community participation.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Butow et al. 2011 Australia	To explore the unmet health-care needs and communication experiences of migrants living with cancer.	Patients (n = 73) and carers (n = 18); the community locations	Arabic-, Greek- or Chinese- (Cantonese or Mandarin) speaking	Qualitative study using semi-structured in-depth interviews and a focus group	To provide culturally appropriate care, health-care systems must address patients' feelings of cultural isolation regardless of English proficiency.
Carlsson 2023 Netherlands	To explore the relational dynamics of care that facilitate access to aged care services for older first-generation migrants.	Older migrants (n = 32, 10 men and 22 women); aged 55 years old and older, and 5 care professionals; day-care centres	Born in Turkey, Indonesia, Suriname, China, Hong Kong, Iran, Afghanistan, Curaçao, Saint Vincent, the Grenadines	Qualitative study using semi-structured in-depth interviews and participants observation	Ethnic minority-specific services and informal care relationships support aged care for older migrants.
Chauhan et al. 2010 UK	To explore the post-acute cardiac event experiences of participants, particularly their engagement with and utilization of cardiac rehabilitation services.	Patients (n = 20, 13 men and 7 women); aged 43–78 years old	Pakistani, Indian, Bangladeshi	Qualitative study using semi-structured in-depth interviews	The findings reveal significant barriers to uptake at the participant level.
Chung et al. 2018 USA	To examine the multifaceted factors influencing health-seeking behaviours among older Korean immigrants.	Focus groups: (n = 11, 6 man and 5 women); Interviews: (n = 6, 2 men and 4 women); aged ≥ 65 years old; community-dwelling	Korean	Qualitative study using semi-structured in-depth interviews and focus group data from two former studies	Culturally appropriate community-based care for older immigrants should address perceptions of health/illness, trust, cultural values, language barriers and affordability.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Cook 2010 UK	To investigate the experiences of no-English-speaking older women migrants in welfare accessing mainstream services and their citizenship rights.	Migrant women (n = 56) aged > 50 years old	Black Caribbean, Irish, Chinese, Somali	Qualitative study using life-story interviews and focus groups	Community and cultural organizations are vital in empowering minority ethnic older women by enhancing their welfare citizenship and agency.
Dabelko-Schoeny et al. 2021 USA	To explore the barriers and facilitators affecting transportation among diverse older adults, with a specific focus on older immigrants and refugees residing in a metropolitan area in the Midwestern United States.	70 (40% men and 60% women); aged 59–92 years old; the volunteers' in-service training site	White/Caucasian, Black or African American, Asian/Pacific Islanders	Qualitative study using focus groups	Four interconnected determinants influence transportation services for diverse older adults in creating an age-friendly community: (1) transportation service factors like affordability, accessibility and coordination; (2) built environment considerations such as safety and walkability; (3) social environment factors including language barriers and information accessibility; and (4) individual attributes like driving ability and mobility options.
Ens et al. 2014 Canada	To explore the key factors influencing adherence to cardiac medications among patients of South Asian descent with cardiac diseases.	Observations: patients (n = 40) and physicians (n = 3), pharmacists (n = 6) and staff members (n = 15, including office assistants, registered nurses, pharmacy assistants, technicians); Interviews: patients (n = 8) and their family (primary care) physicians (n = 3) and pharmacists (n = 2; including staff); patients aged 65–78 years old; while in physician offices and pharmacies; in patients' own homes (n = 2)	Indian; Pakistani; born in Tanzania (and had close ancestral roots in India)	Qualitative study using ethnographic observations and in-depth interviews	South Asian patients depend on family for instrumental support with cardiac medications and seek to establish relationships with healthcare providers to improve adherence.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Garrett et al. 2008 Australia	To explore the perspectives of patients with limited or no proficiency in English who either have sought care in the Emergency Department or have been admitted to the wards of a tertiary referral hospital.	Patients (n = 49) aged 68–80 years old, family carers (n = 9); the Education Centre of the hospital	Arabic-, Vietnamese-, Italian-, Chinese-, Spanish-, Serbian-, Croatian-speaking	Qualitative study using focus groups and grounded theory analysis	The 'happy migrant effect' in hospital care, where patients seem satisfied despite underlying dissatisfaction, is attributed to factors such as language barriers, lack of collaboration between patients and families, feelings of powerlessness, staff shortages, negligence and treatment delays.
Hall et al. 2016 Spain/UK	To explore the lived experience of vulnerable elderly British residents in Spain, with a particular emphasis on their encounters in accessing health-care services.	British households (n = 20), which included older individuals (n = 25, including 9 men and 16 women) aged ~ 78.25 years old; in own homes	British	Qualitative study using narrative interviews	Older British people in Spain rely heavily on support networks from the UK for their care needs, including friends, family and UK-based organizations.
Harrison et al. 2020 Australia	To explore the experiences and viewpoints of culturally and linguistically diverse (CALD) patients regarding their interactions with health-care services.	24 participants aged 25–90 years old; at venues convenient for the participants	Arabic (excluded as not meeting the age group criteria), Mandarin, Dari/Pashto, Turkish	A cross-sectional qualitative descriptive study using focus groups	To meet the needs of CALD consumers and ensure quality health care, providers should assess factors like health literacy, cultural background and language skills.
Hoeck et al. 2022 Belgium	To explore the attitudes, barriers and facilitators impacting participation in the Flemish colorectal cancer (CRC) screening programme.	Non-participants in the Flemish CRC screening programme (n = 39, including 23 Turkish: 11 men, 12 women, aged 56–77 years old)	Non-migrant Flemish; Turkish	Qualitative study using focus groups; an inductive approach	Identified barriers to CRC screening include common factors like feeling healthy and fear of cancer, as well as CALD-specific challenges such as language barriers.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Horne et al. 2013 UK	To explore the factors preventing and sustaining consistent physical activity (PA) among adults in their sixties in the United Kingdom.	Older adults (FG: n = 116; I: n = 75), aged 60–70 years old	Indian, Pakistani, other South Asian, white British	Exploratory qualitative study – naturalistic inquiry – using focus groups and in-depth semi-structured interviews; thematic analysis	Barriers to regular PA include misunderstandings about its value in later life, fear of exacerbating existing health issues, and ethnic-specific factors (language barriers, religious beliefs, cultural practices).
Hurley et al. 2013 Australia	To explore the perspectives and experiences of consumers and service providers regarding access to services, utilization patterns, and reasons behind reluctance to engage with formal service offerings.	Older people (n = 70: FG: n = 48; I: n = 22) aged 69–92 years old, and community-based service providers (n = 20); FG: in community settings, I: in participants' own homes, and over the phone with service providers	Greek	Qualitative study using interviews and focus groups	Older Greeks face difficulties accessing services and often prefer family support at home.
Hyman et al. 2022 Canada	To explore barriers and facilitators to using digital health tools for self-management and chronic disease prevention among South Asians in Canada.	(n = 197) aged 31–90 years old (79% > 60 years old)	South Asian speaking: Hindi, Punjabi, Urdu or Tamil	Qualitative community-based participatory action study using focus groups and Photovoice; thematic analysis	The utilization of digital health tools depends on addressing needs, preferences and barriers such as older age, lack of education and poor digital health literacy among the target audience.
Jowsey et al. 2011 Australia	To explore the experiences of patients dealing with chronic illness (type II diabetes mellitus (DM)) and their approaches to managing the condition.	Participants (n = 32) with DM aged 51–85 years old (n = 25) and family carers (n = 7) including immigrants (n = 15 = 10 and 5).	French, Finnish, Hungarian, Hong Kong, German, Filipino, Turkish, Chinese	Qualitative study using semi-structured interviews	Linguistic and cultural barriers contribute to poorer health outcomes for immigrants in Australia, limiting effective engagement with the healthcare system and their ability to manage their conditions actively.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Ju et al. 2024 USA	To explore lived experiences of sleep disturbances and the interconnected sleep dynamics between Korean American people living with dementia (PWD) and their family care-givers.	11 Korean American dyads (people with dementia and family carers); the dyads' own homes	Korean	Descriptive qualitative study using semi-structured interviews	To improve sleep quality for Korean American PWD–caregiver dyads, a comprehensive assessment of both parties is needed to understand their sleep dynamics.
Kaihlanen et al. 2022 Finland	To explore obstacles for vulnerable groups accessing digital health services during Covid-19. To develop inclusive strategies for accessible social welfare and health-care services for all, regardless of background and circumstances.	Older adults (vulnerable groups at risk for digital exclusion n = 5) using (mental) health services (n = 74, including migrants n = 16)	Russian	Qualitative descriptive study using semi-structured over-the-phone interviews; inductive and deductive content analysis	Participants' access to digital health services was hindered by their inadequate digital and/or local language skills.
Kelley et al. 2022 USA	To explore older refugees' understanding of health promotion, maintenance and health-seeking within Western contexts during later life, and its impact on their ageing and development.	A subset of older refugees (n = 37) aged 60–86 years old, from a larger study (qualitative n = 183)	Cambodian, Laotian	Community-based participatory mixed-methods inter-generational study using semi-structured interviews; thematic analysis	To effectively involve older refugees in community health practices, services must be tailored to address the unique needs of this ageing population.
Koehn et al. 2016 Canada	To explore the accessibility of exercise facilities with South Asian seniors, focusing on identifying barriers to access.	PO: n = 65, two sites; FG: n = 25 including 21 women, two sites; I: n = 15 including 13 women aged 53–87 years old, two sites	South Asian (predominantly Indian – Punjabi Sikhs)	Qualitative case study research using participant observation, interviews and focus groups; critical interpretive approach (the 'candidacy framework')	Many participants, especially women, felt empowered and experienced personal growth through a programme that enhanced physical strength and catered to their needs, benefiting both themselves and their families.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Lambert et al. 2021 Canada	To explore the informational requirements of CALD patients who are managing chronic illnesses.	Patients aged 42–86 years old (n = 24, including n = 20 > 60 years old), in patients' homes or private rooms in the clinical setting	Cantonese-, Greek-, Italian-, Mandarin-, Arabic-speaking	Qualitative descriptive study using semi-structured interviews; inductive content analysis	Information needs varied based on the illness trajectory, severity and perception, with many needs remaining unmet.
Legido-Quigley et al. 2012 Spain/UK	To explore the health-care encounters of British retirees who have relocated to Spain.	British retirees living in Spain (n = 58) and who had returned to the UK from Spain (n = 4) aged 50–90+ years old (including n = 55 > 60 years old)	British	Qualitative study using in-depth interviews and natural group discussions; interpretative inductive analysis	British retirees in Spain generally praised the quality of health care they received, noting thoroughness, compassion and cleanliness across all levels of the system.
Liang et al. 2004 USA	To explore the perspectives of Chinese American women regarding health and illness perceptions, and to examine how cultural factors and language may impact their behaviours related to cancer screening.	Women (n = 54) aged 52–82 years old	Chinese (born in Taiwan, Hong Kong, mainland China, other Asian countries)	Qualitative study using focus groups Although not designed to obtain quantitative data, frequencies of occurrence provided valuable information about the strength of reported concerns	Self-care practices, such as morning outdoor exercise for fresh air and maintaining a balanced diet, were deemed crucial for health.
Liu et al. 2017 UK	To explore the experiences of older Chinese individuals in accessing health and care services, as well as the strategies they employ to overcome any difficulties they encounter.	Older people (n = 44; FG: n = 27; I: n = 17) aged 60–86 years old and supporters (n = 15 = FG: 5; I: 5 = 10)	Chinese	Qualitative study using focus groups and interviews; a grounded theory	Older Chinese migrants face challenges in accessing services due to language barriers, lack of information and support, and cultural issues.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Liu et al. 2015 UK	To explore the experiences and attitudes of Chinese elders towards the delivery of health services in primary care settings.	First-generation Chinese Elders (n = 33, 23 women and 10 men) aged 60–84 years old	Chinese	Qualitative study using open-ended in-depth interviews; a grounded theory	Chinese elders experience significant misunderstandings with GPs and express dissatisfaction with their interactions with UK health professionals.
Maneze et al. 2018 Australia	To explore how Filipino-Australian migrants manage their chronic health conditions while living in a Western host nation.	Migrants with chronic disease (n = 58 = 7 men and 51 women) aged 42–93 years old*; in community centres and in a participant's home (n = 3) as a preferred option	Filipino-Australian	Mixed methods study using explanatory sequential design: focus groups; qualitative thematic analysis	Understanding cultural beliefs and language/support needs is essential for elderly Filipino-Australian migrants.
Mao et al. 2022 USA	To explore barriers hindering telemedicine usage among older adults, aiming to enhance their access to and satisfaction with virtual health-care visits.	(n = 15 = 8 site A and 7 site B); over the phone with residents of two independent living facilities	Chinese, Russian	Mixed methods study using semi-structured interviews; qualitative thematic analysis	Older patients face challenges accessing their health-care team through telemedicine video visits.
McCaffrey 2008 USA	To understand the impact of an integration initiative for newly arrived older Haitian adults in a community, and to explore their lived experiences while attending the centre.	(n = 16, 8 women and 8 men) aged 65 years old	Haitian	Qualitative study using interviews; a phenomenology approach; thematic analysis	Older adults who recently migrated and struggled to assimilate into a new culture reported feeling accepted and hopeful for a better life in their new community.
Montayre et al. 2017 New Zealand	To investigate the adjustment experiences of older Filipino migrants settling into permanent life in New Zealand.	Filipino migrants (n = 17) aged > 60 years old	Filipino	Qualitative descriptive study using interviews; inductive thematic analysis	For older Filipino migrants in New Zealand, adjusting to life meant starting anew by learning basic values then progressing forward from there, essentially moving backward to move forward.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Nguyen et al. 2008 USA	To explore the communication experiences related to cancer among elderly Vietnamese immigrants.	Older migrants (n = 20) aged 50–70 years old;	Vietnamese	Comparative qualitative study using interviews; grounded theory	Participants discussed three key themes related to the health-care setting: addressing screening with providers, communication processes with clinicians about cancer, and language/translation difficulties.
Nielsen et al. 2017 Denmark	To explore the daily life circumstances encountered by elderly migrants, leading to distinct behaviours related to age and health.	6 participants (7 men and 9 women) aged over 55 years; conducted in the participants' preferred language and place of choice	Palestinian, Lebanese, Iraqi, Somalian	Qualitative study using interviews with open and active approach	Participants highlighted three key themes in health care: discussing screening with providers, communicating about cancer with clinicians, and facing language/translation barriers, with 40 per cent mentioning all three.
Seto Nielsen et al. 2012 Canada	To explore how older immigrants participating in cardiac rehabilitation manage diabetes self-care while also reducing their cardiac risk.	Adult immigrants (n = 18, 8 men, 10 women) aged 58–80 years old, enrolled in cardiac rehabilitation		Critical ethnography qualitative study using in-depth interviews	Participants shared personal migration stories and the process of adapting to their adopted country, including feeling at home in cardiac rehabilitation.
Parial et al. 2023 Hong Kong	To explore the understanding, beliefs about causes and help-seeking behaviours, particularly challenges, regarding dementia among South Asian migrants residing in Hong Kong.	Older people (n = 21, 9 men and 11 women) aged ≥ 60 years old and family care-givers (n = 17, 6 men and 11 women); conducted in private rooms of a collaborating non-government organization	Indian, Pakistani, Nepalese	Descriptive qualitative study using focus groups and semi-structured in-depth interviews; thematic analysis	Perceptions of dementia hinder the use of community services.

(*Continued*)

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Patel et al. 2006 UK	To explore the factors contributing to the low utilization of eye-care services among the Indian community residing in Ealing, West London.	Older people, family carers and community leaders (n = 44); FG facilitated in local community centres and temples; I (n = 9, 6 older people and 3 GPs)	Indian	Qualitative study using focus groups, semi-structured in-depth interviews and non-participatory observations; thematic analysis	Social attitudes towards visual health, coupled with barriers in accessing health-care practitioners, lead to reluctance or delays in seeking help for visual impairment.
Pot et al. 2020 Netherlands	To explore the experiences when a 'language barrier' may negatively impact the ageing process among a group of older female Turkish migrants in the Netherlands.	Female migrants (n = 42) aged 52–84 years old, in participants' own homes (n = 17), at a cultural meeting centre (n = 14) and a mosque (n = 11)	Turkish	Mixed methods study using qualitative interviews	The impact of the 'language barrier' on migrant ageing can be both negative and preventable/manageable when older migrants have established and maintain a supportive network within their primary language-speaking community.
Radermacher and Feldman 2015 Australia	To explore the health and wellbeing of ethnic minority men as they age in a rural community, with a focus on their access to suitable health and support services.	FG: older men (n = 26) aged 39–86 years old; in local community-based meeting places and centres (residential aged care centre, local mosque)	Italian, Turkish, Albanian, Macedonian	Qualitative study using semi-structured in-depth interviews and focus groups; thematic analysis	Comparing viewpoints of older men, community leaders and service providers led to identification of valuable insights for shaping future policies and practices aimed at enhancing the health and wellbeing of these individuals.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Robotin et al. 2017 Australia	To comprehend the information requirements not currently met among individuals impacted by liver cancer, aiming to shape the development of multimedia resources in their native languages.	People living with cancer, FG (n = 26, 8 Cantonese- and 3 Mandarin-speaking); in venues close to cancer treatment centres attended by participants; I (n = 22, 4 Cantonese-, 3 Mandarin- and 11 Vietnamese-speaking); in various locations selected by participants (own home, specialist's offices or by telephone)	Vietnamese-, Cantonese-, Mandarin-speaking	Qualitative study using community-based participatory focus groups and semi-structured in-depth interviews; thematic analysis	Participants expressed the need for easily accessible information resources on cancer diagnosis, treatment options, nutrition and Chinese medicine, available in community languages and suitable for low literacy levels – to accommodate for specific needs and address language barriers in communication with health professionals.
Sah et al. 2019 UK	To explore the experiences and factors contributing to mental distress among elderly Nepalese women residing in London.	Older Nepalese women (n = 20) aged 61–83 years old; in an informal setting of a local park	Nepalese	Qualitative study using in-depth interviews; grounded thematic analysis	The resettlement of older Nepalese women in a new country without family support has a detrimental effect on their mental health.
Siddiq et al. 2023 USA	To examine the individual and socio-cultural factors influencing the health and health-care experiences of older Afghan refugee women.	Older Afghan refugee women (n = 14) aged > 50 years old, family members (n = 5) and community key informants (n = 8)	Afghani	Ethnography qualitative study using semi-structured open-ended interviews; grounded thematic analysis	To support the long-term health and wellbeing of older Afghan refugee women after migration, targeted interventions should account for social and cultural factors, including family and religion.
Suurmond et al. 2016 Netherlands	To explore barriers to accessing home-care services experienced by elderly individuals of Turkish, Moroccan, Surinamese and ethnic Dutch backgrounds.	FG (n = 50, 7 Dutch) aged 52–83 years old; I (n = 5, 3 men and 2 women, 1 Dutch man) aged 60–80 years old	Turkish, Moroccan, Surinamese and Dutch	Qualitative study using semi-structured group and individual interviews	To ensure equitable access to home-care services, individuals require comprehensive support throughout the process.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Todd et al. 2011 Canada	To explore how older Chinese immigrant women in Canada, whose first language is not English, seek and experience cancer information, taking into account their varying levels of health literacy.	Adult women (n = 50) aged 50–80 years old	Cantonese-, Mandarin-speaking	Qualitative study using semi-structured interviews; exploratory thematic analysis	Older Chinese immigrant women in Canada prefer to receive cancer information from their physicians and trusted individuals like friends and family.
Van Son and Gileff 2013 USA	To explore how older Slavic migrants manage chronic health conditions and how cultural, historical, personal and social factors shape their health beliefs and behaviours. To identify barriers faced by both patients and family care-givers, comparing their viewpoints with those of key informants.	Older migrants (n = 12) aged > 65 years old living with co-morbidities, family care-givers (n = 7) and key informants (n = 9)	Russian	Ethnography quality study using partici-pant observation, examination of cultural artefacts and semi-structured interviews	Study findings indicate that the life experiences of older Slavic migrants significantly shape how they manage chronic health conditions and influence their health behaviours.
Wilkinson et al. 2016 UK	To explore end-of-life care for South Asian patients with end-stage kidney failure.	16 patients interviewed; 45 differ-ent care providers participated in 14 focus groups; across the sites	South Asian, Urdu-, Punjabi-, Gujarati-, Bengali-speaking	Qualitative action research method-ology using semi-structured interviews and focus groups	South Asian patients with kidney disease face barriers accessing end-of-life care within the kidney setting, including challenges in recog-nizing the end-of-life phase, lack of awareness about end-of-life care, and com-munication issues influenced by family members acting as gatekeepers.

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Table 1. (*Continued.*)

Author, year and country	Aim/objective	Sample and setting	Ethnicity/ country of origin	Methodology and methods	Summary of findings
Worth et al. 2009 UK	To inform service developments through understanding the barriers to and facilitators of accessing services.	25 patients and 25 professional and family carers; 92 interviews conducted at patients' homes or over the phone (professional carers)	South Asian Sikh and Muslim	Prospective, longitudinal, qualitative study using in-depth semi-structured interviews	End-of-life care is inadequate for many South Asian Sikh and Muslim patients, especially recent migrants who face significant barriers in accessing services.
Woudstra et al. 2016 Netherlands	To explore the understanding, perceptions and beliefs about CRC and CRC screening among ethnic minority communities in the Netherlands.	First-generation immigrants (n = 30) aged 48–75 years old, (n = 21) aged > 60 years old; in own homes or at the Academic Medical Centre (AMC)	Turkish, Moroccan, Surinamese	Qualitative study using semi-structured individual interviews	Ethnic minority groups perceived CRC screening as mainly beneficial for those already experiencing poor health or symptoms.
Yap et al. 2018 Australia	To explore the factors that facilitate and hinder Chinese Australians' engagement with advance care planning.	Community-dwelling Chinese Australians (n = 30, 16 women, 14 men) aged > 55 years old, (n = 27) aged > 65 years old	China, Hong Kong, Macau, Taiwan, Malaysia, Vietnam, Singapore	Qualitative study using semi-structured interviews; grounded theory; thematic analysis	Participants in this study showed openness to discussing future medical planning and end-of-life care, suggesting that the low adoption of advanced care planning among Chinese Australians may be due more to a lack of knowledge than cultural reasons.
Zhan et al. 2017 USA	To explore the perceptions of home and life satisfaction among Chinese immigrant elders.	Elderly immigrants S: (n = 107); I: (n = 21) aged 59–90 years old; in a Chinese culture centre/ an adult day care centre/ a tea house/ a Chinatown food-court/ in own home	Chinese (migrated from mainland China, Taiwan or other Asian countries)	Mixed-methods study using qualitative open-ended interviews following a survey; grounded theory, thematic analysis	Immigrant elders define their sense of home with increased independence from their adult children.

Note: Summary of studies included for the review.

Table 2. Evaluation of qualitative studies included for the review

		Questions*									
No.	Studies	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
63	Arora et al. 2019	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
82	Barenfeld et al. 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
83	Barenfeld et al. 2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
110	Blake et al. 2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
138	Bruland et al. 2023	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
150	Butow et al. 2011	Y	Y	Y	Y	Y	Y	?	Y	Y	Y
165	Carlsson 2023	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
190	Chauhan et al. 2010	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
208	Chung et al. 2018	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
224	Cook 2010	Y	Y	Y	Y	Y	Y	?	Y	?	Y
237	Dabelko-Schoeny et al. 2021	Y	Y	Y	Y	Y	Y	Y	Y	?	Y
296	Ens et al. 2014	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
346	Garrett et al. 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
416	Hall et al. 2016	Y	Y	Y	Y	Y	?	Y	Y	Y	Y
428	Harrison et al. 2020	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
457	Hoeck et al. 2022	Y	Y	Y	Y	Y	?	?	Y	Y	Y
461	Horne et al. 2013	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
475	Hurley et al. 2013	?	Y	Y	Y	Y	Y	Y	Y	Y	Y
480	Hyman et al. 2022	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
513	Jowsey et al. 2011	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
514	Ju et al. 2024	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
517	Kaihlanen et al. 2022	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
523	Kelley et al. 2022	Y	Y	Y	Y	Y	Y	?	Y	Y	Y
550	Koehn et al. 2016	Y	Y	Y	Y	Y	Y	?	Y	Y	Y
580	Lambert et al. 2021	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
591	Legido-Quigley et al. 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
606	Liang et al. 2004	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
623	Liu et al. 2017	Y	Y	Y	Y	Y	?	?	Y	Y	Y
627	Liu et al. 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
654	Maneze et al. 2018	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
660	Mao et al. 2022	Y	Y	Y	Y	Y	Y	?	Y	Y	Y
671	McCaffrey 2008	Y	Y	Y	Y	Y	Y	?	Y	?	Y
705	Montayre et al. 2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
743	Nguyen et al. 2008	Y	Y	Y	Y	Y	Y	?	Y	?	Y

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Table 2. (*Continued.*)

No.	Studies	Questions*									
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
748	Nielsen et al. 2017	Y	Y	Y	Y	Y	Y	?	Y	Y	Y
752	Seto Nielsen et al. 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
814	Parial et al. 2023	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
816	Patel et al. 2006	Y	Y	Y	Y	Y	?	?	Y	Y	Y
851	Pot et al. 2020	Y	Y	Y	Y	Y	Y	Y	Y	?	Y
868	Radermacher and Feldman 2015	Y	Y	Y	Y	Y	?	?	Y	Y	Y
899	Robotin et al. 2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
922	Sah et al. 2019	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
972	Siddiq et al. 2023	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1020	Suurmond et al. 2016	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1054	Todd et al. 2011	Y	Y	Y	Y	Y	?	?	Y	Y	Y
1097	Van Son and Gileff 2013	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1141	Wilkinson et al. 2016	Y	Y	Y	Y	Y	Y	?	Y	Y	Y
1153	Worth et al. 2009	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1155	Woudstra et al. 2016	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1164	Yap et al. 2018	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1181	Zhan et al. 2017	Y	Y	Y	Y	Y	Y	?	Y	Y	Y

Notes: ***Adapted from JBI Critical Appraisal Tools (2020), Checklist for Qualitative Research.**

- Q1: Is there congruity between the stated philosophical perspective and the research methodology?
- Q2: Is there congruity between the research methodology and the research question or objective?
- Q3: Is there congruity between the research methodology and the methods used to collect data?
- Q4: Is there congruity between the research methodology and the representation and analysis of data?
- Q5: Is there congruity between the research methodology and the interpretation of results?
- Q6: Is there a statement locating the researcher culturally or theoretically?
- Q7: Is the influence of the researcher on the research, and vice versa, addressed?
- Q8: Are participants, and their voices, adequately represented?
- Q9: Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
- Q10: Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Further details are summarized in a document: JBI_QA_summary.doc (attached)

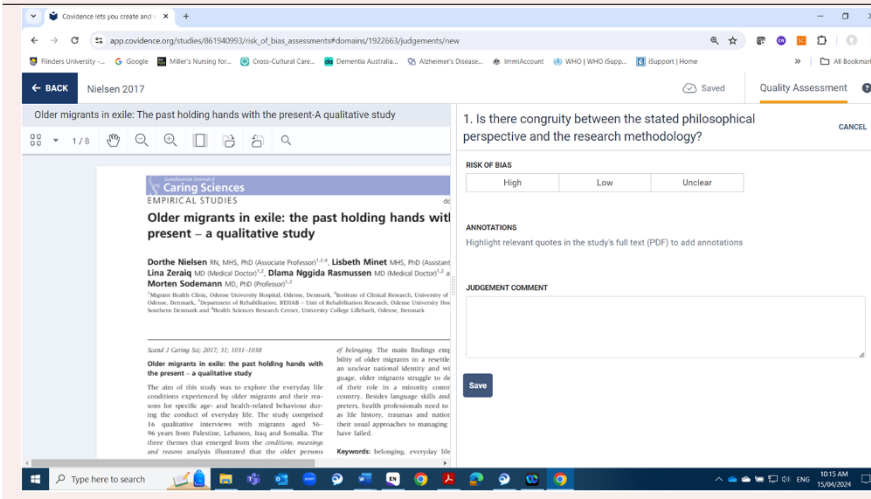
Critical appraisal process has been conducted and documented in Covidence https://app.covidence.org/studies/861940505/risk_of_bias_assessments#domains/summary

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Table 2. (*Continued.*)

No.	Studies	Questions* Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Risk of bias rated High, Low and Unclear.											
Annotations, relevant quotes and comments have been stored in Covidence for each of 51 appraised papers.											



Data synthesis

Of various methods (*e.g.* meta-aggregation, meta-ethnography, thematic synthesis) used to synthesize findings from qualitative studies, we chose JBI's three-step meta-aggregation as it aligns with our review aim and enables us to provide a transparent and auditable synthesis that preserves authors' findings while supporting policy and practice translation. We extracted findings and supporting illustrations, rated findings at three levels described as unequivocal, credible or unsupported. We only included findings rated as unequivocal or credible in the next stage of data synthesis. Then, we aggregated findings into thematic categories, synthesized the categories into synthesized themes. When appropriate, we also conducted an inductive analysis to explore the phenomenon of language reversion.

Ethical considerations

As this review involved secondary analysis of published data, ethics approval was not required.

Results

Characteristics of included studies

We summarized the characteristics of included studies in Table 1 which included detailed information on study and migrant countries of origin. This review

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included 51 high-quality qualitative studies published between 2004 and 2023 (seven in 2017, six in 2016, five in 2022). The studies were conducted across diverse geographical contexts: the United States (11), the United Kingdom (10), Australia (9), Canada (6), the Netherlands (4) and others including Norway, Spain, Sweden, Belgium, Denmark, Finland, Hong Kong and New Zealand. Participants represented a wide range of ethnic backgrounds, including Chinese, South Asian, Greek, Turkish, Arabic and African. Common first languages included Mandarin, Hindi, Arabic and Dari.

Data were primarily collected through semi-structured interviews or focus groups. Recruitment challenges were noted in several studies due to language barriers (nine), mistrust of research (three) or family gatekeeping. Engagement was notably higher when interpreters were involved (18) or when researchers shared participants' cultural and linguistic backgrounds (40).

Synthesized themes

Consistent with our migration-systems and ecological lens, the findings aggregate across system, provider, societal and cultural layers that interact to shape access and communication. Four overarching themes were identified: system factors, care provider factors, societal factors and cultural factors, comprising hindering and enabling subthemes. We elaborate each theme with related subthemes in the following sections, illustrated by quotes to support the findings.

Theme 1: system factors

System factors refer to structural elements within health and aged care systems that either hinder or facilitate older migrants' access to and use of services. These include the availability of linguistically appropriate information, digital access and support for language learning.

Subtheme 1.1: hindering factors

Older migrants frequently encountered difficulties accessing health information in their preferred language, limiting their ability to understand services and engage in self-care: 'A person can only demand what he knows is provided. I don't know … what is needed' (Wilkinson et al. 2016, 5). Some found that care systems, such as cancer services, were inaccessible without English proficiency: 'You must still be able to speak English … Otherwise you don't get through' (Butow et al. 2011, 286). Digital health platforms further excluded those with limited literacy or digital skills: 'If you tell me go to [the] internet … I can't read it so it will go in the garbage' (Hyman et al. 2022, 8). Online forms posed additional challenges: 'You must use the language remotely … but you just don't always succeed … you're afraid to make a mistake' (Kaihlanen et al. 2022, 6). These examples illustrate how digital-only approaches, without language support, disempowered older migrants and hindered access.

Several studies noted older migrants' motivation to learn the mainstream language. However, care-giving responsibilities often prevented participation in language classes: 'I really wanted to learn … but I wasn't able to go out, I wasn't able to leave him' (Jowsey

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et al. 2011, 15). The lack of flexible accessible language learning options for older carers represents a critical gap in service provision.

Subtheme 1.2: enabling factors

Despite challenges, many older migrants expressed appreciation for the health-care systems in their adopted countries: 'We respect the local council … like how parents provide for children' (Yap et al. 2018, 3303). Even when needs were unmet, participants often reported satisfaction: 'Except for some language problems … everything has been good' (Garrett et al. 2008, 102).

Facilitators included services that supported system navigation, flexible care options and opportunities to learn the mainstream language. These enhanced confidence, communication and participation in care: 'Learning Norwegian is more important than activities … language is very important … it is good for the sense of belonging' (Bruland et al. 2023, 6). Language acquisition was linked to improved social integration, mental health and care outcomes.

Theme 2: care provider factors

Care provider factors refer to the attitudes, behaviours and competencies of health-care professionals that shaped older migrants' experiences. These included the availability and quality of interpreter services, cultural competence and provider–patient communication.

Subtheme 2.1: hindering factors

Language barriers often led to disempowerment and miscommunication, reducing older migrants' understanding of treatment and confidence in care: 'I really wanted to know, I felt helpless … He [the doctor] "HOLD" the "POWER". I could only listen …' (Butow et al. 2011, 5). Even those with some English proficiency struggled under stress or with complex health issues: 'It has nothing to do with English … your mind is so confused … I had no choice' (Butow et al. 2011, 283).

Inadequate interpreter services frequently compromised care. Some interpreters were mismatched linguistically: 'They found him a Vietnamese interpreter … we have Cantonese and Mandarin' (Butow et al. 2011, 287). Others translated inaccurately, leading to serious consequences: 'The interpreter said I had a heart problem … I was hospitalized … I suffered so much' (Chung et al. 2018, 5). Time constraints further limited interpreter effectiveness: 'There was only 15 min left … the hospital doesn't have enough resources' (Butow et al. 2011, 287).

When professional interpreters were unavailable, reliance on family members created additional challenges: 'They cannot rely on the children … sickness cannot wait till they are free' (Kelley et al. 2022, 396). Family members often had competing responsibilities, and their involvement could compromise privacy and accuracy.

Subtheme 2.2: enabling factors

Shared language between provider and patient was a powerful enabler, fostering trust and understanding: 'You can relate better … sometimes you grope for words…' (Maneze et al. 2018, 621). Older migrants valued respectful, culturally sensitive interactions and provider expertise: 'I listen to doctors … they know best … they are here to

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save people' (Yap et al. 2018, 3303). Tailored communication – such as translated letters or simplified materials – was highly appreciated: 'They know our names … why don't they put two lines in Greek?' (Hurley et al. 2013, 144). Face-to-face presentations in the preferred language enhanced comprehension and participation: 'If a person comes to explain … then people would participate' (Woudstra et al. 2016, 1319).

Older migrants also used strategies to overcome low health literacy, such as using dictionaries or seeking information in their native language: 'I bought many illustrated books … I went through those books … over and over' (Lambert et al. 2021, 2433).

Even those fluent in the mainstream language struggled with medical terminology: 'It's as if they [doctors] are speaking another language … even if it's in Italian' (Lambert et al. 2021, 2433).

These findings underscore the importance of culturally competent communication, adequate interpreter services and accessible health education to support older migrants' engagement in care.

Theme 3: societal factors

Societal factors refer to the broader social and cultural dynamics that influence older migrants' access to care. These include social isolation, discrimination and the role of community support networks.

Subtheme 3.1: hindering factors

Many older migrants experienced isolation, loneliness and limited social interaction, often due to language barriers. Those with limited proficiency in the mainstream language (L2) relied heavily on first-language (L1) networks, which, while supportive, increased dependence on others for navigating health care: 'Without my daughter … I can only understand a bit … the nurse calls my daughter before coming' (Hurley et al. 2013, 146). This reliance often led to a loss of agency in care decisions: 'They used to talk to my son … they didn't ask me anything' (Chauhan et al. 2010, 71). Some participants felt stereotyped or devalued: 'The doctor sees if you can speak English … if not, you are a handicapped person' (Butow et al. 2011, 284). Others described a growing disconnect from younger generations: 'We cannot understand our own children' (Cook 2010, 265).

While ethnic enclaves offered linguistic familiarity, they could also reinforce segregation and limit integration into broader society. Whether older migrants pursued or abandoned efforts to learn the mainstream language depended on their initial proficiency, available support and daily life context.

Subtheme 3.2: enabling factors

Community groups and peer networks played a vital role in facilitating access to care. Shared language and lived experience created trusted spaces for learning and support: 'The senior group meetings … helped a lot with things I had no idea about … given me opportunities' (Barenfeld et al. 2015, 6). Peer discussions enabled understanding of health systems and rights, empowering informed decision-making. Culturally specific day centres fostered belonging and encouraged proactive engagement: 'By coming

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here, you talk to people … I have learned that I should come outside and mingle' (Koehn et al. 2016, 95). Even those with limited literacy benefited from peer-led information sharing: 'We learn new things, even if we cannot read … we share in our homes' (Koehn et al. 2016, 95). Peers often acted as cultural brokers, trusted more than formal providers, and helped dispel myths and stigma around care-seeking. These findings highlight the importance of investing in community infrastructure and peer-led education to support older migrants' access to care.

Theme 4: cultural factors

Cultural factors shape values, beliefs and communication styles, significantly influencing older migrants' engagement with care. Shared cultural backgrounds and culturally competent care facilitated mutual understanding, while cultural misalignment often hindered access and trust.

Subtheme 4.1: cultural beliefs as barriers

Some older migrants internalized a sense of being a 'difficult group', which discouraged them from voicing concerns: 'We need a lot of care and we cannot express it very well … but that does not mean we should criticise too much' (Carlsson 2023, 1523). Stereotyping by health-care staff also affected communication: 'They rarely talked to me … they were surprised I could understand English' (Montayre et al. 2017, 4).

Cultural differences in non-verbal communication and expectations around family involvement often led to misunderstandings. In unfamiliar clinical settings, family members were relied upon for reassurance. For example, when no support was offered to communicate with health practitioners, older migrants required family members to get involved to explain the diagnosis and care plan: 'I asked them to call my home … I could not communicate with the nurses … I felt unsafe' (Harrison et al. 2020, 165).

While some distrusted community-based interpreters due to confidentiality concerns, others preferred them for their perceived honesty: 'The interpreter won't hide the truth … they will tell you no matter what' (Butow et al. 2011, 286). However, expectations of interpreters as cultural advocates were often unmet: 'If you didn't ask, they won't interpret it' (Butow et al. 2011, 287). These unmet expectations were exacerbated when providers lacked cultural competence, further eroding trust.

Subtheme 4.2: cultural values and communication norms

Some participants felt misunderstood when their communication styles did not align with provider expectations. One noted 'having to put pressure on the doctor' and exaggerate symptoms to be heard (Arora et al. 2019, 5). Stereotypes like the 'happy migrant' or the 'exaggerating migrant' were reported to distort clinical judgement and undermine trust (Garrett et al. 2008).

Cultural norms such as fatalism, modesty and gender roles often inhibited open dialogue. Some participants struggled to describe symptoms experienced and interpreted based on traditional Chinese medicine concepts (*i.e.* flow of energy chi, balance of yin and yang) in terms relevant to Western terms: 'Sometimes I feel my body is groggy … I can't express these clear feelings' (Liu et al. 2017, 134). Others questioned the relevance of Western treatment advice (*i.e.* expecting a holistic treatment including

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lifestyle interventions: diet and physical activity): 'If I eat like Western people, it won't work' (Lambert et al. 2021, 2433).

Taboos around discussing sensitive topics (*i.e.* terminal illness, mental health issues, cervical cancer sample collection, colorectal cancer screening requiring collection of stool samples), especially in mixed-gender or family settings, further limited communication: 'We are just ashamed … I'm even ashamed to tell you' (Hoeck et al. 2022, 39).

Family members sometimes acted as gatekeepers, filtering information to protect each other. Engaging an interpreter facilitated open discussions and disclosing experienced health issues to health practitioners: 'I want to protect them from getting upset … it's better if the children stay out of it' (Butow et al. 2011, 286).

Continuity of care and face-to-face communication with culturally competent providers helped mitigate these barriers and fostered trust.

Discussion

To the best of our knowledge, this is the first qualitative systematic review to synthesize findings from 51 studies across two decades, examining how language barriers intersect with other factors shaping older migrants' experiences in accessing and using care services. While previous literature has acknowledged the challenges posed by language barriers (Khatri and Assefa 2022; Xiao et al. 2022), this review extends that understanding by revealing the nuanced interplay between language and other structural and relational determinants of care. This review identified four interrelated themes – system, provider, societal and cultural factors – that either enable or impede care engagement. Older migrants reported both positive and negative experiences in navigating care systems, with implications for policy makers, care organizations and service providers seeking to create inclusive, migrant-friendly care environments.

Scope and transferability

Of the 51 studies synthesized in this review, most were conducted in English-speaking destination countries, with a smaller number originating from Northern and Western European countries. Although these countries share some broad characteristics as high-income, migrant-receiving contexts, they differ substantially in the organization of their health and aged care systems, the funding and accessibility of interpreter services, the range of languages supported, the operation of digital and administrative access points, and the ways in which integration policies position migrants and linguistic minorities. We therefore interpret the findings as context-specific evidence grounded in the experiences of older migrants, which may not be directly transferable to other national settings.

System-level barriers and co-design opportunities

At the macro level, integration regimes shape how language access is defined, funded and delivered. In Canada, a legislated multiculturalism framework assigns public bodies clear responsibilities to enable participation and remove barriers, with implications for interpreter and translation policy and practice (Government of Canada 1988). In the United Kingdom, the post-2001 'community cohesion' policy stream

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prioritized contact between groups and a shared civic orientation; this framing influenced how interpreter provision was commissioned and how outreach to minoritized communities was structured (Home Office 2001).

At the system level, barriers such as inaccessible health information, digital exclusion and inflexible service delivery models significantly hindered older migrants' ability to access timely and appropriate care. These findings align with prior research on the structural nature of language barriers and their impact on autonomy and health literacy (Khatri and Assefa 2022; Vange et al. 2024). However, this review adds new insights by showing how digitalization – intended to improve access – can exacerbate exclusion for those with limited literacy (*i.e.* unable to read on-screen instructions, follow a manual) or digital skills (*i.e.* do not know how to use computers).

To address the challenges identified in this review, system-level reforms must prioritize co-design and co-creation of services with older migrants. While Australia offers a compelling case study due to its multicultural demographic and policy frameworks, similar inclusive approaches have emerged internationally, reflecting a broader shift towards human-centred, rights-based care.

In the United States, initiatives such as the Money Follows the Person programme and the Ageing in Place Initiative promote ageing in community through person-centred care models that support autonomy and social inclusion (Spencer et al. 2010). These programmes emphasize continuity, compensation, connection, contribution and challenge – principles that align with inclusive care.

In Canada, Ontario's Aging with Confidence strategy embeds cultural and linguistic diversity into senior care planning, emphasizing community engagement and culturally competent service delivery (Spencer et al. 2010). Migrant care workers play a vital role in bridging gaps in formal care systems, and policies increasingly recognize the need for fair employment conditions and ethical recruitment practices (Kumar et al. 2022).

In the Netherlands, municipalities such as Nijmegen and The Hague have implemented a mix of mainstreamed and ethno-specific aged care services under a diversity-mainstreaming framework. These include intercultural eldercare advisors and culturally tailored day- and home-care services. However, the framing of such services as temporary responses to current generations' language needs risks undermining long-term investment in intercultural expertise (Carlsson and Pijpers 2021).

The WHO advocates for diversity-sensitive health and long-term care policies across Europe, emphasizing the importance of skilled interpreters, culturally appropriate care and inclusive service design. Their policy brief highlights the need for participatory approaches that involve older migrants in shaping their care environments (World Health Organization 2018).

Across these contexts, several key principles of inclusive care emerge: (1) person-centred and rights-based approaches that reflect lived experiences; (2) cultural and linguistic responsiveness, including tailored communication and interpreter services; (3) community engagement and co-design, involving older migrants in service planning; (4) support for informal care-givers and investment in peer-led initiatives; (5) ethical recruitment and fair employment for migrant care workers; and (6) long-term commitment to intercultural competence, avoiding assimilationist framings. These international examples reinforce the need for aged care systems to move

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beyond generic models and embrace diversity as a core principle. Inclusive care is not only about access but about dignity, autonomy and meaningful participation in society.

In Australia, the inclusive approach is strongly supported by the Royal Commission into Aged Care Quality and Safety, which called for a shift towards person-centred, rights-based care that reflects the lived experiences of diverse older Australians (Royal Commission 2021). The new Aged Care Act 2024, effective from 1 November 2025, embeds this principle by mandating culturally safe assessments, inclusive planning and accessible complaints mechanisms (Department of Health and Aged Care 2024). Policy tools include the Aged Care Diversity Framework and its associated Action Plans that provide a roadmap for embedding inclusive practices across the sector. These documents emphasize the importance of tailored communication, cultural safety and workforce training to meet the needs of older people from CALD backgrounds (Department of Health 2017). The 2024 Multicultural Framework Review further reinforces the need to engage CALD communities in decision-making and co-produce services that reflect their values and aspirations (Department of Home Affairs 2024). In practice, this means involving older migrants in the design of health promotion materials, digital tools and service models. For example, the co-design of the Support at Home programme under the new Act involved extensive community consultation, including with CALD communities, to ensure that services are accessible, flexible and culturally appropriate (Department of Health and Aged Care 2024).

Despite the noted policy advances, our review highlights a persistent unmet demand for language learning opportunities, particularly among older carers supporting spouses. This gap is rarely addressed in service planning. Older people may have distinct preferences for how they wish to learn and use language in care contexts. Integrating these preferences into education and training programmes is essential to support their autonomy and engagement. Additionally, older migrants often feel disempowered to provide feedback or lodge complaints, even when they experience inappropriate care. This underscores the need for inclusive system designs that integrate language support with digital and health literacy initiatives and actively seek feedback from linguistically diverse populations.

In English-dominant systems where patient portals function as the primary point of entry to care, support for digital skills and clear navigation in an individual's preferred language are essential. In the absence of such support, investments in interpreting services and translated materials are likely to underperform. Although not examined in detail in every included study, discrimination and racism shape whose concerns are recognized, who trusts services and who persists through complex administrative processes. Consequently, service and clinic design should explicitly acknowledge these patterns and incorporate mechanisms to mitigate their effects on communication and access.

Provider-level interactions and communication

Interactions with care providers emerged as a critical determinant of older migrants' care experiences. Consistent with international research, this review confirms that inadequate interpreter services and culturally insensitive communication contribute to

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miscommunication, mistrust and disengagement (Hadziabdic and Hjelm 2014; Khanal 2025). These issues are echoed in the Australian context, where studies have shown that older migrants often feel excluded from decision-making due to limited access to professional interpreters and a lack of cultural competence among health-care staff (White et al. 2019; Das and Chatterjee 2025).

Our findings extend this literature by highlighting the emotional toll of these interactions, including feelings of helplessness when patients are misunderstood or unable to express themselves. We also underscore the risks associated with poor-quality interpretation, such as misdiagnoses and inappropriate treatment, and the limitations of relying on family members – who may lack fluency in the older person's first language or be unavailable due to competing responsibilities.

Our analysis cautions against treating 'culture' as a fixed attribute located in patients or as a checklist to be completed (Tervalon and Murray-García 1998). Evidence from the studies – including the use of stereotypes such as the 'happy migrant' and the 'exaggerating migrant', expectations that interpreters act as cultural advocates, and misalignments around decision-making and symptom talk – shows why practice cannot be reduced to technical proficiency alone. We therefore emphasize cultural safety and structural competence, with explicit attention to power, bias and organizational constraints, and to how language is valued and rationed within care systems (Metzl and Hansen 2014).

These insights reinforce the need for investment in high-quality, culturally competent interpreting services, flexible scheduling and sufficient time allocation during appointments. Furthermore, they support calls for mandatory cross-cultural communication training for care providers and the integration of cultural competence into staff performance evaluations and organizational accountability frameworks. Our findings have implications for enhancing routine access to trained interpreters with appointment structures that permit timely and needs-based access to qualified interpreters. Our findings also suggest the need to co-design training programmes for interpreters and health and aged care professionals to use a lifecourse approach to recognize diverse care needs and the most effective way to address the care needs of older migrants rather than a language barrier perspective. In English-dominant clinical environments, even L2-fluent older adults experience difficulties to understand medical terms in English. Therefore, interpreter services and translated medical information must use plain language and be tailored to the cultures of older migrants.

Social networks: dual roles in care access

Social networks played a dual role in shaping care access. On one hand, social isolation, dependence on family and experiences of 'othering' reduced agency and reinforced marginalization – findings consistent with prior research on the social determinants of migrant health (Kristiansen et al. 2016; Hanewald et al. 2023). On the other hand, culturally specific peer networks and community-based learning emerged as powerful enablers of care engagement. Despite growing awareness, translating such evidence into policy and practice remains a global challenge (Rushmer et al. 2019; Kelley et al. 2022). Sustained investment in community engagement, culturally safe spaces

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and peer-led initiatives is essential to bridge the gap between policy intent and lived experience.

This review contributes novel insights by positioning peer-led environments not as peripheral supports but as central mechanisms through which older migrants build confidence, learn about their rights and navigate care systems. These findings suggest that strengthening community infrastructure and peer education could be a cost-effective strategy to enhance care access and equity. For example, in Australia, community-based programmes such as the Partners in Culturally Appropriate Care (PICAC) have demonstrated success in supporting CALD communities through culturally tailored education and service navigation support.

Cultural norms and communication styles

Cultural beliefs and communication norms also significantly influenced care engagement. While previous studies have acknowledged the role of culture in shaping health behaviours (Gerber et al. 2020; Georgeou et al. 2023), this review offers a more nuanced understanding of how cultural values intersect with language to affect communication.

Fatalism, modesty, family roles and gender norms often inhibited open dialogue, particularly around sensitive topics such as cancer screening or end-of-life care. For instance, older migrants from collectivist cultures may avoid discussing terminal illness to protect family harmony, which can conflict with Western models of individualized care planning. Cultural misalignment between patients and providers led to stereotyping and misinterpretation of symptoms, further eroding trust.

Our findings also highlight the complex expectations placed on interpreters, who were sometimes viewed as cultural advocates rather than neutral translators. When these expectations were unmet, older migrants felt misunderstood or unsupported. This underscores the need for culturally competent care models that go beyond language access to include respect for diverse values, communication styles and family dynamics.

Challenging stereotypes and addressing structural inequities

Importantly, this review contributes new knowledge by exploring how cultural stereotypes – such as the 'happy migrant' or the 'exaggerating migrant' – can distort provider perceptions and lead to diagnostic errors or disengagement. These stereotypes, often rooted in unconscious bias, can result in under-reporting of symptoms, misdiagnosis or dismissal of concerns. Such insights have received limited attention in previous syntheses and highlight the need for provider training that includes bias recognition and interpretation of non-verbal cues. For example, a study by Garrett et al. (2008) found that older migrants often refrained from expressing dissatisfaction due to cultural norms of deference, which was misinterpreted as contentment with care.

By focusing on language-related barriers, this review also highlights persistent inequities experienced by older migrants across diverse cultural and national contexts. These barriers affect both long-settled and recently arrived migrants – including skilled workers, refugees and family reunification migrants – and are compounded by social isolation and dependence on family members.

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Our findings reinforce the need to move beyond language as a stand-alone issue and address the broader socio-cultural and structural contexts in which communication occurs. In Australia, a rights-based approach to healthy ageing, embedded in the Aged Care Act 2024 and the Royal Commission's recommendations, requires that older migrants are not only heard but actively involved in shaping the services they use.

Implications for policy, practice and research

This review underscores the urgent need for health and aged care systems to adopt culturally and linguistically responsive models of care. While previous studies have called for improved interpreter services and translated materials, our findings suggest that these measures alone are insufficient. Language barriers intersect with digital exclusion, cultural norms and systemic design, compounding disadvantage and limiting older migrants' ability to engage meaningfully with care. Policies must integrate language support with digital literacy, culturally tailored health education and flexible service delivery models co-designed with CALD older migrants.

Culturally specific peer networks and community-based learning emerged as powerful yet under-utilized enablers of care engagement. These informal structures foster trust, confidence and a sense of belonging. Investing in community-led initiatives and peer education programmes could bridge formal system gaps, particularly for those with limited literacy or distrust of institutional actors. Such approaches support a shift towards participatory, community-embedded care models and person-centred care promoted in aged care policy.

The review also highlights how cultural stereotypes – such as the 'happy migrant' or the 'exaggerating migrant' – can distort provider perceptions and lead to misdiagnoses or disengagement. These findings call for provider training that goes beyond cultural awareness to include practical skills in cross-cultural communication and bias recognition.

Finally, there is a notable gap in research on older migrants' everyday language use and its impact on health literacy, service navigation and social integration. Future studies should explore the interplay between first (L1) and second (L2) language use across care contexts and migrant subgroups. Longitudinal and intersectional research could offer deeper insights into how language-related barriers evolve and interact with other social determinants of health. A rights-based approach to healthy ageing requires that language be addressed as a systemic determinant, not merely an individual challenge.

Limitations

This review has several limitations. First, we limited inclusion to English-language publications. Therefore, publication bias existed. Future systematic reviews need to include publications from multilingual syntheses of relevant research evidence. Second, over 71 per cent of the 51 included studies are from English-speaking destination countries, meaning that the views of non-English scholarship might be under-represented in this review. Third, all studies included in the review are from developed countries. Findings may not be transferred to developing countries. Considering the increasing South-to-South migrants (or migration between developed countries), future studies

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need to focus on older migrants and their access to health and social care services from developing countries. Fourth, many studies had small sample sizes and considerable heterogeneity in participants' migration histories, socio-economic status and health conditions, limiting generalizability – particularly for recent migrants or those with no English proficiency. Our findings may not represent those from forced migration due to the database search limit. Thus, findings may not be transferable to those older population. Fifth, findings may be biased towards health-conscious individuals engaged in community networks. Finally, a time lapse between study selection and publication may have led to the omission of recent literature.

Conclusion

This review provides new insights into how system factors, provider factors, societal factors and cultural factors either enable or hinder older migrants' access to care services, communication with providers, and health and wellbeing, primarily with evidence from high-income migrant-receiving settings. We provide a rights-aware, systems-level account of language barriers among older migrants while recognizing that these findings are conditioned by the policy, interpreter, service and community infrastructures of the settings studied.

Systemic issues such as inaccessible information and digital exclusion undermine autonomy, while provider-level gaps, including limited interpreter services and cultural insensitivity, erode trust and care quality. Social dynamics, including reliance on family and social isolation, further constrain agency, and cultural norms influence communication and help-seeking behaviours.

Importantly, this review identifies enabling strategies – such as culturally tailored information, peer support and language learning opportunities – that promote more inclusive and effective care. These findings support the development of rights-based, person-centred care models that address both structural and relational dimensions of language barriers. Central to this is the recognition that the right to communicate – including in one's preferred language – is fundamental to realizing other human rights, such as access to health care, education and full participation in society. Implementing culturally and linguistically appropriate services and fostering community engagement are essential steps towards ensuring equitable, sustainable care systems that support older migrants to age in place with dignity and independence.

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accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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