Abstract

Purpose: The purpose of our study was to synthesize data from the existent literature on the experiences of non-Western older migrants in Europe in accessing and using healthcare services.

Design/methodology/approach: 1606 records were reviewed and 12 studies were selected. A thematic synthesis using Thomas and Harden's approach was conducted**.**

Findings: The findings resulted in the three overarching themes 1) traditional discourses under new circumstances 2) predisposed vulnerabilities of older migrants and the healthcare system and 3) the conceptualization of health and the roles of healthcare professionals. We found that older migrants' experience of accessing healthcare is influenced by many factors, such as health literacy, differences in healthcare beliefs and language barriers, and is not limited to cultural and traditional discourses of care. Findings reveal that there is a limited body of knowledge on barriers experienced by older migrant women**.**

Research limitations/implications: The geographical scope of the study and subsequent type of healthcare systems should be taken into account while understanding barriers to care. Another limitation is that although we studied different migrant groups, we synthesized barriers experienced by all. Future research could study migrants as separate groups to better understand how previous experiences with healthcare in their home country and specific social, cultural and economic circumstances shape them.

Originality/Value: This paper provides a synthesis of the experiences of migrants from non-Western countries who moved to a host country with a very different language, culture and healthcare system.

Keywords: Healthcare, access, barriers, older migrants, thematic synthesis

Type: General review

Introduction

The number of migrants in Europe is increasing (Razum and Samkange-Zeeb, 2008) and with it, the proportion of older migrants, giving rise to research on their needs and experiences (Ciobanu and Hunter, 2017). The combined experience of ageing and migration often results in additional health challenges (Park and Kim, 2013), while older migrants may also experience barriers to seeking and receiving healthcare (Kristiansen et al., 2016). Not surprisingly, studies have shown that older migrants form a particularly vulnerable group and that health systems in Europe are, so far, poorly equipped to deal with this challenge (Ruspini, 2009).

It is important to understand the particular healthcare needs, experiences and potential barriers of older migrants in Europe in order to provide more appropriate and timely access to care. To the best of our knowledge, no thematic synthesis has been undertaken to summarise and interpret the research on the experiences of older migrants in accessing healthcare. Our study aims to fill this gap. Since older migrants constitute a highly heterogeneous population (Warnes et al., 2004), the focus of this qualitative synthesis is on migrants from non-Western countries[1] who moved to a host country with a very different language, culture and healthcare system.

Methods

We performed a comprehensive literature search, using the databases CINAHL, PsycINFO, SocINDEX and Medline. Our choice of databases across health, social sciences and psychology was informed by the interdisciplinary nature of the subject of our research, involving social, economic, cultural and psychological barriers to accessing healthcare. A librarian provided advice on search terms and strategy.

We used the following keywords in the final search: “general practitioner” OR “GP” OR “primary care” OR “community care” OR “home care” OR “nursing care” OR “nursing home” OR “hospital” OR “healthcare” OR “health care” OR “access” OR “barrier” OR “facilitator” AND “refugee” OR “migrant” OR “immigrant” OR “ethnic minority” AND “elderly” OR “older” OR “aged” OR “geriatric” AND “qualitative research” OR “qualitative study” OR “qualitative methods” OR “phenomenology” OR “grounded theory” OR “observation” OR “interview*” OR “thematic analysis” OR “content analysis” OR “focus group”.

The search strategy and the results of each search step are presented in the PRISMA flow diagram (Moher et al., 2009) (Figure 1). We applied the following inclusion criteria: having a qualitative design (or a mixed method study with a qualitative component), focusing on experiences of older migrants from non-Western countries, concerned with healthcare, and based in Europe. We included studies that focused on older migrants from Asia, Africa, Central and South America, Oceania (excluding Australia and New Zealand) and European countries outside of the European Union (EU) or the European Economic Area (EEA). While research studies often define old age for migrants originating from countries with lower life expectancy as those aged 50 years and above (Diaz and Kumar, 2014), we included all studies that identified migrants as older, regardless of the ages reported. Where

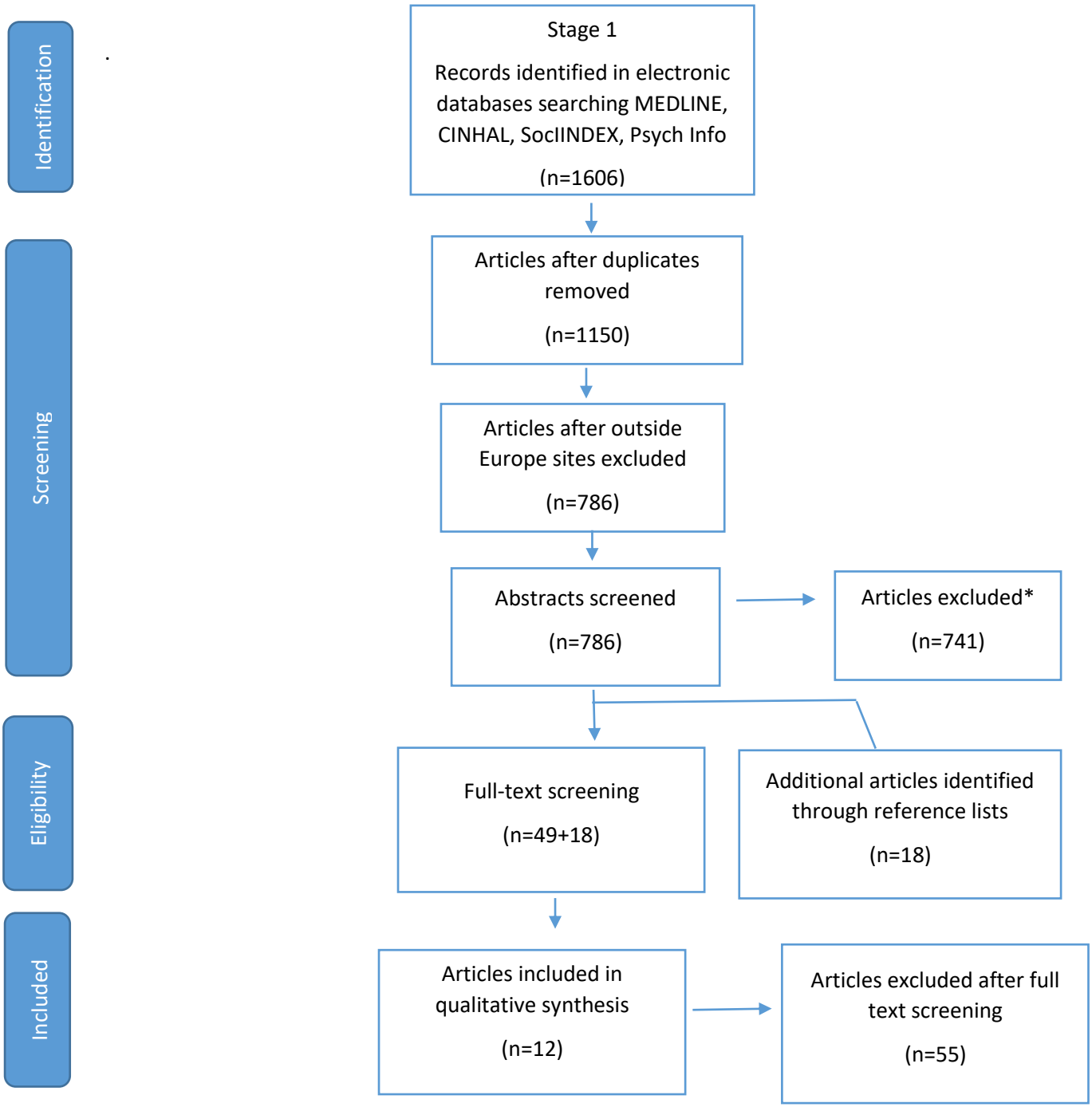
[1] For the purpose of this study, Western migrants are classified as coming from the Nordic countries, Western Europe (excluding Turkey) and North America/Oceania and non-Western migrants as coming from rest of the world

middle-aged participants were also involved, we included only findings pertaining to older participants (Doshani et al., 2007). Finally, we only considered studies for inclusion that were published in peer-reviewed journals and in English. We conducted the search in February 2017 and updated it in May 2018. We searched databases from their opening year until 30 April 2018.

The literature search using the key terms mentioned above resulted in 1606 articles, including from Medline: 573, Cinhal: 583, Psych Info: 243, and SocI INDEX: 207. Deletion of duplicates left 1144 articles. We then selected 801 articles by title, using the inclusion and exclusion criteria. We excluded studies from outside Europe at this stage and added 18 articles identified through reference lists. We checked the abstracts of the remaining articles and selected 67 articles. Full-text screening left 12 articles for inclusion. We used a critical appraisal checklist (http://www.casp-uk.net/#!casp-tools-checklists/c18f8) to evaluate the quality of the selected articles (Ludvigsen et al., 2016). The research group agreed on their relevance to the synthesis, therefore all 12 studies were retained. The characteristics of the included studies are shown in Table 1.

We conducted a qualitative thematic synthesis of the research findings in three stages with the aim of identifying common themes, informed by Thomas & Harden (Thomas and Harden, 2008). In the first stage, we coded findings that related to barriers for accessing healthcare freely, line-by-line, since there was no previous thematic synthesis on this topic. We then organized these codes into key descriptive themes. We developed these themes by staying close to the primary studies. In the next stage of interpretation, the analytical themes were developed, going beyond the primary studies to generate new interpretive constructs and explanations. In the next stage of interpretation, we went beyond the primary studies to generate new interpretive constructs and explanations. This led to the final step where we generated analytical themes.

Figure 1 PRISMA flowchart of studies from identification to inclusion



Note : * Quantitative studies, which were identified during the database search, were excluded at this step. However, mixed methods studies, which had a qualitative component focusing on access to healthcare, were retained. In addition, studies that did not focus on access to healthcare or elderly immigrants were excluded at this stage.

Table 1: Characteristics of studies included in the qualitative meta-synthesis				
Ref. No.	**Author, Year, Country**	**Aim**	**Methods**	**Sample and Setting**
(Liu et al., 2017)	Liu et al., 2017, United Kingdom	This study explored the experiences in using health and care services and the strategies adopted to address difficulties.	Focus groups and individual interviews	4 focus groups with 27 older Chinese and 5 family members and 27 individual interviews with 17 older Chinese and other participants
(Ellins and Glasby, 2016)	Ellins and Glasby, 2016, United Kingdom	Part of a larger study exploring older people's experiences of transitions in care	In-depth narrative interviews	24 participants from minority ethnic communities (Asian or Asian British, Black or Black British, or Gypsy-traveller) aged 60 or above
(Suurmond et al., 2016)	Suurmon et al., 2016, Netherlands	To explore perceptions of older people towards home care services in Netherlands	Qualitative semi-structured group interviews and individual interviews	55 older migrants from Turkish, Moroccan, Surinamese and Dutch ethnicities, aged 52-83 years old
(Oglak and Hussein, 2016)	Oglak and Hussein, 2016, United Kingdom	To explore the experience of older Alevi/Kurdish refugees living in the United Kingdom within the parameters of active ageing	Qualitative methodology through in-depth interviews	30 Alevi/Kurdish participants aged 55 to 98 years
(Saltus and Pithara, 2015)	Salthus and Pithara, 2015, Wales, United Kingdom	Part of a larger study. Aim of this article was to explore the interrelationships between life course events and the multiple roles adopted by women at different points in time that have shaped their perceptions of care and their care expectations in old age.	Semi-structured interviews	Older women (aged 50 or over) living in Wales who self-identified as Black Caribbean, South East Asian (Chinese), South Asian (Bangladeshi Muslim) or Indian by upbringing, birth or acculturation.

(Thyli et al., 2014)	Thyli et al.,2014, Norway	To study older ethnic minority immigrants' experiences of getting old in Norway, with a focus on health and care	Explorative, descriptive design following a grounded theory approach	15 older migrants from Iran, Iraq, Vietnam and Bosnia- Herzegovina, aged 63-85 years
(Liu et al., 2014)	Liu et al., 2013, United Kingdom	To explore experiences and attitudes of older Chinese people towards primary healthcare services	Grounded theory using open ended in-depth interviews	33 older Chinese people aged 60–84 years
(Chew-Graham et al., 2012)	Chew-Graham et al., 2012, United Kingdom	To explore the reasons why older people with depression may not present to primary care	Secondary analysis was carried out, of qualitative data collected in two previous studies in North-West England. 19 Participants of South Asian, African Caribbean, Polish, Caucasian ethnicities	
(Doshani et al., 2007)	Doshani et al. 2007, Leicester, England, United Kingdom	This study aimed to explore views and experiences of incontinence and perceptions of care among South Asian Indian women in Leicester, United Kingdom	Focus groups	24 women aged 36 to 82.
(Lawrence et al., 2006)	Lawrence et al., 2006, United Kingdom	To explore beliefs about depression in later life and help-seeking strategies	In-depth individual qualitative interviews	32 black Caribbean, 33 South Asian and 45 white British older adults, aged 65 and above
(Marwaha and Livingston, 2002)	Marwaha and Livingston, 2001, United Kingdom	To explore and compare views of White British and Black African Caribbean older people on depression and help-seeking strategies	Semi-structured interviews	40 White British (67-93 years old) and Black African Caribbean (67-86 years old)
(Nielsen et al., 2017)	Nielson et al., 2017, Denmark	To explore the everyday life conditions experienced by older migrants and their reasons for specific age- and health-related behaviour in everyday life	Interviews	A total of 16 participants (seven men and nine women) aged over 55 years from Palestine, Lebanon, Iraq and Somalia

Results

The 12 selected studies originated from only four countries, the United Kingdom, the Netherlands, Norway and Denmark (Table 1) and were published in 2001-2018. Participants included older migrants from the following origins or ethnicities: Black Caribbean, South Asian, South East Asian, Vietnam, Bosnia- Herzegovina, Turkey, Morocco, Iran, Iraq, Palestine, Lebanon, Somalia, Poland, China, Gypsy traveller, Surinamese, Alevi/Kurdish, Black British, Caucasian, Asian British and Black Asian.

Our analysis of the 12 articles identified descriptive themes that were grouped under three analytical categories related to how older migrants experience using healthcare services: 1) traditional discourses of care under new circumstances 2) predisposed vulnerabilities of older migrants and the healthcare system and 3) the conceptualization of health and the roles of healthcare professionals. These three categories are discussed below with supporting participant narratives. A summary table shows themes from each of the included studies (Table 2).

Traditional discourses of care under new circumstances

Older migrants and family

Care by, and involvement of, family emerged as an important issue in older migrants' access to, and use of, healthcare. Studies found that older migrants' conceptions of family care are rooted in traditions that emphasize the reciprocity of care between children and parents (Oglak and Hussein, 2016, Saltus and Pithara, 2015). It was also perceived as a duty and obligation (Liu et al., 2017) and a cultural "golden rule" that they wished to uphold (Thyli et al., 2014). The intergenerational reciprocity of caring was also associated with the idea of dignity in old age. For some, older age symbolized having a respectful position in the community and being cared for by children (Saltus and Pithara, 2015).

Several studies found that involvement of family in healthcare was both present and desired by older migrants. Family members provided practical and emotional support and facilitated access to healthcare in many ways. Practical support was provided in the form of assisting in transport, communication with health professionals (Liu et al., 2017, Thyli et al., 2014), providing information or knowledge (Doshani et al., 2007), advocacy and daily healthcare. Emotional support was provided by listening to worries or concerns (Lawrence et al., 2006), while providing a sense of security (Liu et al., 2017) and personalized altruistic care (Saltus and Pithara, 2015), as recounted by a research participant now living in Wales:

"I think it's more about, um, the fact that, your family and friends, it's not paid care, it's, it's love care, it's care from the heart. So that does make a great deal of difference because professionals come in and it's a job, you know, there is, you know, they come in, they do a job, they've got, there are time constraints and all those other things'' (Saltus and Pithara, 2015)

In a study on hospital discharge in the United Kingdom, some older migrants expressed the wish for their family to be updated by healthcare professionals during the care process, and the lack of this could lead to distress (Ellins and Glasby, 2016). Family members were also considered to be better care-takers, with better knowledge and understanding of their practical and emotional needs (Saltus and Pithara, 2015) than what they could expected from formal care-givers.

Some of the studies also found that older migrants' preference for family care was at times present, even when such care could no longer be provided or sustained (Suurmond et al., 2016). However, not

all older migrants preferred involvement of their family to the same extent. Some realized that this caused concerns and distress to family members, notwithstanding the struggle that older migrants experienced while trying to cope by themselves (Chew-Graham et al., 2012) as noted by a participant in the United Kingdom:

''I didn't know what was wrong with me, all I knew was that my mood changed, I mean my thoughts did… believe you me, because I didn't know what was wrong with me, and I'd be alright one minute and I'd be down the next minute, and they didn't know where they were, so it affected the family''. (Chew-Graham et al., 2012)

Some older migrants from Indian-Welsh and Caribbean origin, now living in Wales, regarded professional providers of home care to be more knowledgeable and better suited to their new living circumstances than family members (Saltus and Pithara, 2015). However, despite a traditional discourse on family care (Oglak and Hussein, 2016, Saltus and Pithara, 2015), preferences for the type of care were also shaped by personal circumstances, language barriers (Oglak and Hussein, 2016, Thyli et al., 2014, Suurmond et al., 2016), lack of knowledge of services, poor health literacy (Suurmond et al., 2016), cultural incompatibility of beliefs and language with healthcare professionals (Oglak and Hussein, 2016, Thyli et al., 2014), and perceptions about the quality of formal care (Oglak and Hussein, 2016).

Many older migrants experienced a change in their preference for family care over time, attributed to both their own and their family's roles changing (Saltus and Pithara, 2015, Thyli et al., 2014). They perceived family care as a trade-off between "being reliant and being a burden" (Thyli et al., 2014) or as a cause of distraction to their family members' lives (Saltus and Pithara, 2015). Therefore, some felt guilty about needing help from family members, as recounted by a participant in Norway:

''I feel alone and worthless. I sit here crying. I totally depend upon my children. I have to know when they can come, but I don't like to ask all the time, knowing how busy they are. They have their children and demanding jobs. I can't call them all the time'' (Thyli et al., 2014)

In light of such circumstances, some older migrants adjusted their expectations of receiving family care over time (Saltus and Pithara, 2015), while others struggled with a sense of insecurity in view of changing care models (Thyli et al., 2014).

Decision-making

In the above-mentioned study on hospital experiences of older migrants in the United Kingdom, very few older migrants expressed the desire to be more actively involved in decision-making related to their healthcare (Ellins and Glasby, 2016). Older migrants acknowledged that family members often controlled decisions related to healthcare, because of their own lower cultural competence and reduced parental authority (Liu et al., 2017). One described the case where an older migrant had to choose a nursing home:

''Yes, [my son chose the nursing home for me.] I don't know English… if there is anything, it's always referred to [my son] … my son would sign documents for me, I don't know English and I don't know how to write''. (Liu et al., 2017)

Some older migrants expressed their preference for involving their family in any decisions taken, but recalled the struggle of probing health practitioners actively for information about their health and care (Ellins and Glasby, 2016).

In another case, from Norway, the involvement of family was sought by healthcare practitioners due to language barriers in communicating with older migrants (Thyli et al., 2014). Such practices might indicate an acceptance of older migrants' lack of control over their healthcare decision-making where language barriers exist (Thyli et al., 2014, Liu et al., 2017).

Social capital and access to healthcare services

Social capital emerges in the selected studies as one of the major facilitators for access to and use of healthcare services. It can be understood as the resources available in terms of neighbours, friends, extended family and social workers. After moving to their host country and having aged there, older migrants often felt "vulnerable", "socially excluded" (Liu et al., 2017) and "comfortable only at home"(Thyli et al., 2014). One participant in Norway elaborates:

''It is difficult as you get older, the language. And you have the difference between you and us. It is best to make it on our own, and not bother anybody. I don't like being dependent upon others, who are outside of the family. Then it is better to speak together in the same language. I end up sitting there alone, having to be accompanied by my daughter. For her, there will be even more to do if she has to go out with me'' (Thyli et al., 2014)

Many older migrants relied on their social capital, comprised of people with similar migration backgrounds, for instrumental help, such as gaining knowledge about healthcare services and completing forms but also for emotional support during visits to healthcare facilities (Liu et al., 2017, Oglak and Hussein, 2016). Moreover, this social capital instilled a sense of comfort and support (Liu et al., 2017). It helped to bring people together and mediated their access to, and use of, healthcare services by influencing their perceptions and decision-making (Liu et al., 2017).

Predisposed vulnerabilities of older migrants and the healthcare system

Language proficiency and literacy

Many of the included studies identified language barriers and lower literacy as factors influencing older migrants' access to care. Most of the older migrants either did not speak the native language of the host country or were not fluent enough (Doshani et al., 2007, Liu et al., 2017, Ellins and Glasby, 2016, Oglak and Hussein, 2016, Saltus and Pithara, 2015, Suurmond et al., 2016, Liu et al., 2014, Thyli et al., 2014). Since some older migrants were either illiterate, less educated (Liu et al., 2017, Oglak and Hussein, 2016, Liu et al., 2014, Doshani et al., 2007) or preferred verbal information (Doshani et al., 2007), access to written translated material was also not always helpful for them (Doshani et al., 2007). Barriers were also encountered at the stage of booking appointments (Liu et al., 2017), making transport arrangements (Liu et al., 2017), communicating with healthcare providers (Liu et al., 2017, Thyli et al., 2014), understanding prescriptions, accessing follow-up and social care services (Liu et al., 2017), involvement in their own care (Ellins and Glasby, 2016), and acquiring knowledge about healthcare services (Oglak and Hussein, 2016, Suurmond et al., 2016). Some older migrants blamed themselves for the language barriers they experienced and were sympathetic to the frustration experienced and displayed by staff (Ellins and Glasby, 2016), as recounted by a participant:

''There was just this one problem I had of not being able to speak back to staff, and then they're frustrated. They come to say something and chances are we may not understand and that's not something you can blame them for'' (Ellins and Glasby, 2016)

In emergency care, the inability to understand instructions also created difficulties for older migrants (Ellins and Glasby, 2016). Moreover, language barriers were not perceived and experienced in isolation, but resulted in feelings of anxiety, alienation and vulnerability, due to the inability of older migrants to understand what was going on around them (Thyli et al., 2014, Ellins and Glasby, 2016). Some older migrants felt that language barriers led to inequitable treatment of poorer quality (Saltus and Pithara, 2015, Ellins and Glasby, 2016). Some also believed that, at times, language barriers, coupled with their situation as older migrants, led to prejudice and discrimination (Ellins and Glasby, 2016, Saltus and Pithara, 2015) as described by a participant:

''the other alternative is, it would be good to go, move to St Kitts! [care home] I would love to have six months here and six months there, but the level of care if you were ill, you would get that good care over there. […] it is the way they are thinking they will be only too pleased to help you and they will treat you with care and dignity. You would get it there. You wouldn't get that here, you are just a number as well. The way you are treated, you are treated differently because of your skin colour'' (Saltus and Pithara, 2015)

Language barriers also limited their interaction with people from the same neighbourhood (Thyli et al., 2014), except where they belong to the same culturally confined social networks (Liu et al., 2017). The resulting reliance on culturally confined social capital could potentially limit access to information (Oglak and Hussein, 2016, Saltus and Pithara, 2015). For some others, language barriers were an impediment to developing a trustworthy relationship with their health professional (Nielsen et al., 2017).

The situation was even more difficult for older migrants without family support, as they felt helpless in navigating the healthcare system (Saltus and Pithara, 2015). Some older migrants were also unable to rely on the knowledge of their children, as they themselves had poor health literacy (Suurmond et al., 2016). Unsurprisingly, many older migrants preferred contact with healthcare professionals who could speak their language or had the same cultural background (Suurmond et al., 2016, Oglak and Hussein, 2016).

Interpreters

A number of studies explored the use of interpreters to overcome language barriers. Some older migrants preferred using family members as interpreters for fears that the professional interpreter might be someone from their own neighbourhood, resulting in a breach of confidentiality (Doshani et al., 2007). However, one older migrant was hesitant to use family members for the same reason (Doshani et al., 2007). Others, in a study conducted in the United Kingdom, preferred professional interpreters as they are easily available (Ellins and Glasby, 2016).

The same study found however, that while guidelines for the availability of interpreters existed, staff often failed to make arrangements prior to appointments or at short notice, especially in time-constrained hospital settings (Ellins and Glasby, 2016). In some cases, the presence of bilingual informal interpreters was the reason for not arranging professional interpreters (Ellins and Glasby, 2016). Additionally, the responsibility to arrange an interpreter was often informally assigned to the older migrants themselves, without knowing their capability of, or preference to, arranging this (Ellins and Glasby, 2016), as described by a participant:

''The staff say to me, you ought to bring someone with you. But who can I take with me? People need to be at their own places of work in the mornings'' (Ellins and Glasby, 2016)

Older migrants expected interpreters to function beyond their role of interpreting, but also to facilitate their interaction with healthcare professionals and act as an advocate for their needs (Liu et al., 2017). Older migrants expressed the need for facilitators from their community, such as migrants who had had similar experiences of being in the host country and in navigating the new healthcare system. In one study, such persons were termed "bridge people" (Liu et al., 2017).

For similar reasons of improved verbal and cultural communication, several studies found that older migrants often preferred healthcare practitioners of the same ethnicity (Liu et al., 2017, Doshani et al., 2007, Suurmond et al., 2016, Saltus and Pithara, 2015, Oglak and Hussein, 2016). One participant in a group interview explained:

''Respondent: A Turkish home care provider, for housekeeping activities [I want]. I do not speak the language. Interviewer: Do you experience difficulties in the work you want to have done? Respondent: Of course I face difficulties. If I say she has to do this, I can't tell her, or if she has to do that. I tell her 'door', she understands 'outside'. I can't tell her''. (Suurmond et al., 2016)

Conceptualization of health and the role of healthcare professionals

Different healthcare beliefs and coping strategies

Older migrants from non-Western countries are reported in several of the included studies as being at first unfamiliar with the healthcare system of their new host country and sometimes having different beliefs about ageing and healthcare. Some older migrants who suffered from sensitive health issues associated with stigma and embarrassment, such as depression or incontinence, were reported to hold different views about health and healthcare than their non-migrant peers. They were either fearful of labelling or acknowledging such health problems as a "disease" (Marwaha and Livingston, 2002, Chew-Graham et al., 2012) or dismissed some health issues as a normal aspect of ageing (Doshani et al., 2007, Chew-Graham et al., 2012). In a study about the issue of incontinence among older South Asian migrant women, one of the participants remarked during a focus group discussion:

''Part of the reason is that muscles have gone weak and we feel there is no cure for weakness, it has to happen so it will, we are old, nothing can be done''- (Doshani et al., 2007)

They coped by developing their own etiology of such health problems (Doshani et al., 2007). For example, some older South Asian migrant women suffering from incontinence perceived it to be a side effect of their medicines (Doshani et al., 2007). Similarly, depression was perceived by some older Black African-Caribbean migrants as a result of spiritual matters or living in a different culture (Marwaha and Livingston, 2002), whereas older migrants from South Asian, African Caribbean, Polish and Caucasians ethnicity (Chew-Graham et al., 2012) attributed it to life's hardships and physical problems. Furthermore, most of them did not see a link between mental health problems and resulting physical health problems (Chew-Graham et al., 2012). The stigma associated with such health problems deterred them from using professional help (Lawrence et al., 2006, Marwaha and Livingston, 2002, Doshani et al., 2007, Chew-Graham et al., 2012).

In the long run, most refrained from visiting their GP for such issues, adopting instead self-management strategies (Doshani et al., 2007, Chew-Graham et al., 2012, Lawrence et al., 2006) or losing hope altogether (Marwaha and Livingston, 2002). Older migrants with incontinence adjusted their liquid intake and planned their outings with consideration of access to toilets (Doshani et al., 2007). Social interaction was also perceived as a self-coping strategy for mental health problems

(Lawrence et al., 2006). In another example, some older Black Caribbean and South Asian migrants perceived religion as a help to cope with depression (Lawrence et al., 2006), as described by one participant:

''But of course, religion means that you are in talk with God and if God can't help you what else will help you? God will help you if you believe in him''- (Lawrence et al., 2006).

Differences in beliefs about health and healthcare also emerged a study on older Chinese migrants in the United Kingdom, it was found that they perceived Western medicine as unnatural and associated with side effects, yet helpful for acute diseases and control of symptoms (Liu et al., 2014), as quoted here by a participant

''I do not dislike modern medicine… For major disease or acute disease, you have to use modern medicine. Modern medicine can control the symptoms fast… TCM [Traditional Chinese Medicine] also has its advantages, for promoting general health condition, getting rid of the root causes …furthermore, it doesn't have any side effects'' (Liu et al., 2014)

They reported using a mix of traditional and Western medicine by continuing to use healthcare services while altering their own prescriptions (Liu et al., 2014). Other older migrants also believed in and used herbal medicines for minor health issues, but did not adopt them alongside Western medicine (Doshani et al., 2007). Another study, however, found that older migrants perceived traditional health services in their host country to be of poor quality (Liu et al., 2014). This led them to a selective adoption of traditional medicine, based on personal judgement and that of their friends and family.

For mental health issues, such as depression in particular, older migrants reported negative perceptions about psychotropic medicine. Some saw them as a sign of failure or the severity of their condition (Chew-Graham et al., 2012, Lawrence et al., 2006), as recounted here by a participant: *''I've had erm depression tablets before but I've never taken them. I've looked at them and I've thought why should I have come to that. I've always looked at them and then I've thrown them down the toilet. I've thought I'm not letting people do that to me''*- (Chew-Graham et al., 2012)

Cultural differences were also manifested in the dietary preferences of older migrants in hospital, as they found it difficult to get food of their choice (Ellins and Glasby, 2016). Such issues can curb dignity and self-esteem and accentuate cultural differences as well as heightening barriers to healthcare.

Expectations of the role of primary healthcare practitioners

Understanding older migrants' expectations of the role of primary healthcare practitioners can help to shed light on when older migrants consider it appropriate to access healthcare. Some older migrants perceived GPs to be important as providers of knowledge (Lawrence et al., 2006), for issuing referrals for specialized care and for prescribing medicines (Lawrence et al., 2006). The role of GPs as prescribers of medicines, however, was construed negatively where older migrants suffered from mental health problems (Chew-Graham et al., 2012). Some other older migrants lacked knowledge about the role of GPs, such as when assuming that GPs were the contact providers for home care, as found in a study in the Netherlands (Suurmond et al., 2016).

Desire for a proactive role of healthcare professionals

Some older migrants expressed a desire for a more active role of their GP in their interactions, for example by broaching topics such as home care (Suurmond et al., 2016). The lack of initiative on part

of their GP was understood to result from stereotypical assumptions about older migrants' "preference for family care" (Suurmond et al., 2016). Older migrants who suffered from the sensitive health issue of incontinence also expected this topic to be initiated by their GP, to overcome their own hesitation (Doshani et al., 2007). A proactive role of healthcare professionals was also desired in other settings such as hospitals, where older migrants often struggled to get their needs heard and acknowledged (Ellins and Glasby, 2016). Many older migrants in the included studies longed for compassionate and caring personnel to ensure dignity in care (Thyli et al., 2014, Saltus and Pithara, 2015), as illustrated by the following quote:

''And one day, I was wet, somebody didn't come about two hours, more than two hours. And I said to them 'I can't control myself because of these tablets'. And, you see, I couldn't walk, so I couldn't go to the loo. So I had to change and everything, wash me and everything, but that took them too long, you know, to do those things. Then nurses, they say 'You worry too much, you know, relax' ... So that was bit unhappy part for me''.- (Ellins and Glasby, 2016)

Another issue in the interaction with GPs were time constraints. There was a perspective that GPs and nurses were busy and did not spend sufficient time with them (Lawrence et al., 2006). This compelled some older migrants to discuss only significant health concerns with GPs and not to talk about issues such as mental health, which they perceived as less important (Lawrence et al., 2006). Alternatively, some preferred allied health professionals who could devote more time to them (Doshani et al., 2007).

Feeling invisible in the healthcare system

In the context of time-constrained interactions and different expectations, some older migrants reported encountering indifference or lack of sufficient interest (Liu et al., 2014, Ellins and Glasby, 2016), while others felt their concerns were dismissed as a normal aspect of ageing (Lawrence et al., 2006). In the study on older migrants with traumatic experiences, many participants found it difficult to maintain their routine lives and to be self-dependent in accessing healthcare. In absence of any special support, it led to misunderstandings in communication with the doctor or incorrect treatment (Nielsen et al., 2017), as stated by a participant:

"My doctor doesn't understand me – he gives me vitamin D and I feel depressed, – he has never heard my story"

Such experiences led to poor satisfaction with healthcare practitioners:

''The health services here have serious problems… Just (prescribe) some painkillers… Doctors here do not seem to check carefully. They just give you painkillers if the patient feels painful somewhere and never do detailed checks'' (Liu et al., 2014)

Another study found that lack of trust in healthcare services also hindered access. For example, some older migrants did not utilise healthcare services in their host country for lack of trust and instead bought medical supplies when visiting their country of origin (Thyli et al., 2014). Where some older migrants of Chinese background were satisfied with their GP, the authors of the study attributed this to low levels of expectation and the belief in self-management (Liu et al., 2014).

Discussion

This study is, to the best of our knowledge, the first qualitative thematic synthesis with the purpose of understanding the experiences of older non-Western migrants in Europe in accessing and using healthcare services, as captured in qualitative studies. It found both supply- and demand-side barriers to accessing healthcare. Overall, our findings show that that the nexus of migration and ageing induced vulnerability in the life of older migrants, as the traditional model of care-giving by family-members seemed to become more difficult to uphold. This is consistent with other studies that discuss the struggle older migrants' experience while trying to balance between practical considerations and moral constraints of traditional discourses on family care (Næss and Vabø, 2014).

To make sense of the findings, a more holistic conceptualization of access is helpful, such as the framework developed by Levesque and colleagues (Levesque et al., 2013). This framework understands access to healthcare as the 'possibility of care users to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, and to obtain or use healthcare services, and to actually be offered services appropriate to the needs for care' (Levesque et al., 2013). It implies five dimensions of accessibility: 1) approachability; 2) acceptability; 3) availability and accommodation; 4) affordability; and 5) appropriateness (Levesque et al., 2013). We will discuss our findings in light of these five dimensions.

In the case of older migrants, the dimension of acceptability intertwines with approachability and appropriateness. As Levesque and colleagues point out, approachability "relates to the fact that people facing health needs can actually identify that some form of services exists, can be reached, and have an impact on the health of the individual" (Levesque et al., 2013), while appropriateness "denotes the fit between services and clients' need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services" provided (Levesque et al., 2013).

The availability of interpreters and perceptions and experiences of formal care might also matter. This conforms with previous research which has given various explanations for the high frequency and intensity of family care in migrant groups: limited knowledge about the range of professional care available; a negative image of professional care; difficulty in paying for professional care; and poor alignment of the range of professional care with care needs (de Graaff and Francke, 2003, de Graaff et al., 2010). Lower levels of education and other socio-economic factors have also been found to influence the greater utilisation of family care in migrant groups (Denktaş et al., 2009, Uiters et al., 2007).

The social network formulated on the basis of cultural, religious or political associations, provides migrants with a sense of social embeddedness through a shared migration history, transnational living arrangements and common language (Palmberger, 2017). At the same time, healthcare practitioners might need to be wary of older migrants' reliance on such networks, as they may not always be well informed.

Health literacy or (broadly speaking) lack of knowledge relates to all five dimensions of accessing healthcare. In the event of lower general literacy and language barriers, even translated written material might not suffice. Lack of information has been identified as a major challenge in accessing social and healthcare services (Bolzman et al., 2004, Lai and Leonenko, 2007, Wong et al., 2006). Friends or family can be a potential source of information, but access to knowledge and information

can be improved through the use of cultural mediators, allied health professionals and improved health literacy of the children of older migrants.

While professional interpreters could facilitate access for many, they come for some with a perceived loss of confidentiality. At the same time, relying on family members as informal interpreters can reduce the amount of information some older migrants share with health professionals, as they may feel hesitant to burden their family with their worries. Research shows that reliance of older migrants on interpreters and family member could make them feel powerless and less in control (Stewart et al., 2011).

The included studies suggest that older migrants at times construed formal healthcare negatively because of their different healthcare beliefs. This, according to Levesque's conceptualization, distorts the "acceptability" of healthcare services. In this thematic synthesis, we discussed different healthcare beliefs of older migrants from different cultural backgrounds. Previous research has shown that beliefs about healthcare impact the types of care utilized and the ways in which they are utilized (Rogers, 2010).

The voices of women participants in the studies were mostly subdued. Two of the eleven included studies were exclusively on women participants, seven had both men and women and the remaining two did not report the gender of participants. However, it is not simply the inclusion of women that would be needed, but a gendered analysis. Only the two studies that specifically focused on women participants acknowledged and used a gender lens. Contrary to expectations, one study did not find any gender-specific barriers to healthcare (Liu et al., 2014), while the others mostly remained silent on the subject (Ellins and Glasby, 2016, Lawrence et al., 2006, Marwaha and Livingston, 2002, Oglak and Hussein, 2016, Suurmond et al., 2016, Thyli et al., 2014). Evidence has shown that intersections of old age and gender have further implications for health and access to healthcare services. For example, the multiple roles of women, including their care-giving responsibilities, can reduce their ability to make decisions regarding their own health and limit their access to and use of healthcare services (Prus, 2003). Women also tend to outlive men (WHO, 2015) and are therefore less likely to have support from a spouse in later years. Additionally, migrant women from non-Western countries might face gender-specific challenges, such as the assignment of a male GP for a gynaecological examination, while being unaware of the possibility to request a female doctor (Smland Goth and Berg, 2011). Women in higher age groups also report more distress, as age influences the ability to learn and use a new language, as well as to socialize and cope with stressful environments (Thapa and Hauff, 2005). They may also find it more challenging to integrate, as men from their own community might view this as being in conflict with traditional values and roles of women (Dalgard and Thapa, 2007). Older migrant women therefore face a third challenge, that of being a woman, something that is often referred to as "triple jeopardy" (Chundamala et al., 2006).

The included studies did not describe barriers related to the access dimensions of availability, accommodation and affordability. While this could be due to a high level of public coverage in the health systems of the four host countries (Netherlands, Norway, Denmark and the United Kingdom), it could also be due to a general reluctance to seek care and the inability to get information.

Our thematic synthesis was based on a systematic and transparent process of searching for studies, and analysis, following Thomas and Harden (Thomas and Harden, 2008). However, our qualitative thematic synthesis is subject to certain limitations. First, the geographical scope was very limited, as

studies from only four countries (Netherlands, Norway, Denmark and the United Kingdom) met the inclusion criteria, most of them from the United Kingdom. This may limit the transferability of the findings beyond these countries, since healthcare systems shape the experiences and satisfaction of patients (Xesfingi and Vozikis, 2016). Second, we studied different migrant groups but synthesized barriers experienced by all. Since experiences are shaped by multiple factors such as social, economic and cultural issues, as well as previous experiences with healthcare in the home country, migrants could be studied as separate groups. Finally, we included only studies published in English, which may limit the number of relevant studies included in the synthesis. This can mean that our identified barriers are not exhaustive. Yet, we identified a number of barriers that were consistent across several studies with varying designs, healthcare settings and cultural groups.

Conclusion

This thematic synthesis illustrates that the experiences of older migrants in accessing and using healthcare relate to a multitude of factors, including their own characteristics, skills, traditional discourses, health beliefs and expectations of health professionals and the healthcare system. So far, research on the barriers experienced by older migrants has focused on "cultural reasons", with little or no elaboration of the inherent experiences of being a migrant. Cultural backgrounds and their manifestations in the form of traditional discourses on family care and health beliefs could indeed influence experiences of barriers to healthcare. However, they are also influenced by other factors, such as literacy, language skills and the unique circumstances of older migrants such as their social capital, children and community facilitators. This list of barriers is not exhaustive or hierarchical, but highlights the factors beyond culture that might shape older migrants' relationship with healthcare.

Older migrants constitute an often-neglected group, because they no longer belong to the formal labour force. Yet, their experiences of barriers in the healthcare system should be taken into account while designing healthcare policies and practices. While this thematic synthesis has provided a glimpse into some of these experiences, future research will have to explore both contextual (cultural factors and health beliefs) and individual characteristics (skills and vulnerabilities) to understand older migrants' unique experiences of healthcare. Research should also be directed towards better understanding the aspects of decision-making in healthcare that are controlled by family, how participation in decision-making by older migrants can be improved, and what the role of healthcare professionals is. Finally, more research should be undertaken using a gendered lens to examine experiences of both men and women, given their different life trajectories, health status and healthcare needs.

Declarations

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Consent for publication: Not Applicable.

Availability of data and material: The full details of the search can be obtained from the authors.

Competing interests: The authors declare no conflicts of interest.

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Authors' Contributions: The first author screened the articles. All authors read the screened articles and confirmed the findings. The first author was involved in drafting of the work. All authors were responsible for revising the work.

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