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SYSTEMATIC REVIEW

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Barriers to health, social and long-term care access among older adults: a systematic review of reviews

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Abstract

Purpose The aim of this study was to analyse the different barriers to accessing healthcare, social services and long-term care among older adults.

Methods A systematic review and narrative synthesis were conducted to analyse barriers to accessing healthcare, social care and long-term care services among older adults. We followed the PRISMA guidelines. A systematic search was conducted in the PubMed, Scopus, and Web of Science databases.

Results Seventenn studies were included in the systematic review. Seven articles were systematic reviews, six were scoping reviews, two were literature reviews, one was a rapid review and the last one was an integrative review. The results show that the different types of barriers that hinder access to services for older adults are, on the demand side, socioeconomic factors; and on the supply side, geographical factors. Community factors and the digital divide are on both the supply and demand side. Interaction between barriers should be considered.

Conclusion Adequate access to social and health services is crucial for the health and well-being of older adults and to guarantee equity in health. In summary, access to health services for older adults is determined by a heterogeneous interaction of these factors, on both the demand and supply side. Overcoming these barriers requires a comprehensive approach involving the collaboration of governments, healthcare providers, communities and older adults themselves.

Keywords Access, Barrier, Health and social care, Care, Older adults, Systematic review

Introduction

Health is a human right, equity in the distribution of which is also necessary [1]. Access to services is one of the factors affecting equity [2]. Inequities in access to health have different causes and barriers, including socioeconomic status, gender, age, geographical location and historical characteristics [3], which can be modified by developing regulations and legislation that affect the social determinants of health [4, 5]. The current process of population ageing is associated with an increased demand for health care and social care, among other services [6–8]. To ensure healthy or successful ageing, it is important that older people have adequate access to healthcare, social and long-term care services [9]. For

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example, healthcare may include services such as primary care or hospital care; social care typically encompasses services which help people carry out activities of daily life —i.e.: home care, semi-residential care, residential care, etc., while long-term care, which in most countries is not a distinct social policy issue, can include long-term services for dependent people which are related to both health and social care, and other specific policies, such as cash benefits for care [10, 11]. However, current care systems are not adequately adapted to older adults' complex needs, such as chronic conditions, as they tend to focus more on treating individual diseases than on providing comprehensive person-centred care [12, 13].

The available evidence indicates that, across OECD countries, 11.5% of people over 65 years of age receive long-term care, but there remains an unmet demand for care among those who have limitations in performing activities of daily living and instrumental activities of daily living [14]. In addition, older people face particular barriers to accessing these services, such as economic limitations, reduced mobility or remote locations. e-Health, which encompasses any electronic health intervention, has the potential to improve access and support the delivery of efficient care for older adults [15, 16]. Thus, older people's adoption of information and communication technology (ICT) is on the rise, being perceived as beneficial for their daily lives [17, 18]. Meanwhile, most older people prefer to age in place [19]. However, barriers such as a lack of financial resources, family support and access to health and social services [20] and health shocks [21], make such aging difficult. Therefore, the implementation of local health systems (LHSSs) has positive effects on improving the older population's quality of life [22, 23], since the inability to access this system is linked to greater use of social and health services [22]. In addition, this would mean administrations could reduce their costs [24]. Another important issue is associated with older adults living in rural areas or those who have low economic resources, since they have greater difficulties in receiving medical attention when needed [25, 26]. Similarly, primary care analysis, including prevention of social isolation, can make a great difference through early assessment and management of a risk profile, as negative health exchanges can affect older adults' well-being [27].

Improving universal access to care services generates positive externalities [28, 29], while strengthening equity . Thus, our work focuses on health, social and long-term care in a broad sense, because these are the services older adults most need for well-being and successful ageing. Numerous studies have investigated barriers to accessing services in the older population through systematic reviews and other types of reviews, but no works have combined and analysed this information. For this reason, the objective of this systematic review of reviews is to summarize, synthesize, and organize the evidence from these studies to present an analysis in an aggregated form. Additionally, this work can be useful for decision-makers and for the development and improvement of health, social and long-term care policies, guaranteeing quality care for the older and/or dependent population.

Method

This study is a systematic review of reviews. It follows, albeit with slight variations, the procedure applied in the work by Martinez-Lacoba et al. [30] [31]. This systematic review followed the principles established by the PRISMA statement of systematic reviews and meta-analyses [32].

Data sources and searches

The literature search was carried out during December 2024 to identify all the articles published in Spanish and English. Owing to the multidisciplinary approach of the systematic review, the PubMed, Web of Science and Scopus databases were consulted. The search strategy and the terms used can be found in Table 1.

Table 1 Search strategy

"accessibility" OR "access" OR "accessibilities" OR "barrier" OR "barriers"	AND	"services" OR "provision"	AND	"factor" OR "factors"	AND	"health" OR "care" OR "cares" OR "healthcare" OR "health care" OR "social care" OR "long-term care"	AND	"elderly" OR "ageing" OR "aging" OR "older adults"	AND	"systematic review" OR "review"	

Study selection and eligibility: inclusion and exclusion criteria

The initial search identified n = 2,338 records. First, two researchers (EC, RM) removed duplicate studies, and then selected the articles to be fully reviewed. In this step, the results were compared, and a third researcher (IP) was consulted to solve possible discrepancies in the inclusion criteria and to reach a consensus. Additionally, the references of the n = 16 were reviewed to detect any relevant studies that did not appear in the search process, but none were found.

Studies were included if they met the following requirements: 1) they focused on barriers to access to social and health care —health care, social care and long-term care; 2) they focused on older people; 3) they were published in Spanish or English; and 4) they were reviews of any type. Studies were excluded if: 1) they focused on specific diseases; 2) they focused on a specific country (e.g., China); or 3) they focused on specific population groups.

Quality of the included studies

To assess the quality of the reviews, two investigators (EC, RM) independently used the Joanna Briggs Institute's (JBI) Quality Assessment Tool for Systematic Reviews and Research Synthesis [33]. This instrument has 11 questions or components. Each component receives one point if the answer is "yes" or zero points if the answer is "no", "unclear" or "not applicable". Papers that obtained scores between zero and three points were of low quality from four to seven points of moderate quality, and from eight to eleven points of high quality. Any differences in the evaluation of a particular study were resolved by consensus by consulting a third researcher (IP). The mean quality score was 9.63 points out of 11, with the main reasons for receiving zero points being conflict of interest, the absence of an a priori design, the status of publication as an inclusion criterion and not presenting a list of included and excluded studies. The quality of the individual studies included in each systematic review or meta-analysis was not assessed.

Data extraction

Two researchers (EC, RM) extracted the data from each study. The following information was extracted and included: i) reference and authorship; ii) geographical area; iii) study design; iv) barriers to accessing; v) results — both summarised and extended; and vi) quality measure.

Results

Study selection

The selection process identified 2,496 articles, of which 1,937 were maintained after eliminating duplicates. After reviewing titles and abstracts, n = 66 studies remained. Following the full-text review, n = 17 studies met the inclusion and exclusion criteria. The flow diagram of the study search and selection procedure can be found in Fig. 1. The excluded articles and their references can be found in Table A2 of the Annex.

Study characteristics

The studies included in this systematic review of reviews have different methodological approaches. Seven articles were systematic reviews, six were scoping reviews, two were literature reviews, one was a rapid review and the last one was an integrative review.

The results have been organized into four blocks, grouping the different studies according to the type of barriers or factors that hinder access to the social and health services on which they focus. The types of factors identified are socioeconomic factors, the digital divide, community factors and geographical factors.

Narrative synthesis of results

The main characteristics and results of each study are presented in Table 2. To organize the information, Fig. 2 shows the thematic areas of the studies by groups of factors or barriers. In addition, the figure includes a possible relationship between them.

Socioeconomic factors

Three studies agreed that socioeconomic factors are determinants of access to health services for older people [34–36], one of which considers that unfavourable socioeconomic conditions, such as living in rural environments or insufficient economic resources, influence consultation with, or access to, health specialists [34]. The other two studies cater to ethnic minority groups of older people, examining the need to promote health among these groups, improve access to these services, encourage the development of their physical and cognitive abilities, reduce the occurrence of disease and thus improve long-term care [35, 36].

Digital divide

Six of the included studies reported that the introduction of an electronic health system has positive effects on the health system [37–42]. However, older people are unfamiliar with technology and have difficulties using them. Thus, one study focused on the introduction of mHealth technology [37], i.e., medical assistance through mobile phones, which reduces the burden on caregivers and positively affects their physical and mental health by increasing their ability to receive health care faster. Another study analysed how the loss of confidence and knowledge about technologies harms

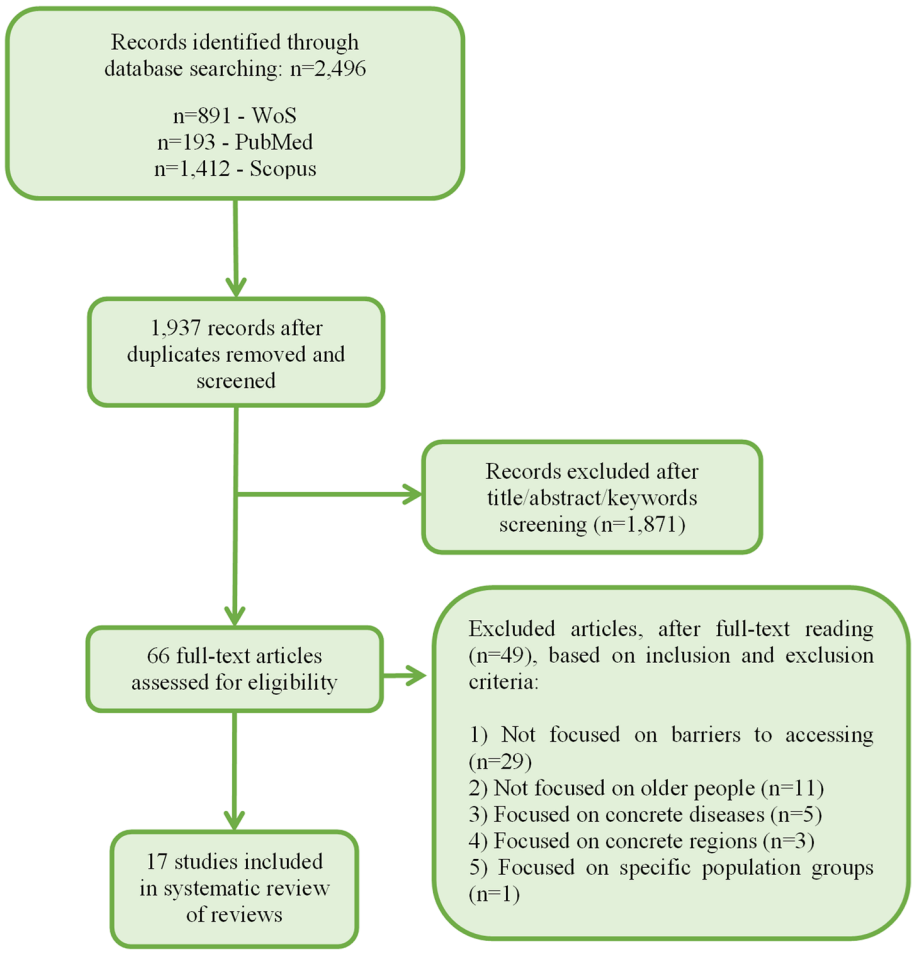

Fig. 1 Flow diagram

independence and quality of life, and having a smart home thus has positive effects on improving quality of life and personalized attention [38]. Another study presents the digital divide with the older population as a barrier, since there is a lack of confidence and skill in its use [39]. This makes it necessary to carry out integrated care in ICT for older adults, as it will facilitate the access to and updating of, health with vertical and horizontal integration, improving primary care. Another study established the need to have integrated care for health services for the older population, since these services have beneficial effects on health, as there is limited support for older people and caregivers in accessing these systems [40]. Another study examines the facilitators of the use of e-health among older people, who have difficulties in using it due to the digital divide —training and education— and because they live in rural areas, making it difficult to use [41]. A further review determined that, to avoid barriers and facilitate the use of e-Health among older adults, interventions should focus on four areas [42]: enhancing social support and community involvement —community peer-to-peer learning and family or caregiver involvement in e-Health education; improving accessibility and usability in diverse living environments —considering space at home, urban vs. rural difference, unequal Internet connectivity; addressing economic barriers and offering cost-effective solutions; and embracing cultural sensitivity and personalized approaches when designing and delivering e-health services, given that cultural traditions influence e-health use.

Community factors

Four studies reported that community factors, such as education, culture or government rigidity, make it difficult for older people to access health services [43–46]. Similarly, one study analysed the need for multi-professional communication and transitional care, in which information is transmitted from the health environment to the home [43]. This multi-professional

Table 2 Descriptive summary of the included studies

Ref	Authorship	Geographical area	Design	Barriers to accessing	Brief summary of results	Results	Quality (JBI)
[43]	Allen J, Psych M, Ottman G et al. 2012	Netherlands, Australia, Canada, Finland and Ireland	Literature review	Community factors: absence of dialogue and understanding	Multi-professional communication and transitional care from the hospital or emergency room setting to the nursing home	Improvement of communication through multi-professional models since the older population often requires communication between health services and social care. This multi-professional communication allows for the reduction of days hospitalized in older adults	9
[34]	Almeida A, Nunes B, Duro S et al. 2017	Canada, Austria, Belgium, France, Denmark, Greece, Italy, Netherlands, Spain, Sweden, Switzerland, USA, Brazil, Mexico, China, Australia, Korea, Japan, Norway, Chile, Uruguay	Systematic review	Socioeconomic factors: low income	Socioeconomic factors and health service use among older adults	Socioeconomic factors have an impact on consulting health specialists, with the poorest people being the most affected. In addition, countries with private healthcare are more affected	9
[44]	Carroll C, Sworn K, Booth A et al. 2022	USA, Hong Kong Sweden, Chile, Portugal, Europe, Poland, China, Japan, Australia, Canada, Netherlands and Singapore	Scoping Review	Community factors: cultural and education (knowledge on the subject)	Equity of universal health coverage, access to health services and health care needs of older persons	Inefficient access to resources, as well as lack of communication and service competence make it difficult for older people to access health services	9
[45]	Ethier A, Carrier as of 2021	Canada	Scoping Review	Community factors: government rigidity, standardization, and lack of management resources	Administrative and organizational factors, primary health care, health promotion and prevention, home support and living arrangements, social inclusion and support for caregivers	There are legal and regulatory, administrative and organizational factors that affect the sustainability of the local health system dedicated to the older population. As a measure to improve it, greater patient engagement flexible to their needs should be prioritized. Greater funding for health care outside of hospitals, incentives and better working conditions are needed to hire workers in health care for older adults	10

Table 2 (continued)

Ref	Authorship	Geographical area	Design	Barriers to accessing	Brief summary of results	Results	Quality (JBI)
[46]	Gaffney H, Hamiduzzama M 2022	Norway, UK, USA, Scotland, Canada, Australia, Germany, Belgium, Sweden and New Zealand	Systematic review	Community factors: personalized health information, health knowledge, and communication issues	Accessibility of appointments, support, health information, person-centred care, and perceived credibility and reliability of the health care professional	Communication factors are decisive in older people's participation in the health system	10
[47]	Galvez-Hernandez P, Gonzalez-De Paz L, Muntaner C 2022	United Kingdom, Spain, Netherlands, Finland, Croatia, Netherlands, Iran, Sweden and Canada	Scoping Review	Geographical factors: lack of belonging to a social group, absence of quality relationships and social commitment	Loneliness and social isolation have a negative impact on health	Need to involve professionals with listening and communication skills, as well as to facilitate access to transportation, since it has been shown that social isolation is related to negative impacts on health, behaviour, psychological and physiological well-being	9
[37]	Garnett A, Northwood M, Ting J et al. 2022	USA, Netherlands, UK and Australia	Systematic review	Digital divide: lack of experience with technology, time availability and realism in the application	mHealth interventions in the health and well-being of informal caregivers of older adults	The introduction of mobile-friendly health care (mHealth) has positive effects on the health system. It reduces the burden on caregivers and positively affects the physical and mental health of older people	10
[48]	Kervin L, Riadi I, Chamberlain S et al. 2023	Canada, USA, Australia, New Zealand, Western Europe and the United Kingdom	Scoping Review	Geographical factors: social isolation	Social isolation of older people hinders health care	It is necessary to determine the barriers and facilitators of access to health care for older people who live in isolation and without informal care support. To improve this, preventive care, support, subsidization and funding of public care services are needed	10
[38]	Li W, Yigitcanlar T, Erol I et al. 2021	India, Korea, Malaysia, USA, Australia, China, Canada, United Kingdom, Hong Kong, Slovenia, Germany, France, Jordan, Israel, Netherlands, Finland, Thailand, Japan	Systematic review	Digital divide: lack of trust in technological systems, financing or understanding their use	Smart Home Technologies	Having a smart home allows older adults to incorporate health care services, which benefits independence, quality of life and provides personalized and timely care	9

Table 2 (continued)

Ref	Authorship	Geographical area	Design	Barriers to accessing	Brief summary of results	Results	Quality (JBI)
[35]	Liljas A, Walters K, Jovici A et al. 2017	England, New Zealand, USA and Canada	Systematic review	Socioeconomic factors: poor health, lack of time and transportation	Health promotion in older people from disadvantaged backgrounds and ethnic minority groups	Actions aimed at promoting health among the older population, with the purpose of encouraging the development and preservation of their physical and cognitive capacities, have been shown to reduce the risks associated with diseases and loss of autonomy	10
[39]	Meng L, Gao M, Wang S et al. 2023	Canada, USA, Netherlands, Hong Kong, China, Austria, Croatia, Germany, Denmark, Estonia, Greece, Israel, Spain, Finland, Italy, Portugal, Serbia, United Kingdom, Czech Republic, Sweden, Taiwan, China, Switzerland, United Kingdom, Australia, Belgium, Ireland, Poland, Andorra, France, Korea	Scoping Review	Digital divide: fear, lack of confidence and skills of older adults in the use of information technology	ICT-based integrated care for older people	ICT facilitates access to, and updating of, health information through vertical and horizontal integration, making efficient use of resources and improving primary care	10
[27]	Nicholson N 2012	Undetermined	Literature review	Geographical factors: physical, social and economic factors that favour social isolation	Social isolation affects health	Need to assess isolation by providing the necessary resources to alleviate this isolation, as isolation has been shown to favour the risk of poorer health	9
[40]	Sadler Ird E, Potterton V, Anderson R et al. 2019	Canada, Netherlands, Sweden, USA, Germany and Canada/France	Systematic review	Digital divide: limited support for users and caregivers to navigate and access the health system	System and organization of integrated care services for older adults with frailty issues	Integrated care for health services for older people who promote physical health, recovery from illness, independence and improved quality of life	10
[36]	Scott M, Mayhew A, Jeong A et al. 2022	USA	Systematic review	Socioeconomic factors: culture, language, family support, fear and mistrust	Long-term care for minority populations	Interventions that improve access to long-term care for minority populations facilitate equity in care	10

Table 2 (continued)

Ref	Authorship	Geographical area	Design	Barriers to accessing	Brief summary of results	Results	Quality (JBI)
[42]	Sharkiya SH. and Hag, AM 2024	Bangladesh, China, Taiwan, UK, Australia, US, Ireland, Italy, Taiwan, Korea	Rapid review	Digital divide: social influence and norms, environmental and infrastructural factors, economic factors and cost considerations, family and caregiver support and organizational culture and technical support	There is a need for e-health solutions to effectively engage older adults	Enhanced social support and community involvement, improved accessibility and usability in diverse living environments and economic barriers should be addressed, offering cost-effective solutions and embracing cultural sensitivity and personalized approaches when designing and delivering e-health services	10
[49]	Sterling-Fox C 2019	USA, Europe and Japan	Integrative Review	Geographic factors: Non-primary care service is not available at home or is not used by the individual	Access to non-primary care services for homebound older people	Access to the five non-primary health services (dental, nutrition, ophthalmologist, pharmacy and psychology) is essential for older adults confined to their homes. Older adults being confined to their homes is associated with poor diet and the appearance of diseases. Therefore, access to non-primary care at home is necessary	10
[41]	Wilson J, Heinsch M, Betts D et al. 2021	Australia, Poland, USA, Finland, France, Netherlands, Sweden, England, Germany and Canada	Scoping Review	Digital divide: difficulties in the use of technology, availability of e-health, financial factors and location	Facilitators of the use of e-health by older adults	Allowing access to e-Health for older people, the design of an e-health service, training and education on e-health and the authenticity of the service is essential	10

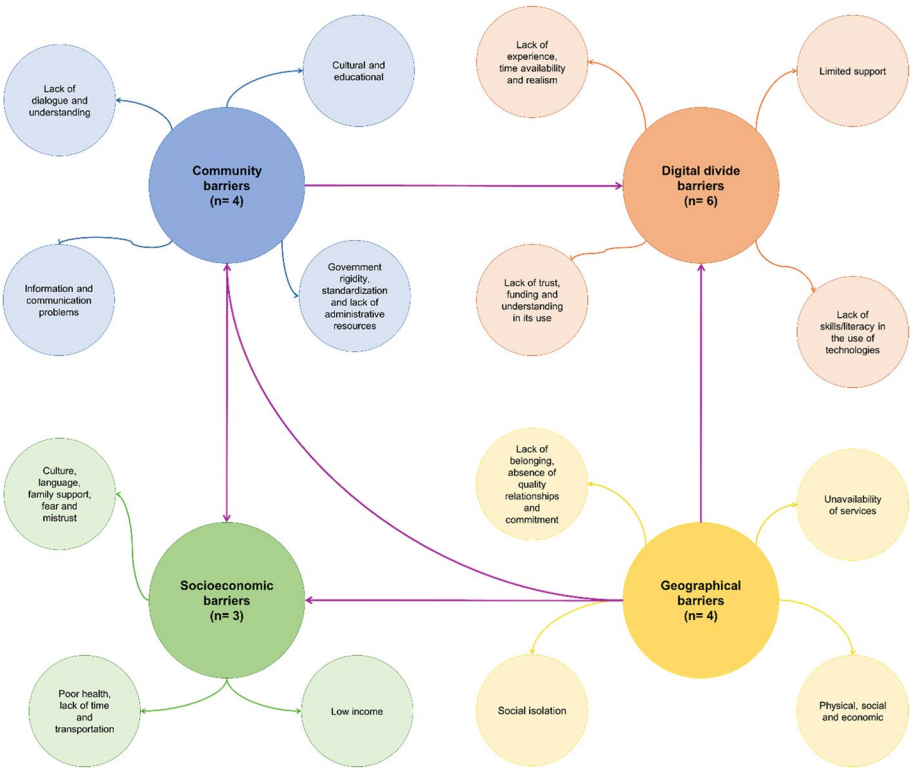

Fig. 2 Diagram with the number of studies included, barriers and connections

communication allows for a reduction in hospitalizations among older people. However, the absence of dialogue between the parties is a barrier, as is the lack of understanding on the part of the older population. Another study focused on cultural and educational barriers, that is, the lack of knowledge about health-related issues [44]. The authors indicated that both inefficient access to resources and a lack of communication and service competence affect access to services, suggesting that equity in health coverage is essential to guarantee adequate care. Another study focused on government rigidity, standardization, and lack of resources as barriers that hinder the sustainability of the local health system for the older population [45]. As measures to improve this system, they proposed greater flexibility in the participation of older people in the health system. They also pointed to greater financing in health care outside the health system and improved working conditions to have more health personnel to improve health care for the older population. The last study analyses communication factors (accessibility to appointments, support, health information, focused care, credibility and trust) as determinants in enhancing participation of older people in the health system [46].

Geographical factors

Four of the studies agreed that geographical factors, such as social isolation, affect access to health care services among older people [27, 47–49]. In this sense, a study shows that social isolation has negative effects on behaviour and psychological and physiological well-being among the older population, and health personnel with listening and communication skills are needed. Also necessary is a transport system that facilitates access for older persons [47]. Another study analysed social isolation as a negative factor in access to health care among older people who are isolated and who, in addition, have no support from informal caregivers [48]. They argued that to improve this, it is important to introduce preventive models, funded by the reallocation of resources to public health infrastructure. Another study revealed how physical, social and economic factors among older people favour social isolation [27]. To address this access barrier, it is essential to assess isolation, providing the necessary resources to alleviate it. The last study focuses on those cases in which, because of social isolation, non-primary care services are unavailable or the older population do not use them [49]. In this way, access to the five non-primary health services —dental, nutrition,

ophthalmologist, pharmacy and psychology— is essential for older people who are confined to their homes. They also find that older people confined to their homes have a greater propensity for diseases and a poorer diet.

Discussion

Summary of evidence

To the best of our knowledge, this systematic review of reviews is the first to synthesize and organize, in an aggregated manner, the scientific evidence provided by systematic reviews on barriers and factors that hinder access to social and health services for older people. This paper includes the results of 17 reviews that, in turn, incorporate the results of a total of 479 studies. The results of this work are relevant and useful for the development and improvement of social, health and long-term care policies. This systematic review of a high level of quality has identified key factors and barriers to accessing services that must be considered to guarantee quality care. In addition, following these results, we have built a conceptual framework that relates or connects the barriers to each other.

This review demonstrates that the factors or barriers obstructing access to social and health services for older adults are socioeconomic, geographical or community-based, or stem from the digital divide. All these barriers could be eliminated or reduced through the development of policies appropriate for this stratum of the population.

Barriers to accessing health services can be considered to arise on both the supply and demand side [50, 51]. Thus, on the supply side, we can consider geographical factors, and on the demand side, socioeconomic factors. The digital divide and the community factors, however, may belong to both supply and demand sides. For example, the digital divide in care arises when the supply of ITC for these services is provided by policy makers, but the demand of older adults cannot benefit totally for different reasons —i.e.: lack of literacy; within community factors, education or culture lie on the demand side, but the rigidity of government is located in the supply. This distinction was made by O'Donell [51], considering that it is essential to be able to intervene appropriately.

First, socioeconomic factors, such as income level, the residential environment and membership of ethnic minority groups, are identified as significant determinants of access to health care. A lack of financial resources and living in rural areas can hinder consultation with specialists and access to specialized services. This reality highlights the need for policies and programmes that address socioeconomic disparities and ensure equitable access to health care for all older people, regardless of their financial situation or geographic location. In this regard, in 2005, the WHO endorsed the concept of universal health coverage [52], defined as access to all promotion, prevention, cure and rehabilitation services at an affordable cost. Carrin et al. consider that this universal coverage guarantees the protection of the health system against possible financial risks [53]: population coverage and the scope of health services. In their work, this socioeconomic barrier to accessing health services is associated with direct payments as a means of financing health systems.

The digital divide emerges as another major challenge, especially in the age of technology. Although the introduction of electronic health systems can improve the efficiency and quality of care, older people face difficulties in adapting to these new technologies. A lack of familiarity and confidence in the use of electronic devices can exclude this group from more streamlined and personalized medical care. Therefore, it is crucial to implement strategies that promote digital literacy among older people and ensure they are not left behind in the digital age of healthcare. This is in line with the analysis of another article, which considered that the incorporation of ICT in the care of older adults has advanced slowly, often being unsatisfactory due to political, financial and infrastructure problems [54]. In addition, the WHO, in its report on the practice "Integrated Care for Older People" (ICOPE) [55], noted that the participation of older adults, the training of providers and the digitization of health information are key enablers. Additionally, the implementation of ICT-based integrated care has been hindered by the fear, lack of confidence, and limited skills of older adults in the use of technologies, leading to lower adoption and acceptance of ICT [56].

In addition, community factors, such as education, culture, and government rigidity, significantly influence access to health care. The lack of communication between health care providers and communities, along with cultural and educational barriers, can limit older people's participation in the health care system. To overcome these challenges, it is necessary to encourage multi-professional communication, improve the cultural competence of healthcare providers, and advocate more flexible and patient-centered government policies. This coincides with another work that includes the importance of community participation to guarantee effective primary health care, with intersectoral participation being necessary to support it [57]. Similarly, another article highlights the importance of institutions addressing health and poverty together, guaranteeing access to services for these people and eliminating the circumstances that promote them [58].

Finally, geographical factors, such as social isolation and physical accessibility, also play crucial roles in older people's access to healthcare. This finding coincides with another article that analysed the improvement of health in environments where health personnel have appropriate support and training [59]. Another study revealed

differences in the allocation of funds, productivity and use of resources depending on the geographical area of residence [60], with this preventing the provision of integrated services because of the high transport costs for people who are geographically isolated [61]. In this way, social isolation can have detrimental effects on the physical and mental health of older people, exacerbating the difference in access to health services. It is critical to implement measures that address social isolation, such as community support programs and accessible transportation services, to ensure that all seniors have equitable access to health care. This is reflected by Bosch-Farré et al., who reported that interacting with other people and participating in local social institutions are key factors in improving the aging process [20].

As mentioned in the synthesis of results, Fig. 2 shows a connection between the different barriers, since they are not always exclusive, and can be interrelated [62]. This proposal for a conceptual framework on barriers to access reveals a relationship between geographical and socioeconomic factors, since the residence of the population will determine their economic situation; that is, those residing, for example, in Jordan, will have a lower income, which will lead to worse health benefits. However, the population of Spain, for example, has greater health facilities — because Spain has a public health system and has a higher GDP per capita. Geographical location also influences ICT knowledge, as the same technological opportunities and facilities are not available in all places. Likewise, it has a direct relationship with community factors, since culture, education, government rigidity or lack of resources are linked to the geographical area in which one lives. In turn, community factors are related to the digital divide and socioeconomic factors. In this way, government rigidity or lack of resources on the part of the administration influences the country's GDP per capita, which is closely related to financing and the ability to use technologies.

To summarize, the findings of this research have yielded a series of policy recommendations that have the potential to overcome the identified barriers. Firstly, developing policies that consider the disparities between older adults could serve to circumvent socioeconomic barriers. Such policies should guarantee universal health coverage, whilst also considering the residential environment and the ethnic group, and should strive to avert financial catastrophism related to care or long-term care [63]. Secondly, the digital divide could be reduced by promoting digital literacy with the support of communities, relatives and families. This would require adequate financing to create confidence in ICTs. Thirdly, the issue of community factors can be addressed by encouraging multi-professional communication and introducing more flexible policies to encourage patient-centred care. Finally, geographical barriers should be avoided by promoting local community programmes that combat social isolation and by ensuring affordable and accessible transportation to services for older adults.

Ensuring equitable access is key to achieving better health systems and more inclusive societies [14]. The theoretical consequences of achieving equity could be, among others [4], greater collaboration between sectors and networks and greater organizational, community and individual capacity, which would favour a healthy life; better individual outcomes that would allow the highest health potential to be achieved —lower morbidity and mortality, better quality of life, etc.; or cost savings in the health system, which could impact the opportunity cost of public and private resources. Now, let us put theory into practice.

Limitations

This work has some limitations that should be considered. The first is the possible existence of selection bias depending on the databases consulted, the search strategy and the exclusion of articles published in languages other than Spanish and English. Considering two languages is a partial limitation, because systematic reviews typically include only articles in English, creating a language bias [64], which can lead to the loss of key information. However, estimations indicate that academia is dominated by the English language and almost 98% of publications are written in English [64]. Our strength in this point was including articles published in Spanish in the review process. Even so, future works on this topic should include other findings from non-English or non-Spanish speaking communities. Secondly, the conclusions presented are conditioned by the limitations of the studies included. On the other hand, the main strength of this work is the use of a systematic and structured methodology for the search of published studies, in addition to incorporating an analysis of the quality of the included articles.

Conclusions

Adequate access to health, social and long-term care services is essential to guarantee the health and well-being of the older population. Older people's access to health services is influenced by a complex interplay of socioeconomic, technological, community-based and geographical barriers or factors; demand and supply side barriers. Addressing these barriers requires a comprehensive approach involving multiple stakeholders, including governments, healthcare providers, communities, carers, families and older people themselves. Only through coordinated collaboration and a commitment to equity and inclusion at all levels can we ensure that all older people receive the care they need.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12939-025-02429-y.

Supplementary Material 1.

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Utilization of large language models
Large Language Models were used exclusively for grammar checking, suggestions or translation. For example, to check the quality of our writing, we used the Curie software provided by Springer Nature in their Submission guidelines (https://equityhealthj.biomedcentral.com/submission-guidelines).

Authors' contributions
ECG, IPG, and RML conceptualized the research. ECG, IPG, RML, and EAS contributed to the development of the Method section, while ECG, IPG, and RML conducted the review process. All authors were involved in validation, formal analysis, and investigation. IPG and EAS contributed to resource provision. Data curation was carried out by ECG and RML. All authors participated in drafting the original manuscript and reviewing the work. IPG and RML supervised the research. IPG handled project administration and funding acquisition.

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Declarations

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References

1. Marmot M. Achieving health equity: from root causes to fair outcomes. Lancet. 2007;370(9593):1153–63.
2. Centers for Disease Control and Prevention. What is health equity? 2024. Available from: https://www.cdc.gov/health-equity/what-is/index.html.
3. Braveman P. What are health disparities and health equity? We need to be clear. 2014;129(SUPPL. 2):5–8. Available from: https://doi.org/10.1177/00333549141291S203. Cited 2024 Sep 26.
4. Lewis CL, Yan A, Williams MY, Apen LV, Crawford CL, Morse L, et al. Health equity: a concept analysis. Nurs Outlook. 2023;71(5):102032.
5. Hahn RA, Truman BI, Williams DR. Civil rights as determinants of public health and racial and ethnic health equity_ health care, education, employment, and housing in the United States. SSM Popul Health. 2018;4:17–24. https://doi.org/10.1016/j.ssmph.2017.10.006. Cited 2024 Sep 26.
6. Beard JR, Bloom DE. Towards a comprehensive public health response to population ageing. Lancet. 2015;385(9968):658–61.
7. Bloom DE, Chatterji S, Kowal P, Lloyd-Sherlock P, McKee M, Rechel B, et al. Macroeconomic implications of population ageing and selected policy responses. Lancet. 2015;385(9968):649–57. https://doi.org/10.1016/S0140-6736(14)61464-1.
8. Martinez-Lacoba R, Pardo-Garcia I, Escribano-Sotos F. Aging, dependence and long-term care: a systematic review of employment creation. Inquiry. 2021;58:1–17.
9. McMaughan DJ, Oloruntoba O, Smith ML. Socioeconomic status and access to healthcare: interrelated drivers for healthy aging. Front Public Health. 2020;8:512143. https://www.frontiersin.org. Cited 2024 Sep 27
10. Spasova S, Baeten R, Ghailani D, Peña-Casas R, Vanhercke B. Challenges in long-term care in Europe: a study of national policies 2018. Brussels; 2018. Available from: https://www.ec.europa.eu/social/BlobServlet?docId=20225&langId=en.
11. European Commission, Directorate-General for Employment SA and I, Baeten R, Spasova S, Coster S, Vanhercke B. Inequalities in access to healthcare: a study of national policies 2018. Publications Office; 2018.
12. Picco L, Achilla E, Abdin E, Chong SA, Vaingankar JA, McCrone P, et al. Economic burden of multimorbidity among older adults: impact on healthcare and societal costs. BMC Health Serv Res. 2016;16(1):173.
13. Mate KS, Berman A, Laderman M, Kabcenell A, Fulmer T. Creating age-friendly health systems – a vision for better care of older adults. Healthcare. 2018;6(1):4–6.
14. OECD. Health at a Glance 2023: OECD indicators. In: Leadership and governance in primary healthcare: an exemplar for practice in resource limited settings. Paris: OECD Publishing; 2023.
15. Wicks P, Stamford J, Grootenhuis MA, Haverman L, Ahmed S. Innovations in e-health. Qual Life Res. 2014;23:195–203.
16. Bujnowska-Fedak MM, Pirogowicz I. Support for e-health services among elderly primary care patients. Telemedicine and e-Health. 2014;20(8):696–704.
17. Alexandrakis D. Factors related to computer and internet use during the third age: results from an empirical research in Greece. Gerontechnology. 2019;18(1):47–58.
18. Pew Research Center. Tech adoption climbs among older adults, vol. 17. 2017. Available from: www.pewresearch.org.
19. Wiles JL, Leibing A, Guberman N, Reeve J, Allen RES. The meaning of "aging in place" to older people. Gerontologist. 2012;52(3):357–66. https://doi.org/10.1093/geront/gnr098. Cited 2024 Sep 26.
20. Bosch-Farré C, Malagón-Aguilera MC, Ballester-Ferrando D, Bertran-Noguer C, Bonmatí-Tomàs A, Gelabert-Vilella S, et al. Healthy ageing in place: enablers and barriers from the perspective of the elderly. A qualitative study. Int J Environ Res Public Health. 2020;17(18):1–23.
21. Costa-Font J, Vilaplana-Prieto C. Health shocks and housing downsizing: how persistent is 'ageing in place'? J Econ Behav Organ. 2022;204:490–508.
22. Allin S, Grignon M, Le Grand J. Subjective unmet need and utilization of health care services in Canada: what are the equity implications? Soc Sci Med. 2010;70(3):465–72.
23. Sibley LM, Glazier RH. Reasons for self-reported unmet healthcare needs in Canada: a population-based provincial comparison. Healthcare Policy. 2009;5(1):87 https://www.pmc.ncbi.nlm.nih.gov/articles/PMC2732657/. Cited 2024 May 21
24. Marek KD, Stetzer F, Adams SJ, Popejoy LL, Rantz M. Aging in place versus nursing home care: comparison of costs to Medicare and Medicaid. Res Gerontol Nurs. 2012;5(2):123–9.
25. Goddard MK. Quality in and equality of access to healthcare services in England. 2008. Available from: http://ec.europa.eu/employment_social/spsi/studies_en.htm#healthcare.
26. World Health Organization. Long-term care for older people: package for universal health coverage. Geneva: World Health Organization; 2023.
27. Nicholson NR. A review of social isolation: an important but underassessed condition in older adults. J Prim Prev. 2012;33(2–3):137–52. https://doi.org/10.1007/s10935-012-0271-2.
28. Moya-Martínez P, Bermejo F, del Pozo-Rubio R. Hard times for long-term care systems? Spillover effects on the Spanish economy. Economic

Systems Research. 2021;33(1):1–19 https://www.tandfonline.com/doi/abs/10.1080/09535314.2020.1752627.
29. Costa-Font J, Vilaplana-Prieto C. 'Investing' in care for old age? An examination of long-term care expenditure dynamics and its spillovers. Empir Econ. 2023;64(1):1–30. https://doi.org/10.1007/s00181-022-02246-0.
30. Martinez-Lacoba R, Pardo-Garcia I, Amo-Saus E, Escribano-Sotos F. Mediterranean diet and health outcomes: a systematic meta-review. European Journal of Public Health. 2018;28:955–61 Oxford University Press.
31. Urrútia G, Bonfill X. PRISMA declaration: a proposal to improve the publication of systematic reviews and meta-analyses. Med Clin (Barc). 2010;135(11):507–11.
32. Aromataris E, Fernandez R, Godfrey CM, Holly C, Khalil H, Tungpunkom P. Summarizing systematic reviews: methodological development, conduct and reporting of an umbrella review approach. Int J Evid Based Healthc. 2015;13(3):132–40 https://www.pubmed.ncbi.nlm.nih.gov/26360830/.
33. Almeida APSC, Nunes BP, Duro SMS, Facchini LA. Socioeconomic determinants of access to health services among older adults: a systematic review. Rev Saude Publica. 2017;51:50.
34. Liljas AEM, Walters K, Jovicic A, Iliffe S, Manthorpe J, Goodman C, et al. Strategies to improve engagement of 'hard to reach' older people in research on health promotion: a systematic review. BMC Public Health. 2017;17(1):349.
35. Scott MM, Mayhew A, Jeong A, Shaver N, Lapenskie J, Hsu AT, et al. Access to long-term care for minority populations: a systematic review. 2022. https://doi.org/10.1017/S0714980822000046.
36. Garnett A, Northwood M, Ting J, Sangrar R, Reg O, Labatt A. mHealth interventions to support caregivers of older adults: equity-focused systematic review. 2022. Available from: https://aging.jmir.org/2022/3/e33085.
37. Li W, Yigitcanlar T, Erol I, Liu A. Motivations, barriers and risks of smart home adoption: from systematic literature review to conceptual framework. Energy Res Soc Sci. 2021;80:2214–6296. https://doi.org/10.1016/j.erss.2021.102211.
38. Meng L, Gao M, Wang S, Tian Y, Zhang Y, Cheng Q. Information and communication technology based integrated care for older adults: a scoping review. 2023. https://doi.org/10.5334/ijic.6979.
39. Sadler Id E, Potterton V, Anderson R, Id ZK, Sheehan K, Butt F, et al. Service user, carer and provider perspectives on integrated care for older people with frailty, and factors perceived to facilitate and hinder implementation: a systematic review and narrative synthesis. 2019. https://doi.org/10.1371/journal.pone.0216488.
40. Wilson J, Heinsch M, Betts D, Booth D, Kay-Lambkin F. Barriers and facilitators to the use of e-health by older adults: a scoping review. BMC Public Health. 2021. Available from:https://doi.org/10.1186/s12889-021-11623-w.
41. Sharkiya SH, Hag AM. Environmental and contextual factors influencing e-health use among older adults: a rapid review. Int J Med Inform. 2024;187:105448.
42. Allen JB, Psych M, Ottmann GB, Roberts Grad Dip G, Allen J. Multi-professional communication for older people in transitional care: a review of the literature multi-professional communi-cation for older people in transitional care: a review of the literature. Int J Older People Nurs. 2012;8:253–69 https://doi.org/10.1111/j.1748-3743.2012.00314.x.
43. Carroll C, Sworn K, Booth A, Tsuchiya A, Maden M, Rosenberg M. Equity in healthcare access and service coverage for older people: a scoping review of the conceptual literature. Integrated Healthcare Journal. 2022;4:92.
44. Ethier A, Carrier A. Implementation of local health and social services for older adults. Healthcare Policy. 2021;17(2):105 https://www.pmc.ncbi.nlm.nih.gov/articles/PMC8665730/.
45. Gaffney HJ, Hamiduzzaman M. Factors that influence older patients' participation in clinical communication within developed country hospitals and GP clinics: a systematic review of current literature. PLoS One. 2022;17(6):e0269840.
46. Galvez-Hernandez P, González-De Paz L, Muntaner C. Primary care-based interventions addressing social isolation and loneliness in older people: a scoping review. BMJ Open. 2022;12:57729. https://doi.org/10.1136/bmjopen-2021-057729.
47. Kervin, L.M., Riadi, I., Chamberlain, S.A. et al. Barriers in Health and Social Care Access and Systems Navigation among Older Adults without Advocates: A Scoping Literature Review and Framework Synthesis. Population Ageing (2023). https://doi.org/10.1007/s12062-023-09430-9.
48. Sterling-Fox C. Access to five nonprimary health care services by homebound older adults: an integrative review. Home Health Care Manag Pract. 2019;31(1):55–69. https://doi.org/10.1177/1084822318810384.
49. Ensor T, Cooper S. Overcoming barriers to health service access: influencing the demand side. Health Policy and Planning. 2004;19:69–79.
50. O'Donnell O. Access to health care in developing countries: breaking down demand side barriers. Cad Saude Publica. 2007;23(12):2820–34 https://www.pubmed.ncbi.nlm.nih.gov/18157324/.
51. World Health Assembly, 58. Sustainable health financing, universal coverage and social health insurance [A58/33]. World Health Organization; 2005. https://iris.who.int/handle/10665/20383.
52. Carrin G, Mathauer I, Xu K, Evans DB. Universal coverage of health services: tailoring its implementation. Bull World Health Organ. 2008;86(11):857–63.
53. Douglas HE, Georgiou A, Tariq A, Prgomet M, Warland A, Armour P, et al. Implementing information and communication technology to support community aged care service integration: lessons from an Australian aged care provider. Int J Integr Care. 2017;17(1):9.
54. World Health Organization. Integrated care for older people (ICOPE) implementation pilot programme: findings from the 'ready' phase. Geneva: World Health Organization; 2022. https://iris.who.int/bitstream/handle/10665/353553/9789240048355-eng.pdf?sequence=1.
55. Knapova L, Klocek A, Elavsky S. The role of psychological factors in older adults' readiness to use eHealth technology: cross-sectional questionnaire study. J Med Internet Res. 2020;22(5). Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC7290459/. Cited 2024 May 20.
56. Walley J, Lawn JE, Tinker A, Chopra M. Alma-Ata: rebirth and revision 8 - primary health care: making Alma-Ata a reality. Lancet. 2008;372. Available from: http://ecommons.aku.edu/pakistan_fhs_mc_women_child health_paediatr/49.
57. Braveman P, Gruskin S. Poverty, equity, human rights and health. Bull World Health Organ. 2003;81(7):539–45 https://pubmed.ncbi.nlm.nih.gov/12973647/.
58. Haines A, Sanders D, Lehmann U, Rowe AK, Lawn JE, Jan S, et al. Achieving child survival goals: potential contribution of community health workers. Lancet. 2007;369:2121–31.
59. Ensor T, Dave-Sen P, Ali L, Hossain A, Begum SA, Moral H. Do essential service packages benefit the poor? Preliminary evidence from Bangladesh. 2002. Available from: http://www.worldbank.org/poverty/health/data.
60. Jacobs B, Ir P, Bigdeli M, Annear PL, Van Damme W. Addressing access barriers to health services: an analytical framework for selectingappropriate interventions in low-income Asian countries. Health Policy Plan. 2012;27(4):288–300.
61. James CD, Hanson K, Mcpake B, Balabanova D, Gwatkin D, Hopwood I, et al. To retain or remove user fees? Reflections on the current debate in low-and middle-income countries. Appl Health Econ Health Policy. 2006;5:137.
62. Del Pozo-Rubio R, Pardo-García I, Escribano-Sotos F. Financial catastrophism inherent with out-of-pocket payments in long term care for households: a latent impoverishment. International Journal of Environmental Research and Public Health. 2020;17(1):295 https://www.mdpi.com/1660-4601/17/1/295/htm.
63. Stern C, Kleijnen J. Language bias in systematic reviews: you only get out what you put in. JBI Evid Synth. 2020;18(9):1818–9.
64. Ramírez-Castañeda V. Disadvantages in preparing and publishing scientific papers caused by the dominance of the English language in science: the case of Colombian researchers in biological sciences. PLoS One. 2020;15(9):e0238372. Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0238372.

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