

Social support and healthcare navigation in later life: Instrumental and cognitive pathways among native-born and migrant older adults

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Abstract

Older adults' healthcare use is shaped by relational mechanisms, which were linked to navigational challenges faced by older migrants. Yet these mechanisms remain under-explored, limiting interventions that support both native-born and migrant older adults' networks in facilitating their healthcare access and use. This study aimed to identify the social paths through which older adults' networks support their healthcare use in response to access barriers, and to examine whether older migrants' disadvantages reflect distinct relational mechanisms or inequalities in social and individual resources. A survey was conducted among 1,332 older native-born and migrants in Switzerland. A set-ESEM model tested associations between forms of social support (tangible, informational, relational), health and healthcare literacy, perceived healthcare access (accessibility, acceptability, accommodation), and frequency of health services use. Social support showed instrumental and cognitive functions. Tangible support was directly associated with perceived accessibility, whereas informational and relational support were associated with greater accessibility, acceptability, and accommodation through improved literacy. Perceived acceptability was, in turn, associated with more frequent visits. While these relational patterns were structurally invariant across migratory backgrounds, older migrants reported fewer individual and social resources and greater perceived barriers. Older adults' networks facilitate healthcare use through complementary forms of support tailored to the barriers encountered. Healthcare institutions should engage in community-based interventions providing instrumental support, and, with practitioners, systematically involve and train relatives who shape older patients' literacy. Reducing inequalities further requires creating relational opportunities that expand older migrants' networks.

Introduction

Older adults' social networks shape their ability to perceive, seek, reach, pay for, and engage with health services (Levesque et al., 2013; Reiss-Brennan et al., 2026). As healthcare needs grow in aging populations, policymakers and institutions are increasingly called upon to design interventions targeting the relational resources that support older adults' use of healthcare (Abudayya et al., 2026; Schulz et al., 2020). Supporting this relational dimension of healthcare, however, requires a clearer understanding of the specific roles that social support plays in addressing different barriers to healthcare access.

Family and community members may facilitate healthcare use by responding to individual needs and capabilities (Mohnen et al., 2019). Specifically, they could help older adults address challenges related to healthcare accessibility, interactions with providers, and the organization of medical visits (Dove et al., 2017; Schulz et al., 2020). Understanding these relational mechanisms may be particularly important for aging populations exposed to heightened healthcare vulnerabilities, such as older migrants (Hawkins et al., 2022; Kobayashi & Khan, 2023). Although older migrants often face various healthcare barriers (Guo et al., 2025; Im & Taylor, 2026), their migration trajectories may also place them in specific relational contexts, potentially resulting in lower levels of support for health services navigation (Dolberg & Lev, 2025; Hall & Kilkey, 2025). However, the relational mechanisms through which older adults' social network shape their healthcare use by addressing different perceived barriers remains under-explored.

This knowledge gap constrains the development of interventions aimed at supporting the social networks of both native-born and migrant older adults. This study therefore aims to identify the pathways through which social support is associated with healthcare navigation in later life, and to examine whether the barriers faced by older migrants may reflect distinct support mechanisms or inequalities in relational resources.

Responding to the limitations of individually centred theories (Gliedt et al., 2023), Mohnen et al. (2019) proposed a contextual and relational perspective on healthcare utilization. The *Neighborhood and healthcare utilization model* suggests that healthcare use is influenced by the physical and social environment in which individuals live (Mohnen et al., 2019). Specifically, the authors posit that the social environment influences healthcare utilization both directly, through individual needs, and indirectly, through individual mediators. Family and neighbourhood contexts may, for example, contribute to the perception of health needs by shaping health behaviours, ultimately influencing individuals' use of health services (Mohnen et al., 2019). When they use healthcare, older adults may also encounter challenges related to the physical access of services (i.e., accessibility), the physician-patient interactions (i.e., acceptability), and the organization of medical encounters (i.e., accommodation) (Levesque et al., 2013). Confronted to such challenges, their social networks may provide specific forms of support that Mohnen et al.'s (2019) model acknowledges but does not fully differentiate.

Older adults may draw on distinct forms of social support for healthcare (Petrescu-Prahova et al., 2020). In response to material barriers, such as the distance from health services or the cost of healthcare, relatives may provide transportation (Iverson et al., 2025; Lanthier-Labonté et al., 2024), and financial assistance (Schulz et al., 2020). During medical encounters, they may also provide emotional support that helps older adults to adjust to interactions with healthcare providers (Sterie et al., 2026). Through companionship, advice, and information, support networks may further contribute to the development of health literacy among older adults (Amoah, 2019), which is in turn associated with their intention to use healthcare (Gillespie et al., 2025). For instance, a meta-analysis showed that, by contributing to their health literacy, social support promotes older adults' self-management in healthcare through an increased sense of self-efficacy (Ren et al., 2026).

These instrumental, emotional, and cognitive functions of older adults' social environment resonate with relational perspectives on autonomy (Dove et al., 2017). Such perspectives suggest that older adults' healthcare autonomy sits at the crossroad of external social conditions and capabilities shaped through interpersonal relationships (Sherwin & Winsby, 2010). A causal perspective assigns the social environment the role of an external condition for autonomy (Christman, 2004). For instance, the social network can enable individual action by removing a physical transportation barrier to accessing healthcare (e.g., Iverson et al., 2025). In contrast, constitutive perspectives consider relationships to be an intrinsic part of autonomy, as they shape individuals' knowledge, skills, and norms of action (Mackenzie, 2008). This perspective may capture the role of informational and relational support in navigating healthcare (e.g., Ren et al., 2026). However, as in Mohnen et al.'s (2019) model, relational perspectives on autonomy gave little attention to the articulation of different forms of social support in

relation to older adults' challenges in accessing and navigating healthcare (Dove et al., 2017). Clarifying these mechanisms would also improve the understanding of healthcare inequalities between native-born and migrant older adults.

Research has shown that older migrants' living contexts and past experiences may be associated with perceptions of healthcare inaccessibility, challenges in healthcare interactions, and in the management of medical appointments (Hawkins et al., 2022; Guo et al., 2025; Im & Taylor, 2026). Meanwhile, some migrants may have limited social support as they age. Older migrants integrating smaller social networks may have less access to companionship, advice, and information from relatives, as well as to tangible support for overcoming everyday barriers (Ahamad et al., 2024; Burholt et al., 2018).

In health and healthcare, literature suggests two perspectives on the relational mechanisms involved. On the one hand, as most older migrants reside in the country since their young age or adulthood, their social support mechanisms may be similar to those observed among native-born older adults (Ilgaz et al., 2025). On the other hand, migration trajectories may be associated with specific network configurations in which support is provided through different relational channels in later life, particularly among older adults living far from their country of origin (Dolberg & Lev, 2025). Through the concept of transnational convoys of care, Hall and Kilkey (2025) suggested that older migrants may benefit from material and immaterial support from network members in their country of residence and from relatives living elsewhere. The lack of knowledge on these mechanisms therefore restricts the scope of interventions, particularly in determining whether they should target migration-specific forms of support or address disadvantages in social resources.

Supporting older adults' networks is thus essential to facilitate healthcare access and navigation, and for reducing disparities in health service use among older migrant populations (Abudayya et al., 2026; Schulz et al., 2020). However, knowledge gaps hinder the development of policies and interventions oriented toward this endeavour. Specifically, research is needed to: identify how different forms of social support contribute to functional pathways that address older adults' specific healthcare access needs, and clarify whether older migrants' healthcare vulnerabilities reflect specific relational configurations or inequalities in social resources. In addressing these gaps, this study aims to identify functionally specific pathways of social support for healthcare access and use in later life. Drawing on Mohnen et al.'s (2019) model, we hypothesize instrumental and cognitive pathways associated with specific barriers to healthcare access, as illustrated in Fig. 1. Specifically, we posit the following:

H1. Informational and relational support is positively associated with older adults' health and healthcare literacy, which is associated with more favourable perceptions of healthcare accessibility, acceptability, and accommodation. Tangible support is only associated with greater perceived accessibility of health services. Perceived accessibility, acceptability, and accommodation are, in turn, associated with their healthcare use (Fig. 1).

H2. The social pathways to healthcare use are invariant between migration backgrounds. However, older migrants, particularly non-European older migrants, have fewer social and literacy resources and

perceive greater barriers to accessing healthcare.

To test these hypotheses, we draw on original survey data collected in Switzerland from native- and foreign-born older adults. Given its aging population, the increasing number of older migrants, and the growing pressure on its health system, Switzerland provides a particularly relevant setting for exploring these mechanisms and for generating insights for Western countries facing similar challenges ([AUTHORS], 2026).

Figure 1

Methods

Study context and participants

This study is part of the Swiss cross-sectional [project name, BLIND FOR REVIEW]. This project aims to examine older migrants’ healthcare pathways and the contextual factors that shape them ([AUTHORS], 2025). The study protocol was approved by the Research Ethics Committee of the Faculty of Social and Political Sciences at the [university name, BLIND FOR REVIEW] ([ethics code, BLIND FOR REVIEW]).

Primary data were collected between October 2025 and January 2026 using both probabilistic and non-probabilistic sampling strategies. Through a private mailing platform, 4,000 older adults were randomly invited to participate in the survey. In addition, 402 community-based organizations working with migrants and/or older adults were contacted to recruit participants among their active members. Based on an a priori power analyses (G*Power, version 3.1.9.4), the sampling strategy aimed to collect data from 368 native-born and 368 migrant older adults. The target sample size was estimated to achieve 95% statistical power for parametric inferential analyses, assuming a small effect size ($f^2 = 0.10$).

Eligible participants were between 65 and 99 years old and resided in French-speaking Switzerland. Long-term settled older migrants were individuals born abroad who had lived in Switzerland for at least 10 years (Ilgaz et al., 2025). Older adults living in long-term care facilities were excluded from the target population. Participation was voluntary, non-remunerated, and all participants provided informed consent. To participate, older adults were asked to complete a paper-and-pencil questionnaire in one of the 11 survey languages: Albanian, Arabic, English, French, German, Italian, Portuguese, Serbian, Spanish, Turkish, and Ukrainian.

A total of 1,332 individuals participated in the survey, of whom 1,117 were contacted randomly (response rate: 28.5%), and 215 were recruited through community-based organizations. The final sample comprised of 1,315 older adults, including 897 native-born and 418 migrants (17 participants did not respond to this study’s variables of interest). Their characteristics are presented in Table 1. Although participants’ age did not differ between groups, the distribution of gender, educational attainment, and financial adequacy varied.

Table 1
Sample characteristics and differences between native-born older adults and older migrants

Age, M (SD)		Total (N = 1,315)	Native-born older adults (n = 897)	Older migrants (n = 418)	χ^2
		74.30 (7.07)	74.32 (6.97)	74.27 (7.29)	1.60
Age categories, n (%)					
65–79 y.o.	987 (75.06)	683 (76.14)	304 (72.73)		
80–99 y.o.	328 (24.94)	214 (23.86)	114 (27.27)		
Gender, n (%)					9.40**
Female	650 (49.43)	417 (46.49)	233 (55.74)		
Male	665 (50.57)	480 (53.51)	185 (44.26)		
Education, n (%)					42.30***
Primary	173 (13.16)	81 (9.03)	92 (22.01)		
Secondary	624 (47.45)	460 (51.28)	164 (39.23)		
Tertiary	518 (39.39)	356 (39.69)	162 (28.76)		
Financial adequacy, n (%)					41.13***
Less than needed	285 (21.67)	152 (16.95)	133 (31.82)		
Enough	884 (67.22)	629 (70.12)	255 (61.00)		
More than needed	146 (11.10)	116 (12.93)	30 (7.18)		
Chronic diseases, n (%)					0.03
Diagnosed	626 (47.60)	425 (47.38)	201 (48.09)		
Not diagnosed	689 (52.40)	472 (52.62)	217 (51.91)		
<i>Note. ** $p < 0.01$; *** $p < 0.001$</i>					

Measures

Measures operationalized Mohnen et al.'s (2019) model. The social environment was operationalized as social support in health, the mediators were health and healthcare literacy, needs were measured as perceived access to healthcare, and healthcare use was assessed as the frequency of health services attendance.

Social support in health. Participants completed the Medical Outcomes Study Social Support Scale (Sherbourne & Stewart, 1991). They reported the assistance they received in relation to health and healthcare through subscales assessing informational (5 items, $\alpha = 0.93$), tangible (4 items, $\alpha = 0.88$), and relational support (5 items, $\alpha = 0.92$). Table A presents the items included in each subscale (Supplementary file). Participants indicated the frequency with which they received each form of support on a scale ranging from 1 (*never*) to 5 (*always*).

Health and healthcare literacy. Participants completed the health promotion literacy (4 items, $\alpha = 0.84$), and the healthcare system literacy subscales (7 items, $\alpha = 0.91$) of the European Health Literacy Scale (Sørensen et al., 2013). For each listed behaviour (Table A), participants indicated how difficult it was for them on a scale ranging from 1 (*very easy*) to 4 (*very difficult*). Items were reversed for the analyses so that higher scores indicated higher literacy.

Perceived access to healthcare. Participants responded to the Perceived Access to Healthcare Scale (Hoseini-Esfidarjani et al., 2021). This scale assessed experienced barriers related to healthcare accessibility (4 items, $\alpha = 0.88$), acceptability (9 items, $\alpha = 0.90$), and accommodation (6 items, $\alpha = 0.84$). Respondents rated their agreement with each statement (Table A) on a 5-point Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Items were reversed for analyses so that higher scores indicated greater perceived access.

Use of healthcare services. Participants were asked to indicate how often they used healthcare services over the past 12 months (i.e., general practitioners, hospitals, clinics). Response options were 1, 2–3, 4–5, 6–7, 8–9, or 10 or more times.

Migration background and covariates. Participants reported their country of birth, which was then categorized into broader migration backgrounds: native-born, migrant (geographically European, non-European). They also reported their age, gender, educational level, financial adequacy, and whether they had any diagnosed chronic conditions. These variables were included as covariates.

Data analyses

Analyses were conducted in R (version 4.5.2). To test hypothesis H1, structural equation models (SEM) were estimated using the *lavaan* package. We used a set-ESEM approach, a form of exploratory SEM that allows observed items to load on all latent factors within the same thematic block (Marsh et al., 2020). The three thematic blocks were social support in health, health and healthcare literacy, and perceived

access to healthcare (Fig. 1). This approach reduces the risk of unmodeled cross-loadings, which may bias correlations between latent factors and the estimated structural parameters (Marsh & Alamer, 2024). Geomin rotation was used, with an epsilon of 0.5 and standardized latent variance parametrization. Given the categorical nature of the variables, the model was estimated using the Weighted Least Squares Mean and Variance adjusted estimator (WLSMV) and missing data were handled using a pairwise approach (Asparouhov & Muthén, 2010). The pairwise approach estimate each polychoric correlation using participants with available data for the corresponding pair of variables.

Robustness and sensitivity analyses were conducted. Model fit and inter-factor correlations from the set-ESEM were compared with those from a traditional CFA model. A reduced version of the set-ESEM model was also tested, excluding items with a target loading below 0.40, a cross-loading above 0.50, or a cross-loading that exceeded the target loading (Tables B.1-B.3, Supplementary file) (Prokofieva et al., 2023).

Hypothesis H2 was tested in three steps. First, the invariance of the model structure was tested following a sequential procedure, fitting increasingly constrained models: configural, metric, scalar, and structural invariance (Chen, 2007). Model comparisons relied on changes in approximate fit indices ($\Delta CFI \geq 0.001$, $\Delta RMSEA \geq 0.010$) rather than on the chi-square difference given its sensitivity to sample size (Chen, 2007). Models were estimated using WLSMV estimator, and missing data were handled using a pairwise approach. Second, structural paths were tested in an exploratory manner using Wald omnibus tests, with Holm-Bonferroni correction for multiple comparisons. Third, one-way Welch's ANOVAs were used to compare native-born older adults and older migrants on levels of social support, health and healthcare literacy, and perceived healthcare accessibility, acceptability, and accommodation. Sensitivity analyses were conducted to explore differences between native-born older adults, older European migrants, and older non-European migrants, with a Holm-Bonferroni correction applied to post-hoc comparisons.

Statistical significance was set at $p < 0.05$. The analyses code, codebook, and database are available on OSF ([link_for_revision](#)).

Results

The set-ESEM model provided a better fit to the data than the CFA model (CFI = 0.985 vs. 0.969; TLI = 0.983 vs. 0.967; RMSEA = 0.040 vs. 0.055; SRMR = 0.032 vs. 0.043) (Table B.1-B.3). Correlations among latent factors were also lower in the set-ESEM model (Table C), consistent with the possibility that constraining cross-loadings to zero in the CFA solution inflated factor correlations and may have obscured structural associations. The reduced set-ESEM model excluded four items (Tables B.1-B.3), and its fit and overall structure were comparable to those of the full set-ESEM model (CFI = 0.988; TLI = 0.986; RMSEA = 0.038; SRMR = 0.029). To preserve consistency with the validated scales and theoretical constructs, the full set-ESEM model was retained as the final model, showing an excellent fit to the data (CFI = 0.978, TLI = 0.980, RMSEA = 0.039, SRMR = 0.039, $\chi^2(1062) = 3209.47$, $p < 0.001$). This model is presented in Fig. 2.

Healthcare utilization model (H1)

Different types of social support were associated with distinct patterns linking support to healthcare perceived access and utilization (Fig. 2). Informational and relational support were positively associated with health promotion literacy and healthcare literacy. Healthcare literacy was, in turn, positively associated with perceived healthcare accessibility, acceptability, and accommodation, whereas health promotion literacy was associated with perceived accommodation, and marginally associated with perceived accessibility and acceptability. In contrast, tangible social support was only associated with greater perceived healthcare accessibility. While perceived accessibility was not associated with healthcare utilization, greater perceived acceptability was associated with more frequent health service consultations, and increased perceived accommodation showed a trend toward lower healthcare utilization.

Figure 2

set-ESEM model for the association between social support and healthcare use in later life

Note

Unidirectional arrows represent direct effects; bidirectional arrows, correlations between latent factors. Dashed arrows denote negative effects and solid arrows positive effects; black arrows indicate significant effects ($p < 0.05$) and grey arrows marginal effects ($p < 0.10$). The model was estimated using WLSMV estimator, with an oblique Geomin rotation and an epsilon of 0.5.

Results further indicated that different forms of support had distinct indirect associations with perceived access and the frequency of healthcare visits. Through healthcare literacy, informational support was positively and indirectly associated with perceived healthcare accessibility ($\beta = 0.09$, 95% CI [0.05, 0.12], $p < 0.001$), acceptability ($\beta = 0.11$, [0.06, 0.16], $p < 0.001$), and accommodation ($\beta = 0.13$, [0.07, 0.19], $p < 0.001$). Healthcare literacy likewise positively mediated the association between relational support and accessibility ($\beta = 0.09$, [0.05, 0.13], $p < 0.001$), acceptability ($\beta = 0.12$, [0.07, 0.17], $p < 0.001$), and accommodation ($\beta = 0.13$, [0.08, 0.19], $p < 0.001$). The indirect associations showed through health promotion literacy were weaker. Informational ($\beta = 0.03$, [0.01, 0.06], $p = 0.014$) and relational support ($\beta = 0.03$, [0.01, 0.01], $p = 0.009$) only retained a small positive association with perceived accessibility. Tangible support did not show any significant indirect effect. Regarding healthcare use, the analyses indicated that healthcare literacy was positively and indirectly associated with the frequency of consultations through perceived acceptability ($\beta = 0.10$, [0.05, 0.14], $p < 0.001$), while showing a trend toward a negative association through perceived accommodation ($\beta = -0.05$, [-0.11, 0.00], $p = 0.058$). The indirect association through perceived accessibility was non-significant, as were all corresponding paths through health promotion literacy.

Pathways vs. resources differences across migration backgrounds (H2)

In multigroup analyses, chi-square difference tests across increasingly constrained set-ESEM models indicated a significant deterioration in fit at the metric level ($\Delta\chi^2 = 177.62$, $\Delta df = 99$, $p < 0.001$), but not at the scalar ($\Delta\chi^2 = 5.17$, $\Delta df = 8$, $p = 0.739$) or structural levels ($\Delta\chi^2 = 30.56$, $\Delta df = 25$, $p = 0.204$; Table D). Given the sensitivity of the chi-square difference test to sample size, we relied primarily on changes in approximate fit indices to evaluate invariance (Chen, 2007). At every step, these changes remained below conventional thresholds for non-invariance, including at the metric ($\Delta CFI = 0.001$, $\Delta RMSEA = -0.002$) and structural levels ($\Delta CFI = 0.001$, $\Delta RMSEA = -0.001$). Full structural invariance was therefore supported, indicating that factor loadings, intercepts, and structural parameters were comparable between native-born and migrant older adults. Given this overall invariance, we examined in an exploratory manner whether specific structural paths nonetheless varied across groups, drawing on the scalar model.

Unadjusted Wald tests pointed to potential variation in a single structural path across migration backgrounds (Table 2). The association between relational support and health promotion literacy differed between groups. Among older migrants, health promotion literacy was more strongly associated with the relational support received from their relatives than among native-born older adults. A marginal difference across migration backgrounds also emerged for the association between tangible support and perceived accessibility, which was stronger among older migrants. These differences should, however, be read as exploratory, as they did not withstand correction for multiple comparisons and the model showed structural invariance.

Table 2

Multi-group set-ESEM: Direct structural paths across migration backgrounds and Wald tests for paths difference

Paths	Native-born older adults (<i>n</i> = 897)	Older migrants (<i>n</i> = 418)	Wald test χ^2 (1)	Holm-adjusted <i>p</i> -value
	β	β		
Informational support – Healthcare literacy	0.23***	0.38***	2.59	1.000
Relational support – Healthcare literacy	0.23***	0.25***	0.16	1.000
Informational support – Health promotion literacy	0.31***	0.43***	2.52	1.000
Relational support – Health promotion literacy	0.22***	0.41***	5.93*	0.209
Healthcare literacy – Accessibility	0.34***	0.33***	0.05	1.000
Health promotion literacy – Accessibility	0.11*	0.04	0.82	1.000
Tangible support – Accessibility	0.14***	0.23***	3.52 ⁺	0.790
Healthcare literacy – Acceptability	0.51***	0.45***	0.98	1.000
Health promotion literacy – Acceptability	0.05	0.11	0.61	1.000
Healthcare literacy – Accommodation	0.57***	0.52***	0.82	1.000
Health promotion literacy – Accommodation	0.11*	0.15*	0.26	1.000
Accessibility – Healthcare use	– 0.04	– 0.02	0.03	1.000
Acceptability – Healthcare use	0.23***	0.19*	0.24	1.000
Accommodation – Healthcare use	– 0.13*	– 0.06	0.35	1.000
<i>Note.</i> Standardized path coefficients (β) are reported from the multigroup set-ESEM estimated using scalar measurement invariance, by constraining factor loadings and intercept to equality across migration groups, whereas all structural paths were freely estimated within each group. ⁺ $p < 0.10$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.				

Native-born older adults and older migrants, however, displayed different levels of resources and constraints related to healthcare use (Table 3). Older migrants received less tangible and relational

support, reported lower healthcare literacy, and perceived greater healthcare accessibility and acceptability barriers. Sensitivity analyses further showed that older non-European migrants were particularly exposed to low resources and high constraints when using healthcare. Long-term settled older European and non-European migrants reported similarly lower levels of tangible and relational support than native-born older adults. By contrast, older non-European migrants showed weaker healthcare literacy, and faced greater barriers in perceived healthcare accessibility, acceptability, and accommodation.

Table 3
Healthcare use resources and constraints differences across migration backgrounds

	Older migrants			Native-born older adults (n = 897)	Mean difference	
	Total (n = 418)	European (n = 293)	Non-European (n = 125)		a	b
	M (SD)	M (SD)	M (SD)	M (SD)	F (1)	F (2)
Social support in health						
Tangible support	3.71 (1.11)	3.75 (1.09) ^a	3.63 (1.14) ^a	3.92 (1.04) ^b	10.32**	5.50**
Informational support	3.88 (0.96)	3.90 (0.96)	3.85 (0.96)	3.97 (0.88)	2.31	1.24
Relational support	3.93 (0.95)	3.94 (0.97) ^a	3.89 (0.92) ^a	4.11 (0.83) ^b	10.82**	5.62**
Health and healthcare literacy						
Healthcare	3.13 (0.57)	3.18 (0.53) ^a	3.01 (0.64) ^b	3.20 (0.47) ^a	4.91*	5.05**
Health promotion	2.99 (0.61)	3.01 (0.61)	2.95 (0.61)	3.01 (0.54)	0.33	0.61
Perceived access to healthcare						
Accessibility	4.04 (0.84)	4.16 (0.68) ^a	3.79 (1.08) ^b	4.16 (0.69) ^a	6.23*	6.99**
Acceptability	3.90 (0.71)	3.99 (0.58) ^a	3.69 (0.90) ^b	4.00 (0.58) ^a	6.15*	7.04**
Accommodation	3.83 (0.71)	3.93 (0.58) ^a	3.60 (0.91) ^b	3.91 (0.60) ^a	3.71 ⁺	7.26***
Note. a) Older migrants vs. Native-born older adults; b) Older European migrants vs. Older non-European migrants vs. Native-born older adults. Within each row, means sharing the same letter do not differ significantly, whereas means with different letters differ significantly ($p < 0.05$) across the three migratory backgrounds, based on post-hoc comparisons with Holm-Bonferroni correction. ⁺ $p < 0.10$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.						

Discussion and implications

This study aimed to identify the social support pathways through which healthcare use is shaped in later life, and to examine whether migratory inequalities arise from distinct mechanisms of from unequal resources endowment. Three key contributions emerged. First, social support operates through

functionally specific instrumental and cognitive pathways that are associated with different needs related to the perceived healthcare access. Second, only the cognitive function was associated with the actual use of healthcare, thereby distinguishing between processes facilitating access and those generating utilization. Third, results suggest that healthcare inequalities between native-born and migrant older adults stem from disadvantages in interpersonal resources rather than from differences in how their network supports them. In discussing these findings, we propose that instrumental and cognitive pathways of social support can be interpreted as complementary forms of relational support for healthcare autonomy in later life.

Consistent with the first hypothesis, results showed that social support operates through functionally specific pathways shaping older adults' needs for healthcare access. These findings extend Mohnen et al.'s (2019) model in two ways. On the one hand, the social environment does not uniformly influence healthcare utilization. Depending on the challenges older adults perceive in accessing health services, the support provided by the social environment may either substitute or empower individuals to engage with them. On the other hand, the results showed that only the empowering pathway was associated with actual healthcare utilization, thereby extending Mohnen et al.'s (2019) theoretical postulates.

Tangible support, which was solely and directly associated with perceived healthcare accessibility, reflects an instrumental and substitutive function of the social environment in healthcare. This finding aligns with previous research describing instrumental support as primarily oriented toward creating the background conditions necessary for older adults' health behaviours, rather than toward modifying the behaviour itself (Steinhoff & Reiner, 2024). When access is hindered by service availability or physical distance, the social environment may therefore act on behalf of the older adult to overcome this material barrier, whether through transportation assistance to distant services in rural settings (Iverson et al., 2025; Lanthier-Labonté et al., 2024) or through more affordable travel options in urban areas (Yuan et al., 2022). By stepping in for older adults when they encounter physical barriers, this pathway does not appear to apply when healthcare utilization is hindered by relational or navigational challenges.

Informational and relational support, by contrast, contribute to a cognitive pathway to healthcare. When perceived challenges concern the relational and organizational dimension of healthcare (Levesque et al., 2013), the social environment may equip older adults with the knowledge and skills needed to plan and navigate healthcare encounters. Echoing gerontological literature emphasizing the socially constructed nature of health literacy (Amoah, 2019), these findings suggest that the social environment fosters the development of capabilities through which older adults exercise healthcare autonomy (Abma et al., 2011; Sherwin & Winsby, 2010). This empowerment appears to be more effective when the knowledge provided concerns specific healthcare situations rather than health in general, reflecting longitudinal findings on the role of specific knowledge in older adults' health behaviours (Xie & Mo, 2025).

Further contributing to a contextual perspective on healthcare utilization (Mohnen et al., 2019), these findings also point to a dissociation in the role of social support between facilitating access and generating health services utilization. Only the cognitive pathway was associated with healthcare

utilization. Removing a material barrier may therefore be insufficient to prompt healthcare utilization, as engagement in healthcare relationships appears to rely on cognitive knowledge that fosters trust in both the healthcare provider and system (Hou et al., 2024). Results further suggest that by improving older adults' knowledge of healthcare, the social environment may help them navigate and adapt to the health system more easily. This could foster more appropriate healthcare utilization and potentially reduce the frequency of visits. These findings may therefore deepen our understanding of healthcare overutilization (Acquadro-Pacera et al., 2024), and further research is needed to examine the trend observed in this study.

These instrumental and cognitive pathways call for a reconsideration of the theoretical role of the social environment in models of healthcare utilization (Gliedt et al., 2023). By contributing to debates between causal and constitutive perspectives on autonomy (Christman, 2004; Mackenzie, 2008; Westlund, 2009), this study suggests that these pathways correspond to two distinct relational modalities of autonomy, mobilized according to older adults' perceived needs of healthcare access. When the external context constitutes a material barrier, the social network may act as an external background condition for individuals, reflecting a causal-type contribution. When older adults encounter relational and navigational challenges, however, their healthcare autonomy may be embedded in the interpersonal relationship that shape the knowledge and capabilities needed to address these situations, reflecting a constitutive-type contribution. Whereas prior research has tended to focus on one or the other of these interpretations (Sherwin & Winsby, 2010; van Loon et al., 2024), these findings suggest that they represent coexisting modalities that older adults draw upon situationally. This clarifies the mechanisms through which the social environment described by Mohnen et al. (2019) operates: not as an overarching determinant of access and use, but as a relational resource whose function, to compensate or to empower, is shaped by the nature of the obstacle encountered.

Moreover, the results advance our understanding of healthcare inequalities between native-born and migrant older adults. In line with the second hypothesis, the results showed invariance in the relational mechanisms of access across groups, suggesting that inequalities stem from the distribution of social resources and access constraints that either facilitate or hinder instrumental and cognitive pathways. This decoupling shifts the issue of inequalities from differences in functioning to differences in resources distribution (Kobayashi & Khan, 2023), thereby opening possibilities for supporting the relational conditions that foster healthcare autonomy among older migrants.

The greater perceived difficulties in accessing, engaging with, and navigating the healthcare system among non-European older migrants reflect inequalities in contextual healthcare resources (Wong et al., 2025), culturally specific needs and discrimination encountered in health services (Hawkins et al., 2022; Im & Taylor, 2026; Peters-Nehrenheim et al., 2026). Meanwhile, as they may be embedded in transnational convoys of care and restricted co-national networks (Burholt et al., 2018; Hall & Kilkey, 2025), they may have less access to relatives providing effective knowledge and support for healthcare in their country of residence. The lower level of healthcare literacy observed in this group may therefore reflect a lack of opportunities to develop the knowledge underpinning their autonomy when facing

relational and navigational challenges in healthcare. These findings offer practical implications for supporting relational forms of healthcare autonomy among both native-born and migrant older adults.

Given that instrumental and cognitive pathways operate through distinct mechanisms, they call for distinct policy and practice responses rather than undifferentiated forms of social support. To support the instrumental pathway among older adults who lack tangible support, including older migrants, institutions and policymakers should promote community-based material support systems. This could include, for instance, financial and logistic support for volunteer-run community transportation services (Lanthier-Labonté et al., 2024). Healthcare services and practitioners could also systematically assess, when scheduling appointments, whether older adults have practical assistance with transportation and appointment organization. Supporting this instrumental pathway could also involve strengthening home-based care, which reverses these access dynamics by bringing services to patients, thereby reducing the distance-related barriers limiting older adults' healthcare access (Carroll et al., 2022).

To support the cognitive pathway, practitioners and institutions need to equip older adults' support networks to serve as empowering alters for navigational knowledge. This could involve engaging with family members in appointments and decision-making, while also supporting them through information sessions and training on how to assist navigation in geriatric care (Folder et al., 2024; Sterie et al., 2026). Such initiatives could take the form of peer-navigator programs, or resources designed for patient-network dyads rather than for patients alone. This approach would acknowledge that healthcare literacy can be distributed across the social network, rather than being solely held by the older person.

Institutions are also called upon to help reduce resource inequalities among older migrants by facilitating programs aimed at increasing relational opportunities. Approaches such as the social cure could help broaden and diversify their social network (Haslam et al., 2022; Haslam et al., 2018), thereby creating new opportunities to support instrumental and cognitive pathways to healthcare. In doing so, interventions could move beyond a general approach to social support and develop differentiated responses tailored to the barriers faced by native-born and migrant older adults.

Limitations

This study has four limitations constraining the scope of its findings. First, its cross-sectional design precludes causal inference. Structural relationships should therefore be interpreted as associations between latent factors, and longitudinal research is needed to better understand the involved processes. Second, as some older migrants were recruited through community-based organizations, the sample may be subject to selection bias, given that their integration in such networks may entail higher levels of social support than among other older migrants. The results may thus underestimate their lack of resources and perceived constraints in healthcare use. Third, the structure, composition, and location of social networks were not measured. Interpretations concerning restricted, co-national, or transnational networks need therefore to remain hypothetical. Fourth, measuring healthcare utilization with a single item limits the ability to identify forms of support favouring different types of healthcare. Diversifying this measurement should be a priority for future research.

Conclusion

This study highlights the contribution of social support to older adults' perceived healthcare access through instrumental and cognitive pathways, of which only the latter is associated with actual utilization. It also suggests that healthcare inequalities between native-born and migrant older adults stem less from distinct relational mechanisms than from the unequal distribution of interpersonal resources that underpin them. By providing insights into the relational nature of healthcare autonomy in later life, these findings encourage scholars to shift their focus toward the contextual factors underlying inequalities across migration background and urge institutions and practitioners to consider social networks in their interventions. Future longitudinal research is needed to understand how migration-related inequalities in different forms of social support exacerbate, over time, the healthcare inequalities observed in later life. Research also needs to examine the relational specificities underlying different patterns of health services utilization to better target interventions. Framing healthcare navigation in later life as a relational process could help better support vulnerable older adults, including older migrants.

Declarations

Author Contribution

PM: Conceptualization, Methodology, Project administration, Data curation, Formal analyses, Visualization, Writing – Original draft, Writing – review & editing. FB: Methodology, Validation, Supervision, Resources, Writing – review & editing. DS: Methodology, Formal analyses, Validation, Supervision, Resources, Writing – review & editing.

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Data Availability

Analyses code, variables codebook, and database are available on OSF at: https://osf.io/386nu/overview?view_only=da458b8a3ec84a3eb07922f9fb962144

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Figures

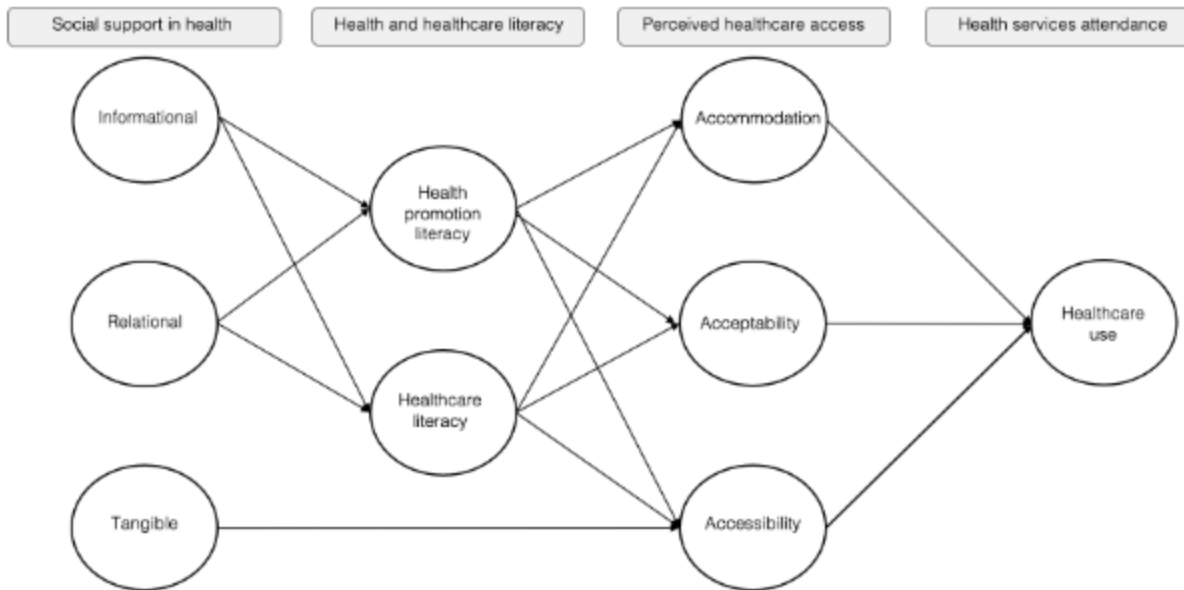


Figure 1

Hypothesized model of social support for healthcare use in later life

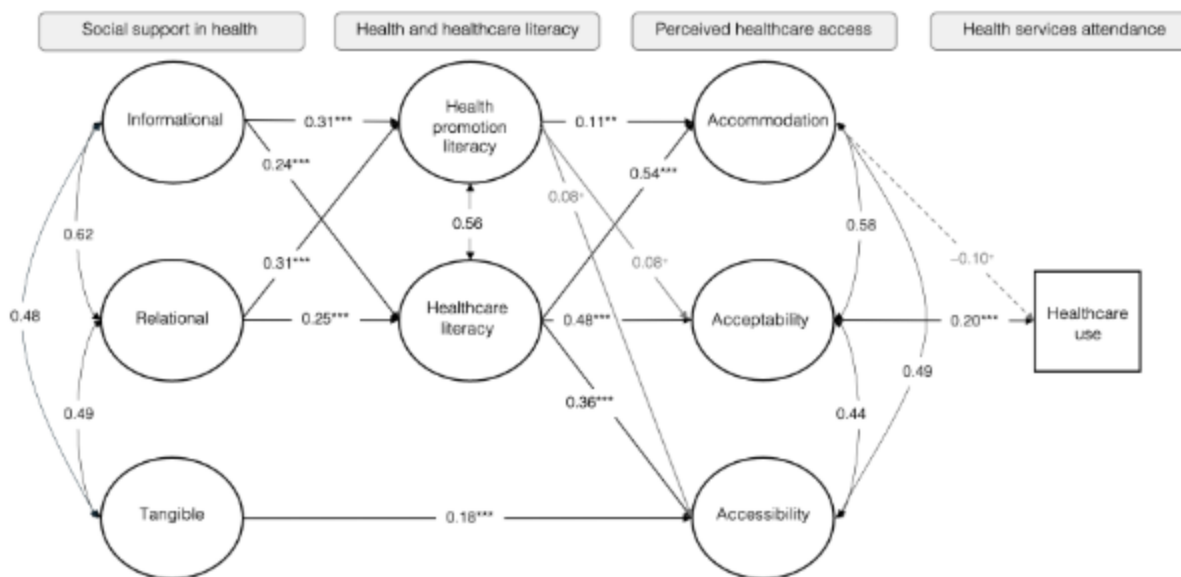


Figure 2

set-ESEM model for the association between social support and healthcare use in later life

Note. Unidirectional arrows represent direct effects; bidirectional arrows, correlations between latent factors. Dashed arrows denote negative effects and solid arrows positive effects; black arrows indicate significant effects ($p < 0.05$) and grey arrows marginal effects ($p < 0.10$). The model was estimated using WLSMV estimator, with an oblique Geomin rotation and an epsilon of 0.5.

Supplementary Files

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