International Research Journal of Multidisciplinary Scope (IRJMS), 2026;7(3):892-905 IRJMS

Original Article | ISSN (O): 2582-631X DOI:10.47857/irjms.2026.v07i03.010847

Healthcare Access Among Older Korean Immigrant Women

Mijin Jeong*

Department of Social Welfare, Keimyung University, Daegu, Republic of Korea. *Corresponding Author's Email: mijinj@kmu.ac.kr

Abstract

Healthcare access is a critical determinant of health and quality of life in later adulthood, yet older immigrant women may face compounded barriers related to immigration, language, gendered caregiving roles and limited familiarity with healthcare systems. In the United States (U.S.) Midwest, Korean immigrants may experience geographic dispersion and limited access to culturally and linguistically appropriate resources. However, little is known about healthcare access among older Korean immigrant women in this regional context. Guided by Andersen's Behavioral Model of Health Services Use, this qualitative study explored perceived barriers, facilitators and coping strategies related to healthcare access among older Korean immigrant women in the U.S. Midwest. Semi-structured, in-depth interviews were conducted with eight Korean immigrant women aged 65 years and older. Interviews were conducted in Korean, transcribed, translated into English and analyzed using thematic analysis. Four themes were identified: immigration and acculturation influence on healthcare access capacity; major barriers in the Midwest, especially transportation and language barriers; support from family and the Korean community; and efforts to maintain independence through health self-management, information seeking and communication strategies. The findings suggest that healthcare access in later life is shaped by immigration history, gendered roles, regional conditions and available social support. This study highlights the need for culturally and regionally responsive strategies to improve healthcare access for older immigrant women in under-resourced settings.

Keywords: Coping Strategies, Healthcare Access, Older Korean Immigrant Women, Qualitative Study, Social Support, U.S. Midwest.

Introduction

Healthcare access is a critical determinant of health and quality of life in later adulthood. During the coronavirus disease 2019 (COVID-19) pandemic, healthcare disparities affecting immigrant populations became more visible and, in many cases, more severe (1-7). Higher COVID-19 infection and mortality rates observed in communities of color and immigrant populations, compared with White and non-Hispanic populations, further highlighted these disparities (8). Prior studies have documented multiple contributors to healthcare disparities among immigrants, including lack of health insurance, limited English proficiency, stigma and marginalization, socioeconomic disadvantage, limited mobility and weak social networks (9-19). Although a substantial body of research has examined barriers to healthcare among immigrants, less is known about how older immigrants cope with these barriers in everyday life and how such experiences shape their ability to access care over time. Because older adults are generally more vulnerable to healthcare access problems, understanding the healthcare experiences of older immigrants is essential for reducing health disparities (14, 20). Among immigrant groups in the United States (U.S.), Koreans (approximately 1.9 million) represent one of the major Asian-origin populations (21). Compared with several other Asian-origin groups, Korean Americans have a relatively older age profile and foreign-born Korean immigrants have a comparatively high median age (21). Despite the aging of this population, how older Korean immigrants access and navigate healthcare services remains insufficiently understood. When examining healthcare disparities among older Korean immigrants, cultural and gendered contexts should be carefully considered (22, 23). In many Korean immigrant families, women have traditionally been expected to serve as caregivers and, at times, economic contributors during the early settlement period (19, 23). These gendered roles may reduce opportunities for cultural exposure and institutional familiarity in the United States, including familiarity with the healthcare

(Received 26th February 2026; Accepted 17th June 2026; Published 16th July 2026)

system (22). As a result, older Korean immigrant women may face compounded barriers in later life due to the combined effects of immigration history, language challenges, cultural expectations and limited access to health-related information and resources (19, 22, 23). For these reasons, older Korean immigrant women can be considered a population at heightened risk for healthcare access disparities (19, 22, 23).

Geographic context is also central to understanding healthcare access among older Korean immigrants. Historically, many immigrants, including Korean immigrants, have settled in coastal regions of the United States, where ethnic communities and immigrant-serving resources are often more established (21). In contrast, Korean immigrants in the U.S. Midwest may be more geographically dispersed and socially isolated, with fewer opportunities to access Korean-language resources or community-based support (24). This regional context may create distinct barriers to healthcare access that are not fully captured in studies focused on coastal or large metropolitan areas (12, 21, 24). However, limited attention has been paid to the healthcare access experiences of older Korean immigrant women living in the Midwest.

To address this gap, the present study examined how older Korean immigrant women in the U.S. Midwest experienced healthcare access, including perceived barriers, facilitators and coping strategies. In doing so, this study drew on Andersen's Behavioral Model of Health Services Use to conceptualize healthcare access among older Korean immigrant women (25, 26). Andersen's model has been widely used to explain differences in healthcare utilization across populations by organizing predictors into three domains: predisposing factors, enabling factors and need factors (25, 26).

Predisposing factors refer to characteristics that shape an individual's inclination to use healthcare services, such as age, gender, education, marital status, family structure, social class and health beliefs (25, 26). In immigrant populations, predisposing factors may also include immi-gration-related experiences (e.g., migration history, settlement process and familiarity with the host society), which influence how individuals perceive and approach healthcare services.

Enabling factors include personal, family and community resources that facilitate or hinder the use of formal and informal services, such as income, health insurance coverage, transportation, language proficiency and availability of community support (25, 26). These factors are particularly relevant for immigrant populations because access to healthcare often depends on whether individuals can secure practical resources and assistance to navigate unfamiliar systems. Need factors refer to perceived or evaluated health conditions that require healthcare services (25, 26). In other words, need factors reflect both subjective health status and clinically assessed illness, which are major drivers of health service use (27).

Although Andersen's model is flexible and has been widely applied to diverse populations and service contexts (26, 28, 29), prior research has noted that the model may not fully capture culturally specific barriers to healthcare among immigrants unless it is adapted to account for immigration and sociocultural context (27). Older foreign-born adults may encounter healthcare systems and institutional environments differently from U.S.-born populations and these differences can shape both their access to and use of healthcare services (27). For example, legal and social positioning, language barriers and culturally embedded expectations regarding family roles and help-seeking may influence whether available resources function as support or barriers.

Previous studies have shown that Korean immigrants often face barriers to healthcare access and health service utilization, including challenges related to communication, information and support systems (22, 24). Therefore, applying Andersen's model to this population requires attention to cultural and community contexts, particularly the ways immigration history, gendered family roles and social support networks shape healthcare access in later life (19, 22-24).

Guided by Andersen's Behavioral Model as a sensitizing framework while incorporating cultural and immigration-related contexts, this study focused in particular on how predisposing factors (e.g., immigration experiences and gendered roles) and enabling factors (e.g., family support, Korean community resources, language support and transportation) influenced healthcare

access among older Korean immigrant women in the U.S. Midwest. Using in-depth qualitative interviews, this study aimed to generate a contextually grounded understanding of how immigration experiences, social support and individual efforts shape healthcare access in later life. The findings may inform culturally responsive healthcare practice and community-based support strategies for older immigrant populations in under-resourced regional settings.

Methodology

This study employed a qualitative design using in-depth, semi-structured interviews to explore healthcare access experiences among older Korean immigrant women living in the U.S. Midwest. A qualitative approach was appropriate because the study aimed to examine participants' perceptions, lived experiences and coping strategies in context rather than to test predetermined hypotheses (30, 31).

A purposive sampling strategy was used to recruit participants with direct experience of accessing healthcare services as older Korean immigrant women in the Midwest. Consistent with the study purpose, participants were eligible if they met the following criteria: first-generation immigrant women, aged 65 years or older, self-identified as having a Korean cultural background, had lived in the United States for more than 10 years and had lived in the Midwest for at least 5 years. Because the study focused specifically on older Korean immigrant women, Korean cultural background and gender were part of the inclusion criteria.

Recruitment procedures evolved during the study because of a low initial response rate. The researcher first contacted pastors at two Korean churches and the president of a local Korean American community association in a Midwestern metropolitan area. Additional church contacts were then identified through these initial networks. Flyers describing the study purpose and eligibility criteria were distributed through Korean churches and participants' social networks. Initial recruitment proceeded through referrals. When the first four interviews provided limited age variation, a second round of recruitment was conducted to increase variation by including women in their late 60s and 70s. Through community referrals, a total of eight participants were recruited between July 2019 and January 2020. To protect confidentiality, specific city names are not reported. However, the study site is specified as urban and suburban cities within the Kansas City metropolitan area and none of the participants resided in remote rural areas at the time of interview.

Although the final sample included eight participants, thematic sufficiency was assessed through the recurrence of key patterns across interviews, including transportation dependence, language barriers, family support, Korean community support and self-management strategies. After the later interviews, no substantially new themes emerged, although individual experiences added nuance to existing categories. Follow-up interviews with two participants and member checking further supported the adequacy of the thematic interpretation.

Data were collected through interviews conducted at locations and times convenient for participants, including participants' homes and church meeting rooms. Each interview lasted approximately 60 to 180 minutes. A semi-structured interview guide was used to ensure consistency while allowing flexibility for participants to describe their experiences in depth. The guide covered four domains: immigration history (e.g., "Can you tell me about your immigration experience in the United States?"), healthcare access experiences in the Midwest (e.g., "Can you describe your experiences using healthcare services in the Midwest?"), barriers or challenges to accessing healthcare (e.g., "What are the main barriers you encounter when accessing and using healthcare services?") and coping strategies (e.g., "How do you address health concerns or healthcare-related difficulties?"). All participants were informed of the study purpose and their rights before the interview. Written informed consent was obtained prior to data collection and participants were given time to ask questions. Interviews were audio-recorded using a digital recorder and were transcribed in Korean. To clarify emerging findings and strengthen interpretive accuracy, follow-up interviews were conducted with two participants. Member checking was also conducted by confirming key statements and interpretations with participants after the interviews (32). Because the interviews were conducted in Korean,

the researcher transcribed the recordings in Korean and translated the transcripts into English for analysis and reporting. The researcher is bilingual in Korean and English, which facilitated accurate transcription and translation. To preserve conceptual equivalence and participants' intended meanings, the researcher repeatedly compared the English translations with the original Korean transcripts throughout the analytic process. Also, because several participants used culturally nuanced Korean expressions related to family obligation, burden, gratitude and emotional restraint, some meanings may not have been fully captured in English translation. To reduce this risk, the researcher compared translated excerpts with the original Korean transcripts and prioritized conceptual equivalence rather than literal translation.

Data were analyzed using thematic analysis with support from Dedoose qualitative data analysis software (version 8.3.41) for code organization, data retrieval, pattern comparison and audit documentation. Thematic analysis was selected because it is appropriate for identifying patterns and themes across participants' accounts while preserving contextual meaning (33). The analysis proceeded in multiple stages. First, the researcher read all English transcripts repeatedly and conducted line-by-line manual coding to identify meaningful segments. Second, preliminary codes were organized using index cards to develop an inductive coding dictionary based on emergent patterns in the data. Third, coded data were imported into Dedoose to support code organization, data retrieval, pattern comparison and audit documentation. Through iterative review, themes were refined and integrated into a cross-case narrative that highlighted recurring patterns in participants' healthcare access experiences in the Midwest. Several strategies were used to enhance rigor and trustworthiness (32). Credibility was supported through member checking, including follow-up interviews with two participants and confirmation of key statements and interpretations. Dependability and confirmability were strengthened through documentation of interview and analytic procedures (i.e., an audit trail) and ongoing supervision from academic advisors during data collection and analysis. To improve transcription accuracy and analytic consistency, the researcher reviewed transcripts and coding decisions repeatedly throughout the analytic process. To address potential interpretive bias, the researcher engaged in reflexive memoing throughout coding and theme development, documenting analytic decisions and assumptions related to language, culture, gender and immigration experience. Emerging interpretations were reviewed repeatedly against original Korean transcripts and analytic decisions were discussed with academic advisors to support critical reflection and reduce overinterpretation. The study procedures were approved by an Institutional Review Board (IRB) of University of Kansas (#STUDY 00144016). All participants provided written informed consent before participation. Interviews were audio-recorded with participant permission and participants were informed of their rights, including the right to ask questions before and during participation.

Results

Using Andersen's Behavioral Model of Health Services Use as a sensitizing framework and incorporating cultural context, this study identified how participants' social environments shaped healthcare access in later life. The analysis also showed that immigration history and life-course experiences were closely related to participants' current capacity to access and navigate healthcare services. Four themes were identified and the sample characteristics are presented first.

During interpretation, the four themes were mapped onto Andersen's Behavioral Model. Immigration and acculturation experiences were interpreted primarily as predisposing factors; transportation, language proficiency, family support and Korean community support were interpreted as enabling factors; and participants' chronic conditions and self-rated health were considered need-related factors. Self-management and communication strategies were interpreted as coping responses that emerged at the intersection of need and enabling resources.

Table 1: Theme Mapping onto Andersen's Behavioral Model

Andersen Model Component	Theme	Interpretation
Predisposing Factors	Immigration and acculturation influence on healthcare access capacity	Age at immigration, migration reason, acculturation, gendered life-course experience
Enabling Factors	Major barriers in the Midwest	Transportation, language, interpreter access, regional resource limitations
	Support from family and Korean community	Family transportation, interpretation, church/community networks
Need + Enabling Factors	Efforts to maintain independence	Health needs, self-management, information seeking, communication strategies

Table 1 illustrates the mapping of the four identified themes onto Andersen's Behavioral Model of Health Services Use. At the time of the interviews, participants ranged in age from 65 to 97 years (mean = 83.9 years). Years since immigration ranged from 23 to 58 years (mean = 41.5 years). The sample included two participants in their 60s, three in their 80s and three in their 90s. Age at immigration ranged from 22 to 54 years (mean = 42.4 years). All participants were U.S. citizens and reported no current legal barriers related to immigration status. Most described their socioeconomic status as middle or upper-middle class. Four participants lived alone and four lived with a spouse or partner. Regarding marital status, four were married, one was divorced and three were widowed. In terms of living arrangements, four participants lived in apartments and four lived in their own homes. Self-reported spoken English proficiency varied: two described their English as good, two as fair and four as poor. Three participants drove and had access to a vehicle, whereas five reported limited mobility related to transportation access (i.e., they did not drive and depended on others for rides). Six participants reported needing family support to access healthcare services, whereas two reported less reliance on family support. Six had work experience in the United States, while two did not. Regarding self-rated health, four participants reported poor health, two reported fair health and two reported good health. All participants are identified using pseudonyms.

First, participants described immigration and acculturation as shaping their healthcare access capacity. Immigration was often described as a major life transition that affected their ability to understand and use healthcare services in the United States. Regardless of education level or social status in South Korea, participants commonly reported that immigration reduced their confidence and capacity to access healthcare in the U.S., especially during the early settlement period. Several participants explained that educational attainment in South Korea did not necessarily help them understand the U.S. healthcare system or communicate effectively with providers. Bella said, "I graduated from college in Korea, but that education does not help me survive here. I have difficulty explaining my symptoms to my doctor because my English is poor." Similarly, Clara stated, "I graduated from college in Korea too, but my education felt useless when I tried to understand and use the U.S. healthcare system. It is very different from the Korean system." These narratives suggest that participants viewed immigration and acculturation experiences as more influential than prior demographic advantages in shaping healthcare access capacity. Participants emphasized the importance of exposure to U.S. culture, familiarity with institutions and practical knowledge of how to navigate healthcare services.

Participants also reported that work experience in the United States helped them adjust to life in the U.S. in some ways, such as learning everyday English, understanding social norms and interacting with non-Korean communities. However, they distinguished this type of acculturation from the specific skills needed to navigate healthcare systems. Work experience was often described as helpful for financial stability and, in some cases, access to health insurance, but not sufficient for developing healthcare navigation capacity.

For example, Olivia said, "I worked at a factory making auto parts in San Jose for about ten years. At work, I learned American culture, like potlucks

and how to speak up for my rights in the U.S. But for health insurance and where to find clinics with Korean doctors, I had to ask people in the Korean community. That was how I learned to use healthcare services in San Jose." Olivia and Elena, who had lived on the West Coast during their early years in the U.S., reported that they could access clinics with Korean-speaking providers and therefore did not need to rely as much on communication with English-speaking medical staff. In contrast, participants who had lived and worked in the Midwest described fewer options for Korean-language care. Sue, who was self-employed in the Midwest, explained:

"I met many Americans through my grocery store, so that helped me learn basic English. But I still feel nervous going to clinics because of English. In the Midwest, there is no choice. If there were a clinic with Koreans, I would go there."

Participants' narratives indicate that place of settlement was a key factor in shaping healthcare access capacity. Those who settled in areas with Korean-language healthcare resources could use services without significantly improving their ability to communicate with English-speaking providers. By contrast, living in the Midwest often required greater direct interaction with the U.S. healthcare system, yet participants' work experiences alone did not necessarily reduce language-related barriers in healthcare settings. Age at immigration and reasons for immigration also appeared to influence participants' opportunities to build healthcare access capacity. Clara and Grace, who immigrated in their 20s for education and had stronger English proficiency, described feeling more comfortable with U.S. institutions and healthcare services. Clara said: "My major was nursing in Korea, so I had some medical knowledge. At first, it was hard to understand the U.S. medical system because it was different from Korea's national health insurance system. But after I understood it, I did not have major problems using healthcare, compared to other Koreans in the Midwest."

In contrast, participants who immigrated in their 40s or 50s for work opportunities or family reunification often described limited opportunities to learn the healthcare system while adjusting to new responsibilities. For example, Ann and Diana immigrated in their 50s to help care for grandchildren. Diana recalled: "My daughter married an American man in the U.S. When she had her first baby, I came to help take care of my daughter and granddaughter. I was always cooking and taking food to my grandchildren. I should have learned how to do things by myself, but at that time I did not have time to learn about life in the U.S. My daughter does everything I need." Similarly, participants who immigrated for economic reasons in midlife reported being focused on work and family survival during the early immigration period. As a result, they felt they had less time to learn how to use healthcare services independently or develop confidence in navigating the U.S. healthcare system.

Second, participants identified major barriers to healthcare access in the Midwest, particularly transportation limitations and limited English proficiency. Those who did not drive and had difficulty communicating in English often relied on family members or Korean friends when visiting clinics or hospitals. Several participants linked these barriers to conditions during the early years of immigration. Women who were now in their 80s and 90s described spending most of their time working, caring for children and managing household responsibilities, which limited opportunities to learn English, drive, or become familiar with U.S. institutions. Olivia explained: "My husband said I did not need to learn to drive because he could take me anywhere. I also thought I did not need to learn. My husband went to language school for six months, but I did not have time to go because I had to take care of the children and we did not have money." Bella described a similar experience: "My husband and I went to language school together at first, but I stopped going because there was nobody to help take care of my children. Only my husband finished the language course." These narratives suggest that gendered divisions of labor during the settlement period shaped long-term differences in opportunities to learn English and drive, which later affected healthcare access.

Within this theme, transportation barriers emerged as a primary constraint on healthcare access. In addition to practical limitations, transportation dependence generated feelings of frustration, guilt and reduced self-worth. Ann said, "I cannot go to a clinic alone because I do not have

a driver's license or a car. My daughter always takes me to the clinic. I often feel sorry because I am interfering with her work." Grace similarly stated, "I feel frustrated because I cannot do anything without my son or friends. They take me grocery shopping or to the clinic. I feel useless. If I could drive and had a car, I could do things by myself and go to the clinic alone." Participants also emphasized the limited public transportation infrastructure in the Midwest compared with places such as Los Angeles or San Jose. This lack of transportation options further constrained their ability to seek care independently, especially when family support was unavailable. Olivia explained:

"When I lived in San Jose, I could take a bus right in front of my apartment and go to the clinic. There was no problem. But here, I am too old to learn driving, so I need someone to take me. It is confusing and frustrating that I cannot go to the clinic by myself. I see some buses here, but not many compared to San Jose."

Language barriers and interpretation challenges also appeared prominently within this theme. Most participants reported difficulty communicating with medical staff, even when they could manage basic English in daily life. They explained that medical visits required more precise communication to describe symptoms, understand instructions and ask questions. Bella said: "I can speak everyday English, but explaining my symptoms to a doctor or nurse is different. I feel limited when I try to explain my illness and I am not sure they understand me. I can listen to English, I think, but I still worry whether I really understood everything. I am concerned about miscommunication with the medical staff. So, I prefer to go with my daughter."

Although most participants had experience with interpreter services, many preferred to attend appointments with family members or Korean acquaintances who could interpret for them. Participants described interpreter services as time-consuming to arrange and some questioned the accuracy or nuance of the interpretation. Ann commented:

"While I was listening to the interpreter explain my symptoms to the doctor, I thought, 'I could say that myself.' I understood the English. The problem is speaking. But what the interpreter said was too simple. It was not exactly what I meant."

These accounts indicate that language barriers involved not only translation of information but also concerns about precision, nuance and trust in clinical communication.

Third, participants described support from family and the Korean community as a key facilitator of healthcare access. Because many participants immigrated for family-related reasons (e.g., reunification, caregiving, or economic support through family networks), they often had relatives in the United States who later became central sources of assistance with healthcare. Diana said, "I need regular check-ups for my heart. Usually, my niece takes me to the clinic and translates English into Korean. She visits my house regularly and helps with chores." Sue similarly reported, "My daughter lives close to me. When I need to go grocery shopping or have a doctor's appointment, I call her and ask her to come."

Participants' accounts suggest that family support was closely tied to daily functioning in later life and healthcare access was often deeply dependent on family availability. Sue said, "I am grateful that my daughter helps me, but I feel sorry whenever I ask her to take me to the clinic. I know she is busy, so I try not to ask unless it is really necessary." Some participants who settled in the Midwest also described a lack of alternative resources during their early years in the region. Sue recalled: "For the first three years, I did not take any medicine because I did not know how to get it by myself. I wanted to know where to buy medicine and what I could take, but nobody explained it. My sister just gave me pills and told me about things like aspirin and Tylenol."

At the same time, participants noted that dependence on family could become a source of vulnerability, particularly when family relationships were strained. Ann described wanting to live more independently but feeling limited in her ability to do so because she still needed transportation and practical support: "When I lived with my daughter, we had conflicts because I did not want to live under so many restrictions. My daughter found a rental house for me. I do not want her to worry because of me, but I still need her help for regular appointments and things like that." Sue also described limited support from adult children due to distance and relationship difficulties: "My son lives far away, about 20 miles from my house.

I do not have a good relationship with my son and daughter-in-law. They are busy running their restaurant and rarely call or visit. When my husband has medical appointments, I usually ask Korean friends in my neighborhood."

These cases suggest that family support may be essential when older adults have limited mobility, small social networks, or ongoing healthcare needs, but strained family relationships may also become a risk factor for healthcare access.

When family support was unavailable or insufficient, participants described the Korean community as an important alternative source of assistance. Church-based networks and informal community relationships helped some participants obtain transportation, interpretation and emergency support. Sue shared an incident involving her husband: "When my husband fell out of bed one morning, I did not know what to do. I panicked. I called the pastor who lives in my neighborhood. He often visits our house to help care for my husband and help him walk. The pastor drove us to the emergency room." Clara and Grace also described helping other older Korean immigrants by accompanying them to medical visits and interpreting when family members could not. Grace explained:

"Until I was in my 60s, I often helped people who needed help using medical services. I translated English into Korean when my friends asked me to go to the clinic with them. One friend's son ran a laundry business and the family was very busy. I felt she might be uncomfortable asking her son and daughter-in-law for help with her health check-up, so I was willing to help."

These narratives indicate that informal support within the Korean community can function as a critical resource for healthcare access, especially when family support is limited or family relationships are strained. However, participants also noted that community support was not formalized and often depended on an individual's social involvement and the local community's capacity to organize support for older adults.

Finally, participants described efforts to maintain independence while managing healthcare access challenges. Although most participants relied on family members or Korean community members to access healthcare services, they also described efforts to maintain independence and reduce reliance on others. Participants—particularly those who reported fair or poor health—described trying to manage their health proactively to reduce the frequency of clinic visits and avoid burdening family members. Grace said, "I do not want to bother my son and husband because of my medical appointments. I try to manage my eating habits and walk for my health. I believe staying healthy helps my whole family."

Given their limited resources and barriers to care, participants developed practical ways to maintain health in everyday life, including walking, stretching and using available community exercise opportunities. Olivia reported, "I often go for a walk outside. I also go up and down the stairs in my apartment during summer and winter." Elena stated, "There is an exercise program in my apartment building at 4 p.m. on Tuesdays and Thursdays. I did not understand everything they said, but I followed what others were doing in the yoga class. It is not a big deal and exercising is better for my health."

Participants believed that these self-management efforts helped them maintain health and potentially reduce their need for medical services.

Participants also described strategies for obtaining health information and managing chronic conditions. Those who were able to use digital technology often searched for health information online, particularly through Korean-language websites and YouTube videos.

Diana reported, "I often watch Korean videos on YouTube for health information and search for things related to my health, like diabetes and back pain." Clara similarly said, "I am very interested in diet for health. I usually search Korean websites for foods that help lower high blood pressure." All participants also described sharing and receiving health-related information within the Korean community, including recommendations for clinics and tips related to health management (e.g., "People tell me where the good hospitals or clinics are" and "I heard at church what is good for diabetes"). Notably, participants generally perceived Korean-language health information and community-based advice as more trustworthy and culturally relevant than U.S.-based information. Clara explained: "I think some health information depends on culture because we have different eating habits. Koreans may be at higher

risk for stomach cancer because of our food habits. So Korean health information is helpful for me because of my culture. In the U.S., there is not much health information about Asian culture."

Participants further described specific communication strategies to reduce language-related barriers during healthcare visits. For example, Ann said: "Before I meet doctors or nurses, I look up some medical words and expressions. I try to use simple words because I want to explain my symptoms and pain by myself." Bella was the only participant who reported using a translation application during healthcare encounters. She described the app as useful for identifying medical terms and supporting basic communication with doctors and nurses, but insufficient for expressing emotions or nuanced concerns: "Listening is not a problem. But medical terms are often difficult to understand, so I use Google Translate from Korean to English when I need medical words. I also search things with the app and show them to the doctor or nurse. If I speak in Korean, it shows English. When the doctor speaks English, I can see Korean. So, the doctor can understand. But it is not enough. When I want to explain my worries or feelings, it does not work that way. A translation app cannot translate my emotions." This narrative illustrates both the potential and the limitations of communication technology in healthcare settings. Translation applications may support information exchange and increase confidence in basic communication, but they may be less effective for conveying emotional concerns, subtle symptoms, or complex experiences.

Discussion

This study explored how older Korean immigrant women in the U.S. Midwest experienced healthcare access, including barriers, facilitators and coping strategies. Using Andersen's Behavioral Model of Health Services Use as a sensitizing framework and incorporating cultural context, the findings showed that healthcare access in later life was shaped not only by current needs but also by immigration history, gendered roles, place of settlement and available social support (12, 19, 22-24, 27). In particular, the results highlight the importance of predisposing factors (e.g., age at immigration, reasons for immigration and acculturation experiences) and enabling factors (e.g., transportation, language support, family support and Korean community resources) in shaping participants' healthcare access experiences (25-27).

A key finding of this study is that immigration experiences across the life course were closely related to participants' current healthcare access capacity. Participants described how the timing and circumstances of immigration influenced opportunities to learn English, drive and become familiar with U.S. institutions, including the healthcare system. Those who immigrated at younger ages and for educational purposes reported greater confidence in navigating healthcare services, whereas those who immigrated later in life for family caregiving or economic reasons often described fewer opportunities to build this capacity. This finding supports prior research indicating that immigration-related conditions and adaptation processes shape healthcare access and service use among immigrant populations (14, 19, 22, 27). It also extends previous work by showing how these processes may have long-term consequences for older women's healthcare access in later life.

The findings also underscore the role of regional context in healthcare access. Consistent with prior studies showing variation in immigrant resources by geographic location (12, 21, 24), participants in this study described the U.S. Midwest as a setting with fewer Korean-language healthcare resources, more limited public transportation and greater social dispersion than coastal areas. Participants who had previously lived in places such as San Jose or Los Angeles compared those settings favorably because they had access to buses and more Korean-speaking providers. In contrast, living in the Midwest often required reliance on family members or local Korean networks for transportation and communication support. These findings suggest that geographic context should be treated as a meaningful structural condition when examining healthcare access among older immigrants, especially in regions with fewer culturally and linguistically tailored services (12, 21, 24, 27).

In addition, these findings align with social determinants of health perspectives, which emphasize that healthcare access is shaped by

structural and social conditions such as language access, transportation, socioeconomic resources, neighborhood context and availability of culturally appropriate services (34). For older immigrant women, these determinants may accumulate across the life course and become especially consequential in later life.

Transportation and language barriers emerged as central constraints, which is consistent with previous studies identifying limited English proficiency, transportation barriers and system navigation difficulties as major barriers to healthcare access among immigrant populations (11, 12, 14, 18, 22). However, this study adds nuance by showing how these barriers were linked to gendered settlement experiences. Participants' accounts suggested that some women had fewer opportunities than their husbands to attend language classes or learn to drive during the early immigration period because of caregiving responsibilities and household labor. These early-life adaptations, often shaped by economic necessity and gender expectations, appeared to have lasting effects on healthcare access in old age. This finding aligns with literature emphasizing the importance of gendered family roles and sociocultural context in immigrant women's health experiences (19, 22, 23).

The findings suggest that healthcare-seeking behavior was shaped by gendered expectations embedded in Korean immigrant family life. Several participants described prioritizing childcare, household labor and later grandchild care over their own adaptation needs, such as learning English, driving, or becoming familiar with healthcare systems. These gendered caregiving responsibilities may have delayed the development of independent healthcare navigation skills and contributed to later-life dependence on family members for transportation, interpretation and appointment management (19, 22, 23).

Another important finding was the dual role of family support. Family members were often the primary facilitators of healthcare access by providing transportation, interpretation and help with appointments, medications and communication. This pattern is consistent with research emphasizing the importance of family and social networks in immigrant health-related information seeking and service use (24, 35). At the same time, participants' narratives also showed that strong dependence on family could become a vulnerability when relationships were strained, when adult children were unavailable, or when participants wished to maintain autonomy. In these situations, healthcare access was not simply a matter of resource availability, but also of relationship quality, emotional comfort and intergenerational dynamics. This finding suggests that family support should be understood as both a resource and a potential site of constraint in later-life healthcare access (24, 35).

These findings are broadly consistent with studies of other Asian immigrant older adults, including Chinese, Taiwanese and Vietnamese immigrant populations, which have identified language barriers, transportation difficulties, family reliance and culturally specific support needs as important influences on healthcare access and service use (11, 22, 24, 29, 35-37). However, this study adds to Asian American aging research by showing how these barriers operate among older Korean immigrant women in a less densely resourced Midwestern context, where Korean-language providers and ethnic service infrastructure may be less available than in larger coastal immigrant communities (12, 21, 24, 27).

The Korean community, especially informal church-based and neighborhood networks, functioned as an important alternative source of support when family assistance was limited. Participants described receiving emergency transportation, interpretation help and practical health information through pastors, friends and other community members. These findings are consistent with prior studies highlighting the significance of culturally familiar networks in healthcare navigation and health information sharing among Korean Americans (24, 38). At the same time, participants noted that such support was often informal and dependent on personal relationships and community involvement. This suggests that community support may be highly valuable but unevenly available, particularly in less densely populated immigrant communities in the Midwest (12, 24, 38).

Participants also described active efforts to maintain independence despite structural and interpersonal barriers. They engaged in self-management practices such as walking, stretching

and participating in local exercise programs and they sought health information through Korean-language online sources and community exchanges. These efforts reflect participants' desire to reduce reliance on family and maintain dignity in later life. Notably, participants often viewed Korean-language health information as more culturally relevant and trustworthy than U.S.-based information, particularly when health advice was perceived to be linked to dietary patterns and cultural practices. This finding supports the need for culturally tailored health information and communication strategies for older immigrant populations (22, 24, 38).

The findings regarding communication technology also have practical implications. One participant described using a translation application during healthcare visits to support basic communication with providers, especially for medical terms. However, she also emphasized the limitations of translation applications for expressing emotions, nuanced concerns and subjective experiences of illness. This suggests that translation technologies may help support basic exchange of information and reduce some communication barriers, but they do not replace the relational and interpretive dimensions of clinical communication. Healthcare organizations serving older immigrant populations may therefore consider combining language technologies with interpreter services and culturally responsive communication practices to improve care experiences.

The expansion of telehealth, patient portals and online appointment systems may create both opportunities and new barriers for older immigrant women with limited English proficiency (37, 39, 40). While digital tools can support information seeking and remote communication, they may also increase dependence on adult children or community members when platforms are available only in English or require digital literacy (37, 39). Therefore, healthcare systems should provide multilingual patient portals, telephone-based alternatives, interpreter-supported telehealth and culturally responsive digital navigation support (39, 40).

The findings have several implications for healthcare practice and community-based support in under-resourced regional settings. First, healthcare providers and clinics should recognize that older immigrant women may have long-standing barriers rooted in immigration history and gendered life-course experiences, rather than viewing communication or transportation barriers as isolated individual problems (14, 19, 22, 23, 27). Second, clinics and local health systems in the Midwest may improve access by strengthening language support pathways, simplifying appointment processes and partnering with trusted community organizations, including Korean churches and community groups. Third, programs that support transportation, health system navigation and culturally relevant health education may be particularly beneficial for older immigrant women who live alone or have limited family support (11, 12, 22, 24, 38).

This study has several limitations. First, the sample was small and drawn from Korean community networks in one Midwestern regional context; therefore, the findings are not statistically generalizable to all older Korean immigrant women in the United States. Second, participants generally reported middle or upper-middle socioeconomic status and legal stability (e.g., U.S. citizenship), which may differ from the experiences of more economically vulnerable or undocumented immigrant populations. Third, because interviews were conducted in Korean and translated into English for analysis and reporting, there is a possibility that some linguistic nuance was reduced during translation despite efforts to preserve conceptual meaning. Additionally, because recruitment relied partly on Korean churches and community networks, participants may have had stronger religious or community ties than older Korean immigrant women who are socially isolated or not connected to ethnic organizations. Thus, the findings may overrepresent the experiences of women with access to informal support through church-based or community-based networks and underrepresent those with weaker community ties. This recruitment context may also have contributed to social desirability bias. Given the collectivist cultural context, participants may have been reluctant to express negative views of family members, churches, or Korean community networks, or may have minimized conflict, dependency and unmet needs to present themselves and their families positively. Finally, as

a qualitative study, the findings provide in-depth contextual insight but do not estimate the prevalence of the identified barriers or coping strategies.

Future research may build on these findings by examining healthcare access among older Korean immigrant women across different regional contexts (e.g., coastal metropolitan areas vs. Midwestern or rural settings) and by comparing experiences across immigration cohorts and socioeconomic groups. Studies could also examine how digital tools, interpreter services and community-based navigation programs affect healthcare communication and service use among older immigrants in later life. In addition, mixed-methods or longitudinal studies may help clarify how immigration history, family support and functional limitations interact over time to shape healthcare access trajectories.

Conclusion

This study found that healthcare access among older Korean immigrant women in the U.S. Midwest was shaped by the intersection of immigration history, gendered life-course roles, regional structural barriers and available family and community support. Transportation limitations and language barriers were major obstacles, but their effects were intensified or reduced depending on participants' settlement experiences, social relationships and access to culturally familiar resources.

At the same time, participants were not passive recipients of support. They actively developed strategies to maintain health, seek information and communicate with healthcare providers while striving to preserve independence in later life. These findings highlight the importance of culturally and regionally responsive approaches to healthcare access that address not only individual-level barriers but also the family, community and structural conditions surrounding older immigrant women.

Improving healthcare access for older immigrant women in under-resourced regions such as the U.S. Midwest may require coordinated efforts across healthcare systems, community organizations and family support networks, with particular attention to transportation, language access and culturally meaningful communication.

These findings should be interpreted in light of the small, community-based sample and the church- and network-based recruitment approach. Future research should examine older Korean immigrant women across different regional, socioeconomic and community contexts and should further investigate how digital healthcare systems, interpreter services and community-based navigation programs influence healthcare access in later life.

Several limitations should be noted. This study was based on a small purposive sample of older Korean immigrant women living in urban and suburban cities within the Kansas City metropolitan area; therefore, the findings are not intended to be statistically generalizable to all older Korean immigrants in the United States. In addition, because participants were recruited through Korean churches, community networks and referrals, the study may underrepresent older Korean immigrant women who are socially isolated or have limited connection to ethnic community resources. The use of Korean-language interviews translated into English may also have reduced some linguistic and cultural nuances, despite efforts to preserve participants' intended meanings.

Future research should examine healthcare access among older Korean immigrant women across diverse regional, socioeconomic and community contexts. Comparative studies of coastal metropolitan areas, Midwestern settings and rural communities would help clarify how regional resources shape healthcare access. Future research should also investigate how interpreter services, transportation support, digital healthcare systems and community-based navigation programs influence healthcare communication and service use among older immigrants in later life.

Abbreviations

COVID-19: Coronavirus disease 2019, IRB: Institutional Review Board, U.S.: United States.

Acknowledgement

The author would like to thank all participants for their valuable time and participation in this study.

Author Contributions

The author solely contributed to all aspects of this study and manuscript preparation.

Conflict Of Interest

The author declares no conflict of interest.

Data Availability

The data are not publicly available due to participant confidentiality and the sensitive nature of qualitative interview data. De-identified excerpts may be available from the corresponding author upon reasonable request, subject to ethical restrictions.

Declaration of Artificial Intelligence (AI) Assistance

The author did not use generative AI or AI-assisted technologies in the writing of this manuscript. The author takes full responsibility for the content's originality, interpretation and accuracy.

Ethics Approval

The study procedures were approved by the University of Kansas Human Subjects Division (#STUDY 00144016).

Funding

None.

References

1. Cholera R, Falusi OO, Linton JM. Sheltering in place in a xenophobic climate: COVID-19 and children in immigrant families. Pediatrics. 2020;146(1): e20201094. doi:10.1542/peds.2020-1094
2. Clark E, Fredricks K, Woc-Colburn L, Bottazzi ME, Weatherhead J. Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. PLoS Negl Trop Dis. 2020;14(7): e0008484. doi:10.1371/journal.pntd.0008484
3. Page KR, Venkataramani M, Beyrer C, Polk S. Undocumented US immigrants and COVID-19. N Engl J Med. 2020;382(21):e62. doi:10.1056/NEJMp2005953
4. Rodriguez DX, Hill J, McDaniel PN. A scoping review of literature about mental health and well-being among immigrant communities in the United States. Health Promot Pract. 2021;22(2):181-92. doi:10.1177/1524839920942511
5. Rollston R, Galea S. COVID-19 and the social determinants of health. Am J Health Promot. 2020;34(6):687-9. doi:10.1177/0890117120930536b
6. Van Dorn A, Cooney RE, Sabin ML. COVID-19 exacerbating inequalities in the US. Lancet. 2020;395 (10232):1243. doi:10.1016/S0140-6736(20)30893-X
7. Williams DR, Cooper LA. COVID-19 and health equity—a new kind of "herd immunity". JAMA. 2020; 323(24):2478-80. doi:10.1001/jama.2020.8051
8. Raine S, Liu A, Mintz J, Wahood W, Huntley K, Haffizulla F. Racial and ethnic disparities in COVID-19 outcomes: social determination of health. Int J Environ Res Public Health. 2020;17(21):8115. doi:10.3390/ijerph17218115
9. Babbar RK, Handa AB, Lo CM, Guttmacher SJ, Shindledecker R, Chung W, Fong C, Ho-Asjoe H, Chan-Ting R, Dixon LB. Bone health of immigrant Chinese women living in New York City. J Community Health. 2006;31(1):7-23. doi:10.1007/s10900-005-8186-y
10. Chu CM. Postnatal experience and health needs of Chinese migrant women in Brisbane, Australia. Ethn Health. 2005;10(1):33-56. doi:10.1080/1355785052000323029
11. Clough J, Lee S, Chae DH. Barriers to health care among Asian immigrants in the United States: a traditional review. J Health Care Poor Underserved. 2013;24(1):384-403. doi:10.1353/hpu.2013.0019
12. Cristancho S, Garces DM, Peters KE, Mueller BC. Listening to rural Hispanic immigrants in the Midwest: a community-based participatory assessment of major barriers to health care access and use. Qual Health Res. 2008;18(5):633-46. doi:10.1177/1049732308316669
13. De Alba I, Ngo-Metzger Q, Sweningson JM, Hubbell FA. Pap smear use in California: are we closing the racial/ethnic gap? Prev Med. 2005;40(6):747-55. doi:10.1016/j.ypmed.2004.09.018
14. Derose KP, Escarce JJ, Lurie N. Immigrants and health care: sources of vulnerability. Health Aff (Millwood). 2007;26(5):1258-68. doi:10.1377/hlthaff.26.5.1258
15. Gaskin DJ, Hoffman C. Racial and ethnic differences in preventable hospitalizations across 10 states. Med Care Res Rev. 2000;57(1 Suppl):85-107. doi:10.1177/1077558700057001S05
16. Haas JS, Phillips KA, Sonneborn D, McCulloch CE, Baker LC, Kaplan CP, Pérez-Stable EJ, Liang SY. Variation in access to health care for different racial/ethnic groups by the racial/ethnic composition of an individual's county of residence. Med Care. 2004;42(7):707-14. doi:10.1097/01.mlr.0000129906.95881.83
17. Park SY, Cho S, Park Y, Bernstein KS, Shin JK. Factors associated with mental health service utilization among Korean American immigrants. Community Ment Health J. 2013;49(6):765-73. doi:10.1007/s10597-013-9604-8
18. Lindsay AC, de Oliveira MG, Wallington SF, Greaney ML, Machado MMT, Pagliuca LMF, Arruda CAM. Access and utilization of healthcare services in Massachusetts, United States: a qualitative study of the perspectives and experiences of Brazilian-born immigrant women. BMC Health Serv Res. 2016;16(1): 467. doi:10.1186/s12913-016-1723-9

19. Meadows LM, Thurston WE, Melton C. Immigrant women's health. Soc Sci Med. 2001;52(9):1451-8. doi:10.1016/S0277-9536(00)00251-3
20. Jeong M, Jen S, Kang H, Riquino M, Goldberg J. Representations of older adults in COVID-related newspaper articles: a comparison between the perspectives of older and younger adults. J Aging Stud. 2022;63:101081. doi:10.1016/j.jaging.2022.101081
21. Budiman A, Ruiz NG. Key facts about Asian origin groups in the U.S. Washington (DC): Pew Research Center; 2021. https://www.pewresearch.org/short-reads/2021/04/29/key-facts-about-asian-origin-groups-in-the-u-s/
22. Jang SH. First-generation Korean immigrants' barriers to healthcare and their coping strategies in the US. Soc Sci Med. 2016;168:93-100. doi:10.1016/j.socscimed.2016.09.007
23. Yoon E, Lee DY, Koo YR, Yoo SK. A qualitative investigation of Korean immigrant women's lives. Couns Psychol. 2010;38(4):523-53. doi:10.1177/0011000009346993
24. Kim W, Kreps GL, Shin CN. The role of social support and social networks in health information–seeking behavior among Korean Americans: a qualitative study. Int J Equity Health. 2015;14(1):40. doi:10.1186/s12939-015-0169-8
25. Andersen RM. A behavioral model of families' use of health services. Chicago (IL): Center for Health Administration Studies, University of Chicago; 1968. https://www.cabidigitallibrary.org/doi/full/10.5555/19702701913
26. Babitsch B, Gohl D, von Lengerke T. Re-revisiting Andersen's Behavioral Model of Health Services Use: a systematic review of studies from 1998-2011. GMS Psychosoc Med. 2012;9:Doc11. doi:10.3205/psm000089
27. Choi S. A critical review of theoretical frameworks for health service use among older immigrants in the United States. Soc Theory Health. 2011;9(2):183-202. doi:10.1057/sth.2010.13
28. Choi S. Insurance status and health service utilization among newly-arrived older immigrants. J Immigr Minor Health. 2006;8(2):149-61. doi:10.1007/s10903-006-8523-3
29. Kuo T, Torres-Gil FM. Factors affecting utilization of health services and home- and community-based care programs by older Taiwanese in the United States. Res Aging. 2001;23(1):14-36. doi:10.1177/0164027501231002
30. Creswell JW. Qualitative inquiry and research design: choosing among five traditions. Thousand Oaks (CA): Sage Publications; 1998. https://books.google.co.in/books/about/Qualitative_Inquiry_and_Research_Design.html?hl=id&id=bjO2AAAAIAAJ&redir_esc=y
31. Malterud K. Qualitative research: standards, challenges and guidelines. Lancet. 2001;358(9280):483-488. doi:10.1016/S0140-6736(01)05627-6
32. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. Int J Qual Methods. 2017;16(1):1-13. doi:10.1177/1609406917733847
33. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101. doi:10.1191/1478088706qp063oa
34. Castañeda H, Holmes SM, Madrigal DS, Young MED, Beyeler N, Quesada J. Immigration as a social determinant of health. Annu Rev Public Health. 2015;36:375-92. doi:10.1146/annurev-publhealth-032013-182419
35. Guo M, Kim S, Dong X. Sense of filial obligation and caregiving burdens among Chinese immigrants in the United States. J Am Geriatr Soc. 2019;67(S3):S564-70. doi:10.1111/jgs.15735
36. Guo H, AlSwayied G, Frost R, Rait G, Burns F. Barriers and facilitators to health-care access by older Chinese migrants in high-income countries: a mixed-methods systematic review. Ageing Soc. 2025;45(7):1355-94. doi:10.1017/S0144686X24000242
37. Nguyen-Truong CKY, Wuestney K, Leung H, Chiu C, Park M, Chac C, Fritz RL. Toward sustaining web-based senior center programming accessibility with and for older adult immigrants: community-based participatory research cross-sectional study. Asian Pac Isl Nurs J. 2024;8:e49493. doi:10.2196/49493
38. Katigbak C, Foley M, Robert L, Hutchinson MK. Experiences and lessons learned in using community-based participatory research to recruit Asian American immigrant research participants. J Nurs Scholarsh. 2016;48(2):210-8. doi:10.1111/jnu.12194
39. Han HR, Chepkorir J, Kim T, Zamora M, Huang E. Perceptions, experiences and beliefs about patient portals among women with limited English proficiency: multicultural qualitative interview study. J Med Internet Res. 2025;27:e60699. doi:10.2196/60699
40. Huang A, Geracitano J, Coffel M, Seashore C, Khairat S. How limited English proficiency impacts patient engagement with telemedicine: a systematic review. npj Digit Med. 2025;8:717. doi:10.1038/s41746-025-02090-3

How to Cite: Jeong M. Healthcare Access Among Older Korean Immigrant Women. Int Res J Multidiscip Scope. 2026;7(3):892-905. DOI: 10.47857/irjms.2026.v07i03.010847