

Barriers to access to Primary Health Care Services: a scoping review of national and international literature

Barreiras de acesso aos serviços de Atenção Primária à Saúde: uma revisão de escopo da literatura nacional e internacional

Barreras de acceso a los Servicios de Atención Primaria de Salud: una revisión de alcance de la literatura nacional e internacional

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ABSTRACT

Primary Health Care (PHC) constitutes the structuring axis of equitable health systems with problem-solving capacity, serving as the main gateway to healthcare. However, barriers to access compromise its effectiveness in different contexts. This study conducted a scoping review aimed at mapping barriers to access to PHC services in the national and international literature. The methodological protocol followed the guidelines of the Joanna Briggs Institute and the PRISMA-ScR checklist, encompassing searches conducted on July 25, 2025, in the databases MEDLINE/PubMed, LILACS, SciELO, BDENF, Scopus, Web of Science, Embase, CINAHL, and Google Scholar, as well as gray literature. Studies addressing barriers related to individuals' or populations' access to PHC were included, with no restrictions regarding year of publication or language. Primary and secondary studies were accepted, whether empirical, qualitative, quantitative, or mixed methods, of any methodological design were accepted. It is noteworthy that studies conducted in specific territorial contexts, such as rural, riverside, and peripheral areas, were included, provided they focused on the general population. The synthesis of the 13 included studies revealed seven main categories of barriers: geographical, organizational, financial, structural, sociocultural, communicational, and relational. Difficulties related to transportation and distance, a shortage of professionals, underfunding, architectural barriers, costs, and gender inequalities stood out. Access to PHC is multidimensional and depends on integrated policies that articulate social determinants, intersectoral management, and the strengthening of continuing education, with the goal of achieving equitable, accessible, and PHC that coordinates care.

Keywords: Primary health care; Health services accessibility; Barriers to access of health services.

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RESUMO

A Atenção Primária à Saúde (APS) constitui o eixo estruturante de sistemas de saúde equitativos e resolutivos, sendo a principal porta de entrada do cuidado. Entretanto, barreiras de acesso comprometem sua efetividade em diferentes contextos. Este estudo realizou uma revisão de escopo com o objetivo de mapear as barreiras de acesso aos serviços de APS na literatura nacional e internacional. O protocolo metodológico seguiu as diretrizes do Joanna Briggs Institute e o *checklist* PRISMA-ScR, abrangendo buscas realizadas em 25 de julho de 2025 nas bases MEDLINE/PubMed, LILACS, SciELO, BDNF, Scopus, Web of Science, Embase, CINAHL e Google Scholar, além de literatura cinzenta. Foram incluídos estudos que abordaram barreiras relacionadas ao acesso de indivíduos ou populações à APS, sem restrição quanto ao ano de publicação ou idioma. Foram aceitas pesquisas primárias e secundárias, de caráter empírico, qualitativo, quantitativo ou de métodos mistos, de qualquer desenho metodológico. Ressalta-se que foram incluídos estudos realizados em contextos territoriais específicos, como áreas rurais, ribeirinhas e periféricas, desde que voltados à população geral. A síntese dos 13 estudos incluídos revelou sete categorias principais de barreiras: geográficas, organizacionais, financeiras, estruturais, socioculturais, comunicacionais e relacionais. Destacam-se dificuldades associadas ao transporte e à distância, escassez de profissionais, subfinanciamento, barreiras arquitetônicas, custos e desigualdades de gênero. O acesso à APS é multidimensional e depende de políticas integradas que articulem determinantes sociais, gestão intersectorial e fortalecimento da educação permanente, visando uma APS equitativa, acessível e coordenadora do cuidado.

Palavras-chave: Atenção primária à saúde; Acessibilidade aos serviços de saúde; Barreiras ao acesso aos cuidados de saúde.

RESUMEN

La Atención Primaria de Salud (APS) constituye el eje estructurante de sistemas de salud equitativos y resolutivos, siendo la principal puerta de entrada a la atención. Sin embargo, las barreras de acceso comprometen su efectividad en diferentes contextos. Este estudio realizó una revisión de alcance con el objetivo de mapear las barreras de acceso a los servicios de APS en la literatura nacional e internacional. El protocolo metodológico siguió las directrices del Joanna Briggs Institute (JBI) y la lista de verificación PRISMA-ScR, abarcando búsquedas realizadas el 25 de julio de 2025 en las bases de datos MEDLINE/PubMed, LILACS, SciELO, BDNF, Scopus, Web of Science, Embase, CINAHL y Google Scholar, además de literatura gris. Se incluyeron estudios que abordaron barreras relacionadas con el acceso de individuos o poblaciones a la APS, sin restricción de año de publicación o idioma. Se aceptaron investigaciones primarias y secundarias, de carácter empírico, cualitativas, cuantitativas o de métodos mixtos, y de cualquier diseño metodológico. Cabe destacar que se incluyeron estudios realizados en contextos territoriales específicos, como áreas rurales, ribereñas y periféricas, siempre que estuvieran dirigidos a la población general. La síntesis de los 13 estudios incluidos reveló siete categorías principales de barreras: geográficas, organizacionales, financieras, estructurales, socioculturales, comunicacionales y relacionales. Se destacaron las dificultades asociadas al transporte y la distancia, la escasez de profesionales, la insuficiencia de financiamiento, las barreras arquitectónicas, los costos y las desigualdades de género. El acceso a la APS es multidimensional y depende de políticas integradas que articulen los determinantes sociales, la gestión intersectorial y el fortalecimiento de la educación permanente, con el fin de garantizar una APS equitativa, accesible y coordinadora del cuidado.

Palabras clave: Atención primaria de salud; Accesibilidad a los servicios de salud; Barreras de acceso a los servicios de salud.

INTRODUCTION

Primary Health Care (PHC) is recognized as the cornerstone of equitable, effective, and cost-effective health systems, serving as the preferred point of entry and coordinator of care. Its classic attributes—first point of contact, longitudinality, comprehensiveness, problem-solving capacity, and coordination—are essential for connecting the population to services. However, the full realization of these attributes requires overcoming various barriers to access, which manifest in different ways across different contexts.^{1,2}

The Astana Declaration³ reaffirmed the global commitment to robust PHC, aimed at universal coverage and people-centered care, with a focus on the quality, availability, accessibility, and acceptability of services. However, essential and timely access to health care is still not a reality for more than half of the world's population,^{4,5} as recent reports have warned of setbacks or stagnation. This situation undermines the principles of equity and efficiency in health systems at the international level.

Conceptually, there has been significant progress: typologies have moved beyond an exclusive focus on supply⁶ now incorporating the dimensions of user capabilities (perceiving, seeking, reaching,

paying, engaging)⁷—the conceptual framework guiding this review for the analysis of barriers to access. This change is crucial, as it allows for analysis not only of the physical availability of services but also of the user's entire journey, from recognizing their need to obtaining appropriate and effective care.

In the Brazilian context, the 2017 National Primary Care Policy (PNAB, Política Nacional de Atenção Básica) reinforces the role of PHC in coordinating care and organizing the Health Care Networks. This entails well-defined responsibilities, such as ensuring timely access, user enrollment, and the comprehensiveness of care. Despite the progress made—notably driven by the Family Health Strategy—the national literature points to persistent challenges. Among these, the following stand out: regional inequalities in the distribution of health care teams, difficulties in coordination between levels of care, queues and wait times, transportation limitations and indirect costs, as well as symbolic and communication barriers, especially for vulnerable populations.⁸

International studies demonstrate the persistence of barriers to health care access, reflecting consistent patterns: accessibility remains the predominant reason for unmet needs;⁹ problems with geographic availability persist in rural areas and urban peripheries; organizational barriers (such as fragmentation, limited communication among professionals, and fragile referral/counter-referral networks) compromise the continuity of care; and barriers to acceptability, such as discrimination and cultural or linguistic diversity, affect minority groups, migrants, and the elderly. Even in universal systems, indirect costs, incompatible schedules, and low cultural responsiveness hinder both first contact and continued adherence.^{5,10}

Although widely recognized, barriers to access to PHC are still the subject of fragmented analyses in the literature. These analyses are often limited to specific contexts, isolated populations, or particular dimensions of access. There is, therefore, a scarcity of syntheses that, within a conceptual framework, are able to integrate national and international evidence. Such a synthesis would be capable of understanding access as a multidimensional phenomenon, linking both factors related to service provision and the population's capacities to access and utilize care.

In this context, this scoping review sought to map the barriers to access to PHC described in the national and international literature, organizing them into interrelated analytical dimensions. By bringing together evidence generated in different organizational and territorial contexts, this review builds upon previous syntheses by highlighting how barriers to access to PHC manifest differently in the settings of Family and Community Medicine (FCM). Unlike reviews that address access predominantly from a structural or administrative perspective, the present study shows that barriers to PHC are not limited to the availability of services but are also generated in the relationships established throughout the care process. In this context, longitudinality, the bond between professionals and users, and the care coordination provided by FCM teams emerge as central elements in promoting continuity of care, building trust in services, and reducing discontinuities in the care pathway.

METHODS

Study design

This is a scoping review, conducted based on the methodological framework developed by the Joanna Briggs Institute (JBI)¹¹ and the recommendations of the Preferred Reporting Items for Systematic Reviews

and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist.¹² The review was registered on the Open Science Framework platform (osf.io/wqd4p) with the DOI: 10.17605/OSF.IO/2XFN9.

The study was conducted in five steps, in accordance with the proposal by Arksey and O'Malley¹³ and the methodological update by JBI:¹¹

- identification of the research question;
- retrieval of relevant studies, ensuring breadth and comprehensiveness;
- selection of studies according to predefined inclusion and exclusion criteria;
- mapping and extraction of data;
- synthesis and presentation of results.

Data collection

The guiding research question was formulated based on the PCC mnemonic (Population, Concept, and Context), defined as follows: Population: users of health services/the general population; Concept: barriers to access (including those of a geographic, organizational, financial, structural, sociocultural, communicational, and relational nature); and Context: Primary Health Care. Thus, the research question was formulated as follows: "What are the barriers that hinder access to Primary Health Care services?"

The search strategy was developed with the assistance of a librarian specializing in the health field to ensure greater sensitivity and refinement of the subject headings and free-text terms used. The searches were conducted on July 25, 2025, in the following databases: Medical Literature Analysis and Retrieval System Online (MEDLINE) via PubMed, Latin American and Caribbean Health Sciences Literature (LILACS), Scientific Electronic Library Online (SciELO), Nursing Database (BDENF) via the Virtual Health Library (BVS), Scopus, Web of Science, Embase, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Google Scholar.

The search strategy was structured based on controlled descriptors from the Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH) vocabularies, in addition to the use of natural language and the Boolean operators AND and OR, in order to ensure greater coverage and retrieval of relevant studies. Chart 1 presents the definition of the PCC elements used in formulating the research question and the search strategy.

The search strategy was adapted to the specific indexing criteria of each database. The search terms were primarily in English, given the higher sensitivity of international databases; studies published in Portuguese, English, and Spanish were included. The supplementary search on Google Scholar employed a strategy similar to that used in the other databases. The first 100 results, sorted by relevance, were analyzed, considering the progressive decline in the relevance of the retrieved studies beyond the first few pages of the search engine. Additionally, a search for gray literature was conducted in institutional documents from the World Health Organization and the Brazilian Ministry of Health, but with no results. No manual search was performed in the reference lists of the included studies.

Selection criteria

The inclusion criteria were publications addressing barriers to access to PHC services, including barriers of a geographic, organizational, financial, structural, sociocultural, communicational, and relational nature, with no restrictions regarding year of publication or language. Primary and secondary

Chart 1. Definition and application of the elements according to the PCC mnemonic (Population, Concept, and Context).

Element	Definition	Application	DeCS/MeSH terms (controlled and alternative)
P – Population	Target group or context	Health care service users/General population/People	“service users” OR “general population” OR “people”
C – Concept	Phenomenon of interest	Barriers to access	“access barriers” OR “barriers to access” OR “health care access” OR “primary health care access” OR “geographic barriers” OR “economic barriers” OR “cultural barriers” OR “organizational barriers” OR “social barriers”
C – Context	Situation or service	Primary Health Care	“primary health care” OR “basic health care” OR “primary care” OR “family health”
Strategy Result	Final combination of descriptors	Structured search in the databases	(“access barriers” OR “barriers to access” OR “health care access” OR “primary health care access” OR “geographic barriers” OR “economic barriers” OR “cultural barriers” OR “organizational barriers” OR “social barriers”) AND (“primary health care” OR “basic health care” OR “primary care” OR “family health”) AND (“service users” OR “general population” OR “health needs”)

studies were accepted, whether empirical, qualitative, quantitative, or using mixed methods, regardless of methodological design. It is worth noting that studies conducted in specific territorial contexts—such as rural, riverside, and peripheral areas—were included, provided they focused on the general population.

Publications dealing exclusively with specific populations or vulnerable groups—such as indigenous peoples, migrants, and the homeless, among others—were excluded, since such groups face their own unique barriers, which impose specific limitations on the discussion of the findings within the scope of this review. Letters to the editor, editorials, incomplete articles, abstracts in conference proceedings, research protocols, or studies without results were also excluded.

After the search, the results were exported to the Rayyan® reference manager, developed by the Qatar Computing Research Institute, where two reviewers independently removed duplicates and selected and screened the studies. Disagreements were resolved with the involvement of a third researcher. The first phase involved reviewing titles and abstracts, and studies that met the inclusion criteria proceeded to the second phase, which involved reading the full texts.

The search process resulted in the identification of 4,911 records from the bibliographic databases, as well as additional studies retrieved from Google Scholar. After removing 1,304 duplicate records, 3,607 studies were screened by title and abstract, of which 3,572 were excluded for failing to meet the eligibility criteria. Thirty-five studies were selected for full-text reading, three of which could not be retrieved. Thus, 32 articles were assessed for eligibility, of which 19 were excluded for not addressing the review’s objective or for focusing on specific populations outside the established scope. In the end, 13 studies comprised the final sample of the review. Details of the selection process are presented in Figure 1.

Data analysis and processing

In step 4, data mapping and extraction were performed based on the JBI tool for scoping reviews, including data such as author, journal, country of origin, year of publication, objectives, methodological design, population/sample, study context, type of barrier reported, and main results. For data analysis and processing, Microsoft Excel® spreadsheets were used, in which two reviewers independently extracted the

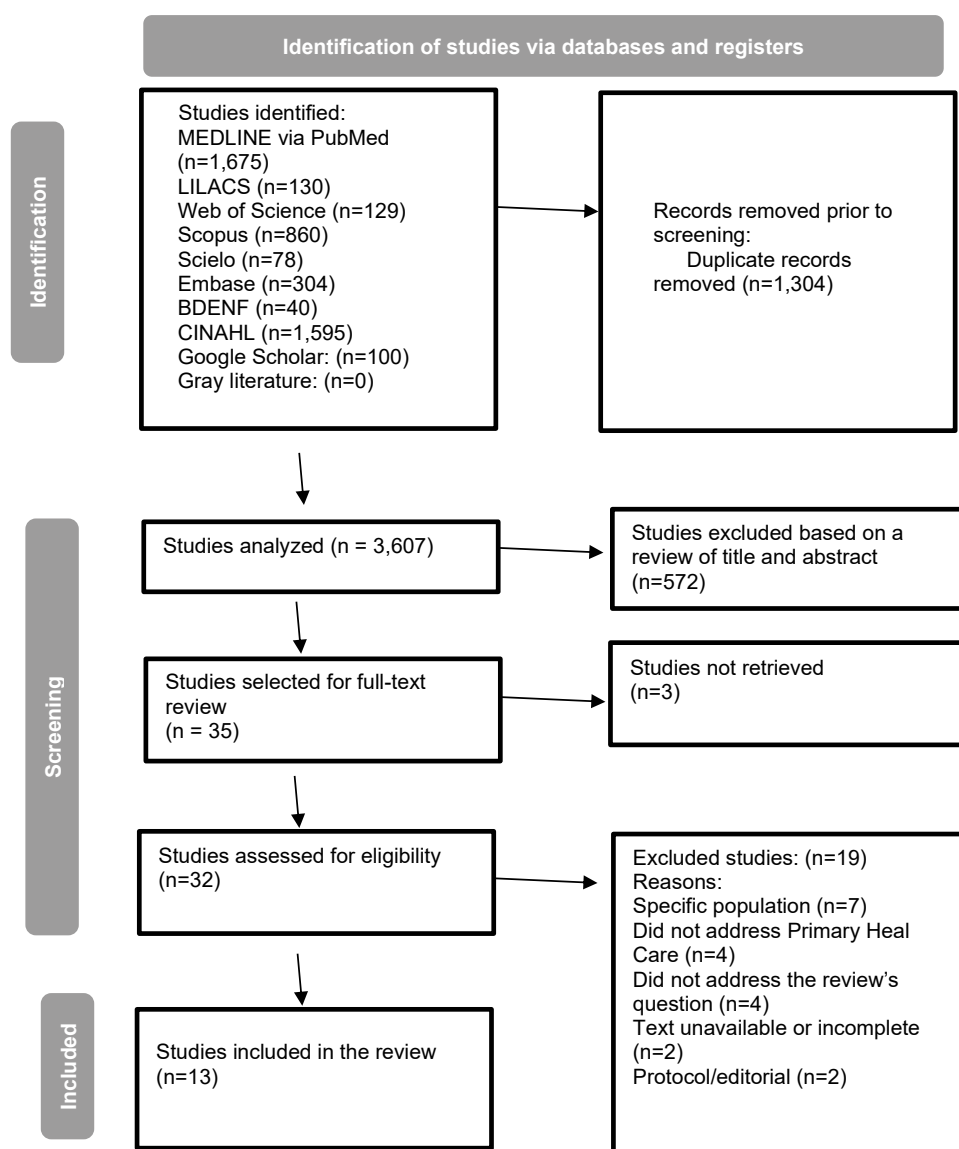


Figure 1. Article selection flowchart.

information, which was subsequently consolidated by a third reviewer. Divergences were discussed until consensus was reached among the authors.

As this is a scoping review, the study did not directly involve human participants and, therefore, did not require review by a Research Ethics Committee; however, the review data—such as search strategies, data extraction spreadsheets, and a list of studies excluded after full-text review—are available in the Supplementary Material.

The conceptual interpretation of access took into account its multidimensional nature and the structuring role of Primary Health Care in the organization and utilization of health services.^{14,15}

RESULTS

Thirteen studies published between 2013 and 2023 were included (Chart 2), with a predominance of research conducted in Brazil, as well as studies conducted in Canada, Pakistan, Nigeria, and

Chart 2. Characterization of the studies included in the scoping review on barriers to access to Primary Health Care.

Title	Authors	Journal / Year	Country	Objective	Study design and sample
Barreiras de acesso aos serviços em cinco Regiões de Saúde do Brasil: percepção de gestores e profissionais do Sistema Único de Saúde ¹⁶	Oliveira et al.	Cadernos de Saúde Pública / 2019	Canada	To explore the complex nature of transportation challenges faced by rural older adults in accessing Primary Health Care	Exploratory qualitative research (83 older adults)
The Complex Nature of Transportation as a Key Determinant of Health in Primary and Community Care Restructuring Initiatives in Rural Canada ¹⁷	Mirza e Hulko	Journal of Aging Studies / 2022	Brazil	To identify barriers to accessing Primary Health Care in a rural settlement from the perspectives of rural residents, health professionals, and managers	Qualitative study (16 participants)
Elementos que influenciam o acesso à atenção primária na perspectiva dos profissionais e dos usuários de uma rede de serviços de saúde do Recife ¹⁸	Lima et al.	Physis: Revista de Saúde Coletiva / 2015	Pakistan	To explore factors affecting access to Primary Health Care with a focus on gender	Cross-sectional study using secondary data (302 users)
Barreiras arquitetônicas e de comunicação no acesso à atenção básica em saúde no Brasil: uma análise a partir do primeiro Censo Nacional das Unidades Básicas de saúde ¹⁹	Santos et al.	Epidemiologia e Serviços de Saúde / 2020	Brazil	To analyze factors influencing access to Primary Health Care in Recife from the perspective of professionals and users	Case study with semi-structured interviews (46 informants)
Access, affordability, and insurance complexity are often worse in the United States compared to ten other countries ²⁰	Schoen et al.	Health Affairs / 2013	Brazil	To analyze access to primary care between 2012 and 2018, considering the availability, structure, and organization of Basic Healthcare Units	A descriptive, cross-sectional, and longitudinal study using data from the PMAQ-AB (15,378 teams; 59,354 users)
Acesso e cobertura da Atenção Primária à Saúde para populações rurais e urbanas na região norte do Brasil ²¹	Garnelo et al.	Saúde em Debate / 2018	Brazil	To analyze architectural and communication barriers in Basic Healthcare Units based on the 2012 Census	Cross-sectional study (38,812 Basic Healthcare Units in 5,511 municipalities)
Trajetórias assistenciais de usuáries pela APS em uma região de saúde: trânsito livre, pontos de lentidão e parada ²²	Galvão et al.	Physis: Revista de Saúde Coletiva / 2019	Brazil	To analyze access at a referral primary care clinic in the Belo Horizonte Metropolitan Area	A qualitative-descriptive study using interviews and questionnaires (15 professionals, 38 users)
Acesso, acessibilidade e demanda na estratégia saúde da família ²³	Chávez et al.	Escola Anna Nery / 2020	Brazil	To identify strategies and limitations of Primary Health Care in riverside communities	Qualitative and ethnographic research (users and professionals)

It continues...

Chart 2. Continuation.

Title	Authors	Journal / Year	Country	Objective	Study design and sample
Fatores que influenciam o acesso aos serviços de saúde na visão de profissionais e usuários de uma unidade básica de referência ²⁴	Viegas et al.	Saúde e Sociedade / 2015	Brazil	To analyze barriers to access in five health regions	Qualitative descriptive study (interviews with managers and professionals)
Como os brasileiros acessam a Atenção Básica em Saúde: evolução e adversidades no período recente (2012–2018) ²⁵	Sousa e Shimizu	Ciência & Saúde Coletiva / 2021	Brazil	To understand access and accessibility in the Family Health Strategy from the perspective of professionals and users	Grounded theory and symbolic interactionism (34 participants)
The long walk to universal health coverage: patterns of inequities in the use of primary healthcare services in Enugu, Southeast Nigeria ²⁶	Okoronkwo et al.	BMC Health Services Research / 2014	Brazil	To assess access to and organization of Primary Health Care using cervical cancer as a tracer	Qualitative evaluative study (26 care pathways)
Factors affecting access to primary health care services in Pakistan: a gender-based analysis ²⁷	Panezai et al.	Development in Practice / 2017	United States and ten countries	To highlight the vulnerability of the uninsured and the limits of coverage	Comparative survey of users in different countries
Barreiras de acessibilidade à atenção básica em assentamento em Pernambuco, Brasil, sob a ótica de camponesas, profissionais de saúde e gestão ²⁸	Ó et al.	Cadernos de Saúde Pública / 2022	Nigeria	To analyze inequalities in the use of Primary Health Care services toward universal health coverage	Cross-sectional study (385 adult users)

multicenter studies involving different countries. A predominance of qualitative, descriptive, and cross-sectional study designs was observed, conducted in diverse territorial and organizational contexts of PHC, including rural, riverside, and peripheral areas, as well as universal or mixed health systems.

The Chart 3 summarizes the analyzed articles, organizing the main barriers identified, their types, and the respective conclusions. The studies highlight barriers of a geographic, organizational, financial, structural, sociocultural, communicational, and relational nature, related to factors such as transportation, distance, shortage of health professionals, structural inadequacies, direct and indirect costs, cultural aspects, and gender inequalities.

These categories were interpreted in light of the conceptual model of access adopted in this review, which views access as the result of the interaction between dimensions of health service supply and the population's capacities to recognize the need for care, seek out services, reach them, afford the associated costs, and engage in the therapeutic process. Thus, the findings show that barriers to access to PHC operate in an interdependent and multidimensional manner.

The analysis of the studies was conducted using a combined analytical strategy, integrating deductive and inductive approaches. Initially, the conceptual model of access adopted in the review was used as a theoretical framework to guide the interpretation of the findings. Subsequently, the categories

Chart 3. Summary of the main barriers to access to Primary Health Care identified in the included studies.

Main Barriers	Type of barrier	Conclusions
Transportation and mobility	Geographic and social	Transportation is a social determinant of health in rural and urban areas
Inadequate transportation, distance, shortage of health care professionals, poor infrastructure, high demand	Geographic, organizational, and financial	Need for intersectoral coordination and strengthening of continuing education
Distance, transportation, staff availability, income, schedule, gender	Organizational, financial, and sociocultural	Women have greater access, but gender barriers and limited resources restrict overall access
Underfunding, lack of supplies, shortage of doctors, wait times, few home visits	Structural, organizational, and relational	Underfunding creates interrelated structural and organizational barriers
Physical infrastructure, architectural barriers, reception, hours of operation	Structural and organizational	Improvements have been made, but inequalities and recurring problems persist
Architectural and communication barriers for the elderly, people with disabilities, and the illiterate	Structural and communicational	The need to adapt Basic Healthcare Units to reduce inequalities
Lack of resources, difficulty scheduling appointments, shortage of doctors, cultural barriers	Financial, organizational, and relational	Access is multidimensional; the relational dimension is crucial
River transportation, distance, inadequate organization of Fluvial Mobile Health Units	Geographic and organizational	Urban model replicated in rural area does not address the specificities
Transportation, travel time, shortage of doctors, waiting lists, undefined patient flows	Geographic and organizational	Barriers vary by region, but a shortage of doctors is a recurring issue
High demand, low problem-solving capacity, shortage of professionals, curative approach	Organizational and structural	The Family Health Strategy remains focused on curative care, with insufficient resources
Access to medications, diagnostic tests, health education, and poor coordination	Organizational and structural	Selective, fragmented Primary Health Care, with gaps in care integration and coordination
High costs, difficulties with insurance, discontinuation of care	Financial and organizational	Having insurance does not guarantee access; costs and bureaucracy are major barriers
Inequality of access, financial and organizational barriers	Organizational and financial	Need for system reform to achieve Universal Health Coverage

of barriers were refined and organized based on an analytical reading of the included studies, allowing for the identification of recurring dimensions related to access to PHC.

Organizational barriers were the most common among the included studies, appearing in various national and international contexts and associated with a shortage of professionals, high demand, difficulties in scheduling appointments, low problem-solving capacity, and weaknesses in care pathways. These findings indicate significant limitations in the attributes of first contact, longitudinality, and coordination of PHC, especially in services characterized by underfunding, fragmented care, and an approach centered on curative needs. Brazilian studies conducted in rural settlements, health regions, and riverside communities have shown that the shortage of physicians, waiting lists, and poor integration between levels of care compromise continuity of care and exacerbate territorial inequalities in access.

Geographic barriers have also proven to be central, particularly in rural, riverside, and urban peripheral areas, where poor transportation, long distances, and travel time hinder physical access to

health services. In these contexts, geographic access was found to be directly related to users' ability to obtain care, highlighting that the mere existence of PHC facilities does not guarantee effective use of services. Financial barriers, on the other hand, were more evident in studies conducted in Nigeria and the United States, where costs associated with consultations, medications, insurance, and travel limited the ability to pay and led to the abandonment or postponement of care, even in health systems with formal health coverage. At the same time, sociocultural, communicational, and relational barriers—such as discrimination, cultural mismatches, architectural barriers, and communication difficulties with older adults and illiterate individuals—compromised attributes related to user acceptability, rapport, and engagement, demonstrating that access to PHC involves dimensions that go beyond the physical and organizational availability of services.

DISCUSSION

In contrast to reviews focused on specific barriers or isolated national contexts, this study integrated evidence from diverse health systems, revealing the interdependence and cumulative effect of barriers to access. Organizing the findings into geographic, organizational, financial, structural, sociocultural, communicational, and relational dimensions made it possible to map how territorial, institutional, and social factors combine to generate inequities in access to PHC. Furthermore, the results highlight that territory transcends its role as a mere space for service delivery, acting as a factor that exacerbates inequalities in access, particularly in socially vulnerable regions, such as urban peripheries and rural areas.

Although PHC is internationally recognized as the most equitable and cost-effective level of care for improving the population's health,^{14,15} the findings of this review demonstrate that effective access remains constrained by multiple structural, organizational, and socioterritorial factors that go beyond the mere physical availability of services. Among the most common barriers identified in the included studies are those of an organizational and geographic nature, particularly related to the shortage of health care professionals, clinical overload, long wait times, weaknesses in referral and counter-referral systems, transportation difficulties, and limitations in transportation infrastructure. In this sense, the findings align with contemporary frameworks that expand the classical notion of access beyond initial entry into the system, understanding it as a continuous, dynamic process shaped by social and territorial inequalities.^{6,7}

Geographic barriers have proven to be particularly relevant in studies conducted in rural, riverside, and urban peripheral areas, which highlights the direct influence of the spatial distribution of services on the effective use of PHC. Studies conducted in Canada, Brazil, and Pakistan have shown that physical distance, poor transportation, and travel time act as persistent obstacles even in systems with formally established coverage.^{17,21,27} These findings align with the international literature discussing the production of health inequalities stemming from the territorial organization of services and the unequal concentration of health infrastructure.^{16,17}

The studies analyzed go beyond the geographical boundaries of a territory, demonstrating that space is a factor in access or exclusion. This is because users' actual capacity to reach services is shaped by factors such as mobility conditions, population density, and urban organization. This spatial dimension has direct implications for PHC and FCM, particularly affecting the first-contact attribute and highlighting the need for territorial planning that is sensitive to local specificities.

In contrast, in urban contexts, the studies analyzed highlighted the predominance of organizational barriers. These include high demand, insufficient number of professionals, low problem-solving capacity, restricted operating hours, and weaknesses in care coordination.^{18,22-25} These findings suggest that the mere quantitative expansion of PHC alone is not sufficient to guarantee timely access and continuity of care, especially when limitations in the organizational capacity of both teams and care networks persist.

Brazilian studies have shown that factors such as long waiting lists, difficulty in scheduling appointments, and high staff turnover compromise essential attributes of PHC, such as longitudinality, coordination, and comprehensiveness of care.^{18,22,24,25} In line with international studies,^{20,26,27} the results of this review indicate that chronically underfunded health systems tend to lead to fragmented care and low organizational responsiveness. This scenario limits the role of PHC as the coordinator of care networks. Therefore, the discussion on access to health care must inherently consider working conditions, service management, and the sustainability of funding for primary care models.

Financial barriers were found to be less common in studies conducted in well-established universal health care systems; however, they remained significant even in these settings, particularly when associated with indirect costs, such as transportation, medications, and loss of income resulting from travel or waiting times.^{20,26,29} In countries with partial coverage or insurance-dependent models, such barriers were central and linked to the postponement or abandonment of care.

These findings confirm previous studies indicating that formal health coverage does not necessarily guarantee effective access.²⁰ Furthermore, they highlight that the ability to pay is a dimension intrinsically linked to social and economic inequalities, directly affecting treatment continuity and the regular use of PHC. For FCM, this scenario reinforces the need for equity-oriented practices capable of recognizing how economic vulnerabilities impact adherence to care and users' daily experiences with services.

The studies also highlighted the presence of sociocultural, communicational, and relational barriers associated with low health literacy, communication difficulties, cultural mismatches in services, discrimination, and a weak bond between users and health care teams.^{7,19,23,27,28} Although described less frequently than organizational and geographic barriers, these dimensions proved to be particularly relevant because they influence the acceptability of care and users' engagement in therapeutic processes. Studies involving rural populations, older adults, people with disabilities, and culturally specific communities have demonstrated that communication gaps and a lack of cultural sensitivity can reduce trust in services and limit the recognition of PHC as a legitimate setting for care.^{17,19,21,28} These findings emphasize that access goes beyond the mere physical presence of services, encompassing subjective and relational aspects essential for building rapport, skilled listening, and recognition of the sociocultural specificities of the territories.

Another recurring aspect identified in the studies relates to structural and systemic barriers associated with the fragmentation of care networks, insufficient human resources, and weak coordination between levels of care.^{18,22,24,25} The analyzed studies indicate that such limitations directly compromise essential attributes of PHC, particularly care coordination, comprehensiveness, and therapeutic continuity. Rather than functioning as an effective entry point to the system, some units proved incapable of ensuring longitudinal follow-up or effective integration with specialized services. These findings align with contemporary debates on the crisis of coordination in health systems and reinforce the need to strengthen care networks.^{18,22,25} However, the included studies suggest that fragmentation does not stem exclusively

from structural inadequacies but also from organizational models that are poorly integrated with territorial needs and the actual pathways of users within the system.

An integrated analysis of the studies identified three central mechanisms related to the persistence of barriers to access to PHC. The first refers to the mismatch between service organization and the population's socioterritorial needs, particularly evident in rural and peripheral areas and in regions with higher social vulnerability. The second relates to the weakness of intersectoral policies, which limits effective responses to determinants external to the health sector, such as urban mobility, social protection, and territorial infrastructure. The third mechanism concerns the predominance of fragmented and narrowly focused responses, which are often unable to simultaneously address the organizational, economic, cultural, and territorial dimensions of access.^{7,16,21,25,30} The findings of the review therefore indicate that strategies focused solely on expanding the physical supply of services tend to have limited impact when separated from interventions aimed at demand, community participation, and strengthening users' capacity to interact with health systems.^{7,16,21,25,30}

The synthesized evidence offers important insights for managers, professionals, and researchers in PHC and FCM by demonstrating that barriers to access vary according to territorial context, service organization, and the institutional capacity of local health systems. In rural and remote areas, studies suggest that policies focused exclusively on the physical expansion of health facilities prove insufficient without complementary mechanisms for medical transportation, telehealth, and strategies to retain health care professionals.^{17,21,32,33} In urban contexts, in turn, the findings point to the need to reorganize care pathways, expand the problem-solving capacity of teams, and strengthen care coordination.^{18,22,24,25} Furthermore, the review highlights that culturally sensitive practices, accessible communication, and strengthening the professional-client relationship are fundamental dimensions for enhancing acceptability and engagement in care, especially in areas marked by social vulnerabilities and historical inequalities.

Although this study followed established methodological guidelines for scoping reviews, certain limitations must be considered when interpreting the findings. First, it is worth noting the small number of studies included relative to the breadth of the search conducted, which may reflect both the specificity of the eligibility criteria and the conceptual heterogeneity present in the literature on access to PHC. Furthermore, the analyzed studies exhibit significant diversity in territorial contexts, countries, and methodological designs, making direct comparisons difficult and limiting the generalizability of the proposed analytical categories. The supplementary search on Google Scholar was restricted to the first 100 results sorted by relevance, a strategy adopted due to the high dispersion and redundancy of the retrieved records, though this may have resulted in the omission of potentially relevant studies. Additionally, no critical assessment of the methodological quality of the included studies was conducted, since scoping reviews are primarily intended to map available evidence and identify knowledge gaps, rather than to produce syntheses of effectiveness or clinical recommendations.

These limitations, however, also highlight important gaps for future research. Of particular note is the need for studies capable of evaluating integrated interventions that simultaneously address the structural, organizational, and sociocultural dimensions of access, especially in contexts of greater social vulnerability. Comparative investigations between universal and non-universal systems are also relevant, with the potential to deepen our understanding of the relationships between financing, the organization of PHC, and equity in access.

FINAL CONSIDERATIONS

This scoping review demonstrated that access to PHC is a multidimensional phenomenon, conditioned not only by the formal availability of services but also by the interaction between territorial conditions, the organization of health systems, socioeconomic inequalities, and users' abilities to recognize, seek, access, pay for, and engage in care. The findings demonstrate that barriers to access operate in an interdependent and contextually modulated manner, taking on distinct forms depending on the organizational, socioterritorial, and structural characteristics of local health systems.

The synthesis of national and international evidence has revealed that the persistence of barriers to access is primarily related to the weak alignment between service provision and the concrete needs of the territories, the insufficiency of intersectoral responses, and the continued existence of fragmented organizational models that are unresponsive to the social and cultural particularities of the population. In this sense, the review broadens the understanding of access beyond the physical-geographic dimension, incorporating relational, communicational, economic, and organizational aspects that directly influence continuity, comprehensiveness, and problem-solving capacity of care in PHC.

As an original contribution to PHC and FCM, the study highlights that strategies focused exclusively on expanding care coverage are insufficient to ensure timely, equitable, and effective access. The review demonstrates the need to strengthen essential attributes of FCM, such as care coordination, longitudinal relationships, effective communication, and community-oriented care, linked to territorial planning and the reduction of social and spatial health inequalities. Furthermore, it offers an analytical model that integrates structural, institutional, and relational barriers to access, providing theoretical and operational insights for managers, professionals, and researchers interested in reorganizing local health systems guided by the principles of PHC.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

ADCB: Conceptualization, Data Curation, Formal Analysis, Investigation, Methodology, Project Administration, Visualization, Writing – Original Draft, Writing – Review & Editing. LMSS: Conceptualization, Methodology, Supervision, Validation, Writing – Review & Editing. ACT: Data Curation, Investigation, Formal Analysis, Validation, Writing – Review & Editing. CJCR: Data Curation, Investigation, Formal Analysis, Validation, Writing – Review & Editing. RVC: Data Curation, Investigation, Validation, Writing – Review & Editing. BDQ: Data Curation, Investigation, Validation, Writing – Review & Editing. CAD: Data Curation, Investigation, Validation, Writing – Review & Editing.

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