



BMJ Open General practitioners' perspectives on the management of refugee health: a qualitative study

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ABSTRACT

Objective To explore general practitioners' (GPs) perceptions of the challenges and facilitators to managing refugee healthcare needs in regional Australia.

Setting A regional community in Australia involved in the resettlement of refugees.

Participants Nine GPs from five practices in the region.

Design A qualitative study based on semistructured interviews conducted between September and November 2020.

Results The main challenges identified surrounded language and communication difficulties, cultural differences and health literacy and regional workforce shortages. The main facilitators were clinical and community supports, including refugee health nurses and trauma counselling services. Personal benefits experienced by GPs such as positive relationships, satisfaction and broadening scope of practice further facilitated ongoing healthcare provision.

Conclusions Overall, GPs were generally positive about providing care to refugees. However, significant challenges were expressed, particularly surrounding language, culture and resources. These barriers were compounded by the regional location. This highlights the need for preplanning and consultation with healthcare providers in the community both prior to and during the settlement of refugees as well as ongoing support proportional to the increase in settlement numbers.

INTRODUCTION

Currently, more than 89 million people have been forcibly displaced across the globe because of persecution, conflict, violence and human right violations: the highest number since the aftermath of World War II.¹ In 2018–2019, 18 750 positions were allocation for these displaced persons to be resettled in Australia under the Humanitarian Settlement Program.² The same target was set for 2019–2020; however, due to the COVID-19 pandemic, offshore Humanitarian Visas were suspended on 19 March 2020. For 2018–2019, 58% of applications were from persons in the Middle East, 26.2% from Asia and 14.9% from Africa. These proportions were similar for applicants in 2019–2020 and 2020–2021.^{3,4} While most refugees resettle in metropolitan areas, a growing

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ A first in qualitative research investigating care for refugees newly resettled in regional and rural in Australia, leading to important implications for current and future planning and policies in regional resettlement.
- ⇒ One of few studies exploring the provision of refugee healthcare through an integrated general practitioner (GP)-led model.
- ⇒ Semistructured interview allowed for exploration of challenges, benefits and supports to refugee healthcare in regional and rural settings from the perspective of the healthcare providers.
- ⇒ Sample size was small, given the small number of GPs working in the catchment area that provide care to refugees.
- ⇒ Study community provides healthcare to primarily only one ethnic group of refugees.

number are being encouraged to reside in regional areas to achieve the pre-COVID goal of 50% regional resettlement by mid-2022.⁵ In 2019–2020, the proportion of regionally settled humanitarian entrants increased from 36.8% in 2018–2019 to 38.9%.⁶ Internationally, countries such as Canada,⁷ USA,⁸ Germany,⁹ Belgium, Italy, the Netherlands and Sweden¹⁰ are also attempting resettlement in rural areas. Doing so has the potential to increase regional economic growth, reduce labour shortages and diversify local culture.^{11–13} This potential is enhanced, especially during initial resettlement, by whole-of-community policies and integrative service models. Given that refugees are at a higher risk of poor mental and physical health compared with the general population,^{14–17} healthcare is essential for facilitating positive outcomes with need for 'access to appropriately funded primary healthcare' and ongoing service model evaluations.^{10 18 19}

Within Australia, general practitioners (GPs) provide the majority of primary healthcare service outside of the hospital networks, which includes managing certain health presentations as well as coordinating further healthcare

provision and specialist services. Workforce capacity limits the extent to which GPs can meet the healthcare needs of refugees and other community members. This is particularly true for regional communities that tend to have fewer generalist and specialist services than metropolitan areas.²⁰ This variable mix of services necessitates place-based differences in resettlement models.¹¹ For instance, refugee healthcare in metropolitan areas is often hospital based particularly during the initial resettlement period; however, capacity issues have meant that some regional resettlement sites are relying on GP-led models of care. Despite this, there has been limited study of clinicians' experiences managing refugees' needs in regional general practice. Those that have, have found that the ability to communicate effectively via interpreter services,^{21 22} limited local workforce capacity and refugees' health literacy^{23 24} are key challenges to managing these patients who often have complex presentations that require longer consultations, which, in some instances, clinicians are not sufficiently remunerated for.^{19 20 25} Consistent with these barriers, additional clinical supports including access to interpreters, funded practice nurses and cultural training^{11 18} as well as the altruism of clinicians and local volunteers²³ have each been found to support the management of refugees in general practice. The limited available data on GPs' perceptions of the barriers and enablers of managing refugee health in regional Australia indicates that additional studies are needed.

Given the direct impact of the Australian federal government's regional resettlement policy on the health of refugees and regional workforce capacity, and the limited research on the impact of this policy on clinicians, this study aims to examine GPs' experiences and perceptions of managing refugee health in regional Australia. Results have the potential to inform public policies on resource allocation, how and when planners engage local providers and use these experiences to refine regional policies both in Australia and internationally with increasing numbers of countries developing rural resettlement strategies.¹⁰

METHODS

Sample

GPs were recruited via a GP professional network in regional Australia. The study community was located 330 km (4.5-hour drive) from the nearest metropolitan tertiary hospital, had a population of 29 000,²⁶ and approximately 30 GPs among nine practices with few specialists. Since being selected as a regional settlement area in 2017, the community had accepted a large proportion of refugees, totalling 2.5% of the population in 2019,²⁷ the majority of whom were resettled from the Middle East. This community had established a GP-led model of healthcare service provision to refugees that was based within general practices. This involved the refugees being initially assessed by a local health district-based refugee health nurse. The nurse then allocated patients (usually in family groupings) to participating general practices. Once the practices accepted the refugee family group,

the GPs undertook a comprehensive refugee health assessment within the practice and provided ongoing medical care to that family.

Recruitment

All GPs practising in the study community were emailed an invitation to participate, followed by two reminder emails. The intention of the sampling strategy was to interview a GP from each of the general practices within the study community, in order to include practices that did and did not manage refugee patients.

Semistructured interviews

After receiving the participant information sheet and providing their informed consent, one researcher (RD) conducted all semistructured interviews of approximately 45 min duration via Zoom with both video and audio (due to COVID-19-related social distancing requirements) between September and November 2020. These interviews took place approximately 2 years after regional resettlement of refugees in the area. Interview questions and subquestions were informed by a literature review of previous research and focused on: (1) the challenges, (2) the benefits, (3) available supports for managing refugees in general practice in regional areas and (4) whether refugees' healthcare needs have changed relative to the needs of the receiving community during COVID-19 (see online supplemental file). The interview was then piloted on two GPs, not included in the final analysis, who had seen refugees in their practice and finalised according to feedback given. Participants received no compensation for their time. The audio of each interview was recorded and transcribed using NVIVO's artificial intelligence transcription service. One researcher (MH) reviewed each transcription with the original audio files and amended the transcript where necessary.

Analysis

Data were analysed using the six step thematic analysis methodology described by Braun and Clarke.²⁸ A deductive approach based on the literature and an inductive approach for arising themes were undertaken. Two researchers (RD and MG) undertook data familiarisation and generated initial codes and themes independently. The researchers then met to review, define and name all themes before analysing the remaining data using the agreed approach. All arising themes were reported. Agreement was arrived at through discussion and consensus, and any disagreements were resolved by discussion with another researcher (MH). NVivo V.12 was used during the coding process and conducting the thematic analyses. This study was approved by the relevant human research ethics committee (HE20-131).

Patient and public involvement

Patients or the public were not involved in the design, or conduct, or reporting or dissemination plans of our research.

RESULTS

Participants

Recruitment emails were sent to 31 GPs at the nine different practices of the region. Seven practices managed refugee patients, and two did not. No GPs from the two practices who did not see refugees responded to the invitation to participate. Nine GPs from five of the practices who accepted refugees participated in this study and detailed their perceptions about providing healthcare to refugees in regional Australia. Of these, 7/9 were women, had a median age of 51 years (IQR=42–57), had been practising for 21 years (IQR=18–32). 5/9 reported consulting with refugee patients on a daily basis, 3/9 saw two to four refugee patients per week with the remaining participant reporting that they saw one to two refugee patients per month.

GPs' perceptions of managing refugee health in regional Australia

The following key themes emerged from the semistructured interviews.

Challenges

Ability to communicate with patients

All participants agreed that communication posed the most significant challenge to providing healthcare to their refugee patients particularly during the early months of resettlement. There was also general consensus about the structural barriers to being able to communicate with their patients. These included: there being a very limited number of telephone interpreter service (TIS) interpreters qualified to work with this patient group Australia wide; and that at times, the interpreter spoke a different dialect to the patient. Several participants also reported that scheduling each call posed challenges. These communication challenges were particularly difficult for sensitive health issues including sexual and mental health concerns. Due to these difficulties, significantly more time was needed for consultations. As a way of reducing these communication barriers, patients' family members and community volunteers helped 'bridge the gap' particularly as the younger refugee family members' English-language skills improved over time. However, GPs identified that using family members to interpret posed issues of confidentiality.

Cultural factors

Cultural training

Cultural differences and lack of cultural familiarity were significant challenges identified by all GPs. Sensitivities surrounding gender, lack of health literacy and system familiarity of the refugees were key issues. Most of the GPs stated that they were unfamiliar with the culture and worldview of the refugee community, having received minimal education about this prior to their arrival. A desire to learn more about their culture was expressed; either out of curiosity, a desire to build greater relationships or to

increase confidence in the ability to provide adequate care.

Women preferring female doctors and interpreters

It was evident in a majority of GP experiences that within the refugee culture, there were strong gender preferences for treatment. In particular, women would prefer to see a female doctor, which extended to preferences for a female translator. This presented challenges due to the lack of available female doctors, specialists and translators. The lack of female specialists for areas of medicine such as gynaecology presented the additional challenge of travelling to out-of-area practices where female gynaecologists were available.

Lack of health literacy and healthcare familiarity

There was reported to be a lack of health literacy on diagnosed medical conditions, human physiology and the use of long-term medication, among the refugees. Additionally, a number of GPs noted that refugees had difficulties navigating the Australian healthcare system and had differing expectations of what care they would receive. For instance, some patients reportedly lacked an understanding of the role of a GP, which resulted in non-urgent presentations to the emergency department as well as coming to GPs for non-medical issues such as housing and job application paperwork, resulting in time spent educating the refugee patients. A lack of familiarity in the process and purpose of booking and attending appointments was also a challenge, including patients not booking appointments or not attending appointments that were booked. Understanding of the system surrounding allied health and specialists was also limited. There was a sense that the refugees had high expectations of GPs and other specialists, and what services they could provide in regional centres. However, several GPs reported that some of their patients contrastingly had low expectations for treatment. This lack of familiarity with the healthcare system meant that GPs in addition to providing healthcare were also educating refugees how to navigate the system requiring significant time commitments.

Sufficient workforce capacity and resources

Limited number of GPs in the area

Workforce capacity is constrained in rural and regional areas of Australia and GPs identified this as a major challenge. This encompassed the lack of, or strain on, resources including: GP workforce capacity; costs and time and usefulness, coordination and access of additional services. The lack of GPs and GP registrars to accommodate the number of refugees being settled was difficult, particularly due to the rurality of the settlement location and the large number of refugees settled beyond what was expected. The saturation of GP workforce led to some refugees being unable to access GPs at all because of concern that this might limit treatment availability for the rest of the community.

Time and financial costs to practices

Refugee consultations were reportedly longer in length, due to language translation and health literacy/system familiarity barriers. This resulted in longer wait lists for refugee patients. Many of the GPs were giving extra time outside of consultation hours. Managing refugee patients had significant financial costs to local practices due to lost income. However, GPs indicated that this would stop not stop them from managing this patient population.

Service integration

Lack of local specialists meant that co-ordinating treatment was difficult across healthcare sectors and services. Logistical issues related to available transport and travel times were common. As a result, there was a general desire for more specialty resources distributed locally.

Government-provided services

Additional government-funded services were provided for refugees' healthcare. GPs assumed that these services included the provision of caseworkers who would assist refugees booking and attending appointments. However, GPs instead found that caseworkers would only be able to attend one or two initial appointments with the refugees and did not seem to offer much healthcare support beyond this. GPs concluded that this level of support was inadequate and that communication with service coordinators was insufficient, especially during early settlement.

Complex mental health issues

Refugee trauma and somatisation

While managing the refugee patients' physical health was not particularly complex or difficult in comparison to the general population, trauma was a major healthcare challenge. Cultural differences and language barriers further complicated treating these issues. For example, many GPs experienced hesitancy from the refugees to disclose trauma and a resistance to counselling, accompanied by a lack of acknowledgement and education of psychological health. Somatic symptoms particularly chronic pain were frequently refugees' presenting complaint(s). In addition to traumatic histories, GPs found that the psychological health of the refugees was exacerbated by ongoing stressors such as separation from family members and the difficulties of integrating into a new society.

Mental health support for GPs

The vicarious trauma experienced by GPs when consulting patients disclosing their personal experiences of torture and trauma led some GPs feeling overwhelmed and burnt out. A need for support for GPs was highlighted by participants.

These challenges to refugee healthcare provision as experienced by GPs are summarised in [table 1](#).

Clinical and community support systems

Clinical supports

Refugee health nurses were a valued part of healthcare provision and considered a key component of the success

of the GP-led model of care. The refugee health nurses co-ordinated intake procedures with the local practices, conducted some initial health assessments, provided additional medical histories gleaned from home visits and provided the GPs with a local point of contact, advice and cultural education. However, GPs reported that the number of refugee health nurses did not increase proportionate to the increasing number of refugees settling in the community. This created a large workload for the nurses. Due to the complex mental health conditions of the refugee population, access to trauma counsellors was also fundamental to patient care. Consistent with their discussion of language being the primary challenge to providing care, GPs agreed that access to face-to-face interpreters improved their ability to manage the needs of refugees. The employment of refugee community members as receptionists within the practice also improved the challenges associated with lack of understanding of the healthcare system.

While noting concerns about not understanding the refugees' culture well, most of the GPs agreed that the cultural awareness training that had been offered was well received, but more was needed. GPs particularly found training on post-traumatic stress disorder and trauma very useful; however, they all mentioned a desire for more cultural awareness and mental health training. Cultural competence was also stated to have improved with time.

Community supports

GPs also agreed that the support provided by the wider community had facilitated care, with community members assisting the refugees to access appointments and explain the healthcare system. Additionally, the refugee community itself had become a facilitator over time, with more established families assisting newer arrivals with navigating the health system and translation.

GP perspectives on clinical and community supports facilitating healthcare service provision to rural refugees are summarised in [table 2](#).

Benefits of refugee resettlement in regional areas

Participants reflected on the benefits of the resettlement programme to the broader community and on the personal and professional benefits of treating refugee patients.

Personal benefits to GPs

Positive relationships with refugee patients were perceived as very beneficial, and patients were described as grateful, friendly and generous. These relationships led to a rapport and continuity of care that facilitated longer term healthcare to refugees. Broadening their cultural awareness and increasing their knowledge and skills by a changing scope of practice was also perceived as a benefit of managing refugee patients. GPs expressed a sense of satisfaction in their experience of refugee healthcare provision, through both overcoming challenges,

Table 1 GP quotes: challenges to rural refugee healthcare provision

Communication barriers	
Language difficulties	'it's probably some of the most difficult medicine I've ever been involved with, and that's mainly because of the language barrier' (P5) 'Language is the biggest barrier' (P11)
Translator service difficulties	'Initially, it was very difficult because the translating services only had [limited] translators on their books'. (P3) 'And there's also the time. You ask a question, the translator asks them, they respond to the translator... it's double handling each way'. (P3) 'it really detracts from a consultation having to talk through a phone' (P4)
Use of family members	'we're just aware of some of the potential conflicts of interest with confidentiality with using people from the local community in-person in the practice'. (P6)
Cultural challenges	
Cultural familiarity	'I didn't feel well equipped as a healthcare provider with my understanding of the people'. (P6)
Gender preferences	'the females have a preference for female practitioners and the males, for male practitioners' (P1) 'I see lots of female patients and they often have a strong preference for having a female interpreter and that's not always possible'. (P4)
Lack of health literacy	'So there's a language barrier, there's a cultural barrier and then there's also just a knowledge barrier'. (P4) 'We've had issues with a low level of health literacy amongst the [refugee] population, which we... didn't really know how to try and work with until we were confronted with it'. (P6) 'they have a quite a different understanding of illness and disease' (P8)
Workforce capacity	
Lack of GPs	'The shortage of GPs in rural areas has been a major issue. I think the general practice community here has gone above and beyond to bring these patients into their practice at a time when there are critical workforce shortages of GPs'. (P6)
Lack of specialists	'we have issues with giving them specialists... the distance, the logistics, it's just harder here'. (P9)
Increased time	'also, the amount of time that it takes to suitably care for a refugee patient. It's typically two, if not three times the amount of time that's required to provide similar care to other non-refugee patients'. (P6)
Increased costs to practice	'we've actually incurred financial loss through seeing refugee patients and that comes about through the high number of non-attendances and the services are all bulk billed'. (P6)
Lack of pre-planning	'I think the government definitely over-extended our local communities by bringing in well over three times the number they said that they were going to come in'. (P3) 'If health practitioners could be involved in the preparation process... [resources] would be organized in advance of the people coming, I think that would make a huge difference'. (P5)
Healthcare challenges	
Complex trauma	'I think some of them, because they're not willing to look at their trauma histories, have psychosomatic worsening of their symptoms of medical disease'. (P3)
GP mental health support	'I could not sleep for days because I'm a doctor that takes things in, and then I dwell on it...' (P7)

GP, general practitioner.

feeling the reward of patient relationship and seeing their patients grow in understanding.

Benefit to broader community

GPs noted that regional refugee resettlement increased the area's multiculturalism, population and altruism. One GP also noted how, due to the need for greater coordination and problem solving between services, the provision of healthcare to refugees had increased communication between healthcare sectors and providers.

The benefits reported by GPs to refugee resettlement are summarised in [table 3](#).

Recommendations for improving the management of refugee health in regional general practices

There was consensus that primary care services require appropriate resources if regional refugee resettlement is to be sustainable, for the refugees themselves, and for GPs to be able to meet the healthcare needs of the receiving communities. Specific recommendations included employing members of the refugee community in healthcare settings, for example, as receptionists and translators; and adequately funding for integration refugee health nurses within general practice. GPs also expressed a desire for opportunity to discuss the challenges they faced with colleagues and gain feedback from the refugee

Table 2 GP quotes: clinical and community supports facilitating refugee healthcare provision

Clinical supports	
Refugee health nurses	'the LHD refugee health nurses are worth their weight in gold. They are fantastic. They have bent over backwards and inside out to try and help these people'. (P5) "As individuals they are outstanding, as healthcare workers, the service that they've provided has been exceptional, above and beyond. We couldn't have done what we have set out to do and continue to do without the refugee health nurses'. (P6)
Trauma counselling services	'I don't think we would have continued, if it wasn't for their [the trauma counsellors] support'. (P7)
Interpreters	'I think face to face interpreters are really important and the potential for there to be people within the community who can provide that'. (P4) 'having [face to face interpreters] has made our lives an awful lot better'. (P8)
Community supports	
Wider community	'the volunteers... I think they've been the facilitators, taking them to appointments, trying to reinforce the message of what health services can provide'. (P3)
Refugee community	'Now, the [refugee] cohort's big enough... they can now offer that support within their community'. (P3)
GP, general practitioner.	

community themselves. The relatively small GP workforce in regional areas also impacted GPs' capacity to provide healthcare to refugees. It was strongly recommended that this be considered by government and other stakeholders in the design and implementation of future resettlement waves.

COVID-19-related changes in refugee healthcare needs

The pandemic not only complicated some aspects of regional refugee healthcare but also relieved some of the workforce issues. GPs reported that health literacy, communication challenges and cultural differences associated with social distancing would present significant problems if COVID-19 was to become prevalent in this community, which at the time that interviews were conducted had very few cases of infection. However, the pressure of increasing new arrivals into the community was

eased because of border restrictions. The GPs reported that this allowed them to 'catch up', enable better support of the refugees already in the community but did interrupt planned cultural training for GPs.

DISCUSSION

This study examined GPs' perceptions of the factors that challenge and support the treatment of refugees in regional general practice. These centred around culture, language and resource provision, which is consistent with much of refugee healthcare literature.^{10 19 21–25} Nonetheless, these data provide novel insights into how these factors are compounded by regional resettlement. Given the Australian federal government policy to increase regional resettlement over the coming years and regional

Table 3 GP quotes: benefits of refugee resettlement

Personal benefits to GPs	
Positive relationships	'they're a joy to look after'. (P1) 'They're doctor-patient relationships but they are warm relationships'. (P6)
Satisfaction	'in some ways, they've been some of the most difficult consultations, but also some of the most rewarding'. (P5) 'I've found it personally very rewarding... It's been a very positive experience'. (P6)
Increasing skills	'Dealing with new, new culture, new community, getting that new knowledge, I think will boost my confidence in dealing with any other culture'. (P1) 'it's been very enriching in doing something that I've never done before'. (P3)
Benefits to wider community	
Multiculturalism and altruism	'I think it's positive because it's bringing in new people and increasing the population'. (P5) 'Doing good for other people is really good for us. So I think it benefits the community'. (P1)
Increased communication within healthcare	'I think it's a good thing because it's breaking down barriers between primary and secondary care. And we all work in the same community with the same people, so having enhanced relationships with healthcare workers in the secondary healthcare system can only be a benefit for our community and the patients as well'. (P6)
GP, general practitioner.	

workforce capacity issues, this study has implications for clinical management models and public planning, policy and stakeholder engagement.

Difficulties communicating with patients, accessing interpreter services and integrating these phone-based services within routine care were significant barriers to managing refugee patients in general practice. These challenges are particularly acute in regional resettlement areas where phone-based interpreter service cannot be as readily supplemented with face-to-face alternatives. This highlights a substantial gap in regional healthcare services that needs to be addressed in consultation with community prior to the designation of new resettlement sites to assess workforce capacity, so that GPs are sufficiently resourced to provide adequate healthcare following existing national and international recommendations^{10 18} As reflected in this study, the workforce and the community would benefit if this was an ongoing consultative process that is responsive to the growing refugee community, increasing English-language skills of earlier settlement waves, and whether members of the respective refugee community have since become qualified as TIS interpreters and/or otherwise employed in general practice. Although these supports were not available to all surveyed GPs, all GPs reported the need for access to face-to-face interpreters. Additional engagement and incentive programmes between secondary and tertiary sectors (eg, via higher education participation and partnership schemes) and members of the respective refugee community could have multiple benefits. First, it could increase refugees' personal occupational and financial agency, which has of itself been associated with improved health outcomes.^{29 30} Second, doing so could increase local health sector workforce capacity and capacity that enhances the community's ability to meet community needs and also its cultural competency, which was also noted as a current barrier to care. Although this appears to be occurring on a small scale in an ad hoc way, additional support from planners and funders has the potential to bolster and formalise this within existing resettlement service programmes and ensure the sustainability of regional GP-led models of care.

Cultural factors that further challenged regional refugee healthcare included a lack of understanding of the Australian healthcare system and poor health literacy. Appointment non-attendance, language barriers and the need for interpreters and to explain system-related information led to increased consultation times and financial losses for GPs and their practices. This is an ongoing challenge. Training and employing members of the refugee community in areas of general practice and implementing programmes that increase newly arriving refugees' language skills and health literacy may assist in the delivery of regional healthcare. Additional government funding for practice nurses to manage refugees' healthcare needs may help offset the financial losses attributable to managing this vulnerable patient population. This

may also incentivise other GP practices to accept refugees and distribute the caseload more evenly.

The challenges associated with managing refugee health in regional general practice were compounded by the need for additional clinical supports. There is a maldistribution of medical workforce in Australia, with a shortage of GPs in regional areas.³¹ Additionally, GPs have a broader scope of practice in these areas due to the lack of availability of other specialists.³¹ The Australian government strategy of settling refugees into areas of medical workforce shortage requires long-term planning in terms of medical practitioner recruitment as well as new models of care. Local refugee health nurses were considered key to the regional service network. In the surveyed community, nurses linked newly settled refugees with a local general practice, consolidated medical histories obtained during GP consults as well as provided valuable cultural advice. Refugee nurses' caseloads need to be considered when planning numbers of new arrivals, and available funding should be proportionate to the number of refugees in the area. A model of care where refugee nurses are employed in general practices would assist with settlements in smaller communities that have limited healthcare providers. Similarly, increasing funding for regional refugee caseworkers should be considered. Access to non-GP specialist care is also a significant barrier for regional Australia³² and needs to be considered in relation to the prevalence of refugee health problems. Mental healthcare particularly specialty trauma services are crucial. Indeed, refugees' psychological and trauma care needs posed a major challenge in regional healthcare including poor mental health literacy, somatisation and resistance to counselling. This is consistent with a study that found that refugees who settle in regional Australia have higher levels of psychological distress but are less likely to seek help for their mental health problems than the general population.³³ Together, these findings suggest that evidence-based policies focused on workforce capacity, resource allocation and local needs that are developed in consultation with community are required to facilitate positive resettlement outcomes for refugees themselves and the broader receiving community. Given that the predictors of health outcomes vary across time,²³ health workforce and available infrastructure need to be adequately resourced and responsive to the stage of resettlement for the respective community.

While there are challenges associated with regional refugee resettlement, there are also bi-directional benefits to settling refugees within communities willing to support them. GPs frequently noted that community members had assisted refugees with factors such as navigating the health system, attending appointments and transport. Early integration into general practice facilitated continuity of care, leading to increased rapport building and refugees' understanding and familiarity with the healthcare system and a willingness to seek treatment for their mental health. Continuity of care also allowed GPs to become more familiar with the culture of the refugees

and how to interact, which they felt was lacking in the training they received prior to their arrival. Furthermore, GPs overwhelmingly expressed a positive sentiment towards treating refugee patients despite the challenges, including positive relationships, sense of personal and work satisfaction and broadening their scope of practice.

The findings of this study have implications for future research, including investigation of other regions, countries, refugee ethnicities and healthcare providers. Research directly comparing experiences in metropolitan areas to regional areas may also enrich the understanding of the success of different resettlement models. Further quantitative research looking at healthcare outcomes for the refugees resettled as well as qualitative analysis of experiences of healthcare from the perspective of the refugee populations themselves would also benefit the growth of knowledge and understanding in this field.

Limitations

Experiences reported herein were limited to GPs and do not reflect the lived experiences of refugees accessing services in regional Australia. Nonetheless, our findings are consistent with other studies that found that refugees' report that access to interpreter services and cultural barriers impact their experiences with healthcare services.²³ Conducting the interviews virtually may have led to limitations; however, the video and audio were adequate for all interviews and the data seemed to be complete. Our inability to interview GPs from all practices in the region due to already high demands on clinicians' time is also a limitation and meant that we were unable to explore the factors that reduced the likelihood that GPs were willing to treat refugees. Although the study relies on a small sample of GPs who were managing the healthcare needs of a group of refugees of similar ethnicity, this is reflective of the size of the general practice workforce and the refugee community in the area.

CONCLUSION

Overall, GPs were very positive about providing care to refugees and reflected on the benefits of doing so for themselves and the wider community, while also acknowledging the challenges encountered in delivering this care. Most of these challenges, centred around culture, language and resources. This study has implications both within Australia and in other countries planning for regional and rural resettlement programmes of refugees. It highlights the importance of preplanning and resourcing regional communities prior to the resettlement of refugees. This preplanning should include consultation with community healthcare providers regarding what to expect and consideration of local general practice, specialist and interpreter workforce capacity. Additionally, resources should not only be allocated based on initial settlement numbers but ought to increase proportionally as settlement numbers increase. Recommendations include additional funding for staff

that are focused on refugee care and clinical coordination; training refugee community members as translators or for other substantive roles within general practice; ensuring access to adequate mental health services and increasing educational resources for GPs and the refugee community.

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ORCID iDs

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