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Injured Workers' Experiences of General Practitioner Care Across Dual Healthcare Funding Systems: A Qualitative Study in an Australian Workers' Compensation Context

Preeti Maharjan[1] · Tessa Keegel[2] · Michael Di Donato[1] · Daniel Griffiths[1,3] · Danielle Mazza[4] · Alex Collie[1]

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Abstract

Background Injured workers often navigate healthcare services funded by multiple payers with distinct eligibility and funding rules. In Australia, general practitioner (GP) care is subsidised through the publicly funded health insurance system (Medicare). Injured workers may also access care funded by the workers' compensation system for work-related conditions. Consequently, injured workers may be required to navigate two healthcare funding systems simultaneously. This study examined injured workers' experiences of GP care across both systems to inform improved patient care and system reform.

Methods Twelve participants with work-related musculoskeletal injuries were recruited. Data were analysed using reflexive thematic analysis, following an inductive approach to coding and identifying key themes.

Results Three themes were identified: (1) "Navigating dual care funding systems", where participants described challenges accessing care across workers' compensation and Medicare; (2) "Workers' compensation systemic strains on care", where systemic pressures within workers' compensation affected workers' access to and GPs' delivery of care; and (3) "GPs' management of workers' compensation-related tasks", where care experiences varied depending on how individual GPs approached workers' compensation-related tasks.

Conclusion Workers described significant challenges arising from system fragmentation, administrative demands, and variability in GPs 'willingness to engage with the workers' compensation process. These experiences shaped access, continuity, and quality of care received. Workers preferred whole-person care, often changing GPs when their regular GP refused to engage with the workers' compensation system. Strengthening coordination between funding systems, streamlining administrative processes, and improving GP training could improve the care experiences. These findings highlight the system-level reforms prioritising patient experience.

Keywords General practitioner · Injured workers · Workers' compensation · Medicare · Work-related musculoskeletal conditions · Work disability

Introduction

Injured workers in many countries must navigate healthcare services funded by multiple payers, each with distinct eligibility rules, administrative processes, and co-payment requirements[1]. Australia presents a compelling case study for examining how workers navigate two distinct healthcare funding systems simultaneously [2, 3].

In Australia, workers' compensation funds healthcare and rehabilitation related to injury or illness incurred by workers in the course of their employment (known as 'compensable injury') [4]. Nearly two-thirds (60%) of injured workers with accepted workers' compensation claims identified general practitioner (GP), equivalent to family physician or primary

✉ Preeti Maharjan
Preeti.maharjan@monash.edu

1 Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia

2 Monash Centre for Occupational and Environmental Health, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia

3 Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia

4 Department of General Practice, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia

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care physician in other countries, as their main healthcare provider [5]. GPs are the primary point-of-care in the Australian healthcare system, with their services primarily subsidised by the Medicare Benefit Scheme (Medicare), a national health insurance scheme [6]. When a worker has an accepted workers' compensation claim, the GP care for that compensable injury is subsidised by workers' compensation, rather than Medicare. However, pre-existing or co-morbid conditions that arise alongside the compensable injury [7, 8] are not eligible for funding under workers' compensation. Consequently, many injured workers with accepted workers' compensation claims and co-existing other health conditions will seek GP care funded by both Medicare and workers' compensation systems simultaneously [9].

This dual funding scenario presents challenges for injured workers and GPs, as the Medicare and workers' compensation systems operate with distinct funding rules, reimbursement structures, and administrative requirements. GPs have additional responsibilities within workers' compensation schemes that are not often present in Medicare, such as writing reports, certifying work capacity, and coordinating return to work with insurers and employers [10, 11]. Some of these roles are required by workers' compensation legislation, while others are required for claim management processes by workers' compensation schemes [12]. Such system-level complexity may shape how care is delivered and experienced.

Evidence consistently suggests that both injured workers and GPs find workers' compensation systems challenging and complex [13, 14]. An Australian study found that 31% of injured workers experienced stressful interactions with their healthcare providers during their compensation claim, and those experiencing such stressful interactions were 33% less likely to return to work [15]. These stressful experiences may be partly attributable to the administrative demands placed on GPs, who report a high workers' compensation-related administrative load and role conflict due to competing obligations to patients and insurers [14, 16–18]. Such administrative demands have been reported to erode the therapeutic relationship between injured workers and GPs and reduce GPs' willingness to engage with the compensation system [17, 19].

To date, the evidence on injured workers' healthcare experiences has primarily focused on care provision within the workers' compensation system alone. While this has provided valuable insights, it overlooks the fact that these individuals also simultaneously receive GP care through a separate funding system (Medicare) for other health conditions. Consequently, there is a gap in understanding of how these dual funding arrangements influence injured workers' experience of GP care. Crucially, it remains unclear how this dual-system intersection alters the GP–patient relationship and impacts the management of other health conditions. Understanding these experiences is essential for identifying unmet healthcare needs, recognising barriers to care, and examining how relationships with GPs may shift in the context of a compensable workplace injury. Such insights can inform evidence-based policies that better support injured workers throughout their recovery. This study aimed to understand injured workers' lived experience of GP care during their workers' compensation claim, focusing on two research questions:

1. How do injured workers experience GP care across dual healthcare funding systems following a work-related musculoskeletal injury?
2. Do workers' compensation policies and procedures affect injured workers' GP care, and if so, how?

Methods

Setting

The majority of GP services in Australia are subsidised through Medicare. In 2023–24, 84.4% of the Australian population accessed at least one Medicare-subsidised GP service, accounting for approximately 163.5 million GP consultations and a total expenditure of AUD 9 billion [6]. Patients often pay a gap fee out of pocket if their GP charges above the Medicare fee schedule [20]. Only 12% of Australian GPs indicated that they "bulkbill" all of their patients (i.e. accepting the Medicare subsidy as full payment with no charge) [21], meaning many patients face out-of-pocket costs (see Table 1).

Australia comprises 11 workers' compensation schemes (Table 1). In 2022–23, GP services comprised 21.2% of medical services in Western Australia alone, totalling AUD 21.5 million [22]. Patients may incur gap fees under workers' compensation, but the proportion is unknown.

Study Design

This is an exploratory qualitative study using semi-structured interviews. The study is reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) guidelines (Supplementary file: Appendix A).

Eligibility

Eligible participants were workers with accepted workers' compensation claims in Australia for a musculoskeletal injury within five years from April 2020 to April 2025.

Table 1 Key features of the medicare benefits scheme and workers' compensation schemes

	Medicare benefit scheme	Workers' compensation systems
System structure	One national scheme administered by the Federal government	Eleven separate schemes in total 8 state and territory-based (New South Wales, Victoria, Queensland, Western Australia, South Australia, Tasmania, Northern Territory and Australian Capital Territory) 3 national schemes include Seacare (for maritime workers), Department of Veterans' Affairs (for current and former members of the military), and Comcare (covering Australian federal employees and some large national employers)
Coverage for GP services	Covers all health conditions for eligible patients, except compensated conditions	Covers treatment for work-related conditions and only when an insurer has accepted a workers' compensation claim
Funding Source	Medicare levy charged as part of the general taxation revenue	Employer insurance premiums and scheme investment income
GP consultation fee (standard 6–19 min)	AUD 43.90 [23]	Varies across schemes ranging from AUD 76.55 in Victoria [24] to AUD 112.00 in New South Wales [25]
Gap fee	Common	Unknown
Billing process	GPs bill Medicare directly, or the patient pays and claims a rebate	GP invoices the relevant insurer
Administrative requirements	Minimal (standard referral letters, care plans, sick certificates)	Substantial (includes writing certificates of capacity, writing progress reports and referral letters, coordinating with return to work and liaising with insurers and employers, certifying for household assistance and travel)
Communication	Minimal communication with Services Australia	Frequent communication with workers' compensation insurer

Participants were eligible if they were aged 18 years or older at the time of interview, were able to provide informed consent and participate in interviews conducted in the English language.

Recruitment Strategy

Participants were recruited through purposive sampling to include workers who had accepted claims for musculoskeletal injuries. Recruitment was conducted via online advertisements across multiple platforms, including relevant websites, social media (LinkedIn and Facebook), newsletters, online support groups, and national research registers such as Join Us [26]. Advertisements included a QR code and a direct link to an expression of interest form. Eligibility was confirmed by screening questionnaires included in the expression of interest form. Individuals who expressed interest and were eligible were contacted by email to arrange an interview. Participation was voluntary, and participants were not compensated. Recruitment proceeded concurrently with data collection and analysis. Recruitment continued until no substantially new insights emerged from the interviews.

Data Collection

A semi-structured interview guide (Supplementary file: Appendix B) was designed to elicit responses addressing the study aims. One-to-one interviews were conducted online via video conference, using the Zoom platform, between June 2025 and February 2026. Interviews were conducted using a neutral approach, incorporating active listening, reflective prompts, and open-ended questioning to foster a supportive interview environment [27]. Interviews were between 25 and 90 min in duration and were recorded on a secure device with restricted access to approved researchers. Closed captions were enabled to support transcription. Transcripts were de-identified and checked thoroughly for accuracy and imported into NVivo 15 for analysis [28].

Data Analysis

Data were analysed inductively using reflexive thematic analysis, following Braun and Clarke's six-phase framework encompassing: data familiarisation, generating codes, theme identification, theme refinement, theme definition and naming, and preparation of the final report [29, 30]. A team-based approach enhanced the trustworthiness of the analysis

through triangulation of the data. First, two transcripts were coded line-by-line collaboratively by three researchers (PM, MDD, and AC), allowing multiple perspectives to inform code generation. Next, two researchers (PM and TK) independently conducted line-by-line coding for six transcripts, establishing and refining codes. Remaining transcripts were coded by an individual researcher (PM) with regular team meetings to discuss codes, emerging themes, and refinement of the coding framework. Initial codes were organised into descriptive themes and iteratively refined into analytic themes. Reflexive note-taking was used throughout the analysis to document insights and emerging connections. This iterative, recursive process facilitated the identification of meaningful patterns and themes, enabling a comprehensive and nuanced interpretation of the transcripts relative to the research questions [31].

Researcher Positionality

Interviews were conducted by PM, a final-year PhD candidate in public health, whose prior experience analysing linked Medicare and workers' compensation administrative data informed her understanding of the structural and interpersonal complexities surrounding injured workers' GP service use [9, 32]. This background provided PM with deep familiarity with the administrative overlap and system boundaries between Medicare and workers' compensation frameworks in Australia, allowing her to identify nuances in the transcripts. Participants were not known to the interviewer before the study; rapport was established during interview arrangements and at the commencement of each interview. The broader analytic team comprised an extensive, multi-disciplinary mix of expertise in general practice, health services research, and workers' compensation. This team dynamic ensured that the data were analysed from both a clinical and policy viewpoint.

Results

Study Participant Characteristics

Twelve injured workers, aged between 38 and 63 years, were recruited. This sample included workers with accepted workers' compensation claims for musculoskeletal injuries under state-based schemes in New South Wales, Victoria, Tasmania, and Comcare. Participant characteristics are described in Table 2. All participants reported at least one other health condition requiring GP care. Nine reported more than one other condition concurrently. Six participants reported having more than one accepted claim.

Table 2 Characteristics of injured workers who participated in this study

Injured workers	Total ($N=12$)
Gender	
Women	8
Men	4
Claim status at the time of the interview	
Claim closed	8
Claim open	4
Return-to-work status at the time of the interview	
Returned to work	7
Not returned to work	5
Country of birth	
Australia	9
Not Australia	3
Other health conditions	
Single	3
More than one other health condition	9
Number of workers' compensation claims	
One claim	6
More than one claim	6

Themes

Three themes were identified from the data: "Navigating dual care funding systems", "Workers' compensation system strains on GP care", and "GP management of workers' compensation-related tasks". Together, these themes characterise interrelated individual, GP and system-level factors that shape injured workers' experience of GP care after a compensable musculoskeletal injury.

Theme 1: Navigating Dual Care Funding Systems

This theme explores participants' experiences of managing care funded by Medicare and workers' compensation systems simultaneously. It emerges from two subthemes, preferences for whole-person care and coordinating care across two funding systems. This theme highlights the impact of structural fragmentation on care experiences.

Preference for Whole-Person Care Participants preferred the whole-person care made possible through a single GP, who manages both the compensable injury and other health conditions, regardless of whether the care is funded by Medicare or workers' compensation, as illustrated in the excerpt below.

> I saw the same GP. [—]. He has results of my scans, blood tests, and everything on his computer for my

> [compensated injury] and [other health condition] as well". And my GP is able to ensure that, the right medications are working for each health condition, and not impacting. IW 08.

Some participants reported consulting multiple GPs over the course of their claim, but they consistently consulted one GP at any given time for all their healthcare needs. When their regular GP refused to manage workers' compensation cases or when disputes arose over compensation matters, participants changed their GP, not only for their compensable injury but also for all their healthcare needs. They prioritised a GP willing to engage with the workers' compensation system, even if this meant seeing a GP unfamiliar with their medical history. The excerpt below illustrates a participant's preference to switch to a new GP who could issue the certificate of work capacity required for claim decisions.

> I am seeing new GP. So, I've gone from the GP who I see regularly to someone brand new, who knows nothing about me, essentially, because they're the one who's willing to sign that piece of paper. IW 05.

Coordinating Care Across Two Funding Systems While accessing services funded by both systems simultaneously, the responsibility for coordinating care was usually borne by participants. Participants were aware of the system-level administrative requirements, including separate billing and funding processes. To comply with these requirements, some participants reported booking two separate successive appointments: one appointment for each system. The following quote highlights how participants navigated these constraints.

> "I saw the same GP. [….] they are separate appointments. Appointments, where I get, the next certificate of capacity, they belong to the [name of workers compensation system] claim. My other stuff, they're totally separate, and they need to be separate." IW 08.

Participants' experiences were also shaped by their interactions with administrative staff within general practice. Supportive administrative processes, such as assistance with scheduling appointments and responsive communication, contribute positively to participants care experiences. As reflected in the quote below, supportive interactions with administrative staff were valued by participants and helped facilitate access to GP care.

> The medical practice, I would ring up and say I need to get in today and they would move heaven and earth to get me in on that day. IW 01.

In contrast, some participants received inadequate administrative support, which made care coordination challenging. Instances in which staff were perceived as rude or failed to respond to communications from workers' compensation systems complicated their care coordination. In certain cases, these challenges led participants to change their GPs. Such experiences highlight how administrative interactions outside the typical GP–patient relationship play an important role in shaping participants' care experience.

> I tried this doctor, and the receptionist, and everyone quite friendly at the place. Because the receptionist at the other two practices I went to were quite rude and abrupt. IW 04.

Some participants described arranging their care for other health conditions around workers' compensation processes, such as treatment approvals and legal hearings. One participant described paying privately for surgery for other health condition rather than waiting in the Medicare-funded public hospital queue. This was because the participant had no control over the approval and timing of treatment for a compensable injury and had an upcoming compensation hearing. By paying privately, the participant was able to manage the timing of care for their other health condition.

> I was more stressed over my [work-related condition], because I had no control over the treatment, have to prove if anything, where my [other condition] only included surgery and test. I said, I'd just do it in the public hospital. My GP said I might have to wait. [–] I knew I wanted to get my [work-related condition] surgery done, and I knew I had a compensation claim hearing coming up, so, I said, I'll just do surgery for other condition first. I'll pay it out of my pocket, even though I was struggling financially IW 07.

Some participants accessed Medicare-subsidised services for care related to their compensable condition in instances where workers' compensation delayed or did not approve the services. Some later received a Medicare debt and were required to repay these costs once the services were retrospectively deemed to fall under the workers' compensation scheme. The quote below highlights how navigating two funding systems created administrative and financial challenges, including situations where workers' compensation did not approve services ("blocked"), or claims were suspended, forcing participants to use Medicare-subsidised care they were later required to repay.

> *So, when your stuff is blocked. You have to see a doctor under Medicare. [….] So, when you're suspended, you're penalized, financially at the end of your claim. Because you have to pay back the Medicare services that you got when you were suspended. IW 02.*

Coordinating Care Across Two Funding Systems

Theme 2: Workers' Compensation Systemic Strains on Care

This second theme explores participants' contrasting experiences of accessing Medicare-funded care with relative ease, while navigating workers' compensation systems, which were perceived as challenging. Drawing on the subthemes 'Barriers to care access' and 'Constrained GPs' delivery of care', this theme highlights how workers' compensation system rules and administrative demands shape injured workers' access to care as well as GPs' delivery of care and clinical practice.

Barriers to Care Access

Participants identified three key barriers to what they perceived as timely and effective GP care. Firstly, participants expressed difficulty in finding a GP willing to accept a patient with a workers' compensation claim. The quote below illustrates a participant's difficulty in finding a GP who could issue the initial certificate of capacity, which is mandatory to initiate the workers' compensation process.

> My regular GP won't see workers' compensation patients. As soon as I mentioned workers' compensation, outright won't see you. I probably approached 6 or 7 different GPs, trying to find one who would actually see me. So, it was really, really frustrating just trying to find an initial person who would even do a certificate of capacity at the very start. IW 05.

This hindered participants' entry into the workers' compensation system and their ability to access timely care. Participants also recognised that GPs refuse to see workers' compensation patients due to the administrative workload and the low remuneration involved. Secondly, some participants remained with the same GP despite dissatisfaction, perceiving that changing GPs during an active claim would prompt complications with the insurer. This restricted participants' choice of GP, limiting access to care they considered effective. These participants sought care outside the compensation system to address unmet needs for their compensable injury. This required paying out of pocket to see another GP or specialist, which added financial strain. In a quote below, a participant explained consulting the GP funded by workers' compensation to complete administrative paperwork while seeking clinical treatment for a compensable injury from another doctor.

> I see the GP for stuff like if I need a prescription for painkillers, or I need a referral. But for actual treatment, [–-] I will just pay privately to see my sports doctor. IW 05.

Lastly, participants who changed their GPs during an active claim encountered further barriers in obtaining insurer approval for services requested by a new GP. This further limited their access to care.

> I went to another doctor, he took over my claims, and from day one, he was basically blocked and obstructed by an insurer. So, his treatment of me was made very hard by previous mistakes of two GPs, the insurer and rehab. IW 02.

Constrained GP's Delivery of Care

Participants perceived that the administrative demands imposed by the workers' compensation processes constrained the delivery of clinical care by their GPs. Many described that their GPs were preoccupied with completing compensation-related documents during GP–patient consultations, leaving limited time to discuss recovery progress or broader health concerns. These administrative requirements were seen as consuming GPs' time and clinic resources, affecting the quality and focus of care. One participant explained:

> My GP said she never gets to medically check and see how I'm going. Every time I go to see her, and even if I book in time in advance, by the time I get there, there's another 3 or 4 forms or referrals that need to come from the GP. So, we never actually get to discuss the injury and how I can get better. IW 06.

In addition, participants expressed that their GPs had limited control over clinical decisions, as treatment under workers' compensation often required insurer approval rather than being guided by clinical need. This process constrained GPs' ability to provide timely care, as a participant illustrated, saying,

> The GP has no authority to approve treatment. I see the GP and he recommends treatment. And I gotta wait 21 days, care delays, care denied [–-] In that aspect that the GP doesn't have any control over my care in a true sense. IW 07.

Theme 3: GP Management of Workers' Compensation-Related Tasks

This final theme describes how participants perceived their GPs' management of workers' compensation-related tasks and how their experiences differed depending on which GP they saw. Drawing on the subthemes 'Workers' compensation-related documentation', 'Understanding of workers'

compensation', and 'Advocacy and support', this theme highlights the ways in which GPs' knowledge, administrative practices, and willingness to advocate shaped participants' experiences of workers' compensation-related care.

Workers' Compensation-Related Documentation

Participants described varied experiences with their GPs' willingness and approaches to completing workers' compensation-related documentation, including certificates of capacity, writing reports, and referral letters. Some participants described the challenges when their GPs were unwilling to complete the necessary paperwork:

> "My caseworker tried to contact my GP for a report or comments on IME and sent about 4 or 5 emails over a 4-month period, plus a phone call. She somehow, or her office, managed to lose all those emails, plus did not reply to phone call. She never wrote anything, so then I got cut off. [-] And then she started charging me directly for coming to her upfront." IW 06.

The above excerpt illustrates how GPs' reluctance to engage with administrative paperwork directly affected claim continuation and imposed financial and emotional burden on participants. By contrast, some participants reported positive experiences with their GPs who provided supporting letters alongside referrals to justify the requested services. While this documentation is required by the workers' compensation system, this is beyond what is typically required in Medicare-subsidised care; participants perceived this as going above and beyond their normal expectations. One participant explained,

> My GP was very helpful. He would write not just a referral, but he'd write a supporting letter for me to send off to workers' compensation, explaining why, and the causation. IW 07.

These experiences demonstrate that proactive GP engagement not only facilitated claim processes but also strengthened GP–patient relationships. Similarly, participants reported varied experiences in how their GPs considered other health conditions when completing certificates of capacity, a document outlining functional abilities related to compensable injury to guide claims decisions and return-to-work planning. Some participants reported that their GP included both compensable and other health conditions in their assessments, offering a whole-of-person evaluation irrespective of system requirements:

> When he's writing the certificates of capacity, he did include some of this [other health condition] investigation stuff on those certificates of capacity into the limited return to work hours as well. IW 08

Others, however, received separate certificates for each health condition consistent with system requirements. One participant recounted receiving three separate certificates for three different conditions: *"This doctor had zero hours capacity for my psychological condition, 40 h for my right elbow, and 24 for my back. Yes, that's correct. Three separate capacities. Now, that's, what am I, half a person? A third of a person, or one person? IW 02"*. This reflects participants' frustration with the fragmented treatment of their health rather than being seen and treated as a whole person.

Understanding of Workers Compensation

Participants relied on their GPs to navigate workers' compensation processes. When GPs demonstrated a strong understanding of workers' compensation, this enhanced participants' trust and confidence. As one participant described,

> My GP was very comforting and coaching to me about the system. For me my GP was a source of knowledge and the go-to when I didn't understand something. And if he didn't understand it, he would refer me to somebody to talk to outside of my case manager and insurer. IW 07.

In contrast, other participants perceived their GPs as less informed, which shifted the burden of navigating the system onto the participants themselves. These participants described having to independently seek information and take on additional administrative responsibilities, such as liaising with workers' compensation. One participant explained: *"Doctor says they haven't been paid yet [–-] so they're not going to write the report, and then I try and follow up with insurer, and I work out why they haven't been paid" IW 06.*

Advocacy and Support

Participants expected their GPs to act as advocates for their interests rather than prioritising those of the insurer or rehabilitation provider; however, experiences varied. Some participants perceived that their GPs' recommendations, particularly regarding return to work, were influenced by case managers or rehabilitation providers. A participant described,

> My GP was very supportive earlier. Slowly her behaviour changed. [–-] Maybe insurance is putting pressure on her. Even my specialist said it will take time to recover, but GP suggested me to go back to work. IW 03.

Trust was enhanced when GPs communicated transparently, including providing advance notice of rehabilitation providers attending consultations, explaining their role, and clarifying what information would be shared. Some

described their GPs as consistently supportive, as one participant quoted, *"GP would have me in his room first and discuss everything with me first, and then he would bring return to work guy in. [-] He was the only person on my side really". IW 01.*

By contrast, some described that their GPs did not provide prior notice about the rehabilitation providers attending consultations, which strained the GP–patient relationship. A participant explained: *"workplace rehabilitation person turned up at my medical appointment and stole my appointment. My GP allowed this to happen" . IW 02.*

Discussion

This study aimed to understand injured workers' experience of GP care across dual healthcare funding systems and how workers' compensation policies and procedures shape that care. While previous studies have well established the challenges of compensation systems, our findings show the friction that occurs when these two different systems intersect. The findings contribute to growing evidence showing workers in a multi-payer healthcare system face system-level fragmentation that falls disproportionately on workers themselves. While injured Australian workers typically consulted a single GP for all their healthcare needs regardless of funding source, system-level fragmentation of care required that they coordinate care for their work-related compensable injury and pre-existing or additional health conditions separately. For example, injured workers were required to define boundaries around their health requirements by organising separate consultations with the same GP for compensable and non-compensable conditions via each funding source. The policies and eligibility criteria imposed by workers' compensation schemes created barriers for injured workers to accessing care due to approvals for specific treatments and the scope of funding being limited to the compensable condition only, rather than the whole person. Importantly, these rules altered the GP–patient relationship and actively impacted care for other health conditions funded by Medicare. These processes also shaped workers' broader healthcare decisions. Lastly, workers' compensation administrative tasks were reported to limit the time for clinical treatment and management in a GP consultation, with considerable variations in how individual GPs approached these tasks. This GP-level variability means the injured workers experienced the same system differently, depending on their GP's experience, knowledge, and willingness to engage with the system. Overall, these findings highlight how key features of workers' compensation systems shape healthcare access and delivery to this population.

Injured workers often consulted the same GP for care funded by both systems (workers' compensation and Medicare), reflecting a preference for a whole-of-person care. However, workers' compensation funding is restricted to the injury accepted for the compensation, while Medicare funds care for other health conditions, creating fragmentation in the funding of care for the same individual. These funding restrictions and GPs' willingness to navigate multiple systems substantially shaped how treatment for compensable and other health conditions was delivered. This suggests that coordination at the person-level requires corresponding coordination at the system level [33]. There is an absence of formal mechanisms for cross-system coordination between Medicare and workers' compensation in Australia. A lack of formal mechanisms to coordinate care has been documented in Canada, where workers' compensation and publicly financed healthcare systems operate as separate, fragmented funding systems [34]. Some healthcare funding models address this structural fragmentation by removing the distinctions between whether the condition is work-related or not. For example, in the United Kingdom, healthcare is provided by the National Health Service regardless of whether the injury was work-related or not, removing the structural divide experienced by injured workers in Australia and Canada [35].

Injured workers reported that the administrative demands of the workers' compensation system posed significant challenges for them and their treating GPs. Workers described requirements such as prior approvals, writing medical certificates, reports, and referral letters, which added to GP workload beyond their routine Medicare-subsidised care, contributing to reduced consultation time, and delayed treatment. The broader literature has documented that such administrative demands shape GPs' clinical practices and behaviours, constraining their capacity to provide effective care and straining GP–patient relationships [17, 36]. Reflecting these pressures, injured workers faced challenges finding a GP willing to engage with the workers' compensation system, a pattern consistently reported in other studies [19, 37]. This increasing reluctance among GPs limited injured workers' entry into and access to care within the compensation system. Furthermore, injured workers reported that the system's complex administrative processes constrained their ability to seek alternative GPs when dissatisfied with the care they received, undermining their access to quality care. Injured workers in our study described that the workers' compensation system's influences extend beyond the compensable injuries, shaping the way they manage broader health conditions. This aspect has received little attention in the existing literature, where studies have predominantly focused on the compensable injury/illness only, potentially underestimating the full burden of workers' compensation systems on injured workers' health.

Injured workers' experiences varied considerably depending on which GP they saw, reflecting marked differences

in GPs' understanding of and willingness to engage with the workers' compensation system. This suggests that not all GPs are equally motivated and equipped with the workers' compensation-related information and training, leaving them to interpret system requirements based on their own knowledge and experience. Previous studies also identified that GPs have limited information and inadequate training about workers' compensation [11, 38, 39] and variability in GP knowledge is a key contributor to inconsistent workers' experience [38]. Given that workers' compensation cases represent only about 3% of the cases GPs see [40], the additional burden required for such a small proportion of their workload provides little incentive for GPs to engage with the system. The consequences of these workers' compensation systems and GP-level factors are ultimately borne by injured workers, contributing to uneven experiences and poorer outcomes, including delays and additional stress at an already vulnerable time [10].

A key strength of this study is its in-depth insights into injured workers' experiences across the Australian workers' compensation scheme and Medicare; perspectives which are often under-represented in policy and administrative evaluations. While this study was conducted within the Australian workers' compensation context, the core challenges identified are likely to resonate in other countries where primary care operates at the intersection of universal healthcare, private healthcare, and separate injury or disability schemes. Though the specific administrative rules are unique to Australia, the underlying structural friction is universal to other healthcare systems with multiple funding models. International jurisdictions such as Canada, the United States, Japan, and South Korea similarly have separate cause-based workers' compensation systems from broader healthcare funding systems. Consequently, these findings may offer relevant insights for international frameworks with similar systemic divides, though the extent to which they apply will depend on the specific system features. These findings are relevant specifically to work-related musculoskeletal disorders; the dual care pathway may operate differently for other work-related conditions, such as mental health. However, participants with mental health conditions in our study, whether as a secondary workers' compensation claim or as other health condition, also used the same GP for all their health needs. This study captured the perspectives of workers from multiple jurisdictions, including New South Wales, Victoria, Tasmania, and Comcare. The New South Wales and Victorian workers' compensation systems are the two largest jurisdictions in Australia, and Comcare represents the federal government scheme. However, we did not have any participants from the state of Queensland. This is particularly relevant given that GP service use and time off work patterns in Queensland differ from those in other jurisdictions [41, 42]. Most of our participants were from major cities, with a few from regional areas, meaning variations in experiences between urban and rural/remote locations were not captured.

These findings suggest several opportunities to improve injured workers' experiences of GP care. At the practice level, clear communication about the administrative process and information sharing may help reduce uncertainty and strengthen trust[17]. Given variation in participants' experiences depending on the GP they saw, providing training and support for GPs in navigating workers' compensation requirements may promote more consistent practice and lessen the burden on both injured workers and GPs [11]. However, given the time constraints and competing demands faced by GPs, educational initiatives would need to be accessible and feasible to implement within routine practice [11]. Furthermore, education alone is unlikely to address all challenges. At the system level, strategies including reducing administrative complexity and improving communication between GPs and workers' compensation systems may also be needed to support coordinated care and reduce GP reluctance to treat compensable patients [37]. Reducing fragmentation between funding arrangements for compensable and other health conditions may support a more integrated, whole-person approach to care. While this study does not evaluate specific system models, the findings highlight the potential value of unified systems, such as a single insurance framework or a more coordinated dual funding model to support injured workers. However, achieving such integrated care is difficult in practice as Medicare and workers' compensation are operated separately. Future research may examine feasible mechanisms to integrate care despite this system-level fragmentation. While this study provides valuable insights into workers' experiences, incorporating perspectives from other stakeholders, such as GPs, employers, insurers, or case managers, may provide a more comprehensive understanding of system-level barriers and identify more practical opportunities for policy or service improvement.

Conclusion

This study provides new insights into injured workers' experiences of receiving GP care for both work-related and other health conditions. Injured workers often sought care from the same GP for all health conditions, preferring a whole-person approach. However, complexities around workers' compensation policies and procedures created barriers for injured workers to receive timely and effective care. The quality and continuity of GP care were also shaped by the individual GP seen. These findings are relevant to other nations where similar tensions between universal or private healthcare and separate compensation schemes exist in

primary care systems. Addressing these challenges requires a more integrated and supportive system, alongside targeted reforms. This includes simplifying administrative processes and improving GP training to reduce the administrative, clinical, financial, and emotional burden experienced by injured workers.

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Data Availability No datasets were generated or analysed during the current study.

Declarations

Conflict of interest The authors declare no competing interests.

Ethical approval Ethics approval was obtained from Monash University Health Research Ethics Committee (Project ID 46947, May 2025).

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