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Australian General Practitioners' and Compensable Patients: Factors Affecting Claim Management and Return to Work

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Abstract
Purpose General Practitioners (GPs) play an important role in personal injury compensation systems yet system processes have been perceived as burdensome. Objectives were to (1) determine attitudes of Australian GPs on health benefits of return to work (RTW) after injury/illness and (2) identify associations between GP characteristics and agreement with issues surrounding treating compensable patients. *Methods* Cross-sectional postal survey of 423 Australian GPs to determine agreement with issues associated with compensable patients (including patient advocacy, conflicting opinions between GPs and compensation systems, fitness-for-work certification, and refusal to treat). *Results* The vast majority of GPs agreed there was a health benefit to early RTW. GPs with 16–20 years' experience had significantly higher odds of agreeing that the certificate of work capacity is the primary method of communication between RTW stakeholders (OR 2.36 [1.13–4.92]) than those with greater experience. 49% of GPs agreed they should be able to refuse to treat compensable patients. Female GPs had significantly lower odds (OR 0.60 [0.40–0.90]) of agreeing with right to refuse than male GPs, as did those from remote or regional practices (OR 0.43 [0.20–0.94]; OR 0.60 [0.39–0.92]) than GPs from urban practices. *Conclusions* Reducing administrative barriers identified by Australian GPs and improving communication with compensation systems will likely have a positive impact on their refusal to treat compensable patients.

Keywords Injury · Return to work · Health services administration · Refusal to treat · Workers' compensation · Traffic accidents

Introduction

The health benefits of work are widely recognised, and can include greater self-esteem and self-efficacy, improved physical and mental health, and general wellbeing. Evidence also suggests that return to work (RTW) can facilitate recovery from injury and illness [1], and that extended work absence can increase the risk of adverse health outcomes and reduce the likelihood of successful RTW [2, 3]. This evidence has led peak medical organisations to adopt position statements emphasising the positive relationship between good work and health, and encouraging RTW as a means of facilitating recovery [4].

Australia has multiple insurance-based compensation systems that provide income support and fund healthcare and rehabilitation for people who acquire injury/illness in settings such as at work or in a motor vehicle crash (collectively called personal injury compensation). General Practitioners (GPs) play a number of important roles in these compensation systems. In addition to coordinating healthcare, GPs also provide medical certification of fitness-to-work, which is a statutory requirement for injured and ill people to receive ongoing access to benefits. GPs may also engage in RTW planning with employers and insurance case managers, and provide medical evidence during disputes [5].

Numerous recent studies of GPs' behaviours and attitudes within Australian injury compensation systems shed light on the clinical and administrative challenges faced by GPs in

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promoting the health benefits of work. Despite evidence and medical opinion supporting promotion of fitness-to-work, GPs are more likely to write unfit-for-work certificates than 'fit notes' [6], and this is particularly the case for workers with mental health conditions [7]. The medical certification role can be problematic for GPs [8] as not only must they treat the patient but also determine optimal sickness certification in terms of the right amount of work absence, for which there is limited understanding [9]. Moreover, as we have shown in our previous work, RTW is a socially negotiated process and there are several non-clinical influences affecting GP sickness certification (e.g. availability of alternative duties; childcare and family responsibilities; fear of re-injury) [3].

Qualitative data suggests that GPs' interactions with compensable patients are complicated by burdensome procedural requirements [8] and clinical challenges, such as the dilemma of how to re-integrate a worker with a work-related mental health condition back into the environment that contributed to the condition [7]. GPs report that compensation system complexity leads them to play an advocacy role on behalf of their patients to ensure access to appropriate benefits and services [8].

In the Australian model of personal injury compensation, GPs play an advisory rather than a decision-making role. Decisions regarding payment for services and treatment are made by insurers, at times with evidence provided by independent medical examiners or third party doctors. This approach to insurance claim management can result in role conflict, and differences of opinion between GPs and insurers may contribute to delays in access to care and prolonged work absence [7].

Poor communication between GPs and others involved in RTW processes have been reported as negatively impacting on patient work outcomes [8]. Qualitative findings suggest GPs may perceive the medical certificate as the main opportunity for communicating with employers, workers and insurers, and that there is a lack of other formal communication channels [8]. In other jurisdictions the implementation of guidelines for sickness certification have been reported as facilitating engagement with patients and the compensation system [10]. Conversely, lack of communication between RTW stakeholders can create barriers to RTW [3, 10]. The complexity of engaging in RTW within Australian injury compensation settings has led to reports that some GPs are reluctant to treat compensable patients [5].

To date, Australian research in the treatment of compensable patients by GPs has been primarily qualitative in nature, and has been limited to a single Australian state (e.g. Victoria) rather than nationwide. This study sought to assess RTW attitudes and behaviours among a large group of GPs across multiple Australian injury compensation jurisdictions. Specific objectives included assessing the level of agreement with recent policy statements on the health benefits of work, examining GP attitudes towards communication, advocacy, certification and refusal to treat, and identification of GP characteristics associated with these attitudes.

Methods

Context

The majority of Australian workers are covered for work-related injury through eleven major systems of workers' compensation generally organised by state or territory, with three national workers' compensation schemes. Compulsory third party insurers generally provide cover for transport-related injury. The structure of each system (no-fault, tort, hybrid) differs between states and territories. These systems vary in their legislation and practices, but all can provide benefits in the form of payments for medical treatment and income replacement whilst unable to work.

Most Australians receive primary care through their GP [6]. Exceptions include acute or traumatic cases where emergency hospital treatment is required or where treatment is sought from another health professional (e.g. allied health). However, GPs are generally involved in follow-up care. This is mirrored in personal injury compensation where a GP is heavily involved in the initial and/or follow-up treatment, and is generally considered the gatekeeper to the compensation system [7].

Procedures

This observational, cross-sectional study involved Australia-wide administration of a paper-based survey to assess attitudes of GPs about RTW after a compensable injury. The full survey consisted of 24 questions, of which eight were demographic questions and 16 were overarching questions asking respondents to address 69 sub-questions of statements. Three thousand randomly selected GPs across Australia were mailed surveys that tested knowledge of post-traumatic stress disorder and whiplash treating guidelines, as well as questions about interactions with compensable patients [11]. Demographic information on the GP's gender, age, years of experience, and location, size and state of practice were collected. Survey questions around treating compensable patients were based on a previous qualitative study on GPs' management of injured worker RTW [8] and research literature detailed earlier. GPs were asked to rate their level of agreement to statements relating to attitudes and practices towards RTW and sickness certification following compensable injury/illness using a five-point Likert scale from strongly agree to strongly disagree. The statements were:

1. There is a health benefit to early return to work
2. Patients should only return to work when they are 100% fit
3. My role is to advocate for the patient
4. The certificate of work capacity is the primary method of communication between the return to work stakeholders
5. Conflicting opinions between GPs and compensation authorities can delay return to work
6. GPs should have the risk to refuse to treat patients with compensable injury

Data Analysis

Frequency distributions to describe the responding cohort were calculated. Responses to each of the above statements were displayed in graphical format. To fully assess associations, missing responses and demographic data were imputed using the Fully Conditional Specification method with five imputations. Likert responses to statements three to six were dichotomised into strongly agree/agree and not sure/disagree/strongly disagree. The first two statements could not be included in regression models due to ceiling and floor effects. Demographic variables detailed earlier were used as predictors. Pearson correlations of these predictor variables were conducted to determine whether all should be included. Age and years of experience as a GP were strongly correlated ($r(423) = 0.805$, $p < 0.01$) and hence age was removed from further modelling. Due to low responses in some states, the state of practice was not included in regression analysis.

Non-parametric tests were conducted to test for associations of the remaining predictor variables (gender, years of experience, location of practice, and size of practice) and dependent variables. The binary response to each survey question was the dependent variable. The Mann–Whitney-*U* statistic was calculated for dichotomous variables, Kruskal–Wallis for categorical variables (more than two categories). Predictor variables that had a statistically significant relationship ($p < 0.05$) with any of the four statements were retained. Size of practice was not statistically significant and hence not included in regression models. Binary logistic regression models were conducted with agreement with each of the four statements as the dependent variable. Results were presented as odds ratio describing odds of agreeing with the statement by predictor variables.

Analyses were conducted with SPSS Version 25 (Armonk, NY, USA) and RStudio Version 1.0.153 (Boston, MA, USA) (using R Version 3.4.1 [Vienna, Austria]). Ethics was approved by Monash University Human Research Ethics Committee (CF14/1374-2014000642).

Results

There were 423 returned surveys (14.1% response rate). Male and female GPs were equally represented, with more than half having more than 20 years' experience (53.2%) (Table 1). New South Wales, Victoria and Queensland had the largest proportion of participants (30.5%, 25.1% and 21.7% respectively). More than half of respondents were located in an urban area (59.3%).

Ninety-nine percent of responding GPs agreed that there was a health benefit to early RTW (Fig. 1). Additionally, 95% disagreed that patients should only RTW when fully fit. There was greater variability in responses for all other

Table 1 Characteristics of the responding GPs

	N	%
Age group		
25–35 years	50	11.8
36–45 years	96	22.7
46–60 years	168	39.7
60+ years	109	25.8
Gender		
Male	214	50.6
Female	209	49.4
Years of experience as a GP[a]		
≤ 5 years	62	14.7
6–10 years	40	9.5
11–15 years	50	11.8
16–20 years	45	10.6
20+ years	225	53.2
State where practice is based		
VIC	106	25.1
NSW	129	30.5
SA	38	9.0
QLD	92	21.7
NT	6	1.4
WA	27	6.4
TAS	19	4.5
ACT	6	1.4
Location of practice		
Remote	33	7.8
Regional	139	32.9
Urban	251	59.3
Overall number of GPs in the practice[b]		
1	41	9.7
2–3	71	16.8
4–7	169	40.0
≥ 8	139	32.9

[a]1 missing

[b]3 missing

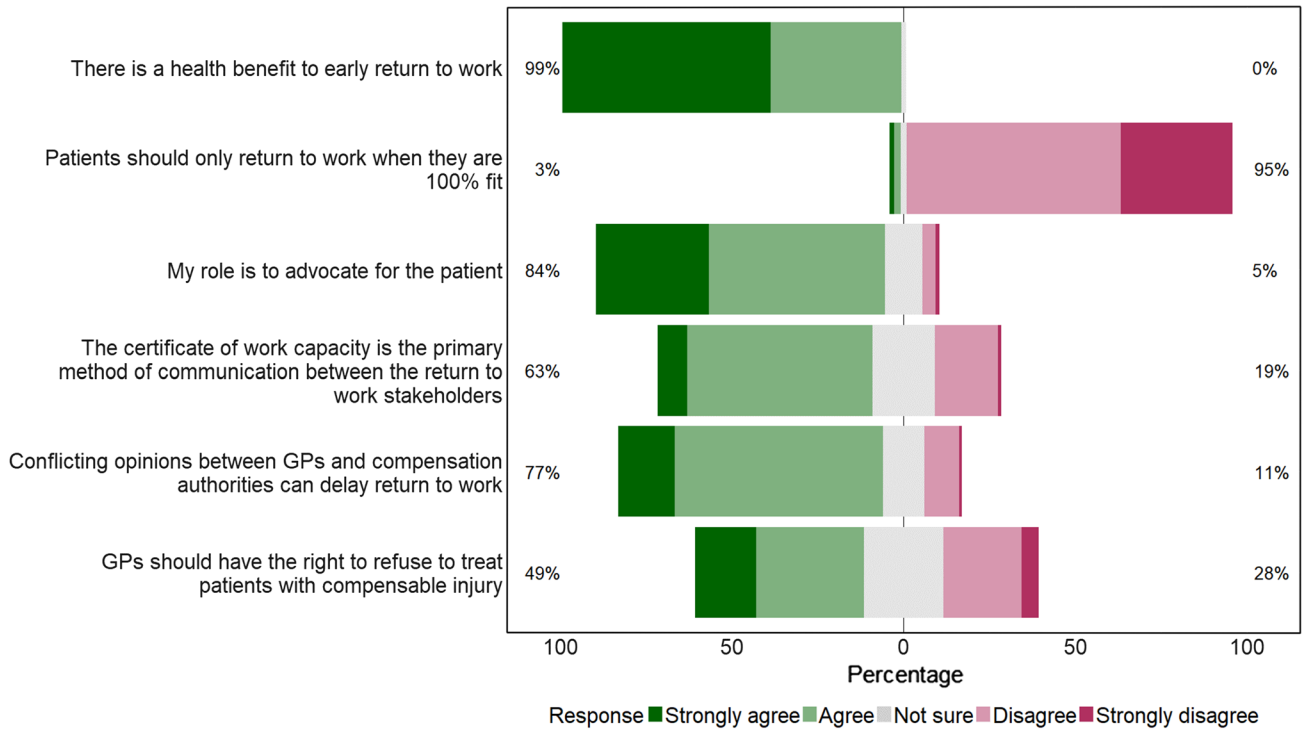

Fig. 1 Level of agreement for each statement

statements. 63% of GPs agreed the certificate of capacity was the primary method of communication. One-third of GPs strongly agreed their role was to advocate for the patient. Most GPs agreed that RTW can be delayed where there are conflicting opinions between GPs and compensation authorities (77%). Almost half of GPs agreed they should be able to refuse to treat compensable patients and 23% were unsure.

There were no significant differences between GPs with the advocacy or conflicting opinions statements (Table 2). GPs with 16–20 years' experience had significantly higher odds (OR 2.36 [1.13–4.92]) of agreeing that the certificate of work capacity was the primary method of communication between RTW stakeholders than those with more experience. Male GPs and those from urban practices had significantly higher odds of agreeing that GPs should have the right to refuse to treat compensable patients than female GPs (OR 0.60 [0.40–0.90]) and those from remote or regional practices (OR 0.43 [0.20–0.94]; OR 0.60 [0.39–0.92]).

Discussion

This study provides important information regarding the beliefs and attitudes of Australian GPs towards injury compensation systems, their role in those systems and towards the link between health and work. Promotion of the health benefits of work has been led by peak medical bodies and supported by injury compensation regulatory authorities and insurers [4]. This study confirms that two key messages of this awareness campaign—there is a health benefit to RTW, and patients don't need to be fully fit to RTW—have been broadly adopted by Australian GPs. These messages have been promoted for nearly two decades, with prior studies showing that awareness campaigns specifically relating to back pain have had a positive impact on GP attitudes [12]. While we did not specifically evaluate the effects of a campaign, this study confirms that most Australian GPs endorse these messages.

There appears to be less agreement among Australian GPs with respect to their role engaging with injury compensation schemes. This study has corroborated qualitative findings that GPs consider one of their roles as advocate for patients involved in injury compensation schemes [7, 10]. These prior qualitative studies reported that advocacy resulted from GPs considering the compensation schemes to be complex and that many patients require support to navigate this complexity. This was particularly evident when there were conflicting medical opinions or when the treating medical practitioners' opinion was challenged [7, 10].

The majority of GPs reported that disagreements between GPs and compensation authorities can negatively impact on RTW. This is consistent with previous research [7, 8], with disagreements being reported as a major deterrent to

Table 2 Odds of agreeing with statement

	My role is to advocate for the patient				The certificate of work capacity is the primary method of communication between the return to work stakeholders				Conflicting opinions between GPs and compensation authorities can delay return to work				GPs should have the right to refuse to treat patients with compensable injury			
	Odds ratio	95% CI		p-value	Odds ratio	95% CI		p-value	Odds ratio	95% CI		p-value	Odds ratio	95% CI		p-value
		Lower bound	Upper bound			Lower bound	Upper bound			Lower bound	Upper bound			Lower bound	Upper bound	
Gender																
Male	Ref.				Ref.				Ref.				Ref.			
Female	1.21	0.70	2.11	0.50	0.92	0.60	1.40	0.69	0.86	0.53	1.40	0.54	0.60	0.40	0.90	0.01
Years of experience																
≤ 5 years	0.79	0.35	1.77	0.56	1.54	0.82	2.89	0.18	0.56	0.29	1.08	0.08	1.35	0.73	2.49	0.33
6–10 years	1.44	0.47	4.44	0.53	1.28	0.62	2.63	0.50	2.07	0.75	5.72	0.16	1.30	0.64	2.64	0.47
11–15 years	0.86	0.37	2.01	0.73	1.62	0.84	3.11	0.15	0.53	0.27	1.05	0.07	0.65	0.34	1.22	0.18
16–20 years	0.72	0.32	1.64	0.43	2.36	1.13	4.92	0.02	1.80	0.71	4.52	0.21	0.91	0.47	1.75	0.77
20+years	Ref.				Ref.				Ref.				Ref.			
Location of practice																
Remote	0.80	0.31	2.07	0.65	1.49	0.65	3.43	0.35	0.61	0.27	1.41	0.25	0.43	0.20	0.94	0.03
Regional	1.66	0.89	3.12	0.11	0.94	0.60	1.46	0.77	0.86	0.51	1.44	0.57	0.60	0.39	0.92	0.02
Urban	Ref.				Ref.				Ref.				Ref.			

CI confidence interval

certifying RTW capacity [8]. These conflicting opinions hamper RTW efforts and often result in prolonged time on compensation, thus potentially leading to poorer health outcomes [1]. Certification, however, is the main communication channel between GPs and compensation authorities, and thus conflicts can create barriers to RTW.

Certification by GPs has been acknowledged as problematic [9, 10, 13]. As the treating doctor they are required to assess the degree to which the injury/illness reduces functional capacity for work, and determine the optimal level and duration of work absence. This can be difficult given that a GPs' role is to treat the patient, yet determine the right amount of work absence that does not lead to any secondary adverse effects, whilst acting as a medical expert for compensation systems [13]. Furthermore, a certificate of work capacity is irrelevant if the employer refuses to provide suitable alternative duties or does not want the worker to return [3, 9].

Whilst GPs almost unanimously acknowledged the importance and benefit of early RTW for recovery and health, issues have been identified when translating this knowledge into practice. For example, a study of initial medical certificates issued for workers' compensation claims found that over 70% were written as 'unfit for work' and only 22.8% recommended 'modified or alternate duties' [6]. It is possible that GPs more familiar with compensation systems who possess greater skills for managing their processes are more comfortable issuing 'fit notes' [14]. Alternatively, these results suggest an opportunity for GPs to collaborate with allied health professionals (e.g. occupational therapists, physiotherapists) that may enable greater likelihood of RTW.

Due to these issues, it is unsurprising that some GPs believe they should have the right to refuse to treat compensable patients. While we observed that nearly half of all GPs reported they should have the right to refuse treatment, this effect was statistically stronger among male and urban GPs. Gender differences may be due to females approaching their role differently [15]. It is possible that those from urban areas are aware there are considerably more options with respect to healthcare, and that compensable patients will not be required to travel far to find an appropriate doctor. Additionally, qualitative findings suggest GPs find administrative and financial burdens major barriers to engagement in compensation systems [5]. GPs face challenges when patients do not comply with their treatment recommendations, and find it difficult assessing and treating patients they have just met with whom they have not established trust [5]. Studies report that GPs have felt "angry" and "upset" when dealing with compensation systems, particularly where there have been conflicting opinions on diagnosis and treatment [7].

There are potential solutions to make the prospect of treating compensable patients more appealing, including streamlining payment to GPs [5, 16], minimising the administrative burden placed on GPs [5, 8, 16], or increasing GPs' understanding through education of compensation systems [5, 7, 8]. These strategies may ensure that GPs are more likely to treat compensable patients, who are then not subject to treatment delays and delayed RTW.

This study was the first of its kind to gain insight from such a large sample of Australian GPs. The sample comprised GPs from a diverse range of backgrounds, locations, levels of experience, sexes and ages. Despite these strengths, this study has limitations. Whilst the demographic characteristics of this sample resembles that of the national GP population [17] and demographic characteristics of responders did not differ from non-responders, it is acknowledged that responders may have held stronger attitudes towards compensable injury management that biased their responses. Additionally, the low response-rate limits generalisability, however this is not unusual as GPs are considered a hard-to-reach group [18]. Due to low responses from some demographics (e.g. state), we were unable to look at all possible predictors for agreement with the statements. Furthermore, we were unable to factor in the level of experience or familiarity of GPs treating compensable patients into the regression model as this information was not collected. Inclusion of state in the regression model could have altered results and allowed for the exploration of jurisdiction-specific differences with regard to compensation systems.

Despite agreeing there are health benefits associated with early RTW, issues such as patient advocacy, conflicting opinions, and certification are identified by GPs as complicating a patient's treatment and potentially delaying their RTW. The interactions between GPs and compensation systems need to be improved in order to better manage differing opinions and streamline the certification processes to overcome these issues. By reducing these barriers and improving engagement and communication, there will likely be a positive impact on refusal to treat.

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Compliance with Ethical Standards

Conflict of interest The authors declare they have no conflicts of interest.

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