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Changes in public health-seeking behaviours for self-limiting respiratory tract infections across England during the COVID-19 pandemic

Brieze Read [1], Monsey McLeod [2], Sarah Tonkin-Crine [3,4], Diane Ashiru-Oredope [1,2], Anna Quigley[5], Colin S. Brown[1,2], Donna M. Lecky [1,2,]

1 Healthcare-Associated Infection, Fungal, Antimicrobial Resistance, Antimicrobial Use & Sepsis Division, United Kingdom Health Security Agency, London, UK
2 Health Protection Research Unit in Healthcare Associated Infections and Antimicrobial Resistance, Department of Medicine, Imperial College London, London, UK
3 Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, UK
4 National Institute for Health Research (NIHR) Health Protection Research Unit (HPRU) in Healthcare Associated Infections and Antimicrobial Resistance, University of Oxford, Oxford, UK
5 Social Research Institute, Ipsos MORI UK Ltd, London, UK

Correspondence: Donna M. Lecky, Primary Care and Interventions Unit, UK Health Security Agency, Twyver House, Gloucester GL1 1DQ, UK, Tel: +44 20 84953254, e-mail: donna.lecky@ukhsa.gov.uk

Background: National Health Service (NHS) guidance for acute respiratory tract infections (RTIs) advocates self-care, encourages utilization of local pharmacies and recommends consulting general practitioners (GPs) primarily for the vulnerable or those with persistent symptoms. Coronavirus disease 2019 exerted substantial strain on the English NHS, affecting public access to primary care services. **Methods:** For 3 years, public surveys assessed RTI incidences in the previous 12 months and associated health-seeking behaviours. Telephone surveys of 1676 respondents across England were conducted in March 2021 and 1663 respondents in March 2022. Findings were compared with a face-to-face baseline survey of 2022 respondents from March 2020. Key demographics were representative of the population. **Results:** In 2021, the proportion of respondents who reported an RTI (51%) significantly declined from 2020 (70%, $P < 0.05$), then returned to pre-pandemic rates in 2022 (67%). Respondents reported more proactive symptom management in both 2021 and 2022 from 2020: there were greater reports of seeking over-the-counter treatments (55%, 55% vs. 35%, $P < 0.05$) and use of alternative remedies (38%, 38% vs. 21%, $P < 0.05$). 2022 observed a reduction in those who reported consulting their GP for their most recent RTI (15%) compared to 2021 (25%, $P < 0.05$) and 2020 (23%), which was not accounted for through greater consultation rates with other healthcare services. **Conclusions:** Public health bodies should consider how pandemic-related changes may have facilitated increased self-care for self-limiting infections such as RTIs. Resources and support must include safety-netting advice to safeguard against unintentional consequences of increased self-care.

Introduction

The coronavirus disease 2019 (COVID-19) pandemic is the most significant public health challenge for a century and had an unprecedented global impact, with over six million deaths worldwide.[1] The UK government recommended non-pharmaceutical interventions, including infection prevention and control (IPC) measures to the public,[2] enforced national lockdowns[3] and closed borders.[4] These lockdown measures exerted significant strain on national healthcare delivery, with the cancellation of most non-urgent operations and outpatient clinics.[5]

On 5 March 2020, the National Health Service (NHS) in England[6] advised general practitioners (GPs) to shift towards remote consultations, with further guidance issued on 19 March 2020 recommending remote triage of all patients prior to any consultation. This resulted in over a quarter of appointments occurring via teleconferencing during March 2020, twice as many as in February 2020.[7,8] This unparalleled strain on the NHS caused initial concerns over access to healthcare.

A continuous cough and a high temperature were initial key symptoms of COVID-19.[9] NHS guidance for any respiratory tract infections (RTIs)[10] encouraged self-care, avoidance of social contact, highlighted the role of community pharmacies and recommended contacting a GP for the vulnerable, or those with persistent symptoms.

As most antibiotics prescribed in primary care are for RTIs,[11] and remote consultations limit physical examination and culture sampling, there was an initial sense of trepidation that remote consultations may negatively impact antimicrobial prescribing.[11] Antimicrobial stewardship (AMS) in primary care is complex, with perceived patient demand[12] and maintaining patient relationships[13] amplifying clinically unnecessary antimicrobial consumption. Therefore, understanding how patient consultation behaviour and expectations may have changed as a result of the pandemic, may enable the promotion of appropriate self-management[14] to compliment efforts to prevent inappropriate prescribing. To measure this, health-seeking behaviours for RTIs which occurred in the previous 12 months, and subsequent health-seeking behaviours were assessed via national surveys in 2020,[15] 2021 and 2022.

Methods

The market research company Ipsos MORI conducted interviews as part of routine surveys (initially commissioned by Public Health England, and then by UKHSA) across England. The baseline survey,[15] carried out between 24 January and 24 February 2020 [pre-pandemic (pre-P)], was performed face-to-face in the interviewees' own homes

via computer-aided personal interviews (CAPI). Due to national lockdown restrictions, the 2021 [pandemic-year-one (P-Y1)] and 2022 [pandemic-year-two (P-Y2)] surveys were carried out over 2 weeks in February to March and were conducted remotely, via computer-aided telephone interviews (CATI). Each survey asked about infections and actions taken in the last 12 months (figure 1).

Partially completed interviews were excluded. Representativeness of the sample was ensured (in 2020) by two-stage random sampling,[16] where interviewers were given age, gender, household tenure and working status quotas of respondents, and (in 2021 and 2022) by random digit dialling, and publicly available targeted data (see Supplementary appendix). To ensure the results are broadly representative of the population, CAPI/CATI uses a random iterative method weighting system to correct for known selection biases, and which weights survey data to the latest set of census data or mid-year estimates and national readership survey profiles for age, social grade, region and working status, within gender and additional profiles on tenure and ethnicity. Pearson's chi-squared test, corrected

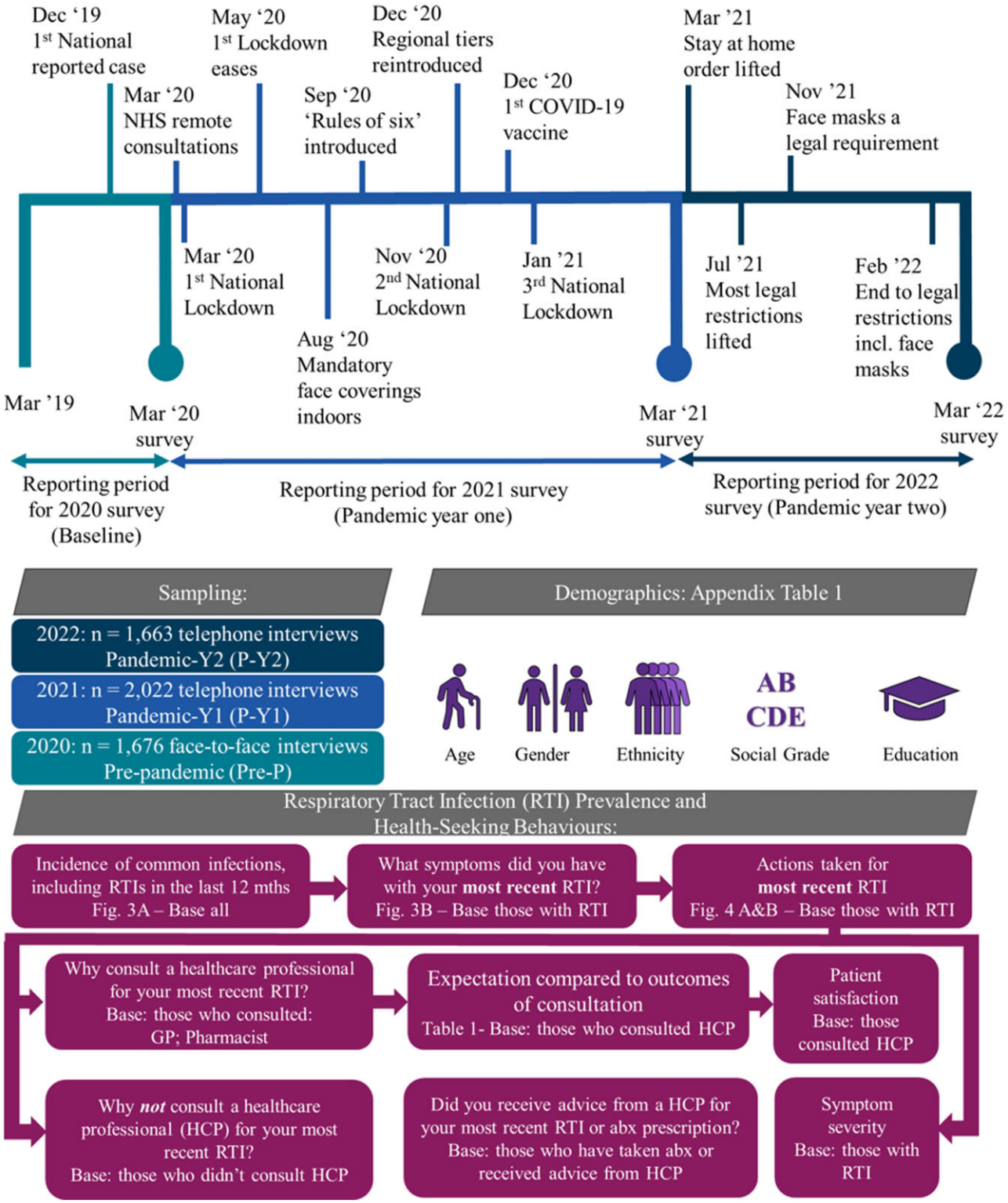

Figure 1 (A) A brief overview of some key restrictions applicable to England to provide context for the reporting period of each survey. (B) Overview of the questionnaire structure. The boxes detail the question and the figure/table number (if applicable)

for survey design, was used to test for differences in proportions across levels of categorical variables and between responses across the 3 years.

Ethics

The Ipsos MORI surveys and interviews were undertaken outside the NHS setting, and NHS Research Ethics Committee review is not required for healthcare market research conducted by professional market researchers. This ethical position was confirmed by the Head of Research Governance, Research Translation & Innovation Division at Public Health England. Ipsos MORI is an independent research agency bound by the rules of the Market Research Society. The surveys are regular household 'consumer' surveys into which clients of Ipsos MORI can insert sets of questions. Consent for personal responses to be used by Ipsos MORI clients for research purposes is indicated by verbal agreement and by the member of the household voluntarily completing the survey questionnaire/interview. There were no financial or other incentives and participants were free to withdraw their participation during the interview. All data processing and storage comply with the General Data Protection Regulation and UK Data Protection Act 2018.

Results

Responses were obtained from 2022 (pre-P), 1676 (P-Y1) and 1663 (P-Y2) respondents: see Supplementary appendix for a breakdown of demographics, which were representative of the population and similar across all time points.

Incidence of respiratory tract infections

In P-Y1, the proportion of respondents who reported experiencing RTI symptoms in the previous 12 months (51%) significantly declined compared to pre-P (70%, $P < 0.001$); however, reported incidence almost returned to pre-P figures in P-Y2 (67%; figure 2A). Respondents reporting confirmed COVID-19 cases accounted for 3% of RTIs in P-Y1 and 20% in P-Y2. Across all 3 years, a cough was the most frequently reported RTI symptom of their most recent RTI (pre-P: 46%, P-Y1: 37%, P-Y2: 41%; figure 2B).

Health-seeking behaviours for respondents' most recent RTI

Each year respondents who had an RTI were asked 'Thinking of your most recent illness, which of the following actions, if any, did you take as a result?' and could choose from a pre-defined list of self-managing and/or consulting actions (figure 3). Overall, the proportion of respondents who reported self-managing their RTI (i.e. those not consulting a healthcare professional (HCP) significantly increased in P-Y2 (73%) compared to P-Y1 (61%, $P < 0.05$) and pre-P (65%, $P = 0.001$). Equally, the proportion of those who reported consulting an HCP significantly decreased during P-Y2 (27%) compared to P-Y1 (39%, $P < 0.001$) and pre-P (35%, $P = 0.001$; figure 3C).

In P-Y1, respondents with an RTI reported being more proactive in managing their own RTI symptoms and all self-care reported behaviours increased from pre-P; this proactivity was largely sustained into P-Y2 (figure 3C). In P-Y2, self-reported COVID-19 testing was more prevalent than during P-Y1 (P-Y2: 56%, P-Y1: 34%; $P < 0.001$), however, self-isolating was less prevalent (P-Y2: 26%, P-Y1: 39%; $P < 0.001$).

During P-Y1, respondents most frequently reported staying at home (57%) and continuing their usual activities (56%): both behaviours were significantly less prevalent in P-Y2 (43%, $P < 0.001$; 47%, $P < 0.001$, respectively). The rise in the use of non-prescriptive (over-the-counter) treatment for symptoms (pre-P: 35%, P-Y1: 55%, P-Y2: 55%) and alternative remedies (pre-P: 21%, P-Y1: 38%, P-Y2: 38%) observed during P-Y1 were sustained for P-Y2.

Respondents were asked what (from a predetermined list) factored into the decision not to consult an HCP, with not wanting to take up NHS staff time (P-Y1: 35%, P-Y2: 23%; $P < 0.05$) and fear of spreading (P-Y1: 23%, P-Y2: 15%; $P = 0.001$) or catching COVID-19 (P-Y1: 15%, P-Y2: 6%; $P < 0.001$) most prevalent during P-Y1, although these concerns were less prevalent in P-Y2 (and not asked pre-P).

In both P-Y1 and P-Y2, the main reason for not consulting an HCP was that respondents felt their symptoms were not severe enough (P-Y1: 72%, P-Y2: 73%). In P-Y2 only, symptom severity was recorded as: 45% reported mild, 36% reported moderate and 17% reported severe; and the extent to which their symptoms affected their daily life: 47% not at all, 31% somewhat and 21% felt their ability to perform most of their activities were prevented. Those with severe symptoms were more likely to consult an HCP (58%) than those with mild symptoms (16%, $P < 0.001$).

Expectations and outcomes of consultations for most recent RTI

The way in which respondents consulted an HCP remains unchanged from P-Y1 and P-Y2 with comparable reported telephone (P-Y1: 75%, P-Y2: 77%) and face-to-face (P-Y1: 28%, P-Y2: 28%) consultations.

Of those who contacted an HCP (pre-P: $n = 302$, P-Y1: $n = 239$, P-Y2: $n = 229$), respondents most frequently contacted GPs (pre-P: 83%, P-Y1: 62%, P-Y2: 55%), and pharmacists (pre-P: 26%, P-Y1: 27%, P-Y2: 35%). In P-Y2 only, respondents were asked how satisfied they were with their consultation: 80% were satisfied with their GP; 86% with their pharmacy consultation, and this did not differ according to the mode of contact. Table 1 highlights differences between both expectations and outcomes when respondents consulted a GP or pharmacist.

GP consultations

The reasons why respondents consulted their GP remain largely unchanged compared to pre-P, with most wanting treatment for their symptoms (pre-P: 26%, P-Y1: 50%, P-Y2–48%) or because their symptoms lasted longer than expected (pre-P: 23%, P-Y1: 42%, P-Y2: 41%) (table 1). During P-Y1, more respondents consulted their GP because they were worried that their illness could get worse (43%) than pre-P (20%, $P < 0.001$), or P-Y2 (30%, $P = 0.0596$).

Across all 3 years, when consulting a GP, most frequently, respondents expected to be prescribed treatment for their symptoms. During P-Y1, this expectation for treatment (56%) was higher than pre-P (38%, $P = 0.001$). Clearly not all expected this treatment to be antibiotics; under one-third (30%) expected to be prescribed antibiotics pre-P, which increased in P-Y1 (48%, $P = 0.001$). This was accompanied by an increased expectation of advice on the need for antibiotics in P-Y1 (48%) compared to pre-P (23%, $P < 0.001$). During P-Y1 there was also a greater expectation for advice on how to look after symptoms (36%, $P = 0.039$) and how long the symptoms may last (28%, $P = 0.005$) compared to pre-P (25% and 15%, respectively). Across the board, these heightened expectations observed in P-Y1 were sustained into P-Y2: expectation for treatment (60%); antibiotics (48%); and advice on: antibiotics (39%); how to look after symptoms (35%); and symptom duration (22%) (table 1).

In line with increased expectation, more respondents were prescribed treatment for their symptoms in P-Y1 (41%, $P = 0.014$) and P-Y2 (45%, $P = 0.003$) compared with those in pre-P (28%), although it was not asked what this treatment was.

Pre-P more respondents reported being prescribed antibiotics (52%) than expected (30%, $P < 0.001$). This discrepancy between expectation and reported prescribing narrowed during P-Y1 and P-Y2, although this is attributed to the aforementioned heightened expectations for antibiotics during the pandemic, not due to changes

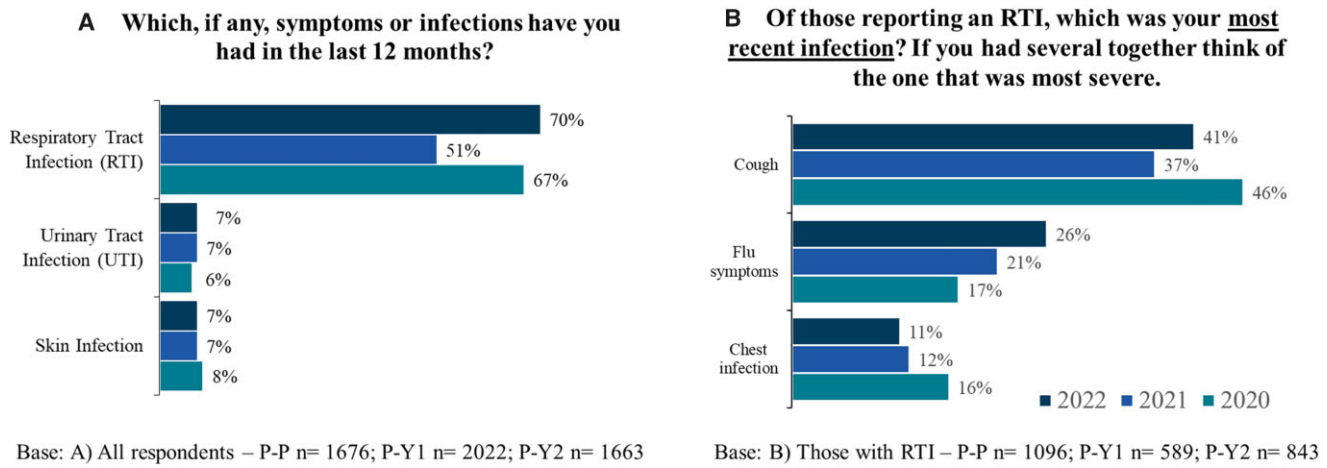

Figure 2 (A) The prevalence of self-reported symptoms over the last 12 months. Respondents were asked to select from a pre-defined list of symptoms (see Supplementary appendix) and net RTI is accumulated from those selecting any one or more of: throat, chest, sinus or ear infection; cold/runny nose; flu symptoms; cough; sore throat, (B) of which was the most recent symptom/infection. The rest of this survey pertains to actions taken for their most recent infection, which across all 3 years, was most frequently, a cough. Top: pandemic-year-two; middle: pandemic-year-one; bottom: 2020 pre-pandemic

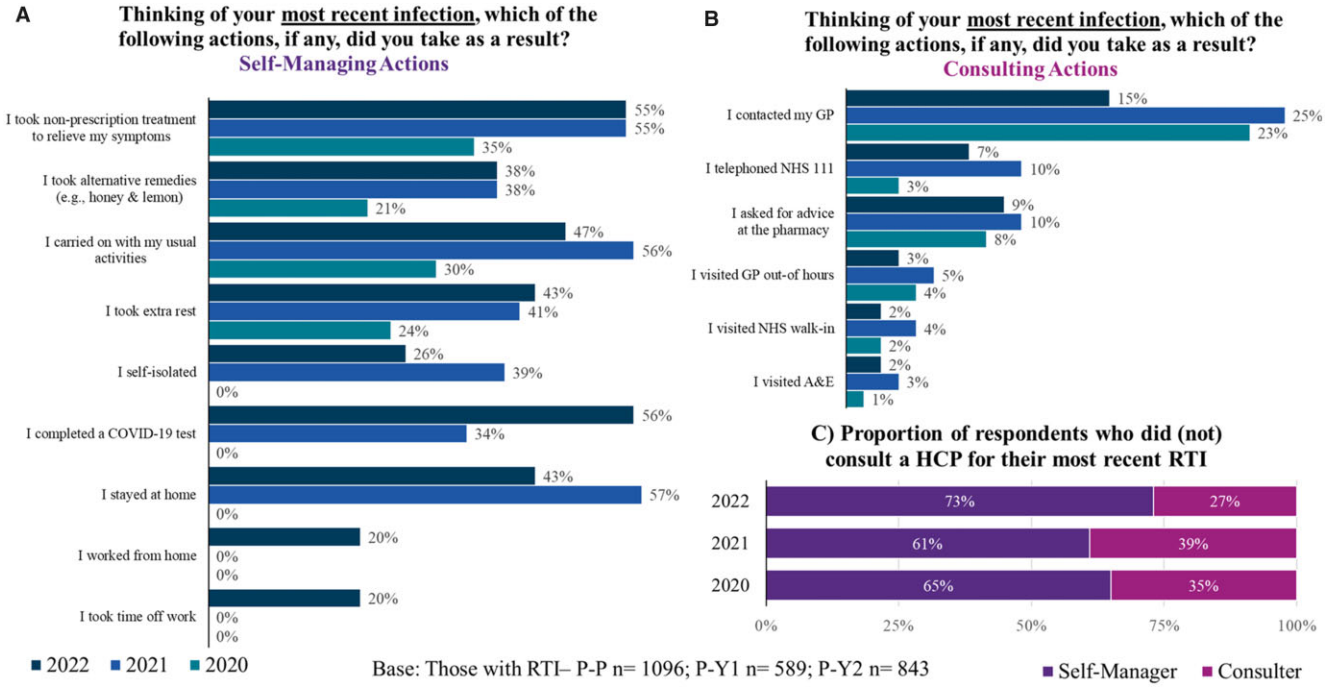

Figure 3 Actions taken for most recent RTI. (A) Self-managing actions; (B) consulting actions; (C) proportion of self-managers and consulters. Top: pandemic-year-two; middle: pandemic-year-one; bottom: pre-pandemic

Table 1 Expectations vs. outcomes of consultations with a healthcare professional for a respiratory tract infection

	Pre-pandemic[a]		P-Y1[b]		P-Y2[c]	
	Expectation (%)	Outcome (%)	Expectation (%)	Outcome (%)	Expectation (%)	Outcome (%)
GP						
To be prescribed treatment to reduce symptoms	38	28	56a	41a	60	45
To be prescribed antibiotics	30	52*	48a	54	49	48
Advice on the need for antibiotics	23	18	48*a	40a	35	41
Advice on how to look after my symptoms	25	26	36a	40a	39	36
Advice on how long my symptoms might last	15	18	28a	31a	24	24
Pharmacist						
To be prescribed treatment to reduce symptoms	45	53	69a	61	66	61
To be prescribed antibiotics by the pharmacist	5	3	9	5	16	12
Advice on the need for antibiotics	19	11	39a	28	28	25
Advice on whether I need to see another HCP	22	18	26	28	26	24
Advice on how long symptoms may last	11	17	17	24	22	24

Letters represent significant differences in either expectation or outcome across years; asterisks denote significant differences between expectation and outcome within the same year.

in reported prescribing, which remained consistent across the 3 years (pre-P: 52%, P-Y1–54%, P-Y2: 48%).

Although during P-Y1 (40%, $P < 0.001$) and P-Y2 (41%, $P < 0.001$) respondents reported receiving more advice on the need for antibiotics compared to pre-P (18%), respondents' expectations were not always met during P-Y1, with fewer, although not significantly so receiving advice (40%) than expected (48%, $P = 0.083$).

Heightened expectations for advice on symptoms were recognized during P-Y1 but not during P-Y2. Compared to pre-P, significantly more respondents reported receiving advice on how to look after their symptoms (40%, $P = 0.008$), and how long their symptoms might last (31%, $P = 0.004$), compared to pre-P (26% and 18%, respectively), but those receiving said advice in P-Y2 (36%, $P = 0.063$; 24%, $P = 0.150$, respectively) was no greater than pre-P.

Pharmacy consultations

Comparable with those consulting GPs, across all 3 years, most respondents consulted pharmacists to buy treatment to alleviate their symptoms (table 1). Pre-P, 45% expected treatment, with 53% reportedly buying treating, thus expectations were met. During P-Y1, expectations to buy treatment (66%) rose significantly compared to pre-P (45%, $P = 0.012$) and was sustained into P-Y2, yet buying of treatment (61%) was not significantly higher than pre-P (53%, $P = 0.411$).

During P-Y1, there was a significant increase in respondents expecting advice from the pharmacist on the need for antibiotics (39%), compared to pre-P (19%, $P = 0.015$). These heightened expectations were not met, with those receiving advice (28%) significantly lower than those expecting to receive advice ($P < 0.001$). However, expectations for advice on antibiotics were reduced in P-Y2 (28%) and were more closely met by the pharmacy (25%).

Across all years, respondents further expected to receive advice on whether to consult another HCP (pre-P: 22%, P-Y1: 26%, P-Y2: 26%) and this expectation was mostly met (pre-P: 18%, P-Y1: 28%, P-Y2: 24%). Similarly, there was a year-on-year increase in expectation for advice on how long symptoms may last (pre-P: 11%, P-Y1: 17%, $P = 0.365$; P-Y2: 22%, $P = 0.461$) and these expectations were met for each year (pre-P: 17%, P-Y1: 24%, P-Y2: 24%).

Respondents who had either contacted an HCP or taken an antibiotic in any way were asked if and what advice they received. Advice relating to antibiotics was higher in P-Y1 (38%) than in pre-P (26%, $P < 0.001$) and P-Y2 (30%, $P < 0.001$). This advice included whether an antibiotic would work for the infection, how to take the antibiotic, side effects and antibiotic resistance. Over three-quarters of advice was received verbally (P-Y1: 81%, P-Y2–76%). Of those receiving printed materials (pre-P: $n = 106$, P-Y1: $n = 153$, P-Y2: $n = 160$), the HCP discussed the resources with approximately half (pre-P: 45%, P-Y1: 54%, P-Y2: 56%).

Discussion

The incidence of self-reported RTIs across England reduced significantly during the first year of the COVID-19 pandemic and rebounded to pre-P levels in P-Y2. This initial reduction in RTIs is likely due to national restrictions enforced by the UK government to minimize the spread of COVID-19, for example, reduced national travel,[4] enforced social distancing[3] and increased hand and respiratory hygiene practices.[2] Despite restrictions and a reduction in RTI incidences, 50% still reported an RTI in P-Y1, which highlights the difficulties in restricting the transmission of RTIs.[17]

The English public was significantly more proactive with self-care actions in both years of the pandemic compared to the baseline. This increased health conscientiousness may be driven by many pandemic-related factors, i.e. heightened responsiveness to any respiratory symptoms, increased awareness of their own mortality or derived from a sense of empowerment from government public messaging: 'Stay home. Protect the NHS. Save lives'/'Stay alert, Control the virus, Save lives'/'Hands, Face, Space',[2] coupled with increased hand hygiene messaging and improved knowledge surrounding IPC.[18] Further, changes to the 'normal' environment such as working from home, or the furlough scheme[19] (not assessed in these surveys), may have facilitated the ability to self-manage symptoms, with more reportedly taking extra rest, and continuing with their usual activities, as well as taking treatment or alternative remedies for their symptoms. These behaviours were sustained into P-Y2.

Most RTIs are self-limiting infections, and self-care is recommended under the National Institute for Health and Care Excellence (NICE) guidelines.[20] When asked why they didn't consult an HCP, many considered their symptoms were not severe enough. This supports ours and others' findings[21] that those with more severe symptoms were more likely to consult for their RTI. Other reasons for not consulting an HCP, particularly in P-Y1, were COVID-19-related factors—fear of spreading or contracting COVID-19, or not wanting to take up NHS staff time. This echoes another online UK survey that found three-quarters researched their symptoms during the start of the pandemic and many did so to avoid 'bothering the GP'.[22] However, these factors were less prominent in P-Y2, and as of 2022, the government's public messaging focuses on encouraging those who require care to seek it.[23] The NHS has also relaunched a series of 'Help Us to Help You' campaigns to raise awareness of common symptoms for the life-threating disease, such as lung[24] and cervical[25] cancer, as they are facing late presentation and referrals due to delayed/missed routine resting, or patients not coming forward. This accentuates the potential for unintended consequences of self-care if clear guidance on when to consult is not available. Public health bodies have acted on the requirement for clear guidance on how to manage an array of common infections, including RTIs, through the development of patient self-care guides.[26] They are digitally available, in plainly written English for those with low health literacy, and in languages to encompass England's diversity. This aims to address any unintentional consequences of self-care through safety netting and advising when to seek help.

During P-Y1, there was no reduction in the proportion of respondents who consulted an HCP; however, there was a seven-percentage-point reduction in P-Y2 compared to the baseline. This appears to be reflected in the reduction of those reporting having visited a GP during P-Y2. This reduction in GP consultations could be attributed to any number of factors, for example, the resumed availability of wider healthcare provisions, such as out-of-hours services and clinics (although our findings do not suggest an increase in the use of these services); the public becoming accustomed to self-care and reduced reliance on HCP for self-limiting infections; or may perhaps reflect potential (perceived) difficulties in accessing GP appointments.[27] Interestingly, although pharmacies across England remained open throughout the pandemic, and NHS choices advised the public to consult their pharmacist for RTIs,[10] there was no increase in pharmacy consultations in either P-Y1 or P-Y2 compared with baseline. This suggests the public may lack awareness or understanding of the role of community pharmacists, a misunderstanding which has also been reported by other HCPs.[28] As healthcare becomes less COVID-19 orientated, it should be considered how the public can continue to self-care, and, if appropriate, how both pharmacists and GPs in tandem can continue to support and facilitate this.

Healthcare professionals, in particular pharmacists, who continued to provide face-to-face frontline services,[10] faced many challenges during the pandemic, including a lack of training on public health emergency preparedness,[29] a change to their job role and policies[30] and insufficient personal protective equipment.[31] GPs have also faced challenges including staff retention.[32] Yet despite this, patients expected, and continue to expect more from their consultation with GPs and pharmacists, compared to pre-P. During P-Y1 and P-Y2, there was a significant increase in expectation for antibiotics to almost half of those consulting their GP, and 16% of

those consulting their pharmacist. This was coupled with an increased expectation for advice on the need for antibiotics, which was mostly met. Despite increased expectations, reported prescribing remained consistent with baseline, suggesting that prescribing did not increase during the pandemic. The current study cannot comment on how this may have impacted patient satisfaction as data was only collected during P-Y2.

According to national data, prior to the pandemic, total antibacterial prescribing had been decreasing (0.3% per month) in primary care across England.[33] During March 2020, there was a sudden increase of 1.5 items per 1000 population compared to March 2019.[33] This raised initial concerns about inappropriate antimicrobial prescribing and that COVID-19 may deprioritize AMS.[11] However, primary care RTI prescribing remained stable, and the expected rise in the winter was not observed in P-Y1[34] nor P-Y2.[35] Faced with these initial concerns, the challenges of remote prescribing, and the extent to which COVID-19 has dominated healthcare provisions, stable antibiotic prescribing should be considered a noteworthy outcome of the pandemic and a solid foundation for refocusing AMS going forward.

Finally, there was a notable shift in *how* respondents reported having sought healthcare advice, with an increase towards remote consultations: this is echoed by national consultation data, whereby remote consultations doubled from the month prior to and the month commencing national lockdown restrictions in England.[7] Remote consultations continued to rise during P-Y1 and are sustained into P-Y2.[7] There were initial concerns surrounding telemedicine, including digital inequity,[36] quality of care,[37] communication and language barriers[38] and patient satisfaction, yet our data suggest respondents were no more satisfied with in-person than remote consultations, which is echoed by others.[39] Remote consultations remove geographical barriers for patients and improve time efficiency for HCPs,[38] but these concerns, particularly around digital inequity, are still withstanding. As with work in other sectors, the pandemic has shown the benefits of technology and accelerated its application in healthcare provisions, and the forecast suggests remote consultations, in some capacity, are here to stay. Therefore, it is important that there are resources in place to support this. Our results highlighted that most advice was still received verbally. Ley's model on effective medical communication[40] emphasizes that up to 80% of information during a consultation is immediately forgotten, but written resources can improve information retention. It is, therefore, crucial that HCPs have the resources to facilitate patient wants for advice, during both face-to-face and remote consultation, and that these resources[26] are available digitally so that they can be shared electronically post-consultation.

Strengths and limitations

The current study explored respondents' health-seeking behaviours in the 12-month period up to March 2022, covering the first and second years of the COVID-19 pandemic and the associated restrictions imposed in England. The health-seeking behaviours pertained to their most recent infection, which could have been anytime in the previous year, thus capturing a crude measure of behaviour changes occurring due to the pandemic which does not differentiate between the different time points throughout the pandemic where levels of local/national lockdown and guidelines varied.

Our findings consistently align with national consultation data[5,7,33] while providing additional insight into patient health-seeking behaviours.

Although the P-Y1 and P-Y2 (telephone interview) differs from the pre-P (face-to-face household interviews), and as such, are not directly comparable, both methods are interviewer-assisted, and thus were deemed most comparable to face-to-face sampling while considering government restrictions.

Conclusion

Unsurprisingly, the first year of the COVID-19 pandemic dramatically impacted health-seeking behaviours across England with more self-care for RTIs, suggesting the public has been more proactive and empowered to look after their own health. It should be considered that NPI restrictions such as working from home, which rapidly became 'the new normal', may have enabled greater self-care, as well as likely reduced the incidence of infection. Therefore, it is essential that we do not revert to pre-P norms, and instead, embrace policies and guidelines that facilitate self-care under the proviso that there is clear information, such as self-care leaflets[26] to advise the public on when they should consult for their symptoms to protect against unintentional consequences of self-care, with appropriate safety-netting for those whose condition does not self-resolves, or deteriorates.

Supplementary data

Supplementary data are available at *EURPUB* online.

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Conflicts of interest: None declared.

Data availability

The authors confirm the data supporting the findings of this study are available within the article and its Supplementary material. Raw data that support the findings of this study are available from the corresponding author, upon reasonable request.

Key points

- There is a need to increase awareness of available resources to foster and facilitate self-care of self-limiting infections, such as RTIs, through self-care guides which include safety-netting messages.
- Emphasize to the public the role of the pharmacy in caring for RTIs and inform pharmacists of the public's expectations to further encourage and support self-care.
- For those who consult, expectation of antibiotics for RTIs has increased in primary care.

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