

General practitioners' experiences delivering essential care services during the 2020 and 2021 COVID-19-related lockdowns

Pallavi Prathivadi, Mridula Shankar, Asvini Subasinghe, Jennie Raymond, Cathy Grech, Danielle Mazza

Background and objective

The UK provided guidance for general practitioners (GPs) to deliver essential care services during the COVID-19 pandemic. Our objective was to describe local GP experiences and approaches to delivering care while similar formal guidance in Australia was unavailable.

Methods

Two hundred and ninety-one GPs who practised during the March 2020 to December 2021 COVID-19 lockdowns in Melbourne and Sydney undertook an electronic survey exploring perceptions of essential care service delivery. The provision of care by Australian practices was compared to UK Royal College of General Practitioners' recommendations.

Results

Of 274 completed surveys, Australian GP practices were 60% concordant with UK guideline recommendations. There was a large shift towards telehealth service provision across the board, from diagnosis to follow-up. Most care continued if it was deliverable through telehealth or had urgent or time-sensitive need.

Discussion

Local guidance for delivery of essential care services should be developed for future calamities, informed by GPs' experience practising during the COVID-19 pandemic and considering Australian contextual factors.

DURING THE HEIGHT of the COVID-19 pandemic from March 2020 to December 2021, fear of overburdened hospitals and high mortality rates observed internationally contributed to aggressive pandemic mitigation strategies in Australia. During this period, the population was mostly unvaccinated.¹ Lockdown orders to work and learn from home, closure of public spaces (including dining and retail), curfews, and restrictions on exercise and group activity (including organised sport and social gatherings) were intended to reduce viral transmission.²

Healthcare delivery was particularly challenging during the lockdowns. Healthcare workers and patients risked COVID-19 transmission in healthcare settings, and managing serious COVID-19 illness became a public health priority.¹ In general practice internationally, strategies such as the rapid adoption of telehealth services (through telephone and video consultations) and prioritising treatment of COVID-19-related illness were used to minimise healthcare-related COVID-19 transmission, streamline workflow, enhance surge capacity, and conserve personal and protective equipment (PPE).

In March 2020, within weeks of the World Health Organization (WHO) declaring COVID-19 a pandemic and months before the introduction of vaccinations, the UK Royal College of General Practitioners (RCGP) released formal guidelines for general practitioners (GPs) and practices for safe service delivery during the

COVID-19 pandemic.³ The guidelines acknowledged that some general practice services were 'unlikely to cause harm if delayed for a short number of months' and the risk of patients dying from non-COVID-19 illnesses if all healthcare resources targeted only COVID-19-related service delivery.³

The guidelines also presented recommendations for delivering essential care services using a traffic light system (Table 1).

There was no similar published protocol-based guidance available in Australia, and GPs and practices had to make autonomous decisions on how to feasibly provide care. Although primary health networks (PHNs) and state-based Royal Australian College of General Practitioners' (RACGP) chapters provided educational webinars and Q&As with key health officers and similar to ensure GPs were aware of restrictions and legislative changes relating to COVID-19, emerging evidence and business support, no standardised guidelines were produced to guide actual service delivery. The aim of this study was to describe GPs' experiences and approaches to delivering essential care services during the COVID-19 pandemic and explore whether GP service delivery in Australia was in line with RCGP guidance.

Methods

Participants

Participants were GPs who were practising in metropolitan Melbourne and Sydney during COVID-19 lockdowns and had practised for

at least six consecutive months prior to the pandemic to compare baseline practices. A recruitment target of 381 GPs was identified to reduce research demands on overworked GPs but still meet necessary sample size calculations. Electronic invitations were circulated through newsletters and social media of professional networks (including the Monash University Practice Based Research Network, the SPHERE Centre of Research Excellence, the Australian Medical Association Victoria and NSW, PHNs and the RACGP) and the GPs Down Under Facebook group (for a copy of the electronic invitation, please contact the corresponding author). Interested participants were sent a personalised link to the survey following a short electronic eligibility assessment. On completion of the survey, GPs were offered gift cards to the value of \$30.

Procedures

The de-identified electronic survey was conducted in May 2021 using the Qualtrics platform. It included 45 close-ended, multiple-choice questions and took 10–15 minutes to complete (for a copy of the survey, please contact the corresponding author). After a brief section on demographics, Part 1 of the survey collected data relating to change in delivery of general practice care during the COVID-19 pandemic. In Part 2, participants reported their experience delivering various care items as one of three responses modelled on the UK RCGP traffic light system of green (continued regardless of outbreak scale), amber (continued if capacity allowed) and red (postponed, with aim to revisit). Pilot testing for usability and technical functionality was undertaken by 16 academics from various backgrounds at the Monash University Department of General Practice, and feedback was incorporated into revisions before fielding the survey.

Statistical analysis

Survey responses were summarised as descriptive statistics. Participant demographics and practice characteristics are presented as discrete frequency counts and percentages. We assessed homogeneity in proportions based on *P*-values associated with Pearson χ^2 statistic. Statistical significance was determined at an alpha of 0.05.

Ethics approval

The project was approved by the Monash University Research Ethics Committee (project ID 27635).

Results

Between May and December 2021, 291 electronic surveys were received, of which 17 were only partially completed.

Participant demographics were generally comparable to the wider Australian metropolitan GP population (Table 2). Most were from Melbourne (190/291; 65.3%), 53% were women (154/291; 52.9%), and half were aged 46 years or over (144/291; 49.5%). Most participants were Fellows of the RACGP (249/291; 85.6%).

Experiences and approaches to delivery of clinical services

Lockdowns changed the mode of GPs' delivery of medical care, with almost universal uptake of telehealth. Overall, 95.2% of participants reported increased use of telehealth for diagnosis, investigation and management of clinical conditions, and 96.6% increased use for follow-up. Many aspects of general practice were triaged for time sensitivity and postponed by GPs (Table 3). Some 61.2% of participants postponed or delayed a procedure or referral, and 52.9% of participants

postponed a GP-initiated scheduled consult. In contrast, only 36.8% of participants postponed a patient-initiated scheduled consult. Additionally, 47.1% of participants reported a decrease in clinical care to emergency walk-in patients.

Preventative care

A varied approach was taken to the delivery of preventative care during lockdowns. Some preventative health activities were largely continued as normal, including childhood and adult immunisations, which only 5% of participants postponed despite requiring face-to-face care. However, other activities were often delayed, including health assessments and medication reviews, which were postponed by 37.6% of participants despite the potential for telehealth delivery of some of these activities. Variation in delivery seemed to relate to the potential health effects of services; activities that had *definite* or *immediate* health outcomes (eg immunisations) were continued more commonly than services that had *possible* health implications (eg screening or health assessments).

Women's health

Of the seven women's health-related items asked about, four were continued regardless by most participants: high-risk cervical cancer screening, 68.7%; contraceptive counselling, 68.3%; postnatal checks, 63.3%; and abortion services, 62.3%. Items that necessitated face-to-face care and were not perceived as clinically urgent were more commonly postponed than services that could be delivered by telehealth or were not time sensitive (eg routine low-risk cervical screening was postponed by 28.1% of participants, intrauterine device insertion or removal was postponed by 18.1%,

Table 1. Summarised UK RCGP 'guidance on workflow prioritisation during COVID-19', presented as a traffic light system with examples of corresponding essential care services³

Green	Yellow	Red
<i>Aim to continue regardless of the scale of the virus outbreak</i>	<i>Continue if capacity allowed with remote review strongly recommended</i>	<i>Postpone, aiming to revisit once the outbreak ends</i>
Symptoms consistent with cancer that might require referral, wound management and childhood immunisations	Contraceptive services, routine low-risk cervical screening and blood monitoring for lower-risk medications	Minor surgery, minor self-limiting illness and worried well, spirometry and routine ECGs

ECG, electrocardiogram; RCGP, Royal College of General Practitioners.

Table 2. Demographic and practice characteristics of GPs in metropolitan Melbourne and Sydney who responded to the survey on delivering ECS during the COVID-19 pandemic, 2021 (n=291)

Characteristic	n	%
Gender		
Woman	154	52.9
Man	137	47.1
Age in years		
<35	51	17.5
35-45	96	33.0
46-55	59	20.3
≥56	85	29.2
Primary practice area		
Metro Sydney	101	34.7
Metro Melbourne	190	65.3
Years in general practice		
<5	56	19.2
5-10	69	23.7
11-20	54	18.6
>20	112	38.5
Fellowship status		
RACGP/ACRRM ^a	250	85.9
GP in training	12	4.1
No GP fellowship	29	10.0
Total	291	100.0

^aACRRM membership, n=1.

ACRRM, Australian College of Rural and Remote Medicine; ECS, essential clinical services; GP, general practitioner; RACGP, Royal Australian College of General Practitioners.

and contraceptive implant insertion or removal was postponed by 14.2% of participants).

High clinical acuity conditions

Care for five of the six conditions requiring urgent care or that were of high clinical acuity were continued by most GPs. For instance, 93.6% of participants continued as normal for care of symptoms consistent with cancer, and 91.1% of participants continued investigations for immediately necessary conditions such as serious anaemia. Most urgent or high acuity care could be delivered by telehealth and was postponed by less than 3% of participants. In contrast, acute home visits to housebound/residential or nursing home patients, which required face-to-face delivery, were postponed by 18.1% of participants.

Low clinical acuity conditions

Care for low clinical acuity conditions varied markedly and was similarly driven by time sensitivity or options for safe telehealth delivery of care. Items commonly postponed included spirometry and routine echocardiograms (postponed by 66.2% of participants), data collection requests (50%) and minor surgery (43.1%). Only 20% of participants postponed aviation or driver's licence medical examinations and less than 2% postponed (time-sensitive) essential injections such as Prolia for the management of osteoporosis.

Table 4 provides further details regarding GP delivery of specific services during the COVID-19 pandemic. Few differences were found between Melbourne- and Sydney-based participants or by years of practice.

Table 3. Changes in service provision during the March 2020 to December 2021 COVID-19 lockdowns among a sample of metropolitan Melbourne and Sydney general practitioners

Consult type	n	Decreased	Stayed the same	Increased
Tele consult for diagnosis, investigation and management	291	1.7	3.1	95.2
Tele consult for follow-up (including results)	291	1.4	2.1	96.6
Clinical care to emergency walk-in patients	291	47.1	42.6	10.3
Recommend postponing or delaying scheduled consult	291	4.5	42.6	52.9
Recommend postponing or delaying patient-initiated medical consult	291	5.8	57.4	36.8
Recommend postponing or delaying a procedure or referral	291	5.2	33.7	61.2

Table 4. Approach to services during the March 2020 to December 2021 COVID-19 lockdowns among a sample of metropolitan Melbourne and Sydney general practitioners

Healthcare service	n	Continued if capacity	Continued regardless	Postponed
Women's health				
Routine cervical screening for women considered to be low risk	281	37.7	34.2	28.1
Cervical screening for women with previous high-risk changes/treatment to cervix or on more frequent recalls	281	26.7	68.7	4.6
Postnatal checks	281	31.0	63.3	5.7
Contraceptive counselling and prescriptions	281	27.0	68.3	4.6
IUD insertion/removal	281	44.1	37.7	18.1
Contraceptive implant insertion/removal	281	42.3	43.4	14.2
Abortion services	281	30.6	62.3	7.1
Preventative health				
Administer routine childhood or adult immunisations	281	40.2	54.8	5.0
Preventative care, health assessments and medication reviews	274	47.1	15.3	37.6
Urgent/high clinical acuity				
Investigations for immediately necessary conditions such as serious anaemia	281	8.2	91.1	0.7
Symptoms consistent with cancer that might require referral	281	5.7	93.6	0.7
Palliative care including anticipatory care and end-of-life conversations	281	16.0	82.2	1.8
Blood monitoring for high-risk medications (eg INR, DMARDs and immunosuppressants)	274	16.1	82.5	1.5
Acute home visits to housebound/residential or nursing home patients BUT only following remote triage and when clinically necessary	281	44.1	37.7	18.1
Reviews for those at higher risk	281	33.1	64.1	2.8
Low clinical acuity				
Mild self-limiting illness and worried well	281	49.1	21.0	29.9
Medication/problems that cannot be dealt with by community pharmacy	281	36.7	60.9	2.5
Dealing with complaints	274	18.2	78.1	3.6
Travel vaccinations, insurance reports, medical reports and non-urgent paperwork	274	41.2	19.7	39.1
Aviation and driver eligibility assessments	274	55.8	25.2	19.0
Data collection requests unless related to COVID-19 (eg audits, routine reviews and inspections, and appraisal and accreditation processes)	274	32.5	17.5	50.0
Face-to-face reviews of routine care for most at-risk groups	281	46.6	26.3	27.0
Advice regarding self-isolation or information for employers and schools	281	21.0	76.9	2.1
Spirometry and routine ECGs unless clinically indicated	281	22.8	11.0	66.2
Minor surgery	281	38.4	18.5	43.1
Wound management/dressings	281	35.9	61.6	2.5
Ear syringing	281	39.9	32.0	28.1
Vitamin B12 injections	281	43.8	40.2	16.0
Essential injections (eg Prolia or testosterone)	281	24.2	74.0	1.8
Blood monitoring for lower risk medications and conditions (eg ACE inhibitors, antipsychotics or thyroid disease)	274	41.6	42.7	15.7
Blood results review and filing	274	18.2	78.8	2.9

ACE, angiotensin-converting enzyme; DMARDs, disease-modifying anti-rheumatic drugs; ECG, electrocardiogram; INR, international normalised ratio; IUD, intrauterine device.

Guideline concordance

Of the 30 essential care services outlined in the RCGP guidance, GPs reported consistent practices for 17 items. Except for acute home visits (which the UK recommended to continue as normal but Australian GPs continued if capacity allowed), the remaining 12 services were all continued as normal or if capacity allowed by Australian GPs, whereas UK recommendations advised more restrictive practices. Table 5 compares RCGP recommendations and consensus Australian GP practices using the colour-coded traffic light system.

Discussion

GPs delivering essential care services during COVID-19 lockdowns described a large shift towards telehealth delivery across the board from diagnosis to follow-up, even for high acuity or urgent care conditions. Almost one-fifth of GPs postponed home visits for housebound/residential and nursing home patients. Time-sensitive conditions and preventive care that might be perceived as having a definite or immediate effect were also continued by a larger number of practitioners.

Despite the lack of clear national guidance (or even local guidance by PHNs, state health departments or state-based RACGP chapters, all of whom were suitably placed to provide standardised guidelines), Australian GPs still appear to have workably triaged the provision of essential care services throughout the lockdowns. This might have been guided by community priorities, social media forum discussions, modelling of peer practices, and independent clinical judgements of COVID-19 risks to providers and patients.^{1,4,5} Australian practices were concordant with close to 60% of the UK RCGP guidance and otherwise tended to continue providing care as normal, while the RCGP recommended more restrictive practice. Emerging studies of UK GP compliance with RCGP guidance suggest a similar embrace of telehealth services with potentially more encouragement of video-based consultations.⁶ A qualitative study from 2021 showed general compliance with RCGP recommendations, with some UK GP autonomous decision-making around safe face-to-face care delivery where there was 'knowledge of the patient, experience and practice resilience'.⁷ Similarly, our

results showed that GPs in Australia followed the broad guidance that was issued. The interview study associated with our project might provide more insight into the specific factors that guided Australian GP decision-making processes around service delivery during the lockdowns.

The differences in international findings are likely to reflect the influence of several contextual factors. First, at the onset of the pandemic and throughout lockdowns, Australia introduced rapid and widespread access to bulk-billed telehealth services.⁸ As a result, Australian GPs and practices could continue to provide even low clinical acuity care through telehealth while eliminating the risk of COVID-19 transmission. Second, the UK experienced a significantly worse COVID-19 outbreak than Australia, with more pressure on GPs and GP practices to provide COVID-19-related care.⁹ At the height of the 2020–21 pandemic, Victoria was reporting fewer than 900 new daily COVID-19 cases,² compared to over 50,000 in the UK.⁹ Third, the lockdown objectives in Victoria included eliminating COVID-19 transmission and reaching a 'COVID zero' goal.¹ Therefore, more aggressive restrictions were implemented, including healthcare and aged care workers needing to limit their physical presence to a single workplace or healthcare setting to conserve PPE and avoid cross-contamination.¹⁰ This might have influenced Australian GPs postponing visits to homebound or nursing home patients, despite such visits being recommended by the RCGP guidance to continue as normal. Finally, during the lockdowns, GPs faced considerable shortages of and difficulty accessing PPE. Government stockpiles were preferentially channelled to hospitals and practices, practices needed to source and purchase PPE privately, and there was a lack of access to routine fit testing of masks.¹¹ Further research in terms of a national study of Australian GPs might further clarify disparities in practice, given the widely differing lengths of lockdown across the country and the severity of regional COVID-19 outbreaks.

Services that were time sensitive or had immediate health effects were generally continued as normal, even if delivered face to face. Our findings that only 5% of GPs postponed routine childhood immunisations was supported by Australian Immunisation

Registry data demonstrating that the Victorian childhood vaccination program was largely unaffected by COVID-19.¹² Local health promotion efforts in later lockdowns might have encouraged parents to follow vaccination schedules despite parental and provider fears of COVID-19 transmission.¹² These Australian findings differ starkly to global averages of 7–8% reductions in childhood diphtheria–tetanus–pertussis and measles-containing vaccinations during the COVID-19 pandemic.¹³ Although participants reduced reported delivery of clinical care to emergency walk-in patients, duty of care requirements did not change during the COVID-19 pandemic. Therefore, it is unlikely that half the number of GPs stopped providing urgent medical assistance. Rather, half of our participants might have seen reduced emergency walk-in patients because of the lockdown.

A key limitation of this study is that it did not achieve the targeted number of participants despite using reliable techniques to improve recruitment (ie a physician recruiter, university affiliation, financial incentivisation and brevity in design).^{14,15} COVID-19-related work commitments and personal and professional burnout are likely to have contributed to GP reluctance to engage in this research.^{1,5} Demographic data relating to practice funding models (ie bulk-billing or private billing) would have assisted with meaningful interpretation of differing practices, given the financial pressures on GP practices as small businesses during the COVID-19 pandemic. Data relating to proximity or concurrent practice at a government-funded COVID-19 respiratory clinic (that typically had well-stocked PPE) would have provided additional insights into scope of practice delivered and telehealth practices. Finally, some GPs might have had difficulty interpreting survey items due to the wording being derived directly from the RCGP guidelines and, therefore, being more appropriate for the UK setting. Again, the interview study that followed this survey will help explore and interpret these findings.¹⁶

Future research could compare the provision of essential care services across differing healthcare settings (eg general practice, hospital outpatient clinics, councils, schools, and community maternal and child health centres) and timepoints (including before and after the rollout of the national

Table 5. Comparison and consensus between UK RCGP guidance recommendations for essential care service delivery and reported predominant practice by a sample of metropolitan Melbourne and Sydney GPs

Item	RCGP recommendation	Australian GP majority consensus
Routine cervical screening for women considered to be low risk	<i>Continue if capacity</i>	<i>Continue if capacity</i>
Cervical screening for women with previous high-risk changes/treatment to cervix or on more frequent recalls	<i>Continue regardless</i>	<i>Continue regardless</i>
Postnatal checks	<i>Continue regardless</i>	<i>Continue regardless</i>
Contraceptive counselling and prescriptions	<i>Continue if capacity</i>	<i>Continue regardless</i>
IUD insertion/removal	<i>Postpone</i>	<i>Continue if capacity</i>
Contraceptive implant insertion/removal	<i>Postpone</i>	<i>Continue regardless</i>
Abortion services	NA	<i>Continue regardless</i>
Administer routine childhood or adult immunisations	<i>Continue regardless</i>	<i>Continue regardless</i>
Preventative care, health assessments and medication reviews	<i>Postpone</i>	<i>Continue if capacity</i>
Investigations for immediately necessary conditions such as serious anaemia	<i>Continue regardless</i>	<i>Continue regardless</i>
Symptoms consistent with cancer that might require referral	<i>Continue regardless</i>	<i>Continue regardless</i>
Palliative care including anticipatory care and end-of-life conversations	<i>Continue regardless</i>	<i>Continue regardless</i>
Blood monitoring for high-risk medications (eg INR, DMARDS and immunosuppressants)	<i>Continue regardless</i>	<i>Continue regardless</i>
Acute home visits to housebound/residential or nursing home patients BUT only following remote triage and when clinically necessary	<i>Continue regardless</i>	<i>Continue if capacity</i>
Reviews for those at higher risk	<i>Continue regardless</i>	<i>Continue regardless</i>
Mild self-limiting illness and worried well	<i>Postpone</i>	<i>Continue if capacity</i>
Medication/problems that cannot be dealt with by community pharmacy	<i>Postpone</i>	<i>Continue regardless</i>
Dealing with complaints	<i>Continue if capacity</i>	<i>Continue regardless</i>
Travel vaccinations, insurance reports, medical reports and non-urgent paperwork	<i>Postpone</i>	<i>Continue if capacity</i>
Aviation and driver eligibility assessments	<i>Postpone</i>	<i>Continue if capacity</i>
Data collection requests unless related to COVID-19 (eg audits, routine reviews and inspections, appraisal and accreditation processes)	<i>Postpone</i>	<i>Postpone</i>
Face-to-face reviews of routine care for most at-risk groups	<i>Continue if capacity</i>	<i>Continue if capacity</i>
Advice regarding self-isolation or information for employers and schools	<i>Postpone</i>	<i>Continue regardless</i>
Spirometry and routine ECGs unless clinically indicated	<i>Postpone</i>	<i>Postpone</i>
Minor surgery	<i>Postpone</i>	<i>Postpone</i>
Wound management/dressings	<i>Continue regardless</i>	<i>Continue regardless</i>
Ear syringing	<i>Postpone</i>	<i>Continue if capacity</i>
Vitamin B12 injections	<i>Continue if capacity</i>	<i>Continue if capacity</i>
Essential injections (eg Prolia or testosterone)	<i>Continue regardless</i>	<i>Continue regardless</i>
Blood monitoring for lower risk medications and conditions (eg ACE inhibitors, antipsychotics, or thyroid disease)	<i>Continue if capacity</i>	<i>Continue regardless</i>
Blood results review and filing	<i>Continue regardless</i>	<i>Continue regardless</i>

ACE, angiotensin-converting enzyme; DMARDS, disease-modifying anti-rheumatic drugs; ECG, electrocardiogram; GPs, general practitioners; INR, international normalised ratio; IUD, intrauterine device; NA, not applicable; RCGP, Royal College of General Practitioners.

COVID-19 vaccination program and during outbreaks of differing COVID-19 strains). Studies evaluating whether UK GPs followed the recommendations of the RCGP document or had discordant practices themselves are only just emerging and would help in understanding the contextual effects on GP decision making and guiding appropriate revision of the guidelines.

Conclusion

This study reports on the experiences of Australian GPs in 2020 and 2021 during the COVID-19 pandemic. Unfortunately, we are likely to face future pandemics. Understanding the experiences of GPs during the COVID-19 pandemic and providing guidance to practitioners in primary care about how to approach service delivery during a pandemic will help future preparedness. Australian guideline developers should act soon to develop national guidance that considers local contextual factors and provider experiences through the COVID-19 pandemic.

Authors

Pallavi Prathivadi PhD, MBBS, BMedSc (Hons), MMed (Pain Mgt), DCH, GAICD, FRACGP, Adjunct Senior Lecturer, Equity, Primary Care, Implementation and Community (EPIC) Research Unit, Monash University, Melbourne, Victoria

Mridula Shankar PhD, MPH, BA, Research Fellow in Sexual and Reproductive Health and Rights, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Victoria

Asvini Subasinghe PhD, BA/BSc (Hons), Preconception Health Network Research Fellow, Eastern Health Clinical School, Monash University, Melbourne, Victoria

Jennie Raymond BNurse, Research Assistant, Department of General Practice, Monash University, Melbourne, Vic

Cathy Grech MBBS, FRACGP, Senior Lecturer, Department of General Practice, Monash University, Melbourne, Vic

Danielle Mazza MD, MBBS, FRACGP, DRANZCOG, Grad Dip Women's Health, GAICD, CF, Head, Department of General Practice, Monash University, Melbourne, Vic

Competing interests: None.

Funding: The study was supported by the HCF Research Foundation/RACGP Foundation COVID-19 Research Grant in 2020.

Provenance and peer review: Not commissioned, externally peer reviewed.

Correspondence to:

pallavi.prathivadi@monash.edu

Acknowledgements

The authors thank Dr Tara Dev and all the participants of the study.

References

1. Basseal JM, Bennett CM, Collignon P, et al. Key lessons from the COVID-19 public health response in Australia. *Lancet Reg Health West Pac* 2023;30:100616. doi: 10.1016/j.lanwpc.2022.100616.
2. Australian Government. 3 step framework for a COVIDSafe Australia. Australian Government, 2020. Available at www.health.gov.au/sites/default/files/documents/2020/06/3-step-framework-for-a-covidsafe-australia-3-step-framework-for-a-covidsafe-australia_2.pdf [Accessed 29 January 2024].
3. Royal College of General Practitioners (RCGP). COVID-19 workload prioritisation unified guidance. RCGP, 2021. Available at www.rcgp.org.uk/getmedia/b18afc5e-a380-4e09-9205-82492cda7871/RCGP_BMA-COVID_workload_prioritisation_5112020.pdf [Accessed 29 January 2024].
4. Copp T, Isautier MJ, Nickel B, et al. COVID-19 challenges faced by general practitioners in Australia: A survey study conducted in March 2021. *Aust J Prim Health* 2021;27(5):357-63. doi: 10.1071/PY21165.
5. Tsirtsakis A. GPs seek clarity on impending role in managing COVID patients. *NewsGP*, 2021. Available at www1.racgp.org.au/newsgp/professional/gps-look-for-clarity-on-impending-role-in-managing-cov [Accessed 29 January 2024].
6. Trethewey SP, Beck KJ, Symonds RF. Video consultations in UK primary care in response to the COVID-19 pandemic. *Br J Gen Pract* 2020;70(694):228-29. doi: 10.3399/bjgp20X709505.
7. Turner A, Scott A, Horwood J, et al. Maintaining face-to-face contact during the COVID-19 pandemic: A longitudinal qualitative investigation in UK primary care. *BJGP Open* 2021;5(5):BJGPO.2021.0036. doi: 10.3399/BJGPO.2021.0036.
8. Aubusson K. GP push to remove ban on private billing for telehealth. *Sydney Morning Herald*. 24 August 2020. Available at www.smh.com.au/national/gp-push-to-remove-ban-on-private-billing-for-telehealth-20200824-p55oti.html [Accessed 29 January 2024].
9. World Health Organization. WHO COVID-19 dashboard. World Health Organization, 2024. Available at <https://covid19.who.int/2021> [Accessed 29 January 2024].
10. Department of Health and Human Services (DHHS). Plan for the Victorian aged care sector. DHHS, 2020.
11. Woodley M. New research reveals extent of PPE struggles when COVID hit. *NewsGP*, 2022. Available at www1.racgp.org.au/newsgp/clinical/new-research-reveals-extend-of-ppe-struggles-when [Accessed 29 January 2024].
12. Hull BP, Hendry AJ, Dey A, et al. The impact of the COVID-19 pandemic on routine vaccinations in Victoria. *Med J Aust* 2021;215(2):83-84. doi: 10.5694/mja2.51145.
13. Causey K, Fullman N, Sorensen RJD, et al. Estimating global and regional disruptions to routine childhood vaccine coverage during the COVID-19 pandemic in 2020: A modelling study. *Lancet* 2021;398(10299):522-34. doi: 10.1016/S0140-6736(21)01337-4.
14. Veitch C, Hollins J, Worley P, Mitchell G. General practice research. Problems and solutions in participant recruitment and retention. *Aust Fam Physician* 2001;30(4):399-406.
15. Pit SW, Vo T, Pyakurel S. The effectiveness of recruitment strategies on general practitioner's survey response rates – A systematic review. *BMC Med Res Methodol* 2014;14(1):76. doi: 10.1186/1471-2288-14-76.
16. Subasinghe A, Prathivadi P, Epstein D, Amos N, Raymond J, Mazza D. Prioritising essential clinical services (ECS) in general practice during the COVID-19 pandemic: A protocol for the evaluation of the Royal College of General Practitioners (RCGP) guidance for the Australian context. *Aust J Prim Health* 2021:xlix.

correspondence ajgp@racgp.org.au