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Primary Care Practice in Response to the Covid-19 Epidemic.

Between Weakening and Strengthening of the Dynamics of Local Coordination

Cécile Fournier[1], Lucie Michel[1], Noémie Morize[1,2], Laure Pitti[1,3], Matti Suchier[1]
with the collaboration of Isabelle Bourgeois[1,4] and Vincent Schlegel[1]

The first section of the survey entitled Coordinated Primary Care Practice in Response to the Covid-19 Epidemic (EXECO2) focuses on the reconfiguration of the organisation of primary care during the first wave of the epidemic (March to June 2020), in six areas of mainland France with contrasting characteristics. This sociological survey lies on a comparative case study, based on prior knowledge of the areas studied and on qualitative interviews, conducted between March and December 2020, with members of multidisciplinary primary care teams and their partners in response to the epidemic.

By suspending routine healthcare services organisation, the health crisis has highlighted areas in which primary care initiatives have local relevance. These areas appear to be distinct from the official administrative ones. Depending on the contexts, the epidemic has suspended, activated, or strengthened pre-existing forms of multidisciplinary collaboration and of intersectoral coordination, more than it has created new forms. Two conflicting developments –the weakening or strengthening of pre-existing dynamics– have been observed.

In this initial phase of the epidemic, the dynamics observed largely depended on the history of the relations between the actors in the areas, while the intensity of the epidemic, the density of healthcare provision, and the socio-demographic characteristics of the population had indirect and contrasting effects.

In the current drive to structure local primary care services in France, encouraged by national public authorities and supported by certain regional authorities (Hassenteufel et al., 2020), the Covid-19 epidemic has disrupted healthcare practices and the organisation of healthcare services since February 2020. Multidisciplinary collaboration and intersectoral coordination in the health sector have been strengthened or weakened. Although "the hospital was the epicentre of the health crisis and the place where all the stories unfolded" (Gaudillière et al., 2021), little was done to highlight primary care practice. The aim of this survey was to study how primary care organisations have contributed "from the bottom-up" to the management of the epidemic in contrasting areas, during the first epidemic wave in March to July 2020. This sociological study is a complement to the qualitative research on a national scale on the "top-down" management of the health crisis (Bergeron et al., 2020; Gaudillière et al., 2021), to the research on a regional scale on the ways in which primary care teams integrated national guidelines into their practices (Schweyer et al., 2021), and to the research on a more local scale in working-class areas (Mariette and Pitti, 2021). It also complements quantitative research conducted on the activity of general practitioners (GPs) and other healthcare professionals during the epidemic (Monziols et al., 2020; Saint Lary et al., 2020; Bourgueil et al., 2020), and the role played by Multiprofessional Group Practices (*Maisons de santé pluriprofessionnelles*, MSP)) and Healthcare centres (*Centres de santé*, CDS) [ACCORD, 2020].

The extent of the first wave of the epidemic, on the basis of excess mortality, differed according to the area, although there was a feeling of uncertainty and a sense of urgency everywhere. One would have thought that local responses would be proportional to the extent of the epidemic. However, in the initial phase of the epidemic, in which this level of decision-making was predominant, the hasty restructuring of primary care services was guided by three types of pre-existing dynamic: multidisciplinary collaboration (the division of labour in and between professional groups); coordination (between the various primary care providers); and local integration (creation of a network of public and private actors, who work on developing

1 The Institute for Research and Information in Health Economics (IRDES).
2 The Centre for the Sociology of Organisations, a research unit of Sciences Po.
3 The Centre for Sociological and Political Research Centre of Paris (CRESPPA).
4 Icone Médiation santé.

norms in order to organise primary care services in the same area).

An assessment of the differentiated local structuring of primary care was firstly made, based on the six areas studied (see Inset "Method and Sources"). It brings an understanding of the levels of action in response to the epidemic. The restructuring of the dynamics of coordination –the weakening or strengthening of coordination– between the actors in these areas was then analysed. The determinants of the local integration of primary care were therefore examined and the dynamics of professional collaboration, outlined in this article, will be discussed at greater length in a future article.

The areas of the health crisis

The first wave of the epidemic affected the areas studied in different ways: in the light of departmental statistics of excess mortality, the epidemic was of lower intensity than the national average in three of the areas (Menhir, Acacias, and Sapins). The Prairies, Pierre-Neuve, and Cornaline areas were much more severely affected. Cornaline was characterised by an excess mortality rate that was amongst the highest in France (see the figure below and see annex online[1]). The comparison between these areas shows that the coordinated response to the epidemic was less conditioned by the extent of the first wave and more by the existence of a process that was already underway–intersectoral coordination and the regional integration of primary care at various levels.

How was primary care organised before the epidemic?

Before the epidemic, the organisation of primary care in the six areas covered a range of practices that reflected greater or lesser degrees of multidisciplinary collaboration, intersectoral coordination, and even local integration. The intensity of these practices varied according to whether the dynamics were driven from the top down, or, on the contrary, they were longstanding local initiatives undertaken by health professionals and regional authorities.

Active collaboration and minimal coordination. The Multiprofessional Group Practices (MSP) in Acacias represents a form of organisation embodied by a MSP, whose self-employed members actively collaborate, but without a local integration dynamic at this stage. Created in 2009, this MSP brings together around thirty self-employed healthcare professionals, working in mono- and multidisciplinary practices located in three peri-urban municipalities. Although the creation of a Local Health Professionals Community (*Communauté Professionnelle Territoriale de Santé*, CPTS) is under consideration to increase coordination with other MSPs in the *département*, no concrete steps have been taken for the moment. In this configuration, the MSP structure appears to be a veritable benchmark for multidisciplinary collaboration.

> *"The MSP is a great system ... the communication, the interchange between professionals, getting to know each other ... That's what's needed, it's not good for everyone to work separately doing their own thing."*
>
> Self-employed chiropodist, MSP (04/2020)

Well-developed coordination, but limited collaboration. Conversely, in certain areas, dynamics of intersectoral coordination existed even though multidisciplinary collaboration remained limited. Hence, the MSP in the Prairies area was created in 2015 in a rural area comprising around forty communes, located in a *département* in which, at the beginning of the 2000s, local councillors and the Departmental Medical Council (*Conseil Départemental de l'Ordre des Médecins*, CDOM) acknowledged that the medical demography was declining sharply. A strategy of creating MSPs and recruiting young doctors was implemented, providing the *département* with a homogenous package of health services through MSPs. However, the Interprofessional Society for Ambulatory Care (*Société Interprofessionnelle de Soins Ambulatoires*, SISA) in the Prairies

[1] https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/260-les-soins-primaires-face-a-l-epidemie-de-covid-19-annexe.pdf

METHOD AND SOURCES

A multiple case study was carried out in six areas, with which the authors were familiar and which had contrasting characteristics (see the Figure below).

Eighty interviews were conducted –reaction and retrospective interviews– between March and December 2020, by telephone, via videoconference, or face-to-face interviews with members of primary care teams: working self-employed in multiprofessional group practice centres (MSP), or as salaried healthcare professionals in an associative Healthcare Centre (CDS) [doctors, nurses, pharmacists, speech therapists, chiropodists, dieticians, physiotherapists, medical secretaries, and coordinators of MSPs, CDS, and Local Health Professionals Communities (CPTS)…]; and with their partners (healthcare professionals and social workers, auxiliary nurses, home care workers, project managers and heads of Local Health Contracts, of associations for continuity of care, etc.). They are working self-employed or salaried in healthcare centres, hospitals, local authorities, or regional public health institutions. The areas were renamed to preserve the anonymity of the people interviewed.

Quantitative data characterising the areas studied can be seen in the Table online. The chosen indicator of the severity of the epidemic is the excess mortality per *département*, a criteria, which, during the first wave, became the leading indicator in the public debate on the epidemic.

Two types of material were used:

- Interviews conducted in previous studies (Fournier et al., 2014 and 2019; Mariette and Pitti, 2016), providing insight into the history of the relations between the actors involved in the organisational response to the epidemic.
- Interviews conducted with 80 actors, members of 6 primary care teams (5 MSPs and one Healthcare Centre (CDS)) and their partners, in 4 areas (see Figure below and annex online, link in the note at the bottom of p.2).

Principal characteristics of the areas and the organizations studied

		Number of years: dynamics of collaboration	Healthcare provision or medical density (number of GPs per 10,000 inhabitants)	Intensity of the epidemic or excess mortality at the departmental level
Les Acacias	• Group of 3 communes, in a peri-urban area • Multi-site MSP, 30 HP	● ● ○	● ● ○	● ○ ○
Cornaline	• District listed as a QPV on the periphery of an urban centre • Associative CDS, 8 HP, creation of CPTS underway	● ● ●	● ○ ○	● ● ●
Menhir	• Group comprising a commune and 2 hamlets, in a peri-urban area • Multi-site MSP, 30 HP, creation of CPTS underway	● ○ ○	● ● ○	● ○ ○
Les Prairies	• Group of 2 communes, on the periphery of an urban centre • MSP with a single site, 20 HP, creation of CPTS underway	● ○ ○	● ● ○	● ● ○
Pierre-Neuve	• Group of communes (40 communes) in rural areas • Multi-site MSP, 25 HP	● ● ●	● ○ ○	● ● ●
Les Sapins	• Group of 3 downtown communes • Multi-site MSP, 50 HP, creation of CPTS underway	● ● ●	● ● ●	● ○ ○

Number of years: dynamics of collaboration: ● ○ ○ ≤ 10 years; ● ● ○ 11 to 20 years; ● ● ● ≥ 21 years

Healthcare provision or medical density (number of GPs per 10,000 inhabitants). National average: 8. The National Social Welfare Fund (FNPS), 2019. ● ○ ○ ≤ 7 GP; ● ● ○ 7.1 à 10 GP; ● ● ● ≥ 10.1 GP

Intensity of the epidemic or excess mortality at the departmental level. National average: 26%. Difference in deaths between 2020 and 2019, from 1 March to 13 April. ● ○ ○ ≤ 15%; ● ● ○ 16 to 35%; ● ● ● ≥ 36%

CDS Healthcare centre employing salaried professionals
CPTS Local Health Professionals Community
MSP Multiprofessional Group practice with self-employed professionals
GP General practitioner
HP Healthcare professional
QPV An urban policy for distressed areas

area continues to be perceived as an "imposed organisation created purely for effect" by some of its members, who, although they are pursuing a health project together, continue to work in mono-professional groups in their respective practices.

Local collaboration, coordination, and integration. Lastly, there are configurations in which multidisciplinary collaboration, intersectoral coordination, and local integration are combined. These dynamics, identified in four of the areas studied, highlighted the role played in this regard by Local Health Professionals Communities (CPTS) that were being –or had already been– created, on different scales: a district (Cornaline), a commune and two hamlets (Menhir), three communes (Sapins), and a canton (Pierre-Neuve). Three of these areas have in common that they are urban areas (The Sapins), and even marginal urban areas (Pierre-Neuve and Cornaline), in which the population's poverty rate is much greater than the national average, the prevalence of chronic diseases is significantly higher, and the principles of coordination are outdated.

In the Cornaline area, the CPTS, which was being set up at the communal level, was based on a project that was initially at district level, a district listed as a "*Politique de la Ville*" (QPV, an urban policy for distressed areas). The team in this health centre played a key role in the structuring of more or less formalised local healthcare networks: via a peer group in the case of the ten or so GPs in the health centre and the doctors in two private practices in two other QPV districts, one of which has been implementing a MSP project for several years; via an ambulatory practice-hospital network, which emerged in 1990 during the HIV AIDS pandemic, and which was revived in 2013 in the form of bi-monthly meetings between GPs and hospital doctors, coorganised by an endocrinologist in the Regional Hospital (*Centre Hospitalier Régional*, CHR) and the coordinating doctor in the Healthcare centre (CDS). This coordination, which was initially informal, led to the project to set up a CPTS, initially at district level, which was implemented by the associative health centre and comprised three private practices, a nursing practice, and the two local pharmacies. The CPTS was extended on a communal level thanks to links established between the centre's team, private practices, and the city's department of health. These links have been facilitated by the fact that this local authority has a public health unit, whose policy officers are assigned according to particular "themes" and to a district – one of them is in fact the district's "health advisor", and is at the same time responsible for the city's healthcare provision.

The same longstanding dynamic of informal local integration was the basis for the CPTS in Pierre-Neuve, as explained by the various types of actors encountered:

> *"We already had a small pool [in commune A], a very dynamic MSP, which was traditionally part of the local health contract. They had even begun to talk about coordinated practices in the 80s. (...) a team (...) that had good working relations with the municipality, the various medico-social and social welfare teams."*
>
> Policy officer, Local Health Insurance Fund [CPAM] (02/2021)

The Sapins area is committed to the extension of the scope of primary care coordination, which, as in Cornaline and Pierre-Neuve, originated at the beginning of the 1980s as part of a local initiative of multidisciplinary collaboration, formalised in an associative form of collaboration.

> *"In 1982, an association was created (...). A group consisting of some GPs wrote in their statutes that it would be a good idea to work intelligently with other professionals in the area (...). This association endured and was transformed, (... with) the creation of the Interprofessional Society for Ambulatory Care (SISA) in 2016."*
>
> Self-employed GP, MHC (07/2020)

This gives some measure, unlike the Prairies area, of the dynamic of coordination created by the SISA, when the establishment of such an organisation emanates from longstanding forms of multidisciplinary collaboration. Hence, primary care coordination in the Sapins area is quite complex, combining various forms of organisational support: this multi-site MSP, bringing together around seventy professionals in one commune was, at the beginning of 2020, in the process of being transformed via a project to set up a CPTS, which aimed to bring together self-employed professionals from another two communes, the area's healthcare facilities (the university hospital, two clinics, and two nursing homes (*Établissement d'hébergement pour personnes âgées dépendantes*, EHPAD), and, lastly, a Territorial Support Platform (PTA).

The situation in Menhir shows, however, that it is possible to create a dynamic of structural coordination, although it is more recent. In this peri-urban area centred around a small commune and two hamlets, there has been a drive to structure primary care since 2010, bringing together all the area's healthcare professionals in a multi-site MSP (a SISA since 2014), which was implementing a project to set up a CPTS that was about to draw up a contract with the French National Health Insurance System (*Assurance Maladie*), in order to be funded, when the epidemic began.

The six organisational configurations of primary care show that –in areas where there are powerful dynamics of multidisciplinary collaboration, intersectoral coordination, and local integration– they are based on areas that are perceived as relevant by the actors involved and that do not necessarily correspond with administrative boundaries. It was in these areas with experience of primary care, created through and by dynamics of collaboration and coordination, resulting from local interaction and often proven longstanding configurations of actors, that primary care was mobilised and coordinated in response to the Covid-19 epidemic.

The epidemic has highlighted areas in which there are primary care initiatives

Rather than creating new dynamics, the epidemic has activated and strengthened pre-existing dynamics of primary care coordination. In the absence of pre-existing and well-established dynamics of coordination before the epidemic, the mobilisation of primary care teams in this critical situation did not improve coordination at local level. Hence, there was minimal coordination of healthcare in the Prairies and Acacias areas, whereas excess mortality due to the epidemic was between five and seven times greater than in the Sapins area (see Table online). Conversely, in the Pierre-Neuve, Sapins, and Cornaline areas, where the extent of the epidemic wave varied greatly, there was increased primary care coordination during the health crisis, largely driven by healthcare teams at the local level, and this strengthened the pre-existing process of local integration. The situation in Menhir was intermediate between these two configurations, with coordination based on increased professional collaboration at the level of the MSP, but which was undermined by a top-down approach to the regional primary care network, in which the Regional Health Agency (*Agence Régionale de Santé*, ARS) played a pivotal role. In the other areas studied, the Regional Health Agencies (ARS) remained on the sidelines with regard to the organisation of primary care at this stage of the epidemic, choosing instead to support certain initiatives.

2 A legal status allowing a group of self-employed professionals to receive collective funding.

CONTEXT

The project Coordinated Primary Care Practice in Response to the Covid-19 Epidemic (EXECO2) was carried out by temporarily redirecting the objectives and resources of three projects undertaken by the Institute for Research and Information in Health Economics (IRDES), funded by the French health insurance system, the Ministry of Health and France Strategy: 1) An assessment of the interprofessional conventional agreement for multiprofessional group practices health centers (EOS), 2) An assessment of the experiments aimed at finding alternatives to fee-for-service payments in the context of Article 51 of the 2018 Social Security Funding Act (Era2), and 3) Understanding paramedical practices in primary care (PARAMED).

Communication without collaboration, and collaboration without coordination: an organisation of primary care that changed little in response to the epidemic. In the SISA in the Prairies area, the epidemic clearly highlighted the fact that each of the practices was still operating in a very independent way, working alongside other practices rather than in a coordinated way, as it was considered that:

"... medical and paramedical work are completely different. We organised things in our practice and the nurses in theirs."

Self-employed GP, MSP (03/2020)

However, the primary care team maintained a basic service, providing an area for interchange and support. In the context of this epidemic, the SISA enabled the healthcare professionals to feel that they were not alone and provided a comforting setting for interchange, compared with health professionals who worked on their own.

"We work in the Interprofessional Society for Ambulatory Care [SISA]; the doctors are really wonderful; they call us up in the evening, and we can call them up when we want (...) we're fortunate; I feel sorry for the poor women (home helpers) who work alone far out in the countryside."

Self-employed nurse, MSP (03/2020)

The reassuring setting for interchange was part of the traditional working and symbolic hierarchical relationship between doctors and nurses, and also between nurses and home helpers. In this area, the Covid strategy was in part a top-down one: initiated by the Departmental Medical Council (CDOM) and supported by the Regional Health Agency (ARS), it was based on regional "e-santé" infrastructure (regional digital coordination tools used to coordinate the work of health and medico-social professionals), which quickly designed an epidemiological monitoring tool, used by all the doctors at the beginning of the epidemic. It was also used when the Covid strategy was primarily initiated by the medical teams, as was the case in the Acacias area; the epidemic did not generate primary care coordination in areas in which it had not existed. In the Acacias area, the multidisciplinary collaborations that existed before the epidemic were used to support the organisation of patient monitoring during the epidemic:

"We have provided a teleconsultation service, and, if required, non-Covid patients come to see us in the morning, and patients suspected of having Covid in the afternoon. There's one doctor every day for the afternoon period. We have created a special waiting room, to prevent other patients from being contaminated (...). We've ensured that there are nurses to help check and monitor patients."

Self-employed GP, MSP (03/2020)

The GPs in the MSP in the Acacias area organised one video meeting, at the beginning of April, in order to disseminate information. Although this meeting was welcomed by the participants, the various actors admitted that there was little communication. The Covid-19 epidemic did not, in fact, prompt the area's health professionals to accelerate the process of creating a CPTS, which was still not particularly formalised at the beginning of the epidemic.

Local dynamics and departmental rivalries: a situation with limited coordination in MSPs. In the Menhir area, the longstanding and well-established multidisciplinary collaboration at the level of the MSP provided a good basis for the organisation of primary care in response to the epidemic. The MSP implemented a dual patient admission system in the centre: a Covid facility staffed by paramedics who had closed their practice, and the admission of non-Covid patients.

"There was a swift response in the MSP. The paramedics closed their practice; they wanted to help us. The coordinator organised their participation. We installed a tent in front of the MSP with two paramedics who rotated their shifts to deal with incoming patients. (...) The advantage of paramedics dealing with incoming patients is that all the patients are sorted. No one with Covid symptoms enters the MSP."

Self-employed GP, MSP (03/2020)

The MSP's members acknowledged the reassuring and protective nature of this collaboration, driven on the basis of a proven experience, enabling them to work in a cohesive way in this critical situation.

"Everyone has found their place and I take my hat off to all those who worked on a voluntary basis. If we didn't have this dynamic, there wouldn't be any goodwill. It's related to the team work in recent years. It's facilitated rapid management and mutual aid."

Self-employed doctor, MSP (04/2020)

This local collaboration, supported by the MSP, contrasts with the increased rivalry generated by the Covid strategy employed on a departmental level. Indeed, in the Menhir area, unlike the other five areas, the Regional Health Agency (ARS) played a pivotal role, by establishing a departmental Covid committee at the end of March, bringing together the french national Medical Council, a hospital coordinator (an infectious disease specialist at the Regional University Hospital), a private coordinator (GP working in a monoprofessional healthcare practice), and the Association for the management of continuity of care (*Association de Gestion de la Permanence des Soins*). This committee set up Covid centres (around thirty at the height of the epidemic) in the *département*'s network, by informally using the network of MSPs. This top-down strategy created tension between the departmental actors, as attested by this extract from an interview:

"There's a whole system with the Covid centres that's been implemented with the social networks, the french national Medical Council, etc. On the regional level –it's quite a mess–, everyone has their own way of organising things. (...) Where we've succeeded in maintaining some cohesion, it's in the MSP. It is the basic unit that has enabled us to maintain a reassuring and comforting working environment. Just yesterday in the departmental meeting, I saw the institutions fighting to have a piece of the cake that's going to be dished out."

Self-employed doctor, MSP (04/2020)

In May 2020, the medical advisor in the Regional Health Agency's local delegation underlined the severe limitations and tensions generated by the fact that "decisions have been taken in a top-down fashion (… which) doesn't work at all". She underlined, on the other hand, the role of mediator between the regional institutions and the local actors, which she had to play in this context.

The role played by local integration in primary care coordination in response to the epidemic. In the light of the survey, the most advanced forms of primary care in response to the epidemic were based on teams that were already involved in local initiatives and participated in the deployment of public policy instruments at a local level, in particular CPTS. In this configuration, the epidemic

strengthened primary care coordination and revealed the role played by local integration in these coordination dynamics.

In the Cornaline area, the continuity of care was based almost exclusively on the coordination promoted by the Healthcare Centre (CDS), which played a leading role in the project to set up a CPTS. In the district studied, two of the three private healthcare practices closed shortly after the beginning of the lockdown. The healthcare centre quickly reorganised itself in order to continue to receive patients in two pathways of care, which had been set up informally several weeks before it became a Covid centre in May 2020, to receive funding for something that had been done de facto.

"The Healthcare Centre became a Covid centre (...), we knew that it was going to be the only Covid centre in the district (...). It was a period during which we received just about everyone. No distinction was made between patients with and without a family doctor."

Employed GP, CDS (09/2020)

During the epidemic, the CDS provided continuity of care that went beyond providing care for patients with a family doctor, by using local coordination mechanisms –which had been strengthened rather than created by the epidemic–, in particulier coordination with the pharmacy and the district's nursing practice, in the framework of the CPTS, which was at a preliminary stage of development at the district level.

The use of the CPTS lever as an instrument in a coordinated response to the epidemic strengthened rather than weakened collaboration between the multidisciplinary structures, in particular the MSPs in the Menhir and Sapins areas, on the one hand, and the CDS in the Cornaline area, on the other hand. Again, in the Sapins area, the initial initiative introduced by the actors in the MSP was the opening of the Covid centre; from the outset, the MSP's management wished to involve actors in the CPTS.

"We very soon thought that, from a healthcare point of view, this project should not be an in-house project at the MSP, and that preferably it was a project that was related to the Local Health Professionals Communities (CPTS), as there was obviously a local dimension to it. So, (...), when we created the Covid centre, we thought that all the actors in the CPTS should definitely be involved, from all over the region (...). Everyone realised that the way in which the CPTS was organised made it possible to respond collectively to something for which no one was prepared."

Self-employed physiotherapist, MSP (05/2020)

In the Pierre-Neuve area, the constituent general meeting of the CPTS was held in February 2020 and the validation of its project by the Regional Health Agency (ARS) was underway when the epidemic began. Based on collaboration between a MSP and the municipality, with the institutional support of the ARS and the Local Health Insurance Fund (CPAM), the CPTS initiated the creation of a Covid centre, which provided an opportunity for many forms of multidisciplinary collaboration and intersectoral coordination between actors who were not all familiar with each other: the centre was run by volunteers who came from all over the region; the healthcare team developed protocols for patient consultations and patient follow-up protocols, which were based on and gave substance to the dynamics generated by the creation of the CPTS.

The organisation of primary care in response to the epidemic was therefore structured in areas that were viewed as relevant by the primary care teams, in terms of previous dynamics of coordination, and even local integration. This reorganisation of primary care was not, however, carried out in a uniform manner, in this emergency situation, and it completely reshaped the approaches of the actors in the area.

The reconfiguration of the dynamics of collaboration and coordination between local actors

In all the areas studied, the health crisis disrupted previous dynamics of collaboration and coordination between the actors in the areas. Two trends were observed, simultaneously or successively. Firstly, there was a global drive to focus on professional approaches and organisational routines. These developments revived the existing structural hierarchies between the healthcare professional groups, and between the hospital sector and that of the private medical practices. Hence, in certain areas, the epidemic was the source of collaboration between members of the same professional group, sometimes to the detriment of previous dynamics of multidisciplinary collaboration. Secondly, the primary care teams, which were already coordinated, strengthened their coordination, in particular with regard to the collection and distribution of protective masks, gloves, and clothing, and by creating links with hospitals and municipalities, thereby strengthening or extending the dynamics of local integration.

An initial retreat on professional approaches and organisational routines

The healthcare professional group as the primary source of collaboration. In all the areas, during the month of March and in response to the development of the Covid-19 epidemic and the introduction of restrictive measures, the healthcare professionals were initially inclined to retreat on their professional competencies, whatever the development of the dynamics of coordination in the areas. They organised their treatment area and practices at the level of their professional group, via, amongst other means, communication networks at different levels (the nurses in the canton, the GPs in the *département*, and the pharmacists and biologists in the region), via knowledge sharing, or, in a more formalised way, via initiatives taken by professional organisations. The retreat on healthcare professional groups did not, however, have the same impact in all the professions: certain healthcare professional groups saw it as a form of isolation–many paramedical professionals were obliged to end their work, considered as less essential than that of the doctors, nurses, midwives, auxiliaries, and home helpers. The latter, which are highly feminized, who were working on the frontline in patients' homes during the epidemic, found themselves having to reorganise their practices, particularly when they were private, with very little information from professional organisations (unions, the regional union of healthcare professionals (URPS), etc.) and national and regional institutions, unlike the doctors.

In March 2020, the information at national level and in the press was confusing and often contradictory. The mobilisation of professional networks enabled nurses to organise themselves in the absence of clear instructions from the authorities.

"We were a bit lost; I called my colleague in the morning and I said: "I'm going to wear a mask this afternoon". I spoke to a nurse in the other nursing practice, who said: "We've been wearing masks since Saturday". (...) I realised that I lugged my bag around and put it in people's houses and that that wasn't going to work, so I looked online and saw that nurses had suggested alternative solutions: a shoulder bag, a belt bag..."

Self-employed nurse, MSP (03/2020)

This professional mobilisation often enabled the nurses to liberate themselves from the competitive relations with other nurses, which existed before the epidemic in the areas studied. In the Acacias area, for example, the

three nursing practices have organized themselves to share the Covid patients.

"Owing to the health crisis, we decided to collaborate with three practices (self-employed nurses) (...) people who said hello but nothing more than that. We thought, well, (...) if there are Covid patients on our round, we won't be able to manage. So we organised ourselves, (...) there was a dedicated Covid nurse every week."

Self-employed and salaried nurse, MSP (04/2020)

Hence, the retreat on healthcare professional groups was the initial reaction of self-employed healthcare professionals. It made up for the lack of information and recommendations at the national level, even though the nurses were particularly exposed to serious risks of infection. The retreat on healthcare professional groups did not occur in other professional groups, and in particular amongst GPs. In all the areas studied, they quickly organised themselves to set up a teleconsultation service and treat suspected Covid patients. In the Cornaline area, the doctors in the healthcare centre divided themselves into 'a doctor who dealt with emergency consultations, a doctor who answered the phone, and two doctors who continued to some extent to deal with appointments'.

The epidemic did not call into question professional hierarchies and the division of roles and responsibilities between doctors and non-doctors was strengthened. For the GPs, the epidemic corresponded with a focus on their role in primary care: inundated with institutional mails ("an avalanche of emails from the local and the regional levels of the Health Insurance Fund, the french national Medical Council…"), they had to sort through an information overload, while other people working in other professions had no information at all.

Their professional networks were often highly developed, and their medical knowledge was also reaffirmed at the beginning of the epidemic, in a context of uncertainty in which the information was still very imprecise and limited.

"We didn't meet the doctors; they're sort of our bosses, and we haven't been given any guidelines, so we've had to manage everything, all alone."

Self-employed nurse, MSP (03/2020)

This retreat into professional jurisdictions was unevenly sustained and depended on the region and the professions. Furthermore, in some cases, the epidemic weakened the dynamics of coordination between local actors.

No coordination between private ambulatory practices and hospitals in certain regions. In the context of the "white plan" (*Plan Blanc*), extended to all the hospitals in France on 13 March 2020, the hospitals were obliged to organise their services in a specific way. In certain regions, the epidemic revealed an absence of coordination, and even ended previous dynamics of coordination. In the Cornaline and Prairies areas, which both had a high incidence rate of Covid-19, the hospitals ended coordination between private practices and hospitals, in contrast with certain areas where it has been revived or developed (the Pierre-Neuve and Sapins areas). In the Cornaline area, an initiative called "hospital discharges" ("*sorties d'hospitalisation*") –set up before the epidemic by the local hospital and a Healthcare Centre (CDS) via a private practice and hospital network– ended.

"We implemented this 'hospital discharges' coordination initiative, but it didn't work. (...) I think they'd kept their nose to the grindstone. Quite frankly, even though there had been some preparatory discussions about the joint development of the initiative, (...) on care, they were overloaded with work..."

Health Provision Officer, Municipal Public Health Unit (11/2020)

More specifically, the extent of the epidemic wave in the *département* put an end to the dynamics of coordination, at least for a little while. The latter were still active at the beginning of the epidemic: in February 2020, the infectious diseases department in the hospital took the initiative of arranging a briefing, conducted through the local network of private practices and hospitals. At the beginning of the epidemic, the organisation of hospital work left little room for the dynamics of coordination with self-employed healthcare professionals and the municipality actors. From mid March onwards, there was a sharp increase in the number of people infected with Covid-19. The hospital was very soon on the verge of saturation and on several occasions sent patients home, despite the protocol established with the self-employed doctors several weeks earlier. The previous dynamics of coordination between private practices and the hospital, which were nonetheless strong, were weakened during the first wave, due, in particular, to insufficient ambulatory and hospital care provision.

In the Prairies area, contact with the nearest hospital, a level-2 hospital with around 1,200 beds integrated into a large Regional Hospital Group (Groupement Hospitalier de Territoire, GHT), was limited. The hospital was in fact mobilised to take in patients from neighbouring *départements*.

"The hospital services were awaiting an enormous wave expected this weekend. Even the emergency department has been deserted by patients. The whole healthcare system has been suspended, it's incredible!"

Self-employed GP, MSP (03/2020)

The absence of coordination with the hospital was not, however, solely due to the intensity of the epidemic: in the Acacias area, for example, which was little affected, the relations with the hospital were no better.

"There's a private hospital that's right next door to us, which takes in Covid patients; we don't know what their figures are and it's all the more difficult because very few of the specialist doctors' secretariats were open. We had less contact with them because we weren't able to call them."

Medical secretary, employed, MSP (04/2020)

The epidemic generally disrupted routine hospital services, whatever the intensity of the epidemic, probably to deal with the uncertainty or, in the most affected départements, the excessive workload and the pressure generated by the reorganisation of the services. This led to new difficulties in coordination between the ambulatory sectors and the hospital. Communication and patient referrals were further complicated by the fact that the self-employed healthcare professionals were not always kept informed of the adaptations made by hospitals in response to the epidemic. This observation also shows the fragility of the coordination mechanisms implemented at local level, which were based on many actors.

However, this finding was not consistent across all the areas: in other situations, the epidemic led to the development of relations between private practices and hospitals. Indeed, the first level of organisation by professional group, which was often simultaneously or subsequently complemented by reflection on the organisation of primary care teams (MSP and/or CDS), may increase coordination at a broader local level.

Pre-existing forms of coordination were deployed and modified

In certain regions, the epidemic context led the primary care teams to strengthen coordination with a view to local integration.

Cross-sectoral efforts to alleviate a shortage of protective equipment. In all the areas studied, the shortage of equipment (masks, gowns, oxygen bottles, etc.) was the focus of cross-sectoral efforts. Indeed, access to protective and healthcare equipment was one

of the primary challenges for the healthcare professionals who continued to work with the patients. The healthcare professionals and regional authorities mobilised their networks on the local level –formal and informal networks, and structured in the framework of Urban Health Workshops[3] (Ateliers Santé Ville, ASV) and Local Health Contracts[4] (Contrats Locaux de Santé, CLS)– in order to collect and distribute a large number of donations from various sectors: inhabitants, volunteers, private companies, sports associations, vets, hospitals, clinics, paramedical practices that had closed…

"There was a big panic because we realised that we didn't have enough equipment; we asked everyone (…), a company gave us some safety glasses; there was also a man who owned a building company–he gave us 100 gowns. (…) People gave us some headwear…"

Self-employed nurse, MSP (03/2020)

In certain regions where Covid centres have been established, as in the Pierre-Neuve and Sapins areas, the local hospitals and clinics were particularly active with regard to supplying medical equipment, in particular in order to administer oxygen to any patients with respiratory decompensation in the Covid centres.

"We managed, the hospital (…) gave us an armchair and an examination table. There was some equipment that we'd already ordered for the centre, a blood pressure monitor and a pulse oximeter–and in fact through some nurses we found someone who could supply us with oxygen, who came and installed an oxygen concentrator and who kindly gave us all the masks, the tubing, and, as a result, we also quickly succeeded in equipping the Covid centre with oxygen concentrators."

Self-employed doctor, MSP (04/2020)

Collecting equipment was more or less coordinated, by the healthcare professionals on an individual basis (in the Prairies area), by the coordinators and pharmacists in multidisciplinary organisations (in the Acacias, Sapins, and Cornaline areas), and by the local authorities (one or several municipalities, as in the Pierre-Neuve area). These efforts, which were made in all the areas, were a symbolic recognition of the healthcare professionals' work in the local area by the population.

These dynamics of coordination, encouraged and valued by the public authorities and the professional associations, were, however, palliative measures that were often insufficient to overcome the problem of a lack of equipment and an absence of solutions provided by the public authorities at the national level.

An epidemic that confirmed the validity of a local approach to healthcare. In the Menhir, Pierre-Neuve, Sapins, and Cornaline areas, the epidemic strengthened the local integration of the coordinated organisation of primary care. Although this coordinated organisation of care had often been prefigured before the epidemic, the health crisis provided advocates of primary care coordination with an opportunity to implement it. In these four areas, the local organisation of care was carried out through the creation or consolidation of a CPTS. Depending on the areas studied, the organisation of care was carried out by different actors. In the Menhir, Cornaline, and Pierre-Neuve areas, the regional authority actors helped create the CPTS.

"The Local Health Contracts played a key role in the CPTS, because the healthcare professionals participated in the work related to the local health contracts, and they said: "If we were in a CPTS, it would be much easier for us". There are, however, MSPs in the area that are well-established. I think they're going to boost the CPTS. The health crisis has also boosted them."

Employed doctor, local delegation of the Regional Health Agency [ARS] (05/2020)

"The idea behind the creation of this Covid centre was to redirect Covid patients away from our more or less organised practices, enable us to practice normally as much as possible, and, above all, orient the patients correctly so that they didn't call 15 (emergency phone number) or go to the emergency department. (…) This enabled the healthcare professionals, the authorities, the municipalities, and the local authorities to see what a real CPTS is."

Self-employed GP, MSP (04/2020)

The intensity of the dynamics of coordination between local authorities and primary care teams varied according to the area. Hence, in the Sapins area, unlike the Pierre-Neuve area where the municipalities were more involved, the CPTS was mainly set up by self-employed healthcare professionals and employees in a MSP. In both cases, the epidemic was seen as an "opportunity" to breathe life into the CPTS, which had until then not been fully developed, mobilising few healthcare professionals. Likewise, in the Cornaline area, before the epidemic, the CPTS was at a preliminary stage of development: an offer of employment as a "person responsible for the preliminary creation of a CPTS" was posted in September 2019 by the local health association (which developed as a result of "ASV" legislation); the position remained vacant at the beginning of the epidemic. The post was due to be filled in November 2020.

"In fact, the Local Health Professionals Community (CPTS), yes, we've been working on that for a while. But it's true that we thought that, basically, it really was an opportunity for the CPTS to use that occasion [the Covid-19 epidemic] to (…) to rapidly launch the project."

Director of the Healthcare Centre [CDS] (07/2020)

The epidemic led the healthcare professionals in the health centre to take action, and also actors who were used to working in a local network, which grew out of the ambulatory practice-hospital network. In the Sapins area, a similar dynamic was observed. The CPTS, whose agreement had not yet been signed in March 2020, was supported by healthcare professionals in a MSP in the area, and included many actors in the medico-social sector (a clinic, a nursing home (EHPAD), a university hospital, a care network, and an association). However, the Local Health Insurance Fund (CPAM) demanded that the area covered by the CPTS be extended to include two neighbouring communes, and asked the senior healthcare professionals to recruit self-employed healthcare professionals in these communes. The epidemic led the healthcare professionals in the MSP to collaborate with self-employed doctors in two other communes.

"There were tons of people who weren't working in the MSP and who came to work with us very quickly, and who actively worked in the Covid centre, whether they were paramedics or doctors. In the end, there were around fifty different doctors who came and were on duty in the Covid centre, whereas there were fourteen doctors in the MSP. This Covid centre really was a unifying initiative launched by the Local Health Professionals Communities (CPTS), because we'd been trying to "seduce" all the healthcare professionals for a year…"

Self-employed physiotherapist, MSP (05/2020)

There was a similar drive in the Pierre-Neuve area. In these organisations, the epidemic made it possible to justify a project to create a CPTS, and bring together healthcare professionals in a given region around a common goal, which led them to re-evaluate their different perceptions of their profession and healthcare. However, these local dynamics of coordination remained centred around doc-

3 Urban Health Workshop: instrument of the City Policy made available to professionals in the health, social and educational sectors, as well as to residents and elected officials, to encourage and facilitate the implementation of prevention and health promotion actions in priority districts.

4 Local Health Contrat: contract signed between a Regional Health Agency and an Intermunicipality, involving other actors, in order to implement actions aimed at reducing social inequalities in health.

tors, who often played a bigger role in the decision-making process than the paramedics and the local authority actors. Furthermore, these dynamics of coordination were more beneficial for the doctors: hence, in the Sapins area, the inclusion of two other communes in the CPTS mainly led to the inclusion of GPs, and, working more outside the hospitals, paramedics, who generally worked on a voluntary basis.

In some areas, dynamics of coordination between ambulatory private practices and hospitals developed. In the Prairies, Acacias, and Cornaline areas, the epidemic led hospitals to focus on their own services, and sweep aside the existing coordination. However, this finding was not consistent across the areas studied: hence, in the Menhir, Pierre-Neuve, and Sapins areas, the epidemic led to a strengthening of the pre-existing coordination, developed in particular thanks to projects to create CPTS, between healthcare professionals in hospitals and self-employed healthcare professionals. In the Pierre-Neuve area, unlike the Cornaline area, work focused on the admission and discharge of patients at the hospital.

"There were physical meetings at the hospital every week (...) to discuss how we could organise ourselves. (...) The collaboration started from scratch: we sent patients to the hospital, but we didn't know what became of them. (...) We ran with it and said to the hospital doctors: "Listen, this can't be right, we still need to know whether they've been hospitalised or not. (...) You're overloaded with work, perhaps we can relieve you of a certain number of things that we're capable of doing. (...) When a patient is discharged, send us the patient's medical files, and tell us the patient's been discharged and needs to be monitored, and we'll take over.""

Self-employed GP, MSP (05/2020)

With the support of the Director of one of the hospitals in the Regional Hospital Group (GHT) in the Pierre-Neuve area, who was also responsible for relations between private practices and the three hospitals in the GHT, a pre-existing but little developed form of coordination between the GPs and the hospital doctors was activated and restructured at the beginning of the epidemic, around a hospital admission and discharge protocol.

"The Covid centre dealt with the initial follow-up consultation and sending patients to the family doctor if they had one, or, if they didn't, assigning the patients concerned to voluntary family doctors [in the Local Health Professionals Community]. (...) Using this system, we were able to ensure that none of the patients went off the radar without medical monitoring and that, that really, really worked."

Hospital director (07/2020)

Likewise, in the Sapins area, the pre-existing dynamics of coordination between the clinics, the area's CHU university hospital, and the primary care teams were strengthened during the epidemic. Since patient orientation was seen as a major issue to divide the burden of the epidemic between private healthcare practices and the hospitals, it was the focus of several initiatives. Hence, the University Hospital and the clinics coordinated with each other to establish patient orientation criteria according to diseases, and then inform the area's GPs of the criteria of the criteria.

"We had guidelines about which patients were to be sent to which hospitals, and for which problem. For example, if patients were suspected of having Covid, they all had to be sent to the university hospital..."

Self-employed GP, MSP (05/2020)

In these areas, the epidemic further strengthened a local dynamic of patient care: the clinics and hospitals coordinated with each other, and included self-employed professionals –who were nevertheless not decision makers– in this collaboration. The pre-existing rivalries, arising from competitive dynamics between hospitals and clinics with regard to the treatment and acquisitiveness of patients (Bergeron and Castel, 2010), were suspended by the epidemic. The hospital overload and the closure of services due to the epidemic led to a review of the dynamics of coordination at local level, without fundamentally calling into question the hierarchies between private practices and hospitals.

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In the initial phase of the Covid-19 epidemic, in which the response to the epidemic was organised from the "bottom-up" in areas with experience of primary care, the dynamics of coordination mainly depended on the history of the relations between the actors in the area, which were often based on projects that existed prior to the epidemic. They were based on the rearrangement of the division of tasks amongst healthcare professionals, which will be analysed in more detail in a forthcoming article. In contrast, the intensity of the epidemic, the socio-demographic characteristics of the population, and healthcare provision in the areas had more indirect and contrasting effects on the dynamics of coordination.

Although the pre-existing projects made it possible to create a shared culture, tensions remained –even in the areas in which the local integration of primary care was the most advanced–, relating to the political and institutional balance of power, with alliances and competition to secure control of the local organisation of primary care. ♦

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