Ann Ig. 2022 Sept-Oct; 34(5): 431-438 doi: 10.7416/ai.2021.2492. Epub 2021 Nov 30

# The Legal Status of General Practitioners at the dawn of the New Primary Care in Italy

S.R. Vinceti[1]

*Key words: Primary care, general practitioner, employment status, health reform, comparative health law, public health law*

*Parole chiave: Assistenza primaria, medico di medicina generale, dipendenza, riforma sanitaria, diritto sanitario comparato, diritto della sanità pubblica*

**Abstract**

*A debate is developing in Italy on the reform of the employment status of general practitioners. The dispute was prompted by the extraordinary resources the European Union has allocated to Italy on the condition of several structural reforms, among which lies the renewal of the primary care system. One of the most debated questions is whether general practitioners should become civil servants or remain autonomous workers. The issue is not only relevant to the quality and efficiency of primary care but is propitious for improving the legal certainty of this "hybrid figure" in Italian health law. The commentary suggests that, from a public law point of view, the employment status of civil servants better agrees with the foreseeable conditions of general practitioners working in Community Houses. In any case, national and regional policymakers must take into consideration possible controversies and litigation arising from an inappropriate qualification of the legal status of general practitioners in building the new system of Italian primary care.*

## Introduction

A heated debate is shaping up in Italy on how to reform the national system of primary care (PC). The premises were set by the European Union 800 billion NextGenerationEU (NGEU) and the Italian government's National Recovery and Resistance Plan (NRRP) that allocates the roughly 200 billion allotted to Italy. Among the several reforms envisioned in the NRRP, health care takes a prominent role, ranging from the hospitals' technological update to the re-organization of the Scientific Institutes of Hospitalization and Treatment (*Istituti di ricovero e cura a carattere scientifico*) (1). However, hardly any health care intervention is more crucial to the NRRP than the reform of PC. In particular, the NRRP envisages the creation of 1288 Community

[1] *Department of Law, University of Modena and Reggio Emilia (UNIMORE), Modena, Italy*

Annali di Igiene : Medicina Preventiva e di Comunità (Ann Ig)
ISSN 1120-9135 https://www.annali-igiene.it

Houses (*Case della comunità*) defined as "structure[s] in which a multidisciplinary team will operate, composed of general practitioners, pediatricians, specialized physicians, community nurses, other health care professionals, and that could also comprise social workers" (2).

In Italy, PC is essentially provided by general practitioners (GPs), pediatricians, and specialized outpatient physicians. Whenever they are unavailable (e.g., at night or during the weekends), PC is offered by the Service of Continued Assistance. While all these primary care actors could undergo relevant changes within the NRRP's "healthcare renaissance" (1), the GPs' employment status seems to be the real crux of the debate. Dedicated newspapers are filled with daily interventions and heated exchanges between GPs, union leaders, hospital physicians, and policymakers, as to the best way to reform the employment status of GPs (3-5). Reassurances by the Minister of Health that the GPs' employment status "is not the heart of the debate" (6) failed to persuade both the GPs in favor, and those against, a possible reform (7, 8).

This commentary aims at providing an overview of the legal issues involved in Italy's current debate on primary care—specifically, on the GPs' employment status. Such an overview could hopefully allow foreign researchers to keep track of the Italian dispute and knowingly observe its unfolding. From a comparative health law perspective, this means replicating the achievements of the Italian PC reform and avoiding its pitfalls. At the same time, the article chimes in the debate by suggesting that more legal certainty is needed on the employment status of GPs and that an unclear legal framework of their role in the Community Houses will arguably lead to litigation and further dysfunctions. In this respect, emphasizing the possible adverse legal effects of health care legislation can be seen as part of an alliance between healthcare and legal area professionals (9, 10).

## Methods

The keywords "primary care," "general practitioners," "Italy," "community care," have been variously combined and inserted into Google Scholar to single out relevant scholarship on the subject of Italian PC. Policy papers from the Organisation for Economic Co-operation and Development (OECD) on the Italian health care system and PC in general were also central in framing the legal context, as well as in pointing out best practices and guidelines on PC organization. Legal texts were consulted on the Normattiva website (11), while the GPs' National Collective Contracts were taken from the SISAC website (12). Case law was sifted through in the Dejure legal database by searching the keywords "general practitioner" (*medico di medicina generale*) and "self-employed physician" (*medico convenzionato*) (13).

## Results

Primary care systems in OECD countries face several challenges, such as excessive avoidable hospital admissions, inappropriate antibiotic prescriptions, insufficient preventive tests for people in chronic conditions, and problems of coordination between primary care and specialized care (14). The OECD recommendations are various, ranging from enhancing the role of pharmacists to empowering patients, and strengthening implementation of digital services (14). However, no organizational intervention is more pivotal to the optimization of PC than the establishment of multi-disciplinary units where GPs work alongside other various health care professionals, from

specialized physicians to pediatricians, nurses, psychologists, social workers, and non-clinical support staff. OECD countries are thus exhorted to abandon the model of GPs running solo practices and introduce different forms of coordination between GPs, specialized physicians, and other healthcare professionals (14).

The problems outlined by the OECD are familiar to the Italian experience. In Italy, the antibiotics prescription rate in PC is exceedingly high (15), while coordination with hospitals is often dysfunctional—a situation that leads to a relevant number of avoidable hospitalizations (16). At the same time, the Italian health system is also acquainted with the policy solutions envisioned in the OECD publications. From the early 2000s, legislative reforms have increasingly encouraged team working with national collective agreements providing additional payments for GPs working in associated forms (17, 18). The Law no. 189 of 2012—the so-called "Balduzzi Reform"—was particularly important in that it introduced innovative models of GPs' multi-disciplinary aggregations (17). Moreover, in the last decade, several Regions have piloted multi-professional health care aggregations, such as the Health Houses (*Case della Salute*) (18). Results from these community-based centers are encouraging (19), as higher levels of primary care outcome have been registered in places where Health Houses were established (20-22).

Nonetheless, despite the incentives by the central government and the regional innovative models, multi-professional practice is still underdeveloped in Italy. While data from the National Health System shows that 68 % of GPs received compensation for taking part in some kind of associative model (23), other researchers point out that the percentage has not increased in the last years (24) and that only 47 % of GPs work in "group medicine" (*medicina di gruppo*) (25)—the most significant form of multi-professional association. For these reasons, Italian PC is still mainly considered within the province of GPs working in solo or solo-like practices (26-28). The NRRP aims at changing this situation by establishing a hub-and-spoke system of Community Houses where teams of GPs, pediatricians, nurses, specialized outpatient physicians, and other health care and social service workers will work together to address the PC needs of the local population (2).

However, an obstacle seems to stand in the way of the reform of primary care: the employment status of GPs. In Italy, physicians are either civil servants, private employees working in health care private facilities, or self-employed professionals. GPs, nonetheless, have a hybrid legal status: they are self-employed professionals but are remunerated by the government through a financial system of capitation and fee-for-service (17, 18). Their contract, in other words, is not with the patients or a private employer, but with the government.

While not exclusive to GPs, this hybrid legal regime has been the source of important legal disputes that have eventually blurred the difference with civil servants. For example, for some time the local health units (LHUs) were not held responsible for GPs' damages, as they were considered fully autonomous workers (29). In recent times, however, Italian courts have extended civil liability so as to make local health units' accountable (30). Moreover, the GPs' unions' national collective compact of 2005 and its subsequent amendments have consistently reaffirmed the disciplinary powers of the LHUs over GPs (31-36). And while it is still stated that "public authorities [do not exercise] any authoritative power on [GPs], besides that of control" (37), some forms of public direction apply also to them: for example, the GPs must participate in continuous medical education, just as physicians working as civil servants (32). Furthermore, through the pharmaceutical plan (*piano terapeutico*)

the Italian Medicines Agency influences the GPs' prescriptive activity (38).

Within this framework, the NRRP establishment of Community Houses could be the final nail on the coffin of GPs' self-employment. In fact, GPs are expected to be the first and foremost workforce in the NRRP's multi-professional structures (2). The organizational independence of GPs would thus naturally subside. Would it then be possible to consider as "self-employed" workers that are stationed by law in public facilities, are paid by the government and are amenable to various forms of control and direction from LHUs? A positive answer is, to say the least, dubious.

A straightforward way to avoid legal uncertainty would be making all GPs civil servants, but unions seem almost unanimously against this solution (8, 39). To some extent, however, it may be unavoidable. In fact, even if regional and national policymakers yielded to the unions' requests and refrained from formally employing all GPs, it would seem at least necessary to limit the self-employed regime to those practicing outside the Community Houses (i.e., those that will continue to work in standalone fashion in rural zones, where the opportunity costs in building new Community Houses may be negative). But as to the GPs stationed in Community Houses, their status seems apparently at variance with the features that the law requires for self-employment.

In Italian labor law, in fact, workers are either subordinate (i.e., employees) or autonomous (i.e., self-employed), the boundary line being that autonomous workers do not entertain a subordination relationship toward an employer (40). This means that self-employed workers are not subject to an employer's directive, organizational or disciplinary powers. Because of already existing powers of control, discipline, and direction, GPs have been considered "parasubordinate workers" (37). As it is unlikely that GPs will retain significant organizational independence in Community Houses, they will lose another level of autonomy in favor of LHUs. In this sense, the GPs' status of civil servants seems to flow naturally from their stationing in the NRRP's Community Houses.

Given the unions' staunch resistance to shifting toward the employed working status, Italian policymakers may be tempted to resort to some legerdemain to win over their approval while simultaneously modifying the primary care system—thus obtaining the 7 billion of NGEU funds that depend on the reform of Italy's primary health. Most notably, the self-employed status could be maintained for all GPs if the concrete obligations that come with the status were to be so stretched, as to bestow on GPs duties and constraints that currently apply only to civil servants. By doing so, Italian policymakers will dodge the unions' accusation of removing the self-employed status, while at the same time realizing the objective of compelling GPs into Community Houses.

However, legal reasons advise against any kind of chicanery in addressing the GPs' working status. Maintaining a self-employed status for GPs working in Community Houses would likely increase litigation since GPs working in Community Houses are at risk of suffering detrimental effects from enduring in a "hybrid" regime of employment. In fact, they could find themselves practicing in a *de facto* civil-servant fashion while missing on the benefits that normally comes with the status (e.g., the severance pay, the thirteen-month salary, etc.). As it happens, their differentiation from specialized physicians working as civil servants would arguably contrast with the Italian Constitutional Court's interpretation of Article 3 of the Constitution under which equal cases should be treated alike (41-43)—the so-called "Reasonableness Criterion" (44-46).

Short-circuiting the harsh process of

convincing, or neglecting, those resistant to change in the GPs' employment status could thus lead to a fragmented, uncertain legal framework that would only fill the dockets of Italian courts and potentially harm the GPs themselves. In this respect, whatever decision will be taken on the GPs' employment status, national and regional policymakers in Italy must take into consideration the ensuing legal effects, since GPs' working conditions that resemble those of civil servants—and yet legally framed as self-employed—would hardly pass judicial scrutiny.

## Discussion and Conclusions

Improving primary care in Italy is a multi-faceted goal that requires interconnected policy interventions. It would be superficial, therefore, to assume that all boils down to the issue of GPs' employment status. To name just one related issue, it seems of the utmost importance that post-graduate education of GP trainees be administered by Italian universities in line with all other postgraduate medical specializations, as several scholars have already stressed (47-50). Within the current legislative framework, in fact, regions are responsible for the three-years postgraduate course to become GP, and teaching is thus not necessarily provided by universities or similar higher-education institutions (51-53). Furthermore, the presence of GPs' unions and scientific societies in the courses' organization has been recently decried by the press on grounds of quality and conflict of interests (54-55).

At the same time, the employment status of GPs remains a crucial part of the reform of Italian primary care. If anything, clarifying the GPs' employment status would foster legal certainty, which is a well-known determinant of the rule of law (56) and in turn of every well-performing social community (57). As the organizational conditions of GPs working in the NRRP-envisioned Community Houses seem incoherent with the self-employed status GPs have historically had in Italy, it may be legally sensible to qualify them as civil servants. An implausible legal qualification, in fact, could be conducive to a spike in litigation—because, for example, GPs working in Community Houses may rightfully demand the extension of benefits traditionally applying only to civil servant physicians. Avoiding numerous legal issues seems in and of itself a significant reason to overcome the current legal framework with a clear-cut, albeit uncompromising, solution.

**Acknowledgments**
Funding: None
Competing interests: None declared
Ethical approval: Not required

**Riassunto**

***Lo status giuridico dei medici di medicina generale all'alba della nuova assistenza primaria italiana***

Nella sanità italiana è in atto un vivace dibattito sulla possibile revisione dello status giuridico dei medici di medicina generale. La discussione è occasionata dagli eccezionali fondi che l'Unione europea ha attribuito all'Italia a condizione di riforme strutturali tra cui, appunto, il rinnovamento del sistema di assistenza primaria. Una delle questioni più dibattute concerne la trasformazione dei medici di medicina generale in dipendenti pubblici, ovvero la conservazione dello status di lavoratori autonomi, sebbene "parasubordinati." Tale circostanza non è rilevante soltanto per la qualità e l'efficienza dell'assistenza primaria ma può rappresentare anche un momento per dare maggiore certezza giuridica ad una figura "ibrida" del diritto sanitario italiano. Nel contributo si conclude che, da un punto di vista giuspubblicistico e costituzionale, il rapporto di lavoro dipendente è quello che meglio si attaglia alle verosimili condizioni lavorative dei medici di medicina generale nelle Case della comunità. A livello generale, in ogni caso, è opportuno che legislatore nazionale e regionale tengano in adeguata considerazione i possibili riflessi legali e giudiziali della ridefinizione giuridica dei medici di medicina generale nel nuovo sistema di assistenza primaria italiana.

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Corresponding Author: Silvio Roberto Vinceti, Department of Law, University of Modena and Reggio Emilia (UNIMORE), Modena, Italy
e-mail: silvioroberto.vinceti@unimore.it