Doctors, Partitocrazia, and the Italian State

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NO SOCIAL INSTITUTION, ESPECIALLY AN institution such as the learned professions, can be studied in isolation. The important social context of any profession involves not only the study of its market and the way it was created—Larson's (1977) main emphasis—but also the precise ways that capitalism and the state in each nation relate historically to that profession in a given period of time. Sectors of capitalism and specific state bureaus and elements may affect—and even in large part create—a given profession in a particular nation. These forces may aid the development of a profession, or retard it, or reshape in ways that could be quite different from those described in the rather ethnocentric and parochial literature quite common in the sociology of Anglo-Saxon (American and British) professional institutions.

In this study of doctors, political parties, and the state in Italy, we will "bring the state back in" to use the terminology of Skocpol and her colleagues (Evans, Reuschemeyer, and Skocpol 1985). Each state, such as the Italian, has a different history, shape, and strength—all of which must be related to the development of each profession in each nation. Nor can we assume a unilateral and across-the-board "capitalist rationalization" of professions across nations, implying an overall proletarianization of the medical profession, without understanding the ways in which the state and sectors of capitalism work together (or do not work together, as in Italy) vis-à-vis a particular

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profession. The rise and fall of professional group political/economic or guild power is a complex topic, demanding respect for historical and political processes, profession by profession and nation by nation (Krause 1989).

This article will begin with a broad and necessary review of the almost unique history of the growth and development of the Italian state, of the Italian social and governmental dynamics called "partitocrazia" which organizes both the state and sectors of civil society such as the universities and the professions. We will then briefly review the rather unique way the Italian medical profession was formed and nourished by the Italian state, as well as the complex set of interrelations it developed with that state previous to the formation of the Italian National Health Service—the SSN or Servizio Sanitario Nazionale—in 1978. The third section of the analysis will show both continuity and crisis in the political and economic system after 1978. This may point finally not only to the (long overdue) growth in strength of the central Italian state, but also and paradoxically, to a stronger, more unified, and solidary profession, fighting against the actions of the state toward cost control. In the final section we will consider two out of many possible alternatives for the future position of the Italian medical profession, depending on which variables, parties, and power blocs "win out" in the next decade. But it seems only fair to warn the reader in advance that Italy is the graveyard of political and sociological theories, and those of the professions are no exception.

Analytical Dimensions: State, Profession, Capitalism

To begin with, we must consider each bloc of power relevant to the process under consideration, and the history of the development of that bloc in relation to others. The Italian *state* was late in formation, with Italy a historically fractionated group of feuding principalities, who had been enemies since the Middle Ages and Renaissance. When "unification" came in 1876, the central state was weak. Only in the Fascist period (not remembered with fondness) of the late 1920s and the 1930s did Mussolini begin to gather any power to the central state. But though the state remained weak the bureaucracy did grow, and he bargained with the church and with professional groups as well as capitalists even during his peak of power.

Defeat in World War II led to the accession of power by the Christian Democrats (DC) and the building of a very strong Communist party (PCI). Neither the DC nor the PCI wanted a strong central state with any independence from party power, and they have worked successfully ever since to use the state, the very large state-related industrial combines, the state railroads, the national airline, the TV/radio networks, the energy and petro-chemical complexes, and, of course, the civil service itself, as fiefdoms, as areas for political patronage. Even areas which in other nations show some independence from direct party control, such as the universities and the learned professions, are in Italy so permeated with the three kinds of political parties—the DC on the right, the PCI on the left, and the "secular" and small parties in the middle—that no career, no job, no action by the state, by a profession, or by a union is made without checking first with party headquarters.

This government by political party, with the permeation of political party control in all spheres of life and certainly across the vague boundary between the Italian state and civil society, is called *partitocrazia* or "party-ocracy" (Spotts and Wieser 1986, 4–12; LaPalombara, 1987). This governing format has no real parallel in the United States or Western Europe, but is best understood as if the Soviet Union, instead of having one party permeating all areas of social life, had two major ones and a few minor ones which were nevertheless important to the coalitions that make up the fragile balance of power that makes it possible for the government to function. Of course, given the intense individualism of the Italian culture, there are freedom of speech and other non-Soviet institutions. But all major decisions, and many minor ones, are made inside the hierarchical party headquarters, and then, only then, acted out in the nation at large.

Jobs are parceled out by political party: so many professorships, judgeships, ambassadorships, civil service posts, hospital directorships, even jobs in the public hospital wards, by party—so many to the DC, so many to the PCI, so many to socialists, etc. Proportional representation according to informal norms decide the percentages of jobs, according to current political strength in the electorate. This parceling-out process or *lottatizazione,* is supported by all parties and makes career advancement in any field dependent on party sponsorship. Since the two major parties—DC and PCI—cooperate behind the scenes while openly, and theatrically, disagreeing in public, govern-

ments fall regularly but nothing changes very much in most areas of life. When real and long-term cooperation is required, such as in reforming the universities or the health care system, years and even decades will pass without handling a crisis, usually because of quarrels over the potential spoils.

Intense regionalism—with different dialects and even different languages—are a fact of Italian life. The regions were finally officially recognized in the mid-1970s, which have devolved much state decision-making power away from the center, thereby setting up a new set of struggles, or institutionalizing an old set of struggles between center and periphery (Bassanini 1976). Just a few years before the SSN was enacted into law, the regional governmental structure was created. This made it almost impossible for a uniform health care system to be set up after 1978, since each region could (and did) set up their part of it without any restrictions on the shape of the service system from the central government. Consequently, to use the health care example, in "red" (PCI) regions such as Tuscany or Emiglia-Romagna (Bologna) the regional government attempted to set up a health care system with citizen participation and area planning along the lines of the new law. But in "white" or DC regions such as Veneto the funds were used primarily to expand the network of church-related and DC-brokered hospitals, which further expanded the power of the party and the income of the physician elite. In Sicily and Naples, both DC and corrupt, a large share of the SSN funds—some say up to 15 percent—simply disappeared. In an interview in Palermo in 1987, one physician told me that the changes of the SSN were visible in Palermo in greater hospital building (cash for friends of the DC and perhaps the Mafia) and a small office with two secretaries.

Professions, and the universities that train them, are just as permeated by partitocrazia as the rest of the society. Thus, as Barbalgli (1982) has shown that for the period of 1859 to 1973, the central government has never had the power to control the overproduction of professionals trained by the universities, many of which have strong local ties (and all of which are to a small degree locally funded, though most money comes from Rome).

After 1970, with the Italian university in even greater crisis than usual due to mass admission of extra students (thousands of whom were "studying medicine") the state was still paralyzed to act vis-à-vis the state system, because the parties could not agree on what to

tell the state to do about it. As Ross (1987) shows, when the different political parties finally acted to "reform" the university, they did not do so by tightening admission standards or instituting a "numerus clausus" limiting the number of professionals turned out. Rather, they simply added more professors to the civil service rolls to teach these students (the universities were certainly understaffed.) But they did not refrain from the policy of lottatizazione. While the national competition for medical school or sociology professorships is formally and in theory politics-free, in fact the party of the candidate is a factor in parceling out the jobs.

Another aspect of partitocrazia has until recently weakened the solidarity of another related institution—the professions themselves. As I have recently noted (Krause 1986, 1988) each profession has a right wing and a left wing in each nation, but in Italy the professionals of the right wing are heavily involved with the DC and those of the left with the PCI. In medicine, for example, the small (about 10 percent) group of elite specialists usually vote with and work with the DC, while the mass general practitioners are more likely to be involved with the Socialists or the PCI. (Piperno and Renieri 1982, 82). The legal profession, generally conservative, does have a group of radical and leftist judges and activist magistrates usually associated with the PCI. As LaPalombara (1987) and Capurso (1977) both show, the law and the legal profession are so politicized that the entire society has grown cynical about the validity of the legal system itself. Thus, professional group solidarity, and membership in professional unions (syndicati), is divided by political party, with one professional association and union for DC general practitioners, a second for PCI, and so on.

Finally, capitalism itself is complex in Italy, and is intimately involved with partitocrazia. Given the large public sector (almost 45 percent of the economy) and the expanding sector of small firms and craft enterprises or microimprese which are the source of much of Italy's high productivity, the classic American model of 400 to 1,000 giant capitalist firms acting almost unimpeded as a power bloc, simply does not exist. Furthermore, though corporations and family firms do have much power in Italy, not all support the DC (Agnelli of Fiat is a Socialist). In addition, since the state is so weak, it is difficult for capitalism as a whole, or even one sector, to use it as a tool to attack other targets, such as the professions or the unions. It is more

relevant to look at the state as a feeding trough, where the political parties, the professions (especially medicine), and capitalist corporations belly up, allowing the state just enough autonomy to barely function, but not enough to discipline them. Only with the expansion of the Welfare State after World War II, and the fiscal crisis of that state in the 1970s and 1980s, have capitalism and the political parties reluctantly agreed to give the state temporary power and authority to deal with the crisis. And that change, related as it is to the SSN, Italy's largest welfare state operation, is beginning to have, finally, an impact on the medical profession.

To sum up, neither the state nor any profession, or even capitalism itself, can function on their own, with solidarity, independent of political party decision making. The evolution of professional group autonomy, such as that of the Italian medical profession, cannot be understood apart from this fact of life.

The Italian Medical Profession: Nourished by the State

Perhaps the single most important aspect of the development of the Italian medical profession, which differentiates its history from that of the English and American ones, is its growth because of and partially within the state. The provincial city-states of Renaissance Italy (Tuscany, Veneto, Rome, etc.) each had a small number of physicians as community and public health physicians for the poor. They also dealt with the problems of epidemics, such as the Bubonic plague, though smaller communities sometimes delegated others, if physicians were not present, to deal with these problems (Cipolla 1987). These community physicians, in publicly contracted or condotto status, had job security. In an age when the vast majority of those trained, unless they could attach themselves to a wealthy family as a house physician, could barely make a living, a state job as a doctor was a prized possession. It could provide a small but dependable income for treating the poor, to be used as a base while one expanded one's practice and began to treat paying customers on the side, from the craftsman and the new middle classes.

The Italian university, continuously since the Middle Ages, has trained doctors and lawyers. Thus, Italy did not go through the apprenticeship and nonuniversity-based professional model of England

or the United States until about 1880, when it moved most training to the university for good. Italy always depended (and still does) on the formal (and often very formal) classroom model without lab training except for a few, including medical training. An internship was not until very recently required for medical practice, either, but was the badge of the elite who would attempt to become specialists. Second, it should be understood that, in common with all continental universities, the Italian universities were (and remain to this day) all public. Tuition was relatively inexpensive. The ticket for admission to the university was and remains the licea degree—about the level of the end of our second year of college. One goes directly to professional training from the licea, as one does in France from the lycée or in West Germany from the "gymnasium."

As Barbalgli (1982) shows, for professionals with degrees but for whom there is no demand, or no political connections to get a state job, emigration was a common solution. Before the turn of the century, public employment in medicine was often the only alternative to leaving the field. In 1889, for example, almost half of the physicians in Italy were on the public payroll (Piperno 1983, 149). The development of a state-regulated professional monopoly came in Italy at about the same time as it did in the United States. The creation of the ordini for doctors in 1910 was a major step. An ordine is a regional semipublic organization to which all doctors with medical degrees must belong in order to practice medicine. (Other major professions have ordini as well.) The ordini have licensing functions and disciplinary power in the sense of an American board of registration in medicine in each state. They exist in each region, and there is a national ordine federation for each profession in Rome. The ordini are run by the profession itself but have always had legally trained staff to deal with questions related to legislation. The ordini attempt (and after the technological revolution from 1910 to 1930 attempt rather successfully) to enforce professional monopoly. They try to define what the division of labor will be in health care (such as between physician and nurse, physician and physician assistant, or optometrist, etc.).

Mussolini created Fascist ordini for most professions. But since the state had special need for the aid of the medical profession, he did not completely suppress the medical ordini, but allowed them to function informally while creating a new Fascist medical ordine at the center for "official" reasons. After World War II the primary task

of the Italian profession was to find financial support for the growing number of medical graduates. The period from 1900 to 1945 was also characterized by the growth of private health insurance associations, or mutualità, which provided much of the increasing income for the Italian profession, but provided it primarily for inhospital care. Thus, the profession grew in a hospital-based manner, with the elite corps of hospital-based specialists getting the lion's share of the growing private health insurance pool. The gap grew in the prewar era between the continually poorly paid general practitioners in the community and the well-paid hospital-based specialists, many of whom also had a community office and who combined public payments, mutualità payments, and extra charges to the wealthy which they paid out of pocket for special treatment.

But Italy never took the step before or, in fact, in the first two decades *after* the war toward the kind of universal, comprehensive health insurance system (as in France or Germany) or toward the creation of a national health service on the British model. This did not mean that the percentage of the population given some partial private coverage did not increase. What happened was the gradual growth and proliferation of literally thousands of private health insurance plans—for different groups in the population. There were groups for unions, for professional groups, for farmers, for craftsmen, for civil servants of different political parties, each with their own degree of coverage. The percentage covered in some way did grow: from 3 percent of the population in 1929, to 35 percent in 1939, to 40 percent in 1940 (Bocci 1944). The trend continued after the war, with 38.2 percent in 1950, to 82 percent in 1966, to near total inclusion of the population (without each plan being comprehensive) by 1970 (Piperno 1983, 157).

But these plans were poorly managed, and since they encouraged hospitalization in a service system where almost no medical equipment existed in the average general practitioner's office—many had no blood pressure devices (Perkoff 1984), fewer than 9 percent had paramedics, and only 13 percent had secretaries (Piperno and Renieri 1982, 72). Lack of confidence in outpatient care by patients, the need to hospitalize in order to diagnose, etc., all led to hospitalization as the only route for most patients beyond minor illness. Also, since most general practitioners were poorly trained in general clinical work, their fear of making a mistake added to these other factors and led to massive

overhospitalization in the 1950s, 1960s, and early 1970s (Perkoff 1984).

Finally, as length of stay for most illnesses tripled the length found in most other Western European nations, while the costs of care escalated, the entire system of private insurance went into bankruptcy. It was this fiscal crisis of the 1970s that finally led the DC and the PCI, along with the Socialists, to create the Italian National Health Service as a cost-control measure. The private plans would be replaced by a national public fund (there would be exceptions, of course, to the idea of ending all private insurance). The central management of the SSN, which would now be in a position to cap costs through global budgeting of a maximum of funds to be sent to each regional government and then to each service area, would begin to control the crisis, at least in the public hospitals that constitute two-thirds of Italy's hospitals, including the prestigious university-related research centers. (Note that both university and university-related elite hospitals tend to be public.) All hospital doctors were to be (hopefully) put on full-time salary with (hopefully) prohibitions on private practice in addition to it. Costs in the community would be controlled by putting the general practitioners on a patient-panel-payment method.

The PCI pushed for the new SSN on both ideological and practical reasons, while the DC and the Socialists did so primarily for cost-control goals. For a brief moment, only the medical profession stood in opposition. But—and this is critical—it had been nourished by the state, and had become used to defrauding the state in previous decades. The usual approach here was to work "full time" in the public sector and then, in the same week, work full-time in the private sector as well. Since they stood to gain as well as lose, and since all the parties (which at that time divided the profession's power) were all behind it, their opposition was not a major factor in passage of the legislation. Technically, the SSN was created in 1978. Many physicians' general attitude, both before and after passage of the SSN, was the same. They would be *for* any increasing state support and *against* any attempt by that state to control how the state's money would be spent. Again, this approach to the state and its resources was historically, and typically, Italian.

Before proceeding to the history of the power struggles involving the Italian medical profession after 1978, it is necessary to review the structure of the profession in contrast, for example, to the situation

in the United States. First, there was before the SSN and there remains after the SSN a tremendous polarization in the profession between the 10 percent or so who are not only specists but also successful at this role and are attached in most cases to university teaching hospitals, and the others. Nearly all of the remainder are either in multispecialty practice or are family physicians, combining a community practice with an attempt to develop a specialty market. About 35 percent are in general medicine and another 30 percent in nonelite public hospitals, the vast majority being also generalists (Bompiani 1984, 154). The massive expansion of the Italian university system in the 1970s, and the continuing absence of a numerus clausus, has meant, for instance, that about 20 percent of these medical students drop out or continue only part-time, that only in the 1980s and after two decades of widespread unemployment of medical graduates have the numbers of those entering medical school begun to turn down slightly. Italy, with 26 medical schools, admitted 17,000 medical students in 1980 while the United States, with 124 medical schools, admitted 19,000 students in the same year (Bompiani 1984, 145-46).

For the vast majority of these students, no real bedside clinical training exists in medical school—and a year of internship is *not* required before beginning practice in the community. The political power of the physician elite has *not* been, according to my sources, mobilized against this marginal situation of low-quality education. Either massively to expand clinical training, or to set up a numerus clausus, is beyond the capacity of the state and the universities at present. The medical elite might also make less money if some of their time were devoted to training students. Thus, in spite of major studies and exposés such as *Rapporto Perkoff* little has changed in the past three decades (Freddi 1984).

Doctors and the SSN: 1978–1988

The Italian National Health Service does not exist. Only a careful reading of the critiques and studies done since the passage of the law creating the SSN on paper, in 1978, will help to explain why it is not a service, (it is a funding mechanism and an attempt at cost control), it is not national (but varies by region depending on how

or whether each regional government tends to enact or not enact it), it deals with payment for services (not health prevention, as clearly stated as the main goal of the new bill), and it does not involve a reorganization of the existing system of services. We can deal with these facts in detail, and illustrate the role of all of the actors thus far elaborated, in order to understand the action,and slowly changing role, of the Italian medical profession as a result of Law 833 which "created" it.

The most important point, to begin with, it a political/historical one. The SSN was passed at a time of maximum power by the PCI, and it was the slow ebbing of PCI power *after* passage of the law that allowed the DC to pull back from its agreement to work with the PCI to enact the new law into reality after passing it on paper. Along with this, one should understand that this national law, like many in the human service and welfare areas in Italy, is stated in terms of broad generalities and goals, with the details to be worked out by each new (1974) regional government. That said, it should be noted that some regions (especially but not only "red" ones) have made attempts at changes in the existing system along the lines of the original legislation. The Italian medical profession, divided by political parties and the elite/mass gap before passage of the law, has developed more power and solidarity after the law due to its provisions that professional groups must contract as groups for fees and payments with regional and local governments.

Important dimensions for understanding this issue are: the structure (theoretical and actual) of the SSN as a funding mechanism and cost-control device, the political role of the regional medical ordini and the national federation of ordini (Personal Communications with legislative staff of the Federazioni Nazionali degli Ordini Medicali or FNOM, August 1987), the role of the national labor unions (CGIL, CISL, UIL), the role of the local health service administrations (USLs), and, of course, the role of the political parties. Ironically, and once again making Italy a deviant case, the attempt of the state to rationalize the health system and control costs has forced the Italian medical profession to organize strongly against this state effort, giving them as a result more solidarity and unity than they had before the passage of the law. This, the main conclusion of Vicarelli (1986) may have alternate futures for the profession, depending on future changes in

the balance of power among sectors of capitalism, the state, the political parties, and the profession in the future. These alternate outcomes will be considered in the concluding section.

The SSN on paper looks like a cross between the British National Health Service, with its nationalized public hospitals (though technically it is not really so in Italy where the money is nationalized rather than the places) and aspects of health planning found in the United States under Public Law 93-641, which set up health systems agencies (HSAs) for every 100,000 to 200,000 people to plan for services, each state having a regional planning body (the SHPDA) and a national federal headquarters. Like Britain and unlike the United States, the central government, regional governments, and local health agencies have the cash, as well as the planning function. In Italy the HSA is called a USL (Unitá Sanitaria Locale) and each regional government gets the funding from Rome and passes it on to each USL in the region. As with the SHPDAs and HSAs in the United States, the regional and local agencies have boards with voting power, with consumers and politicians, but not (in 1978) physicians. Until the medical profession organized in 1981 for revisions in the law, they were not represented directly. It is an index of their growth in power that they now comanage the USLs and have strong representation on regional and national boards that oversee spending.

While the 1978 law had hoped to put physicians on full-time salary both in the hospitals and the community, the compromise worked out in the first three years was the contracting system, with medical unions (syndicati) affiliated with each major labor union (and some nonaffiliated doctors' unions) signing three-year contracts with the SSN for their panel reimbursement or hospital salaries. Precisely this need to organize to bargain for better contract terms was the political/economic impetus that led to greater solidarity for the profession after 1978. The role of the ordini are critical here. As semipublic professional regulatory and licensing bodies, they had historically had some prestige and some minor national political role. But as the only bodies to which all doctors had to belong, after 1978 they became increasingly important as bargaining agents with USLs, regional governments, and the SSN administration in Rome. Even the PCI, very much opposed to the idea of a private liberal or "free" profession after 1978, realized that the doctors had the power to totally frustrate the

new law, given the weak state and their own slight loss of power as a party to push for its enactment. As Vicarelli (1986, 110) puts it:

> The PCI maintained that a greater efficacious outcome would be guaranteed by maintaining their professional group autonomy, and guessed that contracting with the medical profession would assure not only their approval of the new law but also its *legitimation* and its practical *enactment.*

But of course, Vicarelli (1986, 110) also notes that since the PCI now agreed with the DC about "letting up" on the doctors, this created a profession with greater power after 1978 than before:

> This recognition of the "contracted free profession" signified, in fact conceded to the general practitioners, a "private government" within limits, one in which they would be required to contract periodically in terms of a "specific agreement," without giving them a formally recognized role in political planning [concertazione].

The next step was easily predictable. Once the general practioners—the vast majority of Italian physicians, as we noted—could contract, they could bargain, and if things were not going well they could either threaten to strike or actually do so, on a national level, thus shutting down the health system of the nation. This was a new, and real, power. It is interesting but not surprising that the general practitioners, after many years of trying, finally formed their own professional association in 1982—the Società Italiana di Medicina Generale. It would probably never have been formed had the state, through the mechanism of enabling practitioners as a bargaining unit, not forced them to see their common interests as a profession, regardless of party affiliation.

The role of the ordini is critical here. In my interviews at FNOM headquarters in 1987, it became clear that the lawyers who are the actual operating staff (leading doctors are the FNOM board and general practitioners are heavily represented in the FNOM administration) worked very closely with the parliamentary committees to write health legislation—giving their "consultations" or reactions before, not after, passage. This is particularly important because in Italy committees in parliament can legislate a lot of details of large laws (the SSN, for

example), without needing to have a full vote, even though the entire parliament was required to decide on the broad outlines of the SSN in Law 833.

The victory of the physicians, organizing to frustrate some of the original aims of the SSN, has made the FNOM a political model for other professions in Italy. Exaggerating a little, I think, but nevertheless noticing a possible trend, Camusi (1986) speaks of a return of professional guild power as the political parties (in her opinion) begin to weaken their grip on the state and civil society. The creation of a cross-national federation of *all* professional ordini (those from each region, in each profession)—the Federazione Nazionale degli Ordini—is a next step in this direction. Yet, significantly, when I went to their offices for interviews, I found two secretaries, a row of empty offices with names of each profession on a series of doors, and a suggestion from their tiny staff to go to the real professional power center in Italy (they said)—the FNOM.

One should not close this historical/political section without observing that the state, too, is finally becoming at least less passive vis-à-vis the health care cost crisis. As Sterpi and Dirindin (1985) document statistically, the average length of stay has dropped drastically in the public hospitals covered by the cost cap of the SSN. It has gone from an average of 20 days to 12 days—a 40 percent cut in average length of stay since the SSN and regional governments, and USLs, introduced global budgeting into the hospital system. Private hospitals (outside the SSN), with a high balance of chronic patients and the better-off mentally ill, have not lessened their length of stay. The SSN hospital figures, while still outrageously high by American and most Western European standards, still reflect real power, for perhaps the first time, by the state. If the physicians have become organized, they are now for the first time beginning to deal with, at least in this area, an organized state.

Profession, Party, State, Capitalism: Future Possibilities

Most policy-related discussions of the future of the SSN in Italy, and the role of the medical profession within it, tend to be practical and technocratic—pointing to the need for better accountability, better data collection, greater cooperation between medical profession, health

workers, and the politicians that dominate the USLs, and, above all, experiments in cost control. As Donati (1985) points out, these are needed, but one cannot view the SSN as a "closed system," as one not affected by Italian values on freedom versus social control, on attitudes toward the state, and so on.

The general trend in welfare states after World War II is for the state, with parties of the left supporting them until about 1970, to gain power and control over social spending. As greater percentages of professional graduates work for the state or under contract to it, the state begins to exert leverage over professional group power. It slowly wanes, especially as large capitalist sectors work closely with this stronger state to cut back somewhat on professional group power. In Western European states of this type (France is a good example) the state challenges professional group power. Professions begin to fight a rear-guard action against these attempts to rationalize work in public sectors (Tinayre 1974) or against attempts by the state to let its underpaid professionals compete after hours with their colleagues in private practice. (Union Nationale des Associations des Professions Liberales 1980).

But Italy, as we have seen, does not have the strong state, the reasonably solid capitalist class and capitalist sector/state combination working smoothly as a mechanism directed against professional group interests. Of course, as I have noted elsewhere, France is more complex than this—and its complexities are presently under investigation. But nothing like the Italian situation exists. Here, political parties, through partitocrazia, colonize capitalism, the state, and the professions, with a particular interest in colonizing and controlling the action in welfare state service programs. So future alternatives about Italy can be viewed under at least two sets of assumptions. The first will be that Italy will finally, after a thirty-year delay, develop modern capital/state politics more similar to those of other Western European nations, and a stronger state, and that crises in the SSN will force Italy to do so, even if the political parties do not want the state to get too independent, for fear of the DC and PCI and Socialists losing their grip on it.

Not irrelevant to this first scenario is the replacement of old party leaders in PCI, DC, and Socialist sectors by newer, younger, and more technocratically oriented offials, who know it is now or never for the Italian state. Also, since much tax evasion goes on in Italy by small business, the professions, and the service industries, those

who do pay—the large corporations and the unions who foot the bill for the SSN—may put new, more effective pressure on the state to "get its act together." Or political parties may simply begin to pull away, a little, from so much direct involvement. We now have some evidence of this in more effective cost control of hospital spending, from 1983 to 1988.

If this trend really exists, and continues, the present location of the medical profession within the state, or contracted to it, will eventually force the profession into a more rationalized and industrialized set of working conditions. This could lead to a trend which could alternately be described (depending on theoretical perspective) as de-professionalization or proletarianization, though neither view asks questions of some of the factors and processes central to Italy.

One recent student of the professions in Italy, and of the medical profession in particular (Tousijn 1986, 26) predicts that "because of concomitant processes being brought into play, the medical profession may be progressively losing its position of supremacy." He lists some causes as: the growth of health expenses (and the reaction of the state to them), growing doubts on the efficacy of medicine, the "revolt of the patients" (but here he quotes American and not Italian sources), the political action of other health workers (in Italy unions of physician assistants are strong and challenge medical authority in hospitals), and the even further growth of polarization within the profession between elite and mass. He does not discuss, at all, the political reaction of the profession to the SSN. Finally, he is optimistic about the state's strength once a welfare state is constructed:

> In Italy, and in other European nations there prevails . . . a further tendency, toward the enlargement and the consolidation of the role of the state, historically relevant from the beginning of the professionalization of the health professions.

But, this being Italy, other scenarios are possible. Camusi (1986) believes that the political parties may finally, in the mid-to-late 1980s, be beginning to lose their tight grip on the state precisely because that tight grip has paralyzed the state, brought chronic fiscal crisis to Italy, and caused problems for capitalism. In this situation of weakening partitocrazia, professional associations—such as the medical profession and especially FNOM, the national medical ordini federation—

may be gaining power, to become "le nuove gilde Italiani" (the new Italian guilds). She writes that her findings on professional actions in the Italian parliament

> indicate that the professional organizations are approaching a true and proper transitional phase. While they have not yet acquired a complete functional and normative autonomy, one is no longer able to say that they are completely submerged by political [party] goals or administrative bureaucracy. Rather, we are dealing with associations that alternate moments in which they control and determine their working conditions with moments of incapacity and fragility in this regard (Camusi 1986, 3).

Clearly, if the hold of partitocrazia weakens, both state and civil society (both professional groups and capitalism itself) will gain in its ability to deal directly with the politics of professional authority and control. But the most important word in the previous sentence is "if."

What does this case study of the Italian medical profession reveal for standard conceptual models of professional group power and professional autonomy? Clearly the Freidson (1970) model of "professional dominance" by doctors is shown to be curiously incomplete, if not ethnocentric and irrelevant. If political power and control over work came from medical expertise, then surely the Italian medical profession would have begun to dominate the work place and its relation to the state before 1981. Only a knowledge of the historical relations between *professional* group political solidarity and power, on the one hand, and state solidarity and power, on the other, can begin to show why doctors rose in power and influence over their work place. Capitalist rationalization of work places is somewhat irrelevant to the primarily public Italian system, yet the increasing pressure of sectors of capitalism on the DC and the Socialists may have already helped to push the SSN in a cost-control direction. Yet, the private pharmaceutical industry in Italy continues to fight, by fair means and foul, against cost-control attempts in the drug prescription area, protecting their huge profits caused by massive overprescription by under-trained Italian general practitioners. They may even be intervening politically on the side of the physicians in their fight against the state.

Finally, neither the functional, nor the interactionist, nor the neo-Marxian models of professional power and its change predict the central role of political parties in the relations among state, capitalism, and

the professions in Italy. Partitocrazia is almost a system unto itself. While long-term capitalist rationalization of the economy—even support for a stronger state to aid in this process—may be the future in Italy, with a medical profession losing once again their new-found partial autonomy, the short-run outcome is rather the reverse. The state, in attempting to control the medical profession, has in this specific nation, at this particular moment, strengthened and begun to unify a weak profession. This is not unique: the Hartmanbund gained power in Germany before the rise of Hitler in just such a bargaining situation, as did the British Medical Association at the start of the National Health Service in 1945. But it is a process that needs much further study. The degree of professional group power and the autonomy of individual workers on the work place are the result of complex social, historical, and economic processes. We are just beginning to see just *how* complex they are.

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