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Crisis and Austerity in Southern Europe: Impact on Economies and Societies

Crise e austeridade no Sul da Europa: impacto nas economias e sociedades

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CRISIS AND AUSTERITY IN SOUTHERN EUROPE: IMPACT ON ECONOMIES AND SOCIETIES

Abstract: This article discusses the economic and social impact of the 2008 crisis and its related austerity policy on South European countries (SEC). Damages caused by these policies includes the decrease in GDP, the increase in unemployment and precariousness, especially amongst the younger population, and the worsening of social services. SEC health systems have also been seriously affected by the crisis, with a particular impact on the most vulnerable social groups, as a result of the decrease in public health expenditure. The increase in health inequalities is another side effect of the structural adjustment programs.

Keywords: crisis, health inequalities, health systems, South European countries.

CRISE E AUSTERIDADE NO SUL DA EUROPA: IMPACTO NAS ECONOMIAS E SOCIEDADES

Resumo: Este artigo analisa o impacto social e económico da crise de 2008 e das políticas de austeridade dela derivadas nos países do Sul da Europa (PSE). Os danos causados pelas políticas de austeridade incluem a diminuição do PIB, o aumento do desemprego e da precariedade, especialmente entre a população mais jovem e a degradação dos serviços sociais. Os sistemas de saúde dos PSE também foram seriamente afetados pela crise, atingindo particularmente os grupos sociais mais vulneráveis, como resultado da redução da despesa pública em saúde. O aumento das desigualdades na saúde é outro efeito colateral dos programas de ajuste estrutural.

Palavras-chave: crise, desigualdades de saúde, países do Sul da Europa, sistemas de saúde.

Since Richard Titmuss's seminal work on the welfare state and social policy (Titmuss, 1958, 1974), there have been concerns with the detection and understanding of the diversity of existing welfare state models and of the functions of social policy in order to define the relevant options for decision-making. More recently, Esping-Andersen (1990), in his research on the political economy of the welfare state in advanced capitalist societies, empirically confirmed the validity of Titmuss's typology for a broad set of the

Organisation for Economic Co-operation and Development (OECD) countries, and refined its conceptual framework through the theoretical attributes of de-commodification, social stratification, and welfare mix. By renaming his own typology as the three worlds of welfare capitalism, this author associates to a certain extent a geographical dimension to the political dimension (liberal, conservative or social-democratic) of each regime by using the USA as an example of the Anglo-Saxon world; Germany of the continental European world; and Sweden of the Scandinavian world.

The impact of this typology on subsequent studies has been enormous, some of them claiming that other groups of countries do not fit properly in Esping-Andersen's trilogy and that they therefore represent a flagrant gap to be filled. This is the case of the Southern European countries (SEC) that joined the European Union later – that is, Greece, Portugal and Spain – and which, according to several authors, represent, together with Italy, a different world of welfare – the Latin-rim or Mediterranean model (Ferrera, 1996; Leibfried, 1992; Andreotti *et al*., 2001; Silva, 2002; Karamessini, 2008) – which is framed by a particular historical and socio-political context. One of the outstanding attributes of the welfare state in these countries, particularly suitable for health systems, is their universalist approach. In fact, all of these four countries, in the final phase of the expansion of their welfare states between the 1970s and 1980s created their own national health services (NHS) with universal access inspired in the Beveridgean model established in the United Kingdom in 1948. Among the common aspects of these Southern European NHS the following should be mentioned: (i) inconsistency between the universal promises and the effective response given to citizens' needs due to limitations in the process of implementation of national health services, in particular financial constraints (Giarelli, 2006); ii) difficulties in the management of the public system that led governments to introduce reforms aiming to improve efficiency, namely by following the rules of new public management (Cabiedes and Guillén, 2001); iii) the importance of non-professional human resources, such as family and primary care networks to compensate for the NHS's deficiencies (Santos, 1987; León and Migliavacca, 2013); iv) lack of participation by the users' representatives in decisions about health policy and in the organization of health services (Matos and Serapioni, 2017).

Despite these limitations, the four countries have significantly improved health indicators thanks to the social and economic development of the last decades and the continuous improvement of health care. However, these indicators, which are generally very positive, conceal situations of great inequality both in the distribution of economic and social resources and in the access to health services. At critical times, inequalities widen and larger groups of citizens are affected. This is precisely what happened during

the recent financial crisis of 2008 in these four Southern European countries, which soon became a systemic – economic, social, and political – crisis (Laparra and Pérez Eransus, 2012).

Due to inequalities between Eurozone economies, crises may affect only some of them and spare the others, with the Economic and Monetary Union (EMU) common rule not applying in such cases. On the contrary, EMU contributes both to the reinforcement of inequalities, i) when promoting the specialization of economies in productions in which they have higher relative efficiency and ii) when removing from Member States the possibility of using important economic and monetary instruments, such as the reduction of interest rates, currency devaluation, or public expenditure increase.

What seems to be particularly distinctive in this crisis is that, thanks to the existence of a monetary system that imposes strict limitations on the use of traditional crisis management tools, the room for government maneuver has been greatly reduced in so far as the supervision of supranational institutions is concerned. In turn, for those under financial assistance the imposition of adjustment programs eventually came to control their sovereignty.

The creditors' own preferred solution – austerity rule – has been adopted against the risk of worsening the financial crisis even by those Member States which did not have to resort to financial assistance, as in the case of Italy. Austerity rule has contours that are not well defined and may have quite different interpretations. In a nutshell, it refers to a set of economic and social policies by which governments aim to halt or reduce public expenditure. We would also highlight the fact that these options allow for the "modification of the State's redistributive policy and of the expenditure related to the functioning of the economy and social reproduction" (Ferreira, 2014: 117).[1]

Damages caused by austerity policies to the economies and societies of countries which had to adopt them showed in different forms. From early on, decrease in the GDP or even deep recessions (Table 1) with serious future implications occurred, not only due to investment halt and sovereign debt increase (Table 2), but mainly as a result of social consequences: job destruction and increase in unemployment (Table 3); precariousness, especially in younger segments of the economically active population; large emigration flows of qualified workers; and the worsening of poverty, social exclusion (Table 4) and income inequalities (Table 5).

[1] All the translations have been made by the authors.

TABLE 1 – GDP Growth Rate (%):
Greece, Portugal, Spain, Italy and Eurozone (2008-2014)

	2008	2009	2010	2011	2012	2013	2014
Greece	-0.3	-4.3	-5.5	-9.1	-7.3	-3.2	0.7
Portugal	0.2	-3.0	1.9	-1.8	-4.0	-1.1	0.9
Spain	1.1	-3.6	0.0	-1.0	-2.9	-1.7	1.4
Italy	-1.1	-5.5	1.7	0.6	-2.8	1.7	0.1
Eurozone	0.5	-4.5	2.1	1.6	-0.9	-0.2	1.4

Source: Eurostat (2018).

TABLE 2 – Sovereign Debt (% of GDP):
Greece, Portugal, Spain, Italy and Eurozone (2008-2014)

	2008	2009	2010	2011	2012	2013	2014
Greece	109.4	126.7	146.2	172.1	159.6	177.4	178.9
Portugal	71.7	83.6	96.2	111.4	126.2	129.0	130.6
Spain	39.5	52.8	60.1	69.5	85.7	95.5	100.4
Italy	102.4	112.5	115.4	116.5	123.4	129.0	131.8
Eurozone	68.7	79.2	84.8	86.9	89.9	91.8	92.0

Source: Eurostat (2018).

TABLE 3 – Unemployment Rate (%):
Greece, Portugal, Spain, Italy and Eurozone (2008-2014)

	2008	2009	2010	2011	2012	2013	2014
Greece	7.8	9.6	12.7	17.9	24.5	27.5	26.5
Portugal	8.8	10.7	12.0	12.9	15.8	16.4	14.1
Spain	11.3	17.9	19.9	21.4	24.8	26.1	24.5
Italy	6.7	7.7	8.4	8.4	10.7	12.1	12.7
Eurozone	7.6	9.6	10.2	10.2	11.4	12.0	11.6

Source: Eurostat (2018).

TABLE 4 – At-Risk-of-Poverty or Social Exclusion* Rate (%) (2008-2014)
Greece, Portugal, Spain, Italy and Eurozone

	2008	2009	2010	2011	2012	2013	2014
Greece	28.1	27.6	27.7	31.0	34.6	35.7	36.0
Portugal	26.0	24.9	25.3	24.4	25.3	27.5	27.5
Spain	23.8	24.7	26.1	26.7	27.2	27.3	29.2
Italy	25.5	24.9	25.0	28.1	29.9	28.5	28.3
Eurozone	21.7	21.6	22.0	22.9	23.3	21.1	23.5

* People in one of the following conditions: at-risk-of-poverty after social transfers (income poverty), severely materially deprived or living in households with very low work intensity.

Source: Eurostat (2018).

TABLE 5 – Inequality of Income Distribution Ratio (S80/S20*) (2008-2014)
Greece, Portugal, Spain, Ireland and Eurozone

	2008	2009	2010	2011	2012	2013	2014
Greece	5.9	5.8	5.6	6.0	6.6	6.6	6.5
Portugal	6.1	6.0	5.6	5.7	5.8	6.0	6.2
Spain	5.6	5.9	6.2	6.3	6.5	6.3	6.8
Italy	5.2	5.3	5.4	5.7	5.6	5.8	5.8
Eurozone	4.9	4.9	4.9	5.0	5.0	5.1	5.2

* S80/S20 – ratio of total income received by the 20% of the population with the highest income (the top quintile) to that received by the 20% of the population with the lowest income (the bottom quintile).

Source: Eurostat (2018).

The comparative analysis of austerity policies effects in four countries severely affected by the crisis (Greece, Portugal, Spain, and Italy) shows that, although the range of available political instruments is limited and not very diversified, the way in which they are combined and implemented is crucial to explain the different effects austerity policies had in each country.

Table 6 summarizes the measures adopted by these four countries. It should be noted that only two of them (Greece and Portugal) were under a very heavy financial assistance program, contrary to what happened in Spain where the intervention was not in the form of a sovereign debt relief but of a program of assistance for the recapitalization and restructuring of the banking sector. The same applies to Italy, where the possibility

of requesting an emergency loan in order to overcome the sovereign debt crisis was seen as the "point of no return" for the stability of the euro area in its entirety. As the Eurozone's third largest economy, Italy was considered "too big to fail, too big to bail" (OXFAM, 2013).

TABLE 6 – Under the Austerity Rule (2008-2010): The Main Reforms in Policies in Greece, Portugal, Spain and Italy

Greece	Portugal	Spain	Italy
Increase in individual income tax rates, partially compensated by decreasing tax rates for lower bands; Changes in the fiscal benefits and bonuses Widening of the contributory basis.	Increase in individual income tax rates; Introduction of an additional tax rate for top earners; Reduction of fiscal benefits.	Introduction of an additional income tax rate for top earners.	Increase in individual income tax rates; Reintroduction of a housing property tax.
Cuts in public pensions; Introduction of a one-off additional tax on incomes and a special tax on pensions.	Freezing of nearly all social insurance benefits and pensions.	Freezing of public pensions.	Reform of the pension system, raising the retirement age for women and men. Deep cuts in social spending at national and local level
Increase on VAT taxes.	Increase on VAT taxes.	Increase on VAT taxes.	Increase on VAT taxes.
Cuts in public sector wages.	Cuts in public sector wages.	Cuts in public sector wages.	

Source: Adapted from Callan *et al*. (2011) and OXFAM (2013).

Without going into further detail, the differences regarding the implementation of austerity rule are evident, as well as the similarities between the policy instruments used. With regard to the structural adjustment programs agreed with the Troika in the health sector, it is worth recalling the factors triggering the financial crisis and the problems that led three Southern European countries (Greece, Portugal and Spain) to be submitted to a readjustment programme.

In the case of Greece, the expansion of the internal demand between 2000 and 2009, when the Gross Domestic Product (GDP) growth rate was higher than that of the Eurozone, determined a fast growth of bank credit demand (especially for expenses with durable consumer goods, including housing) favored by low interest rates. As a consequence, foreign commerce registered an increasing negative balance whereas

competitiveness levels deteriorated, at the same time that public administration expenditure expanded; this resulted in the aggravation of the annual deficit in public accounts, which reached the peak of 14% of the GDP in 2008, and a sovereign debt of 115% of the GDP in 2009 (European Commission, 2010). This was the earliest case of external intervention, which occurred in May 2010; it is also accounts for the longest ongoing intervention, with a second rescue program starting in June 2012 in the form of a partial debt relief, and a third program starting in August 2015 (European Commission, 2012, 2015)

In Portugal there were similar causes: accumulation of high external debts in previous years by the State as well as by families or firms. The growing demand for external financing for public debt and banking investment originated a strong interest rate increase in the financial markets along with a rating degradation of the Portuguese sovereign debt and bank solvency.

The adjustment program started in May 2011 and lasted until mid-2015 (European Commission, 2014). There are two aspects to be highlighted in the Portuguese case for the assessment of the reforms: firstly, since 2009, before entering the program, the government had implemented a set of measures to combat the crisis – Stability and Growth Programs I, II and III – basically consisting of public expenditure reduction; secondly, the right-wing coalition government, which had the responsibility for implementing the adjustment program agreed with the Troika used the opportunity to impose its own agenda, clearly of a neoliberal character, moving further than the settled goals by means of reinforced austerity measures (Table 7).

TABLE 7 – The Adjustment Programs in Greece, Portugal and Spain

Greece	Portugal	Spain
2010 (May 2nd): First economic adjustment program in the amount of €80 billion euros to be released during be period from May 2010 to June 2013. 2012: Second economic adjustment program in the additional amount of €130 billion euros for the years 2012-2014; later postponed until the end of June 2015. 2015 (August 19th): Third economic adjustment program in the amount of €86 billion euros in financial assistance from 2015 through 2018.	2011 (May 17th): The economic adjustment program in the amount of €78 billion euros, during the period of 2011 to mid-2014, to re-establish access to financial markets, enabling the recovery of the economy to sustainable growth and to safeguard financial stability in Portugal, in the Eurozone and in the EU.	2012 (July 23rd): The economic adjustment program in the amount of €100 billion euros for recapitalization and re-structuring of the Spanish financial sector.

Source: Hespanha, 2017.

In the case of Spain, the intervention was not made by means of a sovereign debt relief, but rather through a financial assistance program for the recapitalization and restructuring of the banking system. The decapitalization of banks followed the burst of a construction industry bubble in 2008 and the deep involvement of banks in financing that sector. Reforms undertaken by the Spanish government were insufficient to reduce the pressure of financial markets and the stress levels of banks; this forced the Spanish government to request financial assistance in 2012 (European Commission, 2012).

The Memorandums of Understanding (MoUs) subscribed by the governments of countries subjected to financial aid comprise a set of measures specifically directed at the health sector, along with other transversal measures aiming to reduce public expenditure that equally affected this sector. Our analysis will focus on these measures.

The main remark to be made when comparing the general objectives of the MoUs is that Troika's 'recipes' did not differ much and concentrated on a limited amount of objectives, somehow hindering the adaptation to the specificities of each country in economic, social and political terms, and making it necessary for governments and the Troika to maintain permanent negotiations. On this issue two ideas should be added: a) Troika's attitude was or has been quite rigid in the sense that it did not easily accept the alternatives offered by the national governments for the attainment of the same targets; b) each of these three countries received a different treatment regarding the margin of flexibility consented by the Troika. For example, in the case of Spain there was no such detailed program concerning the measures to be implemented in order to reach the goals (European Commission, 2012).

Therefore, the main axes of the health sector reform the three countries had in common concerns control of public expenditure and improvement of the services efficiency and effectiveness, including the promotion of a more rational use of resources and services, such as, for example, the reduction of the fragmentation of services or the dispersion of their tutelage (Table 8).

Vigorous external pressures for economic policy change were exerted in all SEC. Although Italy did not sign a MoU, the EU's involvement in defining economic policies was significant during the sovereign debt crisis between 2011 and 2012. In order to have the support of the European Central Bank, Italy engaged in a series of structural reforms, accepting the 'implicit conditionality', an instrument used by the European Union during the Eurozone crisis and "based on an implicit understanding of the stakes and sanctions involved […], even in the absence of detailed covenants" (Sacchi, 2015: 77, 79). Even if the Monti government identified pension and labour policy as the main issues that could be submitted to reforms, other sectors were also affected. Among the austerity policies

implemented in the Italian health sector, it is worth mentioning the following (Dirindin, 2011; Ferré *et al.*, 2014; Maciocco, 2015):

- Increased co-payment for medicines, out-patient care and non-necessary emergency admissions;
- Reduction of the number of hospital beds from 4 to 3.7 per 1.000 inhabitants;
- Reduction of expenditure on health-care personnel;
- Reduction in the prices of pharmaceuticals, increase in use of generic drugs and decrease in pharmacy revenue;
- Reduction in the expenditure caps on purchasing medical equipment and services.

TABLE 8 – General Objectives of the Adjustment Policies in Health in Greece, Portugal and Spain

Greece	Portugal	Spain
General objectives: - Control public expenditure and increase efficiency, cost-effectiveness and equity of the system; - Stimulate savings by means of a more rational use of resources; - Concentrate all institutions and policies related to health under the responsibility of the Ministry of Health.	*General objectives:* - Improve efficiency and cost-effectiveness; - Stimulate a more rational use of health services; - Control public expenditure in health.	*General objectives:* - Implement reforms in the public sector to improve the efficiency and the quality of public expenditure in all of governmental levels; - Integrate the funds in order to simplify a highly segmented system; - Concentrate measures related to health under one ministerial coordination.

Source: Hespanha, 2017.

The average annual rate of contraction of public health expenditure in the SEC between 2009 and 2017 has been significant. According to the OECD it was more pronounced in Greece, followed by Spain, Italy, and Portugal (Table 9). In the same period, the majority of the countries of other European macro-regions have maintained the normal rate of growth in public health expenditure (Germany, France and Sweden), or have registered smaller decreases (Czech Republic, Poland and Hungary), with the exception of Great Britain and Ireland, which suffered a substantial reduction (5.1% and 4.5% respectively) (Serapioni, 2018).

TABLE 9 – Evolution of Public Health Expenditure (2009-2017) as % of Total Spending in the SEC

	2009	2010	2011	2012	2013	2014	2015	2016	2017	Differences
Greece	68.5	69.1	66.0	66.5	62.1	58.2	58.3	61.3	61.2	-7.3%
Portugal	69.9	69.8	67.7	65.6	66.9	66.1	66.2	66.4	66.6	-3.3%
Spain	75.4	74.8	73.8	72.2	71.0	70.4	71.3	71.2	70.8	-4.6%
Italy	78.3	78.5	77.0	76.1	76.1	75.6	74.6	74.5	74.0	-4.3%

Source: OECD – Health Statistics, 2018.

Several studies have highlighted the effects of the crisis on health systems in Southern European countries, particularly on the most vulnerable social groups, leading, for instance to an increase in mental disorders as well as in suicides (De Vogli, 2014). These effects have already been observed in Greece, Ireland, Italy, Portugal and Spain (Karanikolos *et al*., 2013; Ruiz-Pérez *et al*., 2017), i.e. in countries where austerity policies have been imposed or vigorously recommended (Petmesidou *et al*., 2014), and involved "blind cuts and disqualification of services" (Hespanha, 2017: 95). The increase in health inequalities, both social and geographical, is also one of the side effects of the structural adjustment policies applied in the SEC (Escolar-Pujolar *et al*., 2014; Guillén *et al*., 2016).

This thematic issue of *e-cadernos CES* gathers contributions from scholars and researchers who have dealt with the relationship between crisis, austerity policies and NHS reforms on the one hand, and the growth of health inequalities on the other. In the first article, Maria Petmesidou presents the slow and tortuous process for reforming the health system in Greece from the early 1980s until the outbreak of the crisis in 2008. In this context, the author analyses how, under the pressure of the sovereign debt crisis, the shift in institutional and power relations has forced political actors to recognize the functional limits of the health system and to accept the implementation of a set of policy measures and regulatory instruments that formed the basis of reform. In the second part, the article illustrates the main reforms defined in the Troika rescue package and then examines the impact of such measures. Among the expected results of the reform, the author emphasizes the unification and rationalization of health insurance, in order to oppose the fragmentation of the health system and the inequalities of coverage and access. At the same time, however, the author notes that the contraction of financial and human resources has dramatically reduced the scope, quantity and quality of the

services provided, as well as increasingly unmet medical needs, especially among the most vulnerable social groups, thus deepening inequalities in terms of accessibility.

The case of Portugal is analysed by Pedro Hespanha by debating the guidelines of the main health reforms carried out or planned in Portugal to ensure the financial sustainability of the health system since 2010; Hespanha concludes from distinct evidence that, although most of the health reforms would be useful and necessary, those implemented produced negative and somehow unforeseen consequences due to their short-run duration and their universal-based design. In the absence of a well-structured reform program, the blind application of cuts on expenses prevailed, regardless of the impact these cuts would cause on very sensitive areas of medical care. The manner in which slowness, insufficiency or downgrading of services affects citizens differs according to their social condition and the ways in which they deal with the situation. Hence, health inequalities were kept consistently higher than those observed in other European countries in the last decade and continue to be closely associated with socioeconomic factors.

The article by Juan Antonio Córdoba-Doña and Antonio Escolar-Pujolar reviews the main findings on the impacts of the crisis on health inequalities in Spain. The authors first present a historical background of the Spanish National Health System (SNHS), from the dictatorship period through the democratic era, until the latest recession. Then, they look into the implemented austerity policies and their effects on the public spending on health as well as the privatisation and dismantling of the SNHS, focusing especially on citizens' responses to austerity measures. The widespread discontent and the civic indignation against neoliberal austerity policies are considered by the authors as the most remarkable episodes of social mobilization in defense of the welfare state in Spain since the introduction of democracy and maybe the strongest bulwarks against health inequalities. The second part of the text reviews almost exhaustively the academic literature and official data on the impact of the 2008 crisis on health inequalities, to conclude that the SNHS displayed considerable resistance to the effects of recession during the early years but its buffer capacity was exhausted by 2013, aggravating social inequalities and disproportionately affecting the most vulnerable populations.

Two articles compare the cases of Spain and Portugal. Elena Cachón González analyses the impact of the crisis and austerity on health inequalities, combining objective indicators on health and health services with subjective indicators on quality of life related to health and also on the individual satisfaction with health services. The data shows that, although the objective indicators have improved once the crisis was overcome, the same did not occur with the subjective indicators because, among other reasons, the social determinants of health are still far from normal. Raúl Payá Castiblanque in turn, is

particularly concerned with the effect of the crisis and austerity on the increasing rates of work accidents and the unequal ways in which this affects different groups in the active population. Two categories of workers are particularly hit in both countries: those in precarious sectors in the areas of construction and the industry, and those in small enterprises, especially young people.

The case of Italy is scrutinised in two different articles, one by Stefano Neri, the other by Rossella De Falco. Stefano Neri examines the process of reform of the National Health Service (NHS) since the beginning of the 2008 crisis, with an aim to focus on the changes to NHS governance. The author illustrates the characteristics of the Italian health system and the main stages of the decentralization process from the State to the regions, highlighting the changing of their respective roles and the operation of the State-Region Conference, a mechanism of joint policy making between the central government and the regions. Neri also analyses the repercussions of the economic crisis on intergovernmental relations, explaining how the crisis strengthened the role of the central government (namely, the Ministry of Economy but indirectly also the European institutions) in the development of national policies, to the detriment of the role played by the regions. For the author, this change in intergovernmental relations could endanger the universalist nature of the Italian NHS and its capacity to guarantee the values of equity and solidarity, especially on a geographical level. From the perspective of human rights, Rossella De Falco studies the impact of post-2008 austerity policies on increasing inequalities in the Italian National Health Service. After describing the fiscal adjustments implemented by the government, the author examines key right-to-health indicators over the 2010-2016 period. Finally, based on the analysis of secondary data from national and international sources, De Falco focuses on the increasing level of unmet medical needs due to costs, waiting time, and increased user fees. The results, the author argues, evince how the regressive health policies undermine equitable access to care.

To expand the reflection on the South initiated with the case of the SEC, the @cetera section presents two articles from the perspective of the global South (Santos, 2018), namely Brazil. These texts address the impact of neoliberal and conservative reforms implemented in recent years. The text by Tânia Krüger, entitled “Sistema Único de Saúde: redução das funções públicas e ampliação ao mercado”, illustrates the deconstitutionalization of the Unified Health System (SUS) as a result of the process of dismantling and privatisation of public health institutions and services. The author examines the recent counter-reforms hitting the SUS, presenting indicators that show how it is becoming subordinate to the private health sector.

Rosana Mirales’s essay focuses on 21st century conservative thinking and its negative impact on both social services and professional training in this field of

intervention. Mirales looks into Josep Bacqués's recent study *El liberalismo-conservador. Fundamentos teóricos e recetario político ss. XVIII-XX* with an eye to developing a critical analysis of the foundations of conservatism and its close ties to liberalism.

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