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The Open Method of Coordination on health care after the Lisbon Strategy II: Towards a neoliberal framing?*

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Abstract: This paper undertakes a content analysis of the discourse on the Open Method of Coordination on health care (OMC/HC) in order to show how equity and solidarity are increasingly linked to optimisation and, as such, how neoliberalism increasingly frames health care. Some of the side-effects of this reframing for politics are highlighted: legitimating and extending European Union governance, reducing the space for oppositional formations and limited citizenship. The analysis begins by interrogating the broader context of the Lisbon Strategy II, after which the techniques of the OMC/HC and its substantive outputs are analysed.

Keywords: liberalisation; governance; health policy; power analysis; legitimacy; political science

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1. Introduction

As a legal scholar I am interested in how health care is framed, and the way in which it is being *reframed* within a neoliberal mould, by the European Union's (EU's) legal and governance discourses. In the EU health care systems (HCSs) have traditionally been framed as being about ensuring access to health care in a way that fosters equity and solidarity (Flear 2007; Hervey 2007). However, those systems are under pressure from such factors as aging populations, new and more expensive treatments, rising public expectations, intensified fiscal pressures generated by the current global financial and economic crisis, and cross-border patient flows (for a review see: Flear 2006; Hervey 2008). The latter have been promoted by the European Court of Justice's (ECJ's) jurisprudence,⁽¹⁾ which conjures patients of HCSs as 'market citizens' (Everson 1995; cf. Lehning 1997 and Kostakopoulou 2005) as it provides

them with a limited right to migrate to another member state of the EU where they pay for and receive healthcare treatments, the cost of which is then reimbursed by their home member state (Hervey 2007).

As I note elsewhere, this jurisprudence is double-edged (Flear 2007). It might *inter alia* actually promote equity where it prompts state action to assist those in most need of treatment, for instance by reducing waiting times and providing everyone with the opportunity to migrate in a structured way that also helps to manage or reduce costs and stimulate innovation. The jurisprudence might also foster solidarity, particularly between patients in different member states, such as when they work together to develop treatments for their conditions. But there are also risks. One risk is that free movement might generate excessive and unpredictable flows of patients, with the consequence of unplanned costs and wastage of increasingly scarce public resources. Another, perhaps more salient, risk is the circumvention of waiting lists by the middle classes. They are most likely and able to travel abroad, because of their greater confidence, their possession of foreign language skills unavailable to those from lower socio-economic groups, and, crucially, their ability to pay for travel and treatment upfront and wait for reimbursement. This “threatens equity and the solidaristic basis of healthcare systems, [by] submersing constitutional (and especially social) values beneath the swirling currents of the market” (Flear 2007: 240; cf. Newdick 2006).

Safeguarding equity and solidarity as the frame for health care by buttressing them against neoliberal jurisprudence and making the best of the opportunities it provides, as well as meeting the other challenges to HCSs, has not proven straightforward. At the time of the Open Method of Coordination on health care’s (OMC/HC) inception in 2004, obtaining an alternative or supporting solution through Community legislation seemed an unrealistic prospect. To some extent this was due to the EU’s famed constitutional asymmetry, which privileges the economic sphere through the internal market but provides limited legal bases for action in the social sphere (Scharpf 2002), for instance, by the prohibition on the harmonisation of differences between HCSs under Article 152 EC Treaty(2) (Flear 2007: 240). New governance seemed to provide the only viable buttress, and the OMC/HC seemed the most plausible appropriate form available to “coordinate, support, monitor and assess the impact of [...] [member state] reforms, promoting universally accessible, high-quality and sustainable health and long-term care for all” (EC 2009b) and maintaining distinct and autonomous HCSs (cf. Hervey and Trubek 2007)(3).

Yet, it is arguable whether the OMC/HC is suitable as a buttress. Some have argued that the Open Method of Coordination (OMC) more generally promotes moves towards the ‘free market’ or the ‘market compatibility’ of national welfare settlements, with the consequence that social welfare settlements of the ‘Continental’ model are pushed towards the ‘Anglo-Saxon’ – a (more) neoliberal – model (Scharpf 2002; Offe 2003; Moreno and Palier 2005; Büchs 2007; Büchs this issue). Alternatively, it has been suggested the OMC/HC in particular does not advance, circulate and disseminate liberalisation, privatisation, competition, and consumer choice – key referents of neoliberalism – in health care provision (Hervey 2008). Whether used implicitly or explicitly, and whether or not it is viewed as operating through the OMC, neoliberalism is commonly viewed as an *economic doctrine* promoting the dominance of a market ideology that seeks to limit the scope and activity of governing (cf. Brown 2005: 37-38; Kröger this issue).

In this paper I trace the operation of neoliberalism as a *political rationality* and governmentality that, as Ong puts it, “results from the infiltration of market-driven truths and calculations into the domain of politics” (Ong 2006: 4). In this contrasting understanding, neoliberalism seeks to optimise societal and individual energies by inducements to self-management, which facilitates governing at a distance by and through freedom. As a consequence of this move the scope and activity of governing expands. Moreover, the space for politics is reconfigured by the erosion of the gap in liberalism between the economy and the social. The development of oppositional formations and claims located outside market rationality is stymied by this move, and citizens are limited as they become rendered in a neoliberal mould as sovereign individuals pursuing their self-interest. In order to trace

neoliberalism's operation I undertake a content analysis of the discourse on the relaunched Lisbon strategy, the Lisbon Strategy II (LSII), and the techniques and substantive outputs of the OMC/HC. The analysis highlights the growing linkage of equity and solidarity with optimisation in the context of 'modernisation', which serves to place health care within a neoliberal frame.

The argument made in this paper – that neoliberalism qua political rationality *is* being advanced, circulated and disseminated at the EU level through the OMC/HC – supplements and reinforces analyses highlighting the neoliberal orientation of the OMC more generally (Haahr 2004)(4) and the national welfare reforms of the member states (an orientation highlighted by the construction of citizen-consumers in the United Kingdom and beyond: Clarke et al. 2007). Other reasons for interrogating neoliberalism's operation by reference to the OMC/HC include the following. As the papers in this collection demonstrate, the OMC is growing in importance. According to some the OMC is now a template for EU soft law mechanisms (Greer and Vanhercke 2010). That the OMC is the preferred method for EU action in sensitive policy areas at the core of national sovereignty, such as health care, affirms this point. Further affirmation, and an added reason for interrogating the OMC/HC, is to be found in moves to reinforce the current OMC/HC and the wider Social Protection and Social Inclusion (SPSI) OMC (OMC/SPSI) (EC 2008a). In essence, the OMC is expanding EU involvement and power, and this necessitates reflection. By shedding light on how we are being governed by and through neoliberalism, this paper seeks to contribute towards to this collection, the wider commentary on the OMC, and the broader subsequent task of critical reflection and imagining alternative ways of governing and being.

In the next chapter I outline neoliberalism and the governmentality perspective adopted for the analysis of the LSII, as well as the techniques and substantive outputs of the OMC/HC in [section 3](#). In [section 4](#) I summarise the paper and discuss the findings.

2. Neoliberalism and governmentality

In order to trace neoliberalism's operation I undertake a content analysis of the discourse found in official documents(5) and webpages. The analysis is necessarily non-exhaustive and indicative, and it is divided into the overarching context for the OMC/HC provided by the LSII (see [section 3.1](#)), techniques of the OMC/HC (see [section 3.2](#)) and its outputs (see [section 3.3](#)). Neoliberalism is understood as a political rationality (Foucault 2008, interpreted by Lemke 2001 and especially Brown 2005: 39-44). Rose et al. describe this as “a way of doing things that...[is] oriented to specific objectives and that...[reflects] on itself in characteristic ways” (Rose et al. 2006: 84). The fusion of various modes and techniques of governance with neoliberal political rationality can be understood as governmentality or that which organises the conduct of conduct (Foucault 1998: 2002). In this view power is relational and dispersed across society through a variety of often unrecognised, informal and sometimes contradictory elements, including discourses. Power often operates without intention and it can produce unforeseen consequences.

As a way of doing things neoliberalism seeks to organise policies in the market and non-market spheres by extending and disseminating market rationality from the former to the latter and into all domains. The discursive and practical integration of the economy and the social has as its corollary a narrowing of the gap (and distinction) between them found in liberalism (Brown 2005: 45). The criteria for good social policy are thus limited and conflated with economic optimisation. Governance openly responds to market needs through its various institutions and policies; cost and benefit become the measure of its practices. Entrepreneurialism frames political discourse. The reason for all this is neoliberalism's central objective: The gathering, deployment and optimisation of the energies of individuals and the population as a whole (Brown 2005: 39-44), so-called biopower (Foucault 2008).

Neoliberalism governs at a distance and is operationalised through such ways of doing things as “budgets, audits, standards and benchmarks” (Rose et al. 2006: 91). These give the

impression of devolution, but in fact they govern and seek to optimise performance through the production of self-management. That is, institutions and individuals are treated as autonomous *and* responsible agents. In this way, neoliberalism seeks to extend and enhance the scope and activity of governing.

Governmentality gives access to the broader significance of the powers operating through political phenomena like the OMC. In particular, since state-like organisations like the EU are the singularly accountable sites of power in society, legitimacy becomes a vital concern in understanding the operation and use of neoliberalism through the OMC/HC and the LSII (Brown 2006: Chapter 4, modifying Foucault's account, which ignores legitimacy; cf. Pfister this issue). An emphasis on governmentality brings out the ways of governing and, therefore, the underlying rationalities, and their effects.

3. Neoliberal architectures, techniques and outputs

3.1. Architectures

The operation of neoliberalism in the overarching architecture of the LSII reinforces its operation in the OMC/HC as the frame for health care. Analysis of the architecture also exposes neoliberalism's use as a way of legitimising EU power and governance, the way in which that involvement is naturalised and expanded through neoliberalism's depoliticising effect, and its limitation of politics and citizenship (see further, Zeitlin 2008; cf. Hervey 2008, who misses the strategy's framing potential).

To begin with the operation of neoliberalism, by way of essential background, the OMC, and its variants such as the OMC/HC (sketched more fully in [section 3.2](#)), were inaugurated to further the Lisbon Strategy. The latter was launched by the European Council in March 2000, and had the goal of making the EU "the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth with more and better jobs and greater social cohesion" by 2010 (CEU 2000). The original 'Lisbon triangle' being concerned with economic, social and employment policies was replaced by a 'quadrangle' with the addition of the environment at the EU's Gothenburg summit on Sustainable Development Strategy in 2001 (Armstrong 2008: 413-414).

However, the Lisbon Strategy was relaunched in 2005 with an explicit focus on growth and jobs – that is, market rationality. This followed a mid-term review in 2003-4 which criticised the strategy's overarching design and the OMC's role within it. In particular, the report of the High Level Group chaired by Wim Kok highlighted benchmarking and peer review within the OMC as ineffective. The Kok Report (2004) recommended that the strategy's key techniques, its objectives, targets and indicators, be refocused on growth and jobs. Further pressure in this direction was provided by the then incoming Barroso Commission (EC 2005b), which essentially reinforced the Kok Report's findings. The consequence of this political and institutional pressure was a focus on growth and jobs.

As Zeitlin explains, the architecture of the LSII fuses "the European Employment Guidelines and the Broad Economic Policy Guidelines into a single set of 24 Integrated Guidelines for Growth and Jobs" (Zeitlin 2008: 437). Social objectives are absent from this new overarching architecture. The importance of this reframing is made acutely apparent by the Commission, which notes how "[m]ost importantly, the relaunch of the Lisbon process in March 2005 has *sharpened the context into which work on social protection and inclusion must fit*. The revised Lisbon strategy concentrates on policies to boost growth and employment and seeks to overcome the implementation gap identified in the review of Lisbon" (EC 2005a: 3, emphasis added). That is, the social fits *into* the economy – the market and economy frame the social and, therefore, the OMC/SPSI, which streamlined the pre-existing social OMCs, including the OMC/HC (infra [section 3.2](#)). This framing of the social further indicates the extension and dissemination of market rationality into formally non-market domains, which are thereby

subordinated.

Nevertheless, the European Council has, in its 2005-2009 spring meetings, repeatedly reaffirmed the importance of creating greater social cohesion and reducing social exclusion as core objectives (CEU 2005, 2006, 2007, 2008, 2009). This is supposed to be achieved through interaction between the streamlined OMC/SPSI and the Integrated Guidelines (Zeitlin 2008: 438). Yet, there is little evidence of such a relationship. For instance, the political commitment of the European Council to the social dimension of the Lisbon Strategy – now II – is not found in the Integrated Guidelines used by member states in the preparation of their National Reform Programmes (NRPs, produced under the LSII), nor in the assessment of the NRPs by the Commission (Zeitlin 2008: 441). In the 2006 NRPs just ten member states included social cohesion/inclusion objectives (including gender equality) in their national priorities or referred to them extensively. Of the other member states, nine briefly cross-referenced the NSRs (from the OMC/SPSI) submitted the previous month, four referred exclusively to labour market inclusion, and the remaining four omitted any mention of social cohesion altogether (ibid.: 439).

Linking forward to the principle of subsidiarity (infra [section 3.2](#)), although national ownership of the OMC is stressed there is a structural bias towards finance and economics ministries i.e. those most likely, given their remit, to privilege market rationality in their work (Zeitlin 2008: 439-440). This bias generates difficulties for the social partners and health ministries since they have little history of contact with the ministries. The place of these national actors, and the apparent lack of integration with social and health ministries, further demonstrates the primacy of market rationality in the LSII.

In summary, it appears member state social policies are to be coordinated in pursuit of financial sustainability and employment promotion, which the OMC/SPSI was “developed to overcome” (Zeitlin 2008: 442). In support of this Zeitlin uses the example of the 2007 joint recommendations. These note eight member states who received formal recommendations to accelerate the reform of their HCSs in order to ensure the sustainability of public finances. Moreover, another three member states were exhorted to accelerate implementation of overdue health care reforms. The subordination of the social to the economy is made clearer in a statement on the Commission’s webpage for ‘Growth and Jobs’: “[w]e need to make Europe an attractive place to invest and to work” and “[t]hat means *budgetary sustainability*, better regulation and the right tax and benefit systems” (EC 2009a: emphasis added). Benefits systems, which can be assumed to include HCSs, are more explicitly placed in the service of the economy.

Overall, the LSII marks an overt response to market needs. Social progress is not just conflated with, but is subordinated to and framed by the economy. The policy areas governed by the OMC, such as health care, are enfolded, infiltrated and animated by neoliberalism through the LSII. The architecture reinforces the ‘modernisation’ agenda of the OMC/HC and the reframing of health care as being about optimisation. Ensuring sustainable public finances, promoting and facilitating economic optimisation, and the index of cost and benefit, become the key measures of successful health care policy. This framing reinforces the linkage of equity and solidarity with optimisation in the OMC/HC. Consequently, the visibility and autonomy of EU and national social policy is undermined.

The EU is not just concerned with governing the market. Through the LSII and the OMC/HC, the EU reveals and projects itself as thinking and behaving like a market actor right across its spheres of activity (cf. Brown 2005: 42). The prominence of market rationality reveals the deeper rationale and use of neoliberalism. It is a way of legitimating *and* extending EU power and governance into sensitive policy areas at the core of national sovereignty. This process is abetted by the effect of depoliticisation: Neoliberal discourses give the impression of being natural, putting a gloss over their historical and political production. Neoliberalism is thereby installed as commonsense. This process is given further assistance by the formal emphasis on the maintenance of differences between HCSs, a shell within which neoliberalism’s operation is concealed, and which risks limiting reflection on neoliberalism’s use and consequences.

Neoliberalism's legitimating and empowering function can be brought into sharper focus by reference to just a few examples. For instance, the Lisbon Strategy sees the EU taking explicit responsibility for the economy even as it does so by governing at a distance, by and through the freedom of responsabilised autonomous agents. The Kok Report (2004) was produced with the advice of political appointees, business people and academic economists. The market-oriented expertise of the last two was used to provide authority and legitimacy in the absence of significant empirical evidence (Zeitlin 2008), which highlights the importance and operation of neoliberal rationality as a way of producing results that might legitimate and extend EU governance. The importance of producing output legitimacy, i.e. producing results that legitimise EU governance (Scharpf 1999), is highlighted by Commission President Barroso. The President figures prominently on the EU's LSII 'Growth and Jobs' webpage, and is quoted as saying: "Europeans have told us that they want results, not divisive ideological battles. The Lisbon Growth and Jobs Strategy is the way we can deliver those *results*" (EC 2009a: emphasis added).

As a further consequence for politics, the subordination of the social to the economy erodes the discursive space available for the development of oppositional formations and claims is that are "located outside capitalist rationality yet inside liberal democratic society, that is, the erosion of institutions, venues, and values organized by nonmarket rationalities in democracies" (Brown 2005: 45). This limits citizenship to the pursuit of self-interest and renders more clearly the sovereign, neoliberal citizen.

3.2. Techniques

Having outlined the context and programmatic level provided by the architecture of the LSII, I turn to examine the operationalisation of neoliberalism through the techniques of the OMC/HC. The latter was launched in October 2004, but with the LSII it joined the OMC's on social inclusion and pensions to become a strand of the OMC/SPSI (Greer and Vanhercke 2010; Dawson this issue). The Social Protection Committee (SPC) (a high level group of officials) provides advice on and manages the OMC/SPSI. The OMC/HC comprises three main stages. As I explain, these entail various techniques which serve as repositories and sites for the operation of neoliberalism, an analysis which contrasts with extant contributions, such as Hervey's (2008: 110-113).

1. The first stage involves the setting of objectives at the EU level, some held in common with the other strands of the OMC/SPSI, three so-called common objectives, and others that are specific to the health care sector. A set of indicators are then used in the third stage to assess member state performance.
2. In the second stage, member states submit their National Report on Strategies for Social Protection and Social Inclusion (National Strategic Reports or NSRs) every three years. The reports include a section on health care, which is used to explain member state progress on meeting the common and sector specific objectives. Various national and sub-national actors are supposed to participate in the drafting process (Kröger 2007). This drafting process provides the first main opportunity for peer review (the second occurs in the third stage).
3. The third and final stage is where member state performance is evaluated by the European Commission (Commission) (in the guise of the Directorate General on Employment and Social Affairs). The Commission undertakes an analysis and assessment of the NSRs in order to determine member state progress towards the common and sector specific objectives established in the first stage of the OMC/HC. This process is assisted by the indicators adopted in June 2006, fully agreed by the SPC in May 2008. The Commission's assessment – the substantive outputs discussed [infra section 3.3](#) – is published in a joint report. This provides the second main opportunity for peer review. This report is adopted by the Commission and the Council. They then submit the report to the spring European Council, which is thereby informed of progress in the area of the OMC/SPSI.

It will be apparent from the foregoing that the OMC/HC renders national health care policies legible and open to discussion and development at the EU level by deploying various techniques: the involvement of various actors, information gathering, peer review, indicators, and consequent learning. The techniques operate together and with cumulative effect to gather and enhance the energies in society by inducements to institutional and individual self-management (cf. Haahr 2004: 217) and to prepare the ground for reframing the understanding and organisation of health care (section 3.3). The techniques are *steering* tools (cf. Hartlapp this issue) that promote governance by and through information or knowledge (cf. Pfister this issue). As Foucault observes “power and knowledge directly imply one another [...] there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (1998: 27). It is in discourse, here that on the OMC/HC and the LSII, that “power and knowledge are joined together” (ibid.: 100).

In this vein the techniques permit, as Rouse explains, a “more extensive and finer-grained knowledge”, and this, “enables a more continuous and pervasive control of what people do, which in turn offers further possibilities for more intrusive inquiry and disclosure” (Rouse 2003: 99). Individually and collectively the techniques open up patterns of thought on health care (cf. Hartlapp this issue) by penetrating “the knowledge domains and national *frame of reference* of member state bureaucracies” (Haahr 2004: 219, emphasis added). It is noted that given the supposed successes of using the techniques on the economic side under the LSII “[i]t seems [...] logical to progressively adopt some of the methods and the approaches [such as targets, see *infra*] [...] for the Social OMC [...] It would [...] ensure optimal interaction between jobs, growth and social policy” (EC 2008a: 4). Optimisation as a reason for sharing information in the context of the LSII is made clear by the Commission, which stresses how the relaunch provides “more room for the learning, exchange and policy dissemination which participants value” (EC 2005a: 10). This renders health care susceptible to *reframing* as a neoliberal – market-oriented – issue rather than as being about equity and solidarity, which is of course the objective of the techniques. The effect of depoliticisation assists reframing in that it helps to make the extension of EU involvement in the governance of health care appear *natural*.

To focus on the involvement of various national, sub-national and civil society actors in the second stage report drafting process and the first instance of peer review at the second stage, this underlines the formal importance of the principle of subsidiarity to the OMC in general and the OMC/HC in particular (Armstrong 2008: 420-421). Subsidiarity, institutionalised in Article 5(2) EC Treaty, (6) emphasises the importance of ensuring governance is undertaken at the lowest possible level. The formal importance of involvement from various actors across society was reinforced after the revision of the Lisbon Agenda in 2005 (ibid.; supra section 3.1) and is emphasised in moves to reinforce the OMC/HC by “enhancing ownership” (EC 2008a: 2) “through peer reviews, mutual learning and involvement of all relevant actors” (ibid.: 7), to include “[e]nsuring greater involvement in peer reviews of officials at local and regional levels” (ibid.: 5). As Haahr puts it, in the OMC, society is seen as a “pool of resources, the energies of which can be released through the use of partnerships” (Haahr 2004: 215) and ‘contractualism’ (ibid.: 217). Peer review at the second stage augments the emphasis on subsidiarity since it involves asking member state officials and outsiders from civil society to “participate in structured and contextualised exchange of information” (Greer and Vanhercke 2010). Subsidiarity therefore valorises market rationality through its figuration of the agency and responsibility of included individual and institutional actors, who are deemed capable of self-management and participation in the deliberative process of information gathering and drafting. It appears “real exchanges of practical knowledge” are promoted by the inclusion of line officials rather than the international division of health ministries (ibid.). Participation positions and co-opts the actors for the reframing of health care whilst *also* reframing them in a neoliberal mould.

Turning to the objectives of the OMC/HC, these serve as guidelines for national policy and they are established in the first stage through reflexive evaluation and targeted inducement to generate information on progress (cf. Hartlapp this issue). The objectives valorise market rationality and begin the reframing exercise by defining what is to be achieved. Examples of

common objectives include the promotion of “social cohesion, equality between men and women and equal opportunities for all *through* adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies” (EC 2007: 83, emphasis added). Whilst social values pertaining to equity and solidarity are stressed these are to be achieved *through* optimised social protection systems. Similarly, the sector specific objectives highlight ensuring “access for all to adequate health and long-term care [...] and that inequities in access to care and in health outcomes are addressed”, but they must also be read with what appears to frame and support them: “financial sustainability” and optimisation (EC 2007: 83). Both sets of objectives not only extend market rationality and facilitate governing at a distance by inducements to self-management. They also promote moves away from equity and solidarity as the frame for health care, which are limited by their subordination to, and not just conflation with, optimisation.

Information gathering and exchange, particularly in the first stage report drafting, the first instance of peer review and third stage production of joint reports (infra [section 3.3](#)), is undertaken by those in the ‘partnership’. This facilitates governing at a distance by involving those who provide the information, making them complicit in the work of assessing whether objectives are met. Such work is vital for reframing health care since it constitutes the field of power/knowledge. The field is augmented by the PROGRESS programme,⁽⁷⁾ which:

“[W]ill support the enhancement of statistical capacity and data collection [...] For example [...] on life expectancy by socio-economic status [...] *Greater involvement of the scientific community and stronger links with other ongoing research activities* [...] will further contribute to developing knowledge- and evidence-based policies” (EC 2008a: 7, original emphasis).

This social data would enhance optimisation. Indeed, the programme also “offers support for the testing of new tools for mutual learning and exchange of best practices [...] [such as] the development of ‘social experimentation’ as a way to test innovative ideas [...] for example in the field of [...] long-term care” (ibid.: 7-8).

Peer review at the second and third stages can “encourage poor performers to rethink their strategy” (Trubek and Trubek 2005: 94, cited also in Hartlapp this issue). In the review of the OMC/SPSI peer reviews, including the OMC/HC, it is noted “context information, a stronger analytical base and broader dissemination of the results would contribute to the identification of good practices and facilitate policy transfer” (EC 2008a: 2). The information gathered and exchanged promotes rethinking and reframing through the assessment of performance and the generation of peer pressure for change (infra [section 3.3](#)). Peer reviewers are coopted into taking responsibility. At the second stage the involvement of actors from the national context creates and positions them as peer reviewers. They are deemed to possess equal capacity to review performance, creating the impression of equality of position and ability, and ‘partnership’. The actors are made responsible for the reframing of national policy when they determine whether national policy meets the objectives set at the first stage, and by providing further information towards the development of indicators, for use in the third stage. Review at the third stage by the Commission places member states on an equal footing in terms of the formality of review. The member states are to be assessed and, therefore, placed in a hierarchy of progress or performance through the use of the common and sector specific objectives established in the first stage of the OMC/HC as well as indicators. The Commission takes “advantage of its ability to muster expert views and its position as a hub of the OMC process” (Greer and Vanhercke 2010).

Moving to indicators, they were not agreed until after the Lisbon-Strategy II and not fully until 2008. Indicators are developed by the Indicators Subgroup of the SPC and are to be used “by Member States to assess their progress towards reaching the common objectives” (Greer and Vanhercke 2010). The indicators operate with the common and sector specific objectives as a technique aimed at making member states take responsibility for their autonomy during peer review. The 14 overarching indicators (including 11 context indicators) are “meant to reflect the newly adopted overarching objectives (a) ‘social cohesion’ and (b) ‘interaction with the

Lisbon strategy” (EC 2009c). These indicators are used to assess whether common objectives are met. They include life expectancy and per capita health expenditure.

There are three main groups of sector specific indicators focused on different core objectives (EC 2006: 40-50; EC 2008b: 40-64) as follows:

1. Access to care (including inequity in access to care) and inequalities in outcomes: Including the proportion of the population covered by health insurance, life expectancy, self-perceived general health and infant mortality.
2. Quality of care (effectiveness, safety and patient centredness): Including various cancer survival rates, vaccination against influenza, length of hospital stay, patient satisfaction, numbers of doctors and nurses and coverage of public and private insurance.
3. Long-term sustainability of systems (expenditure and efficiency): Including total per capita health expenditure and percentage of public/private health care expenditure.

1. and 2. clearly focus on equity and solidarity, and since they must be sustainable, the focus of 3. can be said to be the same. However, irrespective of whether they are more about equity and solidarity than the market or economy, the indicators seek to optimise performance by providing the means to assess whether the objectives are met. This focus on optimisation ensures equity and solidarity are subordinated within a neoliberal frame.

Data corresponding to the new set of indicators is also produced (SPC 2008), and this further constitutes the field of power/knowledge. The data lists Member States (not always comprehensively given limitations in available data) in relation to each indicator. For instance, in 2006, life expectancy was 79.5, 71.1 and 80 in Belgium, Lithuania and the Netherlands respectively. This data can be used by actors to highlight differences in performance, but the indicators and data have yet to be used as the basis for target setting or benchmarking. However, it is noted there is a need to “make a better use of the commonly agreed indicators” (EC 2008a: 3). Indeed, the indicators are “sufficiently robust as a basis for the introduction of quantitative targets [...] [which] would introduce a new dynamism” (ibid.: 5), in particular by supporting the implementation of the objectives. Examples of targets include “health-status related targets, for example on increasing life expectancy [...] and healthy life years, and reducing infant mortality”, but they are directed at optimisation: “Health status is decisive for active participation in the labour market, longer working lives and for reducing poverty” (ibid.). Even without an overt reference to the market, the indicators, perhaps to be enhanced by targets, place equity and solidarity within a neoliberal frame because they seek to optimise performance. In any case, optimisation is reinforced by the explicit overarching objective of interaction with the LSII. Thus, the indicators provide a “more or less technical means of locking the shaping of conduct into the optimization of performance” (Haahr 2004: 218).

To summarise, although traces of equity and solidarity are apparent, the techniques are about producing self-management in order to optimise performance. This reinforces the neoliberal framing of health care provided by the LSII.

3.3. Substantive outputs

Regard to substantive outputs, principally in the form of joint reports and SPC opinions and documents reviewing the NSRs, reveals more about how equity and solidarity are linked to and subordinated by optimisation, which then increasingly frames health care (cf. Hervey 2008: 110-113). Pre-LSII and OMC/HC health care seemed more clearly framed by equity and solidarity, for instance in references to equality of access to health care as a way of producing social inclusion (EC 2004). Some linkage was made to optimisation by making health care “more affordable and accessible” (ibid.: 64). Yet, with the inauguration of the OMC/HC around the time of the LSII, the linkage was made more explicit. This is demonstrated by the SPC’s valorisation of market rationality as it highlights the use of exchanging information on best practices:

“[S]uch as new types of organisations, different management structures, new budgeting and financial procedures (e.g. prospective budgets, activity based financing...fix-level payment schemes e.g. for medicines), hospital collaboration structures, payment systems to staff and fee negotiation *may be of interest to the OMC work*” (SPC 2005: 31-32, emphasis added).

Other useful information includes that on:

“[E]vidence-based prescriptions and *cost-saving* distribution of pharmaceuticals, regulation, *supervised competition* and *privatisation*, and *contractual* relationships between purchasers and providers can contribute to a more rational and cost effective use of care systems *may also be useful in helping Member States develop their own policies*” (ibid.: 32, emphasis added).

The SPC emphasises ways of optimising performance by reducing state expenditure and governing by and through techniques of self-management such as competition, privatisation and contracts. In these ways market rationality and rational economic behaviour are extended and disseminated to the formerly non-market policy area of health care, which they increasingly frame.

Post-LSII traces of equity and solidarity are again present, for instance in the 2008 joint report’s focus on inequalities (CEU 2008). However, bearing in mind the LSII’s architecture, these values are perhaps more clearly linked with and framed by optimisation, particularly in the current financial and economic crisis. For example, the SPC highlights optimisation when it notes “[i]mproving the health status of the population, within the EU in general but particularly in many Member States of more recent accession is of utmost importance”. This neoliberal turn is then reinforced by an explicit reference to the economy when it is noted improved health “will contribute to the *quantity and quality of labour force*, as well as to the overall *productivity* levels of the *economy* and to *economic prosperity*” (SPC 2007: 9, emphasis added). This pattern of linkage and framing is repeated later when it is noted “[g]ood health is indeed the precondition both for well-being and good quality of life, *as well as* for high productivity and active ageing. Furthermore, healthcare should also be considered as a highly innovative sector with considerable potential for growth and employment” (ibid.: 12, emphasis added).

In the 2008 and 2009 joint reports economic, employment and social policies are noted as being “closely inter-related and mutually supportive”. Moreover, “[w]ell-designed *social protection systems* [...] *are productive factors contributing considerably* to [...] economic achievements” (CEU 2008: 6, emphasis added; cf. a focus on financial sustainability, public/private funding and privatisation in CEU 2009: 12-13). As the report continues: “*Ongoing* [...] *healthcare reforms have a positive impact both on the sustainability of public finances and on labour market behaviour*. Successful action on healthcare improves quality of life *and productivity*” (ibid.: emphasis added). The linkage again serves to emphasise optimisation and, therefore, install HCSs within a neoliberal frame.

Reforms or ‘modernisation’ strategies are aimed at “ensuring [...] long-term financial sustainability, and beyond this [...] social sustainability, that is [...] high quality, accessible health services” (SPC 2007: 13). The point here is not just that through various strategies market rationality is used to produce sustainability and optimisation, but that the latter supplants equity and solidarity as the frame for HCSs. Equity and solidarity are increasingly subordinated to, and not just conflated with, market-like conditions in the ‘modernisation’ of public services. The use of optimisation strategies can be demonstrated by the following three examples, taken from the joint reports. First, optimisation through competition is valorised. Competition is supposed to “promote *efficiency* [...] [and this is to be achieved by] *separating* the provision and funding roles”. The separation is a way of “fostering competition between health service providers” (CEU 2007: 9). Competition “among providers (and in some countries among insurers) is seen as a means to reduce costs of care and to enhance quality” of provision. Yet, competition “has to be *regulated* so as to best balance access by all, high

quality and financial sustainability” (CEU 2006: 14; CEU 2007: 9, emphasis added). Hervey points out “no normative statement is attached to” the emphasis on competition, and does not appear to form the basis of future benchmarking or best practice statements (Hervey 2008: 112). That might well be, but the stress on regulation sanctifies competition because it is made to seem more ‘social’ in nature or ‘health care friendly’ (cf. Offe 2003). The normative impulse here is for optimisation through the use of market rationality.

Second, an emphasis on a more ‘rational’ use of resources in HCSs deepens the reframing exercise by references to “overall caps on expenditure, co-payments and use of generic medicines, staff guidelines, and health technology assessments” (CEU 2007: 9). It is noted how member states are “seeking greater effectiveness and efficiency as well as aggregate cost containment through *reorganisation*, prioritisation and the development of *incentive structures* to users and providers” (CEU 2006: 5, emphasis added). The language is that of incentives and, by implication, disincentives and sanctions. Further, it is noted that the OMC/HC should focus on “*strengthening incentives* to users *and* providers for rational resource use” (CEU 2006: 15, emphasis added). Thus, both users and providers are constructed as rational actors who are to be steered towards rational economic behaviour within a market-like context.

Third, patient choice is noted and it reinforces the neoliberal framing of HCSs. It is not just institutions that must self-manage, but also individuals. The OMC/HC “should focus on [...] increasing patient choice and involvement” (CEU 2006: 15). Also, “to enhance [...] patient satisfaction a more patient-centred pattern of care is developing [...] ensuring patients’ rights, choice, involvement in decision-making and feedback through patient surveys” (CEU 2007: 8). The focus on choice builds on and enhances the importance of competition and incentives, since choice can only be achieved through different providers, which implies a degree of competition between them and incentives for action. Choice and rights to treatment (supra 1.) figure patients as more active, sovereign individuals in the liberal mould – they must be such in order to make choices and wield rights. Hervey notes “‘patients’, although their choices are to be enhanced, remain ‘patients’, not ‘consumers’” (2008: 113). Yet, patient enhancement through choice and rights are well-known ways of introducing market mechanisms into the provision of publicly funded services (Le Grand 2003) and complement wider moves within medicine to activate patients and encourage self-management (Rose 2007: Chapter 5).

Enhanced patients are, in common with consumers, endowed with agency and deemed able to self-manage as entrepreneurs, rational actors utilising and displaying economic behaviour within the context of market-like conditions fostered by regulated competition and incentives. ‘Patients’ are ‘consumers’ in all but name. The figure of the neoliberal citizen feared by some as only too present in the ECJ’s jurisprudence reemerges in the substantive outputs of the OMC/HC. As Brown explains, within this neoliberal frame citizens are reduced “to an unprecedented degree of *passivity* and political *complacency*. The model neoliberal citizen is one who strategizes for her- or himself among the various social, political, and economic options, *not* one who strives with others to *alter* or *organize* these options” (Brown 2005: 43, emphasis added). Patients might be constructed as active, but they must operate within the given market order. As such patients must tend to their own interests, and they are deemed incapable of sharing power. This construction undermines the fostering of a public sphere aimed at democratic political culture and community (Brown 2006: 89).

Stepping back, the context of the current global financial and economic crisis can be seen to draw the neoliberal frame for health care even more clearly – unsurprising, but nonetheless revelatory. For instance, the SPC notes “health and long-term care directly contribute to economic growth and employment” (SPC 2009: 3). Equity and especially solidarity are noted, but again linked to, and framed by, optimisation: “In the present context of economic downturn, solidarity is key to restore citizens’ confidence and *help pave the way for recovery*” (ibid.: emphasis added). Further, “[t]he importance of health and care as strategic and emerging sector should be strengthened in light of its role in matching future labour demand and providing growth potential” (ibid.: 4). Of course, the focus on, and increasing installation of, neoliberalism as the frame for health care is expected in the context of the LSII and how the SPC’s “work since its establishment has been largely determined by the strategic

goal for the EU's socio-economic progress set out at [...] Lisbon" (EC 2009d) (supra [section 3.1](#)).

As a result of the growing linkage between the social and the economy produced by neoliberalism's operation at the level of the operationalisation of the LSII, the gap between them is narrowed. This assists the extension and circulation of neoliberalism into the social, here legitimating and extending EU governance into health care. The narrowing gap also reemphasises the production of limited citizens and the reduced discursive space for politics, with the attendant undermining of oppositional formations and claims.

4. Conclusion

In this paper I used a governmentality approach ([section 2](#)) to trace the operation of neoliberalism as the frame for health care ([section 3](#)). The analysis demonstrates the increasing use of neoliberal political rationality through the architecture of the LSII ([section 3.1](#)), techniques of the OMC/HC ([section 3.2](#)) and its substantive outputs ([section 3.3](#)). There are certainly traces of equity and solidarity (particularly in [section 3.2](#) and [3.3](#)), yet especially post-LSII there seems to be a stronger link made between equity and solidarity on the one hand and the market/economy on the other. Since the link is directed at producing optimisation, equity and solidarity are reworked and transformed by, and increasingly subordinated to, neoliberalism, which then frames health care.

Neoliberalism bypasses ideological battles despite being highly ideological, because it is profoundly depoliticising. Indeed, the EU's *choice* for neoliberalism is glossed over by an emphasis on producing results. Neoliberalism is a non-choice: It is the commonsense (and only) response to the demand for growth and jobs. Besides reinforcing the operation of neoliberalism as the frame in the techniques and substantive outputs, the LSII highlights the importance of the supposedly non-ideological and impartial market in legitimating reform and policy choices, as well as the extension of EU governance into sensitive areas like health care, as something authorised by citizens. As a further consequence for citizenship, neoliberalism's operation through the LSII, and the techniques and substantive outputs of the OMC/HC, reduces the discursive space for politics and the potential for oppositional formations. Consequently, the figure of the neoliberal citizen in the ECJ's jurisprudence is perpetuated and rendered more strongly in EU discourses (especially in relation to [3.3](#)). Given its nature and consequences it appears the OMC/HC is unable to buttress HCSs against neoliberalism.

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Endnotes

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(1) Inaugurated in Case C-158/96 Kohll [1998] ECR I-1931. See further: Hervey 2007.

(2) This paper was produced before the ratification of the Reform Treaty or the Treaty of Lisbon, which repeals and replaces Article 152 EC with Article 168 Treaty on the Functioning of the European Union (TFEU). The Treaty of Lisbon is due to come into force on 1 December 2009.

(3) The asymmetry is affirmed given

1. that the initial proposal to codify the ECJ's jurisprudence (the so-called Bolkestein Directive) produced huge political opposition since it yoked health care to services more generally and, therefore, found its legal base in Article 95 EC (repealed and replaced by Article 114 TFEU) (i.e. internal market law)
2. the subsequent extraction of health care from services more generally
3. the use of discrete legislation for health care – but still with Article 95 EC as the legal base.

(4) Cf. Haahr provides a more general analysis of discursive and non-discursive elements, such as graphs and charts before the Lisbon Strategy II. The governmentality perspective differs from that adopted in this paper, particularly in relation to considering legitimation and citizenship in power's operation.

(5) Most of which are to be found at http://ec.europa.eu/employment_social/spsi/the_process_en.htm [last accessed 5 August 2009].

(6) The Reform Treaty repeals and replaces Article 5 EC with Article 5 amended Treaty on European Union.

(7) <http://ec.europa.eu/social/main.jsp?catId=327&langId=en> [last accessed 5 August 2009].