

# CROSS-BORDER ACCESS TO HEALTHCARE IN THE EU: A GENEALOGICAL ANALYSIS OF REGULATORY ASPECTS

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*The question of cross-border access to healthcare in the European Union has long surpassed the idea of merely encouraging the movement of workers across borders. Nevertheless, remnants of the nation-state-based discourses have retained their grip on certain member states, making access to cross-border healthcare less effective. This article will perform a genealogical analysis of the regulatory aspects of cross-border access to healthcare. On the one hand, an ethical need for increasing inclusivity will be emphasized. To retain the quality of public healthcare, this has to be balanced with realist considerations, taking into account economic and other social factors.*

**Key words:** Cross-border healthcare; Genealogy; Regulation; Inclusivity; Public health.

## 1 INTRODUCTION

The right to curative medical treatment and preventive healthcare is an interesting area of public health research in the European Union, especially in terms of its genealogy. The European Court of Justice has played a crucial role in the formation of the current regulatory environment, especially with groundbreaking judgements in the cases such as the so-called Geraets Smits/Peerbooms (European Court of Justice 2001, Case C-157/99), Kohll (European Court of Justice 1998, Case C-120/95) and Decker (European Court of Justice 1998, Case C-158/96). Nevertheless, the power of the European Union in enacting public policies in this regard had been limited for a long time, primarily due to the principle of subsidiarity, where the EU member states retained a high margin of appreciation in terms of the regulatory solutions to enact the right to cross-border access to healthcare (Brooks 2012, 33–37). Public policy and regulatory solutions were largely based on the discourses and the ideological concept of the nation-state.

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With the enactment of the directive 2011/24/EU and its implementation in individual member states (Peralta-Santos and Perelman 2018, 879–884), it can be argued that a shift has occurred toward a more inclusive, EU-level access to healthcare. Nevertheless, remnants of the traditional, nation-state-based discourses have retained their grip on certain institutions in certain member states, making access to health-care access in other member states more difficult and less effective. This paper will attempt to perform a largely Foucaultian analysis of the current state of regulatory and public policy aspects of cross-border access to healthcare in the EU, which will draw heavily on the idea of the archaeology of knowledge. On the one hand, a need for inclusivity will be emphasized. On the other, an abstract limit will attempt to be placed on the proposed concepts to prevent an over-inclusive approach, which might have negative consequences on the quality of services rendered. General stepping-stones towards more inclusivity in this regard will be proposed.

In methodological terms, the approach employed will be heavily qualitative and abstract. Critical analysis will be used to evaluate the merits and demerits of the current situation and how the positive regulatory solutions in combination with dominant societal modes of discourse might influence the provision of cross-border healthcare in the EU. Derrida's phallogocentrism (Kingston 2019) will be rejected for a more traditional approach, employing the toolbox of informal logic and dialectic to substantiate the proposed claims. A dogmatic approach will be used to reflect on the theory itself. This is important since when implementing public policy, especially through enacting regulatory rules, the traditional order of epistemology and ontology is turned on its head (Hage 2008). Foucaultian archaeology-of-knowledge-inspired approach will be combined with elements of Nietzschean genealogy to further delve into the main characteristics of dominant discourses on the existing regulatory framework and their past, as well as potential future ramifications. The analysis in this paper will be limited to the right to access to public healthcare. Non-public healthcare will be addressed only to the degree that it serves to deepen the understanding of the genealogy of contemporary public-health care.

The structure of the paper will follow the path from the abstract to the particular. After this introduction, the relationship between belief and law will be examined. This discussion will entail the role of ontology and epistemology in the formation of legal frameworks, their connection to knowledge/power and the ideological hegemonic bloc, as well as more in-depth methodological musings about the Nietzschean genealogical approach and the Foucaultian architecture of belief, both in relation of the problematic at hand. The third part of the paper will focus on historical analysis and the genealogy of the dominant discourses that brought us to the present ideological landscape. In the fourth part, the general regulatory acts of the European Union and the decisions of the European Court of Justice, which constitute the basis for the contemporary EU-wide net of regulatory frameworks, will be analysed. In the fifth part, the potential for broadening the right of cross-border access at some point in the future, to include non-EU citizens, will be explored. This exploration will be performed mainly considering this idea's humanist ramifications. The potential need for limitation through Kant's first formulation of the categorical imperative will be discussed, and a broad route of steppingstones towards greater inclusivity will be proposed.

## 2 ON BELIEF AND REGULATION

Public policy and regulation through enacting solutions are specific to the degree that the standard order of ontology and epistemology is turned upside down. Namely, there are observable phenomena in natural sciences, which then become the subject of theorizing. On the other hand, the regulation itself is a particular type of a codified theory of reality, which influences reality through the collective beliefs and through (when necessary) the mobilization of the repressive apparatus of the state (Hage 2008). The regulatory frameworks are at least in part codified belief systems, which render the relationship between themselves and belief one that is also best characterized as a feedback loop. Changes in belief influence the public policy system, and changes in the public policy, in regulatory frameworks and court decisions in a particular society influence the beliefs that the societal members hold in a particular society. An analogy could be drawn in a Gramscian sense, where regulation and public policy are understood as base and belief as superstructure (Sotiris 2018, 94–119).

In the Aristotelian framework, the activity of individuals engaged in the social practice of setting public policy and enacting regulation can be termed *phronetic*. Aristotle namely differentiates among other things between *techne*, *episteme* and *phronesis*. The first two, *episteme* and *techne*, can roughly be equated with scientific knowledge and craft. On the other hand, *phronesis* is to be understood as practical wisdom, as an argumentative activity with an ethical goal (Xanthaki 2010, 111–128). Such a definition corresponds very well with the practice of public policy and regulation. When interpreting and co-creating a particular state's political and regulatory traditions, the individuals engage in this sort of rational activity with ethical considerations from an internal point of view (Westerink 2020, 246–259).

In doing so, they are using their knowledge and creating additional knowledge, both in the exercise of power. The degree to which such promulgation of public policy knowledge is intertwined with power rests on a spectrum between the possibility of being solely about power and the abstract alternative of being solely about knowledge. The Foucaultian definition of power conceptualizes it as a mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on existing actions or those that may arise in the present or the future (Foucault 1982, 789). There is a fundamental connection of the power-knowledge, of the *pouvoir-savoir*, with the process of temporal subjectivation, through which the subjects of policy and regulation become the principles of their subjection through internalization, habitualization and ritualization of temporal norms (Foucault 1995, 203; Portschy 2020, 392–419).

To understand the degree to which such temporal subjectivation shapes the policies and regulatory frameworks in cross-border access to health care within the European Union, a genealogical understanding of the formation of the contemporary positive legal norms on cross-border healthcare, is necessary. This is even more true since ethical considerations such as *parrhesia* the desire to tell the truth (Westerink 2020, 246–259) are essential in connection with attempting to penetrate the deeper layers of the socio-legal permutations that constitute the regulation of the studied field (Xanthaki 2014, 66–80). In this regard, especially the Nietzschean genealogical approach and the Foucaultian archaeology of knowledge seem especially useful.

According to Nietzsche's writings, the former is connected to a historical spirit and a demand for truth-seeking. In Nietzsche's work *On the genealogy of morals*, he namely criticizes the lack of historical spirit in specific authors that had been performing genealogical research before him (Nietzsche 2017, 11). In the spirit of Ranke, he seems to emphasize empathy for the *spirit of the hour* to really understand the history and especially the history of ideas as it was (Greenberg 2020, 143–146).

To perform genealogical research thus means to delve deep into history, with a critical eye, attempting to cast aside any contemporary prejudices, concentrated squarely on the pursuit of the truth. Although Nietzsche himself and many who have sailed in his wake have been deeply subversive, the above definition shows that such a genealogical method is by its nature not necessarily such. The desire for truth grounds it firmly in the light of the regulative ideal of truth itself and enables the potential even for the vindication of any analysed positive normative system, as long as such a viewpoint is indeed per the truth and not the consequence of any prejudice in intellectual pursuit (Queloz 2017, 727–749). This type of research is to be done within and outside of any monotonous finality. It can be sought even in unpromising places, such as in conscience and in other sentiments on a particular contemporary social arrangement that is the subject of the study (Ibid.).

Foucault builds upon the described Nietzschean methodological framework but differs regarding at least three crucial points. He thus emphasizes the piecemeal fashion of alien forms that characterizes a lack of any essential and timeless secret behind things (Foucault 1978, 140–141). He posits the idea, which is at the core of his archaeology of knowledge, that discursive formations or *epistemes* are subject to an operation of rules that transcend the consciousness of individual subjects and define the conceptual possibilities and boundaries of thought at a certain point in time, in each domain (Gutting and Oksala 2021). Because such an approach says nothing about the intertemporal transitions between ways of thinking, it must by necessity be supplemented by a more 'traditional' Nietzschean genealogical approach (Ibid.).

When it comes to the issue of cross-border healthcare, a combination of both approaches might prove especially illuminating in terms of the understanding of the current socio-legal environment. The different approaches to truth between Nietzsche and Foucault might, in this regard, not be as incompatible as they seem at first sight. In terms of understanding a particular epoch and its normative systems pertaining to the selected domain, both emphasize the need for understanding the past without the unnecessary burdens of the present. At the same time, both seem to find value in mining the past to gain crucial insights about the present societal situation, which we intend to do in our analysis of regulatory of the cross-border access to healthcare in the European Union.

### 3 GENEALOGY OF CROSS-BORDER HEALTH CARE IN LIGHT OF THE CONCEPT OF BORDERS

People seeking medical treatment outside of their place of residence, in other cities or countries, has existed since ancient times. In antiquity, it was primarily the sacred sites that attracted patients' attention, often for pseudo-medical purposes and prayer, related to a desire to be healed by the power of the gods (Rai 2019). Another form of medical tourism emerged in the Middle Ages, with

wealthy individuals visiting thermal baths for healing across Europe and the Middle East (Tonga et al 2021, 227–232).

What characterized the access to healthcare and health-related services in geographical locations, other than the sick person's place of residence, was the requirement of sufficient funds to fund any medical care available at the time. Access to healthcare across geographical distinctions was thus class-related to some degree. This became especially true in the Early Modern Era, after the first hospitals, vaguely resembling the contemporary use of the word, were created in the 16<sup>th</sup> century Italy and then across entire Europe (Borisov 2009, 376).

Preventive public health campaigns have existed for many centuries in different countries but began to develop into a more far-reaching and serious discipline with the extensive use of indicators of health-related outcomes in the 18<sup>th</sup> century (Klazinga et al 2001, 433–438). Nothing resembling cross-border public healthcare existed at the time since even public provision of health care, in general, was more of a progressive idea than a societal reality.

Organized public provision of curative healthcare is thus a relatively new phenomenon. It had been facilitated on the one hand by the rise of the prominence of science and knowledge, especially regarding the possibility of large-scale disease control and on the other, by the shift in public's perception of disease control as both a possibility and responsibility of the society (US Institute of Medicine 1988). In the late 18<sup>th</sup> century, it began to be formalized and given structure by the establishment and later proliferation of general hospitals for people suffering from different mental and physical ailments (Ibid.). This process was furthered in many countries in the 19<sup>th</sup> century by establishing a secondary apparatus, entailing state agencies such as boards of health, health departments, and local health departments (Hanlon and Pickett 1984).

Access to services of such institutions was and to a certain degree remains intimately connected to the idea of borders. These are essential societal constructs that separate those on the inside from those outside. In this manner, borders, on the one hand, potentially enable a more predictable and conservative functioning of societal organizational units on the inside while depriving those on the outside of perceived benefits (Zorn 2021, 93). Borders thus always exist based on an antecedent relation to another and are accepted in terms of this relationality, in a generalized condition of precariousness (Butler 2009, 48). As such, they can be seen as an attempt to protect our vulnerable bodies and the discussion of them as a concept and a construct of social reality can draw attention to their protective and exclusionary function (Starr and Most 1976, 17). Only those, whom the society, through public-political activities, deems to be on the inside, thus have access to public healthcare, while those on the outside are not allowed to be beneficiaries of the same standard of care.

In the traditional international order, borders can be seen as intimately connected to the idea of a nation-state and are a part of structural characteristics that affect the interaction and opportunities of states and with that also of the individuals belonging to those nation states through the enactment of the concepts of citizenship and statehood (Bamji 2019, 441–464). The line between those that are allowed access to healthcare and those that are not on a particular territory has throughout the 20<sup>th</sup> century been drawn primarily based on citizenship and statehood.

That however, such drawing of borders as societal constructs is not static but is subject to a dominant paradigm of the time, can be seen in the example of the passes, that as a form of ephemeral print, enabled bearers to travel from city to city in the times of plague, when borders were in reality not enacted on the level of nation-states, but on the level of cities (Ibid.).

In such subversion of the idea of borders as it relates to access to cross-border healthcare, there lies a possibility to surpass the understanding of borders as a necessary protective barrier and to supplant this idea with the notion of an, in Der Derian's terms, inherently connective liminal space (Der Derian 2001, xix). Such an ethical foreboding is at least to some degree in line with actual contemporary occurrences in the field of law. Namely, in the European Union, in the field of cross-border access to healthcare, the traditional idea of borders is in the process of being deconstructed to a certain degree, and a move was made towards EU-wide access to cross-border public health-services in some instances. The unit of analysis and the subject of legal provisions in these cases is thus not a citizen of an individual nation-state but a citizen of the European Union.

#### 4 CURRENT STATE OF AFFAIRS IN THE EUROPEAN UNION

Regarding regulation and proliferation of cross-border access to healthcare within the European Union, the public policy is primarily based on a regulatory framework, established by relevant European Union legal acts and ensuing court practice. The two main elements of European Union public policy in the field of cross-border access to healthcare are provision of information on available healthcare in other countries of the European Union and ensuring appropriate access to healthcare options or specialized treatment abroad (European Commission 2022).

In this manner Directive 2011/24/EU entailed a monumental leap forward. Most importantly, its main idea was to establish a right to medical care in a member state, other than that of patient's residence, in certain situations and to be reimbursed according to the tariffs of the country of residence (The European Parliament and the Council of the European Union 2011). Such a right was not established out of the blue but because of decades of societal and public policy development, both on the level of European Union legislation and its practical ramifications and the level of decisions of the European Court of Justice.

Its origins within the Community can be traced back at least to Regulation No 1408/71 of the Council of 14 June 1971 on applying social security schemes to employed persons and their families moving within the Community. Its primary focus was the enactment of the necessity of social benefits for laborers and for family members of laborers, whose state of employment is not the same as their state of residence, if both of those states were members of the Council of the European Communities (Council of the European Union 1971, Article 13).

Decades of standstill in the realms of normative and ideational development, relevant to access to cross-border health care, ensued. The European Court of Justice moved the normative development forward at the turn of the millennia. The most important in this regard were Kohll (European Court of Justice 1998, Case C-120/95), Decker (European Court of Justice 1998, Case C-158/96) and Geraets Smits/Peerbooms (European Court of Justice 2001, Case C-157/99) cases.

In the *Geraets Smits/Peerbooms* case, the European Court of Justice held that a medical service, which the patient pays for and is provided in a member state different from the one in which the costs are reimbursed, remains within the scope of the freedom to provide services (European Court of Justice 2001, Case C-157/99, § 55). At the same time, the Court deemed a prior authorization regarding the assumption of costs under a national social security system to be a potentially necessary and reasonable measure (*Ibid.*, § 80). Discretionary decisions by national authorities should not be contradictory to the Community law, especially regarding fundamental freedoms (*Ibid.*, § 90).

It was held in the *Kohl* case that national rules should not act as a deterrent, so that insured individuals would not utilize medical services established in another Member State, and as such should not form a barrier to the principle of freedom to provide services, which is of paramount importance to the Community (European Court of Justice 1998, Case C-120/95, § 35). In this regard, doctors and dentists must be afforded the same rights guaranteed to doctors and dentists established on the territory of the individual Member State (*Ibid.*, § 48).

The *Decker* case entails another crucially important decision of the European Court of Justice about accessing cross-border health care within the Community. In that case, a national regulation was put under scrutiny and it was found that national rules should not act as barriers that discourage the free movement of goods in the sense that insured individuals would be incentivized to purchase medical products in the territory of their Member State, instead of purchasing them in the territory of another Member State (European Court of Justice 1998, Case C-158/96, § 36).

The above case-law can be claimed to entail a normative and ideational basis that inspired the public-political adoption of the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on applying patients' rights in cross-border healthcare. The above directive is the one currently in force and has codified among else the responsibilities of Member States regarding treatment (Article 4), the right and the legal framework regarding the reimbursement of costs (Article 7), as well as mutual assistance and cooperation (Article 10) and the recognition of prescriptions, issued in another Member State (Article 11). In such a manner, a regulative framework was formed, governing and more precisely delineating the right to access to cross-border healthcare within the European Union.

The above regulatory development, in connection with the decisions of the European Court of Justice, can be claimed to reflect a shift in the socio-political environment and the ideational framework of the European Union and its member states. A step was made from the world where the public provision of healthcare is generally confined within national borders to a more inclusive world, where EU-wide access is ensured under certain conditions.

The relevancy of cross-border aspects regarding healthcare has been further emphasized by the Regulation 2021/522 of the European Parliament and of the Council establishing a Program for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, which deals with cross-border matters in healthcare in relation to the pandemic (2021, Article 2).

Such developments notwithstanding, remnants of the nation-based, protectionist understanding public of healthcare are still present in the normative environments of the certain Member States and the legal culture entrenched within national regulatory frameworks. Some member states have, namely, transposed the directive's requirements in the most restrictive way allowed to them, which Vasev (2017, 271–286) has appropriately termed as the 'world of dead letters', borrowing the terminology from Falkner and Treib (2008). The most notable examples include Austria, Bulgaria, Denmark, and Poland (Kowalska-Bobko et al 2016; Vasev 2017).

Such an approach to implementation can be criticized within the Fullerian framework of understanding the rule of law (Cormacain 2017, 115–135). The moral requirements and one of Fuller's eight *desiderata* for a functional regulatory system require that regulations in books be congruent with their application in practice (1964). The need is accentuated by the fact that health-care crises can quickly escalate into political crises (Kukovič 2022, 10).

Taking this into account, the situation regarding the access to cross-border public healthcare within the European Union is not ideal. In this small segment, it may even entail a contradiction to the general requirements of the theoretical notion of the rule of law and the inner morality of the legal system of the European Union, based among other things on the ideas of European citizenship and solidarity (Paju 2017).

## 5 POTENTIAL FUTURE DEVELOPMENTS AND THEIR IMPLICATIONS

As the analysis of the genealogy of the right to cross-border access to public healthcare in Europe, and the assessment of the current state of regulatory affairs show, there seems to be a movement from a national-state-based conception towards a more inclusive one. Such a relatively novel conception of cross-border access to health-care spans across the entire territory of the European Union. This paradigm shift entails a redistribution of power between the states and the supranational European Union that might be driven by economics, politics, and even technological developments in the fields of medicine and healthcare (McGrew 2011, 295). The critical question seems to be how far such a process should go and its broader ramifications.

Let us call upon the understanding of regulation and public policymaking as a phronetic practices. It seems that the potential delimitation of the broadening and deterritorialization is fundamentally an ethical question. The arguments for adopting a potential regulatory solution that broadens the sphere of cross-border access to healthcare should be carefully weighed before such a policy is enacted. In this regard, at least three distinct but interconnected issues should be considered.

The first are the benefits for the existing holders of the right to access to public healthcare, both within national territories and across the borders of Member States. Further broadening of the right to cross-border healthcare might lower health-care standards for existing right-holders.

The second are the benefits for the potential new holders of rights or broadening of existing rights to cross-border health care. Deprivation of the broadening of rights might, namely, retain a *status quo* and by regulative inaction negatively



impact the lives of individuals who would benefit from a more inclusive approach to cross-border public healthcare.

The third is the rights of medical and health-care professionals, especially concerning the free movement of goods and services across the territories of the Member States of the European Union. They are essential stakeholders whose interests should be considered, both from an economic and an ethical standpoint.

The issue of future policy developments in access to cross-border health care in the European Union is thus clearly a complex one. Before making further regulatory interventions, the European Union should stabilize the existing framework by ensuring that the Member States comply with the requirements of the Community law regarding this issue. This would ensure a higher standard of compliance with the rule of law and the broader moral demands since regulation and public policies are effective and of benefit to the populace only if they are enacted in practice.

Regarding the further broadening of rights, the ethical issues of both the existing and potential right holders and the interest of medical and health-care professionals should be considered. A potential tool for analysis could be Kant's first formulation of the categorical imperative. Its potential usefulness stems from the nature of the theory, which considers humanity in such terms, that individuals are viewed as moral, and that nature is viewed as a functional whole (Gillroy 1998, 131–155).

The categorical imperative in its first formulation requires individuals to act as if the maxims of their actions were to become, through their will, a universal law of nature (Kant 1993, 30). In the present context, the policymaker thus asks themselves how society would function if access to cross-border public healthcare was given to an in-advance determined and more inclusive broader circle of right-holders. In this regard, potential stepping-stones towards greater inclusivity in cross-border access to healthcare within the European Union can be identified.

After the amelioration of the discrepancy between the normative environment and its enactment in social practice, by bringing the Member States from the 'world of dead letters' on board with the current regulatory framework in the field of access to cross-border healthcare within the European Union, a potential further step towards greater inclusivity is deterritorialization of healthcare within the European Union. This will have to be assessed in terms of the categorical imperative and the phronetic nature of normative activity in enacting cross-border healthcare public policies.

A further, more far-reaching step would be ensuring that even individuals, who are not citizens of the European Union, have full access to public healthcare within the European Union (Ekmekci 2017, 432–444). Either way, such a broadening of access would require careful weighing of economic and other factors to ensure retaining the standard of care of existing right-holders.

Nevertheless, and perhaps somewhat counterintuitively, state-of-the-art of research evidence that restricting the access of asylum seekers and refugees to healthcare is costlier than granting them full access, on equal footing with the citizens of the European Union and individual member states (Legido-Quigley et al 2019; Bozorgmehr and Razum 2015, 1994–2013). Furthermore, it has been

shown that by enacting such inclusive policies regarding access to healthcare, considerable savings in medical and indirect non-medical costs related to public health can be achieved (Trummer et al 2018). That such viewpoints go against the common political talking agendas stems from the fact that migrants have long been subjects of deep-rooted prejudices and stigmatization processes (Spada 2021, 145–146; Milharčič-Hladnik 2016, 85).

A more inclusive approach could potentially even have positive ramifications for the soft power of the European Union, as the world sees its inclusive approach and enactment of humanist values, which are at the center of its formation and existence (Grazia 2021, 19–59; Eylemer and Söylemez 2020, 315–342).

In responding to the various challenges that cross-border access to healthcare presents, there is, as in addressing other transnational issues, a pressing need to master the paradoxes and competing demands, reconciling the many contradictory and co-existing oppositions (Malešič 2021, 77).

## 6 CONCLUSIONS

Greater inclusivity in healthcare is generally positive from a humanist standpoint. It must be carefully weighed in terms of its impact for all individuals, including present right-holders so that an adequate standard of care is retained and ensured. The European Union has made great strides in broadening cross-border access to public health care and enacting a normative paradigm shift, which is beginning to substitute the nation-state with the European Community as the adequate level of analysis in questions of the cross-border access to healthcare. As certain implementation issues persist, achieving congruence between law in books and law in practice should be a priority from the policy standpoint.

Potential future normative developments could entail a move toward even greater inclusivity regarding access to healthcare, by making nation-level provision of healthcare, based on citizenship less relevant. In this regard, state-of-the-art research seems to indicate that there can be a potential for savings and even lessening of costs by enacting more inclusive policies regarding cross-border access to healthcare within the European Union. A stepping-stones approach, considering the generalized consequences of granting access, in terms of the categorical imperative, might be in order.

This article has delineated the genealogy of the current regulatory environment regarding access to cross-border public health care within the European Union. At the same time, the present regulatory framework was analysed and situated in the lingering potential of future developments. In this manner, it highlights critical potential areas of further research. In this regard, what would be very welcome is further confirmation of the economic, cost-related potential of ensuring broader access to public health care across national borders, including additional right-holders. The question of the influence of such an approach on the soft power of the European Union and its Member States could be addressed in detail by scholars in the field of international relations.

Access to cross-border health care remains an important area of regulation and public policymaking within the European Union. It is expected to remain such in the foreseeable future. Further developments in this area will be symptomatic of the trends regarding greater inclusivity or reterritorialization based on the

concept of individual nation-states. It remains to be seen whether the humanist trend of the broadening of access will be the one that continues. Considering the categorical imperative, the stepping-stone approach towards greater inclusivity seems to be the appropriate way to assess and decide on future policies in the field of cross border access to public healthcare within the European Union and beyond.

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## ČEZMEJNI DOSTOP DO ZDRAVSTVENEGA VARSTVA V EU: GENEALOŠKA ANALIZA REGULATORNIH VIDIKOV

*Vprašanje čezmejnega dostopa do zdravstvenega varstva v Evropski uniji že dolgo presega zamisel o zgolj spodbujanju gibanja delavcev prek meja. Kljub temu so ostanki diskurzov, ki temeljijo na nacionalni državi, ohranili nadzor nad nekaterimi državami članicami, zaradi česar je dostop do čezmejnega zdravstvenega varstva manj učinkovit. Članek se osredotoča na genealoško analizo regulativnih vidikov čezmejnega dostopa do zdravstvenega varstva. Po eni strani je poudarjena etična potreba po vse večji inkluzivnosti. Za ohranitev kakovosti javnega zdravstva je treba to uravnovežiti z realnimi premisleki, ob upoštevanju ekonomskih in drugih družbenih dejavnikov.*

**Ključne besede:** čezmejno zdravstveno varstvo; genealogija; regulacija; vključenost; javno zdravje.