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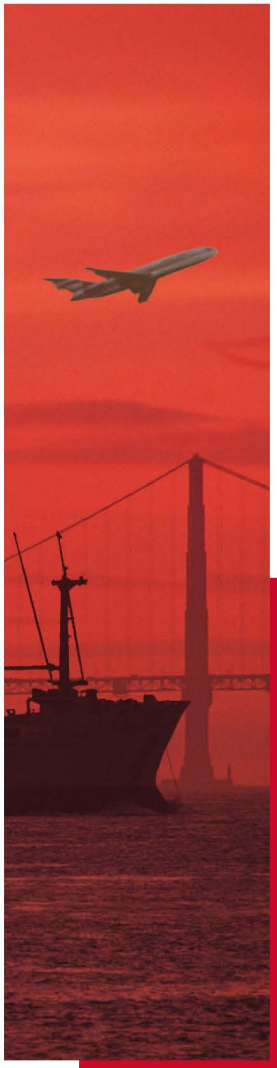

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Research for TRAN Committee - Health tourism in the EU: a general investigation

STUDY

EN FR

2017

European Parliament

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This document was requested by the European Parliament's Committee on Transport and Tourism.

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Acknowledgements: We would like to thank Prof. Dr. Olaf Timmermans, University of Antwerp, Belgium, and Dr. Sabina Stan, Dublin City University, Ireland, for their valuable comments on an early draft of this report.

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LINGUISTIC VERSIONS

Original: EN
Translation: FR

ABOUT THE PUBLISHER

To contact the Policy Department or to subscribe to updates on our work for the TRAN Committee please write to: poldep-cohesion@ep.europa.eu

Manuscript completed in June 2017

Print	ISBN 978-92-846-1181-2	doi:10.2861/072	QA-01-17-633-EN-C
PDF	ISBN 978-92-846-1182-9	doi:10.2861/951520	QA-01-17-633-EN-N

This document is available on the internet at:
http://www.europarl.europa.eu/RegData/etudes/STUD/2017/601985/IPOL_STU(2017)601985_EN.pdf

Please use the following reference to cite this study:
Mainil, T, Eijgelaar, E, Klijs, J, Nawijn, J, Peeters, P, 2017, Research for TRAN Committee – Health tourism in the EU: a general investigation, European Parliament, Policy Department for Structural and Cohesion Policies, Brussels
Please use the following reference for in-text citations:
Mainil et al. (2017)

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Research for TRAN Committee - Health tourism in the EU: a general investigation

STUDY

Abstract

This study defines and explores health tourism and its three main components: **medical, wellness, and spa tourism**. Health tourism comprises around 5% of general tourism in the EU28 and contributes approximately 0.3% to the EU economy. Health tourism has a much higher domestic share than general tourism does. Increasing the share of health tourism may reduce tourism seasonality, improve sustainability and labour quality, and may help to reduce health costs through prevention measures and decreased pharmaceutical consumption.

IP/B/TRAN/IC/2016-134 June 2017

PE 601.985 EN

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LIST OF ABBREVIATIONS

BAU	Business As Usual
BOPS	Balance of Payments Statistics
CF	Cohesion Fund
EAPTC	European Association of patients and users of Thermal Centres
EC	European Commission
ECVET	European Credit System for Vocational Education and Training
EDEN	European Destinations of Excellence
EEIG	European Economic Interest Grouping
EHTDB	Expanded Health Tourism database
EHTTA	European Historic Thermal Towns Association
ERDF	European Regional Development Fund
ESF	European Social Fund
ESPA	European Spas Association
ETC	European Tourism Commission
GDP	Gross Domestic Product
GWI	Global Wellness Institute
H&WB	Health & Wellbeing Destination
HTGS	Health Tourism Growth Scenario
HTH	Hohe Tauern Health
HTVS	Health Tourism Vitality Scenario
ICT	Information and Communication Technology
IMTJ	International Medical Travel Journal
IVF	In-vitro fertilization

NHS	National Health Service (in the UK)
NHTV CSTT	Centre for Sustainability, Tourism and Transport of NHTV Breda University of Applied Sciences
NICe	Nordic Innovation Centre
OECD	Organisation for Economic Co-operation and Development
RNAO	Registered Nurses' Association of Ontario
SME	Small and Medium-sized Enterprise
SNHZ	Stichting Nederlandse Herstellingsoorden en Zorghotels [Netherlands Foundation of Nursing Homes and Care Hotels]
SOWELL	Social tourism Opportunities in Wellness and Leisure activities
STH	Social and Therapeutic Horticulture
SWOT	Strengths, Weakness, Opportunities, and Threats
TOHWS	Tourism Observatory for Health, Wellness and Spa
TSA	Tourism Satellite Account
UNWTO	United Nations World Tourism Organisation
USD	United States Dollar ($)
WHO	World Health Organisation
YEI	Youth Employment Initiative

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EXECUTIVE SUMMARY

Background and definitions

Health tourism is a subsector of general tourism that comprises **medical, wellness, and spa tourism**. **Medical tourism** involves people travelling expressly to access medical treatment. People travel for **wellness tourism** to maintain or enhance their personal health and well-being. **Spa tourism** focuses on healing, relaxation or beautifying of the body that is preventative and/or curative in nature.

The three forms of health tourism (medical, wellness, and spa) reside on two parallel continuums: 'illness-health-wellness' and 'curative-preventative-promotive'. **Medical tourism** is associated with curing illness; **wellness tourism** promotes personal well-being and **spa tourism** is positioned in between, aiming to prevent illness and wanting to sustain health. **Wellness and spa tourism** are also associated with certain types of facilities offered at 'wellness centres' and spa destinations, while **medical tourism** focuses on (non-tourism) medical facilities. General tourism provides complementary amenities like accommodation with facilities for people who require medical care, are disabled or suffer from health problems. The objective of this report is to provide an overview of the statistics, knowledge, case studies and policies relating to health tourism.

Market size and growth of health tourism

Due to limited, fragmented and often unreliable data, as well as varying definitions of health tourism and its components, it is difficult to estimate the size and growth of health tourism as a market. Within the EU28, 56 million domestic and 5.1 million international trips in total were recorded for 2014. Health tourism's share of these trips is small at 4.3% of all arrivals. Only 5.8% of all domestic arrivals and only 1.1% of all international arrivals are health tourism trips.

Health-tourism revenues total approximately €34 billion, which represents 4.6% of all tourism revenues and 0.33% of the EU28 GDP. The seasonality of health tourism differs from general tourism and tends to be less pronounced. Health tourism actually helps counter average seasonality in tourism as a whole. The share of health tourists arriving from outside the EU amounts to an estimated 6%.

Scientific and public sources point to a stable development of EU health tourism, whereas market reports indicate medium to strong growth in **medical, wellness, and spa tourism**. As discussed in this study, we expect that health tourism will develop at an average 2% growth per year, equal to overall EU28 tourism.

Medical tourism is a volatile market that is dependent on legislation and waiting lists in regular healthcare. Whereas, **wellness tourism** accounts for roughly two-thirds to three-quarters of all health tourism.

France, Germany, Italy, Sweden and Poland are economically important destinations for health tourism. Finland, Bulgaria, Germany, Spain and Ireland all have a relatively high supply of wellness facilities in their accommodations, while the highest geographical densities of health and wellness facilities are found in Central and Eastern Europe and the Spanish and southern Baltic coasts. Large source markets for health tourism include France, Germany and Sweden.

Case studies

In the 28 case studies analysed for this study, the UK, Italy, Germany, Belgium and Croatia were the most frequently referenced countries. Over 70% of the case studies were international. Several case studies highlighted issues with the goals of Directive 2011/24/EU (on the application of patients' rights in cross-border healthcare) and national healthcare policies, where national governments have not always supported the free mobility of patients. The tourism industry does not appear to be actively involved in Directive 2011/24/EU, nor politically active in providing the hospitality and transportation services involved, even though opportunities to do so exist. In some case studies, e.g. Alpine Wellness and Nordic Wellness, health tourism is shown to better utilise environmental resources. Of the six case studies that were analysed in greater depth, the main factors for successful development of health tourism were policies, stakeholder cooperation, international approach, communication and promotion. However, there is a discrepancy between understanding customers' needs on the continuum between health and wellness and what stakeholders in destinations believe these needs to be.

Policies

We reviewed European, national and regional policies on health tourism. Though the EU-level policy for patient mobility (Directive 2011/24/EU) provides opportunities for **medical tourism**, there are still substantial taxation, financial and legal differences between member states that could hamper the development of **medical tourism**. **Wellness and spa tourism** are not explicitly supported by EU policies. Health-tourism projects take advantage of EU funding, for instance through the ERDF. National and regional health-tourism policies are quite common in the member states and are either included as part of general tourism or part of health policies, but they are seldom integrated. These policies aim to improve or guarantee the quality of health tourism through supporting collaborations, promotional campaigns, regional specialisation, legislation, health-tourism projects and by using health tourism to reduce tourism seasonality. Based on our SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis we arrived at recommendations to better integrate health tourism into general EU tourism policies and to improve its connection to healthcare and the growing market for wellness at the workplace.

We explored three scenarios: a 'Business As Usual' (BAU) one and two policy scenarios. One scenario, 'Health Tourism Growth Scenario' (HTGS), aimed at obtaining the highest possible growth for all three forms of health tourism. The purpose of the second scenario is to achieve the optimal positive effects of health tourism on the health of the population ('Health Tourism Vitality Scenario', HTVS). Although the HTGS offers advantages for economic growth, it also poses certain risks for health costs. The HTVS is likely better positioned to reduce health costs while simultaneously generating additional growth in tourism.

Recommendations

From our study, we derived the following general policy recommendations (please see Section 7.5 for a more detailed list):

- Regarding **medical tourism**, include more spa treatments in national healthcare systems, remove upfront payment for cross-border healthcare and more effectively promote the uptake of Directive 2011/24/EU in national health policies. Facilitate knowledge sharing and exchange of experiences between the hospitality and tourism industry and the health sector. Also, it is important to better regulate procedures in **medical tourism** to prevent incidents (e.g. in cosmetic surgery), as this generates negative press and a problematic image of all medical and health tourism.

- For better understanding and promotion of health tourism improved data are necessary. This means that health tourism and its three components should be distinguished in national and EU statistics, tourism satellite accounts and the Tourism Observatory, and it should be based on a clear set of definitions.
- Continue funding for health-tourism projects. Target such funds by using health tourism development to improve labour quality, sustainability and seasonality. Also, use funding to increase domestic tourism over international (departures) tourism as a way of reducing tourism's dependence on less sustainable transport and to enhance the sustainable development of tourism. Also, there is scope for funding renovation and renewal projects of existing spas to better equip these for the national and international markets.
- A policy scenario aiming at enhancing health in the EU through further developing and integrating health tourism and healthcare and using the opportunities for prevention rather than cure may have a better potential for the general good than a scenario aiming at just economic growth of the health-tourism market. The latter may provide benefits to the economy, but it may also come with a risk of increased cost for the regular healthcare systems. In a scenario where health policies prioritise improving health, there is a role for the tourism and hospitality sector to cooperate with the health sector by exchanging experiences and requirements for accommodation, transport, services, employee competences, etc. that help to facilitate accommodation and mobility for less-abled visitors or visitors requiring special treatments.

1 INTRODUCTION TO HEALTH TOURISM

KEY FINDINGS

- Health tourism consists of medical tourism (travel for the purpose of medical treatment), wellness tourism (aiming to enhance 'health'), and spa tourism (travel to spas combining medical and health components).
- The three elements exhibit not only differences, but also overlaps, on the 'illness-health-wellness' and 'curative-preventative-promotive' continuum.
- Health tourism in the EU is still a largely understudied and undocumented field in academic and professional literature.
- Health tourism contends with both national and European legislation, which generates issues with equal access to healthcare and wellness.

1.1 Aim and objectives

Health tourism - defined in this report as a combination of **medical tourism**, **wellness tourism** and **spa tourism** - is claimed to be a booming subsector of general tourism in industry reports drafted by the Global Wellness Institute (GWI, 2017, p. 7), but, for instance for **medical tourism**, this is disputed by academics like Connell (2013). Also, we have found substantial differences between the statistics compiled by official statistical offices (e.g. Eurostat, 2017) and those cited in industry reports (e.g. GWI, 2015, 2017). These conflicting claims may arise in part from issues with the definition of health tourism. Therefore, we will elaborate on these definitions in Section 1.2 and their conceptual overlaps between the different forms of health tourism in Section 1.3. In addition, a range of definitions can be found in Annex I.

The objective of this report is to provide a qualitative and quantitative overview of the current status of EU28 health tourism, its role in general tourism, current policies directed at its promotion and/or legislation and to provide recommendations for its future development. Current EU general tourism policies focus on the following challenges (European Commission, 2015f):

- Security and safety — environmental, political and social security; safety of food and accommodation and socio-cultural threats to sustainability.
- Economic competitiveness — seasonality, regulatory and administrative burdens; tourism-related taxation; the difficulty of finding and retaining skilled staff.
- Technological — staying abreast of Information and Communication Technology (ICT) developments caused by the globalisation of information and advances in technology (ICT tools for booking holidays, social media for providing advice on tourism services, etc.).
- Markets and competition — increasing demand for customised experiences, new products and growing competition from other EU destinations.

Even though current shares of health tourism are not very large, they may play a role in the development of sustainable tourism, place a value on environmental quality, reduce seasonality, customise supply to a specific demand, diversify the overall EU tourism product and most likely impact our relationship with food, taxes and labour skills. In particular, we will explore the following main questions:

- How large is the health-related tourism market within the EU and in comparison to other major world players in the market?
- What are the current trends in the three health-tourism markets within the EU?
- Which factors are contributing to changes in European health tourism, and what are their economic implications both for the entire EU and for those individual countries and regions that are the largest participants in these specific tourism markets?
- What are the strengths and weaknesses of health tourism in the EU compared to other competing regions in the world?
- What are opportunities and challenges for the health-tourism market in the EU?
- How might policy scenarios develop based on the implementation of different policy measures?
- What could and/or should be done, particularly at the policy level, to further improve the positioning of European health tourism?

To answer these questions, we analysed the professional and scientific literature, performed eight in-depth expert interviews, created a health tourism dedicated database and had our findings reviewed by two additional experts in the field. The answers are discussed in Chapter 7 and all answers to the detailed questions this study is based on are provided in Annex VII. The next Section begins by discussing the definitions of health tourism and its three main elements (**medical, wellness, and spa tourism**).

1.2 Definitions

To understand 'health tourism', one first needs to define what 'health' is. According to Benhacine, Hanslbauer, and Nungesser (2008, p. 36), health is a 'state of complete physical, mental and social well-being and not only the absence of illness and ailment'. This definition suits the broad nature of the health tourism market that not only contains elements of recovering from illness, but also includes the whole spectrum from illness to health and wellness and from curative to preventative and then promotive (Hall, 2011).

The leading handbooks with regard to health tourism (M. Smith & Puczkó, 2014; M. K. Smith & Puczkó, 2016), both report on studies that indicate that in some cases female health tourists are the majority of clients. Certainly, retreats and yoga treatments show evidence of this development. Also Erfurt-Cooper and Cooper (2009) reports on wellness tourists to Malaysia and Thailand, both indicating that the majority of these tourists were female. In the case of **medical tourism**, IVF treatment and cosmetic surgery tourism are also gendered: female medical tourists form the majority in those forms of **medical tourism**, following Lunt, Horsfall, and Hanefeld (2015).

Many definitions exist for health tourism (please see Annex I for an overview), but we chose to follow M. Smith and Puczkó (2015, p. 206) who define **health tourism** as:
'those forms of tourism which are centrally focused on physical health, but which also improve mental and spiritual well-being and increase the capacity of individuals to satisfy their own needs and function better in their environment and society'.

Over the last decade or so, the definition of **medical tourism** has been the subject of vivid academic debate, including 'intentional movement of patients' (Bookman & Bookman, 2007) and 'organised travel' (P. M. Carrera & Bridges, 2006), referring to intentional travel in **medical tourism**. Furthermore, we have extended the definition of **medical tourism** a consideration of the distinction between out-of-pocket payments and public coverage (also

highlighted by P. Carrera and Lunt (2010) and Mainil (2012)). The first two references defining **medical tourism** as being based solely on out-of-pocket payments, with 'cross-border healthcare' covering travel that thus involves public coverage of care, most notably through EU legislation. However, as P. Carrera and Lunt (2010) have highlighted, the boundary between the two forms of cross-border patient mobility is permeable.

Following the discussion provided by Connell (2013), our proposed definition for **medical tourism** is:
'the phenomenon of people travelling from their usual country of residence to another country with the expressed purpose of accessing medical treatment'.

Following Johnston, Puczkó, Smith, and Ellis (2011), we define **wellness tourism** as:
'involving people travelling to a different place to proactively pursue activities that maintain or enhance their personal health and well-being, and who are seeking unique, authentic or location-based experiences or therapies that are not available at home'.

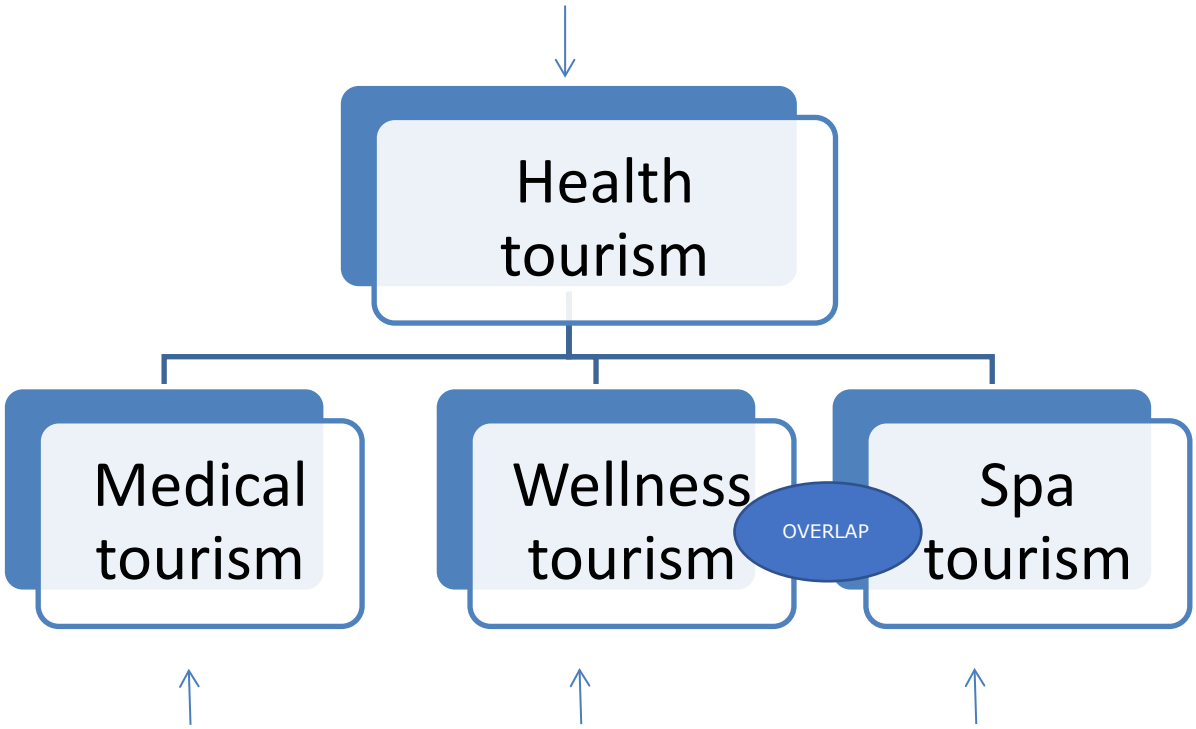
We choose this definition because of its all-encompassing focus on well-being, although other definitions for **wellness tourism** show notions and concepts along the same lines, such as physical, mental and social harmony (Mueller & Kaufmann, 2001), trips aiming at a state of health (M. Smith & Puczkó, 2015) and a multi-dimensional state of being (Hritz, Sidman, & D'Abundo, 2014).

Following M. Smith and Puczkó (2014, p. 10), we define **spa tourism** as:
'tourism focused on the relaxation, healing or beautifying of the body in spas using preventative wellness and/or curative medical techniques'.

We follow this definition because it makes specific reference to spa facilities, and both preventative and curative medical techniques, as crucial elements of this type of health tourism. Other definitions include places devoted to overall well-being (M. Smith & Puczkó, 2015) and programmes devoted to an individual's health and fitness (Steiner & Reisinger, 2006), but we do not consider these to exclusively address spas as element of the destination. Figure 1 is a graphical representation of the choices made for defining the several forms of health tourism.

Figure 1: Overview of health-tourism definitions

Health tourism: 'Those forms of tourism which are centrally focused on physical health, but which also improve mental and spiritual well-being and increase the capacity of individuals to satisfy their own needs and function better in their environment and society' (M. Smith & Puczkó, 2015, p. 206).



Medical tourism refers to 'the phenomenon of people travelling from their usual country of residence to another country with the expressed purpose of accessing medical treatment' (Connell, 2013).	**Wellness tourism** involves people 'travelling to a different place to proactively pursue activities that maintain or enhance their personal health and well-being, and who are seeking unique, authentic, or location-based experiences or therapies that are not available at home' (Johnston et al., 2011, p. iv).	**Spa tourism** entails tourism for the purpose of 'relaxation, healing or beautifying of the body in spas using preventative wellness and/or curative medical techniques' (M. Smith & Puczkó, 2014, p. 10).

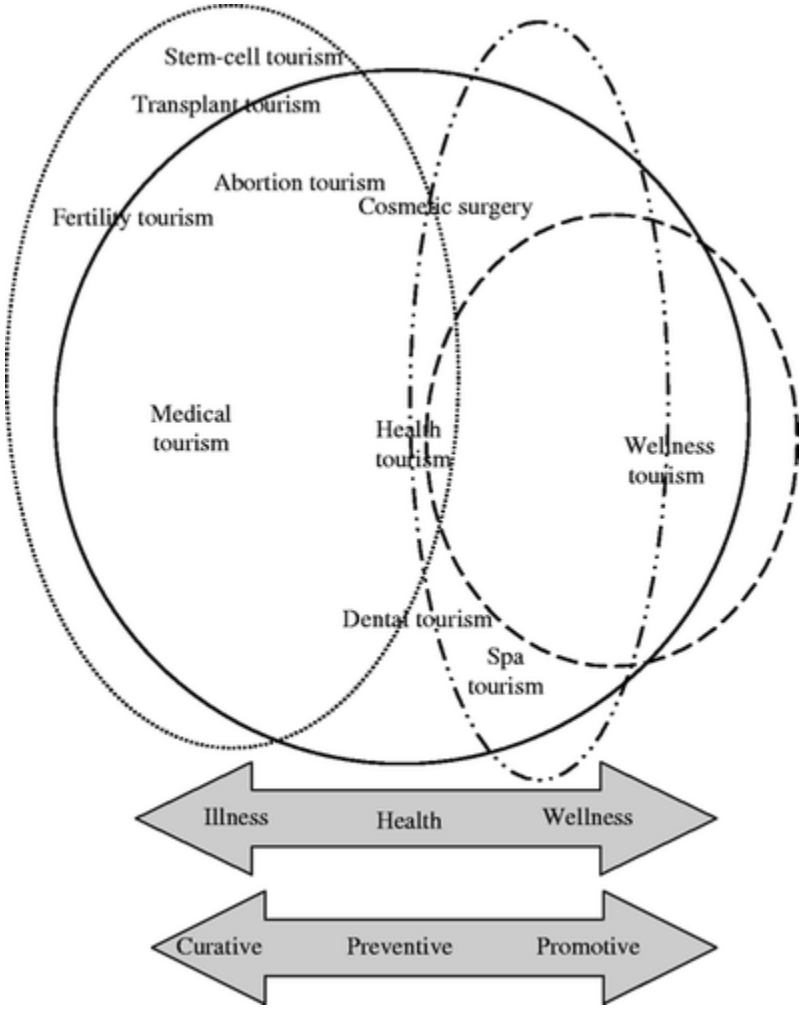
Source: Author's own elaboration.

In Section 1.3, we elaborate on the choices made for this diversification between **medical, wellness, and spa tourism**.

1.3 Conceptual overlaps in the study of health tourism

While some organisations(such as GWI) include **spa tourism** under **wellness tourism** (GWI, 2017), we consider the latter as a separate type of health tourism combining medical and non-medical elements, and thus situated between **medical tourism** and **wellness tourism** at the other end. This refers to what Hall (2011) describes as the continuum moving from 'illness' to 'health' and, finally, 'wellness' and the continuum moving from 'curative' to 'preventative' and, lastly, 'promotive' (Figure 2). Illness is related to **medical tourism**; an example being citizens with a medical condition who seek treatment. **Wellness tourism** can be perceived as promoting services to healthy citizens who want to enjoy a healthy holiday. Prevention may be linked to **spa tourism** that appeals, for example, to people with chronic disease or medical conditions. Thus, while in the case of **medical tourism**, suffering and illness are part of the experience, **wellness tourism** entails enjoyment, health and rejuvenation — with **spa tourism** involving both medical and non-medical services. There are overlaps between these fields: this is proven, for example, by the medical wellness and/or medicalised spa treatments available in Eastern Europe, such as present in the OFF TO SPAS project or the development of health tourism in the Balkans (please see both in Annex V), both in relation to balneology and rehabilitation.

Figure 2: Overlaps in health tourism



Source: (Hall, 2011).

1.4 The three forms of health tourism

1.4.1 Medical tourism

The medical-tourism literature is dominated by studies on non-European regions and countries, with very few comprehensive studies on **medical tourism** in Europe (Lunt et al., 2015). Non-European **medical tourism** is represented mainly by visitors and arrivals from neighbouring countries for destinations such as South-Africa, Malaysia and Thailand (Connell, 2013; Crush & Chikanda, 2015; Ormond & Sulianti, 2014). Lunt et al. (2011) highlighted the lack of reliable data on medical tourist flows around the globe. Volgger, Mainil, Pechlaner, and Mitas (2015) focus on the development of transnational health regions. Health regions need to build organisational capacity for the funding, management and delivery of healthcare, as well as investing in personnel and communication channels. Regional governments have an important role to play in the development of such structures, in order to manage their medical and health capacity for both national and international patients.

Glinos, Baeten, Helble, and Maarse (2010) designed a typology of cross-border patient mobility describing the drivers for patient mobility: availability, affordability, familiarity and perceived quality. These drivers could also hold for health tourism in general. Stan (2015) has provided evidence in the EU of cross-border healthcare by Romanian immigrants in Ireland, pointing to the still poorly researched phenomenon on 'diasporic **medical tourism**'[1] in the EU, which is described by Main (2014) and Osipovič (2013) for Polish migrants. Also for Europe, several studies have shown that **medical tourism** in the EU is linked to inequalities of access to healthcare services and the uneven distribution of healthcare resources across the continent. Whereas medical care is in many EU countries only partly a commodified good, in **medical tourism**, medical care becomes a commodity, only accessible to more affluent citizens. However, under Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (European Union, 2011), cross-border healthcare is regulated by EU legislation, and more embedded in citizenship rather than consumer rights, more democratic in nature (Mainil, 2012). However, the upfront payment system for patients under the Directive 2011/24/EU can lead to inequalities in healthcare.

A European Commission survey (European Commission, 2015a) indicates that a significant proportion of citizens in the EU (49%) is willing to travel for medical care. Further research could be undertaken on the relation between patient mobility and the ageing population and the silver economy within the EU. This certainly also holds for **wellness and spa tourism**.

The report of the European Public Health Alliance (EPHA) (European Public Health Alliance, 2015, p. 6) on cross-border healthcare explicitly states the relation between inequalities of access to healthcare services and the EU Directive on patient rights implementation: 'The Directive requires Member States to reimburse citizens to the value that care would have cost at home an essential provision for protecting the financial sustainability and viability of national health systems but this immediately disadvantages patients from poorer countries with less-developed health systems. Health services are provided for substantially less money in Croatia, for example, than in Sweden. Thus, a Croatian patient would have to cover the considerable difference in the cost in treatment out of their own pocket, whilst patients from wealthier Member States are free to travel almost anywhere else for their care without contributing to the costs themselves. Another side effect is that wealthier governments are effectively gaining if the treatment is less expensive abroad'.

[1] People returning to their homeland to receive medical treatment.

Concerning consumer rights in health services in the EU legislation, we would like to refer to the following paper (where European patients/medical tourists are perceived/observed as both citizens and consumers): 'In the European context, medical tourists may be conceptualized in two ways. First, they may use their European citizenship rights to avail themselves of medically necessary surgery in another E.U. member state and seek to have their national purchaser reimburse the costs of the treatment. A second group of European medical tourists may be seen as consumers, because they use purchasing power expressed through the market to access a range of dental, cosmetic, and elective surgeries. These dual roles of citizen and consumer—and the attendant guarantees to claim and choice of such roles—set Europe apart from the U.S. circumstances, where the medical tourist is more accurately described as a consumer rather than citizen' (P. Carrera & Lunt, 2010, p. 475).

If international patients want to go abroad to receive treatment in another member state, they need to pay the cost of treatment upfront by themselves. It takes a longer period to recover those costs. They only receive the money for the amount that the treatment would cost in their home country, so if the treatment is more expensive in the treating member state: there are extra costs out-of-pocket for the patients.

Even in Directive 2011/24/EU, there are currently mechanisms that could enhance privatisation of healthcare services, according to the European Public Health Alliance (EPHA): 'Already there is a noticeable rise in patients travelling abroad for private healthcare offers that may not be available in their home countries (or to shop around for less costly / better quality treatments) and the Directive should not exacerbate this trend by extending private sector rules and conditions to public healthcare systems, thereby creating a new avenue to stimulate health tourism for the few' (European Public Health Alliance, 2015, pp. 8-9).

1.4.2 Wellness tourism

Wellness is a broad concept and its meaning is determined culturally and geographically. For instance, where wellness in the south of Europe is connected to the seaside, sea air, a slow pace of life and abundant Mediterranean food, the Scandinavian way to achieve wellness is based on the outdoors, with a focus on walking and swimming and with simplicity as a leading principle (M. Smith & Puczkó, 2014). Germany, Austria and Switzerland are not only geographically in-between the Mediterranean and Scandinavia, but also combine in wellness the physical health of the north with the slower pace of the south of Europe. Furthermore, M. Smith and Puczkó (2014) show that wellness is connected more to 'medical sources and waters' in Central and Eastern European countries or the Baltic States.

All these cases, present in the EU, serve as evidence for the overlap between **wellness and spa tourism**. Furthermore, the UK (and USA, Australasia and Canada) have a strong cosmetics and pampering edge to their wellness spas. In these countries, a large share of the wellness industry is shown to be serving daily life and not just tourists. This is an important issue to understand because many industry reports about the wellness industry show the overall economy of wellness, including these large everyday life shares. It is important to keep in mind that **wellness tourism**, as many other forms of tourism, makes use of more everyday facilities, such as the transport and food service industries.

Voigt and Pforr (2013) describe the relation between destination management and wellness development and show that the development of any region, including those focusing on **wellness tourism**, into a successful tourism destination requires a collaborative approach with several motivated stakeholders. They believe the wellness industry is largely unregulated, with a genuine risk of negative impacts on sustainable development. A report by the Tourism Observatory for Health, Wellness and Spa on the development of a health

tourism strategy for the Baltic States shows the potential of cooperation in health tourism development (M. Smith & Puczkó, 2014). However, because **wellness tourism** is more accepted as a commercial activity and much better fits the more common tourism products than both **medical and spa tourism**, such cooperation could be hampered on grounds of competition between companies.

Additional overlaps between **medical tourism** and **wellness tourism** also include, besides **spa tourism**, initiatives to facilitate tourism for people with chronic conditions. Thus, some touristic regions such as Veneto and the province of Zeeland are offering kidney dialysis services to tourists (Footman et al., 2014; Timmermans, Marijs, Bijl, & Tempelman, 2016), in a bid to enable them to enjoy a holiday.

Kidney dialysis on holiday is already a wide spread practice in the EU and elsewhere. Many websites are offering instructions on where to look for such tailored holidays. Examples in the literature are less obvious but show evidence in the Veneto region: 47-50 patients arrive from other countries each year to receive dialysis when on holiday. Patients were satisfied with the services and some patients saw the treatment as identical to their home centre. The continuity of care was seen as important although language barriers were also mentioned (Footman et al., 2014). Another good practice is the Big Red Kidney Bus in Australia, an innovation which shows another perspective than the casual holiday stays where you also can receive dialysis: 'This bus was fitted with three dialysis machines and chairs and parked at predetermined locations and time periods, enabling to dialyse while on holiday' (Sims et al., 2017). This intervention seemed to have an impact on the mood of the tourists, although it was not confirmed that this effect was established by the intervention.

1.4.3 Spa tourism

Academic and business literature on **spa tourism** is dominated, at least in numerical terms, by research on products and services in Central and Eastern Europe, where spas around medical waters have a long tradition (M. Smith & Puczkó, 2014). According to Derco (2014, p. 250), 'the activities of natural curative spas in Slovakia are being currently influenced by the commercialisation of spa services targeted at self-payers within health tourism. The health insurers' limited spa care and standard spa stay expenses require the spas to focus on the creation of wellness products (such as beauty stays, weekend wellness stays) and on marketing activities to present such products'.

A Polish case study showed that for spa resorts a difference can be made between commercial and non-commercial spa tourists (Dryglas & Różycki, 2016). Furthermore, Szromek, Romaniuk, and Hadzik (2016) showed the privatisation process for the traditionally state-run spas in Central and Eastern Europe. The process is rather chaotic because of a lack of a clear policy vision, eligibility criteria and ideas about how to maintain the therapeutic potential of the spa sector.

In Germany, the traditional spas (or 'Kurorten') have been significantly affected by recent reforms of the German healthcare system and have reacted by focussing more on the development of medical wellness (Pforr & Locher, 2012). This also shows the close relationships and some overlaps between **medical and spa tourism**.

1.5 Tourism statistics

The lack of clear and unified definitions of health tourism makes it difficult to include health tourism in tourism statistics. Generally, national or local tourism statistics fail to accommodate health tourism. Even the economic tourism statistics like the Tourism Satellite Accounts (Eurostat, 2011) do not define or distinguish health tourism. This makes it difficult to assess the importance, growth, impacts and effects of health tourism, the subject of Chapter 2. To be able to provide a first estimate of health tourism's size and structure, at least in the EU, we have developed the Expanded Health Tourism Database (EHTDB), by combining several existing databases and survey results (please see Subsection 2.1.2).

2 HEALTH TOURISM: SIZE, STRUCTURE AND IMPACTS

KEY FINDINGS

- Health tourism lacks reliable figures and credible data sources, with definitional issues contributing to a wide range in the figures available.
- The total volume of health tourism in the EU28 is estimated at 56.0 million domestic arrivals and 5.1 million international arrivals (from all over the world), totalling 61.1 million health-tourism arrivals in the EU28 for 2014. This is health tourism with the main objective of wellness, spa and health.
- The health tourism share of all EU28 arrivals is 4.3% (international plus domestic).
- Germany, France and Sweden are key players in EU28 health tourism, with 56% of all health tourism arrivals and 58% of all departures.
- With two-thirds to three-quarters of the total market, wellness tourism dominates EU health tourism.
- Health-tourism revenues total €46.9 billion in the EU28, which represents 4.6% of all tourism revenues and 0.33% of the EU28 GDP. More than three quarters of the EU health-tourism revenues are contributed by just five countries: Germany, France, Poland, Italy and Sweden.
- The health-tourism market share in the EU is stable, with market reports indicating an increase.
- Health tourism may have beneficial effects on the labour market and the environment, and it may help reduce tourism seasonality.
- Most medical tourism clinics are also serving local patients and exploit medical tourism as an addition to their 'market'.

2.1 Introduction and methodology

2.1.1 EU tourism

This Chapter presents information on the volume and structure of the health-tourism market in the EU28. This information, which we have limited to tourism trips with at least one overnight stay, includes data on domestic and internationals arrivals and departures. The basic definitions developed by the UN Department of Economic and Social Affairs (2010, p. 9) for these tourism terms are: 'Travel within a country by residents is called domestic travel. Travel to a country by non-residents is called inbound travel, whereas travel outside a country by residents is called outbound travel. Inbound and outbound trips are also categorised as 'international arrivals' and 'international departures', respectively. In this report, we will only use the terms international arrivals, international departures, domestic arrivals and domestic departures.

This introductory Section will present an overview of key figures for tourism in the EU28, before moving to health tourism in the following parts. For these figures, the Expanded Health Tourism Database (EHTDB) has been created (please see Annex IV). Subsection 2.1.2 gives a description of the methodology used for the EHTDB and this Chapter. Section 2.2 continues with an overview of the size of EU health tourism in terms of trips made, nights stayed, the supply of health facilities and revenues. It ends with information on health tourism growth and a comparison with global health tourism. Section 2.3 looks at health tourism from a

destination perspective. Section 2.4 presents information on the structure of EU health tourism and its impact. The Chapter ends with some conclusions (please see Section 2.5).

Table 1 below presents key EU28 tourism figures for 2014[2]. A key point illustrated is that EU residents spend the majority of their overnight trips either within their own country (75%) or elsewhere within the European Union (19%). In 2014, only 6% of EU residents' overnight trips transpired outside of the EU (Eurostat, 2016).

Table 1: Key figures of EU tourism, 2014

	Trips of EU residents					International arrivals
	All departures (domestic and international)	Domestic departures	International departures			
			Intra-EU	Outside EU	Total	Total
Trips (million)	1,209	900	231	77*	309	461
Trips (%)	100	74.4	19.1	6.4	25.6	
Nights (million)	6,334	3,700	1,976	659*	2,634	1,930
Nights (%)	100	58.4	31.2	10.4	41.6	
Expenditure (billion €)	n/a	664	n/a	n/a	n/a	362
Average trip length (nights)	5.2	4.1	8.5	8.5	8.5	4.2
Average expenditure per trip (€)	n/a	738	n/a	n/a	n/a	785

Source: Based on the Expanded Health Tourism Database (EHTDB) which makes use of IPK International data (IPK International, 2016) supplemented with data from Eurostat (2016) for 'departures' and from UNWTO (2016a) for 'arrivals'. Some numbers have been updated with national data (Sweden and the UK) to complement missing data.
Note: *Calculated using Eurostat percentages.

For international tourism, the EU28 is still by far the most visited region in the world, with 40% of all global international arrivals. This share is slowly decreasing, however, as the annual growth in international arrivals has been slower on average in the EU than it has been worldwide (2.7 vs. 3.9% between 2005-2015, see UNWTO, 2016a). And international travel

[2] In this report, we use figures for 2014 in the data-related sections (unless stated otherwise), as it was the most recent year for which agencies such as Eurostat, UNWTO (United Nations World Tourism Organisation) and IPK International had nearly complete statistics. Given that we had to combine different data sets for a comprehensive overview of domestic and international departures of EU residents, as well as overall international arrivals, the figures about tourism volumes sometimes slightly deviate from those provided by our main sources (Eurostat, 2016; UNWTO, 2016a).

to EU28 countries is expected to grow slower than the global average until 2025: 2.1% vs. 3.5% annually (UNWTO, 2014)[3]. Table 1 above lists the general-tourism figures for the EU28, as a point of reference for the health-tourism data.

2.1.2 Methodology

In this Chapter, we describe the methods we used in our study: a literature review, data collection and calculation, and expert interviews. Records on the size of health tourism and its three markets are mostly kept by organisations who have a commercial interest in these same markets and are frequently accused of 'industry boosterism' (Horsfall & Lunt, 2015, p. 27). Also, definitional issues are another reason for a wide variety in figures. An example being the global trips and revenue figure for **medical tourism**, with industry estimates ranging as high as approximately 40 million trips and $60 billion USD. Horsfall and Lunt (2015), extrapolating from public statistical data, arrive at a more reliable figure of some 5 million trips for **medical tourism** in 2015.

Due to this lack of direct, reliable figures for health tourism, this study combines various data sources to obtain credible figures for the number of trips, nights stayed and revenues for health tourism in the EU28, which together make up the EHTDB. We present data for domestic and international health tourism. The first pertains to EU residents' overnight health trips in their respective country, and the latter to EU residents' overnight health trips in other EU countries and those travellers from outside the EU visiting EU countries. We also present several figures for international trips as we also intend to demonstrate the importance of international health tourism for EU residents.

All of the data in Section 2.2 has been calculated on the basis of information for 2014, unless stated otherwise. An overview of the most important figures of the EHTDB is available in Annex IV.

The number of domestic health-tourism trips was determined by multiplying the domestic trip figures for EU countries (UNWTO, 2016b) with the average percentage for 'Wellness/Spa/Health treatment' provided by the Eurobarometer surveys (European Commission, 2014c, 2015b, 2016) as the main reason for going on holiday in 2013, 2014 and 2015. We took an average of the two-year span (2013 through 2015) to even out the variety in results in order to provide a more reliable and up-to-date figure. We focused on the primary purpose of travel being health tourism ('main reason' in the surveys) in order to highlight health tourism for primary purposes.

The arrival figures for health-tourism are 'Health oriented/Wellness/Spa Holiday' trip numbers provided by IPK International (2016). IPK International had data available for 2012 and 2014, so we averaged the health-tourism shares for 2012 and 2014 to produce more reliable figures. This means that although we may have overlooked potential trends in the share of health tourism between 2013 and 2014, we did capture the overall trend of tourism figures, achieving close to 2014 estimates.

Both Eurobarometer and IPK International indicate the magnitude of aggregated health tourism on a country level, but do not distinguish between the three markets. Note that we use the terms 'Health treatment' (Eurobarometer) and 'Health oriented' (IPK International)

[3] The figures for expenditures and length of stay are not always consistent between Eurostat and UNWTO — sometimes not even internally. This discrepancy is partly due to incomplete figures and partly because the country based data sometimes differ per source.

for covering health tourism, although we acknowledge that these were only the best-available — rather than optimal — methods for generating data on the health tourism market.

The number of nights was determined by applying average per country length-of-stays in domestic and international tourism.

Health-tourism supply is shown in terms of health-related facilities offered by EU accommodations. These figures are based on an extensive accommodation database developed independently from the EHTDB by NHTV (Centre for Sustainability, Tourism and Transport (CSTT)) in collaboration with bookdifferent.com (a non-profit foundation). Because bookdifferent.com is an affiliate of booking.com, the database holds information on the number of rooms and facilities offered on the booking site booking.com, and it lists 435,800 accommodations. Each accommodation can offer all or a portion of the 136 different facilities listed. The health-related facilities, like saunas, several kinds of pools, back massage, emergency cords in bathrooms and wellness and spa packages are listed in Annex III. The database allows us to show the extent to which accommodations offer health-related facilities (please see Map 3 in Subsection 2.3.2), as well as a weighted, visual representation of health-tourism accommodations per country.

The 'weighted facilities' were calculated by multiplying the number of health-related facilities with the number of rooms and then averaging that number for all of the accommodations for each country. This number provides a proxy for the overall supply of health-related facilities that accommodations offer tourists. For instance, a fifteen-room accommodation offering ten facilities receives a score of '150', equal to a five-room accommodation with thirty facilities.

The health-tourism revenues have been calculated using mean spending figures from IPK International (2016) for all trips and health-oriented/wellness/spa trips and the trip estimates provided in Subsection 2.3.1.

Finally, we conducted eight semi-structured telephone interviews with experts in the fields of **medical, wellness, and spa tourism**. In this report, we refer to anonymous statements provided by these experts, as indicated by the coding E1 through E8. Depending on the individuals' field of expertise, the semi-structured questionnaire was adapted for the **medical, wellness, or spa tourism** markets. The generic, semi-structured questionnaire and an overview of all the interviewees has been included Annex II.

2.2 Market size of health tourism

According to our calculations in the EHTDB, in 2014, the total size of the health-tourism market in the EU28 was 56.0 million domestic arrivals and 5.1 million international arrivals (from all over the world), totalling 61.1 million health-tourism arrivals within the EU28. The precise share of health tourism arrivals from outside the EU28 is not known, nor is it regularly published for general tourism. But this share is not likely to be large considering the overall share of arrivals from outside the EU25 (plus Norway, Switzerland, Bulgaria and Romania) only amounted to 6% of all arrivals in 2000 (P. M. Peeters, van Egmond, & Visser, 2004). There is no evidence that this (6%) figure would necessarily differ for health tourism, which we assume will behave according to the same general economic, travel time, travel cost and attraction rules as general tourism does. The total health-tourism market (international plus domestic trips) comprises 4.3% of all EU28 arrivals, 5.8% of domestic arrivals and 1.1% of international arrivals, please see Table 2 below.

Table 2: Volume and share of health tourism arrivals in the EU28, 2014

	All trips	Domestic	International
Total trips (million)	1,361	900	461
Health tourism trips (million)	61.1	56.0	5.1
Health tourism share of total trips (%)	4.3	5.8	1.1

Source: UNWTO (2016b) and our own calculations.

By comparison, this trip estimate is much lower than the combined wellness and spa figures for Europe in frequently cited industry reports. For example, the Global Wellness Institute (GWI) cites the figure of 250 million trips, but this presumes an 89% share of 'secondary purpose' trips and includes non-EU countries such as Russia, Switzerland and Turkey (these countries represent a 13% share of the total according to GWI). If we calculate European 'primary purpose' wellness trips by drawing upon the 11% share cited by the GWI (2017), we arrive at approximately 27.5 million wellness and spa trips, which is lower than our estimate. It is worth mentioning that GWI figures do not include medical-tourism trips. For this study, the domestic share of arrivals of EU health-tourism trips is 92%, deviating from the 83% share for primary plus secondary global wellness trips in GWI (2017)[4].

In terms of night stays, health tourism in the EU comprises 233.7 million guest nights for domestic trips and 16.7 million international trips, totalling at 250.4 million. The average domestic length-of-stay is 4.1 nights per trip, while for international travel this is 8.5.

As already discussed, distinguishing the size of each of the three markets in health tourism (i.e. **medical, wellness, and spa tourism**) in the EU is difficult due to the limited and fragmented data available and the wide (and often overlapping) scope of the definitions used by different sources and statistical bureaus. For example, an Austrian study based its estimate of the market size of health tourism on the number of businesses/facilities per market segment, but it treated invasive **medical tourism** as a separate market. According to this study, in 2014, **wellness tourism** (including so-called Alpine Wellness) dominated in Austria, with 76% of all health tourism, followed by 13% of **spa tourism**, 9% of medical wellness and 2% of minimally invasive/aesthetic **medical tourism** (Donau-Universität Krems, 2014).

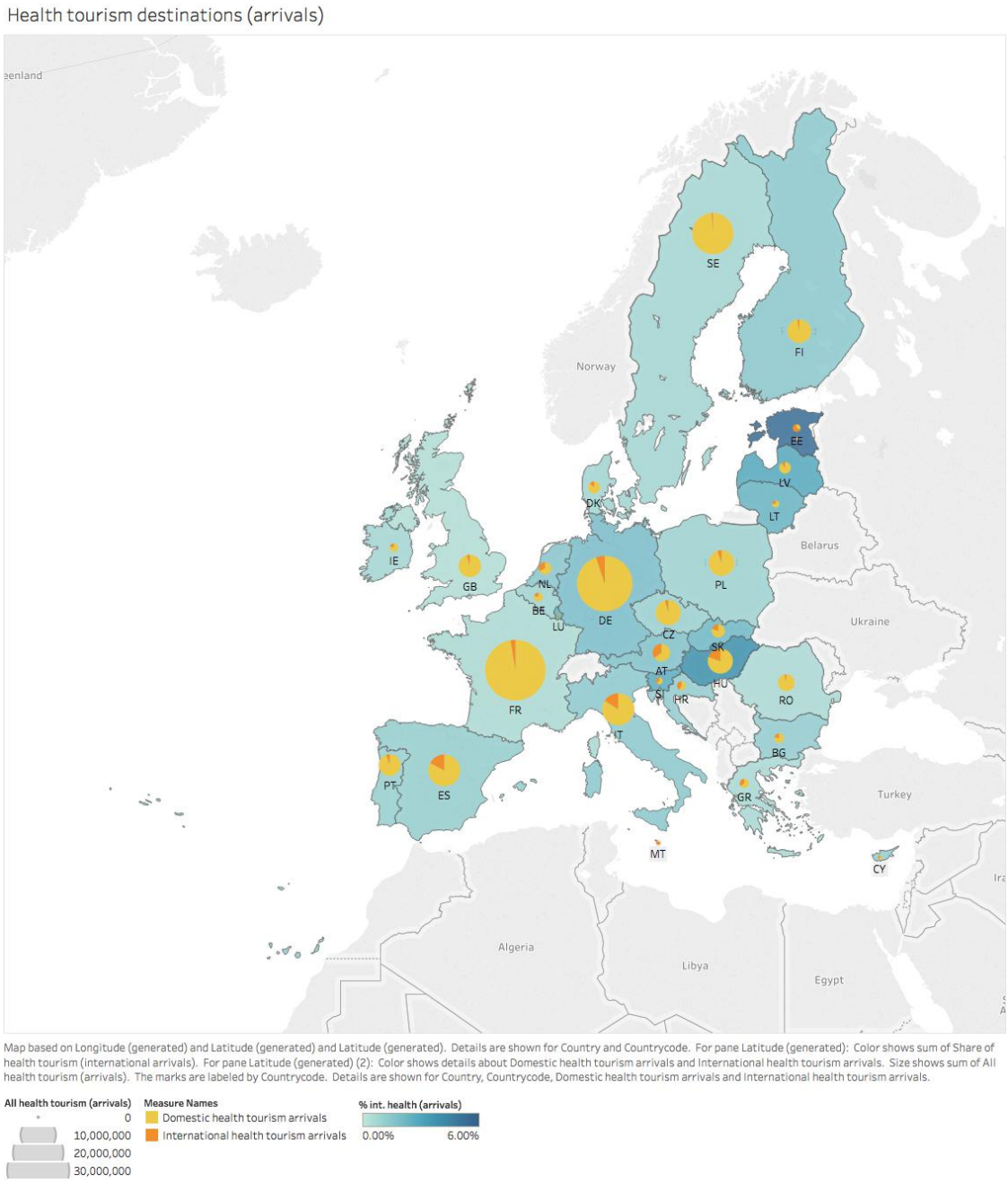
The term 'medical wellness' is an example of the varying definitions used in the market, but for the purposes of this study we consider any form of tourism with a medical purpose or element to be **medical tourism** and not **wellness tourism**. A similar facility-based sample analysis for Germany estimated **wellness tourism** at 63% of health tourism, medical wellness at 15%, **spa tourism** at only 4%, pure **medical tourism** at 1% and other health-oriented tourism at 17% (Betsch, Klink, & Schur, 2014). In most EU28 countries, shares of **medical tourism** will be relatively low, though the figures (and definitions) vary widely between countries. For example, Germany recorded an estimated 255,000 foreign medical tourists in 2015 (Juszczak, 2017), whereas Austria's size of this market is estimated at some 10,000 foreign medical tourists (Baierl & Hoepke, 2016).

[4] GWI wellness-tourism estimates are based on general international and domestic travel and tourism industry data obtained from Euromonitor International (GWI, 2017).

2.3 Health tourism from a destination perspective

Below, Map 1 shows EU28 health tourism from the destination perspective, that is, all domestic and international health-tourism arrivals. The share of international health-tourism arrivals (as a percentage of all arrivals per country, indicated by blue shading) varies from 0.3% (UK) to almost 5.3% (Estonia). The small pie charts indicate the ratios of domestic and international arrivals per country and clearly show that countries such as Sweden, Finland and France have very small international health tourism shares (1-3%), while Austria receives a 35% share of international health tourists and for small countries like Luxembourg and Malta, this share is even approximately 80%. The size of the pie chart in Map 1 represents the total number of health-tourism trips (domestic plus international) per country, revealing that France, Germany and Sweden are important health-tourism destinations as they receive 56% of all domestic and international health-tourism arrivals. Please see the ETHDB in Annex IV for the percentages of all countries.

Map 1: Health-tourism arrivals in the EU28 in 2014

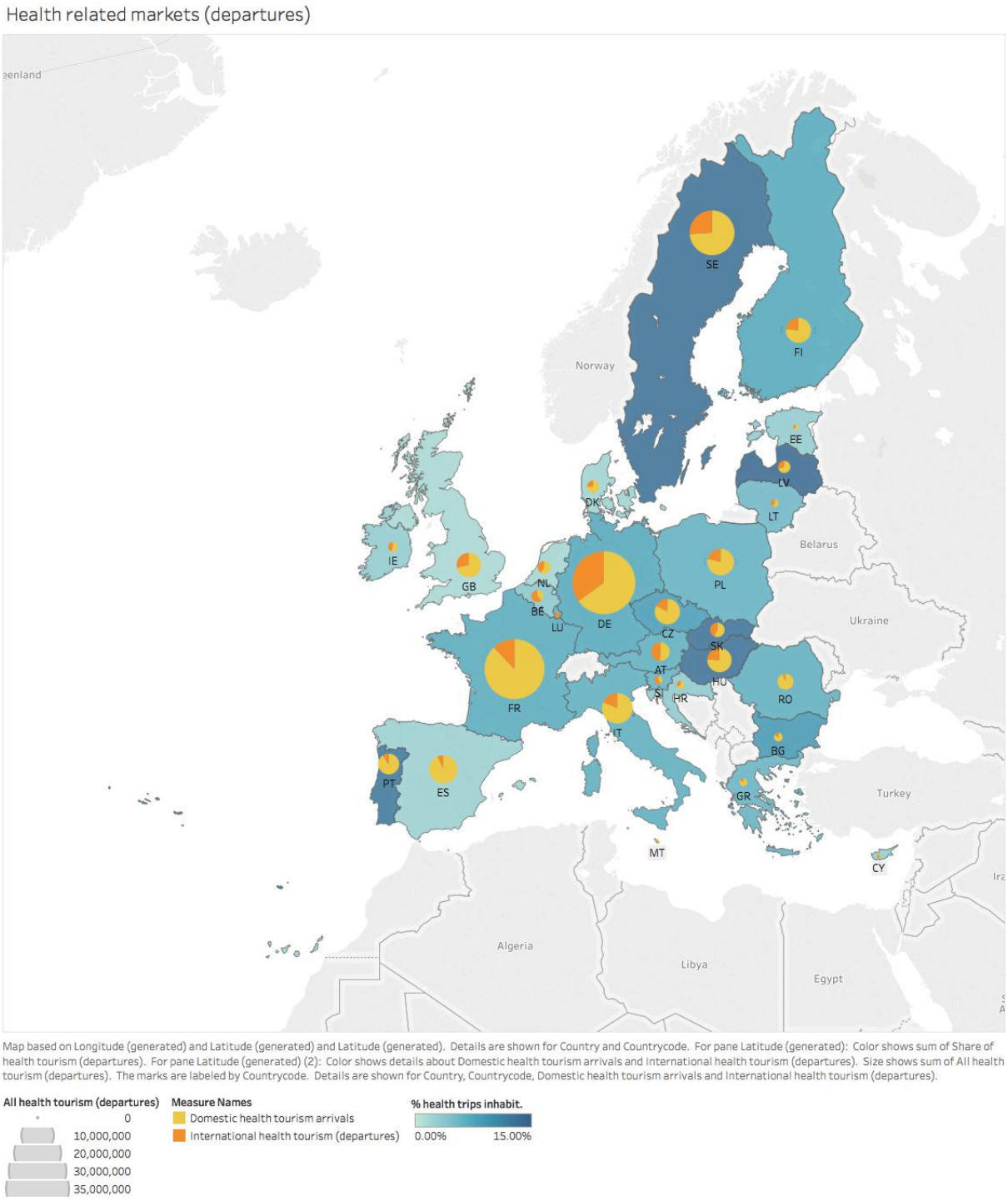


Source: Author's own elaboration.

2.3.1 Health-tourism markets

Map 2 below shows health tourism from a country-of-origin perspective (i.e. departures). The share of total health-tourism trips (domestic plus international) taken by residents (as a percentage of all departures per country, indicated by blue shading) varies from approximately 1.3% (UK) to 14.3% (Latvia). The small pie charts indicate the ratio of domestic and international health departures taken by residents per country. International departure shares range from below 12% in Romania, Spain, Portugal and France, to above 60% in Belgium and Malta, and 95% in Luxembourg. The size of the pie charts represents the total number of health-related departures (domestic plus international) taken by residents of each country. Again, like with arrivals, Germany, France and Sweden are the main players, accounting for 58% of the health-tourism market in number of departures. Please see the ETHDB in Annex IV for more country specific figures.

Map 2: Health-tourism departures in the EU28 in 2014

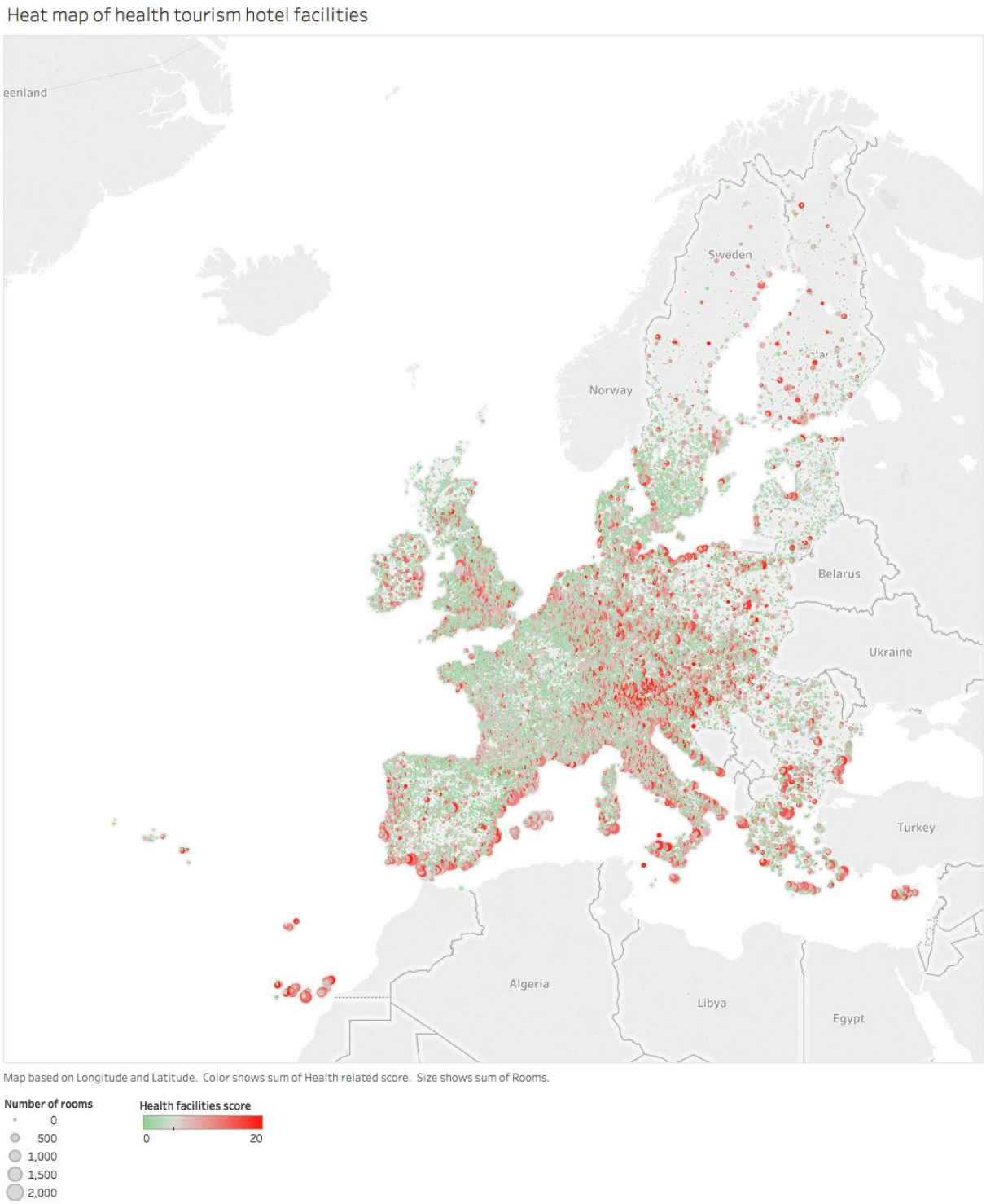


Source: Author's own elaboration.

2.3.2 Health-tourism supply

The distribution of facilities offering health tourism in Europe (EU28 plus Switzerland) is depicted in Map 3 as a heat map. This shows the extent to which accommodations offer health-related facilities. Each dot on the map represents a single accommodation. Green dots offer less than five health-tourism facilities, while dark red dots offer twenty or more. The size of the dots represents the number of rooms. Concentrations are particularly visible around many larger cities, the whole of Central Europe, Italy and Mediterranean and some Baltic coastal areas.

Map 3: Characteristics of the supply of health-tourism facilities at EU28 accommodations in 2016

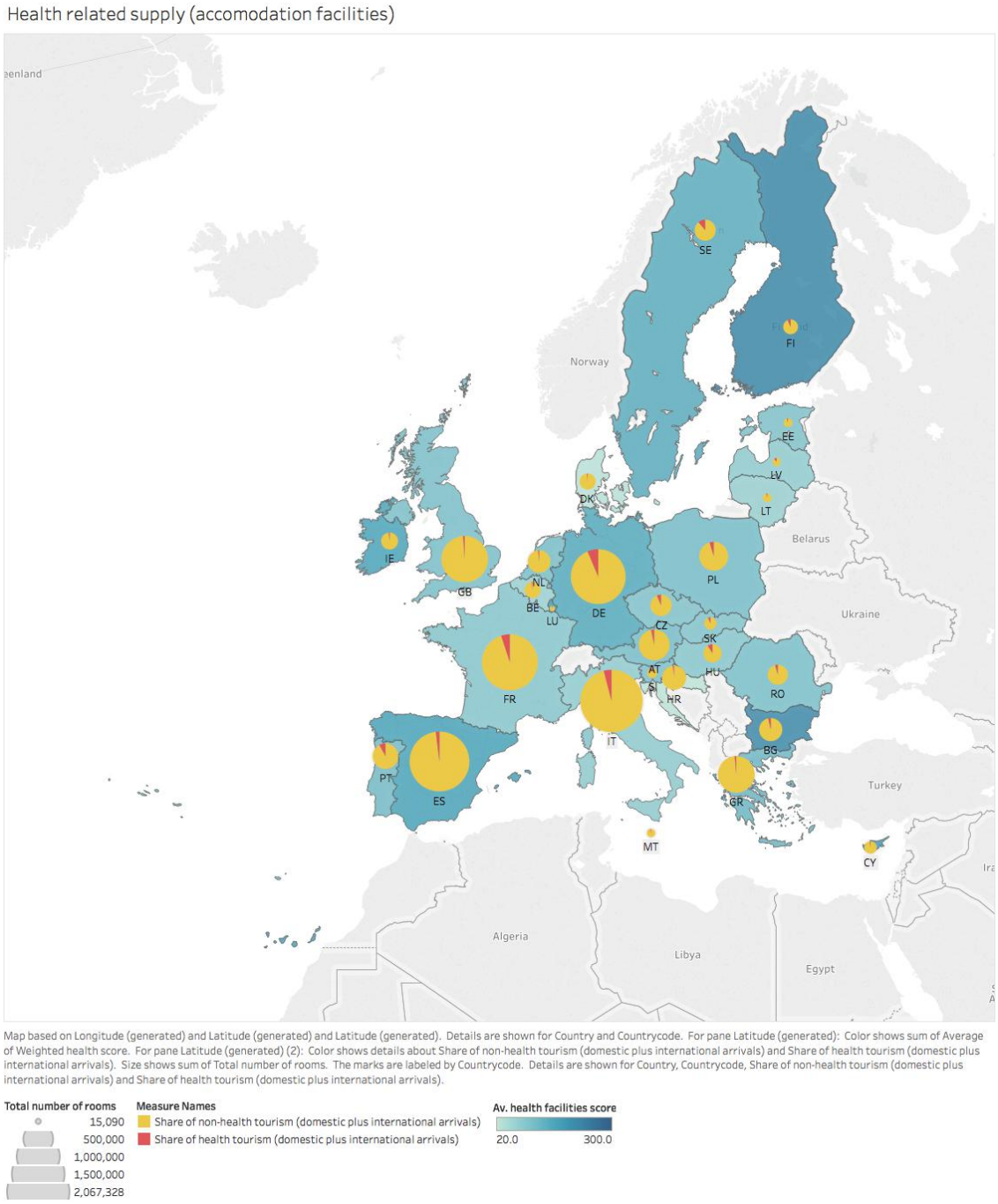


Source: Author's own elaboration.
Note: Green dots represent accommodations with a low number of health-tourism facilities (less than five) and red dots with high numbers (twenty or higher). The size of the dots is representative of the number of rooms. All 450,000 accommodations analysed have been included.

Below, Map 4 gives a weighted, visual representation of health-tourism accommodations per country. The average score for health tourism facilities per accommodation is indicated by the blue shading. Finland and Bulgaria score particularly high in this respect, indicating that accommodations in these countries offer a relatively high level of facilities to health tourists.

The small pie charts indicate the ratio of health to non-health domestic and international arrivals per country, indicating how international the market is that attracts this supply. The size of the pie charts represents the total number of rooms on offer per country (based on booking.com data). Clearly, Italy, Spain, France, Germany and the UK have the largest supply of accommodation of health-related facilities. In all cases, the share of health tourism arrivals is small, which is as to be expected, but the higher shares of health-tourism as indicated by the pie charts do not always relate to high shares of health-related facilities indicated by the blue shading. Most notable is France, with a relatively high share of health tourism arrivals and a low share of facilities and Spain where the reverse is shown on the map.

Map 4: Health tourism supply of accommodation health-related facilities in the EU28 in 2016

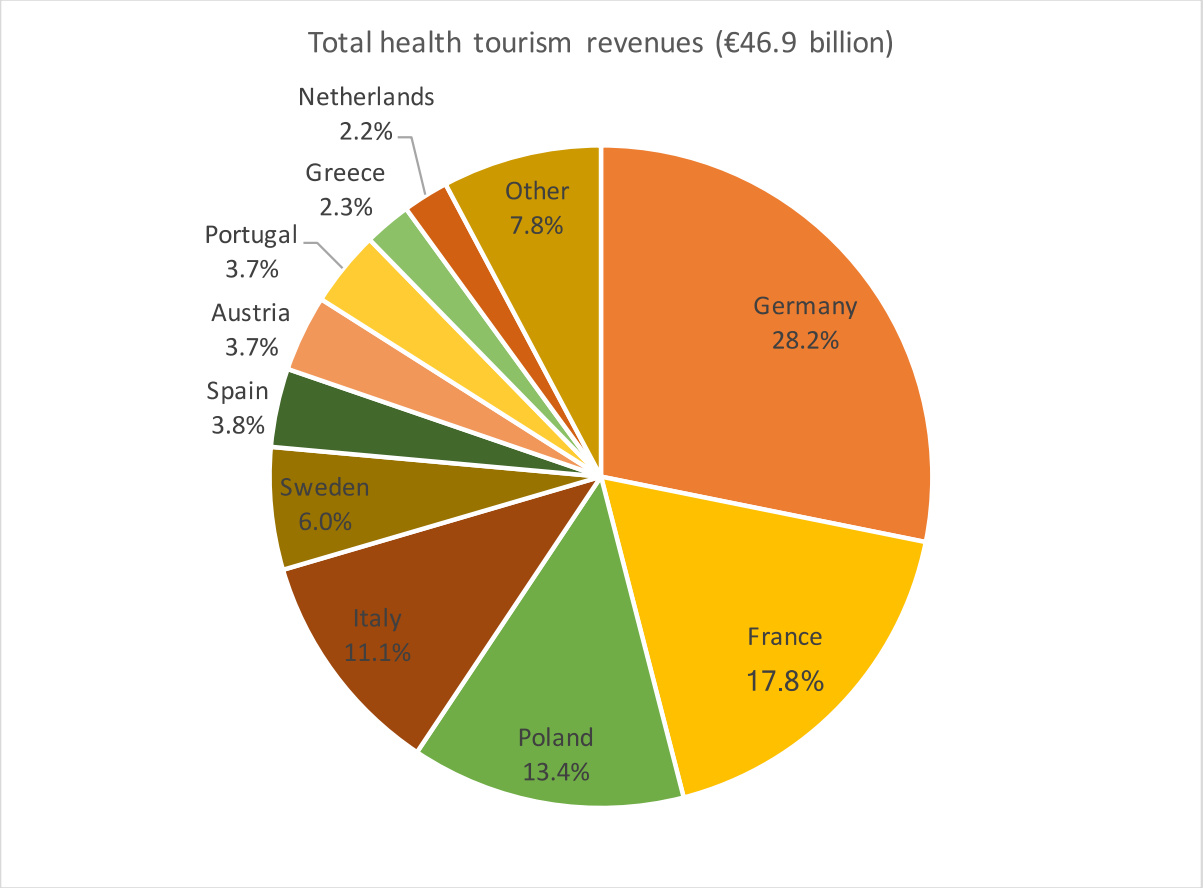


Source: Author's own elaboration.

2.3.3 Revenues

The revenues from health tourism total €46.9 billion in the EU28, which represents 4.6% of all tourism revenues and 0.33% of the EU28 GDP. Figure 3 below shows the division of all EU health-tourism revenues across the member states. More than three quarters of the EU health-tourism revenues are contributed by just five countries: Germany, France, Poland, Italy and Sweden. By comparison, GWI (2017) estimates wellness-tourism expenditures in Europe in 2015 at $193 billion (USD), equivalent to €181 billion[5]. Around €31 billion ($33 billion) is for **wellness tourism** as a primary trip motive, representing only 17%, while the remaining 83% is for wellness expenditures for tourist trips with other purposes (including business).

Figure 3: Shares of health-tourism revenues (domestic plus international)

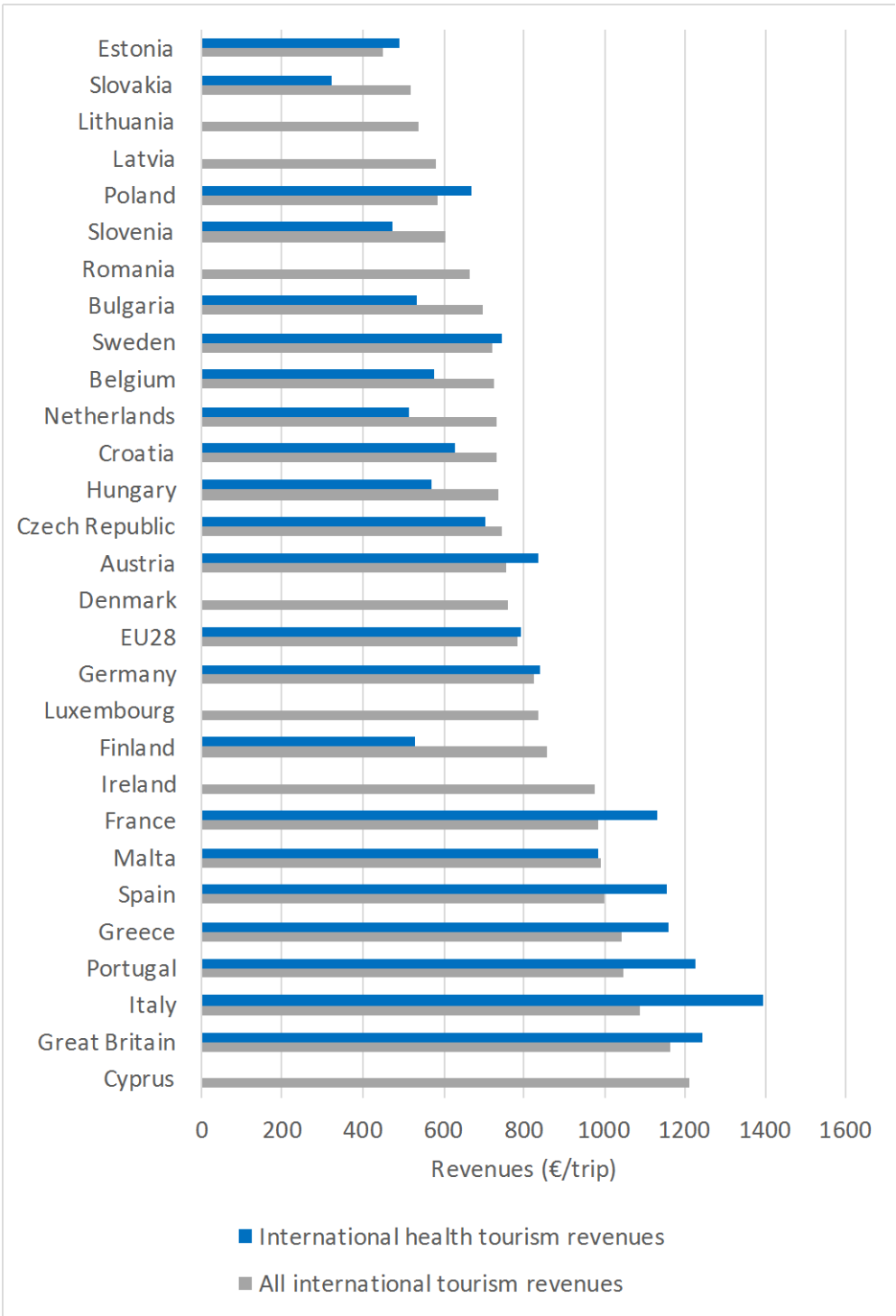


Source: Author's own elaboration.
Note: Please see Annex IV for all revenue data.

We have also looked at the expenditure per trip for health tourism. Below Figure 4 shows that, on average, the difference between health-tourism and general tourism for all EU28 countries is very small (€791/trip for international health tourism arrivals compared to €783/trip for general EU28 tourism). However, the revenue rates vary between countries, from Finland with 39% lower revenues per trip compared to all international arrivals to Italy, where the health-tourism revenues per trip are 28% higher than the average for health-tourism.

[5] Conversion rate of 15 January 2017 used to match January 2017 publication of GWI (2017).

Figure 4: Overview of revenues per trip for overall international tourism and international health tourism.



Source: Author's own elaboration.
Note: To calculate the missing values for health-tourism revenues, we assumed health-tourism revenues to be the same as the average revenues for general international trips. The IPK International (2016) database contains no data on health tourism revenues for Lithuania, Latvia, Romania, Denmark, Luxembourg, Ireland and Cyprus, with the explanation 'No indication of spending due to insufficient trip volume'.

2.3.4 Growth in health tourism

It is very hard to depict changes in the demand for health tourism on an EU member state basis due to the limited reliable data available and the varying usage of the definitions. Hence, we also asked our interview respondents about their perspectives on the growth of their personal field, that is, as stakeholders. Expert E4's comment was striking, urging the need for future measurement of health tourism in the EU: 'Health tourism in general? Growing or shrinking, it has not been defined so everyone can say what they want, there are no data in a comparable fashion, therefore we don't really know. General tourism is growing, it differs for country and regions, but it certainly is going up'. Accordingly, Eurobarometer results only allow a short comparison between 2013 and 2015 – an insufficient time-span. Earlier versions of Eurobarometer surveys on the attitudes of Europeans towards tourism are incomparable due to different phrasing of the relevant question. Market reports like GWI (2017) have portrayed health tourism as a booming segment for a long time, displaying faster growth than regular tourism.

The demand for **medical tourism** services in particular appears volatile, depending on economic and other external factors, as well as changing consumer preferences (Lunt et al., 2011). In Germany, for example, a 4.4% increase in foreign medical tourists in 2014 was followed by a year of stagnation (1.4% in 2015). Volatility here was clearly caused by rapid growth and decline, or vice versa, of the Russian and Arabic markets, as a result of (un)favourable national economic situations (Juszczak, 2017). Analysing the 'Health-Related Travel' series in the International Monetary Fund's Balance of Payments Statistics database (BOPS) for the period 2003-2009, Loh (2014) concluded that worldwide engagement in international health-related travel was static. He based this conclusion on the fact that the growth in the total import of health tourism did not outpace population growth. However Expert E1, also referring to the unclear **medical tourism** numbers, does signal growth, stating: 'Overall **medical tourism** is growing, but no one has an idea how much, not at an exponential level. **Medical tourism** is not one marketplace, there are a lot of market niches'. This is confirmed by Connell (2013, p. 5), who indicates that 'the numbers stated by some countries and hospitals are substantial exaggerations, but inflated figures imply growth and success and encourage private sector investment and national support'. As we have already remarked in Subsection 2.1.2, some organisations are accused of 'industry boosterism' (Horsfall and Lunt (2015). Expert E5 says, '**Medical tourism** is mainly found in France, Italy and Spain'.

At the heart of the growth of **medical tourism** 'lies commercialisation and in some part this is premised on the availability of web-based resources to furnish the consumer with information, imagery and market destinations and to connect consumers with an array of health-care providers and brokers' (Lunt et al., 2015, p. 8). This point of view is supported by Expert E1, who observes that '**medical tourism** is cost-driven, and the future pressure on national healthcare systems could steer people to private clinics' and thus 'the success of destinations is based on the entrepreneurial capacities of the businesses, there were no city or regional governments that attracted medical tourists'.

Expert E6, using the term of **wellness tourism** as encompassing **spa tourism**, indicates that this sector is growing globally: 'Does **wellness and spa tourism** grow globally? It is clear that it is growing. You say **wellness and spa tourism**, but we just say **wellness tourism**, so if someone goes to India for a yoga retreat, that is not **spa tourism** but still **wellness tourism**'. This reflects market reports like those of GWI. For 2015-2020, GWI (2017) forecasts various parts of the global wellness market to grow at an annual rate of between 5% to 7.5%, which is faster than global GDP projections. The forecast by the United Nations World Tourism Organisation (UNWTO) for annual international tourism growth

between 2010 and 2030 is 3.3% on average (UNWTO, 2011). But when comparing the wellness trip figures available for seven EU countries from 2012 (GWI, 2015) to 2015 (GWI, 2017), annual growth rates vary between -6% (Italy) and +23% (Sweden). This kind of short-term fluctuation seems inexplicable. Eurobarometer results that identify 'Wellness/Spa/Health treatment' as the main reason for going on holiday in 2013, 2014 and 2015 show far less variation per country. It is probably safest to look at the EU28 average for this question, which remained stable at 6% in both 2013 and 2015 (European Commission, 2014c, 2016). This kind of stabilisation (or stagnation) was confirmed for Germany. Lohmann and Schmücker (2015) show that there is no overall growth in demand for health tourism. Looking at a ten-year period (2004-2014), however, they do demonstrate a change of focus in the demand: moving from **medical and spa tourism** towards more **wellness tourism**, whereby a decline in the first two is, more or less, compensated by growth in the latter.

In the case of **wellness tourism**, the role of government is emphasised by Expert E6. Expert E6 stresses the long history and high status of Europe, as it 'is acknowledged as a pioneer, one of the cradles of **wellness tourism**, with all the bathing facilities and all the mineral springs'. However, 'in earlier days, governments were paying for these services. That changed when the US opened spas and starting charging people for these services and made it a successful business model that was the genesis of the industry. Europe is still catching up to make this business case work fully, causing the role of governments to be still a large factor in the European wellness industry, that may hamper growth to some extent'.

Regarding European **spa tourism**, Expert E2 indicates mild growth for the sector, stating: 'We can say that **spa tourism** is growing at all destinations, but at a linear rate, not exponential'. However, research from the Global Wellness Institute (GWI) shows that Germany, France, the UK, Italy and Spain are in the top 10 of spa destinations (GWI, 2017). Expert E2 mentions that with regards to **spa tourism**: 'Two countries have lost market share. Switzerland because of the price of their spas: the Swiss national health insurance made contracts with Slovenia and Slovakia because the price for spas in Switzerland was extortionate. The other country is Austria: the spa philosophy was changed from medical to wellness oriented, through a lot of promotion of wellness therapies'. But Expert E4 states clearly that there are 'no data on that: we don't have any form of harmonised data collection' and we were not able to find any additional data for both countries.

For **spa tourism**, several other growth factors are presented (Expert E2). Firstly, the demographic change resulting in a growing number of the elderly increases the interest in **spa tourism**. Secondly, the change of lifestyle in the EU population that boosts interest in spas and thirdly, people's greater awareness about health. Several projects support this development, like the 'OFF TO SPAS' project[6] where spa packages are tailored to meet the needs of senior tourists and tourism is promoted as a method for active and healthy ageing.

2.3.5 Global comparisons

The shares of health tourism in the rest of the world are not systematically known. For the wellness and spa markets, the GWI (2017) estimates the share of primary and secondary purpose trips to be around 7% of all global domestic and international tourism trips, whereby domestic wellness trips outpace international ones (83% and 17%, respectively). Primary wellness/spa trips would amount to 0.8% of all global trips. According to the GWI (2015), the European share of all domestic and international wellness and spa trips is 39%. In terms of total international arrivals, the EU28 market covers about 59% of the global market. Also,

[6] Official website: http://offtospas.eu/project (University of Pannonia, 2016).

the EU share of health-related international tourism is, at 1.6%, significantly higher than for the rest of the world, at 0.9%. However, in Section 2.2, we demonstrated that the GWI estimates are higher than those presented in this study.

Assuming that the overall continental figures cited in market reports are somewhat truthful, Europe appears to be losing ground compared to other continents. The growth of wellness trips and revenues per continent between 2012 and 2015 is stated at 22% and 23% for Europe (including non-EU countries like Russia and Turkey), and all other continents displaying higher or much higher growth (GWI, 2015, 2017). In contrast, North America is seeing slower growth. In total trips, Europe is still the world leader, but Asia-Pacific has overtaken North America as second, and - with high projected growth - is closing in on Europe. It should be noted though, that health tourism in the EU is not declining but rather stabilising, as shown in the previous Subsection. In view of the overall size of health tourism, changes in its size and flows have relatively little effect on EU economies overall.

2.4 Impact of health tourism

2.4.1 Introduction

Whereas the previous Section discussed health tourism mainly in quantitative terms, this Section discusses several structural aspects of health tourism. These aspects include seasonality, labour, mobility and the environment. For our discussion, we examine the results of the expert interviews and the literature review. In each Subsection, we will discuss the three markets of health tourism — **medical, wellness, and spa tourism** — to the extent that the information could be found. Voigt, Brown, and Howat (2011, p. 16) observe that: '**Wellness tourism** remains an area with few empirical studies from which to glean in-depth information about who these tourists are or exactly what they are looking for, and what it is worth to them'. This is true for **medical and spa tourism** as well.

2.4.2 Seasonality

In general tourism, seasonality is acknowledged as one of the 'burdens' hampering the economic competitiveness of tourism (European Commission, 2015f). The question is whether health tourism is suffering from seasonality to the same extent or whether it could be part of the solution to this problem. For the Costa del Sol region (southern Spain), Padilla-Meléndez and Del-Águila-Obra (2016) asserted the latter to be true. Hjalager et al. (2011) demonstrated that **wellness tourism** can reduce the sharp seasonality exhibited at Scandinavian destinations. The same was found by Weiermair and Steinhauser (2003) for Alpine Wellness. For **medical tourism** to the Hungarian medical centre of Sárvár, however, the nearly equal distribution of trips in 2000 gradually changed to a very distinct summer peak in 2010 (Jónás-Berki, Csapó, Pálfi, & Aubert, 2015). Still, for the remainder of the year, the flat distribution of medical arrivals remained steady in the Hungarian case. For lake **wellness tourism**, a lake destination offers opportunities for health tourism in summer and in winter (Tuohino, 2013), thus somewhat spreading out seasonality.

Expert E1 found that seasonality depends on the kind of **medical tourism**. For instance, there is low seasonality with regard to IVF (in-vitro fertilisation) tourism, but higher seasonality for dental and cosmetic treatments. Expert E6 sees a positive role for **wellness tourism** to overcome seasonality. For example, according to Expert E6: 'People are more oriented to **wellness tourism** in January than in December'. The GWI (2017, p. 48) also sees a role for **wellness tourism** to reduce seasonality because it 'will provide a wider range of wellness and complementary tourism offerings in order to attract more leisure/wellness-oriented visitors', and 'extend the tourism season'. However, Expert E2 indicates that **spa**

tourism is definitely seasonal with the main season in 'the Baltic and North Sea from June till end of September, and in the south of Europe to the end of October'. With regards to senior tourism (an increasing market for health tourism), seasonality still plays a role, but, according to Expert E8 'the seasons change'. It appears that elderly people increasingly choose to travel in spring and autumn and less in summer, as also found by Gheno et al. (2016).

2.4.3 Labour

Just as in general tourism, health tourism is a labour-intensive form of tourism requiring a wide range of skills across tourism, hospitality, health, healing, fitness, sport and spirituality (Dvorak, Saari, & Tuominen, 2014). Labour also can be rather costly, certainly in the case of Nordic countries (Hjalager et al., 2011). Szromek et al. (2016) emphasised the role of spas in the development of local labour. Also for **spa tourism**, Expert E2 noted: 'Some spas are large employers, like a town with 7,500 inhabitants, of which 450 work at the spa facility'. According to Expert E2, other sectors also benefit indirectly from spa guests: **spa tourism** in Germany for example may provide some 350,000 working places, most of them indirect. A consequence of the labour intensity and relatively high level of skills required could be that the wellness sector struggles to find enough employees, warned Expert E6.

Expert E4 added that **medical tourism** not only provides work for thousands of plastic surgeons and dentists, but also many working in the associated wellness hotels. Interestingly, most medical-tourism clinics are also serving local patients and exploit **medical tourism** as an addition to their 'market'. This means, according to Expert E4, that their employees work generally in the public part of the institute during the week, but more in the private part during weekends.

Another relationship between health tourism and labour is the growing demand from labour organisations for wellness facilities. Therefore, the increase of the cost of employees' sickness absence has become a source of demand for the 'wellness industry'. According to GWI (2017, P.34), 'employers are spending more on employee wellness as a means to lower health-care costs, improve morale and recruitment, raise productivity and stay competitive in the market'. In 2015 across Europe, roughly 96 million workers were covered by workplace wellness programmes and services associated to roughly €15 million in revenues. It is unknown what share covered tourist activities.

In Subsection 2.3.3, we saw that health-tourism revenues per trip for the whole EU28 are only slightly higher than for all tourist trips. Therefore, it seems there is not much room to conclude that health tourism is much more labour intensive or that it provides much higher wages than general tourism.

2.4.4 Mobility

Connell (2013, p. 11) found that 'surprisingly little is known about cross-border mobility, even in Europe, despite its considerable and regulated significance'. This regards health tourism, but it might as well be a statement about all tourism (Lumsdon & Page, 2004). A couple of issues may be of importance with respect to health tourism and mobility. One is whether access to the destinations, for health tourism purposes, differs from access in overall tourism. Bristow and Yang (2015) analysed **medical tourism** (including **spa tourism**) for US tourists visiting Costa Rica. They found that the main reasons to travel for medical or spa treatments were cost, reputation of the medical doctor/facilities, and post-treatment opportunities at the destination, rather than the unavailability of the specific treatment at home. Connell (2013) noted that in **medical tourism** there is also a diasporic component in

the travel motivation, referring to people not living in their original homeland, as they take the opportunity to be with family during treatment.

From Expert E7 we learn that crossing the borders between different sectors could be a plus for the sector of health tourism: 'In healthcare one must learn about hospitality, in hospitality one must learn to care. Every country searches good business models, you are situating yourself between regular hotels and hospitals'. For Europe, Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (European Union, 2011) regulates patients' rights for reimbursement in cross-border healthcare and has an important impact on the mobility of medical tourists. In 2015, the European Commission (2015a) reported that over 39,000 reimbursements were paid under Directive 2011/24/EU: the majority for Denmark. Also, it showed that only a minority of European citizens are aware of the possibility (some 10%) and that procedures are not clear in most member states (if implemented at all). Furthermore, the non-regulated reimbursements run into the hundreds of thousands though there is much uncertainty about what part involves medical tourists (European Commission, 2015a). This means that a large potential for growth of mobility in **medical tourism** exists. On the other hand, Kurtulmuşoğlu and Esiyok (2016) found that older people with chronic diseases may prefer destinations rather close to their residence, which may help reduce the average distance travelled for health tourism. Furthermore, it may also help health tourism to avoid environmental damage, the subject of the next subsection.

2.4.5 The environment

The relationship between health tourism and the environment is two-way: most health tourism depends very much on a clean environment, but at the same time it also has an impact on the environment due to the mobility involved and the facilities in often vulnerable landscapes and ecosystems. Specifically, **wellness and spa tourism** depends largely on high quality environment including clean water, clean air and an attractive ecosystem. Expert E2 stated that 'spas need to be in a green environment'. This is supported by Expert E6, who said: 'In the wellness arena, wellness is seen by people as a term that includes the environment, you cannot be well if your environment is polluted, it is definitely a part of wellness, but with **medical tourism** there is no correlation, you can go to a hospital for surgery in a polluted environment'. Hjalager et al. (2011, p. 36) mentioned a role for nature in Nordic health ('well-being') tourism: 'Responsibility for nature is another key term in the Nordic […] values. However, it might be only modestly clear to well-being tourists how the sustainability policy is consistently organised and how it affects the products and services in the destinations'.

A clean environment is an important reason to travel to health and well-being destinations and features as a unique selling proposition that is mentioned as the second most important factor for choosing a destination, with diverse beauty and pampering treatments being the first (Dvorak et al., 2014). This means that all those involved in health tourism should take responsibility for sustainable development of the environment (Dvorak et al., 2014). But at the same time, environmental quality is also under pressure by industry, agriculture, transport, as well as by health and other tourist flows due to air pollution from traffic, even though (Benhacine et al., 2008) believed that health tourism is environmentally sustainable.

To conclude, environmental quality plays a larger role in the success of health tourism than in general tourism (with perhaps **medical tourism** being the exception). This could provide an incentive for the health-tourism sector to develop more sustainably than general tourism does overall. The main environmental problems for tourism are caused by a strongly increasing dependence on (long haul) flights (P. Peeters et al., 2015). The large share of

domestic health tourism, as shown in Subsection 2.3.1 and by Kurtulmuşoğlu and Esiyok (2016), certainly helps to keep the environmental footprint of health tourism relatively low.

2.5 Conclusions

In this Chapter, we explored health tourism's size, growth, economic share and impact on certain aspects like seasonality, labour, mobility and the environment. One major conclusion is that health tourism lacks reliable figures and credible data sources. Issues with definitions, but also commercial interests and regular quantitative research being commercial, contribute to the wide range in the figures we found.

In 2014, the total size of health tourism in the EU28 was estimated to be 56.0 million domestic trips and 5.1 million international (from all over the world), totalling 61.1 million health tourism arrivals in the EU28 – this is health tourism with wellness/spa/health as a 'main purpose' of the trip. The share of domestic plus international health tourism of all EU28 arrivals was 4.3%. In international trips, the share was much lower (1.1%), than in domestic trips (5.8%). Domestic tourism dominated the market with a share of 92%, while general EU tourism had a domestic share of 63%.

There was not a great deal of information about the shares of the three submarkets (**medical, wellness, and spa tourism**), but it seems clear that **wellness tourism** dominates EU health tourism with two-thirds to three-quarters of the total market. Health tourism revenues total nearly €47 billion in the EU28 for 2014, which represents 4.6% of all tourism revenues and 0.33% of the EU28 GDP in that year. The market share for health tourism in the EU is likely stable, even though market reports indicate further growth. Increasing the share of health tourism may have beneficial effects on the labour market and the environment, and it may help reduce tourism seasonality.

3 CASE STUDIES OF HEALTH TOURISM IN THE EU

KEY FINDINGS

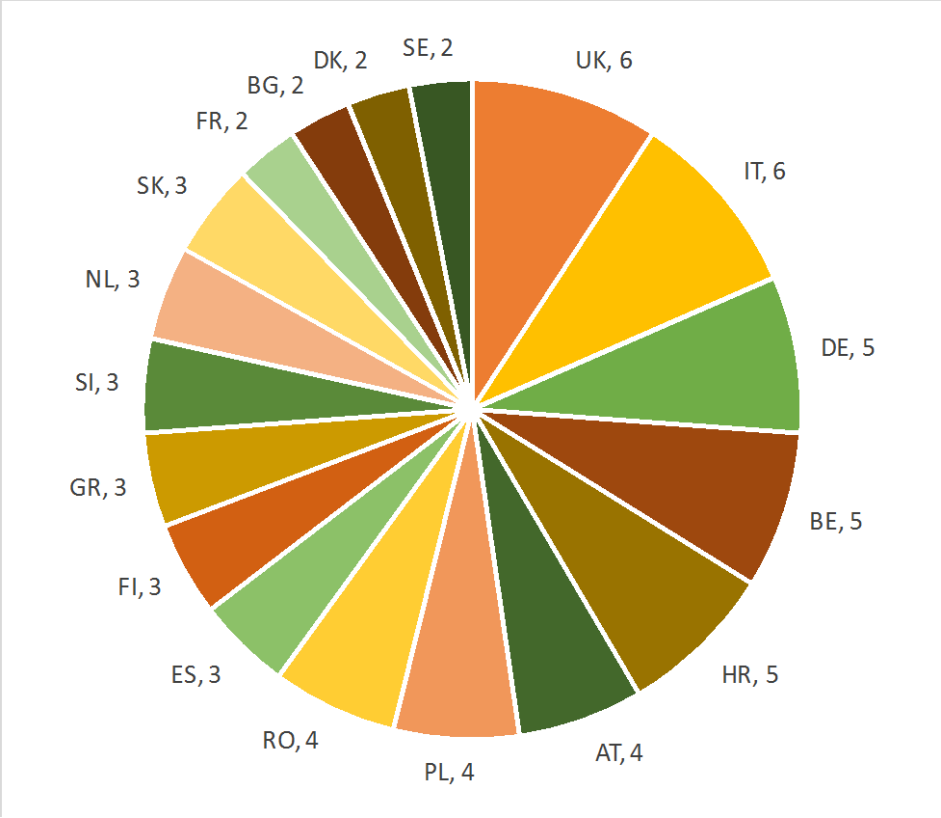
- The UK, Italy, Germany, Belgium and Croatia were the most frequently involved countries in the case studies we identified for health tourism.
- Several case studies revealed issues with the implementation of Directive 2011/24/EU in national healthcare policies.
- Several best practices demonstrate how health tourism can better utilise environmental resources.
- Dedicated policies, cooperation, international approach, communication and promotion are the main factors of success.
- There is a lack of understanding of the needs of customers regarding the boundary between health and wellness and what stakeholders in destinations believe these needs to be.

3.1 Introduction to the case studies

In this section, we present five detailed case studies, which were selected from a total of 28 case studies identified (please see Annex V for details about all 28 case studies). The objective of this overview of case studies is to provide more detail about health tourism in practice[7]. In the 28 case studies identified, 27 of the EU28 countries were involved (only Luxembourg was not covered). Eight case studies were national, involving just one member state, while 20 were international (of which two EU-wide). Five case studies involved **medical tourism** and 23 spa and/or wellness (11 case studies were a study or evaluation, 12 a best practice and five a national or regional policy).

[7] It is certainly not the objective to provide a complete overview of all projects, studies and evaluations of health tourism in the EU. That would be far beyond the scope of this study.

Figure 5: Participation of member states in the 28 case studies listed in Annex V



Source: Author's own elaboration.
Note: Only countries shown with two or more case studies are represented. Participation in one case study was found for PT, HU, EE, LV, LT, CZ, CY, IE, and MT and none for Luxembourg.

Figure 5 shows a count of all occurrences of participation for each country in the international case studies we identified (hence those involving more than one member state). The UK and Italy (IT) have the highest participation with six case studies each. Germany, Belgium and Croatia each participate in four case studies, most countries participated in three of our case studies. Luxembourg did not participate in any of the cases we found.

The case studies cover the period 2005-2020 (2020 is the envisaged final dates of two of the case studies). Most case studies we found began after 2010. Common goals were to assess or evaluate health tourism developments at certain destinations, to create new health tourism products, and to make better use of natural resources like clean water, clean air and thermal springs, to promote tourism and to enhance the local economy. Also, several case studies formulated goals to improve the health of visitors or health of both visitors and locals. Results included management plans, manuals, reports, policy recommendations and insights into the relationships between the three forms of health tourism. Several opportunities to better utilise existing environmental conditions were discovered, such as using the fine waterfall mist to treat asthma patients (as in the case study on 'Hohe Taueren Health' in Austria). In many of the case studies, the cooperation between stakeholders was found to be important for the successful development of a health-tourism destination. This may contrast with calls for a more commercial approach because considerations of competitiveness may hamper cooperation between more profit-focussed destinations and enterprises.

3.2 Case study: Nordic Well-being

Case study summary

Type: study.
Countries: Denmark, Finland, Iceland, Norway and Sweden.
Period: 2008-2010.
Status: completed.
Main goal: to achieve a deeper understanding of the driving forces behind coherent well-being tourism in the Nordic region and find policies that will support a Nordic Well-being brand.
Results/findings: the best practice is to determine unique selling points, develop new sports and leisure activities and forge links to food, medicine, cosmetics, lifestyle diseases and spirituality and enhance the Nordic infrastructure and raise international media awareness.
Sources: Hjalager and Flagestad (2012); Hjalager et al. (2011).

3.2.1 Background and stakeholders

The study was financed by the Nordic Innovation Centre (NICe), whose main purpose is to fund projects and cooperate with governments to stimulate innovation in all economic sectors. The centre is governed by the Nordic Council of Ministers which comprises the participating countries of Denmark, Finland, Island, Norway and Sweden. The Nordic Well-being project tries to develop an innovative Nordic content for well-being tourism and a concept of well-being that could be offered across all Nordic countries (Hjalager et al., 2011).

The stakeholders in the study are researchers from all five participating countries, mainly universities of applied sciences, and partnering with the following regions of the Nordic countries (Hjalager et al., 2011):

- Kainuu and Vuokatti (Finland)
- Jyväskylä (Finland)
- Vaasa (Finland)
- Åre (Sweden)
- Southern Denmark
- Beitostølen (Norway)
- Mývatn (Iceland).

Innovations were tested in the 'laboratory areas'[8] during the period 2008-2010. Within these laboratory areas, several innovations are being developed such as (Hjalager & Flagestad, 2012):

- Core product and service innovations (e.g. the role of water quality in wellness products)
- Product diversification (e.g. introducing a well-being concept for families)
- Technological innovation (e.g. a technology business providing health and well-being monitoring services)
- Institutional innovations (e.g. networking and cooperation between different business sectors)

[8] Regions where new ideas are tested in practice.

3.2.2 Aims and objectives

The project has various aims and objectives, with the overarching aim being to generate processes of collaborative processes into innovative and substantial wellness products (Hjalager et al., 2011). This includes exploring a variety of resources, both material and immaterial, to investigate the driving forces that motivate tourism providers to collaborate in developing well-being products, and to develop a Nordic Well-being image and brand. Finally, the project aimed to communicate the results to stakeholders and policymakers to ensure a wide application of the results (Hjalager et al., 2011).

3.2.3 Insights

A range of insights from the project were gained (Hjalager et al., 2011). Well-being tourism market trends were investigated in a Nordic context to reveal the new well-being customer and opportunities for 'holistic well-being' offers that include all elements of well-being (body, relaxation, health and mind). Unique selling points that make Nordic Well-being destinations outstanding were found to be aesthetics, the value of simplicity and harmony and taking care for the environment. Apart from these common values, each country has its own 'branding accents', like nature for Norway, fun in Denmark and simplicity in Sweden. Successful branding means continuously crafting and reinventing the product through developing niches. Different types of innovations (product, diversification, technological, institutional) can steer Nordic Well-being tourism towards the future in destination development.

Policies appeared to be important. Three categories of publicly initiated interventions were identified:

- A policy of embedding in and coordination with other policies like planning, labour and health policies raised chances for success.
- Promotion of resource based collaboration in local contexts, where entrepreneurial zeal is essential to make things happen.
- New branding and marketing models that use small-scale branding, broadcasted branding, community branding and engaging branding. This involves the use of social media as 'opinion makers' in a way to brand a destination or tourism product based on values and meaning.

3.2.4 Challenges

The Nordic Well-being project generated several other academic publications that reported challenges and limitations regarding longstanding collaboration, coordination and efficiency. Hjalager et al. (2011, p. 4) expected the 'genuine and determined joint venture for marketing Nordic Well-being' to be a 'matter of a long-term strategy and expanding networks of collaboration, and is not likely to come about swiftly'. A complication added to this is that 'in many instances, the resources for a diversification are plentifully available in a region, but a coordinating conceptualisation and marketing are the missing links' Hjalager and Flagestad (2012, p. 731). This is confirmed by Tuohino (2013, p. 278) for the Finnish situation, who observed that, for instance, 'lakes and lake landscapes are not utilised efficiently, and there are so far no clear profiles of well-being in the laboratory areas from a tourism perspective'. Other challenges listed include integrating natural products into the experience, boosting the use of technology, enhancing medically related offers and creating well-being events (Hjalager & Flagestad, 2012).

3.2.5 Conclusion

Hjalager et al. (2011, p. 4) propose eight pillars of specific policies revolving 'around harvesting the benefits of unique selling points, developing new or adapted sports and leisure activities, integrating food producers, creating new markets through developing cosmetics and medicine, addressing lifestyle diseases, emphasising spirituality, enhancing infrastructure and creating international media attention'. Our findings are consistent with the conclusion of (H Konu & Smith, 2016) that such cross-border collaboration projects could lead to enhanced transnational cooperation between several stakeholders, but that also the economy of scale can influence these joint decision-making processes.

3.3 Case study: Alpine health and wellness

Case study summary

***Type*:** study.
Countries: Austria, Italy, Germany and Switzerland.
Period: 2005-2008.
Status: completed.
Main goal: improve competiveness and sustainability of the Alps as a health destination.
Results/findings: factor (human resources, touristic infrastructure) and demand (income, insurance) conditions are the most relevant determinants of competitiveness in health tourism. Health tourism is moving towards more specialised, narrow markets (e.g. medical wellness).
Sources: Bausch, Nungesser, and Hanslbauer (2008); Schalber and Peters (2012).

3.3.1 Background and stakeholders

The resources provided by mountainous areas not only attract many tourists, but they also combine well with health and **wellness tourism**. Approximately 100 million people worldwide spend their holidays in altitudes of 2000 metres or higher. The Alps attract about 40% of these visitors and a quarter of them, 10 million, spend their holidays in Austria (Schalber & Peters, 2012). In the past, there have been various attempts to develop an Alpine Wellness product. The special interest group 'Alpine Wellness International Inc.' was founded in 2003 and forms a cooperation between Austria, Switzerland, Bavaria and South Tyrol (Pechlaner & Fischer, 2006). An example of an integrated approach is the EU Interreg III B project 'ALPSHEALTHCOMP', which aims to improve the competitiveness and sustainability of the Alps as a health destination (Bausch et al., 2008).

3.3.2 Aims and objectives

The Alpine regions, in varying compositions (with higher efforts in German-speaking areas of the Alps), wanted to pinpoint that the natural resources of the region are a condition for wellness development. The Alps allow for a multitude of wellness applications. For instance, a stay in the Alps potentially has direct positive effects on the metabolism, as it reduces body fat, enhances the quality of the red blood cells and improves neuro-psychological values (Schalber & Peters, 2012). The objective of the ALPSHEALTHCOMP project was to secure the competiveness of the Alpine space as a holistic health and wellness destination for the long term, through the creation of a competent network (Bausch et al., 2008). The overall idea is to create a distinct health-tourism product in the Alps, making use of the natural healing and relaxing properties of the alpine landscape, climate and natural resources.

3.3.3 Insights

The study by Schalber and Peters (2012) found that the core strength of health tourism for the Alps is the market of (medical) prevention. Positive factors of competitiveness were natural, human and material resources, willingness to cooperate, supported by economic developments in target markets. Furthermore, health tourism was found to grow because of increased health consciousness, ageing, and new medical technologies. Within health tourism, medical wellness, work-life balance awareness, beauty and aesthetics were important factors. Cooperation with public labour service agencies appeared to be very effective for knowledge development and product improvement. Both factor (human resources, touristic infrastructure) and demand (income, insurance) conditions are relevant determinants of health tourism competitiveness. A lack of high rated accommodations or

qualified employees was found to slow down developments. The ALPSHEALTHCOMP found 454 training courses for health and wellness employees in the whole Alpine region (Bausch et al., 2008). Bausch et al. (2008) showed that tourists took the environmental and natural quality of the region for granted and, more importantly, that the qualities required differed substantially between Alpine countries. For instance, where in Italy traditional and regional treatment was high on the list of attraction factors, this was 'walking in the mountains' in Germany. In terms of quality management, it appeared that cooperation (specifically cross-sectoral) was of paramount importance for successful development of health tourism. Furthermore, remedies like water, air and herbs are important natural factors to exploit as well as better knowledge of and communication with the customer.

3.3.4 Challenges

Schalber and Peters (2012, p.311-312) state that: 'A large proportion of businesses in health tourism destinations are micro or small enterprises, often family owned and managed, characterised by informal business practices and lack of (strategic) planning. Due to their small size they lack economies of scale and scope, and are hardly able to undergo international marketing on their own'.

3.3.5 Conclusion

Alpine Wellness has been shown to possess potential to develop a competitive health tourism product. The 'ALPSHEALTHCOMP' project illustrates the importance of cross-sectoral cooperation, quality management, professional education and exploiting natural locational factors.

3.4 Case study: WeLDest

Case study summary

Type: study.
Countries: Austria, the Czech Republic, Germany, Finland and the UK.
Period: 2012-2014.
Status: finished.
Main goal: to create a development framework for public bodies, destination management organisations and private companies for developing health and well-being tourism destinations and to identify current knowledge and competence needs in managing health and well-being tourism destinations.
Results/findings: the project yielded two products: (1) an electronic handbook that can be used by businesses, destinations and the education sector, and (2) a blog for academia, industry and citizens to share knowledge.
Sources: Dvorak et al. (2014); Illing (2014).

3.4.1 Background and stakeholders

The 'WelDest' project can be seen as a genuine transnational project regarding health tourism, bridging destination development and health. WelDest is an 'Erasmus/Lifelong Learning'-funded project combining the expertise of five higher education institutes with ten industry and 15 associate partners from Austria, the Czech Republic, Finland, Germany and the UK. The project comprised 52 stakeholder interviews and a customer survey with 784 subjects.

3.4.2 Aims and objectives

The central aims of WelDest were to create a development framework for public bodies, destination management organisations, and private companies for developing health and well-being tourism destinations, and to identify current knowledge and competence needs in managing health and well-being tourism destinations.

3.4.3 Insights

An important finding was the differentiation between (medical) health and wellness, where the tourism sector stakeholders have a strong focus on wellness and much less eye for health aspects. Furthermore, the stakeholders largely ignored the sports elements of health tourism, while the customers found sports, both indoors and outdoors, important. In addition, the customers also enjoyed natural scenery and nature, even though pampering or indulging spa procedures were still also important assets of a health destination. Stakeholders acknowledged the importance of communication between themselves (both formal and personal). Qualified staff was found to be quite essential in offering well-being and medical services. Of importance were also (public) transport and natural beauty of the landscape (Illing, 2014). The project yielded two products: (1) an electronic handbook that can be used by businesses, destinations, and the education sector, and (2) a blog for academia, industry and citizens to share knowledge.

3.4.4 Challenges

It is clear that the development of a Health & Wellbeing destination (H&WB) is not without investments in products, services, policies and skills. A SWOT analysis for health and well-being destinations concluded that weaknesses and threats included competition, less public funding, the economy, accessibility, failing to market unique selling points and a lack of networking (Illing, 2014).

3.4.5 Conclusion

The project demonstrated that destination development can be driven by health tourism, but that stakeholders and customers value different aspects of medical health and wellness. The project has shown that a well-defined destination profile is necessary to attract the right tourist segments. Also, the project found that nature-based resources have the potential to support the development of rural places and revitalise these areas (Dvorak et al., 2014).

3.5 Case study: Implications of cross-border healthcare in Poland

Case study summary

Type: study.
Country: Poland.
Period: 2011-2014.
Status: completed.
Main goal: to review the implementation of Directive 2011/24/EU.
Results/findings: the current Polish national legislation do not seem to facilitate access to cross-border healthcare.
Sources: Helena (2016); Kowalska-Bobko, Mokrzycka, Sagan, Włodarczyk, and Zabdyr-Jamróz (2016); Ried and Marschall (2016).

3.5.1 Background and stakeholders

Directive 2011/24/EU (on the application of patients' rights in cross-border healthcare) aims to facilitate patient mobility, and thus **medical tourism**. The idea is that in this way waiting lists can be shortened by better allocating demand to supply. Also, rare specialised medical treatments might be concentrated in certain centres of excellence offering an opportunity to save on budgets. However, apart from such positive effects, patient mobility can also have negative impacts on national healthcare systems. The case of Poland has been presented in the academic literature as an example of the negative impacts and a country struggling with the development.

3.5.2 Aims and objectives

The studies aimed to evaluate the way Poland reacted to Directive 2011/24/EU, on the application of patients' rights in cross-border healthcare, and to find out how this had shaped the country's national legislation.

3.5.3 Insights

Directive 2011/24/EU stipulates how regulated cross-border care should take place in the EU. As with all EU Directives, it is only when member states implement the Directive in their national legislation that the desirable effects will be obtained. Poland applied Directive 2011/24/EU but also put in place several barriers to restrict the access to healthcare abroad:

- barrier 1: pre-authorisation requirement including simple therapies and diagnostics;
- barrier 2: annual reimbursement limit;
- barrier 3: need for a referral or prescription to obtain reimbursement; and
- barrier 4: complexity of the reimbursement process in Poland (Kowalska-Bobko et al., 2016).

In doing so, the Polish government may have not taken advantage of the potential positive effect patient mobility could have on the quality of care in Poland. If the barriers were removed, patients may obtain better healthcare and insurers may potentially save on spending and Poland may benefit from international **medical tourism** arrivals. In the case of border regions between for example Germany and Poland: cross-border collaboration (between providers and insurers) could enhance access to healthcare (Ried & Marschall, 2016).

3.5.4 Challenges

Several studies which include Poland in reference to cross-border healthcare show the sensitivities between the national implementation of Directive 2011/24/EU and the rights of the Polish citizen/patient (Kowalska-Bobko et al., 2016). Another challenge is that the cost of the treatment in Germany for Polish patients would be reimbursed according to the (lower) tariffs in Poland (Ried & Marschall, 2016).

3.5.5 Conclusion

Poland could serve as a practice environment, where several conflicting layers are present: the patient and several governance and legislation levels. Due to the higher costs of healthcare in other member states and the reimbursement process, seeking healthcare abroad is not a realistic option for many Polish patients (Kowalska-Bobko et al., 2016). However, the citizens of other bordering countries such as Germany, may financially benefit from receiving medical treatment in Poland (Ried & Marschall, 2016). The issues surrounding the implementation of Directive 2011/24/EU are closely correlated with the dynamics of **medical tourism**. Some member states, such as Poland, and their national healthcare systems will potentially suffer from the private spending of their citizens to purchase healthcare abroad.

3.6 Case study: Medical tourism in Malaysia

Case study summary

Type: case study.
Country: Malaysia.
Period: 1998 - present.
Status: on-going.
Main goal: to illustrate the role of the Malaysian government in stimulating patient mobility.
Results/findings: N/A.
Sources: (Abd Manaf, Hussin, Jahn Kassim, Alavi, & Dahari, 2015; Chee Heng, 2010; Klijs, Ormond, Mainil, Peerlings, & Heijman, 2016; Moghavvemi et al., 2017; Ormond, 2011; Ormond, Mun, & Khoon, 2014; Whittaker, Chee, & Por, 2017).

3.6.1 Background and stakeholders

The Malaysian government identified **medical tourism** as a growth sector during the 1997-98 Asian financial crisis. They sought to attract not only the citizens of Indonesia (cross-border patient flows or intra-regional medical travel) but also aimed at higher spending medical tourists incorporating higher geographical distances (Ormond et al., 2014). **Medical tourism** is believed to contribute to the national economy in Malaysia. Healthcare became one of the 12 National Key Economic areas, which could contribute to economic growth of the country (Klijs et al., 2016). The government-initiated Malaysia healthcare Travel Council (MHTC) promotes the Malaysian hospitals and clinics through endorsements on their website (Moghavvemi et al., 2017).

3.6.2 Aims and objectives

Ormond (2011) showed that the Malaysian government promoted privatisation of healthcare services now for more than two decades. But in the late 1990s, the government targeted not only medical tourists but also Malaysians in a bid to keep locals receiving healthcare in their own country.

3.6.3 Insights

Abd Manaf et al. (2015) showed – based on their survey - that the majority of the medical tourists in Malaysia arrived from Indonesia, a neighbouring country. This also confirmed by Whittaker et al. (2017). They specified that 'the patients perceive Indonesian health services as poor, and their lack of confidence in these services is the main reason they prefer to travel for care. Patients mistrust the credibility and quality of doctors and paramedics in Indonesia'.

3.6.4 Challenges

Critics about Malaysia's development as a **medical tourism** destination have indicated that social services have been devolved for profit enterprises, leading to commodification of healthcare (Ormond et al., 2014). Other challenges include a movement of medical expertise out of the public sector, pressure on costs and a growing gap between corporate and public healthcare sectors, resulting in inequity.

3.6.5 Conclusion

Malaysia and its relationship with patient mobility shows that support and governance of private healthcare services in a structural way, can increase the level of healthcare delivery

in the country. This can however lead also to medical professionals moving out of the public healthcare system, but this case study shows that it is possible to gather enough stakeholders, organisations to provide medical services to a large number of patients (own citizens, intra-regional mobility from mainly Indonesia, and transnational mobility from other countries around the globe). The country could be perceived as a health region with an explicit programme/design, which means that the EU could learn from Malaysia's past and current situation.

3.7 Case study: Quality management at Thalasso centres in Spain and Portugal

Case study summary

Type: study.
Country: Spain.
Period: 2011.
Status: completed.
Main goal: to assess the implementation level of quality management in Spanish Thalasso centres.
Results/findings: leadership with learning make up the strengths. The major barriers perceived by managers were resistance to assuming new responsibilities and inadequate knowledge of quality management.
Sources: Crecente, Santé, Díaz, and Crecente (2012); (García, de la Cruz del Río, González-Vázquez, & Lindahl, 2015); de la Cruz del Río, García, Rodríguez, and Fraiz (2015); Peris-Ortiz, de la Cruz del Río, and García (2015).

3.7.1 Background and stakeholders

According to de la Cruz del Río et al. (2015), Thalassotherapy in Spain was found to be an important niche in health tourism for which three factors are important: salinity, density and movement. The goal of Thalassotherapy is to cure diseases, treat aesthetic problems and encourage relaxation by using infrastructure and equipment and the beneficial aspects of the sea. Another study by Crecente et al. (2012) indicated some of the advantages of developing Thalassotherapy in Galicia, Spain; namely that it reduces seasonality and decentralises tourism by creating new destinations during the winter season.

3.7.2 Aims and objectives

The authors (de la Cruz del Río et al., 2015) analysed the level of quality development in Spanish Thalasso centres to identify their strengths and ways to improve their quality management. Another aim was to identify the motivations for implementing this kind of a quality management system (García et al., 2015).

3.7.3 Insights

García et al. (2015) suggested that companies in this niche want to implement a quality-management system in relation to the improvement of the services, internal processes and procedures. Control and efficiency could be used as internal motivations.

3.7.4 Challenges

Peris-Ortiz et al. (2015) identified a couple of barriers for managing the directors of Thalasso centres when implementing quality management: a resistance to adjusting to new responsibilities and inadequate knowledge about and a lack of understanding of quality management, the fear of change and insufficient time for completing quality tasks.

3.7.5 Conclusion

García et al. (2015) emphasised the relationship between the professionalising, the emerging market of Thalassotherapy and the role that quality management can play in this respect. They concluded that internal motivations are the most important.

3.8 Case studies conclusions: Lessons learned by stakeholders

Having looked in detail at these six case studies, it seems past experiences have demonstrated that large-scale projects to develop health tourism in the EU are feasible and possible, if they have a certain focus and stakeholders are willing to invest. In the case study on WeLDeST, destination management was the central theme, while Alpine Wellness and Nordic Well-being both strived to commodify natural resources. The case of the implementation of Directive 2011/24/EU showed that the governance role of the EU in the case of patient mobility and **medical tourism** is sometimes opposed to national healthcare system policies and dynamics, such as in Poland. Furthermore, a divide seems to exist between what consumers of health tourism need and what stakeholders developing and managing destinations, believe their customers want.

4 HEALTH-TOURISM RELATED NATIONAL AND REGIONAL POLICIES IN THE EU

KEY FINDINGS

- EU policies exist for patient mobility, but not for health tourism as such. Still, several health-tourism projects are funded by the European Regional Development Fund (ERDF).
- Health-tourism policies (as part of tourism, or health policies, or as a separate policy) on a national and regional level are common in the members states.
- National and regional health-tourism policies aim to improve upon or guarantee the quality of the health tourism by supporting collaborations, promotional campaigns, specialisation, legislation and health-tourism projects and by using health tourism to reduce tourism seasonality.
- In spite of the EU Directive 2011/24/EU, there are still considerable taxation, financial and legal differences between the member states.

4.1 Introduction

In this Chapter, we discuss health-tourism policies on the regional, national and European level. The table in Annex VI[9] provides an overview of European, national and regional policies that specifically mention health tourism as a strategy, priority, ambition for, or as a means to improving tourism or the local economy. The table starts with an overview of European policies and projects and then lists separate summaries for 28 member states and one candidate member state[10]. A select number of regional policies and projects have been included in the national summaries. It is our firm belief that these are not exhaustive and that there are many more regions in Europe where health tourism plays an important role in policies and/or projects. The table also indicates the relevant governmental level (regional, national or European) and the period. The next section of this Chapter (4.2), provides an overview of EU-level policies and projects. Section 4.3 examines national and regional policies. The Chapter ends with conclusions, in Section 4.4.

4.2 European policies

On the European level, part of the legal framework for health tourism (cross-border healthcare to be more specific) has been laid out in Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (European Union, 2011). Directive 2011/24/EU, which entered into force on 24 April 2011, aims to establish rules for facilitating access to safe and high-quality cross-border healthcare in the EU, to ensure patient mobility in accordance with the principles established by the European Court of Justice and to promote the member states' cooperation on healthcare. The main points of attention in Directive 2011/24/EU are patient mobility (prior authorisation and reimbursement for patients), national contact points, and cross-border cooperation (e-health and European reference networks). Subsidiarity plays a role because, in general and specifically in regard to Directive 2011/24/EU, decisions must be made by member states unless the objectives of a decision

[9] Although the table in Annex VI should not be seen as a complete overview, as it is solely based on documents and websites that were found using Google and that were available in English, it does provide a good impression of how health tourism is being addressed in policies.

[10] For the remaining candidate countries and remaining current member states (the ones not included in the table), no relevant policies were found.

cannot be sufficiently achieved by the member states, but can be better achieved at Union level (European Union, 2011). Although this legislation only pertains to regulated patient mobility, meaning it does not cover 'out-of-pocket **medical tourism**', it could serve as a good practice for understanding the dynamics of patient mobility in reference to increasing privatisation and commodification of healthcare.

Directive 2011/24/EU is operational and the first evaluation studies have already been published (European Commission, 2015a, 2015e). In addition to Directive 2011/24/EU, Expert E1 believes that the freedom of movement as a citizens' right within the EU is a strong facilitator of cross-border healthcare and health tourism. In that sense, the EU compares favourably to other regions in the world.

Aside from Directive 2011/24/EU, there is little to no explicit reference to health tourism and its three components (**medical, wellness, and spa tourism**) in EU tourism policies, such as 'Europe, the world's No 1 tourist destination – a new political framework for tourism in Europe' and its 'rolling plan of tourism action framework' (European Commission, 2013). The European Commission does however regularly support tourism-related projects, some of which are directly related to health-tourism. For instance, the European projects 'WelDest', 'SOWELL' (Social tourism Opportunities in WELlness and Leisure activities) and 'OFF TO SPAS' were designed to strengthen cooperation between the actors who facilitate health tourism. These projects focused, respectively, on developing health and well-being destinations, the possibilities for opening up access to wellness activities for seniors and young people, and the creation of new, thermal-water-related international health-tourism products in spa towns within Central Europe. Chapter 3 contains a discussion of the 'WelDest' project. The 'SOWELL' and 'OFF TO SPAS' projects are discussed, along with other examples, in Annex V.

Finally, health tourism is eligible for EU funding from the European Regional Development Fund (ERDF) (Directorate-General for Enterprise and Industry, 2016) because it helps develop quality value-added products and services in niche markets by mobilising specific local resources and by contributing to smart regional specialisation. Example projects financed entirely or partially by the ERDF include 'Krimml Waterfalls' and the 'Hohe Tauern Health' (Austria), 'IT Spa tourism' (Greece/Bulgaria), 'Back-health centre of excellence' (Germany) and 'Revitalisation of the Brine Park' (Poland). The projects are briefly described below (please also see Annex VI):

- For the 'Krimml Waterfalls' project, regional authorities set out to develop new tourism products for Hohe Tauern National Park (in the Oberpinzgau region of Austria), exploiting scientific evidence about the health benefits of the highest waterfalls in Europe. The project was developed in close cooperation with the regional tourism association, the national park association and the regional hospital. A feasibility study examined the necessary conditions for hotels to participate in this new health-tourism package, how they could be certified and whether a sufficient number of hotels could qualify. In the end, 11 hotels underwent the required renovation and/or adaptation measures. Furthermore, a promotional campaign was launched to target individuals with allergies and guests with high health awareness.
- The 'IT Spa tourism' project supported health, tourism and culture in the Greek-Bulgarian border area by creating an integrated IT system for **spa tourism** and e-health services. This allowed municipalities to operate hot springs as health-tourism centres offering comprehensive services and to provide online booking and customer reviews, with a view to attracting more tourists (especially those from abroad).
- With an innovative tourism concept for people suffering from back problems, the Rostock-based 'vital & physio GmbH' brings together businesses, hotels, doctors and

furniture manufacturers. The medical treatment offered by 'vital & physio GmbH' provides relief to over 10,000 patients, tourist customers and prevention-course participants.

- The 'Revitalisation of the Brine Park' project focussed on the development of health tourism in Brine Park in Inowroclaw (Poland). To better serve the growing number of tourists, the park had to undergo a full renovation. This EU co-funded project resulted in a newly built mineral-water pump room, a palm house full of exotic plants and birds, and a renovated park. Brine Park now receives visits from 34,000 tourists annually, and it has created 19 permanent jobs.

4.3 National and regional policies

On the national level, there are and have been many tourism strategies that refer to health tourism as a strategic tourism product, a priority, a thematic area, an investment opportunity, etc. (again please see Annex VI). The importance of this subsector of tourism has always been recognised in the national tourism policies of countries such as Albania, Andorra, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Estonia, Hungary, Ireland, Latvia, Lithuania, Macedonia, Monaco, Montenegro, Poland, Portugal, Romania, Serbia, Slovenia, Slovakia and Turkey. Several countries also refer to health tourism in their national health policies. Finally, some countries such as Cyprus and Greece have (or have had) specific national health tourism strategies. The content of the strategies is described in detail in Annex VI.

Of course, there are differences between the health-tourism policies of the current and candidate EU member states — depending, among other things, on the specific type of health tourists the country attracts or would like to attract. Nonetheless, many of the strategies have recurring ambitions and/or actions, such as:

- Guaranteeing the overall quality of health tourism. This includes medical and wellness facilities, services and personnel, as well as the accommodations and recreation on offer. Quality criteria that have been proposed and those adopted include:
  - skill development programmes;
  - inspections and (minimum) standards;
  - licensing and certification;
  - (international) accreditation[11]; and
  - customer satisfaction reviews.

  For example, in Austria, Bulgaria, Croatia, Cyprus, Ireland and Turkey, the national tourism strategies highlight these quality criteria and ways to uphold them. The need to improve (modernise and extend) the health-tourism offer is emphasised by countries such as Croatia, Cyprus, Portugal and Slovakia. In all of these strategies, attracting greater (private) investment is seen as a condition for improvement.
- Strengthening the cooperation between healthcare and wellness, accommodations and recreational service providers and many other public and private actors on the national and destination level. Health-tourism clusters and/or networks have been created (e.g. in Hungary, Latvia, Romania and Spain) involving actors such as:
  - central and local public authorities;

[11] There are several specific national quality schemes in **wellness and spa tourism** in the EU, but none of them are internationally recognised (please also see Cohall, Johnson, von Storch, and Mullin (2013)).

- hospitals, clinics, physicians, medical schools;
- research institutes;
- tour operators, hotels, restaurants;
- equipment and device suppliers;
- economic operators, etc.

These clusters and networks are mainly preoccupied with jointly promoting health tourism and quality improvement. For example, the Polish 'Tourism Development Plan 2020' emphasises the need to strengthen cooperation between its Ministry of Sport and Tourism and its Ministry of Health, as well as regional and local government entities and the tourism sector organisations. What's more, Portugal's National Tourism Strategy emphasises the need to involve organisations like the national tourist authority, Ministry of Health, municipalities, tourism regions, business associations and tourism trade associations.

- Undertaking promotional health-tourism campaigns, ultimately aiming to attract more tourists. These types of campaigns were initiated in Cyprus, Monaco and Turkey, among other countries. They involved:
  - printed material and print advertisements;
  - electronic promotion;
  - workshops and congresses;
  - ambassadors and facilitators;
  - collaborations and networking; and
  - the creation of a corporate health-tourism identity.

  In addition, several countries are attempting to encourage private sector action and/or investments by using promotion (e.g. Andorra, Turkey), including presenting investment opportunities (e.g. Monaco).
- Identifying regions that should focus on health tourism or specific subsectors thereof, leading to specialisation and differentiation. Examples include the Jurmala region in Latvia, Gozo in Malta and several regions of Lithuania and Portugal.
  - Jurmala is home to mud bathing and mineral water, and within the Tourism Development Strategy of this region in Latvia (2007–2018) there is a major focus on public and private actions to promote and support health tourism.
  - The tourism policy for the Maltese Islands for the period 2012-2016 stated that Gozo would be promoted as a destination for post-operative and recovery treatment holidays.
  - The Lithuanian Tourism Development Programme 2014-2020 identified the regions of Vilnius, the coastal area, the Nemunas Lowlands, the Southern Dzūkija, the Eastern Aukštaitija and the Žemaitija Highlands as areas that are particularly ripe for tourism development potential.
  - Finally, in Portugal, Madeira and the Azores, Porto e Norte and Centro regions were identified as priority regions for health and **wellness tourism**. The Portuguese 'National Tourism Strategy 2006-2015' identified a focus for each region (e.g. exotic experience in tandem with natural beauty in the Azores) and suggested strategies and actions.

- Adjusting legislation dealing, for example, with cross-border patient mobility, with obligations of healthcare providers and resort operators, and with investments. In Latvia, for example, a new legal framework for resort operators and destinations was drawn up in 2012. This established a procedure for a local authority to submit an application to grant resort status and to use the spatial-development planning process to report on resort development and associated environmental quality indicators. By the end of 2015, two resorts were approved: Jurmala and Liepaja.
- Allocating government budgets to health tourism or its three subsectors, and actions to acquire European funding for health-tourism projects. In Cyprus, for example, there was the ambition to form and develop an open dialogue between the Ministry of Health and the Planning Bureau in order to secure European funding for projects within the healthcare sector.
- Identifying the possibilities and the actions necessary to be able to use health tourism to stimulate tourism in the low season, e.g. by creating special offers during the winter (like in Monaco) and/or by 'creating a diversity of offer suitable for year-round exploitation' (like in Slovakia).

A specific consideration regarding national policies is the financial and legal context under which health-tourism facilitators operate. Despite European Directive 2011/24/EU, the financial and legal contexts vary significantly between member states. For example in relation to **spa tourism**, the subsector on the edge of cures and wellness provision, one of the experts (E3) stated that there are only a limited number of member states that reimburse spa treatments: 'There are only four member states that include these spa provisions in the national health basket (Germany, Austria, Italy, and Hungary)'. Other differences between the financial and legal frameworks within countries are treatments that may or may not be covered by insurances (E6), VAT (in some countries you pay nothing, and in others 20-25%) and visa legislation. The exchange of data can be problematic. Finally, the legal requirements for spas, such as for hygiene and labour, also differ per country (E2). These differences can be ascribed to the many sensitivities between national policies and interests, the rights of national citizens/patients and Directive 2011/24/EU.

One of the experts contextualised health tourism, and the way it is reflected in national policies, within the current political climate of the EU (E3): 'A general thought, we have moved from post-Schengen to financial and economic crisis and populism rise, I think national healthcare systems were earlier more open to foreign healthcare systems […] I live near the border with Austria. […] Until recently German citizens came to Italy to spas, but the social insurances have closed that route, which means [Italian] spa institutes are facing an era which they didn't encounter in the past'. German insurers have started asserting that people have to use the health spas in Germany, and that the usage of foreign health spas will not be reimbursed. Developments such as these, which can be seen as a consequence of competition between healthcare systems (E3) create a (new) barrier for health tourism.

The table in Annex VI describes a number of projects and health-tourism policies in which regional authorities participate. As expressed above, these should be seen as examples, as there will be many more regions throughout Europe for which health tourism is important, or that have ambitions to develop health tourism. This includes regions where relevant projects have taken place or are planned (such as the ones partly financed with ERDF funding) and regions, such as Jurmala in Latvia, where health tourism is a very prominent part of their tourism strategies. Based on the examples included in the table, we conclude that many of the ambitions/actions that we described above with regard to the national level can also be identified in strategies on the subnational level.

4.4 Conclusion

In this Chapter, we reviewed policies directed at health tourism on a European, national and regional level.

On a European level, except for EU policies for patient mobility in the legal framework of Directive 2011/24/EU, there are little to no explicit references to health tourism and its three elements (**medical, wellness, and spa tourism**) in EU policies. The European Commission does regularly support health tourism-related projects, and these projects are eligible for EU funding from the ERDF.

On a national and regional level, health-tourism policies are rather common. Themes in many of these policies are the need to:

- guarantee (and improve) the quality of the health tourism offer;
- support collaboration between the actors involved;
- develop and implement promotional campaigns;
- focus on regional specialisation;
- introduce and adjust legislation;
- effectively allocate the government budgets for health-tourism projects; and
- use health tourism to stimulate tourism in the low season.

5 SWOT ANALYSIS

KEY FINDINGS

- After conducting our SWOT analysis, we drafted recommendations to better integrate health tourism into general EU tourism policies and to strengthen their connection to healthcare and the growing market for wellness in the workplace.
- The SWOT analysis lead to suggestions for the EU, including to:
  a. coordinate the collection of reliable data on health tourism,
  b. integrate joint promotion of health tourism in the 'rolling plan of tourism action framework';
  c. support knowledge and professional skills training to SMEs;
  d. integrate the renovation of wellness and spa facilities into destination-related actions;
  e. urge the uptake of Directive 2011/24/EU to develop medical tourism accommodations and services; and
  f. introduce certification schemes.

5.1 Introduction

This Chapter provides a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis of European health tourism. We have based this SWOT analysis on the expert interviews we undertook and the findings from the previous Chapters. We have also taken into account other health tourism-related SWOT analyses, which have been carried out on various destinations, including:

- In Europe: a Portuguese destination (Costa, Quintela, & Mendes, 2015), north-west Croatia (Radnic, Gracan, & Fister, 2009), and the Balkans (Kornélia Kiss, 2015);
- In Malaysia (Aniza, Aidalina, Nirmalini, Inggit, & Ajeng, 2009); and
- In South Korea (Kim, Lee, & Jung, 2013).

The overall SWOT overview is included in Section 5.6. Here, we also highlight policy-relevant findings and provide a range of policy recommendations.

5.2 Strengths

The strengths of the health-tourism market lie in its current size (€ 46.9 billion), growth potential and complementary seasonality. Its strong reliance on high-quality environmental and natural resources and features could incentivise the preservation of these natural resources, adding to sustainable development. As shown in Subsection 2.3.4, health tourism grows faster than tourism in general. This is due to the ageing population, the patients' right to be reimbursed in all EU countries regardless of their nationality (based on Directive 2011/24/EU) and the commercialisation of the spa market in particular. Within Europe, several destinations are market leaders in, for instance, thermalism (Costa et al., 2015). Also supporting industries, like cosmetics, are strong in Europe, with several market leaders based in France (Araujo, Paiva, Ribeiro, & Coutinho, 2015). A number of member states (like Germany, Italy, Austria, Hungary, Spain and Poland) are all in the top ten of the thermal springs market (GWI, 2017). Another strength is the long-standing European tradition of

wellness and spa tourism, including a firmly established supply of spas and wellness facilities (e.g. Radnic et al., 2009). For instance, Croatia profits from abundant thermal and mineral sources, favourable natural and geographical conditions (Radnic et al., 2009). The EU is recognised as a 'pioneer and one of the cradles of **wellness tourism**' (E6). Many of the typical wellness and spa resorts regions, like the Balkans, have strong traditions in herbal and plant medicine, a favourable climate and beautiful, even pristine, natural environment (Kornélia Kiss, 2015). The fact that health tourism has nearly equal revenues per trip as standard tourism, but at the same time certainly delivers additional services, can be seen as a strength of the sector in that it offers relatively good value for money. Basically and intentionally, Directive 2011/24/EU (on the application of patients' rights in cross-border healthcare) (European Union, 2011) and the basic EU citizen's right of freedom of movement (E1) facilitate patient mobility between EU member states.

Most European health-tourism regions are highly accessible to visitors from most regions in the world and some of these regions, like the Balkans, are in price competition with other destinations in the world (Kornélia Kiss, 2015). Health tourism has the potential to create many jobs, both directly and indirectly, for medical and non-medical sectors. Nonetheless, we did not find convincing evidence that health tourism is more labour intensive or provides higher wages than average tourism. Finally, in most member states, the quality of healthcare (facilities, personnel, etc.) is high and is perceived as such by current and prospective medical tourists from other countries.

5.3 Weaknesses

As shown in Chapter 1, there is inadequate clarity and consensus on the nature of health tourism, its defining components and the aspects that distinguish it from other related phenomena, as well as a lack of reliable data on medical tourist flows. Expert E4 mentions that health tourism is not well defined ('what is a wellness hotel?', and 'what should a hospital-oriented hotel look like?'). Even the definition of a 'health tourist' varies considerably in literature, and between statistical offices and governments.

There is also a strong discrepancy between data provided by industrial reports and from academia (Horsfall & Lunt, 2015). Furthermore, systematic data are not available. For example, we do not have data on how many Dutch tourists will be visiting Freiburg or Stuttgart for thermal baths. According to Expert E4, a 'full understanding of the health-tourism sector is completely lacking'. This lack of knowledge about the sector may also cause deficient legislation of the wider health-tourism sector. These weaknesses may be related to the fact that the health-tourism sector in Europe is largely unregulated. In some countries, attempts are made to define and uphold quality criteria, but in the absence of EU-wide quality guarantees and/or accreditations, this may result in strong variations in quality and pose risks for individuals who use the services.

Medical tourism faces a negative image in the media due to 'terrible stories like in the UK, where the National Health Service (NHS) is under pressure because of medical tourists' (E1). Lunt et al. (2014, p. v) warn that the 'medical-tourism industry is almost entirely unregulated and this has potential risks for those travelling out of the UK'. They also note that 'existing information regarding **medical tourism** is variable' and that 'there is no authoritative and trustworthy single source of information'. This is also an issue in other parts of the world, such as in Canada, where the Registered Nurses' Association of Ontario (RNAO) strongly opposes international **medical tourism** (departures and arrivals) and has asked for a complete and immediate ban (International Medical Travel Journal, 2014). Specifically regarding **medical tourism** in Europe, E1 notes that the public is largely unaware of

Directive 2011/24/EU, providing the right to go elsewhere, with the effect that '99% of UK patients who are on an NHS waiting list don't know that they can go elsewhere'. This inadequate investment in public relations and image building for the overall health-tourism sector is also noted by Costa et al. (2015) and Kornélia Kiss (2015), as well as a corresponding inadequate marketing effort (Radnic et al., 2009).

Additionally, there are doubts about the governmental support to sustain **medical tourism** (E1). Even though Italy and France have the ambition to become a **medical tourism** destination, this desire has not materialised in their policies. Often, there is a sense of distrust and an inability to cooperate (Kornélia Kiss, 2015). Establishing networks (clusters) for collaboration can be challenging because of the need to involve many different players (airline operators, accommodation, healthcare and well-being providers, etc.). Other challenges include the need for public-private cooperation, and political and/or financial sensitivities. Regarding **spa tourism**, an important weakness is the lack of joint promotion within the EU (E2). The promotion, as carried out by certain regions and countries, is not integrated into a coherent 'Europe-wide health-tourism story'. There is no EU funding for **spa tourism**, and Eastern Europe no longer has national funding for its **spa tourism**. More generally, insufficient private investment causes health tourism products to become increasingly old-fashioned in, for instance, the Balkans (Radnic et al., 2009). Many countries currently have or once had the ambition to attract (more) private investments for health tourism facilities, with varying degrees of success. Contrary to, for example, the US, Europe is still catching up to make the business case of health tourism fully viable (E6).

5.4 Opportunities

A review of the literature (Costa et al., 2015; Kornélia Kiss, 2015; Radnic et al., 2009) identifies opportunities for the growth of the sector, like the renovation of existing wellness and spa facilities, an ageing population, sustainable development, changing lifestyles and developing health clusters and collaborations. With regards to thermal tourism and European thermal municipalities, Expert E5 concluded that the outlook for this market is good for many European cities, and that both the wellness- and medical-tourism markets are growing. The increasing share of the senior citizens' market will increase demand for all three health-tourism submarkets. Lifestyle changes create a demand for relaxation as a counterweight to the stressful lifestyles that more and more people are experiencing (Manzano, 2016; Padilla-Meléndez & Del-Águila-Obra, 2016; M. Smith & Puczkó, 2015).

Though not directly a form of tourism, the increase in workplace wellness expenditures generate many related business opportunities. This includes: 'a proliferating number of third-party providers that supply services, products and platforms (e.g. screening assessments, diagnostic tests, incentive programmes, wearable devices, counselling services, etc.) to serve a wide range of employee wellness needs – from exercise, healthy eating, and sleep, to chronic illness, obesity, addiction, depression and stress. There are now dozens of associations, conferences and events, and research/consulting/training organisations, as well as hundreds of studies and surveys devoted specifically to this sector each year. We estimate that workplace wellness is now a $43.3 billion (€40 billion) global industry' (GWI, 2017, p. 34). Such integration of tourism, leisure, human resource management and health may provide many opportunities.

In cross-border healthcare, the opportunity exists for the EU to set up centres of excellence for rare diseases, as proposed in Directive 2011/24/EU (European Union, 2011), because this kind of specialisation in cross-border healthcare for rare treatments can be shared throughout the EU (E3). This, of course, could create a spin-off of **medical tourism** providers as

specialised accommodations for patient rehabilitation and tourism services dedicated to people with disabilities. In 2014, a significant proportion of citizens in the EU (49%) showed a willingness to travel for medical care, though this number was down from 53% in 2007 (European Commission, 2015h). So far, centres of excellence have not been created by the sector nor the member states.

Regarding **spa tourism**, demographics will play an important role (E2): 'demographical changes like ageing will raise the number of guests even though there will be a loss regarding young travellers'.

Furthermore, digitalisation and the internet could also be perceived as an opportunity (E7), because while booking sites and other service providers currently do not provide specifically health-tourism related information, they could do so. Customer-to-destination and customer-to-customer data flows and big data could provide opportunities, certainly when the different subsectors in health, both tourism and non-tourism, work together (Dvorak et al., 2014).

Finally, Expert E7 sees a growth market developing for citizens who are in need of medical care but also want to enjoy a holiday. This is connected to the 59% of senior tourists who found 'health tourism' an important motivation for their travel (Gheno et al., 2016).

5.5 Threats

Threats to EU health tourism vary from disorderly privatisation of traditionally state run spas in Central and Eastern Europe to failing communications about Directive 2011/24/EU. Also, the loss of (the diversity of) natural environments and resources because of (human-caused) pollution, urban sprawl, etc. impairs the resources, clean air, clean water, 'whole ecosystems of **wellness and spa tourism**'.

Regarding **medical tourism**, Expert E1 suggested that only commercial providers with significant funding will be able to enter the market, but that up til now these providers have been far less successful due to the public's low awareness of the opportunities and the generally negative press about incidents. The lack of clear legislation for **medical tourism** and specifically for cosmetic surgery is one of the main causes for the negative image in the press and with the public (Lunt et al., 2014). But Lunt et al. (2014) listed many other issues caused by a lack of (clarity of) legislation. Issues may arise when medical treatments in other countries fail to meet the quality of the medical services in a medical tourist's country of origin. This may cause additional costs for the origin country's medical services. Another health risk of **medical tourism** may be found in the accelerated spread of infectious diseases through global **medical tourism**, because patients are at higher risk by residing in hospitals where the density of infectious diseases is much higher than in regular tourism facilities (Hall, 2011).

Global competition is increasing in health tourism (Costa et al., 2015). Dimitrovski and Todorović (2015) showed that global competition in **spa tourism** and the concept of global competition with other regions in the world is important. Expert E2 emphasises the 'need to stay in the pole position worldwide and to find the means to survive as European spas'. For this, specialised tour operators will be needed so that potential health tourists can be questioned about their medical condition. Quality control for such tour operators would be desirable, because inaccurate information could directly impair the health of the tourist/patient. The current lack of such an approach may further damage the reputation of health tourism.

Expert E3 said countries fear that their own citizens will leave their national healthcare systems (e.g. Italy), which might lead to healthcare facilities being underused and their costs (partly) uncovered, or that international (arrival) patients will enter their system in massive waves from overseas, causing additional costs (e.g. the UK). However, the UK health service experiences very long waiting lists for many treatments, suggesting that UK residents will increasingly flock to Europe for more timely treatments. The uncertainty caused by Brexit is also linked with this.

A final identified threat is the wellness-tourism market actors' lack of knowledge about their customers (Voigt et al., 2011). This is particularly important in a global tourism market, where competition is increasing. More and more destinations market themselves as wellness tourist destinations and it will be essential to understand customer profiles.

5.6 SWOT overview, conclusion and recommendations

Table 3 below provides an overview of the results of the SWOT analysis for health tourism in the EU. From this table, we can derive the following conclusions and recommendations for EU policies.

Regarding **strengths**, there are no evolving hints for EU policies, except the notion that current EU tourism policy may more actively use the health tourism's capacity to reduce overall seasonality (see further European Commission, 2017b).

Weaknesses do trigger more recommendations for EU policies. There seems to be a potential role for EU coordination for gathering reliable data about the health-tourism market. This could be done by supporting The Tourism Observatory for Health, Wellness and Spa (TOHWS, M. Smith & Puczkó, 2015) or the European Commission's Virtual Tourism Observatory (European Commission, 2017a). The lack of uptake of Directive 2011/24/EU in national legislation is a missed opportunity for **medical tourism** and the development of specialised accommodations and services. Therefore, the European Tourism Commission (ETC) should try to cooperate with the Health Ministries and departments in member states. The joint promotion of health tourism could become part of the 'rolling plan of tourism action framework' (European Commission, 2013).

Opportunities related to EU policymaking may be identified for facilitating the integration of non-tourism facilities, such as workplace wellness. Potential actions could involve providing knowledge and professional-skills training to small and medium-sized enterprises (SMEs) (European Commission, 2017c). Also, the renovation of a large number of ageing wellness and spa facilities might be part of, for instance, the European Commission's destination programmes, like European Destinations of Excellence (EDEN) or other actions involving destinations (European Commission, 2017d). The ageing population increases the shares of senior tourists who desire health-tourism services and products. These are connected to existing programmes like the European Covenant on Demographic Change[12], WHO Global

[12] The Covenant on Demographic Change gathers all local, regional and national authorities, and other stakeholders in Europe, that commit to cooperate and implement evidence-based solutions to support active and healthy ageing as a comprehensive answer to Europe's demographic challenge (Covenant on Demographic Change, 2016).

Strategy on ageing[13], and the Silver economy[14]. The removal of upfront payments in the case of cross-border healthcare could lower barriers for patients, particularly low-income ones.

Finally, the identified **threats** may require EU policies. However, the issue of the accelerated spread of diseases through global **medical tourism** means health tourism may not form a logical addition to general tourism policy, except maybe for informing the public and educating professionals. The same is true regarding the loss of (the diversity of) natural environments and resources because of pollution and urban sprawl, among other causes. Indeed, this would go against the current goals outlined in the European Commission's sustainable tourism policy (European Commission, 2017e). Introducing certification schemes which would identify tour operators and travel agencies with the requisite knowledge to assess the medical situation of tourists (and their requirements and limitations for travel) would not only benefit health tourism, but it would also anticipate other tourism policies for senior travel and tourism accessibility.

[13] WHO's Global Strategy and action plan on ageing and health (2016-2020) is directed at fostering healthy ageing, defined as 'the process of developing and maintaining the functional ability that enables wellbeing in older age' (WHO, 2016, p. 4).

[14] The Silver Economy refers to 'the economic opportunities arising from the public and consumer expenditure related to population ageing and the specific needs of the population over 50' (European Commission, 2015d, p. 3).

Table 3: SWOT-analysis table for EU health tourism

STRENGTHS	WEAKNESSES
• Substantial income in the EU (€46.9 billion in 2014). • Several member states are among the leading world market players. • The long history and high status of **wellness and spa tourism**, including a firmly established supply of spas and wellness facilities throughout Europe. • Diversity of natural environments and resources conducive to health tourism. • Well-developed infrastructure (tourist attractions, accommodations, transport facilities, etc.). • **Wellness and spa tourism** depend on high-quality environments (clean water, clean air, attractive eco-systems) that incentivise safeguarding the environment. • Its seasonality is partly complementary to mainstream tourism and helps reduce overall tourism seasonality. • Directive 2011/24/EU provides mobility and funds for patients between EU member states. • The quality of healthcare in the EU (facilities, personnel, etc.) is high and is perceived as such by international medical tourists.	• No consensus on the definition of health tourism and its components. • Lack of reliable data on medical tourist flows and revenues. • The market is largely unregulated, resulting in varying quality levels and risks for individuals and development. • Overly dependent on government support and lacking a commercial approach. • The large gap between Directive 2011/24/EU and its integration into national legislation, which is a missed opportunity for developing **medical tourism**. • Insufficient collaboration between destinations, enterprises and other stakeholders. • Insufficient joint promotion within the EU. • Increasingly old-fashioned facilities in some European health-tourism hotspots.

OPPORTUNITIES	THREATS
• A significant proportion of citizens in the EU (49%) is willing to travel for medical care. • Use of ICT and web-based resources to connect consumers with destinations, healthcare providers and brokers. • Application of data flows and big data provides opportunities, certainly when tourism and non-tourism data flows are combined. • Worldwide growth of tourism. • The ageing population increases the shares of senior tourists who desire health-tourism services and products. These are connected to existing programmes like the European Covenant on Demographic Change, the WHO Global Strategy on ageing, and the Silver Economy. • Setting up centres of excellence for rare diseases that may save on health costs and advance quality levels based on the cross-border healthcare Directive and which would advance the development of medical-tourism-specialised accommodations and services. • Change of lifestyle in the EU population that boosts interest in health tourism. • Integrate non-tourism facilities, e.g. workplace wellness, with **medical, wellness, and spa tourism** development, investments, strategies and policies. • Renovation of a large number of ageing wellness and spa facilities.	• Disorderly privatisation processes of healthcare facilities in Central and Eastern Europe. • Lack of public awareness and knowledge of the opportunities provided by Directive 2011/24/EU. • Negative press, caused by countries not regulating their health-tourism providers. This is especially problematic for unregulated medical procedures. • Countries' fears that their own citizens will leave their national healthcare systems (e.g. Italy), causing over-capacity and uncovered costs, or will enter other national healthcare systems in massive waves, causing additional costs (e.g. the UK). • The accelerated spread of diseases through global **medical tourism** because patients are at higher risk by residing in hospitals where the density of infectious diseases is much higher than in normal tourism facilities. • Loss of (the diversity of) natural environments/resources because of (human-caused) pollution, urban sprawl, etc. • Lack of a certification scheme for tour operators and travel agencies with knowledge to assess the medical situation of tourists and the requirements and limitations for travel. • Increasing competition for health tourism from destinations in Asia and the Middle-East. • Brexit provokes uncertainty about the development of tourism in general, and **medical tourism** in particular.

6 SCENARIOS FOR HEALTH TOURISM IN THE EU

KEY FINDINGS

- Two futures have been explored: one that aims at the highest tourism growth ('Health Tourism Growth Scenario' or HTGS) and one that aims at the most beneficial health effects of health tourism ('Health Tourism Vitality Scenario' or HTVS).
- The HTGS may indeed provide some benefits to the tourism economy but may also risk additional costs for unnecessary treatments and medicalisation.
- The HTVS would enhance health in the EU, save costs and shift towards the opportunities for prevention rather than curing.

6.1 Introduction

To develop full scenarios for a subsector of tourism, like health tourism, it is necessary to have sufficient knowledge of its size, character, main developments and existing policies. As shown in the previous chapters, we do not present a complete overview of health tourism in the EU: its definitions are under debate, its size is not well defined, the prospects are unclear and there are no obvious dedicated policies. Although EU tourism policies are not dedicated to health tourism, some goals may be reached through health tourism. These include reducing seasonality, adapting to the growing target market of elderly people and the sustainable development of tourism. The only EU policy related to health tourism is Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (European Union, 2011), but this is not part of tourism policy nor directly linked to it. Indirectly, it certainly may provide opportunities to **medical tourism** providers, but as such there is no mutual tourism-health policy at the EU level.

Another issue is that health tourism only exerts a very minor direct impact on the European economy: a share of less than 0.5%. Furthermore, within general tourism, health tourism is not a major player, with health tourism trips representing only 5.8% of all domestic arrivals and 1.1% of all international arrivals. This means that effects on the tourism sector of health tourism dedicated policies would be rather limited.

Therefore, a 'no policy' scenario will not be much different from a 'Business As Usual' (BAU) scenario, unless we assume in a 'no policy' scenario that Directive 2011/24/EU will be withdrawn. But we do not consider Directive 2011/24/EU to be a tourism-related policy and thus beyond the scope of this report. Therefore, we focus our analysis on the description of two policy scenarios: one aiming to achieve optimal growth for all three forms of health tourism ('Health Tourism Growth Scenario' or HTGS) and one aiming to obtain the most beneficial health effects of health tourism ('Health Tourism Vitality Scenario' or HTVS). These two scenarios are outlined respectively in Sections 6.2 and 6.3, while Section 6.4 presents the final policy conclusions.

6.2 The Health-Tourism Growth Scenario

In the HTGS, EU policies try to eliminate barriers to the economic growth of health tourism. Private investments in spas and wellness destinations are stimulated and legislation is removed, wherever possible. The public-private partnerships that are set up lead to market growth. At the same time, the EU promotes Europe as the world leader in **wellness and spa tourism**. In **medical tourism**, private enterprises are stimulated and Directive 2011/24/EU is better integrated into the national legislation of the member states where this has not yet

happened. At the same time, national healthcare systems will be opened up to commercial treatments in a more or less free trade environment. This commercialisation will stimulate the growth of non-healthcare systems, including public and private medical treatments such as cosmetic surgery, medical check-ups, dental tourism and others. There is a risk that a rise in non-essential medical treatments will generate complications for national healthcare systems, increasing the medical costs for governments and insurance companies and, consequently, the public.

There is scope for this scenario. Expert E7, for example, observed that the market for health tourism is growing due to an increasing number of senior citizens who have both expendable time and money. But the supply will need to develop according to the demand, and this demand has not been adequately researched. In comparison to general tourism as a whole, health tourism is a far more domestic phenomenon. As older people are less inclined to engage in long-distance travel, a greater number of senior health tourists might further increase the domestic share of the health-tourism market (E7). This means that there is a clear need for a tourism policy that connects with transport policy to improve long-distance transport's destination accessibility. This is particularly true for the **medical and spa tourism** markets but probably less for the wellness market. Trends in Germany show that overall interest in health-oriented holidays is gradually decreasing, also among senior travellers. That said, **wellness tourism** — the largest market segment — is still enjoying growing interest. One of the problems here may be that health is not a prime motivation for holidays, and that perceptions of health-oriented holidays are prone to change (Lohmann & Schmücker, 2015).

A well-designed programme to modernise current spas could potentially increase the share of health tourists travelling from other continents. Tentative impacts of this HTGS future scenario might be the following:

- Additional growth and higher revenues for tourism, mainly domestic;
- A potential cost increase for national healthcare systems due to a rise in mistakes in private treatments;
- Depending on the success of 'selling' EU health tourism destinations outside the EU, there will be additional monetary revenues to the EU;
- But also a shift away from sustainability, mainly due to increased carbon footprints and energy use for transport (P. Peeters et al., 2015); and
- Overall tourism may become a bit less seasonal and slightly less sustainable.

6.3 The Health-Tourism Vitality Scenario

In the HTVS, the EU will take a different direction by integrating new health-tourism policies in national health policies. This means that the focus will be on the opportunities health tourism provides for improving the health of the population by providing prevention through wellness and by specialised treatments for a greater portion of the EU population than is possible without these policies. The way to achieve the latter is by creating centres of excellence for specialised and rare treatments, and to align these centres with hospitality and transportation facilities and services for both the patients and family or friends caring for them. The point here is that the 'tourism' part of this kind of **medical tourism** of, in many cases, seriously ill patients, could now be a factor causing the centres to fail. The reason for this is that medical centres are less well equipped to provide high quality hospitality (lodging, food, leisure, atmosphere), while this is very important for these patients, especially when being much further from home than usual and probably seriously ill. Including spas and parts

of wellness treatments in national healthcare systems will help to cure and prevent certain illnesses, likely at a relatively low cost.

The experts we interviewed saw scope for improving overall health through health tourism. For instance, Expert E2 made the suggestion to 'position EU spas as a brand for health and recreation' as a means to pivot away from pills to more natural remedies. This would also reduce the costs and power of the pharmaceutical industry. Expert E3 sees substantial benefit in taking the opportunities Directive 2011/24/EU provides for cross-border healthcare and specialisations. In Bologna (Italy), for instance, hospitals are well known for curing cancer. In this scenario, a patient-centred approach is needed, including cross-border insurance. In many member states, the pressure on governments to manage their healthcare expenditure is increasingly becoming a problem. The main drivers are the ageing population, but the higher costs for drugs and treatments also play a role. These costs could be reduced by prevention measures, and it is in prevention that health tourism can play a much larger role then it currently does. This does imply though that effective preventative treatments should be identified and partly remunerated through insurance or by state aid (E1).

What would support the HTVS is that many people nowadays prefer a preventative approach (E3). Health-tourism providers might be given a role in this, because doctors are afraid to be confronted with lawsuits when they decide not to operate. Their liability is increasing (E3).

Also, e-health, data security and mobile health are expected to take-off in this scenario. 'You see medical professionals travelling to the demand, where for instance a specialised dentist travels from Germany to the Netherlands for one day a week' (E3). This is a kind of 'reversed **medical tourism**', but there are also barriers that should be removed by policies in the HTVS. 'If a thermal bath in Stuttgart would set up a new therapy, it would not get the same funds or clinical trials as a multinational company would get for a new treatment or drug' (E4). So the EU can 'help local providers in developing clinical trials, and incorporate these in training modules of medical professionals and protocols'.(E4)

Tentative impacts of HTVS might be the following:

- A minor shift from curing to prevention;
- A minor decrease in national healthcare systems' costs;
- A shift towards a role for national and regional governments to manage their region as a health and prevention-driven system, where tourists and local citizens benefit from the organised health, medical and well-being structure and landscape;
- Public guidance to enhance the sustainable health of both citizens and tourists; and
- Overall tourism may become slightly less seasonal and a bit more sustainable.

6.4 Scenario conclusions

The policy scenario referred to as Health-Tourism Vitality Scenario (HTVS) would aim at enhancing health in the EU through further developing and integrating health tourism and healthcare. Furthermore, it would make use of the opportunities for prevention rather than curing. The HTVS may have a better potential for the general good than the other scenario we described: the Health-Tourism Growth Scenario (HTGS). The HTGS aims at just achieving economic growth for the health tourism sector, which indeed may provide small benefits to the tourism economy but may also come with several disadvantages. The main risk in the HTGS scenario is that it may lead tourists to undertake unnecessary treatments of which inevitably some will fail and cause additional cost to the regular national healthcare system.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Definitions

For this study, health tourism is defined as the combination of three overlapping fields: **medical tourism**, **wellness tourism**, and **spa tourism**. **Medical tourism** refers to the phenomenon of people travelling from their usual country of residence to another country with the express purpose of accessing medical treatment. **Wellness tourism** is travel with the purpose of proactively pursuing activities that maintain or enhance personal health and well-being, with such travellers seeking unique, authentic and/or location-based experiences and therapies unavailable at home. **Spa tourism** focuses on healing, relaxation and/or the beautifying of the body at spas, using preventative wellness and/or curative medical techniques.

The three forms of health tourism, although different in many ways, overlap a great deal. **Medical tourism** is concerned with curing illness, **wellness tourism** promotes personal well-being, while **spa tourism** is positioned somewhere in between, aiming to prevent illness and sustain health. Furthermore, **wellness and spa tourism** are associated with certain types of facilities – 'wellness centres' and spa destinations: accommodation with complementary therapy facilities for people who suffer from health problems or are disabled. **Medical tourism**, on the other hand, focuses on the (non-tourist) medical facilities.

7.2 Size and growth

Estimating the total size of health tourism in the EU, and of each of the three markets, is difficult due to the limited, fragmented and often unreliable data available, as well as the wide and overlapping definitions used by different sources. To partly overcome these difficulties, we developed the EHTDB (Expanded Health Tourism Database). The total size of health tourism in the EU28 in 2014 is estimated to have comprised 56 million domestic trips and just over 5 million international arrivals, totalling 61 million trips for health tourism arriving at EU28 destinations in 2014. The share of health tourism of all EU28 arrivals is 4.3% (which means health tourism trips represent only 5.8% of all domestic arrivals and only 1.1% of all international arrivals). **Wellness tourism** dominates EU health tourism, with about two-thirds to three-quarters of the total market. The division between **medical and spa tourism** is not known precisely. Health-tourism revenues in 2014 totalled €34.2 billion in the EU28, which represented 4.6% of all tourism revenues and 0.33% of the EU28 GDP. The share of health tourism is relatively small on average, as all of the market leaders – whether inside or outside the EU – have quite large tourism markets. Seasonality plays a role in health tourism, but depends on the geographical location and the type of health tourism. Because health tourism seasonality tends to differ from general tourism seasonality, it is seen as a way to reduce the seasonality of all tourism. Furthermore, special target groups such as senior citizens and citizens with disabilities show different patterns of seasonality, complementing those of other markets. The exact share of health tourists arriving from outside the EU is not known, but it is likely to be comparable to the share for all tourism (6%).

Scientific and public sources suggest a stable development of EU health tourism, whereas market reports indicate spectacular growth in all three markets. One source shows a decrease in **medical and spa tourism** in Germany but an increase in **wellness tourism**. **Medical tourism** appears to be quite a volatile market, depending on legislation and waiting lists in standard healthcare. We did not find evidence of a slower or faster development of health

tourism as compared to other tourism sectors in the EU. Both are expected to grow by about 2% per year until 2025.

More than three-quarters of EU health-tourism revenues are made in just five countries: France, Germany, Italy, Sweden and Poland. The highest scores for wellness-related facilities in accommodations are found in Finland, Bulgaria, Germany, Spain and Ireland. However, the highest densities (rooms in accommodations with health-related facilities) of health and wellness facilities are found in Central and Eastern Europe, and the Spanish and southern Baltic coasts. The highest shares (>10%) of health tourism markets are found in Finland, Latvia, Slovakia, Hungary and Portugal. In absolute numbers, both domestic health tourism and international health tourism departures are largest in France, Germany and Sweden. As a share of total domestic and international tourism departures, the largest countries of origin in EU health tourism are Latvia, Hungary, Sweden, Slovakia and Portugal.

7.3 Developments and structure

At the EU level, policies exist only for patient mobility in the legal framework of Directive 2011/24/EU (on the application of patients' rights in cross-border healthcare) (European Union, 2011), but not for **wellness or spa tourism**. This means no special factors at the EU level stimulate the growth of **wellness and spa tourism**, apart from general tourism growth factors.

At the national and regional level, policies enhancing health tourism growth are quite common evidence of health tourism as an important strategy within general tourism planning. The main factors for the growth of spas is the local environmental conditions including clean water, warm springs, clean air, and outstanding natural assets. **Medical tourism** increases due to the varying quality and cost of medical care among member states and the position of the national governments in implementing Directive 2011/24/EU. For **wellness tourism**, important factors are:

- stakeholder collaboration;
- natural assets and environmental conditions;
- the demand from nearby markets including the domestic market;
- tradition and culture; and
- the ability to educate employees in the tourism sector.

Health tourism is not a very important economic factor in the EU: it is responsible for, on average, much less than 1% of GDP. Furthermore, changes in its size are limited and gradual. However, in some regions, health tourism is important — maintaining, for instance, spas is a way to develop some regions. Special attention should be paid to the increased demand for facilities (in accommodation and in transport) for persons with disabilities and persons with reduced mobility. If the share of health tourism in general tourism were to increase, seasonality would be reduced, sustainability improved, tourism transport reduced and the quality and quantity of labour improved.

7.4 SWOT analysis

After carrying out a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis for European health tourism, we determined the following main strengths:

- Several member states are among the leading world market players.
- Europe's long history and high status of **wellness and spa tourism**, including a firmly established supply of spas and wellness facilities throughout Europe.
- The diversity of natural environments and resources conducive to health tourism.
- A well-developed infrastructure (tourist attractions, accommodations, transport facilities, etc.).
- Directive 2011/24/EU provides mobility and funds for patients between EU member states.

The main weaknesses are:

- No consensus on the definition of 'health tourism' and its components and a lack of reliable data on health tourist flows and revenues.
- No EU-level regulation, resulting in varying quality in **medical tourism** and risks for individuals and development.
- The relatively few member states that have fully adopted and promoted Directive 2011/24/EU into their national legislation.
- Insufficient collaboration between destinations, enterprises and other stakeholders.
- Insufficient joint promotion within the EU.
- Increasingly old-fashioned facilities in some health-tourism hotspots in Europe.

The main opportunities are:

- The significant proportion of citizens in the EU (49%) willing to travel for medical care.
- Use of ICT and web-based resources to connect consumers and destination, healthcare providers and brokers.
- The application of data flows and big data provides opportunities, certainly when tourism and non-tourism data flows are combined.
- The ageing population increases the shares of senior tourists who desire health tourism services and products. These are connected to existing programmes like the European Covenant on Demographic Change, the WHO Global Strategy on ageing, and the Silver economy.
- Changes of lifestyle in the EU population have boosted interest in health tourism.
- Integration of non-tourism facilities - e.g. workplace wellness, with **medical, wellness, and spa tourism** development, investments, strategies and policies.
- Renovation of a large number of existing but ageing wellness and spa facilities.
- Centres of excellence for rare diseases that may save health costs and advance the quality of rare disease **medical tourism** based on Directive 2011/24/EU.

The major threats for health tourism are:

- Negative press due to countries not regulating aspects of their health offer, specifically **medical tourism** providers.
- Countries fearing that their own citizens will leave their national healthcare systems causing over-capacity and uncovered cost, or that large numbers will enter their healthcare systems, resulting in additional costs.
- The accelerated spread of diseases through global **medical tourism**, because patients are naturally at higher risks of infection and will be staying in hospitals where the presence of infectious diseases is much higher than in normal tourism facilities.
- Loss of (the diversity of) natural environments/resources because of (human-caused) pollution development, urban sprawl, etc.
- Lack of knowledge among tour operators and travel agencies to assess the medical situation of tourists and their requirements for and limitations on travel.
- Increasing competition for health tourism from destinations in Asia and the Middle-East.
- Brexit provoking uncertainty about the development of tourism, specifically **medical tourism**.

7.5 Policy recommendations

From the case studies and the policy analysis, we have extracted some tentative policy recommendations:

- Increase the number of member states that include spa treatments in their national healthcare system and policies.
- Remove, where possible, upfront payments in the case of cross-border healthcare, as this appears to be a barrier, certainly for low-income patients.
- Improve the effectiveness of Directive 2011/24/EU in its implementation in national healthcare systems. In some countries, mobility of medical tourists is currently restrained because of worries about the effects on health (lower quality overseas) and an overly large flow of medical tourists into their own healthcare system.
- Uptake of health tourism in (EU and national) tourism statistics and Tourism Satellite Accounts (TSA). This will also require a unifying set of agreed definitions that respect local, cultural and language-determined specifics. This will help growth stimulating policies, which are currently difficult to produce due to a lack of data and knowledge and an absence of agreed definitions.
- Consider the benefits of a joint EU promotion of **wellness and spa tourism**.
- Use health-tourism development as a way to improve labour quality, sustainability and seasonality. Also use it as a way to increase domestic tourism over international (departures) tourism, to reduce tourism transport, and to enhance sustainable tourism development.
- Aim specifically to mitigate the loss of environmental and ecological quality in wellness and spa destinations due to pollution, increasing traffic levels, urban sprawl, industry and agricultural developments.
- Regulate procedures in **medical tourism** to prevent undesirable incidents (e.g. in cosmetic surgery), as this generates negative press and creates a problematic image for all **medical tourism**.

- Though there is no specific health tourism policy within the EU, a range of EU funded projects did aim at improving health tourism or one of its three components (**medical, wellness, and spa tourism**). A specific role for world market leaders could not be established in this study.
- Continue funding health-tourism projects. Aim such funds at solving or improving the following recurring themes:
  - improving and guaranteeing the quality of the health-tourism offer;
  - supporting collaboration between the actors involved;
  - funding promotional campaigns;
  - funding regional specialisation;
  - introducing and adjusting legislation;
  - allocating government budgets to health-tourism projects; and
  - using health tourism to stimulate tourism in the low season.
- The policy scenario referred to as Health-Tourism Vitality Scenario (HTVS) would aim at enhancing health in the EU through further developing and integrating health tourism and healthcare. Furthermore, it would make use of the opportunities for prevention rather than curing. The HTVS may have a better potential for the general good than the other scenario we described: the Health-Tourism Growth Scenario (HTGS). The HTGS aims at just achieving economic growth for the health tourism sector, which indeed may provide small benefits to the tourism economy but may also come with several disadvantages. The main risk in the HTGS scenario is that it may lead tourists to undertake unnecessary treatments of which inevitably some will fail and cause additional cost to the regular national healthcare system.

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ANNEXES

ANNEX I: HEALTH-TOURISM & RELATED DEFINITIONS

The academic debate on the definition of health tourism and its three main components is lively but far from over, generating myriad definitions for each phenomenon. This annex lists some definitions while providing an overview of the full range in existence.

Definitions of health and health tourism

DEFINITION	REFERENCE
'Health tourism is the sum of all relationships and phenomena resulting from the journey and residence of people whose main motive is to preserve, promote and if necessary rebuild their physical, mental and social health by use of health care for whom the residence is neither a principal nor permanent place of residence or place of work'.	Benhacine et al. (2008, p. 36).
'Health is a state of complete physical, mental and social well-being and not only the absence of illness and ailment'.	Benhacine et al. (2008, p. 36).
'Health tourism is the provision of health facilities utilising the natural resources of the country, in particular mineral water and climate'.	M. Smith (2015, p. 358).
Definition of health: 'The extent to which an individual or a group is able to realise aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasising social and personal resources as well as physical capabilities'.	This definition, which was taken from the World Health Organisation (WHO), was developed in 1984 and cited by M. Smith and Puczkó (2015, p. 206).
Health tourism includes 'those forms of tourism which are centrally focused on physical health, but which also improve mental and spiritual well-being and increase the capacity of individuals to satisfy their own needs and function better in their environment and society'.	M. Smith and Puczkó (2015, p. 206).
Goodrich and Goodrich define healthcare tourism as 'the attempt on the part of a tourist facility (e.g. hotel) or destination (Baden, Switzerland) to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular tourist amenities'.	Goodrich and Goodrich (1987, p. 217).

Definitions of medical tourism

DEFINITION	REFERENCE
Medical tourism is a term commonly used to refer to the phenomenon of people travelling from their resident country to another with the expressed purpose of accessing medical treatment.	The authors' own formulation, based on Connell (2013).
Medical tourism 'refers to cross-border health care motivated by lower cost, avoidance of long wait times, or services not available in one's own country'.	Hopkins, Labonté, Runnels, and Packer (2010, p. 185).
'Loosely defined as travel with the aim of improving one's health; **medical tourism** is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism'.	Bookman and Bookman (2007, p. 1).
'In its broadest conceptualisation, **medical tourism** refers to travel with the express purpose of obtaining health services abroad'.	Arellano and Ramírez (2007, p. 1).
'Conceptualising all cross-border mobility for medical care as 'medical travel', or more grandly 'transnational health care', rather than '**medical tourism**', provides umbrella terms that avoid value judgements over intentionality or the gravity and necessity of procedures'.	Connell (2015, p. 22).
Medical tourism is 'the organised travel outside one's natural health-care jurisdiction for the enhancement or restoration of the individual's health through medical intervention'.	P. M. Carrera and Bridges (2006).
'All the activities related to travel and hosting a tourist who stays at least one night at the destination region, for the purpose of maintaining, improving or restoring health through medical intervention'.	Musa, Thirumoorthi, and Doshi (2012, p. 527).

Definitions of wellness tourism

DEFINITION	REFERENCE
Wellness is defined 'as the particular health condition which includes general well-being of body, mind and spirit, depending on its environment'.	Dimitrovski and Todorović (2015, p. 260).
Wellness is 'a multidimensional state of being describing the existence of positive health in an individual as exemplified by quality of life and a sense of well-being'.	Hritz et al. (2014, p. 134).
'Trips aiming at a state of health where the main domains of wellness are harmonised or balanced (e.g. physical, mental, psychological and social). There is an emphasis on prevention rather than cure, but some medical treatments may be used in addition to lifestyle-based therapies'.	M. Smith (2015, p. 359).
'**Wellness tourism** involves the efforts of individuals to preserve their healthy state through activities provided by health institutions'.	Dimitrovski and Todorović (2015, p. 260).
Wellness tourism is 'defined as the sum of all the relationships resulting from a journey by people whose motive, in whole or in part, is to maintain or promote their health and well-being, and who stay at least one night at a facility that is specifically designed to enable and enhance people's physical, psychological, spiritual and/or social well-being'.	Voigt et al. (2011, p. 17).
'The concept of wellness takes this idea even further and includes domains such as physical, mental and spiritual health, self-responsibility, social harmony, environmental sensitivity, intellectual development, emotional well-being and occupational satisfaction'.	M. Smith and Puczkó (2014, p. 5).
Wellness is 'a way of life oriented toward optimal health and well-being in which the body, mind and spirit are integrated by the individual to live more fully within the human and natural community'.	M. Smith and Puczkó (2014, p. 5).
'**Wellness tourism** involves people to travel to a different place to proactively pursue activities that maintain or enhance their personal health and well-being, and who are seeking unique, authentic or location-based experiences that are not available at home'.	Johnston et al. (2011, p. iv).
'In order to qualify as a contemporary **wellness tourism** experience, we would contend that some deliberate contribution has to be made to psychological, spiritual or emotional well-being in addition to physical. This takes **wellness tourism** from the realm of being merely a passive form of tourism with a focus on escapism to one where tourists are purposefully driven by the desire to actively seek enhanced wellness'.	M. Smith and Kelly (2006, p. 2).

Definitions of spa tourism

DEFINITION	REFERENCE
Spas are 'places devoted to overall well-being through a variety of professional services that encourage the renewal of mind, body and spirit'.	M. Smith and Puczkó (2015, p. 207).
'**Spa tourism** focuses on the relaxation, healing or beautifying of the body in spas using preventative wellness and/or curative medical techniques'.	M. Smith and Puczkó (2015, p. 208).
Wellness places like spas, resorts and camps provide programmes devoted to an individual's health and fitness, are designed to make the guests feel significantly better than when they arrived. The combination of fun, exercise, a healthy and balanced diet, pampering relaxation, and education on managing stress offers magnificent chance for renewal.	Steiner and Reisinger (2006, p. 8).

ANNEX II: EXPERT INTERVIEWS AND PROTOCOL

List of experts (in alphabetical order)

ORGANISATION AND POSITION	INTERVIEWEES
International Relations representative of the European Historic Thermal Towns Association (EHTTA)	Mr Luca Bruschi
CEO of the Global Wellness Institute (GWI)	Ms Susie Ellis
Research project manager at AGE Platform Europe	Ms Ilenia Gheno
Honorary Secretary-General of the European Spas Association (ESPA)	Mr Joachim Lieber
CEO of Intuition Communication Ltd and International Medical Travel Journal (IMTJ)	Mr Keith Pollard
Co-founder of Xellum, representing the European Travel Commission (ETC) and the United Nations World Tourism Organisation (UNWTO)	Mr Laszlo Puczko
Senior Lecturer of International Law & Health, University of Bologna/Secretary-General of the European Association of Patients and Users of Thermal Centres (EAPTC)	Mr Alceste Santuari
Director of Zorghotel De Kim and Chair of Stichting Nederlandse Herstellingsoorden en Zorghotels (SNHZ)	Mr Marc Vieten

Interview protocol

General introduction

- What is your current position and affiliation with health tourism? Your latest research, publications and/or data?

Analysis of current trends

- Is your sector (health tourism) growing or shrinking?
- At what speed is it developing?
- Which are the major (EU?) destination countries and/or regions for these health-related services?
- Which are the major source countries and/or regions for these health-related services?
- Are there changes in health tourism, in terms of member states and/or regions that have lost or gained market share?
- How does seasonality affect these health-related services?
- Are there EU destinations that target disabled people and those with limited mobility?
- How is health tourism influencing the labour market?
- How is health tourism influencing the transport system?
- How is health tourism influencing the environment?

Evaluation of factors of change

- Which factors have stimulated the growth of European health tourism?
- Which factors have contributed to regional success at attracting a majority of the health-related tourists (good practices)?
- What barriers (technical, administrative and/or legal) at the EU and/or national level might hinder health tourism?

Strengths and weaknesses

- How is European Health tourism performing (advantages/disadvantages) compared with other world leading players?
- Is health tourism supported by public sources in the EU?
- Is health tourism supported by other leading market players in the world?
- What is the role of funding in the development of health tourism?
- Which regional and/or national policies are influencing health tourism?
- What role do insurers play in the development of health tourism?
- What is the role of the media in the development of health tourism?

Challenges and opportunities

- What are the identifiable challenges in the health-tourism market (e.g. digitalisation and the rise of the sharing economy)?
- What are the major opportunities for health tourism, given, *inter alia*, trends in demography?

Recommendations/scenarios for the future

- How do you view the future of health-related tourism in the EU? What do you consider possible scenarios? What would be the most effective scenario?

Final questions and conclusion

- Is there anything we did not cover in the interview?
- We will process the interviews in order to complete the report, which will subsequently be published.
- I would like to thank you for providing your expertise in this study!

ANNEX III: ACCOMMODATION HEALTH FACILITIES

The following table lists the specific health tourism-related facilities that accommodations offer, which are counted as proxy accommodations for the supply level of health-tourism services and facilities.

allergy-free rooms
back massage
barber/beauty shop
beauty services
body scrubs
body treatments
body wraps
couples massage
bathroom emergency cord
facial treatments
facilities for disabled guests
fitness
fitness centre
fitness classes
fitness/spa locker rooms
footbath
foot massage
full body massage
garden
hamman
hand massage
head massage
heated pool
higher level toilet
hot spring bath
hot tub/Jacuzzi
indoor pool
indoor pool (all year)
indoor pool (seasonal)
infinity pool
lift
light therapy
low bathroom sink
manicures
massage
massage chair
neck massage
non-smoking rooms
open-air bath
outdoor pool
outdoor pool (all year)
outdoor pool (seasonal)
pedicures
plunge pool
pool with view
pool/beach towels
private park
rooftop pool
salt-water pool
sauna
solarium
spa and wellness centre
spa facilities
spa lounge/relaxation area
spa/wellness packages
special dietary menus (on request)
steam room
swimming pool
toilet with grab rails
visual aids: braille
visual aids: tactile signs
wheelchair accessible
yoga classes

ANNEX IV: EXPANDED HEALTH TOURISM DATABASE - MAIN NUMBERS

	HEALTH-TOURISM TRIPS (MILLIONS)			HEALTH-TOURISM SHARES		HEALTH-TOURISM REVENUES (BILLION €)		HEALH-TOURISM SPENDING (BILLION €)
COUNTRY	DOMESTIC	INTERNATIONAL ARRIVALS	INTERNATIONAL DEPARTURES	DOMESTIC PLUS INTERNATIONAL DEPARTURES	INTERNATIONAL ARRIVALS	DOMESTIC ARRIVALS	INTERNATIONAL ARRIVALS	INTERNATIONAL DEPARTURES SPENDING
Austria	0.77	0.42	0.73	6.7%	1.7%	€1.44	€0.31	€0.61
Belgium	0.25	0.06	0.40	3.7%	0.8%	€0.07	€0.04	€0.23
Bulgaria	0.29	0.08	0.05	9.0%	1.1%	€0.04	€0.03	€0.03
Croatia	0.18	0.13	0.09	3.3%	1.1%	€0.09	€0.08	€0.06
Cyprus	0.04	0.03	0.04	3.0%	1.0%	€0.03	€0.03	€0.04
The Czech Republic	2.34	0.10	0.49	8.7%	1.0%	€0.25	€0.04	€0.34
Denmark	0.48	0.07	0.17	2.0%	0.7%	€0.15	€0.03	€0.13
Estonia	0.08	0.15	0.04	3.0%	5.3%	€0.01	€0.07	€0.02
Finland	2.12	0.06	0.64	7.3%	1.3%	€0.31	€0.04	€0.34
France	13.87	0.37	1.91	7.0%	0.4%	€8.11	€0.26	€2.17

	HEALTH-TOURISM TRIPS (MILLIONS)			HEALTH-TOURISM SHARES		HEALTH-TOURISM REVENUES (BILLION €)		HEALH-TOURISM SPENDING (BILLION €)
COUNTRY	DOMESTIC	INTERNATIONAL ARRIVALS	INTERNATIONAL DEPARTURES	DOMESTIC PLUS INTERNATIONAL DEPARTURES	INTERNATIONAL ARRIVALS	DOMESTIC ARRIVALS	INTERNATIONAL ARRIVALS	INTERNATIONAL DEPARTURES SPENDING
Germany	11.29	0.60	6.09	7.3%	1.8%	€12.70	€0.51	€5.11
United Kingdom	1.88	0.09	0.76	1.3%	0.3%	€0.74	€0.11	€0.94
Greece	0.22	0.12	0.04	6.0%	0.5%	€0.95	€0.13	€0.05
Hungary	1.98	0.48	0.63	13.3%	3.9%	€0.18	€0.13	€0.36
Ireland	0.22	0.06	0.18	3.0%	0.7%	€0.31	€0.06	€0.17
Italy	3.34	0.64	0.77	6.7%	1.3%	€4.32	€0.88	€1.06
Latvia	0.47	0.05	0.20	14.3%	2.8%	€0.05	€0.03	€0.11
Lithuania	0.15	0.05	0.10	5.7%	2.3%	€0.04	€0.03	€0.05
Luxembourg	0.01	0.03	0.12	6.7%	2.5%	€0.00	€0.02	€0.10
Malta	0.01	0.06	0.03	9.0%	3.4%	€0.01	€0.06	€0.03

	HEALTH-TOURISM TRIPS (MILLIONS)			HEALTH-TOURISM SHARES		HEALTH-TOURISM REVENUES (BILLION €)		HEALH-TOURISM SPENDING (BILLION €)
COUNTRY	DOMESTIC	INTERNATIONAL ARRIVALS	INTERNATIONAL DEPARTURES	DOMESTIC PLUS INTERNATIONAL DEPARTURES	INTERNATIONAL ARRIVALS	DOMESTIC ARRIVALS	INTERNATIONAL ARRIVALS	INTERNATIONAL DEPARTURES SPENDING
The Netherlands	0.41	0.20	0.29	1.7%	1.4%	€0.88	€0.17	€0.15
Poland	2.43	0.13	0.65	6.3%	0.8%	€6.19	€0.09	€0.43
Portugal	1.72	0.09	0.18	12.7%	1.0%	€1.62	€0.11	€0.23
Romania	1.06	0.04	0.07	6.7%	0.5%	€0.30	€0.01	€0.05
Slovakia	0.53	0.14	0.39	13.3%	2.2%	€0.09	€0.03	€0.13
Slovenia	0.12	0.07	0.17	6.3%	2.7%	€0.09	€0.05	€0.08
Spain	3.26	0.68	0.24	2.3%	1.0%	€1.19	€0.60	€0.28
Sweden	6.52	0.07	2.29	13.3%	0.7%	€2.74	€0.06	€1.71
EU28	56.03	5.05	17.51	5.8%	1.1%	€42.92	€3.99	€13.85

ANNEX V: OVERVIEW OF CASE STUDIES

Medical tourism

CASE STUDY	COUNTRIES INVOLVED	SHORT DESCRIPTION	SOURCE
British citizens undergoing bariatric surgery in Belgium	UK, BE	*Type:* study. *Period:* 2015. *Status:* completed. *Main goal:* to address the experiences of medical tourists who undergo bariatric (stomach reduction) surgery with regard to travel, treatment, complications and follow-up treatment. *Results/findings:* certain results indicate that not all of the patients were eligible for treatment by the NHS. Belgium was viewed as a centre of expertise for bariatric surgery. Patients in the study consulted the internet for information. Continuity of care is deemed important in light of follow-up care.	Hanefeld and Horsfall (2015)
British senior citizens residing in Spain	UK, ES	*Type:* study. *Period:* 2012. *Status*: completed. *Main goal:* to explore the healthcare experiences of British pensioners who have migrated to Spain. *Results/findings:* British pensioners reported high levels of satisfaction with their experiences of Spanish healthcare, in contrast to their more negative experiences of other public services in Spain. The perceived high quality and humanity of care provided were the pivotal features of healthcare encounters, at all levels of the healthcare system.	Legido-Quigley, Nolte, Green, la Parra, and McKee (2012)
Poland policy implications of cross-border healthcare	PL	*Type:* study. *Period:* 2016. *Status:* completed. *Main goal:* to research how Poland implemented Directive 2011/24/EU in its national legislation.	Helena (2016); Kowalska-Bobko et al. (2016); Ried and Marschall (2016)

CASE STUDY	COUNTRIES INVOLVED	SHORT DESCRIPTION	SOURCE
		Results/findings: by not promoting Poland as a health-tourism destination, key stakeholders have overlooked the potential benefits of Directive 2011/24/EU. The number of applications for treatment abroad has been very low, with most rejected as they did not meet very strict formal requirements. The current Polish legislation does not facilitate access to cross-border healthcare (please see Section 3.5 for more detailed information).	
Sharing capacities – Malta and the United Kingdom	UK, MT	*Type:* study/policy. *Period:* 2006. *Status:* completed, but results are still ongoing. *Main goal:* to describe how Malta has dealt in the past with patient mobility. *Results/findings:* a bilateral healthcare agreement exists between Malta and the UK. It facilitates patient mobility so Maltese patients can undergo treatment in the UK and medical specialists can deliver medical services in Malta.	Rosenmöller, McKee, and Baeten (2006)
The development of health tourism in the Balkans	AL, BA, BG, HR, GR, MK, ME, RO, SL, RS,TR	*Type:* study. *Period:* 2015. *Status:* completed. *Main goal:* to analyse the challenges to developing health tourism in the Balkans. *Results/findings:* natural resources are present, but health tourism in the Balkans has focused mainly on government-supported domestic rehabilitation of spa and balneology-based tourism. This has frequently resulted in focusing on old-fashioned facilities that require renovation and a more commercial approach.	Kornélia Kiss (2015)

Wellness and spa tourism

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
ALHTour (Assisted Living Technologies for the Health Tourism sector)	PT, BE, NE, IT	*Type:* best practice. *Period:* 2016-2018. *Status:* ongoing. *Main goal:* to encourage scientific excellence and increase technological innovation in independent living, to be applied to the health-tourism market. *Results/finding:* N/A.	http://alhtour.eu/
Alpine Wellness (ALPSHEALTHCOMP, EU Interreg III B project)	AT, DE, IT	*Type:* study. *Period:* 2005-2008. *Status:* completed. *Main goal:* to secure the competiveness of the Alpine space as a long-term holistic health and wellness destination, by creating a competent network. *Results/findings:* best practices include innovation and product development, quality management based on the Alpine Wellness model, and the perception of the alpine space as a health and wellness destination. Decision making in favour of alpine health and wellness products was also put in place (please see Section 3.3 for more detailed information).	Bausch et al. (2008) Schalber and Peters (2012)
Bad Wörishofen, Bavaria Germany	DE	*Type:* study. *Period:* 2012. *Status:* completed. *Main goal:* to assess German health reforms for the wellness and spa industry through a case study of Bad Wörishofen. *Results/findings:* certain crisis-recovery strategies have benefitted Kur destinations affected by Germany's health reforms.	Pforr and Locher (2012)

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Baltic health tourism cluster	EE, LV, LT	*Type:* study/policy. *Period*: 2013-… *Status:* completed, but results are still on-going. *Main goal:* to increase the global competitiveness of the region in health tourism. *Results/findings:* collaboration could lead to improvements in reputation, quality, new product development, packaging, education and training, knowledge transfer and pooling of financial resources.	M. Smith (2015)
CHARMED - Characterisation of a Green Microenvironment and to Study its Impact upon Health and Well-Being in the Elderly as a Way Forward for Health Tourism	NE, DE, IT, PL, UK, DK, SK	*Type:* best practice. *Period:* 2017-2020. *Status:* ongoing. *Main goal:* The project has six goals: a) to develop cross-disciplinary and inter-sectorial knowledge of how to improve physical and mental well-being in the elderly; b) to characterise the environmental geology of the Italian village of Nemi and correlate the identified features with improvements in health, well-being and recovery; c) to train a new generation of specialists in the recreational and health sectors for the tourism industry; d) to train specialists in social and therapeutic horticulture (STH), as a way to improve physical and mental health; e) to create a model for health tourism; f) to develop a business plan that contains an economic impact analysis. *Results/findings:* N/A.	http://www.charmed-nemi.eu/

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Destination Feel Good, Bournemouth University case study	UK	*Type:* best practice. *Period:* 2014-2015. *Status:* completed. *Main goal:* to accelerate tourism growth via an improved understanding and implementation of well-being. In practice, the aim was also to encourage public engagement towards wellness, tourism and small business development in a UK coastal resort. *Results/findings:* it will facilitate the exchange of knowledge between tourism businesses, policymakers (both public health and tourism) and well-being academics. The natural attributes of the coast and its association with healthy living can now be repackaged and rediscovered by tourism entrepreneurs to better suit the wellness paradigm.	https://microsites.bournemouth.ac.uk/destinationfeelgood/
DOSTWELL - Development Of Sustainable Tourism Focusing on WELLness	SL, DE, CH, AT, IT, GR	*Type:* best practice. *Period:* 2005-2007. *Status:* completed. *Main goal:* to explore growth opportunities in the participating regions based on new and innovative wellness-tourism concepts. Related to wellness concepts and products based on water, whether involving thermal spas, the seaside or lakes. *Results/findings:* N/A (the final report, two manuals, a cluster wellness model and other deliverables could not be found on the web, nor retrieved).	http://www.interreg4c.eu/uploads/media/pdf/DOSTWELL_4E0065N.pdf

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
ECVET Health Tourism (European Credit System for Vocational Education and Training)	HR, IT, BE, SK, RO	*Type:* best practice. *Period:* 2012-2014. *Status:* completed, and still in force. *Main goal:* apply the ECVET process to create transparency and develop learning outcomes and professional qualifications for the health-tourism market that are acknowledged European-wide. *Results/findings:* three types of professionals in health tourism were defined: cosmeticians, health-tourism managers and fitness-wellness assistants. A country-specific thesaurus defines the competences, knowledge and educational learning outcomes for the three types of professionals. In addition, country-specific memoranda of understandings and learning agreements were signed.	Lifelong Learning programme (2017)
EU standard for health & wellness. Funded by the European Economic Chamber of Trade, Commerce and Industry, European Economic Interest Grouping (EEIG)	EU	*Type:* policy. *Period:* 2012. *Status:* completed. *Main goal:* to encourage standards in health and wellness; to encourage confidence in health and wellness organisations; to establish a common professional and ethical basis in health tourism. *Results/findings:* A standard was developed (please see the reference in the 'Source' column).	EEIG EU Standards Certification Secretariat (2012)
Fortune Health Resort	CY	*Type:* best practice. *Period:* started in 2017. *Status:* ongoing. *Main goal:* the project is dedicated to promoting health, longevity and well-being through a unique combination of integrated healthcare, wellness and other services, functionally supported by surrounding hotel, commercial and residential developments. Special emphasis is given to senior citizens' care. *Results/findings:* N/A.	KPMG (2016)

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Health Tourism: Conceptual Framework and Insights from the Case of Spain (Costa del Sol)	ES	*Type:* study. *Period:* 2016. *Status:* completed. *Main goal:* to describe health tourism in the Costa del Sol, a mature Mediterranean destination in the south of Spain, and to show the multi-dimensionality of health tourism. *Results/findings:* the health-tourism market in the Costa del Sol, as a mature destination, has developed in recent years. However, work remains to integrate, rationalise and improve the quality of the services associated with health tourism.	Padilla-Meléndez and Del-Águila-Obra (2016)
Hohe Tauern Health (HTH)	AT	*Type:* policy. *Period:* 2008-… *Status:* completed, but results are still ongoing. *Main goal:* to help the regional authorities develop a new range of health-related tourism products that exploit the health benefits of the Krimml Waterfalls, a notable local feature. Indeed, tourism in this part of the Hohe Tauern National Park near Salzburg has been stagnating in recent years. *Results/findings:* scientific evidence has demonstrated that the fine mist near these waterfalls is effective against asthmatic and allergic diseases. In addition, excellent air quality, low levels of fungal spores and the region's short flowering season help make it an ideal place for a bronchial asthma treatment or cure.	http://ec.europa.eu/regional_policy/en/projects/austria/health-tourism-initiative-developed-in-the-mountains-of-austria

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Innovating and re-branding Nordic Well-being tourism	DK, SE, IS, FI, NO	*Type:* study. *Period:* 2010-2012. *Status:* completed. *Main goal:* to achieve a deeper understanding of the driving forces behind coherent well-being tourism in the Nordic region and find policies that will support a Nordic Well-being brand. *Results/findings:* best practice is to determine unique selling points, develop new sports and leisure activities and forge links to food, medicine, cosmetics, lifestyle diseases and spirituality and enhance the Nordic infrastructure and raise international media awareness (please see Section 3.2 for more detailed information).	Hjalager and Flagestad (2012); Hjalager et al. (2011)
Medical spa and wellness in the Visegrád Space – online portal	CS, SK, PL, HR	*Type:* best practice. *Period:* N/A. *Status:* completed. *Main goal:* focus on one of the most important tourist attractions in the Visegrád Space. The objective is to make the offer of medical spas and less complex and more synoptic, to promote this tourism sector and to attract new clients. *Results/findings:* a multilingual database of health resorts and medical wellness facilities was created.	http://www.v4medicalspas.eu/content/7
OFF TO SPAS	HU, BE, RO, SE	*Type:* best practice. *Period:* 2015-2016. *Status:* completed, but results are still ongoing. *Main goal:* to create new thermal-water-related international health-tourism products (international balneology product) in the spa towns of Central Europe that could serve as a main attraction, bringing seniors to these regions in the low tourism seasons. *Results/findings:* creating new balneology tourism products and focusing on senior citizens would ensure new jobs and new regional growth opportunities.	http://offtospas.eu/project

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Quality management at Thalasso centres in Spain	ES	*Type:* study. *Period:* 2011. *Status:* completed. *Main goal:* to assess how well quality management has been implemented at Spanish Thalasso centres. *Results/findings:* leadership and learning form the strengths. Managers perceive the major barriers to be resistance to assume new responsibilities and inadequate knowledge of quality management (please see Section 3.6 for more detailed information).	Crecente et al. (2012); García et al. (2015); de la Cruz del Río et al. (2015); Peris-Ortiz et al. (2015)
SAIL	NE, BE, UK, FR	*Type:* best practice. *Period:* 2016-… *Status:* ongoing. *Main goal:* to encourage active ageing and extend independent living by identifying new ways to help people remain independent longer and be more self-reliant and less dependent on traditional healthcare and social-care services. *Results/findings:* ten pilots were created in the partner regions for two themes (movement & well-being), created through social innovation and the active participation of the elderly and service providers (incl. business, local authorities and healthcare providers), based on the specific needs of the elderly and by looking at local potential in the region.	http://www.interreg2seas.eu/nl/SAIL
Spa development in Poland	PL	*Type:* study. *Period:* 2016. *Status:* completed. *Main goal:* to present the course of spa-company privatisation in Poland during 2001-2011. *Results/findings:* privatisation has potentially improved the infrastructure standards of spas, but the method of application also seems to limit the therapeutic potential of spas.	Szromek et al. (2016)

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Transnational healthcare practices of Romanian migrants in Ireland	RO, IE	*Type:* study. *Period:* 2014. *Status:* completed. *Main goal:* to study the transnational healthcare practices of Romanian migrants in Ireland. *Results/findings:* Romanian migrants' healthcare mobility also serves as a social-mobility strategy for migrants. Furthermore, such processes are found in many pairs of countries of origin and migration.	Stan (2015)
WelDest: Health and Well-being in Tourism Destinations	AT, CZ, DE, FI, UK	*Type:* best practice. *Period:* 2012-2014. *Status:* completed. *Main goal*: to develop competitive health and well-being destinations. *Results/findings:* a destination profile was defined in a way that attracts the desired tourist segments by better meeting customers' needs (please see Section 3.4 for more detailed information).	Dvorak et al. (2014)
Well-O-Live project	IT, FR, FI, BG, HR, GR	*Type:* best practice. *Period:* 2016-2017. *Status:* ongoing. *Main goal:* to diversify EU tourism by developing and promoting transnational, thematic rural-tourism products that focus on wellness and well-being throughout the 'Routes of the Olive Tree'. *Results/findings:* the project's participative products are well-integrated thematic offers of sustainable tourism that foster enhanced accessibility, visibility and market uptake of experiential rural tourism.	http://olivetreeroute.gr/2016-017en/

CASE STUDY	COUNTRY CODE	SHORT DESCRIPTION	SOURCES
Wellness 3 Plus Development of a cross-border wellness destination by connecting countryside tourist products, Interreg Slovenia-Croatia	SL, HR	*Type:* best practice. *Period:* 2009-2012. *Status:* completed. *Main goal:* to transform the area into a prominent and desirable 'Wellness 3 plus' destination, which will upgrade the spas' existing offers. This offer consists of three thematic parts: active holidays, experiencing nature, and gastronomy and culture. *Results/findings:* no information was published on the findings, only on the intended findings such as cross-border packages, provider networks and education/training of nearly 100 guides.	http://www.si-hr.eu/en2/map/wellness-3-plus/

ANNEX VI: OVERVIEW OF POLICIES

Europe

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, with the aim to establish rules for facilitating access to safe and high-quality cross-border healthcare in the EU and to ensure patient mobility in accordance with the principles established by the European Court of Justice and to promote cooperation on healthcare between member states.	EU	From 2011	European Union (2011)
Report, policy brief and evaluation of patient mobility and cross-border healthcare in Europe. Attention for legal frameworks, financial implications, quality monitoring, patients' rights, liability issues and impacts.	EU	Several	Bertinato et al. (2005); International Federation for Spina Bifida and Hydrocephalus (2017)
Health tourism is eligible for EU funding in the European Regional Development Fund (ERDF) because it helps develop quality value-added products and services in niche markets by mobilising specific local resources and contributing to smart regional specialisation.	EU	2014-2020	Directorate-General for Enterprise and Industry (2016)
The 'WelDest' project was funded with support from the EC (€299,966) and in conjunction with five higher education institutes from Austria, the Czech Republic, Finland, Germany and the UK. The aim was to create a *framework* and a *toolkit* for destination management organisations, public bodies and private companies in destinations looking to develop or strengthen themselves as health and well-being destinations. An *electronic handbook* has been developed that offers a *self-assessment tool*, a *development tool* and a *course with educator instructions*. A *blog* has also been set up where industry, academia and citizens can share their knowledge.	EU	2012-2014	Directorate-General for Enterprise and Industry (2016); Please also see http://weldest.blogspot.nl/

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The objective of the SOWELL project was to examine the possibilities of increasing the access to wellness activities for a large number of people, specifically seniors and young people, and to develop off-peak tourism. SOWELL aimed to exploit the potential of thermal spas and to develop the other tourist activities throughout the territory (by proposing offers of stay combining various types of activities). This tourist activity helps maintain the local economy year round, and it indirectly supports the activity of other local economic actors (accommodation, catering, service providers, etc.). As the thermal resorts are typically situated in rural and/or mountainous areas, developing tourism activities contributes to a more balanced development of territories. The project aimed to identify good practices as well as the options for combining social tourism offers in each territory, for seniors and young people alike, in order to define the possibilities for developing transnational exchanges and increasing tourism. This project also examined the existing incentives or systems for social tourism. Finally, SOWELL's objective was also to strengthen cooperation between the partners by promoting the sharing of experiences and good practices.	EU	?	Please see https://www.sentour.eu/other-eu-projects
The main idea of the OFF TO SPAS project was to create new, thermal-water-related international health-tourism products in spa towns within Central Europe, in order to attract seniors to these regions during low tourism seasons. One of the main objectives was to involve and mobilise various players in the health-tourism value chain. Therefore, the project was open for the direct involvement of key stakeholders (e.g. spa towns, health-related associations). The stated objectives were to encourage better cooperation and promote agreements among different actors to increase the number of tourists during the low and medium seasons, to communicate and promote tourism as a strategy for active and healthy ageing, and to foster the development of innovative health insurance policies to make the health-tourism products more sustainable. This led to actions such as: • creating a new, international balneology-tourism product network; • senior market analyses, surveys, comparative analyses and other related studies; • a local resource-based and market-oriented re-positioning of the complementary spa destinations; • holding discussion platforms, workshops and other events; and • fostering and facilitating the negotiations amongst the health-insurance companies and health services.	EU	2015-2016	Please see http://www.sentour.eu/other-eu-projects

Albania

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism was a tourism product in the 'Tourism Development strategy in Albania 2007-2013'.	National	2007-2013	Metodijeski and Temelkov (2014)

Andorra

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The Andorra government, as part of its strategy 'Invest in Andorra', views health and wellness as chief constituents for leveraging the tourism sector. The government is leveraging this asset by doubling the budget for tourism promotion. The aim is to maintain a presence in traditional markets, while developing new emerging markets such as health tourism. With this approach, the government is attempting to attract investments in new healthcare and wellness-related services.	National	?	Municipality of Andorra (N.Y.)

Austria

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Quality health tourism is guaranteed by the Best Health Austria platform, which integrates 36 partners (including clinics, rehabilitation centres, spas and wellness facilities). This public-private partnership ensures excellent health-tourism services, while upholding all quality standards.	?	?	Lackovic, Milojica, and Zrinic (2011)
The Krimml Waterfalls-Hohe Tauern Health (HTH) project was launched in 2008. Tourism was stagnating at Hohe Tauern National Park (in the Oberpinzgau region of Austria).	EU, Regional	2008	Directorate-General for

Regional authorities set out to develop new tourism products, exploiting scientific evidence about the health benefits of the highest waterfalls in Europe. The project was developed in close cooperation with regional authorities, the regional tourism association and the national park association. Funded partly with financial support from the ERDF programme 'Strengthening Regional Competitiveness Salzburg 2007–13' (totalling €125,000), a feasibility study looked at the requisite conditions for hotels to be included in this new health-tourism package, how to certify the hotels and whether a sufficient number of hotels could qualify. Eleven hotels underwent the required renovation/adaptation measures. A leading woodworking company joined the initiative to work with a university institute on the construction of 'allergy-proof' wood products. Collaboration with the regional hospital was also encouraged to help hotels provide access to medical services as part of their 'premium product'. The ensuing promotion campaign targeted persons with allergies and guests with high health awareness.			Enterprise and Industry (2016); European Commission (2007); European Union (2016)

Bosnia and Herzegovina

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism is a tourism product in the 'Strategy in Bosnia and Herzegovina 2008-2018'.	National	2008-2012	Metodijeski and Temelkov (2014)

Bulgaria

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The National Tourism Act focuses on wellness activities. Article 138 focuses on medical Spas and Spa & Wellness services to be delivered in wellness centres, certificates for delivering services and special requirements for employee competences.	National	From 2013	Baltova (2013)

Health tourism was a tourism product in the 'Strategy for sustainable development of tourism in Bulgaria 2009-2013'.	National	2009-2013	Metodijeski and Temelkov (2014)
The 'IT Spa Tourism' project supported health, tourism and culture in the Greek-Bulgarian border area by creating an integrated IT system for **spa tourism** and e-health services. This allowed municipalities to operate hot springs as health-tourism centres offering comprehensive services and to provide online booking and customer reviews, with a view to attracting more tourists, especially from abroad. This project was partly funded by the EU. Total investment for the project was €1,578,868 (of which ERDF contributed €1,342,038 from the 'Greece - Bulgaria' Operational Programme for the 2007-2013 programming period).	EU	2007-2013	European Commission (2015c)

Croatia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism is a tourism product with distinctive growth potential, according to the 'Tourism development strategy in the Republic of Croatia until 2020'. The focus is on market development, commercialisation and specialisation, networking and upgrading the quality of the accommodations. Ambitions include, but are not limited to: • Enriching the existing offer with services relevant to different segments of potential clients of health, medical, wellness and recreational services. Apart from the modernisation and construction of diagnostic and therapeutic centres, this particularly refers to improving the quality of accommodation (ensuring a high hotel-standard accommodation), as well as ensuring the development of a number of fun activities (water parks, sports and other leisure activities). • Complementing the health offer with the development of new hotels, which would have equal access to natural health factors.	National	Up until 2020	DATOURWAY (2011); Metodijeski and Temelkov (2014); Republic of Croatia (2013a, 2013b)

• Focusing on the environment and authenticity of the area when developing new health-tourism facilities. This would lead to the following development activities: • Creating an action plan for the development of health tourism (by the Ministries of Health and Tourism) to establish priorities for the modernisation of the offer/service of existing destinations/institutes and recognising priority locations for the development of the offer. The action plan includes actions such as (1) proposing the concept of best use and the most appropriate business and management model (2) developing activities related to staff training, interest affiliations and other activities for improving market performance and (3) detailing activities necessary to achieve selected projects, their key players and implementation deadlines. Efficient implementation of this action plan requires (1) amendments to the existing legislation related to equal allocation of concessions of the use of geothermal sources, as well as other naturally healing facilities to all interested public and private investors and (2) establishing ways for usage and management of condominium stakes in buildings and areas for the health-tourism offer. • Establishing minimum standards for wellness centres, health centres, health-tourism centres, including standards for facilities, equipment, safety, service quality and environmentally sound 'green' trading; • Croatian health destinations will strategically link and network with internationally recognised and established service providers in health tourism in the countries within their competitive circle (Austria, Italy, Germany, Hungary and Slovenia). • Creation of destination cooperation that focuses on health (e.g. accommodation, catering, infrastructure and specialised health services); • Professional leadership by a national health-tourism association with the aim of market research, information, education, lobbying and membership.			

Cyprus

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
From 2010 to 2013, Cyprus had a 'Strategy and Action Plan for the Organisation, Development and Promotion of Health Tourism in Cyprus'. Proposed actions included (e.g.): 1. Organise road shows to attract investors and international companies in hospitality management 2. Incentives for international accreditation of private hospitals: • Agreements with healthcare systems of other countries. • Reviews on satisfaction of healthcare travellers. • Establishment of 'Medical Facilitators' who are responsible for the promotion of specialised packages. • Creation of criteria concerning the licensing of parties involved in the tourism sector who want to participate in the health-tourism sector. • Provision of incentives for the development of existing health facilities and touristic accommodations that wish to change and adapt their services to attract specific healthcare travellers. 3. Start a dialogue between the Ministry of Health and the Planning Bureau to secure European funding for projects. To achieve this, best practices include: 1. to use ambassadors to make international organisations more aware and sensitive to the Cyprus market (insurance companies, hospitals, etc.); 2. to create an electronic portal for the dissemination of information and coordination between stakeholders; 3. to give presentations for projects and investment opportunities in the healthcare market; 4. to develop a specialised translation system or translation service for healthcare travellers and their guides; 5. to publish a manual (advisory/guidelines) for the development and adoption of minimal standards for the operation and promotion of a medical SPA in Cyprus; and 6. to use promotion:	National	2010-2013	Qualevita (N.Y.)

• Via printed materials: information guides and brochures (in several languages and aimed toward different target groups), print posters, window displays, etc. • Via print advertisements: magazines, newspapers, town house brochures, in-flight magazines, hotel magazines, etc. • Via electronic promotion: advertisements in health-tourism internet platforms, Cyprus Health Service Promotion Board electronic portal, banners, etc. • Via support actions for marketing: marketing committees, mailings lists, incentive for tour operators and facilitators, educational workshops, direct marketing, relationship marketing, collection of data and desk research, organising and attending exhibitions, seminars, workshops, and conferences, newsletters to press, trips for journalists, infomercials, distribution lists of journalists, etc. • Via the creation of a corporate identity (branding health tourism).			
Several interventions were done to enrich the tourist product and upgrade services, based on the EU Sustainable Development and Competitiveness Operational Programme ERDF (European Regional Development Fund) and CF (Cohesion Fund).	EU	?	European Union (2016)

Estonia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Given the potential resources and target markets of Estonia as a travel destination, health tourism is included one of the thematic areas in 'National Tourism Development Plan for 2014-20'.	National	2014-2020	OECD (2014)

Finland

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The Finnish Tourism Board advocates well-being tourism as a major future area of tourism. There are areas in Finland which are already making good progress and other areas where the first step is yet to be taken.	National, Regional	2011	Henna Konu, Tuohino, and Björk (2011)

Germany

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
With an innovative tourism concept for people suffering from back problems, the Rostock-based vital & physio GmbH brings together business with hotels, doctors and furniture manufacturers. The medical treatment offered by vital & physio GmbH, therefore, provides relief to over 10,000 patients, tourist customers and prevention-course participants, but it also contributes to the German economy. Total investment for the 'Back-health centre of excellence' project was €150,000 (with the ERDF contributing €112,000 through the 'Mecklenburg-Vorpommern' Operational Programme for the 2007-2013 programming period).	EU	2007-2013	European Commission (2014a)

Greece

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
In 2012, the Greek National Health Tourism Strategy and Road Map were being developed. The ultimate goal was the development of a comprehensive, formal national strategy and the creation of clusters for all stakeholders and operations involved in every aspect of health, dental, **medical and spa tourism** – including a comprehensive framework law for health tourism.	National	From 2012	Mercury Advisory Group (2012)

ERDF and ESF funding is allocated to Greece to promote spa-health tourism, increase the service offering, prolong the active season, and achieve quality improvements. This is based on the Competitiveness, Entrepreneurship and Innovation Operational Programme. Between 2007 and 2013, funding from the Operational Programme Improvement of Accessibility (ERDF and CF) was used to develop skills of medical professionals, to support private investments in the tourism sector, including plans to enhance and support health tourism, and to develop health-tourism centres.	EU	2014-2020	European Union (2016)
The 'IT Spa tourism' project supported health, tourism and culture in the Greek-Bulgarian border area by creating an integrated IT system for **spa tourism** and e-health services. This allowed municipalities to operate hot springs as health-tourism centres offering comprehensive services and to provide online booking and customer reviews, with a view to attracting more tourists, including from abroad. This project was partly funded by the EU. Total investment for the project was €1,578,868 (of which ERDF contributed €1,342,038 from the 'Greece - Bulgaria' Operational Programme for the 2007-2013 programming period).	EU	2007-2013	European Commission (2015c)

Hungary

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
In Hungary, EU funding is used to increase demand for health-tourism services using a range of special tools that are based on the Economic Development and Innovation Operational Programme. Sources: ERDF, ESF (European Social Fund) and YEI (Youth Employment initiative).	EU	2014-2020	European Union (2016)
Health tourism is seen as a joint responsibility of several ministries (the Ministries of the Economy, Tourism & Catering and Human Resources).	National	?	OECD (2016)
Health tourism is included in a list of investment opportunities, prepared by the Hungarian Investment and Trade Agency.	National	2014	Hungarian Investment and Trade Agency (2014)

Hungarian legislation addresses the issues of **medical tourism** and patient mobility in two regulated areas. On the one hand, in the healthcare legislation, and, on the other hand, in tourism and development policy. The health-tourism legislation is limited to the development of natural medical factors, baths and medical institutions from a medical tourist point of view. In Hungary, the law that regulates medical services contains the rules of reimbursement of necessary healthcare for foreigners who reside in Hungary and Hungarian citizens who reside abroad.	National	?	National Institute for Strategic Health Research (N.Y.)
Health tourism based on medical services was seen as a point of departure for Hungarian tourism and was afforded real significance in the Széchenyi Plan of the national government from 2001 to 2004. In the new Széchenyi Plan, which ran from 2004 onwards, health tourism is discussed in a separate Section. The strategy discussed there aims at (1) a more optimal and efficient exploitation of the country's thermal water and geothermal potentials and (2) organising a network of related production and service sectors to create a distinct national industrial sector emphasising the positive attributes of the country. The National Tourism Development Strategy (2005–2013) prioritised the development of health tourism. In the National Tourism Marketing Plan 2014, health tourism is a strategic product for both the domestic and foreign market. From 2007 to 2013, there was a national strategy for the development of health tourism. The central issue of the 'Healing Hungary – Health Industry Programme' was the development of the health and the thermal-health industry, it also contains novel points which reflect a sustainability-driven approach.	National	From 2001	Hungarian Tourism Ltd (2014a, 2014b); Katalin Kiss (2012); Ministry for National Economy Hungary (2010); PolicySolutions (2010)

Ireland

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The introduction of categorisation criteria for health-tourism facilities was mentioned as a quality improvement in the Tourism Product Development Strategy 2007–2013.	National	2007-2013	Fáilte Ireland (2007)
In the national tourism development strategy from 2003, health and well-being tourism was seen as a major opportunity and a key market activity segment.	National	From 2003	Tourism Policy Review Group (2003)

Italy

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The regional government of Veneto has been planning and organising specific healthcare services for tourists. This included facilities aimed at tourists in need of urgent healthcare services as well as health tourists. Since 2003, a special 'task force' has been operating in the region with the aim of broadening the knowledge of this tourist phenomenon and of patient mobility, as well as improving the ability to cope with underlying administrative and organisational problems. It analyses the impact of cross-border health demands and related health issues at the regional level.	Regional	2007	Bellometti and Bertinato (2007)

Latvia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The National Development Plan of Latvia for 2014–2020 includes health tourism and resort development as strategic tourism products.	National	2014-2020	Sīrava (2015); M. K. Smith (2013)
The Health Tourism Strategy for 2012–2020 includes product development, research and joint health-tourism marketing activities.	National	2012-2020	M. K. Smith (2013)
The Latvian 'Operational Programme', which defines the priority axes of the assistance from the EU funds in accordance with the Europe2020 Strategy, names health tourism as a priority.	EU, National	2013-2020	Ministry of Finance of the Republic of Latvia (2013)
Jurmala is the largest resort city in the Baltic States: home to mud bathing and mineral waters. In the Tourism Development Strategy of the Jurmala region, there is a major focus on public and private actions to promote and support health tourism, such as: 1. Legislative adjustments. 2. The identification of priority zones. 3. Development of complex health-tourism products and services.	Regional	2007-2018	IMTJ (2013); Resonance (2007)

4. Usage of the best foreign medicine products in health tourism, thus ensuring better identification of the location and credibility. 5. Development of high-quality medical services. 6. Promoting the development of current rehabilitation centres and establishment of new ones. 7. Attraction of foreign and local investors, as well as establishment of new modern medical, rehabilitation and beauty and spa institutions. 8. Popularisation of nature curatives. 9. International certification of health-tourism institutions, in order to ensure the possibility of insurance companies covering the expenses for services. 10. Attraction of local and international insurance companies. 11. Market research to determine the demand for complex health-tourism products. 12. Developing study programmes related to health tourism and balneology and implementing them in existing educational institutions. 13. Renovation and improvement of parks, resorts and minor infrastructure.			
The Latvian Health Tourism Cluster includes a wide spectrum of health-tourism entrepreneurs, ranging from surgical, medical rehabilitation, resort rehabilitation, health restoration, wellness and spa to the organic cosmetic industry and higher medical education institutions. Group members promote the country at marketing events and health-tourism conferences and seminars. The group works on: • Implementing joint health-tourism marketing activities. • Promoting the expansion of export markets. • Developing new and innovative health tourism export products. • Promoting cooperation between group members for the provision of services. • Developing health-tourism packages. • Working on industry-friendly legislation. The overall aim is to increase the number of medical, wellness and spa tourists to Latvia and to develop the local health tourism industry.	Regional	?	IMTJ (2013); OECD (2016)
In order to realise the potential of Latvia's **medical and wellness tourism**, a new legal framework for resort operators and destinations was drawn up. In 2012, the government approved the 'Procedure for Granting and Annulling the Resort Status'. This established a	National	2015	OECD (2016)

procedure for a local authority to submit an application to grant resort status and to use the spatial-development planning process to report on resort development and associated environmental quality indicators. By the end of 2015, two resorts were approved: Jurmala and Liepaja. The main outcome of this legislation is municipal interest in developing resort infrastructure, attraction of investments in the industry and constant environmental quality monitoring.			

Lithuania

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Lithuania is partly promoted as 'The Land of Health and Care'.	National	?	M. K. Smith (2013)
Health tourism is one of the four priorities in the 'Lithuanian Tourism Development Programme 2014-2020'. It is seen as a niche market for priority development. The regions of Vilnius, the coastal area, the Nemunas Lowlands, the Southern Dzūkija, the Eastern Aukštaitija and the Žemaitija Highlands have been identified as areas that are particularly ripe for tourism development potential.	National	2014-2020	Ministry of Economy of Lithunia (N.Y.); OECD (2016)
Health tourism was mentioned as one the main goals and objectives of the 'National Tourism Development Programme 2010-2013'.	National	2010-2013	British Chamber of Commerce in Lithunia (2013); Lithunia (2014)
Health tourism was mentioned as one of the areas in which investments from the ERDF were used.	EU, National	?	Ministry of Economy of Lithunia (N.Y.)

Macedonia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism is a (new) opportunity in the national tourism strategy, especially in relation to senior tourists.	National	2013-2021	Hinteregger (2016)
Health tourism was a tourism product in the 'Tourism development strategy in the Republic of Macedonia 2009-2013'.	National	2009-2013	Metodijeski and Temelkov (2014)

Malta

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
The tourism policy for the Maltese Islands for the period 2012-2016 stated that Gozo would be promoted as a destination for post-operative and recovery treatment holidays, where one could relax and recover from interventions ranging from medical operations to therapy treatments.	National	2012-2016	Ministry for Tourism Culture and the Environment (2012)

Monaco

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
According to the 'Roadmap 2009-2014', Monaco was to be promoted as a genuine 'spa destination' for health and fitness, including (1) an analysis of the requirements of consumers from target markets; (2) launching the unique brand 'Monaco Spa Experience'; (3) encouraging the creation of fitness and well-being packages in hotels; and (4) drafting an action and publicity plan for marketing and promotion that focuses on healthy eating and fitness:	National	2009-2013	The Tourist and Convention Authority of the Principality of Monaco (2009)

1. Healthy eating: • Raise hotels and restaurants' awareness to increase the number of establishments offering dietary and healthy menus. • Integrate healthy cooking workshops scheduled by the Monaco establishments into the publicity and promotion campaigns. 2. Fitness: • Compile a list of fitness-related activities that are already offered and integrate them into the publicity and promotion efforts. • With Monaco's partners, study innovations that may be provided in order to meet international clients' expectations. • Encourage the different operators of spas and well-being centres in Monaco to use preferably — and in time, exclusively — organic cosmetic products and treatments. 3. The following promotional actions were proposed: • Create a leaflet entitled 'Monaco SPA Experience'. • Summarise the new destination offer. • Develop publicity and public-relations campaigns (press packs and releases). • Create a microsite[15]. • Coordinate an internet-based targeted advertising campaign, in partnership with the Monegasque professionals concerned. • Set up specific offers for the winter season offering stays of at least 7 days that combine treatments and outdoor activities. • Build partnerships with those involved in the health and fitness, well-being and spa industries: media, tour operators and specialist websites.			

[15] 'A microsite is an individual web page or a small cluster of pages which are meant to function as a discrete entity within an existing website or to complement an offline activity. The microsite's main landing page can have its own domain name or subdomain'. Source: https://en.wikipedia.org/wiki/Microsite.

Montenegro

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism as a tourism product/new development opportunity in the 'Tourism Development strategy in Montenegro until 2020'. Proposed actions are e.g. to: • Develop integrated concepts. • Attract investments in proper facilities.	National	Up until 2020	Metodijeski and Temelkov (2014); Montenegro Ministry of Tourism and Environment (2008)

Poland

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism, with particular emphasis on **wellness and spa tourism**, is recognised as one of the priority areas in the 'Tourism Development Plan 2020'. The focus is on the demands of the target group of consumers interested in **wellness and spa tourism** and on strengthened cooperation between the Ministry of Sport and Tourism and the Ministry of Health, as well as regional and local government entities and the tourism sector organisations.	National, Regional, Local	Up until 2020	The Council of Ministers (2015)
In the strategy 'Directions for Tourism Development until 2015', health tourism was presented as a major opportunity and a basic tourism product to be marketed.	National	Up until 2015	Piotrowski, Soliński, Pacholska, and Warzybok (2010); Śliwa-Martinez (2012)

In the years 2012-2015, the Ministry of Economic Affairs allocated zł 4 million (€0.95 million) to promote **medical tourism** in Poland. It was the first government programme to be co-financed by the EU. The aim was to convince foreign medical tourists to use medical services that are available in Poland.	EU, National	2014	Haberla and Bobowski (2014)
Medical tourism was included in the 'Strategy of development of tourism in Poland in 2007-2013', and was seen as a priority area for the expansion of the tourism market as a whole.	National	2007-2013	
The 'Revitalisation of the Brine Park' project focussed on the development of Inowroclaw's therapeutic function. The traditions of health tourism in Brine park in Inowroclaw, date back to 1875 when the park was first established. To further serve a growing number of tourists, the park required a full renovation. The EU co-funded project resulted in a newly built mineral-water pump room, a palm house full of exotic plants and birds and a renovated park. After renovation, all facilities are accessible for disabled people. Every year, the Brine Park is now visited by 34,000 tourists and it has created 19 permanent positions. To develop Inowroclaw's therapeutic function cost €8.7 million, of which the EU's ERDF contributed €5.2 million from the 'Kujawsko-Pomorskie' Operational Programme for the 2007 to 2013 programming period.	EU, Regional	2007-2013	European Commission (2015g)

Portugal

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
In the 'National Tourism Strategy 2006-2015', health tourism was identified as a strategic tourism product for the country as a whole and several of its regions. The priority regions for health and **wellness tourism** are Madeira and the Azores, Porto e Norte and Centro regions. These regions should attempt to create offers with a degree of differentiation. For this purpose, it is necessary to alter business models, especially in the Porto e Norte and Centro regions. It is also essential to capitalise on the conditions offered by Madeira, once a leading destination in this field, together with the Azores that has the conditions for exotic experiences in tandem with natural beauty. In terms of the spas segment, all regions require quality infrastructure, associated with the hotel offer. In order to ensure the	National, Regional	2006-2015	Turismo de Portugal (2007)

competitive development of this product, the existence of quality health facilities is also required. Funding sources for actions in this domain include the National Strategic Reference Framework and the Tourism Intervention Programme. Important actions include: (1) to develop distinctive and innovative concepts of (thermal) spas – separately and/or in leading hotels; (2) to evaluate the hotels based on the offer of healthy eating, the availability of health and wellness specialists, and the provision of information of the establishment's health and well-being philosophy (integrated in the assessment of the quality level of the hotel); and (3) involvement of several entities (National Tourist Authority, Ministry of Health, municipalities, Regional Directorates for Tourism, tourism regions and Regional Tourism Promotion Agencies, business associations, tourism trade associations and others).			

Romania

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Spa tourism as a tourism product in the 'Master plan for Tourism Development in Romania 2007-2026'.	National	2007-2026	Metodijeski and Temelkov (2014)
A strategy used in Romania is the development of spa-tourism clusters, which are networks with many actors such as central and local public authorities, treatment bases, hospitals, clinics, physicians, universities of medicine and pharmacy, research institutes in the medical field and balneology, tour operators, hotels, restaurants, suppliers of equipment and devices, economic operators and other organisations. They support and promote members, and support and build the country's reputation for high-quality health tourism. Clusters adopt and promote high standards of ethical and professional medical care, identify (potential) attractions, define tourism products, initiate scientific research, facilitate a dialogue between the public and private areas, academics and specialists in healthcare, and develop integrated management and services oriented to tourists/patients.	National, Regional	From 2014	Fundeanu (2015)

Serbia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism was a tourism product in the 'Tourism Development strategy in Serbia until 2015'.	National	Up until 2015	Metodijeski and Temelkov (2014)

Slovakia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
In the 'National Tourism Strategy 2008–2013', spa and health tourism were considered to be experiencing the most significant growth and were considered focus areas. Action points included: (1) a campaign to increase of participation in **spa tourism**; (2) the creation of a diversity of offer suitable for year-round exploitation; (3) improvement of the quality of the micro-structure of spa resorts and spa environment; (4) extend the offer with additional services; (5) extend the offer of leisure activities; and (6) make other forms of tourism more attractive. The high-quality wellness services and different sports activities must be integrated into hotel-type facilities in spa resorts with a higher quality environment. All facilities together use the advantages of a higher quality environment. Also in the strategy from 2013 onwards, health tourism is one of the strategic areas.	National	From 2018	Center for Policy Studies (2005, 2010); DATOURWAY (2011). Please also see http://www.aalep.eu/slovak-tourism-industry

Slovenia

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health tourism (health resorts, wellness, **medical tourism**) was a tourism product/priority in the 'Tourism Development Strategy in Republic of Slovenia 2012-2016'.	National	2012-2016	Metodijeski and Temelkov (2014)
Health resorts and spas merged their knowledge, experience and development under the Slovenian Spas Association that has been operating as an economic interest grouping for more than 50 years. The main objectives in the future five-year period include the development of programmes for health maintenance, including preventative programmes, modern healthcare programmes that are based on a holistic approach, the specialisation of individual health resorts and the development of new programmes for relaxation and entertainment.	National	?	Vučković et al. (2012)

Spain

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
A health-tourism cluster has been created in Spain, through the combined efforts of different ministries and the private sector in international promotion.	National	?	OECD (2016)

Turkey

DESCRIPTION	POLICY LEVEL	PERIOD	SOURCES
Health and thermal tourism is included as a tourism product/diversification strategy in the 'Tourism Strategy in Turkey until 2023'. Example objectives include:	National	Up until 2023	Metodijeski and Temelkov (2014); Ministry of Culture &

• Development of settlements into regional destinations with thermal facilities and cultural themes. • The implementation of several studies in this domain. • Construction work on thermal-tourism centres. • Efforts to make the country the top ranking destination in Europe for thermal tourism. Example actions include: • Development of a thermal-tourism action plan. • Encouraging private sector activity. • Feasibility studies on thermal projects to be initiated by local governments. • All hot spring areas shall be drawn by architectural design professionals, and the technical opinion of the Turkish Ministry of Culture and Tourism shall be solicited, before the designs are approved. • Efforts to ensure that thermal resort facilities are constructed with state-of-the-art technologies. • Information of regions known to have hot springs facilities and thermal spring waters will be emphasised in promotional brochures. • Contracts will be established and maintained with healthcare and social aid organisations. • National and international symposia, seminar and promotional programmes will be held to inform the private sector and society at large.			Tourism (2007)
Health tourism is one of the goals of the 'National Health Strategy 2013-2017' in Turkey, with the following strategies: • Advertising and creating attractions regarding health tourism: o To cooperate with the Ministry of Culture and Tourism to promote health tourism at the international level. o To cooperate with the Ministry of Culture and Tourism to promote health tourism to the foreigners in Turkey. o To establish promotional campaigns on health tourism at international fairs. o To cooperate with the international airlines for the promotion of health tourism. o To establish cooperation with the other sectors to integrate health tourism with other tourism services.	National	2013-2017	Kaya, Yildirim, Karsavuran, and OZer (2013); Ministry of health of Turkey (2012)

• Improving the quality of services offered under health tourism:
  ○ To identify the standards for the health facilities to provide health-tourism services.
  ○ To increase the infrastructure, training and technological capacity of the health facilities providing health-tourism services.
  ○ To increase the number of the accredited health facilities providing health-tourism services.
  ○ To carry out national and international inspections of the health-tourism facilities.
• Expanding the service scope of health tourism:
  ○ To identify the standards of thermal tourism (Hot Spring, + Spa & Wellness) and health tourism for elder care.
  ○ To increase the infrastructure, training and technological capacity of thermal tourism (Hot Spring + Spa & Wellness) and health tourism for elder care.
  ○ To increase the number of the accredited facilities providing thermal tourism (Hot Spring + Spa & Wellness) and health-tourism services for elder care.
  ○ To ensure the integration of health-tourism activities with evidence-based alternative medicine practices.
• Enhancing the management of health tourism:
  ○ To establish scientific advisory boards to ensure that the health-tourism practices carried out are evidence-based.
  ○ To continue cooperating with the sectors on investment, planning and incentives within the framework of health tourism.
  ○ To cooperate with the other sectors to identify the education standards for the intermediary/support staff to work in health-tourism services and to provide their education in cooperation with the Ministry of Education and the Council of Higher Education.			

Turkey's 'Tenth Development Plan 2014-2020' contains a 'Health Tourism Development programme'. The aim of this programme is to raise the service quality in **medical tourism**, thermal tourism and elderly-disabled tourism. Goals are (e.g.) to achieve a higher capacity of beds, treating more patients, earning more income and establishing a position in the top 5 destinations in thermal tourism.	National	2014-2020	Kaya et al. (2013)

Component 1: Development of Corporate and Legal Infrastructure for Health Tourism (Ministry of Health) • Preparing a health-tourism strategy and an action plan considering the target country, region and branches. • Developing coordination mechanisms between public institutions and strengthening the cooperation between public and private sectors. • Constructing a legislation infrastructure that allows for price differentiation. • Developing a statistical infrastructure. Component 2: Improvement of Physical and Technical Infrastructure in **Medical tourism** (Ministry of Culture and Tourism) • Preparing the inventories of thermal tourism assets and medical-tourism infrastructure. • Increasing the possibility to use facilities such as hospitals, thermal hotels, elderly and disabled nursing centres, etc. in health tourism. • Providing support for investment and planning under health tourism, creating new models for land procurement. Component 3: Enhancement of Service Quality in Health Tourism (Ministry of Health) • Qualitative and quantitative professional development of the personnel working in health tourism. • Raising the service and facility standards for health tourism. • Developing facilitative mechanisms for accommodation and other assisted services. Component 4: Effective Advertising and Marketing in Health Tourism (Ministry of Culture and Tourism) • Increasing advertising and marketing operations in the target country and regions. • Increasing the collaborations of public and private sectors in advertising and marketing.			

ANNEX VII: OVERVIEW OF RESEARCH QUESTIONS AND ANSWERS

QUESTION	ANSWER
A. ***Identification of the size of the health-related tourism market within the EU and in comparison with other major world players in the market.***	
Q1. How are the terms for health, **medical, wellness, and spa tourism** defined?	**Q1:** Section 1.2 defines 'health tourism' as the combination of three overlapping fields: **medical tourism**, **wellness tourism**, and **spa tourism**. **Medical tourism** refers to the phenomenon of people travelling from their usual country of residence to another country with the expressed purpose of accessing medical treatment (Connell, 2013). **Wellness tourism** is travelling to a different place to proactively pursue activities that maintain or enhance their personal health and well-being, and who are seeking unique, authentic or location-based experiences and therapies that are not available at home (Johnston et al., 2011). **Spa tourism** focuses on the relaxation, healing or beautifying of the body in spas using preventative wellness and/or curative medical techniques (M. Smith & Puczkó, 2014).
Q2. What are the differences between them?	**Q2: Medical tourism** is associated with curing illness, **wellness tourism** promotes personal wellness, while **spa tourism** is positioned in-between aiming to prevent illness and sustain health. Differences as well as overlaps are discussed in Section 1.3.
Q3. What is the size of each of the three tourism markets in terms of value and volume in relation to other EU tourism sectors and the EU economy?	**Q3:** Estimating the total size of the health-tourism market, and of each of the three markets, is difficult due to the limited, fragmented and often unreliable data available, as well as the wide and overlapping scope of definitions used (please see Subsection 2.1.2). The total size of health tourism in the EU28 is estimated at 56.0 million domestic trips and 5.1 million international arrivals, totalling 61.1 million health tourism trips arriving at EU28 destinations in 2014. This is health tourism with wellness/spa/health as its main purpose. The share of health tourism of all EU28 arrivals is 4.0% (international plus domestic). **Wellness tourism** dominates EU health tourism with two-thirds to three-quarters of the total market. Health tourism revenues total €34.2 billion in the EU28, which represents 4.3% of all tourism revenues and 0.24% of the EU28 GDP (please see Section 2.2).
Q4. What is the share of health tourism in the economies of the leading world market players?	**Q4:** We answer this question for the EU only, because global data are simply too unreliable to draw conclusions from (please also see Subsection 2.3.3. A number of EU member states is among the leading world market players in **spa and/or wellness tourism** (see the GWI, 2017). The share of health tourism greatly depends on the overall size of tourism in a country, but is relatively small on average, as all of the market leaders — whether inside or outside the EU — have quite large tourism markets.

QUESTION	ANSWER
Q5. Are the health-related services based on seasonality or can they be provided on a year-round basis in the most successful EU countries and regions?	**Q5:** Seasonality plays a role in health tourism, but this depends on the geographical location and the type of health tourism. Because health-tourism seasonality tends to differ from average tourism, it is seen as a way to combat seasonality (see for instance OECD, 2016). **Medical tourism** has no strong seasonality. Furthermore, special target groups such as senior citizens and citizens with disability exhibit different patterns of seasonality (European Commission, 2014b).
B. *Analysis of the current trends in the three tourism sectors in the EU*	
Q6. Which of the three sectors is growing and which is shrinking?	**Q6:** Non-market sources point to a stable development of EU health tourism, whereas market reports indicate further spectacular growth for all three markets. One source shows a development of decreasing **medical and spa tourism** towards more **wellness tourism** (for Germany). **Medical tourism** appears to be a quite volatile market depending on source market issues, legislation, waiting lists for regular healthcare (Subsection 2.3.4)
Q7. Are all of them developing at the same pace?	**Q7:** Most likely not; please see Q6.
Q8. What is this pace like in comparison to the pace of development of other tourism sectors?	**Q8:** Probably not very different (the United Nations World Tourism Organisation (UNWTO) expects global international arrivals to the EU to increase by 2.1% annually until 2025), but the data on health tourism are simply not sufficiently reliable. Note that domestic tourism is much more important in both health and overall tourism and has high growth rates in developing countries like China.
Q9. Is Europe's share in the global health-related market growing or shrinking?	**Q9:** Based on market reports, the EU share in global health tourism is shrinking slightly, as other continents show faster growth. (Subsection 2.3.4)
Q10. How do the development trends in European health tourism compare to the trends in other economies?	**Q10:** The trends are comparable, but growth tentatively appears to be faster in other continents, according to market reports.
Q11. Which are the EU's major countries and regions (NUTS 2) of destination for the health-related services?	**Q11:** More than three-quarters of EU health-tourism revenues are earned in just five countries: France, Germany, Italy, Sweden and Poland (please see Subsection 2.3.4). The highest scores of wellness related facilities in accommodations are found in Finland, Bulgaria, Germany, Spain and Ireland. However, the highest densities of health and wellness facilities are found in Central and Eastern Europe and the Spanish

QUESTION	ANSWER
	and Southern Baltic coasts. The highest shares (>10%) of health tourism in markets are to be found in Finland, Latvia, Slovakia, Hungary and Portugal. Note: Map 3 shows densities of health-tourism related facilities in EU accommodations. However, no data exist at the NUTS-2 level, so we cannot answer questions up to that level and recommend to add health facilities to the regular accommodation data gathered by Eurostat.
Q12. Which are the EU's major countries and regions (NUTS 2) of origin for the health-related tourists?	**Q12:** In absolute numbers, both domestic and international (departures) health tourism is the largest in France, Germany and Sweden. As a share of total domestic and international (departures) tourism, the largest countries of origin in EU health tourism are Latvia, Hungary, Sweden, Slovakia and Portugal. For the numbers, please see Annex IV.
Q13. What is extent of the changes in health-related tourism? Which EU member states and regions lost/gained most as result of changing travel patterns?	**Q13:** Change has been partly covered under Q6. We compared data for 2012 and 2014 provided by IPK International (2016), but the **variation** for these data was far too large to provide reliable growth data.
Q14. Is European health-related tourism attracting tourists from other parts of the world?	**Q14:** Yes, but most likely this share is not much different from the general travel share of tourism from outside Europe (around 6%).
Q15. Are there any specific destinations or therapies offered to disabled people and those with limited mobility?	**Q15:** A recent study of the EU (International Federation for Spina Bifida and Hydrocephalus, 2017) shows indications of the use of cross-border healthcare for disabled citizens. The most visited country for medical treatment abroad is Germany. The study shows that only a small minority of citizens with a disability has travelled for medical reasons, and the majority of the subjects in the study were not aware of the possibilities of Directive 2011/24/EU (European Union, 2011). Medical services for tourists with a need for e.g. kidney analysis are offered leisure and tourism services in combination with the treatment. The 'OFF TO SPA' project aims at combining spa treatments for senior and disabled citizens.

C. *Evaluation of the factors that contribute to the changes in the European health-related tourism as well as their economic implications both for the entire EU as well as for those individual countries and regions, which are the largest participants in these tourism markets.*	
Q16. What are the major factors (at the EU and national level) that stimulated the growth of European health-related tourism?	**Q16:** Policies on the EU level only exist for patient mobility in the legal framework of the Directive 2011/24/EU (European Union, 2011), but not for **wellness and spa tourism** as described in this report. This means there are no special factors at the EU level that stimulated the growth of **wellness and spa tourism** apart from general tourism growth factors. At the national and regional level, policies enhancing health-tourism growth are quite common and showing evidence of health tourism as an important strategy in combination with tourism planning.
Q17. What are the factors (other than geographical) that contributed to the success of the regions in attracting health-related tourists? Please, provide examples of best practices.	**Q17:** The main factors for spas are the local environmental conditions including clean water, warm springs, clean air and outstanding natural resources. For **medical tourism**, the main factors are the local quality and cost of medical care and the position of the national government with implementing Directive 2011/24/EU. Important factors for **wellness tourism** include stakeholder collaboration, natural and environmental conditions, the demand from nearby markets (including the domestic market), tradition and culture and the ability to educate employees in the tourism market.
Q18. Are there any technical, administrative or legal barriers at the EU/national level that might hamper further growth of these three tourism markets?	**Q18:** The following are barriers for further development: • Differences between the financial and legal frameworks within countries are treatments that may or may not be covered by insurance (such a spa treatments), VAT (in some countries you pay nothing, and in others 20-25%) visa legislation, and legal requirements for spas (such as for hygiene and labour); • unawareness of the public of Directive 2011/24/EU providing the right to EU citizens to go elsewhere for healthcare; • upfront payment for cross-border healthcare; • some national healthcare systems currently restraining **medical tourism** mobility, as they fear that national healthcare system may suffer from underutilisation (because of international **medical tourism** departures) or overutilisation (because of international **medical tourism** arrivals); • growth-stimulating policies are difficult due to the lack of data and knowledge and of unifying definitions of health tourism; • loss of environmental and ecological quality in wellness and spa destinations due to pollution, increasing traffic levels. Urban sprawl and agricultural developments; • unregulated procedures in **medical tourism** causing strong variations in quality (within and in between member states) and incidents (e.g. in cosmetic surgery) which generates negative press and a problematic image of all **medical tourism**;

Q19. How do the changes in the size and the origin/destination of health-related tourism affect the EU and national economy?	**Q19:** Health tourism is not a very important economic factor in the EU (on average, far less than 1% of GDP). Furthermore, changes in size are limited and gradual. However, health tourism is important in some regions and maintaining, for instance, spas is a way to develop such regions. Special attention is required for the increased demand for facilities in accommodations and transport for disabled people.
Q20. Particularly, how do these changes affect the labour market, transport system or the environment?	**Q20:** If the share of health tourism increased in tourism, then the seasonality would be reduced, sustainability improved, mobility reduced and the level of labour probably improved.
D. *Analysis of strengths and weakness of the health-related tourism in the EU against the other world competing regions.*	
Q21. What are the advantages and disadvantages of European **medical, wellness, and spa tourism** as compared with other world leading market players?	**Q21:** Main advantages (strengths) of European health tourism: • Several member states are among the leading world market players. • The great history and status of **wellness and spa tourism**, including a well-established supply of spas and wellness facilities. • Diversity of natural environments and resources conducive to health tourism. • Well-developed infrastructure (tourist attractions, accommodations, transport facilities, etc.). • Directive 2011/24/EU provides mobility and funds for patients between EU member states. The main disadvantages (weaknesses) include: • No consensus on the definition of health tourism and its components and lack of reliable data on health tourist flows and revenues. • No EU level regulation, causing varying quality levels in **medical tourism**, and risks for individuals and development. • The large gap between Directive 2011/24/EU and active uptake into national legislation. • Insufficient collaboration between destinations, enterprises and other stakeholders. • Insufficient joint promotion within the EU. • Increasingly old-fashioned facilities in some health tourism hotspots in Europe.
Q22. Is development of the health-related tourism supported by public sources in the EU and world leading market players?	**Q22:** Though there is no specific health-tourism policy within the EU, a range of EU-funded projects (mostly based on the European Regional Development Funds (ERDF) did aim at improving heath tourism or one of its three components. A specific role of world market leaders could not be established.
Q23. What is the role of the EU's funds in the promotion and development of health-related **medical tourism**?	**Q23:** Based on the Guide on EU funding for Tourism, it is possible to appraise which funds are to be connected with health tourism. Furthermore, from the policy analysis, we identified a range of recurring themes: the need to guarantee (and improve) the quality of the health tourism offer, support collaboration between the actors

	involved, promotional campaigns, regional specialisation, introducing and adjusting legislation, the allocation of government budgets to health tourism projects and using health tourism to stimulate tourism in the low season.
E. *Analysis of new opportunities and challenges of the European health, medical and tourism markets in the EU.*	
Q24. What major challenges for the sector can be identified, including those resulting from the digitalisation and rise of the sharing economy?	**Q24:** The major challenges for health tourism are: • Negative press, caused by countries not regulating their health, specifically medical, tourism providers. • Countries fearing that their own citizens will leave their national healthcare systems causing over-capacity and uncovered costs, or entering the systems in massive waves, causing additional costs. • The accelerated spread of diseases through global **medical tourism** because patients naturally possess a higher risk and reside in hospitals where the density of infectious diseases is much higher than in normal tourism facilities. • Loss of (the diversity of) natural environments/resources because of (human-caused) pollution, urban sprawl, etc. • Lack of knowledge by tour operators and travel agencies to assess the medical situation of tourists and the requirements and limitations for travel. • Increasing competition for health tourism from Asian and Middle-East destinations. • Brexit provokes uncertainty about the development of tourism, and specifically **medical tourism**.
Q25. What are the major opportunities for European health related-tourism, given the current trends in the demography?	**Q25:** The main opportunities for health tourism are: • A significant proportion of citizens in the EU (49%) is willing to travel for medical care. • Use of ICT and web-based resources to connect consumers with destinations, healthcare providers and brokers. • Application of data flows and big data provides opportunities, certainly when tourism and non-tourism data flows are combined. • Ageing of the population increases the shares of senior tourists who desire health tourism services and products. Connecting to existing programmes like the European Covenant on Demographic Change, WHO Global Strategy on ageing and the Silver economy. • Change of lifestyle in the EU population that boosts interest in health tourism. • Integration of non-tourism facilities, e.g. workplace wellness, with **medical, wellness, and spa tourism** development, investments, strategies and policies. • Renovation of a large number of ageing wellness and spa facilities. • Centres of excellence for rare diseases that may save health costs and advance quality based on cross-border healthcare.

F. *Presentation of possible scenarios based on the implementation of different policy measures in order to understand the influence on the development of the sectors.*	
Q26. The Treaties leave tourism in the competence of member states, and they only allow the EU to support, coordinate or supplement the actions of the member states. Given the abovementioned facts, what would be the results of applying various sets of policy measures at the EU level on the development of the health-related tourism? Please provide at least three different scenarios, including the 'business as usual' scenario.	**Q26:** This question could only be answered partially due to an overall lack of clear definitions, data and existing EU level policies. The latter means that the business as usual scenario is almost equal to a scenario without further EU policies. This assumes that the current level of financing health tourism related projects (through Interreg, ERDF, etc.) is continued because the aims of such funding fit these programmes without any specific role of health tourism. At the national and regional level, the role of health tourism is appreciated and enhanced. This shows that health tourism may not currently require a strong EU-level intervention. If anything, it may require EU-level promotion and stimulation to integrate health-tourism policies with health policies.
G. Recommendations on what could or should be done, particularly at the policy level, to improve the positioning of European health-related tourism.	
Q27. Based on the various scenarios provided in the study, what would be the most effective option to further stimulate the growth of European health-related tourism?	**Q27:** A policy scenario aiming at enhancing health in the EU through further developing and integrating health tourism and healthcare and making use of the opportunities for prevention rather than curing may have a better potential for the general good than a scenario that just aims at economic growth of the health-tourism market, which may provide small benefits to the economy, but may also present several disadvantages.

CAT: QA-01-17-633-EN-C (paper)
CAT: QA-01-17-633-EN-N (pdf)

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PHOTO CREDIT: iStock International Inc., Photodisk, Phovoir

ISBN 978-92-846-1181-2 (paper)
ISBN 978-92-846-1182-9 (pdf)

doi:10.2861/072 (paper)
doi:10.2861/951520 (pdf)

Publications Office