Travel for Physical and Mental Health Improvement

Discovering the new Concept of Prescriptive Health Tourism

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Affidavit

I hereby affirm that this Bachelor's Thesis represents my written work and that I have used no sources and aids other than those indicated. All passages quoted from publications or paraphrased from these sources are properly cited and attributed.

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Abstract

Along with the rising interest in health and well-being of the society, the health tourism industry has become increasingly important for emerging destinations on this planet. This thesis does not only describe the relevant players on the current health tourism market but also explores the consequences of the intense sector growth, such as the deficiency in medical tourism policymaking, the absence of insurance coverage for treatments outside of the European Economic Area, the phenomena of mass tourism in overly advertised health tourism destinations, and the lack of mental health tourism offers on the market.

In the light of the increasing globalization of the health care sector, this thesis introduces the reader to a potential problem-solver for the mentioned concerns related to health, medical and wellness tourism, in a concept called Prescriptive Health Tourism (PHT). The hybrid concept solution combines the health and medical industry with the hospitality industry in a way that is beneficial for both sectors. This thesis aimed to find out if the concept of prescriptive health tourism has the potential to be beneficial and practical for society and if the solutions proposed by the concept are indeed solving existing problems in the current health and medical tourism sector. Besides, the thesis aimed to expose any constraints and threats, which could hinder the patients from participating in PHT and lastly revealed possible aspects of improvement of the concept, which would call for additional research and concept developments.

The results of the mixed approach online survey conducted by a versatile range of participants revealed that 84% of the participants found the general concept idea attractive and 76% would actively ask their local doctor for possible options regarding PHT. Furthermore, results showed that through the concept 86% of the participants would be motivated to take better care of their mental health and 67% would be encouraged to visit unknown destinations. Nevertheless, the study revealed, that certain participants wouldn’t travel for health reasons due to environmental concerns or due to the potential language barrier at the treatment facilities. Even though the concept introduces several solutions to the occurring problems, issues such as possible corruption between different sectors and the possibility that PHT could turn into a privilege for the upper-class, call for further concept developments and additional research.

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List of Abbreviations

EEA – European Economic Area

EU – European Union

GWO – Global Wellness Organization

IPPR – Institute for Public Policy Research

ISO – International Organization for Standardization

LTC – Long Term Care

OECD – Organisation for Economic Co-operation and Development

PHT – Prescriptive Health Tourism

RKI – Robert Koch Institut

TAT – Tourism Authority of Thailand

TPA – Third Party Administrators

TPB – Theory Planned Behaviour

UNWTO – United Nations World Tourism Organization

USP – Unique Selling Point

WHO – World Health Organization

1 Introduction

The consumption of healthcare in a foreign land is not a new phenomenon, and the developments of the entire health tourism industry must be situated within the historical background. The Ancient Greeks were the first ones to lay a foundation for a comprehensive health tourism network (Lunt et al, 2011). In honor of the Greek gods, pilgrims from all over the world traveled to the Asclepias Temples to obtain cures in exchange for their ailments (Kazemi, 2007). Fasting forward to the 1900s where health tourism was at first a privilege to the affluent European and American citizens. The flower child movement contributed to the rediscovery of yoga, Ayurvedic medicine, and the development of the medical tourism industry. In the 1980s and 1990s, with the rising costs of healthcare, Americans started considering foreign health tourism destinations such as Central America or Asia (Singh, 2013). Due to the Asian economic crisis, some of the nations tried to save their economy by putting an extreme effort into marketing their country as first-class destinations for health and medical tourism (Noree et al., 2016). Thailand and Malaysia, for example, became the hot spots for plastic surgeries, offering prices at a fraction of what Western countries could offer (Hin et al., 2013).

In recent years, health, medical, and wellness tourism have experienced significant growth and have become increasingly important in emerging destinations on this planet. Factors like globalization, growing interest in a healthy lifestyle, sustainability, technological advancements, and successful collaborations among the public-private health care sector, shape and magnify the health tourism sector (UNWTO, 2018). The financial reason is no longer the only decisive point for a patient to undergo treatment abroad. The possibility for patients to enter out-of-state healthcare systems is creating new treatment opportunities and the chance for patients to reach a medical specialist or treatment methods that are available for them there that do not exist in their home country (Trauner & Weißenböck, 2019).

However, the emergence of a global market in health services as well as the changes and advances in the health tourism industry triggers profound consequences in the industry and other sectors. Academic researchers claim the lack of quality and accreditation control in the medical tourism sector (Bristow & Yang, 2015; Sousa & Alves, 2019; Szromek & Naramski, 2019; Turner 2011).

Other industry experts address issues regarding health insurance and publicly funded healthcare (Turner, 2011) or the connection between popular health tourism destinations and mass tourism (Carrera & Bridges, 2006). Another increasingly discussed topic is the widening gap between the need for mental treatments and its provision all over the world (WHO, 2013) and therefore also in mental health tourism.

Even though there is existing literature on health tourism-related problems, a solution that combines the two different sectors, the medical/healthcare sector, and the tourism sector, in a way that could potentially resolve the previously described problems in health tourism, while also enhancing and strengthening existing advantages of the health tourism industry, has not been introduced and explored yet. As a result, this thesis aims to explain the existing issues of the current health tourism sector followed by an introduction and in-depth description of the concept of prescriptive health tourism (PHT). Finally, the thesis purpose is to find out, with the help of a mixed-approach online survey, if the concept has the potential to solve the current health tourism-related issues but also if the concept would be beneficial and practical for the patients and lastly, to define which possible constraints and threats would hinder the patients from taking advantage of the concept and which would call for additional research and concept developments.

Therefore, the thesis aims to answer the following research questions:

RQ1: How attractive is the concept of prescriptive health tourism to society and would potential customers want to utilize it?
RQ2: Would PHT help to reduce the problem of missing quality and accreditation control in medical tourism?
RQ3: Would PHT help to reduce the effect of mass tourism in popular health tourism destinations?
RQ4: Would PHT encourage society to take better care of their mental health?
RQ5: Which factors could hinder society from taking advantage of the concept?

The final results of this thesis can especially be valuable for government organizations, healthcare experts but also for tourism boards looking into finding a tool that supports the connection between healthcare and the hospitality industry and which could be beneficial for all participating stakeholders. Furthermore, the thesis could be a source and reference point for further health, wellness, and medical tourism-related research. Lastly, the thesis could be used as a guideline or foundation for other students and researchers, to elaborate further or complete additional research on the concept and feasibility of prescriptive health tourism.

2 Literature review

2.1 Health Tourism

Along with the overall growth of health awareness and education of the population, health, wellness, and medical tourism have grown exponentially (UNWTO, 2018). Nowadays, the health tourism industry is considered to be one of the fastest-growing hospitality sectors in the world. A study published by Forward Intelligence (2019) stated that the market size of health tourism in China grew from 2015, 40 billion yuan to 2019, 82.9 billion yuan, and was expected to hit the 100 billion mark in 2020. However, due to the global pandemic beginning in 2020, this mark was not reached. Nevertheless, tourism experts have diagnosed that once the hospitality industry starts to recover from the effects of the crisis, established and emerging destinations will continue to tap into the potential of the health tourism segment (Chen, 2020).

Over the last decade, health tourism has developed into an umbrella term, including several conceptualizations, such as wellness or medical tourism. Health tourism, medical tourism, and wellness tourism are often used interchangeably. However, it is essential to know that each of the terminologies is different (UNWTO, 2018; Amouzagar et al., 2016). The exact definition, similarities, and differences between wellness and medical tourism will be explained in a later stage of the thesis. Important to note is that health tourism involves all tangible and non-tangible activities and services, with the ultimatum to improve the tourist's health and state of wellbeing (UNTWO, 2018).

2.1.1 Factors shaping Health Tourism

Health tourism has been getting an increasing amount of attention. The question remains which factors have supported and continue to support this trend? The answer lies in the following four aspects: urbanization, increased health awareness, long-term care, and technological developments (Figure 1).

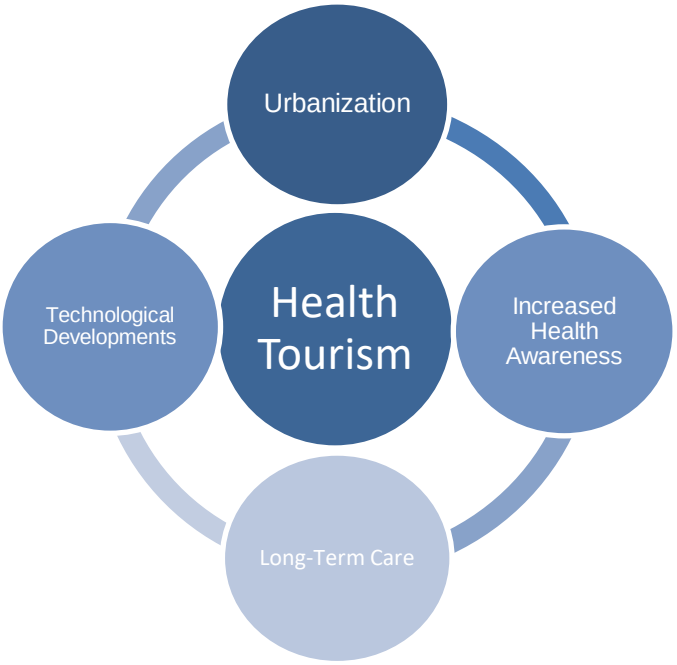

Figure 1: The Factors Influencing Health Tourism

Urbanization is changing public health, but not necessarily in a good way. As mentioned by the WHO Director-General in the 2007 World Health Report, global urbanization is ranked as a threat to “Public Health Security” (WHO, 2007). An increasing population living in cities may increase the spread of epidemic diseases but also leads to the fact, that more people are dealing with urban living health conditions and/or are being diagnosed with chronic diseases. This situation is leading to higher demand for health tourism services. The urban population wants to compensate for the daily busy city life with more natural alternatives in tourism, such as active retreats or wellness getaways (UNWTO, 2018).

The second major factor shaping health tourism is the increasing consumer health awareness and the overall increase in time spent on leisure activities, including health care and prevention (UNWTO, 2018). This phenomenon is certainly supported by governmental campaigns, which are trying to draw attention to health and well-being in our society and raise awareness of healthy lifestyles (OECD, 2016). Raising awareness supports the demand for health and wellness services in developed counties and therefore shapes the development of health tourism.

The third factor, influencing the development of health tourism is the increasing long-life expectancy (OECD, 2016) and the associated “long-term care” (LTC) expenditures. In fact, with the aging population and the increasing retirement migration, the demand for health, medical and wellness services, which are to the majority funded from public sources, will increase to a level, which will put a great burden on governments (UNWTO, 2018). Nevertheless, the increasing requirement for health services from the aging population will most probably lead to an increase in the demand for health tourism.

The last major factor influencing travel for wellbeing and health purposes is the rapid technological development and the new inventions on the health care market. Companies with a global outreach are developing tools for minimally invasive procedures, such as “laparoscopy”. A surgical diagnostic procedure to examine organs inside the abdomen (Giorgi, 2018; UNWTO, 2018). Innovations like these influence the development of local medical tourism. Technological advancements are not only enhancing medical procedures but are also bringing the healthcare services closer and faster to the patients. The new Industrial Revolution called IR 4.0 is connecting the digital, physical, and biological spheres. Different technologies such as robotics, cloud solutions, virtual reality or artificial intelligence are not only disrupting business practices but also influencing the health tourism industry by strengthening the merge of the health care and travel sector (Kee Mun Wong & Hazley, 2020).

2.2 Medical Tourism

Medical tourism is a section of the health tourism industry and involves two branch categories: the medical branch and the tourism branch. Interestingly, academic definitions of medical tourism are quite distinct in content. Some researchers define the industry by concentrating on the medical aspect. Hong (2016) claimed that patients travel abroad to seek special medical services, including minor or major surgeries such as liposuction or dental implants. Other narrators expressed a broader definition and included concepts of wellbeing and wellness in their notion. Majeed et al. (2017) noted that medical tourism is the act of experiencing natural treatments while benefiting from the destination’s tourists’ attractions, to improve the traveler’s overall health status.

Furthermore, experts in medical tourism often refer to patients as consumers because they pay “out-of-pocket”, meaning that they do not receive medical care reimbursement from their insurance companies. (Bertinato et al., 2005; Lunt et al., 2011). The global generated annual revenue of the medical tourism industry is estimated to be US$ 50-60 billion, with an annual growth rate of up to 20% (MacReady, 2007). Why people travel to a different country to seek health treatment is linked to different factors. The traditional reasons are related to medical advancements, specialized treatments, and well-developed infrastructure in developed countries (Majeed et al., 2017). Patients from developing countries would travel to developed countries to seek treatment of better quality. However, in recent years, this phenomenon has been reversed (Crush & Chikanda, 2015).

Nowadays, due to inflated healthcare costs and the limitations of domestic healthcare infrastructure, a growing number of patients from well-developed counties, travel to developing countries to seek healthcare (Ruggeri et al., 2015). In an online survey from the U.S. Government asking about the motivations for abroad healthcare, 61% of all participants said that it was less expensive to receive the treatment abroad than in their home country (YouGov, 2019). The ease of traveling and communication across countries and continents has supported the growing sector of the medical tourism industry and many third-party administrators (TPAs) have started to capitalize on that opportunity, by offering medical tourism management services. TPAs, also called medical tourism companies, or medical tourism facilitators, have a very broad network and scope of services. They manage patients’ medical trips, from their arrival up until their return back home (Majeed et al., 2018**).** Most agencies are rather small and provide information about their services, accredited hospitals, quality, reliability, and affordable prices via their websites. Important to note is that even though TPA’s are identified as service providers in the medical tourism industry, they tend not to be obliged to receive accreditation for their services and should therefore always be evaluated with great caution (Turner, 2011).

2.3 Wellness Tourism

Smith and Kelly (2006) noted that wellness is a state of health that features a harmony of body, spirit, and mind. It is therefore considered to be a rather psychological than a physical state. In historical terms, when considering the activities of ancient Greece and Rome, wellness tourism was the first manifestation of health tourism (Smith & Kelly, 2006). Nowadays, the term wellness remains widely used concerning travel and tourism (Clarke, 2010). Valenty (2014), the CEO of Wellness.com, described wellness as "the result of personal initiative, seeking a more optimal, holistic and balanced state of health and wellbeing across multiple dimensions". These dimensions include mental, physical, spiritual, and social wellbeing. Wellness tourism is therefore an all-encompassing term relating to health, adventure, fitness, and other types of travel, seeking to improve someone's health and wellbeing (Bushel & Sheldon, 2009). Wellness tourism is made up of the intersection of two very strong industries, which have experienced significant growth over the last decade: the tourism industry and the wellness industry. The Global Wellness Institute defined wellness tourism as "a way of travel which is associated within the pursuit of maintaining or enhancing one's wellbeing (Yeung & Johnston, 2018). In 2017 the GWI estimated the wellness tourism industry to be a $639 billion market (GWI, 2018).

Tourism companies in today's challenging market, use the wellness and spa industry, as a way to extend business and create their USPs. Due to its diverse characteristics, companies can even connect wellness and spa offers with several other forms of tourism, such as destination or business tourism. The global top three wellness tourism destinations are China counting 21.9 million international and inbound trips, followed by India, which counts 17.3 million trips, after that the U.S. with 15.4 trips. Austria is in 17th place, counting 2.2 million international and domestic wellness trips. Some of the most common wellness sights to visit are the dead sea spa resorts in Israel, the meditation and Ayurveda retreats in India, or the surf & yoga retreats in Australia (GWI, 2018).

2.4 Similarities and Differences in Medical and Wellness Tourism

By analyzing the definitions and characteristics of the two health tourism subcategories, wellness, and medical tourism, it turns out, that on the one hand, both have certain attributes in common. Reddy et al. (2010) narrated that medical tourism is closely linked to wellness tourism since in both cases, tourists leave their home country and travel abroad to benefit from different treatments and therapies. On the other side, as the Global Wellness Institute (2019) pointed out, there is one major difference between medical and wellness tourism. Namely the difference between reactive and proactive handling. Travelers who participate in medical tourism undertake their journey, because they have been diagnosed with a disease, an ill condition, or because they seek enhancement. Their activities are most of the time reactive to an illness and are medically necessary. Their motivation to travel abroad treatments is drawn from its cost-effectiveness and/or the higher quality care and/or the availability of the treatment. Wellness tourists, however, undertake their journey, because they are most of the time reacting proactive and voluntary to the maintenance of their health and wellbeing. Their activities are non-medical and their motivation comes from their desire to live a healthy and balanced life. Participants in wellness tourism want to reduce stress, prevent disease, improve their lifestyle habits, and/or simply experience an authentic stay (Yeung & Johnston, 2018).

2.5 Limitations and Problems in Health, Medical and Wellness Tourism

In the current context, it is important to note, that among the different focuses of the research that include health tourism and its subcategories, this literature research is incomplete without pointing out different limitations and problems occurring in the health, medical, and wellness tourism industry.

2.5.1 Medical tourism and the lack of quality control

One major problem, occurring in the medical tourism industry is its deficiency in accurate policymaking. Although medical tourism companies have a very broad portfolio of medical clinics and retreats, from all over the world, the quality of the treatments and therapies, they offer, remains quite hard to control (Ruggeri et al., 2015).

Nowadays, individuals often choose to book their medical treatments via medical tourism agencies and no longer contact the medical clinic directly (Turner, 2011). The TPA chooses among their portfolio the fitting clinic, and the client receives an offer with one or more treatment providers. Since the TPA's do not oblige their service providers to undergo accreditation or to have fixed standards of practices, quality control of the offered services, remains hard to control. Unfortunately, several health tourism destinations are lacking in state laws, regarding quality control or quality checkups. Medical clinics and retreats can set their own rules and regulations, resulting in a lack of transparency for the client. Among that, Turner (2011) found out, that the country Iran has an overall great potential for medical tourism. However, due to the disregard of international medical standards and the lack of communication between the medical clinics and the health tourism companies, quality control of the treatments in Iran remains very limited (Turner, 2011).

Of course, there are other health tourism destinations such as Germany or Austria, which do have internationally regulated quality controls, for example, the ISO 9001:2015, in place. However, due to the elevated treatment costs, treatments offered from German clinics are no longer among the most popular ones (Ivanisova, 2017). The current challenging medical tourism industry is deficient in accurate policymaking. This growing market needs industry regulatory authorities to make a coordinated effort to undergo the lack of quality control (Turner, 2011).

2.5.2 Health Tourism and Health Insurance Coverage

The second problem regarding health tourism rather concerns the subcategory of medical tourism and the coverage of costs by the respective national health insurance companies in and outside Europe. Under the directive, 2011/24/E and the Social Security Regulations (EC) 883/2004 and 987/2009, countries that are part of the European Economic Area (EEA), so to say the 28 member states of the EU plus Iceland, Norway, Switzerland, and Lichtenstein, the citizen can take advantage of cross-border healthcare. According to the European Commission, "cross-border healthcare refers to medical treatments outside the patient's country of residence, where she or he is entitled to public healthcare, whether or not under the social security legislation of another Member State" (European Parliament and the Council, 2011).

Looking at the respective lists of social security agreements for health insurance in the respective EU countries, one can identify that there is only an agreement for Bosnia-Herzegovina, Israel, Morocco, Serbia, Montenegro, Macedonia, Turkey, and Tunisia (European Parliament and the Council, 2004). Nonetheless, EU-citizen who are planning to take advantage of cross-border healthcare such as planned hospital stays, cures, or dentures must receive prior approval for their treatment by the health insurance fund, according to the German Federal Social Court (B 1 KR 19/08 R, 2009). As a rule, patients may only use doctors and hospitals that are authorized to provide care for statutory insured people in the health insurance system of the country of residence.

However, medical tourism patients willing to travel to countries outside of the European Economic Area, with which there is no social security agreement, will not be reimbursed by the health insurance for the treatment costs incurred abroad (Sozialgesetzbuch V, 2021). In fact, with the existing certifications according to the European standard - such as the ISO mark, the national health insurance companies check and assess whether the foreign institutions in the qualified countries with social security agreements, meet the quality standard, and thus decide if they reimburse the treatment costs from the patient or not. For all other countries, partly very popular medical tourism destinations, such as the USA, Thailand, the Philippines, Canada, India, China, or, as from 2021 (Brexit), the UK there is no social security agreement and therefore none of the medical treatment costs of EU citizens can be reimbursed by their national health insurance (European Parliament and the Council, 2019; Sozialgesetzbuch V, 2021).

2.5.3 Health Tourism and Mass Tourism

The third problem concerns the health tourism destinations and their local inhabitants. The rise in health tourism, including wellness and medical traveling, increases mass tourism in concerned countries. With its changing symptoms across destinations, mass tourism is one of the most urgent issues in the tourism industry these days. Among other things, it is seen as a threat to local heritage, culture, and nature.

Mass tourism also defined as over-tourism is defined as “the excessive growth of visitors leading to overcrowding in areas where residents suffer the consequences of temporary and seasonal tourism peaks, which have enforced permanent changes to their lifestyles, access to amenities and general wellbeing” (Milano et al., 2018).

The phenomenon of mass tourism does not only concern the current overcrowded cities such as Venice, Paris, or Barcelona. In fact, due to the overall increasing popularity of health tourism destinations, the phenomenon of mass tourism is becoming a substantial threat to them. Moreover, as many patients like to combine medical treatments with a sightseeing vacation (Kucukusta et al., 2019), health tourism agencies are progressively focusing on supporting trendy destinations, by putting a big focus on their destination marketing.

One popular health tourism destination, which is promoted by several health tourism organizations in Thailand. After Thailand’s tourism industry was hit by the negative effects of the Asian Economic Crisis in 1997, the Iraq war, the SARS, and bird flu viruses in 2003, the TAT (Tourism Authority of Thailand) hoped to improve the economic status by promoting the country as a new medical and wellness tourism destination (Rerkrujipimol & Assenov, 2011). Over the years, Thailand managed to reduce its bad sex tourism image and succeeded in making a name for itself in the health tourism industry. The country is offering a wide range of medical and wellness tourism accommodations, including health resorts, destination-, medical-, and day-spas. Visiting Thailand became rapidly very trendy and in 2018, the UNWTO ranked Thailand with 38.28 million international tourist arrivals, as the second most visited country, in the Asia Pacific region (UNWTO, 2018). However, the high number of tourists also has negative effects on the country. Due to the immense number of visitors, the Thai government decided to limit access to certain touristic regions. The most prominent example is the four-month closure of the famous beach Maya Bay, on the island Koh Phi Phi in 2018. During high season, four thousand tourists visited daily the small beach, famous for the movie “The Beach” starring Leonardo DiCaprio, via boat. It was therefore no coincidence, that sooner or later the marine ecosystem was damaged (Koh & Fakfare, 2019.)

According to the figures of the wellness tourism growth projections, 2017-2022, the Asian-Pacific market, including China, Japan, Vietnam, Indonesia, and Thailand, is expected to have an annual growth rate of 13%, which is considerably more than all other regions worldwide (Global Wellness Institute, 2017). Even though the growth certainly got interrupted by the pandemic crisis in 2020, it can be assumed that after the pandemic the numbers will continue to rise, and thus more and more health tourists will visit these regions and intensify the phenomenon of over-tourism.

2.5.4 Health Tourism and the Lack of Psychological Treatment Options

The total economic costs of poor mental health in urbanized developed nations were estimated at ~ 10% of GDP, before the COVID-19 pandemic (Buckley & Brough, 2017). In recent years, and especially through the psychological effects of the pandemic, the current society is increasingly acknowledging the importance of mental health (Pfefferbaum et al., 2020). Nevertheless, governments and healthcare systems have not yet adequately responded to the burden of mental disorders (WHO, 2013). As reflected in the constitution of the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Therefore, one can say that mental health plays an essential role in the overall well-being of every single individual (WHO, 2013). The Mental Health Action Plan 2013-2020, published by the WHO, points out that only depression alone accounts for 4.3% of the global burden of disease and is therefore among the largest single causes of disability in the world (2013). Mankind is increasingly struggling with mental illnesses and the gap between the need for treatment and its provision is large everywhere in the world (WHO, 2013).

When analyzing the current health tourism market, one can notice that the offer for mental or psychological treatments and therapies is indeed very spare. Due to the reasons above, mental health tourism or mental health medical tourism are segments with emerging potential, focusing on mental wellness, and offering patients the possibility to travel to another country to seek treatment and rehabilitation services for a vast array of mental illnesses, including anxiety disorders, eating disorders, addictive disorders, or depression (Hanai, 2016).

Nevertheless, the question remains: why is the market of mental health tourism so narrow? Reasons for the spare offer of mental health tourism may be related to the fact, that mental health has a poor reputation, and that psychological practice has been stigmatized and neglected for many years. Furthermore, the report “Mental Health in the Mainstream” published by the UK’s leading think tank, the Institute for Public Policy Research (IPPR) states that individuals with long-term mental health issues are part of the most excluded groups of our society (p.3) (Rankin, 2005). Mental health in general but especially mental treatments and therapies often have a degrading status in human well-being and are frequently classified as a taboo subject in our society (Foster et al., 2021). People are uncomfortable talking about mental issues, they are ashamed of them and unfortunately, this behavior hides the real need for mental and psychological therapies, both in the medical sector and tourism sector, hence in mental health tourism.

3 Introduction to the Concept of Prescriptive Health Tourism

3.1 Composition & Definition

To elaborate on the concept of prescriptive health tourism, the researcher is first going to define the term *perspective*. The Cambridge Dictionary describes prescriptive as “saying exactly what must happen, especially by giving an instruction or making a rule” (Cambridge Academic Content Dictionary, 2017, no page number). In medical terminology, the word prescriptive comes from the word “prescription”, meaning a health-care program implemented by a qualified specialist in the form of instructions, that guide the patient through a plan of treatments and remedies (Belnkap et al., 2008). Prescriptive health tourism is, therefore, a combination of a medical prescription in form of one or more treatments abroad, issued by a physician or other kind of specialist, and a tourism product, such as a stay in a hotel, retreat, or clinic.

3.2 Visual Representation of the Concept

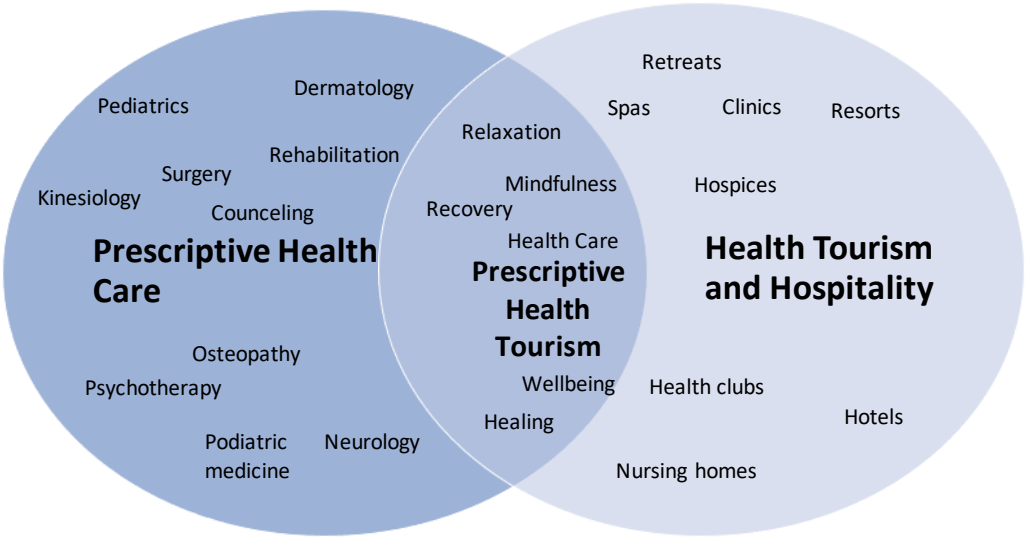

Figure 2: Venn Diagram: Prescriptive Health Tourism

Figure 2 above shows a Venn Diagram that visualizes the concept of prescriptive health tourism and the interference of the two sectors, health care, and hospitality. Venn diagrams have been invented by John Venn to aid in logical reasoning, understanding, and organizing of ideas and concepts (Upton & Cook, 2008). In this case, one circle represents prescriptive health care and includes treatments and therapies such as surgeries, osteopathy, podiatric medicine or neurology, and even mental treatments such as psychotherapy, which the patients can be prescribed from the doctor of their choice. The second circle represents the hospitality and tourism industry, with its stakeholders such as hotels, resorts, spas, and retreats but also medical accommodations like hospitals, nursing homes, or clinics. The Venn diagram shows that the closed curves are overlapping and create a synergy, a new category. The overlap area of the diagram is composed of the sectors, health care, and hospitality, and can describe as the concept of prescriptive health tourism. Tailored to the patient's illness, he or she gets prescribed a customized journey, including one or more health treatments in combination with matching accommodations. For the well-being of the patient, medical specialists and hospitality employees work hand in hand to provide outstanding service and excellent health remedies.

3.3 Description of the Prescriptive Health Tourism Procedure utilizing an Example.

1. The patient has been experiencing severe knee pain for a while and decides to visit his general practitioner. The patient has public health insurance and is also covered by private supplementary insurance.
2. The local physician examines the patient and diagnoses him with a cruciate ligament rupture. The medical professional investigates suitable treatments and discusses possible remedies with the patient. He also explains to him that there is the possibility to take advantage of the prescriptive health tourism service, which means that the patient could opt for therapy abroad to a specialized treatment center.
3. The patient decides that he wants to take advantage of the prescriptive health tourism service and chooses together with the doctor a fitting treatment center, which offers special therapy including physiotherapy, orthopedics, and rehabilitation from the prescriptive health tourism platform.
4. The prescriptive health tourism platform works as a database search engine for the prescriptive health treatments, offered by participating facilities, retreats, or clinics. The program is run by an administrative agency and works as a connector between the different treatment facilities and the hospitality industry. In other words, the agency is responsible for combining the treatments with a fitting accommodation. Sometimes it can be the case that an institution is offering treatments and a stay in one single space (e.g., retreats or clinics).
5. Since the patient is covered by social security, he is eligible to get reimbursed for a certain amount of costs of the package with the precondition, that the patient gets preliminary approval of the package from the insurance fund. In the next step, the prescriptive health tourism online portal will enable the physician to immediately request the cost estimate from the treatment facility for the chosen treatments and period.
6. The facility submits its costs estimate and the prescriptive health tourism portal automatically matches the location and dates with a matching accommodation. The final quotation of the package is ready for the patient. In the current case, the patient receives a package including therapy over five days at a treatment center in the south of France. Furthermore, the package includes board and lodging at the treatment center and transportation costs.

7. In the following step, the patient will submit the final quotation together with a justification of the diagnosis to the insurance fund. Depending on the package options, public insurance might not reimburse all the costs for the package. The insurance fund will most probably reimburse the costs of the treatment up to the maximum amount that would have been accepted if the same treatment had been provided within the patient's country of residency. Additional costs would also include transportation mode or any off-site accommodation. In this case, the private supplementary health insurance would come into play and cover the additional costs. In the current example, the patient would get reimbursed by the public insurance fund for all treatment costs. His private supplementary health insurance would cover the costs of the train tickets. If the patient was not additionally insured by private insurance, he would have to bear the costs exceeding costs by himself.
8. In the final step, the patient has got approval from his insurance and is ready to take on his journey to the treatment facility.

3.4 Advantages of prescriptive health tourism

After the introduction of the concept, followed by a detailed description of the procedure, it seems relevant to explain the main advantages, which the concept of prescriptive health tourism could entail.

1. The concept is designed to give participating governmental organizations and health care funds the possibility to introduce a uniform and standardized accreditation and quality control system for hospitals, clinics, and even retreats. All participating facilities listed on the PHT portal would no longer set their quality standards, they would have to conform to certain quality regulations, allow the patients access to safe and high-quality healthcare in another country, even outside the EAA. With the introduction of the PHT concept, the deficiency in accurate policymaking in the medical tourism industry could be improved.
2. Since the participating facilities of PHT would comply with the required quality standards, public health insurance would most probably agree with the conditions and would cover the costs, even for treatments taking place in countries that are not part of the social security agreement and outside the EEA, such as the UK, USA, Thailand, Philippines, Canada, India, and China.

Furthermore, the PHT platform would guide the patient through every step of the procedure, by providing him with clear guidelines to follow. Thus, the patient would know exactly how the procedure is carried out, and what he must do to get reimbursed by public and private health insurance.

3. As PHT would enable to travel to the participating specialized facilities from all over the world, a growing number of patients would visit quite unfamiliar and unknown destinations for the first time. On the one side, patients would push revenues of new destinations with promising health tourism resources, which could even then develop into a non-seasonal tourism sector. On the other side, unfamiliar health tourism destinations would draw away attention from certain extremely targeted health tourism destinations and possibly diminish the effect of mass tourism in those regions.
4. Furthermore, the concept of prescriptive health tourism would expand the spectrum of care and would give patients an alternative to traditional locally known cures. Therefore, treatments and therapies covered by health insurance would no longer be limited to the local market.
5. Finally, if the concept of prescriptive health tourism could also enable qualified psychologists or psychiatrists to diagnose patients with mental illnesses, chronic stress, or burnouts, the patients could be able to take advantage of PHT and travel to specialized mental health facilities. The concept would encourage individuals to work against psychological stress and generally motivate them to take better care of their mental health.

4 Methodology

4.1 Methodological approach

As it was noted above, the concept of prescriptive health tourism was developed to solve concerning problems in health tourism, such as the lack of quality control of treatments, absent insurance coverage for treatments outside of the EEA, mass-tourism caused or intensified due to medical and wellness tourism and lastly, the lack of mental health tourism offers on the market and lastly. These problems have been building up over a long time and many researchers have been invested in finding a solution to either one of the problems. However, there appears the question of why researcher have not been trying to combine the two different sectors, the medical/health care sector, and the tourism sector, in a way that could enhance and strengthen several familiar advantages of health tourism, while also acting against concerning problems arising due to the current development of the health tourism industry.

To help evaluate the concept of prescriptive health tourism, it seems important, that after the concept has been concisely defined, explained through a visual representation in Figure 2, and a detailed roll-out of the procedure, an introduction to a larger group of “judges”, namely the participants of the survey and a suitable research data collection should take place.

The research aims to find out if potential customers would be attracted by the idea of the PHT concept and if they would want to utilize the concept in the future. Furthermore, the research aims to find out if the concept would help to reduce the problem of quality and accreditation control in medical tourism and the effect of mass tourism in popular health tourism destinations. Finally, the research purpose is to find out if the concept would encourage society to take better care of their mental health status and which factors could potentially hinder them from taking advantage of the concept.

For the primary research data collection, three methods can be distinguished for conducting a study. The approach for the acquisition can be based on a qualitative, quantitative, or mixed research method. The quantitative research approach is used to investigate phenomena or relationships between variables.

The research is gathered via mathematical, computational, or statistical techniques. All tests are conducted flowing strict guidelines, to avoid bias and enable easy replication of the data (Creswell, 2003). This method is used to conduct survey research, experimental research, correlational research, or causal-comparative research. The quantitative research approach, however, is designed to understand the relationship between social or human problems and individuals or groups. This method originated in the social and behavioral sciences, the results are most often descriptive and non-numerical. One-on-one interviews, ethnographic or case study research are frequently utilized methods used during the process of qualitative data collection. The mixed research method is also described as "*triangulation*" (Page et al., 1966) and integrates both, qualitative and quantitative data collection. The increased use of mixed methods is particularly useful, since the researcher can, on the one hand, take advantage of the reliability and accuracy of quantitative results, while, on the other hand, understand the essence of a phenomenon with qualitative data derived from our mind. Finally, the mixed method applies a pragmatic point of view, which suggests that gathering a different kind of data, will result in a complete understanding of the research problem (Creswell, 2003). However, critics claim certain validity issues of this method, since the mixed method calls for a combination of quantitative and qualitative evaluation criteria, which researchers have to carefully implement (Onwuegbuzie & Johnson, 2006).

A study was conducted to test the validity of the concept and the method that was chosen, as it seemed the most appropriate for such a study, was the survey method. In a survey, researchers administer a survey to the entire population or a chosen or random sample of the population, to define opinions, beliefs, attitudes, or characteristics (Creswell & Hirose, 2019). During this process, investigators collect quantitative, numerical data using closed-ended questions and qualitative data, using open-ended questions. Surveys can be conducted through different procedures, such as web-based, telephone-based, or pen and pencil-based surveys or street surveys (Fowler, 2014). On the one hand, the standardized measurements of an online survey allow the researchers to take advantage of the following benefits: low cost, easy administration and data storage, high reach, and therefore an increased response rate.

On the other hand, surveys, in general, are often associated with a high risk of bias, confusing and wordy questions, and with jargon language or terms that are too vague (Creswell & Hirose, 2019). Nevertheless, due to the advantages noted above, the researcher decided to elaborate an online survey based on the mixed research method, for the primary data collection.

4.2 Methods of data collection

The chosen online survey serves the purpose of gaining additional opinions, beliefs, and attitudes towards the concept of prescriptive health tourism. The collected survey data, as well as the information, gathered from prior intensive data collection, from existing academic literature, enable the researcher to conclude if the concept of prescriptive health tourism is an appealing concept of interest to society and if the solutions proposed by the concept are indeed solving existing problems in the current health and health tourism sector. Furthermore, the evaluation will provide valuable information about which components and sections of the concept would need further research or improvements. In the end, the online survey helps the researcher with the assessment of the feasibility of such a concept.

As for the statistical methods used in the current research, the main method of research was the survey, which was set up with the help of a professional survey platform called “soSci” (www.soscisurvey.de). The survey platform is running on a survey server and was handled through the internet browser of the researcher. The platform supported the researcher in creating the questionnaire and facilitated convenient data collection.

4.2.1 Participants

To target a broad and versatile range of participants with different demographic characteristics such as nationality, level of education, age, and gender, the online survey was developed in English, shared via direct messaging, and published via two social media channels: LinkedIn and Facebook. Using different techniques and channels the researcher was aiming to receive a sample size embodying a part of the whole population. In total, the survey administration period was 32 days, from the 16th of March 2021 to the 16th of April 2021.

The survey was held anonymously; however, participants were asked about age, nationality, and occupation. This information allowed the researcher to determine if certain demographics might influence the answers given in the survey.

4.2.2 Construction of the questionnaire

To obtain a direct result and comparison of the results of different demographic information, only one questionnaire has been developed and made accessible to the sample frame. To make data submission and data collection more convenient, for the participants and the researcher, a few conditions regarding the layout, form, and language, used to design the survey, must be taken into consideration (Ross et al., 2005). One significant aspect is to keep the selected vocabulary as simple as possible and to avoid any use of acronyms or technical jargon. Furthermore, it seems important to shorten the questions as much as possible, since long questions tend to confuse, mislead, or demotivate participants. Basic short questions are faster to understand and to answer. Over more, opting for closed-ended questions support the researcher in managing, handling, and comparing the answers of responses (Babbie, 2007). However, close-ended questions may also induce participants to respond to the questions on a systematic basis (Ross et al., 2005).

When using open-ended questions, the chance of participants filling in the questions without reflection is reduced, furthermore, this method has the advantage of allowing the participants to express their ideas or improvements regarding the subject. However, with the use of open-ended questions, the possibility of a nonresponse error is higher. Nonresponse may occur if the participants are allegeable to skip the question and reject data provision, or if they are unable to perform the required task (Fowler, 2014). A reasonable response rate does not only depend on the nature of the survey sample, their time, and motivation. The design of the survey, meaning a clear and well-structured layout, with spaced and uncluttered questions supports the participants in completing the whole survey (Sanchez, 1992).

4.2.3 Reflections concerning the Questionnaire

The survey consisted of five sequential sections and the questionnaire was semi-structured with close-ended and one open-ended question. After a short introduction slide, including the presentation of the researcher's topic and purpose, the participants could start the questionnaire. At this point, it is essential to note, that all questions and possible answers of the questionnaire were clear and relevant to the research questions. As for most survey questions, the participants had to indicate to what extent they agree or disagree with the statement. While doing so, they could choose theirs answers from the five-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree". However, for some questions, participants only had to choose between "Yes" and "No".

In the first section the participants got to express their general opinion on the connection between health and travel on a Likert scale ranging from one, "Strongly Disagree" to five, "Strongly Agree". This question was placed in the beginning, since it helped the researcher to get a feeling of the participant's general opinion of the connection between health and travel. The evaluation of this question was used by the researcher as a first indication of how attracted the participants could be to the concept of prescriptive health tourism, which was introduced later.

In the second part, the participants got informed about the meaning and differences between medical and wellness tourism. Considering these definitions, the participants had to choose whether they have experienced this sort of tourism before. For both questions, the participants had to choose between "Yes" and "No". If the participants choose "Yes", then they got to evaluate on a Likert scale, their prior experiences in medical tourism and wellness tourism.

Those statements below were specifically designed to help the researcher find out whether the participants had experienced the previously researched problems in health tourism, which are explained in the literature review above. If the participants choose "No", then they got to choose to what extend different factors kept them from experiencing medical tourism and wellness tourism. In this case, the statements were designed to find out what the motivation for their non-participation was and if those reasons could stand concerning the current problems in health tourism.

In the fourth part, the participants were introduced to the concept of prescriptive health tourism. The researcher decided to explain the concept with the use of a self-produced, fact-based video. The short video was uploaded by the researcher on a sharing platform and then built into the survey. After the participants watched the video, they were asked to evaluate the concept based on different statements regarding their first impression, their behaviour, and motivation to take advantage of the concept. Furthermore, they were asked to evaluate different factors which might negatively affect the patient's opinion on participating in prescriptive health tourism. For the final question of this section, the participants were free to leave any further reasons why they might not want to participate in prescriptive health tourism. This section helped to find out if there are other problems regarding the concept, which have not been addressed before.

4.3 Methods of analysis

Since the data was collected in electric form, the answers to the questions were saved and stored by the survey platform and could therefore not be lost because of technical errors. Before evaluating the data, a few preliminary observations helped to structure the following data analysis efficiently.

First, it was necessary to analyze how many participants completed or did not complete the questionnaire to be sure about the future results of the survey. Overall, the survey platform counted 93 participants for the current semi-structured interview survey. However, this also includes the participants which did not complete the survey. In fact, from the 93, 69 participants reached the last page of the questionnaire (page 17 in the survey), meaning that their questionnaire was counted as finished. The division between the total participants and the data sets finished, gives the researcher a response rate of 73%. This rate is quite high for such a study, considering the fact, that the participants had to read some information beforehand and watch a video of two minutes to the entire survey. The high response rate may also be an indicator that the chosen topic of the thesis, namely health tourism, is a topic of interest for a considerable amount of people.

Second, it seemed necessary to consider the answers to question PH05, ("Are there any further reasons why you would not like to take advantage of the Prescriptive Health Services? ") which was the only open-ended question and the only source of qualitative data from the survey. The evaluation of this question was done at hand, before analyzing the other results of the survey. The prior assessment permitted to give the researcher an instant overview of how well the participants understood the concept and to what level the participants were motivated to apply critical thinking.

As for the analysis of the quantitative data, the software Excel and SPSS were used to analyse the obtained information. With the statistical formulas embedded in the programs, the researcher was able to filter the responses according to the need and calculate the percentages and averages as well as different statistical tests. Furthermore, the programs allowed the researcher to display the results in statistical graphs, tables, or other visual representations.

5 Findings

5.1 Questionnaire Participants

The data collection process was carried out for 32 days. In total 93 users participated in the survey and a total of 69 participants finished the entire survey.

5.1.1 Gender

Table 1: Gender of the Participants

Gender	Number of Participants
Female	47
Male	22
Other	0
Total	**69**

Table 2 gives an overview of the gender distribution from the current study. In total 69 surveys were finished, whereby there was a majority of female respondents.

5.1.2 Age

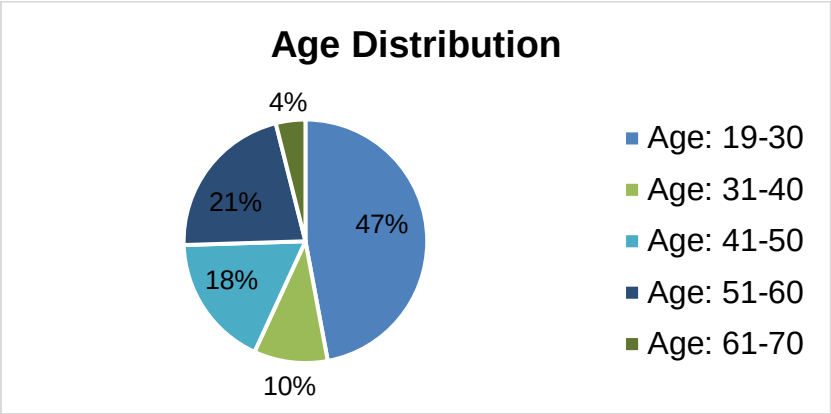

Figure 3: Age Distribution

Figure 3 shows the age distribution of the study participants. One can understand that most of the participants were aged between 19 and 30. The second-largest group of participants was aged between 51 and 60, followed by participants aged between 41 and 50. A minority was aged between 31 and 40 respectively 61 and 70.

5.1.3 Country of Residency

Table 2: Top 4 Countries of Residency

Top 4 Countries	Number of Participants
Luxembourg	42
Austria	11
Netherlands	3
Germany	3

Table 2 shows the four most selected countries of residency. With 42 votes, Luxembourg is by far the most selected country, followed by Austria, the Netherlands, and Germany. The high quote of Luxembourgish residents is linked to the fact that the researcher shared the participation link of the survey over social media channels containing mostly Luxembourgish connections.

5.1.4 Employment Status

Table 3: Employment Status

Employment Status:	Number of Participants
Employed	31
Student	21
Self-Employed	9
Employed Part-time	8
Unemployed	3
Retired	2
Total	**74**

Looking at the results of Table 3, one can notice that the total number of participants is greater than the actual number of participants (69) of the survey. This result is linked to the fact that the participants could choose one or more options from the selection if they were currently holding more than one employment status. Therefore, five participants chose two options. Nevertheless, the majority of the participants stated to be either employed or studying.

5.2 Medical Tourism

5.2.1 Participation in Medical Tourism

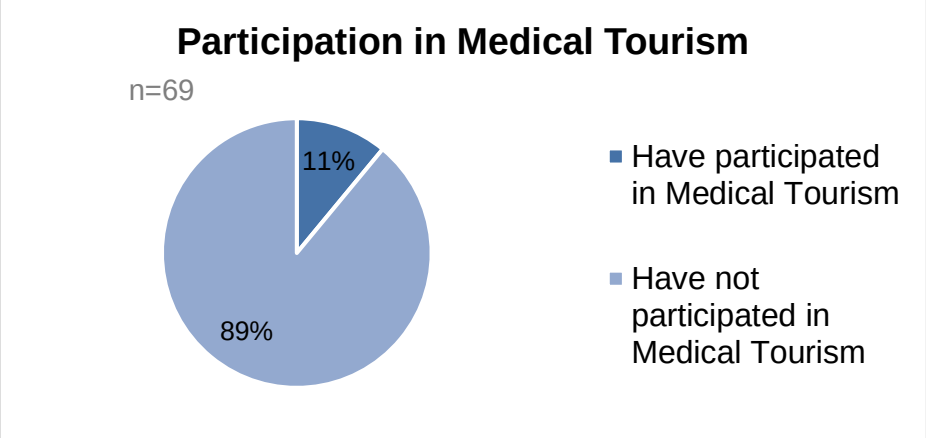

Figure 4: Participation in Medical Tourism

Figure 4 shows what percentage of the total participants have already experienced some form of medical tourism. To the date of the survey completion, only a minority participated in medical tourism. The majority denoted that they haven't had any prior medical tourism experience.

The low number of medical tourism participants may correlate with two different factors: The first one is the age of the participants. As previously noted, 47% of all participants were aged between 19 and 30. The RKI stated that from a science and medical perspective, young adulthood, like childhood and adolescence, is a period of life that can generally be spent in good health (Lampert et al., 2017). The need for medical care, and therefore medical tourism, is simply lower among younger individuals. Another reason for the shortfall of medical tourism experience among the participants may be linked to their country of residency and the primary motivators to undertake medical tourism. As previously mentioned, the reasons for the citizen of developed countries, to practice medical tourism are most of the time linked to either the limitations of domestic healthcare infrastructure or to inflated healthcare costs in the domestic country (Ruggeri et al., 2015). However, as table 3 shows, most participants reported living in a central European country, namely Luxembourg, Austria, Germany, and the Netherlands. According to the WHO ranking, Luxembourg ranks 16th, Austria 9th, Germany 25th, and the Netherlands 17th among the world's best healthcare systems (Tandon et al., 2000). These high rankings indicate that those countries have an elevated overall efficiency of the health systems. The overall efficiency integrates three intrinsic health system goals: health of the population, responsiveness, and fairness in financing (Tandon et al., 2000). Therefore, one can understand that citizens of countries with high efficiency of health systems, tend to have less of an urge to travel to another country to seek medical or cost-related benefits.

5.2.2 Reasons for the non-participation in Medical Tourism

After analysing how many users have had and haven't had prior medical tourism experience, figure 4 helps us to understand what the most chosen reasons for their non-participation in Medical Tourism were. For this question of the survey, participants who had previously chosen that they have not yet participated in medical tourism (63), had to evaluate each of the six reasons on a Likert scale ranging from one to five (1 → strongly disagree; 2 → disagree; 3 → no opinion; 4 → agree; 5 → strongly agree). For the matter of finding out the highest-ranked reason, it was necessary to only count the total number of votes for "agree" and "strongly agree" for each reason.

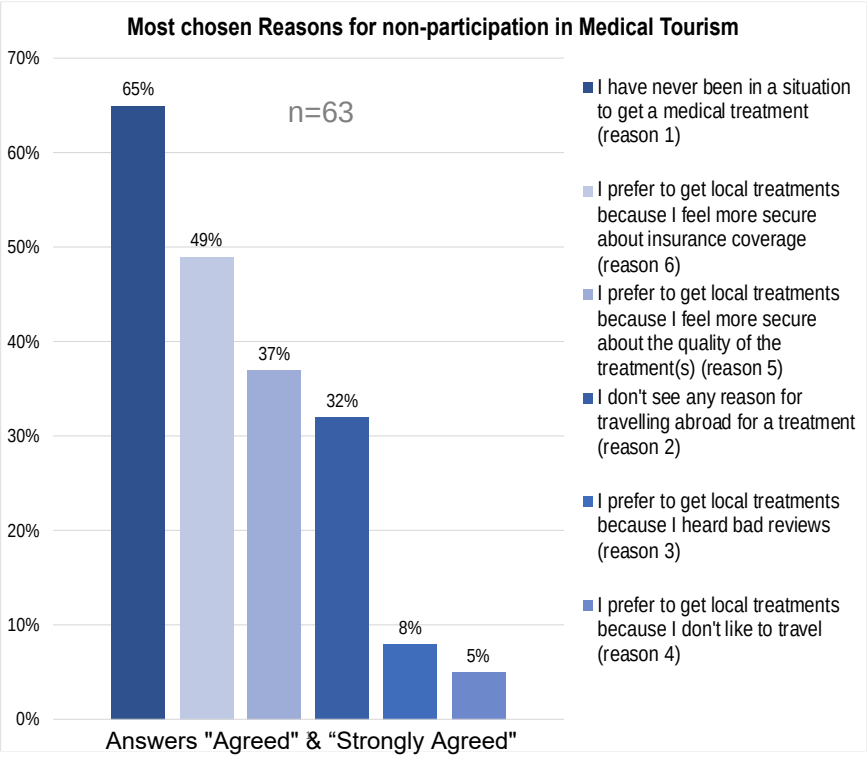

Figure 5: The most chosen reason for non-participation in Medical Tourism

The chart in Figure 5 above shows that 65% of all respondents who have not participated in medical tourism agreed or strongly agreed to the reason that they have not participated since they have never been in a situation to get medical treatment. This outcome might correlate with the previously announced reason why such a small percentage of participants have participated in medical tourism.

With 49 %, the second strongest reason is linked to the fact that respondents prefer to get local treatments instead of treatments abroad since they feel more secure about local insurance coverage. This outcome shows that nearly half of the respondents have insecurity towards health insurance coverage for treatments abroad. One can argue that the insecurity might be caused by the missing literacy over health insurance coverage. The findings from a Jama Netw Open study, suggest that lower health insurance literacy may be associated with greater avoidance of preventive and non-preventive services, including health tourism (Tipirneni et al., 2018). The study also suggested that policymakers may need to communicate health insurance regulations incomprehensible ways, regardless of someone’s health insurance knowledge (Tipirneni et al., 2018).

37% of all concerned respondents agreed or strongly agreed on the fact that they prefer local treatments since they feel more secure about the quality of the treatments than with treatments abroad. 37% is a moderately strong outcome and states that over one-third of the participants found this reason to be accurate and true. A study published in the International Journal of Health Care Quality Assurance found another factor that might support this perception; in fact, researchers found out that potential medical tourists have expectations over six times higher than those of experienced medical tourists (Guiry et al., 2013) Hence why the expected service quality of individuals who have not experienced medical tourism before is rather high.

32% of the participants agreed or strongly agreed on the fact that they simply do not see any reason for traveling abroad for a treatment. About one-third of the total respondents found this reason to be accurate. The reason for the outcome may be linked to the fact that most of the respondents live in countries with highly ranked health systems (Tandon et al., 2000). It could be the case that participants are satisfied with the local medical offer and therefore do not look for alternative treatments abroad.

8% agreed or strongly agreed on the fact that they haven't participated in medical tourism since they heard bad reviews. This result is not particularly surprising, since most of the participants simply haven't dealt with the topic of medical tourism yet and therefore haven't considered other people's opinions experiences with medical tourism. Lastly, only 5% agreed or strongly agreed on the fact that they simply don't like to travel.

5.3 Wellness Tourism

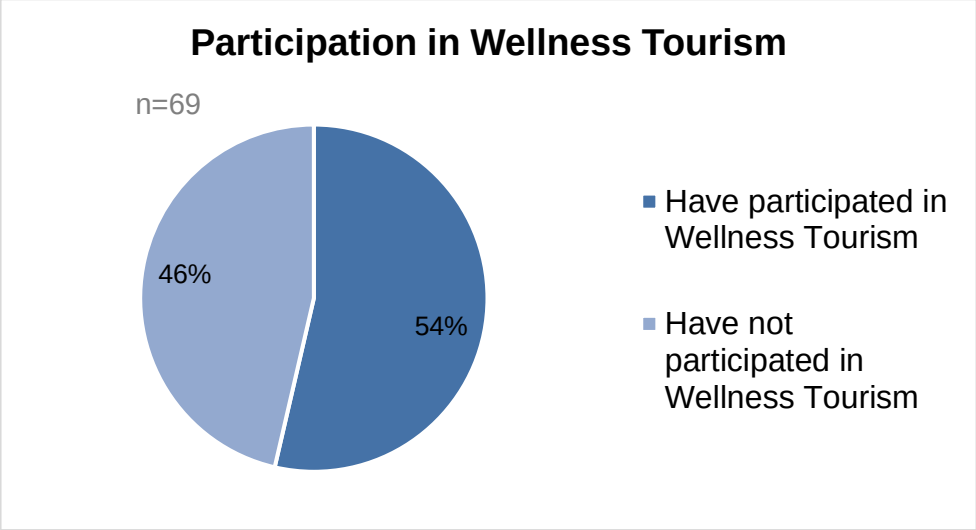

Figure 6: Participation in Wellness Tourism

After the evaluation of the medical tourism section, all participants were informed about the definition and meaning of wellness tourism. Again, all participants were asked if they had previously experienced some form of wellness tourism. Comparing the results in Figure 6 to the ones in Figure 2, one can identify that more participants have had prior experience in wellness tourism as in medical tourism. The outcome of this question may be linked to the fact that the wellness tourism industry offers a very broad scope of products and services, ranging from the classical wellness/spa vacation within to specialized stress-reducing activities, meditations, or yoga retreats. The wellness tourism market is vast and attracts many kinds of travellers (Bushel & Sheldon, 2009).

5.3.1 Reasons for non-participation in Wellness Tourism

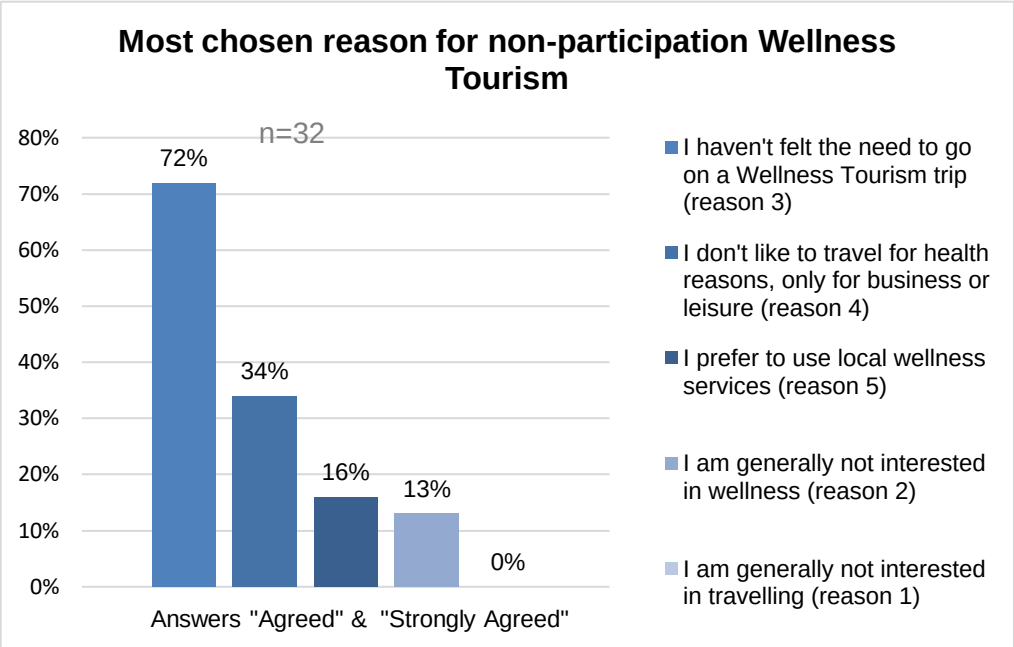

Figure 7: The most chosen reason for non-participation Wellness Tourism

When looking at the 46% (n=32) of the participants who have no prior experience in wellness tourism, it seems important to point out why the participants have not participated in wellness tourism yet. For this reason, participants had the option to rank on a Likert scale, ranging from one, “strongly disagree” to five “strongly agree”, five possible reasons. For the matter of finding out the most chosen reason, it was necessary to only count the total number of votes of “agree” and “strongly agree” for each reason.

Figure 7 shows that 72% of the respondents who haven’t experienced wellness tourism agreed or strongly agreed on the fact that they haven’t felt the need to go on a wellness tourism trip. This considerably strong outcome may be related to just personal preferences, age, or country of residence of the participants. 34% agreed and strongly agreed on the fact that they don’t like to travel for health reasons, only for business or leisure. 16% agreed or strongly agreed on the fact that they prefer to use local wellness services and 13% agreed or strongly agreed on the fact that they are generally not interested in wellness. Nobody agreed or strongly agreed on the fact that they haven’t experienced wellness tourism because they don’t like to travel.

5.4 Evaluation of the Concept of Prescriptive Health Tourism

5.4.1 Overall Interest in the Concept of Prescriptive Health Tourism

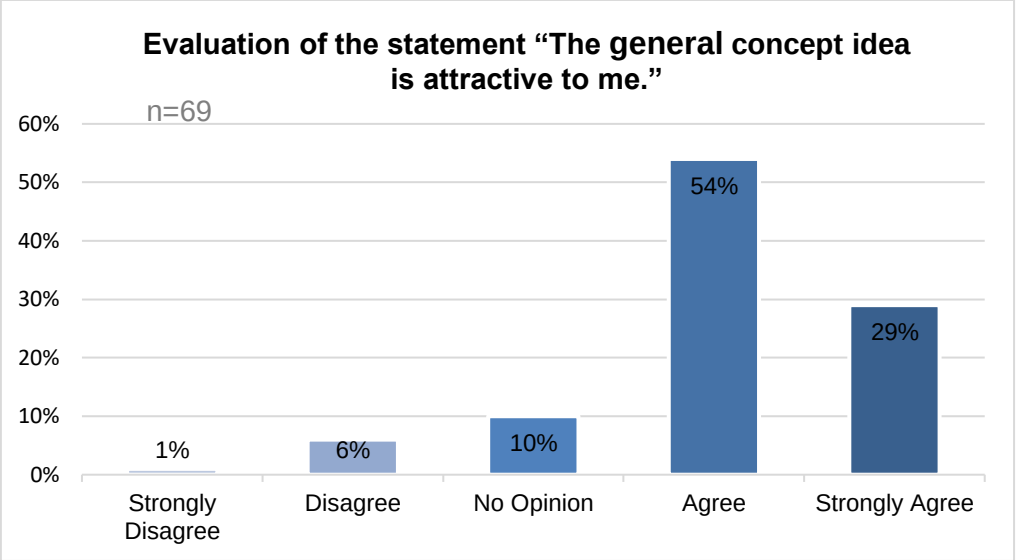

Figure 8: Evaluation of the statement "The general concept idea is attractive to me"

After the participants watched a short video, which introduced and explained the concept of prescriptive health tourism, they were asked to evaluate a few statements on a Likert scale, again ranging from one, "strongly disagree" to five, "strongly agree. The bar chart (Figure 8) above shows the evaluation of the statement "The general concept idea is attractive to me". Using this specific statement, the researcher aimed to receive first general feedback of the concept from the participants.

By looking at the figures, one can pinpoint that, only from watching the video, the participants find the general idea of the concept attractive. However, it seems important to indicate that the participants rated the statements only based on the two-minute video. None of the participants had more in-depth information available about the concept. Thus, it would have been possible, that the participant's opinion would have, to some extent, changed in both ways, if additional information, about the concept, would have been made accessible to the participants. Nevertheless, the evaluation of the question shows that most of the participants find the idea of the concept attractive.

5.4.2 The Level of Interest between Female and Male Participants

After evaluating the overall interest in the concept, it would be of relevance to assess a gender-based outcome, screening which gender might be the most attracted to the concept of prescriptive health tourism. In total, 87% of all female participants and 72% of all male participants of the survey agreed or strongly agreed with the statement: “The general concept idea is attractive to me.” Nevertheless, the Mann-Whitney U test indicated that the interest in the concept was not significantly greater for female participants (Mdn = 4) than for male participants (Mdn =4), U =454.5, p=0.374.

5.4.3 Correlation between Attractiveness of the Concept and Age of the Participants

To find out if the age of the participants could be associated with their expressed attractiveness regarding the concept, the researcher decided to undergo a Pearson Correlation. Results show that there is a very slight negative relationship (-.15<0) between the age of the participants and their level of attractiveness regarding the prescriptive health tourism concept. Nevertheless, it remains important to say, that there is insufficient evidence to conclude that there is a significant linear relationship between the age and the attractiveness to the concept of the participants since the correlation coefficient is not significantly different from zero (r = -.15, p=.213, N=69). Therefore, one cannot use the regression line to model a linear relationship between the two variables. As shown by the result of the Pearson correlation, in the current example, it is not said that participants would be more or less attracted to the concept due to their age.

5.4.4 Direct Interest

The next evaluation statement is closely linked to the statement before, however, this time, the participants were asked to evaluate on a Likert scale from one (strongly disagree) to five (strongly agree), the statement: “I would consider asking my doctor about available options for myself, regarding PHT With this question the researcher didn’t aim to find out the general appeal of the concept but rather the direct interest and whether the participants would actively go to their local doctor asking about their options regarding prescriptive health tourism.

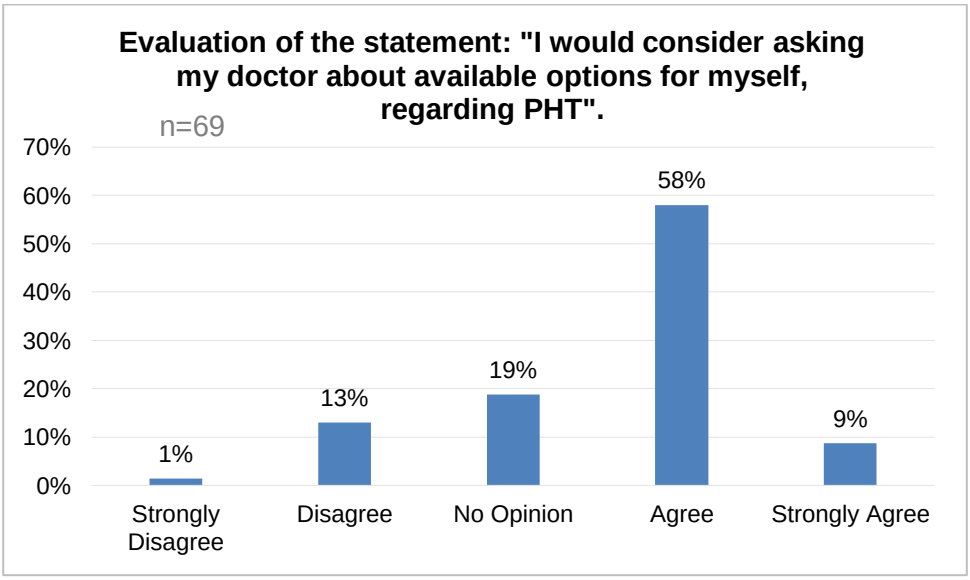

Figure 9: Evaluation of the statement: "I would consider asking my doctor about available options for myself, regarding PHT".

The bar chart above (Figure 9) shows that in total 67% (58+9) of all the participants agreed or strongly agreed with the statement. 19% of the participants had no opinion and 14% of the participants either disagreed or strongly disagreed.

One can recognize that the majority of the participants would consider asking their doctor about possible options. However, the evaluation of the statement doesn't say that 67% would like to participate in PHT. Determining whether patients would then actually take advantage of the concept, depends on multiple other factors such as whether the physician would recommend prescriptive health tourism for the treatment and whether the proposed package would appeal to the patient.

5.5 Understanding the aimed Benefits of the Concept

After the general evaluation of the concept, with the next question, the researcher aimed to find out if the participants understood how the concept of prescriptive health tourism could benefit individuals, the medical sector, and the tourism sector. For this reason, the participants were asked to evaluate on a Likert scale ranging from one to five, the statement “I understand how individuals/the medical sector/the tourism sector could benefit from this concept.

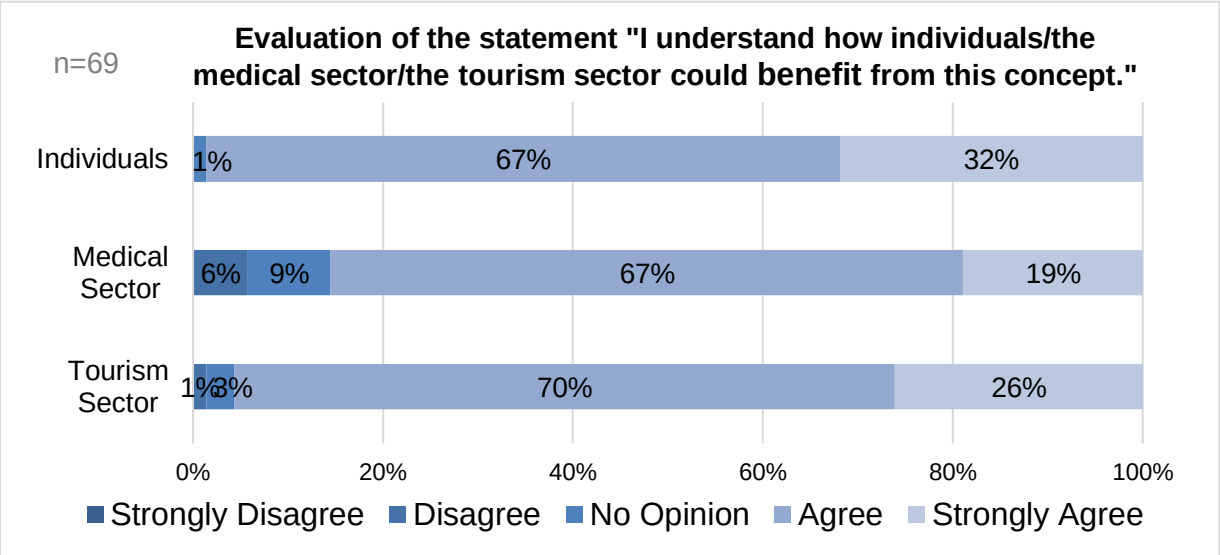

Figure 10: Evaluation of the statement "I understand how individuals/the medical sector/the tourism sector could benefit from this concept."

The statistics in Figure 10 show that most of the participants either agreed or strongly agreed with the fact that they understand how the concept could be beneficial for individuals, the medical sector, and the tourism sector. In fact, for the “Individuals” 99% of the participants agreed or strongly agreed. For the tourism sector, 96% and for the medical sector 86% of the participants agreed or strongly agreed. The result indicates that a small part of the participants did not directly understand the benefits for the medical sector. In this regard, the outcome seems reasonable since the benefits for the medical sector might not be as obvious or more complex to understand. However, the outcome could also be linked to the fact that the video, which explained the concept, did not directly describe the benefits of the concept for the medical field.

The researcher carefully designed the video in a way that excluded all biased information, by no means influenced the viewers' opinions, and wasn't too complex, nor lengthy. Therefore, the video did not include extended details from the medical perspective.

5.6 PHT and Mental Health Treatments

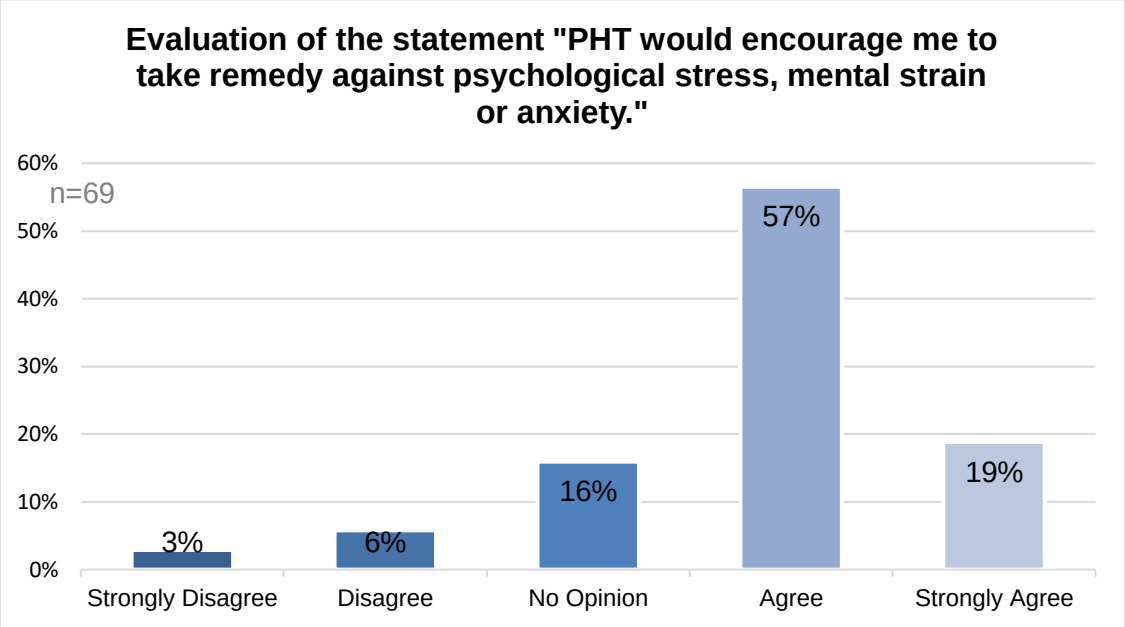

Figure 11: Evaluation of the statement "PHT would encourage me to take remedy against psychological stress, mental strain or anxiety."

The statistics (Figure 11) display the outcome of the statement evaluation: "PHT would encourage me to take remedy against psychological stress, mental strain or anxiety." For this evaluation, the participants had to choose on a Likert scale, ranging from one to five, how much they agree or disagree with the statement.

Since most of the participants either agreed or strongly agreed with the statement, one can recognize that not only the concept of prescriptive health tourism could motivate people to act against their psychological stress, mental strain, or anxiety but also that patients would find it appealing and meaningful to follow a therapy aboard within the framework of the concept. The positive responsiveness might be linked to the fact that the participants could have the possibility to escape or disconnect from their habitual environment and thus be able to switch off and recover in another place offering specialized psychological therapy or treatment services.

5.7 PHT and Mass-Tourism

Since the concept is set up in a way that the local physician is recommending one or more facilities, participating in PHT, to the patient, a growing number of partaking patients would have the possibility to visit quite unfamiliar and unknown destinations for the first time. With the next question, the researcher aimed to find out whether patients would be willing to be directed to a previously unfamiliar place as part of the concept since such an approach could be a chance to get patients out of crowded health tourism destinations and introduce them to new destinations. For that reason, the participants were asked to evaluate on a Likert scale, ranging from one to five, how much they agree or disagree with the statement: “PHT would encourage me to discover unknown destinations”.

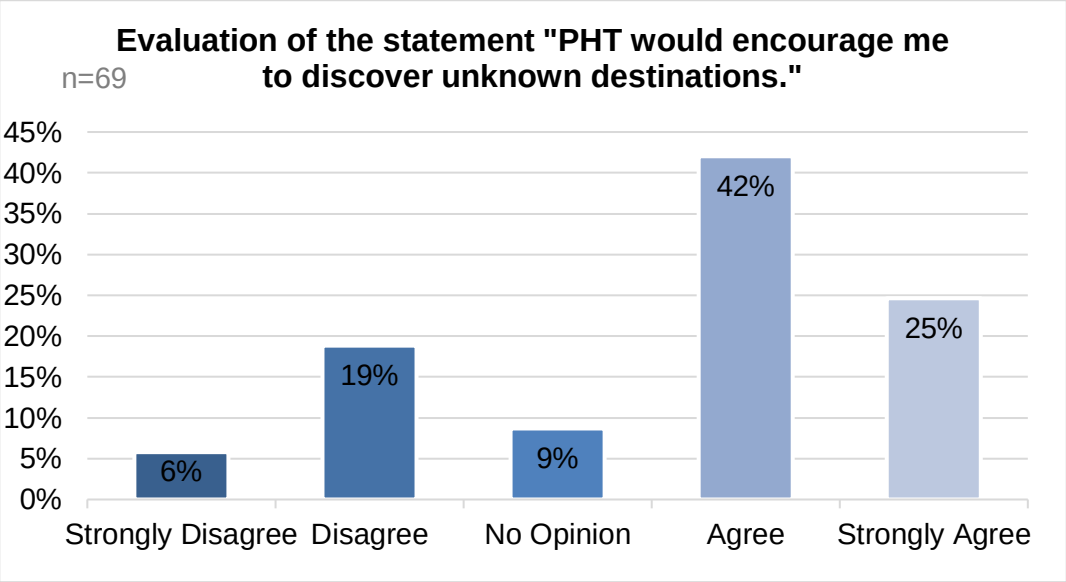

Figure 12: Evaluation of the statement "PHT would encourage me to discover unknown destinations."

Figure 12 above shows that a considerable amount (67%) of participants agreed and strongly agreed to the fact that the concept of prescriptive health tourism would encourage them to discover unknown destinations. One could identify this as an opportunity to spread patients throughout lesser-known health tourism destinations which in turn could relieve the pressure put on cultural and natural resources of destinations threatened by mass tourism (Powell & McGroarty, 2019). Furthermore, one could draw from the result of the question, that PHT could help support rather unknown destinations with promising health tourism potential.

5.8 Concerns and Obstacles regarding PHT

5.8.1 Factors that would hinder the Participants from taking Advantage of the Concept

Some of the previous findings showed that the introduction of the prescriptive health tourism concept could bring certain benefits to society, tourism, and the medical industry. Yet, the patients who would take advantage of the concept would probably have to face certain compromises regarding increased fees for health care coverage, solo traveling, spending time with unfamiliar people, or spending their holidays on behalf of personal health and wellbeing. To find out if the previously announced potential compromises could turn into hindrances for the patients, the researcher decided to let the participants of the survey evaluate each factor on a Likert scale ranging from one, “strongly disagree” to five, “strongly agree (Figure 13).

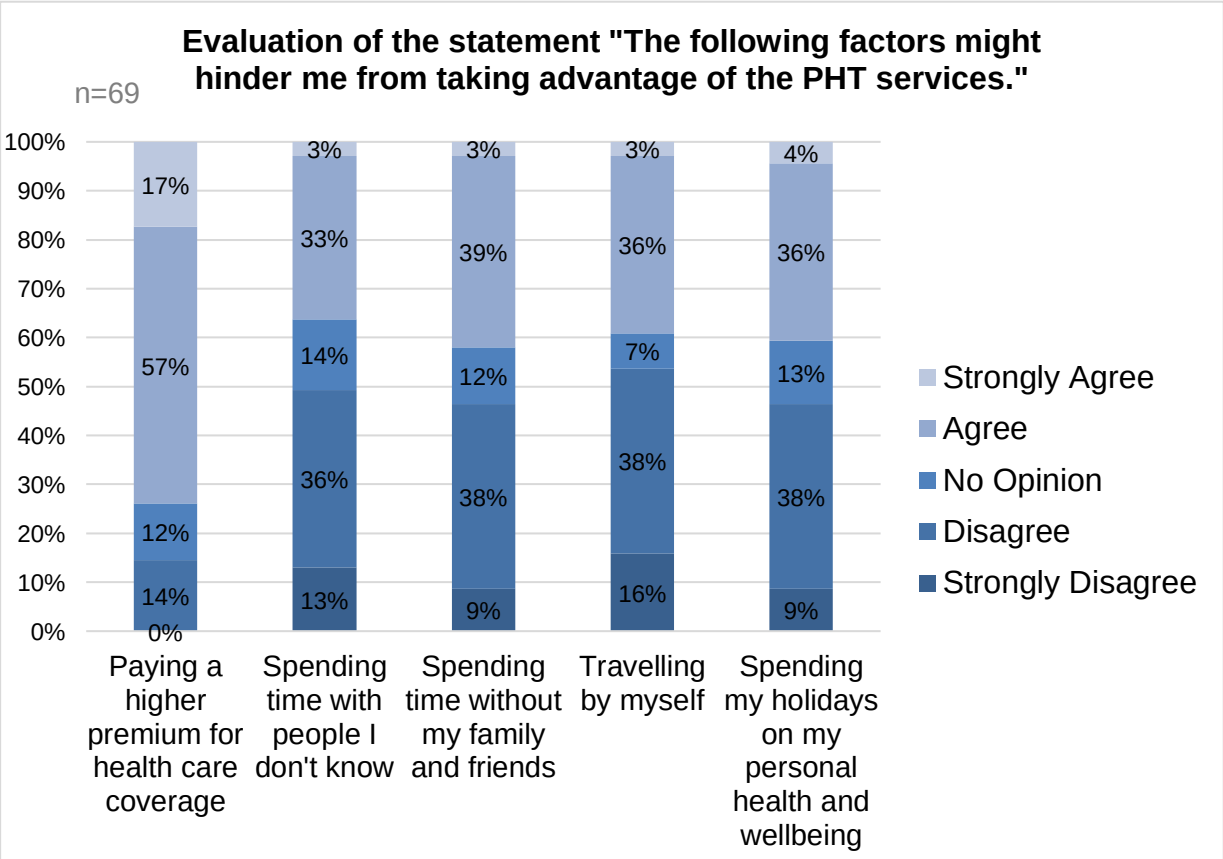

Figure 13: Evaluation of the statement "The following factors might hinder me from taking advantage of the PHT services."

Figure 13 shows that 74% agreed or strongly agreed with the fact that “paying a higher premium for health care coverage” could hinder them from taking advantage of the PHT services. For the second statement, 36% of the participants agreed or strongly agreed and 49% disagreed or strongly disagreed, the remaining 14% had no opinion on this statement. This outcome shows that nearly half of the respondents do not consider the fact that they would have to spend time with unknown people as an obstacle to their participation. The results show a large variability across persons, meaning that for each statement approximately half of the participants agreed or strongly agreed and half of them disagreed or strongly disagreed.

Overall, one can say that paying a higher premium for health care coverage could potentially hinder the participants from taking advantage of the concept. Previous studies showed that the willingness to pay a higher premium for health insurance is associated with higher income, higher education, and higher individual health care costs among the adult population and individuals in late life in Germany (Bock et al., 2016; Hajek, 2020). Furthermore, it was found that individuals with high openness to experience may also be willing to accept higher premiums or deductibles for health insurance (Hajek, 2020). Nevertheless, in the context of prescriptive health tourism, public health insurance should be able to offer the PHT services without increasing the premium for health care coverage, as the insurance fund would only reimburse the costs of the treatment aboard, that do not exceed the same treatment costs in the country of the patient’s residency and therefore wouldn’t make any additional expenses.

The outcomes from the remaining four obstacles (Spending time without my family and friends; Spending time by myself; Spending my holidays on my health and wellbeing) confirm that opinions towards personal preferences are very divided (Lelkes, 2005). Some participants have no problem traveling alone without their family, for others however this is a no-go. In the end, Prescriptive Health Tourism would certainly be applicable voluntarily, patients must then decide for themselves whether they would agree to the compromises.

5.8.2 Other potential Problems – Open Question

In the last question regarding the concept of prescriptive health tourism, the participants were asked to leave any additional reasons why they might not want to take advantage of the concept services. ("Are there any further reasons why you would not like to take advantage of the Prescriptive Health Services?"). Since the question was voluntary, 13 out of the 69 participants left comments. The analysis of the qualitative data involved a formal division of the responses, according to the addressed topics from the answers of the participants. When analysing Table 7, one can see that overall, six topics were identified from the responses of the participants.

Table 7: Further reasons for non-participation

Topics	Participants
Environmental aspect	2
Language barrier	2
Possible corruption between the different sectors	2
Privilege to the affluent	3
Misuse of the concept by the society/everyone would take advantage	4

Table 7 shows that two participants addressed the environmental impact of encouraging patients to travel. Indeed, concerns over the environment have taken the stage, over the last years. However, travelers and the travel industry have started to show a commitment to sustainability. In addition, especially smaller retreats and resorts are very exemplary in terms of sustainability and attach great importance to saving water, reducing food waste, or energy consumption. To keep the carbon footprint as small as possible, when planning the prescriptive health tourism stay, one could consciously decide to use environmentally friendly means of transport, such as trains, or even look for environmentally friendly facilities, which are part of the PHT concept.

Two participants expressed their concern about the language differences in the countries abroad, and that the language barrier could lead to miscommunication between the professional staff and the patients. Certainly, different languages can create communication problems among the patient and the staff. To avoid miscommunication, the PHT system could allow the patients to choose among treatment locations where one of his or her languages are spoken.

The next three topics rather address general constraints regarding the introduction of the PHT concept. Two participants argued that the medical and tourism sector could benefit from each other in a way that it could lead to corruption. As officials and organizations are increasingly using their influence and power for self-enrichment. Corruption in the private and governmental health care systems, especially in low- and middle-income countries, is as present as never before (Clancy, 2003). Under no circumstances should the concept of prescriptive health tourism foster corruption. The system of PHT needs to be transparent, and explicit. Patient's rights should be clearly defined, and the system should make it easy for patients to register and inspect complaints. Over more, anti-corruption regulations may be introduced which could audit and regulate the cooperation between the medical and tourism sector.

Three respondents addressed the fact that the concept could turn into a privilege to the middle or upper class. Indeed, according to the recent metrics, the global trends suggest, that inequality is at a historic peak (Piketty & Saez, 2014). Furthermore, data indicates, that societal health gets worse as the economic inequality raises (Wilkinson & Pickett, 2006). However, the concept was not designed to strengthen the gap between the social classes, on the contrary, prescriptive health tourism was developed to give all insured patients access to specialized facilities abroad. The concept should encourage patients of all social classes to take care of their mental and physical health. Since the general treatment costs would usually be covered by public health insurance, the participants would be left with additional costs such as transportation. Those costs would then either be reimbursed by private additional health insurance (if available), or the participants would have to cover the costs. In the last case, participants could decide to replace their PHT journey with another vacation, thus the travel budget would balance out again.

The last four respondents addressed the fact that some individuals could be triggered to pretend that they have a certain illness or disease and thus misuse the PHT concept to their advantage. The risk that individuals manipulate the system is omnipresent, in every sector and any business. However, the misuse of the concept gets reduced if the medical professional is performing a fair, honest competent, and thorough medical examination, and consultation of the patient. To get reimbursed by public health insurance, a signed medical certificate from the attending medical professional must be submitted to the insurance fund. Without the certification, no reimbursement can take place.

6 Discussion and Conclusion

The previous research, discussed in the literature review of this thesis, indicates concerning problems threatening society, the medical and tourism industry. The deficiency in medical tourism policymaking, the absence of insurance coverage for treatments outside of the EEA, the phenomena of mass tourism in overly advertised health tourism destinations, and the lack of mental health tourism offers on the market, are problems, which have been building up over a decade. Indeed, the topic of health tourism is widely discussed throughout academia. However, there appears the question of why researcher have not been trying to combine the medical/health care sector, and the tourism sector, in a way that could enhance and strengthen advantages of health tourism, while also acting against concerning problems occurring due to the current development in the health tourism industry.

Hence, this thesis aims to inform the readers about the current problems in health, medical, and wellness tourism and introduces them to the concept of prescriptive health tourism, a concept based on the idea of finding an innovative and feasible solution concerning the problems arising due to the current development of the health tourism industry. In the light of the thesis, an online study was conducted, to gather information regarding the participant's medical and wellness tourism experiences, but foremost, to collect opinions, feedback, and recommendations regarding the concept, to find out if the concept has the potential to be beneficial and practical for the society and lastly to expose any constraints and threats, which could hinder the patients from participating in PHT. The outcome of the study seeks to provide information about the feasibility and validity of the concept.

Furthermore, the results provide valuable information about certain concerns and aspects of improvement, which would call for additional research and concept developments.

According to Weiner (2020), the first step for the implementation effectiveness of a concept or program is the organizational readiness for change. This refers to the extent to which society is psychologically and behaviorally prepared to support innovation (Weiner, 2020). Therefore, in the second part of the survey (5.4), which included the introduction of the new concept, participants were asked to evaluate their interests and give opinions on certain aspects of the concept.

The first questions aimed to find out how open and responsive the society would be to the introduction of the concept. The study demonstrated that a large majority (84%) of all the participants found the general concept idea attractive and 76% would actively ask their local doctor for possible options regarding prescriptive health tourism. The study also showed that female participants were slightly more attracted to the concept than male participants. Therefore, with the results of the study one could assume that the concept of prescriptive health tourism could be accepted and utilized by most of the citizens in the central European countries represented in this study unless other variables were to change their perception.

Conferring to Soland et al., (2002), individuals and groups are more likely to accept changes or innovations, if they understand the reasons for the changes and can identify their role within the strategy. The explanatory video, which was presented before the evaluation of the concept, served as the educational campaign for the participants. It was designed to help them understand the idea behind the concept and the possible benefits of prescriptive health tourism. In part 5.5, the participants were asked to evaluate on a Likert scale, if they understood how the concept of prescriptive health tourism could benefit individuals, the medical sector, and the tourism sector. The statistics showed that 99% of the participants understood how the concept could benefit individuals, 96% understood how the concept could benefit the tourism sector and 86% understood how the concept could benefit the medical sector.

Overall, one could assume that with the right educational campaigns, the benefits of the concept are expected to be understood by most of society. In which case, it would be a positive prerequisite for people to utilize the PHT services.

Looking at further results of the study, it can be stated that on the one side, concerns about health insurance coverage and the quality of the treatments abroad are factors that demotivate the participants, from considering treatments other than the ones offered locally. However, since the concept of prescriptive health tourism would allow the joining governments to introduce a uniform quality control system for all participating facilities and therefore, public health insurance might cover the treatment costs from abroad, the concept could eliminate the concerns of quality and insurance coverage and therefore encourage people to take advantage of treatments offered abroad.

On the other side, the concept of prescriptive health tourism could partly seem unattractive, since, as researchers claim, citizens from central European countries are used to having a well-established high-quality health care system and therefore might prefer to be treated at home in their familiar setting and their health system (Rosenmöller; McKee & Baeten, 2008). A theory that was also supported by the outcome of the current study, as 37% of the participants agreed or strongly agreed with the statement “I don’t see a reason for traveling aboard for a treatment”. Nevertheless, the increasing proportion of European citizens showing interest in seeking health care abroad, plus the growing number of patients obtaining care from abroad (Legido-Quigley et al., 2011), is speaking in favor of the success of the PHT.

Regarding further potential constraints and threats to the concept, the outcome of the evaluation statement: "The following factors might hinder me from taking advantage of the PHT services." showed that 76% of the participants agreed or strongly agreed with the fact that paying a higher premium for health care coverage could potentially hinder them to take advantage of the PHT services. Furthermore, a few respondents mentioned that they wouldn’t travel for health reasons due to environmental concerns or due to the potential language barrier at the treatment facilities.

Other concerns regarding the functionality of the concept, such as possible corruption between the different sectors, the possibility that PHT could turn into a privilege for the upper class, and the risk that individuals could misuse the concept to their advantage were mentioned and discussed in the findings above.

Looking at the results of the survey regarding the concept of prescriptive health tourism and the effect on mental health, 86% of the participants agreed or strongly agreed with the statement “PHT would encourage me to take remedy against psychological stress, mental strain or anxiety." One could assume that the concept could indeed motivate people to take remedy against their mental disease or illness, as the patients would have the possibility to travel to a specialized treatment facility and even get reimbursed by their health insurance. However, a topic that has not been addressed in this thesis, is how governmental institutions will have to set up their mental health funding through the health care sector, to reimburse mental health patients. Nevertheless, an increase in demand to receive mental health treatments abroad could lead to an increase in mental health tourism offers on the market.

Furthermore, the findings of the online survey showed that 67% of the participants agreed or strongly agreed with the fact that they would be encouraged to visit unknown destinations due to the concept of prescriptive health tourism. The result indicates that in fact, the concept could work as a tool to lead patients to new destinations, with promising health tourism resources, which could push their revenues and help to develop a non-seasonal tourism sector. Nevertheless, the result of the survey question doesn’t provide enough information to determine if PHT would decrease mass tourism in crowded health tourism destination countries.

After reviewing the outcomes of the survey, it is relevant to say that the findings of this study must be seen in light of some limitations. The generalizability of the results is limited by certain restrictions regarding the methodological analysis. Firstly, even though, through the Internet of things, online surveys tend to reach many individuals (Wellman, 1997), non-sampling errors, such as coverage error and under-coverage (Rawlins et al., 1992; Dillman, 2011) may lead to deviations of estimates from their true values.

Coverage error may occur when there is no equal correspondence between the sampling frame and the population (Dillman, 2011). Under-coverage may occur when the survey sample does not include all members of the target population (Rawlins et al., 1992). Coverage error and under-coverage may be caused by different incidents, one of them being the limited reachability of respondents who can't access the world wide web.

Another reason for coverage error or under-coverage is caused by the self-selection bias, which implies that certain users are more likely than others to complete an online survey and therefore lead to systematic bias (Thompson et al., 2003). Since the current study was conducted online, the reachability of the study was limited to technology users and therefore automatically excluded individuals which did not have Internet access, mostly elderly people. Thereby, only 4% of the participants were aged between 61 and 70 and the oldest participant was 63 old. As a fact, elderly people were not represented in the current sample size, however, they make up an important part of the whole health care system, and therefore also of the PHT concept.

Secondly, foremost in educational research, it is not always possible to receive a big and diverse enough sample size and thus, the randomization requirement cannot always be met. The occurrence of the missing sample size might be caused by the limited access students have to people, organizations, data, or documents. In the current case, even though, that the study was published on the researcher's public social media accounts, the nationality and origin of the researcher influenced the survey sample. In general, the sample cannot claim to be representative and results may depend on the actual choice of the sample.

Over more, students are often dealing with time constraints (Brutus et al., 2012). In the current context, the completion of the extended literature review, the development of the concept, and the preparation of the video, which was included in the study, let to the fact, that the survey was conducted over a period of one month. The rather short administration period of the current study may have reduced the sample diversity and size, and thus for some questions, it remained difficult to find significant relationships from the data.

The fourth limitation of the survey is caused by the attitude-behavior gap, the most frequently cited definition of this phenomenon is the Theory of Planned Behavior (TPB) (Ajzen, 1991). The TPB states that “the behavior is affected by behavioral intentions which in turn are affected by attitudes towards the behavior” (Van’t Erve, 2013). Therefore, the attitude can be defined as “the result of a consumer’s assessment of particular behaviors” (Ajzen, 1991, p. 14). In the current case, it could be the case that participants of the survey may have chosen certain answers to questions however, in reality, their behavior may not correlate with the chosen answer. Therefore, one can say that there could be a behavior gap between what participants think they would do in a situation, and how they actually act.

The issues regarding the concept of prescriptive health tourism as well as the limitations mentioned above, call for further concept developments and additional research. First, even though it was outside of the scope of this thesis to do a cross-analysis, for future research, it would also be interesting to know if certain demographic factors such as country of residency, would make a difference in the perception of the PHT concept. Second, to receive a strong and diverse sample size it seems important to note that future studies should possibly be conducted offline and for an extended period of several months. Third, future concept developments should focus on the structure and introduction of the quality and accreditation control system, regulating the participating facilities, and finally, developments should focus on the anti-corruption regulations and principles against PHT misuse by individuals.

Finally, besides the previously mentioned aims of the thesis, one relevant goal of this work is to encourage and show academic writers, researchers, and especially tourism and hospitality students, that to find solutions to problems, one should have the courage to be creative and start thinking out of the box.

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8 Appendices

Appendix 1: Survey Questionnaire

• **General** "General opinion on Health Tourism"
HT02_04 Tourism (and travel) is an activity that can contribute to the creation or improvement of wellbeing. 1 = Strongly Disagree 2 = Disagree 3 = No Opinion 4 = Agree 5 = Strongly Agree -9 = Not answered
• **Medical Tourism**
[MT01] Selection Medical Tourism Experiences "Medical Tourism Experiences"
MT01 Medical Tourism Experiences 1 = Yes 2 = No -9 = Not answered
[MT02] Scale (fully labeled) MT Satisfaction "Medical Tourism: Overall satisfaction, paid time off, health insurance coverage"
MT02_01 I was fully satisfied with the quality of the medical treatment(s) provided **MT02_02** I felt well informed about every process of the medical treatment(s) provided **MT02_05** I would fully recommend this/these exact treatment(s) to other patients **MT02_03** I was able to use "paid time off" from my workplace for the time I received the treatment **MT02_04** My treatment(s) was/were partly or fully covered by my health insurance **MT02_06** Overall I was fully satisfied with the cost/quality ratio for my treatment(s) 1 = Strongly Disagree 2 = Disagree 3 = No Opinion 4 = Agree 5 = Strongly Agree -9 = Not answered
[MT04] Scale (fully labeled)

Reasons
"Reasons for non-participation in Medical Tourism"

MT04_01 I have never been in a situation to get a medical treatment
MT04_06 I don't see any reason for traveling abroad for a treatment
MT04_02 I prefer to get local treatments because I heard bad reviews
MT04_03 I prefer to get local treatments because I don't like to travel
MT04_04 I prefer to get local treatments because I feel more secure about the quality of the treatment(s)
MT04_05 I prefer to get local treatments because I feel more secure about insurance coverage
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

- **Wellness Tourism**

Wellness Tourism Experiences
"Wellness Tourism Experiences"

WT02 Wellness Tourism Experiences
1 = Yes
2 = No
-9 = Not answered

[WT03]
Wellness Tourism Satisfaction
"Wellness Tourism: Satisfaction, cost/quality"

WT03_01 I was fully satisfied with the quality of the treatment(s) I received
WT03_02 All my expectations were fully met
WT03_03 I was able to experience some local culture while being away
WT03_06 Overall I was fully satisfied with the cost/quality ratio for my treatment(s)
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

[WT04]
Reasons
"Reasons for non-participation in Wellness Tourism"

WT04_03 I am generally not interested in traveling
WT04_05 I am generally not interested in wellness
WT04_01 I haven't felt the need to go on Wellness Tourism trip
WT04_02 I don't like to travel for health reasons, only for business or leisure
WT04_04 I prefer to use local wellness services
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

- **Prescriptive Health Tourism**

First Impression
"First Impression"

PH02_01 The general concept idea is attractive to me
PH02_02 I understand how this concept could be applied into practice
PH02_04 I understand how the tourism sector could benefit from this concept
PH02_05 I understand how the medical sector could benefit from this concept
PH02_06 I understand how individuals could benefit from this concept
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

Personal Behaviour
"Personal Behaviour"

PH04_01 I would like to be informed about recent news regarding this concept
PH04_03 I would consider asking my doctor about available options for myself, regarding PHT
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

[PH03] Scale (fully labeled)
Personal Motivation
"Personal Motivation"

PH03_01 PHT would motivate me to consider traveling abroad for my next treatment
PH03_03 PHT would encourage me to discover unknown destinations
PH03_02 PHT would encourage me to take remedy against psychological stress, mental strain, or anxiety
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

[PH07] Scale (fully labeled)
Doubts
"Obstacles"

PH07_01 Paying a higher premium for health care coverage
PH07_04 Spending time with people I don't know
PH07_06 Spending time without my family and friends
PH07_05 Travelling by myself
PH07_07 Spending my holidays on my personal health and wellbeing
1 = Strongly Disagree
2 = Disagree
3 = No Opinion
4 = Agree
5 = Strongly Agree
-9 = Not answered

[PH05] Free Mentions
Missing points
"Are there any further reasons why you would not like to take advantage of the Prescriptive Health Services?"

- **Sociodemographics**

Sex
"What is your gender?"

SD01 Sex
1 = female
2 = male
3 = other
-9 = Not answered

[SD02] Cloze Text
Age
"How old are you?"

SD02_01 I am ... years old
Free input (integer)

[SD08] Suggesting Text Input
Country
"Which is the country, you're currently living?"

SD08 Country

Employment Status "What is your current employment status?"
SD12 Employment Status: Residual option (negative) or number of selected options Integer **SD12_03** Employed **SD12_06** Employed Part-time **SD12_02** Self-Employed **SD12_04** Unemployed **SD12_01** Student **SD12_05** Retired **SD12_07** Others 1 = Not checked 2 = Checked

Appendix 2: Video

https://www.youtube.com/watch?v=75qFSWJL5eI&t=1s