Conceptual framework on health and tourism – an interregional point of view

ITALIAN REGIONAL PARTNER: Basilicata, Campania, Friuli Venezia-Giulia, Lombardy, Piedmont, Sardinia, Sicily, Tuscany, Veneto and Autonomous Province of Trento
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Introduction

In general, the term "health tourism" refers to the set of activities required to organize the traveling and accommodation, needed to obtain specific health services in a foreign country, that have been previously identified by a health professional.

According to the results of the ProMIS conference held on September 2017 in Jesolo, focusing on "Health, social and tourism policies: what synergies?", worldwilde there are ever year 7 million of people that travel for health reasons, generating a turnover of 100 billion dollars. This turnover is, moreover, expected to grow to 200 billion dollars by 2019.

According to estimates by the Bocconi Observatory, presented as incoming and outgoing flows during a conference, revenues generated by health tourism are about 12 billion euros in Europe. During the Jesolo conference, the OECD, confirmed the data: "Health is an important sector of the economy and health tourism is growing rapidly throughout Europe".

According to the conference participants, the main factors that help to explain such an extraordinary evolution in healthcare mobility throughout Europe in the last decades are the following:

1. Increase in the sharing of knowledge thanks to the global use of the internet (which has increased the movement of goods, services, people and capital between countries)
2. The ongoing evolution in the sector of the use of information and communication technologies in health (ICT - Information and communication technology) and, finally,
3. The possibility of traveling at low cost and the accessibility of destinations previously difficult to reach.

Health tourism involves, therefore, traveling to another State or to another Region in order to receive care. Instead of referring to health structures within their territory of residence, there is a trend to travel to other territories, stimulating the growth of a health market.

The European directive 2011/24/EU on cross-border healthcare, implemented in our legal system by legislative decree n. 38/2014, in this sense, represents a more careful instrument to ensure access to health care for European citizens in every country of the Union. According to the Italian Ministry of Health, the Directive represents a further growth opportunity for the Italian health system and, at the same time, an extraordinary vehicle to strengthen the ties between the commercial enterprises and the health sector of the member states of the European Union.

More than 2 years after its implementation, the data reported by the Ministry show however that this opportunity is underutilized by both Italian and European citizens.

What is the current situation in Italy? Currently, the balance of the Italian situation on health tourism is negative, with only 5000 foreigners choosing to be treated in Italy, compared to 200,000 Italian patients for dental care, cosmetic surgery, hair transplantations, and/or for treatments related to well-being in order to save money.

Still, Italy is attractive to foreign patients for services that involve a higher level of specialization (so-called “elective” services) and that are not provided as emergency care but planned in time: neurology, cardiac surgery, oncology, bariatric surgery and orthopedics. Emergency interventions, on the other hand, are provided to tourists and travelers.

Patients from the Arab countries, Switzerland, Russia and Albania are the ones most frequently searching for clinics and hospitals in Italy, spending s between 20 and 70 thousand euro in health in health care and medical interventions.
This amount does not include the revenues generated by the tourist “corollary”, or the expenses of the potential family members accompanying their loved ones in need of care, who take advantage of Italian art, nature and other amenities.

The phenomenon of health tourism is therefore also promising both in terms of global positioning of the tourist sector in Italy, and of economic development.

A coordinated and targeted action is therefore needed to facilitate innovative approaches at the "system" level. There is a need to define a normative regulation, which supports the development of health tourism, in synergy with the other sectors that are directly or indirectly involved in the effort of strengthening the attractiveness of the entire national territory.

Indeed, the Italian territory offers a variety of settings that span from the mountains to the plains and the sea, and can coherently facilitate a personalized combination of art and culture with the offer for health services.

Therefore, considering that the WHO defines the Italian national health system as one of the best in the world for the achieved results on population health; for the approach focused on prevention and health promotion, for the quality of the medical benefits accessible to the entire population; for the variety of public and private structures with departments of the highest specialization; and for the many excellences recognized worldwide, Italy has the strong potential to become a destination of excellence for international health tourism. Indeed, Italian regional health systems offer the possibility to access excellent health services, to recover from disease and to improve patient’s well-being by combining a personalized combination of services with relax and long term stay close to renowned tourist attractions.

The aforementioned event organized by ProMIS allowed an open discussion between experts from several EU Member States (Greece, France, The Netherlands, etc.) in this respect, and highlighted some shared key-points:

1) health tourism can have a tangible development: in this sense it is necessary that the world of health and tourism sit together to agree on the development of a common planning that takes into account the needs and characteristics of each sector, in a synergic and virtuous perspective. It is therefore essential that both sectors share experiences and integrate each other’s excellence while maintaining the focus on citizens and on the demographic evolution;

2) the health care system should no longer be regarded as a cost-generating sector, but rather as a driving force for the economy. Quality health benefits and services can attract citizens who are concerned about maintaining health and well-being as well as patients in search of high quality services from across the Alps, thus contributing to the development of the tourism market.

In this context, ProMIS, activated a working table on health tourism in the spring of 2017, as such playing the role of “trait d’union” among interested Italian regions (Basilicata, Campania, Friuli Venezia Giulia, Lombardy, Piedmont, Sardinia, Sicily, Tuscany, Veneto and the PA of Trento) with the objectives of:

- analyzing the "state of the art" of health tourism in all Italian regions;
- defining a strategy aimed at enhancing the availability of integrated territorial services of the SSN and SSR to international tourists (not exclusively linked to the concept of cross-border healthcare, but also to well-being) so that they create added value and strengthen attractiveness of the territory;
- planning and implementing joint workshops, international events and seminars and embed them into a shared system bringing together existing experiences and projects that are useful to design future strategies;
- defining joint actions/projects to reinforce the attractiveness of Italy as a whole of coordinated and collaborating territories providing tourists with the offer to combine services for health services with worldwide recognized environmental and cultural attractions;
- defining an action plan that identifies targeted offers that integrate, promote and enhance the health benefits provided by the Italian SSN, combining them in an integrated and sustainable way with the tourist services offered by the different geographic areas.

This document proposes to start from the European legislative framework, to reach a shared definition of health tourism, to map the tourist flow at national and international level, to outline their trajectories with a specific focus on ageing (aiming at active and healthy ageing) and finally to outline recommendations to support operational proposals.

1. The background scenario

1.1 European context

Longevity is one of the biggest achievements of modern societies. In the last 20 years, people all over the world have, on average, gained 6 years in terms of life expectancy. Children born after 2011 have a chance of one in three of reaching their 100th birthday. The European population is living longer than ever before and this pattern is expected to continue due to unprecedented medical advances and improved standards of living. By 2020, a quarter of Europeans will be over 60 years of age. Combined with low birth rates this evolution has already brought about significant changes to the structure of the European society, that have impacted our economy, social security and health care systems, as well as the labor market and many other spheres of our lives.

Hence, ageing is one of the greatest social and economic challenges facing the EU. Projections foresee a growing number and share of elderly persons (aged 65 and over), with a particularly rapid increase in the number of very old persons (aged 85 and over). For those senior citizens who remain in good health, some will decide to continue to work or become active in voluntary work, while others may join a variety of social groups, return to education, develop new skills, or choose to use their free time for travelling or other activities. As life expectancy continues to rise, the constraints, perceptions and requirements of retirement are also changing.

The proportion of the population over 65 years old, as a percentage of the population aged 15-64, is projected to increase from 26% in 2010 to 53% in 2060. In other words, there will be just two people in 'the working age' of 15 to 64 for every person older than 65 in 2060, up from one for every four in 2010. What is more, due to the retirement of an ageing workforce and insufficient new recruits, a shortage of up to 2 million health workers in the EU is predicted by 2020.

This demographic change in Europe is seen as a challenge for many policy areas: from family policy, through education, lifelong learning and labor market policy, to social protection systems, pensions, healthcare and long-term care in particular.

Rapid demographic ageing is not only a major societal challenge (in terms of public budgets, workforce, competitiveness and quality of life), but also a big opportunity for new jobs and growth, also defined as the Silver Economy.

The Silver Economy can be defined as the economic opportunities arising from the public and consumer expenditure related to population ageing and the specific needs of the population over 50. The ageing population usually includes several groups, each with their own need-patterns: active, fragile and not self-
The Silver Economy will hence comprise a large part of the general consumer economy, and is also characterized by age-specific spending priorities and patterns. The Silver Economy is driven both by the emergence of new consumer markets and by the need to improve the sustainability of public expenditure linked to ageing.

A developed market of goods and services for active and healthy ageing is likely to have a significant impact on the efficiency of healthcare and social security systems, potentially also increasing their sustainability. Promisingly, the systematic introduction of large scale social and technological innovations (such as eHealth, telecare, integrated care, independent living) has shown the potential to substantially increase the efficiency of healthcare and long-term care systems at regional and national level, and also lead to cost savings.

The European Commission is already pursuing policy initiatives relevant to the Silver Economy, e.g. on:

- developing new markets and economic drivers such as renovation of building stock, including for independent living, and low-season (senior) tourism;
- ensuring accessible, high-quality and sustainable long-term care systems;
- promoting social investments turned to social protection systems and services;
- undertaking large scale innovation actions such as the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA)\(^1\) and the Active and Assisted Living Joint Programme \(^2\);
- developing new entrepreneurship skills in relation to the needs of an ageing population, supported by a new Knowledge and Innovation Community on Healthy Living and Active Ageing under the European Institute of Technology;
- identifying Active and Healthy Ageing as one of the come “smart specialization” priorities;
- promoting the accessibility, quality and financial sustainability of health and social care systems;
- empowering research and innovation in response to demographic change through H2020.

In addition, the Commission's Joint Research Centre, through its research on e-Health, integrated care and Active and Healthy Ageing contributes to inform policy makers and provides direct support to the EIP-AHA initiative.

Because of the growing population of elderly and the connected chronic diseases, it will be beneficial to linked the need of potential patients to be able to move within the territory of the European Union in order to choose the most suitable treatment offer. The free mobility of European citizens is now a fundamental principle and the head balance established initially by several rulings by the European Court of Justice and subsequently by the "Cross-Border directive CE/2011/24”.

1.2 The legal framework

According to the principle of the competences attribution, the European Union can act only in the areas of and for the objectives as established by the Treaties.

Under art.35 of the Charter of the Human Rights of European Union and TFEU, the States are responsible for organizing the provision of health care services, while the Union can only exercise powers of integration and coordination.

Concurrently with these dispositions, EU institutions have always treated health protection as a part of the unique market.

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As a consequence of the freedom of mobility of workers, they also have the right to health care assistance in other EU Countries. The coordination with the social security systems was established firstly with the regulation n. 1408/71, about the application of social security schemes for employed persons and their family members, moving within the Community, and thereafter with the regulation n. 803/04, which included the first one.

Previously, with two pronounces, Kohll ³ and Decker ⁴, the European Court of Justice created a parallel system for access to treatment in other countries of the Union. Thereafter, different cases were decided applying the principle of the free circulation of services to every kind of healthcare service. In this way a real system of access to cross-border treatment was primarily developed, based on the right of European citizens to choose their health care providers within the single market and on the freedom of lenders to carry out their business towards all the potential patients of that market.

Nowadays, persons assisted by the health system of a European Union country may receive treatment by the competent health institutions of their own state and in all other countries of the European Union. Considering the way in which the health care system is financed, the covered system cost of medical healthcare in another EU state is ruled by two community regulatory instruments:
1) Direct payment from the health system belonging to the country where the health care is provided;
2) Reimbursement to the patient of the expenses wholly paid by the same to the health care providers.

The first system, in application of the Community Social Security Regulations n. 883 of 29 April 2004 and n. 987 of September 16, 2009, allows the patient to receive treatment in another EU country, in the other EEA countries and in Switzerland, under the same conditions as those assisted by the health system of the country of treatment.

Health services provided by public or private healthcare facilities or by professionals, are paid directly by their own health system (direct assistance); any participation in health expenses (tickets) is not normally reimbursed. This system is not applied to services provided by health care facilities or by private professionals that are not affiliated (or outside the conventions).

In summary, two possible paths can be identified: one is related to persons who temporarily stay abroad and who need to show the European Health Insurance Card TEAM (or EHIC – European health Insurance Card), which is a document attesting to the right to receive necessary or urgent health care in all countries of the European Union, Switzerland, Norway, Iceland and Liechtenstein.

The other path concerns persons who go abroad to receive highly specialized care not available or unavailable within reasonable time in their country of residence. In this case you must request a prior authorization from the own country of health affiliation. The Authorization is dependent on two conditions:
1) The care is adequate and aimed at ensuring the health protection of the concerned person;
2) The care is part of the health services that can be provided by the health system of belonging, but cannot be practiced in the original country within an acceptable period from a medical point of view, taking into account the state of health and the probable evolution of the disease.

This authorization is granted by issuing a certificate named S2 (ex E112) to be submitted to the competent institutions or health care providers in the country of treatment.

To consolidate this orientation, on 9\textsuperscript{th} March 2014 the Directive 2011/24/EU was adopted, which established patients' rights and clarified the terms of their justified limitations.

It also clarifies the right of patients to obtain reimbursement of healthcare received in another Member State and regulates the phenomenon of cross-border care, in particular the possibility for patients to move to other countries in order to receive health assistance.

The idea behind this legislation is to stimulate the cooperation between health care systems, each operating within its own regulatory framework, rather than integrating all systems into a single one. The directive lays down a system of rules to enable and enhance the movement of patients in the health market, providing for a genuine right to reimbursement of expenditure incurred for cross-border care, thereby creating a new right to European healthcare.

The provision is flanked by social security regulations and provides further opportunities to benefit from health care in other EU countries, under the following conditions:

- the patient anticipates the costs of health care, authorized in the envisaged cases, and subsequently requires reimbursement to the health system of his country (indirect assistance);
- reimbursable treatments are those provided by the health care system, with the exclusion of long-term health benefits; moreover, interventions for organ transplantation are excluded and, with the exceptions mentioned in Chapter IV of the Directive, the public vaccination programs interventions against contagious diseases, aimed exclusively at protecting the health of the population in the territory of Member State and subject to specific planning and implementation measures;
- the reimbursement for health services is at most equal to the cost that the health care system would have sustained if the treatment had been provided in the State of belonging, without exceeding the total cost of the treatment. States may also decide to reimburse the entire cost of the treatment, if it is higher than the costs that the health care system would have sustained if the assistance had been provided on its territory and to reimburse the travel and accompanying expenses.

Art.8 of the Directive allows Member States to use a prior authorization system for health care which is subject to the requirements of planning when such assistance involves the patient's admission for at least one night, or requires the use of health infrastructure or of highly specialized and expensive medical equipment.

In particular, in Italy, with regard to cross-border healthcare, we refer to the Ministry of Health decree of the 16 April 2018, n.50. For eligible benefits, reference is made to the “essential levels of assistance”, as updated by the President of the Council of Ministers’ decree of January, 12 2017 (see article 61, which defines the Cross-border assistance).

Article n.11 implements the principle of mutual recognition of medical requirements between Member States and empowers the Commission to take concrete measures to facilitate such recognition.

These measures were mostly addressed by the Implementing Directive 2012/52 / EU, which established a list of common elements to be included in cross-border medical prescriptions.

According to article n.12, the Commission supports the development of European Reference Networks (RREs) of health care providers and centers of excellence (especially in the field of rare diseases) through the adoption of the criteria and conditions to be met by these networks and by the lenders wishing to join them, the elaboration of the criteria for the establishment and evaluation of these networks and the facilitation of the exchange of information and skills in relation to networks.
The directive on cross-border care provides European citizens with a new right in terms of health care, which is the right to access the European market for health services at the same costs of their national health service. In this way, citizens are offered the opportunity to choose the benefits of the single market and Member States to optimize their resources in this area, with a desirable reduction in cost and the provision of a better quality and specialization of care. The directive also guarantees the recognition and protection of patients’ rights as the essential condition in order to be effective.

With the Legislative Decree n. 38 of March, 14 2014, Italy has implemented Directive 2011/24 / EU on the application of patients’ rights in cross-border healthcare, as well as Directive 2012/52 / EU, which includes measures to facilitate the recognition of medical prescriptions issued in another Member State. The government established:

- the general principles and rights connected to the cross-border health care
- guarantees and means of protection of patients from another Member State of European Union
- The National Contact Point for cross-border health care, with the aim of facilitating the exchange of information between countries and cooperating closely with National Contact points of the other Countries of the European Union and with the European Commission. In order to allow patients to be aware of their rights concerning cross-border health care, the National Contact Points provide all the information related to lenders of health care, including information about the right of a specific lender to provide services or any restriction on its exercise. It also provides information on patients’ rights, on the complaint procedures and data protection systems, in accordance with national legislation, as well as on legal aspects.

1.3 Summary table of the legal framework

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<th>Contents</th>
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<tr>
<td>Charter of the Human Rights – art. 35.</td>
<td>It’s a Member States attribution to provide health services. The Union therefore only exercises powers of integration and coordination.</td>
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<tr>
<td>Regulation n. 1408/71, and the next n. 803/04.</td>
<td>Application of social security schemes for employed persons and their families, who move within the European Community.</td>
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<td>European Justice Court pronounces “Kohll and Decker” of 28th April 1998, cause C-120/95 e C-158/96.</td>
<td>Application of the principle of free movement of services to any type of health service.</td>
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<td>Community Social Security Regulations n. 883 of 29 April 2004 and n. 987 of 16 September 2009</td>
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<tr>
<td><strong>Directive 2011/24/EU on cross-border health care assistance</strong></td>
<td>Definition of a system of rules to allow and improve the circulation of patients on the market, providing a genuine right to reimbursement of costs incurred for cross-border care → new right to European health care system.</td>
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<tr>
<td><strong>Legislative decree n. 38 of the 14 march 2014</strong></td>
<td>Italian transposition of Directive 2011/24/EU on the application of patient rights in respect of cross-border care.</td>
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2. Health Tourism: definitions

It seems appropriate, in the search for a definition of health tourism to make some introduction to the context. It is considered useful to refer only to cross-border flows as the movements for treatment or treatment received in situations of necessity and urgency, in their own country, in a region other than that of one residence, represent flows that at the level of health services doesn’t amend the overall amounts expenses of the Member State.

Considering that a valid and homogeneous representation of the flows of person mobility (movements both at national and cross-border level) can be obtained from the data on the overnight stays and on the tourist presences, to give definitions that are in some measurable ways (at least as orders of magnitude), it seems appropriate to start from the concept of mobility of people trying to relate it to the health care and benefits received in a another country than that of their own residence-affiliation. Referring to the definitions of the HoNCAB Project’s Work Package n.8 and to the terminology of the Directive 24/2011/EU, these are the main three definitions of health tourism:

The HEALTH TOURISM includes all the situations related to people who choose to travel to a state other than the country of affiliation to receive health care-medical treatment (the person will be mainly dealing with scheduled treatment). The reason behind the decision to move, which has health implications, is to obtain a health service in a different state from that of their own health affiliation (provided by an institution and / or professional affiliated to a foreign NHS).

The HEALTHCARE to TOURIST concerns all the situations related to people who during their temporary “tourist presence” (real tourism, transit, occasional work situations, etc.), in a different state from that of their own health affiliation, might have to access to health services / receive care in the holiday locations or where they temporarily staying in. Generally, the need for access to health services has occurred: it will be mostly accessed for urgent and/or occasional care even if in special cases (for example dialysis), and they will be of the programmed type. The motivation to move is a "touristic" motivation. The person chooses to move to another State for "Tourism" (vacation, travel, work, etc.) and access to health services abroad is the consequence of unforeseen necessity that incurred during the temporary stay abroad.

The DIRECT CROSS-BORDER HEALTHCARE includes the case of mobility and cross-border healthcare in border areas concerning the residents in these areas. It is generally found in confined areas characterized by a high cross-border mobility of residents (in the border areas), sometimes with the networking of health facilities or services, existence of collaborative projects, conventions, agreements, etc.

At the country system level, it is also considered useful to distinguish the three components of the health tourism, which are:

- MEDICAL TOURISM that involved people travelling expressly to access medical treatment and associated with curing illness;
- WELLNESS TOURISM which promotes personal well-being and allow people to maintain or enhance their person health;

5 http://honcab.eu/about-honcab/
**SPA TOURISM** that is positioned between, focusing on healing, beautifying and relaxation of the body, aiming to prevent illness and sustain health.

In order to look at the tourism phenomenon according to what the user searches for, it is added two definition:

- **WELLBEING TOURISM**: is acknowledged as sub-concept of health tourism. Besides preventing illness and sustaining wellbeing, the goal of wellbeing tourism is to have experiences of pleasure and luxury (baths, relaxation, beauty treatments, sauna, etc.). Wellbeing tourism differs from health-care tourism regarding tourists’ motivations. In health-care tourism the main motive is to treat illness, whereas in wellbeing tourism the main motive is to prevent illness or maintain one’s health and wellbeing.

- **INCLUSIVE TOURISM**: is a global movement to ensure the social inclusion of people with disabilities by guaranteeing the possibility of travelling (Cit. Scott Rain).

### 3. Mapping of tourist flows at national and international level

#### 3.1 The "need" of data sharing

Figures related to health tourism activities are very fragmented, divergent and often obsolete. It is difficult to trace international flows of patients. Globally, the association "Patients Beyond Borders" shows estimates that changes in a range between 45 and 72 billion dollars for a population of health tourists estimated at about 14 million. The "Medical Tourism Association" estimates a market of about 100 billion for a total of 11 million patients who go abroad to get health treatment. A study by Deloitte estimates that, every year, 7 million people travel globally for health reasons, generating a turnover of 100 billion dollars, which is foreseen to increase to 150 billion in 2018. Revenues generated by health tourism amounted to 12 billion euro in Europe, according to the data of the OCSP Observatory-SDA Bocconi. Furthermore, recent surveys show that 53% of European citizens is willing to seek health care in other EU countries. According to the European Travel Monitor (ETM), travel related to health care weigh approximately 15% on tourist trips in total. If one takes into account that the revenues generated by travel for tourism medical-health in the European Union are around 12 billion Euro per year, according to the estimates of the ECCP Business Review, we can say that about a third of travel related to health is directed to the use of specialized medical facilities. Although data for Italy are fragmented, our market share for health tourism is approximately 17% of the total EU net worth, amounting to 2 billion, which could potentially reach 4 billion, according to international observers, by integrating the delivery of health services with tourist offers to international customers. The lack of updated and structured statistics affects the identification of bottlenecks and gaps to prioritize, in order to harmonize and integrate the services offers throughout the Country and plan the development of this market segment to make it globally competitive in the medium-long term.

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7 http://www.sanita24.ilsole24ore.com/print?uuid=AEb38G9D&refresh_ce=1
8 https://italiantasteforyou.com/cloud/userfile/2JbDm3OSRKa4hl3
9 https://italiantasteforyou.com/cloud/userfile/2JbDm3OSRKa4hl3
3.2 Emerging challenges for the health tourism sector in Europe

There are many factors that feed the recent trend toward the growth of the health tourism sector. In particular, this phenomenon is linked to the demographic changes and population lifestyles, especially in industrialized countries. The ageing of the population and the greater amount of resources devoted to health are key factors in this process. Furthermore, the ever greater diffusion of information accessible to all patients and the increasingly active role that they play in the search of the most suitable treatment, are crucial elements underpinning the traveling for health. Individual decision to travel abroad to receive health-related services are linked to four main elements: (a) the price of the services; (b) their quality; (c) their availability; d) their timeliness. Price differentials are one of the main factors to explain the patients’ choice of a different country rather than the one of origin. The chance to travel at affordable prices (growth of low-cost airlines, growing competition on international routes), the spread of digital technologies (which grant patients direct access to information on healthcare abroad) and the increasing trend to offer packages that integrate holiday-matched offer to the specific health service (thus making the prospect of traveling more attractive and in some cases even convenient) are the driving factors of the growing trend in this demand segment. A different type of health tourism looks for higher quality of healthcare, independently of its cost. In many cases, this is an option which only benefits certain categories of patients with middle to high willingness and capacity to pay. With regards to the unavailability of services sought in patients’ own country of origin, a distinction can be drawn between two situations. The first is linked to the weaknesses and/or the backwardness of the health care system and structures in general. Other motivations are related to the restricted availability of a specific medical service due to legal and ethical matters. Being able to take advantage of a service in a timely manner is another factor affecting the choice of traveling abroad to receive health care and services. A study by the University of York in 2004 emphasized that about 87% of patients in the UK that went abroad for medical treatment was pushed by waiting lists in their own country. In addition to these factors, other considerations may acquire importance in the patients’ choices, not strictly related to the service, such as interests related to the nature or the culture of the place where they are getting treatment. In addition, in many instances, the patient chooses to be treated abroad to maintain anonymity or confidentiality on their health condition, in the case of plastic surgery or celebrities who want to escape the media attention.

The challenge for the EU to strengthen its positioning in this market segment is represented by the growing evidence of ever lowering prices of healthcare treatments in countries such as India, Thailand, South Africa, Brazil and Eastern Europe. Many tour operators offer "medical tours" in the central European countries, especially in Hungary, where the prices of the services such as dentistry were on average 30 % lower than the prices in Germany, where state insurance covers only 10 % of the cost of the service. The cost of surgery in India, Thailand or South Africa can get up to a tenth of that in the USA or in Western Europe: replacement of cardiac valve, which would cost up to USD 200,000 in the USA, for example, may come to cost around USD 10,000 in India, including a return flight and a short holiday package. Many emerging / developing countries export health services through medical tourism: Cuba, for example, has invested to attract patients from countries in Latin America, Europe and Russia. Health facilities have even chosen to differentiate their offer by specializing on the treatment of certain skin diseases and the development of new procedures and medicinal substances, such as treatments for the retinitis pigmentosa or vitiligo.

The most recent estimates indicate that the greater number of people travelling for health reasons chooses service providers in the European Union and North America. Among price-driven destinations, Asian
countries stand in terms of the number of patients that are attracted to their facilities. In particular, India is very active in providing health services to tourist, with a prominent area of specialization in surgery and services in neurology, cardiology, endocrinology and urology.

3.3 The tourism flows in Europe
Because of the lack of direct and reliable data on health tourism, the study "Research for TRAN Committee Health tourism - in the EU: a general investigation" combined different data to obtain credible figures on the number of trips, overnight stays and revenue related to health tourism in the EU. According to the calculations in the study, in 2014, the total size of the European market for health tourism was equal to 56 million domestic arrivals and 5.1 million international arrivals (from all over the world), for a total of 61.1 million arrivals. The total market of health tourism makes up for 4.3% of all the EU arrivals, 5.8% of the domestic ones and 1.1% of international arrivals, as indicated in the table below.

<table>
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<th>All trips</th>
<th>Domestic</th>
<th>International</th>
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<tr>
<td>Total trips (million)</td>
<td>1,361</td>
<td>900</td>
<td>461</td>
</tr>
<tr>
<td>Health tourism trips (million)</td>
<td>61.1</td>
<td>56.0</td>
<td>5.1</td>
</tr>
<tr>
<td>Health tourism share of total trips (%)</td>
<td>4.3</td>
<td>5.8</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: UNWTO (2016) and our own calculations.

In terms of overnight stays, health tourism in the EU comprises of 233.7 million nights for domestic trips and 16.7 million for international trips, totaling at 250.4 million. The average domestic length stay is 4.1 nights, while for international travel is 8.5. Map 1 (below) shows the health tourism in the EU from the destination prospective, namely all domestic and international arrivals. The share of international health tourism arrivals (as a percentage of all arrivals to the nation, indicated by the blue color) varies from 0.3% (UK) to almost 5.3% (Estonia). The pie chart in the map, indicate the ratios between domestic and international health tourism per country and clearly show that countries such as Sweden, Finland and France have very small international health tourism shares (1-3%), while Austria welcomes 35% of international tourists for health reasons and for small countries like Luxembourg and Malta, the figure goes up to approximately 80%.

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

Health tourism destinations (arrivals)

Map 2 shows, instead, data on health tourism from the opposite perspective - departures. The share of total trips (international and domestic) for health reasons (as a percentage of all departures by country, indicated by blue shading) varies from approximately 1.3% (UK) to 14.3% (Latvia). The pie charts indicate the ratio of national and international departures. International departures shares range from values lower than 12% in Romania, Spain, Portugal and France to above 60% in Belgium and Malta and 95% in Luxembourg. The size of the pie charts represents the total number of departures (domestic plus international) of each country. Once again, as far as arrivals are concerned, Germany, France and Sweden are the main actors, which represent 58% of the health-tourism market share in terms of departures.
The distribution of facilities of Map 3 shows the extent to which facilities offer accommodations. Each dot on the map represents a single accommodation. Green dots indicate the presence of less than five healthcare facilities, while red dots those that offer twenty or more. The size of the dots represents the number of rooms. High concentrations are particularly visible around large cities, in Central Europe, in Italy, in the Mediterranean and Baltic coastal areas.
Map 3: Characteristics of the supply of health-tourism facilities at EU28 accommodations in 2016

Heat map of health tourism hotel facilities

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

Map 4 provides a representation of the accommodation for tourists traveling for health reasons. The average score for health tourism facilities is indicated by the blue shading. Finland and Bulgaria have a particularly high score, which indicates that the facilities in these countries offer a relatively elevated level of accommodation. The pie charts show the relationship between the domestic and international arrivals per country. The size of the pie charts represents the total number of available rooms per country (based on Booking.com data). It appears quite clearly that Italy, Spain, France, Germany and the United Kingdom have a greater supply of accommodation for healthcare facilities. In all cases, the share of health tourism arrivals is reduced, which is predictable, but the highest proportions of health tourism – as indicated by the pie charts – not always relate to high shares of health-related facilities – indicated by the blue shading. The most obvious example is France, with a relatively high proportion of tourist arrivals and a low percentage of facilities and Spain, where the reverse is shown on the map.

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

In Italy, health tourism is a growing trend, referred to the high-spending health incoming tourism towards clinics, hospitals, highly specialized professionals, representing the Italian excellence in the world. The countries of origin of health tourists are mainly Russia, Switzerland, Arab states, although the number of tourists from other nations of the world is increasing thanks to the high quality of the Italian health services. There are many different public and private institutions that already work within the framework of international health tourism are disseminated throughout the territory: Humanitas, Leo and San Raffaele of Milan, the Milan’s Niguarda, the Rizzoli Hospital in Bologna and the City of health of Turin. Foreign patients who choose Italy are around 5.000 per year. "Global" patients can spend between €20-70k on surgery or health services. According to Deloitte, the revenue generated in Italy by health tourism from Russia alone is around 1.4 billion per year. Therefore, hospitals and clinics have been developing a new business, thanks to new international paying customers, looking to invest in superior rooms, royal suites of the healthcare facilities. The international "high-paying" patients, in addition to specialist visits, checkups and surgery, can stay in luxurious rooms or can afford to pay luxury local hotel for their spouses, parents and carers and in parallel to the cures, enjoy artistic and gastronomic tours and relax at wellness centers or beaches near the clinic where patients are hospitalized. The 5-stars treatment also includes an accompanying service, interpreter service, rental with driver to and from the airports, to and from the clinic or hospital, the organization of the trip with assistance and handling of the procedures, such as the translation of the medical records according to the patient’s /tourist’s country of origins insurance. In this sense there are also many new professions which embrace the health and tourist-cultural domain, with the ability to create even more new specialized workers and new jobs with very specific and internationally recognized skills.

As anticipated, several countries (in particular Croatia, Romania, Tunisia, India, etc.) have for years progressively increased the volumes induced by a certain health tourism, linked more to the need for a containment of cost for care of medium complexity such as dentistry, cosmetic and reconstructive surgery, hair transplant and spa treatments that today brings more than 200 thousand Italians to cross the Alps to reach structures offering health tourism services of acceptable quality, at a very low cost.

- The driver of patient flows to Italy is excellence at its own price. As for the other goods and services, consumers/patients evaluate their opportunities for consumption of health services as a function of the above variables.

Today’s balance in Italy, however, is negative, with only 5 thousand foreigners who choose to be treated in Italy against the 200,000 Italian patients that go abroad.

Finally, with regards to the interregional health mobility, the data shared by the Ministry of Health provides a non-homogeneous national framework, with tens of thousands of sick people who move from their
region to somewhere else. The graphic shows the admissions of patients who have decided to go to other regions to seek healthcare and those who moved within their region. Leading is Lombardy with 38,000 people coming from other regions in Italy. Follow Emilia Romagna with 25,000, Tuscany with almost 13,000 and Veneto, Umbria, Friuli, Molise, and the province of Bolzano. Most Italian regions, instead, experience an outflow of patients. The regions that ‘lose’ most sick people are Calabria, Campania, Sicily and Puglia, but also the Piedmont and Trentino, mainly as their patients go to Lombardy and Veneto. One should bear in mind it indicates the outflows of patients. For this reason, the histogram of Lombardy is facing down and that of Campania is facing upwards: the first has a negative outflow, the second positive. The Lombardy confirms, therefore, the preferred Italian migrants for care.

![Histogram showing patient movements](https://www.truenumbers.it/turismo-sanitario/)

The Health Tourism sector is a great opportunity for the development of the health service in Italy as a whole, contributing also to address health inequalities and strengthening the services to the resident population. The WHO considers the Italian NHS as one of the best in the world for the quality of medical services guaranteed, for the variety of public and private structures with clinical departments of specialist and for the many excellences recognized at world level, that might be integrated in the tourist offer sustainably and inclusively.
4. Short, medium and long-term development trajectories for “tourism for all”: focus on accessible and age-friendly tourism

4.1 Emerging needs in the age-friendly area

Europe is the first tourist destination in the world, with the highest density and variety of attractions. As a result, the tourism industry is a key sector of the European economy, generating more than 10% of EU GDP, employing 9.7 million people and involving 1.8 million businesses. The Treaty of Lisbon explicitly recognizes the importance of tourism in Article 195.

During the 2007 International Convention on the Rights of Persons with Disabilities, has been stated "Accessible Tourism for All" by promotion of travel experiences for the elderly and people with special access needs, as an integrated part of any responsible and sustainable tourism policy. In the European tourism strategy "Europe, the first tourist destination in the world: a new political framework for tourism in Europe", adopted in June 2010, the European Commission has defined 21 actions for the European tourism industry. Among these, there is the objective of improving the accessibility of tourism services to raise awareness among stakeholders to create greater know-how on the demand of services and profiles of travellers with specific needs and to evaluate the economic impact of "age-friendly" and "patient-friendly" tourism. They represent a very important market, but require an adaptation of the services that takes in account some specific needs. The same is true with regard to accommodation services aimed at the growing number of tourists with reduced mobility (recently estimated at 127 million people), people with disabilities and those suffering from chronic diseases, whose needs should be taken in consideration in the design of dedicated tourism services. Strengthening the provision of services to older adults and people with special access needs presents difficulties linked to social-health care, which depend in part from the lack of integration between the health systems of the Member States and them and the tourist services provision. This makes tourist destinations less accessible to people with specific needs for assistance and personal services. According to Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, healthcare providers should provide relevant information to help individual patients to make an informed choice, including the available treatment options, the quality and safety of health cares provided in the Member State of destination, through the provision of clear information on costs, as well as their accessibility in terms of authorization procedures, booking, insurance coverage and other personal/collective protection rules regarding the responsibilities of the operators.

Eurostat demographic data on the European population predict that the number of people aged over 60 will increase by about two million a year in the next decades, while the working age population, due to the concomitant reduction in fertility rates, will start to shrink. The number of people over 80, who represent those most in need of care, is expected to increase.

Frailty defines a state of decline and extreme vulnerability due to ageing, characterized by weakness and reduction of the physiological reserve, which contributes to increasing the risk of falls, institutionalization, disability and death. It develops as a consequence of age-related decline in many physiological systems, which collectively translates into vulnerability, sudden changes in health status, triggered by minor stress events (Clegg A., Young J., Liffe S., et al. Frailty in older adults, Lancet 2013).

Overall, frailty is defined within two main paradigms: biomedical and bio-psycho social. According to the biomedical paradigm (Fried et al., 2004), frailty is defined as a "physiological syndrome characterized by reduction of functional reserves and resistance to stress factors due to a cumulative decline of physiological systems that cause vulnerability and adverse events".
The bio-psycho social paradigm (Gobbens et al., 2010) defines frailty as "a dynamic state that affects individuals with decline in one or more functional domains (physical, psychological and social), increasing the overall risk of adverse events". Within this approach to respond to the health needs of this target population, several factors should be taken into consideration, relating to clinical, environmental, educational, economic and psychological fields, which generally require a more holistic approach to the patient and his/her condition.

Given the complexity of needs, frailty management requires an integrated, multi-domain and multi-professional strategy, focusing in particular on community-based interventions and primary care services. Aging poses new challenges, such as the need to move from a reactive approach to disease to prevention, health promotion, early detection of health risk conditions, citizen empowerment with respect to their own health. According to the WHO, physical and social determinants are essential elements for active, independent and healthy aging (WHO 2012). Demographic changes, the health status of the older adults and their personal autonomy will have a growing impact on public budgets, but they can turn into an opportunity for goods and services market, as the older adults have both purchasing power and free-time.

Older adults and aging are indeed a precious resource capable of contributing to society. Stimulating the market with products and services useful to address the needs of older people a huge impact could be created on existing and emerging markets, for example through the development of smart homes, products for health and wellbeing, mobility vehicles, robots, specialized medical devices and innovative treatments, that can also enrich the offer of tourist services for older adults (EC 2015). For this reason, the construction of "age-friendly" cities, which allow people of all ages to participate actively in the life of the community, treat everyone with respect with regard to their age and protect the most vulnerable subjects, will help people to remain healthy and active even in the aging phase. According to the WHO, the relevant aspects to be considered in the development of age-friendly environments are:

- Housing
- Transport
- Urban spaces and built environment
- Social participation
- Civic participation and employment
- Social inclusion
- Access to social and health services
- Communication and information

The collection of information by local authorities on older adults and citizens with specific needs and their point of view is an indispensable element to identify the needs of the users in each of the 8 WHO domains. These end-users constitute the best point of view to understand how our cities could adapt to evolving health needs in the context of an aging society (WHO 2007).

Allowing the population to age well offers opportunities within the "Silver Economy" and age-friendly services to be caught inside and outside social-health systems, through the creation of connected local ecosystems, capable of enhancing the services available to the older persons non-residents in different European contexts.

The integration of living environments with innovative tools capable of improving the quality of life of older subjects, even when not completely independent, contributing to psychological and physical wellbeing, social inclusion and active participation in local communities.

"Age-friendly" environments allow older adults to actively contribute to society, working longer and stimulating Industry to create innovative responses to their health needs. In the document "Growing the
European Silver Economy”, the European Commission refers to political initiatives for the development of the Silver Economy, for eg. the development of new markets such as the renovation of buildings for independent living, low season tourism for the elderly people, and sustainable long-term care systems. In many of these markets, European Industry has a strong potential for global leadership.

Further opportunities derive from the growing demand of innovative solutions, mainly based on ICT. In order to sustain an active living and to stimulate greater social participation of the older adults, European cities and regions play an important role and must encourage healthier lifestyle and provide safe and accessible environments, promoting participation, respect and awareness. The trans-sectoral innovation, pivotal to respond to the specific needs of older people and to allow for greater social participation, concerns public transport, urban planning and services (such as health care, social assistance and tourism). These objectives cannot be achieved by isolated cities or regions: the creation of international multidisciplinary networks for innovation, development of good practices and common guidelines is essential.

4.2 Possible developments in the age-friendly area

A possible model of tourist mobility of the older adults, based on cultural heritage, must necessarily integrate the tourist services offered with wellbeing and health promotion, encouraging healthy and active aging for people with special accessibility needs. We need to overcome the idea of an elitist tourism, linked exclusively to the concept of contemplative enjoyment, enhancing a broader concept of involvement in local social ecosystems, with coexistence of different needs. This suggests the development of host communities that democratically influence the places’ identity and use cultural resources as an instrument for social involvement, prevention of physical and cognitive decline and participatory innovation. The result is an ecosystem in which the liveability of places is a parameter to address the emerging needs of new users, promoting shared and sustainable uses of places and inclusive approach to community participation, which facilitate both the valorisation of cultural heritage and the intercultural exchanges.

Enhancing tourist services offer for older adults give the opportunity to combine the traditional elements of a tourist trip/stay with personalized services that contribute to wellbeing, healthy lifestyle, socialization and assistance, also facilitating long lasting stays. Integrating special assistance, comfort, free-time activities, cultural events, training courses (eg. cooking, theatre, riding, etc.) to the tourist offer effectively contributes to developing social cohesion.

In an era of increasing competition in the international tourism sector and the emergence of new models of demand that are increasingly wellbeing oriented, the main objective of the proposed approach is to develop a systemic and multi-sectoral evaluation model of additional services to be combined with the traditional tourist offer. The ultimate idea is to provide the older adults with tourism products, based on a personalized, user-friendly approach, using information technology both for the management of information and for the provision of services.

To deliver a certain number of services is important to support and facilitate the tourist stay of the older adults. In particular, the transportation and social-health services can be functionally linked to the existing tourism offer, to facilitate access to cultural heritage. It is necessary to develop assisted tourist routes, based on real-time information, accessible means of transport, the network of contacts of the elderly and their emotions.

Social-health services (accompanying, transportation, activities dedicated to disabled people such as horse riding, swimming, psychological support, outpatient visits, diagnostic tests, nutritional assessment, personalized nutritional intervention, haemodialysis, therapeutic treatments, etc.) are mainly offered by
municipalities and local health authorities or by affiliated private providers. Local authorities provide social-health services through dedicated facilities, with qualified personnel. It is therefore necessary to enhance and integrate the additional services of the territories, allowing greater access to them by the older tourist. In order to do this, it is pivotal to develop functional connections to facilitate access to additional social-health services, encouraging the integration of information with tourist service providers, brokers, tour operators, travel agents and other intermediaries. It will be useful to determine how local authorities provide social-health services interacting with transnational tour operators to manage requests, delivery of services and payment of costs, according to Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

4.3 Development of short-term actions in the age-friendly area

Mapping

One of the first activities to be undertaken for the development of "short-term" actions within the ProMIS is the collection of good practices at national (through the Regions) and European (through the RSCN network\textsuperscript{11}) level. The purpose of the collection is to make the experiences and successes accessible and repeatable, as well as to analyse the "obstacles" the parties involved have already faced for the development of a system in which "Health" and "Tourism" have actively interacted. We will then proceed to the creation of a tool (survey) which, thanks to the elaboration of the responses that the various actors will give, will succeed in providing effective information about the presentation of models of excellence. Among the various issues that will be addressed in the collection of good practices, particular attention will be paid to those experiences that have addressed the following aspects:

- diagnostic tests and nutritional evaluations
- haemodialysis
- spa treatments for respiratory diseases
- lifestyles, wellness and sport
- rehabilitation (hip fracture etc.)
- care and cure of chronic-degenerative diseases, including cognitive functioning and ADL support for carers
- psychological support for patients and carers

The criteria for developing and selecting good practices will be:

- have implemented Health Tourism activities with an effective impact from an economic point of view;
- have developed concrete and lasting partnerships with the tourism sector;
- have activated collaborations with different sectors (eg. transport);
- have had an impact on local policies;
- have defined quality standards;
- have developed communication and marketing actions.

This mapping will result in the creation of a public database with the collection of all the practices and the subsequent implementation of a comparative study, taking into account the territorial peculiarities and health systems operating therein.

\textsuperscript{11} Reference Site Collaborative Network (EIP-AHA)
Action on funds

Another activity that will be carried out is an analysis of the European funds available to achieve joint transnational actions of: exchange of good practices, training, feasibility studies and implementation of pilot actions. In particular, it will focus on the current programs related to education (Erasmus +), territorial cooperation (Interreg) and on the future planning 2021-2027.

Network action/training/pilot actions

In order to stimulate more and more the dialogue between "health" and "tourism", it will be essential to involve the regional directions of tourism and the Management Authorities of the Structural Funds in order to create a structured multidisciplinary network between the administrations involved in the thematic. We will proceed to prioritize healthcare –interest areas and to profile possible customers, proposing organizational models for pilot initiatives, in the light of the experiences already achieved. This organizational model will foresee the communication activity of the healthcare structures to the tourist operators and the training of young people for the sector development.
5. Recommendations to support operational proposals

Taking into account the context of our country and going back to the definitions of HEALTH TOURISM and HEALTHCARE to TOURIST, effective cooperation between the areas of Health and Tourism must now be indispensable, with two primary objectives. The first of these would be to maintain and improve the levels of quality and fairness in the universalist healthcare system, while the second would be to promote the development of the tourist economy of the whole country. Both sectors must interact by sorting their own dynamics, their own strengths and critical findings, and their own strategies. Such an interaction principally demands an important shift in mentality, whether at the micro level (that of single operator) or at the macro level (system-wide).

It would become very useful to conduct an analysis of the foreign international healthcare treatment market from the perspectives of both demand and supply, with a specific focus on ageing. To assess, therefore, its relative strengths and weaknesses with the objective of entering into this market.

Developing Health Tourism will therefore mean equipping ourselves with tools, competencies and strategies and to structure ourselves from an organisational perspective to attract healthcare tourism from abroad:

- Attracting overseas interest within the pathways outlined by the Community Regulations for Social Assistance (EU regulations 883/2004 and 987/2009); for scheduled admissions of European Union patients requiring highly specialised care with form E112-S2 and thus reimbursement of costs incurred through the EU’s own health mobility compensation system.
- Attracting foreign interest with the pathways outlined by EU directive 24/2011, for the “out of pocket” supply system - incurring direct payment for treatment. The organisational layout of the public facilities that derives from these could also be adapted to pathways for supplying treatment for private patients overseas.

Developing Healthcare to tourists, would instead mean being geared towards an attractive Tourist Healthcare Services market, and being equipped with tools, strategies and competences from an organisational perspective, to additionally support the proposed rollout of tourist services to elderly people. In this regard, the attractiveness of the tourist market is favoured by the quality of the therapies and services supplied to elderly people, thus providing additional advantages for tourism-related promotion of the country’s assets. This presupposes that the organisation/specialisation/adaptation of the healthcare system will be able to provide, in addition to its primary nursing mission, the best possible solutions to satisfy tourist-related healthcare requirements, and in particular the “age friendly” market.

Silver economy, silver tourism and active and healthy ageing are indeed the key-words to be taken into account to create integrated services, between tourism and health, that have a positive impact on the economy.

Among older people there are different user groups that express, in fact, different needs in terms of: ability to access to services, health status, social and economic situation.

Healthy life years compared to life expectancy can be translated into services for the elderly (women generally live longer and alone in these cases), as well as the need to support “the active state” of the elderly, strengthening those services that are oriented to health and well-being. In this direction it is also
important to assume "off-season" tour packages, since the elderly - often for economic reasons or for family organization - prefer to travel in spring and / or autumn rather during high season. Equally, we can image more extended stays supported by rehabilitative programs or promoting healthy lifestyle (eg sport, physical activity, nutrition and nutrition, socialization, etc.) also through the use of new technologies to which the elderly themselves are more and more used to.

From all this comes the urgency of strengthening integrated assistance (health and social-health care, hospital and territory) and aligning the intent with the tourism sector, aware that tourism services themselves can be key elements of integration.

In this sense, health tourism becomes an opportunity for the Silver Economy. What actions are necessary?

- Profiling of customers/clients: which countries/regions to focus/prioritize
- Strengthening digital solutions
- To seek for scalable best practices
- Creating age-friendly tourism contexts
- Enhancing culture and tourism to support active ageing policies
- The construction / strengthening of hospital networks in tourist contexts

And what further actions are essential from the system point of view?

- An administrative simplification
- To defend a collaborative and non-competitive approach
- The creation of new business models (access and reimbursement paths, investment mergers, reinvestment of avoided costs for effective health promotion / prevention interventions)
- Communication campaigns (eg on the health benefits of thermal waters, derogation for the protection of specific labels, etc.)
- Training and education of administrative, tourism, health and socio-health personnel

We can therefore think to a characterization of health services that, besides being, by institutional mandate, oriented to "respond to the health needs", should be linked to the presence of tourism, are addressed and supported in order to become also "attractive" health services", in the sense of contributing to the ability to attract tourist flows to a specific location.

Hospitals located in the main tourist destinations or located in close proximity can contribute to qualifying the tourist offer of a territory and therefore cooperate in the development of tourist flows (effectively contributing to orienting a tourist demand towards a territory). These would be hospitals located nearby and operating in support of the most important tourist resorts equipped with an adequate setting of departments able to guarantee all levels of complexity 24 hours a day: urgency - emergency (first aid, general surgery), renal and cardiology unit), the diagnostic and laboratory services, the prevention and health promotion services.
More specifically, the scenario which we aim to outline, is also endorsed by the document “Research for TRAN Committee: health tourism in the EU, a general investigation”\textsuperscript{12} published by the European Parliament in July 2017, aiming to improve the EU’s health through the development and integration of tourism and healthcare, using preventative as well as curative measures.

This scenario, which has been given the acronym HVTS (Health Vitality Tourism Scenario) as defined by the European Parliament, expresses greater potential with respect to the health tourism scenario (HTGS - Health Tourism Growth Scenario) that has been developed until now.

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