ZSÓFIA PAPP & KATALIN LŐRINCZ

HEALTH TOURISM TRENDS

Although consumer and tourism trends vary destination by destination, some mainstream development focusing on technology, sustainability, health consciousness – and recently shared economy – forms the environment for tourism receiving areas. Big data and mobile technology influences mostly tourism which results personalisation. However, the main 'essence' of travel experience remains something similar, namely feeling happier, better rested, closer to the family, less stressed and more relaxed (Euromonitor 2015). Population ageing, lifestyle changes, tourism alternatives, and particularities of healthcare systems are supporting health tourism development already for some decades (García-Altés, 2005). All these trends influence the Off to Spas project's success in a positive way, because the health tourism destinations involved offer a non-conventional, innovative way of travel experience, outside of the tourism hot points. The health tourism product is to be developed also in line with mainstream trend by providing a contribution to an increased health status, and quality of life. The Off to Spas project has a clear remit and the terms of reference make our task clear, as we address the health tourism experience of senior citizens (50+) within the European Union. However what becomes clear is that closer scrutiny reveals that there is greater complexity involved in the remit than would be at first appear. As will become obvious, the environment we are operating within lacks definitional and operational certainty. Therefore this article attempts to set out some health tourism trends.

Keywords: trends, health tourism, medical tourism

Health & health perceptions

According to the World Health Organization (WHO, 1984), *health* can be defined as 'the extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities'.

Seniors in the focus

Increased *life expectancy* is a 'triumph of humanity' that has benefited individuals, communities, and society as a whole (WHO, 2008). Along with the invaluable contributions older adults have made to society, added risks to their

health have emerged (Vincent – Velkoff, 2010). Risk of chronic illness, functional decline, and geriatric syndromes threaten the well-being of older adults. Survey research reveals that at least 42% of persons over the age of 65 have a functional limitation. One study reported that 25% of older persons with one or more chronic condition also have one or more co-existing geriatric syndrome (Lee – Cigolle – Blaum, 2008). In addition to changing physical and health circumstances, older adults tend to spend less of their leisure time socializing and communicating as they grow older (Federal Interagency Forum on Age Related Statistics, 2010).

The better health condition of elder people is reflected also in the higher life expectancy. Western (France, Spain and Switzerland) and Northern European citizens are among the longest living nations in Europe: the life expectancy (LE) at birth is about 81.1 years in Finland, 81.8 years in Norway, and 82.0 years in Sweden (Tab. 1). Even if these countries have long traditions in welfare societies, the LE has developed continuously during the last few years, as well. The good health status is accompanied and supported by a strong health care system, easily available health care services in the Northern European countries.

Table 1: Overview of Health Statistics in the Involved Countries of the Off to Spas project (2014) (Source: OECD Health Statistics)

	Finland	**Norway**	**Sweden**
Current expenditure on health, per capita	3517 USD	6177 USD	4904 USD (2013)
Out-of-pocket expenditure on health, per capita	681 USD	889 USD	726 USD
Doctor consultations per capita (2013)	2.6	4.2	2.9
Life expectancy at birth (2013)	81.1 years	81.8 years	82.9 years
Obesity (total population) (2013)	15.7%	10.0% (2012)	11.7%

The *quality of life* (QoL) is a much broader and more complex concept that also influences the seniors' tourism potential and the success of health tourism (balneology) product potential. According to the well-known and widely used model of Rahman et al. (2005, in: Smith – Puczkó, 2013), the QoL's main domain include health, work and productivity, material well-being, feeling part of one's local community, personal safety, quality of environment, emotional well-being, and relationship with family and friends. Adopting the model to tourism, Smith – Puczkó (2013) highlights health as one of the most important areas influenced positively by tourism (tourism in general, not health tourism).

Currently it is estimated that 15 per cent of the world population has a physical, mental or sensory disability (WHO, 2011), and it is estimated that one third of the world population is affected by disabilities in a direct and indirect way. Because of the demographic ageing in the western world the number of people with mental and physical disabilities and with chronic diseases (such as hearing impairments) is expected to increase (Lee et al., 2012; Hoeymans et al., 2014; UNWTO, 2013). This has two implications. First, tourists with disabilities are becoming an important part of the tourism market. Second, the demand for an accessible tourism environment, transport and services will increase. The combination of both presents a challenge to the global travel industry (UNWTO, 2013).

Health spending

According to the OECD Health Statistics which is the most comprehensive source of comparable statistics on health and health systems across the 34 OECD countries (including the source markets in the focus of Off to Spas project), there are good signs of recovery after the global economic crisis. Parallel with the overall economic growth, *health spending* showed an increase, as well. This resulted that health expenditure as a share of GDP has remained stable in recent years.

Taking a look at the split between public and private expenditure, the USA has a much more significant share of private expenditure among OECD countries (Fig. 1). In the case of Finland, Norway and Sweden, *public expenditure dominates* – as in the case of most countries listed.

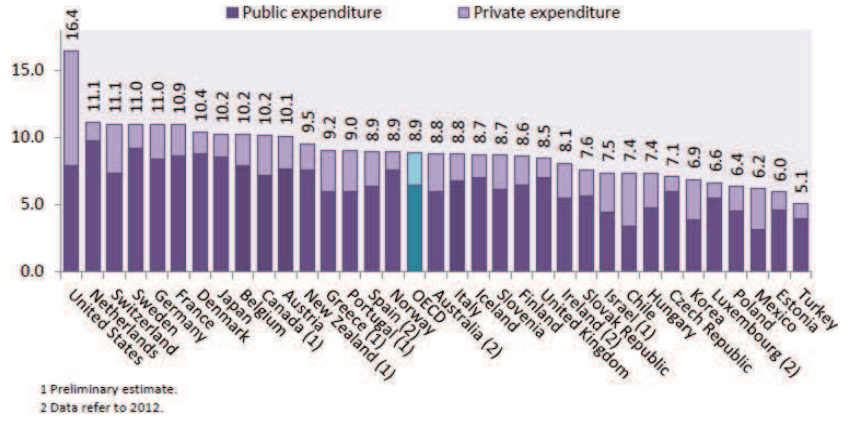

Figure 1: Health spending as a share of GDP (2013) (Source: OECD Heath Statistics, 2015)

In the United States, health spending grew by 1.5% in 2013, less than half the average annual growth rate prior to 2009. The latest available forecasts from the Centres for Medicare and Medicaid Services point to faster growth in 2014 as more Americans gain health insurance coverage.

Although tourism (taking medical services outside of the home country) is not directly referred to in the OECD report, the out-of-pocket spending – hit by the global financial and economic crisis – has showed a moderate increase recently.

Private health insurance (PHI) can play different roles in health systems. Whereas PHI provides primary health care coverage for large population groups in the United States and Germany it complements or supplements public coverage for the vast majority of the population in countries such as France, Belgium and Slovenia. In other countries, e.g. Australia and Ireland, it serves as duplicate insurance providing access to a larger group of providers. On average across OECD countries, spending for PHI accounts for only 7% of health spending. For a number of countries PHI plays only a marginal role, but in others it represents a sizeable share, e.g. in the United States (35%). The share is also above 10% in Slovenia, France, Ireland and Canada.

In per capita terms, Norway spent 5862 USD, and Sweden spent 4904 USD in 2013, which is well above OECD average (3453 USD). This amount was 3442 USD in Finland, just below the OECD average.

The health environment and the above mentioned positive trends impacts health tourism services in a positive way. However, the strong lobby activities linked to the enhancing of international patient mobility is beyond the project's responsibilities. The 'traditional' *North – South flows* (Northern Europe – Mediterranean) are hard to change on a shorter term, however the excellent resources, accompanied by a good reputation can support Central and Eastern European stakeholders to make more benefit from this potential.

Concept of health tourism

According to development tendencies health tourism is the most important touristic segment of 21st century's first decade. It is a complicated notion without consensus either in tourism and health care industry. The reason for it is that there are significant differences in various countries concerning usage of different definitions connected to health tourism (Fig. 2). (Rátz, 2011; Smith – Puczkó, 2009)

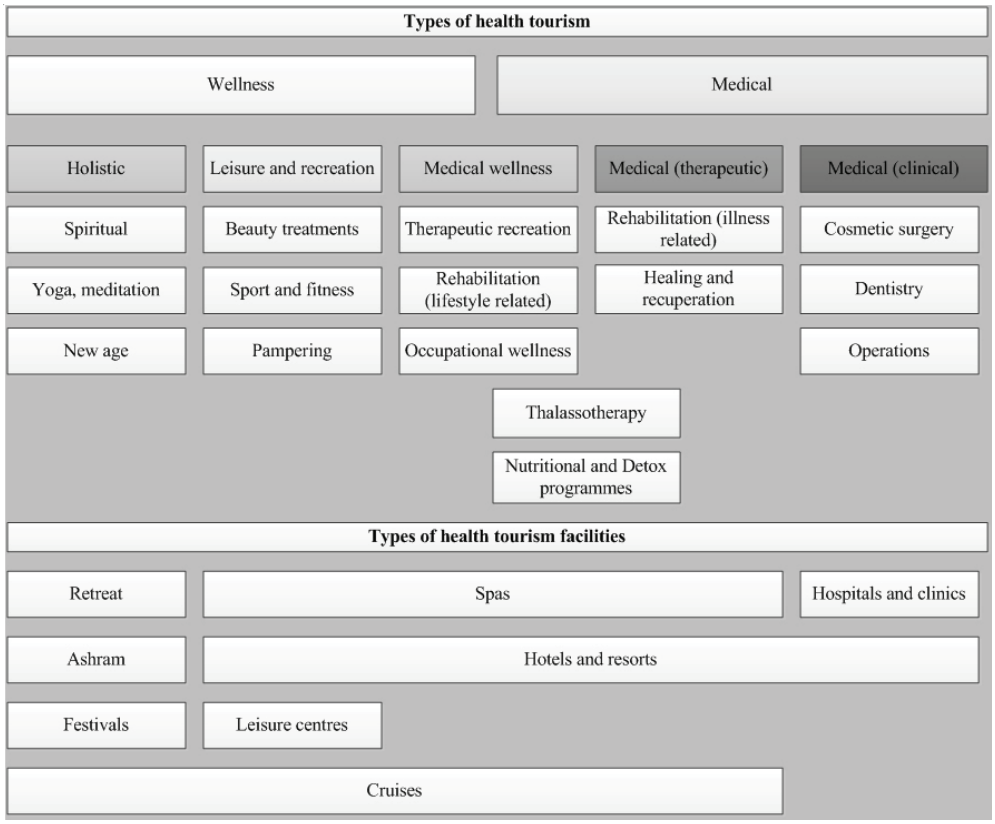

Figure 2: Fields of health tourism (Source: Smith – Puczkó, 2009, 7.)

Cultural differences

Socio-cultural differences and attitudes undoubtly influence the success of *a new health tourism development*. The *balneological dimension* of the Off to Spas project has a special added value, so it is very important to understand the perceptions of the involved source areas and potential Northern European travellers.

On the *supply side*, Central and Eastern Europe has a strong focus on medical waters and natural assets (Smith – Puczkó, 2013), treatments based on the benefits of healing water does have a curative effect. However, in other cultures, balneotherapy is not known or understood that – because of the lack in perception – can influence the success of such developments. In order to benefit the most of the available resources, many of the Central and Eastern European governments (e.g. Hungary) invest a lot in developing the 'medical' pillar of health tourism, and so

developing a medical health tourism including high quality services, providing modern, innovative and attractive experience to the participants.

Taking a look at the *potential demand side* of the Off to Spas project, namely Northern Europe, we can see a good understanding of and strong focus on the *holistic approach*, on the wellbeing dimension. On the perception level, because of the lack of natural healing assets and traditions, guests are not familiar with the benefits of medical waters. However, Nordic people have a generally healthy attitudes to life (Smith – Puczkó, 2013). Here should be highlighted that the Baltic countries that are known and popular destinations for Nordic people have strong tradition in wellness (including thermal bath). So, this can help to develop the *perception of new health tourism products* related to medical waters.

In order to understand the main factors of tourism demand, another cultural fact can be described, namely the *Nordic Wellbeing*. The *concept itself* (Nordic Wellbeing Report, 2011) is a widely acknowledged, well developed issue that influences the perception of potential Northern European health tourists, as well. This concept highlights that *tourism support wellbeing and health in general*, where older age groups (45+) are especially attracted. The geographically bounded 'umbrella' brand, the Nordic Wellbeing has a strong focus on *nature, quietness, activities*, and *food* (Fig. 3).

Figure 3: The elements of Nordic Wellbeing concept
(Source: Nordic Wellbeing Report, 2011)

Wellness and wellbeing

Although the word *wellness* appeared in the mid 1950's, the concept has roots back to the ancient times (e.g. 'regimens' in early Greece). The 'traditional' health tourism definition differentiates between wellness and healing dimensions which has been fine-tuned a lot during the last decade. Although the prevention and the healing activities have plenty of specific characteristics, there is a complementary option for

both, enriching each other. GSS (2010, in Smith – Puczkó 2013, 5) describes wellness using the following dimensions:

- wellness is multi-dimensional;
- wellness is holistic;
- wellness changes over time and along a continuum;
- wellness in individual, but also influenced by the environment;
- wellness is self-responsibility.

It seems to be the case that the concept of health and wellness are increasingly being used inter-changeable, but it should still be emphasized*: health tourism includes medical and cure aspects*; while *wellness is more preventive than curative*.

In the 19th and early 20th centuries, the connection between spirituality and health was emphasized (Miller, 2005). Besides the traditional medicine, a lot of new solutions, products and services has been developed and widely used in order to support the physical-mental-spiritual wellbeing of human beings. Also, consumer and tourism trends are reflected strongly in the concept of *wellness*, *wellness tourism* and *wellbeing (tourism)* – for example, the increased share of urbanized people, more active seniors lead to a lot of new solutions under the umbrella of tourism. Adopting the wellness concept to seniors, McMahon – Fleury (2012) identifies *becoming, integrating,* and *relating* as main attributes that can result being well and living values as important outcomes or consequences for this segment's life.

Although the literature lacks of a clear health tourism definition, the different dimensions of it can be identified much more easily. According to Smith – Puczkó (2013, 25), *wellness tourism* is: 'trips aiming at a state of health where the main domains of wellness are harmonised or balanced (e.g. physical, mental, psychological, social, etc.). There is an emphasis on prevention rather than cure, but some medical treatments may be used in addition to lifestyle-based therapies'.

Dimitrovski – Todorovic (2015) identifies six dimensions of *motivation* among wellness tourists, namely:

1. rejuvenating;
2. socialization and excitement;
3. hedonism;
4. obsession with health and beauty;
5. relaxation;
6. escape.

Among the benefits for wellness tourism, we can see transcendence, physical health and appearance, escape and relaxation, important others and novelty, re-establish self-esteem, and indulgence (Voigt et al., 2011).

Spas and mineral springs

From the wide range of stakeholders and actors involved in the health tourism value chain, *spas* have a *special role*. These 'new cathedrals of the 21st century' transmits a holistic view of health, where leisure is central (Gustavo 2010, 134.). Because of the very popular use of the term 'spa', furthermore the flourishing environment of spa facilities, spa does have a strong influence on the perception about health related tourism. Modern spas have their roots in ancient towns famed for the healing powers of their mineral waters and hot springs. Travelers would come to 'take the waters' and restore their health. The practice of bathing in hot springs and mineral waters dates at least to the Babylonians and Greeks. Water treatments are still considered the heart of the spa experience in Europe. Today massages and facials are by far the most popular spa treatments in America.

Based on the natural resources (medical water, mineral hot springs), Central and Eastern Europe is very rich in different kind of *spas*, where both domestic and international guests can enjoy the water-related services and treatments. Especially in Hungary some spa complex focus on the elderly generation and offer them water-based medical cures.

There are several different types of spas (e.g. destination spa, medical spa, resort/hotel spa, mineral springs spa, club spa, cruise ship spa, airport spa etc.) including a handful of dedicated destination spas that are all about healthy living, resort spas where the spa is another amenity (like golf or tennis courts). In general, a spa is a place where you can *receive spa treatments*, most commonly massage, facials, and body treatments. Spas are devoted to enhancing health and well-being – though medical spas have a stronger focus.

A *destination spa* is a place whose sole purpose is to help individuals develop a healthy lifestyle through:

- healthy spa cuisine that emphasizes whole grains, fresh fruits and vegetables and nutritional education;
- a full program of fitness and stress reduction classes;
- therapeutic spa treatments including massage;
- educational lectures that teach you how to bring your healthy habits back home.

From the Off to Spas project point of view the *mineral springs* and *mineral water* have special role in health tourism. Mineral springs have been valued for centuries for their power to ease joint pain, arthritis, and treat other physical ailments such as depression and rheumatism. The practice of soaking in hot springs, which have naturally occurring minerals, almost certainly began with native peoples – or perhaps their predecessors.

Mineral springs have naturally occurring minerals and trace elements (such as calcium, magnesium, potassium, sodium, iron, manganese, sulphur, iodine, bromine, lithium, even arsenic and radon), which in very low quantities can be beneficial. In the 19th century, not just bathing, but drinking the mineral waters was an important part of the cure. This kind of treatment is still living tradition, but the main service offers the practice of bathing in hot springs.

Medical travel

According to Smith – Puczkó (2013, 15.), the *concept of medical tourism* involves a trip to a place outside a person's normal place of residence for the purpose of receiving medical treatments, interventions or therapies. It is notable that the touristic qualities of the destination are secondary and not even be used. The global *medical tourism* has been *static* at around 7 million people for five years and shows no signs of growth (Youngman, 2016). According to health-tourism.com medical tourism generated between $60 and $70 billion in 2015. Over the last few years medical tourism has gained popularity among highly industrialized countries such as the United States. The number of medical tourists from the US has increased from about half a million in 2007, to an expected estimate of 1.25 million Americans in 2014.

However it is very difficult to measure medical tourism. Although the number of hospital patients are measured in many countries it is *not an exact and reliable number*. There are two main reasons:

1. the collected data contains the number of 'non-resident' hospital patients, but this includes not only the medical tourists but also the temporary expatriates, holidaymakers or business travellers (who are in hospital because of an accident so medical treatment was not the primary motivation of the travel);
2. the figures are always 'in-hospital' figures, which means that the patient spends at least one night in the hospital. But several medical treatments can be mentioned, when no overnight stay is needed – these day-cases are excluded from statistics.

Therefore the number of medical travellers should be increased by the number of one-day patients and decreased by the number of non-medical travellers staying in the hospitals, as it is shown in Figure 4.

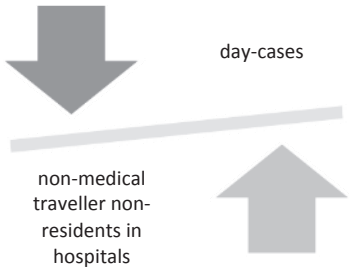

Figure 4: The number of medical travellers (Source: own compilation)

According to several sources the *most popular and typical medical tourism products* are *dental tourism* and *cosmetic surgery tourism*. However medical tourism has far more products and possibilities. The most typical products are listed in Table 2.

Table 2: Typical medical tourism products
(Source: own compilation based on Lunt et al., 2012)

Addiction treatment	Fertility treatment
Birth tourism	Obesity treatment
Cancer	Organ transplants
Cosmetic surgery	Sex change tourism
Dental treatment	Spa tourism
Diabetes treatment	Sports medical tourism
Elderly care	Stem cell treatment
Eye care	Surgery

These products are usually quite similar to other tourism products; tourists need the same services like transportation to the destination, accommodation (if not staying in a hospital) and they may need additional entertainment services as well.

There have been some innovative ideas as well, like *'cruise ship medical tourism'* for example. A few years ago various business ventures sought to bring medical tourism on cruise ships as a logical mixture of three popular areas: medical tourism, wellness tourism and cruising. The failure of the idea was mostly because of the characteristics of the cruise liners: these are designed for movement and delivery rather than continuous occupation.

Medical tourism destinations

There are countries which appear as typical *medical tourism destinations* – but it is very changing unlike holiday destinations for example.

The Medical Tourism Index (MTI) developed by the International Healthcare Research Center (IHRC) is a new type of country-based performance measure to assess the attractiveness of a country as a medical tourist destination. (Fig. 5)

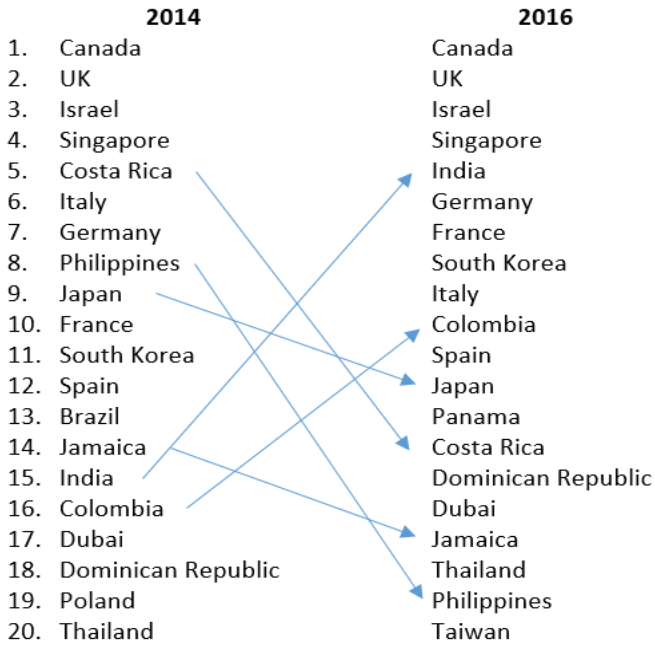

Figure 5: Ranking in medical tourism destination, according to MTI (Source: IHRC, 2016)

It can be a worldwide reference point on the attractiveness of countries as medical tourism destinations, rating and analysing the state of a country as a medical tourism destination, how it is positioned and should be positioned to increase the prosperity of its population.

The index was first formulated and calculated in 2014 and provided a ranking of the 41 examined countries based on 34 criteria from hard data and a primary survey.

Figure 5 shows the top 20 countries of 2014 and 2016. According to the results the top four countries remained the same while there are serious changes among the rest. The most visible change is the role of the India (improved), Costa Roca and the Philippines (deteriorated).

It is very interesting to examine India. The position of India has changed by 10 places mainly thank to the medical tourism industry development and the good quality of medical tourism facilities and services. It is shown by the detailed ranking in Figure 6 – which also shows that the first place of Canada is mostly because of its good performance as a destination.

Figure 6: Overall top destinations according to MTI (Source: healthcareresearchcenter.org)

This ranking may be objective and performance based but is not general. The country choice of medical travellers depends on several factors and motivations. Medical tourists from the US prefer Mexico (due to its close proximity), Costa Rica or Panama – mainly for dental services or cosmetic surgery. In case of orthopaedic and cardiovascular cases Southeast Asia and India will be the choice destinations (due to the high quality of healthcare and a significant number of US accredited hospitals).

Germany can be another example. Although German healthcare is one of the best, most efficient, most advanced and most available in the world, several German medical tourists go to the Czech Republic, Poland, Hungary, Turkey or other Eastern European countries. The strange situation occurs: while Germans go to other countries for low price cosmetic surgery and dentistry, the country is a magnet for Middle Eastern countries due to its very high medical standards. The most important factor is the motivation of medical travellers.

Motivations

The Medical Tourism Association (MTA) is a global non-profit association for the medical tourism and international patient industry. The MTA works with healthcare providers, governments, insurance companies, employers and other buyers of healthcare – in their medical tourism, international patient, and healthcare initiatives – with a focus on providing the highest quality transparent healthcare. The MTA has worked to address information gaps in the medical tourism industry through its medical tourism surveys.

According to the MTA survey, one of the most important facts of the survey results was about the motivation. In 2013 80% of the respondents said *that medical travel is driven by cost savings* (Fig. 7) and the most important factors in their decision were the cost of the medical treatment and the *state-of-the-art technology*. It has also been found that medical tourists spend between $7,475 and $15,833 per medical trip.

Another motivation of participating in medical travel is the *unreachability of the domestic healthcare services*. Many medical traveller choose travelling because of the long waiting lists in their home country. It is typical in developing countries, where the number of doctors may be relatively low, but in some developed countries as well. In Belgium there are several medical travellers from the Netherlands; the reason why they cross the border is still to avoid the typically long waiting lists of their country (Youngman, 2016).

Figure 7: Motivations of medical tourism (Source: own compilation)

Conclusion

In this fast changing world – tourism trends are also changing quickly. Although consumer and tourism trends vary destination by destination, some mainstream development focusing on technology, sustainability, health consciousness – and recently shared economy – forms the environment for tourism receiving areas.

In this article the authors tried to collect the most recent and important new trends focusing on two main fields: health and medical tourism. In health tourism a very strong new trend is the search for wellbeing – therefore wellness offers are more and more demanding; including spas and mineral springs. In medical tourism however it is interesting to see which new destinations arise and how insurance companies behave.

References

Dimitrovski, D. – Todorovic, A. (2015): Clustering wellness tourists in spa environment. *Tourism Management Perspectives.* 16. 259–265.

EUROMONITOR (2015): WTM Global Trends Report.

Federal Interagency Forum on Aging-Related Statistics. Washington DC: U. S. Government Printing Office. Jul, 2010. *Older Americans 2010: Key Indicators of Well-Being.*

García-Altés, A. (2005): The Development of Health Tourism Services. *Annals of Tourism Research.* 32. 1. 262–266.

Gustavo, N. S. (2010): A 21st century approach to health tourism spas. The case of Portugal (Special section). *Journal of Hospitality and Tourism Management.* 17. 127–135.

Hoeymans, N. – Van Loon – A. J. M. – Van den Berg, M. – Harbers, M. M. – Hilderink, H. B. M. – van Oers, J. A. M. – Schoemaker, C. G. (2014): *Een gezonder Nederland. Kernboodschappen van de Volksgezondheid Toekomst Verkenning 2014.* Rijksinstituut voor Volksgezondheid en Milieu (RIVM). Bilthoven.

Lee, B. K. – Agarwal, S. – Kim, H. J. (2012): Influences of travel constraints on the people with disabilities' intention to travel: An application of Seligman's helplessness theory. *Tourism Management.* Vol. 33. No. 3. 569–79.

Lee, P. G. – Cigolle, C. – Blaum, C. (2009): The co-occurrence of chronic diseases and geriatric syndromes: The health and retirement study. *Journal of the American Geriatrics Society.* 57(3). 511–516.

Lunt, N. – Smith, R. – Exwoethy, M. – Green, S. T. – Horsfall, D. – Mannion, R. (2012): *Medical Tourism: Treatments, Markets and Health System Implications: A scoping review.* OECD – Directorate for Employment. Labour and Social Affairs. http://www.healthcareresearchcenter.org/medical-tourism-index/. downloaded: 11.11.2016.

McMahon, S. – Fleury, J. (2015): *Wellness in Older Adults: A Concept Analysis.* Available on the web at Miller, J. W. (2005): *Wellness: The history and development of a concept.* Spektrum Freizeit. 27. 84–106.

Nordic Innovation Centre (2011): *Innovating and re-branding Nordic wellbeing tourism.*

OECD (2015): *Medical Tourism: Treatments, Markets and Health System Implications: A scoping review.*

Rátz, T. (2001): *Zennis és Lomi Lomi, avagy új trendek az egészségturizmusban*. Turizmus Bulletin. V. 4.

Smith, M. – Puczkó, L. (2013): *Health, Tourism and Hospitality.* Routledge, UK.

Smith, M. – Puczkó, L. (2009): *Health and wellness tourism*. Butterworth-Heinemann, Burlington. 3.

Vincent, G. K. – Velkoff, V. A. (2010): *Current Population Reports, P25–1138. U. S. Census Bureau: Washington, DC: 2010: The next four decades, the Older Population in the United States: 2010 to 2050.*

Voigt, C. et al. (2011): Wellness tourists: In search of transformation. *Tourism Review.* 66. 1/2. 16–30.

Youngman, I. (2016): *Medical tourism research – facts and figures 2016.* https://www.imtj.com/resources/medical-tourism-research-facts-and-figures-2016/.

Websites

Centres for Medicare and Medicaid Services – www.cms.org

www.health-tourism.com

International Healthcare Research Center (IHRC) – healthcareresearchcenter.org

Medical Tourism Association (MTA) – http://www.medicaltourismassociation.com/en/index.html

World Health Organization (WHO) – www.who.int

World Tourism Organization (UNWTO) – http://unwto.org/

Zsófia Márta Papp is an associate professor at the Department of Tourism, Faculty of Business and Economics, University of Pannonia, since 2008. She graduated as an Economist specialized in Tourism and Hotel Management in 2001 at the University of Veszprém. She got her master's degree two years later as an Economist specialized in Enterprise Management at the University of Szeged. Her main research field has been destination competitiveness; she completed her PhD in this topic. As she teaches subjects in connection with travel agencies, she is an expert of travel agency market and travel agency management – which is supported by her experiences at a tour operator company. She has also got experiences in tour guiding, and in training guides. Zsófia has international teaching experiences as well. She has been a visiting lecturer at several universities all over Europe (mostly as an Erasmus teacher's mobility programme participant). She is a founder member of the Hungarian Regional Science Association, and a member of the Hungarian Economists Association.

Contact: papp@turizmus.uni-pannon.hu

Katalin Lőrincz is an associate professor at Tourism Department and the Head of Business Institute, University of Pannonia. Besides lecturing spatial-based modules (Tourism Geography, International Tourism Geography, Cultural Tourism), her research interest is focusing on urban and cultural tourism in Hungary, the role of destination management organizations and the linkage between tourism and sustainable development. She maintains contacts with both colleagues from academics and professionals of tourism/regional

development sector. She was invited to various international universities in order to teach as a short-time lecturer in Erasmus program (University of Lapland, University of Lisbon, University of Handlowa, and University of Derby). Furthermore, she has been involved in various consultant activities (tourism strategies, product development, tourism marketing) and participated international conference, she is also working as a KRAFT-Point coordinator of Veszprém. In 2015 she worked as a fellow-researcher at New Central Europe II program, Kőszeg, with a special research, entitled Sustainable Tourism in Historic Towns – Kőszeg Case Study.