Polish aesthetic medicine market in the context of Swedes’ beauty tourism.

High-quality, low-cost services towards demanding Swedish patients.

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Statutory declaration

"I declare in lieu of an oath that I have written this Master thesis myself and that I have not use any sources or resources other than stated for its preparation. I further declare that I have clearly indicated all direct and indirect quotations. This Master thesis has not been submitted elsewhere for examination purposes."

Date: June 12th 2012

Signature
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Abstract

This thesis concerns Swedes’ medical tourism to Poland with an indication of travelling for beauty treatments. Its goal is to study Swedes travelling to Poland because of aesthetic medicine purposes. Trips with medical background, e.g. surgeries, dental treatments or spa/wellness tourism were not taken into account in this assignment. However, in many aspects, some of this data were also included because of the unavailability of more precise sources. The aim has also been to try to reach an insight in what kind of factors and motivations cause that more and more Swedes choose to seek medical help in Poland. The goal has been also to show how the future of this kind of tourism could look like. The study is based on qualitative interviews with clinics and medical centres performing those treatments and patients/customers with such an experience. The theoretical framework concerns laws and regulations, also personal motivations and needs. I came to the conclusion that there are several reasons for people to travel to Poland for medical services: relative low costs of treatment, high quality of service and technology, short waiting periods, insignificant cultural differences and geographical proximity of both of the countries.

Keywords: beauty tourism, skönhetsturism, cosmetic tourism, medical tourism, medicinsk turism, health tourism, hälsoturism, Poland, Polen, Sweden, Sverige, plastic surgery, plastikkirurgi, cosmetic surgery, treatment, skönhetsbehandling, motivations, motivationer
1. Introduction

Medical tourism is a significant niche in the contemporary tourism industry. Beauty tourism is a significant niche in contemporary medical tourism. The idea of traveling around the world for medical treatment has captured much attention and imagination. Although medical travellers have many motives, lower-cost procedures and discretionary cosmetic operations represent only small segments. Most of these people seek the world’s most advanced technology, better quality, or quicker access to medical care. Even a cursory market research reveals that this market has great potential for growth, though current volumes are relatively modest. The benefits to providers attracting international patients are big—in addition to filling beds and increasing revenues per bed, such patients may boost an institution's domestic prestige. Furthermore, several global forces and a number of important structural barriers may prevent or inhibit the market’s growth.

The pressure of the media is creating a culture of self-obsession and poor self-esteem, often to the degree that people will do anything to enhance their looks. This includes frequent and multiple operations to look younger, slimmer and more beautiful (Smith and Puczko, 2011). Many people today are prepared to go ‘under the knife’ to improve their appearance. There are countless examples of people who have endured great suffering in the name of beauty and physical appearance — either voluntarily, as with modern-day cosmetic surgery where the tip of the surgeon’s knife promises to hold an elixir to immortality, or because of societal pressures and habits, as with China’s foot-binding practices or Victorian corsets. Although modern techniques have removed much of the ‘pain’ from the ‘gain’, beauty enhancers, such as body-piercing, tattoos, chemically enhanced hair products, waxing and acid skin treatments, mean that the cliché still rings true for many. Middle-class consumers will travel anywhere in the world to seek out the best services and the most competitive prices. As better health in later life reinforces the consumers’ focus on appearance and physical condition, cosmetic surgery and beauty treatments will become more important (Douglas et al. 2001). Cosmetic surgery, which is rarely covered by insurance policies, is one of the most popular medical treatments in the medical tourism market and, arguably, gave rise to the medical tourism phenomenon (Heung et al, 2010).

According to Lister (1999), healthcare and health treatments will be the world’s largest industry in 2022, principally driven by an ageing population who are active rather than passive when it comes to healthcare. Lister goes on to say that tourism will become the world’s second largest industry over the same period. Combined, health and tourism will represent 22% of the world GDP. Therefore, ‘the search for the fountain of youth’ will become one of the world’s largest leisure activities. Douglas relates to this observations somewhat cautiously: ‘With the increasingly frenetic pace of everyday life in the twenty-first century, the desire to use leisure time to pursue activities that positively contribute to health and wellbeing will probably increase, opening opportunities for entrepreneurs, both large and small, to value-add to existing products or design new products meet the demand. Broadly speaking, participants in a variety of tourist experiences could be motivated by health reasons’ (Douglas et al. 2001). Today, health and travel have become global phenomena, to the extent that a trend has emerged, giving new meaning to the idea of going on holiday and returning ‘a new person’. With the expansion of the European Union, destinations such as Poland, Hungary and Bulgaria offer value-for- money packages.

The fate of the medical-travel market has important implications for the financers of health services (governments, health insurers, and employers), the uninsured, providers trying to attract medical travellers from other countries, and providers in countries where medical
travel originates. The medical-travel market is significantly smaller now than it could be in the longer term. Major barriers include the inability of providers in medical-travel destinations to enter the networks of the developed markets’ payers, a lack of transparent worldwide data on the quality of health care, the inconvenience of travel, and the desire to undergo medical procedures in familiar settings (McKinsey & Company, 2008).

According to McKinsey’s report health tourism sector is rapidly growing, by 20-30 per cent annually and by the end of 2012 could be worth 100 billion USD. Medical tourism industry is currently worth about 85 billion USD and covers approximately three million patients traveling for medical care. Around 20 per cent of them come from the Middle East. For instance, United Arab Emirates’ citizens spend more than two billion dollars a year on medical tourism. The leader among the destinations related to medicine is Europe, particularly Germany. Close behind it there are Asian countries like Thailand, Malaysia and India.

What is beauty tourism? The list does not claim to be a definitive one.

- The attempt on the part of a tourist facility or destination to attracts tourists by deliberately promoting its health-care services, cosmetic treatment services and facilities in addition to its regular tourist amenities
- The principal travel motivation being for health/beauty reasons, such seeking a different climate or taking a cruise
- Wider range of service, faster or cheaper service as a travel motivator
- Travel to specific locations for a complete spa experience / treatment
- Travel for specific medical reasons
- ‘Diet resorts’, usually located in a desirable climatic area, where people go to lose weight and regain physical vitality.

Unlike a hospital, a medical spa may draw its clientele from all over the country. In many cases clients stay in hotels rather than in the treatment centre. Of course, most clients also enjoy other entertainments and diversions in the town and are therefore no different from other kinds of tourists.

The leisure side of the health tourism business has greatest potential for growth. Although Europeans are increasingly inclined towards private medicine, most still look towards the state to provide, which is where the European market differs from the US and Australian markets. Australians have never been sent to spas at government expense. One of the problems for traditional European spas in the development of new markets is that ‘healthy’ clients interested in being pampered and in relaxation and beauty treatments will not happily holiday alongside people who have serious medical conditions. Moreover, although many traditional spas are worried about curbs on government spending, the client volumes they still enjoy are sufficient to rule out the need for serious new marketing initiatives. The growth will come from the destination, resorts spas and beauty clinics where the emphasis is on relaxation, fitness, stress reduction and beauty (Douglas et al., 2001).

As Tresidder (2011) states, health tourism offers a more traditional tourism experience, whereby the customer is pampered with the major motivation of relaxation and rejuvenation, and fits within more established notions of tourism. Cosmetic tourism, although involving a medical element and often an operation, commonly mixes the procedure with usual tourist behaviour. This category falls very much into what de Arellano (2007) defined as ‘scalpel safaris’ or ‘rainforest and rhinoplasty’ packages. The final category of medical tourism is defined by the fact that the explicit purpose of the trip is to purchase and have a medical treatment or to purchase health services abroad (this increasingly includes travelling for the purposes of euthanasia, now termed ‘suicide tourism’). Although this definition may also be used for cosmetic procedures, the motivations and experiences are very different for the
traveller as the trip is undertaken on medical grounds rather than for aesthetic purposes, and is generally used to improve the quality of the individual’s life through a medical intervention. Although both may come under the same definition, the motivations, facilities required and ethics differ and it can be argued that these niches or sectors are clearly interrelated and reliant upon each other.

Nowadays, social acceptance for different cosmetic surgeries is common in the developed countries. To undergo an aesthetic medical treatment is no longer any taboo. It is easy available and becoming more and more cheaper. Media describe the theme on the daily basis. In Sweden, travelling to Poland for a medical treatment was not new and quite popular among those, who were searching for a cheaper option. There was thousands of successful operations, as well as some failures. In November 2010 the case of a woman, who went under breast surgery in Poland was broad described in media. Something went wrong and she remains in a coma since then. It still remains unclear who is responsible for this state of affairs. In the end of 2011 thousands women all around the world were called to their clinics to remove their breast implants. According to United Kingdom’s National Health Service the French implants caused global concern after it was revealed they contained industrial silicone rather than medical-grade fillers and that they may be more prone to rupture and leakage than other implants. Initially reports also linked the implants to a rare form of cancer known as ALCL. This cancer link has been now been firmly discounted by medical experts in Europe.

Aesthetic tourism becomes an important issue and lots of people and organizations are starting to discuss it properly – is it really safe to go abroad for a treatment? How many Swedes do it? What kind of treatments they choose? How much money they spend? Are they prepared properly? And, why exactly they choose to go to Poland to do it? The author raises these issues later in the thesis.

In May / June 2012 a very interesting report will be released: ‘International Medical Tourism Directory – Poland Ukraine 2012’ by Panamedical Consulting Ltd (UK). According to the editor publication will provide updated and extended information on medical establishments and resorts in both countries offering medical services in such popular fields as aesthetic dentistry, plastic surgery, reproductive medicine, ophthalmology, orthopaedics, cosmetology, recovery, SPA, and wellness among others.

There are also several branch trade fair and international conferences, some of them held annually, all over the world, e.g.:

- International Medical Tourism, Wellness, and Spa Congress in Dead Sea, Jordan,
- European Medical Travel Conference in Berlin, Germany,
- Global Connected Care and MediTour Expo in Las Vegas, USA,
- Exotic Medical Tourism Congress & Expo, Maldives Islands,
- Destination Health: Health & Medical Tourism Show, London, UK,
- Annual Global Spa Summit, Aspen, USA,
- Well-Being Travel Conference, Scottsdale, USA,
- World Medical Health Tourism Conference: Destination Down Under, Brisbane, Australia
- World Medical Tourism and Global Healthcare Congress, Chicago, USA.

There is a need for research into the desire for improved health and beautiful appearance as a motivation for travel.
1.1 Background

1.1.1 Definitions

Wellness can be defined as a balanced state of body, spirit and mind, with fundamental elements such as self-responsibility, physical fitness, beauty care, healthy nutrition, relaxation, mental activity and environmental sensitivity. According to Mueller and Lanz-Kaufmann (2001), wellness is viewed as a way of life, which aims to create a healthy body, soul and mind through acquired knowledge and positive interventions. Health tourism is defined as any kind of travel to make oneself or a member of one’s family healthier. Health tourism and wellness tourism are frequently used interchangeably.

Tourism is described by United Nations as the activities of persons travelling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business or other purposes. The definition covers virtually all activities and consumption directly connected with travel.

Medical tourism (also: health tourism, medical travel, surgical tourism, medical value travel, medical outsourcing, offshore medical, medical vacation or global healthcare) describes the practice of travelling across the borders to obtain health care. Typical services include elective procedures as well as complex specialized surgeries such as joint replacement (knee/hip), cardiac surgery, dental surgery, in-vitro fertilization and cosmetic surgeries. Wellness and spa tourism can also be held to this kind of tourism.

Medical traveller is a person whose primary and explicit purpose in traveling is medical treatment in a foreign country.

Beauty tourism / aesthetic tourism / cosmetic tourism concerns travelling to improve appearance and patients’ well-being without specific medical background. The most common treatments are breast surgeries including implants, gastric bands, liposuction, dermal fillers, rhinoplasty and face lifts. The main goal for the “aesthetic tourist” is to undergo an aesthetic treatment without medical need. Usually she/he stays for one or more nights and visits tourist attractions of the area.

Dental tourism – is travelling abroad for dental treatment (surgery).

Spa/wellness tourism - describes a phenomenon to enhance personal wellbeing for those traveling to destinations, which deliver services and experiences to rejuvenate the body, mind, and spirit.

1.1.2 History of health tourism

Travel to enhance one’s health is not new. People’s desire to improve their health has been a major motivation in the historical development of tourism for more than two thousand years. (Bookman et al., 2007). From the 15th to 17th centuries, the poor sanitary conditions in Europe prompted an interest by the rich in medicinal spas, mineral springs and the seaside for health purposes. These wealthy individuals would also travel to renowned medical schools for medical assistance. This continued into the 18th and 19th centuries where spa towns, particularly in the south of France, became popular for health cures, the sun, and escaping the cold climatic conditions in the north of Europe.
The term spa comes from the Latin ‘sanitas per aqua’ — health through water — and according to Mintel (2005) is broadly defined as water-based and non-water facilities offering a range of health/medical/beauty/relaxation treatments. Hydrotherapy or water-based treatments are the cornerstone of what European spas have traditionally had to offer with a focus on health and physical well-being. It is only in the recent years that cosmetic and beauty treatment have become more popular, as well as more spiritual and psychological activities (Smith and Puczko, 2011).

In more recent times, developments that specifically addressed the health motivations of tourists took place on land and at sea, with the growth of spa towns. The formation of the railways allowed increasing and diverse flows of people to more distant seaside and coastal resorts, which provided a distinctive and escapist environment from urbanization. At the same time, escaping to spas and seaside resorts for ‘taking the waters’, was not simply about health, as it became a fashionable and sociable activity. In the late nineteenth century, the emerging urban middle class sought the healthy benefits of fresh seawater or mountain air as an antidote to the overcrowding and pollution caused by industrialisation. Many flocked to spas in pristine mountain locations or by the sea, particularly in Europe and the United Kingdom. In the early twentieth century, ‘health farms’ or ‘fat farms’ emerged, with an emphasis on fitness and a healthy diet. According to a report in Health and Wellness (Mintel, 2004), the modern era of health tourism is considered to have begun in 1939 when Deborah and Edmond Szekely opened a US $17.50-a-week, bring-your-tent spa and healthy-living retreat (Yeoman, 2008). To this day, numerous health and spa resorts exist globally. After World War II, spa resorts in Western Europe went into stagnation. In communist Central and Eastern Europe and in the Soviet Union the spas or thermal baths entered a new phase of development, with treatment mainly sponsored by the state or the trade unions in their specialized facilities. The democratization of access to the spas was coupled with a narrow specialization in medical treatment (Smith and Puczko, 2011).

There is clearly a spectrum of medical tourism, which ranges from necessary surgery for life-threatening conditions (e.g. cancer), to more aesthetic but sometimes necessary practices (e.g. orthodontic dentistry), to physically non-essential, but psychologically boosting cosmetic surgery. The figure below demonstrates the wide range of health and wellness products and facilities, which have emerged in recent years.

![Figure 1.1 Spectrum of Health Tourism.](image-url)

Medical tourism can have two major forms: surgical and therapeutic. There is a clear distinction between the two. Surgical, certainly involves certain operation(s), whereas
therapeutic means participating in healing treatments. Surgical medical tourism has been a growth sector since the 1990s and is increasingly being assisted by the Internet, agents and brokers. Medical tourism has been frequently described as ‘First World treatment at Third World prices’ as it tends to take place in locations of the world where medical (surgical) treatment is much cheaper than in the tourists’ own country (e.g. India and Thailand) (ibid).

1.1.3 How the Swedish healthcare system is constructed nowadays

According to The Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Landsting) the health care system in Sweden is highly decentralised. Mainly, the 20 county councils and 290 municipalities in Sweden finance and manage health services within their respective areas. Health policy is a national-level responsibility that rests with the Government and the Parliament. Decentralisation has been successively reinforced as the State, previously responsible for large segments of health care, has gradually shifted financial and provider responsibilities, in one area after another, to the county councils. Another step toward decentralisation – this time from the county councils to the municipalities – was taken with the so-called Ädel Reform (1992). This reform designated all municipalities as health care providers. The municipalities are responsible for all health services that are associated with residential care, excluding physician services. They can also enter into contracts with the county councils to provide home care, which approximately half the municipalities have done.

Health services in Sweden are overwhelmingly tax-financed, through county and municipal taxes. Patient fees (i.e. out-of-pocket) charged by the county councils account for 2.7% of the revenues. Privately financed care is marginal, approximately 500 million SEK annually – only a few thousandths of the total health care expenditure. In other EU nations, financing is more diverse, with voluntary private health care insurance accounting for a substantially greater share of financing (2% to 10%). Private financing, mainly through employers, is the dominant model in the United States.

In Sweden, the county councils and municipalities are also the main providers of health care, with only about 10% of all health services delivered by private providers. All counties contract to varying degrees with private providers, mainly in primary care where approximately 25% of the primary care centres are managed privately. Many municipalities also contract with private providers. Compared to other countries, the Swedish health care system is relatively unified, with county councils and municipalities serving as the financiers and dominant providers.

According to European Union’s statistics in 2005, about 20 000 Swedes received planned or unplanned care in another Member State: 157 individuals applied to the Swedish Social Insurance Agency for authorization beforehand for planned treatment abroad; 1050 patients claimed reimbursement for planned health care abroad. In 2000 the Swedish authorities stated that they received only few applications for treatment abroad. In 2002, six applications were made under E112 and all were refused (Wismar et al., 2011).
The most common way of comparing costs internationally is to use the cost per inhabitant and year, expressed in US dollars (USD) adjusted for buying power (purchasing power parity, or PPP) in the respective countries. Using this approach, the cost for health care per inhabitant in 2002 was three times higher in the United States ($5,267 USD) compared to Spain ($1,646 USD) and Portugal ($1,702 USD). Among the Nordic countries, health care costs per inhabitant were highest in Norway ($3,409 USD) followed by Denmark ($2,583 USD) and Sweden ($2,517 USD), while Finland reported a substantially lower cost ($1,943 USD).

Of the 17 countries in the comparison, seven had higher costs than Sweden, and nine had lower costs (SKL).

The OECD’s – Organisation for Economic Co-operation and Development (2006) data
In this figure, the annual, per-person healthcare spend, in purchasing power parities (PPP), varies from around US $700 in Poland and Slovakia to above US $3500 in Switzerland and Norway. Continental Western Europe and the Nordic countries fall between US $2300 and US $2800. Spain and Portugal rank at the bottom of the EU 15 countries, with figures around US $2000. In America, expenditure has now reached almost 15% of the GDP, by far the highest share anywhere.

In the special cases where the Swedish healthcare lacks the resources to treat the patient and if care is considered essential and not available in Sweden, the treatment can be made abroad (e.g., cancer and tumor treatments, specific transplants, etc.). To obtain the compensation, treatment must be approved before the surgery is performed. Many self-funded individuals seek private healthcare not only in Sweden but also abroad (usually dental care and cosmetic surgery). One has to mention here that European Health Insurance Card, which is issued for every insured EU citizen by the national social insurance institutions, enables only to the emergency aid abroad.

According to SKL, in comparison to other countries, Sweden:

- provides for most health care needs (using the percentage of elderly in the population as an indicator),
- has a moderate cost level (measured as cost per capita and year, and as a percentage of GDP),
- has a moderate resource level (measured as the number of physicians and nurses per 1000 population),
- has good accessibility to care (measured as number of operations per 100 000 population for common interventions, e.g., cataracts, hip replacement, and bypass surgery) and
- has good medical outcomes and effects (e.g., lowest infant mortality rate, high survival from cardiovascular diseases, low mortality from cancer, etc.) (Sveriges Kommuner och Landsting, 2012).

In the public healthcare system there are only medical reasons, which may be the reason for surgery. For instance, waiting time for breast reduction varies in Stockholm region from 4 to 12 months, nose operations – 4 to 12 months, abdominoplasty – also 4 to 12 months, varicose veins – 3 to 16 months. And the second record is a lot more probable.
2. Tourism in Sweden

2.1 Swedish tourism – general issue

According to Swedish Agency for Economic and Regional Growth in 2010 foreign visitors spent over SEK 87 billion, while Swedish leisure and business travellers spent over SEK 167 billion in Sweden. This means that the Swedish tourism industry has a higher export value than both iron and steel exports (57.1 billion Crowns) and car exports (38.4 million Crowns). In Sweden, the total turnover for tourism rose by 3.2 per cent to almost SEK 255 billion. According to international analyses, travel and tourism will achieve global annual growth of just over 5 per cent between now and 2020. Sweden is well placed to take a share of this increase, as it has the basic resources – attractive destinations and facilities, and value-added natural environments and culture.

Since 2000, the employment generated by tourism within the hotel and restaurant sector has shown the highest growth. 24,600 new jobs have been created, an increase of just over 48 per cent. Tourism in Sweden generated the equivalent of 162 000 annual full-time jobs in 2010.

Nearly a quarter of all overnights in commercial accommodation in Sweden come from abroad. The number of domestic/Swedish nights spent at hotels, holiday villages, youth hostels, campsites and in commercially arranged private cottages and apartments in Sweden increased by 2 per cent to 26.2 million in 2011.

Swedish travel abroad 2011 (percentage change from 2010):
• 2.5 million business trips abroad with overnight stays, + 12%
• 12.1 million leisure trips abroad with overnight stays, + 12%
• 14.6 million total trips abroad with overnight stays, + 12%
Source: TDB, 2012

According to data from Resurs AB and the Travel & Tourist Data Base (TDB), the number of trips abroad with overnight stays rose by 12 per cent in 2011. This represented a strong recovery for travel abroad after a similarly large decline (11%) in 2009. 2.5 million of the 14.6 million trips abroad with overnight stays by Swedes in 2011 were business trips, while 12.1 million were leisure trips. 100 000 Swedes has been travelling for medical purposes in 2010. During 2011 approximately 13 000 Swedes travelled abroad for planned dental treatment, surgery or other hospitalization.

Norway, Germany and Denmark are the three largest markets for foreign visitors in Sweden, while Finland, with over 11 per cent of all foreign overnight trips, and Spain, with 9.6 per cent, were the most popular destinations. There was a sharp increase in the number of trips to both Finland and Spain in 2010. With the exception of the USA, all the top ten foreign destinations showed an increase. Germany, Italy and Finland were the top ten destinations that recorded the largest increases in 2010. Travel to the top ten destinations, which accounted for almost 70 per cent of all travel abroad in 2010, has increased by 27 per cent since 2000. Poland was though, not taken into account.
The main purpose for Swedish business trips abroad in 2010 was individual business trips. Swedish leisure travellers travelled primarily in order to get away from everyday problems, although visiting friends and relatives was also a common reason. Tourists are most active during the industry holidays, i.e. in July and August.

This figure shows different purposes of Swedish traveling. As there is no data concerning medical tourism, the motivations and purposes will be shown in the following
sections.

The country is ranked 1st out of all countries in three key areas that span the three sub indexes of the Travel and Tourism Competitiveness Index 2011: environmental sustainability, ICT infrastructure, and cultural resources. The country’s supportive policy environment, excellent safety and security environment, and excellent air transport infrastructure contribute to this strong result and help the country to overcome its lack of price competitiveness (ranked 120th) (Blanke and Chiesa, 2011).

2.1.1 Medical, wellness and aesthetic tourism in Sweden

During the second half of the 17th century it was high fashion in among the nobles of Europe to visit a spa, health wells and drink the healthy water. The medical paradigm was built on the body fluids, the humours, and unhealth or disease meant they were out of balance. One way of balancing fluids again was to drink water, preferably water with high mineral content. In Northern Europe, because of the lack of natural healing assets and tradition, people do not tend to believe in or trust the beneficial impacts of medical waters. This results in health and wellness (tourism) being based on relaxation and mainly includes fitness services, massages, (fun) baths with hot water and saunas. However, the first bath of the North (Malmorgsbadet and Sturebadet) was initiated in Stockholm by a medical doctor Carl Curman in 1885 to meet the ‘desperately needed swimming, exercise and a road to better health’. In Nordic countries the sauna often represents an integral part of everyday life (especially in Finland) rather than being a luxury that is associated with wellness programmes. It is well known that Nordic people have a generally healthy attitude to life and many of the fitness activities, which are part of everyday life (e.g. Nordic walking), have now been exported to wellness centres and spas all over the world (Smith and Puczko, 2011).

The history of wellness tourism in Sweden begun with a cult of mineral water drinking. Around 350 different health resorts was established in the end of 18th century. In the 19th century well water culture grows to seaside bathing resorts, especially in Halland, Bohuslän and Skåne.
During the 19th century the business developed and bathing in the beneficial water got more common and democratic – workers vacations became available for men and women. In 1950s wider availability of cars brought new possibilities and travelling for leisure became more popular. In the beginning bathing places were though available primarily for the wealthy people. The most popular destinations were: Mölle (Ransvik), Falsterbo, Ystad (Surbrunnen), Saltsjöbaden, Vitemölla, Åhus (Täppet) and much more – they still are the very frequently visited summer destinations in Sweden. Lots of small cities and villages become extremely popular thanks to their curative and mineral springs, e.g. Medevi (Scandinavia’s oldest spa founded in 1678), Loka, Sätra, Porla, Vårby, Kivik, Ramlösa, Strömstad or Gustafsberg. Already in 1866 in Mörsil the farmer named Elias Olofsson was marketing his services in ‘tub baths, sit baths, mud wraps, all kinds of showers, steam bath, hot air bath and two spacious pools with constantly running water’ – and it was thus far ahead before the railway time!

There are several hotels in Nordic countries (Swedish Lapland), which offer a cryotherapy treatment. The benefits of dipping into freezing lakes or rolling in snow after sauna are well-known throughout the region – cell production, pain killing, treatment of injuries and inflammatory diseases and improving general health.

Quite specific in 19th century was Northern Sweden’s ‘kallvattenkuranstalter’ – cold-water sanatorium in Haparanda, Finnborg, Kullstaberg and Sundsvall. It turned out rather fast that bathing in icy cold water has actually no medicinal meaning and mainly residents of surrounding villages and local enthusiasts visited sanatoria.

Branches related with beauty enhancing are growing in Sweden incredibly fast. The three most popular plastic surgery clinic in Sweden: Akademikliniken, Art Clinic and Plastikkirurggruppen ten folded their profits under the last 4 years (revenues from 170
millions SEK in 2007 to 318 millions SEK in 2010, gains, respectively – 3,5 to 32 millions). Swedes spend millions of Swedish Crowns on breast operations, wrinkle treatments and liposuction – although there is no legislation concerning beauty treatments at all. Monica Hedlund writes in ‘Dagens Nyheter’ that ‘that increases the most is, so-called, injection treatments, which means that different substances are injected under the skin to smooth wrinkles. But even breast surgery and various forms of face-lift is an industry, which undergoes a significant growth. The average customer is a woman just under 40, who performs a breast augmentation.’
3. Poland as a beauty tourism destination

3.1 Polish tourism – general issue

Poland, officially the Republic of Poland is a country in Central Europe with 38 million inhabitants and a total area of about 313 thousands sq. km. Poland is bordered by Germany, Czech Republic, Ukraine, Lithuania and the Russian exclave ~ Kaliningrad Oblast and its territory extends across several geographical regions. This location makes Poland a very attractive tourism destination with the Baltic seacoast, beautiful rivers, lakes, Bieszczady and Tatra Mountains. Poland is also a member of the European Union, NATO and OECD.

Poland is developing fast as a tourist destination. Interest in visiting Poland is running high, the country itself offers much in the way of attractions, which are forming the basis of a varied and extensive tourism trade. Some of Poland’s principal tourist destinations are Krakow, Warszawa, Gdansk, Poznan, Wroclaw, Zakopane and others (see the map). The cities of Krakow, Gdansk and Poznan offer much in the way of mediaeval and Renaissance art treasures. In spite of enormous war damages, the monuments to Poland’s past which abound in these, and other, cities have been painstakingly restored. Poland was the second country to be assaulted by Nazi troops, thus starting the Second World War, and there still are some marks of the atrocities of war. These too now play a role as part of Poland’s heritage. The former concentration camps, such as Oswiecim (Auschwitz) have been turned into museums. There is a lot of beach resorts of the Amber Coast offering a complex service from sunbathing to spa treatments. Rural attractions include Masuria Lake District, a broad belt of forested lakelands stretching 300 kilometres across the northeast corner of the country, towards the Lithuanian border. The region is an eco/agro/and food-tourism destination – it offers nature reserves, hunting, fishing and sailing opportunities. Poland’s winter resorts are centred on Beskid and Tatra Mountains in the southern part of the country (see the map).

Most of the major international hotel chains (8 from 10) are present in Poland, there are around 200 hostels opened throughout the year (ca. 450 opened during the summer season). Agricultural tourism is evolving significantly and there also are over 200 campsites across the country. In 2012 the number of hotel rooms will increase from 73 000 in 2007 to 100 000. As reported by Polish Tourism Institute the increase of tourist arrivals to Poland in the coming 5-10 years will primarily depend on general factors such as:

- good economic situation of countries generating tourist traffic to Poland,
- the increase of income in Poland, what has an impact on the consumption model and behaviour of citizens (free time activities like visits in the restaurants, hotel stays and tourist activities),
- improving the overall image of Poland and Poles in the world,
- accessibility and transportation improvement,
- intensive participation in the international cultural exchange,
- increasing the tourist offer,
- promotion of Poland showing the changes (Poland of yesterday, today and tomorrow are the three different countries) (Polish Institute of Tourism, 2007).

A lot of problems, such as road infrastructure are gradually resolved, especially before UEFA’s 2012 European Football Championship. In the places of competitions new hotels and entire infrastructure is built or rebuilt.
Polish Central Statistical Office state that Swedes, like the other tourist are coming to Poland primarily in July and August (during the whole year the amount of Swedish visitors reached 88 000 in the year 2010). The table below shows the relation between the time of the year and tourist traffic.
According to the Polish Tourism Organisation the total number of hotel nights booked by tourists from Scandinavia are increasing: 791 000 nights in 2011, where the Norwegians and Swedes are for 256 000 and 228 000 of these. It still remains unknown how many tourist came to Poland for an aesthetic or medical treatment. Prognoses estimated by the Polish Institute of Tourism are showing that amount of Swedes coming to Poland in order with tourism activities are increasing gradually. Health and well-being tourism is still relatively low-range, but rapidly growing segment of polish tourism, which in the further development can be a promotion force for Poland.

According to quarterly report of European Travel Commission ‘European Tourism in 2011: Trends & Prospects (Q2/2011)’ foreign arrivals continue to perform solidly across most of Europe with 19 of 21 countries reporting year-to-date growth. And seven of these countries have posted growth of 10% or more. Visitor nights have not been quite as strong, with five destinations reporting declines in visitor nights and 9 of 16 destinations reporting slower gains in nights than arrivals. Add to this, year- over-year growth rates for most destinations will skew growth upward as those destinations will get a bounce from last April’s air space closures. When it comes to international tourist arrivals, Poland is placed on the relatively high 10th position.
3.1.1 Health tourism to Poland

In many Central and Eastern Europe countries spa trends have always been characterized by the overwhelming role of social tourism and prescribed cure trips (e.g. to sanatoria owned by trade-unions) in the last 40-50 years. On the other hand, the lack of investment for renovation and new projects is one of the major problems of the spas in other CEE countries, especially in those with delayed privatization such as Poland, Romania and Bulgaria (Smith and Puczko, 2011).

Poland enjoys a similarly long history of health tourism, destinations have been attracting health tourists since the 13th century. There are altogether 43 health resorts, most of which are ‘sanatoria’ type facilities. Visitors can find thermal waters, salt caves, medical muds and even oxygen bars in Poland. Recent extensions and upgrades added beauty, cosmetic and some wellness treatments (ibid).

Country’s accession to the European Union in 2004 has resulted in an increase in Europe’s awareness of Poland’s ability to provide high-level healthcare at very affordable rate. It also provides leisure holidays so medical travellers can enjoy their vacation after accessing their medical facilities. The high quality of medical services and their relatively low
prices has begun to attract patients not only from Europe but also from overseas. The Polish Association of Medical Tourism estimates that in the year 2012 the value of the medical tourism market may exceed PLN 800 million. They also state that approximately 320,000 foreign ‘medical tourists’ visit each year Poland. They generally make use of the services of dentists and plastic surgeons. The majority of foreign patients are coming from Germany, United Kingdom, Sweden and other Scandinavian countries. There is also a trend with Polish American immigrants to return to have medical procedures done while visiting their relatives, raising a much greater interest in Poland as a medical tourism destination among other US citizens.

The rise of the low budget flights has made Poland even more accessible. It takes a maximum of a two-hour plane flight from any Western European airport to reach Poland. The country is now better linked to the west than any other ‘new European’ nation. Patients are attracted to Poland due to its low prices, state of art equipment, the latest techniques and top quality materials. Because of that foreigners choose Poland as their destination for medical tourism. Medical tourism services are carried by private sector with very modern equipped clinics and medical centres.

Krakow, Wroclaw, Warszawa, Szczecin and Gdansk are the most visited cities, mainly because of the tourist attractiveness and near localized airports. The most popular medical procedures are: plastic surgery, dentistry, aesthetic medicine and wellness and spa centres. In connection with the organization of the UEFA European Championship - 2012 year may become a breakthrough for the Polish medical tourism. It is an ideal opportunity for foreign tourists to combine business with pleasure. Undoubtedly, this will contribute to even more medical tourists in Poland, which will be very beneficial for the medical and service industry as well as Polish economy by a significant increase in GDP.

There is over 40 spas in Poland, hundreds of medical clinics specialised in dermatological and other beauty treatments. Lots of them are oriented for foreign customers, especially those ones that are easy to reach by plane (low-cost carriers) or a ferry. Though Germans are most enthusiastic medical tourists in Poland there is a significant group of tourists from Scandinavia oriented in different medical and aesthetic treatments. The number of this kind of visitors is increasing as the language skills and communication possibilities are increasing.

In April 2012 Poland starts with the EU funded programme promoting Polish medical tourism. The Ministry of Economy has identified the medical tourism as one of the fifteen high export potential sector. It has become the one of the priorities of the Polish export policy for 2012 – 2015. The promotional programme will last 36 months. The budget for the project is PLN 4 million (EUR 1M). The campaign focuses on the following markets: Denmark, Sweden, Norway, Germany, Russia, UK and USA.

As one can read at Medical Tourism Poland’s website the following activities are planned in the promotional campaign:

• participation the representatives of the Polish medical centres in international conferences and exhibitions (Moscow Medical & Health Tourism Congress in Russia, the European Medical Travel Conference in Germany, Destination Health in the UK, the Health & Rehab in Denmark, the World Medical Tourism & Global Healthcare Congress in the US);

• organization of trade missions to Denmark, Sweden, Norway, Germany, Russia, Britain, US;

• organization of trade missions and study tours for foreign journalists and foreign companies to Poland;

• organization of trainings for representatives of medical companies;

• organization of business meetings and match-making sessions with companies, associations, institutions;

• production of co-branded information and promotional materials for the medical sector
as the industry strategy, the film, the sectorial catalogues and brochures, the on-line portal.

Wellness Tourism World wide’s Report (2011) states that the most popular wellness tourism services are:
1. Beauty treatments – 89% of the respondents named it as very popular and popular
2. Sport & fitness services – 89%
3. Leisure & recreational spas – 85%
4. Spa & wellness resorts – 83%.

These services can easily be considered as global products since most of the service offers and provision has a tendency to be standardized and is available in almost all parts of the world.

Figure 3.3: Health tourism in Europe, 2011 (including surgeries, cosmetic treatments and dental care). Foreign visits to select destinations. 2011, year-to-date, % change year ago.

According to the table above the most improving European medical tourism destinations is Lithuania, Latvia and Malta. Poland is placed on the tenth position with a 9% growth according to the year 2010. The number of visitors in comparison with the year 2009 is 7% higher.

3.1.2 Products/services

Talking about products and services one has to be familiar with aesthetic medicine treatments available in Poland and the nomenclature concerning this area. Plastic surgery includes both reconstructive and cosmetic surgery. Reconstructive plastic surgery is used to correct abnormal structures of the body. These abnormalities are usually caused developmentally, or through tumours or diseases. Reconstructive plastic surgery is typically performed to improve functions, however it is sometimes performed where a normal appearance is desired.
On the contrary, cosmetic surgery is performed to improve the appearance and self-esteem. Cosmetic surgery involves reshaping parts of the body that are otherwise functioning properly. Among orthopaedics, non-trauma disease treatments, replacement/corrective surgery, sex changes, in vitro fertilizations, dental surgeries there are treatments strictly directed in appearance improvement that is the main field of this dissertation:

- **Abdominoplasty, tummy tuck** - a procedure used to give a tighter, flatter stomach and reduce the appearance of stretch marks on the lower abdomen.
- **Botox** - Botulin Toxin Type A; Botox injections treat wrinkles via an injection. Botox was invented to treat neurological disorders, but today, it has been very used in the treatment of wrinkles, frown lines, and crow’s feet.
- **Blepharoplasty (eyelid surgery)** - a cosmetic surgical procedure that removes fat deposits, excess tissue, or muscle from the eyelids to improve the appearance of eyes that have become hooded or saggy, or have extra fat deposits. Blepharoplasty can be performed on the upper or lower eyelid and eliminates the tired appearance of aging eyes.
- **Breast augmentation (mammoplasty)** - insertion of a saline or a silicone-filled implant behind natural breast tissue to enhance breast size.
- **Breast lift (mastopexy)** - surgical procedure to raise and reshape sagging breasts to a higher position.
- **Breast Reduction** - a procedure to reduce the size of large breasts. Breast reduction is performed for physical relief as well as for cosmetic reasons.
- **Breast Implant Replacement/Removal** – breast implant removal and breast revision.
- **Breast Reconstruction** - an operation to try to get back the shape of the breast after mastectomy procedure (removal of a breast), or lumpectomy (removal of part of the breast).
- **Buttock Augmentation (butt enlargement, implants)** - the surgical insertion of artificial implants into the buttocks to enhance their size and shape.
- **Buttock Lift** - a surgical procedure to remove excess fat and loose skin in the buttock area; sometimes combined with liposuction.
- **Chemical Peel** - smooths the texture of the skin by removing the outer layers and encouraging the formation of new skin cells.
- **Dermabrasion** - a form of mechanical exfoliation that smoothes out irregular surfaces.
- **Facial Implant** - used to improve the contours of the face. Implants, which build up the cheekbones, chin, and/or jaw, may be used individually or in combination to create a more attractive profile and face shape. Facial implants may be used to restore a youthful appearance, to enhance features in an already youthful face, or in reconstructive surgery.
- **Injectable Fillers** - used primarily for wrinkle correction. Some wrinkles are the result of habitual muscle contraction, and these wrinkles are generally correct either with a brow lift, similar surgery, or with the use of Botox injections. Other wrinkles are the result of loss of skin tone and the loss or displacement of subcutaneous fat in the face. These wrinkles can be corrected either with facelifts or with injectable fillers. Injectable fillers can also be used for facial augmentation instead of facial implants. They are commonly used in lip augmentation, and less commonly used for chin and cheek augmentation. The base of the filler is collagen or hyaluronic acid (Restylane, Juvederm, Perlane) or Calcium hydroxyapatite (CHA) in Radiesse and polymethylmethacrylate (PMMA) in ArteFill.
- **Endermologie** – a non-invasive technique for diminishing visible cellulite.
- **Thermage** - a procedure that makes skin tauter and brings about enhancements in skin contour, tone and texture. It achieves this objective by stimulating collagen. Thermage
involves no operation and no injections.

- **Sclerotherapy and laser/light therapy** - both are capable of reducing the appearance of spider veins.
- **Facial Scar Revision** - performed when an individual wants to improve the appearance of acne scarring.
- **Forehead Lift, Brow lift** – a forehead lift (or brow lift) is the surgical removal of excess fat and skin and a tightening of the muscles in the forehead area. It can correct sagging brows or deep furrows between the eyes. It is often done in conjunction with a facelift in order to create a smoother facial appearance overall.
- **Arm Lift** – a surgical procedure that reshapes the upper and lower arm to reduce excess sagging underarm skin, remove fat and smooth and tighten the appearance of the arm.
- **Gynaecomastia (Male Breast Tissue) Reduction** – a cosmetic surgery procedure to remove excess 'male breast' tissue, by liposuction and/or excision.
- **Hair Replacement** - a surgical procedure where hairs are taken from an area of the scalp resistant to baldness (usually the sides and the back of the head) and grafted to the bald area of the scalp.
- **Intense Pulsed Light Treatment** - lower-impact alternative to laser therapy. It can be used to diminish freckles, sunspots, flat birthmarks, and other discolorations of the skin. It can also be used as a hair removal treatment. It treats as well facial redness, such as that caused by rosacea.
- **Laser Hair Removal** - works by a process called selective photothermolysis. In laser hair removal, the energy of the laser is absorbed disproportionately by the hair and especially the hair follicles and transformed into heat, destroying the hair follicle.
- **Laser Vein treatment** - an alternative to sclerotherapy. It is a vein removal procedure (spider veins or varicose veins). It is considered a low-risk, non-invasive procedure with very few documented side effects. It can enhance how the face, arms and legs appear through removal of these unwanted features.
- **Laser Skin Resurfacing (LSR)** – a treatment based on carbon dioxide laser - available for treating skin damage, acne scars, and the wrinkles and discolorations of aging and sun exposure.
- **Labiaplasty** - removes loose or excess skin from the labia and reshapes the labia to enhance its appearance.
- **Liposuction** – a cosmetic procedure in which a cannula is used to break up and suck out fat from the body. This procedure is also known as lipoplasty.
- **Mentoplasty (Chin Surgery)** - chin augmentation is a surgical procedure to reshape or enhance the size of the chin, to achieve a stronger profile or more balanced facial features.
- **Chin implants** - a surgical procedure to reshape or enhance the size of the chin. Also commonly performed to correct a weak chin and improve the facial profile.
- **Cheek implants** - a surgical procedure that restructures cheekbones and balances facial features by implanting fillers into the cheeks.
- **Microdermabrasion (Skin Rejuvenation)** – used to reduce signs of aging and sun exposure, such as crow’s feet, age spots and laugh lines. It may also be useful in reducing the appearance of acne scars in both teens and adults. Micro-crystals are used in this peeling treatment.
- **Neck Lift (Platysmaplasty, Cervicoplasty)** - a procedure designed to reduce the loose look of sagging skin in the neck area and under the jaw line, sometimes including neck liposuction to remove excess fat deposits.
- **Otoplasty (Ear Surgery)** – a procedure designed to reduce the size of large ears or allow them to lie closer to the head. Otoplasty involves adjusting the shape of the
cartilage of the ear in patients whose ears protrude from the side of the head, which allows folds to be created which make the ear lie close to the side of the head.

- **Rhinoplasty (Nose Surgery)** - a facial cosmetic procedure, usually performed to enhance and improve an injured or misshapen nose. The term rhinoplasty means "nose moulding" or "nose forming." During a rhinoplasty procedure, the nasal cartilages and bones are modified to make the nose smaller (reduction rhinoplasty), or tissue is added (augmentation rhinoplasty).

- **Rhytidectomy (Face Surgery)** - a surgical procedure designed to make the face appear more youthful by lifting up the facial skin and tissues and/or the underlying muscle, to make the face tauter and smoother. The facelift procedure involves making incisions in the hairline from just behind the ear into the scalp by the temples. Also, if the neck is being worked on, a small incision will be made below the chin.

- **Thighplasty (Thigh Lift)** – a surgical procedure to tighten sagging muscles and remove excess skin in the thigh area.

- **Thread Lift** - procedure uses very fine surgical sutures inserted in the soft facial tissues to lift and support sagging areas of the face, brow and neck. The threads remain under the skin to provide structure and support.

- **Lip augmentation (Lip enhancement)** – a procedure to enhance the fullness of lips.

In the above specialisations, Poland has the advantage of cost savings and expertise, as well as minimal waiting times for treatment. Therefore, price becomes a key driver in the choice of this destination. The price comparison below shows a significant difference between Polish and Swedish beauty treatments market.

**Figure 3.4: Aesthetic treatment costs - price comparison, in Euros, 2012.**

<table>
<thead>
<tr>
<th>Type of treatment</th>
<th>Average price in Sweden</th>
<th>Average price in Poland</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facelift</td>
<td>8 970 €</td>
<td>2 160 €</td>
<td>24 %</td>
</tr>
<tr>
<td>Lip enhancement, lipofill</td>
<td>1 680 €</td>
<td>960 €</td>
<td>57 %</td>
</tr>
<tr>
<td>Rhinoplasty</td>
<td>4 940 €</td>
<td>1 800 €</td>
<td>36 %</td>
</tr>
<tr>
<td>Botox - forehead treatment</td>
<td>314 €</td>
<td>84 €</td>
<td>26 %</td>
</tr>
<tr>
<td>Breast augmentation</td>
<td>8 420 €</td>
<td>2 830 €</td>
<td>33 %</td>
</tr>
<tr>
<td>Tummy tuck</td>
<td>7 350 €</td>
<td>2 400 €</td>
<td>32 %</td>
</tr>
<tr>
<td>Liposuction, abdomen</td>
<td>2 970 €</td>
<td>1 100 €</td>
<td>37 %</td>
</tr>
</tbody>
</table>

The prices were taken from Akademikliniken and Estheticon’s website in May 2012.

Such price differences apply to all treatments from the list above. The most important factor contributing to these differences is not the cost of materials itself, but the cost of performing the service, which in Sweden is extremely high.
Currently, the most popular procedure for both men and women is Botox treatment — a muscle-relaxing injection, which softens wrinkles and gives a more youthful appearance. Part of its popularity is that it is a non-surgical treatment, which means that its users can pop out for lunch and return looking years younger. On a worldwide scale, Botox treatments grew in popularity from 9% of total procedures in 2001 to 14% in 2003. For men the second most popular treatment is eyelid lifts, whereas for women it is breast enlargement. Breast augmentation apart, it is clear that the growth in the market is driven by an ageing population — most treatments are sought by the middle-aged, but an increasing percentage is being carried out on under-21s. The gender division is also clear; 89% of procedures are carried out on women (Yeoman, 2008).

Figure 3.5: Most popular types of plastic surgery
4. Problem discussion & research objectives

4.1 Problem description

This thesis concerns the problem of Swedish beauty tourism to Poland and its determinants. The author examines the scale of the phenomenon, since it seems that in Sweden it is an extremely niche tourism, in contrast to many other countries, where the tourism with medical background is the weighty part of the whole health service market (e.g. USA). So far, any significant sources regarding this issue have not yet been published (those not being promotional materials).

This thesis is written to approach the above-mentioned issue to branch professionals, potential brokers, patients and tourism students as well. Besides, the author also hopes that this research will contribute to the future researches within the same or similar field.

This research was designed to verify possibilities of polish aesthetic medicine market and determine the factors, which are attracting Swedish health/beauty tourists to Poland. It was also significant to learn about opinions of people, who have such an experience. The researcher believes that the conduction of the study might provide valuable information to the general picture of Swedish outbound tourism. It is hoped that the study also contributes to better understanding the nature of Polish aesthetic medicine service providers.

4.1.1. Legal framework in beauty tourism

Receiving medical care abroad may subject medical tourists to unfamiliar legal issues. While some countries currently presenting themselves as attractive medical tourism destinations provide some form of legal remedies for medical malpractice, these legal avenues may be unappealing to the medical tourist. Should problems arise, patients might not be covered by adequate personal insurance or might be unable to seek compensation via malpractice lawsuits. Hospitals and/or doctors in some countries may be unable to pay the financial damages awarded by a court to a patient who has sued them, owing to the hospital and/or the doctor not possessing appropriate insurance cover and/or medical indemnity. It is the duty of the treating hospital/clinic to explain all the relevant legal matters to a patient in a language and manner patient can understand.

European Union’s directives regulate all kinds of medical traveling within Europe (cross-border healthcare). In a vote on Jan. 19, 2011 the European Parliament approved the Cross-Border Healthcare Directive, a law that will enable citizens within the European Union to travel more easily to member states to receive healthcare.

The law has created a set of regulations for the free movement of patients, payment policies and patient management while upholding citizens’ health rights. The new directive provides clarity about the rights of patients who seek healthcare in another member state and supplements the rights that patients already have at EU level through the legislation on the coordination of social security schemes.

More specifically, the new directive contains the following provisions:

- as a general rule, patients will be allowed to receive healthcare in another member state and be reimbursed up to the level of costs that would have been assumed by the member state of affiliation, if this healthcare had been provided on its territory;
- instead of reimbursing the patient, member states of affiliation may also decide to pay the healthcare provider directly;
- for overriding reasons of general interest (such as planning requirements for ensuring permanent access to a balanced range of high-quality treatment or the wish to control
costs and to avoid any waste of resources) a member state of affiliation may limit the application of the rules on reimbursement for cross-border healthcare;

- member states may introduce a system of prior authorisation to manage the possible outflow of patients. This is, however, limited to healthcare that is subject to planning requirements, such as hospital care (defined as care involving overnight hospital accommodation) and healthcare that involves highly specialised and cost-intensive medical infrastructure or equipment, healthcare that involves treatments presenting a particular risk for the patient or the population, or healthcare which would be provided by a healthcare provider which could raise serious concerns with regard to the quality or safety of the care;

- in order to manage incoming flows of patients and to ensure sufficient and permanent access to healthcare within its territory, a member state of treatment may adopt measures concerning access to treatment where this is justified by overriding reasons of general interest (such as planning requirements for ensuring permanent access to a balanced range of high-quality treatment or the wish to control costs and to avoid any waste of resources);

- member states will have to establish national contact points that must provide patients with information about their rights and entitlements and practical aspects of receiving cross border healthcare, e.g. information about healthcare providers, quality and safety, accessibility of hospitals for persons with disabilities, to enable patients to make an informed choice;

- cooperation between member states in the field of healthcare has been strengthened, for example, in the field of e-health and through the development of a European network which will bring together, on a voluntary basis, the national authorities responsible for e-health; another example is rare diseases, where the Commission will have to support member states in cooperating in the field of diagnosis and treatment capacity;

- the recognition of prescriptions issued in another member state has been improved; as a general rule, if a product is authorised to be marketed on its territory, a member state must ensure that prescriptions issued for such a product in another member state can be dispensed in its territory in compliance with its national legislation;

- sales of medicinal products and medical devices via internet, long-term care services provided in residential homes and the access and allocation of organs for the purpose of transplantation fall outside the scope of the directive (EU’s Cross border Healthcare Directive, 2011).

The European Committee for Standardization is currently running a public consultation on the draft of a European Standard on Aesthetic Surgery Services. The aim of the consultation process is to develop a ‘European best practice standard for surgeons, doctors and nurses in private healthcare facilities that offer cosmetic procedures’. As may be seen from its title, the standard is primarily concerned with “services”, rather than with products or devices (such as breast implants). As the Committee states, when the final standard is released in 2013, it will result in:

1. Improvement in aesthetic surgery services through enhancing patient safety and avoiding the risk of complications and patient criticism about poor services;

2. Adoption of consistently high standards for aesthetic surgery providers across Europe;

3. Enhancement of patient satisfaction and reduced criticism of poor service delivery.

In terms of scope, both surgical and non-surgical medical services are included. It provides recommendations for procedures for clinical treatment, including the ethical framework and general principles according to which all aesthetic practitioners provide clinical services. Dentistry procedures are excluded. Cosmetic non-medical procedures (e.g.
tattoos, piercing) provided by non-doctors (e.g. beauticians, masseurs, hairdressers) in non-medical facilities (such as spas, salons) are excluded from the scope of the European Standard (Pollard, 2012).

Internationally recognized accreditation and certification schemes, such as the Joint Commission International (JCI) scheme, the International Organization for Standardization (ISO) scheme, and the Trent Accreditation Scheme (TAS), are making the standards of medical services worldwide increasingly transparent. Such international accreditation serves to demonstrate that the hospital employs only licensed, well-educated and experienced medical, nursing, and other professional staff (Heung et al., 2010).

Sweden is, though, the one and only European country, which nowadays has no legislation concerning beauty treatments. Personnel conducting laser treatments in a beauty purposes does not need any qualification at all. Karin Lindell from Swedish Consumer Agency states that there is a lot of cheap equipment on the market, coming particularly from China, that are not CE marked, thus they may be too powerful. Fillers that are used to enhance the lips may not be safe. It is possible to buy botulinum toxin (Botox) on the Internet. Lindell emphasizes that there are no skill requirements or rules on patient insurance in this case. It is rather strange that Sweden, which tends to be far ahead in terms of legislation, is rather behind every other country in Europe.

According to the act from 2001 all the doctors in beauty clinics has to report their operations to the National Board of Health and Welfare’s patient data register, but ‘Today there is no overall picture of the private plastic surgery. We would need some sort of system of registration of, for instance, implants’, said Disa Lidman, a vice chairman of the branch organization for specialists in aesthetic plastic surgery, the Swedish Society for Aesthetic Plastic Surgery, SFEP (Hedlund, 2011).

At the European level there is a work continuing regulations of various beauty procedures. Then, those that meet the requirements of skills, record systems and technical equipment would be certified.

In September 2011 the National Board of Health and Welfare stated that there is an urgent need to clarify the rules concerning the procedures and treatments carried out in a beauty purposes. An external evaluator will analyse the need for the special legislation (ibid).

In Poland Patients’ Rights Act regulates quite comprehensively the rights of patients. The main idea behind this piece of legislation is to codify and arrange in logical order the most important patients’ rights, taking into account recent developments in medicine and bioethics. From its very beginning, the Patients’ Rights Act highlights that the observance of patients’ rights stipulated in the Act is the responsibility of public authorities competent in the field of health protection, the National Health Fund, entities providing health services, health care professionals and any other actors participating in providing health services.

The following rights are stipulated in the Act:

- right to health care services,
- right to information,
- right to privacy,
- right to informed consent,
- right to dignity and intimacy,
- right to clinical documentation,
- right to question the opinion of a doctor,
- right to respect for private and family life,
- right to religious services (that is, visits by a priest),
- right to have belongings safely stored.
Patients’ rights and medical law are generally considered to be part of private laws governing relations between formally equal parties, namely the physician and the patient, the physician and the hospital, or the hospital and the National Health Care Fund.

In Sweden medical treatment is not considered to be a contractual relationship and public law regulations apply. Sweden has no special patients’ rights Act. Patients’ rights are, however, promoted and protected in several acts – such as the Health and Medical Services Act of 1999 (split legislation). These rights are typically quasi-legal rights. For instance, doctors have an obligation to obtain consent from the patient prior to any form of physical intervention. Doctors who violate this right can in practice only be held responsible (apart from administrative sanctions) on grounds of varying degrees of crimes against other people’s life and health (Wismar et al., 2011).

The idea of legal recourse is something all medical tourists need to consider before travelling. Most medical facilities catering to foreign patients have international accreditations and affiliations with esteemed centres establishing a high level of quality. However, physicians are still likely to make errors, in which case a patient should be able to receive retribution in the form of medical malpractice (Jagyasi, 2011).

4.1.2 Motivations and needs in beauty tourism

Travel can make people happier three ways: 1) with the anticipation and planning of the trip, 2) enjoying the vacation, 3) relishing the memories that often last a lifetime. Tourism can enhance well-being and quality of life, especially if one does it regularly enough, and one may even experience moments of joy. Research studies suggest that going on trips can affect meaningful change, increase work productivity and as importantly, improve health by enhancing sleep and remarkably, decreased the incident of heart disease. These benefits can be enhanced significantly if we engage in health or wellness tourism specifically. That is to say, we travel with the explicit aim or principle motivation of improving our physical and mental condition. This can include improving emotional well-being, such as stress reduction and calming the mind, as well as healing or rejuvenating the body (Puczko, 2011).

‘What we anticipate in our destinations is not holiness or divine visions, but something even more miraculous – the opportunity to feel different form the way we feel at home. It is as if the act of travelling to a certain place in the world entitles us to feel happier and more alive’ (ibid).

Motivation theory as an idea underpinning action was operationalized as a set of needs by Murray (1938), and presented as a hierarchy of needs by Maslow in 1943 including basic human needs of food, security socialization, self-esteem, and self-actualization. Adopting these thoughts into a tourist context, Pizam, Neuman and Reichel (1979) depict tourist motivation as: "...a set of needs, which predispose a person to participate in a tourist activity". Motivation can thus reflect numerous sets of needs, which will subsequently affect individual choices in various ways (Chen et al., 2008). Tourism then is about relaxation, pleasure and an increase in personal wellbeing and even health (Connel, 2006). The tourism industry tries to meet health-related needs by offering products that recover and improve people's quality of life. The businesses focusing on wellness within tourism have developed and offered products involving elements such as spa, massage, body treatment (pampering), healthy gourmet meals, fitness classes and clinical treatments. Values forge a system or a formation where each value is defined and compared to other values. When a consumer has decided to travel during his or her vacation, the process of choosing has already started. The cognitive as well as emotional aspects of intentions related to how and where to spend the vacation will now effect the various choices related the specific journey. As the driver of procuring the product of
wellness, the cognitive element may relate to consumers’ updated knowledge on health problems and environmental degradation whereas the emotional part may come from a renewed interest in novelty seeking (Chen et al., 2008).

Today’s society is aligned between the consumers’ strong interest in health and the rising affluence, resulting in a plethora of consumer products, whether anti-ageing creams or medical procedures. Two of the measures of society’s well being are life expectancy and rates of infant mortality; when combined, these measures paint a picture of the age structure of society as it will be in the years to come. Living longer means that consumers have more time to do the things that they want to do and they want to stay pretty even in the later age. Part of this is as a result of advances in medicine, but it also has to do with affluence and looking after one’s health. It can be anticipated that advances in science will play a greater role in shaping the demographic structure of the society through the increased success of IVF treatments, new treatments for cancer, the role of genetic engineering and, potentially, an HIV vaccine (Yeoman, 2008).

Sociologists tell us that humans, as animals, are programmed to appreciate a youthful, healthy appearance because this signals fitness for reproduction. But consumers are vain and cultural definitions of beauty also encapsulate a youthful appearance. It is no surprise, therefore, that health concerns encompass physical appearance. It goes without saying that, since time immemorial, women’s appearance has been influenced by the ideal of feminine beauty prevalent at the time — from the voluptuous curvaceousness of the early Greeks to the waif-like frailty of the 1990s supermodels, which has led to the contemporary emphasis on looking thin (ibid).

According to Smith and Puczko (2011) we can see that there are a high number of women and people over 30 involved in wellness activities, but relatively few men and young people. The reasons for this have not been explored in great depth, but of course women have always been far more interested in physical appearance, weight issues, make up and hair care than men. This is partly due to social expectations, fashion, media pressure and so forth, but it has meant that women more regularly frequent day spas and beauty salons. In comparison, men may prefer different modes of relaxation, some of which have a wellness dimension such as sports or fitness activities. The labelling that is used to target men needs to take a different form, as it is unlikely that beauty or pampering would sound appealing.

Are people satisfied with their own health and appearance? Figure 4.1 shows that women are less satisfied than men are. Moreover, satisfaction naturally declines across the age groups, older being less satisfied than younger ones. Bodies fail as people get older and, as a result, satisfaction with health declines. Accordingly, as expectations of perfect health and appearance increase in society, people perceive that their bodies are failing to conform to this standard (Yeoman, 2008).
In contemporary Western society the standard of female beauty is normally unattainable for the majority of women — an ideal has been set of being young, slender and highly attractive. It is a fact that beauty fascinates and there is a strong desire for the body beautiful in contemporary society. This is partly fuelled by consumers’ aspiration to look like the supermodels they see in the media. These portrayals of the ‘ideal’ body have a profound impact on women’s self-perception, their self-esteem and how they rate their own attractiveness. Many women feel intense additional pressure to look good because modern culture increasingly equates internal and external characteristics. The ideals of the feminine beauty evolved over the years; in the 1960’s the ideal was a British model Twiggy. In the 1990’s it was Pamela Anderson, in 2000’s there are lots of contemporary ‘ideals of beauty’, which have though one thing in common – as ideals, they do not exist in nature. So, there are a lot of women all over the world, who are undergoing same breast operations, same treatments, just to look like the ‘ideals’ look.

According to the Future Foundation’s Changing Lives Survey (Fig. 4.2), the key concern among European women is staying fit and healthy (80%), closely followed by three-quarters of women agreeing that their appearance is important to them. It is impossible to look at any of these statements in isolation and the results may indicate that wellbeing among women is primarily derived from feeling fit and healthy in general. But agreement with the statement ‘My appearance is important to me’ is also high. Despite the ambiguity of this statement, the fact that 71% of women agree that ‘successful twenty-first century women can be concerned about looking feminine’ shows that conventions of what constitutes feminine beauty still guide opinion. Physical appearance is integral to women’s lives and wellbeing. There is simply no denying that physical attractiveness is still upheld as a great measure of success in life and that women feel pressure to work on attaining this ideal, which often has implications on their self-esteem and eating habits. In a survey conducted by Harvard University for Unilever (Etcoft et al., 2004) women in ten countries were asked to choose from a list of terms those which best described their view of the way they look. The results show that women tend towards modesty when asked to reflect on their own looks and also that women in the different countries have very different ideas about their appearance (Yeoman,
Certainly there is an increased emphasis on healthy living in contemporary Europe and women are at the forefront of a trend towards a healthier lifestyle. This is driven largely by an ageing population, but also because of the desire for well-being and inner development, which we are witnessing as a result of a backlash to our 24-h, ‘have-it-all’ lifestyles. Data from the Future Foundation’s Changing Lives Survey show that an average of only 10% of working women’s time is spent on meals and personal care. This is just a fraction compared to the time that goes into working (whether paid or housework), sleeping and socializing. This research reveals that an average of 40% of European women say that ‘I never have as much time as I would like to spend on my appearance’, pointing to a balancing act for women, who have to juggle family and working life and, therefore, lack the time they would ideally like to invest in looking after themselves (Yeoman, 2008). That is the mystery of success of the beauty trips – there is only ‘me’ in the centre of universe, then comes the time for all the beauty treatments and relaxation.

Figure 4.3 show that a minority of Europeans say that they are ‘prepared to suffer physical discomfort to look attractive’. More women admit to this than men: 28% versus 18%. Italians, Czechs, Poles and Hungarians are more likely to say that they are willing to suffer in the name of attractiveness, but the numbers are low and there is a degree of resistance to openly declaring a willingness to suffer discomfort, either because of pure vanity or simply because of the taboo nature of the subject. It is undeniable, however, that one of the most extreme forms of body modification — plastic surgery — is on the rise in many parts of the world. At a global level, by far the largest market for aesthetic plastic surgery is the United States. According to the International Society of Aesthetic Plastic Surgery, the American market accounted for 16.4% of the global market in 2003. But the European market for plastic surgery is expanding. Procedures in the three biggest countries — Spain, France and Germany — total 14% of all global cosmetic surgery operations.
According to the McKinsey&Company analysis (2008) the largest segment, with 40 per cent of all medical travellers, seeks the world’s most advanced technologies. These men and women take their search for high-quality medical care global, giving little attention to the proximity of potential destinations or the cost of care. Most such patients—originating in Latin America (38 per cent), the Middle East (35 per cent), Europe (16 per cent), and Canada (7 per cent)—travel to the United States.

With 32 per cent of all medical travellers, the second-largest segment comprises patients who seek better care than they could find in their home countries, which are often in the developing world. When selecting a destination, such patients generally trade off perceived quality against burdens such as costs, distance, and unfamiliar cultures. Some of these people disregard costs to some degree; others are looking for higher quality at the best available price. Patients in this segment seek care in several different specialties, particularly cardiology.

The third-largest segment comprises people who want quicker access to medically necessary procedures delayed by long wait times at home for orthopaedics, general surgery, or cardiology. Its numbers depend on capacity in the home countries, so health investments there can reduce the need to seek care abroad. Recent and on-going infrastructure investments in the United Kingdom, for example, have focused on cutting wait times.

While only 9 per cent of the travellers seek lower costs for medically necessary procedures, this segment has the greatest potential for growth. Since the price of treatment varies greatly around the world, patients can save significant amounts, depending on the procedure.

Patients seeking lower costs for discretionary procedures, such as breast augmentation and reduction, abdominoplasty / liposuction, or rhinoplasty, come mostly from developed markets. This segment, whose expansion correlates with growth in GDP and discretionary incomes, is the most fragmented: patients travel to many smaller, specialized providers rather than to large, multispecialty hospitals.
Top provider destinations can offer treatment at a cost compatible with its perceived value, focusing on one or more patient segments, regionally or globally. Providers should consider and shape the quality of the variables they largely control, such as their local and international reputation, the credentials of their physicians, the outcome of treatment, and even the maintenance of infrastructure. Nonetheless, they must recognize that the perceptions of patients are heavily influenced by the provider’s location, for example, the country’s economic-development level, which can affect perceptions of safety and ease of transportation, and its reputation in a patient’s country of origin. Providers in any country should also assess its general relationship with foreigners, its attractiveness as a tourist destination, and its cultural affinity with the home countries of potential patients.
Medical travellers either approach providers directly for information on physicians, the price of procedures, and logistics, or they work with intermediaries. As a liaison between a potential patient and providers, intermediaries typically collect from them a percentage (up to 20 per cent) of the price of the treatment. Patients often find providers and intermediaries on the Internet after seeing news reports on medical travel or hearing about it by word of mouth. The phrase that patients’ type into the initial search field often influences which provider or intermediary they choose.

Successful providers offer services, such as translators and airport pickups, to ease patient worries, from travel hassles to cultural disconnects. In particular, successful providers reassure patients by giving them access to physicians ahead of time. Many medical travellers know more about their doctors overseas than about their doctors at home: they have the physician’s CV in hand, have spoken with the physician, and receive assurances that during their stay they’ll have 24-hour access to personal care from the physician. The more advanced providers have systems and processes to accommodate the special demands and idiosyncrasies of medical travellers. Some patients seeking quality care abroad, for example, arrive ready to pay in cash. The normal delays associated with billing won’t do for these travellers—the provider must be able to expedite billing and track its progress so that patients can pay before leaving (McKinsey&Company, 2008).

There are two main reasons for which Swedes are searching for healthcare, especially surgery, abroad. Long waiting times and relatively high costs of treatment or surgery makes that a potential Swede starts to think about traveling somewhere else to do it faster and cheaper, but still on the same quality level as in the homeland or even higher (especially when one can connect it with exploring new places and, for instance, relaxing on the beach). The situation concerns specialist’s surgery, for instance, hip/knee replacement and other orthopaedic treatments, dental care, eye surgery or aesthetic treatments as well as surgeries.
Sweden does not subsidize, with certain exceptions, cosmetic surgery, so the patient himself must bear the costs.

One can assume that the problem lies down in the not sufficient amount of specialized doctors and surgeons. Although the possibilities are good enough with modern hospitals and utilities, however allocation of public resources is too restrictive and not enough for everyone in need.

4.1.3 Ethical framework in beauty tourism

Because of the mostly private character of aesthetic medicine facilitators there is a high risk of malpractice. Ethical approaches to the development of medical tourism are significant and needed and governments, medical providers, the tourism industry and ultimately the tourist, should carefully regulate the practice.

When analysing the significance of the sector it is important to identify that there are three strands – health, cosmetic and medical tourism – each of which has differing ethical, moral and technical requirements. Although medical tourism has become a significant element in the tourism offering and a focus of many developing countries (because it offers a distinct niche in which to cement their role within the international tourism industry) (Bookman and Bookman, 2007), it does have benefits in terms of encouraging investment in medical resources and encourages qualified staff to stay in or to return to their home countries.

Some countries are following a dual pricing system offering treatments to domestic patients at lower prices and the same to the international tourists at a much higher rate. This could be in the form of overprescribing hospital tests. It could be considered as an unethical practice, as medical tourist should be charged the market rate and no more. Some countries enforce standard guidelines and price bands for treatments, established by the government or a health association in order to demonstrate equality for all patients (Jagyasi, 2011). In Poland though the patient can find a whole pricelist on the clinic’s website so this kind of situations are rather rare.

There are major ethical issues around medical tourism. For example, the illegal purchase of organs and tissues for transplantation had been alleged in countries such as India and China prior to 2007. The Declaration of Istanbul distinguishes between ethically problematic "transplant tourism" and "travel for transplantation". Medical tourism may raise broader ethical issues for the countries in which it is promoted. It, centred on new technologies, such as stem cell treatments, is often criticized on grounds of fraud, blatant lack of scientific rationale and patient safety. However, when pioneering advanced technologies, such as providing 'unproven' therapies to patients outside of regular clinical trials, it is often challenging to differentiate between acceptable medical innovation and unacceptable patient exploitation.

For instance, Swedish Medical Association and Swedish Society for Aesthetic Plastic Surgery defined the basic values in medical ethics. It is stated that physicians should refrain from intrusive marketing, and in the other inappropriate way draw attention to themselves or their medical achievements. The guidelines are addressed to the health care providers, both public and private. According to SMA (Sveriges Läkarförbund), misleading advertising, aggressive sales practices, discrediting and exploitation of goodwill is extremely improper. Marketing of medical activity should be factual and correct and worthy in appearance and content. Advertising must not arouse unrealistic hopes or creating unnecessary anxiety among the patients.
Marketing message should be designed so that it provides meaningful information and not failing to focus on methods or equipment as a guarantee of quality. Advertising must be legal, decent, honest, and truthful. Information on technical equipment and method may not be dominant in the advertising. Ensuring certain result is obviously not allowed. A doctor has to document his or hers education or experience in the field. Physicians may not participate in the publicly directed medicinal advertising or appear as a guarantor of certain product, which is related to the medical activity.

Patient - physician relationship is fragile. The patient is almost always, in terms of knowledge, at a disadvantage versus the physician. But this is a doctors’ duty to determine when “enough is enough” in the case of a person who displays signs of plastic surgery addiction or the patient perceives flaws that are not really there, and wants them corrected (Body Dysmorphic Disorder, BDB). Many regard aesthetic surgery as a panacea for their personal and relationship difficulties. The doctor's knowledge may never be commercially exploited in the patient's expense. A clear distinction between medical activities and financing activities must be maintained. Any type of medical activity should be free from the marketing of credit. This applies to information brochures at the clinic as another form of marketing, such as a link on the homepage. Nor should the recommendations of business lenders be provided during the visit to the doctor or otherwise made available in a clinic. According to the British Association of Aesthetic Plastic Surgeons patients must undergo thorough pre-operative assessment and counselling before surgery. This may require expert psychological assessment. Surgeons must ensure that patients' expectations are realistic. Surgeons need to explain the likely benefits of surgery, alternative non-surgical options as well as the risks of surgery and anaesthesia. Patients need to make an informed choice regarding whether surgery is right for them. Consultant surgeons and consultant anaesthetists treating patients, undergoing cosmetic procedures, should be on the General Medical Councils' Specialist Register. Surgery should only be undertaken in premises that are fully equipped, with resuscitation facilities and staff trained in advanced life support. Clinics and hospitals providing aesthetic surgery should be registered with the Healthcare Commission. For his own safety any prospective patient must remember and double-check these principles to feel secure before the treatment, and, most of all, after it.

4.1.4 Quality in medical services

“Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr, 1990).

Several authors and organizations have defined quality of medical care by describing the concept according to a set of dimensions. The most frequently quoted dimensions include (in descending order of frequency) effectiveness (refers to the extent to which the intervention in question produces the desired effects to improve the health of those being treated), efficiency (defined in terms of the extent to which objectives are achieved by minimizing the use of resources), access (measure of the proportion of a given population in need of health services that can obtain them), safety (reduction of risk, freedom from accidental injury due to medical care, or medical errors), equity (implies considerations of fairness), appropriateness (how the treatment corresponds to the needs of the patient), timeliness (refers to receiving treatment within a reasonable time frame), acceptability (how humanely and considerately the treatment is delivered), satisfaction (how the treatment and the patients’ health improvement
meets her/his expectations), **patient responsiveness or patient-centeredness** (refers to the importance of individual patients’ and society’s preferences and values) and **continuity of care** (alludes to all phases of the patient pathway). These dimensions are, however, neither comprehensive nor mutually exclusive (Wismar et al. 2011).

The issues pertaining to quality and safety in cross-border care are different depending on the type of patient mobility being considered. While everyone in Europe is entitled to be reassured that the key elements of a high-quality system are in place, issues relating to continuity of care or doctor–patient communication will be different for a young person developing an acute but self-limiting disease while on holiday than for an older person falling ill with a complication of diabetes after retiring to a different country (ibid).

There are three major EU-funded projects, concerning the quality of medical services within the EU. The first project is Europe for Patients. The project sought to provide evidence that would maximize the benefits that can be achieved with enhanced patient mobility in Europe (Europe for Patients, 2005). Europe for Patients combines in-depth country case studies with crosscutting thematic issues, including the quality of health care strategies across Europe. The second project is MARQuIS, also executed within the Scientific Support to Policies component of the EU’s 6th Framework Research Programme. MARQuIS will help to assess the value of different quality strategies and provide needed information both for countries when contracting care for patients moving across borders, and for individual hospitals when reviewing the design of their quality strategies (MARQuIS, 2007). The third project is SIMPATIE (Safety Improvement for Patients in Europe), funded by the European Commission programme “Public Health – 2004”. The purpose of the project across two years (2005–2007) was to improve the safety of patients in all European countries. More specifically, it aims to establish a common European vocabulary, indicators, and internal and external instruments that will enhance safety of health care (Wismar et al. 2011).

The quality of care in Poland must comply with EU standards. The best hospitals and clinics in Poland are concentrated in various organizations such as medical-tourism-poland.com or the Polish Association of Medical Tourism (PAMT). The Association claims to be responsible for the development of this sector of the economy in Poland.

According to the Joint Commission International, one of the most respected accreditation bodies, to implement international quality standards around the world one should define accreditation as ‘a process in which an entity, separate and distinct from the healthcare organization, usually nongovernmental, assesses the healthcare organization to determine if it meets a set of requirements (standards) designed to improve the safety and quality of care’. The fact that a healthcare facility has gone through the rigorous preparations in order to be bestowed with a stamp of accreditation proves that they are making a commitment to patient safety and care.

Even though there is a lack of JCI accredited facilities throughout Poland, hospitals have other international accreditations like the ISO, Trent and the European Society for Quality in Healthcare. The medical services provided through clinics and hospitals are equipped with modern equipment and technology equivalent to the standard of Western European countries. Most of these medical facilities are government provided, but some leading private institutions cater to the needs of foreign medical patients (Jagyasi, 2011).

In Poland, more than 50 hospitals have gained the ISO accreditation. In France, Germany and Sweden, some hospitals have undertaken the ISO 9000 process but it has not become popular and it is widely seen as inappropriate for health services. The European Foundation for Quality Management (EFQM) model is a framework for self-assessment used by facilities
seeking the European Quality Award or national awards. The model is not, however, widely used in the health sector (Wismar et al. 2011).

The travellers I interviewed were uniformly quite satisfied with their experience. They wouldn’t hesitate to go abroad for care should they need it again and would strongly recommend that friends and family members do so as well. Some patients and family members were so pleased with what they perceived as the quality of care that they said they would seriously consider traveling abroad to get better care even if care were accessible and quickly available in their home countries.

The private healthcare has a beneficial interest and hence it is important for them to provide a good service to get new and keep their customers. Given that the Swedish healthcare is largely public and non-profit, it is conceivable that the services are not prioritized in the same manner as in private companies.

### 4.1.5 Research objectives

6 specific research objectives of the study are proposed as follows:

1. Is there any beauty tourism between Sweden and Poland?
2. Who is the average Swede looking for a treatment in Poland?
3. What are the motivations to undergo a treatment in Poland?
4. What are the relationships between prices and availability of this kind of services?
5. What is the general picture of Poland as a medical tourism destination in Sweden?
6. Is there any future for Swedish beauty tourism to Poland?

Those objectives are to realize how does the market look nowadays, to address the distinct motives inducing the current travel-for-beauty demand and will be discussed later in this work.
5. Theoretical framework

There are different motivation theories referring to tourism:

- Maslow’s Hierarchy of Needs,
- The travel career ladder (TCL, Pearce, 1993),
- Iso-Ahola’s (1982) optimal arousal theory,
- Plog’s (1974) allocentric - psychocentric theory.

The most popular is Abraham Maslow theory called the 'Hierarchy of Needs'. This hierarchy referred to the various needs that characterised humans. Maslow identified five main human needs. These are:

- **Physiological needs** - the need for food, clothing and shelter and the other basic functions in life including sex, sleep and the need to do simple things like going to the toilet.
- **Safety needs** - the need for humans to feel secure in their home and work environment, the need to feel that our jobs are not going to be taken away, that we have good basic health and that our property is secure.
- **Love needs** - all humans, need friendship to feel a sense of belonging, to have the support of a family, to identify with groups and to have some element of intimate relationships.
- **Esteem needs** - humans have a need to feel respected and of having their skills and talents recognised by others. We want to feel that the things we do are recognised and appreciated by others, that we feel we have some competence at what we do and we are encouraged and do not feel inferior.
- **Self-actualisation** - a need to feel fulfilled, to feel that we have achieved our potential. Maslow suggested that people who reach this need are aware of their own potential but also that of others around them.

Maslow's hierarchy is generally shown in the form of a triangle or pyramid with physiological needs at the bottom and self-actualisation at the top. Part of the reason for this is that Maslow felt that the first two needs were needs that could be characteristic of both humans and some animals. The other three needs, however, were specific to humans. Maslow suggested that if none of the 5 needs had been satisfied then the physiological needs would dominate. If it was a choice between food and wanting to be loved for example, then the human would be motivated primarily by food. Once that need has been satisfied, the other needs will start to become more important to the individual. What this means for tourism is that every tourist might have different needs. What might act as a motivator to one individual might not act as a motivator to another.

Pearce’s Travel Career Ladder is based on a hierarchy of travel motives and builds on Maslow’s model (Pearce et al., 1998):

- Each person has a “travel career” just as they have a “work career”,
- People start their travel careers at different levels during their travel careers,
- Broadly, the TCL theory proposed that people progress upward through the levels of motivation when accumulating travel experiences,
- People’s travel decisions and decision-making processes are not static; they change over a person’s lifetime based on their travel experiences.
S. E. Iso-Ahola’s develops optimal Arousal Theory, also named two-dimensional theory of tourist motivation. The basic principle behind the optimal arousal theory is that a person seeks out a level of stimulation that is best for him/her as an individual. If a person’s life is too quiet, the person may seek out stimulation through activity. If too much is happening in a person’s world, then the person seeks to cut off stimulation and find a quieter environment. Tourism provides an excellent means of accommodating a person’s need for an optimal level of stimulation. Someone whose day-to-day life is overbearing may choose to visit a remote, peaceful setting to counter the pressures of home and work. Someone whose work and life are boring may want a vacation that supplies adventure and excitement.

Plog’s allocentric - psychocentric theory was historically important in providing one organizing theory of travel motivation. It offers only a single trait: a static and extrinsic account of tourist motivation, it is not of universal application and it is limited by its formulation in the tourism context of the early 1970s. Psychocentric is conservative in travel pattern, prefer ‘safe’ destinations, while allocentric is adventurous and discover, prefer ‘new’ destinations.

There are as well two different factors of the motivation (the drive to satisfy needs and wants, both physiological and psychological through the purchase and use of products and services):

Push factor: internal, socio-psychological motivations that predispose the individual to travel - whether to go?

Pull factor: external motivations that attract the individual to a specific destination once the decision to travel has been made - where to go?

Psychological, physiological, intangible and internal factors are pushing people to travel. The destination features, such as image, recreation facilities, education, beautiful scenery, safety and local cuisine pull people towards tourist activity.

An individual is affected first by the push factors and then the pull factors. It is primarily the situation in homelands’ healthcare system that the idea to seek care in foreign countries is taken into account. After that the chosen country and its possibilities are starting to play the role. Two important factors of influence in Sweden are: long waiting time for the healthcare and high prices in medical and dental care, which means that there is a need to get treatment faster and cheaper. When this need is identified, then the Internet plays a role as an information source for those patients, who are traveling on their own. Through this great marketing tool, one can find out what there is to offer, both in Sweden and other countries. Given that new entrepreneurs in the field of health tourism are entering the market, the amount of advertising will increase. This can be seen as a mental availability that affects stakeholders and different destinations’ image; this pull factor is also contributing to the choice of medical tourism destination.

Prices significance can be seen as an economic push factor. As mentioned, healthcare abroad can be paid either by the patient himself or by the health insurance. The economy is a crucial factor in the privately paid healthcare abroad; one must simply be able to afford it. A country's economic situation affects the residents' consumption; for instance, in the economical crisis individuals spend less money on entertainment, such as travelling. Traveling for aesthetic treatments (with few exceptions like face-reconstruction after an accident) is mainly privately paid.

Even demographic factors play a role in a person's propensity to travel in the medical purposes, which goes hand in hand with the economy. For example, a retired couple has usually a lot less purchasing power as a pair of DINKS (Double Income No Kids). An increased longevity has also an impact on medical tourism. Elderly people today are more likely to travel than before, this combined with the fact that they actually need more care than younger people, is leading to the higher demands on the Swedish healthcare system. One has
to mention about even longer waiting queues (push factor) and a lower treatment cost in the foreign clinic (pull factor). All this factors have an enormous influence for patients’ choices.

A possibility to experience something different, to see new places and to taste new dishes, while being on a medical trip, is also an important factor. There are a lot of treatments available, which do not interfere with patients’ everyday life, even during the whole process (not to mention about ‘‘lunch break cosmetic procedures’’, ‘‘lunchtime treatments’’ like lip augmentation or different injections). Combining treatment in another country with a family vacation is also quite popular – one can save the time, while still socializing. This social factor is significant in the relationship between medical / beauty care and tourism. In this case availability to the tourist attractions plays a key role: while one person is undergoing a treatment, the rest of the family is having fun with sightseeing or in the entertainment parks.

A trip from Sweden to Poland is easy and relatively cheap, there are also different possibilities how to get there. The fastest way is a flight. Nowadays there are several airlines flying to different Polish cities, where the healthcare service is ready to accommodate foreign clients. Swedes usually seek medical / dental care in the Baltic countries, because of their geographical proximity (not to mention about price and quality). Trips to Thailand (one of the most popular medical tourism destinations of the world), even though they are a great tourist goal, are a lot more expensive. One can also be exposed to cultural differences, tropical diseases and microbial flora. For a medical tourist it is crucial that the country of destination is politically stable.

Thus, almost only those, who can pay privately or have a private insurance, can utilize a treatment abroad. EU’s directives about free trade of goods and services between countries could lead to including the public health system, so the individual should be free to choose where he / she wants to be cared for. In the long run, this could cause that problems with the long waiting times would decrease or even disappear.

One can state that in the public healthcare system, all over the world, there is a problem with a service quality. A patient is not seen as a client, as a source of finance. For the private clinics, actually private companies, a patient is a lot more important and that is why they are providing quality treatment at a high level.

In Maslow’s hierarchy of needs there is a need for safety and security, which could have an impact on medical and beauty tourism. The need for security is strong, so Swedes choose care in Sweden or in those countries, which are culturally similar as Sweden. As I mentioned before, people avoid countries, where they believe, there is an increased risk of infection and diseases such as HIV / AIDS etc. Furthermore, people, according to Maslow, have the need for appreciation and respect. Every potential aesthetic medicine patient would like to feel good with himself and with his / her look. Plastic surgery and aesthetic medicine treatments are relatively common among Swedes, who travel abroad for care and due to that they enhance their quality of life and a life satisfaction.

The definition of Health, according to the World Health Organization (1984) states that ‘‘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’’. This definition corresponds to what is commonly becoming known as wellness. Well-being though is more than just happiness. As well as feeling satisfied and happy, well-being means developing as a person, being fulfilled, and making a contribution to the community. The concept of wellness takes this idea even further and includes domains such as physical, mental and spiritual health, self-responsibility, social harmony, environmental sensitivity, intellectual development, emotional well-being and occupational satisfaction. Quality of life is arguably even broader and more complex, combining both objective and subjective elements, for example health, standard of living and well-being (Puczko, 2011).
Tourist’s overall life satisfaction is derived from satisfaction with the primary life domains, like health, family, job. The concept of quality of life is implicit in much of the academic literature on tourism impacts. Tourism academics have explored in some detail the contributions that tourism makes to various aspects of the quality of life of destination residents. According to Constanța (2009) tourism can increase quality of life, which is carried out in various forms: rest, relaxation, recreation, maintenance of tone, knowledge development and sense of taste for beauty, aesthetic feelings, cultivate, etc. (Fariborz, 2011).

Peoples’ lifestyle and standard of living has an enormous impact on their travel patterns. By the concept of standard of living it is meant that when the resources, material and impersonal, with whose help the individual can steer their vital conditions and satisfy their needs. Different standards of living create different lifestyles among people. The individuals at different levels of life would develop their own lifestyles (Steene, 1991).

Quality of life is the degree of well-being felt by an individual or group of people. As stated by Steene (1991) the quality of life is something more than the standard of living – experience of beauty, hope for the future, a nature that is not ruined, general rich life. Things that are very difficult to measure. World Health Organization (WHO) has defined it as individuals’ perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is measured for many different purposes but mainly for economic and political reasons; in fact indicators of quality of life can give observers information on how well a country or a government is doing if compared to other countries or previous governments, or can be of support when taking certain decisions whose outcomes can impact the quality of life of people or when to evaluate certain strategic decisions at community levels. According to Argyle & Lu (1990), quality of life is measured by well-being, life satisfaction, made up of happiness, and absence of ill being. According to Kim (2002) quality of life has been categorized in five domains including: material well-being, community well-being, emotional well-being, and health and safety well-being (Fariborz, 2011).

Different studies conclude that tourism has the positive effect on quality of life (well-being). It should contribute to the improvement of the quality of life of citizens as well as visitors. For the local communities lack of understanding of tourism impacts is a factor for underdevelopment.
6. Methods

Empirical research normally starts with some a priori theory, which develops to try for explaining and/or predicting what happens in the real world. This study was conducted as an empirical research because characterized by the collection of data, which is guided by preliminary theoretical exploration.

In this study quantitative techniques were used to obtain informations about Swedes beauty tourism. To observe and analyse them, qualitative approach would be selected. The method that is used in this research is called triangulation (both qualitative and quantitative method). The structured questionnaire was used to collect data from a part of population.

Qualitative research is an unstructured, primarily exploratory design based on small samples, intended to provide insight and understanding. Qualitative methodology is an approach, which emphasizes an inductive way as regards the relationship between theory and research, this means that the researcher is generating theories rather than testing them. After a qualitative research an interpretive approach is used to understand the results. However, because in qualitative research a small number of individuals is interviewed or observed, these results are difficult to generalize to a population and will instead be generalized to a theory. Although the results are not generalizable, they can provide a contextual understanding, thus we can say that qualitative approach is rather detailed.

Quantitative research seeks to quantify data and apply some form of statistical analysis. Such methods collect numerical and analyse statistical methods. In the contrast to the qualitative method, the quantitative approach focuses on a deductive approach to theory; these studies often focus on the theory testing and not on theory generation. In the former, one formulates hypotheses that are grounded in theory, these hypotheses are used to either falsify the theory or verify it. Often the researcher wants, through quantitative studies, to generalize the results and therefore it is ideal to make use of an entire population in the survey. This is virtually impossible in most cases and therefore one have to make a choice, what is important here is that the sample is representative. The selection process can proceed in various ways; for example, one can implement a random sample or probability sample.

The selection of an appropriate research method is critical to the success of any research project and must be driven by the research question and the state of knowledge in the area being studied. A combination of research methods may be most effective in achieving a particular research objective. For instance, when a subject area is not well understood, qualitative methods may be used to build theory and testable hypotheses. This theory may then be tested using quantitative methods such as surveys and experiments. While most researchers develop expertise in one style, the two types of methods have different, complementary strengths and when used together can lead to a more comprehensive understanding of a phenomenon (Kazemi, 2007). With the support of the above reasoning applies a mix of quantitative and qualitative methods.
6.1 Data collection

This paper uses both qualitative and quantitative methods of research to examine beauty tourism market in Poland. The work began with a collection of general data from different organizations responsible for tourism data collection: Swedish Agency for Economic and Regional Growth, Swedish Travel and Tourist Database - TDB, Statistics Sweden, Polish Social Insurance Institution, UNWTO Statistics and others. In addition, a participation observation technique was used.

Some research has been done on the basis of the written publications (see: Reference list). In the moment when this thesis was written, there still was no data concerning Swedes’ travelling for beauty treatments, so the research had to be done by the author. Because this dissertation is a pioneer project embracing this issue, it would be indicated to broaden the knowledge about it in the future.

In this study a structured questionnaire was used to collect data from a part of the former patients and current facilitators. Every interviewed person is familiar with medical tourism issue between Sweden and Poland. These persons belong to two groups:

- former patients
- actual service providers and facilitators (clinics and medical centres).

The request sent to the clinics and medical centres performing beauty treatments contains questions about their activities, possibilities/facilities and foreign/Swedish patients. The questionnaire was distributed to a total of 40 providers, (the questionnaire is annexed) by electronic mail with a reminder. After that, some of the clinics, which the author considered to be especially relevant, but they not responded to the questionnaire, were reached by the telephone. The author wrote also an article on the Polish Medical Tourism webpage www.medical-tourism-poland.com, ‘Poland as a destination for Swedish medical tourists’ with the link to the survey. The final number of 13 clinics/interviews was reached. Because of the ‘internal confidentiality policy’ data acquisition was complicated and very limited; providers were extremely unwilling to share their knowledge and other issues relating to their enterprises. The author did not get the permission to mention the name and address of the clinics in the dissertation or the other publicised documents.

Interviews were also conducted with patients – they were sent out in the plastic surgery/beauty treatment Internet forums, forums belonging to specific clinics or privately by the author. The questionnaire was distributed (the questionnaire is annexed) by the link attached to the forum post and electronic mail. Therefore, it is impossible to tell how many surveys were sent out, but the final number of 58 surveys has been answered. Some of the questionnaire questions were finally not taken into account during the analysis as not relevant ones.

The main factor that web surveys were chosen was the possibility to reach potentially unlimited amount of interviewees, possibility to get detailed information played a significant role as well. Personal interviews were conducted as a valuable source of information, but because of the lack of time, there were only few of them during the research. The main purpose of choosing persons, who already had an experience in the mentioned field, was to get the most trustworthy information and data. It could be problematic to obtain informations from former patients, because the data I have been trying to get was intimate and sometimes perplexing. But there was always a possibility to leave the survey question without an answer.
Interviews were conducted in Swedish (towards Swedish patients) and Polish (towards Polish providers). Afterwards they have been translated into English.

I have chosen analyzer.se to prepare and conduct a research as the most appropriate survey tool.

By interviewing providers and facilitators I got a wider perspective of the medical service market, although some financial questions remained unanswered, or the answers were perfunctory and not detailed. I conclude that my interviewees were highly relevant to the study, because of their knowledge about the market (providers and facilitators), as well as former patients as persons with appropriate experience. Providers were chosen from international (= available for potential Swedish health tourist via the most popular search engines) medical tourism websites.

No personal data were needed so getting information did not interfere with Personal Data Protection Law or Data Protection Directive.

Desk research was the third way of getting informations about the main theme. There are a lot of publications about health/wellness/spa tourism on the market, although there are so far no publications, no data, about beauty tourism, especially between Sweden and Poland. However, I have taken note of existing statistics in the form of a few graphs to supplement the qualitative interviews. In order to be open and flexible to the new ideas I read also branch magazines, newsletters and paid attention to any reports on beauty tourism, which appeared in the media, even those, which had the nature of gossip and sensationalism.

The sequencing was carried out from the middle of April 2012 to the end of May 2012.
7. Analysis

7.1. Patients’ survey analysis

Typical consumer research focuses on a number of factors. Demographic segments are clearly important such as age, gender, income level, life stage, geography, religion or education. In addition, psychographic segments become even more important for wellness tourism analysis, such as life-style, values, occupation, personality and hobbies. Clearly, the life stage of individuals or the aspiration of being the part of ‘tribes’ makes a difference to their needs. For example, young people may have relatively few physical health problems, will be unencumbered by family responsibilities, tend to have more free time, but will have less spending power. Busy middle-aged executives tend to have very little spare time, because of long working hours and family responsibilities, but have high spending power. Elderly travellers will have less spending power, but more time and they may suffer from more physical health problems (Smith and Puczko, 2011).

The first part of the survey concerned socioeconomic and sociodemographic data. The average patient is a higher educated married woman, between her 30’s and 40’s, living in Stockholm county, with approximate annual income 320 000 SEK. A total of 13 providers and 58 patients responded to the survey.

According to Yeoman (2008) women’s attitudes towards their looks have been conditioned by the prevailing stereotypes, which are reinforced by the media and by society as a whole. But there is a growing awareness of the pressure, which men and boys are under to fit the male stereotype of beauty and how the media also construct, inform and reinforce prevalent ideas about men and masculinity. The pressure to look good has intensified for both sexes over the years, leading to an age of the image, where visual appearance is prized above all else. Post-feminist empowerment in the 1970s heralded a new era of ‘women doing it for themselves’, that is, looking good for their own satisfaction, not for men. Now we are seeing an emphasis on health and youthful vigour alongside an alternative ideal that values internal as well as external beauty. The result below confirms the theory that women more often subjected themselves to the beauty treatments enhancing their looks.

Figure 7.1. Respondents’ gender.

![Respondents' gender](chart.png)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>78</td>
</tr>
<tr>
<td>Male</td>
<td>22</td>
</tr>
</tbody>
</table>
The majority of respondents that have answered for the survey are between 30 and 40 years old (41%), there were also some people in their 60’s (4%) and 2% were under 20 years – the youngest patients use to undergo ear and nose surgeries. The figure below shows the other age groups as well.

Figure 7.2. Respondents’ age.

Figure 7.3. Respondents’ place of residence.

58% of the responders are living in Stockholm municipality, so the author decided to place Stockholm and not the name of the landscape, which are Södermanland and Uppland. There is 25 landscapes in Sweden, but it became apparent that I got the respondents from 6 of them
only. Because of their diversity (both geographic and economic) one can assume that the sample is relevant. In the Stockholm area there are two airports, from which one can fly to Poland, so this is one of the reasons why people from the capital are travelling over the Baltic Sea. The other one is that it is in Stockholm, where the income is highest in Sweden and the living standard is one of the highest as well.

Respondents state that their annual income is from 140 000 SEK to 500 000 SEK. Their average income is then 320 000 SEK. One can say that cosmetic surgery is for those with higher income, it is cheaper in Poland than in Sweden, but it is still a considerable expense. The average monthly salary of the respondents is 27 000 SEK, which is also average in the country scale.

Figure 7.4. Respondents’ average annual income.

The majority of the former patients declare higher education (53%); post secondary (after gymnasial) level – 37%, 5% respondents declare upper secondary school level and 5% of them has a ground school education.

According to the survey the most of beauty travellers are married (41%), in cohabitation (‘sambo’) lives 35% of interviewees, 22% of them are singles and 2% set their status as ‘in the relationship’.

A Yeoman (2008) states that Botox is the most popular anti-wrinkle treatment in Europe, but also on a worldwide scale. The research confirms the thesis, because the most popular treatments indicated by the responders are as follows:

1. Botox injections – 46%
2. Fillers injections – 30%
3. Dermabrasion and chemical peels – 16%
4. Hair removal treatments – 14%
5. Acne treatments – 13%
6. Breast implant – 12%
7. Lip augmentation – 12%
8. Rhinoplasty / nose surgery – 10%
9. Cellulite treatments – 10%
10. Otoplasty / Ear surgery – 10%
11. Laser skin resurfacing – 7%
12. Skin alterations removal – 7%
13. Tattoo removal – 7%
14. Permanent make – up – 6%
15. Rhytidectomy / face lift – 5%
16. Chin augmentation – 4%
17. Liposuction – 4%
18. Blepharoplasty (eyelid surgery) – 3%
19. Anti sweating treatments – 2%
20. Hair transplantations – 2%

Results do not add up to 100%, because it was possible to select more than one answer.

Respondents were asked to give reasons why they had travelled to Poland for beauty treatments. Poland was the place of treatment because of the price and geographical proximity and good word of mouth. Some of the respondents answered that they wanted to visit Poland before, but they needed a necessary stimulus. Connection between treatment possibility and a tourism experience, for the good price, made that they chose Poland as a destination of their medical trip.

While enhancing physical appearance emerged as the primary motivation, a series of other reasons scored very highly, for instance:
- old tattoos, of which they have been ashamed of,
- skin changes associated with age,
- skin changes caused by diseases or accident,
- complexes about the appearance,
- excessive adipose tissue.

Respondents also mentioned good after-care as a reason for choosing Polish clinic. Faster access to the care was not mentioned often.

89 % per cent of the respondents answered that they arranged their trip privately, 6% by the broker and 4% "in a different way". None of the interviewed persons used the services of the tour operator. 74 % said that the main source of the information regarding treatment in Poland was Internet – clinics’ websites and user forums. 16 % used the friends’ or family members’ recommendation and 10 % based their choice on media releases.

The most popular mean of transport is a plane (74 %), a ferry (16 %) and a car also 16 % (multiple choice possibility due to multiple trips).

According to the respondents March is a most popular month to travel for a treatment, 21 % of them travelled this time of the year, May is the second one (16 % of answers), January, April, June and November 11%, February, July and August were best for 5% of the respondents each, December were chosen by 4% of interviewees.

Figure 7.5. Year of the visit.
24% of the respondents have chosen to travel in the year 2011. Decline value in 2012 is not a result of a decreased interest, but shows only data collected by 27th of May 2012, when the figure is created.

It was rather obvious that the respondents would travel to the main cities of Poland, when the airports and the most popular tourist attractions are located; the results of this question are shown below:

- Warszawa – 39%
- Gdansk – 35%
- Szczecin – 32%
- Krakow – 30%
- Wroclaw – 24%
- Poznan – 16%
- Lodz – 7%

Results do not add up to 100 %, because it was possible to select more than one answer.

According to the answers the most active in experiencing tourist attractions were those persons, who have been to Krakow and Warszawa. Wawel, Jewish district, churches, art museums, Salt Mine in Wieliczka and Concentration Camp in Oswiecim were the most popular attractions visited by respondents. Old Town and art museums were pointed most often in Warszawa. Gdansk visitors have been to the Old Town and different villages and beaches by the Baltic Sea. Relatively big amount of the respondents mentioned that shopping in the different shopping malls was taking a lot of time during their stay.

Safety is a significant issue for every medical traveller, so I asked the respondents if they have done any medical test before they treatment/operation. Only 16 % of them answered “yes”, 84 % have not done any test before the treatment. I presume that the medical screening preceded each surgical procedure, because the majority of treatments do not need any specific preparations. All the tests have been done by the clinic/hospital in Poland.

**Figure 7.6. Average expenditure on the trip – total, in SEK.**

Respondents of the survey did not spend relatively large sums on their treatments and the trip as a whole. A part of them, for instance, have been staying by their friends or families so they did not incur the cost of accommodation; the total sum can also depend on intensity of
sightseeing and other tourism-related expenditures. The average expenditure on the treatment itself varies from 44% to 76% of given cost of the whole trip. The interviewees declare savings from 11% to 36% comparing the costs of the treatment they have carried out. Sweden does not subsidize, with certain exceptions, cosmetic surgery, so the patient himself must bear the costs. None of the respondents receive reimbursement from the Social Insurance Agency.

Figure 7.7. Duration of the trip.

47% of beauty travellers do their treatments during 5 to 10 days stays. There are several of them, who needed only 2 days and 5% answered that they needed 20 to 30 days for the treatment and Polish tourism attractions.
The overall satisfaction after the treatment/operation is a crucial factor concerning the medical trip. Therefore, it is reasonable to examine former patients’ satisfaction on the three levels: the treatment (the process itself and the result), price and availability of the treatment itself.

Figure 7.8. Satisfaction level regarding quality of the treatment.

![Satisfaction with the quality](image)

Figure 7.9. Satisfaction level regarding price of the treatment.

![Satisfaction with the price](image)
Patients/tourists have different needs in relation to the medical traveling depending on their medical and economical situation, physical condition and geographical location (time aspects), but one can state the most stringent requirements are for the quality of care. Over half of respondents stated that they are fully satisfied with the price, quality and availability of the treatments they underwent and with the whole trip to Poland. On the economical aspect of the experience, patients were asked ‘How satisfied are you regarding the price of the treatment?’. An overwhelming number (56%) answered they were ‘very satisfied’. Another 20% of respondents chose ‘satisfied’, 8% were ‘partly dissatisfied’ and 2% ‘dissatisfied’.

Several respondents stated that they would not repeat the medical journey, because traveling longer distances on the way back home after a surgery can be painful, when done same day or the day after the procedure.

The quality of care was mentioned as the primary most positive aspect of treatment in Poland (‘very satisfied’ - 61%). 27% of the respondents are content, ’satisfied’, with the care they obtain at the destination. In comparison, only 1% of patients had a negative experience of the journey and 3% partly negative experience. When looking at patients’ satisfaction with the price they were obliged to pay for the trip, one notices the generally high levels of satisfaction (56 % very satisfied and 20 % satisfied). In 55 % it appears that it is a lot easier, faster and cheaper to find a proper place for the treatment in Poland, than in Sweden.

Hospitality of the staff, helpfulness, competences and professionalism of doctors and nursing staff were highly valued in the survey. 78% of patients state that they would repeat the experience and 89% of them would recommend the clinic/hospital they have been to. 22% would not repeat a medical trip to Poland and 11% would not recommend it to their relatives and friends.

It is, of course, important for patients to feel that they are adequately informed about the procedure before the treatment, during the whole process and afterwards. The survey shows that interviewed patients are rather satisfied about the information they received from doctors and other staff. 72 % have not experienced any communication problems and 28 % interviewees had faced difficulties in communicating in English.
7.2 Providers’ survey analysis

The questionnaire was distributed to a total of 40 providers. A total of 13 providers responded to the survey – 3 aesthetic medicine health centres, 8 private plastic surgery clinics and 2 hospitals. Providers without Swedish patients were removed from the material; those, which fill out the survey, are located in:
- Warszawa – 6
- Gdansk – 3
- Krakow – 3
- Wroclaw – 1.

The cities above are easy available for the Swedish patients, because each one of them has an airport connected to the biggest Swedish cities. One can also get to Gdansk / Gdynia by a ferry from Nynäshamn, Karlskrona and Ystad.

Interviewed clinics provides wide range of invasive and non-invasive skin / face / body / breast treatments.

Figure 7.11. Types of treatments provided by the respondents and their popularity among patients.

The most available treatments among interviewed providers are Botox (100%), injectable fillers (98%), nose and ear surgeries (98%), scar correction (90%) and breast surgeries (85%). Labiaplasty still are a niche surgical service (2%).
All the treatments mentioned above are of interest to clients; according to the interviewees there is no difference between nationalities, when it comes to the treatment choice. One of the interviewed persons – a doctor from the clinic in Gdansk, states that Swedish patients (mostly women) are very cautious with ‘unnatural’ methods of face rejuvenation like fillers or radical facelifts. They choose methods that allow to look younger without surgical invasions in the tissue, e.g. laser treatments. However, this does not apply to breast augmentation, abdominoplasty and liposuction.

Chosen clinics have from 650 to 2500 patients per year, of which 12% to 30% are the foreign patients. Swedish patients seem not to be a biggest group in none of the interviewed centres. The biggest amount of them one can observe in Gdansk, where 30% to 50% of foreign patients are Swedes (Germans and British patients are the rest, other nationalities, even Norwegians and Danes are actually not taken into account). Krakow, as a one of the most popular destinations in Poland, seems to be interesting from the Swedish point of view. 5% to 20% of foreign patients have Swedish nationality. Warszawa is chosen not as often as a beauty tourism destination – clinics have stated that 5% to 10% of foreign visitors are the visitors from Sweden. The surgical clinic in Wroclaw states that they have had only 3 persons from Sweden in the year 2011.

The results above are approximate, because almost none of the clinics register patients’ nationality.

According to the survey problems with communication in English are not reported. 65% of the respondents states that there is increased amount of foreign (Swedish as well) patients in the first months of 2012 comparing to the same period last year.

The majority of the clinics are advertising themselves on polish and international medical tourism websites (Medical Tourism Poland, Estheticon, placidway.com), beauty and branch magazines. Some of them are cooperating with the brokers connecting patients from the whole world with Polish facilitators (in Swedish - e.g. medi-tour.co.uk, Medica Travel, visitkrakow.se). They also declare that a lot of patients are coming to undergo another treatment in their clinic and that they get new patients by recommendation from former customers.

‘Do you prepare patients before the treatment by doing any medical tests?’ – 100% of answers was ‘yes, if it is an invasive procedure’.

The costs of the treatments varies a lot, so it was impossible to determine the average amount of money spend by just Swedes in Polish aesthetic medicine centres; as stated by one of the interviewed surgeons – ‘it can be all from 500 PLN to 20 000 PLN for more complicated surgeries’.

All the plastic surgeons, dermatologists, aesthetic medicine doctors in Poland have to be highly skilled and undergo a long medical education. The majority of mentioned beauty centres have also different certifications and accreditations like ISO 9001:2008, The American Society of Plastic and Reconstructive Surgeons accreditation, Quality International, QI Services, and different of aesthetic surgery branch acknowledgments from all over the world. Information about surgeon’s qualifications and clinic’s accreditations are available on demand or even on the websites. According to the survey hospitals, clinics and health centres are not cooperating with any tourism facilitator, like hotels, restaurants or transport services. The only cooperation is with medical tourism brokers and contact websites.

In this research it has been expressed that:

1. Health tourism to Poland is getting more popular among tourist from all over Europe. It seems obvious that Swedes are searching medical care outside Sweden as well. The exact number of Swedes seeking for a treatment there is still unknown, due to the lack of available information from the state institutions. The
research shows that Poland as a beauty travel destination is becoming more popular among Swedes and Northern Europeans and the number of visitors with this background in medical care facilities is increasing.

2. According to the survey it is a higher educated married woman, between her 30’s and 40’s, from Stockholm, with approximate annual income 320 000 SEK.

3. There are several effective factors that attract people to undergo a treatment in Poland - high quality together with low prices and geographical proximity; a lot less language and communication problems between patients and personnel, than it was only several years ago; relatively cheap flights; marketing of services, which became more sophisticated and global. Among Swedish press reports there are a lot more positive pictures of Polish medical care, than the negative ones. Good word-of-mouth plays also a significant role.

4. Cosmetic medicine treatments are relatively easy available in both of the countries. The main factor that differs them is a price. For more details see the figure 3.2. Aesthetic treatment costs.

5. Because of the case of the accident, which occurred in 2010 (unsuccessful breast augmentation surgery, after which the patient remains in a coma to this day) the public picture of Poland as a health tourism destination declined strongly. However, situations like this happen very rarely and the research shows that the number of clients is nonetheless increasing. There are many satisfied patients, who after their homecoming are sharing good word of mouth, recommend the clinics to each other among family, friends or websites.

6. Considering the phenomenon of Swedish travelling for health and beauty one can state that medical tourism from this land will increase if the prices remain high in the private medical services and aesthetic dermatology. People become more aware of different options due to the increased amount of companies in the health industry, brokers and their intensive advertising on the Internet and mass media.
8. The future of medical and beauty tourism

Scenarios for the future of health tourism are optimistic; beauty tourism is a significant niche that will continue to grow. By 2030, new markets will emerge, based on specific consumer segments; for example, spas are expanding and in the near future every destination in the world, a rural or an urban location, will have some sort of health proposition. Beauty bars will open up in leisure centres and hotels will offer these products as part of the room-service menus. Hotels will extend the range of health-style services, such as ‘the waiter as nutritionist’ who can advise on the right balance of food, water and the calorie count of meals. Indian and Chinese medicine spas will appear in resorts all over the world, combining herbal medicine and yoga with spa treatments. Wellness products will focus on men, teenagers, children and the family pet. The metrosexual man will seek feminine-like treatments, such as manicures and facials. Metrosexual-man centres will combine physical, emotional and medical products, whether climbing mountains, camping out, massage services or cosmetic surgery. Rising obesity in children will lead to fitness camps and lifestyle gurus for teenagers, and spa days for groups of female children aged 7+ will become mainstream. Parent-and-baby packages will become more popular, both for fathers and mothers, as offered at Evian Spa in France. These packages will focus on the concept of goodparenting and healthy lifestyles. Spa centres will also offer grooming and massage services for pets and their owners. Every major health and spa centre will have a resident behavioural therapist available for both owners and pets in order that they can understand each other. As health and beauty becomes more of a commodity rather than an experience, the consumer will use only price as a distinguishing factor (Yeoman, 2008).

Prognosis of Wellness Tourism Worldwide Report concerning year 2020 state that in Central and Eastern Europe therapeutic medical services still dominate the market, but wellness and lifestyle-based services will be important. The region should focus on producing innovation capacity and developing product diversification. Northern Europe will be the most important hub for wellness and lifestyle-based services, with leisure and recreational spas. Nature and the natural healing assets are the dominant resources of the region, but these so far are partially used in wellness tourism. According to trends, wellness and lifestyle-based services will gain ground (e.g. Nordic Well-being) (Puczko, 2011).

There will be a proliferation of new, cross-over and fusion services and products, which will support the development of wellness tourism in countries and regions that are not yet on the global map of wellness tourism (in Poland the trend will improve). These need to position themselves in a distinctive way so as not to ‘disappear’ in a competitive environment. Unique and signature products and services need to be developed (ibid). As Tresidder (2011) states, in order for the niche to develop sustainably it needs international regulation to protect the host or donor (transplant tourism) and the guest or recipient (medical, health and beauty tourism). Such regulation needs to be implemented without driving the sector underground and into the arms of the illegal groups that operate on its margins.
8.1 The future of Swedish health and beauty tourism

Considering the phenomenon of Swedish travelling for health and beauty one can state that medical tourism from this land will increase due to problems within the public health system, and if the high prices remain high in the private medical services and aesthetic dermatology. Another contributing factor may be that people become more aware of different options around the world due to the increased amount of companies in the health industry, their intensive advertising on the Internet and mass media. There is a possibility that Swedish medical and dental tourism will decrease (as a result of improved medical care in Sweden), particularly because of shorter waiting times, through increased resources in the public health and reduced costs of the private healthcare. If wages between Sweden and Poland equalize (in a very distant future), and healthcare cost increase in the same time, it may cause that Swedes would choose any other neighbouring country or more exotic destinations as Thailand, Malaysia or India. Increased epidemiological or political risks, natural catastrophes around the world, can negatively impact the choice as well. Tourism providers have to take into consideration the risk of standardization and uniformization of products and services – this can significantly decrease uniqueness and competitiveness, what may contribute to lower interest of potential visitors.
9. Conclusions

As health and beauty becomes more and more important, the need of travelling for improving appearance will increase. Poland, with constantly growing possibilities, facilities and infrastructure will grow more popular as both health and beauty destination. Demand for wellness will sore as the consumer’s perception of health changes into a concept of a combination of mind, body and spirit. According to World Tourism Organisation and Yeoman (2008), tourism and health will become the world’s two biggest industries by 2022. Together they will be an unbeatable consumer force. In Poland, first-class standards can be combined with price competitiveness — and a holiday in an interesting destination.

The progress of the medical tourism phenomenon has had enormous impact not just for the patient alone but it has also influenced economic, social, environmental, business and medical sectors. As the price of health care increases, more and more people are looking elsewhere to receive affordable health care. Reports of significant cost discounts, shorter waiting times, improved service by health personnel and sometimes vacations seem to be driving people abroad to seek health care.

Collecting reliable data on participation, expenditure and development in this sector of health tourism is very difficult. There is also very little consistency in available statistics. No recognition is given to health as a primary reason for travel, although a number of official categories have obvious health associations. National and regional tourist offices and the industry federations provide some information, but the former can rarely extract specific detail on beauty treatments tourism from general tourism statistics, while the latter rely on data supplied by their members.

What becomes immediately obvious in a literature search is that very little material specifically on health/beauty tourism is available, and even less that is recent. The health tourism sector is discussed in many recent books, but usually in a brief and somewhat disjointed way and they are usually written in rather cursory and descriptive way. However, it is easier to find a handbook with informations for potential patients (mostly advertising) than proper scientific positions.

Geopolitical events can quickly impact patient flows. The providers recognize that events driving the global economy at large (such as changing currency values) can affect their value proposition and flows of medical travel. This market is also particularly susceptible to geopolitical events and acts of nature that could influence the willingness of patients to visit a given country, or their ability to do so. The events of September 11, 2001, for instance, drastically reduced the number of Middle Eastern patients admitted to US facilities for care, but considering European tourism, the stable geopolitical situation has not such a big impact on the issue.

Changes in national health care policy, such as investments in health care infrastructure or insurance coverage levels in the major originator nations can also change the medical-travel market significantly. Spending on health service capacity or quality, for example, may make it less necessary for patients to travel abroad in search of higher-quality care or reduced wait times.
The aim of my study, among other things, was to find out what drives Swedes to seek medical and aesthetic care in Poland. Conclusions below are summarizing this issue:
1. Swedes are affected by the push factors driving them out of Sweden:
   • high costs of medical, dental and aesthetic care;
   • long waiting times in the public healthcare;
   • lack of service in the public healthcare;
   • differentiated treatments’ availability;
   • proper health insurance.
2. Pull factors that contribute to the health tourism:
   1. destinations’ advertising, clinics’ and healthcare centres’ marketing;
   2. lower prices;
   3. faster available care;
   4. wide range of services;
   5. higher quality of service;
   6. geographic proximity;
   7. cultural similarity;
   8. feeling of safety.

In comparison with other European countries Swedish medical tourism is relatively small. The main reason why the Swedish medical tourism is not as extensive nowadays is because the Swedish patient is tied to insurance and a lot of them have private health insurance. If the healthcare system going to cooperate more intensive with the EU, Social Insurance Institution (Försäkringskassa) may offer a greater extent for reimbursement for treatment abroad, so that even middle-income earners will increase their opportunities to travel abroad. Although it may be more expensive for the state to cover the costs treatment abroad, it could be a gain for all the parties in the long run, for instance, patient can join the work market quickly. Such a policy combined with health insurance from the companies for all their employees can lead to the wide spreading of medical tourism. The privately paid medical and dental tourism will increase the most, such as cosmetic surgery and dentistry. This is because they are not driven by public funds, but the patient decides himself.

In recent times the medical tourism phenomenon has begun to be highlighted in media, a lot of positive and negative stories are presented. This causes that potential patients are more aware and understand the health tourism issue really well. High quality products and services, as well as low prices make the complacent patient. Commercial medical companies and hospitals will accelerate enormously the development, if they focus on patient’s needs, skilled management and doctors. Satisfied patients and the low price is crucial regarding to the future of medical and beauty tourism. The next generation’s familiarity with Internet for will cause more possibilities to check properly and book a medical service worldwide. Rising longevity will also impact the issue significantly – bigger amount of elderly patients will search for healthcare abroad to avoid, for example, overloaded local healthcare providers.

The government should see health tourism as a business. The medical tourism market all over the world is an enormous force to improve hospitable countries’ economies. The factors that can decrease Swedish health tourism is worldwide economic equalization (at least equalization between Swedish and Polish medical service costs, what is the subject of this dissertation) or a lot of mistakes will happen. However, I do not think that any cultural problems between these two countries may occur. Common to all the respondents is, that they believe that medical and dental tourism will develop in the future.
It can be concluded that the factors determining the choice of Polish medical service provider are:

- International and well known accreditations of medical facilities
- International and well known accreditations of the staff
- Procedures available in the clinic
- Comparative price quotes
- Choice of website interface language and staff speaking foreign languages
- Local infrastructure and transportation services
- Tourist information on leisure packages and tourist places worth to visit.
9.1 Future research

Future research might take up issues that were not considered in the present study. Any brokers or intermediaries between potential patients and clinics in Poland were not studied, so it could be significant to get familiar with their business performance, profiles and competitors analysis. Future research might be the comparative analysis of multiple Polish regions and their values for aesthetic/wellness tourism. Further research is needed to document accurately patient flows and quality of health care (including patients travelling on their own initiative).

Medical travel is a highly relevant market worthy of further observation. The acceleration of unsustainable health care costs in many developed economies, the advent of advanced technologies in just a few locations, and the increasing concentration of wealth in developing economies are only a few of the factors fuelling it. Over the next couple of decades, these trends may largely dispel the idea that health and aesthetic care and is a purely local service.
Reference list

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Appendix 1 – Question forms

Medical tourism research – patients

- Skönhetsturism enkät - patienter

Mitt namn är Karolina Stockhaus och studerar magisterprogram i turism på Södertörns Högskola. Jag är särskilt intresserad av skönhetsturism till Polen.

Syftet med forskningen är att lära känna polsk marknad för estetisk medicin, att undersöka varför människor åker till Polen för behandling, att ta reda på deras goda och dåliga erfarenhet, kundernas drivkrafter och marknadens framtida möjligheter.

Som en person som har rest för kirurgi eller behandling till Polen, skulle jag vilja bjuda in dig till att delta i min forskning kring medicinsk turism och avvara några minuter på att fylla i enkäten om just dina erfarenheter.

Observera: Du behöver absolut inte ange dina personuppgifter!

Var vänlig och fyll i enkäten:

My name is Karolina Stockhaus and I am a master student in Södertörns Högskola, field of studies: Tourism. I am interested in medical tourism, especially aesthetic tourism to Poland. The aim of the research is to learn more about how and why people go to Poland for treatment, to find out about the good and bad aspects of their experience, to learn about customers’ motivations and future possibilities.

Please complete the medical tourism survey.

As a person who has travelled for surgery or treatment to Poland, I would like to invite you to participate in the Medical Tourism Survey and to spare a few minutes of your time to complete the survey about your experience.

Please note: You will absolutely NOT have to enter your personal data!

1. Kön / Sex
(Ange endast ett svar)

☐ F
☐ M

2. Ålder / Age
(Ange endast ett svar)

☐ 10-20
☐ 20-30
☐ 30-40
3. Bostadsort / Place of residence

- - - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - - -
- - - - - - - - - - - - - - - - - - - - -

4. Civilstånd / Marital status
(Ange endast ett svar)

- Gift / Married
- Singel / Single
- I ett förhållande / In the relationship
- Sambo / Cohabitation

5. Ungefärlig årsinkomst / Approximate annual income

- - - - - - - - - - - - - - - - - - - - -

6. Utbildningsnivå / Level of education
(Ange endast ett svar)

- Grundskolenivå / Compulsory school level
- Gymnasienivå / Upper secondary school level
- Eftergymnasial nivå / post-secondary level
- Högskolenivå / university, college

Annan / Other
7. Vilken typ/typer av behandling/behandlingar genomgick du?
What type/types of treatment/treatments did you do?

(Ange gärna flera svar)

- Buk plastik / Abdominoplasty (tummy tuck)
- Ögonlocksplastik / Blepharoplasty (eyelid surgery)
- Bröstförstor, implantat / Breast implant
- Bröstsminskning, Bröstlyft / Breast reduction, Breast lift
- Skinkplastik / Buttock surgery
- Chemical peel
- Ansiktslyft / Face lift
- Fettsugning / Liposuction
- Näsplastik / Rhinoplasty (Nose surgery)
- Utstående öron / Otoplasty (Ear surgery)
- Hak plastik / Chin augmentation (implant)
- Kind plastik / Cheek augmentation (implants)
- Botox eller någon annan rynkbehandling / Botox (or other wrinkle treatment)
- Ögonbrynslyft / Brow lift
- Dermabrasion
- Fillers / Injectable fillers
- Radiesse, Restylane, Juvéderm
- Cellulit behandling / Endermology (cellulite treatment)
- Thermage (skin treatment)
- Kärlbistningar, åderbräck, ådernät / Sclerotherapy (treatment of vascular malformations)
- Pannlyft / Forehead lift
- Armplastik / Arm lift
Gynecomasti (överutvecklad bröstvävnad) / Gynecomasty reduction (male breast reduction)

Penis förstoring / Penis enlargment surgery

Hår implant, transplantation / Hair implants

Hårborttagning / Hair removal treatment

Laser skin resurfacing

Blygdläppoperation / Labiaplasty (reshaping)

Halslyft / Neck lift

Lårlyft / Tight lift

Trådlyft / Thread lift

Läppförstoring / Lip augmentation

Ansiktsoperation / Rhytidectomy (face surgery)

Indragna bröstvårtor / Inverted nipples

Akne behandling / Acne treatments

Hudförändringar / Skin alterations

Tatueringsborttagning / Tattoo removal

Ärrkorigering / Scar removal

Permanent make-up

Svettning / Sweating

Annan / other

8. Vad var ditt skäl till att genomgå behandling? / What was your reason for the treatment?

9. Hur fick du ordna din behandling? / How did you arrange your treatment?
10. Vad var din huvudsakliga källa till information om behandlingen i Polen? / What was your main source of information regarding your treatment in Poland?

(Ange endast ett svar)

- Privat / Privately
- Intermediär / Intermediary
- Touroperator
- Annan / Other

11. Hur åkte du dit? / How did you travel to Poland?

(Ange gärna flera svar)

<table>
<thead>
<tr>
<th>Med flyg / by air</th>
<th>Med bil / by car</th>
<th>Med färja / by ferry</th>
<th>Med buss / by bus</th>
<th>Med tåg / by train</th>
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12. När reste du till Polen för att genomgå en behandling? / When did you travel to Poland for your treatment?

(Ange endast ett svar)

- Januari / January
- Februari / February
- Mars / March
- April / April
- Maj / May
- Juni / June
- Juli / July
- Augusti / August
- September / September
- Oktober / October
- November / November
- December / December

13. Vilket år? / Which year?

(Ange endast ett svar)

- < 2004
- 2004
- 2005
- 2006
- 2007
- 2008
- 2009
- 2010
- 2011
- 2012
14. Vilken stad har du rest till? / What city did you travel to?

15. Hade du förberett dig inför behandlingen genom att göra medicinska tester? / Did you prepare yourself for the treatment by doing preliminary tests?

(Ange endast ett svar)

- Ja / Yes
- Nej / No

16. Om du svarade ja på föregående fråga, vilken typ av test/tester gjorde du? / If your previous answer was yes, what type of test/tests did you do?

17. Vart gjorde du testerna? / Where did you do the tests?

(Ange endast ett svar)

- I Polen / In Poland
- I Sverige / In Sweden

18. Hur mycket betalade du för din resa (totalt för behandling, resa, boende, mat, turistattraktioner och annat)? / How much did you spend on your trip (in total of treatment, travel, living, food, tourist attractions and others)?

(Ange endast ett svar)

- <5000
- 5001-10000
- 10001-15000
- 15001-20000
- 20001-25000
- 25001-30000
- 30001-35000
- 35001-40000
- 40001-45000
- 45001-50000

(Ange endast ett svar)

- <5000
- 5001-10000
- 10001-15000
- 15001-20000
- 20001-25000
- 25001-30000
- 30001-35000
- 35001-40000
- 40001-45000
- 45001-50000
- 50001-100000
- >100000

20. Har du fått ekonomisk ersättning för din behandling av försäkringskassan? / Have you received any compensation from “försäkringskassan”?

(Ange endast ett svar)

- Ja / Yes
- Nej / No

21. Hur mycket beräknar du ha sparat på behandlingen i Polen jämfört med i Sverige? / How much do you calculate that you have saved by doing the treatment in Poland compared to in Sweden?

(Ange endast ett svar)

- <1000
- 1001-2500
- 2501-5000
22. Hur länge varade din resa? / For how long did your trip last?

(Ange endast ett svar)

- 1-2 dagar / days
- 3-5 dagar / days
- 5-10 dagar / days
- 11-20 dagar / days
- 20-40 dagar / days
- >40 dagar / days

23. Hur tillfredsställd är du avseende kvaliten på behandlingen? 1= inte alls, 5= till fullo. / How satisfied are you regarding the quality of your treatment? 1= not at all, 5= completely.

(Ange endast ett svar)

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24. Hur tillfredsställd är du avseende pris på behandlingen? 1= inte alls, 5= till fullo. / How satisfied are you regarding the price of your treatment? 1= not at all, 5= completely.

(Ange endast ett svar)

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25. Hur tillfredsställd är du avseende tillgänglighet på behandlingen? 1= inte alls, 5= till fullo. / How satisfied are you regarding the availability of your treatment? 1= not at all, 5= completely.

(Ange endast ett svar)

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26. Om du är missnöjd vänligen ange orsaker till ditt missnöje. / If you are dissatisfied of any reason please state the reason for your dissatisfaction.

27. Skulle du vilja upprepa upplevelsen genom en ny eller annan behandling? / Would you like to repeat the experience by a new or different treatment?

(Ange endast ett svar)

☐ Ja / Yes
☐ Nej / No

28. Skulle du rekommendera denna klinik / behandling till din vän / familjemedlem?

(Ange endast ett svar)

☐ Ja / Yes
☐ Nej / No

29. Har du upplevt kommunikations/språk problem med personalen? / Have you had any communication / language problems with the staff?

(Ange endast ett svar)

☐ Ja / Yes
☐ Nej / No

30. Har du besökt någon turistattraktioner i Polen under din vistelse? Om ja, vilken eller vilka? / Have you visit any tourist attractions during your stay in Poland? If yes, which ones?

Tack på förhand för din medverkan! / Thank you in anticipation of your cooperation!

Eventuella frågor om forskningen bör riktas till karolina.stockhaus@gmail.com

Kontakta även:
Anders Steene
anders.steeene@sh.se
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Alfred Nobels allé 7, 141 89 Huddinge, Sweden
Tel.: +46 08-608 45 43 & #8232;
E-mail: ief@sh.se

Any questions about the research should be directed to karolina.stockhaus@gmail.com

You can even contact:
Anders Steene
Nazywam sie Karolina Stockhaus i studiuje Turystyke na Uniwersytecie Södertörn w Szwecji. Tematem mojej pracy magisterskiej jest turystyka medyczna pomiedzy Szwecja a Polska (ze wskazaniem na turystyke estetyczna).

Celem pracy jest zbadanie, dlaczego pacjenci wybieraja Polske jako miejsce do przeprowadzenia zabiegu/operacji, zapoznanie sie z ich doswiadczeniami i motywacjami. Równie interesujace sa doswiadczenia uslugodawców i zbadanie specyfiki rynku. Z zalozenia badanie ma odpowiedziec m.in. na pytanie:

• Dlaczego pacjenci decyduja sie na zabiegi poza granicami
• Jakiego rodzaju zabiegi najczesciej przechodza
• Jakie ponosza koszty z tym zwiazane
• Dobre i zle aspekty turystyki medycznej

Chcialabym prosic Państwa o poswiecenie kilku chwil na wypelnienie ankiety, która pozwoli szwedzkim pacjentom na zapoznanie sie z mozliwosciami polskich uslugodawców medycznych.

My name is Karolina Stockhaus and I am a master student in Södertörns Högskola (Sweden), field of studies: Tourism. I am interested in medical tourism, especially aesthetic tourism to Poland.

The aim of the research is to learn more about how and why people go to Poland for treatment, to find out about the good and bad aspects of their experience, to learn about customers’ motivations and future possibilities. I would like to learn about the market itself, its size, intensity etc.

I also hope that the research will provide insight into:

• Why patients decide to travel for treatment
• What kind of treatment they undergo
• What they spend on the trip
• The good and bad aspects of their customer and patient experience.

I would like to invite you to participate in my survey and to spend a few minutes of your time to complete the survey.

1. Type of activity / Rodzaj dzialalnosci

2. Place of activity / Miejscowosc

3. Type of provided treatments / Rodzaje dostepnych uslug medycznych

4. General number of patients in the year 2011 / Ogolna liczba pacjentow w roku 2011
5. Number of foreign patients in the year 2011 / Liczba pacjentów zagranicznych w roku 2011

6. Number of Swedish patients in the year 2011 / Liczba pacjentów szwedzkich w roku 2011

7. Do you notice an increase of the number of patients in 2012 comparing to 2011? Specify percentage increase. / Czy zauważasz wzrost liczby pacjentów w roku 2012 w stosunku do roku 2011? (procentowo)

   (Ange endast ett svar)
   ☐ No / Nie
   ☐ Yes / Tak

8. The most popular treatments in your clinic. / Najbardziej popularne zabiegi w Twojej klinice.

9. The most popular treatments among Swedish patients. / Najbardziej popularne zabiegi wśród szwedzkich pacjentów.

10. How do you advertise among foreign patients? / Jak reklamujesz swoje usługi poza granicami kraju?

11. Do you plan to advertise more on the Swedish market to get new clients? / Czy planujesz reklamować swoje usługi na rynku szwedzkim? Jeśli tak, to jak?
12. Are those patients coming back to your place for other treatments also? / Czy zagraniczni pacjenci powracają, aby nadal korzystać z Twoich usług?

(Ange endast ett svar)

☐ Yes / Tak
☐ No / Nie

13. Do you prepare patients before the treatment by doing any medical tests? If yes, which ones: / Jak przygotowuje się pacjentów przed zabiegiem w Twojej klinice? Jakie badania są przeprowadzane?

14. Estimated expenditure on the treatment by one patient / Jaką sumę przeznacza na zabiegi zagraniczny pacjent Twojej kliniki?

(Ange endast ett svar)

☐ > 500 PLN
☐ 501 - 1 000 PLN
☐ 1 001 - 2 000 PLN
☐ 2 001 - 3 000 PLN
☐ 3 001 - 4 000 PLN
☐ 4 001 - 5 000 PLN
☐ 5 001 - 6 000 PLN
☐ 6 001 - 7 000 PLN
☐ 7 001 - 8 000 PLN
☐ 8 001 - 9 000 PLN
☐ 9 001 - 10 000 PLN
☐ 10 001 - 11 000 PLN
☐ 11 001 - 12 000 PLN
☐ 12 001 - 13 000 PLN
☐ 13 001 - 14 000 PLN
☐ 14 001 - 15 000 PLN
☐ 15 001 - 16 000 PLN
15. How many staff do you have in your clinic? (doctors, nurses, other staff) / Ile osób pracuje w Twojej klinice?

(Ange endast ett svar)

- > - 5
- 5 - 10
- 11 - 15
- 16 - 20
- 21 - 25
- 26 - 30
- 31 - 35
- 36 - 40
- 41 - 45
- 46 - 50
- 50 - >

16. Do you have any policy/certification? If yes, which ones? / Czy Twoja klinika/personel posiada certyfikaty, pracuje według jakiejś polityki, specyficznych reguł? Jeśli tak, to jakich?
17. Communication/language problems / Czy problemy komunikacyjne/językowe są problemem między pracownikami Twojej kliniki a zagranicznymi pacjentami?

(Ange endast ett svar)

☒ Tak / Yes

☐ Nie / No

18. Do you cooperate with hotels and other tourist service providers to make the whole package for your patient? / Czy współpracujesz z hotelami lub innymi usługodawcami z sektora turystyki w celu stworzenia pakietu usług dla zagranicznych pacjentów?

(Ange endast ett svar)

☒ Tak / Yes

☐ Nie / No

19. Do you have any intermediaries connected with the Swedish market? / Czy masz pośredników między Twoją kliniką w szwedzkimi pacjentami?

(Ange endast ett svar)

☒ Tak / Yes

☐ Nie / No

20. Would you like to cooperate with any intermediary connected to the Swedish market? / Czy chciałbyś współpracować z pośrednikiem w Szwecji oferującymi Twoje usługi?

(Ange endast ett svar)

☒ Tak / Yes

☐ Nie / No

Dziekuje za poswiecony czas! Thank you for cooperating!

Po zakończeniu badań możesz otrzymać kopie raportu bez szczegółowych danych osobowych. Jeśli masz jakieś pytania dotyczące mojej pracy, bądź jej efektów, proszę o kontakt: karolina.stockhaus@gmail.com

Dziekuje za współpracę!

Mozna również kontaktować się z:
Anders Steene
anders.steene@sh.se
Södertörns Högskola
Department of Business Studies
Alfred Nobels allé 7, 141 89 Huddinge, Sweden
Tel.: +46 08-608 45 43
E-mail: ief@sh.se

If you wish to get a free copy of the report of the research without any detailed personal data just e-mail me.
Note: The report will not relate patient experiences to specific healthcare providers.

Thank you in anticipation of your cooperation!

Any questions about the research should be directed to karolina.stockhaus@gmail.com

You may also contact:
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