Journal of Destination Marketing & Management 16 (2020) 100430

Contents lists available at ScienceDirect

Journal of Destination Marketing & Management

journal homepage: www.elsevier.com/locate/jdmm

Research paper

Health destination image: The influence of public health management and well-being conditions

Antonio-Angel Moreno-González[a,*], Carmelo J. León[a], Carlos Fernández-Hernández[b]

[a] Institute of Tourism and Sustainable Economic Development (Tides), Universidad de Las Palmas de Gran Canaria (ULPGC), Calle Saulo Torón, 4, 35017, Las Palmas de Gran Canaria, Spain

[b] Universidad de La Laguna, Department of Applied Economics and Quantitative Methods, Campus de Guajara, Apartado 456, 38200, La Laguna, Tenerife, Spain

ARTICLE INFO

Keywords:
Health and well-being
Public health
Accessibility
Destination image
Expectations
Social-ecological model

ABSTRACT

This study proposes and tests a model that explains the formation of health-related destination image and its influence on tourists' expectations for improving their health when going to a destination. The model incorporates grounded theories related to environmental psychology, public health, sociology and health geography. The data were obtained from international tourists from the United Kingdom, Germany and Spain, surveyed in their source countries and by evaluating two alternative tourism destinations. The results show that two cognitive dimensions influence the healthy destination affective image: (i) health-related environmental factors, and (ii) well-being resources and experiences. In addition, both cognitive factors and the affective destination image on health have a significant effect on the health improvement expectation of tourists planning to visit the destination. The results have implications for the management and positioning of those destinations focusing on health tourism.

1. Introduction

The image of a tourism destination is defined as the mental representation of a destination created from a set of attributes. This image has great significance in tourism because it affects tourists' behaviour, along their consumption process (Beerli & Martín, 2004a). It also precedes tourists' expectations "because it moulds the expectations that the individual forms before the visit" (Bigné, Sánchez, & Sánchez, 2001, p. 609). Tourists' expectations are conceptualised as the preconceived perceptions of travel outcomes (Wang, Qu, & Hsu, 2016). Both destination image and expectations have an important influence on tourists' satisfaction, since this depends on the comparison of expectations with the actual experiences (Bigné et al., 2001).

There is a growing interest in the relationship between tourism and health (Filep, 2014), well-being (Hartwell et al., 2018; Smith & Diekmann, 2017) and quality of life (Dolnicar, Yanamandram, & Cliff, 2012). It has been widely recognised that tourism can have a positive influence on human general health in several ways (Chen & Petrick, 2013; Strauss-Blasche, Reithofer, Schobersberger, Ekmekcioglu, & Wolfgang, 2005). In certain groups and with specific activities, it even seems to improve physical health (Chang, 2014) and it is an important contributor to the perceived improvement of health in some social groups (Ferrer, Sanz, Ferrandis, McCabe, & García, 2016; McCabe, 2009). In addition, the expansion of the niche of health and wellness tourism is considered one of the megatrends of tourism (Smith & Puczko, 2014). In Europe, travelling for the purpose of wellness, spa or health treatments has become one of the main motivations for going on holiday for 13% of tourists, matching in importance the interest in activities related to sports (European Commission, 2015).

Health tourism is commonly divided in two subtypes of tourism, i.e. medical and wellness tourism. However, the different tourism products are commonly placed on a continuum following the proactive-reactive, prevention-treatment paradigms (Fyall, Hartwell, & Hemingway, 2013). This paper focuses on the well-being (proactive) perceptions of health on destinations from a general tourist point of view, and not only from a health tourist perspective (World Tourism Organization and European Travel Commission, 2018). In addition, the study analyses the influence of the perceived public health and health care systems on the tourist image of a health destination.

Several studies have highlighted the importance of good sanitary conditions and well-preserved natural environments for the competitiveness of tourism destinations (Becken, Jin, Zhang, & Gao, 2017). Voigt and Pforr (2013) show that tourists usually relate certain characteristics and specific services of a destination (e.g. landscape and outdoor activities) with their experienced health and well-being. In most cases, these findings have been based on the assessment of tourism

* Corresponding author.
E-mail addresses: antonio.moreno110@alu.ulpgc.es (A.-A. Moreno-González), carmelo.leon@ulpgc.es (C.J. León), cferher@ull.edu.es (C. Fernández-Hernández).

https://doi.org/10.1016/j.jdmm.2020.100430
Received 27 January 2019; Received in revised form 20 February 2020; Accepted 15 March 2020
Available online 01 April 2020
2212-571X/

experts (e.g. Heung & Kucukusta, 2013; Page et al., 2017), and on studies of health and wellness tourists while visiting destinations (e.g. Medina-Muñoz & Medina-Muñoz, 2014).

Furthermore, the perceptions that people have of the therapeutic and restorative properties of places in which they live and/or might visit have been explained by several sociological and public health theories. For instance, the concept of therapeutic landscape refers to those landscapes where the physical and social environments are combined with human perceptions to create an atmosphere that may help healing in humans (Gesler, 2005). Similarly, Attention Restoration Theory (ART) (Kaplan, 1995) postulates that the recovery of attention capacity can be achieved by experiencing certain restorative qualities of places and environments. Lehto, Kirillova, Li, and Wu (2017) conducted ART research on the restorative qualities of holiday destinations as perceived by a sample of Chinese university students.

Following the classification of destination image studies by Bigné, Sánchez, and Sanz (2009), this paper focuses on the health image evaluation of tourism destinations and its influence on tourists' expectations about health. Despite their academic and practical relevance, and as far as the authors are aware, there are no studies that analyse in an integrated way the attributes that create the image of a health destination in the tourist's mind. The empirical application compares the image perception and its influence on tourists' expectations for two alternative destinations specialising in health tourism. Therefore, this paper contributes to the conceptualisation of a health destination image and provides evidence on its crucial role in forming tourists' expectations about overall health when going to destinations. The comparative evaluation of two alternative health destinations also provides further insights on the site-specific effects of image formation and tourists' expectations (Pike, 2002).

2. Literature review

2.1. Perceived image and tourists' expectations

Tourists' perceptions of a destination are conceptualised in tourism through the construct of destination image, which is defined in literature as the subjective interpretations made by tourists of the characteristics of a particular destination (Bigné et al., 2009). There is a holistic and integrated perception of a destination in the tourist's mind (Chi & Qu, 2008; Choi, Chan, & Wu, 1999), and there is no need to visit a destination in order to form an image about it (Cherifi, Smith, Maitland, & Stevenson, 2014). Researchers agree that perceived cognitive attributes influence the affective perceptions that tourists have of destinations, and that both of these integrate the destination image (Baloglu & Mangaloglu, 2001; Kock, Josiassen, & Assaf, 2016). Affective and cognitive images have also an effect on the expectations that tourists have before the visit (Del Bosque & Martín, 2008) and on the preconceived perceptions of the travel outcomes (Wang et al., 2016). Thus, the concept of destination image has a relative nature, which is both subjective - since it is based on subjects' perceptions – and comparative – because the perceptions of an object are formed with respect to others (Gallarza, Saura, & Garcia, 2002).

2.2. Manageable public health and health-related environmental factors in tourism destinations

Public health conditions of destinations have been shown to be important for a successful tourism development in many destinations around the world (Dwyer, Edwards, Mistilis, Roman, & Scott, 2009). Thus, there can be relevant implications of public health for tourists' choices and destination image. From a global perspective (WHO, 2019), public health involves aspects such as health-care services and emergencies, health promotion, the control of the risk of contracting infectious diseases, the elimination of barriers for the participation of all in tourist experiences and some aspects of the management of the natural environment (e.g. pollution, water or soil with chemical agents, agricultural methods, human-made ecosystem change or behaviour related to natural environment factors, such as physical activity fostered through natural parks) (Prüss-Ustün et al., 2016). All these can be considered human-made environmental factors that can be managed or modified at the destination (Bettcher, Sapirie, & Goon, 1998).

Health services are defined by the World Health Organization (WHO) as all services dealing with diagnosis and treatment of disease, or the promotion, maintenance and restoration of health (WHO, 2017). The quality of health care services is one of the public infrastructures commonly included in cognitive destination image studies (Beerli & Martín, 2004a; Carter, 1998; Fakeye & Crompton, 1991). In addition, poor sanitary conditions and health services at a destination can negatively affect the tourist experience (Kim, 2014).

The risk of contracting a disease is, however, one of the factors perceived by tourists as important when travelling to a destination (Lepp & Gibson, 2003). This risk has been growing because of the increase in international travel (Baker, 2015) while tourists have become more aware of the potential risks posing certain destinations (Rosselló, Santana, & Awan, 2017; Wolff & Larsen, 2016). Further, the higher risk of infection observed in some destinations has caused a decrease in tourism demand (Blake, Sinclair, & Sugiyarto, 2003; Cohen, 1988; Cossens & Gin, 1994; Donohoe, Pennington-Gray, & Omodior, 2015; Rittichainuwat & Chakraborty, 2009). Therefore, the possibility of contracting an infectious disease is one of the perceived risks associated with the trip that has more influence on the process of choosing a destination (Dolnicar, 2005).

Tourism image studies have considered the environmental quality as another cognitive element of the overall image of destinations (Baloglu & Mangaloglu, 2001; Beerli & Martín, 2004b). The attributes related to the destination environment are often associated in these studies with aspects such as hygiene, safety, cleanliness, pollution and local infrastructures. For example, 'safe and secure environment, clean and tidy environment' (Chi & Qu, 2008), 'cleanliness and hygiene' (Bigné et al., 2009), 'unpolluted and unspoiled environment, standard hygiene and cleanliness' (Baloglu & Mangaloglu, 2001) or 'local Infrastructure, cleanliness and hygiene' (Echtner & Ritchie, 1993). Kim (2014) finds that the lack of cleanliness, safety and hygiene at a destination all generate negative memorable experiences.

Degradation of the natural environment matters to tourists because they consider it affects both residents and visitors' health. For instance, Becken et al. (2017), in a study of air pollution in China and its influence on destination image, found that air quality and hygiene were perceived as a risk and pollution affects the decision to visit the country because of the associated health hazard. In addition, Mihalič (2000) argued that perceived environmental quality of a destination influences the decision to travel, especially when there are perceptions of health risks due to air and water pollution.

The World Tourism Organization (2016) (emphasises that tourism destinations must be accessible to all, so that people with disabilities and special needs are also able to enjoy tourist experiences. In addition, accessibility contributes to the well-being of people with different needs, because they do not feel excluded from participation in the social phenomenon of tourism (Eichhorn, Miller, & Tribe, 2013). The 'tourist destination for all' must comply with those aspects related to equity and equal access and opportunities, which are related to the social concept of disability (Buhalis & Darcy, 2011). The importance of accessibility in tourism is enhanced by the fact that it has been estimated that 15% of the world population lives with some form of disability (Guralnik, Fried, & Salive, 1996) and there are prospects of increasing disability across potential tourists, since according to WHO (2011) almost everyone will be temporarily or permanently impaired at some point in life.

2.3. Well-being settings and situations and destination management

Tourist destinations should enhance the well-being of tourists through the appropriate policies managing collective assets capable of providing services and satisfaction to tourists (Jamal & Getz, 1995). There are objective conditions of destinations that may provide perceived well-being to tourists. In this regard, research in health sciences shows that there are conditions in which subjects perceive an improvement in their well-being and overall health. For instance, Kaplan (1995) proposes Attention Restoration Theory (ART) to explain the beneficial effects that certain environments may have on health. The directed attention fatigue has consequences on health, producing alteration of the ability to solve problems, affective and reflection disorders, impulsivity or irritability. Lehto et al. (2017) applied ART to analyse the perceived tourist destination restorative properties to improve well-being and health. Letho (2013) shows that the discord factor (i.e. confusion and chaos that a destination can create for tourists) may affect the restorative capacity properties of destinations. On the other hand, destination image studies have incorporated some aspects of restorative capacities as explanatory cognitive factors, such as 'everything is different & fascinating', 'restful and relaxing places' (Choi et al., 1999), 'relaxation' (Echtner & Ritchie, 1993) and 'exotic' (Beerli & Martín, 2004b). In ART research, natural environments have been the most studied scenarios regarding their ability to improve human well-being and health (Bowler, Buyung-Ali, Knight, & Pullin, 2010). There is evidence that activities in nature – e.g. "'entering the landscape rather than viewing it'" (Frumkin, 2001, p. 237) – can effectively influence health, and therefore are perceived by individuals as a way of improving the same (Brink et al., 2016; Grinde & Patil, 2009; Russell et al., 2013).

ART not only contributes to the explanation of the relationships between human health and nature (Hartig, Mitchell, de Vries, & Frumkin, 2014), but also allows researchers to understand perceived restorative experiences in other settings (Pearson & Craig, 2014). For instance, it has been applied to the study of the perceived restorative properties of museums and gardens (Packer, 2014), monasteries and houses of worship (Herzog, Ouellette, Rolens, & Koenigs, 2009), and shopping centres (Rosenbaum, Otalora, & Ramírez, 2016). In tourism environments, it has been found that cultural landscapes and local culture enable tourists to appreciate the uniqueness and perceived authenticity of destinations (Kirillova, Fu, Lehto, & Cai, 2014), thereby enhancing the restorative capacities of the travel experience (Lehto et al., 2017). In this regard, the local gastronomy experience can be considered one of the elements of a destination's culture (Mak, Lumbers, Eves, & Chang, 2016) and of its tangible and intangible heritages (Rabbiosi, 2016). Therefore, it becomes an important component of tourists' perceived destination authenticity (Robinson & Clifford, 2012). That is, local food can be one of the stimuli that attracts tourists' attention, facilitating positive experiences that enhance tourists' perceived well-being and the perceived restorative capabilities of destinations (Chen, Scott, & Benckendorff, 2017).

The social dimension has been suggested as another key component of the restorative capacity of spaces and places (Scopelliti & Vittoria Giuliani, 2004). The importance of the social context as a factor related to restorative settings seems to be more evident in urban areas (Staats & Hartig, 2004). In tourism research, residents' hospitality and kindness have been utilised as cognitive attributes in destination image studies (Gallarza et al., 2002), and a sound interaction between tourists and residents is considered an important factor for successful tourist destinations (Woosnam, 2010).

ART is not well known in the general health literature although provides an interesting concept for human health improvement (Berto, 2014). However, there have been environmental health literature reviews that have provide reliable evidence of perceptions in terms of reductions in self-reported anger, fatigue, anxiety and sadness, and an increase in feelings of energy (Hartig et al., 2014). Nonetheless, other health reviews have found that there are few studies with the desired design features and it is unclear which aspects of attention may be affected by exposure to natural environments (Ohly et al., 2016).

Another theory that explains the capacity of environmental settings to produce physical and mental well-being in humans follows from the concept of the Therapeutic Landscape (Gesler, 2005). This theory has been applied to analyse the healing properties of places (e.g. spa, healing areas, natural landscapes, coasts, etc) in studies related to geography, health sociology and public health (Bell, Phoenix, Lovell, & Wheeler, 2015; Williams, 2010). The conceptual framework of the Therapeutic Landscape is based on the healing elements found not only in nature but also in constructed and cultural environments. The theory is an extension of the application of the concept of cultural landscape in geography, as well as of the social construction of ideas and institutionalised practices (Gesler, 1992).

In the field of tourism, the landscape is included as a cognitive attribute in most studies of perceived destination image (Baloglu & McCleary, 1999; Chi & Qu, 2008; Gallarza et al., 2002). As is the case of ART, in the Therapeutic Landscape Theory the cultural and environmental components are inseparable (Menatti & Casado, 2016). The concept has been applied to the relationship between settings associated with culture and improvements in mental health, for example in libraries (Brewster, 2014). Both ART and the Therapeutic Landscape Theory postulate that there are spatial settings that promote human health and well-being, where social, affective and material resources are involved (Duff, 2011). In the literature related to health and well-being in tourism, aspects such as the landscape, local resources and activities in nature, are considered essential for the development of health and wellness destinations (Voigt & Pforr, 2013).

The socio-ecological model of health assumes that well-being and health are influenced by people's interaction with their physical and socio-cultural surroundings (Stokols, 1992). Thus, it can be a useful approach to study healthy activities at specific sites. Social and physical environmental factors of settings and situations can be characterised in terms of subjective human perceptions that are utilised to evaluate healthy places (Sallis et al., 2006). The application of the socio-ecological model has shown evidence that perceived environmental factors influence the motivations to undertake physical activities related to health and well-being (Booth, Owen, Bauman, Clavisi, & Leslie, 2000; Parra et al., 2011) or the consumption of fruit and vegetable (Caldwell, Kobayashi, DuBow, & Wytinck, 2009). Thus, the perceived health-related environment factors may influence tourists' perception of the well-being settings and situations of tourism destinations.

3. Hypotheses and proposed model

Based on the preceding discussion and on the theoretical, conceptual and empirical perspectives found in the literature review, the following hypotheses are proposed:

H1. The well-being settings and situations are influenced by the environmental factors associated with health (health-related environmental factors).

H2. The affective destination image on health (healthy destination image) is influenced by the cognitive construct of health-related environmental factors.

H3. The affective destination image on health (healthy destination image) is influenced by the cognitive construct of well-being settings and situations.

H4. The preconceived perception of the health outcome if travelling to the destination (health improvement expectation) is influenced by a healthy destination image.

H5. The health improvement expectation is influenced by health-related environmental factors.

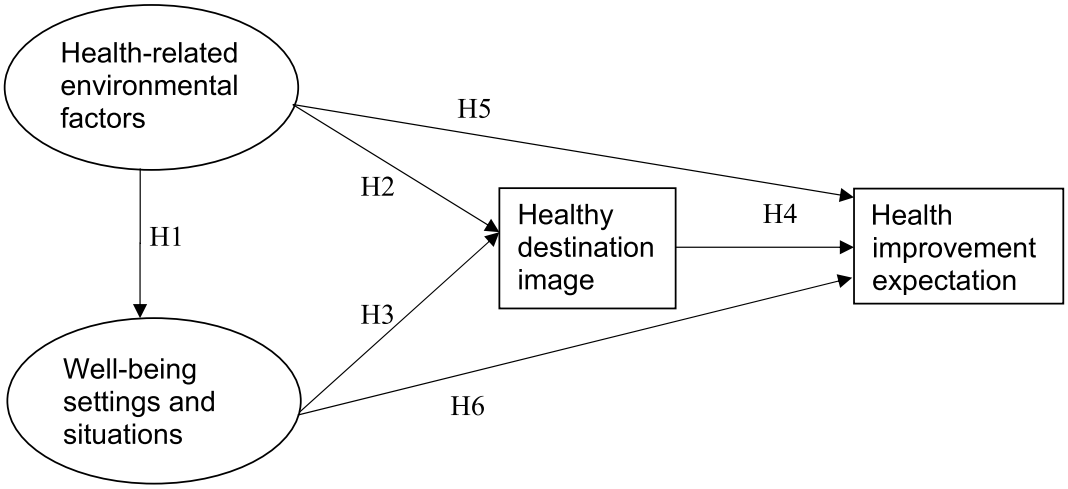

Fig. 1. Hypotheses.

H6. The health improvement expectation is influenced by the well-being settings and situations.

These hypotheses and the proposed model are represented in Fig. 1. The constructs 'health-related environmental factors' and 'well-being settings and situations' are cognitive dimensions of the destination image because they appraise the beliefs of individuals on specific attributes that characterize a destination (Beerli & Martín, 2004a), while 'healthy destination image' is an affective dimension of the destination image because it shows the feelings of tourists related to health at the destination (Baloglu & Brinberg, 1997).

4. Methods

This study was carried out in two stages, following a mixed methods design. The combination of qualitative and quantitative methods provides better support for the findings and increases the quality, accuracy, validity and reliability of the study (San Martín & Del Bosque, 2008). Moreover, the need to combine both methodologies to capture the complexity of destination image has been suggested by several authors (Baloglu & Mangaloglu, 2001; Choi et al., 1999; Echtner & Ritchie, 1993). In order to explain the link of the two stages of the study approach, the contribution, sequencing and stages in the research process were delimited (Ritchie, Spencer, & O'Connor, 2013). The data was collected in two sequential stages, following a *less dominant-dominant* design (Molina-Azorín & Font, 2016), where the emphasis was placed on Stage 2 (quantitative). This design had two purposes: development (Molina-Azorín & Font, 2016) and to confirm and discover (Bryman, 2006). The qualitative part helped to explore tourists' interpretation of the subject, facilitated the development of some hypotheses and allowed to improve the questionnaire used in the quantitative part of the research.

4.1. Stage 1: Qualitative study: focus groups

In health and marketing research, focus groups have proved useful for obtaining primary qualitative data. Focus groups discussions are considered an effective method to elicit those subjects' attitudes and perceptions that become less accessible without the interaction that is created within a group (Sharpley & Jepson, 2011). Focus group sessions were carried out *in situ* in a destination different from those for which the quantitative study was conducted. The sessions were conducted with the participation of a randomly selected group of tourists ($n_1 = 8$, $n_2 = 6$, $n_3 = 6$), belonging to the three countries of origin analysed in this work (United Kingdom, Spain and Germany) and recruited in their place of stay by tourism professionals who were not involved in this research. Participants were not health and wellness tourists and they did not know in advance the subject of the discussions.

Focus groups were conducted in a tourism destination in the south of Spain. Focus group prompts were validated by experts in the fields of tourism and health sciences and tested before the sessions with subjects from other fields and interests. One of the authors is an experienced moderator and thus leaded the sessions. The other two authors took notes of all different aspects of the sessions (such as order of speakers or emerging key issues) and attended practical matters. All discussions were audio recorded after asking for participants' consent. Sessions followed the usual stages (opening and introductory questions, key questions and ending questions) and moderator's intervention was focused on ensuring interaction between the group members and to cover the relevant issues (Gibson & Brown, 2009).

4.1.1. Qualitative data analysis

All the audio-recordings were transcribed verbatim. The analysis of the qualitative data was carried out using an inductive approach, adding aspects based on the attributes most highlighted by the participants and the conceptual grouping of the elements that emerged spontaneously during the meetings (Puchta & Potter, 2004). Following the analysis matrix framework methodology (Ritchie et al., 2013), thematic charts were created by assigning data to the different subjects or emergent categories, identifying recurring themes or ideas and constructing an index based on descriptive categories that remained close to the raw data without abstract classifications. Themes were analysed considering the order of emergence and applying content analysis in that part of the free-ranging discussion where the respondents led the debate, after the moderator introduced the subject and asked open questions. Content analysis was conducted for the elicited opinions that arose due to direct moderator's interventions and the questionnaire evaluation. During the data analysis, researchers kept research questions in mind and practiced reflexivity constantly (Gibson & Brown, 2009). In order to improve validity, each of the authors created thematic charts and their relationships separately. To ensure similar interpretation of data, these analyses were put in common and debated by the authors.

4.2. Stage 2: Quantitative study

4.2.1. Scale and measurement instrument

After its validation and improvement in focus groups, the definitive questionnaire was translated to Spanish, English and German, using the double translation method (Brislin, 1986). In the destination image literature, there is no unanimity about the attributes of a destination

that should be used in the measurement scale (Byon & Zhang, 2010). Therefore, for the assessment of the destination image, those attributes used both in previous destination image studies and health studies that could explain the hypotheses and the relationships of the constructs were selected. In order to develop the specific scales used in this study, these attributes were adapted based on the literature review and on the results of the qualitative study.

The measurement instrument for the cognitive image was a structured questionnaire with questions based on a seven-point Likert scale, reflecting the degree of agreement with the cognitive characteristics of a destination in which to enjoy health and well-being holidays. For the measurement of the affective destination image on health (healthy destination image), a single-overall answer was used in relation to the degree of agreement with the attribute healthy as a characteristic of each of the destinations. The preconceived perception of overall health improvement expectation if travelling to a destination was measured with a one-dimensional global question, which reads as follows: To what extent going to the following destinations would improve your health? Please, answer on a scale of 1–7, where 1 would mean that it 'wouldn't improve my health at all' and 7 that it 'would totally improve my health'.

4.2.2. Sample and data collection

The objective population of the quantitative study was formed by subjects of 18 years or more, who had travelled outside their country, and who resided in Germany, Spain and the United Kingdom. The survey work was carried out on-line in the countries of origin by a highly experienced professional company specialising in market research studies (n = 823). Respondents assessed the image perceptions of two destinations: Phuket (Thailand) and Pamukkale (Turkey), which are well recognised health destinations (Kogiso, 2012; Noree, Hanefeld, & Smith, 2016; Whittaker & Chee, 2015; Yuksel, Bramwell, & Yuksel, 1999).

4.2.3. Quantitative data analysis

To test the hypotheses of the model, a structural SEM path model (Amos 24) was analysed following a commonly utilised two-step technique (Kline, 2011). In a first step, an exploratory factor analysis (EFA) was undertaken (method of the main component with varimax rotation). Even though there is important empirical and theoretical basis to destination image that would obviate the EFA (Bollen & Noble, 2011; Byon & Zhang, 2010), it was used to explore the specific dimensions of health destination image (Deng & Li, 2014). In this step, those variables with a factorial load less than 0.50 and those that shared cross-loads with more than one factor were eliminated (Chen & Phou, 2013). A new EFA was then performed to confirm the stability of the factors. In addition, a confirmatory factor analysis was carried out to test the behaviour of the variables of the model and to check the discriminant capacity of the constructs (Weston & Gore, 2006). Finally, a structural path model analysis was conducted to check the formulated hypotheses.

5. Results

5.1. Qualitative study

Focus-group sessions allowed the evaluation and improvement of the quantitative questionnaire, adapting the attributes of the destination image questionnaire to health and improving wording and sentences. Moreover, together with the theory of the socio-ecological model of health and the literature on perceived environment influence on healthy activities (Duncan, Spence, & Mummery, 2005), focus-group discussions helped to develop the hypothesis which states that well-being settings and situations are influenced by health-related environmental factors (H1). Representative statements included the following:

> (The destination) itself is a health and wellness service if you like, as an island. After one week, you will feel fresher … (but) basic healthcare is important, I'd be worried about going somewhere where there isn't health care, here there are pharmacies, health centres everywhere, this is Europe, we have some level of healthcare, we hope.

> Walking at (the destination) is therapeutic, it's good for the mind and the body … walking in interesting places, routes for walking and so on, health improves with all of this … but we need to know the paths are safe, these are health issues, rockslides and something like that.

Destination health-related factors influence participants' perceptions of the capacity of specific health tourism experiences to improve well-being and health. Characteristic assertions included the following:

> You have to be careful of meningitis when using them [thermal waters]. We've been to thermal parks in New Zealand, and they have signs: do not put your head under the water, the thermal water can cause meningitis …

> … and test (the water) regularly, because in Bath, the Roman's built spa, one of the problems was the purity of the water. It was contaminated. It was a health issue.

> [Services related to health] have to be homegrown in (the destination), all very natural, this would appeal to the people just because is part of the island. The fact this is homegrown and the whole volcanic island … people would be expecting something like that … it is certainly something that could be easily developed.

> I suspect you would get coaches load of people … this place in Turkey (Pamukkale) … is busy every day … you have coaches load of people … if you advertise it all over the world and you build, for example, a spa here, I'll probably avoid it like a plague. [Services related to health and overcrowding].

Furthermore, this relation between perceived destinations health-related factors and well-being experiences is suggested when participants discuss about other types of standard tourism experiences and products:

> There are parts of the island with biological grown, pesticide free vegetables. If I knew that some of the restaurants and cafes are using organic products, or as organic as can be … organic and locally sourced … I have a very healthy diet at home and I find almost impossible to have the same healthy diet when I am on holiday. If you're vegetarian - we are - and if you go out to eat over here, it really is pizza, tortilla and salad drowning in dressing. It seems that everywhere they think 'don't give the vegetarian vegetables, give something like pasta with some nice tomato sauce'.

> Quietness, scenery, mountains, greenery … the island is different, that is the whole wellness … and the culture too, festivals, history. Relaxation, slow pace of life, exercise, walk–spas, yoga, it does not appeal me at all –, but the opportunity to walk, incredible scenery … yes.

The excerpted statements indicate that participants in the focus groups are concerned about the potential influence of destinations health-related environmental factors on well-being settings and situations. Both constructs emerge from the open discussions about the role of health issues on tourists' experiences. Health-related environmental

Table 1
Confirmatory factor analysis of the measurement model.

Latent constructs and items	Phuket				Pamukkale			
	β	CR	AVE	α	β	CR	AVE	α
Health-related environmental factors		0.93	0.76	0.95		0.94	0.78	0.94
Health services for visitors with European quality standards.	0.87*				0.89*			
Health services for residents with European quality standards.	0.91*				0.92*			
Local health authorities promote residents' health and well-being.	0.88*				0.91*			
Safety, security and emergency plans for residents, tourists and the natural environment.	0.89*				0.90*			
Probabilities of getting diseases transmitted by humans.	0.92*				0.91*			
Probabilities of getting diseases caused by ingesting contaminated food or water.	0.82*				0.82*			
Probabilities of getting diseases transmitted by animals and insects.	0.91*				0.92*			
Contamination (atmospheric, acoustic, etc).	0.95*				0.93*			
Tourist overcrowding.	0.77*				0.80*			
Accessible for all visitors who experience access difficulties or have special needs due to disability, long-standing health problems, age-related conditions or other temporary or permanent personal conditions.	0.84*				0.83*			
Restaurants and supermarkets that offer special diets products or menus (gluten-free, dairy-free, etc).	0.83*				0.83*			
Well-being settings and situations		0.89	0.77	0.93		0.88	0.75	0.92
Landscapes that can enhance my physical, mental and spiritual state.	0.91*				0.90*			
Nature based activities.	0.88*				0.90*			
Local gastronomy.	0.87*				0.80*			
Authentic local culture.	0.90*				0.85*			
Revitalising destination.	0.93*				0.94*			
Residents are kind and hospitable	0.77*				0.75*			
Squared correlations between both constructs			0.26				0.37	
Squared correlations between constructs and observed variables								
Healthy destination image								
Healthy destination < − > Health improvement expectation			0.23				0.30	
Healthy destination < − > Health-related environmental factors			0.29				0.37	
Healthy destination < − > Well-being settings and situations			0.30				0.38	
Health improvement expectation								
Health improvement expectation < − > Health-related environmental factors			0.18				0.25	
Health improvement expectation < − > Well-being settings and situations			0.19				0.26	
Measures of fit	$\chi2 = 296.401$ df = 99 GFI = 0.98 REMSA = 0.049				$\chi2 = 323.96$ df = 98 GFI = 0.98 REMSA = 0.05			

Note: *p < 0.05 (t-Values > 1.96); β = Std.factor loading; CR= Composite reliability; AVE = Average variance extracted; α = Cronbach's alpha.

factors were naturally invoked as major determinants of the perceptions that tourists have about well-being settings and experiences on the destination, without intervention of the moderator in the open discussions. Therefore, this qualitative evidence suggests that hypothesis H1 is relevant and should be quantitatively investigated.

5.2. Quantitative study

5.2.1. Measurement model

Exploratory factor analysis (EFA) was carried out separately on the cognitive variables of the scales to confirm the dimensionality of the constructs utilised in the model. After the first EFA, which resulted in the expected factors, the variables 'exotic destination', 'living conditions' and 'slow way of life' were discarded. Then, another EFA was performed, which again resulted in the expected factors (Eigenvalues > 1, total variance explained > 70%, Bartlett's test was significant and the KMO score > 0.6).

To assess the validity of the measurement model, a confirmatory factor analysis (CFA) of the constructs of the model was carried out (Anderson & Gerbing, 1988). The first CFA, even giving acceptable fits, did not allow for the measurement model to be considered to be good. As the climate variable can be considered both a health environment factor associated with health and a well-being resource, and it is not a local human-made factor, this variable was removed from the CFA. With this action, the values of goodness of fit were improved (Nunkoo, Ramkissoon, & Gursoy, 2013). The analysis of reliability was satisfactory in both multi-variable constructs (Cronbach's alpha > 0.7). The resulting measurement model has a good discriminant validity (composite reliability > 0.7, average variance extracted > 0.5), and the squared correlation between both constructs, and between the constructs and the observed variables, was less than the value of the average variance extracted of each construct (Fornell & Larcker, 1981). All this process was carried out in the two evaluated destinations. The results of the CFAs are shown in Table 1.

5.2.2. Structural path model

The relationships established in the theoretical model between the cognitive constructs (health-related environmental factors and well-being settings and situations), healthy destination image and health improvement expectations were studied with a structural path analysis. The fit indices indicate that the path model fits the data well (Hair, Black, Babin, & Anderson, 2010). The relationships between the different dimensions of the model are significant in all the paths and the results provide support to the hypothesised relationships (Table 2). The quantitative results allow us to identify the destination attributes related to services and resources that form the perception of a health destination (Table 1). For both destinations, the model has a good fit and the same pattern of factorial loads are repeated (Table 2). As found

Table 2
Path structural model.

Hypotheses testing for the main effects	**Phuket**	**Pamukkale**	Result
	St. Estimates	St. Estimates	
H1: Health-related environment - > Well-being settings and situations	0.54*	0.67*	Supported
H2: Health-related environment - > Healthy destination image	0.37*	0.31*	Supported
H3: Well-being settings and situations - > Healthy destination image	0.38*	0.43*	Supported
H4: Healthy destination image - > Health improvement expectation	0.31*	0.34*	Supported
H5: Health-related environment - > Health improvement expectation	0.17*	0.17*	Supported
H6: Well-being settings and situations - > Health improvement expectation	0.19*	0.17*	Supported
Mediation test			
Mediator: Healthy destination image			
	Indirect 95% effect BCI$^{(+)}$	Indirect 95% effect BCI$^{(+)}$	
Health-related environment - > Health improvement expectation	0.36 [0.30, 0.43]	0.40 [0.32,0.48]	Significant$^{\&}$
Well-being settings and situations - > Health improvement expectation	0.15 [0.10, 0.20]	0.18 [0.13,0.24]	Significant$^{\&}$
Models Fits			
	$\chi2$ = 278.773 df = 97 $\chi2$/df = 2.8 GFI = 0.987 REMSA = 0.048 AIC14513.652	$\chi2$ = 275.696 df = 94 $\chi2$/df = 2.9 GFI = 0.988 REMSA = 0.048 AIC15162.817	

Note: *p < 0.05 (t-Values > 1.96). $^{(+)}$Bias corrected 95% confidence interval for the estimate (2000 bootstraps). $^{\&}$p = 0.001. Direct effects are also significant, hence there is partial mediation of healthy destination image.

in the qualitative phase of this study, these results confirm that health-related environment at the destinations influences well-being experiences. The healthy destination image influences the expectation of health improvement when going to the destination by a larger amount (almost double) than the health cognitive factors. However, both cognitive factors have approximately the same influence on the healthy destination image.

Mediation tests were carried out to check the mediation effect of the healthy destination image in both destinations. After confirming the significance of the direct effects between the variables of the model without the mediation variable, this was introduced in the model and bootstrapping mediation tests were run (Cheung & Lau, 2008; Preacher & Hayes, 2004). As hypothesised in this study, the tests confirm that the healthy destination image partially mediates the effect of health-related environment and well-being settings and situations on health improvement expectations in both destinations (Table 2).

6. Discussion

The results of this study confirm the hypotheses of the proposed theoretical model, where the affective destination image (healthy destination) is influenced by two cognitive factors: (i) health-related environment (human-made services and conditions associated with health in the destination), and (ii) well-being and restorative resources and experiences. In line with theory, the results show that the expectations of health improvement if going to the destination are influenced by these two factors, and to a greater extent by the affective healthy destination image.

These results are in accordance with studies that find that the perception of health risk in tourism is conditioned by the quality of health services, the risk of contagious diseases and the environmental factors associated with health (Jonas, Mansfeld, Paz, & Potasman, 2011). The risk perception and its influence on destination image is a recent trend in tourism research (Becken et al., 2017). Our evidence contributes to this line of research by demonstrating that the perceived health risk factors not only influence the image of health destinations, but also condition the overall health expectations in the destinations. The quality of health services available for tourists is one of the non-negotiable attributes when considering the competitiveness of tourist destinations (Crouch, 2011; Heath, 2002), and it influences the tourist attractiveness of a country (Lee, 2016). This study shows that the health services for visitors are determining factors of health-related destination image formation.

In order to benefit from those characteristics of a destination that are good for health, it is necessary to become immerse in the place (Grinde & Patil, 2009). Therefore, health and environmental conditions are essentially related in tourist destinations (Dwyer et al., 2009) enforcing synergetic effects. In addition, environmental issues are commonly a cause of major concerns for tourists, especially if they affect the perceptions of key destination conditions (e.g. health) (Dolnicar, 2005). The results of the current study suggest that tourists holistically integrate in their perceptions of destinations this combination of environmental factors that can affect their health on holidays. Furthermore, the overcrowding of the destination is perceived as yet another aspect that negatively affects tourists' well-being experiences at the destination. The latter is consistent with earlier findings on the effects of crowding on tourists' experiences (Jin, Hu, & Kavan, 2016; Jin & Pearce, 2011; León, de León, Araña, & González, 2015).

The quality of health care services for residents together with the promotion of their health and well-being are other factors that are related to the perception of a health destination in this study. In some sense, this follows results from other studies of destination image, where residents' quality of life is included in a social environmental factor (Beerli & Martín, 2004b). In the present study, the perceptions that tourists have of the available health systems for residents influence the healthy destination image and the expectation of health improvement. This suggests that tourists value the social responsibility of the destination in terms of health, similar to results from studies of social responsibility of the destination in relation to environmental issues (Su & Swanson, 2017) and responsible tourism (Lee, Bonn, Reid, & Kim, 2017).

This research also provides evidence of the importance of accessibility to all for the construction of the health image of destinations. That is, the perceived barriers for the participation of people with

special needs in tourism influence the health destination image. This evidence becomes more relevant if we consider that the population studied in this work involved general tourists and not specific health tourists. This indicates that destinations' accessibility matter to all kind of tourists. However, the tourism industry has generally lagged behind in tackling the barriers that affect the participation of everyone in tourism activities, both for people with disabilities (Pagán, 2012) and for people with special dietary needs (e.g. Towers & Pratten, 2003). This means a "subtle discrimination" (Pearce, 2012, p. 16) on important groups of people that together can amount to 27% of the European population (World Tourism Organization, 2016).

Furthermore, this study highlights another dimension that influences the image of a healthy destination and health improvement expectation, i.e. the perceived well-being experiences that can be lived at a destination. In this respect, the landscape with therapeutic capabilities plays an essential role. This result is in line with some theories and empirical research in the field of health and environmental psychology, which suggest that some landscapes may improve or promote health (Learmonth & Curtis, 2013; Velarde, Fry, & Tveit, 2007). Frumkin (2001) argues that human beings find that certain natural landscapes produce a "soothing, restorative, and even a healing sense" (p. 234). The natural landscape is also one of the most valued attributes in destination image studies (e.g. Carballo, Araña, León, & Moreno-Gil, 2015). Hence, the results of this study show that the image of a healthy destination is closely related to the positive perception that an immersion in nature could produce significant improvements in health. Some studies have reported the influence of nature on higher levels of tourists' happiness and well-being (Bimonte & Faralla, 2014), stress reduction and physical improvements (Chang, 2014) and on a better sleep quality (Rantala & Valtonen, 2014), while others have emphasised the strong relationships between nature, the rural environments and tourists' well-being (Agapito, Valle, & Mendes, 2014).

The results also indicate that the perception of a healthy destination is associated with two well-being local situations: (i) authentic local culture, and (ii) local gastronomy. This preference for local products is a characteristic observed in the segments of health tourists (Smith & Puczko, 2014) and slow-food tourists (Lee, Scott, & Packer, 2014). ART and the concept of the Therapeutic Landscape give support to the restorative capacity of cultural landscapes, where experiences related to local culture are linked to the components of ART, i.e. 'fascination' (to be effortlessly immersed in the destination), 'the sense of awayness' (Lehto, 2013) and 'novelty and escape' (Pals, Steg, Siero & Van der Zee, 2009).

In relation to the link between local gastronomy, well-being and healthy destination image, it should be noted that there can be a dichotomy with respect to the perceived impact of local food on health and well-being. From the nutritional and taste point of view, local food does not always imply better perceptions of well-being and often involves the opposite of good health (Brown, Edwards, & Hartwell, 2010). However, the present study shows that there are public health issues such as food safety, the offer of special diet products and the possibility of consuming organic and locally sourced healthy food, which influence how tourists perceive well-being experiences associated with the gastronomy at the destination. That is, the results proved that the perceived well-being and the gastronomy experience of the destination (Björk & Kauppinen-Räisänen, 2017) are determined by the perception of a sound public health management. Murray, Hartwell, Feldmann & Mahadevan (2015) argue that the importance of this issue has not been sufficiently considered in hospitality and tourism management.

Lastly, this study supports that residents' attitudes of kindness and hospitality are elements that influence tourists' perceived health and well-being experiences of a destination. There is strong evidence that social relationships are positive for health (Cohen, 2004). According to Pearce (2012), the positive social support that tourists receive from residents – among which are kindness and hospitality – contributes to tourists' well-being and health. Positive social relationships “have the great potential to improve our mood and the resulting positive emotions of assisting our health” (Pearce, 2012, p. 22). In the field of positive psychology, Filep, Macnaughton, and Glover (2017) explore the value of social interaction in tourism, arguing that acts of kindness and gratitude are an important component of tourists' well-being, integrating the concept of temporary social capital into this model (Filep et al., 2017).

7. Conclusions

Many destinations around the world are trying to focus on generating successful health and well-being tourist experiences as part of their strategies of tourist product development. However, any health tourism strategy should take into account the importance of the promotion of an authentic health destination capable of offering tourists a complete and integral health experience. This study has focused on the relationships between health destination image and health-improvement expectations on the behalf of tourists when deciding upon a health and well-being tourist experience. To this end, the affective and cognitive health destination image and tourists' health expectations were analysed with a sample of general tourists from three origin countries, who evaluated the profile of two alternative international tourist destinations from an overall health perspective. The conceptual framework of the empirical study is based on the theoretical and empirical foundations of destination image and tourist expectation, health environmental psychology, therapeutic landscapes and the social ecological model of health.

One of the main contributions of this paper is that the healthy destination image and tourists' perceived expectations of health improvement if going to a destination, are influenced by two cognitive dimensions: (i) human-made perceived environment factors associated with health, and (ii) well-being settings and situations in the destination. The well-being settings and situations dimension includes those factors related to the experiences associated with the destinations that tourists perceive as restorative and health improvers. In line with theoretical foundations, tourists anticipate the ideas of a healthy destination in their minds based on perceptions of activities in nature, local gastronomy, culture, landscapes with therapeutic capabilities and residents' kindness and hospitality. The perceptions of these destinations' well-being properties are influenced by the perceived human-made health environment dimension, which includes the health systems, the management of the natural environment and the accessibility of the destination.

Health destination image depends on the absence of significant barriers to participation in tourism for people with special needs. Thus, accessibility is a determining factor of the health destination imagine for all tourists, and not only for those with special needs. The perceived quality of health care services for residents and the perceived promotion of their health and well-being by health authorities are other factors that are found to be strongly related to the perception of a healthy destination image. On the other hand, the perceived kindness of residents is an attribute that forms part of the experiences that condition the health destination image.

In addition, the destination's environmental factors associated with health influence both the healthy destination image and the overall health improvement expectation. The enjoyment of a tourist experience necessarily involves the presence of the individual at a holiday destination. For this immersion to be healthy there must be a perceived environment that enhances and protects health, in balance with other resources facilitating tourists' well-being at destinations. This relationship can be explained within the conceptual framework of ART adapted to tourism (see Lehto, 2013; Lehto et al., 2017). One of the components of this theoretical model is 'compatibility', i.e. a tourist destination should be a place that 'stays true to itself' and is “in harmony with its natural and cultural surroundings” (Lehto, 2013, p. 335).

Furthermore, the theoretical conceptualisation supported by the

empirical results of this study demonstrates the relevance that tourists give to factors related to public health in the formation of a healthy destination image and health improvement expectation. These factors are related to aspects such as the quality of health and emergency services, the control of contagious diseases, food safety, the offer of special diets products, the possibility of consuming healthy food, residents' health and well-being promotion, the natural environment of destinations and the absence of the barriers to participation in tourism. Tourists perceive that health destinations are actually those places where health systems are integrated with tourism services.

Hartwell, Hemingway, Fyall, Filimonau, and Wall (2012) propose a conceptual model to explain the fusion between the philosophy of public health and tourism. According to these authors 'both public health and tourism strategy can focus on promoting sustainability and reducing inequalities' where 'tourism policies, destination marketing and the adoption of public health participatory approaches can enhance and promote physical and mental health for both locals and tourists' (p. 1073). In subsequent research, Fyall et al. (2013) propose the need to stimulate a more holistic healthy destination culture in tourist destinations, through collaborative work and the integration of public health and tourism strategies, developing brand strategies to attract attention in the marketplace. In a stakeholder research study, Pyke, Hartwell, Blake, and Hemingway (2016) analyse the barriers that can be found to foster alliances between public health objectives and tourism strategy and policy when using well-being as a tourism asset. Along this line, Page et al. (2017) empirically analyse the practical possibilities of public engagement of tourist stakeholders and public health authorities in a UK coastal resort. The present study contributes to these research lines by demonstrating that the tourism image of a healthy destination depends on tourists' perceived relationships between public health, well-being and tourist experiences that benefit both visitors and residents. This has important implications for developing marketing and branding strategies, and for inducing the participation of tourism stakeholders in health policies at destinations.

In line with the conclusions raised by Martín, Beerli, and Nazzareno (2017) on general destination image, the present study demonstrates that in order to project a complete health destination image, there would be need for collaboration between all health and tourism stakeholders involved. A health-related destination image and health expectations about the destination are perceptions that the individual creates incorporating attributes of the destination in a holistic way, i.e. beyond the mere “tourism-specific experience” (Martín et al., 2017, p. 22).

The generalisation of the results of this paper presents some caveats and limitations that may serve as a basis for reflection and further research. These limitations follow from attempting to evaluate and analyse complex and multifactorial concepts such as a destination image (Gallarza et al., 2002) and health expectations (Jambroes et al., 2014). A first limitation follows from the difficulty of establishing causal relationships between the different dimensions of the theoretical model, since its empirical support is based on a cross-sectional sample and not on a longitudinal study. The image of a health destination – and even more the expectation of perceived health improvement at a destination – may also be explained by a multitude of psychological and motivational factors that go beyond the common attributes of destination image. It would be necessary to perform randomised and longitudinal studies to control for these and other confounding factors. Finally, in order to provide stronger support for the theoretical hypotheses about the inter-relationships between a healthy destination image, health expectations and perceived public health conditions, there would be need for further evidence of other source regions and tourism destinations

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

The authors would like to thank financial support for this research to Excmo. Cabildo Insular de La Palma, and also support from Project ECO2014-60058-P of the Ministry of Economy, Industry and Competitiveness of the Spanish Government, under European Union FEDER funding.

References

Agapito, D., Valle, P., & Mendes, J. (2014). The sensory dimension of tourist experiences: Capturing meaningful sensory-informed themes in southwest Portugal. *Tourism Management, 42*, 224–237. https://doi.org/10.1016/j.tourman.2013.11.011.

Anderson, J. C., & Gerbing, D. W. (1988). Structural equation modeling in practice: A review and recommended two-step approach. *Psychological Bulletin, 103*(3), 411.

Baker, D. M. A. (2015). Tourism and the health effects of infectious diseases: Are there potential risks for tourists? *International Journal of Safety and Security in Tourism and Hospitality, 1*(12), 1–17.

Baloglu, S., & Brinberg, D. (1997). Affective images of tourism destinations. *Journal of Travel Research, 35*(4), 11–15.

Baloglu, S., & Mangaloglu, M. (2001). Tourism destination images of Turkey, Egypt, Greece, and Italy as perceived by US-based tour operators and travel agents. *Tourism Management, 22*(1), 1–9. https://doi.org/10.1016/S0261-5177(00)00030-3.

Baloglu, S., & McCleary, K. W. (1999). A model of destination image formation. *Annals of Tourism Research, 26*(4), 868–897.

Becken, S., Jin, X., Zhang, C., & Gao, J. (2017). Urban air pollution in China: Destination image and risk perceptions. *Journal of Sustainable Tourism, 25*(1), 130–147.

Beerli, A., & Martín, J. D. (2004a). Factors influencing destination image. *Annals of Tourism Research, 31*(3), 657–681. https://doi.org/10.1016/j.annals.2004.01.010.

Beerli, A., & Martín, J. D. (2004b). Tourists’ characteristics and the perceived image of tourist destinations: A quantitative analysis—a case study of Lanzarote, Spain. *Tourism Management, 25*(5), 623–636. https://doi.org/10.1016/j.tourman.2003.06.004.

Bell, S. L., Phoenix, C., Lovell, R., & Wheeler, B. W. (2015). Seeking everyday well-being: The coast as a therapeutic landscape. *Social Science & Medicine, 142*, 56–67. https://doi.org/10.1016/j.socscimed.2015.08.011.

Berto, R. (2014). The role of nature in coping with psycho-physiological stress: A literature review on restorativeness. *Behavioral Sciences, 4*(4), 394–409.

Bettcher, D. W., Sapirie, S. A., & Goon, E. H. (1998). Essential public health functions: Results of the international Delphi study. *World Health Organization Statistic Quarterly, 51*(1), 44–54.

Bigné, J. E., Sánchez, M. I., & Sánchez, J. (2001). Tourism image, evaluation variables and after purchase behaviour: Inter-relationship. *Tourism Management, 22*(6), 607–616. https://doi.org/10.1016/S0261-5177(01)00035-8.

Bigné, E., Sánchez, I., & Sanz, S. (2009). The functional-psychological continuum in the cognitive image of a destination: A confirmatory analysis. *Tourism Management, 30*(5), 715–723. https://doi.org/10.1016/j.tourman.2008.10.020.

Bimonte, S., & Faralla, V. (2014). Happiness and nature-based vacations. *Annals of Tourism Research, 46*, 176–178.

Björk, P., & Kauppinen-Räisänen, H. (2017). A destination's gastronomy as a means for holiday well-being. *British Food Journal, 119*, 1578–1591.

Blake, A., Sinclair, M. T., & Sugiyarto, G. (2003). Quantifying the impact of foot and mouth disease on tourism and the UK economy. *Tourism Economics, 9*(4), 449–465.

Bollen, K. A., & Noble, M. D. (2011). Structural equation models and the quantification of behavior. *Proceedings of the National Academy of Sciences, 108*(Supplement_3), 15639–15646. https://doi.org/10.1073/pnas.1010661108.

Booth, M. L., Owen, N., Bauman, A., Clavisi, O., & Leslie, E. (2000). Social–cognitive and perceived environment influences associated with physical activity in older Australians. *Preventive Medicine, 31*(1), 15–22.

Bowler, D. E., Buyung-Ali, L. M., Knight, T. M., & Pullin, A. S. (2010). A systematic review of evidence for the added benefits to health of exposure to natural environments. *BMC Public Health, 10*(1), 456.

Brewster, L. (2014). The public library as therapeutic landscape: A qualitative case study. *Health & Place, 26*, 94–99. https://doi.org/10.1016/j.healthplace.2013.12.015.

Brink, P. T., Mutafoglu, K., Schweitzer, J.-P., Kettunen, M., Twigger-Ross, C., Kuipers, Y., et al. (2016). *The health and social benefits of nature and biodiversity protection.* London/Brussels: Institute for European Environmental Policy https://doi.org/10.13140/RG.2.1.4312.2807.

Brislin, R. (1986). The wording and translation of research instruments. In W. J. Lonner, & J. W. Berry (Vol. Eds.), *Cross-cultural research and methodology series: Vol. 8*, (pp. 137–164). Sage Publications, Inc.

Brown, L., Edwards, J., & Hartwell, H. (2010). A taste of the unfamiliar. Understanding the meanings attached to food by international postgraduate students in England. *Appetite, 54*(1), 202–207.

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6*(1), 97–113.

Buhalis, D., & Darcy, S. (2011). *Accessible tourism:Concepts and issues.* Bristol: Channel View Publications.

Byon, K. K., & Zhang, J. J. (2010). Development of a scale measuring destination image.

Marketing Intelligence & Planning, 28(4), 508–532. https://doi.org/10.1108/02634501011053595.
Caldwell, E. M., Kobayashi, M. M., DuBow, W. M., & Wytinck, S. M. (2009). Perceived access to fruits and vegetables associated with increased consumption. *Public Health Nutrition, 12*(10), 1743–1750.
Carballo, M. M., Araña, J. E., León, C. J., & Moreno-Gil, S. (2015). Economic valuation of tourism destination image. *Tourism Economics, 21*(4), 741–759. https://doi.org/10.5367/te.2014.0381.
Carter, S. (1998). Tourists' and travellers' social construction of Africa and Asia as risky locations. *Tourism Management, 19*(4), 349–358. https://doi.org/10.1016/S0261-5177(98)00032-6.
Chang, L. (2014). The relationship between nature-based tourism and autonomic nervous system function among older adults. *Journal of Travel Medicine, 21*(3), 159–162. https://doi.org/10.1111/jtm.12108.
Chen, C.-C., & Petrick, J. F. (2013). Health and wellness benefits of travel experiences: A literature review. *Journal of Travel Research, 52*(6), 709–719. https://doi.org/10.1177/0047287513496477.
Chen, C.-F., & Phou, S. (2013). A closer look at destination: Image, personality, relationship and loyalty. *Tourism Management, 36*, 269–278. https://doi.org/10.1016/j.tourman.2012.11.015.
Chen, L. I. L., Scott, N., & Benckendorff, P. (2017). Mindful tourist experiences: A Buddhist perspective. *Annals of Tourism Research, 64*, 1–12. https://doi.org/10.1016/j.annals.2017.01.013.
Cherifi, B., Smith, A., Maitland, R., & Stevenson, N. (2014). Destination image of non-visitors. *Annals of Tourism Research, 49*, 190–202. https://doi.org/10.1016/j.annals.2014.09.008.
Cheung, G. W., & Lau, R. S. (2008). Testing mediation and suppression effects of latent variables: Bootstrapping with structural equation models. *Organizational Research Methods, 11*(2), 296–325.
Chi, C. G., & Qu, H. (2008). Examining the structural relationships of destination image, tourist satisfaction and destination loyalty: An integrated approach. *Tourism Management, 29*(4), 624–636. https://doi.org/10.1016/j.tourman.2007.06.007.
Choi, W. M., Chan, A., & Wu, J. (1999). A qualitative and quantitative assessment of Hong Kong's image as a tourist destination. *Tourism Management, 20*(3), 361–365.
Cohen, E. (1988). Tourism and AIDS in Thailand. *Annals of Tourism Research, 15*(4), 467–486. https://doi.org/10.1016/0160-7383 (88)90044-8.
Cohen, S. (2004). Social relationships and health. *American Psychologist, 59*(8), 676–684. https://doi.org/10.1037/0003-066x.59.8.676.
Cossens, J., & Gin, S. (1994). Tourism and AIDS: The perceived risk of HIV infection on destination choice. *Journal of Travel & Tourism Marketing, 3*(4), 1–20.
Crouch, G. (2011). Destination competitiveness: An analysis of determinant attributes. *Journal of Travel Research, 50*(1), 27–45.
Del Bosque, I. R., & Martín, H. S. (2008). Tourist satisfaction: A cognitive-affective model. *Annals of Tourism Research, 35*(2), 551–573. https://doi.org/10.1016/j.annals.2008.02.006.
Deng, Q., & Li, M. (2014). A model of event–destination image transfer. *Journal of Travel Research, 53*(1), 69–82. https://doi.org/10.1177/0047287513491331.
Dolnicar, S. (2005). Understanding barriers to leisure travel: Tourist fears as a marketing basis. *Journal of Vacation Marketing, 11*(3), 197–208. https://doi.org/10.1177/1356766705055706.
Dolnicar, S., Yanamandram, V., & Cliff, K. (2012). The contribution of vacations to quality of life. *Annals of Tourism Research, 39*(1), 59–83.
Donohoe, H., Pennington-Gray, L., & Omodior, O. (2015). Lyme Disease: Current issues, implications, and recommendations for tourism management. *Tourism Management, 46*, 408–418. https://doi.org/10.1016/j.tourman.2014.07.006.
Duff, C. (2011). Networks, resources and agencies: On the character and production of enabling places. *Health & Place, 17*(1), 149–156. https://doi.org/10.1016/j.healthplace.2010.09.012.
Duncan, M. J., Spence, J. C., & Mummery, W. K. (2005). Perceived environment and physical activity: A meta-analysis of selected environmental characteristics. *International Journal of Behavioral Nutrition and Physical Activity, 2*(1), 11.
Dwyer, L., Edwards, D., Mistilis, N., Roman, C., & Scott, N. (2009). Destination and enterprise management for a tourism future. *Tourism Management, 30*(1), 63–74. https://doi.org/10.1016/j.tourman.2008.04.002.
Echtner, C. M., & Ritchie, J. B. (1993). The measurement of destination image: An empirical assessment. *Journal of Travel Research, 31*(4), 3–13.
Eichhorn, V., Miller, G., & Tribe, J. (2013). Tourism: A site of resistance strategies of individuals with a disability. *Annals of Tourism Research, 3*, 578–600. https://doi.org/10.1016/j.annals.2013.03.006.
European Commission. (2015). *Preferences of Europeans towards tourism report. Luxembourg*.
Fakeye, P. C., & Crompton, J. L. (1991). Image differences between prospective, first-time, and repeat visitors to the lower Rio Grande valley. *Journal of Travel Research, 30*(2), 10–16. https://doi.org/10.1177/004728759103000202.
Ferrer, J. G., Sanz, M. F., Ferrandis, E. D., McCabe, S., & García, J. S. (2016). Social tourism and healthy ageing. *International Journal of Tourism Research, 18*(4), 297–307. https://doi.org/10.1002/jtr.2048.
Filep, S. (2014). Consider prescribing tourism. *Journal of Travel Medicine, 21*(3), 150–152. https://doi.org/10.1111/jtm.12104.
Filep, S., Macnaughton, J., & Glover, T. (2017). Tourism and gratitude: Valuing acts of kindness. *Annals of Tourism Research, 66*, 26–36. https://doi.org/10.1016/j.annals.2017.05.015.
Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable variables and measurement error. *Journal of Marketing Research, 18*(1), 39. https://doi.org/10.2307/3151312.
Frumkin, H. (2001). Beyond toxicity: Human health and the natural environment. *American Journal of Preventive Medicine, 20*(3), 234–240.
Fyall, A., Hartwell, H., & Hemingway, A. (2013). Public health, well-being & tourism: Opportunities for the branding of tourism destinations. *Tourism Tribune, 28*(2), 16–19.
Gallarza, M. G., Saura, I. G., & Garcia, H. C. (2002). Destination image: Towards a conceptual framework. *Annals of Tourism Research, 29*(1), 56–78. https://doi.org/10.1016/S0160-7383(01)00031-7.
Gesler, W. M. (1992). Therapeutic landscapes: Medical issues in light of the new cultural geography. *Social Science & Medicine, 34*(7), 735–746.
Gesler, W. (2005). Therapeutic landscapes: An evolving theme. *Health & Place, 11*(4), 295–297. https://doi.org/10.1016/j.healthplace.2005.02.003.
Gibson, W. J., & Brown, A. (2009). *Working with qualitative data*. London: Sage.
Grinde, B., & Patil, G. G. (2009). Biophilia: Does visual contact with nature impact on health and well-being? *International Journal of Environmental Research and Public Health, 6*(9), 2332–2343. https://doi.org/10.3390/ijerph6092332.
Guralnik, J., Fried, L., & Salive, M. (1996). Disability as a public health outcome in the aging population. *Annual Review of Public Health, 17*, 25.
Hair, J. F., Black, W. C., Babin, J. B., & Anderson, R. E. (2010). *Multivariate data analysis: A global perspective*. Upper Saddle River, NJ: Pearson Education.
Hartig, T., Mitchell, R., de Vries, S., & Frumkin, H. (2014). Nature and health. *Annual Review of Public Health, 35*(1), 207–228. https://doi.org/10.1146/annurev-publhealth-032013-182443.
Hartwell, H., Fyall, A., Willis, C., Page, S., Ladkin, A., & Hemingway, A. (2018). Progress in tourism and destination well-being research. *Current Issues in Tourism, 21*(16), 1830–1892. https://doi.org/10.1080/13683500.2016.1223609.
Hartwell, H., Hemingway, A., Fyall, A., Filimonau, V., & Wall, S. (2012). Tourism engaging with the public health agenda: Can we promote 'wellville' as a destination of choice? *Public Health, 126*(12), 1072–1074. https://doi.org/10.1016/j.puhe.2012.08.013.
Heath, E. (2002). Towards a model to enhance destination competitiveness: A southern African perspective. *Journal of Hospitality and Tourism Management, 10*(2), 124–141.
Herzog, T. R., Ouellette, P., Rolens, J. R., & Koenigs, A. M. (2009). Houses of worship as restorative environments. *Environment and Behavior, 42*(4), 395–419. https://doi.org/10.1177/0013916508328610.
Heung, V. C. S., & Kucukusta, D. (2013). Wellness tourism in China: Resources, development and marketing. *International Journal of Tourism Research, 15*(4), 346–359. https://doi.org/10.1002/jtr.1880.
Jamal, T. B., & Getz, D. (1995). Collaboration theory and community tourism planning. *Annals of Tourism Research, 22*(1), 186–204.
Jambroes, M., Nederland, T., Kaljouw, M., van Vliet, K., Essink-Bot, M.-L., & Ruwaard, D. (2014). A new concept of health—implications for public health policy and practice: A qualitative analysis. *The Lancet, 384*, S39.
Jin, Q., Hu, H., & Kavan, P. (2016). Factors influencing perceived crowding of tourists and sustainable tourism destination management. *Sustainability, 8*(10), 976.
Jin, Q., & Pearce, P. (2011). Tourist perception of crowding and management approaches at tourism sites in Xi'an. *Asia Pacific Journal of Tourism Research, 16*(3), 325–338. https://doi.org/10.1080/10941665.2011.572667.
Jonas, A., Mansfeld, Y., Paz, S., & Potasman, I. (2011). Determinants of health risk perception among low-risk-taking tourists travelling to developing countries. *Journal of Travel Research, 50*(1), 87–99. https://doi.org/10.1177/0047287509355323.
Kaplan, S. (1995). The restorative benefits of nature: Toward an integrative framework. *Journal of Environmental Psychology, 15*(3), 169–182. https://doi.org/10.1016/0272-4944(95)90001-2.
Kim, J.-H. (2014). The antecedents of memorable tourism experiences: The development of a scale to measure the destination attributes associated with memorable experiences. *Tourism Management, 44*, 34–45. https://doi.org/10.1016/j.tourman.2014.02.007.
Kirillova, K., Fu, X., Lehto, X., & Cai, L. (2014). What makes a destination beautiful? Dimensions of tourist aesthetic judgment. *Tourism Management, 42*, 282–293. https://doi.org/10.1016/j.tourman.2013.12.006.
Kline, R. B. (2011). *Principles and practice of structural equation modelling* (3rd ed.). New York, NY: Guilford Press.
Kock, F., Josiassen, A., & Assaf, A. G. (2016). Advancing destination image: The destination content model. *Annals of Tourism Research, 61*, 28–44. https://doi.org/10.1016/j.annals.2016.07.003.
Kogiso, K. (2012). Thai Massage and health tourism in Thailand: Tourism acculturation process of "Thai Massage". *International Journal of Sport and Health Science, 10*, 65–70 0.
Learmonth, A., & Curtis, S. (2013). Place shaping to create health and well-being using health impact assessment: Health geography applied to develop evidence-based practice. *Health & Place, 24*, 20–22. https://doi.org/10.1016/j.healthplace.2013.07.011.
Lee, C.-F. (2016). An investigation of factors determining industrial tourism attractiveness. *Tourism and Hospitality Research, 16*(2), 184–197. https://doi.org/10.1177/1467358415600217.
Lee, H. Y., Bonn, M. A., Reid, E. L., & Kim, W. G. (2017). Differences in tourist ethical judgment and responsible tourism intention: An ethical scenario approach. *Tourism Management, 60*, 298–307. https://doi.org/10.1016/j.tourman.2016.12.003.
Lee, K.-H., Scott, N., & Packer, J. (2014). Habitus and food lifestyle: In-destination activity participation of Slow Food members. *Annals of Tourism Research, 48*, 207–220. https://doi.org/10.1016/j.annals.2014.06.009.
Lehto, X. Y. (2013). Assessing the perceived restorative qualities of vacation destinations. *Journal of Travel Research, 52*(3), 325–339. https://doi.org/10.1177/0047287512461567.
Lehto, X., Kirillova, K., Li, H., & Wu, W. (2017). A cross-cultural validation of the perceived destination restorative qualities scale: The Chinese perspective. *Asia Pacific*

Journal of Tourism Research, 22(3), 329–343. https://doi.org/10.1080/10941665.2016.1250794.
León, C. J., de León, J., Araña, J. E., & González, M. M. (2015). Tourists' preferences for congestion, residents' welfare and the ecosystems in a national park. *Ecological Economics, 118*, 21–29. https://doi.org/10.1016/j.ecolecon.2015.07.003.
Lepp, A., & Gibson, H. (2003). Tourist roles, perceived risk and international tourism. *Annals of Tourism Research, 30*(3), 606–624. https://doi.org/10.1016/S0160-7383(03)00024-0.
Mak, A. H. N., Lumbers, M., Eves, A., & Chang, R. C. Y. (2016). The effects of food-related personality traits on tourist food consumption motivations. *Asia Pacific Journal of Tourism Research, 22*(1), 1–20. https://doi.org/10.1080/10941665.2016.1175488.
Martín, J., Beerli, A., & Nazzareno, P. (2017). Antecedents and consequences of destination image gap. *Annals of Tourism Research, 62*, 13–25. https://doi.org/10.1016/j.annals.2016.11.001.
McCabe, S. (2009). Who needs a holiday? Evaluating social tourism. *Annals of Tourism Research, 36*(4), 667–688. https://doi.org/10.1016/j.annals.2009.06.005.
Medina-Muñoz, D., & Medina-Muñoz, R. (2014). The attractiveness of wellness destinations: An importance-performance-satisfaction approach. *International Journal of Tourism Research, 16*(6), 521–533. https://doi.org/10.1002/jtr.1944.
Menatti, L., & Casado, A. (2016). Landscape and health: Connecting psychology, aesthetics, and philosophy through the concept of affordance. *Frontiers in Psychology, 7*, 571. https://doi.org/10.3389/fpsyg.2016.00571.
Mihalič, T. (2000). Environmental management of a tourist destination: A factor of tourism competitiveness. *Tourism Management, 21*(1), 65–78. https://doi.org/10.1016/S0261-5177(99)00096-5.
Molina-Azorín, J. F., & Font, X. (2016). Mixed methods in sustainable tourism research: An analysis of prevalence, designs and application in JOST (2005–2014). *Journal of Sustainable Tourism, 24*(4), 549–573.
Murray, D. W., Hartwell, H., Feldman, C. H., & Mahadevan, M. (2015). Salt, chefs, and public health: An exploratory investigation of hospitality professionals. *British Food Journal, 117*(5), 1610–1618.
Noree, T., Hanefeld, J., & Smith, R. (2016). Medical tourism in Thailand: A cross-sectional study. *Bulletin of the World Health Organization, 94*(1), 30–36. https://doi.org/10.2471/BLT.14.152165.
Nunkoo, R., Ramkissoon, H., & Gursoy, D. (2013). Use of structural equation modeling in tourism research: Past, present, and future. *Journal of Travel Research, 52*(6), 759–771.
Ohly, H., White, M., Wheeler, B., Bethel, A., Ukoumunne, O., Nikolaou, V., et al. (2016). Attention restoration theory: A systematic review of the attention restoration potential of exposure to natural environments. *Journal of Toxicology and Environmental Health, Part B. 19*(7), 305–343. https://doi.org/10.1080/10937404.2016.1196155.
Packer, J. (2014). Visitors' restorative experiences in museum and botanic garden environments. In S. Filep, & P. Pearce (Eds.). *Tourist experience and fulfilment: Insights from positive psychology* (pp. 202–222). Oxford: Routledge. https://doi.org/10.4324/9780203134580.
Pagán, R. (2012). Time allocation in tourism for people with disabilities. *Annals of Tourism Research, 39*(3), 1514–1537. https://doi.org/10.1016/j.annals.2012.04.005.
Page, S. J., Hartwell, H., Johns, N., Fyall, A., Ladkin, A., & Hemingway, A. (2017). Case study: Wellness, tourism and small business development in a UK coastal resort: Public engagement in practice. *Tourism Management, 60*, 466–477. https://doi.org/10.1016/j.tourman.2016.12.014.
Pals, R., Steg, L., Siero, F., & &Van der Zee, K. (2009). Development of the PRCQ: A measure of perceived restorative characteristics of zoo attractions. *Journal of Environmental Psychology, 29*(4), 441–449.
Parra, D. C., Hoehner, C. M., Hallal, P. C., Ribeiro, I. C., Reis, R., Brownson, et al. (2011). Perceived environment correlates of physical activity for leisure and transportation in Curitiba, Brazil. *Preventive Medicine, 52*(3–4), 234–238.
Pearce, P. (2012). Relationships and the tourism experience: Challenges for quality-of-life assessments. In M. Uysal, R. Perdue, & M. Sirgy (Eds.). *Handbook of tourism and quality-of-life research* (pp. 9–29). Dordrecht: Springer.
Pearson, D., & Craig, T. (2014). The great outdoors? Exploring the mental health benefits of natural environments. *Frontiers in Psychology, 5*. https://doi.org/10.3389/fpsyg.2014.01178.
Pike, S. (2002). Destination image analysis-a review of 142 papers from 1973 to 2000. *Tourism Management, 23*(5), 541–549. https://doi.org/10.1016/S0261-5177(02)00005-5.
Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS procedures for estimating indirect effects in simple mediation models. *Behavior Research Methods, Instruments, & Computers, 36*(4), 717–731.
Prüss-Ustün, A., Wolf, J., Corvalán, C., Neville, T., Bos, R., & Neira, M. (2016). Diseases due to unhealthy environments: An updated estimate of the global burden of disease attributable to environmental determinants of health. *Journal of Public Health, 39*(3), 464–475.
Puchta, C., & Potter, J. (2004). *Focus group practice. London.* Thousand Oaks, CA: Sage.
Pyke, S., Hartwell, H., Blake, A., & Hemingway, A. (2016). Exploring well-being as a tourism product resource. *Tourism Management, 55*, 94–105.
Rabbiosi, C. (2016). Place branding performances in tourist local food shops. *Annals of Tourism Research, 60*, 154–168. https://doi.org/10.1016/j.annals.2016.07.002.
Rantala, O., & Valtonen, A. (2014). A rhythm analysis of touristic sleep in nature. *Annals of Tourism Research, 47*, 18–30. https://doi.org/10.1016/j.annals.2014.04.001.
Ritchie, J., Spencer, L., & O'Connor, W. (2013). Carrying out qualitative analysis. In J. Ritchie, J. Lewis, C. M. Nicholls, & R. Ormston (Eds.). *Qualitative research practice: A guide for social science students and researchers* (pp. 219–262). London: Sage.
Rittichainuwat, B. N., & Chakraborty, G. (2009). Perceived travel risks regarding terrorism and disease: The case of Thailand. *Tourism Management, 30*(3), 410–418. https://doi.org/10.1016/j.tourman.2008.08.001.
Robinson, R. N. S., & Clifford, C. (2012). Authenticity and festival foodservice experiences. *Annals of Tourism Research, 39*(2), 571–600. https://doi.org/10.1016/j.annals.2011.06.007.
Rosenbaum, M., Otalora, M., & Ramírez, G. (2016). The restorative potential of shopping malls. *Journal of Retailing and Consumer Services, 31*, 157–165. https://doi.org/10.1016/j.jretconser.2016.02.011.
Rosselló, J., Santana, M., & Awan, W. (2017). *Infectious disease risk and international tourism demand. Health Policy and Planning.* https://doi.org/10.1093/heapol/czw177.
Russell, R., Guerry, A. D., Balvanera, P., Gould, R. K., Basurto, X., Chan, K. M. A., et al. (2013). Humans and nature: How knowing and experiencing nature affect well-being. *Annual Review of Environment and Resources, 38*(1), 473–502. https://doi.org/10.1146/annurev-environ-012312-110838.
Sallis, J. F., Cervero, B., Ascher, W., Henderson, K. A., Kraft, M. K., & Kerr, J. (2006). An ecological approach to creating active living communities. *Annual Review of Public Health, 27*, 297–322.
San Martín, H., & Del Bosque, I. A. R. (2008). Exploring the cognitive–affective nature of destination image and the role of psychological factors in its formation. *Tourism Management, 29*(2), 263–277.
Scopelliti, M., & Vittoria Giuliani, M. (2004). Choosing restorative environments across the lifespan: A matter of place experience. *Journal of Environmental Psychology, 24*(4), 423–437. https://doi.org/10.1016/j.jenvp.2004.11.002.
Sharpley, R., & Jepson, D. (2011). Rural tourism. A spiritual experience? *Annals of Tourism Research, 38*(1), 52–71. https://doi.org/10.1016/j.annals.2010.05.002.
Smith, M., & Diekmann, A. (2017). Tourism and well-being. *Annals of Tourism Research, 66*, 1–13. https://doi.org/10.1016/j.annals.2017.05.006.
Smith, M., & Puczko, L. (2014). *Health, tourism and hospitality: Spas, wellness and medical travel.* London: Routledge.
Staats, H., & Hartig, T. (2004). Alone or with a friend: A social context for psychological restoration and environmental preferences. *Journal of Environmental Psychology, 24*(2), 199–211. https://doi.org/10.1016/j.jenvp.2003.12.005.
Stokols, D. (1992). Establishing and maintaining healthy environments: Toward a social ecology of health promotion. *American Psychologist, 47*, 6–22.
Strauss-Blasche, G., Reithofer, B., Schobersberger, W., Ekmekcioglu, C., & Wolfgang, M. (2005). Effect of vacation on health: Moderating factors of vacation outcome. *Journal of Travel Medicine, 12*(2), 94–101.
Su, L., & Swanson, S. R. (2017). The effect of destination social responsibility on tourist environmentally responsible behavior: Compared analysis of first-time and repeat tourists. *Tourism Management, 60*, 308–321. https://doi.org/10.1016/j.tourman.2016.12.011.
Towers, N., & Pratten, J. (2003). Managing special dietary needs for food allergies in the hospitality industry: A survey based on the coeliac disorder. *International Journal of Hospitality Management, 22*(4), 341–351.
Velarde, M. D., Fry, G., & Tveit, M. (2007). Health effects of viewing landscapes: Landscape types in environmental psychology. *Urban Forestry and Urban Greening, 6*(4), 199–212. https://doi.org/10.1016/j.ufug.2007.07.001.
Voigt, C., & Pforr, C. (2013). *Wellness tourism: A destination perspective.* London: Routledge.
Wang, C., Qu, H., & Hsu, M. K. (2016). Toward an integrated model of tourist expectation formation and gender difference. *Tourism Management, 54*, 58–71. https://doi.org/10.1016/j.tourman.2015.10.009.
Weston, R., & Gore, P. A. (2006). A brief guide to structural equation modeling. *The Counseling Psychologist, 34*(5), 719–751. https://doi.org/10.1177/0011000006286345.
Whittaker, A., & Chee, H. L. (2015). Perceptions of an 'international hospital' in Thailand by medical travel patients: Cross-cultural tensions in a transnational space. *Social Science & Medicine, 124*, 290–297. https://doi.org/10.1016/j.socscimed.2014.10.002.
WHO (2011). *World report on disability*. Retrieved 10.10.18 from http://www.who.int/disabilities/world_report/2011/en/.
WHO (2017). *WHO. Health services.* Retrieved 15.01.19 from: http://www.who.int/topics/health_services/en.
WHO (2019). *Public health, environmental and social determinants of health.* Retrieved 01.03.19 from http://www.who.int/phe/en/index.html.
Williams, A. (2010). Spiritual therapeutic landscapes and healing: A case study of St. Anne de Beaupre, Quebec, Canada. *Social Science & Medicine, 70*(10), 1633–1640. https://doi.org/10.1016/j.socscimed.2010.01.012.
Wolff, K., & Larsen, S. (2016). Flux and permanence of risk perceptions: Tourists' perception of the relative and absolute risk for various destinations. *Scandinavian Journal of Psychology, 57*(6), 584–590. https://doi.org/10.1111/sjop.12326.
Woosnam, K. M. (2010). Comparing residents' and tourists' emotional solidarity with one another. *Journal of Travel Research, 50*(6), 615–626. https://doi.org/10.1177/0047287510382299.
World Tourism Organization (2016). *Tourism for all: Promoting universal accessibility. Good practices in the accessible tourism supply chain.* Retrieved 10.10.18 from http://www.e-nwto.org/doi/pdf/10.18111/9789284418138.
World Tourism Organization and European Travel Commission. (2018). *Exploring health tourism.* Madrid: UNWTOhttps://doi.org/10.18111/9789284420209.
Yuksel, F., Bramwell, B., & Yuksel, A. (1999). Stakeholder interviews and tourism planning at Pamukkale, Turkey. *Tourism Management, 20*(3), 351–360.