

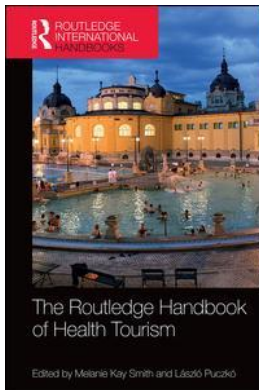
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An overview of lifestyle trends and their impacts on health tourism

Melanie Kay Smith

Introduction

This chapter provides an overview of some of the main lifestyle trends in Western developed countries that influence the health tourism sectors (e.g. spas, wellness hotels, retreats, medical facilities). This includes health developments, such as the increase in life expectancy and longevity, but the parallel decrease in healthy lifestyle practices. It includes the growing obsession with food, not only in positive directions such as healthier eating and local, homegrown produce, but also the more negative sides such as anorexia and other eating disorders like orthorexia. There is a focus on the importance of exercise and fitness for both health and happiness, while recognising that moderation can be as good as, if not better than, excess. Sleep deprivation and poor sleep quality are also growing problems for many people, and research suggests that the impacts of this are significant. Emphasis is placed on the need to slow down, to be more mindful, to decrease the use of technology and to (re)connect with nature. A positive outcome of this may be greener lifestyles and more sustainable approaches to hospitality and tourism. Work plays an important role in life but can also be a major source of stress and even depression. The use of complementary and alternative therapies appears to be growing, despite a convincing lack of evidence to prove their benefits. The implications of these and other trends are then considered for the health tourism sector in terms of product and service development.

A case study is given of research undertaken in 11 Balkan countries about self-perceived health and happiness levels of a representative sample of residents of those countries. Although they were not asked specifically about health tourism, data was collected about how important travel is for health and happiness, whether they travel outside their country to improve their health and happiness and which activities make them happiest. These findings (and others like these) may have implications for leisure and tourism developments in the future.

Healthy lifestyles

The definition of health has broadened in recent years to include not only the physical body, but mental and psychological health too. There are some doubts that conventional healthcare can provide all of the tools that one might need to lead a 'holistically' healthy life. As stated by

Crowley and Lodge (2007: 30), 'Modern medicine does not concern itself with lifestyle problems'. However, the concept of healthy lifestyles in Western, developed countries is a contested one. Research studies seem to emerge every few years which contradict previous studies that had influenced lifestyle trends for years (e.g. eggs are unhealthy; wine is good for health; coffee is bad for health; chocolate boosts mood; all fats are bad, only certain fats are bad). It is difficult even to define what is meant by a healthy lifestyle. Is it one where people live a long time or where they are happy for the time that they are alive (even if it is shorter)? Clearly, a long, happy, healthy life would be optimum, but this is not easy to define and even more difficult to achieve. According to the NHS (2013), despite a continuing trend of increasing life expectancy, overall, many adult populations are less healthy than they used to be in the past. They quote a study that was based on 6,000 adults in the Netherlands aged 20–59 comparing the prevalence of risk factors for stroke, heart disease and diabetes within different generations over a period of 16 years. 'Unfavourable generation shifts' were most pronounced for overweight or obesity, as well as high blood pressure and diabetes. However, it was also reported that a decrease in smoking and improved healthcare compensated for some of these increasing risks, explaining the still-growing life expectancy.

Jaslow (2013) quotes a US study in which researchers found that almost 39 per cent of baby boomers were obese, compared to about 29 per cent of adults in the previous generation. Boomers were also more inactive, with 52 per cent of them reporting a sedentary lifestyle with no physical activity, compared with only 17.4 per cent of the previous generation. Baby boomers were also more likely to have diabetes, high blood pressure and high cholesterol than their parents. Overall, 32 per cent of adults in the previous generation reported they were in 'excellent' health, compared with only 13 per cent of baby boomers.

King et al. (2009) support this finding in another study from the United States. The purpose of their study was to compare adherence to healthy lifestyle habits in adults between 1988 and 2006. The five healthy lifestyle trends included: five fruits and vegetables per day; regular exercise 12 times per month; maintaining healthy weight (body mass index 18.5–29.9 kg/m²); moderate alcohol consumption (up to one drink per day for women, two per day for men); and not smoking. Results from the National Health and Nutrition Examination Survey 1988–1994 were compared with results from the same survey for 2001–2006 among adults 40–74 years. Over the last 18 years, body mass index has increased from 28 per cent to 36 per cent; physical activity has decreased from 53 per cent to 43 per cent; smoking rates have not changed; eating five or more fruits and vegetables a day has decreased from 42 per cent to 26 per cent; and moderate alcohol use has increased from 26 per cent to 40 per cent. Adherence to all five healthy habits has gone from 15 per cent to 8 per cent. Overall, adherence to a healthy lifestyle pattern had decreased in three out of five healthy lifestyle habits.

It seems that there is some consensus about what constitutes a healthy lifestyle and what does not. The Harvard Health Letter (2015) quoted several studies: one large study which found that women who had six healthy lifestyle habits – not smoking, getting regular physical activity, eating a healthy diet, maintaining normal weight, drinking no more than one alcoholic drink per day and watching TV for 7 hours or less per week – were 92 per cent less likely to develop heart disease than those who did not have these lifestyle habits. Two notable studies found that the Mediterranean diet may improve cognitive function and slow the ageing process. Moderate exercise was found to be almost as beneficial as intensive exercise.

Wijnkoop et al. (2013) suggest that nutrition is undoubtedly a major modifiable determinant of disease. They give the example of how trials showed that dietary improvements were associated with between 65 and 72 per cent reduction in all-cause mortality, major cardiovascular events and stroke over the 5-year follow-up among those receiving the Mediterranean diet

compared with those on the American Heart Association diet. But for many people, quick-fix, faddy diets seem a much easier solution for weight loss than a new, long-term regime of healthy eating. However, it is fairly well documented that not only do diets not work, but that more weight will ultimately be gained as a result (Roth, 2010).

On the other hand, it is equally unhealthy to be overly preoccupied by food, diet and exercise. Orthorexia nervosa (ON) is an alleged eating disorder in which the person is excessively preoccupied with healthy food. ON entails a fixation on healthy food or a health food dependence. Fears and worries about health, eating and the quality of food are significant. In extreme cases, the obsessive and compulsive characteristics of ON become pathological and dominate a person's life. The pathological obsession with biologically pure food and shops which sell it leads to a special lifestyle. Orthorectic features are also related to lifestyle habits such as regular sports activity, more dietary restrictions and less alcohol intake and an inclination to persuade others about the importance of a healthy diet (Varga et al., 2014). The National Eating Disorders Association (2016) suggest that eating disorders have grown at an unprecedented rate over the past two decades and that nearly 50 years of research confirms that anorexia nervosa has the highest mortality rate of any psychiatric disorder. A negative body image is one of the main causes of this. Roy and Payette (2012) suggest that a negative body image has been linked with an array of unhealthy physical and mental health outcomes, including emotive, anxious and depressive disorders as well as psychological distress.

The role of exercise in health can be significant, but again, it is difficult to determine how much and what kind is best. Nunan et al. (2013) cite World Health Organization recommendations that all adults should aim for 30 minutes of moderate activity daily on at least 5 days over a 1-week period, with slight variants of these recommendations for children (under-5s and 5–18 years) and older adults (aged 65+). Paoli and Bianco (2015: 610) note that, although 'physical fitness' is not synonymous with 'wellness' or 'health', they conclude from a systematic review that 'beyond age, regular physical activity and a healthy lifestyle (so an increased fitness level) can help individuals in being "healthy"'. Ideally, they recommend a minimum of 60 minutes per day of physical activity. Crowley and Lodge (2007) have written popular self-help books for both men and women that advocate at least 6 days of exercise per week. They state the reason that people are so tired at the end of the day is because they do not get enough exercise. Part of this they attribute to losing touch with one's inherent and ancestral nature and the need for natural movement.

Another area of life that can positively or adversely affect health is sleep. In addition to physical activity, sleep has been shown to be a positive coping mechanism. Darling et al. (2012) quote a study of both genders that showed that subjects who slept less than 7 hours per day had a higher average body mass index and were more likely to be obese than subjects who reported getting 7 or more hours of sleep per day. In their own study, Darling et al. (2012) noted that those women who slept 7 or more hours per day perceived fewer family strains/changes, less health stress and a greater satisfaction with life. Shochat (2012) discusses the impact of lifestyle and technology trends on sleep quality, quantity and timing. Factors include excessive and constant use of technology (e.g. TV, computer, cell phone) and behavioural lifestyle factors like weight gain, insufficient exercise and consumption of caffeine, alcohol and nicotine. In addition to lifestyle changes and reduction of use of technology, especially close to bedtime or in the bedroom, Shochat (2012) suggests that exercise interventions have shown some benefits in sleep quality.

Technology use is also responsible for decreasing time spent outdoors and in nature. Richard Louv's work on nature deficit disorder (2005, 2012) suggests that human beings and especially children, have increasingly lost touch with nature and the natural environment, resulting in

attention problems, obesity, anxiety and depression. In his study of human happiness, Weil (2013: 41) states that 'Not only do we suffer from nature deficit, but we are also experiencing information surfeit'. He concludes that the modern, post-industrial lifestyles that human beings have created for themselves are incompatible with their true nature, which was to thrive in natural environments and in bonded social groups.

Khoury et al. (2013) concluded from their meta-analysis of existing studies on mindfulness-based therapy that it was effective in treating psychological disorders and showed large and clinically significant effects in treating anxiety and depression. Olano et al. (2015) provided an analysis of mindfulness practices (e.g. meditation, yoga, tai chi and qi gong) based on the US National Health Interview Survey from 2002, 2007 and 2012. They concluded that around 13 per cent of all adults engaged in at least one of the practices, but that men were approximately half as likely as women to engage in any of the practices and more than three times less likely to practise yoga.

Many people are exploring alternative forms of healthcare, including treatments and therapies and many are self-diagnosing and medicating using internet sites. Studies report that over 65 per cent of Japanese, 48.5 per cent of Australian, 20–50 per cent of European, the majority (80 per cent) of the Chinese and 42.1 per cent of people from the USA used complementary and alternative medicine (CAM) in the past year (Bomar, 2013). Versnik Nowak and Hale (2012) suggest that Americans are using increasing amounts of CAM. In the USA, 38.3 per cent of adults reported using at least one of 36 types of CAM therapies in the past 12 months. The most commonly used were non-vitamin, non-mineral, natural products (17.7 per cent), deep-breathing exercises (12.7 per cent), meditation (9.4 per cent), chiropractic or osteopathic manipulation (8.6 per cent), massage therapy (8.3 per cent) and yoga (6.1 per cent). The main increases seen are for acupuncture, deep-breathing exercises, massage therapy, meditation, naturopathy and yoga. Posadzki et al. (2012) undertook research on CAM use in the UK. The three most commonly used methods of CAM were acupuncture, homeopathy and relaxation therapy. Zheng and Xue (2013) describe how one-quarter of Australians are using one of the three CAM therapies: acupuncture, chiropractic and osteopathy. Versnik Nowak and Hale (2012) cite the National Center for Complementary and Alternative Medicine, which has organised CAM therapies into five main categories:

- 1 alternative medical systems (e.g. acupuncture, ayurveda, homeopathy, naturopathy, traditional Chinese medicine);
- 2 biologically based therapies and natural products (e.g. diet-based therapies, folk medicine, multivitamin therapy);
- 3 manipulative and body-based therapies (e.g. chiropractic/osteopathic, massage therapy, movement therapy);
- 4 mind–body therapies (e.g. aromatherapy, deep breathing, reiki, meditation, tai chi, qi gong, yoga);
- 5 other CAM therapies (e.g. crystal therapy, light therapy, energy healing, iridology, reflexology).

Bomar (2013) suggests that the reasons for increased use of CAMs are: (1) acceleration in the cost of healthcare; (2) a desire for increased health autonomy by consumers; (3) interest in new CAM healthcare options; (4) belief in holistic values and wellness promotion; and (5) Western medicine/mainstream medicine is not completely effective in meeting consumers' body–mind–spirit needs. A large proportion of doctors in the UK seem to employ CAM, but only 10 per cent had received any training. However, White et al. (2014) suggest that, although serious

CAM-related risks are low, CAM practice is provided outside the national healthcare systems and often practised by non-regulated personnel.

It seems that conventional medicine is only one route to health. The combination of a healthy diet, regular (moderate) exercise, mindfulness practices, contact with nature, as well as some alternative and complementary therapies can afford a surer way to holistic health. The following section explores in more depth some of the ways in which happiness levels can be enhanced further, also boosting health. Davidson and Begley (2013) note that people with high levels of positive emotion tend to rate their health as better than those with low levels of positive emotion even if objectively they are no healthier. On the other hand, there is some evidence to suggest that happier people show better health outcomes and that positive thinkers may live longer.

Happy lifestyles

Happiness is almost as contentious as health in terms of agreed definitions and characteristics. Happiness is often considered to be synonymous with ‘subjective wellbeing’ by positive psychologists (e.g. Diener et al., 1999). Ryan and Deci (2001) suggest that conceptualisations of wellbeing originate from two different philosophical traditions – the hedonic and the eudaimonic approach. The former is associated mainly with happiness, whereas the latter includes self-actualisation and fulfilling one’s potential. Helliwell and Putnam (2004) suggest that the optimum notion of happiness or living life well should include both perspectives. The World Health Organization (WHO, 1998) uses the WHO-5 scale to measure (subjective) wellbeing, which includes:

- I have felt cheerful and in good spirits.
- I have felt calm and relaxed.
- I have felt active and vigorous.
- I woke up feeling fresh and rested.
- My daily life has been filled with things that interest me.

One of the problems with undertaking research on happiness as suggested by Davidson and Begley (2013) is that researchers cannot trust respondents to tell them honestly and accurately how happy or satisfied they are. Feelings and emotions change from moment to moment depending on the weather or if people have had a bad day at work, for example. Therefore, it is always better to measure people’s levels of happiness longitudinally and across multiple moments and to aggregate the data. Power (2013: 145) suggests that “‘happiness’ is an over-worked and ambiguous word, which, it is argued, should be restricted and only used as the label for a brief emotional state that typically lasts a few seconds or minutes’. He also argues that being (over)-optimistic can be detrimental to health; for example, older people who are pessimistic and who experience health events often do better than older people who are optimists. This might be the case if someone were over-optimistic about a disease diagnosis and failed to receive treatment as a result, for example. Weil (2013: 21) states that, ‘The notion that a human being should be constantly happy is a uniquely modern, uniquely American, ultimately destructive idea’.

There is something of a consensus that happiness (as well as health and longevity) is dependent on a number of factors. These include:

- enjoyable or engaging work;
- social activities and a sense of community;
- altruism, helping others or volunteering;

- moderate exercise;
- healthy and light eating;
- enough rest and sleep (7 hours or more);
- living in the present/mindfulness practices;
- regular contact with nature and green spaces;
- spiritual or religious activities;
- slowing down, doing everything at the right speed.

(Chopra, 1993; Honoré, 2004; Haidt, 2006; Davidson and Begley, 2013; Weil, 2013)

Chopra (1993: 249) states that ‘successful aging is far more than the avoidance of disease, although that is important. It involves a lifelong commitment to oneself every day’. Health and happiness are viewed as states that require some effort to achieve. Haidt (2006) suggests that happiness comes from within and without and is about balance and adapting to different approaches at different stages of life (e.g. ancient and new, Eastern and Western). De Botton (2009) suggests that the role of work in people’s lives should not be underestimated, providing not only meaning in life but a distraction from life’s futility and thoughts of death. On the other hand, occupational stress is becoming a major problem for many people. Indeed, the Global Wellness Institute (GWI, 2016) recently brought out a research report which examines wellness at work and how to overcome disengagement and work-related stress.

Still, it is not enough to focus only on one’s individual sense of happiness and health. At the same time as losing touch with nature, many human beings have been over-consuming the earth’s resources, but Pretty (2013) demonstrates that environmental ‘overshoot’ has not actually increased wellbeing. The Happy Planet Index (New Economics Foundation, 2012) was one of the first wellbeing research studies to insist that it is not enough for societies to have a long life expectancy and to feel happy; they must also take some responsibility for the planet and issues of sustainability. Hence, the so-called ‘happiest’ countries in other surveys (e.g. Denmark in Eurofound, 2013 or Gallup, 2013) scored lower in the rankings because of their high carbon footprint. Ericson et al. (2014) insist that the trade-off between wellbeing and environment need not mean huge sacrifices. Many individuals feel that they cannot make enough difference to the planet because of the overwhelming influence of uncommitted governments and global corporations, but Colin Beaven (2009: 221) in *No Impact Man* stresses the power and responsibility of the individual: ‘We cannot wait for the system to change. We individuals are the system’. Ericson et al. (2014) suggest that mindfulness can increase people’s propensity to value nature and encourage sustainable behaviour. Indeed, mindfulness can have multiple benefits for healthy lifestyles.

Case study: health and happiness in the Balkan countries¹

Research was undertaken in 2014 with a sample of the general populations of 11 Balkan countries which asked them to evaluate their levels of health and happiness. The 11 countries were: Albania, Bulgaria, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Montenegro, Romania, Serbia, Slovenia and Turkey. The questionnaire was undertaken in each Balkan country over the telephone with 1,000 residents who were sampled representatively in terms of gender, age, education level

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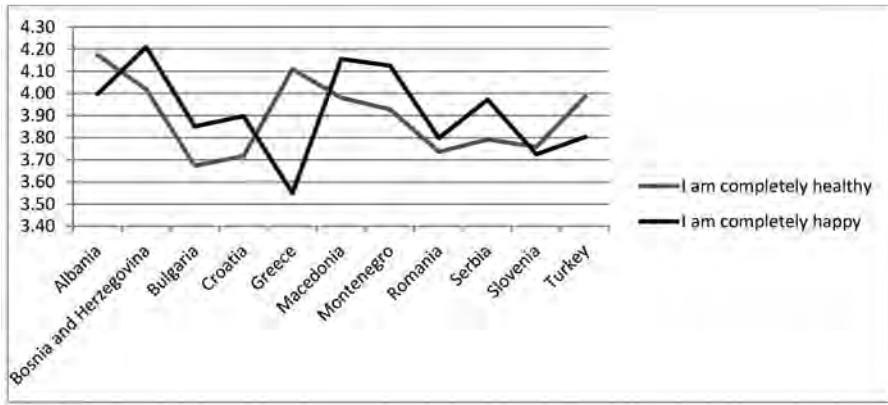


Figure 3.1 Relationship between health and happiness in the Balkans.

and place of residence (town or countryside). Respondents were asked to rank their health and happiness levels. The results were quite diverse (Figure 3.1), showing that it is perfectly possible to feel quite healthy but also very unhappy at the same time (e.g. Greece, which had exceptional political and economic circumstances at the time of the research).

In most cases, Balkan residents rate their happiness higher than their health. This is not surprising given the relatively short life expectancies in the region, the growing cost of medicines relative to salaries and the low number of doctors in many countries because of outmigration, lack of investment and incentives.

In terms of age and health, there is, not surprisingly, a steady decline in feeling completely healthy as people get older and they have more conditions which need constant attention or treatment. On the other hand, healthy living becomes more important and people make more efforts to stay healthy. In all countries, young people (15–29 years) consider themselves to be the healthiest whereas older people (60–99 years) consider themselves to be the least healthy. They have more health conditions which need constant attention, they sometimes travel elsewhere for medical treatments, healthy living is more important to them and they make more effort to keep healthy. Although not statistically significant for the overall sample, women seem to have more health problems, consider themselves less healthy and travel more for medical treatments, but healthy living is more important to them and they make more effort to keep healthy.

In terms of happiness and age, it seems that the youngest (aged 15–29) are the happiest, followed by the oldest (aged 60–69), with the middle generations, especially 40–49-year-olds, being the least happy (this is in line with theories which suggest that middle-aged people have the lowest levels of happiness, e.g. Office for National Statistics, 2016). Older people make a bit more effort to stay happy. People living in the countryside seem to be a little bit happier than those in towns. Education levels affect happiness in quite diverse ways according to each country, but there is a noticeable pattern that people with higher education are often unhappier than those with less. This could be due to unfulfilled expectations in countries that have many economic and political problems and afford few opportunities for highly educated people.

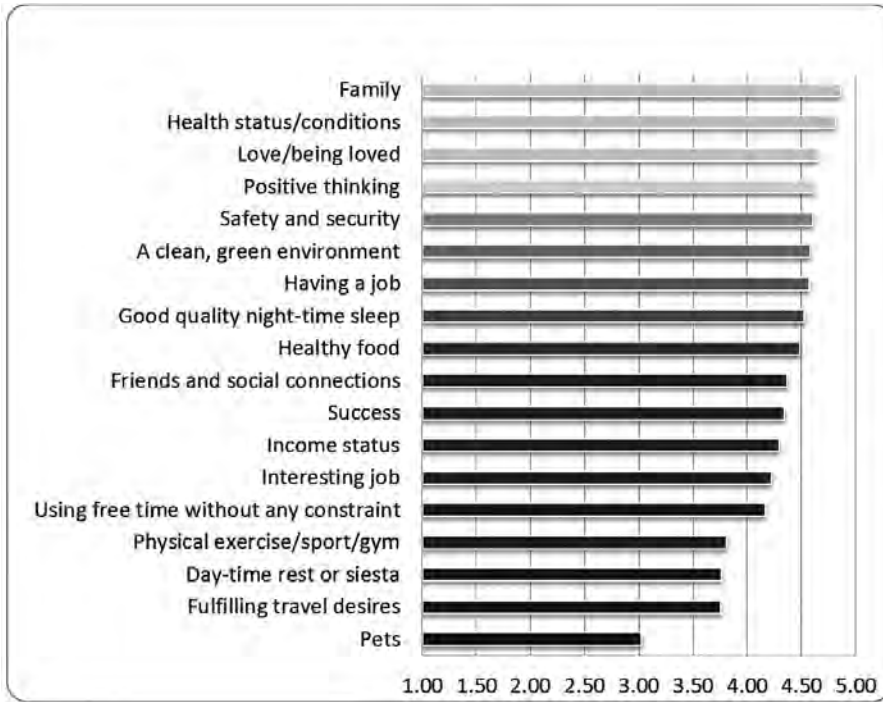


Figure 3.2 Main factors of happiness in Balkan countries.

Family, health and love are the three most important elements (Figure 3.2). This is consistent with quality of life surveys (e.g. Rahman et al., 2005). However, it is surprising that work and income do not feature as prominently as they do in some other studies. For example, Easterlin (2006) stated that, according to most research on quality of life or subjective wellbeing income, family, health and work play the most important role. Travel is the least important (along with siesta). This is also consistent with other quality-of-life studies where travel is not top of mind for respondents, but if it is mentioned by the researcher, they declare that it is actually important or at least the act of travelling regularly rather than individual trips (Puczkó and Smith, 2010). It also has to be remembered that in the majority of the Balkan countries salaries are very low and large numbers of local residents are unable to fulfil travel desires for financial reasons. It is therefore unsurprising that travel may not be top of mind when discussing happiness.

One interesting point should be noted about food. Those countries with a predominantly or partly Mediterranean diet (e.g. Greece, Albania, Slovenia) seem to have the longest life expectancy. Although Greeks and Slovenians have the highest levels of obesity in the Balkans (Becic, 2014), they also have the highest life expectancy (Human Development Index, 2014). As discussed earlier in the chapter, it is possible to be obese yet live a long life. During the research, some discussion took place about food that is good for mood (i.e. happiness) and food that is good for health. The two are not necessarily the same and this raises interesting questions again

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about whether it is better to engage in activities that make one happy or to focus on what is supposedly healthy (assuming that this is known).

A comparison was made between which of the activities in Figure 3.3 were learnt from parents and grandparents and which ones are still practised now. The most significant findings were that in all countries the respondents are cooking and eating traditional foods in far greater numbers than those who learnt; religious activities have increased but non-religious spiritual practices have declined significantly, whereas a reverse trend can be seen in many Western European countries (in many Balkan countries, religion was often suppressed in the past, for example, during socialist times); visits to the sea have increased in almost all countries except in those that became landlocked after the Yugoslavian war (e.g. Serbia, Macedonia); the use of spas, hammams or steam is surprisingly low considering the history of balneology in many of the Balkan countries; however, the use of natural healing resources is increasing. Natural healing resources are used mainly for health reasons (almost 50 per cent); religious activities are undertaken mainly for happiness (42 per cent); 38 per cent of people cook and eat traditional food for health reasons, 27 per cent for happiness. These findings could have useful implications for tourism product and service development, for example, showing the importance of natural healing resources, seaside, healthy gastronomy and religion.

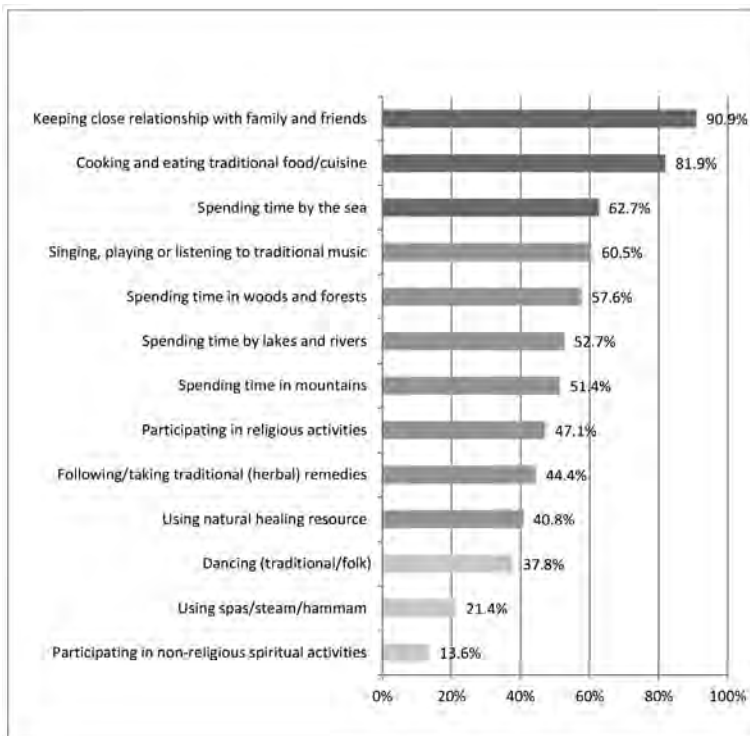


Figure 3.3 Most important activities for happiness in the Balkan countries.

Table 3.1 Lifestyle trends and health tourism products

<i>Lifestyle trend or issue</i>	<i>Related health tourism product/service</i>
Lack of exercise	Fitness retreats; gyms and fitness classes in wellness hotels and spas
Growing obesity/unhealthy eating	Boot camps; detox clinics or spas; retreats with vegetarian, vegan, raw and/or organic food; slow food destinations
Over-use of technology	Digital detox retreats; booking into hotels with limited WiFi access, no TV, etc; visiting areas with limited access to technology (e.g. small islands, mountain villages)
Sleep deprivation/poor sleep quality	Sleep therapy clinics in spas; wellness hotels with special features for promoting sleep (e.g. special pillows, aromatherapy oils)
Occupational/work-based stress	Occupational wellness retreats; incentive spa visits
Negative body image	Psychological counselling in a retreat; beauty treatments in a spa; cosmetic surgery in a medical tourism hospital or clinic
Increasing interest in CAM	CAM therapies on spa menus; energy healing in retreats
Limited contact with nature/unsustainable lifestyle	Eco-therapy in retreats or spas; eco-retreats; eco-villages; green spas
Need to slow down/mindfulness	Stays in small villages or on remote islands; holistic retreats (e.g. offering meditation, yoga)
Need for spiritual activities	Spiritual ashrams or retreats; stays in monasteries; pilgrimages

Note: CAM = complementary and alternative medicine.

Leisure and lifestyle trends: implications for health tourism

Clearly, many of the lifestyle trends that have been identified in the research about health and happiness can be used to inform the health tourism sector in terms of what kinds of products to develop and which services to offer. As a summary, Table 3.1 lists the main lifestyle trends that have been discussed in this chapter so far, including measures that should or could be taken to improve health. Some suggestions are made as to how the health tourism sector has already integrated or could integrate these trends into their product and service development.

Conclusion

The main trends identified in this chapter will be elaborated on throughout this handbook. Although research shows some contradictory and confusing notions about health, there is nevertheless some consensus about what constitutes a healthy and happy life and the two are deeply connected (i.e. healthier people tend to be happier and vice versa). More holistic approaches need to be taken towards health which integrate the physical, emotional, psychological and even spiritual dimensions of life. Subsequent chapters will explore how far it is necessary to engage in tourism experiences in order to enhance health and happiness and what benefits are afforded by tourism compared to everyday life activities. Although it could be argued that tourism experiences are short-lived and contribute to happiness rather than long-term wellbeing or quality of life, healthier holidays which address some of the lifestyle issues that affect human health may have a very different impact. Although they are unlikely to cure illnesses (with the exception of surgical medical tourism in some cases), they can set the tourist on a path towards improved lifestyle and better health once back home. The educational and transformational potential of health tourism is certainly an area worthy of further investigation and will be touched upon in subsequent chapters, especially those which focus on wellness and holistic forms of tourism.

Note

- 1 The research quoted in this case study was financed under the Research and Technology Innovation Fund (KTIA_AIK_12-1-2013-0043) called Adaptation and ICT-supported development opportunities of regional wellbeing and wellness concepts to the Balkans.

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