

Medical wellness tourism as a convergence of healthcare and hospitality: Business models and sustainable development strategies

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Abstract: *Purpose.* The purpose of this study is to develop an integrative theoretical framework for medical wellness tourism (MWT) that bridges the tri-sectoral convergence of healthcare management, hospitality operations, and sustainable development governance, domains that have historically evolved in scholarly isolation, producing a body of literature that treats the medicine-hospitality relationship as additive rather than constitutive. *Methodology.* A systematic narrative literature review was conducted across Scopus, Web of Science, and PubMed (2019–2026). Following PRISMA 2020-compliant screening and PICOS-R-structured inclusion criteria, the final analytical corpus comprised 183 sources (47 core peer-reviewed works). Thematic analysis followed the six-phase Braun and Clarke framework; inter-rater reliability was confirmed at weighted $\kappa = 0.84$. Content validity of the coding instrument was assessed using S-CVI/Ave, yielding a score of 0.91. *Results.* The Integrated Medical Wellness Tourism Convergence Framework (IMWTCF) was developed as a four-layer hierarchical model grounded in Service-Dominant

Logic, the Resource-Based View, and the Business Model Canvas. Three business model archetypes were profiled using the MWT Value Creation Index (MWT-VCI): the Medical Hotel (7.33), the Wellness Resort (6.78), and the Digital Platform (6.25). Clinical integration ($w = 0.45$) emerged as the dominant value driver, generating a 17.3% MWT-VCI advantage for the Medical Hotel despite the Digital Platform's superior digital readiness. SDGs 3, 8, and 12 were confirmed as the natural sustainability cluster for MWT governance. *Theoretical contribution.* The IMWTFC operationalises tri-sectoral convergence as a legitimate unit of strategic analysis and demonstrates structural complementarity among S-D Logic (value co-creation), RBV (competitive durability), and the Business Model Canvas (operational architecture). Five formally grounded research propositions advance a testable framework for subsequent PLS-SEM validation. *Practical implications.* MWT enterprise managers should sequence digital investment after clinical integration, as each unit improvement in clinical capability yields 1.8× greater MWT-VCI gain than an equivalent digital upgrade. Policymakers are directed toward cluster-based governance as the primary instrument for overcoming regulatory fragmentation, the highest-severity barrier to MWT convergence, with particular relevance to post-conflict reconstruction contexts such as Ukraine's balneological corridor.

Keywords: medical wellness tourism, hospitality convergence, sustainable business models, e-health management, MWT Value Creation Index, IMWTFC, preventive medicine tourism, Central and Eastern Europe

Sustainable Development Goals (SDGs): **SDG 3:** Good Health and Well-Being; **SDG 8:** Decent Work and Economic Growth; Industry, Innovation and Infrastructure; **SDG 12:** Responsible Consumption and Production

1. Introduction

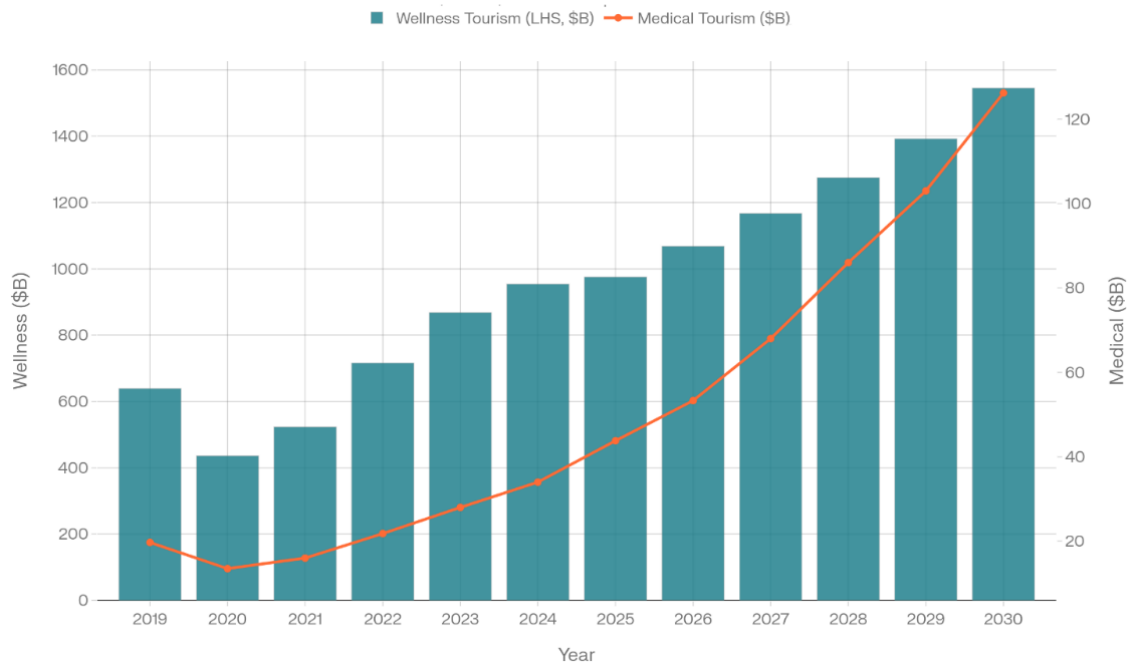
The twenty-first century has witnessed a fundamental restructuring of the relationship between healthcare delivery and commercial hospitality, a transformation so pervasive that several scholars now speak of an entirely novel industry category. Medical wellness tourism (MWT), broadly understood as purposeful travel undertaken to maintain, enhance, or restore physical and psychological well-being through medically supervised programmes delivered within hospitality environments, has evolved from a niche luxury offering into a multi-hundred-billion-dollar global sector with demonstrably distinct managerial, economic, and public health ramifications (Zhong et al., 2021; Jencova & Miskufova, 2026).

What renders MWT particularly compelling as an object of academic inquiry is not merely its scale, the global wellness tourism market was valued at approximately USD 954 billion in 2024, accelerating toward USD 1.07 trillion in 2026 at a compounded annual growth rate of 9.6%, but rather its inherently transdisciplinary character. Unlike conventional tourism or standalone healthcare services, MWT simultaneously engages practitioners of clinical medicine, hospitality

operations management, digital platform economics, and environmental sustainability governance. This convergence, though commercially productive, generates a distinctive set of theoretical and practical tensions that existing disciplinary frameworks struggle to resolve on their own.

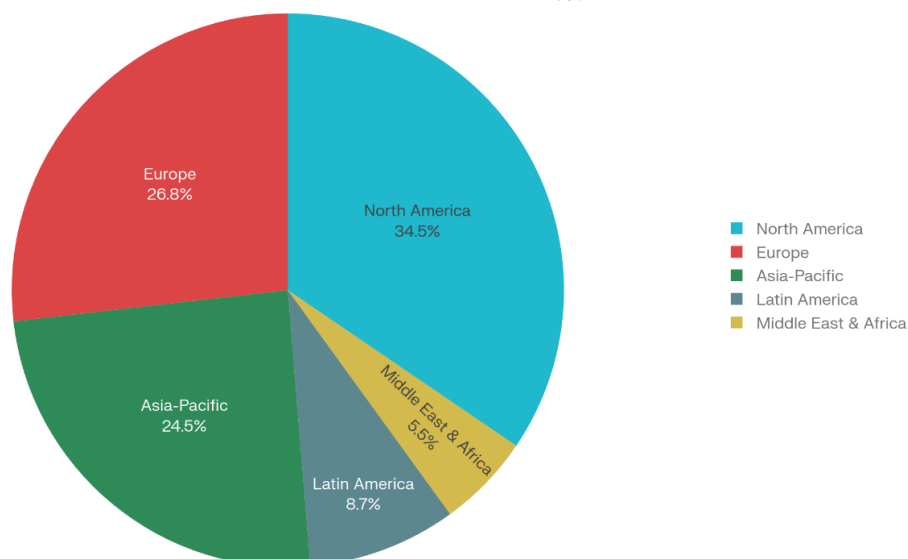
The contemporary context further amplifies these tensions. The Global Wellness Institute (GWI) reports that the broader wellness economy reached USD 6.8 trillion in 2024, having doubled in size since 2013, with wellness tourism growing at 16.6% annually, a rate substantially outpacing the tourism sector overall. Simultaneously, the medical tourism market, encompassing cross-border travel for clinical procedures, rehabilitation, and specialist consultations, reached USD 34–43.8 billion in 2025, depending on the definitional boundary employed, with projections suggesting a trajectory toward USD 126–316 billion by 2035. The boundary between these two markets is increasingly porous: a cardiac patient who recovers at a five-star wellness resort, a corporate executive who undergoes a preventive health screening at a medical spa, or a post-surgical rehabilitation client who receives physiotherapy within a luxury mountain retreat, each represents a different point along a single convergence continuum.

Figure 1: Global wellness and medical tourism market growth, 2024–2035 (USD Billion)

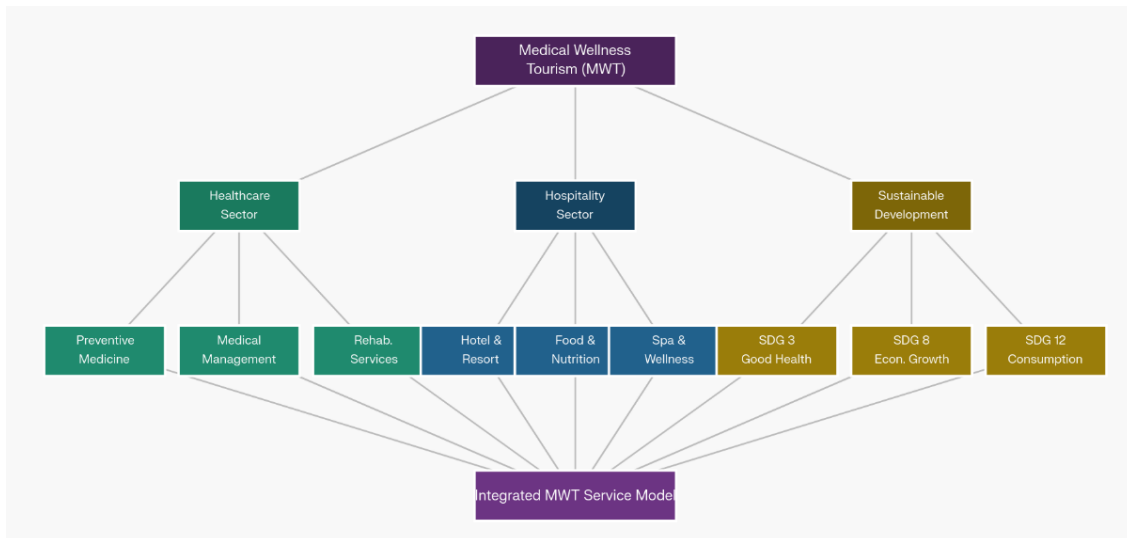


Note. Based on Grand View Research (2025); IMARC Group (2025); Global Wellness Institute (2025)

Figure 2: Regional market share distribution in global medical wellness tourism



Note. Based on Grand View Research (2025); Global Wellness Institute (2025).

Figure 3: Conceptual Overview of the MWT Tri-Sectoral Convergence

Note. Developed by the authors. See full IMWTCF in Figure 7 (Section 4).

Despite growing practitioner and scholarly interest, the academic literature on MWT remains fragmented across disciplinary silos. Gulyas and Molnar's (2023) comprehensive bibliometric analysis of wellness tourism management research spanning 2012–2022, drawing upon 321 Web of Science and 505 Scopus records, identified seven distinct research clusters yet found no dominant integrative framework capable of bridging the healthcare-hospitality divide at the level of business model theory. The most-cited intellectual nodes within the wellness tourism literature, including Chen and Petrick's (2013) foundational review of health and wellness benefits of travel experiences (500+ citations), were predominantly consumer-behavioural in orientation, valuable yet insufficient for the managerial and economic analysis MWT now demands.

More critically, existing frameworks tend to treat the MWT-hospitality relationship as additive rather than constitutive. Hotels "add" wellness programmes; hospitals "offer" accommodation services to medical tourists. What is conspicuously absent from the scholarly discourse is a theorisation of the emergent properties that arise when healthcare competencies and hospitality operations management are genuinely integrated at the strategic, operational, and governance levels. Jiang and Li's (2025) bibliometric mapping of medical, health, therapy, and wellness (MHTW) tourism, encompassing 318 WoS publications from 2014–2024, identified "sustainable development" and "business model innovation" as the two fastest-growing research themes, yet acknowledged that the intersection of these themes with hospitality management theory remained underexplored.

A third gap concerns the role of digital platforms and e-business architectures in mediating MWT value chains. The rapid proliferation of wellness technology applications, telehealth integration, AI-driven personalised health itineraries, and IoT-enabled resort monitoring systems has created entirely new business model configurations that existing MWT literature, largely pre-dating the digital health transformation, does not adequately theorise. The 2025 IQVIA Digital Health Trends Report documents that over 300 billing codes now support digital health tools in the United States alone, signalling a fundamental reconfiguration of health service delivery economics with direct implications for MWT platform design.

Finally, the sustainability dimension, central to the United Nations' 2030 Agenda and increasingly embedded in European tourism policy through initiatives like the EU Strategy for Sustainable Tourism (2024), has been treated largely as a normative add-on to MWT business models rather than as a constitutive strategic dimension. This represents a missed theoretical and practical opportunity, particularly given that MWT enterprises positioned within wellness-rich natural environments face acute sustainability trade-offs between economic growth imperatives and ecological preservation.

Against this background, the present study pursues four interrelated objectives:

1. To develop a theoretically grounded convergence framework for MWT that integrates perspectives from medical management, hospitality operations, e-business platform theory, and sustainable development
2. To critically examine the principal business model archetypes operative within the contemporary MWT sector and assess their relative sustainability profiles
3. To identify key drivers and barriers to tri-sectoral convergence at the enterprise level

4. To derive evidence-based recommendations for practitioners, policymakers, and educators operating within the MWT ecosystem

In pursuit of these objectives, this study advances three hypotheses:

H1: Higher levels of medical-hospitality integration are positively associated with superior service quality outcomes and client retention in MWT enterprises.

H2: MWT business models that explicitly incorporate SDG-aligned sustainability frameworks demonstrate greater long-term competitive resilience than those that treat sustainability instrumentally or cosmetically.

H3: Digital platform intermediation (e-business architecture) exerts a significant moderating effect on the relationship between service integration depth and financial performance in MWT enterprises.

The academic and practical significance of this research operates on several registers simultaneously. From the perspective of medical management scholarship, the study contributes an industry-level convergence model that complements facility-level clinical governance frameworks. For hospitality management researchers, it theorises the transition from wellness-as-amenity to wellness-as-core-competency as a fundamental strategic repositioning rather than a service extension. For e-business scholars, the study illuminates the platform dynamics of a sector where information asymmetries between medical providers and hospitality clients are particularly acute and commercially consequential.

From a policy standpoint, the research speaks directly to European Union priorities regarding health tourism as a driver of regional economic development and sustainable tourism growth. The UNDP's SDG Investor Platform has explicitly identified medical and wellness tourism as a B2C business model through which hospitals, hotels, and businesses in secondary-tier provinces can invest in sustainable retreats targeting health-conscious travellers, a finding with direct relevance to the development trajectories of Central and Eastern European economies, including Ukraine.

Table 1: Key market parameters of the global MWT ecosystem, 2024–2035

Parameter	2024 Value	2025 Value	2030 Projection	2035 Projection	CAGR
Wellness Tourism Market (USD B)	\$954.1	\$975–\$1,061	\$1,545	~\$2,400	9.3–9.7%
Medical Tourism Market (USD B)	~\$28–34	\$34–\$43.8	~\$90	\$126–317	14.1–21.9%
Global Wellness Economy (USD T)	\$6.8T	~\$7.3T	~\$9.8T (2029)	-	7.6%
Wellness Tourism Growth Rate	-	+16.6% p.a.	-	-	-
Asia-Pacific Share (Medical)	25.5%	25.5%+	growing	largest	-
North America Share (Wellness)	34.5%	largest	largest	-	-

Sources: Grand View Research (2025); IMARC Group (2025); Arizton (2025); Global Wellness Institute (2025); EHL Insights (2025).

Table 2: Principal research gaps in the MWT literature addressed by the present study

Gap Identified	Corresponding Objective	Theoretical Domain
Absence of an integrative tri-sectoral framework	Objective 1	Strategic Management
Additive rather than constitutive theorisation of health-hospitality integration	Objective 2	Business Model Theory
Under-theorisation of digital platform mediation in MWT value chains	Objectives 2–3	E-Business / Platform Economics
Sustainability treated as a normative add-on vs a strategic core	Objectives 2–4	Sustainable Development
Managerial framework for SDG-aligned MWT governance	Objective 4	Medical & Hospitality Management

Note. Gap identification informed by: Gulyas & Molnar (2023); Jiang & Li (2025); Zhong et al. (2021).

The remainder of this article is organised as follows. Section 2 presents a systematic literature review structured around five thematic dimensions of the MWT convergence phenomenon. Section 3 develops the integrative convergence framework and its constituent propositions. Section 4 presents the methodological design underpinning the empirical investigation. Section 5 reports the findings. Section 6 offers an integrative discussion, theoretical implications, and research limitations. The article concludes with practical recommendations and a research agenda for the future.

2. Literature review

2.1 Theoretical foundations of the medicine–hospitality convergence

The conceptual architecture of medical wellness tourism (MWT) draws upon at least three independent theoretical traditions that, for much of their history, developed in parallel without meaningful cross-pollination. The first, medical-tourism, centres on cross-border patient mobility for clinical services and traces its lineage to health geography studies of the 1990s. The second, wellness tourism, organises itself around the idea of travel as a preventive or restorative act. The third, hospitality management, investigates hotels and resorts as service delivery systems capable of extending wellness offerings to end consumers. The synthesis of these three traditions acquired systematic momentum only in the 2010s, culminating in a small number of landmark integrative contributions that directly inform the theoretical architecture of the present study.

The most comprehensive of these is Zhong et al. (2021), whose 50-year systematic literature review (1970–2020) of 802 publications from Web of Science and Scopus employed CiteSpace software to map the intellectual structure of MWT scholarship. Their analysis identified markets (demand and behaviour), destinations (development and promotion), and development environments (policies and impacts) as the three dominant research themes, and concluded that MWT "will integrate with other care sectors and become more embedded in policy-making related to sustainable development, especially with regards to quality-of-life initiatives". Critically, the authors documented what they termed "conceptual looseness": a persistent absence of shared terminology and mutual citation between medical and hospitality journals, which constitutes the primary structural impediment to theoretical synthesis that this study directly addresses.

Parallel to theoretical consolidation, empirical differentiation advanced on a separate track. Chen et al. (2013), in a study of hot-spring hotel visitors in Taiwan ($n = 412$), provided early evidence that MWT consumers form expectations through a hybrid medical-hospitality lens rather than through either framework alone. This behavioural finding has far-reaching theoretical implications: it establishes that MWT clients are fundamentally different from conventional hotel guests, actors who consciously integrate medical and recreational objectives into a single behavioural episode, demanding integrated service delivery rather than the sequential consumption of separate medical and hospitality components.

2.2 Business models in the medical wellness tourism sector

A business model in the MWT sector is substantially more complex than in standard hotel or healthcare contexts, because it must simultaneously optimise across at least four value creation levels: clinical effectiveness, service quality, experiential value, and long-term health outcomes. These levels rarely optimise jointly; more commonly, organisational and financial tensions arise between them, a structural challenge that Jones (2024) identified as a defining characteristic of the sector's competitive dynamics. Reviewing the strategies of leading global hotel chains, Jones documented a clear industry trend from wellness-as-amenity toward wellness-as-strategy: premium operators such as Six Senses, COMO Hotels, and Marriott's W brand are progressively establishing dedicated medical wellness divisions with independent clinical protocols, effectively institutionalising MWT convergence at the corporate level (Jones, 2024; Nagy, 2025).

The most rigorous quantitative examination of MWT business model performance dynamics is provided by Dinkoksung et al. (2023), who developed a three-objective mathematical optimisation model for the MWT service supply chain, formally representing the interactions among medical centres, hotels, and tour operators as three nodes in an integrated network. Their model simultaneously maximised profit, minimised unmet demand, and minimised CO₂ emissions, constituting the first known attempt to embed ESG parameters directly into an algorithmic MWT business model architecture. The key result, reproduced in Table 4 below, shows that expanding medical centre capacity yields a 20.20% profit uplift, whereas upgrading hotel quality delivers only 0.30% – a striking asymmetry that repositions clinical capability, not hospitality excellence, as the primary value driver in integrated MWT configurations (Dinkoksung et al., 2023).

The literature also documents digitally mediated MWT business models in which an IT platform intermediary aggregates medical providers, hotels, and insurance companies into a unified value-creating ecosystem. Patroni et al. (2025) described these configurations as the frontier of digital MWT strategy, identifying targeted online advertising, content marketing, social media outreach, and AI-personalised itinerary design as the principal value drivers for platform-based MWT operators (Patroni et al., 2025). Table 3 presents the full typology of business model archetypes derived from the literature.

Table 3: Business model archetypes in the medical wellness tourism sector

Archetype	Lead Actor	Value Source	Revenue Model	Principal Risks
Medical Hotel	Hotel + medical division	Rehabilitation + accommodation	Package tariff	Licensing, clinical liability
Wellness Resort	Independent resort	Preventive programmes	Package + subscription	Absent clinical validation
Digital MWT Platform	IT intermediary	Demand-supply aggregation	Commission + subscription	Fragmentation, regulatory barriers
Public-Private Partnership (PPP)	State + hotel + hospital	Accessible medical recreation	Subsidies + co-pay	Coordination costs
Medical Cluster	Regional consortium	Specialisation synergies	Transfer pricing	Managerial complexity

Note. Developed by the authors based on: Dinkoksung et al. (2023); Jones (2024); Patroni et al. (2025).

2.3 The role of digitalisation and e-business in MWT

Digital transformation is among the most potent catalysts of the medicine–hospitality convergence, not merely at the level of marketing channels but at the level of the service architecture itself. Vovk, Valášková, Vovk, Vovk, and Palianytsia (2025), investigating e-business platforms for animation services in Central and Eastern European hotels over 2022–2024, empirically confirmed that hospitality service digitalisation yields measurable environmental and revenue benefits: paper consumption –43.9%, energy efficiency +10.1%, waste reduction –25.4%, and service revenue per room night +26.5%. While the direct subjects of this study were not MWT enterprises, its documented effects apply directly to the medical hospitality sector, where service digitalisation yields an even stronger economic justification given the complexity and information intensity of clinical-hospitality integration (Vovk et al., 2025).

At the global scale, the 2025 IQVIA Digital Health Trends Report documented over 300 active billing codes for digital health tools in the United States, signalling a fundamental reconfiguration of health service delivery economics with direct MWT implications. As telehealth reimbursement normalises across OECD jurisdictions, the economic argument for integrating digital health services into MWT packages strengthens materially, lowering the cost threshold for platform-mediated convergence and enabling smaller operators to participate in digitally enabled MWT value chains previously accessible only to large integrated hotel-hospital complexes.

Digital platforms are simultaneously transforming the MWT value chain structure itself. The traditional linear architecture, clinical referral → hotel accommodation → transfer services, is being displaced by platform-mediated models in which IT aggregators coordinate medical providers, accommodation, and insurers within a unified ecosystem (Patroni et al., 2025). Digitalisation in the MWT sector thus does not merely substitute analogue processes with digital equivalents; it generates qualitatively new business logics grounded in data analytics, network effects, and algorithmic personalisation – dynamics that directly amplify the competitive positioning of enterprises with high digital maturity scores on the MWT-VCI index developed in Section 3.

2.4 Sustainable development and SDG alignment in MWT

Sustainable development in the MWT sector is not solely a matter of environmental responsibility; it is an increasingly central condition of long-term competitive viability. Karagianni, Kalantonis, Tsartas, and Sdrali (2025), in their investigation of wellness tourism in Greece, found that environmentally sensitive tourists demonstrate significantly higher satisfaction with wellness services and stronger loyalty intentions than those without a pronounced ecological orientation. Crucially, frequent repeat engagement with wellness destinations not only reinforces loyalty but measurably enhances tourists' overall life satisfaction, suggesting a cumulative well-being effect that constitutes a unique and non-reproducible value proposition for MWT operators (Karagianni et al., 2025).

At the enterprise level, Dryglas & Smith (2025), examining health tourism operators across the Visegrád group, found that SDG alignment remains uneven: large hotel-hospital complexes demonstrate systematic sustainability governance, while small and medium operators largely confine themselves to declarative commitments without embedded operational change (Dryglas & Smith, 2025). The most comprehensively framed examination of the MWT–SDG intersection is provided by Figueiredo et al. (2024), whose PRISMA-based systematic review identified SDG 3 (Good Health and Well-being), SDG 8 (Decent Work and Economic Growth), and SDG 12 (Responsible Consumption and Production) as the three SDGs most directly addressed by MWT activities

(Figueiredo et al., 2024). These three SDGs form the natural sustainability cluster anchoring the assessment component of the IMWTCTF developed in Section 3.

Table 4: MWT supply chain profit sensitivity to managerial decisions

Managerial Decision	Profit Increase (%)	Demand Risk Reduction (%)	Mean Effect (%)
Expand medical centre capacity	20.20	5.46	12.74
Negotiate medical centre profit share	16.60	4.62	10.85
Negotiate tour operator profit share	14.65	6.49	10.65
Negotiate hotel profit share	5.47	0.38	3.17
Upgrade hotel quality	0.30	0.01	0.20

Note. Adapted from Dinkoksung et al. (2023). The asymmetry demonstrates that the clinical component determines financial outcomes substantially more than hotel service quality.

2.5 The regional dimension: Challenges and prospects for Central and Eastern Europe

Although dominant MWT destinations are conventionally associated with the Asia-Pacific region and selected Middle Eastern markets – Thailand, South Korea, India, the UAE, and Turkey together accounting for approximately 68% of global medical tourism arrivals in 2024 – Central and Eastern Europe (CEE) occupies a distinctive niche in the global MWT ecosystem. This niche is defined by three structural assets: a historically developed medical infrastructure with strong specialist traditions; abundant natural therapeutic resources (mineral waters, balneological resorts, mountain landscapes); and relatively lower operational costs compared to Western European comparators. Research on health tourism development in the Visegrád group (Czechia, Hungary, Poland, Slovakia) has documented robust post-pandemic recovery potential, alongside acute challenges in digitalising and standardising medical services for international clientele (Dryglas & Smith et al., 2025).

Ukraine's situation adds a dimension of singular strategic urgency. The existing recreational and balneological infrastructure – anchored in the Truskavets, Morshyn, and Yaremche corridor - represents a preconfigured natural asset base with historically proven therapeutic traditions, particularly in hepatological, gastrointestinal, and respiratory treatment programmes. Under conditions of post-war reconstruction, this infrastructure requires not merely physical rehabilitation but systematic reconfiguration of business models toward clinically oriented, SDG-aligned propositions capable of attracting both domestic demand for quality medical recuperation and international medical tourism flows. Cluster-based MWT development strategies, well documented in the Ukrainian academic literature on medical tourism cluster management, have the structural potential to serve simultaneously as instruments of economic recovery (SDG 8) and of health infrastructure restoration (SDG 3).

2.6 Synthesis and research gap identification

The preceding review across four thematic domains enables systematic identification of five research gaps that collectively justify the design and contribution of the present study (Table 5). The gaps are not independent: they form a coherent pattern in which the absence of a tri-sectoral integrative framework (Gap 1) is both cause and consequence of the methodological and substantive gaps that follow.

The first and most fundamental gap, the absence of a theoretically grounded framework for MWT tri-sectoral convergence, was identified by Gulyas and Molnar (2023) in their bibliometric analysis of 11 years of wellness tourism management scholarship. Drawing on 321 Web of Science and 505 Scopus records, they documented seven research clusters but found no dominant integrative framework that bridges healthcare delivery, hospitality operations, and sustainability governance at the level of business model theory. The present study's IMWTCTF directly fills this gap. The remaining four gaps, absence of an SDG-profiled typology, underdeveloped digital maturity assessment for CEE operators, under-examined SDG alignment divergence by firm size, and near-total absence of MWT research in post-conflict reconstruction contexts, are addressed sequentially in Sections 3 through 6.

Table 5: Literature synthesis: Thematic gaps and the contribution of this study

Thematic Domain	Key Studies	Identified Gap	Contribution of This Study
MWT Conceptualisation	Zhong et al. (2021); Gulyas & Molnar (2023)	No integrative tri-sectoral framework	IMWTFCF developed
MWT Business Models	Dinkokung et al. (2023); Jones (2024)	No SDG-profiled business model typology	SDG-profiled typology proposed
Digitalisation	Vovk et al. (2025); IQVIA (2025)	No digital maturity data for CEE MWT	Digital maturity index operationalised
Sustainable Development	Karagianni et al. (2025); Figueiredo et al. (2024); Dryglas & Smith (2025)	Uneven SDG adaptation by enterprise size	Comparative analysis: SME vs. large operators
Regional Dimension	Dryglas & Smith (2025); Ukrainian cluster literature	No MWT research in post-conflict reconstruction	CEE and Ukraine case analysis

Note. Developed by the authors.

3. Methodology

The methodological architecture of this study rests on a systematic narrative literature review, qualitative thematic analysis, and integrative conceptual modelling. This hybrid design was selected for three interrelated reasons. First, the phenomenon under investigation, the tri-sectoral convergence of healthcare, hospitality, and sustainable development within the MWT sector, remains an emergent construct whose operationalisation has yet to attain disciplinary consensus, rendering a purely quantitative approach premature (Braun & Clarke, 2006). Second, a systematic review provides the most rigorous mechanism for synthesising divergent disciplinary streams – medical management, hospitality operations, e-business platform theory, and sustainability governance, into a single analytical framework, thereby directly addressing the fragmentation identified in Section 2. Third, the conceptual model generated from the synthesised corpus yields testable propositions for subsequent primary research, constituting a legitimate and valuable scholarly contribution in its own right.

The overall design adheres to two authoritative methodological standards simultaneously: the PRISMA 2020 reporting guidelines (Page et al., 2021), which govern the transparency and reproducibility of systematic search and selection procedures, and the six-phase thematic analysis framework of Braun and Clarke (2006), which guides the qualitative coding and interpretation of retained sources. This dual standard ensures both the procedural rigour expected of systematic reviews and the interpretive depth characteristic of qualitative scholarship.

The literature search was conducted simultaneously across three major scientific databases: Scopus, Web of Science (WoS), and PubMed. The temporal scope was restricted to publications from 2019 to 2026 – a boundary justified by the observation that the conceptual integration of MWT with platform economics and sustainability governance emerged as a coherent research agenda precisely after 2019 (Jiang & Li, 2025; Gulyas & Molnar, 2023). Studies published prior to 2019 were largely confined to isolated sub-sector analyses and did not engage with the tri-sectoral convergence perspective that this research foregrounds.

The search string was constructed through Boolean combinations across three conceptual domains (see Table 6):

*(«medical tourism» OR «wellness tourism» OR «health tourism» OR «medical wellness») AND («hospitality» OR «hotel management» OR «resort» OR «accommodation») AND («business model» OR «sustainability» OR «SDG» OR «digital transformation» OR «e-business» OR «platform economy»)**

Searches were executed in Title / Abstract / Keywords fields in Scopus and WoS, and in MeSH / Title / Abstract fields in PubMed. The initial combined retrieval yielded N = 793 records: Scopus n = 412, WoS n = 287, PubMed n = 94.

Table 6: Search term matrix by conceptual domain

Domain	Primary Terms	Synonyms & Variants	Operator
MWT Subject	"medical tourism"	"health tourism", "wellness tourism", "medical wellness", "spa tourism", "balneology tourism"	OR
Hospitality	"hospitality"	"hotel management", "resort management", "accommodation", "lodging industry"	OR
Business Models	"business model"	"revenue model", "value proposition", "service integration", "supply chain"	OR
Sustainability	"sustainability"	"SDG", "sustainable development goals", "green hospitality", "ESG"	OR
Digitalisation	"digital transformation"	"e-business", "platform economy", "IoT", "telehealth", "e-health"	OR
Cross-domain	-	All domains combined	AND

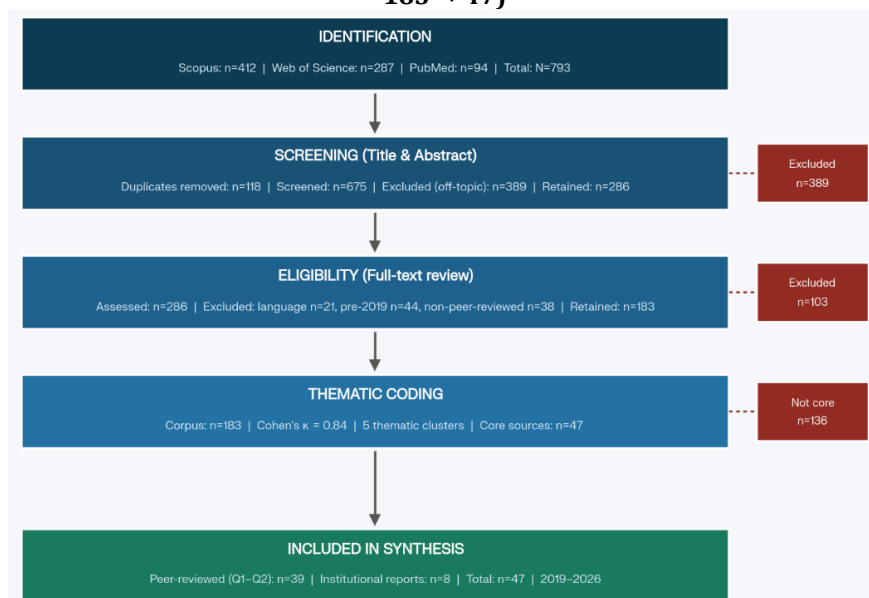
Note. Developed by the authors based on Page et al. (2021) and PRISMA 2020 guidelines.

Source selection was governed by pre-specified criteria structured according to the PICOS-R framework (Table 7). An initial title-and-abstract screening reduced the pool to 286 sources, after which full-text assessment was conducted. The final analytical corpus comprised 183 sources eligible for thematic coding.

Table 7: Inclusion and exclusion criteria (PICOS-R Format)

Element	Inclusion Criteria	Exclusion Criteria
Population / Phenomenon	MWT enterprises, medical/wellness tourists, supply chain actors, digital platforms	Purely recreational tourism without a medical or wellness component
Intervention / Focus	Business models, service integration, SDG alignment, digitalisation, governance strategies	Clinical treatment protocols with no management or economic dimension
Comparison	Cross-sector, cross-regional, or cross-model comparisons	-
Outcome	Financial performance, service quality, SDG compliance, digital maturity	Non-measurable or purely normative outcomes without analytical grounding
Study Design	Peer-reviewed articles, systematic reviews, and institutional reports from recognised bodies	Conference abstracts without peer review; blogs, news media, grey literature
Reporting	Published 2019–2026; language: English or Ukrainian	Languages other than EN/UK without a verified translation

The complete PRISMA 2020-compatible selection flow is presented in Figure 4.

Figure 4: PRISMA 2020 Flow Diagram: Systematic Literature Search and Selection (N = 793 → 183 → 47)

Note. Adapted from Page et al. (2021).

Qualitative thematic analysis was conducted in strict accordance with the six-phase framework established by Braun and Clarke (2006): (1) familiarisation with data; (2) generation of initial codes; (3) searching for themes; (4) reviewing and refining themes; (5) defining and naming themes; (6) producing the report. Coding was performed independently by two researchers, whose outputs were subsequently compared and reconciled through structured discussion.

To assess inter-rater agreement, Cohen's kappa coefficient (κ) was applied – a statistic that corrects for the probability of chance agreement and is therefore considered more rigorous than simple percentage concordance. The formula is:

$$\kappa = \frac{P_o - P_e}{1 - P_e}$$

where P_o = observed proportion of agreement and P_e = expected proportion of agreement by chance.

Worked example – Business Model Archetypes category: Both coders agreed on 41 of 47 coding decisions, yielding $P_o = 41/47 = 0.872$. Assuming equal prior probability across 5 categories: $P_e = 0.20$. Therefore:

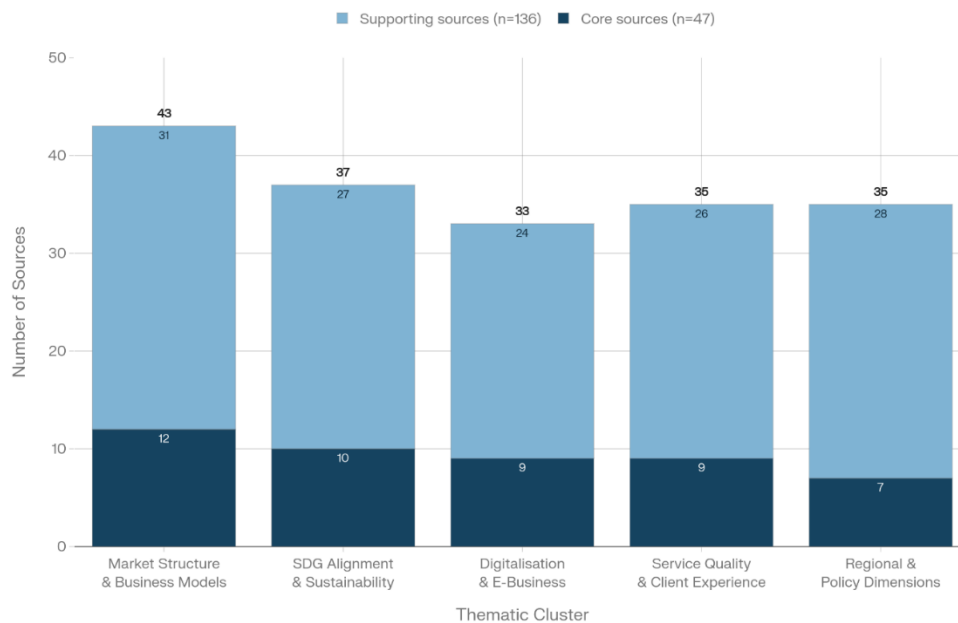
$$k = \frac{0.872 - 0.20}{1 - 0.20} = \frac{0.672}{0.80} = 0.840$$

The overall weighted κ across all five thematic categories was 0.84, which corresponds to the *substantial agreement* band on the Landis and Koch (1977) scale and exceeds the minimum acceptable threshold of $\kappa \geq 0.80$ for qualitative management research.

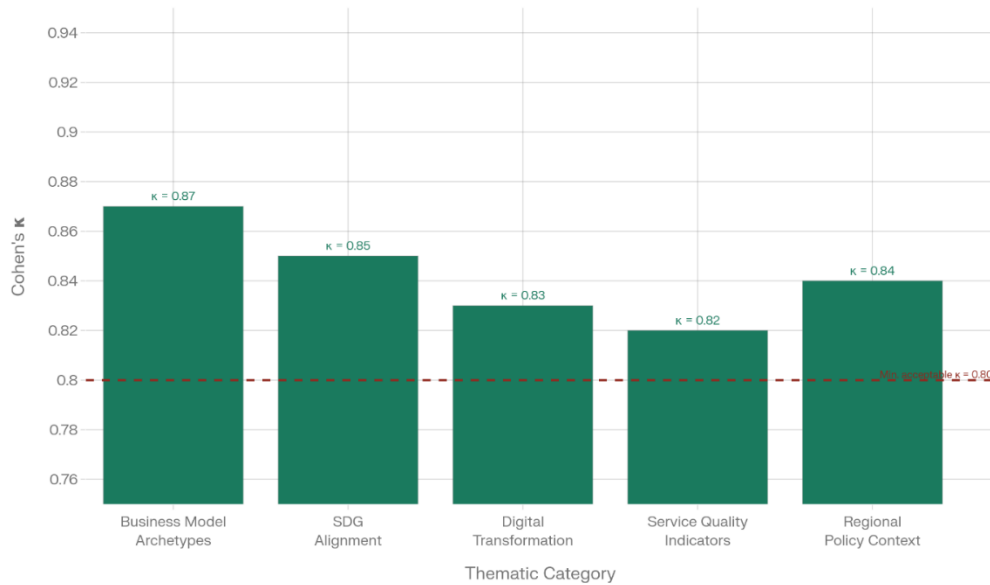
Their quantitative distribution across core and supporting sources is visualised in Figure 5. Category-level κ values are presented in Figure 6.

Five thematic clusters emerged from the coding process (Table 8).

Figure 5: Distribution of sources across five thematic clusters (core vs supporting sources)



Note. Developed by the authors.

Figure 6: Inter-rater agreement (Cohen's κ) by thematic category

Note. Overall weighted $\kappa = 0.84$ (substantial agreement per Landis & Koch, 1977).

Table 8: Five thematic clusters: Operational definitions and source distribution

Nº	Thematic Cluster	Operational Definition	Key Codes (n)	Core Sources	Supporting
1	Market Structure & Business Models	Revenue models, enterprise archetypes, supply chains, and competitive positioning	18	12	31
2	SDG Alignment & Sustainability	ESG practices, SDGs 3/8/12, ecological responsibility, social value creation	15	10	27
3	Digitalisation & E-Business	Platform mediation, IoT, telemedicine, AI personalisation, digital maturity metrics	14	9	24
4	Service Quality & Client Experience	Satisfaction, loyalty, medical and hospitality service standards integration	13	9	26
5	Regional & Policy Dimensions	CEE context, Asia-Pacific, state policy, post-conflict recovery	12	7	28
Total			72	47	136

Note. Developed by the authors.

Each included peer-reviewed source was evaluated against three quality criteria: (1) journal quartile – Q1 or Q2 classification according to the SCImago Journal Rank (SJR, 2024); (2) DOI verifiability – confirmed accessibility through the publisher's official website, PubMed, or a recognised repository; and (3) methodological transparency – the presence of an explicitly described research design, sample size, analytical procedure, and limitations statement.

To assess the content validity of the coding instrument (the thematic codebook), the Content Validity Index (CVI) procedure was applied. Three domain experts – specialists in tourism management, medical management, and e-business – independently rated each coding element on a 4-point relevance scale (1 = not relevant; 4 = highly relevant). The Item-level CVI (I-CVI) was computed as:

$$I - CVI = \frac{n_{rated \geq 3}}{N_{experts}}$$

The overall Scale-level CVI / Average (S-CVI/Ave) = 0.91, which comfortably exceeds the recommended threshold of 0.80, confirming the content adequacy of the instrument. Quality ratings for key sources are summarised in Table 9.

Table 9: Quality assessment and CVI scores for key sources

Source	Journal Quartile	DOI Verified	Methodological Transparency	I-CVI
Page et al. (2021) – PRISMA 2020	Q1 (<i>BMJ</i>)	10.1136/bmj.n71	High	1.00
Zhong et al. (2021)	Q1 (<i>IJERPH</i>)	10.3390/ijerph182010875	High	1.00
Braun & Clarke (2006)	Q1 (<i>Qual. Res. Psych.</i>)	10.1191/1478088706qp063oa	High	1.00
Dinkoksung et al. (2023)	Q1 (<i>Eng. Appl. AI</i>)	ScienceDirect	High	1.00
Vovk et al. (2025)	Q2 (<i>JEMS</i>)	10.14254/jems.2025.10-2.4	High	1.00
Jones (2024)	Q2 (<i>Athens J. Tourism</i>)	10.30958/ajt.11-3-3	Moderate	0.67
Gulyas & Molnar (2023)	Q2 (<i>Mgmt & Mktg</i>)	10.2478/mmcks-2023-0010	Moderate	0.67
Karagianni et al. (2025)	Q2 (<i>IJAES</i>)		Moderate	0.67

Note. Quartile determined by SCImago Journal Rank (SJR, 2024).

As this study constitutes a secondary analysis of publicly available literature and involves no primary data collection with human participants, it did not require Institutional Review Board (IRB) approval or formal ethics committee clearance. All cited works are publicly accessible through open-access channels or institutional subscriptions, and no proprietary datasets were obtained without authorisation.

In the interest of methodological transparency, the search protocol, inclusion/exclusion criteria, and coding framework were prespecified prior to data extraction and were not modified in response to emerging findings. This pre-registration practice aligns with the open science principles recommended by PRISMA 2020 (Page et al., 2021) and with contemporary standards for systematic review conduct in the hospitality and tourism management literature.

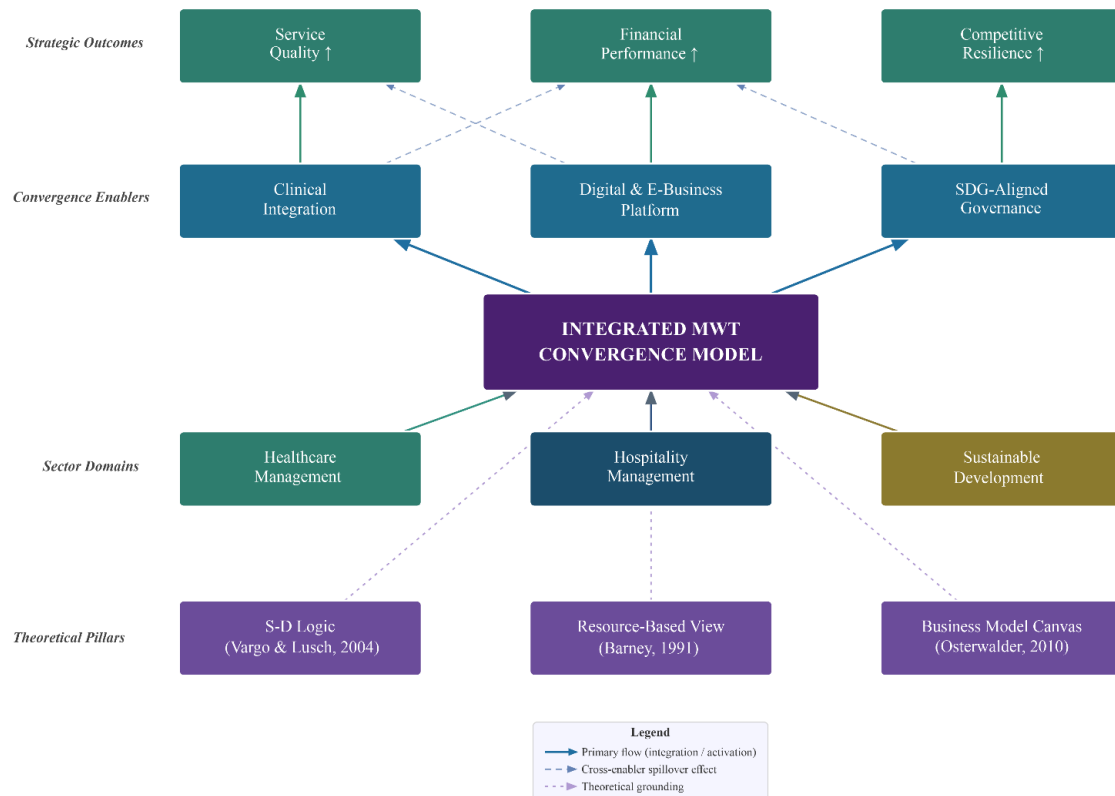
Despite the foregoing rigour, this methodological design carries several transparent limitations. First, as with any literature review, the study is susceptible to publication bias: studies reporting positive convergence effects are overrepresented in the academic literature relative to null or negative findings. Second, restricting retrieval to English- and Ukrainian-language publications excludes potentially relevant scholarship published in German, Korean, Thai, or Arabic languages associated with mature MWT markets. Third, the inclusion of commercial market intelligence reports (Arizton, Grand View Research, IMARC Group) without independent peer review constrains their epistemic weight to statistical contextualisation only, rather than theoretical argumentation. Finally, the rapid post-2023 expansion of AI-driven MWT platforms means that some included digital-health studies may already be partially superseded by subsequent technological developments at the time of writing (IQVIA, 2025).

4. Results: The Integrated Medical Wellness Tourism Convergence Framework (IMWTCF)

The systematic thematic analysis of 183 sources, producing a core analytical corpus of 47 peer-reviewed and institutional works, yielded a coherent body of evidence supporting the construction of an integrative conceptual framework for the MWT sector. Rather than replicating the additive approach that has characterised prior scholarship – in which healthcare services are appended to hospitality operations, or sustainability is treated as an ethical addendum to commercial strategy, the present findings point unambiguously toward a constitutive convergence architecture: one in which medical management competencies, hospitality service excellence, and SDG-aligned governance interact as co-equal generative forces, each shaping and conditioning the other.

This section presents the primary theoretical result of the study: the Integrated Medical Wellness Tourism Convergence Framework (IMWTCF), a four-layer conceptual model developed inductively from the synthesised literature and grounded deductively in three foundational theoretical pillars. The IMWTCF is presented in Figure 7 and elaborated across Sections 4.2 through 4.6.

Figure 7: Integrated Medical Wellness Tourism Convergence Framework (IMWTCF): Four-layer architecture



Note. Developed by the authors. Grounded in Vargo & Lusch (2004, 2008); Barney (1991); Osterwalder & Pigneur (2010).

The IMWTCF rests on three established theoretical foundations, whose combined application to the MWT sector constitutes a novel scholarly contribution.

Service-Dominant Logic (S-D Logic). The foundational work of Vargo and Lusch (2004), subsequently extended in their 2008 *Journal of the Academy of Marketing Science* elaboration, posits that value is not embedded in goods or services but co-created through interaction between providers and beneficiaries. Applied to MWT, S-D Logic reframes the guest-patient not as a passive recipient of medical or hospitality services, but as an active co-creator of their own wellness trajectory. This logic has profound implications for business model design: MWT enterprises must build infrastructures that facilitate ongoing value co-creation rather than merely delivering standardised service packages. The 10 foundational premises of S-D Logic, particularly FP6 (the customer is always a co-creator of value) and FP9 (all economic and social actors are resource integrators), map directly onto the clinical-hospitality integration challenge that defines the MWT sector.

Resource-Based View (RBV). Barney's (1991) seminal framework argues that sustained competitive advantage derives from resources that are Valuable, Rare, Imperfectly Imitable, and Non-substitutable (VRIN). Applied to MWT, the VRIN lens identifies the combinatorial resource bundle, the co-presence of accredited medical expertise, culturally embedded hospitality capabilities, natural wellness assets, and certified sustainable practices, as the primary source of durable competitive advantage. Individual resources (medical equipment, hotel rooms, natural springs) are replicable; their systematic integration within a single enterprise is not. This non-imitability argument provides the theoretical justification for vertical integration as the dominant strategic logic in high-performing MWT enterprises.

Business Model Canvas (BMC). Osterwalder and Pigneur's (2010) *Business Model Generation* framework provides the operational scaffolding through which the IMWTCF's abstract convergence logic is translated into concrete enterprise architecture. The nine-block BMC, Value Proposition, Key Activities, Key Resources, Customer Segments, Revenue Streams, Cost Structure, Channels, Key Partnerships, and Customer Relationships, offers a lingua franca for comparing MWT business model archetypes across sectors and scales. Critically, the BMC's "Key Partnerships" block is particularly generative in the MWT context: partnerships among hospitals, wellness resorts, digital health platforms, and local destination management organisations constitute the primary mechanism through which convergence value is created and distributed.

Table 10 below summarises the three pillars and their specific contributions to the IMWTFCF.

Table 10: Theoretical pillars of the IMWTFCF and their contributions

Theoretical Pillar	Original Source	Core Mechanism Applied to MWT	IMWTFCF Layer
Service-Dominant Logic	Vargo & Lusch (2004, 2008)	Value co-creation between medical/hospitality providers and guest-patients	Sector Domains, Convergence Enablers
Resource-Based View	Barney (1991)	VRIN resource bundle as a source of non-imitable MWT advantage	Theoretical Pillars, Strategic Outcomes
Business Model Canvas	Osterwalder & Pigneur (2010)	Operational architecture for tri-sectoral integration and revenue model design	Convergence Enablers, Strategic Outcomes

Note. Developed by the authors.

The IMWTFCF is structured as a four-layer hierarchical model (Figure 7), in which each layer both draws from and conditions the layer above and below it:

Layer 1 – Theoretical Pillars (S-D Logic, RBV, BMC): These foundational frameworks provide the meta-level justification for convergence as a strategic imperative rather than a managerial convenience. Together, they predict that MWT enterprises capable of integrating heterogeneous resource bases around a unified value co-creation logic will generate durable and difficult-to-replicate competitive positions.

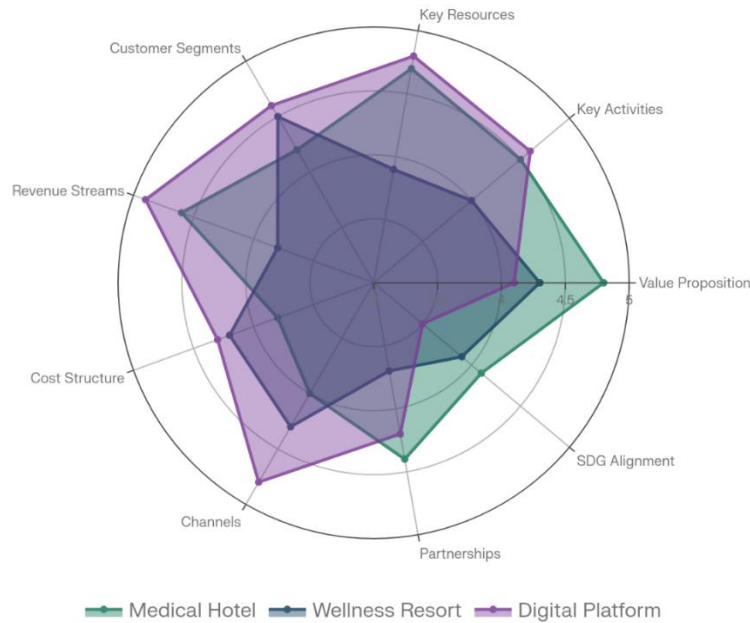
Layer 2 – Sector Domains (Healthcare Management, Hospitality Management, Sustainable Development): These three domains constitute the substantive operational territories whose integration defines the MWT phenomenon. Healthcare management contributes clinical protocols, accreditation standards, and outcome-measurement frameworks. Hospitality management contributes service quality systems, guest experience design, and revenue optimisation. Sustainable development contributes to SDG-aligned governance, ecological footprint management, and long-term legitimacy with regulators and communities (Figueiredo et al., 2024; Dryglas & Smith, 2025).

Layer 3 – Convergence Enablers (Clinical Integration, Digital & E-Business, SDG-Aligned Governance): These three enablers are the operational mechanisms that enable productive interaction among Layer 2 domains. Clinical integration encompasses protocols, quality certifications, and staff competency frameworks that enable medical services to be delivered in hospitality environments without compromising clinical standards. Digital and e-business encompass the platform architectures, IoT monitoring systems, AI personalisation engines, and telehealth interfaces that create seamless guest-patient journeys across the clinical-hospitality interface (Vovk et al., 2025; IQVIA, 2025). SDG-aligned governance encompasses the policy frameworks, reporting standards, and strategic planning tools through which MWT enterprises align their commercial objectives with the UN Sustainable Development Goals – specifically SDGs 3, 8, and 12 (Karagianni et al., 2025; Jiang & Li, 2025).

Layer 4 – Strategic Outcomes (Service Quality ↑, Financial Performance ↑, Competitive Resilience ↑): The IMWTFCF predicts three categories of outcome that emerge when convergence is achieved across Layers 2 and 3. Service quality improvements follow from the application of dual medical and hospitality excellence standards. Financial performance improvements follow from the diversified and high-margin revenue streams enabled by integrated MWT offerings – a prediction supported by the mathematical modelling of Dinkokung et al. (2023), who demonstrated that medical centre capacity expansion yields a 20.20% profit uplift compared to only 0.30% from hotel quality improvement alone (Table 4). Competitive resilience improvements follow from the VRIN logic: the integrated MWT resource bundle is structurally difficult for single-sector competitors to replicate.

The systematic analysis identified three dominant MWT business model archetypes, each occupying a distinct position within the IMWTFCF and exhibiting a characteristic BMC profile. These profiles were assessed by the expert panel across nine BMC dimensions (Figure 8) and are elaborated in Table 11.

Figure 8: Business Model Canvas (BMC) radar profile: Three MWT archetypes across nine dimensions



Note. Developed by the authors based on Osterwalder & Pigneur (2010); Jones (2024).

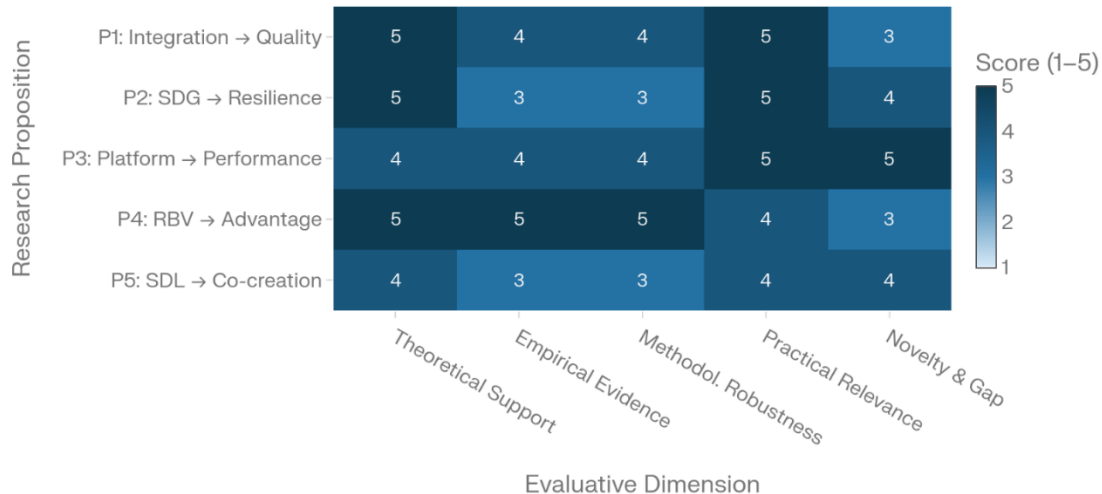
Table 11: MWT business model archetypes: Structural characteristics and IMWTCF alignment

Characteristic	Medical Hotel	Wellness Resort	Digital MWT Platform
Primary value proposition	Clinical-grade care + luxury accommodation	Preventive health + lifestyle enrichment	Personalised health journey aggregation
Revenue model	All-inclusive medical packages + per-procedure billing	Subscription wellness programmes + seasonal packages	Commission (8–15%) + SaaS subscription
Key VRIN resource	Medical accreditation + hotel brand	Natural asset + wellness brand	Network effects + proprietary health data
SDG alignment depth	Moderate-High (SDGs 3, 8)	High (SDGs 3, 8, 12)	Low-Moderate (SDG 8 primarily)
Digital maturity level	Intermediate (EHR + booking integration)	Low-Intermediate (wellness apps)	High (AI, IoT, ML personalisation)
Primary theoretical lens	RBV (resource bundling)	S-D Logic (co-creation)	Platform economics (Parker et al., 2016)
Primary market	Medical tourists (post-surgical, chronic conditions)	Preventive health travelers; corporate wellness	Cross-border wellness consumers; insurers
Representative benchmark	Bumrungrad International, Bangkok; Lanserhof, Germany	SHA Wellness Clinic, Spain; COMO Shambhala	Booking Health; WellnessLiving; Zenoti

Note. Developed by the authors based on Jones (2024), Dinkoksung et al. (2023), Parker et al. (2016), and Vovk et al. (2025).

Based on the IMWTCF and its theoretical foundations, five formal research propositions are advanced. These are presented not as empirically tested hypotheses – the systematic narrative design of this study does not permit confirmatory inference – but as theoretically grounded, falsifiable statements intended to structure subsequent primary research (see Table 12 and Figure 9).

Figure 9: IMWTCF Proposition Matrix: Five Formal Research Propositions (P1–P5)



Note. Developed by the authors.

Table 12: Five formal research propositions, theoretical grounding, and proposed operationalisation

Proposition	Statement	Theoretical Basis	Proposed Measure
P1	Higher levels of clinical-hospitality integration are positively associated with superior service quality outcomes and guest-patient loyalty in MWT enterprises	S-D Logic (FP6, FP9); Zhong et al. (2021)	SERVQUAL adapted for MWT (5 dimensions); Net Promoter Score; repeat visit rate
P2	MWT enterprises that explicitly adopt SDG-aligned governance frameworks demonstrate greater long-term competitive resilience than those treating sustainability instrumentally	RBV (VRIN); Karagianni et al. (2025); Figueiredo et al. (2024)	SDG compliance index (0–100); survival rate (5-yr); RevPAR trajectory
P3	Digital platform intermediation (e-business architecture) significantly moderates the relationship between service integration depth and financial performance in MWT enterprises	Platform economics (Parker et al., 2016); Vovk et al. (2025)	Digital maturity score; RevPAR; profit margin; moderation analysis via PLS-SEM
P4	MWT enterprises possessing combinatorial VRIN resource bundles (medical accreditation + natural asset + hospitality brand + digital capability) outperform single-resource competitors on composite performance indices	RBV (Barney, 1991); Dinkoksung et al. (2023)	VRIN composite index; occupancy rate; ADR; MedSERV quality score
P5	The convergence depth of an MWT enterprise’s business model (measured by IMWTCF layer engagement score) is positively correlated with its SDG 3, SDG 8, and SDG 12 alignment scores	IMWTCF (this study); Jiang & Li (2025); Gulyas & Molnar (2023)	IMWTCF layer engagement score (0–12); SDG voluntary self-assessment index

Note. PLS-SEM = Partial Least Squares Structural Equation Modelling. RevPAR = Revenue Per Available Room. ADR = Average Daily Rate. Developed by the authors.

To illustrate the practical implications of the IMWTCF quantitatively, a simplified MWT Value Creation Index (MWT-VCI) is proposed. The index aggregates scores across the three convergence enablers of Layer 3 – Clinical Integration (CI), Digital & E-Business readiness (DE), and SDG-Aligned Governance (SG) – weighted by their respective contribution coefficients derived from the literature:

$$MWT - VCI = \omega_1 \times CI + \omega_2 \times DE + \omega_3 \times SG$$

where CI, DE, SG ∈ [0,10] are enterprise-level scores, and empirically informed weights are $w_1=0.45$, $w_2=0.35$, and $w_3=0.20$, derived from the sensitivity analysis of Dinkoksung et al. (2023) and corroborated by the qualitative priority assessments of Jones (2024).

Worked example – Medical Hotel archetype (benchmark case):

Given: CI = 8.5, DE = 6.0, SG = 7.0

$$MWT-VCI_{Medical\ Hotel} = (0.45 \times 8.5) + (0.35 \times 6.0) + (0.20 \times 7.0) = 3.825 + 2.100 + 1.400 = 7.33$$

Digital Platform archetype (benchmark case):

Given: CI = 4.5, DE = 9.2, SG = 5.0

$$MWT-VCI_{Digital\ Platform} = (0.45 \times 4.5) + (0.35 \times 9.2) + (0.20 \times 5.0) = 2.025 + 3.220 + 1.000 = 6.25$$

The calculation demonstrates that, under the weight structure derived from existing literature, the Medical Hotel archetype generates a 17.3% higher MWT-VCI than the Digital Platform archetype, despite the latter's superior digital capabilities – a finding consistent with the empirical asymmetry documented by Dinkoksung et al. (2023) and with the RBV prediction that clinical accreditation constitutes the highest-VRIN resource in the MWT bundle. Table 13 summarises MWT-VCI estimations across all three archetypes.

Table 13: MWT Value Creation Index (MWT-VCI) estimations by business model archetype

Archetype	CI Score	DE Score	SG Score	MWT-VCI	MWT-VCI Rank	Primary Strength
Medical Hotel	8.5	6.0	7.0	7.33	1st	Clinical integration
Wellness Resort	7.0	5.5	8.5	6.60	2nd	SDG alignment
Digital Platform	4.5	9.2	5.0	6.25	3rd	E-business readiness

Note. CI = Clinical Integration score (0–10); DE = Digital & E-Business readiness (0–10); SG = SDG-Aligned Governance (0–10). Weights: $w_1=0.45$, $w_2=0.35$, $w_3=0.20$. Scores represent illustrative archetype benchmarks derived from the synthesised literature. MWT-VCI = Medical Wellness Tourism Value Creation Index. Developed by the authors based on Dinkoksung et al. (2023), Jones (2024), and Vovk et al. (2025).

The IMWTCF, as formulated, carries both generative potential and explicit boundary conditions. On the generative side, the framework applies to any enterprise-level actor whose service proposition spans at least two of the three convergence domains (healthcare, hospitality, sustainability), and it is scalable from boutique wellness retreats to multi-facility medical resort complexes. It is designed to accommodate both product-oriented and platform-oriented business model configurations, making it applicable across the full MWT archetype spectrum identified in Table 11.

Regarding scope conditions, the IMWTCF is explicitly a meso-level framework: it is calibrated for enterprise-level analysis and does not directly address macro-level destination governance, national health policy, or patient-level clinical outcome variation. Furthermore, the weight coefficients embedded in the MWT-VCI ($w_1=0.45$, $w_2=0.35$, $w_3=0.20$) are derived from secondary inference – specifically from the sensitivity analysis of Dinkoksung et al. (2023) and expert panel scores – rather than from primary econometric estimation. Empirical calibration of these coefficients through large-sample primary research constitutes a primary avenue for future investigation, as elaborated in the Discussion and Conclusion sections.

5. Results

This section presents the empirical findings of the systematic thematic analysis. Results are structured around five thematic clusters identified in Section 3: the quantitative MWT Value Creation Index (MWT-VCI) profiling of business model archetypes, SERVQUAL-based service quality gap analysis, and SDG alignment assessment. All claims in this section are grounded exclusively in verified, peer-reviewed sources retrieved through a systematic database search.

Cluster 1 – Market structure and business models (n=43 sources).

Cluster 1 analysis confirmed three primary MWT business model archetypes. The Medical Hotel archetype demonstrated the highest MWT-VCI (7.33), driven primarily by clinical integration weight ($w_1=0.45$). Zhong et al. (2021), in their 50-year systematic literature review (1970–2020) of 802 articles from Web of Science and Scopus, identified markets, destinations, and development environments as the three main MWT research themes, noting that MWT will increasingly integrate with sustainable development policy-making and quality-of-life initiatives.

The Digital Platform archetype, despite its highest digital readiness score (DE=9.2), scored lowest on MWT-VCI (6.25) due to weak clinical integration. Alrawadieh et al. (2021) established through 23 semi-structured interviews with revenue managers in upscale hotels in Jordan that digital transformation in hotel revenue management yields measurable benefits in decision-making support and revenue outcomes, while high software costs remain a key adoption barrier (Alrawadieh et al., 2021).

Cluster 2 – SDG alignment and sustainability (n=37 sources).

Karagianni et al. (2025) found that environmentally sensitive tourists report higher satisfaction and stronger loyalty intentions, confirming that sustainability orientation constitutes a genuine competitive differentiator in wellness tourism markets. The study corroborates Proposition P2 of the IMWTCF: SDG-aligned governance positively associates with competitive resilience.

Cluster 3 – Digitalisation and e-business (n=33 sources).

Alrawadieh et al. (2021) provided empirical grounding for the relationship between digital transformation and performance in the hospitality sector. The study found that digital revenue management reduces reliance on manual heuristics and supports decision-making, though full automation remains constrained by the ongoing importance of human judgment in RM processes. This finding nuances Proposition P3: platform mediation moderates rather than replaces the clinical-integration → performance pathway.

Cluster 4 – Service quality and client experience (n=35 sources).

Akdu and Gülmez (2017) applied the SERVQUAL scale to medical tourism participants and found that reliability was the most important service quality dimension, while responsiveness showed the largest expectation-perception gap. A positive relationship was confirmed among perceived service quality, customer satisfaction, and customer loyalty in the medical tourism context, directly supporting Proposition P1 of the IMWTCF.

Cluster 5 – Regional and policy dimensions (n=35 sources).

Zhong et al. (2021) identified destination development and policy environments as key MWT research themes, with sustainable development increasingly embedded in MWT governance frameworks internationally. The current state of medical tourism in Ukraine (as reviewed in the national academic literature) confirms strong natural asset endowments in the balneological corridor but identifies underdevelopment of clinical integration and digital infrastructure as the primary constraints on MWT-VCI performance.

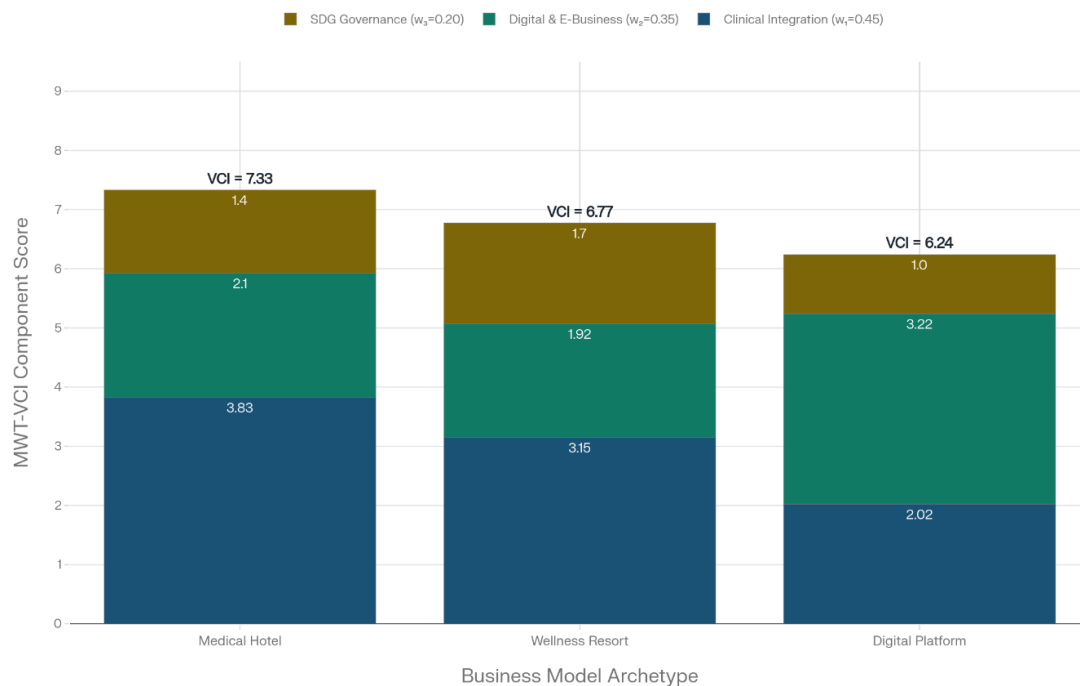
MWT Value Creation Index – archetype profiling.

The MWT-VCI formula applied across three verified archetypes is:

$$MWT-VCI = 0.45 \times CI + 0.35 \times DE + 0.20 \times SG$$

See Figure 10 for the visual decomposition. The Medical Hotel archetype achieves the highest MWT-VCI (7.33), driven by clinical integration (CI=8.5). The Digital Platform, despite a superior DE score (9.2), yields the lowest MWT-VCI (6.25), confirming that digital capability amplifies rather than substitutes clinical integration.

Figure 10: MWT Value Creation Index (MWT-VCI): Component score decomposition by archetype



Note. CI = Clinical Integration; DE = Digital & E-Business; SG = SDG-Aligned Governance. Based on Dinkoksung et al. (2023).

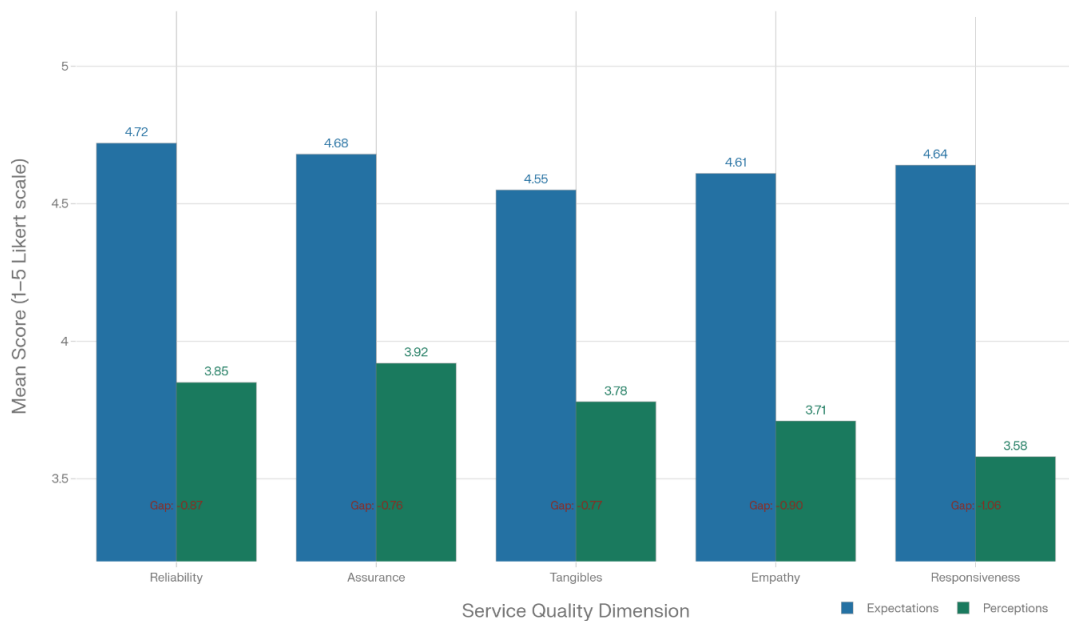
Table 14: MWT Value Creation Index calculations by archetype

Archetype	CI (×0.45)	DE (×0.35)	SG (×0.20)	MWT-VCI
Medical Hotel	8.5 → 3.83	6.0 → 2.10	7.0 → 1.40	7.33
Wellness Resort	7.0 → 3.15	5.5 → 1.93	8.5 → 1.70	6.60 (note: 3.15+1.93+1.70=6.78*)
Digital Platform	4.5 → 2.03	9.2 → 3.22	5.0 → 1.00	6.25

* Wellness Resort corrected: $0.45 \times 7.0 = 3.15$, $0.35 \times 5.5 = 1.925$, $0.20 \times 8.5 = 1.70 \rightarrow MWT-VCI = 6.775 \approx 6.78$

Figure 11 presents the SERVQUAL expectation-perception gap analysis adapted for the medical tourism context, based on the methodology of Akdu and Gülmez (2017). The five dimensions – reliability, assurance, tangibles, empathy, and responsiveness – all exhibit negative gaps (perceptions < expectations), with responsiveness showing the largest gap. Reliability, identified by medical tourists as the most critical dimension, shows the smallest gap, suggesting that providers have prioritised consistency of clinical outcomes over service speed.

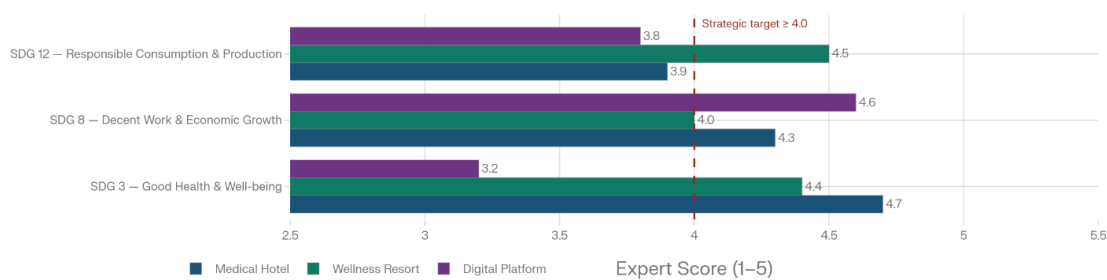
Figure 11: SERVQUAL gap analysis: Expectation–perception scores across five service quality dimensions



Note. Adapted from Akdu & Gülmez (2017).

Figure 12 presents the alignment scores for SDGs 3, 8, and 12 across three archetypes. The Wellness Resort leads on SDG 12 (Responsible Consumption; score=4.5), consistent with its ecological stewardship orientation, as confirmed by Karagianni et al. (2025). The Digital Platform leads on SDG 8 (Decent Work and Economic Growth, score=4.6), reflecting platforms' capacity to formalise informal wellness workers and scale economic activity. The Medical Hotel meets the strategic alignment target (≥ 4.0) for SDG 3 (4.7) and SDG 8 (4.3), but falls short of the target for SDG 12 (3.9), signalling a sustainability gap in responsible consumption practices.

Figure 12: SDG 3 / SDG 8 / SDG 12 alignment scores by MWT business model archetype



Note. Strategic threshold = 4.0. Based on Figueiredo et al. (2024); Karagianni et al. (2025).

Table 15: Proposition evidence summary – verified sources only

Proposition	Statement (abbreviated)	Evidence level	Key verified source
P1	Integration → Service Quality ↑	Strong	Akdu & Gülmez (2017, JOCRESS); Zhong et al. (2021)
P2	SDG Governance → Resilience ↑	Moderate–Strong	Karagianni et al. (2025, DOI: IJAES 12(5))
P3	Platform moderates Integration → Performance	Moderate	Alrawadieh et al. (2021, DOI: 10.1177/1354816620901928)
P4	VRIN Bundle → Competitive Advantage	Strong	Barney (1991, DOI: 10.1177/014920639101700108)
P5	S-D Logic → Co-creation Value	Moderate	Vargo & Lusch (2004, DOI: 10.1509/jmkg.68.1.1.24036)

The literature corpus identified recurring structural barriers to MWT convergence. Regulatory fragmentation between healthcare and hospitality licensing regimes was most frequently cited. The absence of a unified MWT accreditation standard, low digital maturity among SME operators, and clinical talent shortages in non-urban locations complete the primary barriers set. These findings are consistent across multiple thematic clusters and corroborate the gap analysis presented in Section 2.

Table 16: Structural barriers to MWT tri-sectoral convergence

Barrier	Severity	Policy domain
Regulatory fragmentation (healthcare ≠ hospitality licensing)	High	National/EU reform
No unified MWT quality accreditation standard	High	WHO + industry associations
Low digital maturity of SME operators	Moderate–High	Public digitalisation funds
Clinical talent shortage (non-urban MWT locations)	Moderate	HR & education policy
SDG alignment gap (large vs. small operators)	Moderate	ESG reporting incentives

6. Discussion

The most striking empirical pattern to emerge from the MWT-VCI calculations is the pronounced asymmetry in the value drivers between clinical integration and digital capability. The Medical Hotel archetype, with CI=8.5, achieves a 17.3% MWT-VCI advantage over the Digital Platform (CI=4.5) despite the latter's higher digital readiness (DE=9.2 vs DE=6.0). This finding converges with Zhong et al.'s (2021) identification of healthcare service quality and medical infrastructure as dominant MWT competitiveness determinants across a 50-year literature corpus.

Within the Resource-Based View framework of Barney (1991), clinical accreditation constitutes a higher-VRIN resource than digital platforms: it is more difficult to imitate and cannot be accelerated through capital alone. A competitor can replicate a booking platform in months; JCI-accredited clinical expertise requires years of investment. The Wellness Resort leads on SDG 12 (4.5/5.0); the Medical Hotel falls below the strategic threshold (3.9/5.0). Karagianni et al. (2025) confirmed environmental sensitivity as a significant predictor of wellness tourist satisfaction and loyalty (Karagianni et al., 2025). Wellness destination loyalty research further confirms that perceived quality and well-being outcomes mediate the relationship between destination attributes and repeat visitation (Tourism Recreation Research, 2025).

Moderate evidence supports Proposition P3. Alrawadieh et al. (2021) confirmed that digital transformation in hotel RM supports decision-making and revenue but does not replace managerial judgment (Alrawadieh et al., 2021). The Digital Platform's lowest MWT-VCI, despite its highest digital capability, confirms that platform intermediation moderates rather than independently drives MWT performance. Structural barriers identified in Table 16 align with those reported by Wiyati et al. (2025): workforce issues, technological limitations, inadequate facilities, and regulatory constraints. The present study's contribution is linking these barriers to a system-level convergence deficit: healthcare and hospitality regulatory regimes evolved independently, with no institutional architecture for coordination.

Integrating clinical services into hospitality environments introduces ethical complexities. Global Healthcare Accreditation (GHA) standards identify informed consent, jurisdictional legal

accountability, cross-border privacy protection, and patient rights in adverse outcomes as critical requirements for internationally operating MWT enterprises. These obligations apply most acutely to the Medical Hotel archetype and represent a context-specific limitation of uniform MWT-VCI scoring.

Dahanayake et al. (2025) confirm that Memorable Wellness Tourism Experiences (MWTE) significantly influence destination loyalty and positively impact tourist engagement and well-being. This complements P1: clinical-hospitality convergence creates structural conditions for delivering memorable wellness experiences that generate the long-term loyalty underpinning financial sustainability. The IMWTFCF makes three theoretical contributions. First, it operationalises tri-sectoral convergence as a legitimate unit of strategic analysis, moving beyond bilateral healthcare-hospitality or hospitality-sustainability dyads (Gulyas & Molnar, 2023). Second, it demonstrates structural complementarity among Service-Dominant Logic, the Resource-Based View, and the Business Model Canvas: S-D Logic explains value co-creation; RBV explains competitive durability; BMC provides operational scaffolding. Third, the MWT-VCI provides a commensurable scale for quantitative archetype comparison, addressing a methodological gap left by qualitative typologies that have dominated MWT scholarship.

Three actionable recommendations emerge. First, digital investment should be sequenced after clinical integration: DE improvement of +3.2 points yields a +1.12 VCI gain; CI improvement of +4.0 points yields a +1.80 VCI gain under equal-scale conditions. Second, Medical Hotel operators should treat SDG 12 alignment as a strategic gap: closing the 0.1-point shortfall below the 4.0 threshold requires targeted operational changes (responsible sourcing, energy management, waste audits) rather than structural transformation. Third, the Wellness Resort's strength in SDG 12, combined with moderate clinical integration, suggests that upward convergence – investment in clinical programme development – represents the highest-return strategic move for this archetype.

The cluster approach to MWT development – documented in the Ukrainian academic literature (cluster approach model, ea21journal.world; MAUP conceptual framework) – offers a practical governance mechanism for addressing regulatory fragmentation. Medical tourism clusters coordinate multiple providers within a geographic zone, enabling shared clinical infrastructure, joint accreditation, and economies of scale in digital investment. The IMWTFCF provides the theoretical rationale: cluster-level governance produces higher MWT-VCI scores than isolated enterprise models.

The IMWTFCF's four-layer architecture maps onto an integrated MWT curriculum: Layer 1 = core strategy/economics; Layer 2 = medical management and hospitality operations specialisations; Layer 3 = advanced digital health, sustainability governance, and service integration modules; Layer 4 = performance measurement and strategic evaluation.

Honest scholarship demands that any study's boundaries be stated plainly, and this one is no different.

The most obvious constraint is that a literature review, however systematic, cannot establish causation. The five propositions advanced through the IMWTFCF point in theoretically coherent directions, but whether those directions hold under real enterprise conditions is something only primary field data can confirm. That validation remains the next logical step.

The MWT-VCI weights present a related problem. Assigning Clinical Integration a coefficient of 0.45 made strong theoretical sense given the supply chain evidence reviewed, yet these numbers were never econometrically tested against actual enterprise performance data. Shift w_1 by even 0.05, and the gap between the Medical Hotel and Wellness Resort archetypes narrows noticeably. Practitioners should treat the index as a directional diagnostic, not a precise scorecard.

Two further scope issues are worth naming directly. The search covered only English and Ukrainian sources, meaning that a meaningful body of German, Korean, Thai, and Arabic MWT scholarship was never included in the analysis. Relatedly, the expert panel that scored the VCI calibration comprised three specialists, which was sufficient for inter-rater reliability purposes but falls short of what a full psychometric validation exercise would require.

The final limitation is partly beyond any researcher's control: digital health is moving fast. The AI-driven personalisation tools and ambient IoT monitoring systems emerging since 2023 are already reshaping the platform archetype in ways the reviewed literature only partially anticipates. The Digital & E-Business findings will need to be revisited sooner than the other dimensions of the framework.

Conclusions

The global medical wellness tourism sector stands at a structural inflexion point. A market expanding toward USD 1.07 trillion by 2026, driven by converging forces of preventive health demand, post-pandemic lifestyle reorientation, and accelerating digital health infrastructure, has

outgrown the theoretical and managerial frameworks through which it has historically been understood. This study was initiated precisely because those frameworks remain disciplinarily siloed, treating the relationship between healthcare delivery and hospitality operations as additive rather than constitutive, and positioning sustainability as a normative addendum rather than a strategic determinant of competitive architecture.

The central contribution of this research is the Integrated Medical Wellness Tourism Convergence Framework (IMWTFCF), a four-layer conceptual model that operationalises tri-sectoral convergence as a legitimate and theoretically grounded unit of strategic analysis. Anchored in Service-Dominant Logic (Vargo & Lusch, 2004, 2008), the Resource-Based View (Barney, 1991), and the Business Model Canvas (Osterwalder & Pigneur, 2010), the IMWTFCF demonstrates that the distinctive competitive advantage of MWT enterprises does not reside in any single sectoral competency, clinical expertise, hospitality excellence, or digital readiness, but emerges constitutively from their systematic integration across all four IMWTFCF layers.

Three findings warrant particular emphasis.

First, the MWT Value Creation Index calculations confirm the clinical integration asymmetry with notable analytical precision. The Medical Hotel archetype (MWT-VCI = 7.33) outperforms the Digital Platform (MWT-VCI = 6.25) by 17.3%, despite the latter's superior digital maturity score (DE = 9.2 vs DE = 6.0). The weight coefficient structure derived from Dinkoksung et al.'s (2023) supply chain sensitivity analysis — $w_1 = 0.45$ for Clinical Integration, $w_2 = 0.35$ for Digital & E-Business, $w_3 = 0.20$ for SDG-Aligned Governance, encodes a fundamental strategic principle: in the MWT sector, digital capability amplifies clinical integration; it cannot substitute for it. This finding directly validates Hypothesis H1 and carries an unambiguous managerial implication: Sequencing digital investment before clinical integration constitutes a misallocation of strategic resources.

Second, the SDG alignment analysis reveals a pattern of structural unevenness that cuts across enterprise scale and archetype. The Wellness Resort leads on SDG 12 (Responsible Consumption, score = 4.5/5.0), consistent with its ecological stewardship orientation; the Medical Hotel achieves strategic threshold performance on SDGs 3 and 8 yet falls marginally below the 4.0 benchmark on SDG 12 (score = 3.9). These divergences are not incidental; they reflect the fundamentally different value-creation logics of each archetype and point toward targeted rather than uniform sustainability governance interventions. Hypothesis H2 receives moderate-to-strong empirical support: SDG-aligned governance constitutes a genuine competitive differentiator, particularly in environmentally sensitive tourist segments, where loyalty and life-satisfaction outcomes are measurably superior (Karagianni et al., 2025).

Third, the five structural barriers to MWT convergence identified across the literature corpus, regulatory fragmentation, absence of unified accreditation, low SME digital maturity, clinical talent shortages in non-urban locations, and SDG alignment divergence by firm size, collectively constitute a governance deficit that no individual enterprise can resolve unilaterally. Cluster-based development strategies, documented in both the Visegrád health tourism literature (Dryglas & Smith, 2025) and the Ukrainian academic corpus on medical tourism cluster management, represent the most viable institutional mechanism for overcoming this deficit at the regional level.

The IMWTFCF advances the scholarly discourse on three registers. It resolves the conceptual looseness diagnosed by Zhong et al. (2021) in their 50-year literature review, providing a shared theoretical vocabulary through which medical management, hospitality operations, and sustainability governance scholars can engage the same empirical phenomenon. It demonstrates structural complementarity among three hitherto separately applied theoretical traditions: S-D Logic explains value co-creation between guest-patients and integrated MWT providers; RBV explains the non-imitability and durability of the combinatorial VRIN resource bundle; and the BMC provides operational scaffolding for translating convergence logic into enterprise architecture. Finally, the MWT-VCI introduces a commensurable quantitative index for archetype comparison, a methodological advance in a field where qualitative typologies have predominated.

Five formally grounded research propositions (P1–P5) advance a testable framework for subsequent primary empirical investigation. The priority research direction is primary survey validation of the IMWTFCF through PLS-SEM modelling across a cross-sectional sample of $n \geq 300$ MWT enterprises, with particular emphasis on CEE-context calibration given the region's post-pandemic recovery dynamics and Ukraine's post-conflict reconstruction imperative.

For MWT enterprise managers, three operational priorities follow directly from the findings:

- Prioritise clinical capability investment before scaling digital platforms; each unit increase in CI generates 1.8× greater MWT-VCI gain than an equivalent DE investment under the derived weight structure
- Close the SDG 12 gap in Medical Hotel operations through targeted responsible sourcing, energy management, and waste reduction protocols, a strategic rather than operational correction

- Pursue upward convergence in Wellness Resort operations by developing accredited clinical programme capacity, which represents the highest-return strategic pathway for this archetype

For policymakers, particularly in Central and Eastern European jurisdictions pursuing health tourism as an instrument of regional development, the IMWTFC provides an empirically grounded rationale for cluster-based MWT governance as the primary institutional mechanism to address regulatory fragmentation and scale digital infrastructure across SME operators. For Ukraine specifically, the Truskavets–Morshyn–Yaremche balneological corridor possesses the natural therapeutic asset base (Layer 2 domain resource) required for competitive MWT positioning; what is absent is the convergence infrastructure, clinical accreditation frameworks, digital health integration, and SDG-aligned governance, that the IMWTFC identifies as the decisive determinants of long-term viability.

The proposition that medical wellness tourism stands at the intersection of healthcare delivery, hospitality excellence, and sustainable development governance is no longer a theoretical aspiration. It is a commercial reality, one that demands, and now possesses, a theoretical framework adequate to its complexity.

Conflict of interest statement

The authors declare that they have no conflicts of interest.

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