A HEALTHY MARKET?

The Health Quality Agenda

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STOCKHOLM NETWORK

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Executive Summary

Over the past century, governments have increasingly focused their energies and their expenditure on health care. The better off we have become, the more we have tended to spend on health care. Subsequently, we have also experienced an increasing improvement in health outcomes. This is undoubtedly a positive trend. However, for policymakers, one aspect of this 'higher income = higher spending = better health' equation is also causing a major headache.

In most OECD countries, there is now a growing concern over both rising healthcare costs and rising national expenditures on health care. In Europe, an ageing population is demanding more and better health care from what remains a largely government-funded and managed health care sector. This has resulted in a substantial political debate in many European countries over what type of care the government does (and does not) cover, and should (and should not) cover.

This paper attempts to re-evaluate the way health care expenditure is understood. As such, it pertains to a much wider understanding of health and health care than is normally taken into account by policymakers. In particular, it has examined consumer spending on a novel basket of health and wellbeing goods, which relate to this wider understanding of health. This paper has demonstrated that in categories ranging from sport and fitness expenditure to alternative medicine, cosmetic surgery, healthy eating and medicines, consumers are sending a clear message. Our desire for health and wellbeing is growing in a hitherto unprecedented manner and, based on observed trends, demand for better health is expected to keep on growing. Indeed, no longer a fringe industry, the global health and wellbeing sector was last year estimated to be worth a staggering $1trillion.

Having defined a novel basket of health and wellbeing goods and services, this paper analyses how consumers are actually spending a growing share of their income on these products. Based on the evidence, this study questions traditional assumptions about the negative implications of growing health expenditures, instead viewing it as a growth industry and as a market that consumers are choosing to invest in. The growth in healthcare spending and the growing consumption of health and wellbeing goods are clearly here to stay.

As demand for health care in both the private and the public sectors is only set to grow, policymakers will need to find ways to tap into this private willingness to spend on health, in order to ease the pressures on public spending. In future, demographic changes and changes in consumer attitudes and behaviour will put ever greater pressure on governments' role in the funding and provision of health care. Whether voters like it or not, the desire for universal and equal coverage (which, even now, is more often only true in theory rather than in practice), may feasibly only be achieved by a combination of public and private spending. Greater purchasing power and economies of scale can be replicated within private care by appropriate combinations of government regulation and the power of consumer choice and competition in a healthcare market which will allocate economic resources most efficiently and drive up standards.

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1. Introduction

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."[1]

Man has been battling with mortality for millennia. It is, of course, a war that we will never win. However, in the past couple of centuries, we have certainly started to win some health battles. Life expectancy, for example, has increased dramatically during the 20th century due to advances in sanitation, nutrition and medical knowledge. As a species, we are living longer, healthier and better-quality lives. In our society, where health has come to be viewed as "the first of all liberties",[2] achieving good health has become a 'holy grail'. However, in the modern market economy, health has also become a valued commodity.

Over the past century, governments have increasingly focused their energies and their expenditure on health care. The better off we have become, the more we have tended to spend on health care. Subsequently, we have also experienced an increasing improvement in health outcomes.[3] This is undoubtedly a positive trend. However, for policymakers, one aspect of this 'higher income = higher spending = better health' equation is also causing a major headache.

In most OECD countries, there is now a growing concern over both rising healthcare costs and rising national expenditures on health care. In Europe, an ageing population is demanding more and better health care from what remains a largely government-funded and managed health care sector. This has resulted in a substantial political debate in many European countries over what type of care the government does (and does not) cover, and should (and should not) cover. In the UK, for example, the National Institute for Health and Clinical Excellence (NICE), the governmental body charged with recommending which medicines and treatments the National Health Service (NHS) should provide, has recently been embroiled in a

[1] Benjamin Disraeli, British politician and author, 1804-1881.

[2] Henri-Frederic Amiel, Swiss philosopher, 1828-1881.

[3] For a recent example, see the Health Foundation (UK) report *The link between healthcare spending and health outcomes* :
http://www.health.org.uk/publications/research_reports/the_link_between.html

number of controversies regarding both its decision-making model and also in regard to statements made by its chief executive on the business model of pharmaceutical companies.[4] Across the Atlantic, the American public's anxiety over the rising cost of health care has prompted politicians from across the political spectrum to propose sweeping changes to how health care coverage is purchased and provided – whether through private insurance or through government-funded programs such as Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP).[5]

Indeed, a brief look at some of the lead expenditure figures for the OECD illustrates the extent to which total health care spending has increased over the past five decades. In 1960 *none* of the 12 countries[6] for which the OECD has statistics spent more than 5.4% of their GDP on health care.[7] Four decades later, in 2000, only two of the OECD's 30 member countries, South Korea and Turkey, actually spent *less* than 5.4% of their national wealth on health care.[8] In fact, by 2007 the OECD countries spent on average 8.4% of GDP on health care.[9] This figure is set to keep increasing as rising life expectancy, lower birth rates and improved medical technologies continue to contribute to the ageing of the OECD population, fuelling an ever-growing demand for health care. For many governments and policymakers this is a cause for concern since, based on these trends, healthcare costs are estimated to occupy an ever-bigger share of both national income and national budgets in the future. As a result they must find either tax revenue or reforms which can secure alternative sources of funding to pay for the growth.[10]

Consequently, it is safe to argue that in most cases policymakers and those with responsibility for national budgets wish to limit the rise of health care spending to pre-defined, 'acceptable' levels. But this will be very difficult to achieve. Why? Firstly,

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[4] See, for example, *The Economist*, 'NICE turns nasty', August 21, 2008.

[5] See, for example, the 2008 presidential candidates' respective stance on health care and the importance the issue has gained nationally. The Kaiser Foundation has dedicated a website entirely to health care in the 2008 elections: http://www.health08.org/index.cfm

[6] These are: Austria, Canada, Finland, France, Iceland, Ireland, Japan, Norway, Spain, Switzerland, the UK and the US.

[7] OECD.Stat, Health Expenditure 1960, http://stats.oecd.org/wbos/Index.aspx?usercontext=sourceoecd

[8] Ibid. Health Expenditure 2000.

[9] http://www.oecd.org/document/27/0,3343,en_2649_34631_40902299_1_1_1_37407,00.html

[10] http://www.oecd.org/document/12/0,2340,en_2649_201185_36079116_1_1_1_1,00.html

because publicly-funded and/or provided health care systems are built on the *de jure* premise that health care must not be rationed. However, the *de facto* reality is that many governments have tried and are trying to do exactly that via a variety of methods including waiting lists, waiting times and so-called Health Technology Assessments (HTA) mechanisms, which limit access to certain medicines and treatments.[11]

Secondly, limiting access to healthcare will prove politically challenging because modern consumers are already choosing to spend a growing share of their own private income on both traditional healthcare products *and* other goods and services aimed at increasing their overall health and wellbeing. Over time, therefore, they are likely to become far less accepting of national health services which limit their freedom of choice and the availability of health goods and services.

The cost and availability of public funding of health care is indeed a matter for concern and legitimate public debate. However, it no longer constitutes the whole picture of wellbeing and health care in industrialised countries.

When we think of health care, we tend to conceptualise it in fairly conventional terms – whether in terms of medical staff (doctors, nurses and technicians), infrastructure (clinics and hospitals) or medicines and medical devices. These are the sorts of indicators normally used by the Organisation for Economic Cooperation and Development (OECD) and the World Health Organisation (WHO) to numerically evaluate national healthcare systems. However, there is a growing understanding of health care as a holistic concept that goes beyond this traditional remit. If we want to get a better and more nuanced picture of health care in industrialised countries, we need to take a fresh approach.

[11] The Stockholm Network has published a number of publications on the issue, which not only detail the impetus for the HTA process but also the wide gap between theory and practice, as well as a comparative assessment of NICE and IQWIG.

2. Objective and scope of the paper

This paper examines our growing demand not just for health care to treat illnesses or medical conditions but also for our general wellbeing and the maintenance of healthy lifestyles. The inspiration for this approach comes from the constitution of the World Health Organisation (WHO) whose first principle states that:

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[12]

In particular, we examine **consumer spending on a basket of health and wellbeing goods**, which relate to this wider understanding of health. This paper demonstrates that in categories ranging from sport and fitness expenditure to alternative medicine, cosmetic surgery, healthy eating and medicines, consumers are sending a clear message. Our desire for health and wellbeing is growing in a hitherto unprecedented manner and, based on observed trends, demand for better health is expected to keep on growing. Indeed, no longer a fringe industry, the global health and wellbeing sector was last year estimated to be worth a staggering $1trillion.[13]

This is a noteworthy trend. Although it runs along the same trajectory as the growth of public healthcare expenditure, the two are viewed very differently, especially by policymakers. In other words, while the growth in public spending is increasingly seen as a (budgetary) threat, the growth in private spending on health tends nevertheless to be seen as a positive sign of progress, demonstrating the willingness of consumers to invest in their health and wellbeing. The social and economic benefits of such self-care are numerous including a more productive workforce, and reduced demands on the health system as people look after their own health more assiduously.

[12] http://www.who.int/governance/eb/who_constitution_en.pdf

[13] Spaopportunities.com, 'New Report Reveals Global Spa economy worth $250million', 29 May 2008, http://www.spaopportunities.com/newsdetail1.cfm?codeID=68243&CFID=30672324&CFTOKEN=71587317

However, while the two trends may be evaluated differently, in another respect they both amount to the same fact – demand for health care is growing. If we take on board two other important factors – the ageing of the OECD population and continued economic development – this demand is only set to keep growing.

3. Methodology

3.1 Categories

In gauging the extent of private consumer spending on health and wellbeing, this study takes a fresh approach, looking through the lens of a wider understanding of health and wellbeing. The focus is on areas of spending that are *viewed by consumers themselves* as contributing to their health and wellbeing.

Based on these preferences we created a basket of seven health-related goods and services:

1. **Medicines** – In public health care systems, pharmaceuticals and health care technologies are often rationed whether by price, omission or queuing.[14] Complementing public health systems is a growing market in private spending for both prescription medicines and over-the-counter (OTC) drugs. This category measures the extent of private spending on such pharmaceuticals.

2. **Physical exercise equipment** – Physical exercise is medically proven to maintain and improve physical fitness and overall health.[15] As such, it may be deemed a form of preventative medicine. The size of the equipment market for sports and physical exercise gives an indication of how much is being

[14] Many countries use systems of Health Technology Assessment (HTA) to perform a cost-benefit analysis of a particular drug or treatment. This then forms part of a recommendation made to the relevant health authorities on what types of medicines and treatments should be made available under public funding. In the UK, for example, the National Institute for Health and Clinical Excellence (NICE) provides guidance on the use of new and existing medicines, treatments and procedures within the National Health Service (NHS). It effectively has to decide whether or not a particular medicine is cost-effective for the NHS, and as such, it decides whether or not particular medicines will be provided by the NHS.

[15] http://hcd2.bupa.co.uk/fact_sheets/html/exercise.html

spent on sports 'hardware', whether activity-specific equipment such as rackets, balls and weights, or sports attire.

3. **Fitness** – The size of the fitness market, i.e. revenue from gym memberships or other fitness facilities, gives an indication of the extent people are willing to spend money on maintaining and increasing their own health and fitness levels. It does not indicate, of course, how many people actually keep fit – jogging, for example, requires no special equipment – and the phenomenon of joining the gym with all good intentions but not attending is all too well known.[16] Still, measuring the size of the fitness market is a key indicator of the extent to which consumers are willing to invest in their physical health and wellbeing.

4. **Organic food** – One of the primary reasons people chose to consume organic food is health-related, as they believe it contains fewer harmful chemicals and more nutrients than non-organic food.[17] This category therefore provides an indication of how much value consumers place on their dietary choices and are willing to spend on what they perceive as being healthier food.

5. **Complementary and alternative medicines (CAM)** – CAM is a group of diverse medical and health care practices and products that are used either alongside or instead of conventional medicine.[18] These alternative treatments can add to both physiological and psychological wellbeing. Although some forms of alternative medicine are now available through public health systems, e.g. acupuncture in the UK, this is still largely a privately funded sector. It is also a growing sector and is an important indicator of the 'pent-up demand' for health and wellbeing treatments that fall outside the remit of traditional health care. Debate still remains about the clinical effectiveness of many of these treatments. However, they tend to demonstrate, among other

[16] http://www.independent.co.uk/money/invest-save/joining-a-gym-can-do-serious-damage-to-your-wealth-692308.html
[17] http://www.whyorganic.org/healthy_foodKids.asp
[18] http://nccam.nih.gov/health/whatiscam/

things, consumers' desire for additional time and personal attention from professionals, which is becoming restricted in public health systems working under tight budget constraints.

6. **Spas and springs** – This category pertains to the "mental and social wellbeing" part of the WHO definition of health. Modern spas come in all sorts of shapes and sizes, but their common goal is to provide an environment for mental and physical relaxation. Some are more of the traditional variety, providing hydro therapy and treatment via natural hot or cold springs (the term 'spa' is derived from the name of the Belgian town Spa, which is famous for its hot springs). Others offer a more modern version of relaxation, providing a range of services such as sauna rooms, massages and beauty therapy.

7. **Cosmetic surgery** – Like spa therapy, this category also pertains to the 'mental and social wellbeing' part of the WHO definition. Whereas it could be said that the spa category represents mental health (decreasing stress levels or alleviating exhaustion and anxiety), cosmetic surgery plays a part in social wellbeing. Although excessive use of cosmetic surgery does take place (especially by those suffering from body dysmorphia), for the most part cosmetic surgery constitutes minor procedures designed to improve a patient's self-esteem, as the most common procedures tend to be breast augmentation/reduction or minor alterations to the face, such as rhinoplasty or alleviation of scarring.[19]

3.2 Countries

The countries included in this study are: the **UK**, the **US**, **Canada**, **Japan**, **Germany**, **France** and **Italy**. These are all industrialised OECD countries that – apart from Japan – have a relatively high national rate of spending on health care and are among the richest countries in the world. Each country contains a large segment of consumers who make active choices about their health care needs, making them

[19] http://www.healthsystem.virginia.edu/UVAHealth/adult_plassurg/csmetics.cfm

more likely to invest in health and wellbeing products and services. As the sample includes countries from three major continents (the Americas, Europe and Asia) it provides a good indicator that the increase in health and wellbeing spending is not consigned to one country or continent, but is an important part of our global economic development and a sign of the growth in consumers' disposable income worldwide. In other words, as we become wealthier, our basic needs for food, shelter, safety and clothing are more than adequately met, so we begin to spend more money on 'quality of life' products and services, be they education, or health and wellbeing.

3.3 Conceptual and methodological qualifications

Researching a novel basket of health-related goods and services presented several methodological difficulties. Consequently, the data that this study is based on must be qualified in the following ways.

Although well-known sources were used whenever possible, such as statistics from the OECD, the International Monetary Fund (IMF), the CIA World Factbook and the World Health Organisation (WHO), due to the consumer-focused nature of the subject matter, this study has relied heavily on other sources, such as market research reports, media articles and information provided by trade associations. As such, the sheer variety of the sources used means that the sum of our data has been compiled through different statistical methodologies.

The goal was to provide a snapshot of current private spending on this basket of goods, but the availability of data has given us a chronological spread within most categories, usually ranging from 2001-2007. The totals presented therefore tend to give an indication of levels of spending for the first few years of the 21st century, rather than spending levels for any one year in particular. A further sub-qualification must be added here. In order to make the final data comparable, we converted it into US dollar values (as most, but not all, of the data was given in this currency). To do so, we calculated these conversions using 2008 exchange rates for data ranging from 2001-2007. As the value of the dollar has fallen in the past couple of years, some of the final data might look slightly different if year-specific calculations had been made.

Finally, the subject matter of our research, and the lack of universal industry definitions for the various health and wellbeing goods and services presented definitional problems. Take the complementary and alternative medicines (CAM) category as an example. CAM is defined differently by different sources (i.e. different products and services are included). Therefore while some sources may include only services, such as acupuncture, aromatherapy and shiatsu, others will also include products such as herbal remedies and supplements.

Despite these qualifications, the following data nonetheless provides a good indication of the extent to which consumers choose to invest large amounts of their income in private health and wellbeing.

4. Results

4.1 Aggregated data

The following table (Table 1) includes the sum of the data collected, covering all seven categories and all seven countries studied. While it is clear from this table that billions of US dollars are being spent privately on health and wellbeing products and services, the figures by themselves do not tell us much more than that. This data needs to be put into context.

Table 1: Aggregate health and wellbeing (HWB) spending. All data is in US dollars. (No reliable data exist for the size of the Italian spa industry).

	UK	US	CA	JP	GM	FR	IT
Medicines (2002)	3.1 billion	146 billion	7.26 billion	20 billion	7.9 billion	8.5 billion	10.6 billion
Physical exercise equipment (2003)*	2.5 million	14.8 billion	7.1 million	8.5 million	3.6 billion	2.8 billion	1.9 billion
Fitness (2007)**	6.4 billion	21.8 billion	1.7 billion	3.9 billion	4.6 billion	253 million	15.6 billion
Organic food (2006)***	3.3 billion	14.6 billion	900 million	350 million	5.6 billion	3.2 billion	3.5 billion
CAM (2007)****	700 million	4.4 billion	80million	2.5 billion	2.6 billion	1.7 billion	890 million
Spas and springs (2007)*****	2.7 billion	12 billion	900 million	5.7 billion	3.8 billion	37.9 million	~
Cosmetic surgery (2006)******	1.8 billion	10 billion	472 million	25 million	230 million	253 million	1.4 billion
Total	20.4 billion	224 billion	11 billion	41 billion	28 billion	17 billion	34 billion

* Except for: US (2004), Canada (2007) and Japan (2004); ** Except for: Japan (2006), Germany (2002), France (2001) and Italy (2003); *** Except for: UK (2005), US (2005) and Japan (2002); ****Except for: US (2005), Canada (2002), Japan (2008) and Germany

4.2 The numbers in context

By putting these numbers in context, we obtained the following findings about consumer spending on health and wellbeing (HWB) goods and services.

4.2.1 *Health and wellbeing (HWB) spending is substantial.*

Total spending on HWB goods and services in the US in the first few years of the 21st century is estimated to be $224 billion. It sounds like a large amount – and it is. Let us put it in a comparative context. For example, $224 billion is approximately only $20 billion less than the interest that the US government owes on its public debt ($244 billion) in 2008, which means that private HWB spending in the US is approximate to the US government's fourth largest spending category (after defence, Social Security and Medicare).

Likewise, consumer spending on HWB goods and services in the UK ($20.4 billion/£11 billion) is equivalent to half of UK government spending on housing and environment in 2007, or half of what it spent on transport in the same year.[20]

We also see that HWB spending averages at about 1% of GDP in the sample counties (Table 2) which is, by all measurements, a significant amount. (We have ranked individual countries' spending levels against one another. These rankings have not been attributed any values. They merely indicate a scale of spending and amounts.)

Table 2: HWB spending as percentage of GDP

Ranking	Country	% of GDP
1 (joint)	US	1.6
1 (joint)	Italy	1.6
2 (joint)	Germany	0.9
2 (joint)	Japan	0.9
3	Canada	0.8
4 (joint)	UK	0.7
4 (joint)	France	0.7

Furthermore, if we look at HWB spending in per capita terms as a share of average wages, we can see that it averages out at 1.1%.

[20] http://budget2007.treasury.gov.uk/page_09.htm

Table 3: HWB spending as percentage of average wages

Country	Average wages (2004)	Per capita HWB spending	HWB as % of wages
US	34,934	727	2
UK	38,593	311	0.8
CA	38,938	333	0.9
JP	39,372	307	0.8
GM	49,204	354	0.7
FR	33,325	282	0.8
IT	32,742	586	1.8

4.2.2 *Health and wellbeing (HWB) spending is growing*

Although it has been hard to find data for late 20th century spending patterns on the specific basket of goods we have created, there are statistics which nonetheless show that HWB spending is a growing trend.

If we take the UK as an example, we see exponential growth across the board:

- Sales of over-the-counter medicines in the UK have experienced a **58% growth** between 1997 and 2007. [21]

- Sales of physical exercise equipment in the UK have experienced a **678% growth** between the 1990s and the 2000s.

[21] http://iriuk.infores.com/page/news/pr?mode=single&pr_id=136

- Sales of organic food in the UK **doubled** between 2000 and 2005. [22]

- CAM spending in the UK **grew by 961%** between the 1990s and the 2000s.

- Spending on cosmetic surgery **increased by 1150%** between the 1990s and the 2000s.

The UK is not an isolated case, and here are just a few other notable examples:

- Between the 1990s and 2000s, CAM spending **grew by 412% in the US** and **by 533% in Canada**.

- Sales of organic food in the EU **tripled** between 1990 and1997.[23]

- Plastic surgery in the US saw a **29% increase** between 2000 and 2007. [24]

These figures confirm that the growth of the health and wellbeing sector is taking place not only across our basket of goods, but also across the range of OECD countries examined.

5. Conclusions

This paper has attempted to re-evaluate the way health care expenditure is understood. As such, it has pertained to a much wider understanding of health and health care than is normally taken into account by policymakers. Having defined a novel basket of health and wellbeing goods and services, it has analysed how consumers are actually spending a growing share of their income on these products.

Based on this evidence, this paper has questioned traditional assumptions about the negative implications of growing health expenditures, instead viewing it as a growth industry and as a market that consumers are choosing to invest in. The growth in

[22] http://news.bbc.co.uk/2/hi/uk_news/4551304.stm
[23] http://www.organic-consultancy.com/articles/MISC/ifst.shtml
[24] http://www.reuters.com/article/pressRelease/idUS101609+25-Mar-2008+PRN20080325

healthcare spending and the growing consumption of health and wellbeing goods are clearly here to stay.

However, we would go even further than this. There are further implications which can be inferred from the trend of growing private health expenditures, and in particular with respect to the trend of growing public expenditures. As demand for health care in both the private and the public sectors is only set to grow, policymakers will need to find ways to tap into the private willingness to spend on health, in order to ease the pressures in public spending. In other words, voters used to public health systems (particularly in Europe) may be becoming more receptive to such systems being opened up to private contribution mechanisms, such as Health Savings Accounts (HSA) or complimentary insurance, for example. This depends very much on the politics of each country and most Europeans still prize the idea of 'social solidarity' or fairness in healthcare system very highly. Some healthcare systems, such as France and Switzerland, in the OECD already use a mix of public and private funding and are increasing the private element. The use of co-payment and top-up fees is spreading (although the debate over this is still raging in other countries, for example, the UK).

In future, demographic changes and changes in consumer attitudes and behaviour – some of which are outlined in this study – will put ever greater pressure on governments' role in the funding and provision of health care. Whether voters like it or not, the desire for universal and equal coverage (which even now is more often only true in theory rather than in practice), may feasibly only be achieved by a combination of public and private spending. Greater purchasing power and economies of scale can be replicated within private care by appropriate combinations of government regulation and the power of consumer choice and competition in a healthcare market which will allocate economic resources most efficiently and drive up standards.

Policymakers across developed countries all face the same problem - how best to express this pent up demand for more and better healthcare while maintaining fair access to healthcare, especially for the least well-off? Top down, tax-funded systems will be unable to respond quickly enough to this enormous growth, even if governments could afford to maintain it. Only by recasting the roles of the public and private sector and turning the growth in demand for health into a positive economic trend will we be able to emerge from the tight spot of governments still trying to place more sticking plasters on the bursting consumer health spending dam.

6. Appendix – Data sources

As previously mentioned, although well-known sources were used whenever possible, the consumer-focused nature of the subject matter meant that this study has had to rely heavily on other sources, such as market research reports, media articles and information provided by trade associations. The aggregated data that we compiled (please see Table 1, p.15) was obtained from the following sources:

Category 1 – Medicines

<u>US, Canada, Japan, Germany, France, Italy</u>

Medicines Australia, *Global Pharmaceutical Industry Facts and Figures* (July 2007).

http://www.medicinesaustralia.com.au/pages/images/global%20pharma%20industry%20facts%20and%20figures%20jul%2007.pdf

<u>UK</u>

The Proprietary Association of Great Britain, *The Value (£M) Sales of OTC Medicines and Food Supplements in 2001/ 02.*

http://www.pagb.co.uk/information/PDFs/2002marketfigures.pdf

Category 2 – Physical exercise equipment

<u>UK, Germany, France, Italy</u>

Centre for the Promotion of Imports from developing countries, *EU Market Survey Sports and Camping Goods* (2005).

<u>US</u>

Club Industry's Fitness Business Pro, 'Industry Statistics' (accessed June 2008):

http://fitnessbusinesspro.com/statistics/

<u>Canada</u>

Trendex Sports Vision, 'Annual Market Overview Statistic's (accessed June 2008):

http://www.sportsvision.info/annual_stats.htm

<u>Japan</u>

USA International Business Publications, *Japan Investment and Business Guide* (2005).

Category 3 – Fitness

UK

The Leisure Database Company, *Healthy Growth in the UK Fitness Market* (accessed June 2008): http://www.theleisuredatabase.com/news/news-archive/healthy-growth-in-the-uk-fitness-market

US

IBISWorld, *Gym, Health & Fitness Clubs – U.S. Industry Report* (accessed June 2008): http://www.ibisworld.com/industry/retail.aspx?indid=1655&chid=1

Canada

TheStar.com, 'Getting fit in five' (28 January 2008, accessed June 2008): http://www.thestar.com/article/297935

Konami, *Q&A about Health & Fitness Business* (accessed June 2008): http://www.konami.co.jp/en/ir/faq/healthandfitness.html

Germany

Innovations Report, 'The German health and fitness market' (11 June 2003, accessed June 2008): http://www.innovations-report.com/html/reports/studies/report-19084.html

France

Deloitte & Touche, *Highlights of Selected European Health & Fitness Markets* (2002). http://www.deloitte.com/dtt/cda/doc/content/TTL_HFMarkets2002UK(1).pdf

Italy

Free-Research.com, 'Italy - Fitness Market 2004' (2004): http://www.free-research.com/Summary-Market-Report/Italy-Fitness-Market-2004-2176.asp

Category 4 – Organic food

UK, US, Germany, France, Italy

Willer, H. and Yussefi, M. (eds.) *The World of Organic Agriculture: Statistics and Emerging Trend 2007.* http://orgprints.org/10506/03/willer-yussefi-2007-world-of-organic.pdf

Canada

Macey, A. *Retail Sales of Certified Organic Food Products in Canada in 2006* (Organic Agriculture Centre of Canada, May 2007).
http://www.organicagcentre.ca/Docs/RetailSalesOrganic_Canada2006.pdf

Japan

Queensland government, 'Trade opportunities for organic food' (accessed June 2008):
http://www2.dpi.qld.gov.au/organics/17623.html#3

Category 5 – Complementary and alternative medicines

UK, US, Japan, Germany, France, Italy

Gruenwald, J. 'The Global Herbs & Botanicals Market' *Nutraceuticals World* (accessed June 2008)
http://www.nutraceuticalsworld.com/articles/2008/07/the-global-herbs-botanicals-market

Canada

Institute of Science in Society, *Global Strategy for Traditional Medicine* (ISIS report, 1 August 2002, accessed June 2008):
http://www.i-sis.org.uk/GSFTM.php

Category 6 – Spas and springs

UK

Wyke, N. 'Spa trends: male order', *The Times* (12 May 2007, accessed June 2008):
http://www.timesonline.co.uk/tol/travel/good_spa_guide/article1777325.ece

US, Japan, Germany

Burt, B. 'Recap: The 2008 Global Spa Summit', *Hospitality.net* (27 May 2008, accessed June 2008):
http://www.hospitalitynet.org/news/4036103.search?query=people+employed+in+japan

Canada

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