Specialised Rehabilitation, Health Tourism and Investment-Led Service Development: Introductory Note to the Prime Residence Presentation

The Prime Residence presentation introduces a project that sits at the intersection of several important contemporary developments in South-East Europe: the rising demand for rehabilitation services, the gradual expansion of cross-border healthcare and patient mobility, the growing use of advanced rehabilitation technologies, and the search for new private investment models in health-related services. As presented by the company, Prime Residence is envisaged as a robotic neuro-rehabilitation and health tourism facility in Bijeljina, combining medical rehabilitation, accommodation, hospitality, and investor participation mechanisms within a single commercial concept. The presentation highlights a planned facility of 6,500 square metres with a 10,000 square metre park, 75 apartments, a total capacity of 220 beds, a stated total investment of EUR 9.25 million, and two proposed investment models based either on ownership participation or apartment ownership. It also states that construction had already begun in October 2025 and presents projected insurance-based and commercial revenue streams. These claims are significant for understanding the project's ambition, but they should be read as project-side representations rather than as independently verified findings.

Viewed more broadly, the significance of such a project does not lie only in the individual facility proposed by the investor. It also reflects a wider shift in the health economy of Europe and its neighbouring regions. The World Health Organization has underlined the scale of this issue with unusual clarity. In the WHO European Region, 394 million people in 2019 had a health condition amenable to rehabilitation during its course, equivalent to two in five people, with musculoskeletal, sensory and neurological disorders among the most prevalent groups. WHO's conclusion is unambiguous: the scale of unmet and growing need requires stronger rehabilitation services across the region. In that light, proposals for specialised rehabilitation facilities should not be understood simply as niche private ventures. They respond, at least in principle, to a major demographic and service-delivery challenge shaped by ageing populations, chronic disease, post-acute care needs, disability, and longer survival with complex conditions. This broader rehabilitation context is especially relevant to projects that foreground neurological recovery and advanced therapeutic approaches. The Prime Residence presentation

places particular emphasis on robotic neuro-rehabilitation, hyperbaric therapy, therapy pools, physical therapy space, and specialised diagnostic support. That emphasis is not incidental. In rehabilitation policy and clinical literature, there is growing interest in technology-assisted rehabilitation because it offers the possibility of greater training intensity, more standardised task repetition, richer patient feedback, and improved support for motor recovery in neurological conditions. At the same time, the literature is careful not to treat technology as self-executing. A recent position paper on rehabilitation robotics stresses both the opportunities offered by robotics-assisted rehabilitation and the barriers that continue to limit its real-world clinical implementation. Similarly, research on clinician adoption has found that robotic devices may address gaps in rehabilitation intensity, but that clinical uptake remains low unless staff receive training, experience, and embedded technical support. This matters for evaluating the wider significance of a project such as Prime Residence. The promise of robotics in rehabilitation is real, but its effectiveness as a service model depends not only on equipment acquisition, but on organisational capability, staff readiness, clinical protocols, and sustained operational quality.

The project also belongs to the wider field usually described as health tourism, though that term itself requires care. One of the recurrent problems in this field is conceptual looseness. The literature and policy material often combine medical tourism, wellness tourism, spa tourism and rehabilitation travel under broad labels that can obscure important differences in purpose, regulation and service intensity. The European Parliament's study on health tourism in the EU therefore distinguishes among medical, wellness and spa tourism and notes that the field remains relatively under-documented, with fragmented definitions and incomplete data. The same study also argues that patient mobility under Directive 2011/24/EU creates opportunities for medical tourism, while substantial legal, financial and regulatory differences still complicate development across jurisdictions. Older scoping work on medical tourism makes a similar point in another register, noting that public discussion is often not evidence-based and that cross-border treatment introduces both opportunities and risks for patients and health systems. For proceedings purposes, this is an important warning. A project of this type should not be discussed in a simplistic tourism-investment vocabulary. It belongs to a more demanding service category where treatment, hospitality, transport, legal status, insurance coverage, aftercare, and patient safety all intersect.

There is, nonetheless, a credible regional logic behind projects that seek to combine rehabilitation services with cross-border patient access. The European Commission's cross-border healthcare framework states that EU citizens have the right to access healthcare in

another EU country and to be reimbursed by their home country under the conditions laid down by Directive 2011/24/EU. The Directive is therefore relevant to any discussion of patient mobility in Europe, even if actual access, prior authorisation, reimbursement procedures and practical uptake vary considerably between countries and treatments. The European Parliament's health tourism study reaches a similar conclusion, noting that the Directive creates opportunities for medical tourism but that these are mediated by substantial legal and financial differences among Member States. For a project in Bijeljina, this means that geographical proximity to the EU can be commercially relevant, but only within a much more conditional policy environment than investor decks sometimes imply. Cross-border care is not an automatic market. It is a regulated and administratively mediated one.

The Prime Residence deck itself reflects this duality. On the one hand, it presents a very clear value proposition. It positions the centre as a specialised destination for robotic neuro-rehabilitation in the Western Balkans, highlights intended partnerships with health insurance funds, and combines medical infrastructure with hotel-style accommodation and ancillary services. On the other hand, it also moves into the language of property-backed investment, guaranteed income, fixed ownership models and defined return periods. That hybrid character is exactly why an introductory proceedings note is useful. Such projects do not fit neatly into one category. They are part healthcare facility, part hospitality offer, part regional service proposition, and part investment product. The analytical question, therefore, is not simply whether the demand for rehabilitation exists. It clearly does. The more difficult question is whether a private facility can successfully align clinical credibility, insurance and reimbursement relations, workforce supply, regulatory compliance, and commercial viability over time.

That question becomes sharper in the Bosnia and Herzegovina context. From a policy perspective, the country's business environment still imposes significant operational constraints on complex private-sector projects. The OECD's 2025 assessment of Bosnia and Herzegovina's reform agenda for private sector development stresses that clear and transparent requirements for business registration, licensing and permitting are essential for private sector development. It also notes that lengthy and sometimes costly procedures, together with the lack of mutual recognition of licences and certificates, continue to create obstacles to registering and operating nationwide, thereby hindering the development of a fully functioning single economic space. The same report also points to the importance of vocational education and training, workforce relevance, and stronger links between skills systems and private-sector needs. These are highly pertinent considerations for a rehabilitation and health-services

investment. A project of this sort depends not only on capital expenditure and marketing, but on the ability to recruit and retain specialist clinical staff, navigate licensing and inspection frameworks, manage insurer relations, and operate with predictable legal and administrative conditions.

The health-system context is also evolving in ways that may support, though not guarantee, such initiatives. In July 2024, Bosnia and Herzegovina signed the agreement associating the country to the EU4Health programme. According to the European Commission, this will strengthen the health system's capacity to respond to health needs and allows the country's health authorities and wider health community to benefit from EU4Health opportunities on an equal footing with participating states and associated countries. This does not mean that any specific private rehabilitation project is thereby validated. It does, however, indicate that Bosnia and Herzegovina is moving more closely into EU-supported health-system cooperation and resilience frameworks. In the context of a private rehabilitation project, that wider policy movement matters because it reinforces the idea that health-related service development in the country is no longer purely domestic in outlook. It is increasingly linked to regional and European institutional environments.

A further issue concerns health workforce availability, which is one of the decisive operational variables in specialised care projects but often receives less attention in investor-facing material than buildings and equipment. OECD's *Health at a Glance: Europe 2024* identifies workforce shortages as a major and long-standing challenge for European health systems, intensified further by the strain of recent years. This wider European problem matters for South-East Europe as well, where migration, ageing, and uneven training capacity place additional pressure on the supply of qualified personnel. The Prime Residence presentation notes that the future workforce would be supported through arrangements with secondary and higher medical education institutions and through scholarship and recruitment pathways. That is a sensible recognition of the issue. But analytically, it should be seen as recognition of a structural risk rather than a guaranteed solution. In specialised rehabilitation, staff capability is not a secondary input. It is one of the central determinants of whether advanced equipment and ambitious service models can actually be translated into clinical results and stable operations.

For all these reasons, the Prime Residence proposal is best read not merely as an isolated real-estate or hospitality concept, but as an example of a wider category of emerging investment projects in the region. These projects attempt to combine healthcare demand, service specialisation, patient mobility, technology-assisted rehabilitation, and asset-based financing into a single development proposition. Their appeal lies in the fact that they address a real and

growing area of need while also speaking the language of regional competitiveness and private return. Their difficulty lies in the fact that they must succeed simultaneously as clinical platforms, regulated service providers, and commercially disciplined enterprises. That is no small requirement.

Seen from that perspective, the presentation that follows is valuable not because it resolves these tensions, but because it illustrates them clearly. It shows how private actors are beginning to imagine specialised rehabilitation not only as a health service, but as a field of regional investment, cross-border demand and institutional partnership. For the proceedings, this makes the project relevant beyond its own commercial proposition. It opens a wider discussion on how Bosnia and Herzegovina, and the Western Balkans more generally, may position themselves in emerging segments of healthcare-related investment. At the same time, it reminds us that in such sectors, serious evaluation requires more than enthusiasm for innovation or confidence in projected returns. It requires attention to policy, regulation, staffing, reimbursement, technology implementation, and the long-term governance of the service model itself.

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