

TOURISTS' INTENTION TO PARTICIPATE IN WELLNESS TOURISM: DIFFERENCES BY HEALTH CONDITION AND HEALTH CONSCIOUSNESS

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INTRODUCTION

Wellness tourism is defined as travel associated with the pursuit of maintaining or enhancing one's personal well-being (Global Wellness Institute, 2021), including activities such as hot springs, spas, yoga, and forest bathing. Wellness tourism has attracted increasing academic interest since the COVID-19 pandemic, particularly in the behavioral intentions of tourists. Ting et al. (2021) examined the differential effects of pull and push motivations on revisit intentions among health and wellness travelers. Sthapit et al. (2023) examined the relationship between memorable wellness tourism experiences, subjective well-being and revisit intentions. However, the factors suggested in these studies that influence revisit intentions may only be part of the picture. The results of Wang et al. (2019) suggested that both perceived risk and perceived value are important factors influencing consumers' purchase intentions and decisions, with perceived risk reducing consumers' purchase intentions and perceived benefit providing consumers with incentives to purchase behavior. However, no studies in the field of wellness tourism have examined the effects of both perceived value and perceived risk on tourists' behavioral intentions. Therefore, this study introduces perceived risk and perceived value into the model as the most basic independent variables to examine whether they have an impact on the intention of tourists to re-participate in wellness tourism. Attitude is also hypothesized to be an

important mediating variable in the relationship between perceived risk, perceived value and re-participation intention in this study. Attitude is considered to be one of the key determinants of behavioral intention (Ajzen, 1991). The relationship between perceived risk, perceived value and attitude has been tested in many studies (Boguszewicz-Kreft et al., 2022; Chen et al., 2012; Roh et al., 2022). However, their relationship in the field of wellness tourism is still unknown.

Furthermore, from a marketing perspective, there is a need to segment the market by analyzing the personal characteristics and behavioral traits of wellness tourism visitors. This helps operators of wellness tourism products or marketers of destinations promoting wellness tourism to select target markets and develop differentiated marketing strategies (Lee and Kim, 2023). There are also studies in the field of wellness tourism that have segmented the market according to different characteristics of tourists. However, no research has been conducted to examine differences in the intention of tourists to re-participate in wellness tourism by segmenting the market according to their health consciousness and health condition.

Health consciousness refers to "the degree to which health issues are integrated into a person's daily activities (Jayanti & Burns, 1998)." It is predictive of various health attitudes and behaviors (Hong, 2009). Hong (2009) suggested that the effectiveness of health interventions can be improved by using different approaches to groups with different levels of health consciousness. This is

because individuals with high levels of health consciousness are more likely to be willing to take preventive health actions. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1947)." Health condition is an individual's judgment of the state of their own physical, mental and social well-being. Lehto et al (2006) argued that people who seek wellness travel experiences are generally already healthy and are actively thinking about ways to maintain their health. However, through a screening survey, we found that around 75% of respondents who travelled with the aim of being healthy suffered from various health problems. This finding contradicts the previous study. It is therefore reasonable to assume that there are some differences in the processes that form the intention to re-participate in wellness tourism

between groups with different health consciousness and health condition.

Therefore, this study aims to clarify the following three research questions. Finally, based on the findings, to provide methods and recommendations to motivate tourists from different groups to re-participate in wellness tourism.

RQ1: What factors influence tourists' intention to re-participate in wellness tourism?

RQ2: What kind of groups can be segmented according to the health consciousness and the health condition of the tourists, and what are the characteristics of each of these groups?

RQ3: Does the process of forming the intention to re-participate in wellness tourism differ between groups?

Given the above, the research model was constructed, as shown in Figure 1.

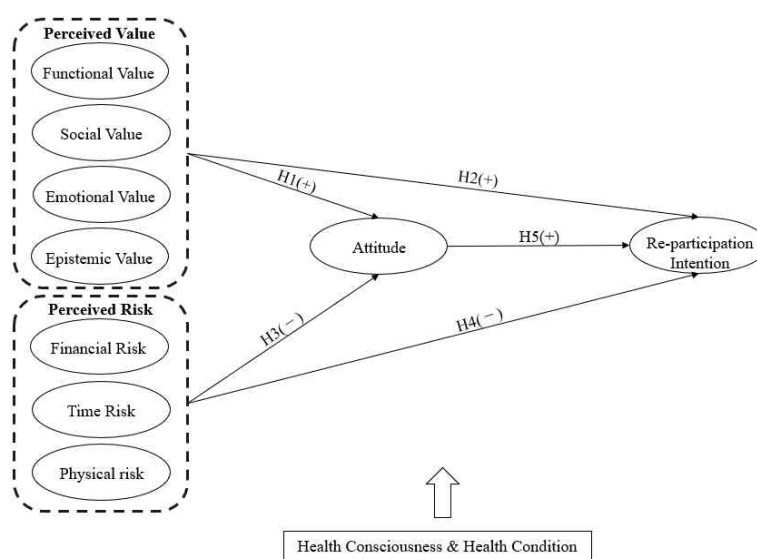


Figure 1. Research model

METHOD

We developed a 7-point Likert scale questionnaire appropriate to the context of wellness tourism, based on scale items tested in previous studies. The questionnaire was distributed to Japanese between 23 January and 14 April, 2023, and 305 valid responses were collected. To test the proposed hypotheses and model fit, a partial least squares structural equation modelling (PLS-SEM) analysis was conducted using SmartPLS 4. The PLS algorithm, bootstrapping (5000 subsamples), and blindfolding algorithm were used to evaluate the

measurement model and structural model, respectively. Next, a cluster analysis was carried out using SPSS, in which the respondents were grouped according to their health consciousness and health condition. Finally, a multi-group analysis was conducted to compare the formation process of intention to re-participate between the different clusters.

FINDINGS

The values of Cronbach's α values varied between 0.851 and 0.942, and the composite

reliability of the constructs was between 0.910 and 0.963, indicating strong internal consistency (Hair et al., 2016). The factor loadings (0.829-0.957) for all items except SV5 (0.649) were above the recommended threshold of 0.70, and the average variance extracted (AVE) values (0.700-0.915) were all greater than 0.50, indicating good convergent validity (Hair et al., 2016). Moreover, the square root of each construct's AVE was greater than its highest correlation with any other construct, indicating satisfactory discriminant validity (Hair et al., 2016). The variance inflation factors (VIF) were less than 3.3, indicating the absence of common method bias and multicollinearity problems (Hair et

al., 2016).

In addition, the R² values for attitude and re-participation intention were 0.629 and 0.606, indicating moderate explanatory power. The Q² values for attitude and re-participation intention were 0.540 and 0.541, with results > 0, indicating that the model has an acceptable level of predictive relevance (Geisser, 1974). The SRMR value was 0.051, which is below the threshold of 0.08 (Henseler et al., 2015). All these results indicated a good model fit. Eight of the 15 hypothesized paths proposed were statistically significant and therefore supported.

Table 1. Results of structural model test

Hypothesis	Path	β	t-Value	Result
H1a	FV → ATT	0.174**	2.896	Supported
H1b	SV → ATT	0.103*	2.243	Supported
H1c	EMV → ATT	0.374***	7.045	Supported
H1d	EPV → ATT	0.191**	2.642	Supported
H2a	FV → IRP	0.211**	2.890	Supported
H2b	SV → IRP	-0.019 ^{ns}	0.372	Unsupported
H2c	EMV → IRP	0.020 ^{ns}	0.278	Unsupported
H2d	EPV → IRP	-0.018 ^{ns}	0.238	Unsupported
H3a	FR → ATT	-0.083 ^{ns}	1.867	Unsupported
H3b	TR → ATT	-0.120*	2.228	Supported
H3c	PR → ATT	-0.013 ^{ns}	0.268	Unsupported
H4a	FR → IRP	-0.103*	6.716	Supported
H4b	TR → IRP	-0.034 ^{ns}	0.497	Unsupported
H4c	PR → IRP	0.070 ^{ns}	1.172	Unsupported
H5	ATT → IRP	0.607***	8.858	Supported

Note. * $p < .05$, ** $p < .01$, *** $p < .001$, ns=non-significant, β =Standardized regression weight, R²=Explained variance, Q²=Prediction relevance, FV=Functional Value, SV=Social Value, EMV=Emotional Value, EPV=Epistemic Value, PR=Physical Risk, FR=Financial Risk, TR=Time Risk, ATT=Attitude, IRP=Intention to Re-participate.

After validating the structural model, we classified the tourists into the following four groups based on their health consciousness and health condition using hierarchical and non-hierarchical clustering. They were: low health consciousness & poor health condition (Group 1, n=56); low health consciousness & good health condition (Group 2, n=111); low high health consciousness & good health condition (Group 3, n=85); high health consciousness & poor health condition (Group 4, n=53). Finally, in order to test whether the process of forming the intention to re-participate differed between the different groups, we did pairwise comparison by means of a multi-group analysis. A total of four paths (H2a, H2c, H3b, H5) were found to be significantly different between groups.

IMPLICATIONS

This study examined the relationship between perceived value, perceived risk, attitude and tourists' intention to re-participate in wellness tourism. In addition, by classifying tourists into four types through health condition and health consciousness, it was clarified that there are indeed some differences in the process of forming the intention to re-participate in wellness tourism among these four types of tourists. This means that there is a need to develop different marketing strategies for groups of tourists with different health consciousness and health condition. For marketers of destinations that are promoting wellness tourism, as well as service providers of wellness tourism products, there is a limit to the amount of money and effort they can

invest. Therefore, the findings of this study may help them to allocate resources in a targeted manner to maximize the benefits.

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