ISSN: 2288-7709
JEMM website: https://accesson.kr/jemm
doi: http://doi.org/10.20482/jemm.2024.12.5.91

Tourists' Re-Participation Intention in Wellness Tourism: Differences by Health Status and Health Consciousness

Jiao LI[1], Han ZHOU[2], Kaige ZHU[3], Juhyeok JANG[4]

Received: September 08, 2024. Revised: September 18, 2024. Accepted: October 30, 2024.

Abstract

Purpose: This study analyses the key variables that influence tourists' intention to re-participate in wellness tourism. To this end, a theoretical model is developed that is grounded in the theories of perceived value and perceived risk. Additionally, this study segments the market based on tourists' health consciousness and health status, examining the differences in the process of forming re-participation intentions. **Research Design, Data, and Methodology:** An online survey of 305 Japanese respondents was conducted, and the research model and hypotheses were validated using SmartPLS 4 and SPSS. **Results:** The findings illustrate that perceived functional, social, emotional, and epistemic values from previous wellness tourism experiences positively influence tourists' attitudes, whereas time risk negatively affects them. Furthermore, functional value and attitudes enhance re-participation intentions, whereas financial risk decrease them. Cluster analysis identified three groups: 'Health-Conscious but Unwell'; 'Not Health-Conscious and Unwell'; and 'Health-Conscious and Well'. Those who are 'Health-Conscious and Well' are more likely to re-participate if they are satisfied with the functional value of their wellness tourism experience. **Conclusions:** The findings of this study offer destination marketers and service providers valuable insights into how tourists form behavioural intentions and how to strategically allocate resources to maximise the potential of wellness tourism.

Keywords : Perceived Value, Perceived Risk, Attitude, Re-participation Intention, Health Consciousness, Health Status

JEL Classification Code: C12, C51, C83, I12, M31

1. Introduction

Smith and Puczko (2014) defined wellness tourism as travel undertaken in order to achieve a balanced state of health in physical, mental, psychological, and social domains. This includes achieving a healthy lifestyle, reducing stress, preventing disease, and minimising unhealthy habits through activities such as immersion in hot springs, spas, yoga, and forest bathing at healing resorts (Research and Markets, 2022). Wellness tourism is a form of health-oriented tourism, similar to medical tourism, while medical tourism focuses more on experiencing leisure

* This work was supported by JST SPRING, Grant Number JPMJSP2119.

1 First Author. Ph.D. candidate, Graduate School of International Media, Communication, and Tourism Studies, Hokkaido University, Japan. Email: rikyou1027@gmail.com
2 Second Author. Research Fellow, Research Faculty of Media and Communication, Hokkaido University, Japan. Email: hanzhou829@gmail.com
3 Third Author. Ph.D. candidate, Graduate School of International Media, Communication, and Tourism Studies, Hokkaido University, Japan. Email: kg970203@gmail.com
4 Corresponding Author. Associate Professor, Research Faculty of Media and Communication, Hokkaido University, Japan. Email: jang.juhyeok@imc.hokudai.ac.jp

services at a destination alongside medical interventions or disease treatment (Smith & Puczko, 2014).

In recent years, wellness tourism has attracted increasing academic interest. It is distinguished from general tourism and is considered a type of special-interest tourism, necessitating separate research (Lee & Kim, 2023). Numerous studies on wellness tourism have been conducted with the aim of encouraging positive behaviours and behavioural intentions in tourists, particularly repeat behavioural intentions (Sthapit et al., 2022; Ting et al., 2021). However, the factors suggested in these studies that influence revisit intentions may be only part of the picture.

According to Peter and Tarpey (1975), consumers consider both the expected positive and negative utility when making decisions, seeking to maximise their expected net utility. A variety of studies related to consumer behaviour indicate that perceived risk and perceived value are significant determinants of consumer decision-making behaviour and repurchase intentions (Demirgüneş, 2015; Wang et al., 2019). Nevertheless, research in wellness tourism, as well as in the broader field of tourism, has not simultaneously examined the impact of both perceived risk and perceived value on tourists' behaviour and behavioural intentions.

Moreover, among research examining the mechanisms that shape tourists' behavioural intentions, some studies have tended to treat perceived value or perceived risk as a holistic structure, overlooking their complexity and multidimensionality (Habibi & Rasoolimanesh, 2021; Sadiq et al., 2022). To address this gap, the present study aims to investigate whether tourists' intentions to re-participate in wellness tourism are influenced by the different dimensions of perceived risk and perceived value.

Furthermore, from a marketing perspective, market segmentation of the wellness tourism sector is necessary to assist marketers in selecting target markets and developing differentiated marketing strategies (Lee & Kim, 2023). In this sector, market segmentation is currently based on tourists' motivations and benefits, and their behavioural characteristics have been objectively analysed through surveys (Lee & Kim, 2023; Voigt et al., 2011). Horner and Swarbrooke (2020) argued that tourists' subjective perceptions of themselves are also important. However, there is no relevant literature on market segmentation based on individuals' self-perceptions.

The present study segments the market based on tourists' perceptions of their own health status and health consciousness to examine differences in their intentions to re-participate in wellness tourism. Three research questions are addressed in this study:

RQ1: What dimensions of perceived value and perceived risk influence tourists' intentions to re-participate in wellness tourism?

RQ2: Based on tourists' health consciousness and health status, what groups can the market be segmented into and what are the characteristics of each group?

RQ3: Does the process of forming intentions to re-participate in wellness tourism differ among these groups?

The findings of this study provide methods and recommendations to motivate tourists to re-participate in wellness tourism and offer different marketing strategies for various groups based on the market segmentation results.

2. Literature Review and Hypotheses

2.1. Perceived Value

In tourism research, perceived value has been identified as a key factor influencing tourist satisfaction and loyalty (Carvache-Franco et al., 2021). Perceived value refers to consumers' evaluations and subjective perceptions of the trade-offs between the benefits they receive and the price they pay (Zeithaml, 1988). Perceived value is inherently multidimensional, with different roles in various contexts (Sánchez-Fernández & Iniesta-Bonillo, 2007). Based on this, perceived value in wellness tourism can be defined as a holistic assessment of the multidimensional benefits and sacrifices experienced by tourists while participating in wellness tourism.

The five-dimensional structural framework proposed by Sheth et al. (1991) incorporates social psychology into consumer behaviour research, enabling a more comprehensive examination of perceived value (Pihlström, 2008). Accordingly, this study aims to measure perceived value based on the multidimensional structure proposed by Sheth et al. (1991), which is defined as follows:

Functional Value: The perceived value to the individual in terms of functionality, utilitarian, or enhanced physical function;

Social Value: The perceived value derived from acceptance and recognition by social groups;

Emotional Value: The perceived value derived from emotional aspects or psychological feelings;

Epistemic Value: The perceived value derived from stimulating curiosity, providing novel experiences, or satisfying the pursuit of knowledge;

Conditional Value: The perceived value gained by an individual in a specific, temporary environment or under unexpected circumstances.

Functional value is reflected in whether the quality of wellness tourism activities can fulfil tourists' needs such as physical relaxation and health restoration through therapies like yoga and meditation. This value is a fundamental driver of consumer choice (Perrea et al., 2015). Regarding social value, tourists may choose a retreat for its high-end image

or celebrity endorsement, expecting to enhance their self-image or gain recognition within their social circles. They may also form connections with new friends during these activities, and such group experiences can meet their social needs and enhance their sense of social identity. Moreover, emotional value is expressed as the emotional fulfilment tourists gain through relaxation and healing during wellness tourism. The overall quality of a consumer's experience is often determined by emotional value (Yi et al., 2014), which is therefore a key focus of this study. Furthermore, epistemic value is also important, particularly when tourists acquire new health knowledge or adopt lifestyle changes through wellness tourism. This cognitive gain may further enhance their overall experience.

However, this study does not examine the impact of conditional value. The reason for this is that conditional value is usually only present in specific situations such as festivals and weddings (Sheth et al., 1991). These situations are not common or universal in wellness tourism. Therefore, this study focuses on the four value dimensions to ensure the relevance of the research.

2.2. Perceived Risk

Consumer behaviour literature often examines the influence of perceived risk and perceived value simultaneously (Demirgüneş, 2015; Wang et al., 2019). However, most extant tourism research examines perceived value or perceived risk individually. Quintal et al. (2010) suggested that concentrating only on perceived value—while disregarding consumers' concerns about potential risks—could result in misjudgements of the attractiveness of service, thereby hindering accurate predictions of consumer behaviour. Therefore, this study examines both perceived risk and perceived value simultaneously to gain a more comprehensive understanding of tourists' behaviour intentions.

Tourism perceived risk refers to tourists' objective evaluation of the potential negative consequences or effects of the tourism process (Cui et al., 2016). It is considered a critical factor influencing tourists' decision-making processes, and can significantly impact tourists' revisiting intentions (Hasan et al., 2017). Nevertheless, discussions on perceived risk in the field of wellness tourism are relatively scarce.

As with perceived value, perceived risk is inherently multidimensional. It is typically categorised into six dimensions, namely, psychological, financial, performance, physical, social, and time risk (Stone & Grønhaug, 1993). Hasan et al. (2017) compiled research on perceived risk across different types of tourism and found that scholars focused on different perceived risk dimensions when examining different types of tourism, such as nature-based tourism and adventure tourism. However, wellness tourism is a type of special-interest tourism that is difficult to categorise within the above types. Therefore, existing studies cannot provide a direct basis for the selection of risk dimensions for wellness tourism. As an exploratory study, this study selected as the focus of examination three dimensions—financial, physical, and time risk—from the six abovementioned dimensions of risk, aiming to provide a preliminary understanding of risk factors in wellness tourism. These are defined as follows (Hasan et al., 2017):

Financial Risk: The possibility that the wellness tourism experience may not be worth the money;

Physical Risk: The possibility of accidents, loss of security, natural disasters, or illness causing damage to one's physical health while participating in wellness tourism;

Time Risk: The possibility that participating in wellness tourism may take up too much time or lead to a waste of time.

The wellness tourism industry currently lacks uniform service standards, and the prices of high-end wellness programmes are usually high. Tourists may experience poor service quality or unsatisfactory results despite paying high prices, making financial risk a primary concern. Additionally, engaging in wellness tourism activities may result in tourists becoming unwell. For instance, hot springs can potentially exacerbate conditions such as heart disease and high blood pressure. Given that physical health is a central focus of wellness tourism, assessing physical risk is crucial. Furthermore, some wellness programmes may require an extended period to yield results. Therefore, tourists' concerns about time investment also represent an important risk factor. Examining tourists' perceptions of these three types of risk can better capture their behavioural intentions.

Although psychological, performance, and social risks may also influence tourists' decision-making processes, these dimensions can be indirectly captured through examining perceived emotional, functional, and social value. Therefore, this study thoroughly analyses financial, physical, and time risks as the primary dimensions.

2.3. Attitude

Fabrigar and Wegener (2010) defined attitude as the relatively long-lasting assessments of an object or concept, based on positive to negative valence dimensions. Šagovnović and Stamenković (2022) noted that understanding tourist attitudes enables researchers and practitioners to more accurately predict trends in tourist behaviour and design more effective marketing strategies to meet changing market demands.

Asiegbu et al. (2012) emphasised that consumers' perceptions of products and services largely determine their

attitudes. Studies in tourism have shown that the higher the perceived value of products and services to tourists, the more positive their attitudes; conversely, the higher the perceived risk, the more negative their attitudes (Boguszewicz-Kreft et al., 2022; Um & Yoon, 2021). Moreover, perceptions of functional, social, emotional, and epistemic value have been found to positively and significantly influence consumer attitudes (Adhitiya & Astuti, 2019; Tahir, 2021), while time, financial, and physical risks have been shown to negatively and significantly affect attitudes (Park & Kim, 2007; Quintal et al., 2010). However, the significance of attitude and its relationship with perceived value and perceived risk within the specific domain of wellness tourism remains unknown. Two hypotheses are proposed:

H1 a-d: Functional/social/emotional/epistemic value is positively correlated with tourists' attitudes towards wellness tourism.

H2 a-c: Financial/time/physical risk is negatively correlated with tourists' attitudes towards wellness tourism.

2.4. Re-participation Intention

Trongjitpituk (2020) argued that the terms 're-participation intention' and 'revisit intention' can be used interchangeably in some cases because they both pertain to tourists' intention to repeat a behaviour. However, there is a difference in the scope of application between the two concepts—revisit intention specifically refers to tourists' intention to plan or prefer revisiting a particular destination (Cole & Scott, 2004; Li et al., 2018). In contrast, re-participation intention is broader and refers to participants' intention to engage in a similar activity or experience again(Chua et al., 2021), without being limited to a specific tourist destination or facility. Therefore, this study chose re-participation intention as the main research variable and defined it as tourists' intent to repeat a wellness tourism activity or participate in wellness tourism again. This broad conceptualisation captures a more comprehensive understanding of tourists' continued interest in wellness tourism as an emerging form of travel, rather than just their preference for a specific location.

According to prior studies, perceived functional, social, emotional, and epistemic value is directly and positively associated with revisit intentions (Azam et al., 2020; Carvache-Franco et al., 2021). Conversely, perceived time, financial, and physical risks are directly and negatively associated with revisit intentions (Çetinsöz & Ege, 2013). In some studies, perceived value and perceived risk have been shown to predict re-participation intention. For instance, Chua et al. (2021) demonstrated that volunteers' perceived value during an event positively influences their attitudes and, in turn, their overall life satisfaction and re-participation intention. Conversely, Park et al. (2014) suggested that perceived risk among marine sport participants negatively affects their motivation to participate again, consequently influencing re-participation intentions. However, these studies did not demonstrate direct relationships between multidimensional perceived value, perceived risk, and re-participation intentions. This gap in the literature leads to the following hypotheses:

H3 a-d: Functional/social/emotional/epistemic value is positively correlated with tourists' intention to re-participate in wellness tourism.

H4 a-c: Financial/time/physical risk is negatively correlated with tourists' intention to re-participate in wellness tourism.

Additionally, attitude, as an affective disposition, is inherently motivational and can either drive or hinder specific consumer behaviours (Asiegbu et al., 2012). Reitsamer et al. (2016) argued that tourists' attitudes significantly affect their choices and overall tourism behaviour. However, despite evidence of its direct and positive impact on revisit intention (Soliman, 2021), attitude has yet to be thoroughly examined in terms of its influence on re-participation intention. It is therefore hypothesized that:

H5: Attitude is positively correlated with tourists' intention to re-participate in wellness tourism.

2.5. Health Consciousness

Wellness tourism emphasises proactivity and prevention (Smith & Puczko, 2014). Therefore, health consciousness, which enables individuals to exercise self-responsibility and maintain a healthy lifestyle, is considered an important influencing factor (Hong, 2009). Health consciousness is defined as individuals' concern and interest in their physical condition, emotional state, and social health-related information, accompanied by an awareness of the need to discover and realise one's true potential (Karn & Swain, 2017).

In studies on food safety and health apps, health consciousness has been demonstrated to predict an individual's health attitude and behaviour, and is a key determinant of health behaviour (Cho et al., 2014; Nagaraj, 2021). However, the effect of health consciousness in predicting medical tourists' behavioural intentions has not been as significant as expected. Ren et al. (2017) found that health consciousness positively affected tourists' perceived value but had no impact on their satisfaction and loyalty towards medical tourism services. This discrepancy may exist because, in medical tourism, health consciousness primarily influences decision-making at an early stage but does not substantially affect satisfaction or loyalty after the experience (Park et al., 2017).

Therefore, this study seeks to explore the role of health consciousness in wellness tourism from different perspectives, without focusing on its direct or indirect effects on tourists' re-participation intentions. Hong (2009) suggested that health consciousness is a key psychological variable in audience segmentation related to health issues, and that targeting different intervention approaches towards groups with varying levels of health consciousness can enhance the effectiveness of health interventions. Tourists with higher health consciousness tend to take more preventive health measures because they actively seek ways to maintain their health and take responsibility for their well-being (Namkung & Jang, 2013). Therefore, it is reasonable to assume that differences may exist in the process of forming intentions to re-participate in wellness tourism between groups with higher versus lower levels of health consciousness. This study segments the market through health consciousness and tests its influence on the decision-making process of wellness tourists.

2.6. Health Status

Health does not only mean the absence of disease or infirmity, but also requires that all physical, mental, and social aspects be in good condition (WHO, 1946). CDC (2024) defines self-perceived health status as a measure of how individuals perceive their overall health. Therefore, an individual's perception of their health status can be viewed as their overall assessment of their physical, mental, and social well-being.

Lehto et al. (2006) noted that people seeking wellness tourism experiences typically already have a better state of health and are actively looking for ways to maintain it. In other words, the healthier a person is, the more likely they are to engage in wellness tourism. Does this mean that wellness tourism is less likely to be taken up by people with health problems? Youm and Park (2015) showed that individuals with poorer health are more likely to engage in exercise for health improvement than those in better health. This implies that individuals in poor health who seek to improve or maintain their health are equally likely to engage in wellness tourism. However, this view requires validation within the specific context of wellness tourism.

Research on health status in wellness tourism remains relatively limited. Health consciousness primarily involves cognition and attitude at the psychological level, while health status is an evaluation of the actual, objective state, encompassing both physical and psychological health indicators. Therefore, this study segments wellness tourists based on their levels of health consciousness and health status to examine the behavioural tendencies of different types of tourists.

Following the discussion above, a research model was developed (Figure 1).

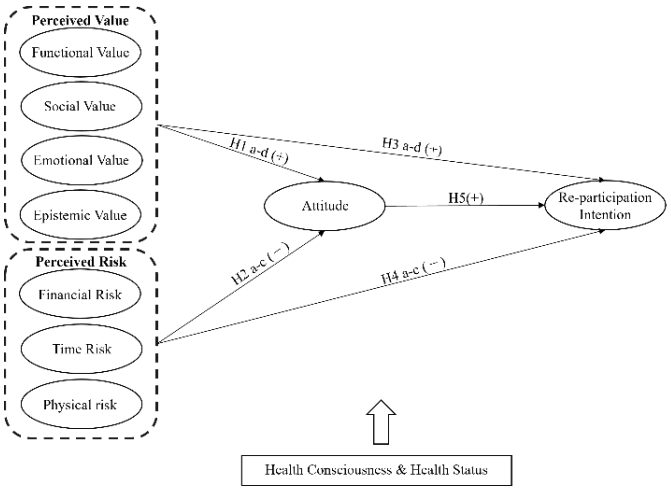

Figure 1: Research Model

3. Methodology

To validate the research model, a questionnaire applicable to wellness tourism was designed based on prior research and responses were measured through a 7-point Likert scale ('strongly disagree'=1, 'strongly agree'=7) (Appendix). From 23 January to 14 April 2023, questionnaires were distributed by Freeasy, a Japanese professional survey company. Two types of questionnaires were distributed. In the first step, 5,000 Japanese individuals were randomly selected to complete a screening questionnaire designed to identify those who had participated in wellness tourism in the past year. Out of these, 738 people had participated in wellness tourism in the past year.

The main questionnaire was then distributed to these 738 individuals, and 610 responses were received. To ensure that respondents fully understood the concept of wellness tourism, several activities (such as spa treatments, yoga, and unhealthy eating) were listed in the first question, and respondents were asked to identify which activities fell within the scope of wellness tourism. Additionally, reverse-worded items were included to detect respondents who did not answer carefully. Finally, a standard deviation greater than 0.5 was required for all responses. After applying these three quality control measures, 305 invalid responses were excluded, leaving 305 valid responses for analysis.

To examine the hypotheses and assess the fitness of the model, SmartPLS 4 was used to perform partial least-

squares structural equation modelling (PLS-SEM) analysis. Using the PLS algorithm, bootstrapping (5000 samples), and blindfolding algorithms, the measurement and structural models were evaluated. Next, cluster analyses were conducted using SPSS 27.0 to group respondents according to their health consciousness and health status. Finally, to determine if there were any disparities in the process of forming re-participation intentions between the different groups, a multi-group analysis was conducted.

4. Results

4.1. Respondents' Profiles

An overview of the respondents is presented in Table 1. There was minimal variation by gender. The age distribution was quite uniform, with the majority (36.72%) being individuals aged 60 years or above. Regarding income, about one-third of respondents had annual incomes between 3 million and 6 million yen. Additionally, only 24.92% stated that they were healthy and had no health problems. Furthermore, 51.15% of respondents indicated that they were more concerned about their health than before because of the COVID-19 pandemic. Respondents were also surveyed about the activities they participated in. Results showed that hot springs were the most popular wellness activity (80%), followed by forest bathing (20.33%).

Table 1: Profile of Respondents (*N* = 305)

Characteristic		Frequency	Percentage
Gender	Male	149	48.85%
	Female	156	51.15%
Age	15-19	36	11.80%
	20-29	27	8.85%
	30-39	45	14.76%
	40-49	34	11.15%
	50-59	51	16.72%
	60 or more	112	36.72%
Annual income (JPY)	Less than 3 million	60	19.67%
	3,000,000-5,999,999	106	34.76%
	6,000,000-8,999,999	60	19.67%
	More than 9 million	79	25.90%
Health problem	Disease	95	31.15%
	Injury	37	12.13%
	Mental/Physical fatigue	143	46.89%
	Mood/Anxiety disorder	69	22.62%
	Worry/Stress	135	44.26%
	Others	7	2.30%
	Nothing in particular	76	24.92%
Concerns about one's health after the COVID-19	More concerned than before	156	51.15%
	Same as before	121	39.67%
	Not as concerned as before	25	8.20%
	Health indifference all the way	3	0.98%
Experienced health activities	Hot spring	244	80.00%
	Spa	37	12.13%
	Yoga	13	4.26%
	Forest bathing	62	20.33%
	Healthy diet	32	10.49%
	Meditation	14	4.59%
	Others	26	8.52%

4.2. Evaluation of the Measurement Model

Cronbach's α values ranged from 0.851 to 0.942, while composite reliability (CR) values ranged from 0.910 to 0.963 (Table 2). All values exceeded 0.70, indicating strong internal consistency reliability (Hair et al., 2016). Moreover, the factor loadings (0.829–0.957) for all items, except SV5, exceeded 0.70, while the average variance extracted (AVE) values (0.700–0.915) were all above 0.50. In accordance with Hair et al. (2016), these results indicate good convergent validity.

Table 2: Results of Measurement Model Test

Construct	Loading	Mean	SD
Functional Value (FV) (Cronbach's α = .887, CR = .922, AVE = .748)			
FV1	0.862	4.787	1.172
FV2	0.854	4.485	1.210
FV3	0.843	4.511	1.174
FV4	0.899	4.521	1.102
Social Value (SV) (Cronbach's α = .889, CR = .920, AVE = .700)			
SV1	0.879	3.672	1.380
SV2	0.893	3.938	1.343
SV3	0.886	4.056	1.318
SV4	0.851	3.731	1.293
SV5	0.649	2.764	1.485
Emotional Value (EMV) (Cronbach's α = .907, CR = .956, AVE = .915)			
EMV1	0.956	5.302	1.174
EMV2	0.957	5.174	1.168
EMV3	—	—	—
Epistemic Value (EPV) (Cronbach's α = .851, CR = .910, AVE = .770)			
EPV1	0.887	5.052	1.224
EPV2	—	—	—
EPV3	0.901	4.967	1.201
EPV4	0.844	4.633	1.163
Physical Risk (PR) (Cronbach's α = .911, CR = .943, AVE = .847)			
PR1	0.937	3.262	1.297
PR2	0.954	3.256	1.316
PR3	0.868	3.390	1.299
Financial Risk (FR) (Cronbach's α = .861, CR = .915, AVE = .783)			

FR1	0.861	3.859	1.282
FR2	0.923	4.216	1.335
FR3	0.870	4.351	1.347
Time Risk (TR) (Cronbach's α = .891, CR = .932, AVE = .820)			
TR1	0.941	3.220	1.363
TR2	0.941	3.200	1.361
TR3	0.829	3.574	1.304
Attitude (ATT) (Cronbach's α = .926, CR = .953, AVE = .871)			
ATT1	0.939	4.928	1.140
ATT2	0.939	4.816	1.151
ATT3	0.922	4.898	1.154
Re-participation Intention (RI) (Cronbach's α = .942, CR = .963, AVE = .896)			
RI1	0.936	4.387	1.252
RI2	0.951	4.505	1.319
RI3	0.953	4.351	1.325

Note. CR = Composite Reliability, AVE = Average Variance Extracted, SD = Standard Deviation.

Although the factor loading for SV5 was slightly below 0.70 at 0.649, it was retained because there was no significant improvement in CR after deletion (Hair et al., 2016). The square root of the AVE for each construct exceeded its highest correlation with any other construct, which suggests that discriminant validity is satisfactory (Hair et al., 2016).

Additionally, because the variance inflation factor (VIF) values for emotional and epistemic values and re-participation intentions exceeded 3.3, items EMV3 and EPV2, which showed high indicator correlations, were excluded. After these adjustments, the VIF values were controlled within a range of 1.558 to 3.009, indicating no issues with common method bias or multicollinearity (Hair et al., 2016; Kock, 2015).

4.3. Structural Model and Hypothesis Testing

The standardised root mean square residual (SRMR) value was 0.051, which is below the threshold of 0.08 (Hair et al., 2016). Both attitude (0.540) and re-participation intention (0.541) had predictive relevance (Q^2) values above zero, suggesting an acceptable level (Hair et al., 2016). The explained variance (R^2) values were 0.629 for attitude and 0.606 for re-participation intention, indicating moderate explanatory power for both constructs (Hair et al., 2016). Overall, these results showed that the model fit well.

Hypothesis testing revealed that eight of the fifteen hypothesised paths were statistically significant (Figure 2). These include the direct effects of functional value (β = 0.174, p < 0.01), social value (β = 0.103, p < 0.05), emotional value (β = 0.374, p < 0.001), epistemic value (β = 0.191, p < 0.01), and time risk (β = -0.120, p < 0.05) on attitudes as well as the direct effects of functional value (β = 0.211, p < 0.01), financial risk (β = -0.103, p < 0.05), and attitude (β = 0.607, p < 0.001) on re-participation intentions. Therefore, hypotheses H1a-d, H2b, H3a, H4a, and H5 were supported.

However, the direct effects of financial risk (β = -0.083, p > 0.05) and physical risk (β = -0.013, p > 0.05) on attitudes were not significant. Additionally, the direct effects of social value (β = -0.019, p > 0.05), emotional value (β = 0.020, p > 0.05), epistemic value (β = -0.018, p > 0.05), time risk (β = -0.034, p > 0.05), and physical risk (β = 0.070, p > 0.05) on re-participation intentions were also not significant. Therefore, hypotheses H2a, H2c, H3b-d, and H4b-c were not supported.

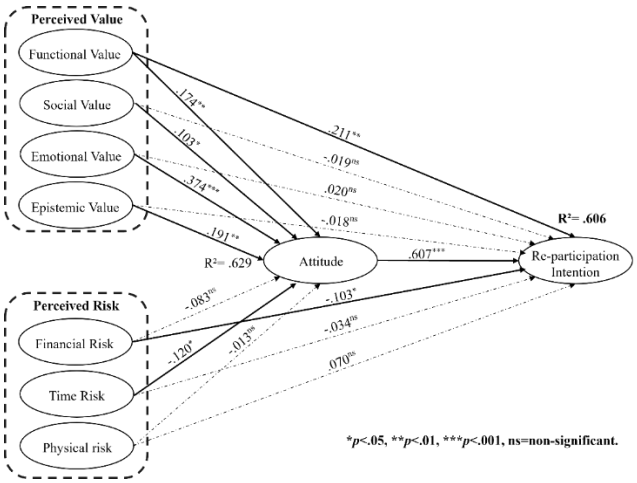

Figure 2: Results of Structural Model Test

4.4. Indirect Analysis

Given that seven hypotheses were not supported, indirect effects were examined (Table 3). The results revealed significant indirect relationships between re-participation intentions and functional value (β = 0.106, p < 0.01), social value (β = 0.063, p < 0.05), emotional value (β = 0.227, p < 0.001), epistemic value (β = 0.116, p < 0.05), and time risk (β = -0.073, p < 0.05). These relationships were mediated through attitude. In contrast, no indirect relationships were found between financial risk (β = -0.050, p > 0.05) or physical risk (β = -0.008, p > 0.05) and re-participation intention.

Table 3: Indirect Effects Estimation

Path	β	t value	Bias-corrected 95% Confidence Interval	
			Lower Level	Upper Level
FV → ATT → RI	0.106	2.823**	0.037	0.183
SV → ATT → RI	0.063	2.135*	0.005	0.120

EMV → ATT → RI	0.227	5.078***	0.144	0.321
EPV → ATT → RI	0.116	2.482*	0.031	0.211
FR → ATT → RI	-0.050	1.780ns	-0.110	0.001
TR → ATT → RI	-0.073	2.181*	-0.141	-0.008
PR → ATT → RI	-0.008	0.264ns	-0.069	0.050

Note. *p<0.05, **p<0.01, ***p<0.001, ns=non-significant, β=Standardized regression weight. FV=Functional Value, SV=Social Value, EMV=Emotional Value, EPV=Epistemic Value, FR=Financial Risk, TR=Time Risk, PR=Physical Risk, ATT=Attitude, RI=Re-participation Intention.

4.5. Cluster Analysis

Clustering is a method of grouping based on similarity or distance between objects (Hair et al., 2018). Hierarchical and non-hierarchical clustering were employed to categorise tourists according to their health consciousness and health status. Hierarchical clustering is used to generate and evaluate large-scale clustering solutions, while non-hierarchical clustering is used to analyse large samples and generate 'optimal' clusters given a specific number of clusters (Hair et al., 2018).

4.5.1. Hierarchical Clustering

Hierarchical cluster analysis groups samples progressively based on their characteristics to identify relatively homogeneous clusters (Hair et al., 2018). In this study, all samples were analysed hierarchically using the Ward clustering algorithm (Table 4). When the percentage increase in the coefficient of agglomeration for a particular step is significantly greater than that of other steps, it indicates the superiority of that clustering solution. However, the two-cluster solution, despite typically showing the greatest change in heterogeneity, is often avoided owing to its limited value (Hair et al., 2018). Therefore, the three-cluster solution with the second-highest heterogeneity increase (32.1%) was chosen for this study instead of the two-cluster solution, which had a 67.2% increase.

Table 4: Agglomeration Schedule for the Reduced Cluster Sample (Steps 298 to 304)

Stage	Cluster Combined		Coefficients	Number of Clusters after Combining	Differences	Proportionate Increase in Heterogeneity to the Next Stage
	Cluster 1	Cluster 2				
298	4	8	133.524	-	18.169	13.6%
299	1	11	151.693	-	25.549	16.8%
300	3	4	177.242	5	38.679	21.8%
301	5	10	215.921	4	59.412	27.5%
302	**1**	**25**	**275.334**	**3**	**88.312**	**32.1%**
303	1	3	363.646	2	244.354	67.2%
304	1	5	608.000	1	-	-

4.5.2. Non-hierarchical Clustering

To verify the validity and stability of the cluster analysis results and to ensure their practical relevance, K-means cluster analysis was performed. It classified the data into three distinct groups (Table 5). Multiple comparisons using Scheffé's method confirmed that these three groups were significantly different from each other. Finally, each group was named according to its characteristics. Group 1 was labelled 'Health-Conscious but Unwell' owing to its below-average health status and above-average health consciousness; Group 2 was labelled 'Not Health-Conscious and Unwell' because both its health status and health consciousness were below average; while Group 3 had both above-average health status and health consciousness and was therefore labelled 'Health-Conscious and Well'.

Table 5: Summary Statistics of k-Means Cluster Analysis

	Cluster 1 (n = 76)	Cluster 2 (n = 101)	Cluster 3 (n = 128)	F Value	Sig.	Scheffe Test 1 vs 2	Scheffe Test 1 vs 3	Scheffe Test 2 vs 3
HS	-0.831	-0.441	0.841	173.778	***	**	***	***
HC	0.301	-1.072	0.668	219.306	***	***	***	***

Note. **$p < 0.01$, ***$p < 0.001$, HS=Health Status, HC=Health Consciousness.

Discriminant analysis was also conducted with the aim of assessing the reliability and validity of the clustering results mentioned above (Table 6). For the initial and cross-validation samples of 305 observations, 95.4% of the sample respondents were correctly classified by the discriminant function. These results demonstrate the reliability of the classification of the three groups.

Table 6: Results of Discriminant Analysis of Clusters

Discriminant Function(s) Results								
	Eigenvalues				Wilks' Lambda			
Function	Eigenvalue	% of Variance	Cumulative %	Canonical Correlation	Wilks' Lambda	Chi-square	df	Sig.
1	1.736	72.6	72.6	0.797	0.221	455.714	4	0.000
2	0.657	27.4	100	0.630	0.604	152.221	1	0.000

Classification Results [a,b]				
Cluster Number of Case	1	2	3	Total

Original	Count	1	63	4	9	76
		2	0	101	0	101
		3	1	0	127	128
	%	1	82.9	5.3	11.8	100.0
		2	0.0	100.0	0.0	100.0
		3	0.8	0.0	99.2	100.0
Cross-validated	Count	1	63	4	9	76
		2	0	101	0	101
		3	1	0	127	128
	%	1	82.9	5.3	11.8	100.0
		2	0.0	100.0	0.0	100.0
		3	0.8	0.0	99.2	100.0

a. 95.4% of original grouped cases correctly classified.
b. 95.4% of cross-validated grouped cases correctly classified.

4.6. Multi-group Analysis

To examine potential differences in the formation process of respondents' intention to re-participate in wellness tourism among the aforementioned three groups, a pairwise comparison was conducted using bootstrap multi-group analysis. Only one path was demonstrated to have significant differences between the groups. The influence of functional value on re-participation intention (H3a) was found to be significant in Group 3 (β = 0.379, $p < 0.001$), but not significant in Groups 1 (β = -0.043, $p > 0.05$) and 2 (β = 0.187, $p > 0.05$). Furthermore, its effect was significantly different between Groups 1 and 3 (β = -0.422, $p < 0.01$).

5. Discussion

This study examined the impact of multidimensional perceived value and perceived risk on tourists' intentions to re-participate in wellness tourism, while also investigating the mediating role of attitude. Cluster analysis was employed to segment wellness tourists based on their health consciousness and health status. This segmentation resulted in the classification of tourists as 'Health-Conscious but Unwell', 'Not Health-Conscious and Unwell', and 'Health-Conscious and Well'. Finally, a multi-group analysis was conducted to compare differences in the formation of re-participation intentions among these three types of tourists.

The results showed that functional, social, emotional, and epistemic values significantly and positively influenced tourists' attitudes, with emotional value having the strongest influence. This suggests that tourists who believe that wellness tourism can help them relax or release stress are more inclined to have a positive attitude towards it. Meanwhile, the service quality and efficacy of wellness tourism, the effect of self-image enhancement, and the possibility of acquiring new knowledge are also important to tourists. Furthermore, time risk significantly and negatively affected attitude, indicating that if tourists perceive that the time spent on planning and participating in wellness tourism does not match the value they perceive, their attitudes will suffer.

Additionally, among categories of perceived value and perceived risk, only functional value and financial risk directly influenced tourists' re-participation intentions. This implies that if tourists are dissatisfied with the service quality or effectiveness of wellness tourism, or if they perceive the price as too high for its worth, they are likely to discontinue participation despite having a positive attitude. Attitude was found to have the strongest influence on re-participation intention among all paths and serve as an important mediating variable in intention formation. While social, emotional, or epistemic value and time risk did not directly impact re-participation intentions, they did so indirectly through attitude. Therefore, to ensure positive attitudes and higher re-participation intentions, it is necessary to maintain transparent and reasonable pricing to reduce financial risk and simultaneously increase the levels of the four categories of perceived value, while reducing time risk.

Moreover, physical risk had no significant impact on attitude or re-participation intention. This finding deviates from initial expectations and may be attributed to the unique characteristics of wellness tourism itself. The primary objective of wellness tourism is to maintain health, in contrast to adventure tourism, which typically involves higher levels of risk. Consequently, tourists tend to place less emphasis on physical risk when participating in wellness tourism activities.

Finally, the process of forming re-participation intentions varied based on tourists' health consciousness and health status, although the differences were minimal. For those who are 'Health-Conscious and Well', their re-participation intention is influenced by their perception of high-quality services and how well these services meet their needs for health improvement. In contrast, for individuals who are 'Health-Conscious but Unwell' and 'Not Health-Conscious and Unwell', the impact of functional value is less significant. This may be because of limitations imposed by their current health status. Individuals in poor health may find it challenging to make significant improvements in their health through wellness tourism, leading them to prioritise other values instead. Additionally, certain activities or treatments may be too intense or unsuitable for individuals

in poor health, preventing them from experiencing the full functional value offered by such experiences.

6. Contributions and Limitations

6.1. Theoretical Implications

This study makes four main contributions to theory. First, it simultaneously examines how multidimensional incentives (perceived value) and disincentives (perceived risk) affect tourists' re-participation intentions in wellness tourism. By integrating these perspectives, this study delivers a crucial understanding of the complexity of the formation of behavioural intentions among wellness tourists and enriches the theoretical framework of the field. Second, this study highlights the important role of attitude in mediating perceived value, perceived risk, and re-participation intentions, further emphasising the significance of attitude in wellness tourism. Third, by combining health consciousness and health status, this study categorises wellness tourists into three distinct groups. Although the differences between these groups were not as pronounced as expected, this segmentation approach provides a new theoretical framework for future research. Finally, the findings suggest that a majority of wellness tourists are not entirely healthy, challenging established views and offering new insights into potential shifts within the wellness tourism market.

6.2. Practical Implications

This study suggests several practical strategies to enhance tourists' re-participation intentions. First, tourism service providers should offer high-quality tourism products to ensure efficacy of the activities. For instance, wellness tourism benefits can be demonstrated through indicators such as blood pressure and heart rate. These health data can be monitored in real-time using devices such as health bracelets, enabling tourists to clearly understand the actual effects of the wellness tourism they engage in. Tourism service providers can utilise these data to offer tourists personalised recommendations for wellness programmes that cater to their specific needs and preferences.

Second, creating a platform for sharing experiences and insights on wellness tourism is crucial. Such a platform not only promotes shared wellness objectives but also enriches tourists' sense of social value. Furthermore, tourists' emotional and epistemic values can be enhanced and their overall experience improved by strengthening their connection with nature, creating a serene and comfortable environment, and providing guidance during activities on how to maintain their health in daily life.

In terms of pricing, it is essential to provide clear and detailed information so that tourists can fully understand the breakdown of travel costs and the specific services offered, thereby avoiding any hidden costs or additional charges. Additionally, to minimise tourists' concerns about wasting time, travel service providers should clearly communicate the objectives and expected outcomes of activities. By increasing tourists' understanding of the significance and benefits of wellness tourism, their time risk can be reduced.

For 'Health-Conscious and Well' tourists, the quality of services and the actual results in terms of health improvement are key factors in considering reengagement in wellness tourism. Therefore, service providers could collaborate with medical institutions or health experts to promote high-end, personalised health services and provide quantifiable health improvement data. For 'Health-Conscious but Unwell' tourists, although they may wish to improve their health, they may be unable to participate in high-intensity treatments or activities because of their physical limitations. Marketing strategies should therefore focus more on their psychological needs and comfort. For instance, offering gentler treatments or activities that emphasise stress relief and mood enhancement can be more appealing. For 'Not Health-Conscious and Unwell' tourists, health improvement may not be a primary goal. Consequently, marketing could emphasise the recreational and entertainment value of wellness tourism, such as providing relaxing activities that require minimal physical effort.

These recommendations will help wellness tourism marketers and service providers utilise limited resources more effectively, ensuring that each type of tourist receives services and experiences tailored to their needs. This approach will not only boost the wellness tourism industry but also enhance overall tourist satisfaction and re-participation rates.

6.3. Limitations and Future Research

This study also has certain limitations. First, 305 samples were collected. While this was sufficient to test the model, in the multi-group analysis, Group 1 consisted of only 76 individuals, with just over a hundred in the other two groups. This may affect the reliability and stability of the results. Future studies should use increased sample sizes to minimise the potential bias caused by sample size limitations. Second, the study was conducted in Japan. While the results are informative for countries and regions with similar backgrounds, cultural and contextual differences may limit their generalisability. Future research should be conducted in various countries and regions to test the external validity of the results and explore the potential impact of different cultures on tourists' behaviours, using

cross-cultural research methods. Finally, this study examined tourists' overall perceptions of wellness tourism—however, different wellness tourism activities may elicit varying perceptual and behavioural responses. Future research could further categorise these activities and explore differences in tourist behaviours for each type of activity.

References

Adhitiya, L., & Astuti, R. D. (2019). The effect of consumer value on attitude toward green product and green consumer behavior in organic food. *IPTEK Journal of Proceedings Series*, *5*, 193-202.

Anannukul, N., & Yoopetch, C. (2022). The determinants of intention to visit wellness tourism destination of young tourists. *Kasetsart Journal of Social Sciences*, *43*(2), 417–424.

Asiegbu, I. F., Daubry, P., & Iruka, C. H. (2012). Consumer attitude: Some reflections on its concept, trilogy, relationship with consumer behavior, and marketing implications. *European Journal of Business and Management*, *4*(13), 38–50.

Azam, N. R. A. N., Rashid, B., Zainol, N. A., & Mohamad, M. (2020). Multi-dimensional values on customers' intention to revisit green resorts: The cultural case in Malaysia. *Journal of Innovation in Educational and Cultural Research*, *1*(2), 41-51.

Boguszewicz-Kreft, M., Kuczamer-Kłopotowska, S., & Kozłowski, A. (2022). The role and importance of perceived risk in medical tourism. Applying the theory of planned behaviour. *PloS One*, *17*(1), e0262137.

Carvache-Franco, M., Carrascosa-López, C., & Carvache-Franco, W. (2021). The perceived value and future behavioral intentions in ecotourism: A study in the Mediterranean natural parks from Spain. *Land*, *10*(11), 1133.

CDC (Centers for Disease Control and Prevention). (2024, August 5). *Health Status*. Retrieved September 6, 2024, from https://www.cdc.gov/nchs/hus/topics/health-status.htm

Çetinsöz, B. C., & Ege, Z. (2013). Impacts of perceived risks on tourists' revisit intentions. *Anatolia*, *24*(2), 173-187.

Cho, J., Park, D., & Lee, H. E. (2014). Cognitive factors of using health apps: systematic analysis of relationships among health consciousness, health information orientation, eHealth literacy, and health app use efficacy. *Journal of Medical Internet Research*, *16*(5), e125.

Chua, B.-L., Meng, B., Ryu, H. B., & Han, H. (2021). Participate in volunteer tourism again? Effect of volunteering value on temporal re-participation intention. *Journal of Hospitality and Tourism Management*, *46*, 193–204.

Cole, S. T., & Scott, D. (2004). Examining the mediating role of experience quality in a model of tourist experiences. *Journal of Travel & Tourism Marketing*, *16*(1), 79–90.

Cui, F., Liu, Y., Chang, Y., Duan, J., & Li, J. (2016). An overview of tourism risk perception. *Natural Hazards (Dordrecht, Netherlands)*, *82*(1), 643–658.

Demirgüneş, B. K. (2015). Relative importance of perceived value, satisfaction and perceived risk on willingness to pay more. *International Review of Management and Marketing*, *5*(4), 211–220.

Fabrigar, L. R., & Wegener, D. T. (2010). Attitude structure. In R. F. Baumeister & E. J. Finkel (Eds.), *Advanced social psychology: The state of the science* (pp. 177–216). Oxford University Press.

Habibi, A., & Rasoolimanesh, S. M. (2021). Experience and service quality on perceived value and behavioral intention: Moderating effect of perceived risk and fee. *Journal of Quality Assurance in Hospitality & Tourism*, *22*(6), 711–737.

Hair, J. F., Jr, Black, W. C., Babin, B. J., & Anderson, R. E. (2018). *Multivariate Data Analysis* (8th ed.). Cengage Learning EMEA.

Hair, J. F., Jr, Hult, G. T. M., Ringle, C., & Sarstedt, M. (2016). *A Primer on Partial Least Squares Structural Equation Modeling (PLS-SEM)* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Hasan, M. K., Ismail, A. R., & Islam, M. D. F. (2017). Tourist risk perceptions and revisit intention: A critical review of literature. *Cogent Business & Management*, *4*(1), 1412874.

Hong, H. (2009). Scale Development for Measuring Health Consciousness: Re-conceptualization. *Proceedings of 12th Annual International Public Relations Research Conference*, 212–233.

Horner, S., & Swarbrooke, J. (2020). *Consumer behaviour in tourism* (4th ed.). London, England: Routledge.

Jamrozy, U., & Lawonk, K. (2017). The multiple dimensions of consumption values in ecotourism. *International Journal of Culture Tourism and Hospitality Research*, *11*(1), 18–34.

Jiang, Y., & Hong, F. (2021). Examining the relationship between customer-perceived value of night-time tourism and destination attachment among Generation Z tourists in China. *Tourism Recreation Research*, *48*(2), 220–233.

Karn, S., & Swain, S. K. (2017). Health consciousness through wellness tourism: a new dimension to new age travelers. *African Journal of Hospitality Tourism and Leisure*, *6*(3), 1–9.

Khan, M. J., Chelliah, S., & Ahmed, S. (2019). Intention to visit India among potential travellers: Role of travel motivation, perceived travel risks, and travel constraints. *Tourism and Hospitality Research*, *19*(3), 351–367.

Kim, Y., & Han, H. (2010). Intention to pay conventional-hotel prices at a green hotel – a modification of the theory of planned behavior. *Journal of Sustainable Tourism*, *18*(8), 997–1014.

Kock, N. (2015). Common method bias in PLS-SEM: A full collinearity assessment approach. *International Journal of E-Collaboration*, *11*(4), 1–10.

Lee, J., & Kim, J.-J. (2023). A study on market segmentation according to wellness tourism motivation and differences in behavior between the groups-focusing on satisfaction, behavioral intention, and flow. *International Journal of Environmental Research and Public Health*, *20*(2), 1063.

Lehto, X. Y., Brown, S., Chen, Y., & Morrison, A. M. (2006). Yoga tourism as a niche within the wellness tourism market. *Tourism Recreation Research*, *31*(1), 25–35.

Li, F., Wen, J., & Ying, T. (2018). The influence of crisis on tourists' perceived destination image and revisit intention: An exploratory study of Chinese tourists to North Korea. *Journal of Destination Marketing & Management*, *9*, 104–111.

Nagaraj, S. (2021). Role of consumer health consciousness, food safety & attitude on organic food purchase in emerging market: A serial mediation model. *Journal of Retailing and Consumer*

Services, *59*, 102423.

Namkung, Y., & Jang, S. (2013). Effects of restaurant green practices on brand equity formation: Do green practices really matter? *International Journal of Hospitality Management*, *33*, 85–95.

Park, J., Ahn, J., & Yoo, W. S. (2017). The effects of price and health consciousness and satisfaction on the medical tourism experience. *Journal of Healthcare Management*, *62*(6), 405–417.

Park, J., & Kim, J. (2007). The importance of perceived consumption delay in Internet shopping: Time-related information, time risk, attitude, and purchase intention. *Clothing and Textiles Research Journal*, *25*(1), 24-41.

Park, S. S., Rhim, Y. T., Kim, M. J., Kim, S. K., & Yoo, J. I. (2014). The influence of perceived risk on participation motivation and re-participation intention in marine sports. *Journal of Coastal Research*, *72*, 96–100.

Perrea, T., Grunert, K. G., & Krystallis, A. (2015). Consumer Value perceptions of food products from emerging processing technologies: A cross-cultural exploration. *Food Quality and Preference*, *39*, 95–108.

Peter, J. P., & Tarpey, L. X., Sr. (1975). A comparative analysis of three consumer decision strategies. *The Journal of Consumer Research*, *2*(1), 29-37.

Pihlström, M. (2008). *Perceived value of mobile service use and its consequences*. Svenska Handelshögskolan.

Quintal, V. A., Lee, J. A., & Soutar, G. N. (2010). Risk, uncertainty and the theory of planned behavior: A tourism example. *Tourism Management*, *31*(6), 797–805.

Reitsamer, B. F., Brunner-Sperdin, A., & Stokburger-Sauer, N. E. (2016). Destination attractiveness and destination attachment: The mediating role of tourists' attitude. *Tourism Management Perspectives*, *19*, 93–101.

Ren, T., Hyun, H., & Park, J. (2017). Medical tourism services: The role of patients' perceived health consciousness and value. *Journal of Service Science Research*, *9*(2), 179–195.

Research and Markets. (2022, August 11). *Global Wellness Tourism Market (2022 to 2027) - Industry Trends, Share, Size, Growth, Opportunity and Forecasts*. Retrieved September 6, 2024, from https://www.globenewswire.com/en/news-release/2022/08/11/2496761/28124/en/Global-Wellness-Tourism-Market-2022-to-2027-Industry-Trends-Share-Size-Growth-Opportunity-and-Forecasts.html

Sadiq, M., Dogra, N., Adil, M., & Bharti, K. (2022). Predicting online travel purchase behavior: The role of trust and perceived risk. *Journal of Quality Assurance in Hospitality & Tourism*, *23*(3), 796–822.

Šagovnović, I., & Stamenković, I. (2022). Investigating values of green marketing tools in predicting tourists' eco-friendly attitudes and behavior. *Journal of Ecotourism*, *22*(4), 479-501.

Sánchez-Fernández, R., & Iniesta-Bonillo, M. Á. (2007). The concept of perceived value: a systematic review of the research. *Marketing Theory*, *7*(4), 427–451.

Sheth, J. N., Newman, B. I., & Gross, B. L. (1991). Why we buy what we buy: A theory of consumption values. *Journal of Business Research*, *22*(2), 159–170.

Smith, M., & Puczko, L. (2014). *Health, tourism and hospitality: Spas, wellness and medical travel* (2nd ed.). London, England: Routledge.

Soliman, M. (2021). Extending the theory of planned behavior to predict tourism destination revisit intention. *International Journal of Hospitality & Tourism Administration*, *22*(5), 524–549.

Sthapit, E., Björk, P., & Coudounaris, D. N. (2022). Towards a better understanding of memorable wellness tourism experience. *International Journal of Spa and Wellness*, *6*(1), 1–27.

Stone, R. N., & Grønhaug, K. (1993). Perceived risk: Further considerations for the marketing discipline. *European Journal of Marketing*, *27*(3), 39–50.

Sweeney, J. C., & Soutar, G. N. (2001). Consumer perceived value: The development of a multiple item scale. *Journal of Retailing*, *77*(2), 203–220.

Tahir, M. (2021). The impact of green perceived value and its additional multidimensional expanded variables effect on customer attitude and purchasing intention for buying green food products: A case of Pakistan. *Journal of Organization and Business*, *2*(1), 24-42.

Ting, T., Changtai, L., Linjun, H., & Zhiping, Z. (2021). Study on the influence of health and wellness tourists' pull motivation on revisit intention-- the moderating role of the push motivation. *E3S Web of Conferences*, *251*, 03047.

Trongjitpituk, T. (2020). *The influence of sports facilities' accessibility, motivation, and satisfaction on word-of-mouth and re-participation intentions of athletes with physical disabilities* (Chulalongkorn University). Retrieved from https://digital.car.chula.ac.th/chulaetd/398/

Um, J., & Yoon, S. (2021). Evaluating the relationship between perceived value regarding tourism gentrification experience, attitude, and responsible tourism intention. *Journal of Tourism and Cultural Change*, *19*(3), 345-361.

Voigt, C., Brown, G., & Howat, G. (2011). Wellness tourists: in search of transformation. *Tourism Review*, *66*(1/2), 16–30.

Wang, Y., Gu, J., Wang, S., & Wang, J. (2019). Understanding consumers' willingness to use ride-sharing services: The roles of perceived value and perceived risk. *Transportation Research. Part C, Emerging Technologies*, *105*, 504–519.

WHO (World Health Organization). (1946). *Constitution*. Retrieved September 6, 2024, from https://www.who.int/about/governance/constitution

Yi, S., Day, J., & Cai, L. A. (2014). Exploring tourist perceived value: An investigation of Asian cruise tourists' travel experience. *Journal of Quality Assurance in Hospitality & Tourism*, *15*(1), 63–77.

Youm, S., & Park, S.-H. (2015). How the awareness of u-healthcare service and health conditions affect healthy lifestyle: an empirical analysis based on a u-healthcare service experience. *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association*, *21*(4), 286–295.

Zeithaml, V. A. (1988). Consumer perceptions of price, quality, and value: A means-end model and synthesis of evidence. *Journal of Marketing*, *52*(3), 2–22.

Zhang, H., Wu, Y., & Buhalis, D. (2018). A model of perceived i mage, memorable tourism experiences and revisit intention. *J ournal of Destination Marketing & Management*, *8*, 326–336.

Appendix

Appendix 1: Measurement scales

Construct and Items	References
Functional Value (FV)	
FV1: Wellness tourism is a good-quality tourism product.	
FV2: The wellness tourism I would participate in has an acceptable standard of quality and service.	Jamrozy & Lawonk (2017)
FV3: Wellness tourism activity has consistent quality.	
FV4: When engaging in wellness tourism, I receive better service than during conventional tourism.	
Social Value (SV)	
SV1: Participating in wellness tourism helps me feel accepted.	
SV2: Participating in wellness tourism improves the way I am perceived.	
SV3: Participating in wellness tourism makes a good impression on other people.	Jamrozy & Lawonk (2017)
SV4: Participating in wellness tourism elicits social approval.	
SV5: Many people I know participate in wellness tourism.	
Emotional Value (EMV)	
EMV1: Participating in wellness tourism makes me feel relaxed.	
EMV2: Participating in wellness tourism makes me feel good.	Sweeney & Soutar (2001)
EMV3: Participating in wellness tourism gives me pleasure.	
Epistemic Value (EPV)	
EPV1: I think that my health knowledge increases by participating in wellness tourism.	
EPV2: Participating in wellness tourism satisfies my curiosity.	Jiang & Hong (2021)
EPV3: Participating in wellness tourism is a good opportunity for me to learn about new people and cultures.	
EPV4: Participating in wellness tourism is educational.	
Physical Risk (PR)	
PR1: I worry that I may get sick or injured while participating in wellness tourism.	
PR2: I worry that I may have an accident while participating in wellness tourism.	Hasan et al. (2017)
PR3: I worry that I may encounter a natural disaster while participating in wellness tourism.	
Financial Risk (FR)	
FR1: I worry that I would not receive good value for my money if I participate in wellness tourism.	
FR2: I worry that participating in wellness tourism would involve unexpected extra expenses.	Khan et al. (2019)
FR3: I worry that participating in wellness tourism would be more expensive than other forms of tourism.	
Time Risk (TR)	
TR1: I worry that participating in wellness tourism would be a waste of time.	
TR2: I worry that participating in wellness tourism would waste my valuable vacation time.	Khan et al. (2019)
TR3: I worry that planning and preparing for wellness tourism would take too much time.	
Attitude (ATT)	
ATT1: For me, participating in wellness tourism is good.	
ATT2: For me, participating in wellness tourism is wise.	Kim & Han (2010)
ATT3: For me, participating in wellness tourism is favourable.	
Re-participation Intention (RI)	
RI1: I tend to participate in wellness tourism again.	
RI2: I'd love to participate in wellness tourism again.	Zhang et al. (2018)
RI3: I think I will participate in wellness tourism again in near future.	
Health Consciousness (HC)	
HC1: I think that I am very conscious about my health.	
HC2: I usually undertake wellness activities such as spa or hot spring bathing to improve my health and wellbeing.	Anannukul & Yoopetch (2022)
HC3: I am always active to improve my health quality.	
Health Status (HS)	
HS1: I think I'm physically healthy.	
HS2: I think I'm mentally healthy.	WHO (1946)
HS3: I think I am socially well-connected and able to interact meaningfully with the people around me.	