

Emotional tourist-experience model: Exploring the health-wellbeing for the active 50-plus tourists

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Abstract

This study aims to examine the emotional tourist-experience model, constructs, and their relationships towards health-wellbeing for the active 50-plus tourists. With the opportunity involving health activities while traveling, the active 50-plus have motivated themselves by setting goals of their own choices to gain the preferred meaningful experiences. The experiences that give value to their later-life well-being can drive them to continue traveling with health reasons. Five underpinned experience factors are sequentially formulated for the study model to understand tourist experience process. The model of which includes goal-driven motivation, positive emotional tourist-experience, tourist satisfaction, memorable experience and intention behaviour. To test the model, the study employed survey questionnaire for data collection and structural equation modelling for data analysis. The findings supported the causal relationships and the effect directions of those factors. The collected experience value has resulted in the individual health benefits and lifestyles of four fundamental PMSE dimensions: physical, mental, social, and emotional. The study offers the results of new mindset changing health-activity behaviour for their later life well-being and contributes to the extended theories of motivation concerning health and well-being.

Keywords:

Tourist experience; goal-driven motivation; positive emotional tourist-experience; memorable experience; health-activity behaviour; later life well-being

1 Introduction

Experiences are a significant self-expression process, giving strong subjective emotions, and memorable personal value (O'Dell & Billing, 2005). As developed in the concept of customer engagement behaviour (van Doom et al., 2010), the behavioural expressions can urge customers to activate their emotional experiences with the goal of maximizing satisfaction (Bigne & Andreu, 2004). Similarly, most researchers in tourism agree that tourists can create emotional experience value resulting from their preferable motivational drivers (Prebensen, Woo, Chen, & Uysal, 2012). Arguing why experiences can allow tourists to engage in activities, pursue them to do things, or encourage them to observe others. Seeking social and psychological tourist experiences from new activity behaviour, this study aims to explore a set of overlapping antecedents that crucially guide tourist engagement behaviour.

During the normal situation, the number of people travelling internationally for health purposes had been increasing yearly through conveniently accessible travel facilities. Currently, travel and tourism have been disabled worldwide in a sudden by coronavirus disease (COVID-19). To date, there have been 45 million confirmed cases of COVID-19, including more than one million deaths (World Health Organization [WHO], 2020). Like other pandemic crisis in the past, travel and tourism are always the most vulnerable businesses that have got affected by the serious decline of tourists. Indeed, travel behaviour after resilient conditions may not be simply justified by price, speed, and comfort but rather be related to attitude, health status and preferences (van Acker, Goodwin, & Witlox, 2016). And yet, travel for health benefits will play the most important motivator, especially among ageing tourists whose health are the most concern.

Over the past decades, the rapid growth of global ageing population have increased the number of ageing tourists for a larger share of vacation spending globally (Patterson, Sie, Balderas-Cejudo, & Rivera-Hernaez, 2017; Balderas-Cejudo, Leeson, & Urdaneta, 2017). Especially, most past studies found active ageing tourists, aged 50 years and over, the most quality target market (Chen, Chang, & Liu, 2015; Milner, 2013). Because they are, on average, healthier, wealthier and better educated (Balderas-Cejudo & Leeson, 2017, p. 1). By 2050, the number of 50-plus is projected to double 1.6 billion people in 2015 to nearly 3.2 billion people (American Association of Retired Persons [AARP], 2016). This age group has a transformative impact, economically and socially, to the ageing tourism market. Having free time and tentatively taking preventive health and health improvement, the increasing active 50-plus tourists are ongoing to require quality travel experiences with health reason (SRI International, 2017; Smith and Puczko, 2014; Hall, 2011; Pyke et al., 2016). However, although health activity is essential, it is hardly compliant routinely. As a result, health benefits can be both the motivator and the limitation due to the chosen pleasurable leisure types and individual ageing activity-behaviour (Balderas-Cejudo & Leeson, 2017, p. 2). To understand tourist behaviour through a diversity of needs and

preferences of the active 50-plus market is necessary and important to further predict their attitudes toward well living design.

As discusses above, this interdisciplinary research has arrived, see Figure 1, to bridge main important issues (ageing tourist, tourism, health, activity) to the central tourist experience. In seeking health and tourism activities that give new meaningful experience, the unexplored experience factors that can activate the active 50-plus tourist's activity behaviour will be examined (Naidoo et al., 2015; Williams & Soutar, 2009).

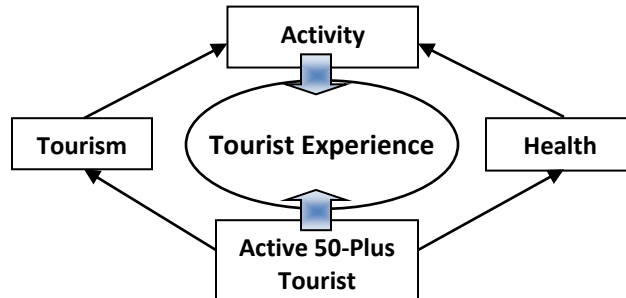


Figure 1: Conclusion of Interdisciplinary research for main study issues and relationships

Sources: Bigne & Andreu (2004); SRI International (2017); Smith and Puczko (2014); Hall (2011); Pyke et al. (2016); Park & Santos (2017); AARP (2016); Patterson & Pegg (2011); Balderas-Cejudo et al. (2017)

To greater extent research, the study discovered the academic gap of tourist experience for an age-health reason. The lack of tourist experience process and activity, with the elements of goal-driven motivation, positive emotional tourist-experience, tourist satisfaction, memorable experience, and intention behaviour, were found in most attentions of many past studies (Brent Ritchie, Wing Sun Tung, & J.B. Ritchie, 2011; Campos, Mendes, Valle, & Scott, 2018; Carù & Cova, 2003; Chen & Chen, 2010; Hosany, Prayag, Deesilatham, Caušević, & Odeh, 2015; Hung, Lee, & Huang, 2016; Jensen, 2014; Jensen & Prebensen, 2015; Kim, Woo, & Uysal, 2015; Kim & Fesenmaier, 2017; Park & Santos, 2017; Prebensen, Kim, & Uysal, 2016; Prebensen, Woo, & Uysal, 2014; Pullman & Gross, 2004; Pyke et al., 2016; Sharma & Nayak, 2019; Tussyadiah, 2014). Although those underpinned elements were frequently discussed, they all were little mentioned in the sequential tourist experience process of full trips, including pre-trip, during the trip, and post trips. When pre-trip started, desire to travel with joy and healthiness becomes initial goal-driven to trip planning. The motives with driving forces guiding individual behaviour becomes the goal-driven motivation so that personal goals can be achieved to bring enjoyment and satisfaction to the individual experience (Patterson, 2006, p. 23). To prove that emotional experiences are the process but not end result (Peacock, 2009), a set of overlapping antecedents guiding tourist activity behaviour to continue their health and well-being value in later life should be explored. Two research questions arise:

RQ1. What will be the effects of those factors towards health-activity experience?
RQ2. How can those factors activate the 50-plus tourists' health activity behaviour in later life?

2 Literature Review

2.1 Emotional tourist experience process and components

Experiences are inherently emotional and personal expressions. The experience can be co-created with people, place, activity, culture, knowledge, process, or story-telling (Tussyadiah, 2014; Peacock, 2009). But tourist experiences are personal interpretation based on individual cultural background, previous experience, mood, sensation, and other factors of oneself (Pullman & Gross, 2004). Emotional expression through three-trip stages is tourist experience process describing the importance of five related constructs as follows.

Pre-trip stage: Motivation is used to develop and promote quality experiences as an important driving force behind all behaviours (Prebensen et al., 2012; Fodness, 1994). Travel motivation is argued by many researchers as an influential factor to understand not only tourist behaviour but also tourists' intention behaviour (Chang et al., 2014; Crompton, 1979). But significantly, tourist motivation can affect satisfaction until individual mental process enters the personal long-term memory (Lee, 2009, p. 230; Larsen, 2007). In search of motivation to travel with health reason, goal-driven activities can activate passionate tourist experiences and drive determinant forces to achieve life satisfaction (Oh, Assaf, & Baloglu, 2016).

During-trip stage: Past studies have indicated that positive emotional tourist-experience factors can increase emotional well-being by broadening judgements of life satisfaction, such as the feeling of happiness and joy (Fredrickson & Joiner, 2002). Referring to Peacock (2009), the positive emotional variables that make meaningful connections of products to customers are enjoy, surprise, excitement, calm, relax, flexible, and freedom. These emotions help customers accomplish higher-level goals of decision making to purchase. Especially, six motivation variables of Oh et al. (2016) can describe the link with positive emotions, which are relaxation, self-reflection, escape, novelty-seeking, engagement, and discovery. Moreover, the quality of perceived experience and memorable experience by Chen and Chen (2010) and Sthapit and Coudounaris (2018) can transform activity engagement to positive emotional expressions, such as adventurous, challenging, surprise, joy, energetic, exciting, curious, enthusiastic, flexible, freedom, self-fulfillment, happiness, escape, and relax and relief. The impacts from tourists' mental and physical activities (Smith & Diekmann, 2017) can bring a satisfying alternative (Perkins & Thorns, 2001) and pleasurable choices of emotions from excitement, discovery, novelty, or relaxation, to the tourists (Cutler & Carmichael, 2010).

As discussed, four indicators of positive emotional tourist-experience are extracted and developed from past studies as the goal to drive motivation to engage in activities of health-experience context. To examine relationships of positive emotional tourist-experience and goal-driven motivation, tourist satisfaction, memorable experience, and intention behaviour, the chosen indicators are excitement (from motivation of adventure), surprise (from motivation of discovery), enjoy (from motivation of novelty-seeking), and calm and rest (from motivation of relaxation).

Post-trip stage: Following Hosany, Prayag, Van Der Veen, Huang, and Deesilatham (2017), tourists' emotional reactions in the post-consumption stage can be defined as satisfaction judgments, evaluated memorable experience and behavioural intentions. Tourist satisfaction is an outcome of tourist experiences, a post-experience attitude, the degree of emotional reactions, pleasurable fulfilment of a need, desire and goal (Cutler & Carmichael, 2010). Also, satisfaction is influenced by tourist motivation and emotions in the experience process and reflects goal fulfilment (Oh et al., 2016). Its result of self-enrichment is a perceived degree of enhanced self-esteem and confidence. As a result, the active 50-plus tourists can continue self-perceived concept of life reimagined to their lives, careers, relationships, and personal purposes toward more meaningful directions (Irving, 2014).

The memorable experience is the result of tourist satisfaction and an outcome of tourist experience process. The memorable experience becomes mentally brain-collected from the series of long-remembered experiences, which are created in a constructive or reconstructive process within the individual (Larsen, 2007, pp. 13-15). The memorable experiences for ageing tourists can be tailored facilitation of an environment that motivate them to repeat activity and to spread positive word of mouth to family and friends (Patterson et al., 2017, p. 354). Three indicators explaining memorable experiences suggested by Cutler and Carmichael (2010) are moment-by-moment experience (occurred during trip), evaluated memorable experience (at post trip), and collected memorable experience (after the recollection of past experiences).

Intention behaviour is the outcome of tourist experience process and the attitudes of judgments, especially intention to share, intention to recommend, and intention to repeat activity (Prayag, Hosany, & Odeh, 2013, p. 120; Hosany et al., 2017, p. 1080).

2.2 Active ageing tourist and preferences

Three factors in social trends influencing ageing travel and tourism are the social values of society, lifestyle and demographics (Dwyer et al., 2008, p. 17). Like other tourists, the active 50-plus are likely travelling for leisure to destress themselves from the unpleasant routines in life (Chen & Shoemaker, 2014). However, they may find travelling as the opportunity to experience different social value and participate in different social activities in destination societies (Patterson & Pegg, 2011; van Acker et al., 2016).

Moreover, becoming an increasing larger market-share (AARP, 2004) and a new niche quality tourist segment (Naidoo et al., 2015; Patterson & Pegg, 2009), the active 50-plus tourists' needs, want, and preferences are important to be studied (Poon, 1993, p. 272). Because of behavioural heterogeneity of travel motivations, activity engagement and destination choices, tourists' lifestyles mostly follow their preferences in life satisfaction. If pursuing tourist behavioural study, the continuity of preferred activities can enhance health and well-being in later life. Degree of physical and mental health activities can be ranged from high to low adventurous engagement (Patterson, 2018; pp. 139-142). Not at full physical strength but a leisure level with emotional fulfilment for active ageing tourists are the preferable concern, such as walking, running, bicycling, hiking and camping, animal watching, photo-taking, and soft-adventure activities. Thus, purposes of tourist engagement become goal-driven motivation of healthy living lifestyle, for examples, to appreciate the natural environment, to interact with people and cultures, to visit authentic destinations and past remains, to learn and acknowledge local wisdom, to try organic food and unique lifestyles, and to experience alternatives of health treatments and services (Oh et al., 2016). Also, today travel and tourism are easier and convenient by using Internet and technology-assisted, such as health and travel applications (Buhalis & O'Connor, 2005; Lifshitz, Nimrod, & Bachner, 2018). And new activity-based experience can be lifelong learning for active ageing tourists to enjoy, excited, or surprise, of discovering new things (Swank, Hollenbeck, Keenan, & Fisher, 2000).

In addition, tourists are basically classified by demographic profile using income, age, gender, nationality, education level, type of professions, travel patterns, and other socio-demographic variables. These are tourists' important background behaviour explaining opportunity to continue activity engagement in later life (Patterson, 2018).

2.3 Intrinsic-Extrinsic Motivation

Cutler and Carmichael (2010) confirm that tourists have different reasons to travel from both internal and external desire. Referring to active 50-plus tourist's needs and preferences, travel for health reason is meant to find new meaningful experiences from both traveling and health activities. Four extrinsic and four intrinsic goals are found setting for eight indicators driving the active 50-plus to travel: new activity-based experience; experiencing through technology-assisted; experiencing the locality and social-related activities; experiencing nature with environmental responsiveness; and experiencing with holistic well-being lifestyle of PMSE: physical, social, mental, and emotional health-wellbeing.

Conceptualized from the principles of wellness dimensions (Hettler, 1976; Milner, 2013; SRI International, 2017), the beneficial four-pillar goal of PMSE health-wellbeing (physical, mental, social, emotional) are extracted as the operationalized principle of fundamental theory in this study. The desire for healthy ageing include first, physical health-wellbeing, which covers the necessity to live independently with lifestyle

choices that maintain or improve health and functional ability or engage in physical activity and healthy foods. Second, mental health-wellbeing is engaged in creative pursuits and intellectually stimulating activities to keep minds alert and interested. Third, social health-wellbeing involves social interactions with family, friends, and people in destinations. Fourth, emotional health-wellbeing concerns the feelings to create balance in life with trustworthy and respectful ways.

3 Methodology

A quantitative research approach using survey questionnaire was adopted as the research instrument for data collection. Also, Structural Equation Modeling (SEM), CFA (Confirmatory Factor Analysis), AMOS (Analysis of a Moment Structures), and SPSS (Statistical Package for the Social Science) for Windows, are the statistical techniques and software programs used in this study for data analysis. The survey questionnaire is chosen for a more rigid way to respond and categorize responses to the set of questions (Creswell, 2012). Questions can be designed in highly structured causal relationships with the 7-Likert scale choices to quantify empirical data from multivariate variables. At the same time, structural equation modeling (SEM) is chosen to disentangle complex of causal relationships among variables in social studies (Gao, Mokhtarian, & Johnston, 2008). The inferences of causality in the SEM are based on hypothesis testing theoretical model and the parameter estimates. If theoretical assumptions fit the empirical data, the results are assumed as being trustworthy. Therefore, SEM analysis is used to predict the sequence of causal relationships and to describe the characteristics and behaviour of the sample population.

3.1 Sample Size and Sampling technique

The estimated sample size was chosen from the criterion of 10 times the number of total indicators (Hair, Black, Babin, & Anderson, 2013, pp. 9-10). In this study, the 21 observed indicators multiplied by ten equal to 210 become the minimum sample size which is considered sufficiently for questionnaire survey's data collection and statistical estimation (Jöreskog, Olsson, & Wallentin, 2016, p. 300; Kline, 1998; Kline, 2016). However, 257 samples were collected, and 234 cases were left for data analysis after cutting off cases of missing data, single-scale data, and outliers. The sampling technique used in this study was the first simple random sampling, and then purposive sampling. The respondents had firstly self-consideration reported that they were the active person at 50 years and over. Then secondly reported that they enjoyed travel experiences with health consciousness. And thirdly, they concerned health-related activities.

3.2 Study Area

A total respondent was reached in tourist destinations and health-activity areas. Tourist destinations included the famous temples, marketplaces, adventurous-activity places, beach, hotels, organic food and homestay, coffee and restaurants,

shopping malls, shopping street and sidewalk. Health-activity areas include badminton courts, fitness, and cycling bike-lane. They all were found in Thailand around Chiangmai, Pattaya, Bangkok, Kanchanaburi, and Lopburi.

3.3 Measurement

Three parts of collected data are the respondents' demographic profiles (age, gender, nationality, education level, and income per annual); the respondents' preferences (travel type, length of travel, health benefit focuses, destination choices, major health-experience activities, additional activities, and special interests); and tourist opinions on experience factors with the 7-point Likert scales.

This study attempts to examine and confirm the emotional tourist-experience model of 5 constructs and 21 indicators. The 7-point Likert Scale was employed to measure and evaluate the tourist sentiment on an emotional experience or attitudes (Hosany & Gilbert, 2010; Hosany, Prayag, Deesilatham, Caušević, & Odeh, 2015). The respondents were asked to rate each item from a 7-point scales ranging from 7= strongly agree to 1= strongly disagree. The emotion item design allows them to rate the intensity of individual emotional experience toward health well-being. Respondents were asked how to feel or what to sense to test the responsive sentiments. After developing and checking reliability and validity (Hair et al., 2013; Heale & Twycross, 2015), the final draft of the research instrument was developed to collect data. The overall items were asked to describe individual opinions, attitudes, preferences, health activities, and behavioural experiences.

The emotional tourist-experience model (see Figure 3) includes five main constructs, which were measured using twenty-one indicators, as follows:-

- i. Goal-driven motivation (MOTA) was measured using 8 indicators of four extrinsic (Patterson, 2018) and four intrinsic motivations (Hettler, 1976; Milner, 2013; SRI International, 2017): new activity-based experience (NewEx), experiencing through technology-assisted (ExInU), experiencing the locality and social-related activities (ExSoc), experiencing nature with environmental responsiveness (ExNE), the benefit of physical health-wellbeing (PhyHW), benefit of mental health-wellbeing (MentHW), benefit of social health-wellbeing (SocHW), and benefit of emotional health-wellbeing (EmoHW).
- ii. Positive emotional tourist experience (EMOEX) was measured using 4 indicators: excitement (Excite) (Hosany et al., 2015), positive surprise (Surp) (Hosany, 2012; Prayag et al., 2017; Scott & Le-Dung, 2017), enjoy (Enjoy) and calm-and-relax (Care) (Sthapit & Coudounaris, 2018; Hosany, 2012).
- iii. Tourist satisfaction (SATIS) was measured using 3 indicators (Cutler & Carmichael, 2010): life-reimagine (ReIm), pleasurable fulfilment (Fulfil), and self-enrichment (Enrich) of need, desire, and goal.

- iv. Memorable experience (MEMO) was measured using 3 indicators (Larsen, 2007; Patterson et al., 2017; Cutler & Carmichael, 2010): moment-by-moment experience (MoEx), evaluated memorable experience (EvaM), and collected memorable experience (CmEx).
- v. Intention behaviour (INTEN) was measured using 3 indicators of an intention to share (Share), intention to recommend (Recom), and intention to repeat activity (Rpeat) (Prayag, Hosany, & Odeh, 2013; Hosany et al., 2017).

4 Findings

4.1 Respondents' demographic profiles

A total of 234 respondents presented males (50.4%), a little higher proportion than females (49.6%). Most of them were 36.3% aged between 50 and 55 years; 32.9% aged over 50 to 60 years; 15.4% aged over 60 to 65 years; 11.1% over 65 to 70 years; and aged over 70 years for 4.3%. Most respondents were Thai (82%) and International tourists (18%) from different countries, including Australia, America, England, New Zealand, Spain, Sweden, Russia, Canada, Netherlands, Germany, Norway, Morocco, Columbia, Finland, France, Japan, and China. Their major education levels were Master degree (47.4%); Bachelor degree (29.9%); PhD (17.5%); Diploma/Under Graduation (3.4%); and High school (1.7%). Their major professions were specialists in different occupations (23%); in academic (19%); office workers (18%); engineer (12%); architects and designers (11.5%); business owner (9.8%); and in tourism (6%). Relating to income per annual, most of the respondents (61%) earned more than 10,000 to 50,000 USD per year; 16% earned more than 5,000 to 10,000 USD per year; 14.5% earned more than 50,000 to 100,000 USD per year; 4.3% earned more than 100,000 USD per year; and 3.8% earned less than 5,000 USD per year.

4.2 Respondents' Preferences

Conclusions of findings (n=234) on respondents' preferences include travel type, length of travel, health benefit focuses, destination choices, major health-experience activities, additional activities, and special interests. For travel type, most respondents felt comfortable to travel with friends (36.7%); partner (20.5%); alone (18.8%); family (14.1%); small private group (8.5%); and others (0.4%). For length of travel, most of them preferred 7-14 days (39.3%); 3-7 days (35.5%); less than 4 weeks (16.2%); more than 2 months (1.3%); and others (0.9%). By asking what health benefit you most concerned when travelling: 45.1% chose "physical health focuses"; 31.5% chose "social, mental, and emotional health focuses"; and 23.1% chose the "holistic focus of four health-wellbeing dimensions," including physical, social, mental, and emotional health-wellbeing. For destination choices, most respondents chose culture (51.7%); nature (47.4%); and leisure (34.2%). For major health-experience activities, most respondents preferred walking (90.6%); bicycling (27.3%); running (20.1%); and hiking (19.2%). For additional activities, most respondents chose photo-taking (57.7%);

visiting iconic places or buildings (44.9%); exploring food to eat (43.2%); and story-writing (20.5%); animal watching (9.4%), web blogger (3.4%), and Yoga places (3%). And for special interests, most respondents chose local interact (47.4%); soft adventure (40.6%); and creative activity (23.1%).

4.3 Measurement Scale and Group-CFA fit analysis

Cronbach's Alpha (α) is used to report the construct reliability of goal-driven motivation, positive emotional tourist-experience, tourist satisfaction, memorable experience and intention behaviour. As a result, the minimum Cronbach's Alpha (α) scores in this study is 0.77, which pass the satisfied threshold of 0.70. The scores of Cronbach's Alpha (α) for all five constructs ranged from 0.77 to 0.89 are verified for reliable measurement scale of the research instrument.

The results of Group-CFA model after modifications in Figure 2 show the perfect confirmation factor analysis fit with high reliability upon the criteria as presented in Table 1. The relative Chi-Square (χ^2/df) is 1.578, as good as lower than the global-fit criteria of 3.0. The chi-square value of 187.808 and 119 degrees of freedom are significant at the 0.001 level; p-value is 0.000. These findings suggest that the Group-CFA model fits the empirical data acceptably in the active 50-plus drew their samples. Corroborating pieces of evidence are provided by Root Mean Square Error of Approximation (RMSEA) and Root Mean Square Residual (RMR) with the obtained value of 0.050 and 0.027. Similarly, the Goodness-of-Fit Index (GFI=0.932) and the Comparative Fit Index (CFI=0.976) are considerably above the 0.90 thresholds, and the Adjusted Goodness-of-Fit Index (AGFI=0.868) is acceptable as nearly denoting satisfactory model fit.

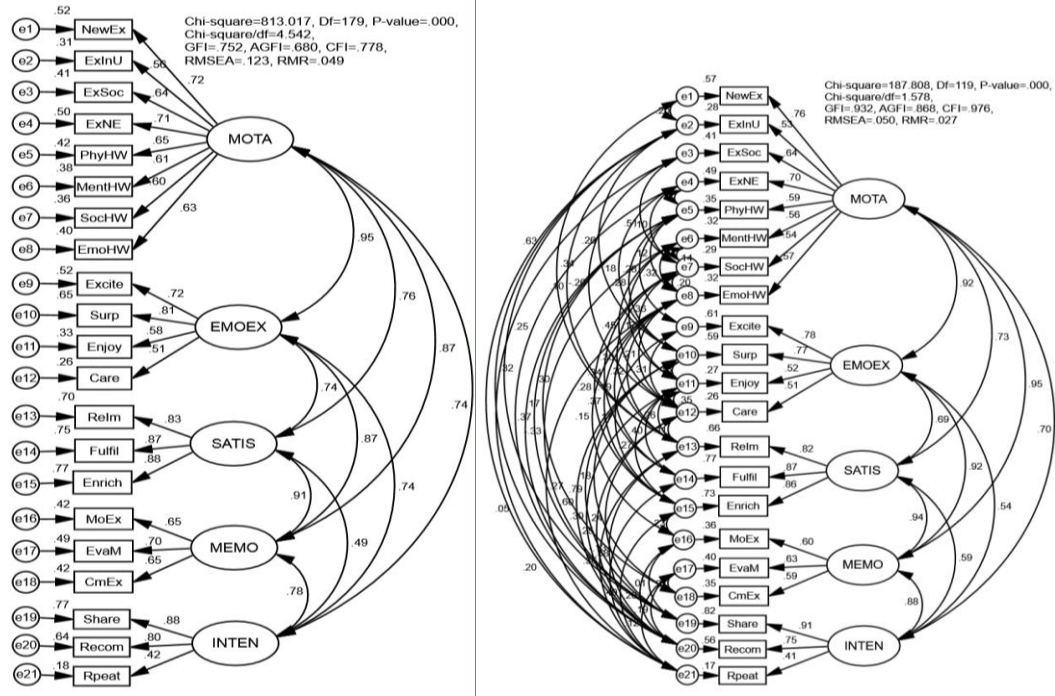


Figure 2: Group-CFA measurement model, before and after modifications

Table 1: Global Fit Indices for the Group CFA

Global Fit Indices	Criteria	Model-fit Statistics*	Results
Chi-Square (χ^2)		187.808	
Degree of Freedom (<i>df</i>)	> 0	119	
Relative Chi-Square (χ^2/df)	< 3.00	1.578	Pass
Goodness-of-Fit Statistic (GFI)	> 0.90	.932	Pass
Adjusted goodness-of-fit index (AGFI)	> 0.90	.868	Accepted
Comparative Fit Index (CFI)	> 0.90	.976	Pass
Root Mean Square Error of Approximation (RMSEA)	\leq 0.05	.050	Pass
Root Mean Square Residual (RMR)	< 0.08	.027	Pass

Note: *P-value < .001

4.4 Structural Equation Modelling (SEM)

4.4.1 Overall model fit

After the structural model is modified, as shown in Figure 3, the results of global-fit indices are presented in Table 2. The results suggest that the overall model fits the empirical data acceptably in the active 50-plus drawn their samples. The relative Chi-Square (χ^2/df) is 1.071, as good as lower than the global-fit criteria of 3.0 as desired. While the chi-square value (χ^2) =116.728 and $df=109$, are significant at the 0.05 level. Corroborating evidence provided by Root Mean Square Error of Approximation (RMSEA) and Root Mean Square Residual (RMR) fit statistics; their obtained value of 0.017 and 0.025 are lower than the global-fit criteria of 0.05 and 0.08 respectively. Similarly, Goodness-of-Fit Index (GFI=0.954), Adjusted Goodness-of-Fit Index (AGFI=0.902), and Comparative Fit Index (CFI=0.997) are considerably above the 0.90 thresholds denoting satisfactory model fit. The goodness of overall fit reflects the degree to which the values predicted by the model agree well with the observed empirical values. The structural model is successfully tested with overall “pass” results by the global fit indices. As a result, the main aim of this study to test the tourist-experience model has been satisfactorily confirmed.

Table 2: Global fit indices for the structural model

Global Fit Indices	Criteria	Model-fit Statistics*	Results
Chi-Square (χ^2)		116.728	
Degree of Freedom (df)	> 0	109	
Relative Chi-Square (χ^2/df)	< 3.00	1.071	Pass
Goodness-of-Fit Statistic (GFI)	> 0.90	.954	Pass
Adjusted goodness-of-fit index (AGFI)	> 0.90	.902	Pass
Comparative Fit Index (CFI)	> 0.90	.997	Pass
Root Mean Square Error of Approximation (RMSEA)	\leq 0.05	.017	Pass
Root Mean Square Residual (RMR)	< 0.08	.025	Pass

Note: * P -value < 0.05

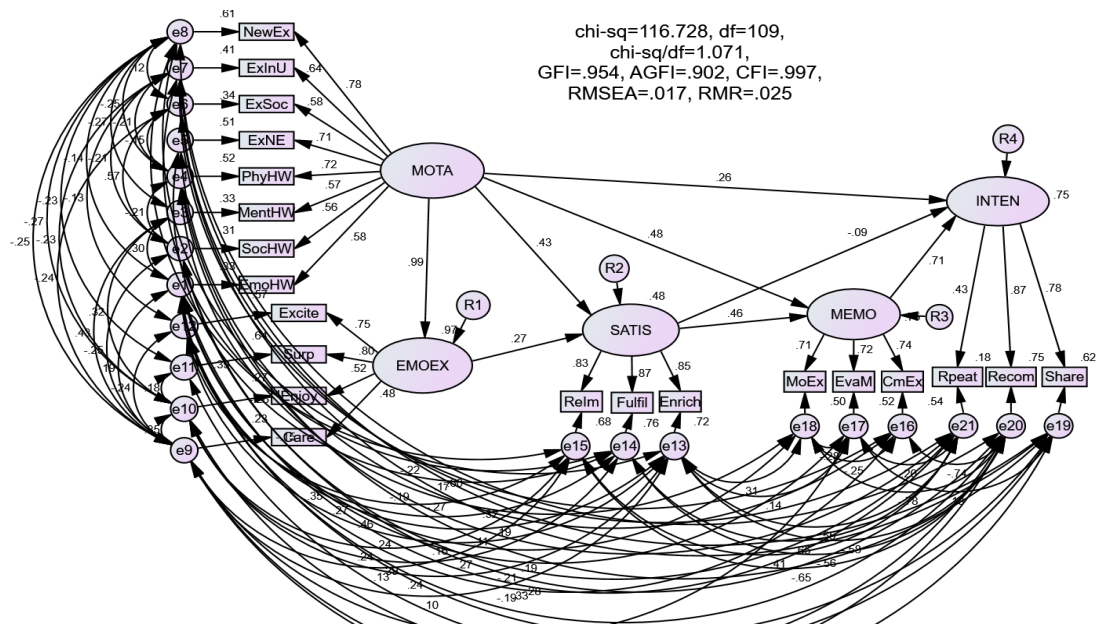


Figure 3: The structural equation model, after modifications

4.4.2 Direct, Indirect. And Total Effects & Path Analysis

The causal-effect relationships of the study variables in the structural model are shown in Table 3 with the effect sizes and directions of each causal relationship between the tourist-experience constructs. Considering the positive direct influences of Goal-driven motivation (MOTA) on other four variables, the direct effect on Positive emotional tourist-experience (EMOEX) is the highest at DE=0.986, nearly to 1.000 with a highly significant statistic level at $p < 0.001$. This reflects a very strong relationship and almost becomes the co-exogenous variable with goal-driven motivation. Meanwhile, the moderate direct effects are on Memorable experience (MEMO) at 0.482 with a highly significant statistic level at $p < 0.001$, and on Tourist satisfaction (SATIS) at DE=0.425 with a significant statistic level at $p < 0.05$. Also, the direct effect on Intention behaviour (INTEN) is the lowest DE=0.264, considering having a relationship but not significant. This result shows that memorable experience and tourist satisfaction are the mediating variables between goal-driven motivation and intention behaviour. Hence, goal-driven motivation has direct effects on memorable experience and tourist satisfaction more than intention behaviour.

But Positive emotional tourist-experience (EMOEX) has very low effects on other variables, except goal-driven motivation. Its positive direct influence on Tourist satisfaction (SATIS) is still recognized with the low DE=0.270, considering having a relationship but not statistically significant. Whereas its positive indirect influences on Memorable experience (MEMO) (IE=0.125) and Intention behaviour (INTEN) (IE=0.064) are clearly weak. Thus, the paths of EMOEX-MEMO and EMOEX-INTEN confirm

exclusion from the study model. However, the positive emotional tourist-experience is related to other dependent variables by influencing mostly via goal-driven motivation.

Meanwhile, Goal-driven motivation (MOTA) has the positive indirect influences respectively, on Intention behaviour (INTEN) with the most IE=0.506; on Memorable experience (MEMO) with IE=0.319; and on Tourist satisfaction (SATIS) with the lowest at IE=0.266. The results have clearly claimed that the three endogenous variables had indirect effects on goal-driven motivation as part of becoming new co-creative goals in tourist experience process. But intention behaviour has stronger indirect influences than the others in the experience process.

However, overall, Goal-driven motivation (MOTA) has the most positive total influences respectively, on Positive emotional tourist-experience (EMOEX) with the highest at TE=0.986; and on Memorable experience (MEMO) with TE=0.801 more than Intention behaviour (INTEN) at TE=0.770 and Tourist satisfaction (SATIS) with the lowest at TE=0.691. These results indicate that goal-driven motivation and positive emotional tourist-experience are the successful co-exogenous in this study model. Goal-driven motivation can be well related to intention behaviour and a memorable experience.

Moreover, Tourist satisfaction (SATIS) has a linear effect of the positive direct influence on Memorable experience (MEMO) with DE=0.462, which is acceptably moderate with a highly significant statistic level at $p < 0.001$. Also, Memorable experience (MEMO) has a linear effect of the positive direct influence on Intention behaviour (INTEN) with the stronger DE=0.712 with a significant statistic level at $P < 0.01$. As a result, the linear causal-effect relationships of tourist satisfaction-memorable experience-intention behaviour are sequentially good enough as three dependent variables in the study model.

Table 3: Direct (DE), indirect (IE), and total (TE) effects of causal variables

Causal Variables	Effect Variables											
	EMOEX			SATIS			MEMO			INTEN		
	TE	DE	IE	TE	DE	IE	TE	DE	IE	TE	DE	IE
MOTA	.986	.986***	-	.691	.425	.266	.801	.482***	.319	.770	.264*	.506
EMOEX				.270	.270	-	.125	-	.125	.064	-	.064
SATIS							.462	.462***	-	.236	-.093	.143
MEMO										.712	.712**	-

Note: A correlation coefficient < 0.3 = weak; $0.3-0.5$ = moderate; > 0.5 = strong (Heale & Twycross, 2015) : Path analysis at: * p -value < 0.05 ; ** p -value < 0.01 ; *** p -value < 0.001

5 Discussion and Conclusion

5.1 Majority of the respondents and their preferences

In conclusion, the findings show the supportive results to previous studies. Demographic profiles of the active 50-plus respondents are proved in addition to the 60-plus tourists studied by Balderas-Cejudo and Leeson (2017) for healthy, wealthy, and well educated. Majority of respondents are middle to high income above 60% earning more than 10,000 to 100,000 USD per year; well-educated above 60% in master degree and above. And they are above 65% aged between 50 and 60 years in preparation age before retirement by working in various professions. Ageing tourists had financially prepared to travel with friends, partners, or alone in this study.

According to SRI International (2017), Smith and Puczko (2014), Hall (2011), and Pyke et al. (2016), it is generally accepted that ageing tourists have free time available to travel for health or wellness reason. As reported, about 70% preferred length of travel up to 1-2 weeks in this study. It is not predicted by the majority of Thai respondents above 80%, but it is tourist behaviour in general following the world trend noted by Dwyer et al. (2008). Across the range of demographic study, the active 50-plus tourists currently acknowledge taking vacation and linking to life well-being, health improvement, stress reduction, active life and healthy lifestyle (Balderas-Cejudo & Leeson, 2017). Travel behaviour has been positively related to ageing tourist's physical health outcomes, including emotional well-being.

It is interesting that almost equally male and female proportion of all respondents are not different in term of tourist activity behaviour. About 50% of respondents preferred destinations relating to culture or nature, more than leisure. In addition, majority of 45% choosing health benefit of most concern on physical health focus, more than social, mental, and emotional health focus, or holistic focus of PMSE health-wellbeing, respondents, require travelling with healthy outdoor activities in destinations close to culture and nature. Meanwhile, the majority chose walking over others which are bicycling, running and hiking. According to Nimrod and Shrira (2016), leisure activity engagement has a significant impact on an ageing tourist in term of physical, psychological, social, and emotional well-being. Although leisure destination has only 30% chosen by respondents, leisure activities, such as walking, become the most popular of 90%.

Moreover, emotional impacts existed when more than 50% chose photo-taking, more than 40% chose to visit iconic places or buildings and exploring food to eat, and less than 20% chose story-writing, animal watching, web-blogger, and Yoga practice. Lastly, according to Buckley (2018), tourist values their experiences more than the strength of taking adventurous activities. Experiences on special interests that respondents preferred more than 40% are local interact concerning social well-being and soft adventure concerning physical well-being, and only 23% on the mental well-being of creative activity. However, purposes of age-health activities are basically for

leisure emotions rather than seriously competitive achievement. Therefore, the active 50-plus in this study should be called leisure tourists who prefer different activity levels giving health improvement and self-learning fulfilment.

5.2 Emotional tourist-experience model

The aim to examine the theoretical, emotional tourist-experience model towards health-wellbeing for the active 50-plus tourists was successfully executed. Also, the findings revealed the effects and directions between factors. All direct (DE), indirect (IE), and total (TE) effects are found relevant to the conceptual structural model, except the cut-off EMOEX-MEMO, EMOEX-INTEN and SATIS-INTEN for less than 0.2 which unfit with the empirical data. Although the direct effect of EMOEX-SATIS is less than 0.3 and the MOTA-SATIS is more than 0.3 (DE=0.425) and not statistically significant, these two paths are still kept to achieve better overall model fit. Finally, the main structural model shown in Figure 4 is well confirmed by both empirical and theoretical results, in accordance with the sequential tourist-experience process, components, and cause-effect relationships.

Two research questions also had good results described in health-wellbeing experiences. Firstly, goal-driven motivation, together with positive emotional tourist-experience, are powerful antecedents influencing tourist satisfaction, memorable experience, and intention behaviour, respectively (Bagozzi & Dholakia, 1999; Aho, 2001; Oh et al., 2016). Intention behaviour is perfectly the study outcome of the theoretical tourist-experience model with two strong mediating effects of tourist satisfaction and memorable experience. Among three dependent factors, intention behaviour also acts as the independent factor having strong indirect effects on the antecedent to set goal again in the next experience cycle (Prayag, Hosany, & Odeh, 2013). The theoretical notion of memorable experience has a strong effect on intention behaviour (Zhang, 2017; Skavronskaya, Moyle, Scott, & Kralj, 2019). And those effects imply that memorable experience had some indirect effects as the collected experience influenced on the antecedents of motivation and emotions to set new goals and to repeat activities in the experience cycles or future ones (Sthapit & Coudounaris, 2018; Prebensen, Woo, & Uysal, 2014; Hosany et al., 2015). Therefore, those factors can possibly activate the intention to repeat tourists' health-activity behaviour and to enhance the healthy routines in later life. In addition, a set of overlapping antecedents is found confirming to guide the tourist engagement behaviour as prior expectation.

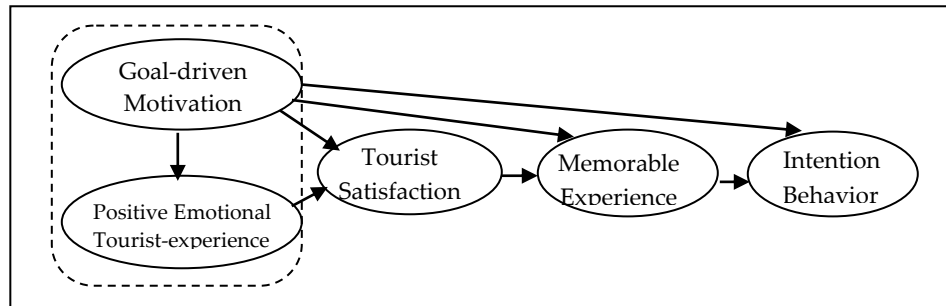


Figure 4: Emotional tourist-experience model with sequential tourist engagement behaviour

5.3 Recommendations and contributions

This quantitative study finds advantage of rigid results to understand multi-issues, but further qualitative research is recommended for better supportive results and interpretation in details. For example, an in-depth interview can allow deeper individual attitudes and opinions that may be useful for new interpretation and model. The future recommendation also includes the study of samples selected by similar demographic profiles and preferences, such as professions, travel purpose, health preference, or health activity. Because levels of motivation and limitations can be in the frame of similar activity engagement behaviour and better results can be able to generalize beyond a given sample.

The contributions of this study findings found the theoretical and managerial perspectives. Expanding the theories applied in this study, especially goal-driven motivation concept, continuity and activity theory, are main principles to explain how the active 50-plus want to travel with health reasons. In term of engagement behaviour, tourists continue their activities from the collected experience value to the new goal driving forces. The result is the intention to repeat activity to achieve health benefits of good PMSE lifestyles, including physical, mental, social, and emotional well-being. Each range of age can give a different value of what they desire to achieve and fulfil life satisfactions. In the case of active 50-Plus, the longer life experiences to perform healthy ageing society of environmental sustainability with personal and social well-being are worth complied. Especially, the in-depth interview after COVID-19 outbreaks should be done to clarify health-experience value from non-activity to new healthy activity behaviour. Thus, the better life quality upon the contribution to extending the theories and concepts of goal-driven motivation, activity, and continuity concerns the better tourist engagement behaviour of health and well-being.

6 References

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