

APPLYING THE HEALTH CONSCIOUSNESS MODEL
TO QUALITY-OF-LIFE SATISFACTION



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ABSTRACT

This independent study examines the relationship between the dimensions of health consciousness on life satisfaction/improvement. Eight dimensions of health consciousness are explored as independent variables, and their impact on life satisfaction is assessed. After a series of statistical analysis, only 5 out of 8 became the refined model for health consciousness scale within this study. The sample consists of respondents who completed a questionnaire measuring health consciousness and life satisfaction. Regression analysis reveals that physical health orientation (PHO) and mental health orientation (MHO) significantly predict life satisfaction. Gender differences in health consciousness are observed, with males showing higher levels of health consciousness. However, there are no significant gender differences in life satisfaction. The findings emphasize the importance of incorporating innovative approaches in promoting health-conscious behaviors and enhancing overall well-being. Future research should address limitations in sample size, explore additional demographic variables, and further integrate innovation into health-related studies. This study contributes to understanding the relationship between health consciousness, life satisfaction, and the implications of innovation in that relationship for various stakeholders.

Keywords: Health Consciousness, Life Satisfaction, Physical Health Orientation, Mental Health Orientation, Innovation

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CHAPTER 1

INTRODUCTION

Health and well-being have always held significant importance in human life. However, the global COVID-19 pandemic has brought these aspects to the forefront in an unprecedented manner. With the rapid spread of the virus and the subsequent implementation of public health measures, societies worldwide have experienced a profound shift in their priorities towards health consciousness. Individuals, grappling with the uncertainties and challenges posed by the pandemic, have developed a renewed focus on personal health and well-being.

In this chapter, scholar will dive into the exploration of health consciousness among different generations, with a specific emphasis on millennials and Generation Z. These generations possess unique characteristics, experiences, and are navigating an evolving technological landscape. By examining their attitudes, behaviors, and motivations towards health, the study aims to uncover valuable insights that can inform the development of effective health promotion strategies and interventions.

1.1 Background and Context of the Study

The pandemic of corona virus has undoubtedly impacted the world in many negative ways. The focus of the world shifted towards health and wellbeing of the people. Preventive measures were implemented for the public to be more health conscious in attempting to stop the rapid spread of the virus. As the globe began the lockdown process, people adopted healthier lifestyles, being conscious about their diet, the need of exercise and stress management. More than ever before, mental health issues brought the attention of the public to the focus not just on their physical health but also their psychological and emotional well-being.

As people get older, the general observation is that people tend to be a bit more attentive towards their health. There is also a saying that goes “Health is wealth”, which many find to be true the moment they experience discomfort or some sort of illness in their wellbeing that hinders their capability to carry out daily activities, they are willing to spend more financially and take more precautionous behaviors to get back to their normal state of wellbeing. Moreover, the state of

wellbeing or health of a person can become a concern for all family members if it leads to major health issues or even death.

For millennials (born between 1981-1996), a study suggested that this group of people value “health” the most after “family”. This generation is known to be more health conscious than the previous generation by engaging more in healthy eating, exercise and smoking less. This is also due to the fact that technology allows access to information like never before, with apps and technology to monitor health at their fingertip. The millennials are also known as the ‘wellness generation’ (Nermoe, 2022) for Generation Z, Healthy eating is essential to their physical and mental health. A new hope survey on consumer trends suggested that millennials and Gen Zs are more in touch with feelings when it comes to evaluating health. Instead of using fact-based measurements (weights, BMI, blood tests, etc.) to measure health, experiential questions like (how my body feels, their energy level, how rested I feel, are you sad or happy, etc.) are redefining the measures for the younger generation. The consumer survey on the 1000 U.S. consumers samples also pointed out that 66% of Gen Zs think about their health every day and 60% are always looking for ways to be healthier (Kapperman, 2022).

1.2 Problem Statement

Studies on health consciousness have gained more traction since. Pu, Zhang, Tang, & Qiu (2020) looked into the relationship between health consciousness and home-based exercise in China during the pandemic. Exploring the theoretical model of influencing mechanism of people’s consciousness, the mediating effect of health life goal and perceived behavior control between health consciousness and home-based exercise. There is a consistency between health consciousness and health behaviors. There is also a large number of studies that suggest regular exercise and a healthy diet will have a positive impact on mental and physical health.

Grant, Wardle and Steptoe (2009) provide insights to how health behaviors relate to life satisfaction. The study analyzes young adults across cultures and has shown that life satisfaction is positively associated with not smoking, physical exercise, using sun protection, eating fruits, and limiting fat intake. Health consciousness on the other hand, has received little systematic examination.

Measurement on health consciousness was heavily examined in Hong's study done in 2009. Hu (2013) study attempted to identify other dimensions of health consciousness using both exploratory and confirmatory factor analysis in developing a more reliable scale to measure health consciousness in her study that examines the relationship between health consciousness and health outcomes.

Therefore, this independent study attempts to use the underlying dimensions of health consciousness developed by Hu (2013)'s study to examine other implication such as its relationship to improvement in quality-of-life satisfaction. The study attempt answers the research questions below while aiming to raise awareness of the younger generation on health consciousness to promote health behaviors that can improve overall life's satisfaction.

1.3 Research Questions

RQ1: Which of the health consciousness variables predicts the satisfaction of life for this group of people (15–29)?

RQ2: What motivates the younger generation to prioritize their health, and how do preexisting medical conditions impact such motivation?

RQ3: Do sex, age, education, and marital status influence individuals' health consciousness and satisfaction of the quality of life?

1.4 Significance and Importance of the Study (Practical and Academic)

The second pillar of the wellbeing economy assessed by OECD is health amongst the European Council. It stated that good health fuels economic growth, productivity, and individual earnings. Mental illness health related costs in EU amount to 4% of GDP which is more than EUR 600 billion. Good health is necessary for the people's wellbeing which allow them to invest in education and skills instead of medical bills. Thus, allowing the people to access better quality jobs and enjoy better quality of life (Gurría, 2019).

Health consciousness is a key factor in shaping individuals' health behaviors and lifestyle choices. By understanding the comprehensive conceptual model of health consciousness and examining its impact on life satisfaction, this study could inform the design of evidence-based interventions to promote healthy behaviors and

improve overall well-being. Understanding the role of health consciousness in individuals' lives is particularly important in the context of the COVID-19 pandemic, which has highlighted the importance of health and wellness. The findings of this study could have practical implications for public health interventions aimed at promoting healthy behaviors and mitigating the impacts of unforeseeable future pandemics.

The study of health consciousness is an emerging area of research that has not yet been fully explored or understood. The study could also contribute to the development of new theories and frameworks for understanding the complex relationship between health consciousness, health behaviors, and overall well-being. This could have broader implications for research in areas such as health psychology, health promotion, and public healthcare systems.

1.5 Outline of the Paper

The rest of the independent study is as follow. The second part will review previous literature on the concept of health consciousness and its dimensions. Third, research process and method will be discussed. The fourth part will expand upon the result found from the data collected. The study will summarize key findings and its practical implication. To conclude the paper, scholar will account the limitations and suggestions for future research.

CHAPTER 2

LITERATURE REVIEW

The literature review is a crucial component of this independent study, as it allows for the exploration of existing research and scholarly works on health consciousness. By reviewing the literature, we aim to identify the dependent variables, such as specific quality of life outcomes, and the independent variables, such as individual characteristics that have been examined in relation to health consciousness. This review will provide insights into the relationships and patterns found in previous research, helping us understand the factors that contribute to health consciousness and its impact on individuals.

Furthermore, the literature review enables a critical assessment of the methodologies, measurement tools, and theoretical models employed in studying health consciousness. By evaluating the strengths and limitations of existing approaches, we can select the most suitable methods for our study. Additionally, this review will highlight gaps and areas for further investigation, guiding the development of our research objectives and hypotheses. Ultimately, the literature review serves as a foundation of knowledge, informing our study's direction and contributing to the advancement of understanding in the field of health consciousness.

2.1 Definition and Conceptualization of Health Consciousness

Three decades ago, a literature that began reconceptualizing the scale for health consciousness and health behaviors was Gould (1990) explaining health consciousness as the degree to which an individual is conscious of his or her own health. By modifying the Self-Consciousness Scale (SCS) into Health Consciousness Scale (HSC) using validity and reliability test. The study concluded that HSC relate to self-reported behavior measures under four factors: (1) Health Self Consciousness, (2) Health Alertness, (3) Health Self-Monitoring, and (4) Health Involvement. Therefore, health consciousness has a positive relationship with healthy behavior and a negative relationship with unhealthy behaviors (Gould, 1990). Likewise, Hong (2009) defined health consciousness as an individual's comprehensive mental orientation towards his or her health, comprising of three underlying cognitive

dimensions of self-health awareness, personal responsibility, and health motivation. as opposed to a specific health related issue or action (e.g., smoking, exercising, dieting) in the attempt to re-conceptualize previous studies by suggesting additional dimensions to the construct of health consciousness.

Kraft and Goodell (1993) measure health consciousness or “wellness-oriented” lifestyle in terms of sensitivity to health hazards (the environment), physical fitness, stress, and nutrition. The paper stated that those that accept the responsibility for their health are more responsive to the need of health information. Hu (2013) supported this statement by stating that health-conscious individual is prompted to be more aware and knowledgeable about their health and wellness which is more likely to take actions to improve their health and overall quality of life. Thus, suggesting that health conscious should be viewed as a fundamental construct predicting the knowledge of health, more inclined to seek health information and engage in health benefiting actions.

Hong (2009)’s empirical study on previous research studies have shown inconsistent measures of health consciousness by using actual behavior such as food consumption, exercise, and substance use for measurement. However, his study approach health consciousness concept as a personal attribute and psychological basis as he suggested that it will have greater power in predicting diverse health behaviors. Opposite of measuring actual behaviors, measuring the psychological state of health supposedly has greater construct validity. One flaw that Hong pointed out from Gould (1990)’s concept was the items seem to be redundant making it less valid when representing the complexity of health consciousness.

Although there may be different approaches in determining the measures for health consciousness, most of the previous studies agree that health consciousness is a complex concept of multifaceted nature (Hong, 2009). With the lack of standardized approach to health consciousness model, Hu (2013) tries to expand upon both approaches of health consciousness in developing a health consciousness conceptual model by identifying eight dimensions for health consciousness scale. In other word, Hu proposed a reconceptualization of the model that incorporate a number of diverse dimensions that were mentioned in previous studies. Her study showed that the construct of health consciousness comprised 8 factors that would predict wellness and

healthier lifestyles. The newly proposed scale has shown good internal reliability, construct validity, and convergence validity. To further use the scale in other implication, this study aimed to measure the level of satisfaction and improvement on life with the use health consciousness scale constructed by Hu (2013).

2.2 Dimensions of Health Consciousness

This section of the paper will discuss eight independent variables (IVs) or other papers have termed it as “dimensions” which are of the more refined and distinct compiled of previous research papers categorized as (1) Health Self Conscious, (2) Health Value, (3) Health Information Seeking, (4) Health Motivation, (5) Physical Health Orientation, (6) Mental Health Orientation, (7) Health Responsibility, (8) Health Knowledge, and (9) Quality of Life Satisfaction/Improvement.

2.2.1 Health Self Conscious (IV1)

Gould (1990) considered this dimension as one the four first order factors in his Health Consciousness Scale. Gould (1990)’s HSC was adapted from Self Consciousness Scale (SCS) that investigate its relationship to health-related behaviors. This dimension focused on the internal cues which dictate the behavior of an individual in attempting to maintain and control his or her health. Presumably, highly health-conscious individuals will more likely act accordingly to their internal attitude towards their health, and be more sensitive to the consequences of their behaviors.

2.2.2 Health Value (IV2)

Hu (2013) and Hong (2009) studies agreed on the definition of “Health Value” from Jayanti and Burns (1998) termed as “an individual’s assessment of benefits relative to costs in engaging in preventive health care behavior”. Thus, health value is measured by asking how much a specific behavior (avoiding tension, staying healthy longer, looking younger) is worth the benefits which assess the expectancies of a desired health goal when an individual engage in health promoting activities.

2.2.3 Health Information Seeking (IV3)

Described in Hong (2009) to have conflict in its definition whether the health information related actions are part of the factor that influenced by one’s health

consciousness. One research suggested that health information seeking can be segmented into those who are just aware of health information and those who are more active in seeking health information to be more engaged in health promoting behaviors. Most recent study on health information seeking in the digital age for the US population was done in 2017, measuring health information seeking from the internet, traditional media, and healthcare professionals indicate that internet is widely used and does create inequality in health information accessibility compared to other sources (Jacobs, Amuta, & Jeon, 2017). Thus, such behavior could be influenced by health condition and the increased use of media due to its availability.

2.2.4 Health Motivation (IV4)

A common dimension discussed in studies regarding the topic of health can be described as “a goal-directed arousal to engage in preventive health behaviors” (Jayanti & Burn, 1998). Hu (2013) considered health motivation to be core to health consciousness, as her study found that it is one significant variable that predicts wellness. Furthermore, she considered this trait to be a pro-health psychological trait that is embedded in one’s mindset that dictates an individual’s health outcome. Health motivation is one variable that is interrelated to other variables as it is the driving force of health benefiting behaviors.

2.2.5 Physical Health Orientation (IV5)

Hu (2013) compiled four items in her scale that measure the physical health of an individual by using questions such as “I try to avoid having a sedentary lifestyle.” which was modified in this study to be “I try to avoid having an inactive lifestyle.” for better understanding. This dimension has received little examination and discussion that might be due to its low predictability on wellness. Not many literatures are researched upon the definition of “physical health orientation” but rather how physical activity affects a person’s health.

2.2.6 Mental Health Orientation (IV6)

According to the World Health Organization (WHO), mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. This dimension is considered to be a significant and unique variable in predicting wellness (Hu, 2013). This variable has

questions such as “I spend time each day trying to reduce accumulated stress”. As observed in Hu’s health consciousness scale, this dimension measures how much an individual can cope with stress in their daily life. Mental health has been a hot topic for discussion as mental illness has certainly affected a majority of people, not to mention it is a complex phenomenon that could be measured in different ways. One of which was measured with three components of emotional well-being, psychological well-being, and social well-being which consist of 14 others sub-dimensions (Keyes, et al., 2008). To simplify the present paper for its purpose, the use of Hu’s questions in her scale will suffice in measuring an individual overall life satisfaction.

2.2.7 Health Responsibility (IV7)

Mentioned in Hong (2009) and Kraft and Goodell (1993) shown that those who are more health conscious are more likely to take responsibility for their own health. A health-conscious person is likely to be a responsible person. Hu (2013) also agrees by mentioning Walker, et al’s (1988) Health Promoting Lifestyle Profile (HPLP) reference to health responsibility. It is referred as “attending to or accepting responsibility for one’s own health, being educated about health, and seeking profession assistance when necessary”. Which is why health responsibility is part of measuring health consciousness with a question such as “I should take care of myself to prevent disease and illness”.

2.2.8 Health Knowledge (IV8)

As it sounds similar to health seeking information, it is not the same. Health knowledge is defined as a person’s stored information about health (Jayanti & Burn, 1998). This could also be termed as health literacy, which Center for Disease Control and Prevention (CDC) pointed out that people need to be able to find, understand, and use health information and services as health literacy can help prevent health problems, protect, and better manage health problem when they do arise (Centers for Disease Control and Prevention, 2022). Health knowledge is essential in defining health consciousness as without it, individuals cannot process health information even after seeking it. Thus, incapable of forming and maintaining consciousness to health. Health knowledge is just as important as health motivation in facilitating health information seeking and promoting behaviors.

2.2.9 Quality of Life Satisfaction/Improvement (DV)

To provide further implication to previous literatures, the construct will be used to measure its relation to the improvement of quality of life and its satisfaction. World Health Organization defines Quality of Life as “an individual perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns (World Health Organization, 2012). Many studies suggests that health has a significant impact on quality-of-life satisfaction. Pinto, Fontaine and Neri (2016) research paper found that physical and mental health have a direct effect on life satisfaction but such effect is mediated by self-rated health. Thus, this paper aims to measure quality of life satisfaction by deriving the questions from WHOQOL-BREF which is a simplified version of the WHOQOL-100, a globally accepted and validated questionnaire compromise of 100 questions used to measure health related quality of life. The two questions are as such “How would you rate your quality of life” and “How satisfied are you with your health”. In this questionnaire, to measure the respondent quality of life satisfaction and improvement, the following questions were asked:

- 1) How satisfied are you with your mental health?
- 2) How satisfied are you with your physical health?
- 3) Has your overall quality of life improved? (Consider all facets of Quality of life such as physical health, mental health, social relationships, financial stability, and personal satisfaction)

In the latter part of the study, each of the questions mentioned will be named as DV1, DV2, and DV3, and DV will be a term used to describe the compounded “Dependent Variables” of the 3 together for the purpose of statistical analysis in answering the research questions.

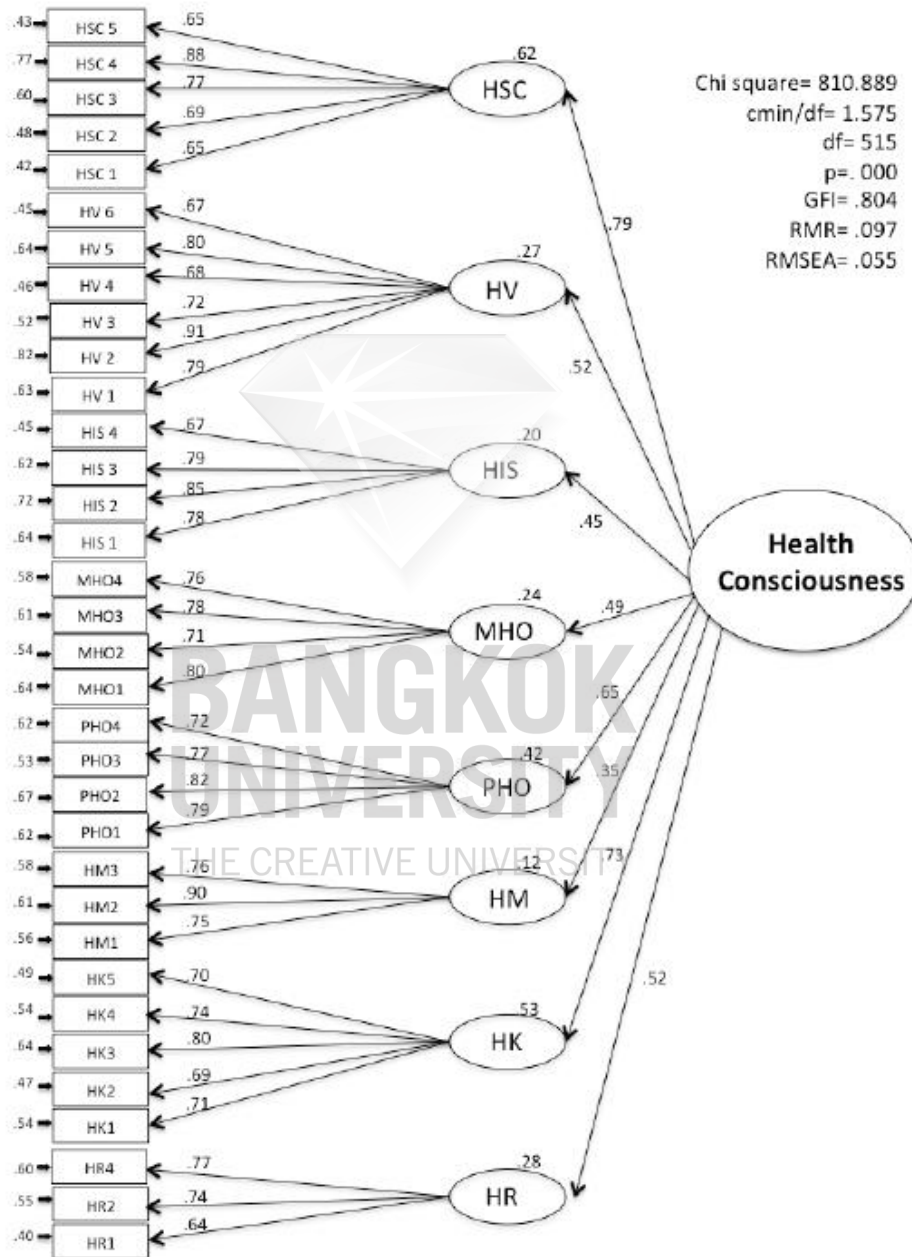
CHAPTER 3

METHODOLOGY

The independent study explores the concept of health consciousness and its effects on the overall quality of life for younger adults (15 - 29) years old as this age group of population will be the driving force of human capital for growth and prosperity to the country.

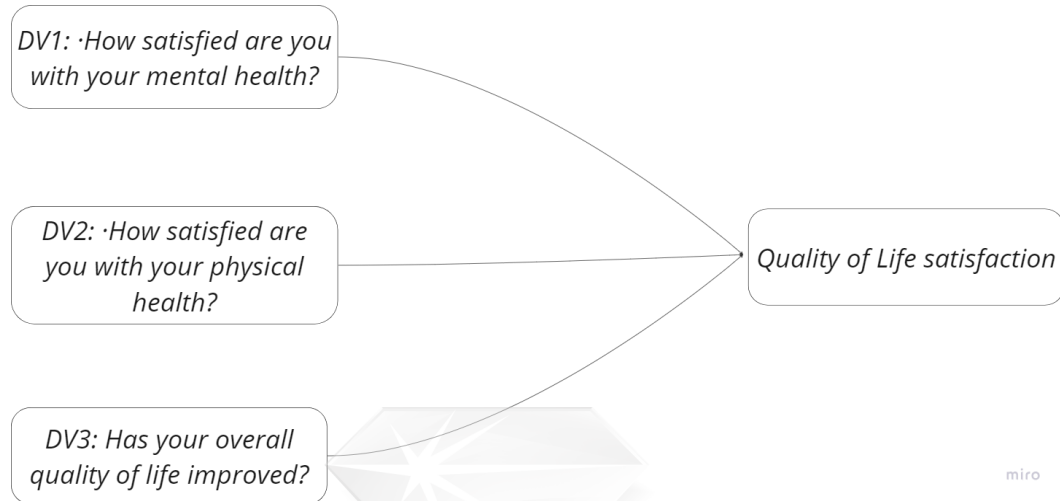
The scale used for the survey was defined in Hu (2013) study and tested for validity and have gone through exploratory and confirmatory factor analysis. As shown in Figure 3.1, her conceptual model framework has been reliability tested that indicated the 34 items of the scale has high internal consistency and high Cronbach's Alpha of 0.904. Although this study will not be using the same statistical analysis (Standardized Estimate Model) as Hu (2013)'s study to test for her HCS (Health Consciousness Scale), her HCS does provide a base framework to create the questionnaires in order for this study to examine the relationship between health consciousness and quality of life's satisfaction.

Figure 3.1: A Confirmatory Analysis of Health Consciousness Scale with Standardized Estimates from Hu’s Study



Source: Hu, C. S. (2013). *A new measure for health consciousness: Development of a health consciousness conceptual model*. Retrieved from <https://www.researchgate.net/publication/301701478>.

Figure 3.2: Three Dependent Variables Measuring QOL Satisfaction (DV)



Following the research questions previously mentioned in chapter 1, and given the two figures of independent variables (Health consciousness scale) and dependent variables (Quality of Life Satisfaction) this study proposes the two hypotheses:

H1: Health consciousness is positively correlated with quality of life satisfaction and is a predictor for quality of life satisfaction

H2: Health consciousness has no impact on any variables that can affect quality of life satisfaction.

3.1 Description of the Research Methods used to Answer the Research Question or Objective

Assessed using self-reported questionnaire form built upon the existing concept framework. The self-assessed survey was administered to participants who are 15 years or older and distributed online through social media platforms. The rating scale on WHOQOL questionnaire has also been used in this research as it is an intensity response. The questionnaire is a 5-point Likert scale that range from (Not at all, A little, Moderate amount, Very much, An extreme amount) with 32 specific items that measure the eight dimensions of Health Consciousness of the respondents. Two items were removed from the original questionnaire, one from Health Self-

consciousness (I reflect about myself a lot) and another from Health Value (Having a wholesome lifestyle is worth the benefit). These items would measure the independent variables that will be quantitatively analyzed to see whether it has significance impact on the respondent quality of life's satisfaction/improvement. The next section of the questionnaire are 3 specific questions that will be compounded to show quality of life's satisfaction/improvement which is the dependent variable. The general questions will be asking the respondents about their gender, age, marital status, level of education, and existing health conditions. The statistical application used to compute the quantitative analysis to answer the research questions will be Jamovi.

3.2 Justification for the Choice of Methods

To ensure the study's focus is representative and aligned with the objectives, the target population for this research is defined as young individuals in Cambodia. Specifically, the study will concentrate on the age group of 15-29 years. This age range corresponds to the United Nations (n.d.)' classification of Cambodian youth, which encompasses individuals aged 15-24. By selecting this age group, the study aims to capture the perspectives and experiences of young individuals who are transitioning into adulthood and face unique health challenges.

The sampling method employed in this study is snowball sampling. Snowball sampling involves identifying initial participants who meet the defined criteria and then requesting their assistance in referring other potential participants who fit the target population. This method is particularly useful when the target population is not easily accessible or when there is a need to reach a specific group with shared characteristics, such as the younger age group in this study.

Snowball sampling allows for the recruitment of participants through social networks and referrals, enabling the study to tap into hidden populations or individuals who may not be easily reached through traditional sampling methods. By leveraging the social connections of the initial participants, the research can access a wider range of respondents within the target population.

The questionnaire uses 5-point Likert scale differ from the 6 points Likert scale of the original that range from "strongly agree" to "strongly disagree" with also slightly different choices that disallowed neutral option. To answer the research

questions, factor analysis and simple linear regression will be used. Jamovi was the application of choice due to its simplicity and capability to provide such analysis. The items will also be tested for its reliability and validity and whether the construct has any significance impact on the quality-of-life satisfaction/ improvement.

3.3 Explanation of the Data Collection and Analysis Process

The data collection is underwhelming, due to time and budget constraints, the data collected has the sample size of only 61 making the test on hypothesis less credible and reliable. The analysis process begins with using the data from google form as csv file which then gets uploaded to Jamovi. The data will then be sorted by group of each dimension and each column of the data will covert to “continuous” type to be able to run regression analysis. As the dependent variable is different from previous study, “Health outcome” was changed to “Quality of life satisfaction/ improvement”, the study will test the its reliability of the 32 independent variable items by looking at the Cronbach alpha. P value and R² value will be looked at during linear regression analysis to determine which underlying dimension has the highest correlation to life satisfaction. If the data showed that it is insignificance, cross loading factor analysis will be used to determine new grouping of the independent variables that will also need to go through confirmatory factor analysis.

3.4 Data Analysis

For RQ1 and RQ2, the scholar first use a filter for the group age bewteen 15-29 only as there are 9 outliers from other age groups that had only a few responses that could be insignificant to the over all result of the data analysis.

For Research Question 1, which aims to identify the health consciousness variables that predict satisfaction in quality of life for the age group of 15-29, the statistical analysis technique used is linear regression. This analysis allows for the examination of the relationship between the independent variables (health consciousness variables) and the dependent variable (satisfaction in quality of life) to determine which variables have a significant predictive effect.

For Research Question 2, which explores the motivations of the younger generation to prioritize their health and the impact of preexisting medical conditions on such motivation, the statistical analysis technique used is an independent sample t-test. This test is used to compare the mean scores of two independent groups (those who are currently ill and those who are not) on the variables of health consciousness and satisfaction in quality of life, providing insights into the differences between the groups.

For Research Question 3, the statistical analysis technique used is the one-way ANOVA (analysis of variance). The one-way ANOVA is utilized to examine the differences in health consciousness and satisfaction in quality of life among different age groups. This analysis allows for the comparison of means across multiple groups and determines whether there are significant differences between them. By employing the one-way ANOVA, the study explores the influence of age on individuals' health consciousness and satisfaction in quality of life, providing valuable insights into this relationship.

These statistical analysis techniques were selected to address each research question and provide insights into the relationships and differences between variables of interest. The results obtained from these analyses contribute to answering the research questions and provide valuable information for the study.

CHAPTER 4

RESULTS

This chapter presents the results of the study, focusing on the relationship between health consciousness variables and quality-of-life satisfaction among a specific age group (15-29). It begins with an overview of the respondents' demographics, setting the context for the analysis. The statistical analysis techniques employed, including linear regression and factor analysis, are briefly described.

The results section provides key findings related to the research questions. The analysis highlights the significant influence of Physical Health Orientation (PHO) on quality-of-life satisfaction, emphasizing the importance of considering physical well-being in relation to overall life satisfaction. The impact of preexisting medical conditions on quality-of-life satisfaction is also explored, revealing that individuals without current illnesses report higher satisfaction levels. Additionally, the influence of demographic factors such as age, sex, education, and marital status on health consciousness and quality-of-life satisfaction is examined. The chapter concludes by discussing the implications of these findings for our understanding of health consciousness and subjective well-being.

4.1 Respondents Profile

The participants were 61 adults age ranging from 15 to above 50. The sample size (n=61) was way lower than what was expected to make the data analysis more accurately represent the target group. The sample group concluded with 54.1% female (n=33) and 45.9% male (n=28). The majority of the participants are between the age range of 15 to 29 years old with 85.2% (n=52), 4 participants are between the age of 30-39, 2 are between the age of 40-49, and 3 are between the age of 50 and above. 60.7% (n=37) of the respondent are still in university, 36.1% (n=22) are doing post graduate. As for the marital status, 33 of the respondents are single, 20 are in a relationship, 7 are married and 1 divorced. As for health status, 62.3% (n=38) says that their health is good. 27.9% (n=17) responded neither poor or good, and 3.3% (n=2) says that their health is poor and 6.6% (n=4) says their health is very good.

Lastly, the general question asked whether the respondent is currently ill and 53 out of 61 respondents (86.9%) says no.

4.2 Linear Regression

From the data collected, the eight independent variables have been computed into its own respected compounded value of all the items within each variable. With a simple linear regression using model fit of F test and looking at R^2 value. The result has very low R^2 and adjusted R^2 value at 0.332 and 0.230 respectively. The only independent variable that showed it has any statistically significant on the dependent variable at 95% confidence interval is PHO (Physical Health Orientation) at P value of 0.004. Every other independent variable has P value > 0.05 making them insignificant. As for assumption checks of collinearity statistics, VIF value for the eight independent variables are low. However, further statistical analysis will be necessary to remove insignificant independent variables to improve the construct validity and reliability.

Below is a table showing a simple linear regression between the eight independent variables to the dependent variable.

Table 4.1: A Simple Linear Regression Model Fit Measures

Model Fit Measures							
				Overall Model Test			
Model	R	R^2	Adjusted R^2	F	df1	df2	p
1	0.577	0.332	0.230	3.24	8	52	0.005

Table 4.2: A Simple Linear Regression Model Coefficients - DV

Model Coefficients - DV				
Predictor	Estimate	SE	t	p
Intercept	1.7573	0.672	2.614	0.012
HSC	0.1618	0.196	0.826	0.413

(Continued)

Table 4.2 (Continued): A Simple Linear Regression Model Coefficients - DV

Model Coefficients - DV				
HV	-0.1548	0.181	-0.854	0.397
HIS	0.0607	0.123	0.493	0.624
PHO	0.3696	0.123	2.998	0.004
MHO	0.1848	0.162	1.142	0.259
HM	0.1653	0.124	1.336	0.187
HK	-0.2212	0.147	-1.505	0.138
HR	-0.0796	0.164	-0.484	0.631

Table 4.3: Simple Linear Regression and Assumption Checks Table

Collinearity Statistics		
	VIF	Tolerance
HSC	1.97	0.509
HV	1.97	0.507
HIS	1.83	0.547
PHO	1.63	0.614
MHO	1.74	0.576
HM	1.36	0.738
HK	1.78	0.562
HR	1.99	0.502

In order to answer the first research question of which variable predict or highly correlate to quality-of-life satisfaction, a series of factor analyses using Varimax based on eigenvalue greater than 1 and factor loading size greater than 0.4 were conducted for data reduction. Out of the 32 items, 13 items were removed as they either have a very high uniqueness value or they have cross loading value. Items deleted during this stage were: “I am familiar with preventing major and chronic problems such as hypertension or diabetes.”, “I am very knowledgeable about taking

care of my general health compared to others.”, “I am responsible for maintaining a healthy body weight.”, “I am constantly examining my health.”, “I am self-conscious about my health.”, “I try to avoid having an inactive lifestyle.”, “I seek guidance or counseling when necessary.”, “I engage in recreational activities to relax as I found myself stressed out.”, “I spend time each day trying to reduce accumulated stress.”, “Becoming happier is worth the benefit.”, “I am aware of the state of my health as I go through the day.”, “I would rather enjoy life than try to make sure I am not exposing myself to a health hazard.”, and “Being full of energy is worth the benefit.”. These items were removed in the order of high uniqueness value, then items with cross loading.

Thus, leaving only 19 items that was grouped into 6 different factors. The 6 initial factors accounted for 77.8% of the cumulative variance. There are 5 items that strongly correlated into factor one which include items from both Health Value (HV) and Health Responsibility (HR) such as “Staying healthy longer is worth the benefit.” and “I should take care of myself to prevent disease and illness.” Which the factor was renamed to become Health Responsibility Benefits (HRB). 4 items strongly loaded on factor two that include most items from Physical Health Orientation and only one item from Health Self Conscious (HSC) such as “I am involved with my health. (e.g., I get enough sleep, managing my stress, and seek medical care when necessary).”, thus factor two was still named Physical Health Orientation (PHO). Factor 3 include 3 items from Health Information Seeking (HIS) such as “I discuss my health concerns with health professionals.” Thus, the naming of the factor stays the same. Factor 4 include 3 items from Health Knowledge (HK) such as “I am familiar with preventing minor and temporary problems such as colds or viruses.” Thus, the naming of this factor stays the same. 2 Items from Health Motivation (HM) that are loaded onto factor five and 2 Items from Mental Health Orientation (MHO) are loaded onto factor six.

The tables under Figure 4.1 will show the data from principal component loading analysis as well as a scree plot of the 6-underlying constructs of health consciousness that are slightly different from the concept used in Hu (2013)’s study. With limited data set, it would be inappropriate to suggest that the six factors are more

refined than the eight factors dimension that were used to measure health consciousness.

Table 4.4: Principal Component Analysis

Component Loadings							
	Component						
	1	2	3	4	5	6	Uniqueness
HV3	0.820						0.3078
HV1	0.816						0.1923
HR3	0.799						0.2773
HR2	0.776						0.3472
HV2	0.729						0.1795
PHO1		0.907					0.1255
PHO2		0.857					0.1680
PHO3		0.800					0.2370
HSC3		0.574					0.3724
HIS2			0.926				0.0886
HIS1			0.924				0.1188
HIS3			0.790				0.2257
HK5				0.874			0.1636
HK2				0.857			0.1968
HK3				0.785			0.3138
HM2					0.862		0.1773
HM1					0.847		0.1959
MHO4						0.814	0.2499
MHO2						0.763	0.2867
Note. "Varimax" rotation was used							

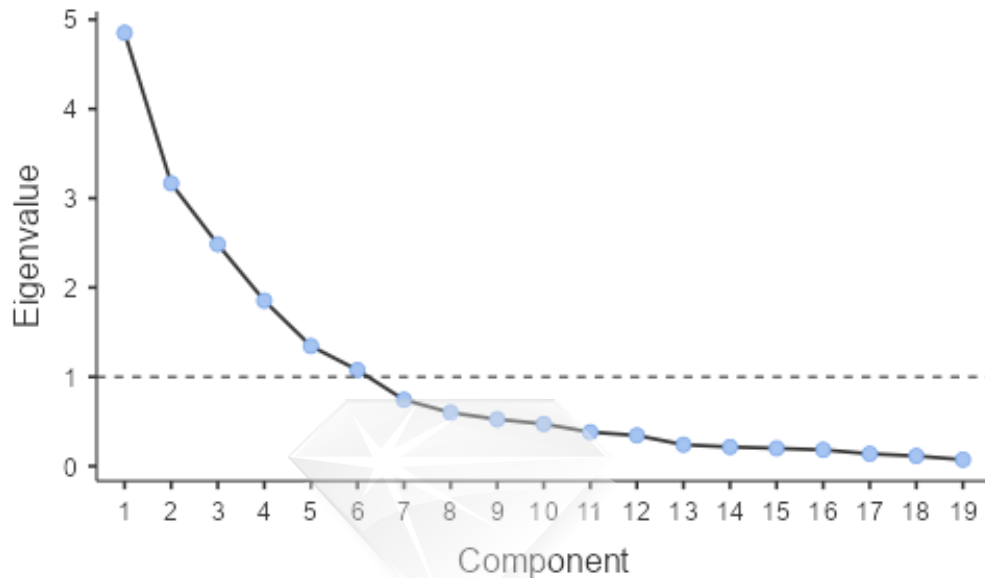
Table 4.5: Eigenvalues's Bartlett's Test and Cumulative % Table

Bartlett's Test of Sphericity		
χ^2	df	p
669	171	< .001

Table 4.6: Initial Eigenvalues

Initial Eigenvalues			
Component	Eigenvalue	% of Variance	Cumulative %
1	4.8520	25.537	25.5
2	3.1660	16.663	42.2
3	2.4842	13.075	55.3
4	1.8526	9.751	65.0
5	1.3450	7.079	72.1
6	1.0763	5.665	77.8
7	0.7424	3.907	81.7
8	0.5991	3.153	84.8
9	0.5246	2.761	87.6
10	0.4722	2.485	90.1
11	0.3810	2.005	92.1
12	0.3440	1.811	93.9
13	0.2396	1.261	95.2
14	0.2148	1.130	96.3
15	0.1993	1.049	97.3
16	0.1824	0.960	98.3
17	0.1380	0.726	99.0
18	0.1138	0.599	99.6
19	0.0727	0.383	100.0

Figure 4.1: The Data from Principal Component



A series of reliability test were conducted for each of the six dimensions and on the scale of the total 19 items. Results indicated that the reduced items had high internal consistency of Cronbach's Alpha = 0.815. However, item from Health Motivation is negatively correlated to the total scale.

As for each sub scale, the Health Responsibility Benefits (5 items) had shown acceptable reliability (Cronbach's $\alpha = 0.867$), Physical Health Orientation (4 items) had shown acceptable reliability as well (Cronbach's $\alpha = 0.834$), Health Information Seeking (3 items) had shown very high reliability (Cronbach's $\alpha = 0.911$), Health Knowledge (3 items) had shown good number (Cronbach's $\alpha = 0.835$), Health Motivation (2 items) and Health Mental Orientation (2 items) both dropped a bit lower in number respectively (Cronbach's $\alpha = 0.744$ and 0.690). As for the Quality of life's satisfaction, consisting of 3 items have an acceptable Cronbach's Alpha of 0.720. The figures below also show the alternative of the Cronbach's Alpha value for each sub scale/dimension if item dropped.

4.3 Reliability Analysis (Cronbach's α)

Table 4.7–4.13 shows values of Cronbach's α for each independent variables showing whether each items within the factors are reliable or not when it is used to test the dependent variables. As shown, numbers are all above or close to 0.700 range will indicates that all these independent and dependent variables are reliable and can be used to make assumption within the parameter of this study.

Table 4.7: Health Responsibility Benefits (HR)

Scale Reliability Statistics			
	Mean	SD	Cronbach's α
scale	4.09	0.716	0.867

Table 4.8: Physical Health Orientation (PHO)

Scale Reliability Statistics			
	Mean	SD	Cronbach's α
scale	3.23	0.852	0.834

Table 4.9: Health Information Seeking (HIS)

Scale Reliability Statistics			
	Mean	SD	Cronbach's α
scale	2.65	1.05	0.911

Table 4.10: Health Knowledge (HK)

Scale Reliability Statistics			
	Mean	SD	Cronbach's α
scale	3.14	0.866	0.835

Table 4.11: Health Motivation (HM)

Scale Reliability Statistics	
	Cronbach's α
scale	0.744

Table 4.12: Mental Health Orientation (MHO)

Scale Reliability Statistics	
	Cronbach's α
scale	0.690

Table 4.13: Dependent Variables

Scale Reliability Statistics	
	Cronbach's α
scale	0.720

As each dimension have shown its validity and reliability for the scale, a simple linear regression will be conducted to see the relationship between the 6 new dimensions and its relationship to the quality-of-life satisfaction. The reconducted

regression had shown better results in R^2 and adjusted R^2 values at 0.394 and 0.327 respectively. P value have significantly improved with the new dimensions, Physical Health Orientation and Mental Health Orientation are the two dimensions that have significant values at 95% confidence interval that could predict the overall quality of life satisfaction for this group of participants.

Table 4.14: Linear Regression using 6 Dimensions

Model Fit Measures							
				Overall Model Test			
Model	R	R^2	Adjusted R^2	F	df1	df2	p
1	0.628	0.394	0.327	5.86	6	54	< .001

Table 4.15: Model Coefficients - DV

Model Coefficients - DV				
Predictor	Estimate	SE	t	p
Intercept	-1.4083	0.6097	2.310	0.025
HRB (new)	-0.2184	0.1266	-1.725	0.090
PHO (new)	0.4920	0.1043	4.716	< .001
HIS (new)	0.0381	0.0916	0.416	0.679
HK (new)	-0.1518	0.1076	-1.411	0.164
HM (new)	0.1872	0.1021	1.834	0.072
MHO (new)	0.2451	0.1143	2.145	0.037

4.3.1 Assumption Checks

Table 4.16: Collinearity Statistics

Collinearity Statistics		
	VIF	Tolerance
HRB (new)	1.21	0.830
PHO (new)	1.16	0.862
HIS (new)	1.36	0.737
HK (new)	1.27	0.785
HM (new)	1.22	0.817
MHO (new)	1.26	0.796

As seen in Table 4.12 above, the model coefficient of HIS (Health Information Seeking) shall be removed as the P value is relatively high in comparison to other dimensions. Linear regression is reconducted using only 5 dimensions to see whether adjusted R² value improve. Normality Test and Q-Q plot will also be shown to demonstrated to show that the dataset is normally distributed. The linear regression with only 5 dimensions has better adjusted R² value at 0.337, and other dimensions of the scale has better p value and PHO and MHO still remain the most significant indicators for quality-of-life satisfaction. The most insignificant variable in this relationship would be Health Knowledge since it has the highest p value.

4.4 Linear Regression

Table 4.17: Linear Regression with New Factors from Principal Component Analysis

Model Fit Measures							
				Overall Model Test			
Model	R	R ²	Adjusted R ²	F	df1	df2	p
1	0.626	0.392	0.337	7.10	5	55	< .001

Table 4.18: Model Coefficients – DV

Model Coefficients - DV				
Predictor	Estimate	SE	t	p
Intercept	1.454	0.5951	2.44	0.018
HK (new)	-0.142	0.1039	-1.36	0.179
PHO (new)	0.503	0.1005	5.00	< .001
HRB (new)	-0.213	0.1249	-1.70	0.094
HM (new)	0.172	0.0942	1.82	0.074
MHO (new)	0.248	0.1132	2.19	0.033

4.4.1 Assumption Checks

Table 4.19: Linear Regression with 5 Dimensions without HIS (Health Information Seeking)

Collinearity Statistics		
	VIF	Tolerance
HK (new)	1.21	0.829
PHO (new)	1.09	0.915
HRB (new)	1.19	0.840

(Continued)

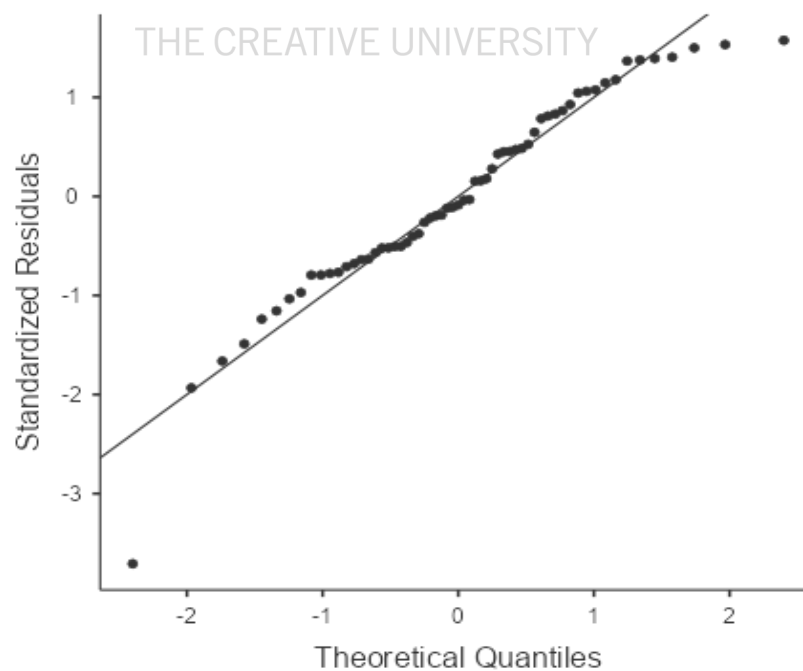
Table 4.19 (Continued): Linear Regression with 5 Dimensions without HIS (Health Information Seeking)

Collinearity Statistics		
HM (new)	1.06	0.945
MHO (new)	1.25	0.798

Table 4.20: Normality Test (Shapiro-Wilk)

Normality Test (Shapiro-Wilk)	
Statistic	p
0.948	0.011

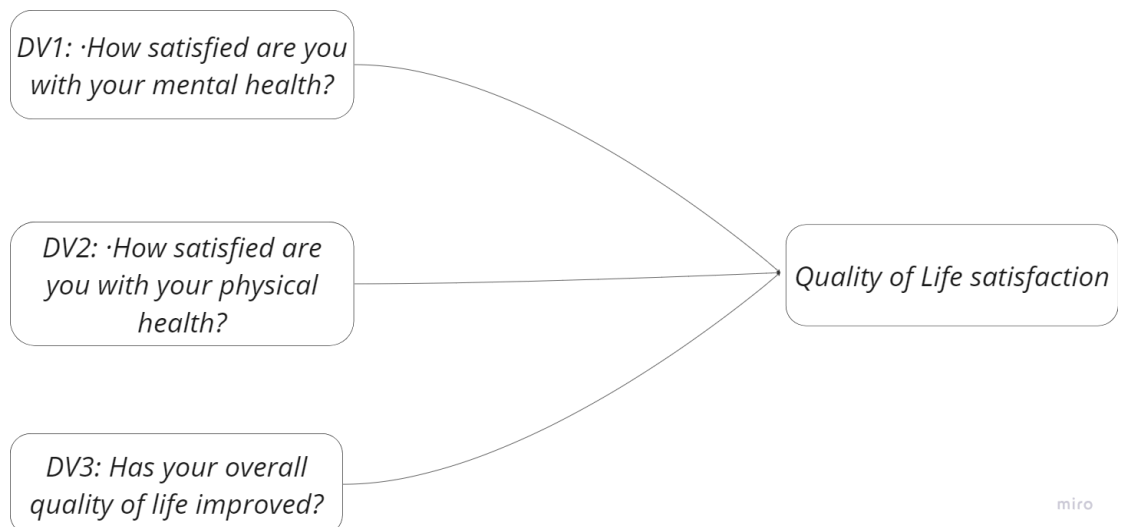
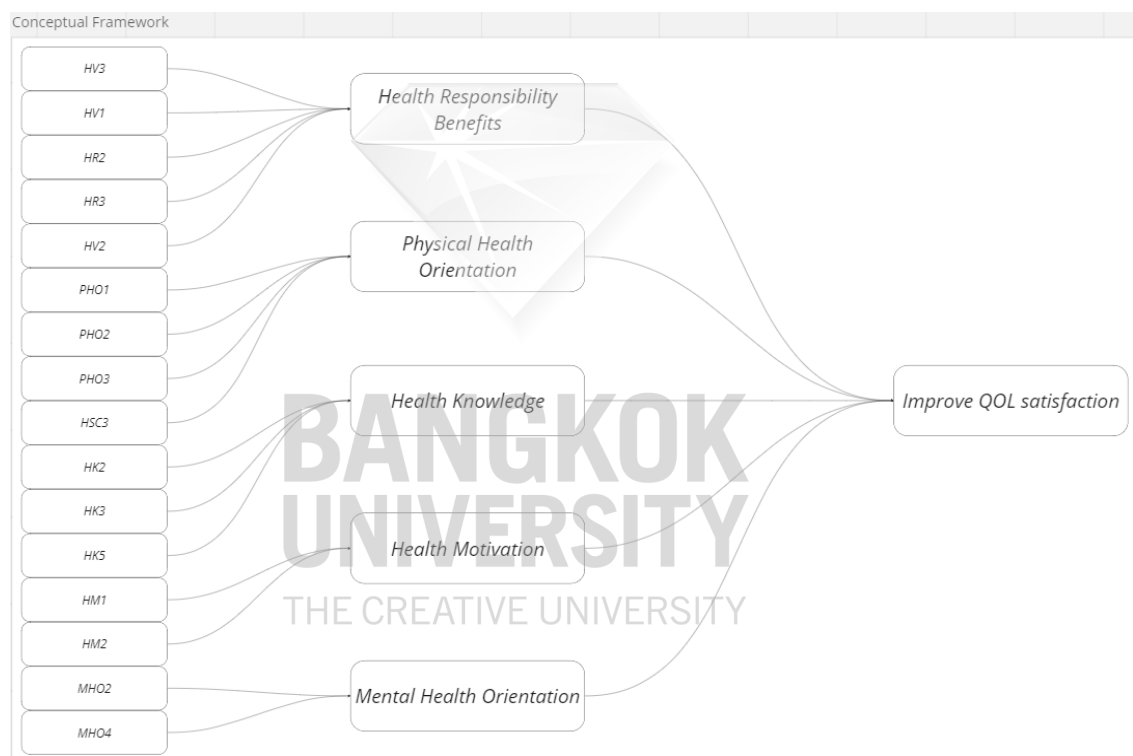
Figure 4.2: Linear Regression with 5 Dimensions without HIS (Health Information Seeking) Q-Q Plot



4.5 Interpretation of the Results

The final refined scale of the health consciousness model and its relation to the quality-of-life satisfaction/improvement within this study suggest that there will be 5 dimensions which are Health Responsibility Benefits, Physical Health Orientation, Health Knowledge, Health Motivation, and Mental Health Orientation.

Figure 4.3: Final Construct of IVs and DVs



4.6 Discussion of the Findings Concerning the Research Question or Objective

Which of the health consciousness variables predict the satisfaction of life for this group of people (15-29)?

Due to our limited sample size, a comparison between age group is not feasible. There are 52 respondents within the age group and only 9 for other age groups. Linear regression for this age group has shown better result than the whole sample group, the adjusted R^2 value is at 0.343 and PHO and MHO are still the most significant variables in prediction the level of satisfaction in their quality of life. This suggest that being health conscious is emphasize upon their physical and mental orientation, and how they feel physically and mentally will determine how satisfied they are with their overall quality of life.

4.6.1 Research Question 1

Table 4.21: Linear Regression for Younger Adults (15-29) Model Fit Measures

Model Fit Measures							
				Overall Model Test			
Model	R	R ²	Adjusted R ²	F	df1	df2	p
1	0.638	0.407	0.343	6.32	5	46	< .001

Table 4.22: Linear Regression for Younger Adults (15-29) Model Coefficients - DV

Model Coefficients - DV				
Predictor	Estimate	SE	t	p
Intercept	1.646	0.661	2.49	0.016
HK (new)	-0.235	0.118	-2.00	0.052
PHO (new)	0.489	0.107	4.59	< .001
HRB (new)	-0.233	0.135	-1.72	0.091
HM (new)	0.174	0.104	1.67	0.102
MHO (new)	0.293	0.123	2.37	0.022

4.6.2 Reasearch Question 2:

What motivates the younger generation to prioritize their health, and how does preexisting medical conditions impact such motivation?

For this research question, I supposed people who are not currently ill to have lower health consciousness than those who are and higher in satisfaction of their quality of life. An independent sample T Test is used. 44 out of the 52 younger adults age between 15-29 says they are not currently ill. The T Test demonstrated that there is no significance different in their health consciousness even though they are ill across all dimensions. On the other hand, the result does show that people who are not ill have significantly higher quality of life satisfaction than those who are. The most significant difference is DV2 which asked whether they are satisfied with their physical health between the two groups. This ties back to RQ1 of how Physical Health Orientation dictates their quality-of-life satisfaction. Highlighted DV2' p value shows that this dependent variables is the most the significant when taking into account of all the DV together.

Table 4.23: Independent Samples T Test for Existing Illness Group

Independent Samples T-Test				
		Statistic	df	p
HK (new)	Student's t	0.116	50.0	0.454
HRB (new)	Student's t	-1.909	50.0	0.969
PHO (new)	Student's t	0.540	50.0	0.296
HM (new)	Student's t	0.442	50.0	0.330
MHO (new)	Student's t	-0.304	50.0	0.619
Health Consciousness (Total 6 Dimensions)	Student's t	-0.270	50.0	0.606
DV1	Student's t	1.150	50.0	0.128
DV2	Student's t	3.248	50.0	0.001

(Continued)

Table 4.23 (Continued): Independent Samples T Test for Existing Illness Group

Independent Samples T-Test				
		Statistic	df	p
DV3	Student's t	0.799	50.0	0.214
DV	Student's t	2.194	50.0	0.016
Note. $H_a \mu_1 > \mu_2$				

4.6.3 Research Question 3:

Do age, sex, education, and marital status influence individuals' health consciousness and satisfaction in quality of life?

Using one way ANOVA test, it was only possible to observe the differences in age groups and genders. For education and marital status, most of the responses are not well distributed which makes it impossible for Jamovi to compute such statistical analysis since there are not enough observations for each group. As for age groups, there is no significant differences when looking at the P value of both dependent and independent variables as well as the majority of the respondent are within the age of 15-29. Thus, age does not influence a person's health consciousness and impact on their satisfaction in quality of life. The QQ plots show that the data collected is more normal distributed in health consciousness scale than the dependent variables.

Table 4.24: One way ANOVA Test for Age Group

One-Way ANOVA (Welch's)				
	F	df1	df2	p
DV	0.892	3	3.91	0.520
Health Consciousness (Total 6 Dimensions)	4.577	3	4.72	0.072

(Continued)

Table 4.24 (Continued): One way ANOVA Test for Age Group

One-Way ANOVA (Welch's)					
	Age	N	Mean	SD	SE
DV	15 - 29	52	3.01	0.7962	0.1104
	30 - 39	4	3.58	0.6872	0.3436
	50 and above	3	3.44	0.6939	0.4006
	40 - 49	2	3.17	0.2357	0.1667
Health Consciousness (Total 6 Dimensions)	15 - 29	52	3.30	0.4650	0.0645
	30 - 39	4	3.44	0.5243	0.2622
	50 and above	3	3.27	0.8135	0.4697
	40 - 49	2	3.67	0.0872	0.0617

As for gender, there is a significant difference between male and female in Health consciousness. Across the 6 dimensions of health consciousness, female has (M=3.2, n=33) and male has (M=3.47, n=28), especially in Health Motivation and Physical Health Orientation with p value at 0.024 and 0.033 respectively which male have higher level of consciousness in those dimensions than female. In the descriptive table below, it can be seen that male has higher average score for both Health motivation and Physical Health orientation. One can make an argument for Dependent variable 3 which asked “Has your overall quality of life improved?” to be significant at 90% confidence interval for the gender group. Thus, at 95% confidence interval, this research question can be concluded that male has a higher health consciousness under HM and PHO, however there is no difference in satisfaction of quality of life between the genders. Due to the sample size, there are not enough observation for level of education and marital status to conclude the relationship between health consciousness and quality of life satisfaction.

Table 4.25: One Way ANOVA Test for Gender

Group Descriptives				
	F	df1	df2	p
DV	0.96705	1	54.9	0.330
Health Consciounsess (Total 6 Dimensions)	5.17449	1	56.7	0.027
HRB (new)	0.00582	1	58.5	0.939
PHO (new)	4.74190	1	58.9	0.033
HM (new)	5.37230	1	57.9	0.024
MHO (new)	1.64923	1	52.3	0.205
HK (new)	0.16076	1	58.2	0.690
DV1	0.09380	1	48.7	0.761
DV2	0.12496	1	56.6	0.725
DV3	3.48449	1	58.8	0.067

What is your gender?	N	Mean	SD	SE	
DV	1	33	2.98	0.740	0.1289
	2	28	3.18	0.824	0.1557
Health Consciounsess (Total 6 Dimensions)	1	33	3.20	0.451	0.0786
	2	28	3.47	0.468	0.0884
HRB (new)	1	33	4.08	0.745	0.1297
	2	28	4.09	0.694	0.1311

(Continued)

Table 4.25 (Continued): One Way ANOVA Test for Gender

What is your gender?		N	Mean	SD	SE
PHO (new)	1	33	3.02	0.875	0.1523
	2	28	3.47	0.768	0.1451
HM (new)	1	33	2.58	0.876	0.1525
	2	28	3.09	0.850	0.1607
MHO (new)	1	33	3.21	0.729	0.1269
	2	28	3.48	0.887	0.1676
HK (new)	1	33	3.10	0.892	0.1552
	2	28	3.19	0.848	0.1603
DV1	1	33	3.06	0.864	0.1504
	2	28	3.14	1.177	0.2225
DV2	1	33	2.91	0.980	0.1706
	2	28	3.00	1.018	0.1925
DV3	1	33	2.97	0.984	0.1713
	2	28	3.39	0.786	0.1485

CHAPTER 5

CONCLUSION

This chapter discusses the findings of the study on the impact of health consciousness on life satisfaction. It presents a summary of the key findings and their implications for different stakeholders. The limitations of the study are also acknowledged, and suggestions for future research directions are provided. The chapter concludes by emphasizing the importance of incorporating innovation in healthcare interventions to positively influence individuals' lives.

5.1 Summary of the Key Findings

The present study aimed to investigate the impact of health consciousness on life satisfaction. Through the analysis of the research questions, the following key findings emerged:

RQ1: The regression analysis revealed that "Physical Health Orientation" (PHO) and "Mental Health Orientation" (MHO) were the most significant variables in predicting life satisfaction. This suggests that individuals who are more focused on their physical and mental well-being tend to have higher levels of satisfaction with their overall quality of life.

RQ2: The comparison between individuals who are currently ill and those who are not indicated that there was no significant difference in health consciousness. However, it was found that individuals who are not currently ill reported significantly higher satisfaction with their quality of life, particularly in relation to their physical health. This finding further supports the importance of physical health orientation in determining overall life satisfaction.

RQ3: Age did not influence individuals' health consciousness or their satisfaction with quality of life, given the limited sample size and dominance of the 15-29 age group. However, significant differences were observed between genders, with males demonstrating higher levels of health consciousness, particularly in health motivation and physical health orientation. Interestingly, there were no significant differences in satisfaction with quality of life between genders.

Innovation plays a crucial role in promoting health consciousness and improving life satisfaction. The key findings of this study highlight the importance of innovative approaches in fostering positive health behaviors and enhancing overall well-being. By identifying the significant predictors of life satisfaction, such as physical and mental health orientation, this study provides valuable insights for innovators seeking to develop creative solutions that positively impact individuals' quality of life

5.2 Implications of the Study

The findings of this study have several implications for various stakeholders. Firstly, the emphasis on physical and mental health orientation as significant predictors of life satisfaction suggests the importance of promoting health-conscious behaviors and interventions targeting these dimensions. Healthcare professionals can use these findings to develop targeted strategies and interventions that enhance individuals' overall well-being and satisfaction with life.

Furthermore, the significant differences observed between genders in health consciousness highlight the need for gender-specific approaches in health promotion efforts. Understanding the unique motivations and orientations towards health can inform tailored interventions that address the specific needs and preferences of males and females. Understanding the impact of health consciousness on life satisfaction can also inform the development of innovative interventions and technologies that facilitate behavior change and promote healthier lifestyles. Innovators in healthcare can leverage these findings to design user-centered solutions, such as mobile applications, wearable devices, or digital platforms, that empower individuals to monitor and improve their physical and mental health.

Additionally, the finding that satisfaction with quality of life did not differ significantly between genders despite variations in health consciousness suggests the importance of considering multiple factors beyond health consciousness alone. Future research can explore additional variables that may influence life satisfaction and further examine the complex relationship between health consciousness and overall well-being.

5.3 Limitations and Future Directions for Research

It is essential to acknowledge the limitations of this study. The primary limitation was the limited sample size, particularly for specific age groups and categories such as education and marital status. This restricts the generalizability of the findings to a broader population. Future research should aim for larger and more diverse samples to obtain more robust and representative results.

Moreover, the reliance on self-report measures may introduce response biases and subjectivity. The use of objective measures or a combination of different data collection methods could strengthen the validity and reliability of future studies.

Additionally, exploring other demographic variables, such as education and marital status, with more balanced sample sizes could provide valuable insights into their influence on health consciousness and life satisfaction.

5.4 Concluding Remarks

In conclusion, this study investigated the impact of health consciousness on life satisfaction. The findings highlighted the significance of physical and mental health orientation in predicting satisfaction with overall quality of life. Gender differences in health consciousness were observed, but these did not translate into significant variations in satisfaction with quality of life.

These findings contribute to the existing body of knowledge on health consciousness and its impact on life satisfaction. They underscore the importance of promoting physical and mental well-being and developing targeted interventions for different genders. However, further research with larger and more diverse samples is warranted to strengthen and expand upon these findings.

By linking the conclusion to innovation, I would like to highlight the significance of incorporating innovative strategies, technologies, and approaches in addressing health consciousness and improving life satisfaction. This reinforces the importance of continuous innovation in the field of healthcare and well-being, paving the way for transformative advancements that positively impact individuals' lives. By embracing innovation in health promotion strategies and interventions, we can empower individuals to take charge of their health and create a positive impact on their lives. Continued research and collaboration between academia, healthcare

organizations, and technology innovators can drive further advancements in this area and contribute to the well-being of individuals and society as a whole.



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BIBLIOGRAPHY

- Centers for Disease Control and Prevention. (2022). *What is health literacy?*. Retrieved from <https://www.cdc.gov/healthliteracy/learn/>.
- Gould, S. J. (1990). Health consciousness and health behavior: The application of a new health consciousness scale. *American journal of preventive medicine*, 6(4), 228–237.
- Grant, N., Wardle, J., & Steptoe, A. (2009). The relationship between life satisfaction and health behavior: A cross-cultural analysis of young adults. *International Journal of Behavioral Medicine*, 16, 259–268.
- Gurría, A. (2019). *The economy of well-being*. Retrieved from <https://www.oecd.org/social/economy-of-well-being-brussels-july-2019.htm>.
- Hong, H. (2009). *Scale development for measuring health consciousness: Re-conceptualization*. Retrieved from <https://osf.io/qre9w/download>.
- Hu, C. S. (2013). *A new measure for health consciousness: Development of a health consciousness conceptual model*. Retrieved from <https://www.researchgate.net/publication/301701478>.
- Jacobs, W., Amuta, A. O., & Jeon, K. C. (2017). Health information seeking in the digital age: An analysis of health information seeking behavior among US adults. *Cogent Social Sciences*, 3(1), 1-11.
- Jayanti, R. K., & Burns, A. C. (1998). The antecedents of preventive health care behavior: An empirical study. *Journal of the Academy of Marketing Science*, 26, 6-15.
- Kapperman, C. (2022). *Health-conscious consumers get in touch with their feelings*. Retrieved from <https://www.supermarketnews.com/consumer-trends/health-conscious-consumers-get-touch-their-feelings>.
- Keyes, C. L., Wissing, M., Potgieter, J. P., Temane, Q. M., Kruger, A., & Van Rooy, S. (2008). Evaluation of the mental health continuum–short form (MHC–SF) in setswana-speaking South Africans. *Clinical Psychology & Psychotherapy*, 15(3), 181-192.
- Kraft, F. B., & Goodell, P. W. (1993). Identifying the health conscious consumer. *Journal of health care marketing*, 13(3), 18–25.

- Nermoe, K. (2022). *Millennials: The wellness generation*. Retrieved from <https://news.sanfordhealth.org/sanford-health-plan/millennials-wellness-generation/>.
- Pinto, J. M., Fontaine, A. M., & Neri, A. L. (2016). The influence of physical and mental health on life satisfaction is mediated by self-rated health: A study with Brazilian elderly. *Archives of Gerontology and Geriatrics*, 65, 104-110.
- Pu, B., Zhang, L., Tang, Z., & Qiu, Y. (2020). The relationship between health consciousness and home-based exercise in China during the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*, 17(16), 5693.
- United Nations. (n.d.). *Peace, dignity and equality on a healthy planet*. Retrieved from <https://www.un.org/en/global-issues/youth>.
- Walker, R. A., O'Brien, E. T., Pryer, N. K., Soboeiro, M. F., Voter, W. A., Erickson, H. P., & Salmon, E.D. (1998). Dynamic instability of individual microtubules analyzed by video light microscopy: rate constants and transition frequencies. *Journal of Cell Biology*, 107(4), 1437-1448.
- World Health Organization. (2012). *WHOQOL: Measuring quality of life*. Retrieved from <https://www.who.int/tools/whoqol>.



APPENDIX

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Health Consciousness Scale survey from the final construct

Dimension	Item	Not at all	A little/ Slightly	A moderate amount/ Moderately	Very much/ Very	An extreme amount/ Extremely
Health Responsibility Benefits	Eating healthier is worth the benefit.					
	Staying healthy longer is worth the benefit.					
	I should take care of myself to prevent disease and illness.					
	My health depends on how well I take care of myself.					
	Staying fit longer is worth the benefit.					
Physical Health Orientation	I try to exercise on a regular basis.					
	I make special efforts to become physically active.					

Health Consciousness Scale survey from the final construct

Dimension	Item	Not at all	A little/ Slightly	A moderate amount/ Moderately	Very much/ Very	An extreme amount/ Extremely
	I try to get fit for my body shape.					
	I am involved with my health. (e.g. I get enough sleep, managing my stress, and seek medical care when necessary).					
Health Knowledge	I am familiar with preventing minor and chronic problems such as allergies or dry skin.					
	I am familiar with preventing major and temporary problems such as flu or measles.					
	I am familiar with preventing minor and temporary problems such as colds or viruses.					
Health Motivation	I don't worry about common health hazards until they become a problem for me or for someone close to me.					

Health Consciousness Scale survey from the final construct

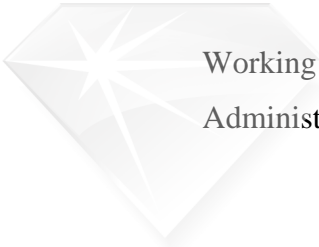
Dimension	Item	Not at all	A little/ Slightly	A moderate amount/ Moderately	Very much/ Very	An extreme amount/ Extremely
	I don't take any action against common health hazards I hear about until I know I have a problem.					
Mental Health Orientation	I take some time to relax each day.					
	I make special efforts to keep myself free from extreme stress					

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