What's good for some is not good for others? A critical inquiry into what constrains and drives wellbeing travel participation in Australia.

Doctor of Philosophy

Alison Marie van den Eynde

College of Arts
Victoria University
Melbourne, Australia

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Abstract

Current literature reports wellbeing travel as a rapidly increasing, profitable international tourism sector. Wellbeing travel is positioned as an antidote to the declining wellbeing in western societies. However, it is also reported that those travelling for wellbeing are for the most part, already 'healthy and wealthy', predominately white, middle class and female.

Partly in response to the literature, this thesis draws attention to wellbeing travel as more than just a growing tourism sector. In a critical examination of wellbeing travel this thesis explores how and why a small group of people are travelling for wellbeing, and why other people are not. It is argued that non-travel is not an indiscriminate occurrence, but a multi-faceted and sometimes deliberate process, resulting in exclusion.

In depth interviews with wellbeing travel stakeholders (n-13), a focus group (n=8) and a mixed method representative survey of Australian people (n=204) explored the increasing wellbeing travel trend and the construction of constraints.

To determine a process for non-travel and travel constraints, the data was examined with Crawford, Jackson and Godbey's (1987, 1991) hierarchical leisure constraints model (structural, interpersonal and intrapersonal constraints). Thematic analysis of qualitative data was undertaken to determine further themes. Findings highlighted an affinity with past research about constraints to travel, but also contradictory and new findings.

Supporting past research, the structural constraints 'time and finances' were the most visible and obvious theme in the data. Research participants who did not travel for wellbeing, were a group without adequate resources to make choices about achieving wellbeing within a consumer orientated environment. As a result, the thesis proposed the reproduction of socio-economic inequalities in society, are purposefully reproduced in wellbeing travel.

Offering new knowledge about what causes non-travel was an emerging theme of self-exclusion woven throughout the data. Self-exclusion was visible within interpersonal constraints such as gender. Additionally, analysis of the data positioned wellbeing travel within a wider discourse of the de-medicalisation movement that both drove and constrained potential travel. Driving travel for wellbeing was the promise of social rewards. Wellbeing travel was constrained by false narratives that

health is a self-responsibility and choice. These findings drew attention to the consumer orientated nature of wellbeing today and the health inequalities reproduced in wellbeing travel.

In conclusion, this thesis proposes wellbeing travel establishments are a socially constructed, symbolic and physical location by which social life is performed and re-produced.

Student Declaration

I, Alison van den Eynde, declare that the Ph.D. thesis entitled “What’s good for some is not good for others? A critical inquiry into what constrains and drives wellbeing travel participation in Australia” is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature 

Date 2/9/2017

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I would like to acknowledge my family for seeing me through this process, each in their own way.

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Chapter 1: Introduction

Australians are increasingly participating in 'wellbeing travel'. All travel can be thought of as motivated towards improving health and wellbeing. However, wellbeing travel is a journey to a single establishment, and is aimed to achieve or improve wellbeing quickly and efficiently (Steiner & Reisinger, 2006). It can range from a weekend of indulgent and passive activities at a spa, or a week long, silent meditation vegan retreat in a tent. Wellbeing travel is considered to be a subcategory of health tourism, defined as "the organized travel outside one's local environment for the maintenance, enhancement or restoration of an individual's wellbeing in mind and body" (Carrera & Bridges, 2014, p. 447). It is also distinguished from medical tourism, defined as travel for wellbeing achieved with "medical intervention" (Carrera & Bridges, 2014, p. 447).

International trends show Wellbeing Travel is a significantly profitable international tourism sector (Berhens, 2007; Global Figueroa, 2011; Spa Summit, 2010, p. 35). The Global Wellness Institute (2016) reports that in 2013 the international wellness tourism market increased by 12.5% from 2012, equating to $494 billion in revenue. In Australia the demand for spa visitation in particular was increasing 13.8% annually, during the period 2001-2004 (Tourism Victoria, 2010, p.11).

A significant growth of wellbeing travellers internationally is also observed (Figueroa, 2011; Global Spa Summit, 2010). Baby boomers and a younger, financially liquid population are the two main markets for wellbeing travel (Bushell & Sheldon, 2009; Magdalini & Tsaratos, 2009; Smith & Kelly, 2006). Ironically, it is reported wellbeing travellers are mostly already well, and financially stable i.e., healthy and the wealthy (Bennet, King & Milner, 2004; Didascalou, Lagos & Nastos, 2009; Smith & Kelly, 2006).

It is also reported that the desire to achieve wellbeing has become an important moral quest in Western cultures and a mostly middle class phenomenon (Conrad & Barker, 2010, p. 397). There are several approaches to explain the increased interest in wellbeing travel. One such approach is raised in tourism literature. Wellbeing tourism researchers, Steiner and Reisinger (2006, p. 8) for instance, believe there is an accelerated need for wellbeing in Western society today due to "escalating civilisation, technology [that has] created existential angst among its citizens, identity

crisis, and feelings of isolation, depression and stress". This ruinous state of human existence was envisaged by Heidegger (1996) who believed it would lead to a loss of our natural humanity, and "we would be unable to attain our full potential as unique and authentic human beings" and therefore eventually turning to outward resources to restore our wellbeing" (Steiner & Reisinger, 2006, p. 9). A considerable theme in the wellbeing tourism literature suggests conditions of modern society are impacting upon our wellbeing and signalling an increasing need for counterbalance. Modern society is driving the need for wellbeing travel.

The second and more critical approach suggests participation in health and wellbeing must be deliberated as a cultural symbolic and potentially exclusionary process. Exclusion or inequality from health is certainly not a new area of study. It is widely acknowledged that socio-economic circumstance can impact upon health (Najman, 2003). For example, in Victoria, socioeconomic status is a significant factor determining self reported wellbeing (Vic Health, 2011). Higher self reported wellbeing was linked to annual incomes of $100,000 or more, a university degree, and to those without a disability (Vic Heath, 2011).

It is proposed that nowhere is this battleground plainer to observe than within the business of Wellbeing Travel. Leisure pursuits such as Wellbeing Travel can be enabled in a country like Australia. As a relatively wealthy and modern country, Australia has a good portion of citizens who have the economic comfort of looking beyond basic necessities for their existence (Easterlin, 1996). Easterlin (1996, p. 2) notes this is the point people can look toward the 'good life' and wellbeing is "the most desired outcome for people". With this comment by Easterlin (1996), the urgency about the pursuit of wellbeing in Australia (in the form of wellbeing travel) begins to be put in perspective.

Current research (Pollock & Willias, 2000; Smith & Puckzko, 2009; Steiner & Reisigner, 2006; Voigt et al., 2009) has established those participating in Wellbeing Travel – those who can look toward the good life - illustrate the characteristics of middle to high socio-economic status. With the rest of the Australian population potentially excluded from Wellbeing Travel, this research questions the social inequalities reproduced in tourism from everyday life (Hall & Brown, 2006; Haukeland, 1990; Holden, 2005; Minnaert, Maitland & Miller, 2006; Urry, 2007).

Rather than overlooking those who cannot travel as an indiscriminate occurrence, it is suggested it is a discriminate but multifaceted process. Non-Travel is

explored as the obvious consequence of social inequality, such as income and time constraints (Lu & Pas, 1999; Smith, 2001) but it is also the result of constructing place - based upon ideologies in society and the performance of the tourist (Edensor, 2001).

This research area addresses several gaps in research. First, the reasons for non-travel are a topic requiring further attention both internationally and particularly in Australia. Secondly, the growing interest in wellbeing travel in Australia has been studied by only a few (Berhens, 2009; Bennett et al., 2004; Global Spa Summit, 2010;Voigt, et al., 2010, 2011) and this research contributes to this body of work. Third, this research looks at, and beyond, existing tourism literature to explain the Wellbeing Travel trend. A sociological perspective of tourism is employed to attend to this gap.

Until this point in time research regarding wellbeing travel has not been studied from a sociological perspective, the absence of this study in tourism is an identified gap in research lamented by some tourism researchers (Jaworski & Pritchard, 2005, p. 8). There are several important inquiries a sociological perspective contributes to study the wellbeing travel trend in Australia. Tourism studies has long perceived tourism as a singular activity or a binary action – home to destination, and back to home - rather than an activity that is socially informed, imagined and planned within an individual's everyday life, and as dependent upon individual circumstances (Lean, 2012, p. 153).

This research examines wellbeing travel as a socially informed and imagined phenomenon with the concept of travel as a social construction. With this perspective Wellbeing Travel becomes a creation of the society we live in (Burr, 2003). A sociological perspective of tourism offers a critical approach to examine the trend. In a critical examination of what drives wellbeing participation, the objectivity of the above health and wellbeing ideology is questioned (Gershunny, 2005; Harley, Willis, Gabe, Short, Collyer, Natalier, & Calnan, 2011). It is argued that health and wellbeing is a battleground between collective or individual responsibility for health; the social control attained when solidifying body norms in society (Briggs, 2000) and a historical and cultural symbol of wealth and social status (Conrad & Barker 2010; Conrad & Scheneider, 2010; Crawford, 1994, 2000, 2006).

By way of addressing the research problem and research gaps, the position of this thesis is to explore the drivers of wellbeing travel and the constraints leading to non-travel in Australia, through a critical and social constructionist lens.

From the beginning conceptual position that travel is socially informed and constructed, the research questions are:

1. How is wellbeing travel in Australia socially constructed?
   a) What are the dominant discourses informing the concept of wellbeing travel?
   b) Is there an overarching discourse of 'wellbeing' for wellbeing travel service providers in Australia and the Australian people?
   c) How does a 'wellbeing' discourse inform the development of wellbeing travel, and potential tourists.

2. What are the drivers and constraints of travelling for wellbeing in Australia?
   a) From the perspective of Victorian wellbeing travel service providers.
   b) From the perspective of Australian people.

These questions are first addressed by exploring the origins of wellbeing travel as an organised activity in the 19th century. Chapter 2 describes the intersection between the rise of travel for the masses and the rise of the medicalisation model as an influence to the development of wellbeing travel. The chapter identifies two models of Wellbeing travel, the 'Egalitarian Model' of Australia and an 'Elite Model', characterizing wellbeing travel in UK and Europe. The drivers to travel are discussed for both models.

The origin of wellbeing travel with Elite and Egalitarian models, demonstrates key propositions for this research - participation in wellbeing travel was driven by more than a desire to travel or a leisure activity. Travelling for wellbeing was a performance of 'health', class and class distinction. Particularly in the Elite model, performance of health occurred at spa establishments introduced the theme of inequality and exclusion; health for some but not for others and travel for some but not for others.

Comparatively travelling today is a social norm that exists within a more formalized tourism industry and is accessible to a majority rather than a minority. Having reflected upon the possible drivers for participation in the past, Chapter 3 reviews wellbeing travel today. Including the growth and categories of wellbeing

travel in Australia and the current literature regarding a profile of the Wellbeing Traveller.

Having provided a clear picture of wellbeing travel in the past and in Australia today, Chapter 4 begins to address the research questions with existing tourism literature. Frameworks to determine constraints and drivers to travel are considered. Concept 1 describes a body of literature regarding non-travel. Concept 2 explores the power of tourism brokers to determine drivers for travel and non-travel. Concept 3 suggests brokers construct establishment s as a stage that reproduces social life and exclusion from travel, but also a performance that drives participation. Concept 4 contends that travellers do not have agency in how they participate in travel. Travel choices are determined by socialization and travellers have little agency to avoid the dominant discourses that govern how to participate in tourism, including determining who does travel, who does not, and how travel is performed in place.

Chapter 5 outlines the theoretical perspective of the research. Discussed is the limitations of past tourism research approaches and the history of social science and tourism, leading to the contention that wellbeing travel must be studied as a social construction. Chapter 6 discusses social constructionism and Critical Discourse Analysis as the research approach. Additionally, Chapter 6 outlines the three phases and procedures of data collection.

The results and discussion begin in Chapter 7 which explores the organisational structure of the wellbeing travel sector and argues that the service providers have the most power to construct and present wellbeing travel to the wider population. Concept 2, Cheong and Miller's (2000) perspective that brokers have considerable power to 'intervene and constrain tourism activities' is applied throughout this chapter.

Having determined service providers to have the most power in the tourism system to construct wellbeing travel, Chapter 8 and 9 identifies the specific travel constraints constructed. The constraints are compared to self-reported constraints from the three survey sample groups, Group 1 with low wellbeing engagement and no travel for wellbeing; Group 2, regular wellbeing engagement and no travel for wellbeing; and Group 3, with regular wellbeing engagement and travel for wellbeing.

Chapter 10 and 11 argue that beyond the power of tourism, what drives and constrains is an already existing wellbeing ideology. Chapter 11 determines how the

survey groups and focus group engage with a cohesive wellbeing discourse. It also finds significant deviations from the wellbeing discourse that highlight further drivers and constraints for the travellers and potential travellers.

Chapter 12 concludes the research with a summation of the main findings, reflections and limitations.

Key Definitions

De-medicalisation movement

Is the rejection of medicalisation, often thought to begin in the 1970's.

Lifestyle and spiritual establishments

Lifestyle and spiritual establishments offer accommodation and programmed treatments and activities, aimed to achieve and improve wellbeing. Lifestyle establishments can vary widely in price and purpose (resorts or retreats).

Domestic travel

Tourism Research Australia (2011) define domestic travel as either a day trip of at least 50 kilometres from home, for the duration of 4 at least four hours; or at the minimum an overnight trip at least 40 kilometres from home.

Medicalisation:

Medicalisation is the process by which human problems become medical conditions, Conrad (1992, p. 211) defines it as "a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession". Sociologists and social researchers study the medicalisation in regard to social control.

Non-Travel

In Australia the non-traveller is identified based on three questions. To determine a non-traveller from a traveller, the response to all three questions must be 'no', 1) Did the participant travel 50km from home and stay overnight in the last four weeks? 2) Did the participant travel 50km from home for a day trip in the last 7 days?, and 3) did the participant travel outbound within the last three months? (Tourism Research Australia, 2011).

Social constructionism

Social constructionism identifies and explores "taken-for-granted knowledge" about "how the world appears to be" (Burr, 2003, pp. 2-4).

Spa establishment

A hotel or resort with spa facilities and accommodation. A Day Spa can be included offer spa facilities without accommodation

Social exclusion

The exclusion from participation in the social system because of social, economic and cultural inequalities, and a lack of resources that are necessary for participation to take place (Levitas et al., 2007).

Self-exclusion

Voluntary exclusion of the self that follows prior systematic rejection or exclusion.

Survey Group 1

This survey group was characterized by low wellbeing engagement and no travel for wellbeing.

Survey Group 2

This survey group was characterized by regular wellbeing engagement and no travel for wellbeing.

Survey Group 3

This survey group was characterized by regular wellbeing engagement and travel for wellbeing.

Wellbeing Travel: A sub category of health tourism, wellbeing travel is a journey to a single purpose establishment or destination, aimed to achieve or improve wellbeing quickly and efficiently (Steiner & Reisinger, 2006).

Wellbeing Travellers: People who have travelled to a wellbeing travel establishment at least once in the past 2 years as either a day trip of at least 50 kilometres from home, for the duration of 4 at least four hours; or at the minimum an overnight trip at least 40 kilometres from home (Tourism Research Australia, 2011).

Chapter 2: The Origin of Wellbeing Travellers

The 19th century marks a point in history when medicine became a dominant ideology and health became an important goal of a growing middle class to 'regenerate' and for 'transformation' (Crawford, 1994). The growth of medicine as a new dominant system of the body is termed the 'medicalization model' and began to replace religion, and other traditional healing practices (Conrad & Scheneider, 2010). The science of hydrotherapy and travelling for wellbeing was linked to the medicalisation model and thus participation in this activity was an expression of acceptance of this new dominant system. Simultaneously, the 19th century marks a point in history where the nature of travel was also changing substantially, from an activity of explorers and merchants, toward an activity for leisure (Theobald, 2005).

The proliferation of 'wellbeing travel' as an organised activity in the 19th century occurred at this interesting intersection between changing dominant system of body (the medicalisation movement) and the changing relationship to travel (leisure). This chapter discusses this curious intersection that enabled the development of wellbeing travel. By discussing the intersection, this chapter seeks to establish participating in wellbeing travel is more than a leisure activity. It is proposed that the events leading to the proliferation of wellbeing travel participation in the 19th century has abundant social significance, such as the relationship between health ideologies, politics and travel, health and wellbeing in relation to gender, class and social mobility.

The following chapter reflects upon the original drivers for wellbeing travellers in the 19th century, first developing in Europe and the UK, and then later in Australia. The practice of wellbeing travel was distinctly different in these two locations as a result of different political and social climates. For this reason the chapter is divided into two models, the 'Elite Model' reflecting the nature and drivers for wellbeing travel in Europe and the UK, and the 'Egalitarian model' in Australia.

The 'Elite Model' of Travelling for Wellbeing: UK and Europe.

Four distinct drivers were identified in a review of the literature for the Elite Model of Travelling for wellbeing: 1) white imperial travel; 2) the medicalisation movement; 3) medicalisation and gender; and 4) performing wellbeing and social mobility. These themes are discussed below.

Driver 1: The Growth of White Imperial Travel

The Elite Model of Wellbeing Travel was contextualised by the growth of white imperial travel. Travel was developing as a social activity in early 19th century alongside an economic infrastructure for a 'tourism industry' (MacKenzie, 2005). At the same time imperialism in UK was at its peak. MacKenzie (2005, p. 19) states:

> Indeed we often miss the fact that the British and other empires were not only empires of war, of economic exploitation, of settlement and of cultural diffusion. They were also increasingly empires of travel. They were playgrounds for the rich or the merely comfortable. They were places where various forms of cultural heritage could be explored...they offered the best evidence of progress, that defining bourgeois philosophy of the age" (MacKenzie 2005, p. 19).

According to MacKenzie (2005) the development of travel for the British in particular was a symbol of the imperial empire, of travellers conquering the lands, and an advertisement for nationalism. The creation and performance of travel was at this point an activity that potentially reflected imperial ideals. Travel was a way of distinguishing UK and Europe from the rest of the world. This is an idea discussed by Hall (2006) in the 'The West and the Rest'. Travel was one way of distinguishing the 'other' geographically and culturally from Europe, "The West produced many different ways of talking about itself and 'the Others'. But what we have called the discourse of 'the West and the Rest' became one of the most powerful and formative of these discourses. It became the dominant way the West represented itself and its relation to 'the Other'" (Hall, 2006, p. 172). For example, distinguishing the 'other' was made possible in travel writing. Devine (2013 p. 1) (speaking of the 'orient' in particular) states this form of communication has garnered interest because of its widespread influence of imperialist discourse "…early English travel narratives about the New World shaped their subject with descriptions of the 'exotic unknown' and with imperialist rhetoric" (Devine, 2013, p. 1).

Analysis of texts - the mapping, atlas and travel guidebooks of this time – found that the phenomenon of travel was aimed towards a specific market, a "white imperial 'imagined community'…Implicit in their pages is the notion, assiduously propagated by such figures as John Buchan and J.A. Cramb, that imperialism constituted an antidote to nationalism" (MacKenzie, 2005, p. 20).

The core topic of this thesis, wellbeing travel, was contextualised within this 'imagined' white imperial 'community'. Not only did travel distinguish UK and Europe from the rest of the world (Said, 1978), it also distinguished citizens of class and social standing domestically. This was particularly recognisable within wellbeing travel and is a theme continued further in this chapter. The origin of wellbeing travel, as an organised activity to improve health and wellbeing, can be traced back to water bathing in Europe and the UK. Smith and Puczko (2009) found, "the earliest reference to magical healing waters is about 700BC... ancient Greek civilizations from 700BC introduced cold water bathing for warriors" (p. 23). In Table 1 below, Smith and Puckzko provide a timeline of water bathing. With the first hydrotherapy spa in Germany in the 19th century, the point in time when travel to bathe became an organised activity was reached. The first 'hydrotherapy spa' appeared in Germany in the early 19th century "offering health packages of treatments, such as fresh air, cold water, and diet" (Smith & Puczko, 2009, p. 23), which reflects the structure of spa travel establishments today and also many lifestyle retreats.

Table 1:Taking the Waters in Europe

Year	Country/Empire	Method
700 BC	Greek civilisation	Cold water bathing for warriors
600 – 300 BC	Persians	Steam and mud baths
200 BC	Hebrews	Purification ritual in Dead Sea
76 AD	Roman Empire legacy in Bath, UK	Bathing in water
100 AD	'Spa' in Belgium	Thermal springs
211 AD	Baden-Baden, Germany	Thermal springs
Until 537 AD	The Baths of Caracalla, Rome	
800 AD	Ottoman Empire, Turkish Baths	
16th Century	Europe	Balneotherapy (water therapy)
18th Century	Europe	Sea Water
19th Century	Germany	First hydrotherapy spa

Source: Smith & Puckzko, 2009, pp. 22-23.

With the rise of formalised wellbeing travel in the 19th century, the majority of wellbeing travellers (those that frequented hydrotherapy spas) were from the upper classes. It was particularly popular among the upper class in Britain, Europe and America (MacKenzie, 2005; Smith & Puczko, 2009) with the popularity declining in late 19th century (Borsay, 2000). Ironically however, it is suggested that hydrotherapy was a treatment initially created for the poor. Father Sebastian Kneipp for example, a parish priest in Bavaria, was a founding advocate of the water cure (Kneipp, 1886 p. viii). After 30 years of study, he began practicing hydrotherapy in 1880 for everyday people, namely his parishioners. He quickly became a sought after practitioner with hundreds of patients daily "of every description and rank of life", travelling to Worishofen to seek treatment (Kneipp, 1886, p. viii).

The water cure was initially disregarded by the medical profession, Smith and Puczko (2009, p. 23) mark a change where the practice of healing from water became a mainstream health pursuit and tourist activity "By the turn of the 19th century, travel guides were promoting the health treatments of air and sun cures all over the world. The era was an increased enthusiasm for health and exercise amongst the upper classes, and active tourism became popular". The development of spa travel, frequented by upper classes, would not have occurred without the rise of the medicalisation model.

Driver 2: The Medicalisation Movement

The medical model or the 'medicalisation movement' began in the 19th century (Morantz, 1977). It was middle class Europe and America who monopolised and offered significance to the health trend, and it will be suggested further later this remains the same today in most Western societies (Crawford, 1994). Crawford (1994) suggests that coinciding with the medical model was the emergence of health as an important goal. The changes brought about by the modern world (social, economic and cultural) meant that people had to redefine themselves in this new world. Crawford (1994) commented:

> as Europe and America modernized, health became one of those projects. For the expanding middle class of the commercial and industrial societies of Europe and America, the goal of health became an essential component of

> what it meant to be modern, progressive, rational, and distinctive. The language of health came to signify those middle class persons who were responsible from those who were not…and ultimately, those who had the right to rule from those who needed supervision, guidance, reform or incarceration (p. 1349).

The medical model of health was characterised by scientific and objective knowledge of the body and the patient/practitioner relationship, which saw the body as a machine (Kelman, 1977). For instance, in contrast to previous ideologies of the body medicalization is supported by scientific knowledge; medical physicians consult with patients for diagnosis of an illness and subsequent treatment; and the physician is given a position of power over the patient. Conrad and Schneider (2010, p. 29) observe that over time the authority of the medical model has reached beyond its basic premise, crossing boundaries and collaborating with other dominant discourses. They state that "in recent years the jurisdiction of the medical profession has expanded and encompasses many problems that formerly were not defined as medical entities". There is much evidence for this general viewpoint- for example, the medicalisation of pregnancy and childbirth, contraception, diet, exercise, child development norms". Illich's (1976) well known term for the expansion of the medical profession is 'the medicalisation of life'.

It is because of this far reaching authority that many sociologists, gender researchers and social constructionist agree that the health discourse was and is one of the most powerful and dominant in society today. The medicalisation movement experienced humble beginnings, Conrad (2010, p.33) comments the authority of this has only taken shape within the past two centuries, and was established only once a collaboration with religion was reached. Conrad (2010, p. 9) states "early Christianity depicted sickness as punishment for sin, engendering new theological explanations and treatments. Christ and his disciples believed in the supernatural causes and cures of disease". Instead of religious 'punishment', the medical model professed scientific knowledge, a seemingly more objective, and therefore, trustworthy source of knowledge. The medical model offered treatments for restoration of the healthy body. The goal of a healthy body then became a symbol of the highly valued protestant work ethic where 'healthy habits' were pursued for their value in achieving and

demonstrating regularity – “the daily discipline of diet, dress and manner” (Greven, 1977) and the most valued social role of that time.

Like religion, the control of health was imperative to a functioning society. It is with this example of the protestant work ethic, it becomes clear that the individual functions within, and for the overall good of, the entire social system (Parsons, 1951). A healthy citizen can complete the work that is of most benefit to a functioning society. For instance, Parsons (1951) observes that a healthy population is imperative for individuals to fulfil their social roles, and that illness was ‘dysfunctional’ to the social system, “but in so far as it is controllable, through rational action or otherwise, it is clear that there is a functional interest of the society in its control, broadly in the minimization of illness” (p. 430). Therefore, to sustain the work ethic, a dominant discourse of health was necessary. It is suggested that the medicalisation movement developed and gathered authority when it became useful to the functioning of the social system.

Parson’s (1951) perspective regarding illness and the functioning social system gives credence to the idea that an increased interest in ‘taking the waters’ occurred for both cultural and medicinal purposes (van Turbergen & van der Linden, 2002). Taking the waters or hydrotherapy, became an often prescribed treatment for numerous ailments which consequently required travelling to hot spring spa’s towns. Bathing in the water, spa goers were often in attendance due to a physician’s orders - physicians were also on hand at spa locations (Paige & Harisson, 1987; Wood & Kroger, 2000). Individuals were given treatment plans which usually consisted of residing in the spa town for a month, and bathing once or twice a day (Paige & Harrison, 1987). Van Turbergen and van der Linden, (2002) reported that:

> doctors were convinced that for each disease Mother Nature possessed an appropriate medicinal spring, which could be discovered through chemical analysis of the waters. Individual treatments were prescribed, based on the composition and temperature of the water. Also, combinations of treatments were developed consisting of hot and cold baths, herbal baths, mud packs, active physical exercises, massages, and diets (p. 275).

The medicalisation movement characterised a new ‘ideal’ state of the body to be achieved for the purposes of maintaining a functioning society. Women in particular were medicalised.

Driver 3: Medicalisation and Gender

Three defining characteristics of the medicalization movement have been stated so far; scientific and objective knowledge of the body, the authority inherent in the patient/practitioner relationship; and the collaboration of medicalization with other dominant ideologies such the protestant work ethic (Conrad & Schneider, 2010; Crawford, 1994). These characteristics result in what sociologists consider a very powerful discourse guiding the values and rules of society.

Further characteristics define the scope and influence of the medicalization movement. The medicalization movement served to ensure a culture of inequality amongst men and women, and also between upper class women and working class women. First, family health was considered to be the concern of the mother, or female in the family; secondly, a key focus of the medical model became the control of reproductive process and mental health of middle and upper class women. As such, illnesses contained upper class women as weak and useless, and working class women as robust, capable, yet unhealthy (Carpenter, 2009; Crawford, 2000; Morantz, 1977).

Women's bodies and functions were no longer in the hands of midwives or female healers, instead it was a public matter (Ussher, 1991) with numerous activities centred upon diagnosis and treatment (Carpenter, 2009). Doctors, gynaecologists and other such specialists emerged unwrapping a discourse upon which "comfortable living, combined with worry, was making white women of the middle and upper classes soft and decadent" (Briggs, 2000, p. 247). It was suggested as a consequence, women were not capable of engaging with activities such as education or politics and instead were busy attempting to reclaim good health.

This perpetual state of illness was described as *invalidism*. Some believed women's invalidism (Ehrenreich & English, 2011) transpired as a symptom of perceived 'over civilisation' (Briggs, 2000). Evidence of this is found by Wood (1973, p. 26) who states that between 1840 and 1900, published books overwhelmingly supported the notion that most American middle class women were sick.

Some women would take on their own and their families health as a mission, or health reform as a forum for women's empowerment (Morantz, 1977). Others within this environment, joined the culture of invalidism and the lifestyle that entailed. Ehrenreich and English (2011) comment that invalidism was a cause of boredom and

“the boredom and confinement of affluent women fostered a morbid cult of hypochondria – ‘female invalidism’... sickness pervaded upper and upper middle class female culture” (p. 17).

Weir Mitchell (as cited in Briggs, 2000, p. 254) supported the knowledge that upper class women were unable to cope with much at all. The hard work of belonging to a privileged class and the fragility of upper class women is again expressed here by Mitchell. Most symptoms of invalidism were associated with women as reproductive beings, for instance the disease impacted upon the women’s ability to reproduce and simultaneously, the inability to reproduce was a symptom of hysteria. The reproductive duties of women were considered the most important element of women’s social roles, therefore the inability to reproduce was accompanied by the label ‘incomplete feminisation’ (White, 2002). Without reproduction, the female was not really a female at all and her body was a site of deviance and morality judgments.

For some time, gender researchers have considered hysteria and invalidism, rather than a medically diagnosed disease, as a cultural phenomenon (Briggs, 2000; Ehrenreich & English, 2011) and a method of social control. Instead of pursuing education or involvement in politics, the perceived sick upper class woman became busy with restoration and self care. Along with the authority to make judgments upon the deviant and moral body, the medical model maintained its authority with physical interventions to heal. Some forms of medical treatments included “bleeding, extended bed rest and for women, surgery to remove the ovaries” (Briggs, 2000, p. 247). Additionally, treatments involved women’s participation in what we now term wellbeing travel as “health spas and female specialists sprang up everywhere and became part of the regular circuit of fashionable women” (Ehrenreich & English, 2011, p. 17). Middle to upper class women were in a perpetual state of sickness (Wood, 1973, p. 26) and doctors often prescribed hydrotherapy to help with these ailments. Together these propositions suggest that the act of participating in wellbeing travel/spa travel is not merely a ‘leisure’ activity. It is in fact an activity that has abundant social significance.

In Europe and the UK, the spas were mostly populated by females, both as staff (Herbert, 2009, p. 368) and the attendees, who were predominately the elite and rich (Paige & Harrison, 1987). Travelling a good distance from home to stay for weeks or months, taking the waters provided a sense of purpose and a direct visible action of improving one’s health, and “in Europe, one would ordinarily take a

vacation form daily life and travel to a spa for a prolonged period of time, usually 14 to 21 days" (Altman, 2000, p. 16). With a sense of self responsibility and an engagement in one's own health, regular travel to a spa town was a popular pursuit. Small bathhouses and drinking pavilions were joined by larger and more elaborate bathhouses (Paige & Harrison, 1987). Paige and Harisson (1987) suggest this occurred to meet the demand for the detailed bathing rituals that had become fashionable. The women travelling for wellbeing were therefore unequivocally engaged with the medicalisation discourse, and taking the waters was a symbol of morality to restore the deviant, sick female body.

The bathing experience, 17th to 19th century and beyond, was quite a trial and process for females. Herbert (2009) speaks of one documented bather, Celia Fiennes:

> Although Fiennes admitted that the baths were crowded, she explained that the practice was to hire two female water guides, one stationed at each elbow of a female bather, kept the patron upright while she was in the pool, 'for the water is so strong it will quickly tumble you down'. (p. 365)

Exhibiting her frailty in the strong waters, the women's rituals involved elaborate cloth dress to hide their form from the other bathers, to which again, the hired staff were needed (Herbert, 2009). Further assistance was needed to help the female negotiate the crowd:

> But in order to protect completely an elite female spa patron from the press of the swimming crowd, Fiennes reported that it was usual to hire, '2 of the men guides (to go) at a distance about the bath to clear the way' during an aquatic perambulation (Herbert, 2009, p. 365).

This description of the female participation and experience of travelling for wellbeing fits with the experience of the female at this time in history. Across history numerous discourses of deviance and restoration have operated regarding women and their bodies, in accordance to class and race. In comparison working class women were somehow exempt from the afflictions of the upper class women. These distinctions, highlight how health and wellbeing was a narrative of social division. Many researchers are interested in the logic employed to explain why working class women were thought of differently (Briggs, 2000; Ehrenreich & English, 2011). Working class women were not considered to be fragile like the upper class women

and consequently were expected to continue with work, child bearing and a variety of unsatisfactory life conditions (Briggs, 2000). They were perceived as strong, child bearing vessels, although not necessarily healthy. Briggs (2000) notes that working class women were not to be respected for their strength, they were "robust, just as they were supposedly 'coarse' and 'immodest" (p. 244). Therefore, it was class or maybe genetics which was the cause of one group of women to be inherently sick and the other group of women inherently strong (Briggs, 2000).

Ehrenreich and English (2011) discuss how auspicious these class differences were, since working class women could not afford medical care but upper and middle class women had the time and the financial means to pursue extended and perpetual medical care. Ehrenreich and English (2011) also observe the irony that female invalidism was an indicator that privilege was 'hard work'. Indeed, it was fashionable to be an invalid. Wood (1973) writes of research undertaken in 1866 by Beecher (a female pioneer of health and hygiene) who asked a number of women to report upon 10 friends and the state of their health. The results established that none of the women knew of a healthy woman, of this Wood stated:

> and what woman in 1855 wanted to admit to so crude a state as robust vitality?...women in the middle ranks of society whose health concerned Beecher, were more often than not bearing up under a burden of sickness that would have incapacitated any less noble being. (Wood, 1973, p. 26)

Wood (1973) suggests to be sick was fashionable and noble, the level of sickness and hence survival commanding a sense of respect from others. Wood (1973) also suggests the culture of invalidism (a 'cult' as described by Ehenreich & English, 2011) was 'exploited' by both patients and practitioners as an excuse to remove themselves from life responsibilities, or as Wood (1973) states, from the "too pressing demands of bedroom and kitchen" (p. 27).

The connection of medicalisation and gender with travelling for wellbeing is a further indication (like white imperial travel) of how culture informs an understanding of how wellbeing is achieved and practiced, at one particular time in a society. The process of visiting a doctor, being diagnosed with an illness that is gender, class and race specific; travelling a large distance and conforming the rituals and rules; indicates the effort and diligent behaviour required to restore the body in accordance with the values of the medicalisation model and cultural gendered ideals of the time.

Driver 4: Performing Wellbeing: Social mobility

A substantial body of research outlined above suggests that women performing the culture of invalidism and participating in spa travel, were victims of social control. Alternatively, or in addition, researchers further suggest taking the waters for women became less about healing, and more about socialising, exercising social mobility and exclusionary practices. Numerous secondary benefits are identified in the participation in wellbeing travel suggesting a certain amount of agency on behalf of the women.

Bourdieu's (1992) concepts of culture can be adopted to show how participation in wellbeing travel could offer a secondary benefit to achieving 'health', that is a symbol of social status and exclusion of others. Although it is common to assume 'economic capital' is the most valued or resource for humans (Adler & Kwon, 2002), it is suggested cultural capital are further resources to determine an individual's social position and access to social mobility (Bourdieu 1992). Cultural capital refers to the use of cultural knowledge as symbols of exhibiting a higher social status (Gauntlett, 2011) such as "familiarity with relevant institutional contexts, processes, and expectations, possession of relevant intellectual and social skills" (Edgerton & Roberts, 2014, p. 196). Bourdieu also suggests cultural capital is 'another tool in the armoury of the elite deployed to ensure that the 'wrong' kind of people don't enter their circles" (Bourdieu, 1986, 1992).

The underlying social motivations for elite wellbeing travellers are evidenced in writings about spa goers in Saratoga, by Sarah J. Hale (1828, p. 347). She notes the importance of cultural knowledge in the success of the visit, such as dress, and correct manner amongst the women. Sarah observed two types of spa goers, those who are unwell and those who are there to relax. However, of the latter, she observes that relaxation does not occur, she said "They never appear to lay aside their cares or give themselves up to the enjoyment of the present pleasure…they are remarking, reasoning, scheming. There is a restlessness in their movements". Sarah thought this was because being at the springs is a socially correct or acceptable practice, to be seen in public as attending the spa and taking care of health:

> the latter think there is a necessity, a reason for their continuance at the Springs. But the healthy ones are in a constant state of excitement to find pleasure, which prevents them from finding it…I meet with but few that pretend to take much satisfaction in this kind of life, they only say it is

> necessary as a relaxation – but I guess they will, the most of them, be glad when they are safe at home again (Hale, 1828, p. 347).

In accordance with the cultural capitol concept, the baths were a space where social networking between women could occur and a place to be seen by others. Herbert (2009), whose research details the history of gender and the spa, offers a further view of the purpose of spa participation, he comments that:

> we understand the spaces of the spa as those populated by wealthy elites, sites which allowed privileged women and men to leave their duties, families, and the 'uncouth' behind in the pursuit of elite frivolity, gambling and sex. (p. 362)

There is further evidence to suggest accruing cultural capital through social relations was a key driver for spa travel. At this time in history female relationships were particularly important, Rosenberg's (1975) research regarding the female to female relationships in the 19th century, suggests these relationships included strong emotional ties and dependence, for affection. An analysis of correspondence and diaries from 1760's to 1880's between various women, found friendships fulfilled many of the needs that 18th and 19th century women were perhaps not finding in their own home (Rosenberg, 1975, p. 3). Homes were often remote and once married, women would have to travel long distances to see each other, Rosenberg (1975) reported many lonely women whose correspondence with other females sometimes lasted a lifetime. Herbert's (2009) research of women who attended spas and Rosenberg's (1975) research upon female relationships together present a picture of lonely and fragile women. Herbert (2009) concludes from women's letters and documents that females travelled with female companions and family, engaging with socialising, networking and other entertainment activities provided in the spa towns. The female presented in this literature conforms to the male physicians methods to restore her body and establishes 'networking' and 'socialising' as a secondary gain of participation in wellbeing travel.

Conclusion

The elite model of wellbeing travel was characterised by the intersection of two changes in 19th century UK and Europe, imperial travel (MacKenzie, 2005) and

the medicalisation model (Conrad, 2010; Morantz, 1977). Women performed the medicalisation model in wellbeing travel, to conform to the values of the body at that time, social mobility and for friendship (Briggs, 2000; Herbert, 2009; Rosenberg, 1975). The four drivers, 1) White Imperial Travel; 2) The Medicalisation Movement; 3) Medicalisation and Gender; and 4) Performing Wellbeing and Social Mobility, reflect upon reasons why women travelled for wellbeing in UK and Europe, taking a historical and sociological perspective. These themes also highlight who is excluded from travelling for wellbeing and why. Those who were not upper class or middle class were less likely to visit a spa, and perhaps also men were less likely. In Australia, similar motivations for wellbeing travel occurred, however there are also significant differences.

The Origin of Wellbeing Travel in Australia: The 'Egalitarian Model' of Travelling for Wellbeing

Research regarding wellbeing travel in Australia (whether today or historically) is scarce. Whilst visiting the mineral springs also became popular in Australia in the 19th century, White (2012) suggests the experience was quite different to that of Europe and UK. For these reasons this section provides the similarities and distinguishing features of Australian travel for wellbeing rather than drivers.

Distinguishing Features: Multi-cultural, Medicalisation and Egalitarianism

Table 2: The Origin of Mineral Springs in Australia

Year	Place	Action
1836	Victoria, Australia	Captain John Hepburn discovers springs.
1860's	Victoria, Australia	Push to protect and declare Hepburn Springs as a tourist destination.
1870's	Hepburn Springs, Victoria Australia.	Hepburn Springs was known as a spa resort town. Numerous guest houses opened up at this time.
1894	Daylesford, Victoria, Australia.	The opening of Daylesford's first Bathhouse.

Source: White (2012).

In comparison to Europe and UK, Australia has a much shorter history as a country settled by a large population of white people. Prior to white settlement, the indigenous people had their own rituals and beliefs in regard to springs and bathing (Pearn & Little, 1998; White, 2012, p. 86). However, as a tourist destination, it is recorded that the springs were discovered in the Hepburn Springs district, Victoria, Australia in 1836 (Webb, 2005) by Captain Hepburn (Tourism Victoria, 2007). Springs in the surrounding towns like Daylesford were also discovered (Tourism Victoria, 2007, p. 19) with the area containing "over 80% of Australia's mineral water reserves" (Lawrence & Buultjens, 2009, p. 9).

European gold searchers were already acquainted with mineral springs from their homeland, so with European Settlement (1890's to 1930's) the commercial development of the springs in Victoria began (Tourism Victoria, 2007, p. 19). Bathing, consumption of the water and socialising were the drawcards for patrons (Tourism Victoria, 2007, p. 20).

White's (2012) research traces the historical context of the mineral spa movement in Australia finding three key themes to distinguish the culture. The first cultural theme is that although White Australia was predominantly British settlers at this time, the mineral spa culture was not a reproduction of British Spa's, as "there was always a 'continental' rather than a British tone to the spa culture of Daylesford

[a town nearby to Hepburn Springs]: it was by no means simply a transplantation of British spa culture to the colonies" (p. 86). Instead the mineral spa culture offered a 'cosmopolitan culture' for the white community and a 'refuge' for the non British Australian settlers such as the Italians (White, 2012, p. 87).

At this time in the Hepburn Springs there was a large Swiss-Italian population, "from 1851 to 1855, about 2000 northern Italians and Swiss came to Daylesford…more came later." (Webb, 2005, p. 5). This population pursued the establishment of the springs as a tourist destination and protection from mining (Gervasoni, 2005, Lawrence & Buultjens, 2008), a fact that White (2012) says is largely ignored in the marketing by current mineral springs service providers.

The second distinguishing feature of the spa culture was similar to the previously discussed Elite Model in that the motivation for taking the waters sprouted from science and medicine (White, 2012, p. 87). That is, similar to Europe and UK, taking the waters was thought to be participated in for medicinal purposes. An example Ludwig Bruck (who features in much research regarding Australia tourism and spa development) who expressed the desire to build a spa resort 'developed as medical facilities' to mirror those in Europe resulting in the Clifton Hotel and Spa Company in 1887,

> [Bruck] built a hotel with 'tastefully' landscaped grounds, 'rustic seats and swings', a tennis court, a pavilion and pump room and sea and hot mineral baths, which were 'said to have proved highly beneficial in cutaneous affections, gout, rheumatism and piles' (White, 2012, p. 90).

The final characteristic however, provides a contrast to European spa participation, White (2012) suggests that in its origin, Australian spa participation included a culture of equity so that the class disparity noted in the UK spas – did not translate in Australia:

> Australia was conspicuously egalitarian: that is not to say social class and class consciousness were not significant in Australia-indeed it can be argued that class mattered even more in a society where there was such social fluidity - but that the culture claimed to be relatively classless and democratic conventions prevailed. (White, 2012, p. 91).

A culture of equity with bathing is evident in the picture below. The picture depicts the opening of the St. Kilda Sea Baths in Victoria in the 1850's. There is no way of knowing who exactly is in the crowd and what it represents, however, instead of a small elite there is a large crowd of people, children, men and women. The photo appears consistent with White's (2012) egalitarian claims.

Source: http://www.portphillip.vic.gov.au/tourist_attractions.htm

Figure 1: The Opening of the St. Kilda Sea Baths, Victoria in 1850's

White (2012) states that spa participation was "generally free" and suggests a conscious effort was made by some proprietors to provide accommodation for those who wanted "good hotels, furnished rooms and houses, restaurants, and cafes [sic] to suit all classes, must also be available" (p. 91). A concerted effort was made to maintain this value, for example:

> the Daylesford Herald Almanac put the democratic case forcefully in 1885...it said: [of the spring before 1885] 'In those days the spring was free to all, but several attempts being made to enclose it, and thus monopolise the precious fluid, the municipal council took the matter in hand and very properly adopted such regulations as would prevent the greed of some depriving the general public of a fair participation in the blessing. (White, 2012, p. 92)

Another reason an egalitarian culture was present in the Hepburn Springs was that the upper classes would instead travel internationally to participate in the already

established spas of Europe, which did include the already established upper class culture (White, 2012, p. 100). The Elite Model presented above did not occur to this extent in Australia. Shirtless men and families took the waters in Australia (White, 2012).

The culture of mineral springs and the development of a form of wellbeing travel in Australia is presented by White (2012) as an egalitarian establishment in contrast to British spa participation at the same point in history. It is suggested this occurred because the Hepburn region was populated by European immigrants, combined with the egalitarian values which was infused in the early settlers, provided an environment which was less saturated by the British gentry (Russel, 1994). The egalitarian values demonstrated here should be celebrated. Making an absolute claim that Australia was predominately an egalitarian society (Hirst, 1988) is problematic. It is marred by the struggle of the British gentry to maintain their status and importance once they had settled in Australian society.

"Crowds of shopkeepers ... very few gentry (quoted from Jane Macartney)" is the beginning quote used by Russel (1994, p. 1) to highlight the discontent of the gentry in Australia. The struggle to maintain status in Australia was attributed to "the fluid and uncertain colonial world" (Russel, 1994, p. 2). After the gold rush of 1850's, Australia was full of ex-convicts, migrants and a small population of gentry whose traditional claim to their status was not necessarily applicable anymore and "those who defined themselves as 'gentry' were overwhelmed by a world full of strangers who they did not wish to meet" (Russel, 1994, p. 1). The gentry were not successful in preserving social and political dominance, yet, even though they did not want to liaise with the rest of the population, they did wish to maintain their place at the crest of the society (Russel, 1994, p. 7). Russel (1994) states the gentry adapted to their new society and learnt new symbols and practices to display their status, achieving 'cultural' dominance. It was women in particular who struggled in this time, therefore it was women who constructed the cultural society by 'performing gentility'. Performances were made in social occasions such as balls, theatre etc. (Russel, 1994):

> Through the creation of a complex, self-defined 'Society' they controlled and defined the social practices and knowledge which were deemed necessary for the acquisition of prestige in the city. Melbourne Society was dominated by standards, rituals and language which drew upon a model of gentility, and

> these were absorbed and adopted by the newly wealthy as legitimation of their own social position. (Russel, 1994, p. 7)

Therefore, in this example of society in Melbourne, Australia was not without class struggle (see Davidson, Dunstan & McConville, 1985). In fact, it was social occasions where demonstration of class distinction was made possible.

The Hepburn Springs was just one form of wellbeing travel that developed in the 19th century for Australian settlers. Class performances were demonstrated in a different form of travelling for wellbeing within the seaside resort holiday. Resorts were developed to mimic the England seaside. Inglis (2000) comments:

> Australian resorts styled themselves 'the new Margate' or adopted names like Torquay, Brighton, Cowes and Rye. In defiance of the obvious physical differences, most resorts set out to imitate the appearance of English seaside townships, complete with pavilions, piers, promenades and unwieldy bathing machines. (p. 20)

Similar to the mineral waters, sea resort attendance was motivated towards improving health and wellbeing (Inglis, 2000). The sea water and the climate was thought to be remedial as "pure cool air and a salubrious climate were held to assault germs in the atmosphere" (Inglis, 2000, p. 20). Inglis (2000) emphasises the British influence of the medicalisation of the water as "was widely shared in Australia and contributed significantly to the prescriptive and serious character of the seaside sojourn" (p. 23). Current understandings of the seaside culture in 19th century Australia is similar to the popular image of egalitarian culture described by White (2012) in the travel to the mineral springs. Inglis (2000, p. 22) suggests current research has too quickly concluded that the 19th century holiday by the beach, was a public destination where Australians unwind, "have fun, relax and enjoy themselves in an informal and hedonistic manner" (Inglis, 2000, p. 22). Also a part of this popular image was that the beach culture contributed to reduce class difference (Inglis, 2000, p. 22). Inglis instead considers that it is popular images of the seaside in Australia in the 20th century and beyond that have constructed these notions about egalitarianism as "this modern way of seeing has tended to overshadow any other view of the shore and has served to obscure the very different nature of the seaside in the 19th century" (Inglis, 2000, p. 22).

Inglis (2000, p. 22) instead describes seaside resort participation as a performance, specifically as a reproduction of the English format; not unlike the performances of the gentry re-establishing their status in society in social occasions, which was described by Russel (1994, p. 9) as:

> A trip to the seashore then was a serious and ceremonious undertaking. It was associated not so much with pleasure and amusement as with fanciful activity, the improvement of the mind and body and the demonstration of status and class.

For Inglis (2000) social class performance in Australian seaside resorts was for the purposes of identifying and demonstrating class difference as "the more distant the coastal resorts provided an exclusive stage for the performance of a variety of upper and middle class rituals and observance which affirmed class distinction and social status" (Inglis, 2000, p. 22). Inglis (2000, p. 22) suggests that for most of the 19th century, spa participation or the 'conduct' of participating was defined by upper to middle class values. This meant anyone who attended the seaside resort had an unwritten rule book of behaviours and an awareness of 'class consciousness'.

Conclusion

The discussion so far has outlined the origins of wellbeing travel in Australia and Europe and UK. Two forms of travel were conceptualised based upon the literature. In Australia the structure and participation in wellbeing travel reflected an 'Egalitarian Model' and the UK and Europe, an 'Elite Model'. Four distinct themes were identified to have driven travel in the Elite Model of Travelling for wellbeing. First, travel was driven by 'White Imperial Travel'. The traveller was a person of certain social status. The development of travel for the British was a symbol of the imperial empire, of travellers conquering the lands, and an advertisement for nationalism (MacKenzie, 2005). Secondly, 'the Medicalisation Movement' was a new dominant ideology prompting the desire of middle and upper classes to achieve 'health'. The third driver 'Medicalisation and Gender' explained that within the medical model women in particular were subject to social controls of the body. The medical model labelled women as sick, and offered restoration. Wellbeing travel was one consequence or restoration of this narrative. Fourth was the driver 'Performing

Wellbeing and Social Mobility', the secondary benefit to travel for women was to increase 'social mobility'. To 'perform' health, to be seen by others to be achieving or participating in health, was a symbol of social status.

With the 'Egalitarian model' in Australia (Daylesford) taking the waters was also foremost driven by a medicinal curative function (White, 2012, p. 87). As such, a key driver shared between the two models was medicalisation. A further important theme to emerge from both models was that travelling for wellbeing occurred as a performance. It was a performance of upper to middle class in the seaside resort in Australia and in the UK, and a demonstration of egalitarianism in Australian mineral springs. Travelling for wellbeing was a performance of 'health', class and class distinction. Particularly in the Elite model, performance of health and wellbeing was played out at the springs and introduced the theme of inequality or exclusion where health is for some and not for others, and travel for some and not for others.

The specific point of difference between the two models (Australia and the UK/Europe) is the social and political history and how wellbeing travel was socially constructed. The historical context of wellbeing travel in Australia demonstrates a clash of many cultures and cultural ideals that is highly reflective of Australia today. A model that enables the presence of egalitarianism yet the confusion of a British influenced society. Australian settlement saw a push and pull regarding how participating in taking the waters was to be defined. As suggested by White (2012), the British settlers wanted to reproduce the Elite model, yet the Swiss Italians were more interested in an Egalitarian model. Literature suggests the Egalitarian model triumphed at this point in history. However, the seaside developed in Australia as a direct reproduction of the British Elite Model of travelling for wellbeing.

The 'Egalitarian model' was based upon the premise that taking the waters was an activity open for anyone to participate, male, female, of any class. This model was apparent in Daylesford in the inception of the springs.

The origin of wellbeing travel with Elite and Egalitarian models, demonstrates key propositions for this research. That is, participation in wellbeing travel was driven by more than just a whimsical desire to travel or a leisure activity. The significance of participation is varied, it can tell us a lot about the social and cultural histories of a country and its society. Participation in travel can demonstrate a performance of time specific social and cultural ideals.

Today, there is a renewed interest for wellbeing travel in Australia (Bennet, King, & Milner, 2004; Biging, 2009) and it exists within a more formalised tourism industry. Travel is accessible to a majority rather than a minority and participation is a cultural norm (Dann, & Cohen, 1991). Having reflected upon the possible drivers for participation in the past, this project seeks to explore the drivers of wellbeing travellers in Australia today whilst additionally drawing attention to constraints to travel and subsequent non-travel.

Chapter 3: Wellbeing Travel Today in Australia and International Trends. Re-imagining the Elite and Egalitarian Model

The Definition of Wellbeing

The political context of the body has changed since the origin of wellbeing travel in the 19th century. The body has changed governance from the medicalisation movements philosophy of reactive 'health' and the body as a machine (Kelman, 1977) to a de-medicalisation movement's philosophy of total 'wellbeing' and preventative health.

The narrative of health today has evolved to incorporate the terms 'wellness' or 'wellbeing'. For some time, the term 'wellness' has represented a movement in public knowledge toward health consciousness. It emerged in the 1950's as a concept supporting "active health promotion through lifestyle change" (Miller, 2005, p. 84). The term 'wellness' is a historical marker of the movement away from understanding good health as a mere physical manifestation. It particularly represents western societies movement away from medical health and the medicalisation movement towards preventative health.

In fact, the term wellness was a very deliberate conception as "the concept of wellness initially emerged in reaction against what is called the medical model of health which describes health or wellness as the absence of illness infirmity or disease of the mind or body" (Steiner & Reisinger, 2006, p. 6). The term was coined by Dunn, a medical practitioner who captured important ideas about wellness in 1959. Dunn (1959) located wellness as closely related to health, or the complete representation of health.

Dunn's (1961) perspective reflected a critical analysis of wellness. He called for an upheaval by medical and health workers to begin an investigation aimed to understand all dimensions of preventative health (Dunn, 1959). Dunn's (1959, p. 786) assertion was in response to 1) the tendency to view an individual's health mainly in terms of their physical body, and 2) what Dunn believed was a changing "demographic, social economic and political character of civilisation" impacting upon individual's wellness like never before.

Additionally in 1997 Fox (1977, p. 13) stated professionals in the medical realm, "consumer and 'civil-rights groups' published a growing critical perspective

which identified the concern of the medical models ability to label what is normal, abnormal and to then manage redemption" (Fox, 1977, p. 13). In combination with the increase of published material identifying the potential power of the medical model, Fox (1977) observed other actions from the general public that pointed toward a desire for change. Namely a need to take control of one's own health from the doctor to the patient, "the family, and the home". Fox (1977, p. 17) observes this in the revisited interest in midwifery and home births; and the movement away from using the term 'patient' toward 'consumer' or 'customer'. Lowenberg and Davis (1994) state that the doctor patient relationship is now thought to be more of a 'consultancy' where the patient (now the consumer) consults the medical doctor as one part of the information gathering process upon which they will make the decision about how best to be treated.

The idea that we should aspire towards 'high-level wellness' - including the unity of mind, body spirit – has provided a starting point for wellbeing travel research attempting to explain the current eruption of demand for tourism and wellness or wellbeing.

The de-medicalisation movement and the ideology of wellbeing has replaced the medicalisation movement as the institutional structure to govern the ideal physical state. It has provided the setting for a health consumer - empowered customers in control of their preventative health. Therefore, it is suggested, it has provided a stage for the new wellbeing traveller.

Despite the force of the de-medicalisation movement, it is difficult to find a consensus about the definition of 'wellbeing' today in academia or any other sector. In its most simple form it can be defined as follows; "The term *well-being* usually refers to the degree to which an individual is well" (Veenhoven, 2000, p. 1). Veenhoven's (2000) definition creates a foundation but also more questions. The definition does not declare how or at what point wellbeing is achieved, who decides when an individual is well and to what degree they are well. It begs the questions, is wellbeing a subjective or objective measure?

Subjectivity and relativity are inescapable when asking at what point someone is well or not well. A definition of wellbeing is dependent upon culture and time in history. For some, being well might be access to an adequate amount of food, shelter and physical comfort. For others who already have food and shelter, wellbeing might mean an ultimate state of enlightenment and a pain free human existence.

To provide some clarity, in this thesis I focus upon the meaning of wellbeing today in the current culture of the Western world. Carlisle and Hanlon (2007) suggest to understand anything about what drives wellbeing today, we must first understand the culture from which it derives. This is because we are shaped by and pull from our culture including our "beliefs, values and systems of symbolic meanings" (Carlisle & Hanlon, 2007, p. 262). The role of culture is a key component to define and understand what wellbeing means for a particular group of people. The characteristics of culture that are particularly shaping wellbeing, according to Carlisle and Hanlon (2007), are capitalism and a consumerist culture. Wellbeing is a product of capitalism/consumerism and commodification and as such, a meeting of the two is the understanding of wellbeing as "synonymous with a 'state of virtue…an affirmation of the consumerist values of mainstream culture" (Carlisle & Hanlon, 207, p. 264). In accordance with Carlisle and Hanlon (2007, further narrowing the definition in this thesis is then the commodification of wellbeing driven by today's culture.

So far, the difficulty in defining wellbeing is acknowledged and perimeters are set to examine Western cultural wellbeing today. However the tension between various discourses of wellbeing in Western culture are of key importance to the thesis research questions; when examining the drives and constraints to wellbeing travel and how it is socially constructed.

Four discourses of wellbeing are clarified by Carlisle and Hanlon (2007) and are useful to begin discussing this tension. The 'scientific discourse' grounds wellbeing in academic disciplines and medicine, such as biology and neuroscience and psychology. The 'popular/political discourse' represents a business driven representation of wellbeing aimed at the general public that is thought to 'sell well', "terms such as 'well-being' are used interchangeably with notions of 'happiness' and 'positive emotions'" (Carlisle & Hanlon, 2007, p. 264).

The 'environmental discourse' of wellbeing declares the consumerist lifestyles of people today have peaked to a point that is ultimately leading to "discontent, disharmony, depression and division" (Carlisle & Hanlon, 2007, p. 265). The environmental discourse represents the idea that our wellbeing has declined and will decline further because current lifestyles are beyond our environmental and social means and ultimately will end in a disastrous collapse.

The popular and environmental discourses encapsulate a body of knowledge that perceives the current state of society to be the cause of being 'unwell'. This body of knowledge has historically featured in western societies. Research has used such terms to describe this narrative such as, 'social acceleration' (Scheuerman, 2005), to represent the increasing busy status of society today. Alternatively, Gerhuny (2005) explores "busyness" as the juxtaposition between increasing perceptions of being busy and the development of leisure in western societies since the 19th century. The 'critical discourse' (Carlisle & Hanlon, 2007, p. 264) of wellbeing peels away the layers of the former three and examines what wellbeing represents, how culture influences our bodies and what this tells us about society. For example, the perspective that wellbeing has become commercialised and in the absence of religion or other governing systems of the body, pursuing wellbeing fills the gap to construct "authentic selves" (Carlisle & Hanlon, 2007, p. 264).

As a stand alone concept, the pursuit of wellbeing is a positive goal for people. However, Carlisle and Hanlon (2007, p. 264) suggest, as the pursuit of wellbeing becomes increasingly connected to identities, it is also becoming increasingly commodified, and would be beyond the reach of the average Australian. Sociologists such as Crawford (2006) and Conrad (1994) offer a similar critical perspective of wellbeing. Crawford (2006) pinpoints the importance of wellbeing particularly for middle class identities and Conrad (1994) provides the term 'wellness' seekers. Both Conrad (1994) and Crawford (2006) study a moral health narrative that since the beginning of the de-medicalisation movement it is important to be healthy and perceived by others as healthy.

Specifically, this thesis deals with the tension resonating in Carlisle and Hanlon's categories. Between the dominant knowledge imparted to the general public with the 'scientific', 'environmental' and 'popular' discourse of wellbeing and the less public body of knowledge in the 'critical' examination of wellbeing.

This section has discussed the movement away from the medical model for health towards wellbeing. It has acknowledged the lack of consensus about the definition of wellbeing and provided a perimeter for discussing wellbeing in this thesis. Wellbeing is understood as a relative and subjective concept. An understanding of wellbeing is characterised by a consumer culture and for this reason is an inherently unequal pursuit. Following from this context of wellbeing, the section below examines Wellbeing Travel today.

Wellbeing Travel Today

All travel can be thought of as motivated towards improving health and wellbeing. Wellbeing travel however, are activities that take place at a single destination or establishment, aimed to improve wellbeing quickly and efficiently (Steiner & Reisinger, 2006). Chapter 2 established that this formalised wellbeing travel began in the 19th century and was mostly an activity undertaken by upper classes. Travel at this time necessitated money and social standing. Today wellbeing travel continues to be a commodified activity, connecting the pursuit of wellbeing to the consumer culture. Today it can be questioned if social standing is a pre-requisite for Wellbeing Travel, but money is certainly a constraint. The discussion above has also stated the governing system of the body has changed since the origins of a formalised wellbeing travel in the 19th century. Similarly, the value and meaning of travel for health has changed dramatically since the 19th century.

The diversity of service providers has grown beyond mineral springs/spas to include lifestyle and spiritual retreats that practice alternative medicines, activities and nutrition. The mineral springs/spas evolved (or devolved) into pampering, beauty and relaxation rather than a medicinal treatment of illness. The popularity of the mineral springs/spa to treat physical health or illness began to wane in Europe when "better health care regimes and preventative wellness techniques, spas have shifted from physical and medical to more relaxing and pampering activities (Smith & Puckzko, 2009, p. 24). Nevertheless, there is evidence to suggest there are still similarities in the construction of wellbeing travel (Elite or Egalitarian) and the way people understand and participate in wellbeing travel today. As stated above, the consumer culture connected to the pursuit of health and consequent social inequality associated with the pursuit; the importance of achieving health and a performance of health.

This chapter outlines the international re-interest in wellbeing travel within the past decade; the growth in Australia and the profile of the wellbeing traveller. Additionally, the need for further research in Australia is highlighted as currently little research has focused upon exploring the re-interest in wellbeing travel today.

The Growth and Categories of Wellbeing Travel in Australia Today

Although it has historical origins in other parts of the world, the wellbeing travel trend today has grown (Berhens, 2007; Smith & Puczko, 2009) particularly amongst Western nations and the middle class (Crawford, 2006). International trends are reporting an increase in wellbeing travellers within a significantly profitable sector. In 2010, research conducted by SRI International found the international wellbeing travel sector is worth $106 billion (Global Spa Summit, 2010). The SRI estimates the wellness tourism sector to represent an international market size of US $106 billion[1].

In Australia particularly, it is reported the demand for wellbeing travel has grown considerably in the last 10 years. For instance spa visitation in particular is increasing 13.8% annually during the period 2001-2004 (Tourism Victoria, 2010, p.11). The top three states in Australia with wellbeing travel service providers were New South Wales (not including Sydney), 22%, followed by Queensland (not including Brisbane), 19% and Victoria (not including Melbourne) 15% (Voigt et al., 2010). However, between 2006 and 2008 the majority of wellbeing travel has occurred in Victoria (39%) (Voigt et al., 2010) which is thought of as the capital of mineral springs in Australia with Daylesford, the Macedon ranges and Mornington Peninsula (White, 2012). Voigt et al. (2013, p. 63) estimate a total of 590 wellbeing travel service providers based on the creation of an Australian wide database.

This increased trend in Australia is joined by similar growth trends occurring internationally, for instance in Europe, America, Middle East, New Zealand and the South Pacific (Berhens, 2009, p. 31; Global Spa Summit, 2010, p. 35). The International Spas Association estimates there are 150 million ‘active spa-goers’ internationally, some of the regions were estimated with the following figures: the US as most prominent spa goers at 32.2 million; Thailand 27.1 million; UK 6.7 million and Australia 3.2 million (Brown, 2007).

[1] The estimation was an extrapolation from numerous sources about consumer spending and industry size data. Among others data sources included the Nutrition Business Journal, IHRSA, Markets and Markets, Euromonitor, Global Industry Analysts, LOHAS/NMI, Kaiser Family Foundation, PWC, and Deloitte.

Additionally, researchers observe regions in the world are specialising in different categories of wellbeing travel (Brown, 2007; Bushell & Sheldon, 2009; Smith & Puczko, 2009). European wellbeing travel leans toward a medicinal theme while the US and Asia-Pacific are specializing in the cosmetic massage and indigenous treatments (Mintel, 2007). The 2007 International Spas Association report also suggests the type of services offered in these regions vary. The services are classified as 1) leisure and recreation spas; 2) medical (surgical) hotel/clinic/hospital; 3) spa/wellness cruise; 4) Medical therapeutic hotel/clinic; 5) wellness hotels and resort spas, and 6) holistic retreats/Ashram (Brown, 2007). A further and perhaps more simple categorisation of wellbeing travel categorisation is provided by the SRI (Global Spa Summit, 2010, p. ii). The inclusions in wellbeing travel market, that is what can be defined as a wellbeing travel service, is defined by this research group to be either a ‘reactive’ or ‘proactive’ service,

SRI (International) depicts a continuum, “with reactive approaches to health and wellness (i.e., treatment of existing conditions) at one end. At the other end are sectors such as the $60 billion per year spa industry that are involved in proactive measures to enhance quality of life” (Figueroa, 2011; Global Spa Summit, 2010, p. ii). This categorisation cites the difference between services that focus upon prevention of being unwell, and those that focus upon management or treatment of wellbeing.

The closest category of wellbeing travel provided by Australian Bureau of Statistics ‘Standard Classification of Visitor Accommodation’ (1995) is ‘Resorts’. Resorts are defined as accommodation that provides more resources and activities than a general hotel, “accommodation in establishments which are integrated complexes containing accommodation and a variety of eating and drinking places. These establishments provide facilities/services additional to those commonly provided by hotels or motels. The may encompass some natural physical amenities, a special location, attraction or activity’ (ABS, 1995, p. 13). Additionally, defined in ‘other accommodation’ the ABS provide a ‘Health and Fitness establishments’ category defined as “accommodation in establishments which specialise in the provision of health/fitness/dietary activities on-site. These activities are usually included in the tariff…Excludes hospitals, nursing homes, sanatoria etc.”

One of the few attempts to define and categorise wellbeing travel in an Australia context is provided by Voigt et al. (2011). Wellbeing tourism exists as a category of health tourism. Health tourism is the overarching title including wellness/wellbeing and medical tourism, (Voigt, et al. 20111). The distinction being that medical tourists are motivated to address illness or conditions, and wellness tourists are motivated to improve wellbeing (Mueller & Kaufmann, 2001).

Voigt et al. (2009) provided the following categories of wellbeing travel in Australia: 1) Spa hotel/resorts; 2) Day spas; 3) Lifestyle resort/retreat; 4) Spiritual retreats, and 5) Day Spa retreats. The Spa hotel/resort comprised of establishments with spa facilities and accommodation; the Day Spa's offer spa facilities without accommodation. Lifestyle resort/retreats offer accommodation and "a range of activities and treatments delivered by trained staff with a controlled regimen with objective of achieving lifestyle changes, typically including at least exercise, nutrition, and stress management" (Voigt et al., 2010, p. 20).

This thesis explores the growth of Australian wellbeing travel which focuses upon health tourism rather than medical tourism. It explores Wellbeing Travel within the categories set out by Voigt (2010). In Australia, the category of wellbeing travel establishments corresponds to the type of wellbeing traveller identified in research thus far.

Wellbeing Travellers Today

The Wellbeing Traveller Today is a similar group to the wellbeing travellers of the 19th century. In Western countries, the participants of health and wellbeing are socio-demographically similar, mainly middle to upper class women. It is observed in Australia and America that middle to upper class women are increasingly participating (Bushell & Sheldon, 2009; Smith & Puczko, 2009; Voigt, 2010).

Two main markets are established by first the baby boomers, and secondly the younger financially liquid population (Bodecker & Cohen, 2008; Bushell & Sheldon, 2009). Bushell and Sheldon (2009) claim:

> these aging baby boomers are the prime targets of almost all types of wellness tourism, having both the time and the financial resources to pursue wellness much more than during their working years. Younger generations living high-paced urban lives are another key market. (p. 5)

Past research establishes wellbeing travellers have both time and money (Bennet, King, & Milner, 2004; Didascalou, Lagos & Nastos, 2009; Olimpia, 2009; Smith & Kelly, 2006). Also, for the older generation particularly, wellbeing travel appeals to the search for the 'fountain of health', where "the ageing developed world whose aging populations are actively encouraged in a never-ending search for beauty, rejuvenation, and longevity are the main source markets for wellness tourism" (Bushell & Sheldon, 2009, p. 5). As the primary consumers of beauty and rejuvenation, women fit into this category more so than men. Observing the content in a special journal edition regarding wellbeing travel, Smith and Kelly (2006) identify a similar market, baby boomers, female and 'late 30's to mid 50's, they comment that:

> the core market for spas/health retreats are baby boomers who are very keen, and very willing to spend on preventing those health conditions that are potentially going to stop them in their tracks - they demand preventative services. Younger professionals are also seeking preventative services for stress related/burn out conditions that are impacting them far too early in life. (p. 5)

Similar constructions of the wellness tourist are evident in international research. In Greece, Magdalini & Tsaratos, (2009, p. 137) interviewed 20 wellness informants/stakeholders. The age distribution of customers were middle aged, between 40-60 and the gender balance of customers was thought to be equal. Women customers main employment type was 'household activities'. The sample were mostly middle to upper class with high level of education " and this might come in accordance with their income level. "They tend to spend important amounts of money in wellness services and treatments additionally to their general tourism experience" (Magdalini & Tsaratos, 2009, p. 137).

For the purpose of this thesis, Australian wellbeing travellers are defined in conjunction with Australian domestic travel (TRA, 2011). They are people who have travelled to a wellbeing travel establishment at least once in the past 2 years. Either as a day trip that is at least 50 kilometres and for the duration of at least four hours; or an overnight trip of at least one night, and at least 40 kilometres from home (TRA, 2011).

Voigt et al. (2011) categorises three types of wellness tourists - beauty spa visitors; lifestyle resort and spiritual retreat visitors (Voigt, 2009). In 2006, Smith and Kelly identified the Holistic Tourist, therefore at this point they will be explored in

two categories according to the research available 1) Lifestyle/Spiritual/Holistic Tourists, and 2) Spa tourists.

The Lifestyle/Spiritual/Holistic Tourist

Wellbeing Travel literature use the terms 'lifestyle/spiritual/holistic tourist' interchangeably. This tourist engages with active wellbeing rather than the passive spa and beauty activities, such as yoga tourism (Lehto, Brown, Chen, Morrisson, 2005). They are not necessarily interested in the luxury, comfort or indulgence, but rather they are on a journey for mental, spiritual and physical wellbeing. Smith and Kelly (2006) add that:

> holistic tourists seem to crave the enhancement rather than the avoidance of self, and many go away to confront the very problems that other tourists are only too happy to leave behind. Holistic tourists are often more interested in 'finding' their true selves, rather than emulating others in role play…or engaging in the luminal, hedonistic behaviour typical of mass tourists...Holistic tourists' inner journey will be equally, if not more, important than the outer one. (p. 16)

Here Smith and Kelly (2006) suggest the holistic tourist may not be interested in performing the wellbeing traveller, in the sense of the Elite Model 19th century mineral springs traveller performing the healthy citizen, or Carlisle and Hanlon's (2007) wellbeing consumer (discussed earlier in this chapter). The target market for holistic tourism is baby boomers as "these consumers are often at their peak earning potential, have high education levels, enjoy greater freedom from debt, have more time for travel and greater desire for 'self-fulfilling' activities" (Smith & Kelly, 2006, p. 19). The Lifestyle/Holistic tourist is not just a baby boomer, they are people in positions of power and "health retreats and spas are sought largely by people who are in high stress positions of employment in the cities" (Smith & Kelly, 2006, p. 19). This tourist is also thought to have a holistic lifestyle, therefore travel for wellbeing accompanies an already established lifestyle (Smith & Kelly, 2006).

Spa Tourists

According to Mak, Wong and Chang (2009, p. 185) spa travel is "currently one of the fastest growing subsectors of health tourism." Spa tourists are much more researched than the holistic tourist, perhaps because of the prevalence, high visibility and profitability of spa travel compared to other categories. The study conducted in Hong Kong found the four main perceptions of spa benefits are relaxation, pampering, beauty treatments and "enhancement of overall health" (Mak et al., 2009, p. 185). While 'relaxation and relief', 'escape' and 'self-reward and indulgence' were the top three motivations.

Mak et al. (2009, p. 196) concluded that the Hong Kong sample fitted in between motivation factors in America and Europe as "the result contrasts interestingly with general European spa-goers' perception that spa experience is largely for curative or therapeutic purposes (Douglas, 2001, Miller, 1996), and American spa-goers' perception that spa experience is a means of self-reward (ISPA, 2006, Kaspar, 1990)". In combination with differing travel motivations, countries have diverse rates of spa travel. Research by Biging (2009), managing director of 'Healing Hotels of the World', compares Australian and international spa participation in Table 3 below.

Table 3: Percentage of Spa-goers in Australia, US, UK & Singapore by Healing Hotels of the World, 2008

Country	Active Spa-Goer %	Spa Goer %	Non Spa-Goer %
Australia	21	20	59
US	23	20	57
UK	26	17	58
Singapore	69	16	17

Source: Biging (2009)

Table 3 outlines results from a survey, participants were asked if they had been to a spa in the past 12 months, the categories were defined as "1) 'Active spa-goer – A

person who has attended in the past 12 months; 2) Spa-goer – a person who has attended before but not in the past 12 months; and 3) 'Non spa-goers – a person who has never attended a spa" (Biging, 2009, p. 3).

Table 3 shows that 59% of Australian survey participants were 'Non Spa-Goers', 21% were 'Active Spa-Goers' and 20% 'Spa Goers' and interestingly these results were not much different for the UK and US. The participants in Singapore however, reported that 69% were 'Active Spa-goers', 16% 'Spa Goer' and only 17% 'Non Spa-Goer'. Spa travel in Singapore was therefore considered a somewhat normal activity compared to the Western nations, Australia, US and UK. Biging suggests the results indicate there is room for growth in the Western countries. Biging (2009) demonstrates it is because current spa participation is low, that wellbeing travel in fact has a potential market in Australia. However, this result could also suggest spa travel in Singapore would reflect the Egalitarian model and the Elite model in Western countries. If it is the Elite model here in Australia, growth may not be possible without restructuring the image of the spa establishment.

The Spa Association Australian also explored spa participation and gender. The gender distribution in Germany and Thailand was nearly equal "Spa-going is almost evenly matched between men and women (53% vs. 47% and 54% vs. 46 %, respectively.)" (Brown, 2007). The Western countries again reflected the Elite model of spa travel, in the US men made up just 31% of spa goers, Canada, 29% and UK 22% (Brown, 2007). Furthermore, the type of treatment varied by gender and reflected traditional values about gender traits, as "in general, men tend to seek treatments that "get work done," meaning they enjoy a deep tissue massage or other body treatments. Women, on the other hand, are much more likely to receive treatments that enhance their appearance, such as services for their face, hands or feet" (Brown, 2007, p. 33)

Despite differences in travel motivation between countries it is clear that spa travel is an aesthetic and passive form of travel compared to lifestyle/holistic. It is also clear that wellbeing travel in typical Western countries are similar in form and purpose, attracting approximately 20% of the population as active spa-goers. The Global Spa Summit report (2011, p. 39) offers similar conclusions as "Australia has much in common with many other Western developed countries (e.g., United Kingdom, United States, as well as much of Europe). Australia's emphasis is mainly on wellness tourism and day spas, and holistic retreats also play an important role".

Australian Wellness Tourists

The Global Spa Summit (2011) reported that wellness tourists in Australia are short break travellers and mostly domestic tourists. Their holiday purpose is not necessarily 'wellbeing travel', however, spa visitation can occur in combination with the holiday (Global Spa Summit, 2011, p. 39). In 2006-2008 the number of tourists was approximately 229,000 to 497,000, "or 0.3%-1.3% of all domestic tourists" (estimate from Sustainable Tourism Cooperative Research Centre, STCRC cited in Global Spa Summit Report 2011, p. 40).

Voigt et al. (2010) and Bennet et al. (2003) are the two main Australian academic studies about wellbeing travel. Bennet et al. (2003) studied the development of the wellbeing travel sector rather than the tourists. Voigt et al. (2011) studied the differences between the three wellbeing traveller categories, beauty spa visitors; lifestyle resort and spiritual retreat visitors (Voigt, 2009). Of the total sample, 84% were female, and 36% male. Of the total sample, 79% of the wellbeing travellers were full time or part time employed and 61% had a university degree (Voigt, 2011). These results mostly confirm the profile of the wellbeing traveller in international research outlined above.

Voigt et al. (2011, p. 20) reported noteworthy difference between the three categories. Spiritual retreat visitors comprised of "the highest proportion of respondents aged 55 and over" (38%), and beauty spa visitors represented the highest proportion (38%) of the youngest respondents (34 and under). Spiritual retreat visitors were also the highest educated of the three categories. Lifestyle resort visitors had the highest income "with a higher proportion of lifestyle resort respondents (25%) reporting the highest household income category (over $230,000) compared to beauty spa (2%) and spiritual retreat visitors (7%). Compared to lifestyle/holistic/spiritual tourists, the beauty spa visitors represented those who were mostly full time employed rather than unemployed or students (Voigt et al., 2011, p. 20).

This thesis seeks to further examine the Australian wellbeing traveller in regard to what drives and constrains travel, including the impact of a Western cultural discourse of wellbeing discussed earlier in the chapter. The above examination of international wellbeing travel research has found wellbeing travellers today are still mostly the upper to middle class and predominately female. They are the populations with time and money, the baby boomers and the younger and financially well off. Global research pinpoints two main categories of wellbeing traveller, 1) The

Lifestyle/Holistic/Spiritual who are driven by active enhancement of self rather than luxury. In Australia the older generation mostly represent this category and have a higher household income. 2) The Spa Tourists who are driven by 'escape, self reward and indulgence' (Mak et al., 2009, p. 185) and in Australia are the younger generation dominate this category.

Complexities of Wellbeing Travel

There are several difficulties in regard to the wellbeing travel sector identified in research. Internationally there are numerous focuses, infrastructure, and definitions for wellbeing travel (Bushell & Sheldon, 2009). A consistent definition of wellbeing travel shared by academics and stakeholders, would offer a solid foundation for further research and assist to define a wellbeing travel market (Bushell and Sheldon, 2009).

Despite efforts to conceptualise what constitutes wellbeing travel, in Australia it is also evident amongst tourism organisations and academia that the focus for development clearly rests with spa or mineral springs – reflecting the elite model of wellbeing travel – rather than lifestyle or spiritual establishments. Within the last decade both Tourism Victoria and the Australian Tourism Export Council (ATEC) (ATEC, 2010) have given attention to wellbeing tourism as recognition of current consumer interest and potential tourism expansion opportunities. Strategic plans such as 'Victoria's Spa and Wellness Tourism Action Plan, 2005-2010' (Tourism Victoria, 2010) are evidence of the tourism agencies' commitment to this area. Within ATEC's 'Health and Wellness Travel Advisory Panel' a stated aim was "to position Australia as a leading health and wellbeing destination through the promotion of advanced medical services, natural attributes and wellbeing experiences" (ATEC, 2010), ATEC and Tourism Victoria have, for the most part, acknowledged spa facilities, spa resorts and medical tourism as the definition of what is available as a wellbeing activity in Australia. Voigt et al.'s research (2010, p. 217) supports this observation. At the time of publishing spa tourism consisted of the majority of the wellbeing travel sector in Australia as " 'the industry' consisted of five hundred and ninety wellbeing tourism suppliers, of which were 262 day spas, 201 spa/resorts/hotels, 28 lifestyle retreats 83 spiritual retreats and 16 hybrid businesses".

These figures do suggest spa travel is the predominant form of wellbeing travel in Australia. However, literature also suggests estimating the breadth of the market may be problematic. This is thought to be in part due to the lack of an overall organisational body or standards board. As a result, it is difficult to quantify growth in any area other than the highly visible spa/mineral springs tourism. For instance, Smith and Kelly (2006) estimated 450 holistic tourism centres (yoga and spirituality) internationally. Thus demonstrating the 'holistic' tourism market is smaller than spa tourism. The holistic or spiritual tourism market is difficult to quantify in comparison to the highly visible spa tourism market. While attempting to estimate the size of the holistic market, Smith and Kelly (2006, p. 16) have highlighted the problem of reporting the exact size due to the visibility of well-established substantial service providers and the non-visibility of smaller service providers. The authors comment "the growth of holistic tourism is difficult to quantify, not least because many of the operators engaging in this form of tourism are small-scale entrepreneurs who rely almost solely on the internet to promote their products".

It is suggested a similar problem applies in Australia. Many wellbeing travel establishments or operators are small, and many would not consider themselves to be defined as such. It is possible many operators are overlooked in any numerical account of a wellbeing travel sector and consequently, a true representation is not possible. Bennet et al., (2004) research regarding 'health tourism' further identified the non-visibility of service providers in Australia which makes the market difficult to quantify, "while many health resorts in Australia actually use the word 'health' in their name and exhibit sufficient characteristics to distinguish them from more generic resorts, there exist other self-evident health resorts which do not use the word 'health' in their title" (p. 126). The lack of research targeted towards giving visibility to a potentially diverse market is an identified gap.

A further problem confronting this tourism niche is that, apart from the sporadic support of organisations such as ATEC to collaborate and develop the wellbeing travel sector (or perhaps, the spa and mineral springs sector), Australia does not have a unified body or Wellbeing or Wellness Travel Association. A collaborative organisation of interested stakeholders does not exist in Australia compared to other countries. Upon interviewing Tourism Victoria and Tourism New South Wales in 2009 Bennet et al. "concluded that health resort tourism is not viewed as a viable target for promotional activity. In contrast, Israel has a health spa authority which

oversees “all aspects of developing and promoting health tourism” (p. 124). Also in comparison to other countries, Bennet et al. (p. 124) observe wellbeing travel in Australia cannot be claimed on private health insurance while “in many European countries treatment at health resorts is recognised as a claimable expense by insurance companies”. Magdalini and Paris (2009) find a similar problem in Greece and are content to discuss the potential consequences of not having a governing body or standards board, they comment:

> the state has formed no clear and strict specs for defining a wellness resort, all sorts of hotels and centres can claim that they offer wellness tourism services without following a specific framework of rules and prerequisites. There is not central planning for this sort of entrepreneurship, so we cannot refer to a well organised or experienced Greek market as a wellness destination but only as wellness resorts. (Magdalini & Tsaratos, 2009, p. 130)

An additional problem in Australia is the cost of participating in wellbeing travel and the lack of research regarding financial exclusion. Table 4 below demonstrates one research study conducted in 2004 calculating the minimum, maximum and average cost.

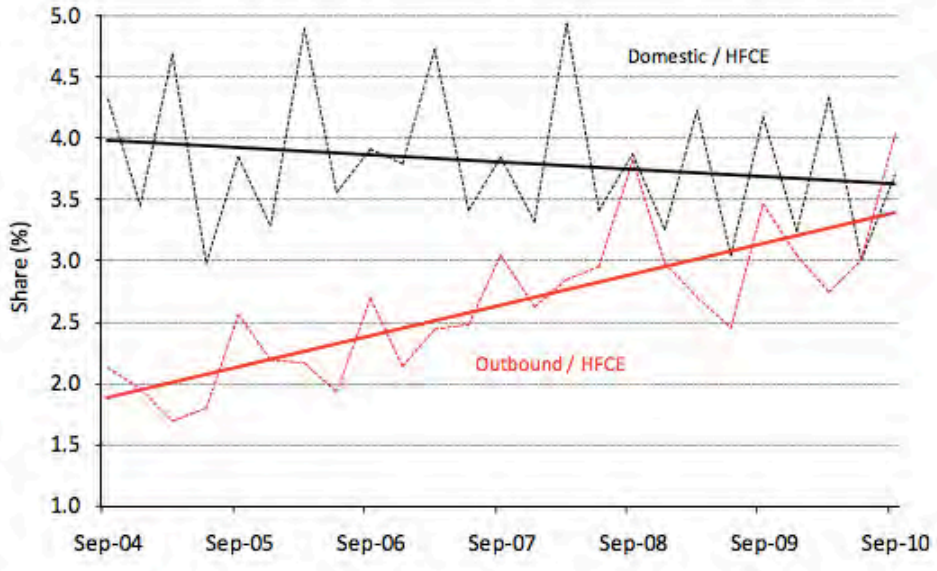
Table 4: Customer Cost of Australian Health Resorts, 2004.

Length of Stay	Minimum Price	Maximum Price	Average Cost
Overnight	$34	$300	$122
Weekend	$200	$425	$295
Week	$530	$1,350	$850

Source: Bennet, King, & Milner, 2004, p. 129

Table 4 shows the mean market price for health resorts was $122 overnight, $295 for a weekend and $850 for the week (Bennet, King, & Milner, 2004). A limitation of their research was focusing upon health resorts only. A further limitation noted by Bennet et al. was that two providers were particularly highly priced compared to the others, which could also skew the results.

Bennett et al. (2004, p. 139) found one service provider charged $2,720 for a five-night stay with a daily two-hour specialised massage as well as pre- and post-treatments and a range of other 'extras' included. Another resort charged $2,600 per week all inclusive (including massages). The cost is a problem when compared to Australians annual average expenditure on holidays. The Tourism Research Australia report titled 'What is driving Australians travel choices' found that income is the primary driver for travel choices (2011). Additionally, domestic travel is decreasing while international travel is increasing (2011, p. 3).



Sources: Australian Bureau of Statistics, *Australian National Accounts: National Income, Expenditure and Product* (ABS cat. no. 5206.0); Tourism Research Australia, *Travel by Australians – December 2010 Quarterly Results of the National Visitor Survey.*

Figure 2: Tourism's Share of Household Final Consumption Expenditure (HFCE)

Figure 2 above is taken from the Tourism Research Australia report 'What is driving Australians travel choices'. The Figure shows between 2004 and 2010 domestic overnight holiday expenditure decreased "by 0.5 percent from 4.3 percentage points to

3.7" while the 'outbound' travel increased "from 2.2 percent to 4.0 percent" (2011, p. 3).

These statistics highlight the high cost of wellbeing travel would be problematic not just for the potential customer, but also for the service providers who would forego the custom of the majority of the Australian population.

In summary, growth and diversity for wellbeing travel in Australia appears to be limited. Research so far has demonstrated it is a niche form of travel within the tourism industry, without an overarching organising body, accountability, and favouring the highly visible and expensive spa travel. The organisations that have given attention to developing and formalising the sector (Tourism Victoria, The Australian Spa Association (ASPA); Tourism Australia) have focused upon marketing spa travel and as such, are presenting a limited definition of wellbeing travel in Australia.

The above factors create a problem that is of central concern for this study. With Spa travel an inherently expensive form of travel, the smaller, cheaper 'holistic' operators are not visible or harnessed to organise and formalise an equitable sector. This is concerning, but not surprising, because like much of the tourism industry, it is suggested that the authority to construct a travel product that may exclude certain sections of the population (those of low income for instance) is ultimately in the hands service providers, among others.

Therefore, to scrutinise the drivers for non-travel (a key part of the research question), the Australian wellbeing tourism sector itself must be examined. Phase1 of the research undertaken for this study is focused upon understanding the wellbeing travel sector from the perspective of service providers. Two key areas of inquiry include, does a wellbeing travel sector exist and what does it look like? Is the authority to exclude in the hands of service providers the wider industry, or the tourists themselves?

Before discussing results a more pertinent issue arises at this point. The literature regarding the history of travel and non-travel for wellbeing has revealed several themes in regard to authority, or power. These themes were evident in the four drivers for travel discussed in Chapter 2. The first theme, 'White Imperial Travel' spoke about a politically and culturally egocentric nation and the power of the white tourist who belongs to it. The second and third theme driving wellbeing travel, 'The Medicalisation Movement' and 'Medicalisation and Gender' demonstrated the power

of dominant discourses to determine a ‘normal’ body and consequent social controls. Finally, the fourth driver revealed an emerging theme of power for the tourist who is driven to wellbeing travel to perform wellbeing for social mobility. Therefore ‘Power’ emerged as a significant theme in the literature regarding how non-travel and travel occurs and this is addressed in the following chapter. Several approaches to inequality in the tourism industry and non-travel are discussed in Chapter 4.

Chapter 4: Concepts of Non-Travel

Chapter 2 and 3 determined several drives for wellbeing travellers of the past, and for today. A reoccurring theme throughout the two chapters was that the drives were situated in the cultural Western discourse of wellbeing, which included participating in the dominant discourse of the body and the secondary benefit of socialising and developing social capitol. Also (particularly for the Elite Model of Wellbeing Travel) the dominant discourse of wellbeing predominately privileged upper classes. It was proposed in Chapter 2 and 3 that the development of wellbeing travel is intertwined with health ideologies, gender, class and social mobility.

Chapter 4 then turns to the residual issue, and a key research question. Why do people not travel for wellbeing, and what are the constraints to travel. Chapter 2 and 3 has already introduced the idea of travel constraints by outlining the social inequality of the Elite Model of travelling for wellbeing. Research investigating people who do not travel for wellbeing does not exist at the time of writing. Current tourism research does offer a body of international research that explore concepts of general non-travel. Some of these concepts equate non-travel with an un-conceptualised idea about authority, power or power relationships. Within the tourism literature this ‘power’ can be determined in two categories, 1) regarding social inequalities, social exclusion and the opportunity to travel, and 2) ‘power’ in the social construction of the tourism industry; here non-travel is equated with discourse and social construction. This is a developing field in tourism studies - merging tourism with social science perspectives.

Chapter 4 outlines four concepts regarding how non-travel may occur, from existing tourism literature. First, that non-travel may occur because of existing social inequalities. Second, a framework of power is suggested; power is everywhere yet place is constructed by the relationship between subject (tourists) and object (organisers and stakeholders of tourism). Third, social inequalities are reproduced in tourism. Fourth, the agency of the traveller is considered as the most powerful determinant of travel or non-travel rather than the tourism industry. Discourses (texts, images, symbols and knowledge) have a part in the construction of travel choices. It is suggested that travel choices are formed on the basis of socialisation and travel is a space for reproducing desires in everyday life. Therefore, unlocking the inquiry about the drivers for travel and non-travel extends to considering everyday life and not just drivers constructed by a tourism industry.

Concept 1: The Non-Traveller and Social Exclusion.

The Growth of a Tourism Industry

The origins of travelling for wellbeing existed in a time where travel was not accessible for the general population (Theobold, 2005). Today, wellbeing travel exists within the sizeable tourism industry and 'travel' has a different meaning for people. In most Western developed countries, travelling is considered a significant component of citizenship and it is generally accepted that socially included citizens have the opportunity to work and have leisure time – including rest, social activities and to holiday/travel (Holden, 2005; Tourism Research Australia, 2011). This section discusses the growth of the tourism industry resulting in the norm that travel should be accessible for most people.

While travel has always existed in some form; for pleasure, business, education; pilgrimage or necessity (Theobald, 2005, p. 5), there are three instances of mass or increasing human movement that are of notable significance to historians and researchers. First, historians suggest that as the result of changing social and political conditions in 19th century England, travel became 'travel en masse', where "the advent of mass tourism began in England during the industrial revolution with the rise of the middle class and relatively inexpensive transportation". Theobold (2005, p. 5) writes that although the term 'tourism' came into existence at this time, the institutional and organisational entity emerged later in the second half of the 20th century. Secondly, travel became more accessible to the public with the advent of the commercial aircraft, particularly marking the beginning of mass marketing international travel, Theobold states (2005, p. 5) "the creation of the commercial airline industry following World War 2 and the subsequent development of the jet aircraft in the 1950's signalled the rapid growth and expansion of international travel". Third and most recent is the post-modern communication environment that is characterised by instant communication via the internet, mobile phones and the associated social impacts, and the resultant increased efficiency of business and tasks. This environment has ensured increasing flexibility of the movement of people and objects, whether physical, imagined, or social mobility (Hannam & Knox, 2010, p. 1).

As a consequence of the increasing perseverance of travel in society, Davidson (2005) suggests a lot of effort has gone into creating the perception of tourism as a cohesive authoritative industry, the authors state:

> under this 'industry' view, the tourism industry is made up of a clearly defined grouping of firms that are perceived to be primarily in the business of selling to or serving tourists. Hotels, restaurants, transportation, and amusements are examples of the types of firms that comprise the tourism industry. (Davidson, 2005, p. 29)

As a result of the effort to construct a perception of a cohesive tourism industry, today tourism is a international industry and accounts for the largest movement of people across the globe in known history (Urry, 2007, p. 4). The international tourism industry has a significant economic, social, environmental and cultural impact. Urry (2007, p. 4) found one fifth of world trade consists of international travel and "international and domestic tourism together accounts for 10% of global employment and global GDP". In Australia, the tourism industry contributed $73 billion to the economy in 2010 (Tourism Research Australia, 2012). Urry (2007, p. 4) also highlights that the trend of tourist flows is unbalanced with the majority of travel taking place between advanced industrial societies.

Travel, or holidays has become a norm for citizens in developed societies in the form of a capitalist work and leisure dichotomy. For instance, in developed countries the opportunity to travel is taken for granted as a presumed annual or bi-annual activity. Holden comments that:

> being able to go on holiday, to be obviously not at work, is presumed to be a characteristic of modern citizenship. Consequently, exclusion from participation tourism may be viewed as a denial of status and citizenship. (Holden, 2006, p. 30).

The concept of a holiday as a human right and as an important component of citizenship is not original. Hall and Brown (2006) acknowledged that "governments granting legal vacation rights in most countries" is a feature of modern citizenship. As stated above Article 23 and 24 of the Universal Declaration of Human Rights (2011) created in 1948, states that leisure and holiday are basic human rights. Further declarations by the World Tourism Organisation in 1980 and 1982 featured vacation

rights (i.e., “participation in and opportunity for recreation and pastimes”). The tourism for all, or the ethical tourism concept has also translated into a “social tourism” movement with practical organisations such as “BITS”, which considers the tourism industry to be accountable to society, not just to those who participate (Minnaert, Maitland & Miller, 2006; Tribe, 2008). However, the international recognition of travel as a basic human right does not guarantee the equality of travel.

The size of the tourism industry, and travels increasing status as a feature of modern citizenship means that tourism has a significant international impact and it follows, significant accountability for this impact (Urry, 2007). This accountability extends beyond sustaining or developing economies for the developed world. It extends to the impact of tourism on the natural, social and cultural environments such as the impact upon host communities; the politics of cultural tourism; the politics of over reliance on tourism in third world countries and consequent exploitation; tourism and the human foot upon the environment and sustainability; tourism for the elite and non-traveller and social exclusion from travel. Until recently accountability in these environments has held only a modest position in tourism research. It has usually featured in the ‘social science of tourism’. This is an identified gap in research and is lamented by some tourism researchers. For instance, Jaworski and Pritchard (2005, p. 8) are content to admit that tourism research thus far has engaged with little “social theorising” leading to a “growing dissatisfaction with the theoretical bases of tourism scholarship”. One such area of accountability is ‘non-travel’.

Until recently the non-traveller was regarded with little interest in comparison to the traveller. The non-traveller is a mostly unseen concept in tourism research. However, it is one concept that acknowledges the role of power and inequality in tourism. The following outlines current non-travel research and why it is considered ‘social exclusion’.

Non–Travel Research.

In comparison to Australia where research is scare, non-travel is a well documented field in Europe and the UK. In the past two decades, tourism researchers have confirmed the non-travel trend in England and the European Economic Community (Hall & Brown, 2006; Haukeland, 1990; Smith & Hughes, 1999). Rates have ranged from 11.5% in Sweden to 45% in Portugal (Ianniello, 2006).

Non-travel research has traditionally attributed the ability or opportunity to travel upon having access to adequate economic resources and identifies minority groups as those at risk of non-travel. To construct a profile of the travel non-participants, existing tourism research has demonstrated low socio-economic status similarities between the studies (Lu & Pas, 1998; Nyaupane & Andereck, 2008; Smith, 2001). Minority groups such as single parent families (Smith & Hughes, 1999), physically disabled or impaired people (Burnett & Baker, 2001), life stage, such as seniors (Fleischer & Pizam, 2002) or youth, are some identified at risk for non-travellers. In various previous studies, socio-economic constraints are considered to be the main obstruction to travel (Lu & Pas, 1998; Smith, 2001; Smith & Hughes, 1999). Observation of the socio-economic similarities found between different studies, leads to the suggestion that travel non-participation primarily occurs as a result of various socio-economic inequalities.

Although this is a reasonable conclusion, further studies identify other indicators, such as the leisure constraint model by Crawford and Godbey (1987, 1991) including, 1) intrapersonal constraints, which are the psychological states and attributes intervening between preference and travel participation, such as, cognitive ability and anxiety; 2) interpersonal constraints, highlighting the social interactions intervening between preference and travel participation, such as between the traveller and service providers, or the traveller and travel companion, and 3) structural constraints, such as time, finances, transport (see Appendix A for leisure constraints model).

Haukeland (1990) in particular has recognised the need to further examine non-participation in travel, stating the opportunity to participate in travel "should be treated as an important factor of social well-being (and) ... should be a major area for further research" (Haukeland, 1990, p. 179). In union with Crawford and Godbey's (1987) findings that income is not the only determinant for no-travel, Haukeland's (1990) study of Norwegian non-travellers identified profiles of non-travellers that extended beyond economic difficulties and highlighted further pathways to travel non-participation.

Haukeland branded three non-travel categories. The 'Type A', non-travellers, those who do not have any particular identifiable obstacles to travel; the 'Type B' non-travellers, although 'social living conditions' are sound, temporary or permanent obstacles present themselves to prevent travel, and 'Type C' non-travellers, who

showed constraints both relating to ‘social living conditions’ and welfare resources such as ‘lack of economic means, health resources, personal freedom’ (Haukeland, 1990). Interestingly, the type C non-travellers amounted to 49% of Haukeland’s (1990) sample, while Type B amounted to 37% and Type A, 14%. Therefore, although the low income and materially disadvantage non-travellers represented almost half of the sample, the remaining 51% demonstrate alternative pathways to non-travel. The Type B non-traveller, with temporary or permanent obstacles, may represent a less straightforward pathway of exclusion to travel than Type C. Various travel non-participation studies have since applied these categories (e.g., McCabe, 2009; Smith & Hughes, 1999).

At the time of writing, Tourism Research Australia (TRA) provides the only known measure of non-travel in Australia. In 2010, the non-travel rate was 60.3% (TRA, 2010; van den Eynde, 2010). These statistics must be viewed with caution as it does not reflect an annual rate. In Australia the non-traveller is identified based on three questions. To determine a non-traveller from a traveller, the response to all three questions must be ‘no’, 1) Did the participant travel 50km from home and stay overnight in the last four weeks?; 2) Did the participant travel 50km from home for a day trip in the last 7 days?, and 3) did the participant travel outbound within the last three months? (Tourism Research Australia, 2011). The likelihood of a participant travelling within the last three months would be lower than travelling within an annual timeframe. For this reason non-travel between the UK and Australia cannot be compared beyond speculating upon general trends because the timeframe to classify non-travellers varies between studies. This caution about Australia’s only known measure of non-travel highlights the need to have further measures put in place.

The general trends regarding those who did not travel in Australia in 2010 are offered by the Tourism Research Australia (2010) domestic survey (van den Eynde, 2010). In 2010 a clear trend is apparent between income and non-travel. The higher annual income, ‘$150,000 or more’, corresponds to the lowest non participation rate (44%). Similarly, lower annual income, such as ‘$36,000-51,000’, corresponds with a higher non-participation rate (64%).

Analysis of non-travel by ‘life cycle’ also shows some general trends. The ‘Older non-working single’ life cycle group had the highest non-travel rate (71%) whereas the ‘Older, working married’ had the lowest (53%). This implies that age may only be a factor when combined with other factors such as relationship status or

accommodation. For instance, the young life cycle groups demonstrate that the 'young single at home' (67%) have a higher travel non-participation rate that the 'young single, share accommodation' (60%). The contributing factor between these two groups is accommodation, which perhaps is an indicator that independence and a social environment are more important than age, or even income (van den Eynde, 2010).

Further challenges to the traditional socio-economic explanation, is provided by the 'No Leave No Life' study (Tourism Research Australia, 2011). This study offers an entirely different category of non-travellers which have little connection with financial difficulties. In fact, they generally represent Australians with above average annual incomes.

One in four full time employed people stockpile leave (Tourism Research Australia, p. 1) and therefore, one in four are potentially non-travellers. One third of these stockpilers earn $80,000 or more annually which challenges the idea that non-travel is solely the consequence of financial difficulty (Tourism Research Australia, 2011, p. 9). Further constraints to travel are identified to be associated with a work environment that is perceived not to support leave taking. TRA report that "57% of stockpilers consider work related barriers prevent them from taking leave compared to 48% of non-stockpilers" (Tourism Research Australia, 2011, p. 8). Stockpiling occurs because of the perception that no one else can do their job; or accruing leave for emergencies or big trips (Tourism Research Australia, 2011, p. 10).

In summary, past research has identified several explanations for non-travel. First, low socio-economic circumstances and income are significant determining factors in non-travel (Lu & Pas, 1998; Smith, 2001; van den Eynde, 2010). Additional findings in Australia pinpoint life cycles, such as the 'older-working and single', who have the highest non-travel rate (van den Eynde, 2010).

Haukeland's (1990) research identified further reasons for non-travel, with Type B non-traveller who have sound living conditions, but with temporary or permanent obstacles preventing travel. The Type C Non Traveller, which identified life cycle, 'social living conditions' and social 'participation' are also likely to impact upon the accessibility to travel; and Haukeland's (1990) Type A non-traveller, who have no identifiable obstacles to travel.

The Australian 'No Leave No Life' (Tourism Research Australia, 2011) study also demonstrated non-travel can be linked to employment concerns, such as losing a job. (Tourism Research Australia, 2011, p. 9). It is apparent that while social inequalities such as a low income and socio-economic status plays a role in determining non-travel, further constraints must be researched in more detail.

Social Exclusion

Social exclusion is a further concept explaining and complimenting non-travel research. Social tourism literature equates non-travel with social exclusion (Minneart, 2012) because tourism is considered a human right and an important component to citizenship. Article 24 of the United Nations (1948), Universal Declaration of Human Right states "Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay". Social exclusion is the non-participation (economically, socially and politically) in what is considered normal daily activities and a lack of resources that are necessary for participation to take place (Levitas et al., 2007). It is a multifaceted process by which the minority of society are unable to participate in what is considered regular daily activities because of social, economic and cultural inequalities (Levitas et al., 2007). Social exclusion impacts the individual and society. Levitas et al. (2007, p. 86) states "the quality of life individuals and the equity and cohesion of society as a whole".

The emergence of the social exclusion concept is pinpointed in 1970's French thought "as an umbrella term describing individuals with problems unprotected by then current social insurance principles" (Miller, 2006, p. 1; Pierson, 2009). Social exclusion was a term created from political ideology, advocating accountability of those in power to the social welfare of society where "social exclusion was viewed as the failure of key state institutions to maintain positive relationships between society and some individuals" (Bhalla & Lapeyre, 1997, p. 414). By the 1980's the term evolved to include more general types of social disadvantages (Miller, 2006). Beginning in the mid 1990's, the concept of social exclusion became central to social policy in Europe and increasingly in other regions of the world (Gore, Figuerido & Rodgers, 1995).

Today, Atkinson (1998) notes three significant themes essential to identify and define social exclusion, 1) relativity; 2) agency, and 3) time. 'Relativity' is the idea that social exclusion is relative "to the norms and expectations of society at a particular point in time" (Hayes, 2008, p. 13). A case of social exclusion in one society at one point in time may not be transferable to another. Secondly, social exclusion is defined by the level of 'agency'. An act of social exclusion can be initiated by an "individual, group or institution" and the level of agency refers to who does the excluding, "A person may exclude themselves by choice or they may be excluded by the decisions of other people, organisations or institutions" (Atkinson, 1998, cited in Hayes, 2008, p. 13). The third feature to define social exclusion is 'Time', "social exclusion is not a result simply of current circumstances but also requires that the person's future prospects are limited" (Atkinson, p. 13). Please see Appendix B for a diagram of social exclusion. When applying these three features of social exclusion (relativity, agency and time), non-travel is something that occurs from existing social inequalities that are specific to place, time and group. The social exclusion theory compliments non-travel research outlined above by offering a wider umbrella to explain how constraints might occur.

Unexamined in the social exclusion and non-travel literature, is the role of the tourism industry in determining non-travel, reproducing social inequalities or constructing constraints. Also unexamined is how the tourist may exclude themselves 'by choice'. The following two concepts examine literature pertaining to the power of the tourism industry and the agency of the tourist.

Concept 2: Repressive Power and Tourism

Cheong and Miller (2000) find that power is everywhere in tourism, and they base this upon Foucault's theory of power (Foucault, 1982 'The Subject and Power). Cheong and Miller challenge two ideas about tourists, power and inequality in tourism. A long held notion is that the negative social and environmental impacts resulting from tourism, are the fault of the tourist. Cheong and Miller state (2000, p. 371) "from the perspective of Western society, tourism is often understood as a product of the individual decisions of tourists". Cheong and Miller (2000, p. 372) write that travellers are thought to be carriers of imperialistic power dynamics; socio-economic differences creating a power relationship between the traveller and the host

and “power as allegedly exercised by the tourist over other people”. This perspective of the traveller cannot be completely discounted because as discussed above, travel for leisure did begin with the upper class UK/European citizen and the creation of ‘otherness’ (Burroughs, 2009). Cheong and Miller show there is more to the narrative.

Instead of the traveller as the sole carrier of suppressive power, they begin with Foucault’s premise that power is omnipresent as “there is power everywhere in tourism”. Other tourism researchers have also given their attention regarding power and tourism to the adaption of Foucault’s theory of power and the authentic gaze (Cheong & Miller, 2000; Hollinshead, 1999; Leiper, 2004; Urry, 2007).

For Cheong and Miller (2000) the basic premise is that society without power is not possible because “power relations are rooted deep in the social nexus, not reconstituted ‘above’ society as a supplementary structure” (Foucault, 1982, p. 791). Foucault suggests that for this reason it is important to understand how power works, to undertake “the analysis of power relations in a given society, their historical formation, the source of their strength or fragility, the conditions which are necessary to transform some or to abolish others (Foucault, 1982, p. 791). Foucault’s notion of power is fluid, in all people and all relationships and is therefore not only a “system of domination exerted by one group over another” (Foucault, 1978, p. 92; 2000, p. 372). It follows then that tourists have not exerted their domination over tourist establishments, and tourist establishments have not only exerted their power over tourists. In the case of non-travel, it is not just the tourist decision not to travel, because of a low income or because they don’t feel like they can spend the money or take time off work, the story must be examined in more detail.

Although power exists everywhere and is exercised by everyone, an act of power, or power relationship most inevitably results in acts of repression and exclusion (Foucault, 1982). Of particular interest to tourism is the idea of ‘repressive power’ including “rejection, exclusion, refusal, blockage, concealment, or mask” (Foucault, 1977, p. 194). In a power relationship people are ‘agents’ and ‘targets’ (Foucault, 1982). The target “is the subordinate actors in power relationships and exists in relation to the agents” such as tourists in relation to the tourist system (Cheong & Miller, 2000, p. 376). Agents also consists of ’the immediate social entourage, the family, parents, doctors etc..” (Cheong & Miller, 2000, p. 376). Foucault’s agents are accountable to repressive power (Cheong & Miller, 2000, p. 376) and occurs when the target does not conform to the agent.

Cheong and Miller (2000) write that Foucault has found various forms in which agents enact power or 'repressive aspects' to target; such as the 'inspecting gaze' whereupon the agent, within a role of 'overseer' (a prison guard or a teacher), observes the target and the action of the gaze induces the target to conform to normative behaviour. The authors explain the following:

> Foucault's agents perform their power via the construction and exertion of knowledge, normalising discourse (what is acceptable and not acceptable), and an 'inspecting gaze'. ...'the agents construct the gaze as they observe the target. In this process, the target ends up internalizing the gaze to the point that he is his own overseer (Cheong & Miller, 2000, p. 378).

In consideration of the Foucauldian concept that power is everywhere and all people are the actors of power, Cheong and Miller (2000, p. 378) explore how power exists within the interactions between tourists and the tourist system to result in exclusion from travel they suggest the tourist is the 'target' and the 'agents' are reconceptualised in a tourism context as 'brokers'. Brokers are defined as those who facilitate the industry of tourism, they are, "persons who in one way or another pay professional attention to tourism" (Miller & Auyong, 1998, p. 3). This category is divided into public and private brokers. Private brokers facilitate the services and products of tourism and the public brokers include "public servants...engaged in the governance and management of tourism" (Miller & Auyong, 1998, p. 3). Additionally Cheong and Miller (2000, p. 379) define further brokers categorisations as "social movement brokers, academic brokers, travel media brokers, and consulting brokers"[2].

Cheong and Miller (2000**)** find the broker is not a neutral actor in tourism, they explain that:

> given that tourists are targets, the Foucauldian agents of tourism power are composed of the various kinds of brokers...they compel the tourist to function in a certain way...brokers are not weak intermediaries...brokers do not serve a neutral role. Rather they intervene and constrain tourism activities generally for the sake of profit and public service (Cheong, 1996, p. 379).

[2] 'Brokers' are one part of a model created by Cheong and Miller, the BLT model refers to 'Brokers, Locals and Tourists'. 'Locals' refers to people who live in or near a tourism destination yet are not facilitators of the tourism industry. The tourists in the BLT model are leisure/pleasure travellers.

The Brokers collaborate with other institutions to further their own interests, and "at any given time, divergent brokers in different professions align themselves around an issue. They discuss and negotiate how far development should proceed, what type of development is optimal" (Cheong & Miller, 2000, p. 379). In Australia, collaborations often take place between destinations and institutional organisations such as councils, or others are a part of government funded entities like Tourism Research Australia, Tourism Victoria or the Australian Tourism and Export Council (ATEC). At various stages of the tourist experience, brokers have the power to determine (exclude or include) the tourist. In the development stages of a tourist establishment, brokers decide who the ideal tourists will be (Cheong & Miller, 2000). The socio-economic characteristics of the target tourist/market will reflect the aims of the establishment. Here the brokers express power, because before the tourist books a holiday, decisions about the target tourist are already made.

The rules, symbols and norms for each tourist sector, or individual establishment, are communicated to the tourist in brochures, other advertisements, and word of mouth; followed by interactions with the mediums that plan and book the holiday, such as travel agents, or travel websites. In the past, the travel agent was understood as the main resource for all travel knowledge. Before the advent of booking holidays online, the travel agent was the barrier between mere planning and actual booking of a holiday, consequently it is possible that the travel agents can "create and limit opportunities for tourists" (Cheong & Miller, 2000, p. 383).

These initial communications with institutional brokers result in tourists forming a mindset of conceptual accessibility about an establishment. They decide if they 'fit in' or relate to the images of the people in the brochures. For those who decide the establishment is not accessible, the brokers have potentially exercised exclusion in the form of repressive power.

The potential for exclusion does not end with non-travel. Power relationships between the broker and the tourist extend to the tourist establishment. Cheong and Miller (2000) discuss the 'onsite brokers', the employees who regulate the rules of the establishments and, using the example of park guards:

> park guards watch over tourists to see if they litter; guides protect, oversee and educate them about how to act properly...subsequently, brokers as agents in a variety of guises constrain their movements, behaviours and even thoughts, and act as a powerful force in the system. (Cheong & Miller, 2000, p. 381).

Although the onsite broker can be an influencing force upon the tourist, it is not necessarily for a ruthless cause. The park ranger for instance serves a dual role of protecting the environment from the tourist footprint.

Concept 2 proposes that power is omnipresent in tourism (from service providers to tourists) but the majority of meaning, symbols and rules of what it means to be a tourist, is largely constructed by the establishments, tourism stakeholders and official tourism organisations. Concept 2 proposes that non-travel, exclusion and inclusion in tourism, is in the hands of the brokers. Other tourism researchers have also highlighted this process of inclusion and exclusion from tourism, and have taken a further step toward a macro social tourism theory with emphasis upon the social construction of 'place'. Exclusion/inclusion is played out in the production and reproduction of society and inequalities within tourist establishments.

Concept 3: Reproducing Social Inequality in 'Place'.

Two different but complimentary perspectives were discussed above to explain who is a non-traveller and how non-travel occurs. Concept 1 offered a perspective that existing social exclusion and inequalities, such as financial constraints or stage of life, precedes and determines non-travel. Concept 2 offered a perspective that non-travel occurs through an environment created by brokers. This third concept agrees tourist establishments have the power to create constraints to travellers and that social inequalities exist in society and impact upon travel opportunity. Further contributing to these observations, the third concept also proposes the importance of 'place' and the narratives (narratives of inequality and exclusion) that are performed in place. It is proposed tourists reproduce social life in tourist establishments. This observation is coined as the "performance of place" (Edensor, 2000; Urry, 1996).

One of the first references to the performance of place concept belongs with Urry (1996, p. 49) who associated place with the physical site by which social life is performed and re-produced. As such, it is a site of discourse making and confirming. He uses the metaphor of walking to explain this concept. Walking is one of the first forms of human mobility, Urry (1996, p. 49) writes that prior to the 18th century Europe people who walked were the "poor, mad, or criminal". Walking was symbolic of social class and deviance. With the commencement of alternative transport in the

19th century, walking was no longer a necessity and could become a voluntary leisure activity of the elite, Urry explains that:

> By the middle of the 19th century the very highest echelon of English society regarded pedestrian touring as a valuable educational experience … In the 20th century leisurely walking has become intertwined with various products including boots, maps, socks" (Urry, 1995, p. 52).

Here the metaphor of walking demonstrates a growing constructed discourse of acceptable travel roles and behaviours that eventually became general knowledge. In the case of walking, the walker who was once a deviant and a symbol of working class, eventually became an activity belonging to the upper classes. Consumable good were symbols of how walking is performed. The key point here for Urry (1995, 1999) is the function of place in reproducing social realities, as "walkers and walking thus give shape to how places are dwelt in and used. While a place, such as a street, is ordered and stable, spaces only exist through movements, velocities" (p. 45). In 19th century Paris, walkers reproduced dominant social class values by performance and 'possessing the place'. Thus, nineteenth century Paris:

> saw the first city of the modern period which provide astonishing new affordances to the peripatetic visitor. It came to be possessed by those who were able to consume, as they walked along the new boulevards and passed by, often into, the brightly lit shops and cafes. (Urry, 1995, p. 45)

Urry's history of walking serves as a useful analogy to understand inequality in tourism. The walker in Paris highlights a social divide specific to that particular time and place. Walking became a symbol of social class. It is because the meaning of walking changed significantly across three centuries, Soja (1989) points out that place is continually re-constructed. Soja (1989) stresses the importance of being aware of how dominant political and ideological practices can be concealed in place. Soja (1989, p. 6) writes of the potential hazards when creating a tourist place, where "each effort to create place becomes an elaboration of the beliefs and values of some collection of people, expressed and fostered in their promotion of a preferred reality". Place' is discussed as the facilitator of transformation, a stage for performing social life, and a site in which the re-production of social life can be witnessed. Analyses suggest that places are more than simply geographic sites with definitive physical and

textual characteristics - places are also fluid, changeable, dynamic contexts of social interaction and memory (Stokowski, 2002, p. 8).

In the creation of a tourist place, the expression or promotion of their preferred reality may be concerning. This is because tourism is largely profit driven and generally not accountable to social welfare. Urry highlights this point with the elite Parisian walkers reality and the motivation to consume and own place. Edensor (2001) further discusses this notion and concurs with Urry's understanding of performing place. Edensor (2001) links performances of tourists, to stages created by a tourist industry. While Concept 1 above discusses the power of brokers to create a establishment and is a similar thought to the construction of the 'stage', Concept 3 takes this further by imagining the stage as a platform for tourists to perform, thus giving the tourist some agency.

A stage can be recognised with the following characteristics, as "these settings are distinguished by boundeness, whether physical or symbolic, and are often organised - or stage-managed - to provide and sustain common sense understandings about what activities should take place". Edensor (2001, p. 62) writes that the creation of particular stages cannot necessarily predict what type of performances will occur, however via "the processes of commodification, regulation and representation that reproduce performative conventions" place, and the associated acceptable performance, are recognised by most.

An enduring relationship occurs when tourism places are organised or 'staged for tourists' followed by the tourist performing in place. Two types of space typically characterise the tourist space, that is, the 'single purpose destination' and the 'heterogeneous space' (Edensor, 2006, p. 330). A single purpose space is "carefully planned and managed to provide specific standards of cleanliness, service, decor and 'ambience'. Tourists are subject to a 'soft control (Ritzer & Liska, 1997, p. 106) – guards, guides and CCTV... shielded from potentially offensive sights, sounds and smells". The heterogeneous space is less controlled and contrived, "it is a multi-purpose space in which a wide range of activities and people co-exist. Tourist facilities coincide with businesses, public and private institution and domestic housing, and tourists mingle with locals" (Edensor, 2000, p. 330). Tourism also constructs the stage for tourists with rituals (festivals or days of celebration), 'themed spaces' such as heritage sites and cultural attractions (Gottdiener, 1997, cited in Edensor, 2000), spaces which have gained publicity in the media (such as from

movies or tragedies) and tourism employees “who are trained to enact roles that fit in with their institutional setting” (Edensor, 2000, p. 330).

The social reproduction of inequalities is evident more so with the single purpose place than the heterogeneous place (Edensor, 2000). Symbols such as the price, the presented cultural environment (elite or everyday) via words chosen to represent the destination and images of people who visit the destination in advertising, confirm or deny the suitability to visit. This example of power can be seen in the creation of travel brochures. Small, Harris and Wilson (2008, p. 17) use Critical Discourse Analysis (CDA) to explore how in-flight magazine advertisements shape travel choices and “produces, mediates and reproduces discourses surrounding air travel”. Small, Harris and Wilson, (2008, p. 18) suggest that many people use flight for travel and represent a broad socio-demographic profile, yet the magazine advertisements are positioned to appeal to a “certain ‘elite’ traveller”. They suggest (2008, p. 18) the “magazine advertisements can be a subtle (or, perhaps not so subtle) way of ‘socially sorting’ airline travellers into those who are socially and culturally acceptable airline travellers and those who are not.” Additionally, by sorting into acceptable and non-acceptable, the non-acceptable travellers are provided with a model by which they can follow to become ‘acceptable’. Regardless of motive, Small et al. (2008) suggest “no matter which way the sorting occurs, in-flight magazine advertising appears to be a powerful medium that overwhelmingly appeals and speaks to privileged groups in society” (p. 18).

Small et al. (2008) show how travel knowledge (or how to be a tourist) is concealed in seemingly harmless mediums of communication such as the inflight magazine. It conveys a plethora of values and sanctioned behaviours such as, who is the acceptable traveller and what it looks like to be an acceptable traveller. The power relations highlighted by Small et al. that the acceptable traveller is ‘elite’ demonstrate a social reproduction of values in tourism from society. Small et al. (2008) demonstrates the power of discourse with the inflight magazine, as a potential constructor of how people become “touristic” and how “tourism becomes ‘of tourism’” (Pernecky, 2012). Similarly, Mordue (2004) finds a contested tourist space in York (UK) between which performances should take place, who should be the consumers of the space, and who is excluded.

In the process of determining how non-travel might occur, Concept 2 has suggested that brokers have the power to construct place and the tourists who visit.

Brokers have the power to exclude and determine people who do not visit. Concept 3 suggests that the tourist performs place, reproducing social inequalities and social and cultural values at that point in time. Travel in this sense is a mirror of society and the agency of the tourist is questioned when researchers, such as Urry (1995) and Edensor (2000) demonstrate the power of brokers to set the stage. In some literature the extent to which non-travel is the result of brokers constructing a tourist stage that excludes, is questioned against the potential agency of the tourist to transcend the power of the tourism industry. The agency of the tourist is the final concept to examine.

Concept 4: The Traveller, Agency and Power.

The struggle to define a person who engages with the tourism industry (tourist/traveller) is historically more an academic concern rather than an industry concern (Miller & Auyong, 1998, p. 3). Overall, in academic research, the traveller has been defined within a fixed dualism, in terms of a consumer and producer relationship (Larsen, et al., 2007). Already discussed above, at times the academic understanding has confined the traveller as a passive actor within the business of tourism; the tourist/traveller has also been defined as a facilitator of imperialistic values (MacKenzie, 2005). To this point the discussion has identified the actors in the construction of power in tourism and power in place. It has largely described a top down approach to power in tourism, rather than a bottom up i.e. the power of the traveller).

It is suggested that all people engage with the tourism system at some point in their lives and fulfil the role of performing the tourist, the traveller or the non-traveller (Cheong & Miller, 2000). They may also at some point be a tourism ‘agent’, or ‘broker’ (Cheong & Miller, 2000). In Australia, brokers come in the form of overarching institutions such as service providers and Tourism Victoria, to the micro onsite brokers, such as tour guides and brochures. It was proposed that travel choices for people are largely constrained by brokers and this represents a large portion of the power relationship between tourists and the tourism system (Cheong & Miller, 2000). Or, as discussed in concept 2, where non-travel occurs from existing social inequalities. However, in these explanations the experience of the traveller and potential agency has gone astray. At this point it is important to further explore Foucault’s concept that power is everywhere conveyed through people and mediated

by the ‘inspecting gaze’ (Cheong & Miller, 2000). The discussion must explore the travellers’ encounter with tourism.

A further body of research emphasises that the traveller continually re-constructs the tourism discourse (Lean, 2012) set out by the brokers/constructors and as such the traveller has agency via ‘constructionism in action’. In conjunction with the process by which ‘people’ become ‘travellers’ and perform in place, they use agency in the tourism space to fulfil the primary motivation of travel and to transform, and fashion their identities. For instance, Adler’s approach to travel as art, can be connected to the widely accepted notion that the motivation to travel occurs from a need to transform the self. Lean (2012) and Adler (1989) both suggest that meaning making occurs in the process of travel that has the potential to result in ‘self-fashioning’. Adler not only suggests travel is art, she uses the phrase ‘performed art’, therefore travel becomes an activity that is publically staged – and is a performance that is recognised by other people via acknowledged symbols of travel in the tourism discourse. By performing travel in a way that is recognised by others and in doing so, attempting a process of transformation and meaning making, Adler’s (1989) traveller is both a product of the tourism discourse but also striving to be a free agent. Discourses of tourism may be fashioned and facilitated by constructors, yet travellers play an active role in re-constructing. The traveller is constructionism ‘in action’ (Lean, 2012).

Social science researchers believe the social being of today is particularly partial to re-construction (Edensor, 2001), they are post-modern subjects in an increasingly mobile world. Baumesiter (1991) states the post modern subject is defined by the ‘self’ as a consequence of post-modernity and freedom in mobility. Baumeister (1991, p. 6, as cited in Cohen, 2010, p. 119) contends that the “self dominates recent trends in our culture” and that development of the self is a significant narrative in “modern Western imaginations”.

Bauman (1996) further theorises these social and political conditions today as ‘liquid modernity’, this is explained by Heimtun as meaning “that the social order is mobile and flexible awaiting people’s way of constructing it” (Franklin, 2003, p. 205) and considers within this environment is a plethora of space for the traveller to find meaning, transform, construct and re-construct their identities. In liquid modernity, Adler’s (1989) traveller has found the ideal environment to perform where there are no clear spatial dimensions to understanding social life. Liquid modern societies

therefore have no flexible, hierarchical social order governing people's lives, but each person has to deal with transformations and states of becoming (Franklin, 2003, p. 206). Liquid modernity is then about individualization and aesthetic reflection (Heimtun, 2007, p. 272).

With the decline of traditional social orders to govern the masses (such as religion) Bauman (2000) observes a breakdown of social networks and the individual has become some sort of free floating consuming entity, more like 'nomads' (Bauman, 1996; Franklin, 2003 cited in Heimtun, 2007, p. 272). Bauman (1996) utilises a metaphor of the tourist to study consumerism in this state of liquid modernity called the 'tourist syndrome' with three key themes.

First, because the traveller is impermanent, they have no need to create fixed bonds with place or people in their travels. They connect with people but are not bound to any rules or commitments, where "everyday norms are therefore suspended, the past and future do not exist and excessive behaviour is allowed or at least tolerated" (Bauman, 1996, as cited in Heimtun, 2007, p. 273). Secondly, with no commitment to people or place, travellers consume place and achieve what they desired for their tourism experience, where the tourists " move on when the place has been sufficiently experienced and consumed". Lastly, "tourists' relationships are frail. Tourism consumption is first and foremost about consumption of new experiences, they do not waste energy on getting involved with people" (Heimtun, 2007, p. 273). Not getting involved with people, is slightly at odds with the idea that tourism exists from the need to create social networks or belonging, that are no longer fulfilled in everyday life under the conditions of liquid modernity (Bauman, 1996; Heimtun, 2007). Heimtun (2007, p. 274) states that Bauman "fears its consequences as tourism offers only 'fraudulent substitutes for the absent real thing' (Franklin, 2003, p. 214). With this statement Bauman suggests travel is a fleeting experience and any bonds made with other social networks cannot be transferred to the person's everyday life. Although this is a very valuable insight into the conditions that motivate the traveller (such as the increasing need to use the tourism space for transformation in liquid modernity) Bauman's idea reaches an impasse at this point. The understanding that bonds made while travelling are 'fraudulent substitutes' suggests Bauman (1996) concurs with much past travel research which suggests tourism exists as a separate entity to the so called everyday life. Throughout this chapter it was identified that emerging tourism research contends this concept.

In concurrence with Bauman, Heimtun (2007) finds similar ideas regarding travel and the need for connections. In a study of single Norwegian women in middle age, Heimtun (2007) found travel is a space for reproducing desires in everyday life, such as a space for friendship and accumulating social capital from a shared experience, by ”bonding with significant others and about social integration in everyday life” (2007, p. 271). These results confirm that travellers reproduce their need for social networks in travel, which is inherent in Bauman’s ‘tourist syndrome’.

Heimtun (2007) findings contest the notion that it would be a ‘fraudulent substitute’ for real social connections. The social connections sought and performed in the travel experiences of the Norwegian women were provisions for the everyday life. That is, the women reflected upon their travel experiences with their travel friends, it provided memories and a shared experience to draw on after travel, and perhaps informing any future travels. Along with travel providing the space for the reproduction of social networks/community desired in everyday life, research has considered travel motivation to be based upon imaginings of travel for transition (White & White, 2004), identity or transforming self (Cohen, 2010, p. 119; Neuman, 1992, p. 182). A social constructionist perspective would hypothesize that transformation is not only possible for humans but inherent in our nature because we are discursive subjects (Burr, 2003, 2005). This means our unavoidable engagement with the world results in new knowledge and ideas of ourselves and our place in society. Our identities are not fixed, but dynamic, according to place and time, indeed “Hall (1996) describes identities as temporary points of attachment to subject positions constructed through discursive practices. Identity is constructed through difference, as the recognition of what one is not, in relation to the ‘Other’ “ (Cohen, 2010, p. 119).

While much of the knowledge that constructs our identities appears as ‘truth’ and is often taken for granted, travel is one space to manufacture transformation. When travelling, the person can imagine and pretend to be the other, their best self or alternative self. Also the traveller meets or observes many ‘others’ that compel them to position themselves in relation to this new knowledge. The traveller can also distinguish themselves as an ‘other’ because when they are the traveller, they are removed from their everyday role at home. Lean (2012, p. 156) writes this transformation can occur because “it is believed that physical relocation enables the

alteration of a reality-confirming amalgam of roles, performances, relationships, expectations, objects, languages and symbols".

Physical relocation can enable transformation, however it is suggested that the relocation cannot be separated from the person's everyday life. There is a tension between the idea that tourists today have agency (no fixed bonds or permanency) and that travel choices cannot not exist in a cultural and social vaccum, because we are ultimately discursive subjects.

The assertion that a traveller has the agency to choose and reconstruct their tourism experience is hindered by the constrictions of their socialisation. That is, research suggests travel choices are continually informed by an individual's socialisation. Lean (2012) confirmed the significant role of socialisation in research that explored the voices of midlife single women in Norway, their travel stories and how they identified the social construction of their travel choices. Lean (2012) found that the prior-travel experiences informing travel choices are unique to each participant's social and cultural composition. This included the primary and secondary socialisation from social relationships, families and friends and the associated "values, attitudes, experiences and socio-economic position of parents" (p. 157). The quandary is then, the agency to transform self and re-construct tourism spaces, meets the counter argument that people can rarely make choices outside of their 'habitus'.

As opposed to Foucault's concept of power where the individual has little agency, Bourdieu offers a similarly bleak yet more hopeful framework. Bourdieu (1986) sees the individual as existing within a habitus, a 'cultural field' - the institutions, knowledge, resources, and discourses that determine an individual's life chances. According to Bourdieu (1986), within this system the individual can be active yet mostly and inevitably detained, therefore the system is inherently unequal and reproduces itself: "For Bourdieu, people did not live their lives according to freely made choices or strategies, but rather, under the constraints of the habitus and the objective conditions of social life" (Reed-Danahay, 2005, p. 56). According to Bourdieu, the individual, though mostly trapped in their cultural field has the potential to move freely with the tools of social, cultural or symbolic capitol.

The habitus can be identified within a second key theme regarding travel motivation. Lean's (2012) research suggests travel choices are made so as not to challenge normative behaviour, and thus live in accordance with the habitus. Normative behaviour is explained by Lean as, the "roles, routines and

performances...and their associated expectations and sanctions for failure to comply. These played a critical role in establishing the thinking, behaviours and realities that travel presented the opportunity to transform" (Lean, 2012, p. 158). In performing travel, the traveller is then governed by what would be thought of as acceptable behaviour. For instance, wellbeing travel is reported from many sources to be patroned primarily by females. Voigt, Brown and Howat, (2010) found domestic spa tourists within Australia are predominantly female (61%). Further, a survey conducted by Intelligent Spas (2006) found an even greater discrepancy between group numbers with 78% of females participating. This demonstrates both the acceptability and normative behaviour of women taking care of themselves and being concerned for wellbeing, and also it is not a normative masculine behaviour for a man to visit a spa and receive a pedicure, facial or mud pack. In tourism it may be that gendered norms are performed in travel choices.

So far the discussion has identified that the agency and power of the traveller is questioned by 1) the power of brokers to inform the travel experience, and 2) Bourdieu's habitus and the quandary regarding an individual's potential to make free choices. The next quandary of agency is, 3) the role of dominant ideologies in the construction of socialisation. The main position of this thesis stems from this tension about how much power or agency anyone has to decide if they want to travel, and what sort of travel they may want to partake. It will be suggested and discussed throughout this thesis that travel choices are a product of the discursive self; an individual who is a product of their social and cultural life and inescapable dominant narratives, but at the same time is not static or passive.

In Lean's study (2012, p. 158) it was found that as a part of secondary socialisation, discourses (texts, images, symbols and knowledge) in the public realm play a part in the construction of travel choices including, "representations of travel to certain places/destinations and in general" via all forms of media, magazines, brochures, television, the internet and "conversation and other travellers' accounts, which may include stories of transformation through travel".

With all these influences informing travel choice, avoiding the dominant tourism discourse created by brokers is almost inescapable. Lean (2012, p. 152) summarises the process of travel choice and motivation as the process where individuals "embark upon a physical travel experience with a perception of travel based upon their socialisation, personal experiences and the various social institutions

to which they belong (Rojek & Urry, 1997). Motivations grow out of roles, routines and thinking within the home environment that draw upon social constructions of place, fantasy, imagination, representations, family heritage".

Travel offers a space for self-change or transformation, it is suggested travel choices and motivations are based on the social construction of self combined with imaginings of travel based upon the mostly accepted discourse of tourism. It is debated to what degree any true and lasting transformation can occur as "some argue that travel simply reinforces existing ways of seeing and acting in the world, supporting prejudices, misguided/'false' representations" (Lean, 2012, p. 152).

Some researchers are approaching the traveller as a subject of a post-modern - and as discussed above - increasingly mobile world. Researchers suggest that liquid modernity offers a perfect conceptual social condition to construct and re-construct the self. This is why some critical tourism researchers and sociologists (e.g. Heimtun, 2007) see travellers as reproducing society either by replicating desires and/or perpetuating social divides in the performance of roles. From this perspective the tourist has little, if any agency in travel.

Travelling allows temporary respite from the everyday and provides an environment where the traveller can imagine (before, after and during travel) the purpose of travel. This is true of both general travel experiences that offer a pause from responsibilities, or travel with a particular purpose such as eco-tourism, adventure travelling or travelling for wellbeing. In each of these contexts the purpose of travel chosen, states something about the individual's values (e.g., action person; eco-friendly; wellbeing focused). By performing the chosen travel role, they construct a version of themselves and have the opportunity to re-construct their identity. The quandary with agency suggested then, is travel choices are first determined by the socialisation of each individual, so the traveller and the citizen in general has a difficult time making any choices which are not a product of their socialisation. The tourist appears to have little agency to escape the dominant discourses that govern how to participate in tourism, including determining who does travel, who does not, and how travel is performed in place.

Conclusion

This chapter has explored if existing tourism literature addresses how non-travel occurs. Analysis of the literature has determined power and the reproduction of inequalities play a role in both driving and constraining travel participation. Four concepts have been proposed to explain the process.

First, non-travel is determined by existing social inequalities, such as low income and socio-economic status. Non-travel occurs at certain stages of the life cycle, such as the single, older and working. Literature looks beyond poverty to explain non-travel and considers the concept 'social exclusion' as a multi-dimensional process determining non-travel. The second concept of power determining non-travel in the literature was Cheong and Miller's (2000) adaption of Foucault's 'repressive power. They state the brokers of the tourism industry (tourism organisations, service providers, government stakeholders etc.) can include or exclude potential customers. The potential tourist is constrained to travel based upon the brokers creating destinations and establishments to attract the ideal customer and exclude others. The third concept of non-travel focuses upon the role of the tourist and the brokers combined. Urry (1995) suggests tourism is used as a stage by tourists to perform social life and consequently reproduce social inequalities in tourism. The stage is constructed by the etablishment/service provider and reconstructed by the tourist - including creating the desired setting for the desired tourist, and excluding others (Edensor, 2001; 2004; Soja, 1989). Soja (1989) warns of the dominant political and ideological practices can be concealed in place - the power concealed in the construction of a preferred reality by the tourist and the broker. The fourth concept highlights a small body of literature that questions the level of agency tourists have to transcend the power of the tourism industry when making travel choices. Bauman (1996; 2000) sees the traveller as a free floating consuming entity, not bound by an 'industry' or stage. Conceivably contrary to Bauman, Lean (2012) suggests a further way agency is expressed by tourists is through performing the stage. According to Lean (2012, p. 158) travel choices are shaped by first and secondary socialisation and the "roles, routines and performances...and their associated expectations and sanctions for failure to comply representations of travel". Both Adler (1989) and Lean (2012) suggest tourists use the tourism stage for meaning making, to transform and fashion their identities and therefore are re-constructing rather than performing.

This body of literature highlighted the tourist may have agency to transform self and re-construct tourism spaces, rather than be constrained by tourism. The counter argument however is that people can rarely make choices outside of their 'habitus' and the 'objective conditions of social life" (Reed-Danahay, 2004, p. 56). Therefore, non-travel occurs first from the conditions of an individual's social life and this determines travel choices.

Concept 1, 3 and 4 shows how the opportunity to travel is determined by the individual's socio-economic status, and travel choices are determined by socialisation. Concept 4 shows the traveller is driven by the desire to transform and perform. Yet, all of the concepts suggest the potential traveller is constrained in some way, whether by determining who can or not travel, or by how travel is performed. Having examined literature available regarding non-travel in Chapter 4, and the original drives for wellbeing travel in Chapter 2, and wellbeing travel today in Chapter 3, the scaffold is built to address the method of this thesis and the main research question; What are the drivers for travel and constraints of travel when travelling for wellbeing in Australia?

Chapter 5: Tourism Research and Limitations: Towards a Critical Analysis of Wellbeing Travel.

This last chapter of the literature review discusses the limitations of tourism research. The main purpose of discussing these limitations is to highlight the minimal role sociology has had in the tourism discipline - and how this study aims to contribute towards further growth. Earlier in the thesis, attention toward the accountability of the tourism industry (social and the environmental accountability) was highlighted as a modest area in tourism research. The absence of a strong social accountability argument in tourism studies is not just the fault of the tourism discipline. It is also due to the fact that social science disciplines have long considered tourism studies as lightweight. Jaworski and Pritchard comment that "many of these ('parent') disciplines have been remarkably reluctant to engage with tourism as a field of study" (2005, p. 8). Not only are they reluctant to engage, Jaworski and Pritchard (2005, p. 8) suggest these disciplines have actively disregarded tourism studies, "as a result ... there is a real sense in which the social sciences and humanities themselves have played an active role in marginalising the study of tourism". As such, innovative approaches to the study of tourism have evolved slowly in the social sciences to take a modest position in the discipline.

The process of incorporating social science into tourism began in the 1970's. In 1974, travel sociologist Cohen (1974, p. 528) conducted a literature search and reported that although he could find research upon traveller types, he did not find anything regarding the "phenomenon of travelling". With that article Cohen (1974) appeared to set in motion an academic conversation about the sociology of tourism. At this time coinciding with Cohen's social science agenda, was tourism studies work to conceptualise the tourist system. One such example is Leiper's highly regarded tourism system model (2005). Devised in 1979 to track the process of tourists' movement and interactions which was thought to move between three regions, these are:

> areas in which there is substantial volume of demand for leisure travel activities are traveller generating regions [TGRs]; areas that attract a substantial number of visitors are termed tourist destination regions [TDRs]; and areas through which travellers pass in moving from their home to their holiday destination region are termed transit route regions [TRRs] (Kelly & Nankervis, 2001, p. 21).

The organisation of tourism is depicted as encompassing the 'tourist', the 'establishment', and the supply/demand process. And until recently, tourism has been understood as a singular activity (significantly so in tourism studies and to a lesser extent within the sociology of tourism). Or, tourism research has considered travel as a binary action – home to destination, and then back to home (Lean, 2012, p. 153) rather than an action that is imagined, planned and informed within an individual's everyday life and as dependent upon individual circumstances.

Herein lies a fundamental criticism of tourism research; in the past if has not often incorporated everyday life in the understanding of tourist motivations, or the drivers and exclusions from travel. This is a fact noted by Larsen (2008, p. 22) who claims "discussion of everyday life is absent from tourism theory and research".

The reasons wellbeing travel demand has resurged in Australia cannot be explained by examining the increasing supply of establishments; the increase of tourists in a one year timeframe.; or with quantitative surveys and marketing prediction models.

One such study is Mueller and Kauffman (2001, p. 3) who used a quantitative survey of 400 participants (69% response rate) for guests in hotels who used wellness services in Switzerland. Using multiple quantitative methods to determine the wellness tourism market including which services they used interconnected with socio-demographic information (Mueller & Kauffman, 2001, p. 3). Mueller and Kauffman's study can inform the opinion of some wellness travellers at one point in time and is important as an exploratory study. However, tourist studies can often observe the tourist as static; do not offer a voice to the tourist (Boote, 1981) and do not consider the drivers and constraints of travel shaped by everyday life.

Lean (2012) has observed one limitation of singular research is that it can result in ambiguous findings and a misrepresentation of the social phenomenon of travel. He commented:

> it becomes evident that the uncertain, and often contradictory, findings within previous studies arise from focusing upon small, isolated fragments of what is a highly complex global phenomenon (Lean, 2012, p. 153).

As a result of these observations about singular research, a key position for this study is to examine the tourist as multi-dimensional, and the motivation to travel as a process that is influenced by the everyday life.

A further fundamental criticism of tourism research (beyond the singular approach criticism) is the reliance upon ‘fixed dualisms’. In addition to physical travel as a binary action, Larsen et al. (2007, p. 21) highlighted that past theories of tourism have focused upon other fixed dualisms, for example “leisure as opposed to work, away as opposed to home, authenticity as opposed to in-authenticity, the extraordinary as opposed to the ordinary, and guest as opposed to host” (Cohen 1972: Larsen, et al., 2007; MacCannell 1976; Urry 1995).

These dualisms are complimentary to the development of the social science of tourism because they identify potential social injustices by way of acknowledging power in tourism and travel. For instance, what Dann and Cohen (1991) term the ‘evolutionary approach’ demonstrates a fixed dualism of tourism as the powerful versus the disadvantaged. The evolutionary approach traces the shift from the origins of travel, from white imperial travel - “the aristocratic grand tour” - to the “contemporary versions of mass tourism” (Dann & Cohen, 1991, p. 159). With the increasing rise of the tourist and tourism as a normative activity, mass tourism began to be understood negatively as the commoditisation of travel, and was “described as a process of unequal power relationships whereby entrepreneurs and economic forces supersede local needs” (Dann & Cohen, 1991, p. 159). Researchers questioned the accountability of the tourism industry in regard to exploiting societies who were powerless to not accept development and the economic benefits it could bring. The individual tourist was also viewed negatively, as MacCannel writes of the time in 1979, “It is intellectually chic to deride tourists” (p. 9). Again, the inherent problem with these dualisms is that despite identifying potential social injustices, it ignores the more complex or subversive processes in tourism. For example, not all tourists or travel will result in the exploitation of host culture; these dualisms highlight how previous research methodologies have limited the agency of the tourist’s capacity to change/reproduce and the host’s capacity for resilience.

In 1995 Urry (1995) argued that tourism research requires more research regarding the social motivations of tourists and less singularity about place. Urry argued that:

> tourism is site specific and case study based...researchers have tended to define physical space by its objective, resource-based qualities. Settings are conceived as physical sites towards which recreationists orient, and alternative theories about place are rarely in evidence. (Urry 1995, p. 370)

The perspective about ‘place’ was introduced in Chapter 4, with the discussion about the importance of considering the political and social values concealed in tourist establishments.

In summary, Larsen et al. (2007) are concerned that tourism, as the study of a single phenomenon or ‘fixed dualisms’, are still the dominant mode in research. They argue “mainstream research still treat tourism as a predominantly exotic set of specialized consumer products that occur at specific places and times” (p. 246). Dann and Cohen (1991, p. 157) explain that instead, tourism or travel, needs to be studied holistically as a part of social processes rather than separate, and “the consensus seems to be that tourism cannot be treated in isolation, but has to be seen as nestling within wider applied domains”.

The concerns raised by tourism academics in this chapter are congruent with a social constructionist perspective, and are the foundations of the methodological approach for this thesis. The idea that 1) concepts of tourism, or travel, should be seen as one part of wider dynamic social processes; and 2) that the tourist is not a singular or static being, reflect principles of social constructionism.

Travel as a Social Construction and a Discourse.

Tourism studies are beginning to consider tourism and travel through the social constructionist perspective. Social constructionism identifies and explores “taken-for-granted knowledge” about “how the world appears to be” (Burr, 2003, pp. 2-4). Early researchers of social constructionism, Berger and Luckman (1966), considered that humans are not passive beings, they are “active as agents who actively construct their world, rather than as passive organisms that simply process information” (Cornebise, 2003, p. 39).

The principles of social constructionism are formed around understanding knowledge and reality. First, humans, as active agents, create knowledge about themselves and their world through language. There is no fixed reality, our knowledge about the world is continually reconstructed with the development of new knowledge (Marvasti, 2004, p. 5); and knowledge is relative to historical and cultural circumstances.

The concept of tourism is socially constructed. For most people in the western world, 'tourism' is an overarching word representing the organisation of, and establishments that offer opportunities for travel. Tourism is not one fixed entity, it does not exist in one country, it is not managed by one overarching organisation, but as a concept, most people have accumulated a body of knowledge about what it is and what it represents. For these reasons one persons' knowledge of tourism is made up of culturally and historically specific information, communicated to us in various formats throughout our lives.

Dann (1996) articulates one way tourism is a social construction, with the language of tourism driving demand:

> via static and moving pictures, written texts and audio-visual offerings, the language of tourism attempts to persuade, lure, woo and seduce millions of human beings, and, in so doing, convert them from potential into actual clients. By addressing them in terms of their own culturally predicated needs and motivations, it hopes to push them out of the armchair and on to the plane – to turn them into tourists. Later, the language of tourism gently talks to them about the possible factors or attractions of competing destinations (1996, p. 2).

Here Dann (1996) suggests the entire travel process begins before the act of travel, during and after. It is a language made up of specific targeted images, by way of advertising; it is tied to and collaborated with by other dominant institutions.

There are further applications of this social constructionist perspective to tourism. First, one persons' knowledge of tourism is most likely similar to those in the society and population groups they belong to. This is because social constructionists believe knowledge is culturally and historically specific. We do not just have individual bodies of knowledge about tourism, but share dominant versions of knowledge. Social constructionists examine how dominant versions of knowledge can construct the way we see the world and are often termed discourses. Secondly, beyond the knowledge making about tourism, by the organisers of tourism (as outlined by Dann) tourism is also constructed by wider social discourses.

A discourse can be simply described as accumulations of mostly accepted knowledge, or knowledge that becomes dominant, created by human interaction over time (Philips & Hardy, 2002). Ussher, a critical psychologist (2011, p. 12) describes discourse as a complimentary relationship between society and individual and as

“what organises our knowledge about a subject and the relation of both the individual and society to that subject”.

Additionally, Burr (2003, p. 64), a social constructionist, defines discourse as “a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events”. It is because this knowledge becomes mostly accepted by people in a group or society, that the discourse appears to hold power or appears as truth. Examples of historically deeply embedded discourses that appear to hold power and govern behaviour are religious; crime and punishment, and the medical model of health, which are also termed ‘dominant discourses’ (Conrad, 2010). Burr (2003) suggests the entire organisation of society is linked this powerful tool that contributes to the identity of each individual - including how we are defined, or how we define ourselves. Burr (2003) further explains our identity from a social constructionist perspective, she argues that:

> the discourses that form our identity have implications for what we can do and what we should do. In our society we have a capitalist economy and we have institutions such as the law, education...they offer us social positions and statuses...makes us into ‘workers’, ‘employers’....’married’...’childless’. (Burr, 2003, p. 75)

Our dominant knowledge about tourism in Australia and other similar capitalist countries, is connected to the work and leisure dichotomy which offers acceptable conditions for travelling or taking a holiday. Sociologists Van Krieken, Habbis, Smith, Hutchins, Martin and Maton (2014, p. 195) highlight how society is structured by ‘work’, notions of citizenship, and social inequality. Travelling can be a symbol of our employment status (having access to paid leave and having disposable income to spend on travel). And in capitalist societies working/employment is a requirement and symbol of a valid citizen (Hall & Brown, 2006; Holden, 2006, p. 30).

The above observations have prompted tourism research to consider that tourism is not a fixed organisation, it is a constructed social reality, constructed by people and echoing central values and faults in our societies. In particular it is a site where social values/processes and power are reproduced and performed by actors (tourists), in the social construction of place (establishments).

From a social constructionist perspective tourism is a discourse that organises ideas about, what we 'can do and what we should do' when making travel choices, and our behaviour when on a holiday, and they constrain and drive our travel choice.

Additionally, discourses of leisure and work have implications for our identity and social inclusion or exclusion in society (Burr, 2003). To not travel may be a symbol of 'what we cannot do', and 'offers us social positions' such as a non-traveller, and not as valued citizens.

The origins of wellbeing travel outlined in Chapter 2 is a good example of tourism as a socially constructed discourse. The notion that it is important to travel to mineral spring spa's for upper class women is a product of the medicalisation movement, increasing travel for leisure, and gender politics.

Wellbeing travel is one type of travel and in Australia and globally, there is a resurgence of demand and supply (see Chapter 2). Through a social constructionist lens, a number of questions are raised about this resurgence. In this research, a social constructionism is utilised to observe and analyse tourism as a discourse; as one part of wider dynamic social processes . It allows us to see the tourism system as a non-static social creation as opposed to the fixed uniform institution that some tourism research has envisioned in the past.

Most importantly, it is not uncommon for tourism, leisure and geography research to acknowledge that tourism and leisure activities can privilege some citizens more so than others (Botterril & Klemm, 2006; Haukeland, 1990). The key value of the social constructionist perspective for this study, is that it broadly allows us to examine power and social inequality in tourism.

Critical Discourse Analysis

Numerous methods of research can be applied through the social constructionist lens – ordinarily discourse analysis. The study of discourse is the analysis of language and traditionally falls into either the micro analysis of socio-linguistics, or a macro analysis of language in a social system (Taylor, 2001). The two main approaches to discourse analysis are constructivist and critical. Both approaches examine the construction of social reality. The constructivist approach includes "fine-grained explorations" of social reality construction, while the critical approach

emphasises on “the dynamics of power, knowledge, and ideology that surround discursive processes” (Philips & Hardy, 2003, p. 10).

Critical Discourse Analysis (CDA) ideally connects the micro and macro approach, and can also include some degree of a constructivist approach with the critical, or vice versa. This is explained by Van Dijk (1998, p. 87):

> Language use, discourse, verbal interaction and communication belong to the micro-level of the social order. Power, dominance and inequality between social groups are typically terms that belong to a macro-level of analysis. In everyday interaction and experience the macro and micro level (and intermediary 'meso-levels') form one, unified whole. For instance, a racist speech in parliament is a discourse at the micro-level of social interaction in the specific situation of a debate, but at the same time may enact or be a constituent part of legislation or the reproduction at racism, at the macro-level.

To examine the social construction of wellbeing travel, this study applied the critical approach to discourse analysis. The critical approach acknowledges tourism as one part of wider dynamic social processes, constructed by global organisations, and by the individual traveller. It also acknowledges tourism as a phenomenon that privileges some people more than others, and therefore examines the concept of power and social inequality (Le & Short, 2009).

Strengths and Weaknesses of CDA

There is no prescriptive CDA method and this is both a strength and weakness of the framework. (Van Dijk, 1998). Without a prescriptive and rigorous method, CDA is often criticised, particularly during the selection and analysis of data (Fowler, 1996). For instance, researchers cannot source and study all texts and claim to have encapsulated a total discourse. Making this assertion would contradict a key principle of discourse analysis – that discourses are always changing and re-constructing.

CDA is also often criticised for subjectivity. With a critical starting point, the CDA researcher may integrate their own ideologies into the data analysis, rather than “being revealed through the data” (Van Dijk, 1998). The majority of risks or weaknesses of CDA can be addressed through researcher transparency. Researchers need to acknowledge CDA is subjective and reflexive, and in the process, can draw

attention to this as a strength of the framework (Phillips & Hardy, 2002; Le & Short, 2009). All academic work inevitable includes the construction and presentation of a reality of some kind. This thesis is contributing to a particular discourse about wellbeing travel and a reality of wellbeing travel. Researchers can be transparent about the limitations of studying all texts in a discourse, by clearly outlining the method used to select "a subset of texts for the purpose of manageability" (Philips & Hardy, 2002, p. 10).

Conclusion

This chapter outlined the theoretical positions of this research, with social constructionism applied as the epistemological approach, and Critical Discourse Analysis as the method of data collection and analysis.

First, the chapter discussed the limitations of tourism research. There is a gap in the critical inquiry of tourism. acknowledged by a group of tourism scholars who suggest 1) concepts of tourism, or travel, should be seen as one part of wider dynamic social processes; and 2) that the tourist is not a singular or static being.

Secondly, and related to the first point, the chapter conceptualised tourism as socially constructed, because there is no one reality or knowledge of tourism; and any knowledge is the result of discourse. The language and communications in our culture construct our knowledge of tourism and travelling. Population groups generally have a shared dominant versions of knowledge about tourism and social constructionists examine how these construct the way we see the world, and how we act. Dominant discourses of tourism drive and constrain our travel choices. Discourses of tourism also organises our ideas about where we should go, and how we behave when get there.

These conceptual positions resulted in the development of the research questions:

1. How is wellbeing travel in Australia socially constructed?
    a) What are the dominant discourses informing the concept of wellbeing travel?
    b) Is there an overarching discourse of 'wellbeing' for wellbeing travel service providers in Australia and the Australian people?

c) How does a ‘wellbeing’ discourse inform the development of wellbeing travel, and potential tourists.

Critical Discourse Analysis (CDA) was highlighted as the specific methodology underpinning this research. CDA focuses upon the power and constraints that can result from discourses.

2. What are the drivers and constraints of travelling for wellbeing in Australia?
    a) From the perspective of Victorian wellbeing travel service providers.
    b) From the perspective of Australian people.

Chapter 6: Method

Exploratory Study

Only a handful of wellbeing travel studies have been conducted in Australia thus far, such as Voigt et al. (2010; 2011) and Bennet, King and Milner (2004). The social construction of tourism in an Australian context is (at the time of writing) absent in research. For these reasons this project is exploratory. Exploratory studies are logical when little is known about the subject matter; "exploratory studies seek to explore what is happening and to ask questions about it," (Gray, 2004, p. 32). Exploratory studies offer preliminary answers to questions about an under-researched topic or area of concern (Gray, 2004; Mason, 2010). In tourism studies particularly, exploratory research is now currently endorsed "as a relatively new field of study, tourism has many topics and themes that are still not well known or fully understood" (Mason, 2010, p. 432).

Critical Discourse Analysis method

Chapter 5 detailed the conceptual position that wellbeing travel is socially informed and constructed. The method applied to examine this position is Critical Discourse Analysis. Many scholars agree there is no one method for conducting CDA but two broad commonalities are 1) to go beyond a description of language to examine how discourses are structured and 2) how they are "deployed in the reproduction of social dominance" (Fairclough & Wodak, 1997; Le & Short, 2009; Philips & Hardy, 2002). In consideration of CDA method and the two key research questions, the tasks for data collection were to identify the ideologies, discourses, structures of power and relationships in wellbeing travel. However, as discussed in the Chapter 5 it is not possible to study an entire discourse, so data collection targeted a 'subset of texts' (Van Dijk, 1998).

Finding out how wellbeing travel in Australia is socially constructed (as per Research question 1) necessitated identifying the stakeholders, exploring the structure and organisation of this travel type; and the discourses of wellbeing and travel represented by these stakeholders. To achieve this Phase 1 of the data collection included in-depth interviews with wellbeing travel service providers; travel agents; an analysis of all available public documents pertaining to wellbeing travel from tourism

organisations (Australian Tourism Export Council (ATEC) and Tourism Victoria); and an analysis of the discourses of wellbeing travel in academic literature.

The next step in CDA is to examine how discourses are used and reproduced; the power enacted in its deployment, and the resulting constraints. The method of data collection aimed to find out what drivers and constraints resulted from the construction of wellbeing and travel discourses (as per research question 2). Phase 2 of the data collection collected information about wellbeing travel with one focus group of people who regularly engaged with wellbeing activities; and a qualitative and quantitative survey with three groups who were classified based upon level of wellbeing activation, and whether or not they had travelled to a wellbeing service provider in the past two years; Group 1: Low wellbeing engagement, no travel for wellbeing; Group 2: Regular wellbeing engagement, no travel for wellbeing; and Group 3: Regular wellbeing engagement, traveller for wellbeing (see Appendix E for survey questions). The interviews with service providers in Phase 1 could also offer data to identify how constraints and drivers were built in to their establishments.

The method of data collection for this study acknowledges value in both qualitative and quantitative research methods. The value of quantitative methods are to "allow social researchers to systematically quantify the world in which we live. …Being able to quantity helps us make sense of the social world. We want to know quantities and the relationship among them …" (Donley 2012, p. 17). Quantitative methods were engaged to quantify descriptive characteristics of the survey sample (such as age and income) and the relationship between characteristics, attitudes and beliefs.

Exploratory studies often include a majority of qualitative research (Creswell, 2003, 2009; Stebbins, 2001) and help to make sense of the social world by "explor[ing] the reasons and motivations for perceptions, beliefs, and behaviours of people and can produce a better understanding of the lived experiences of people" (Donley 2012, p. 39). Exploratory qualitative data allows for the emergence of new themes, often achieved with focus groups (Babbie, 2013, p. 90) and interviews with experts in the field (Gray, 2004, p. 32). The following sections of this chapter outlines the detailed procedures of data collection, and further details about the research approach.

Data Collection

Phase 1– In-depth Interviews with Tourism Brokers and Desktop Research

Following approval of this research from the Victoria University Human Research Ethics Committee on the 18th November 2010 , Phase 1 of the data collection commenced. The broad aim of Phase 1 was to determine more about wellbeing travel in Australia from the perspective of those who organise and/or promote wellbeing travel services with in depth interviews. The brokers chosen for interviews were, tourism organisations, service providers, and travel agents.

The focused aims for Phase 1 was to explore the key themes the service providers utilise to conceptualise wellbeing travel and their role in organising this travel type.

Phase 1 of data collection addressed the following research questions:

1. 'How is wellbeing travel in Australia socially constructed?
    a) What are the dominant discourses informing the concept of wellbeing travel?
    b) Is there an overarching discourse of 'wellbeing' for wellbeing travel service providers in Australia and the Australian people?
    c) How does 'wellbeing' discourse inform the development of wellbeing travel, and potential tourists.

2.What are the drivers and constraints of travelling for wellbeing in Australia?
    a) From the perspective of Victorian wellbeing travel service providers.

The rationale for conducting in depth interviews was to gather quality and complex information from service providers about the development and nature of their business, and that "interviews with a small number of the 'right' people will provide significant insights into a research issue" (Hay, 2005, p. 72). Consistent with exploratory research, the interviews aimed to conceptualise what is 'wellbeing travel'; secondly, and consistent with a social constructionist perspective, to explore a wellbeing discourse and positions made available to tourists (whether participatory or exclusionary).

There are four benefits of interviewing according to Hay (2005, p. 80), 1) close a knowledge gap in a way alternative methods cannot; 2) “to investigate complex behaviours and motivations”; 3) “to collect a diversity of meaning, opinion, and experiences; and 4), the interview “shows respect for and empowers those people who provide the data”. The interviews were semi-structured as opposed to structured, to allow the emergence of new issues and to reveal consensus or diverse opinions such as a consensus about a wellbeing ideology (Hay, 2005). The researcher followed the qualitative interview process outlined by Kvale and Krinkman (2009, p. 107) who define semi-structured interviews as mostly unstructured and open, “in this case the interviewer introduces an issue, an area to be charted, or a problem complex to be uncovered, then follows up on the subjects answers and asks new information about new angles on the topic”. In accordance with this method of interviewing, an interview schedule, or guide, was developed rather than a predetermined set of structured questions. Interview schedules allow flexibility and this suits semi-structured interviews (Hay, 2005, p. 82). The themes developed were to gather information about the service provider, determine a wellbeing philosophy, inquire about customers and travel constraints. Please see Appendix D for the interview guide.

Participants – Service Providers and Travel Agents

To recruit service providers, the student researcher created a database. Service provider participants were selected if they fulfilled three conditions. First they had to be located in Victoria. Secondly, the wellbeing travel establishments needed to fulfil Voigt’s (2010; 2011) definitional categories above. Third, they were single purpose establishments that provided specific activities (structured or unstructured) to improve wellbeing. The database was organised into geographical area in Victoria, and reflecting wellbeing travel type, noted by Voigt et al. (2010, p. 34); 1) Beauty and Spa visitation defined as body and beauty treatments; 2) Lifestyle resorts, “lifestyle transformations, education, nutrition, counselling, stress management techniques, active involvement of participant” (Voigt et al., 2010, p. 34); 3) Spiritual Retreats, defined as “enlightenment, specific teachings or philosophy; religious or non-religious” (Voigt et al., 2010, p. 34).

At the time of data collection for this project, minimal statistics were available to quantify the wellbeing travel organisations in Victoria. Bennet, King & Milner

(2004) found in Australia 49 lifestyle resorts and Intelligent Spas (2008) noted 554 spas in Australia. For this reason, a representative sample was not pursued. Additionally, representative sampling is not a pre-requisite in qualitative research which instead considers a range of responses, and depth of responses, rather than frequencies (Baker, 2012). Qualitative research methods are not linear process, which means the number of interviews is determined by the researcher based upon the progress of the research. For this research 16 service providers from the database were contacted to participate and eight were interviewed. At the conclusion of 8 interviews, the researcher had identified enough mutual ground and themes relevant to the research question.

Listed below are the eight wellbeing travel service providers who agreed to participate. Nine representatives of the organisations were interviewed (two were present for interview 5). All of the interviewees were of Anglo-Saxon origin, four of these were male and five females aged between 35 and 55.

Table 5: Service Providers Interviewed by Categories of Wellbeing Travel

Service Providers	Order of Interview	Main Service	Pseudonym
Lifestyle Retreats	Int. 1	Wellbeing and Nutrition	Michelle
	Int. 2	Yoga and Nutrition	Jim
	Int. 3	Luxury and Relaxation	Kim
Spa Retreats:	Int. 4	Luxury Day Spa	Penelope
	Int. 5	Day Spa and Winery	Tom and Clare
	Int. 6	Mineral Springs	Dominic
Spiritual Retreats:	Int. 7	Yoga/Buddhism	Rachel
	Int. 8	Silent Meditation Retreat	Rick

Travel agents were chosen for an interview based upon their geographical location within Melbourne, Australia. The geographical location was important to ensure the travel agents customers were a representation of different socio-economic groups in Australia, that is, low, mid and high socio-economic groups. The Basic Community Profiles of 2011 (Australian Bureau of Statistics, 2011) provided the

necessary information to target travel agents in specific areas. These are demonstrated in Table 6 below.

Table 6: Community Profile of Travel Agent's Geographic Area, 2011

	Geographic Area- Victoria, Australia				
	Toorak	Frankston	Maribrynong	Mornington Peninsula	Mordialloc
Unemployment Rate	3.7%*	7.8%*	5.8%*	4.7%*	3.8%*
Median Weekly Personal Income	$1031	$517	$701	$551	$682
Median Age (Years)	43	38	32	40	38

Source: *Unemployment rates are from ABS 2011 Quick Stats (http://www.censusdata.abs.gov.au/ABSNavigation/prenav/LocationSearch). Current unemployment rates are being released October 2012.

Based upon the community profiles in Table 7, Mordialloc (Int. 1, Tina) and Maribrynong (Int. 2, Wendy) were selected to represent a mid socio-economic area. Frankston (Int. 3, Wally) and Mornington Peninsula (Int. 4, Wilson) represented the low socio-economic area. Toorak's (Int. 5, Jacques) was selected to represent travel agents whose customers are potentially of high socio-economic status. Listed below are the five travel agents who were interviewed.

Table 7: Selected Travel Agents by SES & Pseudonyms

Interview Schedule	SES	Pseudonyms
Int.1	Low SES	Tina
Int.2	Medium SES	Wendy
Int.3	Low SES	Wally
Int.4.	Medium SES	Wilson
Int.5.	High SES	Jacques

Procedure

In depth interviews were held between April 2011 and July 2011. All interview participants were recruited by the researcher who invited them to participate by contacting their business phone. Potential participants were informed about the research topic, their confidentiality and anonymity and that the interview would be recorded with a digital recorder. Upon agreeing to participate the interview was arranged to take place at a time and place that suited the interviewee - which was generally their place of business or home.

At the time of interview, the participants were given a copy of the Information Sheet and signed Consent Forms before the interview commenced (see Appendix F). The researcher also verbally reminded the participants of their anonymity, confidentiality and that they could leave the project at any time. Consent to the recording of the interview was obtained via the Consent Form which stated that the interview would be recorded. The interview times ranged between twenty minutes and thirty minutes.

Document Analysis for Tourism Organisations

Recruitment of two major tourism organisations for interviews proved to be problematic. As an alternative method, information about the development of wellbeing travel in Australia from the perspective of tourism organisations was collected with a document analysis. The type of document analysis was adopted from Sarantakos (2013, p. 304) definition of a basic document study where the "focus of analysis is description, identification of trends, frequencies and interrelationships".

Phase 1 included a document analysis of wellbeing tourism literature from Australian tourism organisations. For qualitative research methods, such as Critical Discourse Analysis, analysing websites and public documents is a beneficial instrument to contextualise the group, the organisation of the group and its values. As described by Tracy, (2013, p. 83):

> documents furnish background on the group's history, information about rules, policies, or requirements for members ... Learning this background via public documents creates familiarity with the existing hierarchies or coalitions … Furthermore, documents and websites communicate the group's publicly espoused values and image.

Additionally, document analysis is beneficial because the data is quick and easy to access (Sarantakos, 2013).

Procedure

The tourism organisations targeted for exploration were obtained from the organisational structure for wellness tourism, provided by the Global Spa Summit (2011).

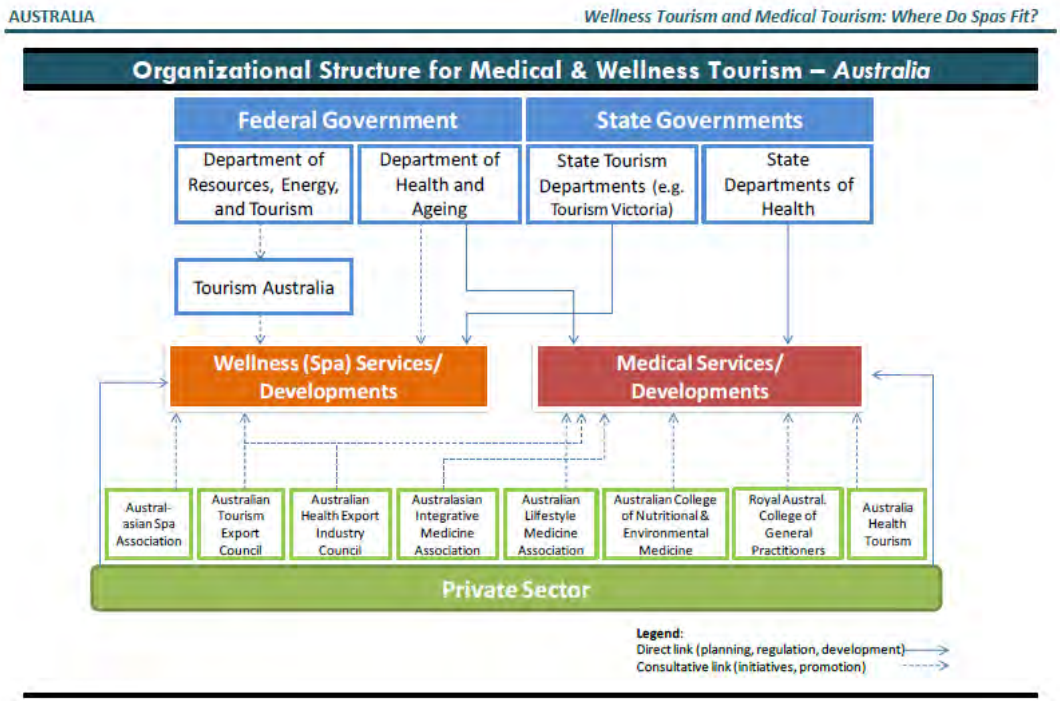


Figure 3: Global Spa Summit, 2011, Organisational Structure for Medical and Wellness Tourism Australia

Figure 3 shows the organisational structure for Medical and Wellness Tourism is divided into a Public/government Sector and a Private Sector. The Federal Government funds 'Tourism Australia' while State governments fund 'State Tourism Departments' such as Tourism Victoria. The Private Sector includes 'Wellness (Spa) Services/Developments' and 'Medical Services/Developments'.

The literature search focused upon public (government) organisations. In the beginning stages of the research (approximately 2010), the website of each of these organisations was extensively explored for information about wellbeing travel. All documents available at that time were downloaded and analysed for key themes

regarding the conceptualisation of wellbeing, and wellbeing travel in Australia. Documents from Tourism Australia and Tourism Victoria were found in the search. Additionally, international private sector organisations such as the Australasian Spa Association (ASPA), The Global Spa Summit in conjunction with the International Spa Association (ISPA) were also included in the document review. The documents found included:

- Two documents from Tourism Victoria: Tourism Victoria (2005; 2011) '*Victoria's Spa and Wellbeing Tourism Action Plan, 2005'* and '*Victoria's Spa and Wellbeing Tourism Action Plan 2011'*.

- Four documents from ATEC: Australian Tourism Export Council (ATEC, 2009) '*Australia enters brave new world of Health and Wellness tourism'; 'National health and wellness travel advisory panel'; 'Australia enters brave new world of health and wellness tourism'; 'Health tourism in Australia: Supply, demand and opportunities'*.

- Five documents from the ISPA and ASPA such as the '*ISPA's global spa study'* and '*Mintel Reports, Spa tourism international'*.

In 2013 the same websites were accessed to gather further information. Much of the previous information was no longer available and wellbeing travel no longer a topic of discussion. The document search omitted the Private Sector 'Medical Services' because it does not align closely with the research topic. The private sector organisation 'Australian Tourism Export Council (ATEC), under the 'Wellness Service/Developments' did align with the research topic.

Phase 1 Data Analysis

Thematic network analysis was the method applied to reflect Critical Discourse Analysis for all of the qualitative data - the interview data, document analysis, and qualitative survey analysis. This data analysis method began with data immersion. The student researcher managed all of the documents and interview data to ensure data immersion, from conducting the interviews, transcription and analysis.

Tracy (2013, p. 188) describes the purpose of data immersion "to absorb and marinate in the data, jotting down reflections and hunches, but reserving judgement." It allows preliminary analysis to take place, for instance, throughout the transcription process observations of the data were recorded into a separate word document for later use.

Following data immersion, the student researcher was then best placed to code the data. The interviews were exported to QSR Nvivo 9 for qualitative analysis. The computer data analysis software, Nvivo, was chosen to increase the rigour of the qualitative data analysis. With this software the data analysis process can be tracked, ensuring rigour through transparency, "In making analysis processes more explicit and easier to report…provides a basis for establishing credibility and validity by making available an audit trail" (Lu &Shulman, 2008, p. 107).

For all of the qualitative data analysis in this study, methods were in place with the thematic analysis process to provide data and coding reliability. Ensuring the reliability of the coding process with qualitative data is a debated issue. Some scholars advocate for more than one coder through the Inter-Coder Reliability (ICR) process, to show a level of agreement and objectivity in coding data (MacPhail, Khoza, Abler, Ranganathan, 2016). However, ICR is traditionally aligned with a positivist methodology, and works best with data that will be analysed with pre-defined coding frames (Bourdon, 2000).

As opposed to coding to a pre-determined framework or hypothesis, the coding process was approached with thematic network analysis. This method of coding aims to elicit patterns and themes from the data ideally without pre-conception, Babbie states "this approach begins with observations rather than hypotheses and seeks to discover patterns and develop theories from the ground up" (2007, p. 380).

As stated earlier in the chapter, this study is exploratory, with a social constructionist approach and Critical Discourse Analysis. To align with a CDA method and exploring evidence of a dominant discourse, the data is best placed with thematic analysis, rather than pre-defined coding frames. As an inductive approach, thematic analysis first allows the identification of basic leading themes, and the development of more complex linkages which represent a dominant discourse. For all of the qualitative data analysis in this study, the student researcher followed the thematic network approach, which simply provides structure to the raw data, rather than coding to a pre-defined code structure.

The first step of thematic network approach is to elicit the basic themes. The student researchers first phase of coding included creating free nodes to represent emerging and basic themes in the initial examination of the interview texts; or what is termed the extraction of "lowest order premises evident in the text" (Stirling, 2001, p. 388). This first step is understood as the 'open coding' process, "to uncover, name and develop concepts, we must open up the text and expose the thoughts, ideas, and meanings contained therein...Broadly speaking, during open coding, data are broken down into discrete parts, closely examined, and compared for similarities and differences" (Babbie, 2007, p. 385). It is only after open coding that categories or themes can be created (Babbie, 2007).

The second step begins to develop complex themes, or the 'organising themes'. The student researcher re-examined the free nodes, whereupon linkages could be made between free nodes, into tree nodes (Stirling, 2001). Nodes were created when a patterns were evident across participant responses, and key themes were established as tree nodes, such as general consensus with regard to defining wellbeing; the state of Australia's wellbeing in general and some attitudes towards constraints to wellbeing travel. Further tree nodes were established that reflected key differences between the sample, such as frequency and attitude towards achieving wellbeing and participating in wellbeing travel between each sample group. Codes, nodes and emergent themes are demonstrated in Appendix J.

The final step develops 'international themes', that can represent conceptual issues and allows the development of theories (Stirling 2001). For instance, the development of the themes 'calamitous society' and 'wellness revolution' and 'busyness' represented the overarching wellbeing discourse in the data and reported in the results chapters. With the three levels of thematic analysis, the interviews, documents and web text distributed by the organisations, offered a dominant depiction (Burr, 2003) about wellbeing travel deployed to the public, and constraints to travel could also be identified.

Phase 2 – Focus Groups

The first phase of data collection addressed research questions from the perspective of those who organsie wellbeing travel, to better understand the construction, development and nature of the sector. The second phase was designed to

address research questions from the perspective of the Australian people, wellbeing travellers and potential travellers. The research questions for Phase 2 were:

1. How is wellbeing travel in Australia socially constructed?
    a) What are the dominant discourses informing the concept of wellbeing travel?
    b) Is there an overarching discourse of 'wellbeing' for wellbeing travel service providers in Australia and the Australian people?
    c) How does 'wellbeing' discourse inform the development of wellbeing travel, and potential tourists.
2. What are the drivers and constraints of travelling for wellbeing in Australia?
    d) From the perspective of Australian people.

To begin exploring these question from the perspective of people a focus group was established. Focus groups are a good method to inform the direction of further research for specific groups of people or topics of research (Dwyer, Gill & Neelu, 2012, p. 354). The focus group offers a condensed site of information and an environment where a group can communicate, agree or disagree with each other and sort through concepts. Additionally, Hay (2005, p. 71-72) states "generally speaking, the more focused our research interest becomes, and the better our background information and understanding, the more certain we are about who we wish to be involved in our research and why".

The data collected from the focus group aimed to achieve a greater focus for approaching the design of the mixed method representative survey, for instance, the results from the focus groups would guide the content of the survey, and the sample selection. In exploratory research, focus group are regularly used prior to the development of surveys to help identify 'priority topics'; they can be called 'Pilot focus groups' (Bloor, 2001).

The original plan for the data collection was to conduct more than one 'pilot focus group, however after the first focus group data collection was complete, the researcher and principal supervisor determined one focus group was enough to assist in the construction of themes for the survey (Bloor, 2001, p. 9).

Participants

Participants were recruited as clients of the Naturopathic Way. Over a period of four weeks, clients presenting at reception were asked if they would like to participate in a focus group. Those who were interested were given the study information. A total of eight participants attended the focus group. It is generally acknowledged that the ideal number of participants for focus groups are between 5 and 15 (Babbie, 2013) "to have enough people to generate discussion, without so many that it becomes difficult for the facilitator to involve all participants" (Dwyer et al., 2012, p. 355). According to Dwyer et al. (2012), focus groups are beneficial for smaller groups who may be unrepresented in a representative research method, and also as a method which can empower small or minority groups. Other advantages include collecting a lot of data in a short amount of time and can be potentially cost efficient (Kruger, 1988).

The eight participants were all female aged between 22 and 56. Six of the participants were married, two single and all except one were employed in some capacity, whether full time, part time or casual. Three participants had Bachelor Degrees, two a Diploma, two had attended TAFE and one had completed year 12. All participants regularly engaged with some sort of wellbeing activities including, exercise, healthy eating habits, yoga, and meditation. Other activities engaged with were Tai Chi, Reflexology, Chiropractor and massage. All participants listed at least three wellbeing activities that they engaged with regularly. Please see Appendix _ for the question sheet that was given to participants and Appendix _ for the question sheet table of results.

Procedure

The researcher made telephone contact with the owner of a naturopathic business in Melbourne's south east, 'Lina' - a person known to the researcher. Lina was asked if she would conduct and facilitate a focus group at her place of business, with participants from her customer base. It was agreed that Lina would recruit participants by asking them if they were interested to participate in the project, and giving them an Information Sheet to take home. At this time, the researcher and Lina discussed the content of the focus group and how Lina would facilitate the group.

Over a period of eight weeks, Lina approached 16 potential participants, 4 male and 12 female, resulting in 8 focus group participants.

On the morning the focus group took place, the researcher and Lina met at the place of business to discuss the focus group themes, the consent form process and how to record the interview. Participants were asked to sign the Consent Form before the focus group proceeded. They were briefly introduced to the research before commencing discussion. The focus group lasted approximately 40 minutes. The researcher returned to the place of business in the afternoon to collect the audio recording, Consent Forms and to debrief with Lina. Similar to the themes which were addressed in Phase 1 of data collection (in depth interviews) the focus group schedule was created as a set of themes rather than questions. Please see Appendix G for the interview schedule.

Focus Group Data Analysis

Following the analysis process described in the interview data, the Focus Group was also recorded and transcribed by the researcher, assisting researcher immersion in the data. The interviews were exported to QSR Nvivo 9 for thematic network qualitative analysis to determine the leading themes making up a discourse of wellbeing for this group, and their knowledge and use of wellbeing travel.

Phase 3 - Qualitative and Quantitative Online Survey

Phase 3 data collection was the qualitative and quantitative online survey. The results from the focus group (Phase 2) helped to inform the development of the survey by highlighting key themes for discussion about wellbeing in Australia today. Like Phase 2, Phase 3 also aimed to answer the research questions from the perspective of the Australian people.

There are several approaches to design, deliver and recruit in survey research. The instrument of collection for this thesis was an online survey with participants collected by a ‘commercial internet panel’ (De Vaus, 2002, p. 78). These are research agencies who have databases of potential respondents. De Vaus (2002, p. 78) explains that these “companies with large panels will, for a fee, contact members of their panel that fit your sample requirements and obtain completed questionnaires”. For this

study, the student researcher required the agency to provide a representative Australian sample from their panel.

Online surveys, particularly when agencies are employed to collect the data, are a quick and efficient method of collecting data (Gray, 2006, p. 202). Concern has been raised about whether online samples can accurately represent a population. Only a specific population of people have access to the internet, potentially excluding populations such as older people, or people who cannot afford internet in their homes (De Vaus, 2002). De Vaus (2002, p. 79) stated that quota internet samples can result in representative surveys, however, it would result in a large sampling error and a lower confidence level. In 2002, it was suggested that internet samples should have more value in the future, when a greater proportion of the population have access (De Vaus, 2002, p. 79). Since this time the internet has become accessible to a wider population. It also must be noted that there are limitations to other methods of survey collection sampling techniques that also must be managed (De Vaus, 2002, p. 80).

The survey was designed to collect both qualitative and quantitative data. Approximately 15% of questions were quantitative and 85% questions open ended requiring a qualitative response. The quantitative questions collected demographic data including gender, age, occupation, employment status, education, religious affiliation, and household income. Further quantitative data represented the wellbeing activity levels of the three survey sample groups; 5 point rating scales, to gain a subjective measure of participants' wellbeing; and a set of questions about the use and exclusions from wellbeing travel.The demographic data enabled inquiry about similarities and differences between each survey group; and also the use of independent variables to test the relationship between survey groups, wellbeing activity levels, and wellbeing travel use, exclusions and knowledge.

With the guiding Critical Discourse Analysis methodology, the majority of survey questions were qualitative open questions. Quantitative and closed responses (Hay, 2005, p. 149) are limited to pre-specified categories and "rest on the assumption that words, categories, and concepts carry the same meaning for all respondents". In contrast, open questions allowed for unexpected, diverse and sometimes comprehensive responses (Gray, 2006), and "offer less structured response options than closed questions, inviting respondents to recount understandings, experiences, or opinions in their own terms. Rather than offer alternative answers, which restrict responses, they provide space (and time) for free-form responses" (Hay, 2005, p. 152).

The qualitative questions sought to allow space for participants to explain their knowledge and experiences of wellbeing and wellbeing travel; and therefore allowing the identification of a discourse of wellbeing, and the social construction of wellbeing travel. Also to explore if a discourse of wellbeing existed between service providers and the survey participants; that is, if participants accepted the position made available to them by service provider constructions and alternatively, what constraints may determine non-travel (Please see Appendix E for a copy of the survey).

Participants

The participants recruited were sourced from Research Now, an online research organisation with a large panel of potential survey participants. The survey sample consisted of 204 people over 18 years of age and was benchmarked from an Australian representative sample panel.

The survey asked two questions to filter participants into three groups based upon their level of engagement with wellbeing activities, and their status as a traveller, or non- traveller for wellbeing. The filtering of the groups was motivated by prior studies which have garnered interesting results when measuring an individual's wellbeing activation level (the Patient Activation Measure), i.e. the health behaviours, beliefs and knowledge. Hibbard and Cunningham's (2008) study showed wellbeing activation levels vary with health status and socio-economic characteristics. Youth, education and private health insurance were variables ensuring higher wellbeing activation, while culture and existing health issues were linked to lower activation levels.

This study did not use the patient activation measure (PAM) because many of the items predominately refer to medical behaviours, and secondly, the 13 item measure was beyond the scope of this survey. Instead, all participants were asked the following question to find a level of engagement with wellbeing activities, 'Do you regularly (at least once a fortnight) partake in activities to improve wellbeing?'. The second filtering question asked participants 'In the last two years have you travelled for the purposes of improving your wellbeing (either spa retreats, lifestyle or spiritual retreats)?'

Based upon the filtering process, the first group represented those in the sample who had no regular engagement with wellbeing activities and were labelled as,

‘Group 1: Low wellbeing engagement, no travel for wellbeing’. The second group, did engage with wellbeing regularly, but did not travel for wellbeing, labelled as ‘Group 2: Regular wellbeing engagement, no wellbeing travel’. The third group were engaged with wellbeing regularly, and also had travelled for wellbeing within the past two years, labelled as ‘Group 3: Regular wellbeing engagement, travel for wellbeing’.

Table 8: Survey group and sample size.

	Number	%
Group 1, Low wellbeing engagement, no travel for wellbeing	74	36.3
Group 2, Regular wellbeing engagement, no travel for wellbeing	62	30.4
Group 3, Regular wellbeing engagement, travel for wellbeing	68	33.3
Total	204	100.0

Each group was directed to a different survey to ensure relevant questions were asked. Those who had never travelled for wellbeing (Group 1 and 2) were asked a series of questions explore their opinions about wellbeing travel and their non-travel status:

Q26. When considering a holiday or short break, have you ever thought about travelling somewhere to improve your well-being (i.e. well-being travel)?

Q30. When you think of well-being travel, what images come to your mind?

Q33. Would you travel to a destination which focused upon well-being if it was an affordable holiday? Please explain why or why not.

Q34. If you were to travel for well-being, please indicate which type of well-being travel you would be likely to take part in, Religious Tourism; Spiritual tourism; Spa Tourism; or Lifestyle Retreat.

Of the total sample 12.3% reported that they had not travelled in the past year. The No Wellbeing group included the majority of non-travellers, 66%, while the Wellbeing Travellers had the least of those who did not travel, 12%, and Wellbeing Non-Travellers 24%. This travel rate cannot be compared with past research in Australia because no other research had been conducted on this topic at the time this research took place (van den Eynde, 2009). Table 9 provides a snapshot profile of the three survey sample groups assembled from key findings of the socio-economic characteristics of the total sample including gender; age; employment type; highest education level; religion; and engagement with wellbeing activities.

Table 9: Socio-economic characteristics of survey groups.

	No-Wellbeing	Wellbeing Non-Traveller	Wellbeing Traveller
Male	67.1%	56.5%	52.9%
Female	32.9%	43.5%	47.1%
Age Median	45-54	55-64	45-54
Income Median	$36,000-51,999	$52,000-79,999	$52,000-79,000
Higher Education Median	TAFE	TAFE	Diploma
Religious Affiliation	18.1%	24.7%	30.8%
Primary Employment Type	Full Time	Pension/Benefit/ Retired	Full Time
Secondary Employment Type	Pension/Benefit/ Retired	Full Time	Pension/ Benefit/Retired

The following provides a profile of the three survey groups representing key findings of the socio-economic characteristics of the total sample including gender; age; employment type; highest education level; religion; and engagement with wellbeing activities.

Group 1: Low Wellbeing Engagement, No Wellbeing Travel.

This group comprised of 74 participants, or 35.8% of the total sample. They were defined as people who do not participate in a wellbeing activity at least once every fortnight, and have not travelled for wellbeing in the past two years. It comprised of a substantial amount of males (67.1%) and was the highest proportion of males to females of all three groups. This group also had the highest proportion of those were the 'Full Time Employed'.

Group 1had the lowest education level (with TAFE certificate as a median highest education level) and had the lowest median income of all three groups, 36.1% of this group with an income between $36,000 and $51,999. The anomaly of this group was that it included the largest proportion of people in the highest income bracket, with 5.6% earning $100,000 or more per year.

Not only did they not participate in wellbeing regularly, they were also the least religious, with 18.1% reporting a religious affiliation. In addition to not travelling for wellbeing, this group also comprised the majority of the survey sample who identified as non-travellers (66%).

Group 2: Regular Wellbeing Engagement, No Wellbeing Travel.

Group 2 comprised of 62 participants and were 30.4% of the total sample. They were defined as a group of people who do participate in a wellbeing activity every fortnight, but have not travelled for wellbeing in the past two years.

Group 2 had the most balanced gender ratio and the oldest age cohort n of all three groups (55-64). However, they also included the highest proportion of people in the youngest age category, 17.9% in the 18 to 25 age group.

The median income for this group was above the average Australian income, $52,000 to $77,000. Particularly characterising this group was employment, 40.3% had pension/benefits as their employment type. Along with not travelling for wellbeing, 24.0% of this group were non-travellers.

Group 3: Regular Wellbeing Engagement, Travel for Wellbeing.

This group comprised of 68 participants, or 33.0% of the sample. They were defined as people who participate in at least one wellbeing activity every fortnight.

They have travelled for wellbeing in the past two years to either a spa, lifestyle, religious retreat or 'other' interpretation of wellbeing travel.

Similar to the other two groups, their median age is between 45 and 54. Group 3 had the highest female sample (47.1%), and the highest amount of those who were unemployed and part time employed. They were also the group with the highest level of those who had completed a Bachelor (29.0%) or Postgraduate degree (11.0%).

Group 3 comprised the lowest rate of non-travellers, recording 12.0% who had not travelled in the past year.

Procedure

The survey was designed after the analysis was completed for Phase 1 (interviews) and Phase 2 (focus group). The resultant survey was significantly informed by the first two phases and included similar themes and a number of additional themes that emerged from this data analysis.

Analysis of the focus group discussion stimulated ideas for new topics of investigation. The focus group discussed wellbeing in terms of gender. They spoke of actively seeking to improve wellbeing as a predominately female pursuit and as the opposite to masculinity. This was personalized in stories about their husbands or brothers who would not consider doing wellbeing travel, going to a naturopath, or going to a doctor. This discussion prompted the addition of a theme and set of questions about gender in the survey.

The in-depth interviews with service providers also promoted the addition of the gender theme for the survey because all indicated their customers were predominately female.

When the focus group were asked to discuss a definition of wellbeing, and if Australian people are well today, a discussion formed which equated technology as an anti-thesis to wellbeing because 1) technology keeps people inside on their screens and 2) technology means we are more connected to other people, and this was perceived as suffocating and contributing to a decrease of feeling well. This discussion prompted the addition of a theme about technology in the survey.

The focus group and the in-depth interviews with service providers also stimulated a theme about how the concept of wellbeing and associated products are

increasing in Australia currently. This data prompted the addition of a set of questions about a collective/society representation of wellbeing in Australia.

Theme 1 In your opinion what is wellbeing?

Theme 2 Have you heard of wellbeing travel? What do you know?

Theme 3 Have you noticed an increase in Australians becoming conscious of their wellbeing?

Theme 4 What are your regular wellbeing activities and what experiences have you had with wellbeing travel?

Theme 5 Can you identify the barriers and constraints of wellbeing? (Please see Appendix J for a breakdown of themes and rationale for themes).

Theme 6 What is relationship does wellbeing and gender?

Theme 7 What is the relationship between wellbeing and technology?

The researcher designed, uploaded and monitored the online survey using 'Qualtrics', a widely used software for online surveys. Pre-testing (p. 155) occurred in the form of a pilot study before the Qualtrics survey was available to participants. Five participants (friends, family and colleagues) read or completed the trial survey to assist with picking up any editing or content issues.

The process of recruitment for the survey began when the researcher first contacted Research Now in 2009. The researcher requested a panel that would be representative of the Australian population. Research Now confirmed they would provide a sample that was benchmarked of the Australian Bureau of Statistics (please see Appendix I for benchmarking information). The conditions of the contract with Research Now (to provide the panel sample) was finalised in June 2012 and the project commenced. Over a period of two weeks, Research Now contacted potential participants from their panel by sending small batches of email invitations. The amount of invitations was closely monitored to not exceed the target amount of surveys (200). Attached to the email was a link to the survey hosted by online survey software 'Qualtrics'.

A total of 244 participants began the survey, however 204 participants completed the survey. Although all those invited were eligible to participate, the total sample (n=204) were filtered into one of three groups.

Consent to participate was presented in the first screen of the survey. On this first screen participants were welcomed to the survey, introduced to the research and informed of their confidentiality if consenting to participate in the research. Participants were asked to tick the 'yes' box to consent to being a part of the research If they did not consent they were re-directed to an end of survey screen.

Survey Data Analysis

The quantitative survey data was analysed with SPSS. Following completion of the survey, the raw quantitative data was exported from Qualtrics to an SPSS file and data clean-up was undertaken. Analysis of quantitative data largely comprised of applying the descriptive and frequency functions to summarise the data, for instance, sample sizes of the three survey groups; the presentation of demographic data concerning the survey sample groups, and measures of central tendency for selected demographic variables, age and income (see the section above titled 'Participants'). The descriptive data provided an initial analysis of the relationship between variables of interest.

The limited quantitative data analysis also included chi-square tests to assist in examining research question two 'What are the drivers and constraints of travelling for wellbeing in Australia?'. As stated in the literature review, past and current research resoundingly finds wellbeing and health is determined by socio-economics, therefore, the student researcher systematically applied chi-square tests with all categorical demographic data to determine if there was a relationship between wellbeing, survey groups, and demographic information. The chi-square test - a non-parametric test - is a common choice to examine differences and relationships with categorical data (Morgan, Reichert, Harrison, 2016, 35).

The systematic application of chi-square tests was undertaken with the following survey questions:

- Q10. Please rate your level of well-being on a scale of 1 to 5 (1= not well, 5=very well).
- Q11. Have you reached your own ideal state of well-being at any point in your life? When and why?
- Q12. If yes, are unwell people not willing to put in this time and effort?
- Q15. Do you think over the past few years the Australian people have become more conscious of their health and well-being?

All significant results from the chi-square test are presented in the results section.

Qualitative data was analysed with QSR Nvivo 9 and 10. Consistent with analysis of Phase 1 and 2 data, coding for phase 3 was conducted with thematic network analysis as a method to examine the themes that can identify an overarching discourse of wellbeing and wellbeing travel.

Chapter 7: Results and Discussion. The Organisation and Construction of Wellbeing Travel in Victoria

Chapter 7 examines the resurgence of wellbeing travel in Victoria and begins to consider if, and how it is socially constructed. First an organisational structure of the wellbeing travel sector in Australia is proposed based upon Cheong and Miller's (2000) model of brokers and power (discussed in Chapter 4). This model proposes the 'brokers' (tourism organisations and service providers) have power in making decisions about 'targets' (tourists). It is an adaption of Foucault's 'repressive power' which argues power lies in the offering of positions by brokers which results in travel or non-travel. Cheong and Miller's concept is one of the only known models to examine the power of tourism planning to include and exclude potential tourists.

Secondly, this chapter discusses the initial push for the development of a cohesive wellbeing travel sector in Australia by tourism organisations, yet the diversity and independence of individual service providers in reality. These two factors combined lead to a discussion about the lack of a cohesive sector and how much power brokers have to determine who travels, and who does not[3].

The Organisational Structure of Wellbeing Travel in Victoria – A Model of Brokers.

Figure 4 below shows the organisational structure of wellbeing travel in Australia. It is an adaption of Cheong and Miller's (2000) model of brokers and suggests the first tier (Tourism Organisations), at the top of the figure, holds more power in the construction of a wellbeing tourism sector than the bottom tiers (Service Providers and People).

[3]Brokers are defined as those who facilitate the industry of tourism, they are "persons who in one way or another pay professional attention to tourism" (Miller & Auyong, 1998, p. 3).

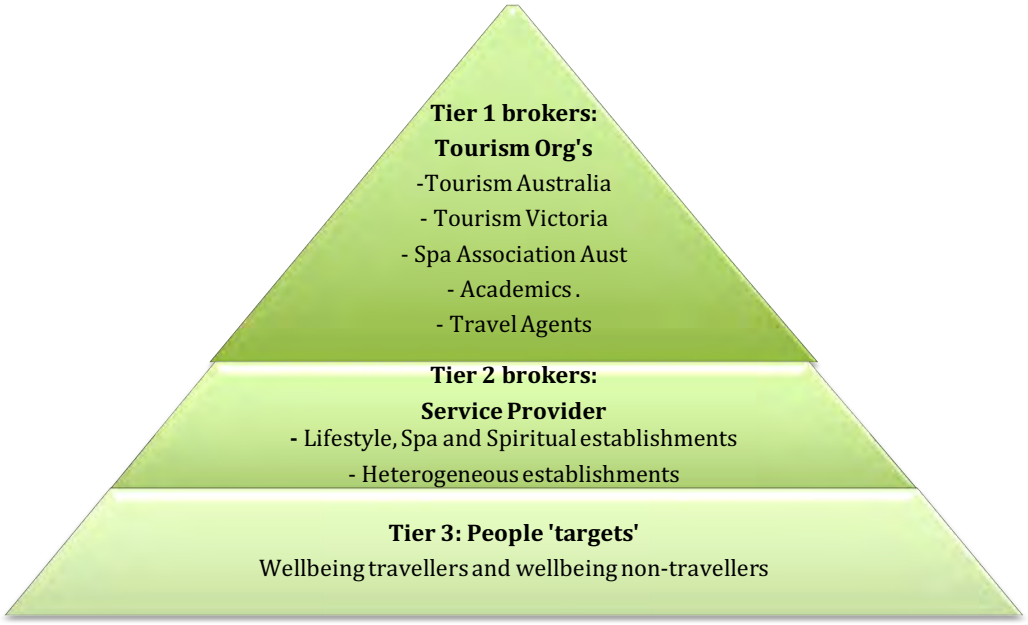


Figure 4: The Brokers of Wellbeing Travel in Australia, Adapted from the 'BLT model', Cheong & Miller (2000)

Tier 1 Brokers: Tourism Organisations and Academics – Building a Wellness Travel Sector

Tier 1 is the 'Tourism Organisations' in Australia, including Tourism Australia, Tourism Victoria, International Spa Association and Academics. An understanding of the role of these organisations in developing wellbeing travel in Australia was reached by a document analysis of publically available documents. The document analysis examined the frequency wellbeing travel was mentioned in leading Australian tourism organisations; descriptions of wellbeing travel, including the predominant definition; and the trends and themes in the documents (Sarantakos, 2013).

Results of a document analysis found in the last decade some Tourism Organisations in Australia, such as Tourism Victoria and the Australian Tourism Export Council (ATEC), have championed the concept of developing wellbeing travel as a profitable sector of the tourism industry. Specifically, they have defined and championed spa travel – akin to the elite model outlined in Chapter 2. It has been suggested it would be the Tier 1 brokers (Public and private tourism Organisations; travel agents; academics) that would have the most power in constructing a tourism

sector. They would have power to define a dominant vision of what wellbeing travel is, and therefore guide participation or entry (who participates) and performance (how they participate). Their power is attributed to 'expert knowledge'.

The overarching bodies of the structure are the Federal and State Government. The Federal government is responsible for the 'Department of Resources, Energy and Tourism' (which includes 'Tourism Australia) and the 'Department of Health and Ageing.' The State government is responsible for state tourism, such as Tourism Victoria. Tourism Victoria has contributed to supporting and constructing a wellbeing travel discourse with the Tourism Victoria Spa and Wellness Action Plan 2005-2010, and the Tourism Victoria Spa and Wellbeing Action Plan 2011-2015. Tourism Victoria is the only organisation who has "actively positioned itself as a wellness tourism destination" (Global Spa Summit, 2011, p. 39).

Three main directions are presented in the 2011-2015 plan: 1) facilitating investment in spa and wellbeing product; 2) strengthening the professionalism of the industry and 3) increasing consumer demand for spa and wellbeing experiences (Tourism Victoria, 2011, p. 3). The majority of the key aims are also related to spa travel, such as "supporting investments that utilise the state's natural geothermal and mineral waters' and " promotion of Victoria's Geothermal & Natural Mineral Water Tourism Investment Opportunities Guide to potential investors" (Tourism Victoria, 2011, p. 3).

The development of this plan was supported and given further strength by academics who state it is a timely plan for Australia, some who claim "its development comes at a time when this sector worldwide is experiencing rapid growth, with the development of new spa resorts and hotels and the refurbishment and upgrade of existing facilities" (White, 2009, p. 151 cited in Bushell & Sheldon, 2009).

In the private sector, ATEC has played a role in attempting to drive a wellbeing travel market and sector. ATEC is a representative organisation of approximately 1100 members who are mainly tourism industry service providers and operators (ATEC, 2010). The council aims to further the growth of the Australian tourism industry (ATEC, 2010) through collaboration. Much of the information on their website regarding wellbeing travel (in 2009) is no longer easily available (2013). An initial reading of the website in 2009 found wellbeing travel was mostly equated with medical and spa travel. ATEC held the first health and Wellbeing Conference which resulted in the 'Cairns Declaration', outlining Australia's plans to "pursue

opportunities in the medical tourism sector and to a lesser extent the wellness tourism sector, including spa treatments, holistic healing services, fitness training, dietary and nutritional services, and spiritual guidance, with an additional emphasis on indigenous traditions" (Global Spa Summit, 2011, p. 39). An ATEC media release titled 'Australia enters brave new world of Health and Wellness tourism', outlined the meeting which resulted in the creation of the Cairns Declaration (ATEC, 2009).

A wellbeing travel movement was demonstrated by the development of policy, declarations and the gathering of a professional body of people from tourism to health professionals 'from around the globe'; the use of words such as 'declarations; landmark document; viable new tourism market' suggest the authority of the new movement (ATEC, 2009). ATEC also established a 'Health and Wellness Advisory Panel', in 2010, a panel of ten chosen by ATEC which disbanded somewhere between 2009 and 2014 (ATEC, 2009b).

The authorative language present in the documents indicated an effort to build a spa orientated wellbeing travel sector, and an attempt to construct an 'official' body of knowledge about what wellbeing travel is and who wellbeing travellers are. According to Cheong and Miller (2000,) and social constructionists such as Burr (2003), this expert knowledge carries significant power to be understood as fact, or truth, in a public discourse. Social constructionism states any dominant discourse has 'constructors' (Burr, 2003). In tourism, it is generally understood that dominant constructors are those who engage with the organisation of the tourism industry, including those who benefit from tourism economically and benefit from its sustainment. With this reasoning the Tier 1 brokers (Public and private tourism Organisations; travel agents; academics) are theoretically supposed to play a large role in the development of a wellbeing travel.

Despite the brokers efforts to construct a dominant knowledge of wellbeing travel, findings from this research suggest the efforts of both private and public sector organisations have resulted in little cohesive development. The failure to construct a cohesive wellbeing tourism sector, lies with in-effective collaboration. Brokers are understood to have considerable power when they collaborate with others, "at any given time, divergent brokers in different professions align themselves around an issue. They discuss and negotiate how far development should proceed, what type of development is optimal" (Cheong & Miller, 2000, p. 379). A plethora of tourism research cites the benefits of stakeholder collaboration but also the potential risks (Aas, Ladkin, Fletcher, 2005; Bramwell & Lane, 2000; Hall, 1999). D'Angella and Go (2009) state "collaboration amongst stakeholders leads to a network paradox" (p. 432) because it can enable success of the individual brokers but constrain at the same time (Ford et al. 2003). A similar sentiment is expressed by Voigt et al. (2013) who studied the collaboration of wellbeing travel destinations internationally. Voigt et al. (2013) find stakeholder collaboration can be beneficial for market visibility and higher quality products; but can be problematic to establish if stakeholders are unwilling to co-operate for various reasons such as mistrust, lack of vision and competitiveness. Findings in this research (from interviews conducted with 8 service providers and 4 travel agents), suggest a collaboration has not occurred in Australia and service providers exist independently of any organised sector.

Tier 2 Brokers: Service Providers – Building a Cohesive Tourism Sector?

The second tier in Figure 4 is the 'service providers'. In the model of power and brokers, the second tier would theoretically have less power to develop wellbeing travel than the first tier. Indeed, in-depth interviews showed a clear disconnect between the Tier 1 and Tier 2 tourism brokers in the understanding and development of wellbeing travel in Australia. Tier 2 brokers (service providers) do not share a vision of a wellbeing tourism sector with the Tier 1 brokers (Public and private tourism Organisations; travel agents; academics). Findings suggest the majority of the service providers and travel agents are not aware of a sector, also confusion and uncertainty emerged in defining Wellbeing Travel.

In comparison, Spa service providers had a sound grasp of wellbeing travel as an existing concept and sector. The following section describes the diversity of the service providers interviewed and suggests this diversity is one reason why cohesiveness or collaboration does not exist. The service providers interviewed were selected from the following categories, 1) Spa/Mineral Springs/Day Spa; 2) Lifestyle resort/retreat; and 3) Spiritual Retreat. Table 8 below indicates each of these service providers, their location, and the pseudonyms used to report their comments from their interviews.

Table 10: Service Providers and pseudonyms

Category of Service Provider	Pseudonyms
Lifestyle Retreats	Michelle
	Kim
	Jim
Spa/Mineral Springs/Day Spa	Dominic
	Penelope
	Tom and Clare
Spiritual Retreats	Rick
	Rachael

Diversity of the Service Providers and Ideological Differences Regarding Wellbeing.

It was found that regardless of broad categorical similarities each service provider varied greatly, that is, the size of business, definition of wellbeing, philosophy, purpose of establishment (the extent that wellbeing forms the purpose of the establishment) and economic purpose (for-profit or not interested in profit). Service providers were also differentiated by the activities they offered as well as the extent to which the stay required either active or passive involvement of the participant. One significant similarity between the service providers was a basic cohesive understanding regarding the question ‘what is wellbeing’. In a first response to the question, the service providers stated it was an active pursuit of ‘mind, body, spirit’. After this similarity, the understandings of wellbeing deviated (mostly the

depth of philosophy) and reflected the diversity of the service providers in general. The diversity of the service providers are discussed below.

Spiritual Retreats

Rick's Spiritual retreat offered single purpose structured programs with intense 'inner work'. Rick is the sole owner and leader of silent retreats with vegan eating, which are held sporadically but numerous times a year in rural Victoria. Rick commented - "I organise a weekend away, four days away for people. And I facilitate it. I lead it, I'm the guide and I suppose I impart some teaching but it's very open you know, it's not dogmatic or constraining."

A Spiritual retreat located in Victoria is also owned and led by one person, 'Rachael' who offers a semi-structured yoga retreat whereupon she organises a timetable of yoga classes yet her guests are free to participate, or not. Guests are provided with four star meals and alcohol if they wish. Rachel's aim was to provide a relaxing weekend city get away which offered good food and accommodation along with yoga. In contrast to Rick, Rachel commented that most yoga retreats in Victoria offered uncomfortable accommodation, and vegetarian/vegan food, which she claimed was unnecessary and would not have an impact on wellbeing. These comments demonstrate the ideological differences about wellbeing that exist between two categorically similar wellbeing travel service providers and are reflected in how they conduct their business.

The Spiritual retreat service providers expressed a philosophy of wellbeing that reflected Dunn's (1969) 'high level wellness'. Yet they also expressed sensitivity to the subjective nature of wellbeing. Discussing wellbeing was a topic they were keen to talk about and intellectualise. The Lifestyle retreats service providers spoke of wellbeing as a difficult concept to define. For Rick (whose business focused upon the wellbeing possibilities in self-reflection and nutrition), it was a balanced combination of factors, such as 'faith, hope and love'. It was also subjective, a personal journey and having the ability to deal with the world and your place in it. Rachel also spoke of this personal and subjective type of wellbeing, however in more practical terms. She stated that wellbeing:

would be a feeling that you feel energised, ready to take on the world, you sleep well, and yeah, ready to take on the world really. Wellbeing does not mean to me, eating, living aesthetically, sitting on a mountain cross-legged, eating a bowl of rice. That doesn't mean that to me.

Lifestyle Retreats

Diversity also existed between the lifestyle retreats. Two of the Lifestyle retreats did not seek to increase profit margins. A Lifestyle retreat, located in Victoria, was one such organisation that began as a support group many years ago. Michelle, CEO of an internationally recognised Lifestyle retreat), said the initial reason for creating this organisation was to provide alternative healing and support through nutrition, meditation and Lifestyle choices. This service provider offered structured programs and the customers are active participants.

Similar to Michelle's organisation, was Jim's Lifestyle retreat in Victoria which he said was established accidently, growing in response to needs from the community. It was established in 1998 by Jim who states his main aim for buying the property was to become a 'recluse', however the retreat instead took on a life of its own. Jim said "…so I was looking for a change, a move to the country to become a recluse, and I ended up with a guest house. So I got something wrong there!". However unlike Michelle's retreat, Jim's retreat is largely unstructured. It generally does not include structured programs with a wellbeing goal in mind to convey to the customer.

Other lifestyle retreats are some of the most expensive wellbeing travel establishments on the market and they mix passive and active wellbeing activities. Such as Kim, the manager of a Lifestyle retreat, who represents a semi-structured retreat with passive and active wellbeing offerings. Demonstrating the diversity of what can be defined a 'Lifestyle retreat', Kim's establishment is primarily aimed to provide pampering and relaxation to the customers. It is located on 25 acres with a 19 room capacity offering various packages for addressing wellbeing such as, art and yoga; fitness; detox; weight loss and meditation. The programs are designed specifically to the needs of the customer yet it is an unstructured program. Activities are set to a particular timetable yet customers can decide if and what activities they take part in. Passive activities include day spa activities (massage, body polish),

alternative therapies such as reflexology in combination with gourmet meals and five star accommodations.

It was clear in the case of Jim, Rick and Michelle, that for the smaller wellbeing travel service providers, the wellbeing philosophy and the involvement of the person who represents the philosophy, forms the primary resource or asset of the business. That is, smaller business owners are more likely to be personally invested in their business with a view to sharing their knowledge of wellbeing with others.

Wellbeing for the chain or larger service providers in comparison can be a secondary product, a side activity that is additional to the accommodation. Therefore, the primary purpose of visitation to the larger or chain service providers is not necessarily the wellbeing offerings (this is discussed in more detail later).

The larger service providers - as establishments that tend toward wellbeing as a secondary motivation to visitation, passive relaxation and pampering - are also more likely to include fancy consumer products. Michelle conceptualised the differences between active establishments like her Lifestyle retreat, which exists for the primary purpose of restoring and healing, compared to the 'ornaments' that characterise the passive, side activities of other establishments. Michelle said:

> we don't actually focus on the ornaments we actually focus on the individual. I like the ornaments, personally, but umm most people who are serious about wellbeing ... it doesn't matter to them. The ornaments attract the people who want them. The people who want the pool and gym and the white fluffy towels and the slippers (Michelle).

Michelle's wellbeing philosophy was a balanced combination of factors:

> wellbeing is ensuring that your body is in an optimal condition, so mind, body, spirit, emotions…we deal with people psychologically, spiritually, emotionally, making sure that those things are all attended to on an ongoing way. That's what wellbeing is. And you can actually be quite ill and still have a level of wellbeing.

Except for Kylie (manager of a large profit driven Lifestyle Retreat), the Lifestyle and Spiritual Retreats shared a wellbeing philosophy. A thematic analysis revealed four key themes, 1) Wellbeing is generally impossible to define; 2) Is a subjective journey; 3) Wellbeing is ensuring that your body is in an optimal condition,

so mind, body, spirit, emotions'; and 4) Can be physically unwell, but mentally, spirituality and emotionally well.

A number of similarities were strongly apparent between Lifestyle retreat CEO Michelle and the spiritual retreats (Rachel, Jim and Rick). All of these service providers referred to wellbeing as a journey and any effort to improve wellbeing is significant, whether or not it includes long or short term goals, is a passive activity at a Spa retreat (i.e., receiving a massage) or actively engaging body and mind work at a Lifestyle retreat (i.e., meditation or learning to cook healthy meals). Therefore, there is no particular right or wrong way to begin the journey. Jim also thought that if nothing else, basic quietness and contemplation was a part of achieving wellbeing. He considered that the consumers' decision to arrive at his health retreat, is an effort in itself, and:

> the means by which someone, anyone, walking through the hedge to improve their life is just to stop and sit on the concrete chair, and think about why am I here, and who am I? And they will be a better person for it.

Lifestyle and Spiritual retreats shared similar understandings of wellbeing as a subjective journey, and as an active pursuit rather than passive. 'Rules' such as vegan eating vs. 5 star dining, or 'ornaments' such as no technology allowed vs. all the creature comforts, guides their understanding of how to achieve wellbeing.

Spa Retreats

The 'Ornamental' establishments are often Spa retreats. Overall service providers interviewed in the Spa category offered passive involvement in wellbeing - such as soaking in mineral springs, or having a massage -activities that do not require inner or physical work from the participant. One such establishment is a Spa retreat managed by Penelope. Located in Victoria, it is one of a chain of hotels in Australia and New Zealand, which provides predominantly four to five star accommodation. Five of these are marketed as Spa/health retreat establishments that fit into the 'Spa retreat' category of wellbeing travel. On site is a day Spa which features mineral water Spa bathing, a steam room and sauna as well as day Spa activities focusing upon beauty and massage. Use of the day Spa is at the extra costs of the guests on top of accommodation costs.

Also a Spa establishment, Tom and Clare represented a vineyard resort and Spa franchise, accommodating sixty-nine rooms. This establishment had several partnerships with local businesses to achieve the aim of the establishment, stated by the manager 'Tom', who commented that:

> the resort business model as described by the owners is a synergetic business model, so one where we bring wellbeing, health, quality, lifestyle all together in one.

However, again proving diversity even between each category is Dominic's spa retreat. 'Dominic' the owner of a mineral springs establishment in Victoria offers outdoor mineral springs public bathing in combination with private bathing facilities and a day Spa.

Ideological differences about wellbeing existed even between these three Spa retreats. In his spare time Dominic was involved with studies to empirically prove the physical benefits of mineral springs, while Penelope, Tom and Clare were more interested in profit margins by providing an exclusive pamper and relaxation establishment.

The Spa retreats passive and commodified wellbeing is reflected in the definition of wellbeing given in interviews and the approach or philosophy of the business. In a thematic analysis of the Spa establishment interviews, the service providers defined wellbeing as 1) An active pursuit to relax and take time out; and 2) Interpreted wellbeing as what their establishment offered customers, such as relaxation and pampering. In stark contrast to the smaller Lifestyle and Spiritual categories the Spa retreats providers (except for Dominic) did not share an elaborate philosophy of wellbeing or the desire to talk about it. Instead they generally associated wellbeing with physical treatments and explained wellbeing in terms of what their establishment had to offer consumers - which was body and mental relaxation and a break from their busy and stressful lives. For the Spa establishments achieving wellbeing was more closely associated with getting away from everyday life, relaxing and utilising ornaments rather than conscious inner work or rules.

Analysis of the interviews showed that the spa, lifestyle and spiritual service providers were not homogeneous groups. Additionally, it becomes clear that the service providers understanding of wellbeing and their philosophy is translated into their businesses structure. Penelope, Tom and Clare all represent chain Spa related

businesses who have many business characteristics in common. The asset of their businesses is not one leader (such as Jim, Rachel or Rick), the wellbeing activities require passive involvement and the economic purpose is profit driven.

Interviews also demonstrated that those who held more complex recipes for achieving wellbeing also had more ‘rules’ about how to achieve wellbeing, such as Michelle, Jim, Rick and Rachel’s establishments where technology was considered the anti-thesis to wellbeing. Guests were discouraged from watching television, using computers or mobile phones. For many these rules may represent an unattractive holiday option. In the Spa category, no such value-set was offered and as stated in Table x, their businesses potentially had limited wellbeing benefits. Whilst the Spa establishments aligned a wellbeing travel philosophy with passive activities and a commodified wellbeing, it can be argued that although the lifestyle and spiritual retreats aligned with an active wellbeing philosophy these service providers also relied on a commodified wellbeing. With the spiritual and lifestyle retreats, the presence of a more sophisticated or intellectual philosophy of wellbeing does not hide the fact that achieving wellbeing relies on spending money on products to enhance wellbeing.

Is Wellbeing Travel in Victoria a Cohesive Sector?

The service provider interviews demonstrated the diversity of what can be defined as a wellbeing travel supplier in Australia. Those interviewed did not have an awareness of any such cohesive or purposefully developed wellbeing travel sector. Table 9 below shows the key themes the service providers attributed to the question 'What is Wellbeing Travel'.

Table 11: Key themes from Service Providers in response to the question 'What Is Wellbeing Travel?'

Type of Service Providers	Key Themes
Spa Establishment	1) Specific establishments with packages that are tailored around complete body relaxation'. 2) Overall wellbeing benefits are limited. 3) Customers do not necessarily visit the establishment with wellbeing as primary purpose.
Lifestyle Establishment	1) Two of the three establishments, did not identify themselves as a wellbeing establishment. 2) None had a firm idea of wellbeing travel as a cohesive sector. 3) Is subjective.
Spiritual Establishment	1) Wellbeing travel is one part of an overall wellbeing journey. 2) Wellbeing travel is a necessary and increasing trend in Australia in regard to the stressors fast pace of today's society.

The first result from Table 9 is that two of the three Lifestyle establishments did not identify themselves as wellbeing travel service providers. Additionally, none of the Lifestyle establishments held a firm idea of a cohesive wellbeing travel sector. For instance, Jim stated:

> well I don't know what wellbeing travel is. I have only heard of it the first time this morning.

Advertised as a small Lifestyle retreat, Jim's business would be defined as a wellbeing tourism operator by tourism academics and perhaps organisations such as ATEC. However, Jim stated that he was not aware his business would belong under any such definition. In comparison, Table 9 shows the Spa retreat operators held a

firm idea of wellbeing tourism. These service providers defined wellbeing travel as specific establishments with packages that are tailored around complete body relaxation. They stated that their establishments had limited wellbeing benefits and the wellbeing services were a secondary reasons for customer visitation. This was confirmed by Penelope who said:

> my understanding is that it is a specific destination targeted at having treatments and total relaxation attached to it. So not just your typical resort with a pool and a couple of bars and a couple of restaurants; specific packages that are tailored around complete body relaxation.

For two of the three Spa service providers, wellbeing travel was understood as a phenomenon connected to a 'single purpose' establishment rather than a 'heterogeneous. That is, travel that occurs at a specific establishment, rather than a travel that occurs without a specific 'place' but with an intended purpose, such as improving wellbeing (Edensor, 2004, p. 330).

Travel Agents Perspectives About a Non- Existent Wellbeing Travel Sector in Australia

The Travel Agents interviewed were only to some extent more aware of the existence of a wellbeing travel sector. Travel agents were chosen for were a representation of different socio-economic groups in Australia, low, mid and high socio-economic groups. The Basic Community Profiles of 2011 (Australian Bureau of Statistics, 2011) provided the necessary information to target travel agents in specific areas. When asked if they sold lifestyle resort holidays, a low socio-economic providing travel agent stated:

> Tina: A lifestyle resort, what do you mean?

A similar response occurred from the online travel agent, Wilson, when asked if they had heard of wellbeing travel:

> Umm no, well I have an idea of what it is, but when you got in contact with me that's the first time I suppose I have heard of that being talked about when you asked me about doing the interview I thought well going on holidays is good for you, it's relaxing and time out I suppose.

The online travel agents' customer base was corporate and retirees. All of their customers were looking for an element of wellbeing incorporated into their holiday, however, the customers did not ask for wellbeing travel in particular:

> some people do ring and say, I just need a holiday, and you know that they want to get away, go somewhere warm and chill out. So there not actually saying 'wellbeing' but they are asking for it in a different way.

The travel agents' awareness or commitment to selling wellbeing travel was dependent upon the location of the agency and the main customer base. For instance, the only travel agents who did have knowledge of wellbeing travel was the middle socio-economic travel agent and the high socio-economic travel agent. The middle socio-economic travel agents (Wendy) main customer base was middle class, she commented:

> the demographic of people around here would not be so wealthy. And so people do very much come in here with a budget so we do sell a lot of Thailand, Bali, Fiji, that would probably be the bread and butter of this store so probably young families small children, who can afford a family holiday but not Europe.

This travel agent however, did not sell or recommend any wellbeing travel holidays, nor had any advertising material on offer for customers. The high socio-economic travel agent had an awareness of wellbeing travel and was the only travel agent interviewed who was purposefully attempting to sell it to customers. When asked what is wellbeing travel, Jacques said "Well I have been to this place called ******. It is a wellness retreat, they did yoga had massages every day, meditation". When asked if they sell any of these holidays:

> Jacques: No we have got others I can probably find you a brochure if you want. But that philosophy of travel is something quite unique and hopefully more and people will look into it.

The lifestyle retreat this travel agent was attempting to sell to customers was $2179 for the cheapest suite for three nights. The most expensive single suite for three nights was $6489.90. The customer base for this travel agent was a loyal repeat group of people, 80 to 90 year olds and their families, and a proportion of upper class people "See our clients are a bit different some of them. Some of them have an unlimited budget so they can spend $40,000 on a holiday" (Jacques, High SES travel agent).

Overall the travel agents did not have extensive knowledge of a cohesive wellbeing travel sector, only one travel agent was actively marketing towards customers. These results suggest travel agents may not have had a role in constructing wellbeing travel in Australia today because customers are not looking to travel agents as a source of knowledge. Those interviewed were well aware of the increasing role of the internet and the decreasing role of the travel agent. For instance, Jacques, the high socio-economic travel agent, stated "I think that they would just Google, that is probably what a lot of people do initially".

These interviews also highlighted that no collaboration exists between service providers and travel agents, or between travel agents and tourism organisations. The aforementioned Spa and Wellness Plans (Tourism, Victoria); and the establishment (and current dissolution) of expert wellness tourism panels (ATEC) highlighted attempts to establish a collaborative sector. From the perspective of Tom and Clare, a Spa service provider in Victoria, the attempt has failed due to proceeding with marketing and hype before communicating with any relevant service providers. Additionally, the attempt to establish 'expert knowledge' has failed by not really understanding the sector before pushing its existence and hence, failing any cohesive market opportunity. Tom commented:

> I don't think the market owners understand the breadth of it for the amount of push it is getting. Well I just think if you're going to spend a lot of money on something then at least make sure the people are going to understand what you are spending your money on. And I think we would benefit greatly if people understood what the marketing concept was.

Tom believed collaboration between service providers was not possible because the size of the market is too small and too competitive. Tom stated the market is small because wellbeing travel was an inherently expensive form of travel and would not be a regular form of travel for the majority of the population (a minority

market). The existence of many individual service providers would not be sustainable for the size of the market and therefore, cohesiveness of this market would not be possible:

> I think in fairness to the individual operators, they are so vastly spread…it is an expensive product to sell. So to have too many in one area, it is not an economy of scale here. It is not a case of breed competition and build business, you can't because you have only some going to an area and those people only have a potential maximum spend per head

It was also suggested collaboration between service providers may only be possible by region. Tom commented:

> and I think that is where Daylesford have found they are limited on their offerings so they have made it a Spa centre of Victoria in their own right. But they all put in their money and they all provided it in some way.

Service providers are aware of the competitive market. Indeed, Tom and Clare are well aware of the intense competition regarding wellbeing establishments in Victoria. However, they were not as aware of competition in regard to alternative wellbeing travel establishments, such as Jim or Rick's. For the most part Lifestyle retreats and Spiritual retreats have observed the existence of an increasing wellbeing travel sector, but have not considered that they were a part of it.

In summary, a cohesive, collaborative wellbeing travel sector in Victoria was not apparent at the time of research. However the power and push of the Spa establishments, from the Second Tier constructors was acknowledged and criticised. This finding is no different from that found in a survey of stakeholders conducted by Voigt et al. (2010, pp. 73-74) where only 10% of stakeholders thought the "industry is well supported by federal tourism bodies" and 17% thought it was "well supported by state tourism bodies". Without an organising body for wellbeing travel it lacks a vehicle for a strong body of knowledge in any official capacity. That is, it can be suggested that without collaborators, such as federal or state tourism bodies, wellbeing travel is also lacking any acclaim in regard to 'expert knowledge'. This is further suggested by Voigt et al. (2010, p. 88), in the same survey where 80% of stakeholders thought the "medical practitioners do not recognise the importance of the wellness

industry" also, 77% of "health insurers do not recognize the importance of the wellness industry."

The following section discusses results confirming there are alternative pathways driving the participation in wellbeing travel. These results draw attention to alternative sources of power determine non-travel.

Alternative Pathways Driving Wellbeing Travellers

According to service providers, instead of collaboration informing or driving a visible wellbeing travel sector, travellers are overwhelmingly using their own resources to find them. Secondly, results show that patronage was motivated by a growing public discourse about wellbeing. Service providers cited that wellbeing travellers were driven by a growing public sentiment towards achieving wellbeing.

From the service provider interviews three key methods motivating the visibility of wellbeing travel became apparent, formal advertising, word of mouth and the internet. First, the Spa establishments and larger service providers use formal advertising and collaboration with other brokers (Tier one or two). For instance, Penelope's chain Spa establishment participates in an annual, Australia wide competition to determine the best Spa establishment. This acts as an advertising platform for them, but is only really possible with the collaboration of other similar establishments in the competition. They are also much more likely to rely on infrastructure (5 star accommodation and facilities) as their key business asset and therefore, the wellbeing part of the business if purely a marketing platform to accompany the existing business.

The second and third method, for the smaller wellbeing travel service providers, is word of mouth and internet. It was suggested that most travellers may already be on a personal wellbeing journey and travelling for wellbeing is a part of an already established leisure or lifestyle commitment. Rick commented:

> and how they find it? It's just you connect with people that way and they end up coming on retreats and people find me on the internet, that is a huge source. And occasionally there are flyers I put up around the place and then word of mouth sort of builds. For a lot of people that come off the retreats they are in a peak experience, there really full and buoyant and you know it's like wow. They feel they have gone through certain epiphany and there is something

> worthwhile about that so they talk. So that really sticks in people's heads. So I haven't got a huge marketing campaign just up on my website; people found me.

For the smaller providers like Rick, their businesses were established in response to a need they felt from their community and consequently resulted in little purpose for formal advertising, such as marketing campaigns or travel agents. Instead, much of their customers attend through word of mouth and searching the internet. Rachel and Rick also suggest this is perhaps the only way that service providers are collaborating with each other. Rick said:

> people are getting together retreat websites there is one, 'meditation yoga retreats' Victoria set up. There's something called 'light stay', they are trying to make money out of websites, people pay 100 or 200 bucks a year...a lot of people are doing yoga retreats.

According to the service providers interviewed the main pathway to patronage was internet and word of mouth. For the lifestyle and spiritual retreat providers, their customers were on an already established wellbeing journey and consequently formal advertising/marketing was not necessary and largely reduced the likelihood of a collaboration between the travel agents and service providers.

Conclusion

This chapter has discussed the organisation and construction of wellbeing travel in Australia today and considered if a sector exists that has power to collectively or individually include or exclude travellers. To answer this question, this chapter offered a structure of power in the sector based upon Cheong and Miller (2000) model of power. The model helped to identify the Tier 1 brokers (Public and private tourism Organisations; academics) have had limited power in collaborating with the Tier 2 brokers (service providers). This chapter has suggested collaboration is considered to be a key method of developing power and without it, the wellbeing travel sector lacks cohesion.

Cohesion is also not possible because the Tier 1 brokers (Public and private tourism Organisations; travel agents; academics) have played a role in highlighting

spa tourism as the most dominant form. Results have highlighted that there is instead a diversity of wellbeing travel providers in Australia that so far has defied categorisation.

It is also noteworthy that interest in wellbeing travel by Tier 1 brokers, has declined in recent years. Consequently, power of a 'sector' does not exist. These results shift the focus from power of Tier 1 brokers to Tier 2 brokers to determine drivers for travel and non-travel. Additionally, service providers had indicated that what drives wellbeing travellers is a public discourse of wellbeing, rather than an organised sector. The following chapters explore both of these points, the extent of power the brokers/service providers have to determine a wellbeing travel sector, and travellers; and secondly the power of the public wellbeing discourse in determining travellers and non-travellers.

Chapter 8: Results and Discussion – Examining the Construction of Structural Constraints to Wellbeing travel

Chapter 7 established that, at the time of writing, Tier 1 brokers have had little, if any, influence on the increase of wellbeing travel supply and demand in Australia. Chapter 7 found that a cohesive wellbeing travel sector does not exist, and that the construction of wellbeing travel as a type of travel lies in the power of Tier 2 brokers. Chapter 8 therefore focuses on Tier 2 brokers and research question one: How is wellbeing travel in Australia socially constructed? This question is explored by comparing the similarities and differences in service providers' narratives of wellbeing. Next, a dominant and shared construction of wellbeing travel is identified by profiling service providers and their key customer base.

The narrative of wellbeing and purposeful decisions about key customers suggest that brokers have the power to construct place and consequently create drivers of and constraints to wellbeing travel.

Service Provider Perspective – Constraints and Exclusion

In the social construction of travel – beyond the power of collaboration – service providers also have power in the creation of place. Service providers decide who the tourists will be because the development and ongoing management of a wellbeing travel establishment necessitates decisions about who the target tourists are. The establishment is purpose built and marketed to the target tourists, and this begins to determine who is included or excluded from participating.

A second and complementary perspective that was discussed in the literature review (concept 3) is that tourism researchers hypothesise that the tourism industry creates a stage in establishments "to provide and sustain common sense understandings about what activities should take place" (Edensor, 2001, p. 62). These commonsense understandings are conveyed by representations, symbols, commodification and regulation (Edensor, 2001, p. 62). Tourism researchers such as Urry (1998) and Edensor (2001, 2004) understand that a single-purpose destination, or place, creates a stage for customers.

The following section explores whether wellbeing travel service providers have constructed place in a way that is consistent with these tourism researcher understandings. This includes exploring the key customer base, how service providers

have constructed place and the constraints to travel reported by those who travel for wellbeing and those who do not.

Who Travels for Wellbeing in Victoria? Key Customers at Wellbeing Travel Establishments

The service providers who were interviewed reported that wellbeing travellers are generally consistent in their age, social class and gender. This was despite the different categories of wellbeing travel (spa/mineral springs/day spa, lifestyle resort/retreat or spiritual retreat) and despite the different structures (small house-run business, chain business or not seeking profit). Consistent with previous research (Hallab, 2006; Smith & Puczkó, 2009; Steiner & Reisigner, 2006; Voigt et al., 2010), all except one establishment reported that the majority of their customers were female, upper middle to upper class, middle aged and well educated, that is, not low socio-economic status.

Table 12 shows that, despite the variation in prices among the establishments, customers were chiefly middle to upper class. Some of the smaller establishments, such as Dominic's spa and Rick's spiritual retreat, aim to offer prices that could be affordable for all. To an extent, this has been successful but the typical wellbeing traveller still prevailed in these establishments. For instance, along with being middle to upper class, wellbeing travellers were predominately female for both Dominic and Rick. Dominic achieved a mixed gender status because, as a large outdoor mineral spring establishment, men could have a sense of anonymity. Furthermore, Dominic stated that many men's sporting clubs visited his establishment for treatment of sports-related ailments.

Table 12: Service Providers' Perceptions of Wellbeing Travellers

Category of provider	Pseudonym	Primary gender	Class	Age (years)	Return visitors	Visiting from
Lifestyle	Kim	Female	Upper middle to upper	40 plus	Yes, 80%	Local & interstate
Lifestyle	Michelle	Female	Middle	35–60	Yes	Varied
Lifestyle	Jim	Female	Varied	20s–30s	Yes	International & local
Spa	Penelope	Female	Upper middle to upper	30–50		Local
Spa	Tom	Female	Middle	25–60	No	Local & interstate
Spa	Dominic	Mixed	Varied	Varied	Yes	Varied
Spiritual	Rick	Female	Middle to upper class	30–50 & varied	Yes	Local & interstate
Spiritual	Rachel	Female	Middle	30–50		Local

Jim's and Dominic's establishments attracted customers from a range of classes and ages. Jim's establishment was visited by younger people and young families because his prices were affordable. Jim does not run his business for the purposes of profit (giving himself an income of $200 per week) because he is interested in providing a place for artists, gypsies and those who need to focus on their wellbeing. One night's accommodation currently costs $45 per person but it is generally $85 per night, including accommodation, food and activities. The retreat is known internationally and nationally, and often attracts people from overseas who participate in the Willing Worker on Organic Farms in Australia program who provide labour in exchange for accommodation. The retreat's main customers are return visitors and those local to Melbourne, in particular, vegetarians, vegans and young families. Approximately 70% to 85% of customers are women aged in their 20s to 30s, Rick stated:

> and so this last ten years I would say 50% of the occupancy has been with families and people in their mid 30s so people who grew up in their 20s continue to come here … but certainly 25% to 30% are return visitors.

The other lifestyle establishment that does not seek profit is managed by Michelle and attracts both international and local visitors. Michelle runs programs to address wellbeing and alternative (to general medicine) healing practices for people with a terminal illness. The two programs are generally attended by middle-class people; Michelle described these as a "white Anglo-Saxon Protestant community". Both men and women participate in the alternative medicine program, with ages ranging from 35 to 60. The wellbeing program generally attracts younger women. The CEO's observation of this age group was that health issues increase at age 35 and the participants repeat visitors who are on a continuing and evolving path towards wellbeing. Michelle stated that "they continually come back building upon their knowledge".

During the week, the spa retreat's main customer base is corporate, while on the weekend, the main customers are couples whose secondary purpose for visiting is wellbeing. Tom and Clare reported that their customers were "couples, honeymooners, weddings, baby boomers coming out for the weekend and people who are visiting family and friends in the area". Tom and Clare stated that their customers primarily visit the region's wineries or visit family and friends; all the other activities are secondary. For this reason, the wellbeing/spa side of the establishment is just one feature in an attempt to attract a wide range of customers. Except for Dominic's establishment, the spa retreats mostly did not cater for children. Penelope stated there were:

> … very few families. It obviously doesn't have the facilities for kids and things like that. Not that it is ideal for young children, there is stairs in it, but some families do and I guess the higher income level families will bring their kids along.

Penelope's comment introduced the issue of purpose-built financial constraints with wellbeing travel to spa retreats. At the time of interview, the standard twin-share hotel room at Penelope's spa retreat was $222 to $240 per night, while standalone spa units were $390 to $450 per night. Use of the on-site day spa and baths cost extra but

can be organised as part of packages costing between $476 to $642 per night that include breakfast, a massage and entry to the hydrotherapy pools. Tom and Clare's establishment has similar prices, but Tom felt uneasy discussing prices and rationalised the expense with the following statement:

> People now spend the money if they feel value for money. If it is $1,500, it doesn't matter; they may save an extra six months to be able to afford it. As opposed to the people who go there and spend $1,500 which is $5 to them in real everyday living.

Tom believes in the worthwhile experience of his resort, suggesting that saving for a year to afford a weekend away would be a satisfying experience for those who could only afford to visit once in a lifetime. Tom also suggested that spending money was relative; poorer people would perhaps enjoy the experience more, and consequently, spending a good deal of money would be worth it. A certain value is insinuated for people spending beyond their means to visit a place that is normally beyond their means or beyond their social status.

Kim (lifestyle retreat, NSW) also rationalised the expense in a similar manner. The patrons at Kim's lifestyle retreat are reportedly upper middle to upper class (90% are women aged 40 years and over). Kim's lifestyle retreat includes a structured program with a day spa and specialists such as doctors and naturopaths on site. At the time of interview, the cheapest package for two nights was $1,145 for a single or $1,915 for a double; for a week's stay, the cost was $7,085 for a single and $9,995 for a double. It was suggested that, as with Tom's establishment, that the minority of visitors who are not upper middle to upper class attend as a special, perhaps once-in-a-lifetime, trip. Kim said, "I mean it's a tricky one, you have a percentage that it is a really big deal, they have saved all this money to have a wellbeing trip that they have been dreaming of".

Tom and Clare's and Penelope's establishments offer a different type of wellbeing holiday compared with Rachel's and Jim's establishments. These establishments offer a four- to five-star accommodation experience with lavish food, wine, relaxing wellbeing activities, beauty and pampering treatments. In contrast, smaller lifestyle establishments offer wellbeing knowledge and activities requiring active participation. Participants do not necessarily have to save for a one-off

experience at these small lifestyle and spiritual retreats. Regarding his meditation retreats, Rick commented that:

> Well I've got some really upper class [customers] and they always say 'you could charge a lot more. This venue you've got, just get a better venue and we would pay a lot more'. Easy. But I would lose a whole core group. And the venue is not comfort, it's basic. And we love it because it's got real character in the building, its 100 years old some of the building.
>
> So you're not in this to make your fortune?
>
> No I'm not into it … but I need to make some money because I have got a family and in some ways when I look at what the corporate situation does with what I offer, I could earn ten times more. But it's not about that, it's helping people.

Although the wellbeing travel service providers who were interviewed were diverse, their customer bases were similar and resemble the profile identified in research in Australia and internationally (Bushell & Sheldon, 2008; Smith & Puczkó, 2009; Voigt, 2010). Of the eight service providers who were interviewed, seven reported an absence of low socio-economic status people, six reported that their customers were predominately aged over 30 years, and six reported that children were not provided for or unwelcome.

Based on these results, a depiction of wellbeing travellers is suggested: female, middle class and middle aged. This leads to the key research question. To what degree is this customer base a result of the construction of a target market by service providers? What role does the service provider have in constructing place and attracting a certain market while excluding others? The following discussion employs Crawford and Godbey's (1987; Crawford, Godbey, & Jackson, 1991) travel constraint models from Chapter 4 to explore how and if exclusion from wellbeing travel occurs through the construction of place.

Service Provider: Structural Constraints from Wellbeing Travel

The section above identified the key customer base for a diversity of wellbeing travel service providers. At the same time, exclusions that were the result of the service providers' construction of place became evident. In the interviews, a theme of exclusivity results in structural constraints became evident (Crawford & Godbey, 1987). Exclusivity and financial constraints were presented as part of the wellbeing travel experience. For instance, Kim stated that "the cost, for some people it might be a little bit too high". Penelope asked that, without the financial constraint, "why wouldn't you do it?" Despite Tom's and Kim's rationalisation of how low-income earners save for a once-in-a-lifetime experience, the financial constraint is a justified concern.

The cost of Kim's retreat, Michelle's retreat, Penelope's spa and Tom and Clare's spa is beyond the means of low socio-economic groups. A week's holiday at Kim's retreat costs approximately $7,000 for a single or $10,000 for a double, and this far exceeds the average annual expenditure on holidays for Australians. According to the Australian Bureau of Statistics Household Expenditure Survey (ABS, 2009-2010), the average Australian household spends $52 per week (or $2729 annually) on holidays. To offer a further perspective, in 2009–2010, the highest income quintile in Australia was $1,704 per week and those in this quintile were spending an average of $105 per week (or $5,450 annually) on holidays (ABS Household Income and Income Distribution, 2011, p. 21). The median income was $721 per week and the lowest was $314 per week (ABS Household Income and Income Distribution, 2011, p. 21). The middle quintile was spending an average of $47 per week on holidays and the lowest quintile was spending an average of $22 per week (ABS, Household Expenditure Survey, Detailed Expenditure, 6530.0, 2009-2010).

As a further indication of prices, Table 13 shows an analysis of process on websites that identified as wellbeing travel service providers in Victoria (and were available at the time of data collection in 2011). The table also indicates the type of images used in marketing material, which will be a constraint discussed a bit further. The cheapest spa package including accommodation and an activity was $550 per person per night, and the most expensive was $7,767 twin share for eight nights. The cost of spiritual retreat packages ranged from $885 per person for two nights to $5,390 per person for five nights. The cheapest lifestyle retreats package was $660 twin share for two nights, and the most expensive was $4,185 per person for seven nights.

Although this is not an exhaustive analysis of prices, when combined with previous research (ABS, 2011; Bennett, 2004; TRA, 2011) and service provider observations, it is clear that, even as a one-off visit, a wellbeing travel holiday is potentially more expensive than a high-income household might spend on holidays annually.

Table 13: Wellbeing Travel Category Maximum Cost Package and Predominant Images on Websites/Brochure search, 2012

Type	Max. cost packages (accom. and activities, spa, consultations etc.)	White person	Middle aged	Female	Male	Couple	Typical gender roles	Serene and relaxed	Natural environment
Spa	$600 (per night, twin)								
Spa	$608 (6 hours at spa, pp, no accom.)								
Spa	$520 (pp, no accom.)								
Spa	$550 (per night)	Y		Y				Y	Y
Spa	$7,767 (8 nights, twin)	Y	Y	Y	Y	Y		Y	Y
Spa	$1,795 (5 nights pp)	Y		Y	Y			Y	Y
Spa	$325 (1 day, no accom)	Y		Y				Y	Y
Spiritual	$1,800 (5 nights, pp)	Y	Y	Y	Y	Y	N	Y	Y
Spiritual	NA	Y	Y	Y	Y		N	Y	Y
Spiritual	$5,390 (8 nights, pp)	Y	Y	Y	Y	Y		Y	Y
Spiritual	$885 (2 nights, pp)	Y	Y	Y	Y	Y	N	Y	Y
Spiritual	$900 (two nights, twin)	Y	Y	Y	Y	Y	N	Y	Y
Lifestyle	$2,495 (5 nights, pp)								Y
Lifestyle	$885 (5 nights, pp)	Y	Y	Y	Y	Y	N	Y	Y
Lifestyle	$2,800 (one night, twin)								Y
Lifestyle	$1,955 (2 nights, pp)	Y		Y				Y	Y
Lifestyle	$660 (2 nights, twin)	Y		Y		Y		Y	Y

The exclusivity theme in the interviews was also evident when the service providers (except for Michelle and Rick) were unapologetic about the price of going to their establishment. A by-product of setting a high price per night is that potential customers understand whether or not they are able to attend. A financial barrier is then purposefully constructed by the establishment.

According to travel agents, the exclusivity and financial narrative attached to wellbeing travel succeeds in excluding families. Discussing client constraints to travel, the mid socio-economic travel agent stated that "financial and lack of time would be the biggest things ... Financial is always it, you always have to work with budgets". This travel agent identified young families paying mortgages with kids in school and pensioners as the two groups who do not travel once a year. The high socio-economic travel agent concurred, commenting that:

> … young people with a family probably wouldn't (travel for wellbeing); they would go camping instead of flying somewhere ... people with huge mortgages. People borrow a lot of money for homes and may not have a lot of spare cash. I think it comes down to money.

Survey Sample Perspective: Structural Constraints - Time Poor and Finances

The three survey groups echoed the service providers' discussion about structural constraints (i.e. finances and time) as the primary barriers to wellbeing travel. The quantitative analysis of the survey showed an association between travelling for wellbeing and a higher income. Structural constraints were demonstrated in the qualitative analysis of income, employment and self-reported constraints. The self-reported constraints were chosen from the most relevant constraints from Crawford, Jackson and Godbey's (1991) hierarchical model of leisure constraints (question 36 of the survey).

According to the Australian Bureau of Statistics (ABS, 2011) report *Estimates of Personal Income for Small Areas (2009–10)*, the average annual income was $48,907 for all Australians and $47,363 for Victorians.[4] The average income for all Australians was used as a marker to consider if wellbeing travellers have an above average income, while the average Victorian income was used as a marker to consider if the two groups who do not travel for wellbeing may be financially constrained. Table 14 shows the distribution of annual income for the three survey groups. The mean income for Group 3 (the group who are regularly engaged with, and travel for wellbeing) and Group 2 (regularly engaged with, but do not travel for wellbeing) was

[4] Although there are more recent figures for income, the figures shown broadly reflect when the data was collected.

$52,000–$77,999, and was higher than the average Australian income. Group 1(low wellbeing engagement and no wellbeing travel) median income was $36,000–$51,999 and lower than the Australian average income.

Table 14: Annual Income by Survey Groups: Group 1 – Low wellbeing engagement, no wellbeing travel; Group 2 – Regularly engaged with wellbeing, no wellbeing travel; Group 3 – Regularly engaged with wellbeing, wellbeing travel.

	Group 1 %	Group 2 %	Group 3 %	Total %
$0–$35,999	36.1	25.0	27.7	30.9
$36,000–$51,999	16.7	21.7	18.5	19.4
$52,000–$77,999	18.1	16.7	18.5	18.3
$78,000–$103,999	9.7	18.3	15.4	14.7
$104,000–$129,999	13.9	16.7	18.5	10.5
$130,000 plus	5.6	1.7	1.5	6.3
Total	100.0	100.0	100.0	100.0

Total income median =2.7.

As with past research (Bushell & Sheldon, 2009; Smith & Kelly, 2006) and the service providers' observations, these findings suggest that those who travel for wellbeing (Group 3) have a higher than average earning capacity. However, this is also the case for Group 2 who do not travel for wellbeing. What these two groups do have in common is that they engage with wellbeing regularly. People who do not regularly engage with wellbeing and do not travel for wellbeing (Group 1) experience the most financial constraints. Of the participants in Group 1, 36.1% are in the $0–$35,000 income category compared with 25.0% of Group 2 and 27.7% of Group 3.

These findings support the studies discussed in Chapter 4 (Concept 1), which find that travel is constrained by inadequate access to economic resources (Lu & Pas, 1998; Smith, 2001; Smith and Hughes, 1999). These studies also consistently show that socio-economic status is a constraint for health status or opportunities in Australia. For example, the Victorian Population Health Survey of 2012 establishes this relationship when stating that "Despite significant achievements in public health in Victoria over the past century, the evidence on SES and health in Australia is

unequivocal; people lower in the socioeconomic hierarchy fare significantly worse in terms of their health" (Department of Health, 2014, p. 518). People categorised as low socio-economic status have higher mortality rates caused by physiological and psychological health issues than those of high socio-economic status (Department of Health 2014, p. 519).

The Australian Bureau of Statistics (2007-2008) National Health Survey has consistently shown a link between social disadvantage and health such that "disadvantaged Australians have higher levels of disease risk factors and lower use of preventative health services than those who experience socioeconomic advantage". In the current political climate around health care in Australia, the financially constrained are less likely to engage in wellbeing activities, even though wealthier people are healthier (Harley et al., 2011; Wilkinson, 1996).

A consistent theme of financial constraints was also reported in the qualitative responses from all three survey groups, but it became clear that each group's financial priorities were different. Those who engaged with but did not travel for wellbeing (Group 2) felt that wellbeing travel holidays were too expensive and could not be considered as a holiday option. Instead, this group allocated their financial resources to family orientated expenses. For instance, Anna (Group 2) said she was "pooling all spare time and resources into renovations of our house with the purpose of selling it then being relocated to a new state for my husband to start a new job".

For those with low wellbeing engagement and no wellbeing travel (Group 1), finances were a constraint evidenced by simple statements such as, "cannot afford it" and "lack of funds" (Suzie and Cliff, Group 1). As with Group 2, financial constraints were linked to family expenses. For example, Kevin said, "We have children and also the cost is not in our budget" (Group 1). Group 1 reported financial constraints (e.g. unemployment and pension status) beyond those of the other two groups. Wally stated that he "sometimes wish to have more money for that [wellbeing travel]" and Howard said he was "on the pension cannot afford it" (Group 1).

While the two groups who regularly engaged with wellbeing were allocating money towards family homes, gyms, wellbeing pursuits or other travel options, those who had a low engagement with wellbeing (Group 1) appeared to be under more pressure, were more frustrated and desired more money to pursue wellbeing pursuits and travel. The survey results confirm a largely intuitive concept: income is not only associated with travel opportunity, it may also be associated with the practise of

wellbeing. An interesting contradiction raised by examining income for the survey groups is that Group 1 had more people (5.6%) in the highest income category ($130,000 plus) than the other two groups. Group 3 had only 1.5% in the highest income category while Group 2 had 1.7%. These statistics suggest that a proportion of people in Group 1 appear to have enough financial resources to make a choice about pursuing wellbeing travel, or wellbeing in general, but have not chosen to do so. This contradiction is important because it shows financial constraints can act in combination with other constraints to result in not travelling for wellbeing.

In the qualitative survey responses, all three groups linked financial constraints with time. In question 36 of the survey (based upon Crawford, Jackson and Godbey's (1991) general travel constraint model), participants were asked to rank their top five constraints to travelling for wellbeing. A perceived lack of time was the top-ranked constraint for 23.5% of Group 1 (low wellbeing, no wellbeing travel) and 23.7% for Group 3 (regular wellbeing and wellbeing travel). Time was also the top-ranked constraint for 17.3% of Group 2 (regular wellbeing, no wellbeing travel), which was noticeably less than that seen for Groups 1 and 3 (see Table in Appendix K).

In combination, access to free time and a good income creates an environment in which wellbeing travel can take place. Robinson et al. (2008, cited in Olimpia, 2009, p. 40) stated, "the connection with the level of income is determined by the *freedom* that a high income gives". A high income offers material freedom and time-flexible employment offers freedom of time. Smith and Kelly (2006) stated that pursuing wellbeing is both expensive and time intensive. For this reason, the ideal wellbeing traveller's socio-economic profile reflects an environment in which income and employment conditions combine to provide free time. These people could be retired with a good income, well-paid part-time workers or corporate employees.

Wellbeing non-travellers are minority groups without time and money freedoms. Having all three groups report time as their top-ranked constraint supports the notion that time is a constraint for people who do not travel for wellbeing, but suggests that this is also an issue for those that do. For the wellbeing travellers, time is a constraint or concern but there are other drivers that lead to the choice to participate. Time alone cannot explain non-travel or travel for wellbeing. To further understand the time constraint, the Table 15 presents employment type by group. Analysis of the table demonstrates a scenario in which the most time poor may be the full-time

employed and those who have the most free time are pension/benefits/retired and the unemployed.

Table 15: Employment Type by Groups: Group 1 – Low wellbeing engagement, no travel for wellbeing, Group 2 – Regular wellbeing engagement, no travel for wellbeing, Group 3 - Regular wellbeing engagement, travel for wellbeing.

	Group 1	Group 2	Group 3	Total
	%	%	%	%
Full-time	45.1	32.3	39.1	39.1
Unemployed	4.2	0.0	6.3	3.6
Part-time	16.9	16.1	21.9	18.3
Pension/benefits/retired	29.6	40.3	29.7	33.0
Domestic duties	4.2	11.3	3.1	6.1
Total	100.0	100.0	100.0	100.0

Those who are employed full time have access to regular income but would potentially have the least free time. Table 15 shows that Group 1 (who do not regularly engage with wellbeing activities or travel for wellbeing) have the highest proportion of full-time employed, 45.1% compared with 39.1% of Group 3 and 32.1% of Group 2. Group 1 may have the most time constraints, and this finding supports the concept of a time–finances balance. That is, they do not travel for wellbeing, they engage regularly with wellbeing, they primarily work full time and are self-reportedly time constrained. The analysis of income (Table 14, above) showed that those in Group 1 have the lowest income of the three groups and are potentially financially constrained. These assumptions are confirmed by qualitative responses. Larissa (Group 1) stated “not enough time and too expensive”. Cameron, a full-time worker and primary income earner, expressed his frustration at not being able to holiday, let alone go on a wellbeing travel holiday: “I am not permitted to because I have to pay for someone else’s lifestyle and wants”. Cameron was commenting about his financial constraints due to a recent divorce. Although all groups identified time as a primary constraint, for Group 1, financial constraints act in combination with time constraints and may contribute to understanding other constraints that determine non-travel.

Cameron also expressed frustration when explaining the following scenario: “Where someone works and requires a break they are not allowed, as a holiday is a

luxury. Where some[one] works as little as possible or doesn't work, a holiday is a necessity". Here, Cameron observes and experiences inequality in the ability to travel – those who are most in need of a holiday cannot because they are time poor and perhaps financially poor. While those who do travel are not time poor or financially poor. Cameron echoes the ideal conditions for travel suggested by tourism researchers. In Chapter 3, Bushell and Sheldon (2009) established that wellbeing travellers in Australia and America were those who have enough time and money to engage with wellbeing. The two main markets were the baby boomers and the younger financially liquid population (Bushell & Sheldon, 2009).

Those in the survey who did have these ideal conditions were in Group 2, the group who are engaged with wellbeing regularly, but did not travel for wellbeing. In Group 2, 40.3% were in the pension/benefits/retired employment type category compared with 29.7% of Group 3 and 29.6% Group 1. The pension/benefits/retired category was Group 2's most common employment type. With the time–finances concept in mind, Group 2 may have the least time constraints. Because Group 2 do not travel for wellbeing, but do appear to have free time, further constraints must exist for this group. One explanation for some of this group is explained by the large percentage in the domestic duties category (11.3%). Taking care of children, others and the home, eradicates the free time rationale. Previous research (Lu Pas, 1998; Smith, 2001; Smith & Hughes, 1999) has found that single parents, those with a disability, retired people, and people on domestic duties were most represented among those who do not travel.

A second scenario that may also provide an environment for wellbeing travel to occur is part-time employed who have less time constraints and access to some income. Supporting this notion, those who do travel for wellbeing (Group 3) had 21.9% in a part-time employment compared with 16.9% in Group 1 and 16.1% in Group 2. Again, disproving the concept of the time–finances constraint, those who travel for wellbeing also had the highest percentage who were unemployed, 6.3% compared with 2.0% of Group 2, 0% and 4.2% of Group 1. The unemployed have the greatest amount of free time but have a limited income, and would represent people who are most constrained finances. This basic statistical inquiry shows that a balance between income and time are the structural conditions that would enable travelling for wellbeing, but these two conditions alone do not explain wellbeing non-travel.

A statistically significant relationship was found between self-reported wellbeing ranking and employment type (Table 15). The self-reported wellbeing scale was presented to participants as a 5 point rating scale, from 1 to 5, where 1 represented “not very well” and 5 represented “very well”. For the purposes of presenting a clearer picture of the results, this variable was collapsed so that 1 represented “not very well”, 2 represented “neutral wellbeing” and 3 represented “very well”. A chi-square test was performed, which demonstrated a relationship between employment type and self-reported wellbeing (χ^2 = 8.410, df=8, p= .395)

Table 16: Self-Reported Wellbeing by Employment Type – total sample

	Employment type (N=179)				
	Full-time work	Unemployed	Part-time work	Pension/ benefits/ retired	Domestic duties
Not very well	11.6%	66.7%	12.1%	13.6%	8.3%
Neutral wellbeing	34.8%	16.7%	24.2%	18.6%	50.0%
Very well	53.6%	16.7%	63.6%	67.8%	41.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

(χ^2 = 8.410, df=8, p= .395)

Table 16 shows that 66.7% of the unemployed category has reported feeling not very well. The unemployed have time, but are without finances. Interestingly, the wellbeing travellers represented those most unemployed in the sample.

The employment category with the highest proportion who reported feeling very well were those in the pension/retired/benefits category (67.8%). Group 2 had the highest proportion in the pension/retired/benefits category (see Table 15), and the results above established that Group 2 have the structural conditions to enable both wellbeing or wellbeing travel. The important distinction here is choice. Group 2 choose not to travel for wellbeing, but choose to regularly engage with wellbeing. The

notion of choice was highlighted in the qualitative responses regarding constraints. Table 17 below shows the top three themes from the survey participants.

Table 17: Self-Reported Wellbeing Travel Constraints by Survey Group: Group 1 – Low wellbeing engagement, no travel for wellbeing and Group 2 – Regular wellbeing engagement, no travel for wellbeing.

Survey group	Self reported wellbeing travel constraints
Group 1	1. Finances/time 2. Wellbeing travel is unnecessary 3. Not well enough to travel
Group 2	1. Finances/family limitations-time 2. Not interested in wellbeing travel 3. Already well.

The particpants in Group 2 are not interested in wellbeing travel. They travel for different reasons, predominately to visit family and friends. General travel was enough to fulfil the needs of this group, which makes any formal travelling for wellbeing somewhat redundant. When asked why they would not travel for wellbeing, Jack (Group 2) described this position: “Cannot think of any reasons to and believe that my travels fulfil those purposes anyway”. Wendy (Group 2) described a similar position:

> Just a holiday, by itself, is enough to improve wellbeing – don't need to tailor destination specific to that purpose. Will travel when financially viable and circumstances right.

Other reasons given were that travel for this group was family or socially orientated and they were just simply not interested in travelling for wellbeing:

> Wellbeing holidays are just not for me (Gavin, Group 2).

> I am past redemption (Adam, Group 2).

In Group 2, a third self-reported constraint was “not a travel priority”. This shows that although this group have the fewest time and financial constraints, they are simply choosing not to travel. The regular wellbeing engagements they have already committed to are enough, and general travel is for wellbeing. They also expressed that wellbeing is achieved in different ways:

> Because my personal wellbeing is up to me (Angel, Group 2).

> My home town has many gyms. There is nothing wrong with going to one of them (Nicholas, Group 2).

An important distinction between the two groups who do not travel for wellbeing is the opportunity to make a choice. The quotes above indicate that those who regularly engage with wellbeing have chosen not to travel, while those who do not regularly engage with wellbeing, are constrained from travel. Some of the choices for Group 2 are to join a gym or to define their own wellbeing travel.

For Group 1, wellbeing travel was unnecessary because they were already too unwell and beyond the perusal of a wellbeing journey. One participant indicated that they were too unwell to travel because of a back injury. Other participants were facing recurring illnesses. Carlos (Group 1) said, “I have been told that cancer has returned after 5 years” while Lia said, “We are not well at this stage of the game”. Some were beyond the benefits of wellbeing travel “because it has too narrow a focus” and is therefore unnecessary. For instance, Aidan (Group 1) said, “Improve how? Physically the doctors have given up on my vision impairment 13 years ago, and spiritually I am as well as I wish to be”.

Bill (Group 1) said:

> I accept the fact that I have a one in a million body and the other 999,999 are delighted it wasn’t them that got stick with it. Mentally I am in very good shape, nothing stresses me because I get things off my chest the moment they start to bother me and do not bother to pretend to have different opinions from the others I have - I call a spade a spade and a fat guy a fat guy - and I am a fat guy!

These findings support prior studies that have noted that a pre-cursor to participating in wellbeing travel was “perhaps ironically” that wellbeing travellers were in “good

enough physical health" as well as financially able to pay for the expensive form of travel and that pursuing wellbeing is "time consuming" (Smith & Kelly, 2009).

Conclusion

This chapter has examined structural constraints to wellbeing travel. A process of exclusion was established by demonstrating that most service providers have constructed a place where the price of wellbeing travel results in financial exclusion of most Australians. While the service providers are essentially profit-driven organisations, they are aware that this may be the key constraint for customers. The spa and lifestyle service providers, except for Dominic, did create financial barriers and are aware that low income groups were generally excluded. This was made apparent with one example of a stay costing $7,000 which far exceeded what the highest income quintile in Australia would, on average, spend on holidays annually.

This chapter also examined the survey respondents' perspectives about structural constraints to travel. The survey respondents' key constraints to travel are finances and time. This was particularly apparent for Group 1 (no regular wellbeing engagement and no travel for wellbeing). The structural constraints found in this research are consistent with Australian research that links low socio-economic status with health inequalities and non-travel (Department of Health, 2014; Harley et al., 2011). It is also clear that financial structural constraints in society are reproduced in wellbeing travel.

The occurrence of non-travel for wellbeing is the result of a specific process: 1) construction of a place, 2) marketing towards a specific customer base (white, female, middle class), 3) attracting the specific customer base and 4) excluding others by financial means. Moving beyond structural constraints, the service providers were far more involved in constructing a stage that excluded people based upon interpersonal and intrapersonal constraints.

Chapter 9: Results and Discussion – Interpersonal/Intrapersonal Constraints and Self-Exclusion from Wellbeing Travel

Other than finances and time, the data showed a consistent set of less obvious intrapersonal constraints (psychological states and attributes intervening between preference and travel participation) and interpersonal constraints (social interactions intervening between preference and travel participation, such as between the traveller and service providers). Combined with the structural constraints, the interpersonal and intrapersonal constraints helped to develop a richer understanding of how non-travel occurs and who are the groups not travelling.

Woven throughout the data was a process of social exclusion and self-exclusion. This chapter will show that social exclusion from wellbeing travel is a combination of all three types of constraints. Social exclusion from wellbeing travel is a structural constraint, with time and finance limitations intervening between travel preference and participation. Self-exclusion is a psychological state, where the individual's comfort level and identification with wellbeing travel intervenes between preference and travel participation. And finally, the social world intervenes between travel preference and participation. These three types of constraint explain how a stage is constructed for target tourists, how constraints to travel are created and how a potential tourist then decides not to travel.

Self-exclusion occurs when a person voluntarily chooses not to participate. There is dispute in the literature as to whether voluntary exclusion can be considered social exclusion (Atkinson, 1998; Barry 1998). Burchardt, Le Grand and Pichaud (1998) propose that groups or individuals who exclude themselves only do so because they have already been systematically rejected or socially excluded. It is argued that self-exclusion is a counter action to a social exclusion that has already been set in motion. Burchardt et al. (1998, p. 228) use the following example to explain this, "if a young person is brought up with a narrow view of the opportunities that society offers (say, on an isolated council estate) and decides his/her best option is to join a local gang that terrorizes the neighbourhood, then it would still seem reasonable to describe that person as socially excluded; for the narrowing of opportunity set that has led to their apparently 'voluntary' exclusion arose from factors beyond their control".

Chapter 8 suggested that through price setting, service provider have constructed a narrowing of opportunity for potential tourists. Financial constraints are a clear reason to not travel and is often cited as a reason for non-travel in the literature

(Haukeland, 1990; Lu & Pas, 1998; Smith, 2001). This chapter highlights the additional and less obvious constraints to wellbeing travel: the interpersonal and intrapersonal constraints gender and ethnicity that result in self-exclusion.

In the service provider interviews, gender and ethnicity explained the homogeneous customer base of wellbeing travellers – middle to upper class women. The first example of self-exclusion was evident in discussions with service providers about the cultural origin of their key customer base. Except for Dominic (spa) and Jim (lifestyle retreat), service providers described their customers as upper middle to upper class and mainly female.

Michelle's account of her customer base revealed a theme of ethnicity and self-exclusion. Michelle identified the typical female middle class wellbeing traveller, but also identified ethnicity and socio-economic status as defining characteristics of her customers. As manager of a internationally known and respected wellbeing establishment, Michelle reported customers from Europe, and Asia on occasion. Mostly she has observed a predominately "white, Anglo Saxon protestant" ethnicity. Michelle had a few explanations for this fairly specific type of customer.

The presence of the ethnicity factor (predominately white) in the wellbeing traveller profile, initially led Michelle to question if financial barriers are the most significant constraint to wellbeing travel. Michelle suggested that new ethnicities to Australia may have more immediate concerns than wellbeing, such as basic survival: shelter, safety and employment. Michelle commented, "I think they are more focused on how to get along in this world, so I think it is different for them".

Michelle stated that she would accept anyone who wanted to participate in a wellbeing or terminal illness program: "if somebody rings me and says 'I actually don't have any money', I would not turn them away". Consequently, Michelle developed a program to include the low socio-economic demographic of Melbourne by offering a token fee to participate in wellbeing seminars. She explained that:

> a couple of years ago we put in a group in Footscray, to try draw people from low socio economic backgrounds and we even paid for them to come. They were to pay $40 for four weeks. Very hard to get them to come … we did the same in Dandenong and again very hard to get them to come. But in Toorak, in the middle of affluent Melbourne, it's full every week. So I don't know if it's got anything to do with education status, socio economic status.

Despite Michelle trying to reduce the financial barriers to attending a wellbeing seminar, low socio-economic and ethnically diverse groups still did not attend. Undoubtedly, reasoning beyond structural constraints for non-travel must be considered. Michelle suggested that, despite the many cultural influences in Australian history (not to mention the largely ignored Indigenous knowledge), a cohesive wellbeing model has never existed. Australia is a western country that is mostly reliant upon the medical model for knowledge. Michelle suggested that these conditions create a perfect market for white Anglo-Saxons to engage with a variety of wellbeing service providers. As an example, she said:

> [the] Australian community is made up of many different cultures, but if you're thinking about the Asian community they have their own whole traditional Chinese medicine network that's what they do, so they would be fairly well served I imagine.

The need to achieve basic survival may well supersede the pursuit of wellness. The premise set by Michelle is that, for settling migrants or ethnicities of low socio-economic status, the task of access to collectivist values may be rather time consuming. Access to vital health and social services would be a priority compared with learning how to meditate or taking the waters. At this point, self-exclusion can be considered as an explanation for non-travel. Self-exclusion is defined as a narrowing of opportunity leading to exclusion of the self (Burchardt et al., 1998). In tourism, the narrowing of opportunity may take the form of structural constraints (as suggested by Michelle) and the need to focus on basic survival (as suggested above).

The narrowing of opportunity may originate from the tourism industry not providing adequate opportunities for ethnically diverse groups. For example, Smith, Fralinger and Litvin (2011) found six main groups of non-travellers in the United States. One of the six groups was the Hispanic working class who had above average income and high employment participation but did not have obvious structural constraints to travel. Lack of interest in travel did not explain the high non-travel status of this group: "fewer than ten percent of members of each segment noted a lack of interest as a rationale for their non-travel; yet members failed to participate in vacation travel opportunities they could afford" (Smith, Fralinger, & Litvin, 2013, p.

145). The researchers concluded that travel providers may not be attuned to the needs or desires of minority groups:

> … as the demography of the USA continues to shift toward a diversified ethnic mix, there needs to be a greater understanding of how these different populations perceive travel … the hospitality industry needs to do a better job of encouraging vacation travel from all ethnicities. With minorities expected to constitute a majority of the USA population by the year 2050 (CNN 2008), the importance is evident. (Smith, Fralinger & Litvin, 2013, p. 146-147)

The need to address the representation and inclusion of different ethnicities in tourism is not a new area of research (Burton & Klemm, 2009), but attention is needed regarding wellbeing travel. Self-exclusion for ethnic groups in Australian wellbeing travel may occur because service providers construct images of belonging that do not include non-white persons. The images on wellbeing travel spa and lifestyle websites are overwhelmingly of white middle aged women (see Table 13[5]).

Images of belonging cannot be underestimated in tourism advertising. Edelheim (2006) argues that hegemonic messages in Australian tourism brochures are detrimental for marginalised groups in Australia. Marshment (1997, p.16) finds that, while holiday brochures and images on websites provide primary information about the destination, they are also "visually dominant" and "most important in the construction [of other] meanings". The images in advertising are the result of a choice made by service providers, and as such can be considered a part of the construction of their 'stage' (i.e. the images of belonging that are offered to potential tourists). Further research is needed to explore and quantify the possible self-exclusion of ethnic groups from general travel and wellbeing travel in Australia. And if self-exclusion does not result from structural constraints alone, it will be the responsibility of the wellbeing tourism sector to "do a better job" (Smith, Fralinger & Litvin, 2013). Images of belonging may not also lead to the self-exclusion of of alternative ethnicities, but also of men. This issue is explored in more detail below as the leading interpersonal constraint from the service provider perspective was gender and exclusion.

[5] Ethics and anonymity of the service providers who were interviewed prohibits showing the brochures and websites.

Service Providers: Gender and Exclusion

A key finding from the service provider interviews was that visitors to wellbeing travel establishments were predominately female. This agrees with current research about wellbeing travel and is consistent with how travelling for wellbeing was historically a female activity (Herbert, 2009; Paige & Harrison, 1987). This finding, however, is not consistent with 19th century Victoria, Australia, where taking the waters was an egalitarian activity (White, 2012, p. 91). Service providers report that today, women are the primary patrons of wellbeing travel in Victoria. This agrees with the Elite Model, described in Chapter 2, which demonstrates that all except for Dominic observe a majority of women at their venues.

Jim, who provides a low-budget lifestyle retreat, said, "I would say 70% to 85% females is being a traditional sort of mix. It might have dropped a bit time to time depending on an event". Jim first highlights a traditional gender role division by suggesting that a reason for this is that wellbeing and health is a traditionally female environment. He said, "healing professions are inundated with women and the traditional carers and assistants, and others in the health regime ...". Culturally, women are more aware of their health and wellbeing and are more willing to do something about it. Jim sees many female health professionals who have burned out:

> Are you saying women burn out more?
>
> No, no! Well, women are much more aware of burning out (laughs). Burning themselves out because they are just more aware. But they are in that spectrum of health professionals that have utilised the place [his establishment]. There are more women I suggest involved, employed in those areas, so we have more women. And particularly also things like cooking courses and things…like it just seems like if we have a group of 16 people, if we have three males, then that is a lot. So maybe 80 to 90% in the cooking area (Jim).

Although Jim is a man in the wellbeing business and has constructed an egalitarian environment at his establishment with affordable prices and with a wide variety of customers – from young families to people who have been recently released from mental institutions – he further encourages the gender divide with his observations about wellbeing as a traditionally female employment and interest area.

At Kim's high-budget lifestyle retreat, the majority of customers are women and participation is attributed to burning out as a result of women working more than in the past – doing it all – as well as women intuitively or naturally know how to be well. Kim commented that:

> women are working a lot more now, 80 to 90% of our clients are women who feel more in tune with what their needs are than males. And yeah working a lot more than we ever did, and women are going back to the workforce as well, and quite high careers.

A key explanation for the gender divide at these establishments was founded upon notions about women as naturally more concerned with their health and wellbeing than men. Women's health is under more threat as they pursue careers, and for other reasons women are thought to have less free time. A further explanation was that, as a general rule, men feel uncomfortable about wellbeing travel because it is largely marketed as a female activity. Tom's establishment is predominately patronised by couples on the weekends, but the women are most likely to participate in the wellbeing activities: spa and beauty. The wellbeing components of Tom's and Penelope's establishments is of secondary importance to visitation. The accommodation and the region are the primary reasons for customers to visit. Tom suggests that it is in the interests of the business to keep it that way.

Tom observes that men are apprehensive about wellbeing travel. He said "anyone who promotes the health and wellbeing side … it is still seen as a bit hocus pocus. They (male customers) don't understand what they are getting from it". Men, but not all it seems, have different ideas about what it means to be well and how to achieve it. Men don't respond to the pampering, being touched and spiritual elements that can be included in wellbeing travel. Tom elaborated further by commenting:

> if you talk about spas with men, it's all about massage and either enjoying it or being uncomfortable because I am not used to being poked and prodded in those ways. Or it's about being healthy and all I want to do when I go to a resort is drink beer and watch TV.

With the mention of beer and TV, Tom suggests that wellbeing travel activities are understood to be in opposition to traditional perceptions of Australian masculinity. Tom states that men do not participate in activities that are seen to be largely

feminine. The service providers observe that men self-exclude out of discomfort in a traditionally feminine purpose-built environment. Tom explains that the gender divide is the dominant knowledge for customers and provides a sound basis for self-excluding "because they (advertising for service providers) talk about the spas with the ladies in particular and it's about relaxation" (Tom).

For men, the service providers suggest that self-exclusion from wellbeing travel can be recognised in the form of criticism of the sector, apprehensiveness or feeling uncomfortable. Penelope has already identified this masculinity crisis in the spa. She said, "I guess males we find particularly aren't keen. They will come as a couple and the female will go to the spa – a lot of males are just happy to get away. Fortunately, Penelope's business has set out rectify this to capitalise on both genders. She commented:

> our new marketing campaign, which is coming out shortly, is directed at getting men into the spa. There is specific men tailored packages and that it is ok for manly men to go to a spa. So we have had photos done, based on you know we have had a guy come in with tattoos down his arm, his got the three day growth, good looking man but he is a manly man. So it's not just the girly men, that's all the ones who go to the spa, so yeah, I think it is for everyone but it's some of them taking the leap to indulge and saying 'hey this is really good'.

Penelope's understanding of masculinity as a muscly man with tattoos, the *manly man*, and in contrast the *girly man*, will result in new images created for the wellbeing travel sector that further encourage and construct typical gender roles. The spa is still not for everyone, but is now depicted for typically feminine women and now, manly men.

Pritchard (2001, p. 79) argues that tourism "is a product of gendered societies, tourism processes are gendered in their construction, presentation and consumption". Although tourism is a product of a gendered society, it is deliberately constructed and reinforced. The recognition of gendered tourism is not a new phenomenon (Kinnaird, Kothari, Hall & Hall, 1994; Kinnaird & Hall, 1996). In 1995, Swain (p. 250) commented that "gendered realities shape tourism marketing, guests motivations, and host's actions".

The mediation of gendered tourism between the host and the public is evident in images and tourism brochures. Pritchard states that "tourism brochures (as all advertising media) make use of desired gendered attributes in the hope of communicating more effectively with their intended target markets ... As such, tourism advertisements carry reinforcements of particular notions of masculinity and femininity" (2001, p. 81). Making use of desired gendered attributes is precisely what Penelope has planned when taking photos of manly men to construct a new meaning for her establishment. In general, tourism reinforces typical gender roles by appealing to socially accepted behaviours and needs for women and men. Pritchard believes that the creation of these images is entirely deliberate. Men are associated with action, power and ownership, and women are associated with passivity such that "women and sexual imagery are used to portray the 'exotic' nature of a destination" (Pritchard, 2001, p. 81).

The service provider findings support Pritchard (2001) and other research (Wearing & Wearing, 2001) regarding gender and tourism. The service providers have constructed a stage for the women to perform wellbeing while men self-exclude to conform to the traditional images of masculinity and femininity. For instance, Tom and Penelope both suggest that image and marketing play a significant role in the self-exclusion of men and the inclusion of women. Additionally, Rick reinforces feminine stereotypes (albeit not through images) with his conclusion that women are naturally more inclined to look after their wellbeing than men.

In the previous discussion about financial constraints, I suggested that, although service providers were responsible for constructing a price per stay that serves as a financial constraint to travel for many, the constraint was predominately a reinforcement of existing social inequalities. A similar statement can be made about gender as a constraint. In the spa category of wellbeing travel, service providers reproduce traditional gender roles in society through the construction of place and the tourists' performance of expected roles. Gender therefore represents an interpersonal constraint because the image or representation of wellbeing travel provided by service providers intervenes between preference and travel participation.

Lastly, as a comment on both financial and gendered constraints found in this study: rather than replicating the egalitarian environment of Daylesford spa region at its conception in the 19th century (White, 2012), Tom and Clare's and Penelope's

businesses have constructed an alliance with the culture of bathing in 19th century United Kingdom and Europe. The spa service providers who were interviewed have reproduced and reinforced the elite model described in Chapter 2. For instance, Herbert's (2009) research of 19th century United Kingdom and Europe suggests that those taking the waters were not only women but women of the upper middle to upper class. Herbert (2009) also found that spas were inhabited by "wealthy elites, sites which allowed privileged women and men to leave their duties" (Herbert, 2009, p. 361). This finding corresponds with Kim's and Jim's observation about women burning out, doing it all and being inherently more conscious of their health and wellbeing. The following discussion strengthens this assertion. It explores the relationship between gender and wellbeing from the perspective of the survey sample and reinforces the service providers' opinions about gender divide.

Gender and Exclusion Themes in the Survey

The section above suggested that tourism is a product of gendered societies (Pritchard, 2001), that gender is a key constraint in travelling for wellbeing and that service providers have the power to reinforce existing inequalities. This section discusses the survey sample's perspective and finds, to some degree, that the gendered divide is already present before the choice to travel takes place. Gendered marketing affected each group differently by either driving (inclusion) or constraining (exclusion).

The total sample conveyed a traditional construction of gender roles: wellbeing is a woman's domain; women are nurturing and have a natural predisposition to look after themselves and others; women have more time on their hands; and women need to be well so they can take care of men, children and the household. These sentiments were consistent with the service provider data and observations about why women outnumber men in wellbeing travel. Male self-exclusion from wellbeing travel, based upon the construction of gender, was strongly evident in the survey sample and focus group data. The data also showed that the same construction of gender drives female travel.

Gender and Exclusion Theme for Those who Regularly Take Care of Their Wellbeing - Groups 2 & 3, and the Focus Group

For Group 2 (regular wellbeing engagement, no travel) and Group 3 (regular wellbeing engagement, travel), there were three main reasons why women would take better care of their wellbeing: 1) it is a natural predisposition for women who are more caring and nurturing then men, 2) men ignore their health and 3) women have to take care of their wellbeing because, in turn, they need to take care of children and men. Both the men and the women in the survey expressed that taking care of wellbeing was considered to be more of a natural predisposition for women rather than men. For instance, Joseph (Group 2), a wellbeing traveller, stated "I think it just comes naturally to the majority of women". Similar comments were made by women; Sophia (Group 3) said, "women, it's their nature to nurture". The use of the terms *nature* and *nurture* indicate a perception that this is a genetic predisposition. Alyssa provided further evidence for the perception of nurture:

> I think on the whole, women take better care of their wellbeing. Perhaps they have a better awareness, as well as having a more nurturing disposition to men. (I am generalising)" (Wellbeing, no travel).

The participants suggested that women were more likely to look after their wellbeing because of nature. For instance, Michael (Group 3) suggested that "women from puberty are taught to look after themselves better than males". In juxtaposition to women who are genetically predisposed and socialised to take better care of their wellbeing, it was suggested that men are predisposed to ignore their health. For instance, Adelaide (Group 3), a wellbeing traveller, said "men often ignore health concerns". That men do not take care of their health is also attributed to socialisation according to wellbeing traveller David, who said, "Men are less likely to acknowledge they have any problems with which they cannot deal – as part of their macho upbringing". Kevin (Group 2) also gives upbringing as a reason that men are taught to ignore their health: "Men tend to be bought up [with] she will be right mate attitude and life goes on".

Traditional gender traits are established for these two groups in a final main theme: women have to take care of their own wellbeing because, in turn, they need to take care of their children and men. This theme was uncovered by Ava (Group 3) who

commented, “normally, the household would collapse if the female didn't run it. Very few men are up to that task”. Similarly, Isabella (Group 3), another wellbeing traveller, stated that women “need to be in control of family life” and that women take better care of their wellbeing “because they end up carrying the load of their family life and, therefore, take better care of themselves and are more aware of their health and wellbeing”.

The focus group participants (who were all female and regular wellbeing participants) spoke more specifically about men’s relationships to wellbeing and why men wouldn’t travel for wellbeing. An interaction between four participants revealed the following:

Rosie: Men wouldn’t travel. They’re too busy making money and they perceive themselves as “I’m all right”.

Lucy: Exactly my husband would think “well why?”

Ginny: If it ain’t broke don’t fix it.

Lina: That’s it; men don’t want to do a yoga retreat!

The women in the focus group perceive that men are ambivalent towards their wellbeing and feel that any attempt to improve wellbeing is futile, and this is why men do not travel for wellbeing. The women presented a traditional view of men with masculine traits. These included men having other familial priorities (making money) and viewing their bodies as essentially okay, until they are not. These perceived socialised or inherent masculine traits were thought to prohibit any interest in their wellbeing.

On the other hand, traditional female traits were identified as drives of women’s interest in wellbeing. Both women and men in Groups 2 and 3 suggested that women feel overwhelmed and unwell as a result of the perception of increasing expectations of women to do it all. In particular, the women in Group 3, who regularly engage with and travel for wellbeing, expressed this attitude:

Yes, we are more stressed. There are more demands on our time as we try to "do it all" (Anna, Group 3).

Women are trying to juggle careers and family, living up to the expectation of 'super mum'. Needing to work harder than men in corporate settings to achieve

same recognition (Emma, Group 3).

> Woman are more stressed because society makes it harder for a woman to achieve anything and they are trying harder to do everything at once (Mia, Group 3).

Not only are women trying to do it all and feeling unsupported in this quest, some participants thought that whatever choices women make, they will be stigmatised and unsupported. Madison (Group 3), a wellbeing traveller, articulated this position:

> Women, still not getting equal wages as men, still get ridiculed for wanting a career or if you want to be a stay at home parent, either way you can't win. Sexual abuse and assault of women are dramatically higher and the conviction rates are very very low, more pressure to conform to a physical ideal than males.

Some men in the survey reinforced these women's fears. Commenting upon women's roles in society as workers and mothers, a particularly outrageous comment (one of many cited throughout the analysis of the qualitative data) was made by Kyle, a wellbeing traveller who said, "they want to walk before they crawl". One interpretation of this comment is that Kyle thinks women have high ambitions but do not yet have the ability to achieve them. A further interpretation of this comment is that Kyle was implying that women are not equipped to transcend traditional roles.

At this point in the discussion, a link can be made between how gender stereotypes drove the elite wellbeing travel of the past and how they also drive elite wellbeing travel today. The gendered approach to wellbeing reflects the performance of travel and wellbeing found in the 19th century elite model of travel that was discussed in the literature review (Hale, 1828, p. 347; Hall, 2006, p. 172; Herbert, 2009; Paige & Harrison, 1987; van Turbergen & van der Linden, 2002).

Women were the natural participants, with the aim of restoring their bodies from their diagnosed reproductive and mental health woes (Briggs, 2000; White, 2002; Wood, 1973). Women were overwhelmed, stressed, unwell and were travelling for wellbeing to negate these feelings (Briggs, 2000). In the 19th century, middle to upper class women's wellbeing and mental health was a public concern (Ussher,

1991), with numerous activities focused on diagnosis and treatment (Carpenter, 2009). Doctors, gynaecologists and other specialists proposed that "comfortable living, combined with worry, was making white women of the middle and upper classes soft and decadent" (Briggs, 2000, p. 247). As a consequence, women were thought not to be capable of engaging with activities such as education or politics and instead were busy attempting to reclaim good health.

This state of being was labelled the *hysteria* or *invalidism* of women. However, for some time gender researchers have considered that, rather than being a medically diagnosed disease, these labels were a cultural phenomenon (Briggs, 2000; Ehrenreich & English, 2011) that allowed society to ensure that women did not partake in any unacceptable social roles. Instead of pursuing education or involvement in politics, the perceived sick upper-class woman became busy with restoration and self-care. Along with the authority to make judgments on the deviant and moral body, the medical model (Conrad, 2010; Kelman, 1977) maintained its authority with physical interventions to heal.

The women and men in the survey who practise wellbeing regularly have articulated the overwhelming nature of life, society and the subsequent impact upon their wellbeing. The participants expressed that women are either more naturally predisposed to look after their wellbeing and their family, or socialised to partake in wellbeing and body restoration. Either way, the women who have travelled for wellbeing (Group 3) reported difficulties in transcending traditional gender roles – a career and family – and the need to look after their bodies.

Gender researchers such as Briggs (2000) and Ehrenreich and English (2011) suggest that normative understandings of health and social controls of the body have acted to distract women from transcending traditional gender roles. The findings regarding gender in this chapter have demonstrated that women are attempting to do it all and are noticing resistance. Keeping wellbeing as the domain of women, in which there are unachievable body controls and ideals, may be the distraction to ensure they do not.

The wellbeing travellers of Group 3 revealed a stereotypical approach to gender, whereby the construction and reproduction of a gendered society in tourism appeals to this group. The participants in Groups 2 and 3, who both engage with wellbeing regularly, shared similar attitudes towards gender and wellbeing. These findings offer a new avenue for inquiry: is wellbeing also a product of a gendered

society? The approach to gender of Groups 2 and 3, and the gender researchers' explanations of health and social control, contribute to an understanding of the factors driving wellbeing participation and wellbeing travel participation for women, and the constraints for men. These findings prompted exploration of the reasons why males are less likely to attend single-purpose establishments compared with females. This issue is discussed in more detail below.

Gender and Exclusion Theme for Those with low Wellbeing Engagement and no Wellbeing Travel

The participants in Group 1 expressed an alternative approach to traditional gender roles. In this group, there was some mention of traditional roles, such as women taking better care to "enable them to keep working and run their homes and families" (Henry, Group 1) and "women, we are the life givers and nurturers, so we are more aware and more responsible for others well being" (Tina, Group 1). However, the participants in Group 1 did not put forward traditional gender roles in the same manner as the other two groups. They also thought that women took better care of their wellbeing, but the main themes underlying this perception were different: 1) women are happier to go to doctors than men, 2) there is an equal representation of men and women and 3) women take better care of their wellbeing because they feel pressure to look good.

In the first main theme, the participants in Group 1 felt that gender and taking care of wellbeing was linked with visiting a doctor. For instance, Julian said, "women [are] more likely to see a doctor and look after themselves", and Charles thought "women probably go to the doctor more readily than men". The link between wellbeing and seeing doctors is important because it demonstrates that the members of this group were more connected to the concept of health and traditional medicine rather than wellbeing and non-traditional medicine. This group also considered doctors to be their second main source of knowledge (TV was the first) when it came to inquiring about their wellbeing. Therefore, for those in Group 1 who had a low engagement with regular wellbeing practices, seeing a doctor was a key symbol of taking care of oneself for Group 1. Coupled with the idea that women are more likely to see a doctor, was a minority view that men are upholding the traditional masculine

approach to health. For example, Bree (Group 1) said, “most men still have the ‘it will be ok’ syndrome … men try and ignore any alarm bells thinking it will just go away”.

A significant theme that was not apparent in the other two groups was the perception of equal gender representation for men and women. One participant expressed an egalitarian view of the matter when he said, “I think in this day and age both take care of themselves” (Isaac, Group 1), while another participant clearly stated that wellbeing is not a gender issue: “I don’t think this is a gender issue” (Austin, Group 1). Some participants began to look beyond the face-value meaning of taking care of wellbeing. Rather than taking care of wellbeing for wellbeing sake, two participants alluded to the performance of the health consumer:

> [Do women take better care of their wellbeing?] Not in today’s society. There is more pressure these days in everyday life, in all aspects, as there is more money around now, more technology, so the pressure is there to keep up with the Jones so to speak to keep up with the ever-changing world (Eric, Group 1).

For Eric, taking care of wellbeing was a performance for the social audience. This was echoed by another male participant who said, “… both but for different reasons. Men for vanity and women for a myriad of reasons” (Claremont, Group 1). Again, taking care of wellbeing was the domain of both genders and not for the sake of improving their state of health, but rather to improve symbols for the social audience. With such a critical view of wellbeing displayed by Group 1, it is not surprising that wellbeing travel would not appeal to them. The gendered representation of wellbeing constructed by the service providers would act as a constraint for some and a repellent for others.

The final key theme also corresponds to the notion of the social audience in connection to the act of taking care of wellbeing. The participants in Group 1 associated women’s appearance (i.e. the pressure to look good) with feeling well and the act of taking measures to be well. It was markedly interesting that this theme was expressed mostly by men. Fred said, “Women. They tend to be more self-conscious about their appearance and usually do a bit more to stay looking good and therefore achieve a better sense of wellbeing through that effort”. Fred associated wellbeing with women feeling happy about their appearance. Adam also associated the word wellbeing with women and the relationship with their bodies, “they are far more conscious of their own bodies – not just conscious of them, but paranoid” (Adam,

Group 1). This is mirrored by Jeremiah who said, “Females … they care more about their looks and figures and general wellbeing than men do”. Self-consciousness about appearance and feeling well because of working towards looking good is understood to be a socialised behaviour. Kevin (Group 1) commented:

> I believe they [women] are bought up in believing that they need to look after themselves. That is they need to look good, great shaped body, nice hairstyles etc. and to spend money on these”.

With this comment, Kevin outlined the socialisation of traditional gender roles in the performance of wellbeing and pointed out the consumerist element of the phenomenon. The participants acknowledged that the pressure to perform wellbeing evolved from other women. Tina (Group 1) commented that there is “peer pressure by other women to look your best”. It became evident that Group 1, who do not practise wellbeing regularly, have an entirely different approach to wellbeing and gender than the two other groups (who do practise wellbeing regularly). The differences contribute to an understanding of why more women would travel for wellbeing than men. The attitude that women take better care of their wellbeing is linked to the likelihood of regularly practicing wellbeing and travelling for the same purpose. The attitude that practising wellbeing is an activity for a social audience is linked to the incidence of not travelling for wellbeing. Therefore, constructing an establishment that markets traditional gender stereotypes appeals to those who travel for wellbeing (Group 3) and constrains or repels those who do not (Group 1).

Having examined the attitudes towards wellbeing and gender, the following section discusses the results of the samples actual engagement with wellbeing travel. There is some inconsistency between the attitude that women are overwhelmingly engaging and travelling for wellbeing, and the actual gender distribution in the survey sample.

Engagement with Wellbeing Travel by Gender: Groups 1, 2 and 3

The total survey sample included more men than women (58.8% and 40.7%, respectively). This gender discrepancy is a potential limitation of the survey data. The ABS (2011) report *Population by Age and Sex, Regions of Australia* shows that the gender ratio for the Australian population in June 2011 was 98.9 men to 100 women.

In Victoria in June 2011, there were 97.8 men for every 100 women (ABS, 2011). The gender distribution of the three survey groups offered the opportunity to explore potential relationships between wellbeing participation and gender. Two reasons were established to explain the increased number of men in the survey sample. The first was the result of exploring gender by sample group, and the second explored the definition of wellbeing travel by gender. Table 16 presents the gender distributions of the three survey groups.

Table 18: Gender Breakdown by Groups: Group 1 – low wellbeing engagement, no travel for wellbeing', Group 2 – regular wellbeing engagement, no travel for wellbeing, and Group 3 – regular wellbeing engagement, travel for wellbeing.

	Group 1	Group 2	Group 3
	%	%	%
Male	67.1	56.0	52.9
Female	32.9	43.5	47.1
Total	100.0	100.0	100.0

The gender distribution of the total study sample was 59% male and 41% female. A clear difference between the genders was evident in Group 1, which was 67.1% male and 32.9% female. This indicates that those who do not regularly participate in wellbeing are more likely to be male. Further supporting this notion is that the gender distributions of the other two groups are not considerably different. Group 3 was 47.1% female and 52.9% male and Group 2 was 56.5% male and 43.5% female. Based upon these results, where men featured prominently in Group 1 (with low wellbeing engagement and no travel) and were least represented in Group 3 (those who travel for wellbeing), it can be suggested that women were more inclined to incorporate wellbeing into their lifestyles than men. This gender discrepancy in regard to wellbeing is not an unanticipated result, but it was unexpected that a gender discrepancy was not found among those travelling for wellbeing. Although the wellbeing travellers (Group 3) had the highest proportion of women, it remains a finding that conflicts with other research.

Several academic and tourism organisation sources (noted in the literature review) report that women are overwhelmingly the primary customers of wellbeing travel providers (Brown, 2007; Bushell & Sheldon, 2008; Smith & Puczkó, 2009; Voigt et al., 2010). This observation was also made by the service providers in previous chapters. To explain this gender anomaly, the second reason offered is that the rate of male participation may depend on the definition of the activity. That is, how men and women define wellbeing travel and what type of wellbeing travel each gender engages with.

Table 19: Gender Breakdown of Group 3 (regular wellbeing engagement, travel for wellbeing) by Category of Travel

Wellbeing travel category	Male		Female		Total	
	N	%	N	%	N	%
Single-purpose destination	12	32.3%	17	53.6%	29	42.4%
Heterogeneous destination	24	67.7%	15	46.4%	39	57.6%
Total	36	100%	32	100%	68	100.0%

In Chapter 4, a heterogeneous destination was described by Edensor (2001, 2004) as travel that occurs without spending time (or all time) at a purpose-built destination that "is a multi-purpose space in which a wide range of activities and people co-exist. Tourist facilities coincide with businesses, public and private institution and domestic housing, and tourists mingle with locals" (Edensor, 2001, p. 64). In contrast, a single-purpose destination is defined as "carefully planned and managed to provide specific standards of cleanliness, service, decor and 'ambience'" (Edensor, 2001, p. 64). Tourists are subject to a soft control (Ritzer & Liska, 1997, p. 106) – "guards, guides and CCTV ... shielded from potentially offensive sights, sounds and smells ...". A single-purpose destination is built to facilitate a specific purpose or category of travel and to attract a certain type of tourist, wellbeing traveller, adventurer or nature tourist. Consequently, because a single-purpose destination is a controlled environment, it is most suitable for the concept whereby an establishment is a stage for the tourist to perform on. The previous chapter

demonstrated how the wellbeing travel stage was built at various single-purpose establishments and how this process of building for some also excludes others.

Table 18 shows that 32.3% of the men in Group 3 attended single-purpose establishments compared with 53.5% of the women. Also, 67.7% of the men attend heterogeneous establishments compared with 46.4% of the women. These results suggest that male wellbeing travellers prefer heterogeneous travel. Although the survey sample has more men than women, the findings also demonstrate that women are drawn towards single-purpose establishments where the stage is best constructed. The women's preference for single-purpose travel (compared with men) supports research findings regarding the higher proportion of women in wellbeing travel (Edensor, 2001). The presence of men in the single-purpose establishments may be explained by Penelope, Tom and Clare, who observed couples during the weekend and corporate clients during the week. This is supported by the work of Voigt et al. (2012), which found "beauty spa visitors were the most social, with more than half of them having travelled with a friend, spouse or a family member" (p. 22).

This research finds that several men have defined their travel activities to be wellbeing travel, but this travel does not necessarily occur at a structured destination. Men may have self-excluded from single-purpose establishments but have their own version of wellbeing travel. Men may either define wellbeing travel differently to women, or they might not want structured or organised and considered wellbeing travel. Conversely, these results suggest that women would be more likely to attend a single-purpose wellbeing travel establishment. Of those in the sample who did not travel for wellbeing, the attitude towards considering wellbeing travel was similar for men and women. Table 18 shows gender differences in considering travelling for wellbeing.

Table 20: Response to the Question “Have you Considered Travelling for Wellbeing?” by Groups: Group 1 – low wellbeing engagement, no travel for wellbeing, Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

	Group 1		Group 2	
	Male	Female	Male	Female
Yes	36.8%	41.2%	60.0%	50.0%
No	63.2%	58.8%	40.0%	50.0%
Total	100.0%	100.0%	100.0%	100.0%

Table 18 shows that, in Group 1, a similar proportion of men and women are likely to consider wellbeing travel (36.8% of men and 41.2% of women). Group 2 have considered wellbeing travel more than Group 1, but there is also little difference between the genders (60% of men and 50% of women have considered travelling for wellbeing). Two key findings were evident from Table 18. First, the women in Group 1 (those with low wellbeing engagement) are more likely to consider wellbeing travel than men, whereas in Group 2, (those with regular wellbeing engagement) men are more likely to consider wellbeing travel than women. Second, Table 18 confirms that those who do incorporate wellbeing into their lifestyles, would be more interested in travelling for wellbeing. A further reason for the disinterest in wellbeing travel for Group 1 may be attributed to wellbeing travel category. Table 19 shows the preferred wellbeing travel category for each gender by group.

Table 21: Gender Breakdown of Preferred Wellbeing Travel Category by Group: Group 1 – low wellbeing engagement, no travel for wellbeing, Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

	Group 1		Group 2	
	Male	Female	Male	Female
Single-purpose: Religious	0.0%	0.0%	3.3%	0.0%
Single-purpose: Spa	18.4%	47.1%	33.3%	34.8%
Single-purpose: Lifestyle	28.9%	23.5%	23.3%	47.8%
Heterogeneous	52.6%	29.4%	40.0%	17.4%
Total	100.0%	100.0%	100.0%	100.0%

Regardless of gender, those with low wellbeing engagement (Group 1) are consistently less interested in single-purpose establishments than those with regular wellbeing engagement (Group 2). For instance, 82% of Group 1 chose heterogeneous wellbeing travel compared with 47.4% of Group 2. Two clear differences are evident between wellbeing travel category type and gender. First, in Group 1, 47.1% of women would consider spa travel compared with 18.4% of men. None of this group would consider religious or spiritual travel, and a similar result was found for lifestyle travel (28.9% for men and 23.5% women). This indicates that men would be unlikely to travel to a spa establishment. Second, in Group 2, women (47.8%) were more interested in travelling to a lifestyle retreat than men (23.3%).

This section has discussed the gender characteristics of the total sample and attempted to explain the discrepancy between expected findings (women would be the wellbeing travellers) and the actual findings (men are travelling for wellbeing more than expected). Findings indicate that men are less likely to attend a single-purpose establishment, and as such are not interested in structured or organised wellbeing travel. Women are more likely to consider single-purpose establishments than men.

The results suggest that the men in the Group 1, with low wellbeing engagement, are predominantly not interested in structured or organised wellbeing travel but may be interested in wellbeing travel defined in a more objective way. Having already established that the participants in Group 1 are less likely to engage with wellbeing, these additional finding suggest that they are less likely to participate in structured wellbeing activities compared with the other survey participants. Although participants who already engage with wellbeing are more likely to consider wellbeing travel, there is little gender difference between the groups.

Total Survey Sample: Wellbeing Travel Constraints

The final discussion of wellbeing travel constraints is presented in this section. The 204 participants of the survey were asked to select the constraints that applied to their decision making about travelling for wellbeing. The choices offered were structural, intrapersonal and interpersonal constraints from Crawford, Jackson and Godbey's (1991) landmark leisure constraints model that is used in both leisure and tourism research (Hinch & Jackson, 2000; Hudson, 2000; Kattiyapornpong & Miller, 2013; Smith Fralinger & Litvin, 2013). In the absence of any literature about constraints to wellbeing travel, this well-regarded non-travel model (Crawford, Jackson and Godeby, 1991) was adopted as a starting point to examine wellbeing non-travel.

Table 22: Wellbeing Travel Constraints- Structural, Intrapersonal & Interpersonal, for Group 1 – low wellbeing engagement, no travel for wellbeing', Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

		Group 1	Group 2	Group 3
Structural constraints	Lack of time	23.5%	17.3%	23.7%
	Transport difficulties	2.0%	3.8%	0.0%
Intrapersonal constraints	Too unwell to travel	0.0%	1.9%	5.1%
	Psychological state	11.8%	9.6%	15.3%
	Physical	5.9%	7.7%	20.3%
	Stress or anxiety	7.8%	1.9%	10.2%
Interpersonal constraints	No caregiver	0.0%	0.0%	1.7%
	Social group attitudes to travel preferences	3.8%	0.0%	1.7%
	Uncomfortable with spa retreats	5.9%	3.8%	3.4%
	Uncomfortable at lifestyle or spiritual retreats	7.8%	13.5%	1.7%
	Not family friendly	15.7%	7.7%	1.7%
	No travel group	5.9%	11.5%	3.4%
	Not having a partner to travel with	5.9%	5.8%	5.1%
	Availability of travel products	0.0%	0.0%	1.7%
	Climate of destination	2.0%	5.8%	3.4%
	Communication difficulties with service providers	2.0%	0.0%	1.7%

For the whole sample, time was the first constraint to travelling for wellbeing.[6] and was almost equally reported by Group 1 (23.5%) and Group 3 (23.7%). The participants who travel for wellbeing (Group 3), then selected intrapersonal constraints as the second and third most common constraints. The second was physical constraints, selected by 20.3%. This result is surprising considering that physical constraints were selected by only 5.9% of those who have low wellbeing engagement (Group 1). The third constraint for wellbeing travel participants was psychological state (15.3%).

The participants in Group 2selected were interpersonal (external) constraints, which are "those arising out of social interaction or relationships among people within social contexts" (Crawford & Godbey, 1987). In Group 2, 13.5% were not comfortable at lifestyle retreats. This is higher than the other two groups, where this constraint was selected by 1.7% of the wellbeing travellers (Group 3) and 7.8% of those with low wellbeing engagement (Group 1). This is an important result because it provides a reason for why Group 2 participants would regularly participate in wellbeing activities, but not have travelled for wellbeing. These findings reflect the findings of other non-travel researchers such as McKercher, (2009) and Litvin, Smith and Pitts (2013), who found that non-travellers are simply not interested in travel. Or, drawing from the discussion above about self-exclusion, perhaps Group 2 are an example of people who have the means to travel, but are not comfortable with wellbeing travel and therefore self-exclude. Further research is needed to elucidate why they feel uncomfortable and if it is a matter of self-exclusion.

As with the wellbeing travellers, the low wellbeing engagement participants selected psychological state as their third main constraint (11.5%). However, more importantly, Group 1's second constraint to wellbeing travel was that it is not family friendly, which was selected by 15.7% of this group. This concern for accommodating family was not shared by the wellbeing travellers (Group 3), with only 1.7% reporting this as a constraint, while it was somewhat of a concern for Group 2, with 7.7% reporting this as a constraint.

These results are like those of non-travel research by Smith, Fralinger and Litvin (2013) who found that young low-income families are one of six categories of

[6] Financial difficulties was not an option given to respondents because I wanted to explore beyond this obvious structural constraint.

non-travellers in the United States. Group 1 were the least socio-economically affluent group, and whether out of lack of interest, time or finances, none of them practised wellbeing regularly. Therefore, even if this group were interested in a wellbeing travel holiday, it would potentially not be affordable for a whole family. If this group were interested, they would likely self-exclude because the service providers who were interviewed in this study do not cater for families and their customer base is generally singles, couples or corporate. This represents both a failure of wellbeing travel service providers to cater for the family market, and an opportunity for expansion. Apart from the constraints reported by participants, recent non-travel research finds that beyond structural constraints, non-travellers may simply not be interested in travelling. Although a lack of interest is a valid explanation for non-travel, the results of this study support a case for further research looking into the notion of self-exclusion from travel.

Summary of Constraints

Chapters 7 and 8, found no evidence of a cohesive wellbeing travel sector in Australia, but individual service providers had the power to construct an environment that constraints or welcomes potential visitors. Despite a non-cohesive sector, individual service providers were constructing their businesses with a vision for achieving wellbeing in the belief that wellbeing is an important goal for Australians.

Chapter 9, builds upon these findings and confirms that potential tourists' travel is constrained by the following process: 1) an intentional construction of place by service providers (findings from Chapter 7 and 8); 2) marketing towards a specific customer base (white, female and middle class); 3) attracting a specific customer base, 4) excluding others by financial means; and 5) excluding others by interpersonal constraints, gender and ethnicity and self-exclusion. The findings of Chapter 9 support some of the key concepts discussed in the literature review regarding power and inequality in tourism, resulting in the opportunity to travel or non-travel. Chapter 9 found that the structural constraints of financial resources and time were the most commonly reported constraints to wellbeing travel by the survey sample and the service providers. Table 21 summarises the main findings regarding structural constraints from the qualitative and quantitative analyses.

Table 23: Main Findings about Structural Constraints by Quantitative and Qualitative Analysis

	Group 1: Low wellbeing engagement, no travel for wellbeing	Group 2: Regular wellbeing engagement, no travel for wellbeing	Group 3: Regular wellbeing engagement, travel for wellbeing
Finances	* Below average Australian income * Strong qualitative theme of financial hardship compared with the other two groups * The most financially constrained group	* Above average Australian income * Participants reported financial constraints to travel but allocation of resources was a choice.	* Above average Australian income
Time	* Participants reported time and finances were a strongly linked constraint * Primary employment type full-time, 45.1% of this group, and therefore, potentially the most time constrained group	* Participants reported time and finances were a linked constraint * Primary employment type, pension/benefits/retired, 40.3% of this group * Met the ideal conditions to allow wellbeing travel – balance between free time and finances	* Participants reported time and finances were a linked constraint. * Primary employment type, part-time, 21.9% in of this group
Constrained/self – exclusion or choice.	* The group most structurally constrained Findings conclude this group are the most likely group excluded from wellbeing travel	* The least structurally constrained Findings conclude this group do not travel for wellbeing by choice rather than constraint. Choice of different travel preferences and choice to allocate funds elsewhere	* The group report financial and time constraint intervene with travel preference, however overcome this to travel for wellbeing

Table 21 shows that Group 2 participants had more free time and money than the other two groups and are classified as the most un-constrained group for wellbeing travel. Their primary employment type was pension/benefits/retired and they had an above average income. Although they reported that financial constraints restricted

travelling for wellbeing, they were allocating their finances to other pursuits, which represented financial constraints as a choice made. Group 2 also expressed alternative travel preferences (visiting family and friends) and stated that this travel fulfilled their wellbeing requirements.

Table 21 shows that Group 3 also had an above average income but their primary employment type was part-time. The group reported that financial and time constraints intervene with travel preferences, but they somehow overcome these constraints to travel for wellbeing. Group 1 were the most constrained of all three groups in regard to finances, time and self-reported wellbeing. Their annual income was below the Australian average and there was a strong qualitative theme of financial hardship compared with the other two groups. Group 1 were the most time constrained, with the highest proportion of those who worked full-time (45.1%). Finally, in a qualitative result that was not apparent for the other two groups, some Group 1 participants were too unwell too travel.

These findings about structural constraints, support key non-travel research discussed in the literature review. Researchers of non-travel, such as Smith et al. (2013) and Caldow (1997), have consistently found structural constraints to be the primary constraints. The majority of non-travel research began from this conceptual position and has proposed that social inequalities, particularly economic resources, are indicators of non-travel (Lu & Pas, 1998; Smith, 2001). The finding regarding structural constraints are also consistent with those of later critical tourism researchers such as Morgan and Prichard (1999) who argue that tourism reproduces the inequalities in society. Urry (1999, p. 49) has observed that the destination is the physical site by which social life is performed and re-produced. Bianchi (2010, p. 82) similarly states that tourism is structured by "the material inequalities of wealth and opportunity …", but goes further to distinguish categories, "… according to class, ethnicity, gender and sexuality".

This research also found that social inequalities in tourism are performed and reproduced beyond structural constraints and that non-travel extends to include interpersonal and intrapersonal constraints (Crawford & Godbey, 1987; Haukeland, 1990). While structural constraints were obvious and easily expressed by the participants, supplementary pathways to non-travel included underlying inequalities. For example, some of Group 1 were excluded from wellbeing travel because they do not cater families, and Group 2 did not feel comfortable or that they belonged at

wellbeing travel establishments. In another example, constraints that were purpose built by the service providers, such as gender and ethnicity, resulted in self-exclusion. One man who regularly engaged with wellbeing but did not travel for wellbeing indicated that he was uncomfortable with attending a wellbeing travel establishment. Although this can be perceived as a choice, it also reveals a set of underlying inequalities founded on the choices of wellbeing travel service providers.

This research shows that a service provider may not be responsible for the existing social inequalities that may constrain travel (such as time and finances), but they are responsible for the reproduction of these inequalities through the creation of place and setting a stage for the performances that occur when tourists arrive. These research findings also support those of Edensor (2000) who maintains that there is a conscious process by which service providers create the site for social reproduction. Edensor (2000, p. 229) suggests that the tourist place is responsible for "commodification, regulation and representation that reproduce performative convention". In the case of wellbeing travel, the tourist destination is responsible for the commodification of being well and sets a price for achieving wellbeing.

At this point, it must be acknowledged that, in general, the wellbeing travel service provider is foremost a profit-driven business and is not committed to public health outcomes. This research maintains that the tourism industry must be held accountable for the smoke and mirrors constructed for the sake of profit. The wellbeing tourism service provider becomes responsible and open to criticism when joining the de-medicalisation movement to commodify the inescapable fluctuating human state of sickness and health, and in doing so, encourages the reproduction of existing inequalities in society.

Conclusion

The results so far have focused upon exploring the constraints to wellbeing travel in the data. A body of tourism research addressing non-travel was discussed to provide context for the research results and offer new knowledge to the field. The following chapters explore the drivers and constraints through a different lens. Non-travel is explored beyond structural, interpersonal or intrapersonal constraints.

Throughout the data, constraints and drivers were also evident in the discourse and language of wellbeing. Chapter 10 discusses this discourse of wellbeing and how

a specific wellbeing narrative in the public realm is the overwhelming factor constructing wellbeing travel establishments and constraining and driving travel.

Chapter 10: Results and Discussion – A Wellbeing Discourse Constructing Wellbeing Travel and Driving Wellbeing Travellers

Chapter 3 established there are many understandings of the terms *health* and *wellbeing*, and that these definitions depend on culture and time in history. Chapter 3 discussed how health and wellbeing are powerful concepts that label what is normal and abnormal and manage redemption (Fox, 1977). Wellbeing today is understood to be a product of western culture, that is shaped by capitalism (production and consumption) and materialistic culture (consumer culture; Carlisle & Hanlon, 2007; King & Watson, 2005). The current rules and norms of the body have been described as de-medicalisation.

From the thematic network analysis, this discourse of wellbeing was found in the service provider interviews, focus groups, travel agent interviews, and the document study. Organising themes were identified as wellness revolution, the calamitous society, busyness and health as a self responsibility. This chapter discusses how the discourse has functioned to provide context for the construction of the establishments, to drive those who travel for wellbeing and to exclude others.

Document Analysis: Evidence of a Wellbeing Discourse

In the thematic study of documents, Chapter 7 established the endeavour of ATEC and Tourism Victoria to create a wellbeing travel sector. There was an effort to build an official body of knowledge about wellbeing travel. The development of policy declarations; a collaboration with professional bodies from tourism to health professionals from around the globe; and the use of words such as declarations, landmark document; and a viable new tourism market suggested the authority of the new movement (ATEC, 2009). In 2010, the ATEC established a Health and Wellness Advisory Panel (which no longer exists) comprising ten members chosen by ATEC (ATEC, 2009b). The efforts of the official organisations to build a wellbeing travel sector is also the construction of an official body of knowledge about what wellbeing travel is, who wellbeing travellers are and the growing wellbeing public consciousness.

This body of knowledge is present in documents produced by academics and other wellness tourism stakeholders. An organising theme from the data analysis was the perception of a growing wellbeing public consciousness from the academics,

official tourism organisations and the focus group, but not from the travel agents. The increase in wellbeing travel is explained by this increase in public consciousness regarding wellbeing (Cooper & Cooper, 2009, p. 129; von Harten & Stoelting, 2011, p. 186). A further key theme was that the increase in wellbeing travel is meeting a growing need in western societies (Smith & Kelly, 2006, p. 16). For instance, *Tourism Victoria's Spa and Wellness Tourism Action Plan* stated, "as the world becomes more focused on health and wellbeing, Victoria needs to be prepared with high quality product to meet the demands of these consumers" (Tourism Victoria, 2010).

According to academics, knowledge of the wellness revolution and the importance of achieving health is accepted to be a truth in information distributed to the public by the media and via the internet. Early literature relied on anecdotal knowledge. For example, van Harten and Stoelting (2011, p. 186) state that despite there not being any official statistical measurement, there is no doubt the wellness tourism market has increased along with an increased public awareness of the importance of wellbeing achievement. Cooper and Cooper (2009) report that the increased interest in wellbeing travel from consumers is the result of overall increased interest in the public. Cooper and Cooper (2009, p. 3) attribute the increased information supply available from the internet to the growing public knowledge about wellbeing:

> use of the immediacy and visual nature of the internet has also triggered a heightened awareness of the long-term benefits of taking care of personal health. This increased information supply has also included non-scientific versions for laypeople of discussions on the results of clinical trials. (Cooper & Cooper, 2009, p. 3)

A similar opinion is given by Magdalini and Tsaratos (2009, p. 130) who stated that "the trends towards wellness tourism imply that the approach towards health and wellbeing is rather in a preventing than a curative way and they are largely influenced by media and popular psychology". Smith and Kelly state that travelling for wellbeing is meeting a growing need for the public; "the psychological as well as the physical benefits of tourism appear to have gained increasing importance" (2006, p. 16).

Bushell and Sheldon (2009) then suggested that the demand from tourists is driving the wellbeing travel phenomenon with service providers and tourism

organisations responding to this need. Bushell and Sheldon (2009, p. 5) state that "wellness destinations responding to these tourists are to be found in many countries; however, clusters of locations in Europe and Asia are aggressively pursuing the wellness markets, including forms of medical tourism". Accordingly, all the service providers who were interviewed in the research had noticed a heightened wellbeing consciousness in the Australian public that included an increased need to engage with wellbeing.

The prevalence and public interest in wellbeing travel seems undisputed, but the explanation for this demand is worth investigating. Not enough research has been conducted to warrant the conclusions about the heightened wellbeing consciousness of people today and the increased need to achieve wellbeing. With little evidence to explain the demand, we can begin to assume that wellbeing travel demand is a social construction. This body of knowledge can be considered a discourse because it was not discovered or found (as suggested by social constructionist, Burr) but it was constructed by people over time (2000, p. 197). Parker (1992) proposes that a discourse is a set of interrelated texts with the "production, dissemination, and reception" (Phillips & Hardy, 2002, p. 5) of these texts constructing a social reality. Cooper and Cooper (2009, p. 3) observe this construction in wellbeing travel literature; they comment that:

> it also became quite obvious during the process of reviewing essential literature that the same basic information regarding the history of health and wellness spa tourism is referenced or paraphrased time and time again. Virtually the same statements are repeated in a number of texts and websites and therefore do not add any new insight.

Thematic analysis of the documents (academic and tourism organisations literature) The service provider interviews showed support for Cooper and Cooper's (2009) observation. Repeated statements and ideas in key documents have resulted in the construction of a body of knowledge about wellbeing travel, and these themes align with the narratives of the de-medicalisation movement: the wellness revolution (Conrad, 2001), self responsibility, busyness and the calamitous society.

Biging (2009; who conducted research for ATEC and is a leader in Healing Hotels of the World) encapsulates these themes with her definition of the wellness industry. She states that "the wellness industry is a global movement [a wellness

revolution], the avant-garde of a new lifestyle. After an age of materialism people are looking for a deeper meaning of life [calamitous society and busyness]. Prof. Marc Cohen therefore defines wellness as a form of secular spirituality … This lifestyle is often called the Lifestyle Of Health and Sustainability (LOHAS): it is based on a new understanding of responsibility towards oneself [self responsibility] and the world around us" (Biging, 2009, p. 5). The following section discusses these themes in more detail.

Service Providers Engagement with the Wellbeing Discourse: Wellness Revolution, Calamitous Society, Busyness and Self Responsibility

Academic texts position wellbeing travel within the wider problem of the health crisis in modern societies that is caused by our "modern material lifestyles" (Powis & O'Leary, 2009, p. 54) and within the context of the consequent wellness revolution. Voigt, Brown and Howat suggest the following regarding the emergence of the wellness revolution:

> These factors include the increasingly hectic pace of living, high stress-levels among the workforce, the loss of traditional community structures and religious organisation, and the resultant desire to slow down, to simplify, and to find meaning in life. (2011, p. 16)

Smith and Puczkó (2009) suggest that the demand for wellbeing travel can be attributed to the conditions of post-modern societies, including a search for community, obsession with the self, media encouragement, the desire to downsize and:

> long hours, excessive stress and too much focus on material living ... Ironically, opulent self-indulgent lifestyles overwhelmed by choice and opportunities are the very thing driving many citizens toward simpler lives. (72)

In the paragraph above, Smith and Puczkó (2009) identify a calamitous society discourse as a driving force for the increased demand for wellbeing travel. Calamitous society is a term created in this thesis to encapsulate the perception of the current state of society to be the cause of being unwell. Bushell and Sheldon (2009) confirm a

calamitous society as a reason for the wellness revolution and increasing wellbeing travel. Bushell and Sheldon (2009) state that "the complexity and speed of modern life urgently requires counterbalancing experiences for human beings to feel well". Accordingly, wellbeing travel has emerged from a wellness revolution:

> A health and wellness revolution is under way as individuals attempt to redesign their lives … Travel has historically offered experiences to improve wellbeing and for the last decade or so, wellness tourism (although poorly defined) has become one of the fastest growing sectors of international tourism (Bushell & Sheldon, 2009, p. 4).

Powis and O'Leary (2009) express similar sentiments about the correlation between the wellness revolution/de-medicalisation movement and wellbeing travel. The authors comment that:

> the demands of the modern world are causing us to look for ways to alleviate the stress and tension of the everyday-to look for ways to feel better within and about ourselves. While we do not suggest there is an easy answer, 'wellness tourism' ...not only offers a means of escaping the pressures of the modern world, but can actually be a vehicle for engagement in practices, activities, and programs that directly address, moderate, and alleviate these stressors. (Powis & O'Leary, 2009, p. 53)

These quotes from academics, show that some of the reasons for and definitions of wellbeing travel have some dramatic undertones. Wellbeing tourism is positioned as a way for consumers to engage with the wellness revolution and negate the calamitous society. Service providers such as Rachel express similar sentiments. In concurrence with Smith and Puczkó's (2009) comment above, Rachel established the busyness theme as a part of explaining the wellbeing crisis in Australia today. Rachel explains that busyness is one cause that is driving the wellbeing crisis and the resulting increase in wellbeing travel. She commented, "people's lives are really busy and the whole pace of life is busy … you get so picked up in life and taken along by the fast pace of it and the stressors of it". Service providers also suggested that structural changes in Australian society are modifying traditional holiday habits and driving the need to incorporate wellbeing engagement in people's lives. Jim suggested that to travel for wellbeing is a part of a new dominant paradigm about how to take

care of ourselves. Jim comments that in wanting to become well, people who travel for wellbeing:

> have a need in life to come up and buy something because that is what they have access to. They have got access to something that is advertised ... People say well you should go away for a weekend, have some time out, a restful place, maybe have a spa or a massage, treat yourself. So these are the dominant paradigms of how people treat themselves.

Rachel (spiritual retreat) saw herself as a leading example of the busyness problem. She drew from her experiences of needing to exit her previous city life and commented that "in 2001, my husband and I both decided we wouldn't do the corporate gig anymore". Rachel attributed the increase in wellbeing travel to the trend towards shorter holidays. She thought that aspects of the economy (such as job insecurity and rising interest rates) was driving people towards shorter holidays: "so the economy was a driver, can't afford to be away from my work just in case I get the slip. I can't afford to go away from my job so will take small breaks". Building upon the wellbeing crisis theme, Rachel also thought that society today was making people unwell – busyness and technology were leading people towards needing shorter breaks or reprieves more often. Rachel thought these breaks were aimed towards self-rejuvenation and to cocoon away from the world. The idea of escaping and cocooning was also addressed by Michelle when she commented:

> I think there is more of that [the need to engage with wellbeing] as society gets more disconnected, it's sort of like this polarisation. You know society gets more disconnected and we are more individuals, were all on computers and internet and individually relating to people instead of in communities, and we go into this spa places to be nurtured, to get what we used to get in the community or in the family you know?...from my experience it is a very nice community that you go into and that's very nurturing and a nice place to be.

According to Michelle and Rachel, people who travel for wellbeing are seeking a cocoon of comfort, safety and reprieve from the storm of the wellbeing crisis in society. In some cases, people seek to build this cocoon, not only by geographically separating themselves from their lives, but through self-improvement beyond physical health and towards mental and spiritual wellbeing. This was the

general sentiment offered by service providers to explain what drives individuals towards participating in wellbeing travel. However, secondary motivations were introduced in Chapter 2 with the elite model of wellbeing travel, whereby participating in health and wellbeing offers a moral stance – a social commendation – because health is a choice and a self-responsibility.

Service Providers and Notions of Choice, Self-Responsibility and Exclusion

The concept of assuming more responsibility for individual health is a key component of the de-medicalisation movement and is presented by the participants in this research. The concept has a dual function. First, it transpires as an empowering concept of health prevention – a rejection of the medical model of health in which decisions about one's health are decided by a doctor (Conrad & Scheneider, 2010). Second, this empowering concept for the masses was used by interested parties in the construction of the health consumer (Crawford, 2006) by organisations such as governments who became interested in stripping the financial responsibility of health to the individual (Harley et al., 2011)

In defining wellbeing or wellbeing travel, many researchers refer to self-responsibility and choice. The tourism literature suggests that wellness is an individual choice and a practical ambition. Ardell (2000, 2004, as cited in Steiner & Reisinger, 2006, p. 7) defined wellness as "a choice to assume responsibility for the quality of your life". Myers, Sweeney and Witmer (2000, p. 252) approach wellness as a lifestyle choice as a "way of life oriented towards optimal health and wellbeing in which the body, mind and spirit are inter related by the individual to live more fully within the human and natural community".

Biging (2009, p. 6) identified the following characteristics of wellness: "Wellness is multi-dimensional. Wellness is holistic. Wellness changes over time and along a continuum. Wellness is individual, but also influenced by the environment. Wellness is a self-responsibility". Mueller and Kauffman (2000) acknowledge the limitations of defining wellness in the Western world and state that "numerous definitions of wellness in the American English language region share certain common features: the key importance of lifestyle, self-responsibility for health, and the exploitation of our potential for a better quality of life" (p. 6).

In a linguistic connection, the definitions of wellbeing travel are similar in the de-medicalisation movement and the wellbeing travel movement. Most definitions describe a lifestyle choice of individuals and structured or organised wellbeing activities to meet this need. For instance, the following definition provided by Wellness Tourism Worldwide mentions wellness as a self-responsibility: "Wellness Tourism refers to trips aiming at a state of health featuring the harmony of the body, mind and spirit, self-responsibility, physical fitness, beauty care, health nutrition, relaxation" (Bushell & Sheldon, 2011, p. 6). However, when defining wellbeing tourism, researchers acknowledge that it is not participated in by all. Meuller and Kaufmann (2007) write that wellness tourism is "the sum of all the relationships and phenomena resulting from a journey … by people whose main motive is to preserve or promote their health. They stay in a specialized hotel that provides the appropriate know-how and individual care. They require a comprehensive service package comprising physical fitness/beauty care; healthy nutrition/diet; relaxation/medication and mental activity/education" (Meuller and Kaufmann, 2007, p. 7). According to Mueller and Kaufmann, those who travel for wellbeing are already on a wellbeing journey. Bushell and Sheldon (2009, p. 7) find other academics who express similar sentiments regarding the conditions that determine a wellbeing traveller. Bennet et al. (2004, p. 124) suggest that "wellness tourism is pursued solely by 'healthy people' and medical tourism by those needing a 'cure' for some condition".

Self-responsibility and choice form a key characteristic of a wellbeing discourse for tourism organisations and academics. So far, wellbeing travel can be understood as a pursuit by people who have had the opportunity and resources to make a choice to participate (those who are already on a journey) and less of a pursuit by those who are quite unwell and do not have the opportunity and resources to make a choice to become well. Service providers also pair self-responsibility with choice. In general, people are responsible for their own wellbeing and can make a choice to improve it. For example:

> I think another thing about wellbeing, people want to take responsibility for their stuff and I think this is one of the things that we at [name of business], it's about people taking back some of the responsibility of their wellbeing. So it's about health, enjoyment, pride in achievement.

Another conversation with Rachel resulted in similar sentiments:

> Q: You talked a bit about self-responsibility, I was wondering if you thought wellbeing was a self-responsibility, or collective, of community or government.
>
> Nah, wellbeing is yours. You can be encouraged; we can promote it as much as you can. But in the end you're the one who decides what goes in your mouth and if you will go for a walk or not.

In regard to engaging with wellbeing Rachel also stated:

> You are either a person who takes responsibility or your one who lets it all happen to you.

Rachel introduces a polarity: people either take responsibility for their health and wellbeing or they are irresponsible. In this characteristic of the wellbeing discourse, little flexibility is offered for circumstances where what you put in your mouth could be dictated by whether or not you were paid that week. Education was also suggested as a precursor to taking responsibility for health and wellbeing. Low-socio economic groups were stigmatised by three service providers who spoke of their wellbeing travellers as being more formally educated than others or had a certain sort of intelligence to pursue the journey of achieving and improving wellbeing. Kim highlighted this notion when she commented:

> low socio-economic groups … I think it is to do with education as well; not as much aware about what is good and not good for you. It's the people who are more exposed, who read more, 'gosh I should really do something' and that goes hand in hand - and it is unfortunate that it is a bit like that.

The relationship between education and health and wellbeing was also discussed by Jim and Michelle. Michelle acknowledged collectivist values in the choice to be well; she discussed the knowledge-making responsibility of the government to inform the public of what it means to be healthy and well in Australia. She mentioned the Life Be In It government initiative, which promoted an active physical lifestyle. She elaborated by commenting that:

> there is a role for the government to play in the wellbeing of the community … there is somewhat of a responsibility on the government or the state to yeah, promote activity and lifestyle and those sorts of things. But they generally limit

> it to the physical. They don't really go beyond. Oh they are starting to do a little bit on the emotional with the depression initiatives, but yes I do think there is a responsibility. It's not the whole responsibility but it has a part to play in the big picture.

Michelle's account of government responsibility does not include policy beyond knowledge production. It does not include health welfare policies to support achieving wellbeing or subsidising wellbeing activities. The issues observed in the data, echo concerns raised in the sociology of health literature. For instance, Harley et al. (2011) propose that the language of health care as a self-responsibility is now largely ingrained in the Australian consciousness and functions to reduce the responsibility of the state. Additionally, choice functions largely in the context of consumerism. Henderson and Petersen (2002) highlight the decreasing role of the state in Australian health care and how the language of consumerism is now omnipresent and:

> reflecting a changed relationship between citizens and the state ... the notion that the state should care for the health of its citizens and, long seen as a fundamental principle of welfare states, in increasingly replaced by the expectation that citizens should play a more active role in caring for themselves "clients" or "consumers". (p. 3)

Harley et al. (2011) state that neo-liberalism has played a significant role in creating the healthcare narrative. A political climate that fosters free markets and privatisation of the state also values the decrease of state responsibility by supporting narratives of self-responsibility and freedom of choice; "notions of individual responsibility and choice are a central feature of neoliberalism and its promotion of consumerism" (Irvine 2002; Rose 1999). A self-responsible human also suits the current neo-liberal political and social environment, which encourages privatisation of the health care system and decreases the role of the welfare state. In Australia, the shift towards these values occurred when the Liberal (conservative) government (of 1996) and private health organisations collaborated and used the notions of self-responsibility, control, choice and wellbeing to encourage Australians to construct a health consumer – one who will purchase private health insurance (Harley et al., 2011). This policy eased the pressure on government expenditure from the public

health system and increased the profits of the private health system (Elliot, 2006). In combination with the public health scheme (Medicare, which was established in 1984) the Liberal government introduced several initiatives between 1997 and 2000 to encourage private health insurance membership. These include the Lifetime Health Cover scheme that adds 2% to the Medicare levy for each year over 30 years of age that an individual does not have private health insurance. This was designed to encourage people over 30 years to purchase private health insurance (Elliot, 2006, p. 135).

According to Harley et al. (2011), the scheme was successful, and "by June 2009 44.5% of the population has hospital coverage, and 51.2% ancillary coverage" (PHIAC 2009: 18). In Australia, there is a marked increase in consumers who are interested in ancillary private health insurance from providers such as Medibank Private (2010), which offers myotherapy, naturopathy, clinical psychology and more. Between 2007 and 2008, 77% of Australians surveyed in the National Health Survey had hospital and ancillary cover (ABS, 2007-2008). From 2001 to 2008, the most common reasons for their purchase were security or protection or peace of mind (41.3% in 2001 and 53% in 2007–2008) and to have extras services such as TCAM (18.4% in 2001 and 26.2% in 2008). Elliot (2006) attributes the success of the scheme to the campaign by the Liberal government to change the health care policy narrative.

Second to the self-responsibility narrative, the scheme was successful with the choice and consumerism narrative. The consumer is informed of their economic transaction power in choosing where to place their money that will result in the best outcome for a healthy and well lifestyle. Harley et al. (2011) supports the power of these narratives. Studying the advertising of United Kingdom and Australian private health insurance companies, they explored how a health consumer was constructed. Three key themes were found to help construct the health consumer: 1) the choice to position the health consumer as rational individual who is responsible for their own health and health care decisions in an environment where consumers are presented with numerous choices of insurer, level of plan or waiting period; 2) the insurers position themselves as collaborators to further support the notion of the consumer choice "forming a partnership with individual consumers in both choosing health insurance products and in maintaining their health; in doing so they offer reassurance"; and 3) the end result is depicted in images accentuating a healthy way of life (Harley 2011). Australian websites represent images of the de-medicalisation of

the “outdoors ... and youth. That is, images of a healthy person were depicted as young, refreshed and relaxed”. Further, Harley et al. (2011, p. 316) state that:

> in the three Australian sites, many images involve leisure activity – a young woman, arms spread, ‘flying’ around the garden ... playing with a dog, picnicking, jogging – and active lifestyle is also implied through the presentation of the outdoors: grass, sunshine, sky and beach. Smiling faces on all individuals portrayed reinforces the idea of relaxation, also apparent in an image of a young woman asleep in a hammock, which illustrates a Medibank page where tax savings can be calculated.

The example here demonstrates a commodification of wellbeing through the construction of a health consumer. Health sociologists are critical of this process, and Harley et al. (2011, p. 317) state that “one of the issues we see here is the association of health management with a broader lifestyle package of consumption”. One of the main ethical conundrums with the health consumer is that it is exclusionary, Harley et al (2011) and Palmer and Short (2010, p. 238) argue that strategies to incite the health consumer are likely to do well with wealthy groups “for it is these groups ‘who bear the lowest burden of ill health and who have the greatest freedom to choose’”.

Harley’s three key themes to construct a health consumer are reflected in the research data and the overarching wellbeing discourse. Potential wellbeing travel participants are positioned as self-responsible for their health and are offered choices of redemption (spa travel, lifestyle or spiritual); the wellbeing travel service provider can facilitate the choices. The images offered as a result were discussed in Chapter 8, with the marketing brochures featuring predominately white middle-aged women. It is also proposed that, while the wellbeing discourse and health consumer discussed in this chapter is what drives some towards participating in wellbeing travel, this same discourse is also what constrains participation.

Conclusion

Having explored the sources of knowledge about wellbeing travel in this chapter, the mostly accepted were the wellness revolution, self-responsibility, busyness and the calamitous society. These organising themes were found in the thematic analysis of the documents and allowed the development of the

conceptual/international theme: that wellbeing travel is socially constructed by a western cultural wellbeing discourse (Carlisle & Hanlon, 2007). These findings begin to address research question 1: How is wellbeing travel in Australia socially constructed? And, what are the dominant discourses informing the concept of wellbeing travel? The organising themes guided the development of a second conceptual theme: that engagement with the wellbeing discourse drives and constrains participation in wellbeing travel. This discussion begins to address the second research question: What are the drivers for travel and reasons for non-travel when travelling for wellbeing in Australia.

A defining feature of the discourses is that they limit and constrain (Parker, 1992; Ussher, 2011). That is, while discourses may facilitate language and knowledge of a topic, they also limit or constrain new knowledge or alternative pathways of thought. In a Foucauldian discourse analysis, the sources of knowledge in our environments are termed discursive resources or a discursive economy (Parker, 1992, p. 107). From a Foucauldian point of view, discourses facilitate, limit, enable and constrain what can be said by focusing upon the availability of discursive resources within a culture and its implications for those who live in it (Parker, 1992, p. 107).

The implications of the wellbeing discourse driving wellbeing travel, is how it constrains travel for others. Service providers have constructed their establishments with this discourse as a central foundation, making use of the already established language of wellbeing in the de-medicalisation movement to drive participation. In adopting the narrative that health is a self-responsibility, the service providers can constrain. For instance, some service providers suggested that if people really want to be well, then they will find a way to overcome the financial barriers (such as Tim suggesting people would save for a year to attend), and if not, they mustn't really care about their health (Rachel, "wellbeing is yours" and "you are either a person who takes responsibility or your one who lets it all happen to you"). In this way, the health and self-responsibility narrative is effective in limiting and constraining travel.

The following chapter examines whether the positions offered (the drivers and constraints) are realised by the survey sample. Do people who travel for wellbeing engage with the wellbeing discourse, and is this a factor that helps predict travel or non-travel?

Chapter 11: The Australian People (Survey Sample) Engagement with a Cohesive Wellbeing Discourse

In the chapter above, thematic analysis of documents and service provider interviews demonstrated organising themes that reflected engagement with a wellbeing de-medicalisation discourse. This chapter demonstrates that the survey participants' level of engagement with the discourse determines whether they travel for wellbeing or are excluded. For instance, how does the healthy self offer a stigmatised position of the unhealthy other (Crawford, 1994). Together, the drivers and exclusions enable further analysis of the travel constraints identified in Chapters 8 and 9.

The Relationship between Engaging with Wellbeing and Wellbeing Travel

At the time of the survey, Groups 2 and 3 participated in regular wellbeing activities (at least once a fortnight) and Group 1 did not. As shown in Table 22, there is a statistically significant relationship between regularity of wellbeing activities and group (χ^2 = 29.58, df= 8, p<.001).

Table 24: Regularity of Wellbeing Activities by Group: Group 1 – low wellbeing engagement, no travel for wellbeing', Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

	Group 1	Group 2	Group 3
Yes, one activity at some point in life	17.5%	20.6%	34.5%
Yes, most of my life	8.8%	17.5%	10.9%
Yes, a variety of activities at one point in my life	31.6%	52.4%	43.6%
No activities at any point in life	36.8%	9.5%	10.9%
No response	5.3%	0.0%	0.0%
	57	63	55
Total	100.0%	100.0%	100.0%

N=175

(χ^2=29.582, df=8, p<.001)

It is not unexpected that the group with the highest percentage of not participating in any wellbeing activities, at any point of their life, was Group 1, the group with low wellbeing engagement (36.8%). In Group 2, who had regular wellbeing engagement and no wellbeing travel, 10.9% did not participate in any wellbeing activities, while 9.5% of Group 3, who had regular wellbeing engagement and travel for wellbeing, did not participate in any wellbeing activities. Group 1 had the smallest percentage of those who participated in wellbeing activities at some point in their lives (31.6%) or for most of their lives (8.8%). Not surprisingly, Table 22 also shows that Group 3 (the wellbeing travellers) have a higher level of engagement with achieving and participating in wellbeing than the other two groups. These results support the idea that pre-existing wellbeing commitments drives participation in wellbeing travel and that non-participation may predict non- travel.

Despite the different levels of engagement, the survey participants used similar language to explain a broad definition wellbeing. All three groups associated the term wellbeing with health and used these terms interchangeably and synonymously. The survey participants were grounded into two main categories: 1) wellbeing is health and health is an action, and 2) wellbeing is a state of being or a feeling. The broad understanding of wellbeing shared by survey participants indicated a dominant discourse of wellbeing. The themes are outlined below.

Engagement with the Calamitous Society

The calamitous society is a key theme that was discussed in Chapter 9 and found to be evident across all three survey groups. The calamitous society theme includes the sentiment that life today causes stress and a state of being unwell. According to the service providers and other constructors, the wellbeing revolution occurred as a response to the calamitous society. Service providers observe that the increase in wellbeing travel – or the motivations of their customers in general – was attributed to the growing wellbeing awareness and the growing need for time out to recuperate from busy and stressful lives.

In the academic literature, Powis and O'Leary (2009, p. 53) suggest that wellbeing travel can be the answer to negate the calamitous society because "the demands of the modern world are causing us to look for ways to alleviate the stress". Service provider Rachel also suggested it was the answer because "you get so picked

up in life and taken along by the fast pace of it and the stressors". Similar results were found in the survey sample where the participants perceived that life in modern societies (presumably they are referring to western developed countries) is faster than in the past. For instance, Benjamin, (Group 2) said, "The world is moving too quickly". Additionally, Victoria (Group 2) stated, "Life today is on a fast forward path and we don't have time to relax and have some me time. That is why there are so many people stressed and depressed". Riley (Group 1) agreed and said, "Most people are relatively well, but a lot are under stress in their day to day lives. Modern times require life to be lived at a faster pace than in the past".

The concept of faster was mentioned regarding the impact of technology, transport, and work or family requirements. Technology and transport were making task completion more efficient but were also crowding life with more information, more to do, and blurring the lines between work and home. This quandary was spoken about in length in the focus group. Sookie (focus group) spoke of the difference between her childhood and that of her young daughters. In her own childhood, she could run free and the only restriction was to be home at a certain time: "… and now it's like, we are always connected. Like, we have got a phone and we can ring up people; and people can always track you down, so you feel an obligation all the time and it kind of confines you a little bit". Sookie felt that technology demanded constant attention from people and restricted a sense of being able to run free. Ginny (focus group) also felt that life was faster and busier for people today. Linking this with increasing social connectedness, she commented:

> I think there is a lot more to do these days, like you get heaps more mail you have got clubs for everything, you get email. And I know when we were kids we went to the closest school and now we drive our kids to a school. And a lot of kids have activities as well that they need to be driven to. So people are doing a lot more.

Transport was frequently mentioned regarding a faster society. Some suggested that city living is an antithesis to wellbeing, making it unachievable: "no [not achievable] not in the cities, in a rush all the time, like when their driving, very very impatient" (Franklin, Group 2). For those in Group 1, who had low wellbeing engagement and no travel, the fast pace was also stated regarding the pressures and stress of the work–life balance: "the majority of people are not well. Most families are

totally insulated or ‘nuclear’ in existence, obsessed with work, money and material possessions” (Chip, Group 1). Group 2, who had regular wellbeing but no travel, demonstrated that stress and time were concerns. The calamitous society had an impact on wellbeing through the lack of time due to work and family responsibilities. Beth (Group 2) commented that:

> most people are under too much stress, as there is always a quota to fill, a time limit, a budget to fill, bad transport, traffic problems, so by the end of the week they are totally stressed out, then it’s time for domestic duties, shopping etc.

The perception of the impact of the calamitous society was similar for Group 1. Anna (Group 1) said, “Most of the population in Australia are too busy earning a living or just don't care about maintaining a balanced lifestyle with exercise, eating healthy and properly, taking time out to do the things they enjoy, saving money for a rainy day”. Anna felt that pursuing wellbeing was not an option for most Australians and Group 1 had a more pessimistic understanding of the impact of the calamitous society compared with the other two survey groups.

The three survey groups all felt that today’s fast-paced society was an antithesis to wellbeing. Technology (described as too fast) and transport were symbols of this fast pace, but it was a lack of control over time that was the crux of the issue. All three groups said there was not enough time to complete all necessary responsibilities and reported difficulties with achieving a work–life balance. The calamitous society represented stress about time constraints, or of being time poor. There was a sense of helplessness or frustration for Group 1, particularly a focus upon the time poor theme and the stress to work and meet the cost of living: “Life is stressful, we spend more time working” (Jonathon, Group 1) and “Many people are worried about the cost of living. Many people are stressed on making ends meet week to week” (Gavin, Group 1).

Kaylee (Group 1) offered a contrary perspective on the connectedness discussion between Sookie and Ginny (regular wellbeing participants) who thought that today’s technology was overwhelming because of more things to do and confining social connectedness. Kaylee, on the other hand, thought society today was leading us towards being disconnected:

> Most people are well but not necessarily healthy. Pressure of job insecurity sedentary lifestyle. Debt for getting an education and cost of lifelong learning.

> High expectation in housing/travel. Very few people converse with neighbours, for fear of involvement or the tired old excuse of haven't got the time. Instead of family get-togethers and communication, families are stuck in front of the television or computers.

Although the definition of the calamitous society is the same (fast, time poor and stressful) for the three survey groups and the focus group –the impact is distinctly different. Those in the focus group (who had active wellbeing engagement in their lives) were overwhelmed by connectedness, while those in Group 1 (who had low wellbeing engagement) felt disconnected. Group 2 also acknowledged the calamitous society and a subsequent disconnect from their selves. They emphasised the impact on individual spirituality and a sense of peace, rather than the impact on social connectedness, as demonstrated by Ava:

> wellbeing is achieved by attempting to get oneself into a state of relaxation so the body, mind and spirit is revitalised. This is important because the body, mind and spirit can become disconnected from self if left too long within a materialistic, consumerism, superficial environment.

Overall, the survey sample and focus group engaged with the calamitous society themes. Group 1 saw the calamitous society as challenging for basic survival, while Group 2 saw the calamitous society as a challenge to the wellbeing of the individual.

Engagement with the Busyness Discourse

Busyness and the calamitous society are clear drivers towards engaging with wellbeing. By engaging with these narratives, the survey sample builds a foundation where, if possible, action must be taken to negate the calamitous society. A secondary gain is that the desire to improve wellbeing against these problems is one body of knowledge driving wellbeing engagement and travel. But it is unknown whether this has any objective factual basis.

Making claims about the calamitous society and busyness is socially rewarded when one takes part in restoration, and this is called the middle class badge of honour (Gershunny, 2005; Scheuerman, 2005). These social rewards established a secondary

advantage driving wellbeing travel. Busyness is a relative term in social science research. The perception of busyness has historically featured in western societies and is not an original attribute of society today. Scheuerman (2005, p. 449) states that "extreme busyness is endemic to modern society" and that "large majorities are plagued by experience of hurriedness and a sense of not being able to keep up". Scheuerman (2005, p. 449) acknowledges that these survey results are based upon subjective experiences but counters this with the comment that "these subjective experiences rest on objective social processes". The objective social processes include the following facts about society contemporarily. First, "we find significant evidence in modernity of technological acceleration (especially in transportation, communication, and production)". Second, "social transformation itself undergoes acceleration, meaning that social structures and basic patterns of social activity now change at an ever more rapid rate". Third, "the tempo of everyday life undergoes rapid fire alterations, as evidenced by the increasingly high speed character of many familiar forms of both social and individual activity" (Scheuerman, 2005, p. 449). Scheuerman's research appears to support the findings by service providers, academics and tourism organisations. The wellbeing revolution is a response to the calamitous society, a particular busyness endemic to society today consequent to technology.

Other perspectives do not consider the objective social processes to be of any value. Gershunny (2005) considers busyness a relative and subjective concept. Gershunny explored busyness as the juxtaposition between increasing perceptions of being busy and the development of leisure in western societies since the 19th century. Busyness is explained as relative, with the shift from idleness a symbol of honour and class in the 19th century, to today when busyness is perceived to be the ultimate badge of honour.

Three reasons are offered to explain this inconsistency. First, in times past, work and leisure demands were allocated in two-parent families. The increase of "dual-earner couples, single mothers and employed parents" has intensified the feeling of busyness (Gershuny, 2005, p. 311). Bittman and Wajcman's (2000) research supports this trend in Australia and similar results emerge for the United Kingdom. Second is the idea that leisure has become increasingly important, or as Gershunny states "changes in the density of leisure" (2005, p. 285). The subjective evidence of people feeling busier in the 20th century is acknowledged, but Gershunny also points

out that there is evidence that leisure time has increased and “there is an equally well-documented, long term, and very substantial growth in leisure time in nearly every country for which we have appropriate evidence” (2005, p. 287).

The third reason challenges Scheuerman’s (2005) objective evidence of technological change resulting in perceptions of busyness. Instead, in the United Kingdom, Gershunny (2005, p. 311) found a “historical reversal, over a remarkably short period, of the relationship between privileged social position and the objective indicators of busyness. The most privileged now work more than the less privileged”. This means that the idea of busyness has changed. Rather than busyness representing the working class and idleness the upper class, busyness has become a badge of honour for the middle class (Gershunny, 2005).

Linder (1970) theorises that the increased production and consumption in Western society has led to “an acceleration of the pace of life and a harried leisure class” (Godbey, 2010, p. 479). Time spent in labour is supposed to result in time for leisure and wellbeing. Linder proposes five categories of time: 1) working time, 2) personal work, 3) consumption time, 4) the cultivation of mind and spirit, and 5) free time. It is not that we have less time (Linder, 1970), but a shifting balance between leisure and work creates an environment where “the demand for time exceeds the supply” (Godbey, 2010, p. 479). People with lower incomes have time, but not voluntarily idleness. People with higher incomes can choose idleness, but Linder finds the pace of life quickens for those with a higher income, “as incomes continue to rise, the demand for yield (to produce or provide) on the use of time increases” (1970, p. 10). Linder suggests that those of a higher income are not necessarily the most satisfied groups in society, “We have always expected one of the beneficent results of economic affluence to be a tranquil and harmonious manner of life. What has happened is the exact opposite” (1970, p. 1).

Analysis of today’s wellbeing discourse establishes two further drivers of wellbeing travel. The perception of busyness and the calamitous society can be understood as a valid subjective experience in this research data. Service providers, academics and tourism organisations suggest that this perception of busyness and the calamitous society is motivating people towards engaging with the wellbeing revolution and hence wellbeing travel. The literature also establishes a further driver for wellbeing travel, that busyness is a middle class badge of honour. Participation in socially accepted wellbeing activities (mostly commodified wellbeing) is a publically

acknowledged and recognised symbol of busyness. Only those who are very busy and stressed need respite and a rigorous self-management of health. Symbols such as regularly going to the gym and wearing gym clothes around town, seeing a naturopath instead of a doctor or travelling for wellbeing to get away from it all can establish an individual as busy. The converse argument is, of course, that not everyone can (or wants to) wear this badge. This is a concept that sits well with the profile of wellbeing travellers today. Chapter 8 established that the wellbeing travellers in the survey (Group 3) had an above average Australian income resembling middle Australia. In all survey groups, the first self-reported constraint was time, revealing that they perceive that a busy life constrains them from travel. The wellbeing travellers could overcome this constraint.

Engagement with the Wellbeing Revolution

In Chapter 8, service providers observed that the increase in wellbeing travellers was attributed to growing wellbeing awareness. This awareness was branded a wellness revolution and was thought to be a direct response to the growing need for time out to recuperate from busy and stressful lives (the calamitous society). The survey sample also cited a calamitous society and a subsequent increase in wellbeing consciousness today. Table 23 shows that in each group, the majority had noticed an increased wellbeing consciousness within Australia.

Table 25: Perception of an Increasing Wellbeing Consciousness in Australia today: Group 1 – low wellbeing engagement, no travel for wellbeing, Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

	Sample groups (N=174)		
	Group 1	Group 2	Group 3
Yes	58.9%	82.5%	76.4%
No	21.4%	14.3%	16.4%
Other	19.6%	3.2%	7.3%
Total	100.0%	100.0%	100.0%

(χ^2=16.976, df=10, p=.07)

In the total survey sample, women perceived an increase in wellbeing consciousness more than men (83.3% and 65.7%, respectively). When examined by group, those who regularly engaged with wellbeing reported the highest percentage who perceived an increased wellbeing consciousness in Australia today: Group 3, 82.5% and Group 2, 76.4%. In Group 1 (who had low wellbeing engagement) the percentage who agreed that there is an increase in wellbeing consciousness in Australia today was much lower at 58.9%. The lower percentage who had noticed an increase in a wellbeing consciousness for Group 1 is associated with their low engagement with wellbeing and their reduced opportunity to engage with wellbeing. The perspective of Group 1 is represented by Wilson, who commented that:

> more people are becoming conscious of their health in particular, mainly due to the constant programming of health issues in the multi media outlets. This includes the multitude of issues surrounding health, e.g. diet, exercise, smoking, alcohol consumption and so on. I`m not convinced that people in general are concerned about their current wellbeing, but more particularly maintaining job security and the wages, mortgage payments and surviving current difficult global financial times. They are more interested it is suggested in the 'now' rather than the future.

This statement shows that Wilson is aware yet sceptical of a wellness revolution (Conrad, 2004) and the level of engagement people have with it because there are more pressing issues to deal with in life. Wilson's emphasis upon financial constraints – job security, wages and mortgage – is consistent with the findings in Chapter 9 where Group 1 was found to be the most time constrained and financially constrained of the three survey groups.

For Group 1, it is not necessarily a lack of awareness or interest that prohibits engagement with wellbeing, but a matter of priorities. That is, as the group with the least economic capital in the survey sample, it is not surprising that a mortgage must be paid before a gym membership or organic produce can be purchased. The two groups who do engage with wellbeing (Groups 2 and 3) have more access to these resources. As discussed in Chapter 8, the dominant wellbeing discourse is exclusionary when engaging with wellbeing is only an option for the healthier and the wealthier. The group that does fulfils the healthier and wealthier definition is Group 3

(those who engage regularly with, and travel for wellbeing), who engage with wellbeing and confirm this dominant health consumer discourse.

Time, financial resources and scepticism are therefore the factors identified in the qualitative survey response that constrain engagement with the dominant wellbeing discourse. Time and finances are structural constraints to travel and are generally understood to be circumstances that precipitate an environment where choice making abilities become severely constrained.

Wellbeing is a Self-Responsibility and the Unhealthy Other - Survey Groups 1, 2 and 3

The final key theme of the discourse – wellbeing as a self-responsibility – was strongly evident in the survey sample data. In Chapters 8 and 9, the choice to engage with wellbeing activities is a significant theme in the service provider data and was founded on early de-medicalisation literature. For early writers such as Dunn (1959) and Ardell (1977; 2004), wellbeing is a self-responsibility, and individuals are empowered to make and actively pursue their own informed choices regarding their health and wellbeing.

This hopeful but perhaps idealistic concept was then used to prop up the wellbeing revolution theme identified in Chapter 8 and ensures a consumer-orientated wellbeing industry. An example of this process was discussed in Chapter 10: the rise of the health consumer by the collaboration between the Australian government and private insurance companies (Elliot, 2006; Harley et al., 2011; Henderson & Peters, 2002). The patient became the consumer and the consumer could choose which health package they wished to pay for to advance their wellbeing, if they could afford it. The concept of health as a self-responsibility has filtered through to the survey sample, focus group and service providers and supports the idea that it has become mostly accepted knowledge. When asked to define wellbeing, the focus group thought it was an active self-responsibility,

> Sookie: Actively seeking to be well.
>
> Lina: Yes.
>
> Betty: Actually yeah, that's true. Actively seeking to be well.
>
> Ginny: Just doing things to look after yourself.

Helen: Yeah there is a big difference, between actively seeking and expecting it to happen.

The unfortunate but desired result of constructing a concept of health as a self-responsibility is that those who cannot make a choice are not acknowledged. At this juncture, the self-responsibility characteristic of the wellbeing discourse undoubtedly begins to be constraining. First, it is constraining because engaging with wellbeing costs money and time and therefore cannot be considered a choice for the whole population. Second, with the choice to participate in wellbeing as a seemingly egalitarian opportunity, those who cannot choose are stigmatised as the unhealthy other (Conrad, 2010; Crawford, 1994).

A significant theme to emerge in the data was a similar stigmatisation and identification of another who is unhealthy. For instance, a general acceptance of the other was demonstrated above with the assertion that most Australian people are unwell. Table 24 shows that the other was identified when the Group 2 (regular wellbeing, no travel) and Group 1 (low wellbeing, no travel) reported similar attitudes towards the question "are Australian people well?"

Table 26: Are Australian people well? Group 1 – low wellbeing engagement, no travel for wellbeing, Group 2 – regular wellbeing engagement, no travel for wellbeing.

		Group 1	Group 2
Are people well in Australia?	Yes	19	19
		42.2%	41.3%
	No	26	27
		57.8%	58.7%
	Total	45	46
		100.0%	100.0%

N=91

Table 24 shows that 57.8% of Group 1 and 58.7% of Group 2 felt that most Australians are not well. The concept of the unwell other was highlighted by the survey sample and stigmatised. For instance, Joseph said of being unwell, "It's probably never thought about in much detail by such people". With the use of the words *such people,* Joseph identifies the notion of Crawford's (1994) unhealthy other.

A Group 2 participant, Ross, considered the unhealthy other to be unaware, ignorant and lazy. He said:

> most people think that they are well, but I believe that most just don't know what else is out there. They have lived most of their lives in a small enclosed environment, but with little effort they can see and do so much more. Stop sitting in front of the TV or computer and get out there.

Obesity was a characteristic of the lazy unwell other. For example, when discussing whether Australian people are well, Brandon (Group 2) also referred to the physical body: “Obesity is a major problem”. In Group 3, David stated, “Educated people have certainly become more so [conscious of their wellbeing] and plenty of low SES people too. However, many seem to have given up the effort and descended into obesity, chronic illness, poor diet, stressful living and no aerobic or weight bearing exercise”.

Further supporting the concept that health is a self responsibility, some of the survey sample thought that the unwell other is choosing to be unwell. For example, June (Group 1) said, “Some believe others should carry the burden of their failure to follow a path to wellbeing and refuse to help themselves believing society owes them a better life”. Grant (Group 3) assumes that we have the necessary knowledge to be well but can make a choice to not follow through: “We don’t always act on the advice we’re given but I believe that this is not due to ignorance”. In the focus group, participants agreed that most people are not well and discussed the severity of this perceived situation:

Lina: thinking of the Australian population, are most people well?

Three people at once: No!

(Laughter)

Betty: It’s getting really bad, isn’t it?

Helen: Yeah.

Emma: Apparently, obesity, we have taken over America. We are the most obese country. Although we have a much smaller population just the ratios; somehow, they have worked out the percentage…

The seemingly positive concept that health is a self-responsibility means that people have a lot to be responsible for. Self-responsibility for health is presented as something to be empowered about and reflects western notions of individualistic freedoms. Gwyn (2002) states that health is offered to us as a human right and is the natural state of being. In fact, the natural state for the human body is not total health but of contending with illness and disease. Gwyn (2002) addresses the disciplinary power that is exercised over the body when we are subject to the idea of total health as a natural state. Gwyn states that the self-responsibility theme is decreed in public health language, and that:

> the rhetoric of public health obscures its disciplinary agenda since health is presented as a universal right and fundamental good. Campaigns aimed at encouraging individuals to change their behaviour, and to minimise risk taking, are therefore regarded as wholly benevolent (2002, p. 7).

The key to encouraging the perusal of the total health ideal in the de-medicalisation model is to position health and wellbeing as a self-responsibility. And indeed, this was demonstrated in the number of the total sample who had practised wellbeing activities regularly at some point in their life. That individuals are trying to change their behaviour, take (self) responsibility and achieve wellbeing is in line with the rhetoric exalting the importance of total health. This concept is not only dangerous because of the decreasing role of the state in health care and the lengths people will go to achieve wellbeing, but it is dangerous because of the stigma of the unhealthy other. In the comments above, the survey sample stigmatised the unhealthy other and linked this physical state with those of low socio-economic status.

Levitas (2004, p. 45) identifies this sort of stigma process as the moral underclass discourse. The moral underclass discourse is a trend towards blaming the cause of social exclusion on those who are socially excluded. Levitas states that "proponents argue that the excluded in effect exclude themselves by engaging in certain behaviour such as drug addition, crime and having children out of wedlock" (2004, p. 45). This implies that socially excluded individuals are making a choice to exclude themselves. A good example of this discourse is applied in everyday Australian politics. In 2001, Tony Abbott, who was the Minister of Employment at the time, presented his opinion of those below the poverty line to the television show *Four Corners*. He said:

> it's the responsibility of government to try to put policies in place which over time will allow people to improve their situation. But we can't abolish poverty, because poverty in part is a function of individual behaviour. We can't stop people drinking, we can't stop people gambling, we can't stop people having substance problems. We can't stop people from making mistakes that cause them to be less well than they otherwise might be (McDonnel, Four Corners, 2009).

Abbott's argument about the free will of the individual is somewhat valid. However, through his speech, he passes the responsibility of poverty from the state to the individual. He provides an excellent representation of the moral underclass discourse and the possessive individualism that can be found in liberal policies. If one of the most currently visible politicians in Australia stands behind these ideologies, then chances are this thinking will also be reflected in the Australian public. In this research, the survey sample demonstrate the opinion that Australian people are unwell and suggest that it may be their own fault because of laziness or a lack of education. In summary, this analysis suggests that because the self-responsibility concept was frequently referenced by the total sample, it is a discursive resource (Parker, 1992, p. 107) in today's dominant wellbeing discourse.

The findings above demonstrate that the concept of self-responsibility constrains wellbeing engagement and encourages self-exclusion from wellbeing. The survey sample did not acknowledge that wellbeing costs money and time and cannot be a choice for the whole population. Further evidence of how self-responsibility is constraining was shown with the tendency of the survey sample to determine that other people are unwell and the stigmatisation that can develop when regarding the healthy self, or just the self, compared with the unhealthy other (Crawford, 1994).

Wellbeing Travellers and the Moral 'Pursuit of Health: Driving and Constraining Wellbeing Travel.

A further key narrative driving and excluding engagement with wellbeing was found in the survey sample data. For those who regularly engage and travel for wellbeing (Group 3), wellbeing is an important state of being, not just for the sake of health but for social enhancement or a moral quest. Table 25 demonstrates this point.

Group 3 did not have highest rate of reaching ideal wellbeing, and almost half (44.8%) had not reached their ideal state of wellbeing at any point in their life, compared with three fifths of Group 2 (58.9%) and one third of Group 1 (33.9%).

Table 27: Response to the Question "Have you Reached an Ideal Wellbeing in your Life?" by Groups: Group 1 – low wellbeing engagement, no travel for wellbeing, Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

		Group 1	Group 3	Group 2
Ideal wellbeing	Yes	36.5%	46.6%	58.9%
	No	54.0%	44.8%	33.9%
	Other	9.5%	8.6%	7.1%
	Total	100.0%	100.0%	100.0%

N=177

It is an interesting result that Group 2 have a higher rate of achieving their ideal wellbeing (58.9%) than Group 3 (46.6%) who are more committed to wellbeing activities. Several conclusions can be drawn from this result. First, travel does not necessarily improve Group 3 participants' ideal state. Second, that the ideal state has not been reached may be one reason why Group 3 participants have gone beyond regular wellbeing exercise to visit a wellbeing travel establishment. Third, stating that the ideal has not been achieved is an indication of the moral virtue inherent in the ideals of wellness seekers. That is, although making a concerted effort to be well, both by travelling and by undertaking regular wellbeing activities, Group 3 participants have still not reached their goals. Wellbeing is a lifestyle requiring a time and effort commitment. They are doing health and wellbeing rather than just a reporting a subjective feeling consequential from taking time out. For those in Group 3, wellbeing is important but somewhat elusive, thus the need for continued effort and perseverance. As evidence of the effort needed, and the morality involved, Alexander

(Group 3) commented, “I feel that you can only continually try and achieve as you will always raise the bar higher and higher”.

Wellbeing is a potentially unachievable journey for Group 3. Not reaching the ideal is important because it reflects the effort made, the efforts that need to be made and identifies that they must be distinguished from Crawford’s (1994) unhealthy other. For Group 3, a frequent and dual understanding of hard work featured in their qualitative survey responses. Financial stability and maintaining a work–life balance with thrifty saving and financial stability were described by some as their primary method of achieving wellbeing. There was a requirement for stringent and sustained effort, such as “being strict with diet and exercise, very important” (Be, Group 3). Elizabeth (Group 3) used the word disciplined to describe the condition under which it could be achieved: “This happens when I am being disciplined with a combination of exercise, prayer, rest and diet. Achieving wellbeing was described as a struggle: “I have been striving for wellbeing all my life” (Alyssa, Group 3) or “not yet still striving” (Matthew, Group 3) and is perhaps not pleasant until, or if, the goal is reached. Even if the ideal had not been reached, the hard work paid off for the Group 3 participants. All survey participants were asked to report their current level of wellbeing on a 5-point rating scale, with 1 representing the lowest level of wellbeing and 5 the highest.

Table 28: Self-Reported Wellbeing Scale by Groups: Group 1 – low wellbeing engagement, no travel for wellbeing’, Group 2 – regular wellbeing engagement, no travel for wellbeing, Group 3 – regular wellbeing engagement, travel for wellbeing.

	Group 1	Group 2	Group 3
1	6.3	1.8	1.6
2	15.6	7.1	11.1
3	31.3	26.8	23.8
4	32.8	50.0	42.9
5	14.1	14.3	20.6
Total	100.0	100.0	100.0

The self-reported wellbeing results corresponded with the level of engagement by the survey groups. The sample with the highest percentage reporting the lowest level of wellbeing was unsurprisingly those who have low engagement with wellbeing (Group 1). Group 3 reported the highest level of wellbeing (20.6%) compared with

14.3% of Group 2 and 14.1% of Group 1. Therefore, although ideal wellbeing has not been reached for Group 3, the wellbeing travellers report that they are currently feeling quite well. This result is consistent with the qualitative responses that showed Group 3 participants perceive wellbeing as a journey requiring hard work, commitment and, most importantly, self-responsibility. And when pairing wellbeing with self-responsibility, those who are unhealthy (the unhealthy other) are identified and naturally positioned in opposition to the wellbeing seeking Group 3.

The Group 3 wellbeing travellers have much in common with Conrad's (1994) wellness seekers who embark on a moral quest for wellbeing. Conrad (2004, p. 387) suggests that "morality and health are often linked" and medicalising the body or identifying ill health is often providing "biomedical definitions for social problems". Conrad's (1994) explored how "health can be a moral discourse and the body a site for moral action". A sample of 54 people from a university ("self-identified wellness participants") were interviewed about their wellbeing beliefs and habits. The following conclusions were reached from the research:

> wellness seekers engage in a profoundly moral discourse around health promotion constructing a moral world of goods, bads and shoulds. Although there are some gender differences in particular wellness goals, engaging in wellness activities, independent of results, becomes seen as a good in itself. Thus, even apart from any health outcomes, the pursuit of virtue and a moral life is fundamentally an aspect of the pursuit of wellness (Conrad, 1994, p. 385).

Further research by health sociologists such as Crawford (2006), has suggested why this moral virtue – the moral health narrative – might be of any value. Its value is not for the individual's physical health or mental wellbeing, but rather as a meaningful social practice. Crawford suggests that wellbeing engagement is a symbol of middle-class identity that has value when it is on display. Today, the social problem that is resolved when embarking upon health and wellbeing achievement is "an opportunity to reaffirm shared values of a culture; a way to express what it means to be a moral person" (Crawford 2006 cited in Conrad, 2004, p. 388) suggests. For Group 3, engaging with wellbeing is, as Crawford suggests, a meaningful social practice (Crawford, 2006). When a performance of wellbeing takes place, it is a symbol of securing and displaying the self as a moral good and a middle-class identity

(Crawford, 2006; Willias, 1998). In this process of identifying as the moral good, the wellbeing traveller also identifies and excludes the unhealthy other. Therefore, the wellbeing discourse explains both what drives (moral quest for wellbeing) and what excludes (identifying the unhealthy other) from participating in wellbeing travel.

Non-Travellers and Wellbeing is Not a Self-Responsibility or Choice Group 1 and 2

To an extent, the notion that health is a self-responsibility was shared by the survey participants who do not travel for wellbeing (Groups 1 and 2). A notable theme for the Group 2 (regular wellbeing, no travel) participants was the attitude of health, wellbeing and relativity. Several participants articulated that, compared with the rest of the world, Australia is a lucky country (Sarah, Group 2) with good health systems and a good standard of living. Red said:

> I think Australians don't realise how good we really have it here in this country and have to adjust our attitude to appreciate what we have.

Group 2 participants also conveyed that because Australia is a lucky country with a good amount of resources, citizens do have access to basic resources and can make a choice about achieving this basic standard of wellbeing. Access to basic resources was demonstrated by one participant who stated that most Australians were well because:

> we have a very generous social security system ... we are a lucky country, with fresh food and water, jobs, and in most cases ability to have affordable living. (Wilson, Group 2)

This sentiment was also expressed by the participants in Group 1(low wellbeing engagement, no travel) but to a lesser degree:

> Australia is very much the lucky country with most people being able to maintain relatively extravagant lifestyles compared to people from many other countries. However, sometimes extravagant lifestyles don't always equate to people necessarily having a sense of wellbeing. (Cole, Group 1)

Cole acknowledges that Australia is a lucky country offering more than basic resources for most people, but wellbeing is more than extravagant lifestyles. Wellbeing may not be achieved, even after access to basic resources. Other factors also negate the choice to be well. For example, a participant commented that:

> probably the majority are well enough (maybe not in the ideal range) – but there will always be others who through personality type or circumstances find it much more difficult, e.g. addiction issues with family members, grieving, disease, disabilities and an inherent tendency towards depression, etc. (Ty, Group 1)

From the perspective of Group 1, the unhealthy other is stigmatised, but it was understood that structural constraints may have a role in restricting the choice to be well. For instance, for Angel (Group 1) identified financial constraints and said:

> there are too many obese people which in turn means they don't exercise. A lot are lazy and just can't be bothered making the effort to cook proper meals, but choose to buy junk food - which they usually eat while lounging in front of the telly. Having said that, why is fresh produce more and more expensive, making it less available for a large proportion of the community.

The participants in Group 1, identified a sense of difficulty when considering how to achieve wellbeing: a deficiency of control or choice. One difficulty or deficiency was financial resources. Xavier (Group 1) remarked that wellbeing means “being fit and financially secure, so you don't die of worry”. It was not only the perception that financial security would improve one’s sense of wellbeing, but also that money offers the opportunity to take part in consumer wellbeing: “with money you can do better things for your wellbeing” (Layla, Group 1).

Unlike the other two groups, the participants in Group 1 expressed feeling little control regarding improving their wellbeing. Tyrone, a retiree, said “don’t think wellbeing can be achieved”. Drawing all themes together, Tyrone cited engagement with life, a sense of difficulty in achieving wellbeing, including financial and social resources, and a lack of control. He said:

> in my case, wellbeing happens when several things come together. Mainstays for me are feeling well and relaxed; usually brought about by having no outstanding debts, tucker in fridge/pantry and recent contact with three adult

> daughters. Apart from the latter component, others are provided by having a surplus of available cash over which I have little or no control; just happens from time to time!

Wellbeing was described by Group 1 participants as access to basic resources rather than the spiritual or internal wellbeing spoken about and pursued by those who do travel for wellbeing (Group 3). Group 1 also reported not feeling well while Group 3 did report feeling well. These findings support those of health sociologists, that wellbeing is for the healthier and wealthier. The wellbeing travel literature states that wellbeing travel is for people who are already quite well and financially stable (Harley et al., 2012; Smith & Kelly, 2006).

In this section, Group 1 demonstrate that achieving wellbeing is not a choice because it is not something they necessarily have control over. Therefore, health as a self-responsibility is a limiting narrative for this group and not something they can engage with. A key result from this research is clear: the wellbeing discourse is driving wellbeing travel for some and is constraining others (Group 1). The final point for this section, is that instead of fully engaging with the health as a self-responsibility narrative, Group 1 were more inclined to be sceptical of the financial gain for some in creating a wellbeing industry. This scepticism was evident in the data and demonstrates a deviation from the cohesive discourse. Scepticism about the intention of wellbeing concern and proliferation in the public realm demonstrated agency for these two groups who are discourse making rather than confirming.

Concept 4 in Chapter 4, discussed the traveller's agency and power, a body of knowledge that suggests that travellers are not just performing the constructed place, they are continually re-constructing it. Chapter 4 suggested that while tourism may be constructed and facilitated by brokers (reproducing and reinforcing social inequalities), travellers play an active role in re-constructing. It was suggested the traveller is therefore constructionism in action (Lean, 2012). However, the results of this chapter suggest survey participants who do travel for wellbeing (Group 3) are discourse confirming by engaging strongly with the discourse that characterises wellbeing travel. Those who do not travel for wellbeing, Groups 1 and 2, are discourse making by not entirely engaging with this dominant discourse. For instance, the wellbeing revolution was overwhelming and Teddy (Group 2) said, "[I] can say [I] get sick and tired of [the] continual stream of band-wagons being paraded. Seems

everyone has a cause to promote". Similarly, Frank (Group 2) said there is "constant bombardment of TV / news articles citing figures on obesity/diabetes/cancer", and Anna (Group 2) said, "There is a lot of news stories, advertisements everywhere". Alexis (Group 2) commented:

> Mainly the media focus on the results of a lack of wellbeing in the whole of the human race …This includes not only the daily new reporting but also the various reality shows, talk show, documentaries and even entertainment.

Kay (Group 2) has observed an element of urgency in the transference of information to the general population through health scares. Clearly, for some, the continual presence of wellbeing knowledge is not entirely welcome and considered to be a form of pressure. Further scepticism was outlined by a wellbeing traveller in Group 3 and a Group 1 participant, who stated that the increase of wellbeing knowledge has suspiciously coincided with the growth of a mega dollar health and wellbeing industry:

> Most people are followers. When they see something that looks good, like healthy happy people, they want it too. I have seen the expansion of people's awareness of how to have a healthy happy life grow exponentially over the years. It has become a mega dollar industry. From self help books, to the acceptance of counselling, to the growth of the fitness industry (Alyssa, Group 3)

> It has been commercialised a lot more and there are more resorts/retreats that deal in wellbeing (Scarlett, Group 1)

The survey participants who did not travel for wellbeing are aware of a growing wellbeing consciousness, but some are not oblivious to its origin in industry and consumerism. They are also aware that, while Australia is a lucky country, some people do not have a choice about whether they can participate with wellbeing. Therefore, by being critical, the participants are not entirely complicit in engaging with the health is a self-responsibility part of the discourse and demonstrate some agency and discourse-making of their own.

Summary

Chapters 10 and 11 have considered the research question: “What are the drivers and constraints of wellbeing travel in Australia?” by looking at the existence of a shared wellbeing discourse. Thematic analysis of the survey responses found key characteristics: the wellness revolution (Conrad & Barker, 2010), the calamitous society and busyness, and health as a self-responsibility. Chapter 11 has discussed a link between travelling for wellbeing and engaging with these themes; the wellbeing travellers engaged totally with these themes, the other two groups did not. There were also important deviations from engagement for the participants in Group 1 and Group 2. Neither group engaged with the concept of health as a self-responsibility. Deviations such as this demonstrated agency from the wellbeing discourse and a link between those who do not practise or travel for wellbeing.

Chapter 12: Conclusion, Reflections and Recommendations

This research conducted an exploratory and critical examination of wellbeing travel in Australia. It explored the development of wellbeing travel as a social construction, with potential travellers driven and constrained by an overarching discourse of wellbeing. The impetus to conduct this research was the need to apply a critical lens to the study of wellbeing travel. Some tourism researchers in Australia have quantified the wellbeing tourism sector by classifying types of travel and travellers (Voigt et al., 2010a, 2010b, 2011a, 2011b) and using a macro destination perspective "to the development and management of wellness tourism destinations" (Voigt et al., 2013, p. 7). This research provided necessary information for Australia. The literature review found that wellbeing travel is largely studied in the context of the traditional consumer and producer relationship. While there is anecdotal knowledge about how society has influenced the growing tourism industry, there is little mention of the consequence of an exclusive tourism product for some that may occur at the exclusion of others. In general, exclusion from travel or non-travel is a neglected topic in Australian tourism research.

For these reasons, the researcher aligned with the tourism literature that has identified a need for more a critical perspective in tourism research: to examine tourism beyond the fixed dualisms of consumer and producer (Cohen & Cohen, 2012; Hannam & Knox, 2010; Pernecky, 2012; Pritchard, 2001) and to acknowledge the importance of exploring the dominant ideologies and inequalities that can be concealed in place (Soha, 1989). Social constructionism was a congruent research approach to align with a critical perspective. Critical discourse analysis was applied as the methodology. The two key research questions were developed to reflect this critical perspective of wellbeing travel, and to interrogate the drivers and constraints of wellbeing travel. These questions were: What are the drivers and constraints of travelling for wellbeing in Australia? and How is wellbeing travel in Australia socially constructed?

The tourism literature (Chapter 4) offered two main explanations for non-travel: 1) existing inequalities (mostly time and finances) constrain travel, and 2) constraints to travel are constructed by the service provider who creates a stage for the performance of the tourist. This research found evidence for both explanations but also identified self-exclusion as an equally important constraints to travel. The broad findings of this research were the identification of several key constraints to travelling

for wellbeing in Australia and a process of exclusion. There were two essential elements in the process of exclusion from wellbeing travel. First, constraints to travel were the result of a dominant discourse of health and wellbeing, and second, constraints resulted from a purposeful construction of tourism place (see Appendix K). In both elements, inequalities from society were reproduced in travel, marking an enduring relationship of inequality in the wellbeing travel industry.

Step 1: Constraints Resulting from the Cohesive yet Limited Discursive Resources for Wellbeing Travel

A premise of this thesis was that wellbeing tourism development and tourist motivations have cyclic dependant relationships with society. Tourism is constructed and re-constructed by the culture it derives. This study suggests that wellbeing travel is constructed by an overarching wellbeing discourse. This was demonstrated by the organising themes identified from the data sources, including: wellness revolution, self-responsibility, busyness and the calamitous society. These organising themes allowed the development of the conceptual theme: that wellbeing travel is socially constructed by a western cultural wellbeing discourse (Carlisle & Hanlon, 2007). This research finds that Carlisle and Hanlon's (2007) popular wellbeing discourse reflects both how the service providers, academics and survey sample understood and expressed wellbeing and how the construction of wellbeing travel has a relationship with wider discourses. This research also concurs with Dann's (1996) observation that that tourism is grounded in discourse, with the language and images of tourism wooing the tourist before the act of travel, during and after. Table 27 shows the organising themes identified from the data and how these reflect the dominant discourse of wellbeing today.

Table 29: Wellbeing Discourse Characteristics and Sources Confirming a Cohesive Wellbeing Discourse in Australia.

Wellbeing discourse characteristics	Wellbeing discourse sources
Wellness revolution: Increased public understanding regarding the importance of achieving health and wellbeing Increase in advertisements and mass media regarding wellbeing	Wellbeing travel academic literature Results from qualitative analysis of service provider interviews Demonstrated in survey samples observations of increase wellbeing dialogue in public realm
Self-responsibility: Taking control of one's health is important and the responsibility of the individual, not collective.	Wellbeing travel academic literature Results from qualitative analysis of service provider interviews Reflected in the attitude of the survey sample towards their own wellbeing and wellbeing of others
Busyness and calamitous society: Society today is busier and more demanding than ever before and depleting wellbeing more than any other time in history.	Wellbeing travel academic literature Results from qualitative analysis of service provider interviews Reflected in the survey samples dialogue about society today, technology and why wellbeing achievement is important.
Limited discursive resources There are repeated themes and knowledge when wellbeing is represented or talked about in society.	Stated by Cooper and Cooper (2009) regarding a sameness in wellbeing travel literature. Survey sample and service providers use similar words to describe wellbeing, demonstrating a similar set of discursive resources or foundation of knowledge.

The service providers established that the world is a faster and more stressful place (busyness and calamitous society). Thus, a wellness revolution is taking place with an increased public understanding regarding the importance of achieving health and wellbeing. The public are empowered and responsible for their health and wellbeing (self-responsibility). The service providers were found to employ the above discourse to construct the philosophical and economic bases of their business (Chapter 10). Table 27 shows that the whole survey sample also engaged with the wellbeing discourse, but to varying degrees. Perhaps unsurprisingly, analysis indicated that the higher level of engagement with wellbeing determined the higher likelihood of participating in wellbeing travel.

The survey sample confirmed an engagement with the calamitous society concept. Participants felt that the existence of the calamitous society was driving wellbeing travel. To the participants, the world is running at a fast pace and people are consequently time poor, stressed, depressed and unwell. An important difference was noted regarding the engagement with this theme. Group 1 (low wellbeing engagement, no travel) felt that the calamitous society is challenging for basic survival, while Group 3 (regular engagement with and wellbeing travellers) considered the calamitous society a challenge to the wellbeing of the internal self.

Because of the calamitous society, the survey sample reported observing an increase in wellness content in the public realm (the wellness revolution). Although the whole sample, and particularly women, were aware of a wellness revolution, engagement with the concept was different for each group. Group 3 were more attentive to this concept; the majority concurred that there was an increase of wellbeing knowledge in the public. While the service providers were found to use this understanding to construct their businesses (Chapter 10), Group 3 were found to engage with this discourse in everyday life. Based on these findings, it is proposed that wellbeing travellers are driven to travel by the wellbeing concept they recognise and engage with in their everyday life (Chapter 11). The identification of this cohesive wellbeing concept and its use by service providers to construct their establishments, prompted further analysis and raised several concerns.

The overarching concern was how the wellbeing discourse limits and constrains potential travel. Discourses facilitate language and knowledge of a topic, but they also create boundaries and constraints (Parker, 1992). This tension was a key finding of the data analysis. The limitations of dominant health discourses were discussed throughout the thesis. In particular, the literature review highlighted how health sociologists and gender researchers consider the power of health narratives to define the deviant and normal body to be a method of social control (Briggs, 2000; Conrad, 2010; Conrad & Schneider, 2010; Crawford, 1994; Ehrenreich & English, 2011; Greven, 1977).

The research proposed that the wellbeing discourse based upon the de-medicalisation movement has replaced medicalisation as the dominant social system of the body. That is, the focus has shifted from reactive medicine – with the body as a machine (Kelman, 1977; Conrad, 2010) – to preventative health (Fox.1977). It is argued throughout the thesis that, although the focus about how to achieve health has

changed, the requirement to maintain a normal healthy body (a relative concept) has not changed (Conrad & Scheneider, 2010; Crawford, 1994).

Chapter 2 explained that in the 19th century, while illness was dysfunctional to the social system, health became an important goal and a valued social role. The medical diagnosis of invalidism for upper-class women was discussed as an example. Invalidism was suggested to be a medical diagnosis with the aim to maintain gender roles. The diagnosis of an inherent sickness ensured that these women became passive and became busy with restoration and self-care (Ehrenreich & English, 2011). The mineral springs and spas at this time were offered as treatment to maintain the dominant normative female body (Ehrenreich & English, 2011), and perhaps a parallel can be drawn for wellbeing travel participants today. Crawford (1994) argues that the mainstream discourse of the body, although repackaged in the de-medicalisation movement, still dictates what is normal, what is abnormal and what methods can be used to treat and redeem this body. In this way it is an exclusionary discourse. Key findings support the above arguments about the impact and limiting nature of a dominant health discourse. These concerns are summarised in Table 28. The analysis established that wellbeing travel reproduces the commodification of wellbeing, which offers false narratives of choice to the general population, and when health is a self-responsibility, those who are not healthy can be stigmatised. It also offers social reward when distinguishing the healthy self from the unhealthy other (Crawford, 1994). These two constraints are summarised below.

Table 30: Drivers and Exclusions from the Wellbeing Discourse

Discourse Characteristics	Drivers	Constraints/excluders
Calamitous society and busyness	Restoration of self. Internal self (Group 3). Basic survival (Group 1). Secondary gain – the middle class badge of honour – social reward for restoration of self.	**Social rewards** are available for those who can participate in the dominant narrative of wellbeing.
Wellness revolution	An outlet to negate the calamitous society.	The **commodification of wellbeing**: A narrative constructed to entice the consumer i.e. people who can afford private health insurance or other privately paid for activities.
Health as self-responsibility	To identify as healthy self. The moral and virtuous self. Secondary gain: Social rewards are offered when restoration of wellbeing takes place	To be identified or identifying as the unhealthy other (Crawford, 1994) **False narrative that wellbeing is egalitarian and a choice**. That it is not an option for the unhealthier and un-wealthier is not acknowledged.

Constraint: A False Narrative of Self-Responsibility - That Wellbeing is a Choice

Table 28 shows that the health as a self-responsibility characteristic was a driver and constraint of wellbeing travel. The service providers, tourism academics, organisations and the survey sample (mostly the wellbeing travellers in Group 3) felt that health is a self-responsibility and a choice. Numerous concerns were identified as a consequence of these findings. Most importantly, health sociologists find that these two key words are representative of the commodification of wellbeing in Australia, which is fundamentally exclusionary (Carlisle & Hanlon, 2007; Harley et al., 2011; Palmer & Short, 2010).

Chapter 11 found that the notion of self-responsibility has become an important cultural value in health management and an ideal arrangement for institutions that benefit from an ever-increasing hands-off approach to health care policy. This perspective:

> is based on the moral supposition that greater autonomy from the medical profession coupled with greater responsibility for self and others in the realm of health and illness is an ethically and societally superior state. (Fox, 1977, p. 17)

The participants in Group 3 engaged with the notion of self-responsibility more than those in the other two groups, who were more aware of the exclusionary nature of health management in Australia. Group 3 demonstrated a moral virtue associated with choosing to be well. They valued and participated in hard work, striving and committing to be well. The wellbeing travellers were linked to Conrad's (2010) wellness seekers and Harley et al.'s (2011) health consumer, who engage in a moral discourse about health: their own health and the health of others. Driving the wellbeing traveller was a distinction of the self from the unhealthy other (Crawford, 1994). Health sociologists find that the identification of the healthy self can only occur with the identification of an unhealthy other (Conrad & Scheneider, 2010; Crawford, 1994).

For Group 3, whether or not wellbeing is achieved was almost beside the point. For them, the display of effort (the moral quest) is important. Evidence of this was seen in the qualitative theme of the unachievable journey, whereby half the wellbeing travellers have not reached ideal state of wellbeing even after making a concerted effort to be well, both by travelling and by undertaking regular wellbeing activities. Not reaching ideal wellbeing was important because it reflects the effort made, the efforts that need to be made and identifies that they must be distinguished from the unhealthy other. The moral pursuit of health is driving participation in wellbeing travel, the regeneration of self for the public eye becomes important – to be seen as healthy is a symbol of middle-class identity.

Constraint: Social Rewards for Those who can Participate in Wellbeing

The quest to achieve wellbeing offers further social rewards. Table 28 shows that engagement with the calamitous society and busyness can result in the middle-class badge of honour. Social science researchers regard the term *busyness* with some caution because the perception of time is relative compared with to past societies. Objective indicators in Gershunny's (2005) research reveal that we are not necessarily

busier people. He notes a historical reversal, where the most privileged are working more than the least. Therefore, rather than busyness representing the working class and idleness representing the upper class, busyness has become a badge of honour (Gershunny, 2005). Claiming busyness builds a foundation to engage with wellbeing improvement for the middle to upper classes (such as the wellbeing travellers).

The healthy self is a moral person (Crawford, 1994, 2000) and external symbols of health and wellbeing contribute to social rewards. Thus, the social constructionist perspective would consider that the pursuit of wellness includes a secondary gain (Conrad & Schneider, 2010). The secondary gain is the benefit of participating in and supporting dominant discourses with the knowledge that self-interest will also be met. In comparison, the self-responsibility and choice narrative constrains those who had low wellbeing engagement (Group 1). As the most structurally constrained group, the participants in Group 1 felt that achieving wellbeing is not a choice, nor is it something they necessarily have control over. Group 1 understood that structural constraints may have a role in restricting the choice to be well in a way wellbeing travellers did not. The popular wellbeing discourse is inherently exclusionary for people such as those in Group 1, and it is a driving force for those who are able to engage with it, specifically the wellbeing travellers in Group 3.

As discussed in Chapter 11, this thesis acknowledges that wellbeing travel service providers are foremost profit-driven businesses and not committed to public health outcomes. However, this thesis aligns with the principles of ethical tourism, which consider the tourism industry to be accountable to all of society, not just to those who participate (Minnaert, Maitland & Miller, 2006; Tribe, 2008). Additionally, this thesis maintains that the tourism industry becomes accountable and open to criticism when encouraging the reproduction of existing inequalities in society. This is particularly true when the philosophical basis of a business is based a discourse that presents health as a “universal right and fundamental good” and a self-responsibility (Gwyn’s, 2002, p. 7). While health and wellbeing may be presented in this way, past research and this research demonstrates that it is not a reality.

Step 2: Constraints Created by the Service Provider

The second layer of exclusion was shown to occur as a result of the tourism place. Chapter 7 established that without an organising body or collaboration among establishments, the service provider is the central constructor of wellbeing travel in Australia. Chapters 8 and 9 concluded that most service providers purposefully constructed single-purpose establishments for a specific exclusive target market. The findings drew attention to Edensor's (2000) concept that a stage is purposefully constructed by service providers to be recognisable for tourists and shows their suitability to become tourists of this place. Edensor's concept resonated throughout the data analysis.

Structural Constraints

The service providers constructed financial barriers by setting prices beyond the average Australian expenditure on an annual holiday (ABS, 20020-2010). Confirming that an enduring relationship of inequality can occur when tourism places are organised or staged for tourists is followed by the tourist performing in place (Edensor, 2004; Mordue, 2004). Spa service providers and large lifestyle establishments marketed towards, and reportedly attracted, a specific customer base: white, female and upper to middle class.

The wellbeing travel service providers have purposefully created something that is highly recognisable for tourists and is founded on the wellbeing characteristics discussed in the previous section. Symbols such as the price and the cultural environment (elite or mainstream) presented via words or images confirm or deny the suitability to visit and the "common sense understandings about what activities should take place" (Edensor, 2001, p. 62). The wellbeing travellers in Group 3 recognise the constructed stage because they engage with wellbeing discourse characteristics more than the other two groups.

Corresponding with the service providers' construction of financial constraints, time and finances were the primary structural constraints for the survey sample. This was demonstrated in an examination of income, time (employment status) and self-reported constraints from survey participants and the focus group. The analysis also showed an association between travelling for wellbeing, a higher income

and more time. This confirms that access to free time and a good income offer an environment in which wellbeing travel can take place.

The significant impact of structural constraints aligned with past non-travel research, such as that by Lu and Pas (1998), Smith (2001) and Nyaupane et al. (2008). Group 1 (with low wellbeing and no travel) were the most structurally constrained, while Group 2 were the least structurally constrained because they had enough resources to make a travel choice (to not travel for wellbeing by choice) rather than being constrained (see Table 22). These findings agree with critical tourism researchers such as Urry (1990) who argues that social inequalities are reproduced in place. Analysis also identified new reasons for non-travel: the concept of self-exclusion leading to the interpersonal constraints of gender and ethnicity.

Interpersonal and Intrapersonal Constraints: Not Interested and Self-exclusion

Chapter 4 discussed the growing notion of social exclusion from travel in the non-travel literature. Social exclusion from travel became a talking point when: 1) travel became more accessible to the public with the advent of the commercial aircraft (Theobold, 2005, p. 5), 2) a holiday became a norm for citizens in developed societies where there is a capitalist work and leisure dichotomy (Holden, 2006) and 3) leisure and holiday are reflected as basic human rights in Article 23 and 24 of the *Universal Declaration of Human Rights* (United Nations, 2011).

Tourism scholars have noted that travel as a basic human right does not guarantee equality of travel, and social exclusion can result in non-travel (Botteril & Klemm, 2006; Holden, 2006). Social exclusion is the non-participation (economically, socially and politically) in what is considered normal daily activities and can result from a lack of resources that are necessary for participation to take place (Levitas et al., 2007). Travel is now considered one of these normal activities.

As the key finding of this research, and in answer to the key research question, this thesis proposed a process of social exclusion resulting in non-travel. Non-travel for wellbeing was the result of specific processes: 1) constructing a place based upon wellbeing discourse characteristics, 2) marketing towards a specific customer base (white, female and middle class) by creating a sense of belonging and 3) excluding the

others by the constructing of structural constraints (finances) and interpersonal or intrapersonal constraints.

This research established that not all instances of non-travel are the result of exclusion or constraints. Non-travel can also be the result of a simple lack of interest in wellbeing of travel. Wellbeing was achieved in alternative ways for Group 2 who engaged with wellbeing but did not travel for wellbeing, instead choosing general travel and staying connected with family and friends.

A further theme supporting the lack of interest in wellbeing travel for Group 1 was their derailing the authenticity of wellbeing. This group expressed criticism of the consumerist nature of the popular wellbeing movement. For instance, they equated wellbeing participation with the pressure for women to look good. Group 1 also supported the concept that wellbeing travel is for people who are already well. The self-reported constraints chosen from Crawford, Jackson and Godbey's (1991) hierarchical model of leisure constraints, also showed that the main reason Group 1 were not interested in wellbeing travel was because it was not family friendly, and Group 2 were not comfortable. Some non-travel researchers report similar conclusions. McKercher's (2009) study of Hong Kong non-travellers concluded that given the option, some non-travellers will not travel because of a lack of interest. Research by Smith, Fralinger and Litvin (2011) identified six types of non-travellers in the United States, and suggested that a lack of interest could explain non-travel for some classified as Hispanic working class and urban professionals.

Although it is valid to suggest that some non-travellers are simply not interested in travel, this thesis proposes a further explanation: an apparent disinterest in travel. The results support a case for further research looking beyond the easily deduced lack of interest to explore self-exclusion from travel. Woven throughout the data was a process of self-exclusion as a key finding to explain how a stage was constructed for target tourists could simultaneously create constraints to travel, and how potential tourists then decide not to travel. Self-exclusion was demonstrated with gender and ethnicity.

Chapter 9 described the dispute in the literature regarding whether voluntary exclusion can be considered social exclusion (Atkinson, 1998; Barry 1998). The findings supported Burchardt et al. (1998) who propose that groups or individuals who exclude themselves only do so because they already experience a narrowing of

opportunity from systematic rejection and social exclusion. It is argued that self or voluntary exclusion is a counter action to a social exclusion that is already set in motion. Therefore, the research proposes that the lack of a family friendly environment has resulted in a counter action, with Group 1 self-excluding from wellbeing travel. This represents a failure of wellbeing travel service providers to cater for the family market. Similarly, for Group 2, not feeling comfortable, may signal a narrowing of opportunity for this group who do not see themselves as part of the establishment and therefore self-exclude.

The strongest predictors of self-exclusion were gender and ethnicity. As discussed in Chapter 8, the absence of some ethnic groups from wellbeing travel was observed by the service providers. Structural constraints and the need to focus on basic survival (as suggested by Michelle) play a part in non-travel for some ethnic groups, but a further narrowing of opportunity occurs because service providers construct images of belonging that exclude non-white persons. Edelheim (2006) argues that hegemonic messages in Australian tourism brochures are detrimental for marginalised groups in Australia.

Chapter 8 confirmed that the people depicted in images on wellbeing travel spa and lifestyle websites are overwhelmingly white, middle aged and female (see Table 11[7]). As a consequence, the impact of images and other symbols of belonging cannot be underestimated in tourism. Marshment (1997, p. 16) finds that while holiday brochures and images on websites provide primary information about the destination, they are also "visually dominant" and "most important in the construction [of other] meanings". The advertising images are the result of a choice made by service providers and can be considered part of the construction of their stage (i.e. the images of belonging that are offered to potential tourists). This finding is supported by Smith, Litvin and Fralinger (2013) who concluded that travel providers in the United States may not be attuned to the needs or desires of minority groups. As stated in Chapter 8, further research is needed to explore the possible self-exclusion of ethnic groups from both general travel and wellbeing travel in Australia (Burton & Klemm, 2009).

Self-exclusion from wellbeing travel due to gender also occurred as a result of images and symbols of belonging. Gender and ethnicity are considered interpersonal

[7] Ethics and anonymity of the service providers interviewed prohibits showing the specific brochures or websites

constraints because the representations of wellbeing travel provided by service providers intervened with travel participation. In regard to gender, women were driven to travel because they saw themselves in the stereotypical feminine roles constructed in the establishment. Men self-exclude to conform to the image of traditional masculinities. These findings are consistent with those of with Pritchard (2001) and Swain (1995) who argue that tourism is deliberately shaped by gendered realities in society. The total sample conveyed traditional attitudes towards gender roles and wellbeing. These included the perceptions that: wellbeing is a woman's domain; women are nurturing and have a natural predisposition to look after themselves and others women have more time on their hands; and women need to be well so they can take care of the men, children and the household. The reproduction of gendered tourism was evident in the service providers' traditional gender role attitudes and was integrated into their establishments. The service providers confirmed they marketed towards women (who were their primary patrons), and advertising material with images of the target market (white, female and middle aged) contributed towards the reproduction of traditional female roles for women in place. Women can see themselves in wellbeing travel and men cannot.

Gendered tourism is a key factor driving the wellbeing travellers because they are the group that conveys the strongest alliance with stereotypical gender roles. Group 1 did not put forward traditional gender roles; they thought men and women were equally concerned about their health, even if women did ultimately take better care of their wellbeing. The research concluded that gender was a constraint for men and for Group 1 (who did not engage with traditional gender role attitudes) because they did not see themselves reflected in the establishment.

These results support a case for further research looking beyond the easily deduced lack of interest, to explore self-exclusion from travel. The constraints of gender, ethnicity, not being comfortable at wellbeing travel establishments and not wellbeing travel not being family friendly are all the result of a pre-existing narrowing of opportunity and systematic exclusion.

Conclusion

Based on the structural interpersonal constraints and self-exclusion findings in this research, it is suggested that spa and lifestyle service providers have largely aligned with the elite model – the culture of bathing in 19th century United Kingdom

and Europe (described in Chapter 2) – rather than the egalitarian model. Parallels are observed between the clientele of the elite model and wellbeing travellers today. Herbert's (2009) research of 19th century United Kingdom and Europe suggested that those taking the waters were women of the wealthy elites who were leaving behind the stressors of their everyday life (Herbert, 2009, p. 361). The service providers who were interviewed observed a similar clientele, mostly women who are burning out, or "doing it all" (Kim).

In Chapter 4, Soha (1989a) stressed the importance of how dominant political and ideological practices can be concealed in place. She writes about the potential hazards when creating an establishment where "each effort to create place becomes an elaboration of the beliefs and values of some collection of people, expressed and fostered in their promotion of a preferred reality" (1989a, p. 6, cited in Stokowski, 2002, p. 369). Numerous concealed hazards about travelling for wellbeing in a western cultural context were identified in this study. Concealed in these places are narratives that reflect wider comments about social inequalities in health and narratives about the reproduction of inequalities in tourism. The hazards established by this research question the conceptualisations of the post-modern traveller. The traveller has been defined as a deviant, a facilitator of imperialistic values (MacKenzie, 2005). More recent theorising defines the traveller as a free-floating individual. We are post-modern liquid travellers (Bauman, 1996, 2000; Heimtun, 2007), free-floating individuals with no boundaries, all consuming place. Adler (1989) and Lean (2012) suggest that tourists use the tourism stage for meaning making, to transform and fashion their identities. Therefore, they are re-constructing rather than performing the stage.

These recent concepts assume that the traveller has agency in regard to their travel experience. Within the context of this research, the wellbeing traveller has the economic means and opportunity to express some agency and make travel choices. Although wellbeing travellers may have enough resources to make travel choices, they are adhering to a set of dominant narratives about health and performing this in travel. It is proposed that there is little agency in this. The participants in Group 1, with their existing social inequalities, do not have the agency to make a travel choice, let alone reconstruct a constructed tourism stage. Group 1 largely rejected the narratives as an act of self-exclusion, but at least partly, the rejection could be considered a demonstration of agency and freedom from middle-class narratives. It is proposed that

wellbeing travel is a battleground where access to pursuits that improve health is evidently good for some, but not good for others. Tourism offers a stage to conduct this performance.

As a final note, this research has identified groups of people who do and do not have the resources to make choices about achieving wellbeing in a consumer-orientated wellbeing environment. Economic growth and the distribution of resources to individuals is supposed to increase the wellbeing of a population, while poverty is a primary determinant of ill health (Carslilie and Hanlon, 2011). An abundance of research suggests that economic growth does not determine a well population. For instance, Chapter 11 discussed Linder's (1970, p. 1) statement that, although we expected economic affluence to result in "a tranquil and harmonious life", the opposite has transpired. As such, it is proposed that today's wellbeing travel may not improve the wellbeing of a population. Today's wellbeing travel promotes a wellbeing that is socially divisive and, in this way, cannot be of genuine help to achieving population health.

Recommendations

The process of exclusion found in this research highlights a few practical and conceptual ramifications. Future tourism research needs to apply a critical examination to address how social inequalities are reproduced in tourism. A conceptual outcome of this research was a critical discourse of wellbeing that is best described by the link between wellbeing travel increasing and a specific group of people participating. This research found that an examination of culture was the key to understanding drivers and constraints to wellbeing travel. An examination of wellbeing culture identified a key research outcome: not travelling for wellbeing was the result of a discriminatory and multifaceted process of exclusion.

The power of discourse in general travel and the health and wellbeing discourse in wellbeing travel will expand critical tourism research. Future wellbeing travel research could focus within an establishment to examine how wellbeing travellers perform in place and understand the soft controls constructed by service providers. With the process of exclusion identified in this research, future tourism research should continue to address how to make tourism accountable and more accessible to lower income groups. Further wellbeing travel research should consider

how Australia could return to the egalitarian model. Moving away from the accountability of the tourism industry, accountability for health and wellbeing should be recognised as the responsibility of the collective, the community and the welfare state. Wellbeing travel is yet another example in the body of knowledge by health sociologists considering how wellbeing in Australia privileges the white middle class and leaves behind those who have minimal resources to achieve health and wellbeing.

Limitations and Suggestions for Further Research

Some limitations were present in the collection of the data. A major part of this thesis explored what constraints and drives people to travel for wellbeing. In the absence of any literature about constraints to wellbeing travel, a well regarded non-travel model (Crawford, Jackson and Godbey, 1991) was adopted to examine wellbeing non-travel. I acknowledge that wellbeing travel is a very specific type of travel that cannot be directly compared to general non-travel. While this can be regarded as a limitation of the research, it was also considered a good starting point for a previously un-researched topic.

Representatives from relevant tourism organisations (e.g. Tourism Victoria and ATEC) were not interviewed. These organisations' stance and support for the development of wellbeing travel was analysed through text, but the request for interviews was ignored. Several emails were sent to tourism organisations to request they take part in the research but these were met with no response. A representative from ATEC was reached by phone but was very reluctant to participate. She mentioned that much of the work regarding wellbeing travel had been recently discarded because it was not deemed a viable or profitable sector. She did eventually agree to be interviewed but could not be contacted on the day of the next proposed phone conversation and could not be reached from then on. A suggestion for further research would be to interview representatives of the relevant tourism organisations and examine their position upon why it is not considered a viable travel sector and why spa retreats have been mostly supported as opposed to smaller, less visible establishments.

Another limitation this research and suggestion for future research is to conduct an extensive content analysis of wellbeing travel service providers in Australia in regard to the prices and images they display on their brochures and

websites. The table in Chapter 4 began to outline these themes of price and image as an example of construction and subsequent financial exclusion and self-exclusion when not fitting the desired image. However, due to lack of time, a content analysis could not be conducted in this project.

There were limitations in regard to the survey, beginning with the size of the survey sample. Due to a lack of resources, only 204 surveys could be completed. While a larger survey sample would have allowed more complex statistical analysis, the sample size was acceptable for qualitative analysis. The survey sample also included more men than women. This is a limitation because, as stated in the literature review, women are the predominant wellbeing travellers. Further research may benefit from a more complex statistical analysis of the socio-economic profiles of wellbeing travelers and wellbeing non-travelers because the analysis of the qualitative data in this study was basic. Finally, due to technical error, the survey did not include a direct question about income as a constraint to travel.

This research contributes to both Australian wellbeing travel research and Australian non-travel research. Currently, research on these topics is scarce. This is evident in the lack of Australian non-travel research in the literature review. Therefore, it would be valuable for marketing purposes, to further understand the potential travel market (not just the existing market) and their constraints and motivations to travel, to further develop the findings outlined in this project.

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Appendix A: Travel Constraints Model

Constraints:

Interpersonal constraints: "involve individual psychological states and attributes which interact with leisure preferences rather than intervening between preferences and participation (Crawford et al. 1991)". Such as a person's psychological state, physical functioning or cognitive abilities (Smith, 1987) and include areas such as stress, anxiety, lack of knowledge, health related problems and social ineffectiveness (Hall & Brown, year).

Intrapersonal constraints: are those arising out of social interaction or relationships among people within social contexts (Scott, 1991): they can occur during interactions with an individual's social network, service providers or strangers, or because one lacks a partner with tho to engage in some leisure activity (Crawford &Godbey, 1987). Smith (1987, p. 381) states the dependency on others may severely restrict pleasure travel if an individual has 'maladaptive social relationships with caregivers and service providers'.

Structural constraints: "represent constraints as they are commonly conceptualized, as intervening factors between leisure preference and participation" (Crawford et al. 1991), they include financial challenges, lack of time, transport difficulties and regulations (Hall & Brown, year). climate, the scheduling of work time, availability of opportunity (and knowledge of such availability), and reference group attitudes concerning the appropriateness of certain activities (Crawford & Godbey, 1987, p. 124).

Source: Hall & Brown (year), and recognised by, Crawford and Godbey, 1987; Smith, 1987; Turco et al., 1998; Hawkins et al 1999; Jackson & Scott, 1999).

Appendix B: Context of Australian Social Exclusion Research

Measure of Exclusion

Source: The B-SEM measures of social exclusion/exclusion demonstrated within the Venn diagram are taken from Levitas et al. (2007).

Figure 5: Measure of Exclusion

The Brotherhood of St. Laurence adopted this measure shown in Figure 5 ,of social exclusion. It originates from Levitas (2007) and was adopted in a study of the multi-dimensional nature of poverty, in Australian. Figure 5 demonstrates that inclusion in 'normal' activities of the given society cannot be achieved without first having basic economic, material and social resources. This then allows health, safety and a sound living environment. All of these components are influenced by having access to social, economic and civil participation. These are the requirements needed to have the ability to participate in normal daily activities and to be socially included .

Appendix C: Service Provider Interview Schedule

For the purposes of consistency a similar interview schedule was constructed for travel agents and service providers. The interview schedule consisted of general themes which aimed to address the research sub questions for Phase 1,

- What is wellbeing?
- What is wellbeing travel?
- What purposes are served by taking part in wellbeing activities such as travelling for wellbeing?
- Does taking part in wellbeing activities reflect a social construction of wellbeing and health participation discourse?

The themes for the interview schedule were created to reflect the sub research questions by inquiring about participants beliefs and observations. Themes for wellbeing travel service provider participants were as follows:

Theme 1: In your opinion and from the position of your business, what is wellbeing?

Theme 2: Have you heard of the concept of wellbeing travel? What do you know?

Theme 3 and 4 were created to address to the idea that wellbeing travel is an emerging trend (as per tourism literature), and to therefore address the inquiry regarding how wellbeing travel is socially constructed. Interviewees could not be asked ‘how is wellbeing travel socially constructed’, instead they were asked to impart their knowledge about the trend which would demonstrate the wellbeing travel discourse:

Theme 3: Have you noticed an increase in customers?

Theme 4: Have you noticed an increased awareness in Australians regarding their wellbeing?

To further address the construction of wellbeing travel, interviewees were asked about the pathways their customers followed to find their business. This included asking about advertising/marketing.

Theme 5: How do customers find wellbeing travel destinations?

For wellbeing travel service providers, this theme was expressed with the following question, ‘How did your customers find you?’. Travel Agents however, were asked if they were a part of the pathway to wellbeing travel. That is, do

customers ask for wellbeing travel holidays? Do the travel agents specifically promote wellbeing travel holidays?

To address the power concept that is a key area of inquiry in critical discourse analysis, interviewees were asked to describe a profile of their customers including, age, gender, class and usual place of living.

Theme 6: Can you describe your customers socio-economic profile?

Finally, within this power theme interviewees were asked to describe the potential barriers of wellbeing travel which would exclude potential travellers.

Theme 7: Can you identify the barriers and constraints of wellbeing travel.

This theme was presented with an open question, 'What sort of people might not travel for wellbeing? Why?'. Also participants were presented with a barrier and constraint created by tourism and travel literature (Crawford & Godbey, 1987; 1991). The barrier and constraints model by Crawford and Godbey (1987; 1991) demonstrates conditions under which persons may be excluded from travel, such as psychological barriers or financial barriers. The model reflects the multi-dimensional context by which people are generally socially excluded. It is because social exclusion is defined as the inability or inopportunity to participate in the normal activities, that parallels are drawn between a model representing the barriers and constraints of travel; and a social exclusion model that represents the in-opportunity of participating in society. Therefore, the barrier and constraint model by Crawford and Godbey (2008) was revised by the researcher to incorporate a multi-dimensional model of social exclusion, based upon Australian and British social exclusion research (Levitas, et al., 2007; Webster, 2008).

It was considered by the researcher that because the research was taking place in Australia; and because at the time of writing, no travel or leisure research had addressed barriers and constraints in Australia; that the barrier and constraints model needed to reflect the particular context of social exclusion in Australia. The definition of social exclusion is the inability or inopportunity to participate in what is considered the normal daily activities of any society (Levitas, 2007). In Australia the opportunity or ability to travel is considered one of those normal daily activities. Therefore the inability to participate in travel in Australian society is social exclusion. Consequently, a multi-dimensional barrier and constraints model, which demonstrates the conditions under which travel may not be possible, reflects a model of social exclusion. To achieve this, the B-SEM (British Social Exclusion Matrix) model

discussed in Chapter _ was the social exclusion model used in combination with the barrier and constraints model. The B-SEM model demonstrates that social exclusion in multi-dimensional therefore inclusion in 'normal' activities of the given society cannot be achieved without first having basic economic, material and social resources (Levitas et al., 2007). Which then allows health, safety and a sound living environment. All of these components are influenced by having access to social, economic and civil participation – a somewhat supportive social environment (Levitas, 2007). These are the requirements needed to have the ability to participate in normal daily activities and pursue wellbeing beyond a basic level.

Crawford and Godbey's model of barriers and constraints (1987) is a widespread model used in travel non-participation and social exclusion travel research (Hudson, 2000; Nyaupane & Andereck, 2008). The model consists of Interpersonal constraints, Intrapersonal constraints and Structural constraints to travel. Their model of constraints is closely aligned with the BSEM model, that is, Interpersonal constraints is similar to 'Participation'. Structural constraints are similar to 'Resources', and Interpersonal constraints echoes 'Quality of Life' (Crawford & Godbey, 1987). The researcher incorporated both Australian context social exclusion measures, and barriers and constraints research to create a barrier and constraints model to present to participants in the project..

As the final question of the interview, participants were asked to select five of the most important barriers to wellbeing travel from the list of conditions in the barrier and constraints model (please see Appendix _ for the barrier and constraint model used).

Appendix D: Focus Group Interview Schedule

The first two themes were the same as the interview schedule.

Theme 1: In your opinion what is wellbeing?

Theme 2: Have you heard of wellbeing travel? What do you know?

Theme 3 was varied slightly for focus group 1 because in the interviews it asked from a business perspective if Australians were becoming more conscious of their wellbeing and do they consequently observe an increase in business.

Theme 3: Have you noticed an increase in Australians becoming conscious of their wellbeing?

Instead focus group participants were asked to discuss their observations of the general Australian population. In doing so, the focus group was identifying if a discourse of wellbeing and wellbeing travel was evolving to a particular level of awareness for the Australian population. Also they were identifying how it was being constructed and by who, where is the knowledge originating?. Their attitude and conversation as a group was also considered a process of building and re-constructing the discourse (discuss the theory of this). Participants were also asked to discuss their wellbeing habits and any experiences with wellbeing travel.

Theme 4: What are your regular wellbeing activities and what experiences have you had with wellbeing travel?

Theme 4: Can you identify the barriers and constraints of wellbeing travel.

Again, similar to the interviews, the power issue was discussed with Theme 4. Focus Group 1 participants were asked to discuss who would and wouldn't be likely to participate in wellbeing travel and what they thought were the biggest barriers.

Appendix E: Survey Questions.

Qualtrics Survey Software

Filter questions

*1. You are invited to participate in a research project entitled "Wellbeing Travel in Australia - defining well being and exploring non-participation". This project is being conducted by student researcher, Alison van den Eynde, as a part of a PhD study at Victoria University under the supervision of Associate Professor Adrian Fisher from the Faculty of Arts, Education and human Development.

The aim of the project is to explore the development of well-being travel in Australia. Including why this has become a trend amongst people and explore what 'well-being' means to the Australian people. Please read the information below to give your consent to participate in the survey:

You are asked to participate in an on-line survey that will take approximately 10 minutes. The information you provide will be included in a PhD research thesis. This information is confidential.

Please read the following statement and click 'yes' to certify that you are least 18 years old and that you are voluntarily giving consent to participate in the study:

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me and that I freely consent to participation involving the below mentioned procedures:

• To participate in an on- line survey, I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Yes No

Filter Questions

In the last year have you travelled at least 50km away from home and

stayed somewhere at least one night (or more)? Yes No

Do you regularly (at least once a fortnight) partake in activities to

improve your well-being? Yes No

In the last two years did have you travelled for the purposes of improving your well-being such as:

- A spiritual retreat, (for instance yoga, meditation)

- A religious retreat

- Spa tourism destination (water based treatments such as i.e. Hepburn Springs bathhouse)

- A lifestyle retreat (i.e any retreat which aims to improve your health/well-being)

- A day spa.

- Or other well-being travel? Yes No

(Q1) Which category below includes your age?

18-24

25-34

35-44

45-54

55-64

65-74

75-84

85 or more

(Q2) What is your gender? Male Female

(Q3) What is your occupation?

(Q4) Which of the following categories best describes your employment status?

Full Time Employed

Unemployed

Part Time Employed

Self Employed

Pensions or Benefits

Domestic Duties

Retired

Other

(Q5) Do you have a religious or spiritual affiliation? If so, what is it?

(Q6) What is the highest level of school you have completed or the highest degree you have received?

Completed High School

TAFE certificate

Diploma

Bachelor Degree

Postgraduate

Other

(Q7) What is your approximate annual household income bracket?

$0 - 25,999

$26,000 -35,999

$36,000 - 51,999

$52, 000 - 77,999

$78,000 - 103, 999

$104, 000 - 129,999

$130, 000 - 155, 999

$160, 000 or more

(Q8) In your opinion, what does the word ‘well-being’ mean?

(Q9) How is well-being achieved and how important is it to achieve well-being? Why?

(Q10) Please rate your level of well-being on a scale of 1 to 5 (1= not well, 5=very well).

(Q10) Please rate your level of well-being on a scale of 1 to 5 (1= not well, 5=very well). 1 2 3 4 5

(Q11) Have you reached your own ideal state of well-being at any point in your life? When and why?

(Q12) If yes, are unwell people not willing to put in this time and effort?

Yes

No

Other

(Q13) If not personal time and effort, what else might determine whether a person may or not achieve a sense of well-being?

(Q14) Thinking of the Australian population, are most people well? Please elaborate why or why not.

(Q15) Do you think over the past few years the Australian people have become more conscious of their health and well-being?

(Q16) If you answered yes to the previous question, what has happened to make the Australian people more conscious of their well-being?

(Q17) At some time in your life have you participated in activities (exercise, naturopath for instance) to improve your well-being? Please list these activities.

(Q18) Where do you mostly get your knowledge about how to achieve well-being? You may choose two from the following list.

Family/Friends

Internet

Government Organisations such as Vic Health

Doctors

Alternative Medical Practitioners

TV

Spiritual Guide

Books

Magazines

Other

(Q19) What role does technology (ipad, computers, phones etc) have in your life? Do you think it adds or detract from your well-being?

(Q20) Do you think women or men are more stressed? Why?

(Q21) Do you think females or males are more well? Why?

(Q22) Do women or men take better care of their well-being? Why?

(Q23) Do you think there are more expectations of women today than they have had in the past?
Yes No

(Q24) What is expected of women today?

(Q25) Do you think increased expectations of women would impact upon women's well-being?

(Q26) When considering a holiday or short break, have you ever thought about travelling somewhere to improve your well-being (i.e. well-being travel)?

Yes No

(Q27) Where do you usually travel to for a holiday?

(Q28) What sort of accomodation do you stay in? And who do you usually travel with?

(Q29) How long do you stay when you travel away from home?

(Q30) When you think of well-being travel, what images come to your mind?

(Q31) What are the reasons you have not travelled/taken a holiday specifically to improve your health and well-being?

(Q32) Thinking of the Australian population who would and wouldn't be likely to participate in well-being travel?

(Q33) Would you travel to a destination which focused upon well-being if it was an affordable holiday? Please explain why or why not.

(Q34) If you were to travel for well-being, please indicate which type of well-being travel you would be likely to take part in.

Religious Tourism – 'the primary aim of furthering religious understanding and enlightenment' (Bennet, King, Milner, 2003).

Spiritual tourism – travel which concentrates on a spiritual quest or addressing the body, mind, spirit

Spa Tourism – Travel which 'focuses on the relaxation or healing of the body using water-based treatments'

Lifestyle Retreat – usually a retreat with structured or Unstructured well-being programs which may address the need for relaxation, or for drug and alcohol detox, anxiety etc. It include services like, nutritionist, naturopath, medical doctor, day spa.

Other

(Q35) If you have heard about travelling for well-being (whether it be specific destinations or activities) where did you get your knowledge from? You may choose multiple answers.

Family/Friends

Internet

Organisations such as Tourism Victoria

Doctors

Alternative Medicine Practitioners

TV

Travel Agents

Spiritual Guides

Books

Brochures

Academic Literature

Magazines

None

Other

(Q36) Below is a list of reasons why travelling for well-being would be difficult or impossible for you. Choose five and number from 1 to 5 in the space provided, what you think are the most relevant constraints.

Psychological state

Physical constraints such as disability

Mental Health

Stress/Anxiety

Problems arising from communication with travel service providers

No social group to travel with (friends, community groups etc.)

Not having a partner to travel with

Not having a caregiver to travel with (if needed)

Lack of time

Transport difficulties (please indicate what sort of difficulty. I.e. no car; can't drive; no public transport to where I want to go)

Climate of destination

Availability of travel products

Social group attitudes to travel preferences

Too unwell to travel

Spa retreats make me feel uncomfortable

Lifestyle retreats make me feel uncomfortable

Well-being travel destinations are not family friendly

(Q37) Would you be interested to take part in an additional focus group to further discuss the issues raised in this survey (approximately 30 minutes)? Participants will be given a minimum of $30 compensation for their time.
Yes No

(Q38) Do you have any further comments you would like to make below? Any queries about your participation in this project may be directed to:

Associate Professor Adrian Fisher

Phone: +613-9919-2335

Survey 1 - WBC

Powered By Qualtrics

Appendix F: Information Sheet and Consent Forms

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled 'Wellbeing Travel in Australia – defining wellbeing and exploring non-participation'.

This project is being conducted by a student researcher, Alison van den Eynde, as part of a tourism PhD study at Victoria University under the supervision of Associate Professor Adrian Fisher from the Faculty of Arts, Education and Human Development..

Project explanation

The aim of this project is to explore the development of wellbeing travel in Australia, including why this has become a trend amongst consumers and what services are available. Specifically this project will explore the meaning of wellbeing and why people do or do not partake in wellbeing travel.

What will I be asked to do?

You will be asked to participate in an in-depth interview that will take place for approximately 40 minutes. The themes explored in the interview will include:

- What does your organisation offer tourists looking for wellbeing travel?
- Exploring the question 'what is wellbeing travel'
- Who participates in wellbeing travel?

What will I gain from participating?

Your participation in this project will greatly contribute to this research project. It will assist in a better understanding of how to achieve wellbeing and who participates in wellbeing travel activities. Also, how the general public understands and participates in wellbeing travel and if a better definition of wellbeing travel can be developed.

How will the information I give be used?

The information you provide will be analysed and included in a PhD research thesis. This information is confidential, which means the information you give will be de-identified so that no one knows you have participated in the project.

What are the potential risks of participating in this project?

It may be upsetting to talk about not being able to participate in wellbeing travel or wellbeing travel activities. If this does occur, you are not obliged to finish the interview. Furthermore, you may like to speak to a counsellor following the interview:

Psychologist: Dr Gerard Kennedy
Phone: 9919 2481
Mobile: 0418 312 160

How will this project be conducted?

- At a time specified and convenient to the participant, the researcher and participant will meet.
- The participant will be greeted and asked to sign a consent form.
- The in-depth interview will begin, participants will offer their opinions upon the questions asked.
- The discussion should take approximately 40 minutes and will be tape recorded.
- The information given will be analysed and included in the PhD research thesis.

Who is conducting the study?

Victoria University, Centre for Tourism and Services Research in the Faculty of Business and Law.

Principal Researcher: Associate Professor Adrian Fisher
Phone: +613-9919-2335
Email: Adrian.Fisher@vu.edu.au

Student Researcher: Alison van den Eynde
Phone: 9919 4928
Email: alison.vandeneynde@live.vu.edu.au

Any queries about your participation in this project may be directed to the Principal Researcher listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Ethics and Biosafety Coordinator, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4148.

CONSENT FORM
FOR PARTICIPANTS
INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study looking into Wellbeing Travel.

The aim of this project is to explore the development of wellbeing travel in Australia, including why this has become a trend amongst consumers and what services are available. Specifically this project will explore the meaning of wellbeing and why an individual does or does not partake in wellbeing travel.

This research project involves participating in a focus group that will take place for approximately 40 minutes. The themes explored in the focus groups will include:

- Exploring the question 'what is wellbeing'.
- Exploring the question 'what is wellbeing travel'
- Who participates in wellbeing travel?

CERTIFICATION BY SUBJECT

I,

_____(name)

of

_____(suburb)

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:

Wellbeing Travel in Australia – defining wellbeing and exploring non-participation', being conducted at Victoria University by:

Associate Professor Adrian Fisher.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Alison van den Eynde, Masters (Social Research), Hon. Sociology and BA

and that I freely consent to participation involving the below mentioned procedures:

- To provide general information about myself on a question sheet (such as gender, age) ☐
- To participate in the focus group discussion. ☐

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date:

Any queries about your participation in this project may be directed to the researcher:
Associate Professor Adrian Fisher Phone: +613-9919-2335
If you have any queries or complaints about the way you have been treated, you may contact the Ethics & Biosafety Coordinator, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4148.

Appendix G: Focus Group Question sheet

Date:

Focus Group Number: *ID number:*

Facilitator:

……

…….

First Name:_____

Q1. Age _____

Q2. Gender (please circle)

Male Female

Q3. What is your marital status?

Single Married Divorced Separated

Q4. What is your employment status?

Full time employed

Part time employed

Self-employed

Housewife/husband

Unemployed

Retired

Q5. What is your occupation?

_____

Q6. What is your highest level of education?

High school_____

TAFE certificate_____

Diploma_____

Bachelor Degree_____

Post Graduate _____

Q7.Have you participated in wellbeing travel?

YES NO

Q8. What sort of wellbeing travel?

Q9. Do you participate in other wellbeing activities in your normal day to day life?

YES NO

Q10. What sort of day to day wellbeing activities? Please list.

Q11. Do you have a religious affiliation?

Q12. Please circle your approximate income bracket per year.

$0 - $25,999

$26,000 - $36,399

$36,400 - $51,999

$52,000 - $77,999

$78,000 - $103,999

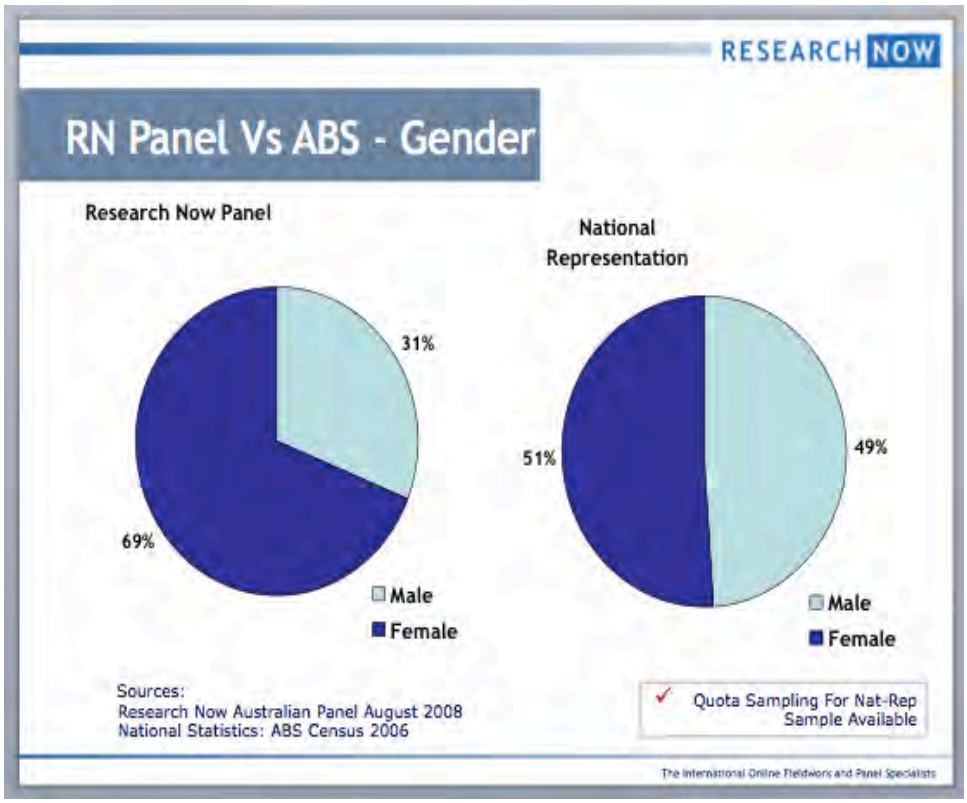
$104,000 - $129,999

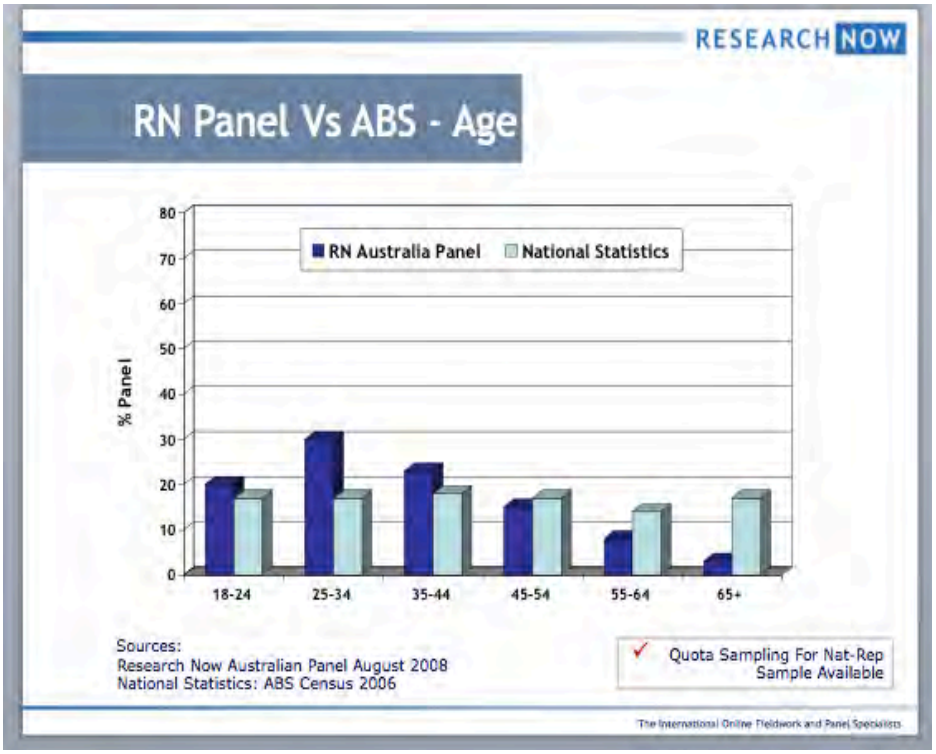
$130,000 or more…

Appendix H: Focus Group Question Sheet, Table of Results.

	Age	Gender	Marital status	Emp. Status	Occ.	Religion	Highest Ed.	Income	WBT	WB Activities
P1	29	F	Married	Maternity Leave	Interior Designer	No	Diploma	$52 – 77,999	Yes	Yes
P2	55	F	Married	Self-Employed	Business Owner	Yes	Bachelor Degree	$26 - 36,999	Yes	Yes
P3	47	F	Married	Self-Employed	Fitness Instructor	Yes	Bachelor Degree	$0- 25,999	No	Yes
P4	22	F	Single	Part time	Admin.	No	TAFE	$0-25000	No	Yes
P5	54	F	Married	Housewife	Caring for elderly parents	No	Year 12	$36- 51,999	No	Yes
P6	43	F	Married	Housewife	PA Admin	No	TAFE	NA	No	Yes
P7	56	F	Married	Full time	Remedial Massage	No	Diploma	$0- 25,000	Yes	Yes
P8	35	F	Separated	Self-Employed	Artist	No	Bachelor Degree	$26- 36,999	No	Yes
P9	32	F	Married	Full time	Health	No	Bachelor Degree	NA	No	Yes

Appendix I: The Research Now Panel - Evidence of Benchmarking an Australian Representative Sample.





Gender	Are you... - [22-03-2006]	Tier 1 Panellists
	Male	73,165
	Female	119,226
Date of Birth	**Please enter your date of birth: - [22-03-2006]**	**Tier 1 Panellists**
Title	**Title - [22-03-2006]**	**Tier 1 Panellists**
	Mr	68,042
	Ms	30,065
	Miss	33,604
	Mrs	44,762
	Dr	947
Occupation	**Please tell us your occupation status: - [22-03-2006]**	**Tier 1 Panellists**
	Employed full-time	48,764
	Employed part-time	26,429
	Self-employed	10,564
	Housewife/husband	20,498
	Retired	7,395
	Student	18,387
	Unemployed	9,640
	Semi-retired	2,080

Chief Wage Earner	Are you the chief wage earner in your household? - [22-03-2006]	Tier 1 Panellists
	Yes	62,439
	No	77,966
Guardian	**Are you the parent or guardian of any children under 18 who live in your household? - [22-03-2006]**	**Tier 1 Panellists**
	Yes	60,995
	No	88,085
Children Groups	**If you are the parent or guardian of any children in your household, please tell us whether they are in any of the following age groups: - [22-03-2006]**	**Tier 1 Panellists**
	Under 5	7,232
	5-11 years old	7,475
	12-17 years old	7,073
	Over 18	4,784
Household Responsibilities	**Are you mainly or jointly responsible for the following in your household: - [22-03-2006]**	**Tier 1 Panellists**
	The weekly grocery shopping	120,889
	Financial decisions	107,685
	Decisions relating to car purchase	91,837
	None of the above	15,092

Household Income	What is your annual household income (gross)? - [22-03-2006]	Tier 1 Panellists
	Less than $21,000	14,800
	$21,000 to $40,999	24,276
	$41,000 to $60,999	25,025
	$61,000 to $80,999	20,419
	$81,000 to $99,999	14,535
	Over $100,000	20,511
	Would rather not say	23,486
Education	**Please select the highest level of education you have attained to date: - [22-03-2006]**	**Tier 1 Panellists**
	Year 10	26,569
	Year 12	32,353
	Bachelor Degree or equivalent	24,014
	Diploma/Certificate or equivalent	33,355
	Postgraduate Degree or equivalent	12,636
	Other qualification	8,578
	Would rather not say	5,351

State	State: - [22-03-2006]	Tier 1 Panellists
	Victoria	45,217
	New South Wales	54,784
	Queensland	37,298
	South Australia	13,133
	Northern Territory	1,195
	Western Australia	15,931
	Australian Capital Territory	2,556
	Tasmania	3,935

Marital Status	Are you... - [22-03-2006]	Tier 1 Panellists
	Single	50,339
	Married/living with partner	83,417
	Divorced/widowed	11,343

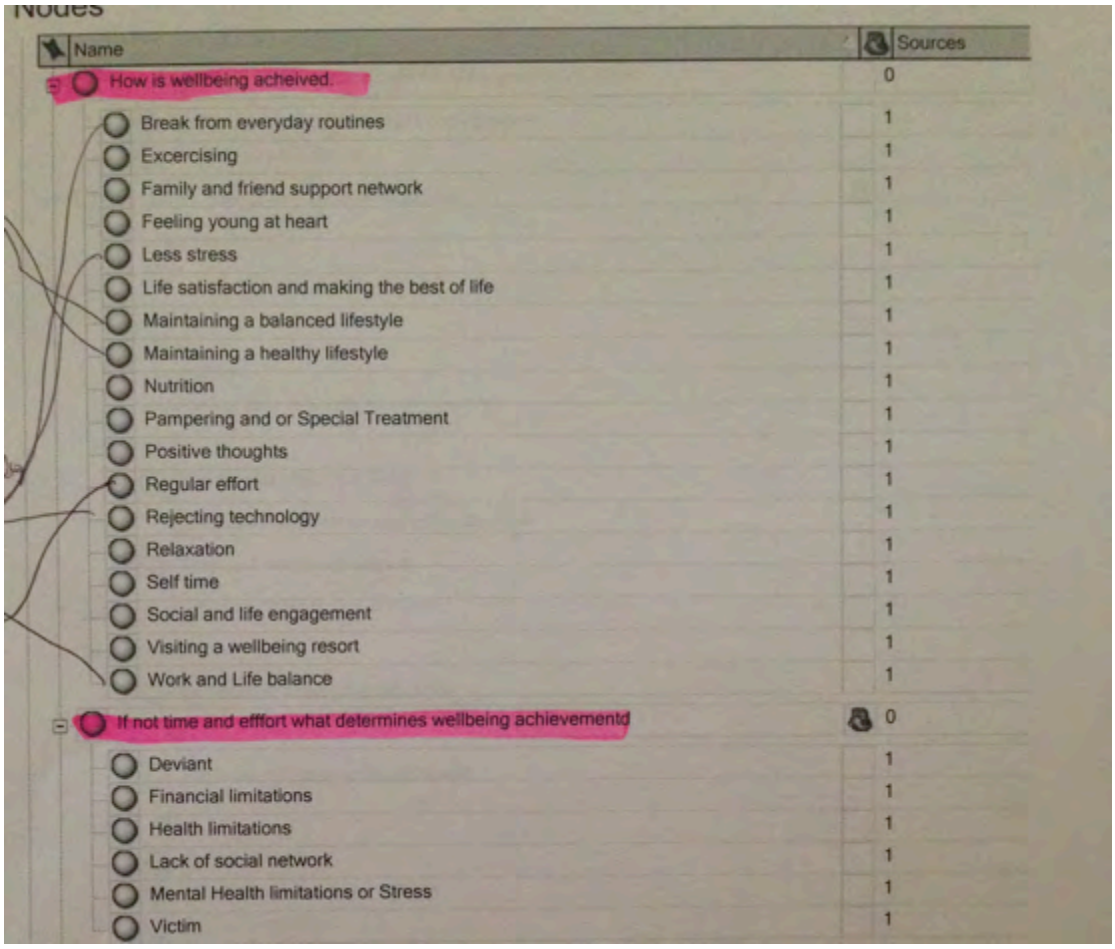
Household Members	In total, how many people live in your household, including yourself? - [22-03-2006]	Tier 1 Panellists
	1	14,147
	2	40,182
	3	31,803
	4	32,431
	5 or more	24,959

Home Status	Is your home... - [22-03-2006]	Tier 1 Panellists
	Owned	82,998
	Rented	58,501

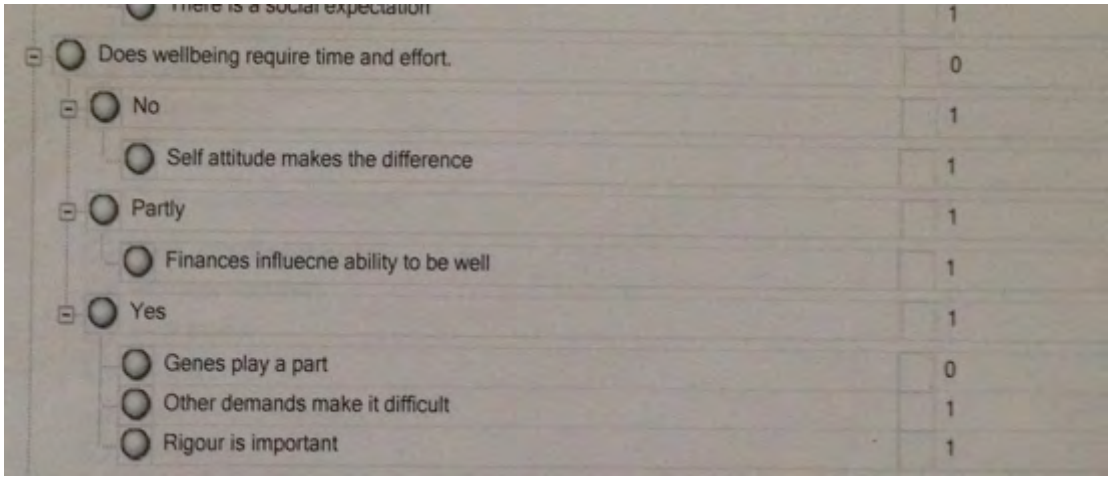
Car	Do you or your partner own or use a car? - [22-03-2006]	Tier 1 Panellists
	Yes - owned	115,702
	Yes - leased/company car	6,015
	Yes - but I/we do not own it	6,774
	No	14,821

Appendix J: Nvivo Nodes From The Survey.

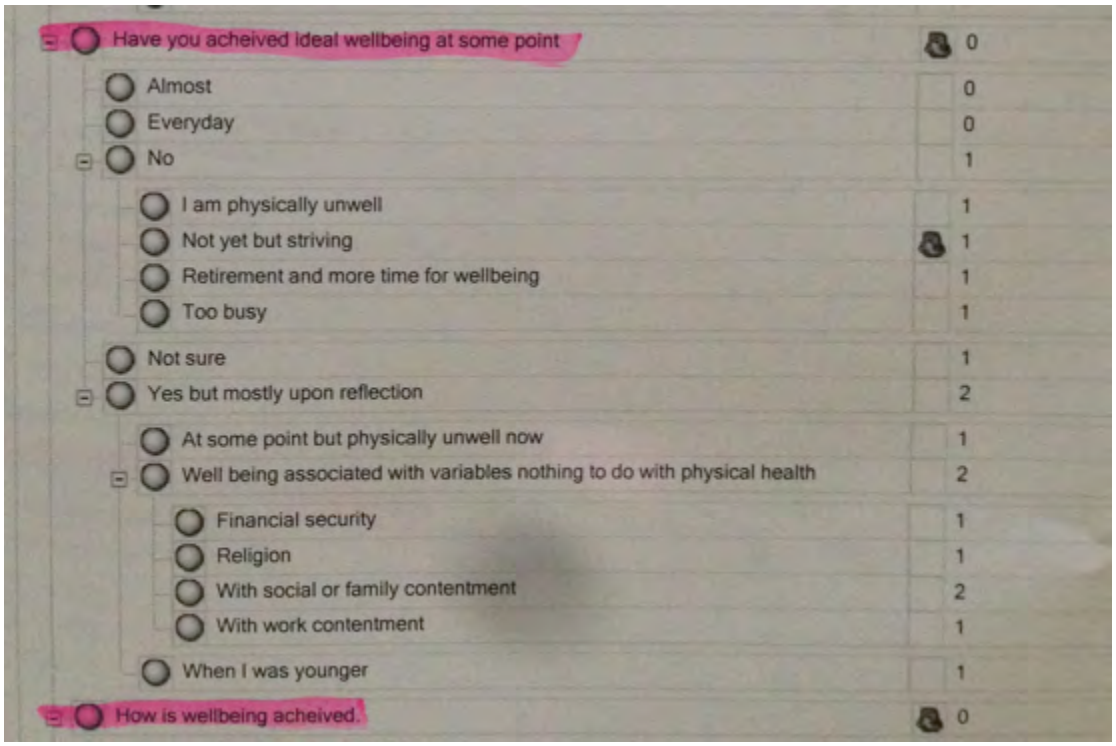
Nodes about if wellbeing has ever been achieved

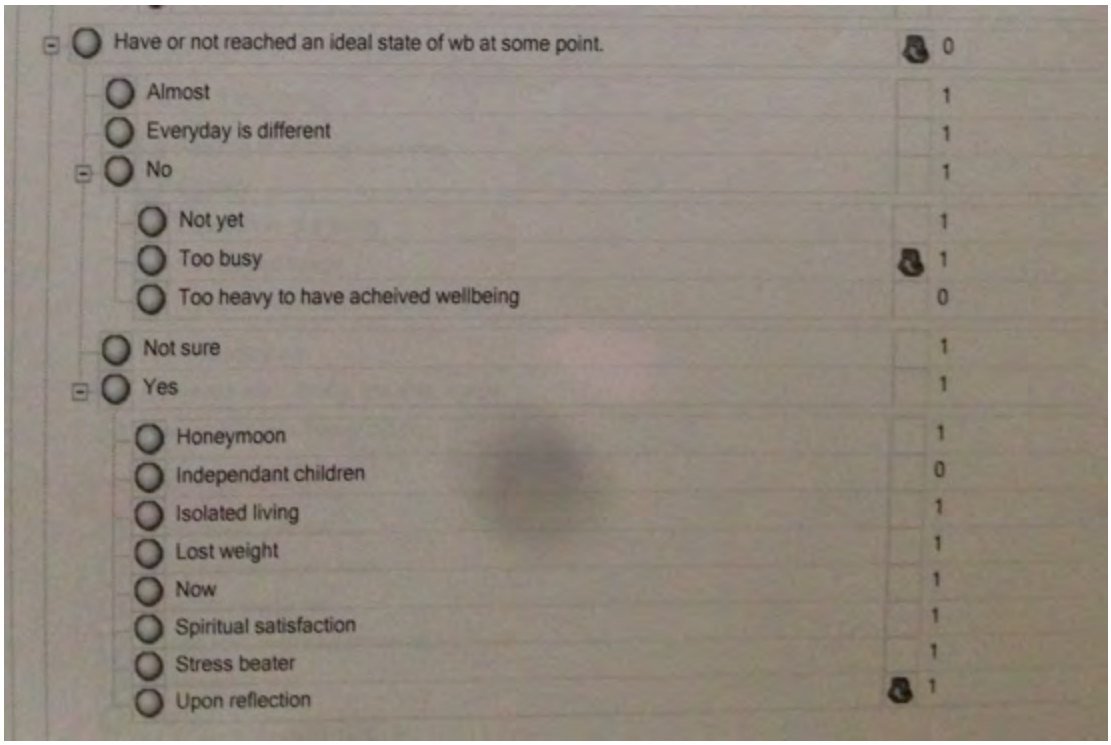


Name	Sources
How is wellbeing acheived.	0
Break from everyday routines	1
Excercising	1
Family and friend support network	1
Feeling young at heart	1
Less stress	1
Life satisfaction and making the best of life	1
Maintaining a balanced lifestyle	1
Maintaining a healthy lifestyle	1
Nutrition	1
Pampering and or Special Treatment	1
Positive thoughts	1
Regular effort	1
Rejecting technology	1
Relaxation	1
Self time	1
Social and life engagement	1
Visiting a wellbeing resort	1
Work and Life balance	1
If not time and efffort what determines wellbeing achievement	0
Deviant	1
Financial limitations	1
Health limitations	1
Lack of social network	1
Mental Health limitations or Stress	1
Victim	1

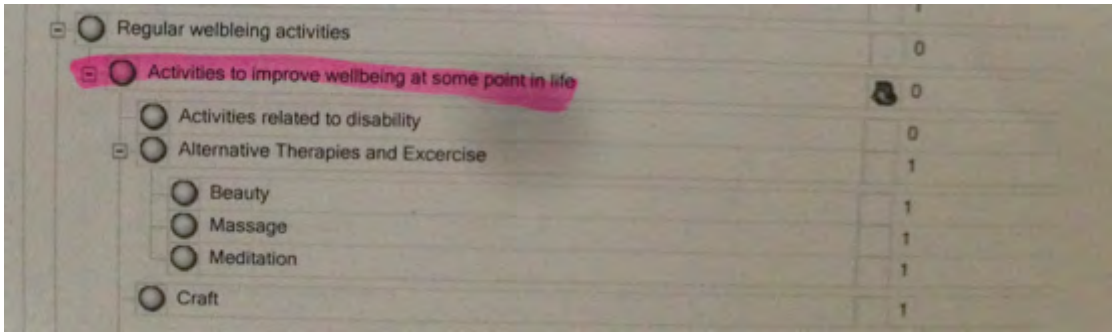


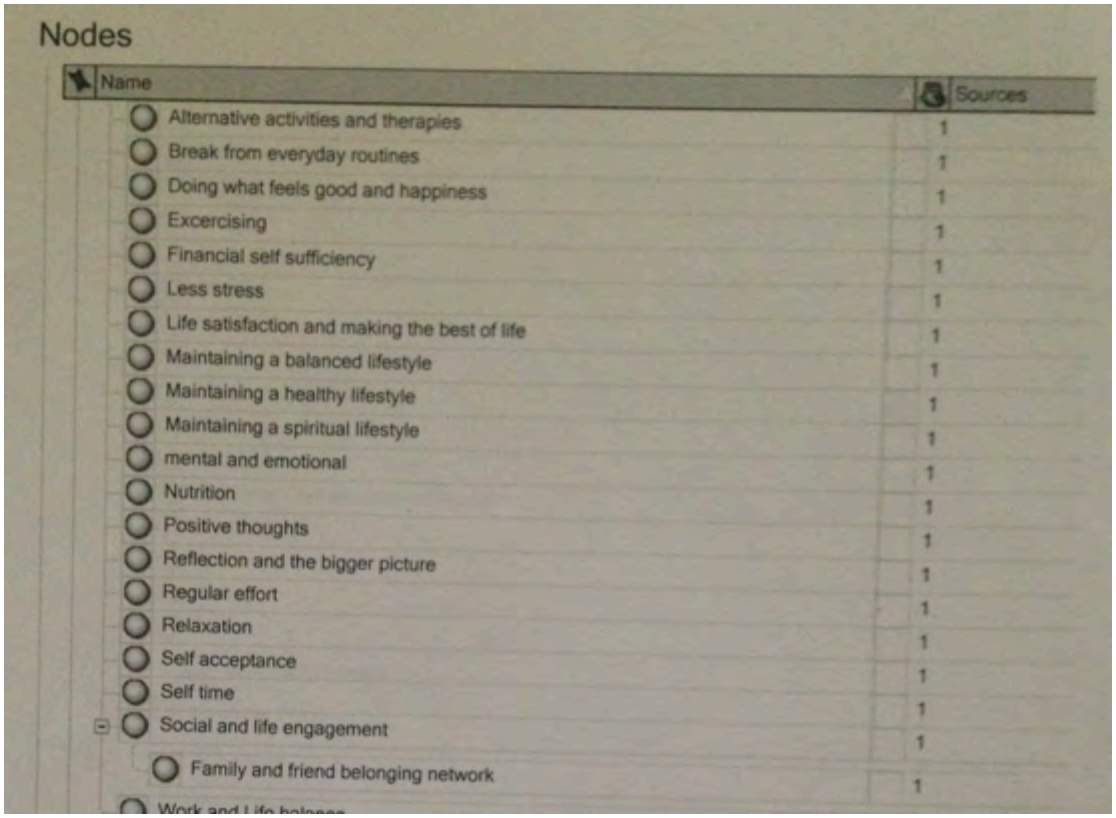
There is a social expectation	1
Does wellbeing require time and effort.	0
No	1
Self attitude makes the difference	1
Partly	1
Finances influecne ability to be well	1
Yes	1
Genes play a part	0
Other demands make it difficult	1
Rigour is important	1

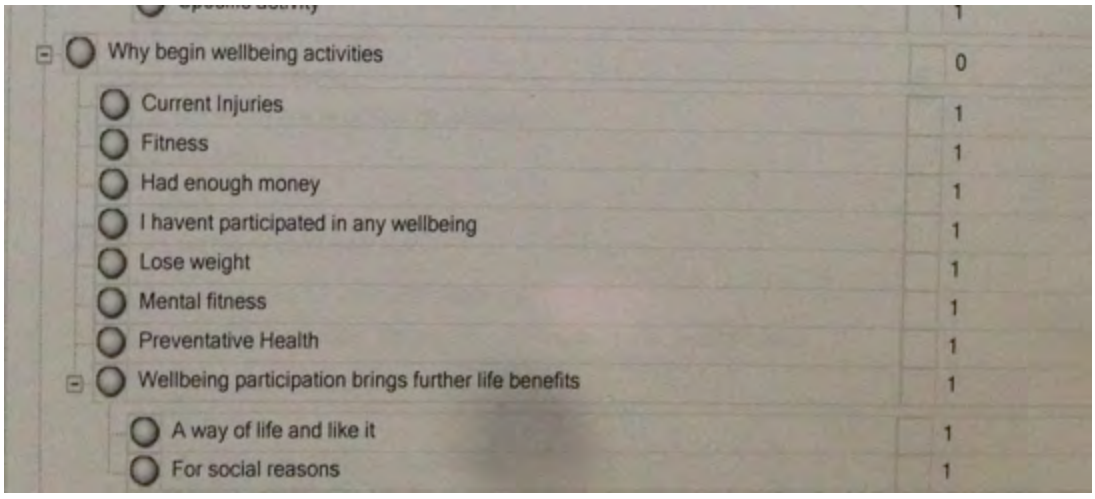

Have you acheived ideal wellbeing at some point 0
Almost 0
Everyday 0
No 1
I am physically unwell 1
Not yet but striving 1
Retirement and more time for wellbeing 1
Too busy 1
Not sure 1
Yes but mostly upon reflection 2
At some point but physically unwell now 1
Well being associated with variables nothing to do with physical health 2
Financial security 1
Religion 1
With social or family contentment 2
With work contentment 1
When I was younger 1
How is wellbeing acheived. 0


Have or not reached an ideal state of wb at some point. 0
Almost 1
Everyday is different 1
No 1
Not yet 1
Too busy 1
Too heavy to have acheived wellbeing 0
Not sure 1
Yes 1
Honeymoon 1
Independant children 0
Isolated living 1
Lost weight 1
Now 1
Spiritual satisfaction 1
Stress beater 1
Upon reflection 1

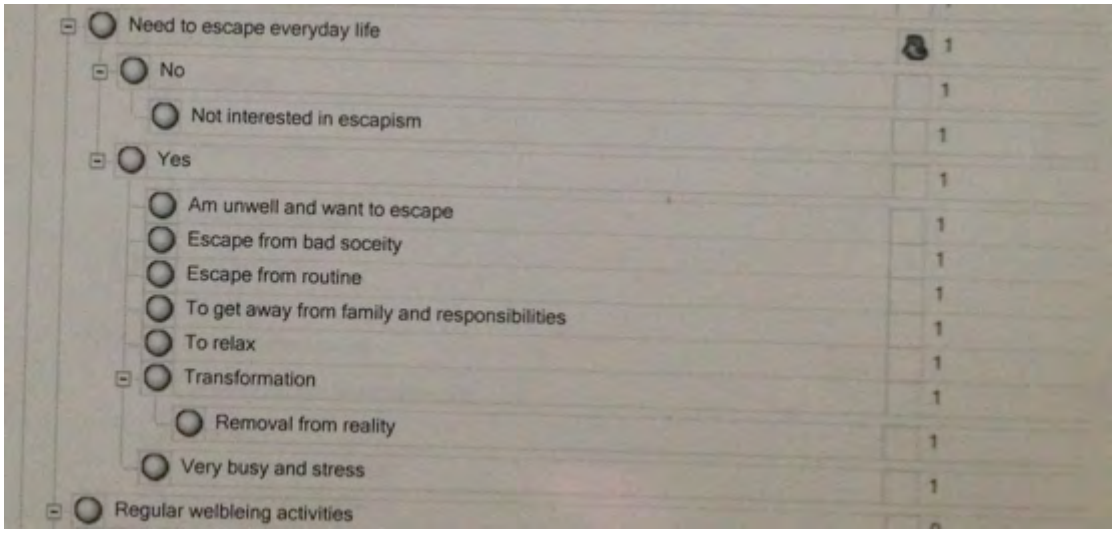
Nodes about wellbeing activities at some point in life

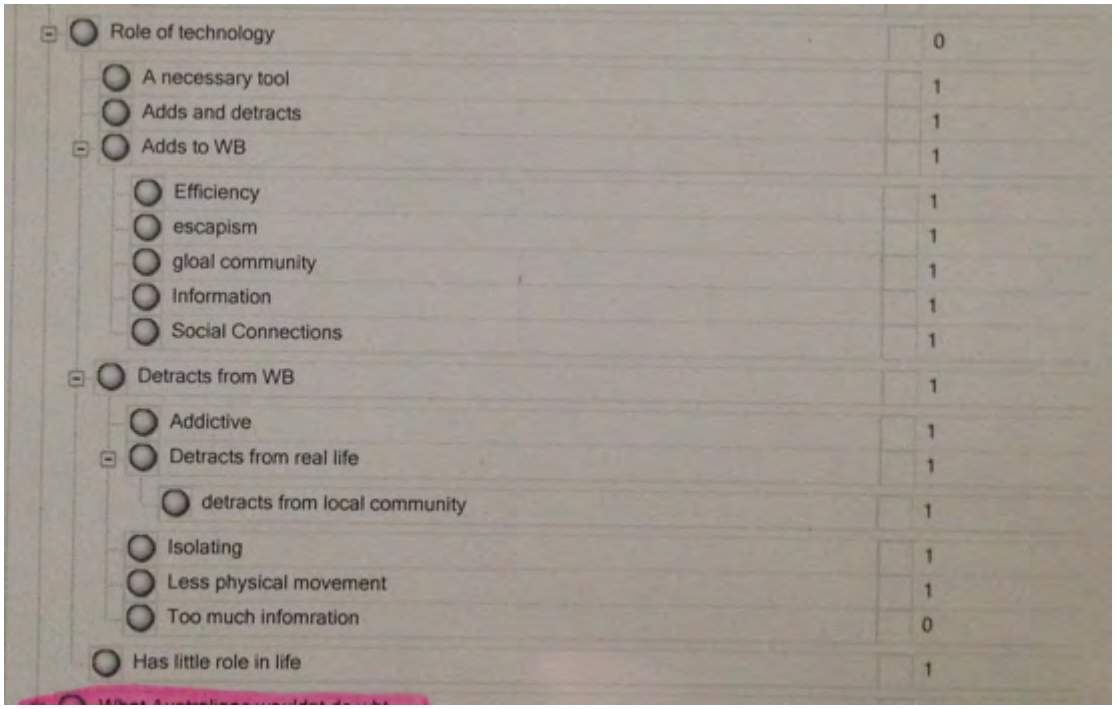


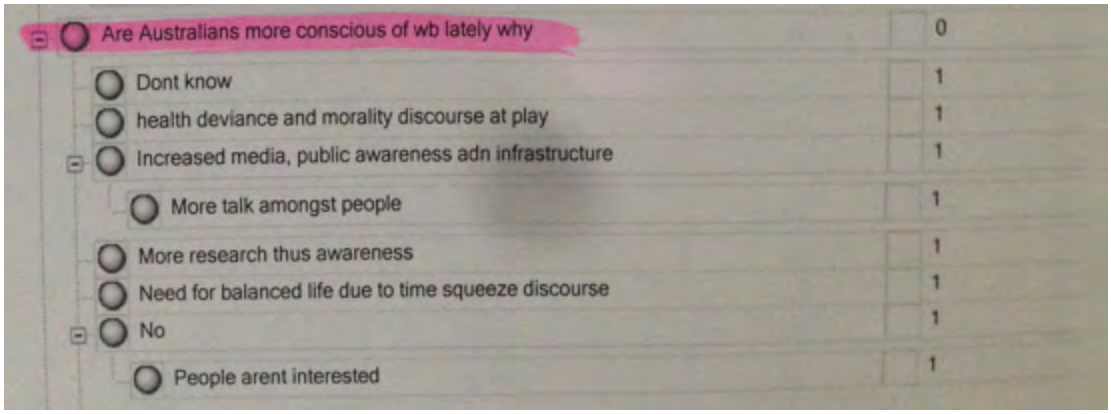


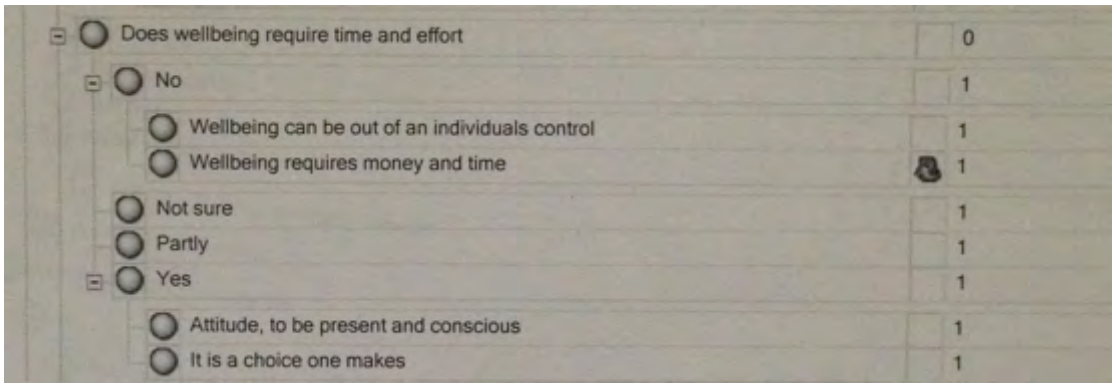


Nodes about the calamitous society/evidence of wellbeing discourse

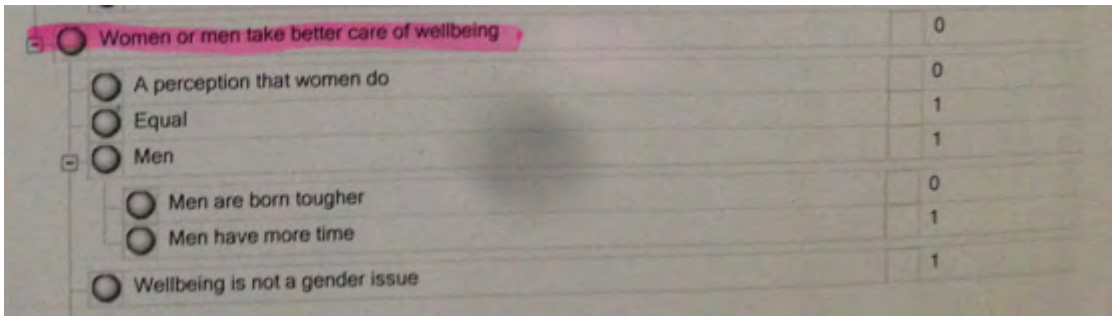


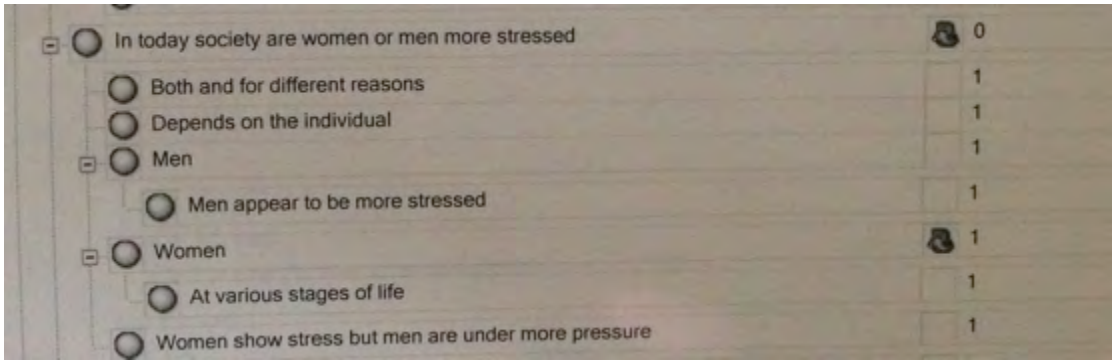


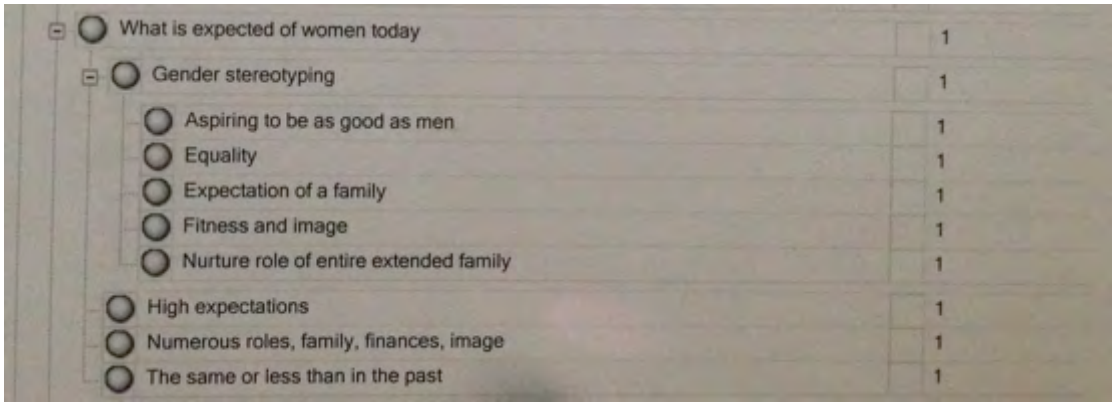


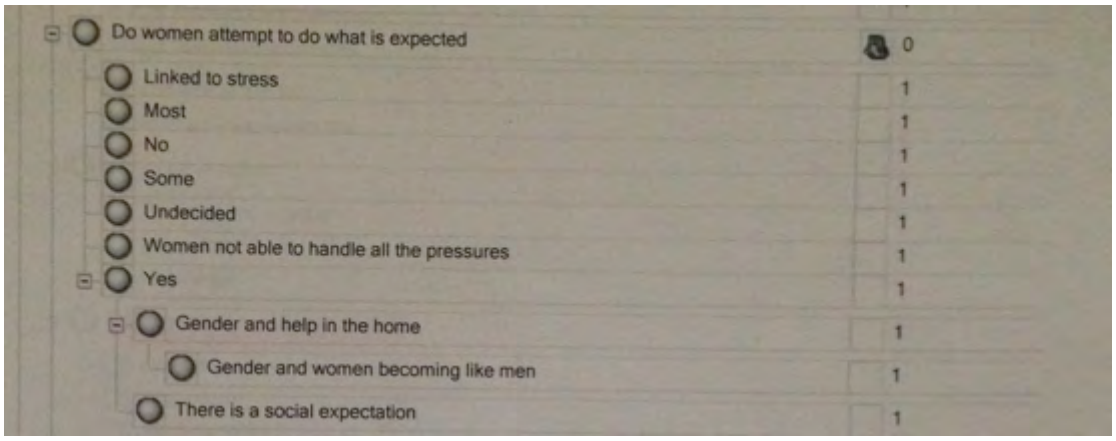


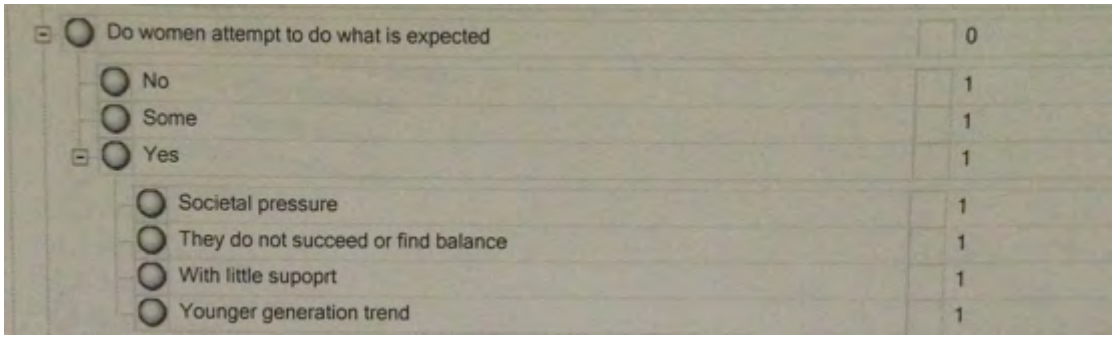
Nodes about gender and wellbeing



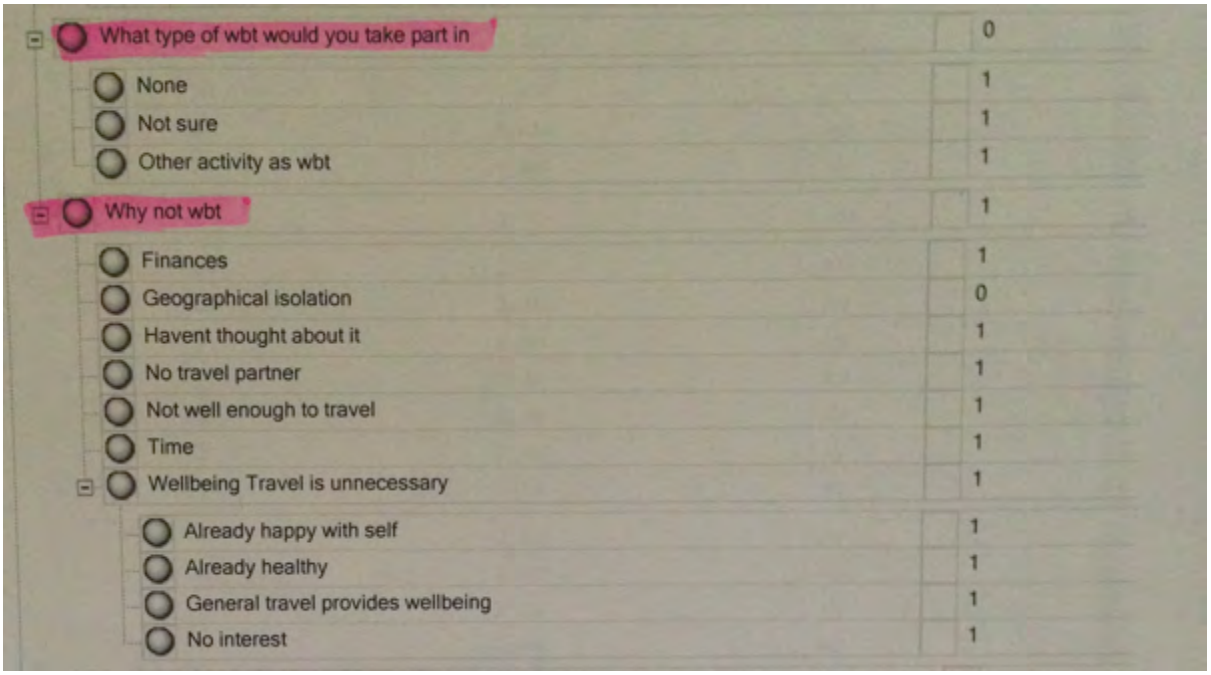


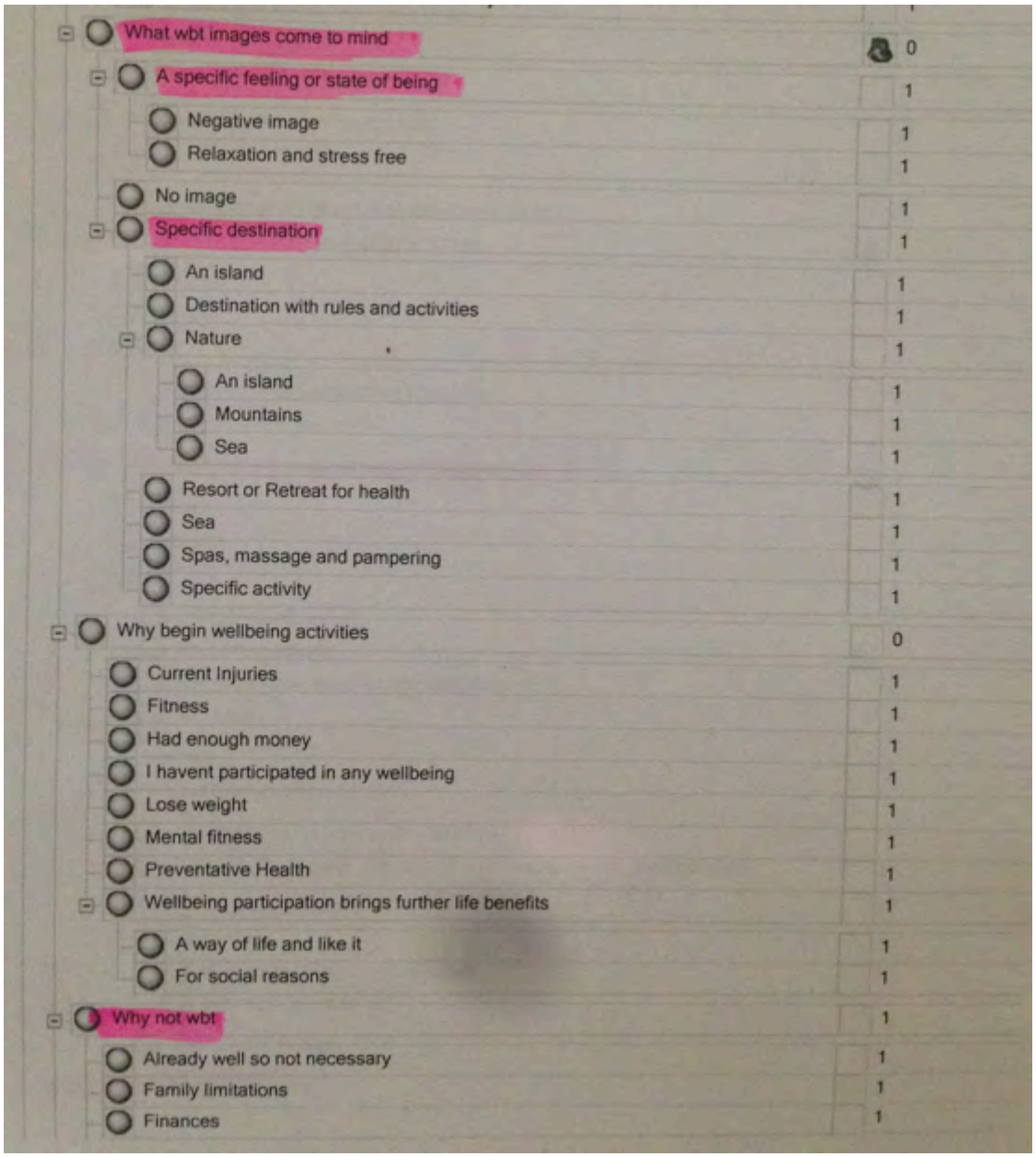






Nodes about and defining wellbeing travel




What wbt images come to mind 0
A specific feeling or state of being 1
Negative image 1
Relaxation and stress free 1
No image 1
Specific destination 1
An island 1
Destination with rules and activities 1
Nature 1
An island 1
Mountains 1
Sea 1
Resort or Retreat for health 1
Sea 1
Spas, massage and pampering 1
Specific activity 1
Why begin wellbeing activities 0
Current Injuries 1
Fitness 1
Had enough money 1
I havent participated in any wellbeing 1
Lose weight 1
Mental fitness 1
Preventative Health 1
Wellbeing participation brings further life benefits 1
A way of life and like it 1
For social reasons 1
Why not wbt 1
Already well so not necessary 1
Family limitations 1
Finances 1

Appendix K: Exclusion from Wellbeing Travel

Addressing Research Gaps and the Theoretical Contributions of Research.

Theory	Confirm	Contribution
Power and Tourism, Cheong and Miller, (2000).	Brokers do not have a neutral in determining tourist experiences and preferences.	In Australian wellbeing travel , the Tier 2 brokers (service providers) have the power to construct wellbeing travel as opposed to Tier 1 brokers (Tourism Organisations)
Non-Travel, Haukeland, 1990; Crawford and Godbey, 1987, 1991.	Wellbeing Non-travel is the result of structural and interpersonal constraints.	Wellbeing Non-Travel also occurs because of: - Self Exclusion, the Moral Underclass Discourse (MUD) - Exclusion from Wellbeing Discourse
Gendered Tourism, Pritchard, 2001.	Wellbeing Travel includes 'Gendered Tourism', i.e. is targeted towards women. Men consequently self exclude from wellbeing travel.	Results showed men prefer heterogeneous establishments; females prefer the single purpose establishment.
Wellbeing Travel is a Social Construction		Wellbeing Travel is driven by a Discourse of Wellbeing. Wellbeing Travel is constrained by a Discourse of Wellbeing
Travel is a Stage constructed for tourist Performances, Edensor, 2004.	Wellbeing Travel is a Stage constructed for tourist Performances.	Performances include: - the 'wellness seeker'. - busyness and the 'middle class badge of honour'

Appendix L: Figure of Dominant Discourse Models