

It is Domestic, it Must Be Healthy: How Health Consciousness and Consumer Ethnocentrism Shape Healthiness Perception and Purchase Intentions of Domestic Food

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Abstract. *Consumer ethnocentrism (CET), healthiness perception and health consciousness have been extensively researched in regard to consumer food choices. Literature on domestic food choices provides evidence that CET positively affects consumer preferences toward domestic food. However, the effect of health consciousness on domestic food choices has not yet received attention. Our online study (N=227, convenience sample from Lithuanian population) closes this gap by showing that health consciousness is an important individual trait in domestic food choices beyond consumer ethnocentrism and represents the first study to analyze CET in light of food healthiness perception. All constructs were measured using established self-report scales. Empirical results obtained through structural equation modelling show that (1) health consciousness increases healthiness perception and willingness to buy domestic food. Moreover, (2) health consciousness is an important individual trait in domestic food choices beyond CET; (3) healthiness perception of domestic food has an impact on consumer purchase decisions; (4) CET has a positive impact on domestic food healthiness perception. The study provides managerial implications for domestic and foreign producers.*

Keywords: *consumer ethnocentrism, domestic food choice, health consciousness, healthiness perception*

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1. Introduction

Consumer food choices are influenced by a diverse spectrum of factors (e.g., Symmank et al., 2017; Sobal et al., 2006) such as product quality (Mai & Hoffmann, 2017), taste (Mai & Hoffmann, 2012), price (Murphy et al., 2004), mood and emotions (Gibson, 2006), image of the store (Ryu et al., 2012), presence of other consumers (Mcferran et al., 2009). According to Steptoe et al. (1995), sensory appeal, convenience, price and perceived product healthiness are the most significant elements when making food choices. Being among the most important factors, perceived healthiness has been extensively analyzed, and scholars seem to agree on the importance of health motives in food-related decision making. A number of studies have also noted the rise of consumer concerns about healthy eating (Lee et al., 2014; Prasad et al., 2008; Leeflang & Van Raaij, 1995). Likewise, the food industry is showing signs of increased interest in becoming healthier, as healthy food categories are growing faster than indulgent categories (Nielsen, 2015).

However, healthy eating does not mean the same for different people, and health importance for consumers depends on individual differences (Ronteltap et al., 2012). One example of those individual differences is health consciousness. Health consciousness affects consumers' food choice such that health-conscious consumers assign higher importance to health-related food attributes such as fat and sugar content, while individuals low in health consciousness choose food based on non-health related attributes, like taste and price (Mai & Hoffmann, 2012).

Another factor which plays a role in consumer product choice is consumer ethnocentrism (CET), a belief about the morality of purchasing foreign products (Shimp & Sharma, 1987). Scholars agree that consumers often prefer domestic rather than foreign food products (Bilkey & Nes, 1982; Balabanis & Diamantopoulos, 2004, Gineikiene et al., 2016), and previous research showed that consumer ethnocentrism is the cause of domestic food preferences (e.g., Balabanis & Diamantopoulos, 2004). An alternative explanation was provided by Gineikiene et al. (2016), who suggested that social categorization theory may explain consumers' preferences for domestic food. Moreover, domestic and foreign food products evoke different healthiness perceptions, more precisely, people evaluate domestic products (apples, tomatoes, bread and yogurt) to be healthier than non-domestic ones and are also more willing to buy them (Gineikiene et al., 2016). However, previous studies have not investigated how health consciousness affects healthiness perception and willingness to buy domestic food. Moreover, consumer ethnocentrism has not yet been studied in the context of food healthiness perception.

This paper aims to contribute to existing knowledge in four ways. First, even though previous studies have extensively analyzed health consciousness effects in consumer food choices, it was not applied to the domain of domestic food choices. Our aim is to address this gap in scientific literature by clarifying the effect of health conscious-

ness on domestic food choices. Second, we extend existing findings by Gineikiene et al. (2016) by showing that health consciousness is an important individual trait in domestic food choices beyond consumer ethnocentrism. Third, this is the first study that analyzes CET in light of food healthiness perception. Finally, our findings may provide valuable insights for marketing practitioners by indicating not only the tendencies of consumer behavior but also showing how intrinsic individual traits have an effect on food evaluations and how these observations can enable practitioners to provide better value propositions for different consumers.

The following sections will cover the theoretical background linking health consciousness, domestic product preference, consumer ethnocentrism concepts and will lead to the proposed hypotheses.

2. Health consciousness and domestic food choice

The concept of health consciousness, defined as the extent to which individuals are concerned with their health (Gould, 1988) and integrate this concern into their daily activities (Jayanti & Burns, 1998), is a motivational construct that drives health behavior (Mai & Hoffmann, 2012). Health-conscious consumers tend to monitor their health condition and are also willing to take the required actions to improve it (Gould, 1988); they are more likely to better their health by eating nutritious food and exercising regularly than non-health-conscious individuals (Kraft & Goodell, 1993).

Health consciousness has been extensively analyzed in the framework of consumer behavior (e.g., Ronteltap et al., 2012; Mai & Hoffmann, 2012, 2015), and previous studies revealed various health consciousness effects on consumer food choices, showing that differences between low and high health-conscious individuals exist on several dimensions (Buhrau & Ozturk, 2018). For example, individuals with low health consciousness are less motivated to engage in healthy behaviors (Michaelidou & Hassan, 2008). One way to motivate them into healthier decisions is to stress the hedonic appeal of healthy options (Buhrau & Ozturk, 2018). Yet another way is to make quality consciousness and physical appearance consciousness salient (Mai & Hoffmann, 2017).

On the contrary, health-conscious people base their food choice on health reasons and benefit from nutritional information provided on food products (Ghvanidze et al., 2017). Moreover, they avoid eating unhealthily (Glanz et al., 1998) and believe in the efficacy of their actions potential to benefit their health (Jayanti & Burns, 1998). Health consciousness has also an impact on willingness to buy food with health benefits (Bower et al., 2003), and households that are more health conscious are less price sensitive towards those products (Prasad et al., 2008). When making decisions about their meals, consumers with lower health consciousness and lower self-efficacy tend to limit their attention to a single food attribute, i.e., taste (Mai & Hoffmann, 2012). Moreover, there is a prevailing belief that unhealthy food is tastier (Ragunathan et al., 2006). A recent study by Mai & Hoffmann (2015) shows that health consciousness operates as a

mitigation of healthiness and tastiness. Increasing consumers' health consciousness can reduce the notion that unhealthy food is tastier (Mai & Hoffmann, 2015).

Based on evidence that individuals prefer domestic products (Bilkey & Nes, 1982), for example, British consumers choose domestic food rather than foreign (Balabanis & Diamantopoulos, 2004), we propose that health consciousness could be related to domestic food healthiness perceptions. Domestic and foreign food products also evoke different healthiness perceptions (Gineikiene et al., 2016). Gineikiene et al. (2016) proposed social categorization theory (Turner et al., 1987) as a tool to explain this healthiness bias, when domestic products are perceived to be healthier than foreign ones, suggesting that domestic products are perceived as belonging to the in-group and categorized with the self, whereas foreign products are seen as belonging to the out-group. Therefore, people tend to identify more with domestic rather than foreign products (Gineikiene et al., 2016).

Drawing on the knowledge that health consciousness can have an effect on food attitudes and purchase intentions (Michaelidou & Hassan, 2008) and that domestic food is perceived as healthier than foreign products, so that, as a consequence, people are more willing to buy domestic options (Gineikiene et al., 2016), we are interested in how health consciousness can affect the perceptions of domestic food. As a result, we hypothesize that:

H1: *Consumer health consciousness will be positively related to domestic food healthiness perception.*

H2: *Consumer health consciousness will be positively related to willingness to buy domestic food.*

3. Consumer ethnocentrism and domestic food choice

The concept of consumer ethnocentrism (CET) was inspired and derived from the 20th century notion of ethnocentrism (see Sumner, 1906; Shimp & Sharma, 1987) that refers to individuals exhibiting a group-centered worldview as a "frame of reference" and incites them to judge others accordingly, which usually means "judging them inferior" (Booth, 2014, p.13). CET is commonly defined as "the beliefs held by [American] consumers about the appropriateness, indeed morality, of purchasing foreign-made products" (Shimp & Sharma, 1987, p. 280). CET represents a general inclination to prefer domestic products (Klein et al., 1998, Fernández-Ferrín & Bande-Vilela, 2013) that affects choices between domestic and foreign products (Klein, 2002) and thus serves as a behavioral regulation mechanism. CET is consequently distinct from other concepts reflecting consumer expressions of national identity (Carvalho et al., 2019), such as patriotism (Balabanis, Diamantopoulos, Mueller & Melewar, 2001), animosity (Klein, Ettenson & Morris, 1998) or nationalism (Ariely, 2012). Carvalho et al. (2019, p. 312) summarize the essence of (consumer) ethnocentrism as "a feeling of superiority to other nations and protective behavior towards one's own nation", acting as a de-

fensive mechanism (Siamagka & Balabnis, 2015). Ethnocentric consumers may hence be motivated to judge domestic products as superior or suppose purchasing foreign products may hurt their nation's economy (Zeugner-Roth et al., 2015). As a result, ethnocentric consumers do not only prefer to buy domestic brands (He & Wang, 2015), domestically manufactured cars (Shimp & Sharma, 1987; Klein, 2002; Verlegh, 2007), electronic products (Watson & Wright, 2000; Kim & Pysarchik, 2000) or dietary supplements (Šmažienė & Vaitkienė, 2014) but also food of domestic origin (Bilkey & Nes, 1982; Balabnis & Diamantopoulos, 2004; Schnettler et al., 2011; Fernández-Ferrín & Bande-Vilela, 2013; Gineikiene et al., 2016; Fernández-Ferrín et al., 2018).

This general preference of domestic over foreign products is not only limited to be a question of the right choice, or appropriateness of choice, but is also reflected in consumer perceptions of product attributes in the form of perceived product quality. Perceived quality in the sense of a "global assessment" of a product's "excellence or superiority" (Zeithaml, 1988, p. 3) was shown to be a relevant criterion for consumer choice (e.g. Zeithaml, 1988; Dodds et al., 1991; Grewal et al., 1998; Vigneron & Johnson, 1999). Similarly, ethnocentric consumers tend to evaluate the quality of domestic products as superior to foreign ones (Chrysochoidis et al., 2007; Šmažienė & Vaitkienė, 2014). However, as ethnocentric consumers are positively biased towards product quality of domestic products, it might also apply in respect of perceptions of product healthiness.

An explanation for this supposition can be found when we look back at the previously stated moral dimension of CET. CET provides a code of conduct in respect of the "appropriateness [, indeed morality,] of purchasing foreign-made products" (Shimp & Sharma, 1987, p. 280), and as such, morality represents a constituting element of CET that affects consumer opinions about the purchase of non-domestic products. A recent study by Prince et al. (2019) examined the aspect of morality in CET and identified three moral dimensions as important predictors. Employing moral foundation theory (Haidt, 2001) their research concluded that out of five moral dimensions (care/harm, fairness vs. cheating, loyalty vs. betrayal, authority vs. subversion, sanctity vs. degradation), authority, loyalty and sanctity were the driving moral forces in CET. CET thus leads to morally restraint purchase behavior, where moralized opinions and moral standards provoke moral issues when considering the purchase of non-domestic products (Shimp & Sharma, 1987; Sharma et al., 1995; Seitz & Roosen, 2015). Since it creates intrapersonal moral issues and conflicts, keeping up with one's moral standards (loyalty or sanctity) requires self-control (see, self-control as a "moral muscle" (Baumeister & Exline, 1999)). Self-control was shown to instigate positive spillover effects from the domain in which it is exerted into other domains in which it was initially not; for instance, increasing attentional or emotional control can reduce the consumption of unhealthy food (Tuk et al., 2015). CET as a moral dimension should hence not only render consumers to perceive domestic food as being of greater quality (as outlined above) but also, by means of the same moral-based heuristic, incite them to perceive domestic food as healthier. Consequently, ethnocentric consumers may not

only regard domestic products as of greater quality but also judge them to be healthier. Perceived healthiness can thus be considered another dimension of perceived quality.

Our argument is further supported by findings in social categorization theory, which delineates how through in-group/out-group categorization (“we” and “they”) general preferences are being formed and differences stressed (Turner et al., 1987; Dovidio et al., 2007). These preferences and the distinction between in-group and out-group may function as a disease avoidance mechanism that makes individuals shun unfamiliar foods which belong to an out-group, as those food products may host unfamiliar pathogens and hence could pose a potential threat to one’s health (Johnson et al., 2011; Schaller, 2011; Schaller & Neuberg, 2012; Terrizzi et al., 2013). In consequence, people naturally tend to view domestic products as healthier than foreign alternatives and should thus be more inclined to buy domestic food.

As outlined before, CET represents a general inclination of consumers to prefer domestic products (Klein et al., 1998; Fernández-Ferrín & Bande-Vilela, 2013) that also affects the judgement of perceived product quality (Chryssochoidis et al., 2007; Šmaižienė & Vaitkienė, 2014). The component of morality in CET could incite people not only to judge domestic products’ general quality as superior, but also evaluate their healthiness, as a result of moral diligence and self-control spillover (Baumeister & Exline, 1999; Tuk, Zhang & Sweldens, 2015). Since perceived healthiness was also identified to be a predictor of food choice (Steptoe et al., 1995; Gineikiene et. al., 2016), we expect a positive impact of CET on perceived product healthiness of domestic food and consequently an increased willingness to buy it. Our suggestion finds further corroboration in social categorization theory. We thus hypothesize:

H3: *Consumer ethnocentrism will be positively related to domestic food healthiness perception.*

H4: *Consumer ethnocentrism will be positively related to willingness to buy domestic food.*

H5: *Healthiness perception will be positively related to willingness to buy domestic food.*

Figure 1 presents the conceptual framework of our research.

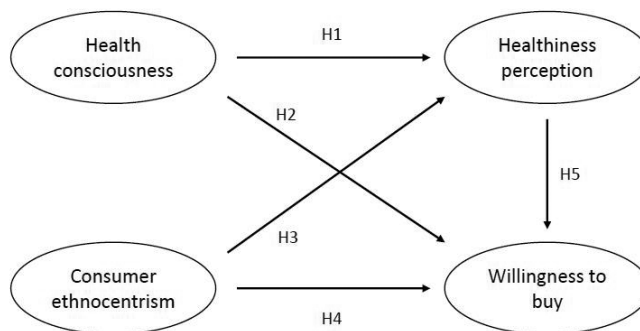


FIGURE 1. **Conceptual Model**

4. Measures and data collection

To measure the constructs of this study, we conducted quantitative research administering established self-report scales online. The empirical study was carried out in Lithuania due to reasons of convenience and accessibility to respondents. Validated scales from previous research have been used for the empirical study (see Appendix 1). *Health consciousness* was measured with a 4-item scale asking respondents to evaluate statements relating to health on a 7-point Likert scale (example item: *I reflect on my health a lot*) that was adapted from Gould (1988) and that has been previously applied in a research by Mai and Hoffmann (2012). *Purchase intention* (adapted from Aaker & Keller 1990; Taylor & Bearden 2002; Gineikiene et al., 2016) was measured with a 3-item scale (example item: *I am going to purchase food products made in Lithuania*). *Healthiness* was measured on a 5-item scale adopted from Homer (2006) and developed by Gineikiene et al. (2016) (for item examples please see Appendix 1). *Consumer Ethnocentrism* was measured on a 5-item scale (example item: *It is not right to purchase foreign products*) (Klein et al., 1998, Shimp & Sharma, 1987). Data for this study were collected online during the period of 3-21 April 2017, using convenience sampling. The age of our target population was 16-64 years. This decision was based on information retrieved from the Official Statistics Portal in Lithuania, which states that people between the age of 16 and 64 are most actively using the internet. That renders them the most relevant age group and target population for this online study. The total sample of our study comprised 234 respondents, however, seven respondents did not pass the attention check procedure. Excluded respondents failed to correctly answer one or both of the two attention check questions that had been randomly added to our construct measures: “My native language is Czechoslovak” and “I was born on the 30th of February”. They served as careless response indicators which allowed us to identify responses that could potentially distort our survey data. Therefore, 227 responses were eventually considered for the analysis of the results. The majority of our respondents (65.6 %) were females, and the average participant age was 31 years. The income of 56.8% of respondents was more than 701€ per family member, which is well above the Lithuanian average (the average disposable income per month for one household member in 2016 was 403.1 €¹). Moreover, most participants (84.2 %) had a higher education degree.

5. Measurement and structural model

To test dimensionality, reliability and validity of the construct measures, we applied confirmatory factor analysis (CFA; Anderson & Gerbing, 1988). Composite reliabilities ranged from 0.820 to 0.918, while values of average variance extracted (AVE) ranged from 0.536 to 0.706. All AVE values exceeded the squared correlation between

¹ Lietuvos statistikos departamentas <https://osp.stat.gov.lt/statistiniu-rodikliu-analize?theme=all#/>

each construct with all other constructs (Fornell & Larcker, 1981). Convergent Discriminant validity assessment and inter-construct correlations are provided in Table 1, while factor loadings and reliabilities are to be found in Appendix 1, showing that both convergent and discriminant validity have been achieved for the measured constructs.

TABLE 1. Discriminant validity assessment and inter-construct correlations

		Mean	SD	1	2	3	4
1	Consumer ethnocentrism	2.03	1.29	0.620	0.152	0.035	0.091
2	Health consciousness	5.27	1.03	0.39	0.536	0.025	0.051
3	Healthiness perception	4.59	1.12	0.186*	0.157*	0.694	0.326
4	Willingness to buy	5.13	1.31	0.301**	0.226**	0.571*	0.706

Note: Correlations are shown below the diagonal, AVEs on the main diagonal (bold text), and squared multiple correlations above the diagonal. SD = standard deviation; * $p < .05$; ** $p < .01$.

In order to test the hypotheses, the structural equation model was estimated with LISREL 9.1, which produced an acceptable fit ($X^2 = 312.12$, $df = 129$, $RMSEA = 0.079$, $CFI = 0.948$, $GFI = 0.867$) (see Figure 2). Health consciousness has a positive effect on domestic food healthiness perception ($\beta = 0.15$, $t = 2.04$, $p < 0.01$) and a positive impact on willingness to buy domestic food ($\beta = 0.17$, $t = 2.65$, $p < 0.01$). Hence, $H1$ and $H2$ are confirmed. Also, CET has a positive effect on domestic food healthiness perception ($\beta = 0.20$, $t = 2.80$, $p < 0.01$) and willingness to buy domestic food ($\beta = 0.18$, $t = 2.86$, $p < 0.01$). Therefore, $H3$ and $H4$ are confirmed. Moreover, healthiness perception positively affects willingness to buy domestic food ($\beta = 0.53$, $t = 7.83$, $p < 0.01$), confirming $H5$. These results demonstrate that in the domain of domestic food healthiness perception and purchase decisions, CET is not the only important individual trait. Health consciousness is also related to domestic food healthiness perception and leads to willingness to buy domestic food.

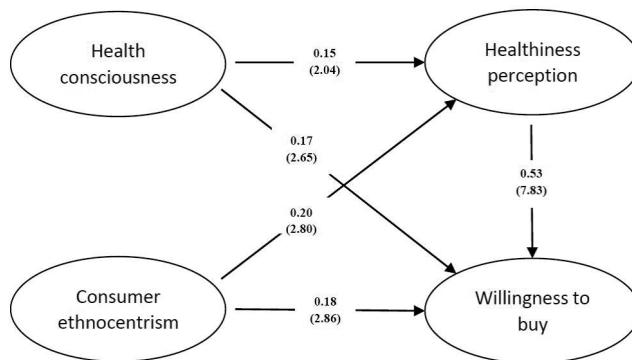


FIGURE 2. Structural model with model estimates

Note: standardized estimates are shown as t-values in brackets, all p -values < 0.01 .

6. Discussion

The findings of our study show that health consciousness and CET both have a positive impact on consumer willingness to buy domestic food. Besides, the two variables also positively affect healthiness perception of domestic food, which in turn increases consumer willingness to buy those products. Our findings are in line with previous studies on the relationship between CET and consumer willingness to buy domestic food (Kavak & Gumusluoglu, 2007; Bilkey & Nes, 1982; Balabanis & Diamantopoulos, 2004; Schnettler et al., 2011; Fernández-Ferrín & Bande-Vilela, 2013; Fernández-Ferrín et al., 2018) and on the relationship between healthiness perception and willingness to buy domestic food (Gineikiene et al., 2016). Likewise, we corroborate past research results about the relationship between health-conscious consumers and intentions to purchase domestic food (Kavak & Gumusluoglu, 2007). We also provide new insights about the relationship between health consciousness and healthiness perception and show that CET influences healthiness perception in the context of domestic food choices.

The significance of our work for the academic discourse lies to a large extent in three theoretical contributions. First, even though previous studies have extensively analyzed health consciousness effects in consumer food choices, those effects had not been sufficiently studied in the domain of domestic food. We are providing first insights into this specific food domain by uncovering the effect of health consciousness on healthiness perception and willingness to buy domestic food. Second, we show that the effect of the intrinsic individual trait of health-consciousness is not only relevant for food product choice in general, but also specifically in respect of *domestic* food choice. We therewith extend findings of Gineikiene et al. (2016) by illustrating that health consciousness is an important individual trait in domestic food choice beyond CET. Finally, CET has not been investigated in the context of healthiness perception. With this study we show that CET has also a positive impact on domestic food healthiness perception.

7. Managerial implications

In terms of managerial implications and applications, our findings may be valuable for domestic and foreign producers alike. Intrinsic individual traits are relevant for food evaluations both in respect to healthiness perception and consumer willingness to buy domestic food. Insight into how these traits affect consumer decisions may also help to change consumer behavior in favor of commercial interests and enable practitioners to provide better value propositions for different consumers.

Our results indicate that domestic producers can generally rely on a competitive advantage over their international competitors. As their products have been manufactured in the (domestic) market, they can benefit from the effect of CET on willingness to buy domestic food. For domestic producers it is most important to communicate that their products are domestic and to actively highlight this aspect to their customers.

They should also tailor their value propositions to health-conscious consumers as they are 'naturally' inclined to choose domestic over foreign produce. Consumers who are ethnocentric are especially prone to perceive domestic products as healthier. Hence, domestic producers should orient their marketing strategy towards promoting their domestic origin with the purpose of appealing to ethnocentric consumers, taking advantage of the effect of CET on healthiness perception of domestic food. When targeting health-conscious consumers, domestic producers will also benefit from increased health perception of their products, which will be positively reflected in consumers' willingness to buy domestic food. Furthermore, domestic producers can improve their competitive edge by advertising and highlighting characteristics of their products that are related with healthiness (low sugar, low fat, low calorie, etc.) and likely fare better by offering healthy products, or products with a healthiness claim. A product line extension with a healthy product could additionally utilize the positive effect of healthiness perception on willingness to buy in the interest of domestic producers.

Overall, domestic food producers can apply the insight into the relevance of health consciousness and healthiness perception on domestic food choice by tailoring their advertising messages to promote product value propositions that are associated with healthiness, or healthy lifestyle. In this way, they can both appeal to health-conscious consumers and enhance their products healthiness perception. By highlighting domestic products origin, producers can also attract ethnocentric consumers.

Furthermore, our findings provide insight for foreign producers which plan to compete with domestic producers and products by entering a "domestic" market. They should consider their generally disadvantageous position when entering domestic markets with ethnocentric consumers. In this situation, it is recommendable to conceal their foreign origin, e.g., by means of making this aspect less salient when advertising their products. Foreign producers should also be cautious in domestic markets whose consumers range high in health consciousness, as they will be inclined to choose domestic products over foreign products. Generally, foreign producers should be cautious when entering markets whose consumers range both high in CET and health consciousness, as those traits render them even more inclined to purchase domestic food.

For their strategical orientation, foreign food companies can aim at positioning their products as healthy and should adjust their marketing messages to fit in the domestic markets. They should avoid stressing the product foreignness and instead adjust their advertising to better fit in the domestic context.

Considering that domestic food producers have an advantage among health-conscious consumers as well as those high in consumer ethnocentrism, foreign food brands can also choose an opposite strategy than suggested – to target consumers who are not healthconscious. This could be achieved by creating advertising that highlights product aspects more appealing to those low in health consciousness. Previous research suggests that these could be non-health-related product attributes, like taste and price (Mai & Hoffmann, 2012), as consumers low in health consciousness are more inclined to

select food products based on their tastiness or reasonable pricing. By means of highlighting such product aspects, foreign producers might be able to attract consumers in domestic markets who are less concerned about their health.

8. Limitations and further research

Our study examined the importance of health consciousness and CET for domestic food perception and willingness to buy it. Several points call for attention for further research. First, current empirical data is limited to a Lithuanian sample, thus subsequent studies could gather evidence from respondents representing other nationalities. A replication of our research with other nationalities would allow for greater generalizability of the results of this study. Second, future research may focus on measuring concrete behavior, going beyond behavioral intentions as expressed in willingness to buy. Such a study could be set in a real-life environment where food choices are made. This would further enrich the body of knowledge in the domain of domestic food choices. Therefore, we propose a field study as a method to gather more grounded empirical evidence. Finally, future studies could also explore how influence of peers and social norms could affect the relationship between health consciousness, CET, healthiness perceptions and willingness to buy domestic food.

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APPENDIX 1. **Study scales, Cronbach's Alpha measures, composite reliability, average variance extracted, and standardized factor loadings**

Health consciousness adapted from Gould (1988).	$\alpha=0.814$; C.R.=0.820; AVE=0.536	
HC1: I reflect about my health a lot.	$\alpha=0.763$	0.738
HC2: I'm very self-conscious about my health.	$\alpha=0.747$	0.779
HC3: I'm generally attentive to my inner feelings about my health.	$\alpha=0.818$	0.578
HC5: I'm constantly examining my health.	$\alpha=0.732$	0.813
Purchase intention adopted from Aaker & Keller (1990), Taylor & Bearden (2002); scale developed by Gineikiene et al. (2016).	$\alpha=0.872$; C.R.=0.877; AVE=0.706	
WTB1: I am going to purchase food products made in Lithuania.	$\alpha=0.794$	0.853
WTB2: I would recommend Lithuanian food products to others.	$\alpha=0.782$	0.911
WTB3: With current supply I would choose to buy Lithuanian food products.	$\alpha=0.881$	0.745
Healthiness scale adopted from Homer (2006) and developed by Gineikiene et al. (2016). Lithuanian food products characteristics:	$\alpha=0.917$; C.R.=0.918; AVE=0.694	
HEA1: healthy for me	$\alpha=0.897$	0.874
HEA2: natural	$\alpha=0.887$	0.917
HEA3: useful for my body	$\alpha=0.886$	0.910
HEA4: grown without using unnatural additives	$\alpha=0.907$	0.746
HEA5: fresh	$\alpha=0.917$	0.689
Consumer Ethnocentrism (Klein et al., 1998; Shimp & Sharma, 1987).	$\alpha=0.885$; C.R.=0.890; AVE=0.620	
CET1: It is not right to purchase foreign products.	$\alpha=0.875$	0.708
CET2: A real Lithuanian should always buy Lithuanian-made products.	$\alpha=0.869$	0.728
CET3: We should purchase products manufactured in Lithuania instead of letting other countries get rich off us.	$\alpha=0.843$	0.864
CET4: Lithuanians should not buy foreign products, because this hurts Lithuanian business and causes unemployment.	$\alpha=0.848$	0.837
CET5: We should buy from foreign countries only those products that we cannot obtain within our own country.	$\alpha=0.863$	0.787

Note: Cronbach's Alphas of the scale items are shown in the second column, standardized factor loadings are shown in the third column. Scale reliability, composite reliability (C.R.) and average variance extracted (AVE) are indicated for each scale.