

Extending the animosity model in times of the COVID-19 pandemic: A cross-national validation of the health animosity scale

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Abstract: The concept of consumer animosity encompasses factors that influence consumers' negative attitudes and feelings toward other countries, which decrease consumers' buying behavior concerning foreign products. However, the impact of health concerns has been widely neglected in the literature on consumer animosity. To fill this void, this paper extends the established animosity models by introducing the new concept of health animosity and by developing a health animosity scale. The paper empirically validates the new scale in a multi-national study in the U.S., Germany, Brazil, and India. The scale measures the respondents' health animosity toward China, as many consumers worldwide blame China for the COVID-19 (coronavirus disease) pandemic and criticize the government's misbehavior during the outbreak. The analyses confirm suitable convergent and discriminant validity of the newly developed scale for most of the countries. The paper extends the understanding on consumer animosity, as not only incidents due to single nations' concrete purposes (e.g., military, economic or political actions) but also natural catastrophes and the reactions of single nations can cause feelings of animosity. The research implications outline directions for future studies, which could investigate the consequences of health animosity.

Keywords: Consumer Animosity; Health Animosity; COVID-19 Pandemic; Scale Development; Coronavirus

1. Introduction

The COVID-19 (coronavirus disease) pandemic affects various countries on all continents and caused more than 950,000 deaths worldwide—with increasing tendency [1]. Most governments took a variety of measures to prevent the proliferation of the COVID-19 pandemic. This implied a shutdown of public life, work restrictions for many businesses, and contact limitations for individuals. Due to the restrictions, the world economy experiences the deepest recession since the Second World War with a global growth trend of -5.2% for 2020 [2]. Accordingly, within the first two months of implementing the restrictions, the unemployment rate in the U.S. increased from 3.5% to 14.7% at the beginning of May [3]. Many countries closed their borders to their neighboring countries—even between member states of the European Union (EU). Thereby, every country reacts differently and applies actions solely on a national level. The call for national measures to counteract these negative impacts on the economy while simultaneously warranting the society's health security leads to a strong national focus by the governments. A recent survey by Civey in Germany demonstrates that in May 2020 58% of the respondents perceive globalization as a risk instead of an opportunity—10% more than one year before [4]. Therefore, the COVID-19 pandemic causes a shift from a multilateral perspective toward a rather nationalistic view. This appears to weaken the multilateral vision of transnational unions as for example the EU and gives the impression of enforcing nationalistic and hence animose tendencies. For example, relations between the U.S. and China fell to new lows in the wake of the COVID-19 pandemic. In line with these political tensions, many conspiracy theories are spread through social media in which citizens, celebrities, public figures, and even politicians blame the Chinese government for the COVID-19 pandemic. Individuals often express their anger toward a nation by boycotting the nation's products [5].

Consumer animosity is widely understood as the conscious rejection of products from a certain country due to previous or ongoing negative incidents without regard to the quality judgment of those products [6]. Previous research confirmed nationalism as a strong antecedent of animosity [7-8]. Therefore, it can be assumed that the risen nationalistic feelings also foster animosity feelings toward certain countries. Furthermore, economic hardship positively affects the animosity of individuals [9]. Both, developing countries and developed

countries, suffer economically from the preventive measures. For example, the massive increase of the unemployment rate in the U.S. [3] and in India [10] during the COVID-19 pandemic illustrates the damaging impacts on these economies. Thus, increased animosity can also emerge owing to the economic suffering of individuals, which are enforced by the measures that the governments take. Current speculations about the origin of the COVID-19 pandemic and the blame assigned to China regarding their misbehavior during the first outbreak led to a series of boycott threats by the U.S. [11]. At the UN General Assembly at the end of September 2020, US President Donald Trump publicly blamed China's government for the global COVID-19 pandemic [12]. Statements of official representatives like this can heat up animosity feelings toward China and can increase existing tensions between both countries. An external attribution of a certain incident—even when it is only on a speculative basis—can lead to an increase in situational animosity [13]. The assumed increase of animosity toward China is hence threefold: The rise of nationalistic tendencies owing to national actions of single states, the economic hardship for many individuals also in industrial states, and the attribution of blame toward a specific country, namely China, due to the outbreak of the COVID-19 pandemic are indicators of an increased animosity toward China. The concurrent COVID-19 pandemic could thus pertain to the animosity concept in a new unexplored manner and point to health animosity. Researchers confirmed various antecedents for animosity, such as previous or ongoing military, economic, political, religious, and mental disputes [6,14,15], while no study has yet researched health animosity.

Health animosity constitutes the antipathy toward a specific country as a result of governmental reactions to health-related incidents or catastrophes. This is related but distinct from political animosity as it constitutes the reactive rather than proactive behavior of a nation's government on natural catastrophes. Thus, the concept of health animosity co-exists beside a variety of already examined drivers—such as political, economic, military, or cultural animosity—, which can shape consumers' general animosity feelings toward a specific target country. The perceived threat originating from the COVID-19 pandemic may be the fundament of health animosity. With the COVID-19 pandemic, the perceived threat does not result out of military, economic or political incidents but out of a natural disaster. Managers and policymakers need to learn more about this type of animosity, as it may have strong practical implications for businesses and governments. For example, as animosity negatively influences the trust in businesses [16] and attitude toward brands [17], increased tendencies of animosity could detrimentally impact a long-term perspective. Accordingly, the COVID-19 pandemic could likely increase animosity toward China in several countries. In a short-term perspective, it may negatively affect the willingness to buy Chinese products and in a long-term perspective, it may negatively affect the attitude toward Chinese products and brands. Since the global supply chain network is strongly linked to China, the negative effects of animosity on the attitude of and the willingness to buy products from China could backfire on companies producing in China.

Both perspectives highlight the importance of the present research investigation. This paper contributes to the literature by introducing the concept of health animosity. A deeper and comprehensive understanding of how consumer animosity arises can significantly contribute to ensuring socio-economic sustainability in the world. The publishers develop and validate a new health animosity scale in a multi-country study.

2. Materials and Methods

In order to develop the new health animosity scale, we initially held group discussions with experienced researchers in the field of consumer animosity. As a result, an initial scale with six items was created. The scale was then refined and validated in a multi-country study.

Data was collected in April 2020 with use of an online questionnaire using LimeSurvey and spreading the questionnaire to participants via Mturk. To validate the newly developed scale in a cross-national context, participants from four countries in four different continents, namely Brazil, India, Germany and the U.S., were acquired. All of these countries are large and important industry nations of the global economy and have strong trade interdependencies with China. China is hence the number one importing nation for all four countries under investigation [18]. In September 2020 the U.S. exhibited the highest numbers of total infections confirmed by tests with more than 6,500,000 cases. Brazil had fewer reported infections with more than 4,500,000 cases. India had approx. 5,600,000 reported cases. In total, these three countries reported the highest number of cases worldwide accounting for almost 50% of total reported cases. Germany had the fewest infections of the investigated countries with approx. 270,000 cases [1]. Thus, besides the economic relevance of these countries,

the tremendous impact of the COVID-19 pandemic on these nations emphasize the necessity to examine health animosity in these countries.

The survey consisted of a short introduction indicating that all answers were treated anonymously, and that there were no wrong or right answers. Participants were encouraged to answer the questions spontaneously. Participants were then asked to answer questions on ethnocentrism, general animosity towards China and the newly developed scale on health animosity towards China. After conducting an explorative factor analysis (EFA) with Varimax rotation, one item of ethnocentrism (“Americans should not buy foreign products, because it damages the American economy and causes unemployment.”) and two items of the newly developed health animosity scale (“The way the Chinese authorities are dealing with the Covid-19 pandemic makes me angry” and “The Chinese are to blame for the fact that the corona virus now also occurs in the U.S.”) needed to be eliminated due to inconsistent factor loadings across the countries. For the analyses four items of Shimp and Sharma’s CETSCALE [19], namely “Only those products that are unavailable in the U.S. should be imported”, “It is not right to purchase foreign products, because it puts Americans out of work”, “We should purchase products manufactured in the U.S. instead of letting other countries getting rich at our expense” and “It may be more expensive in the long run, but I prefer to support American products” were used. These items were adjusted for the German, Indian and Brazilian sample. To measure general animosity, two items of Klein et al.’s animosity scale [20], namely “I do not like China” and “I am angry towards China” were adopted. Both scales are widely adopted in the animosity research field. Participants rated their degree of agreement on a seven-point Likert-scale ranging from 1 (totally disagree) to 7 (totally agree). The items of the health animosity are given in Table 1. The study received ethical approval from the Central Ethics Committee of the University of Kiel.

In total, 267 participants from the four countries took part in the survey. Due to incompleteness, 33 respondents needed to be eliminated. All participants with the citizenship of the home country under examination and only participants, who have been living for at least ten years in that country, were included in the final sample. As it can be assumed that a permanent stay of ten years in a foreign country leads to a suitable familiarity and identification with that country, another 15 cases needed to be eliminated. Two outliers in the U.S. sample and two outliers in the Indian sample, respectively, could be identified and thus, needed to be eliminated for the analyses. The final sample consisted of 215 participants, 50 for the German sample, 53 for the U.S. sample, 55 for the Indian and 57 for the Brazilian sample.

3. Results

To assess the validity of the multi-item constructs, we ran confirmatory factor analyses (CFA, with AMOS 26.0). Our initial CFA, in which we did not separate the four countries, demonstrated a satisfactory level of model fit [$\chi^2(32) = 77.118$; $\chi^2/df = 2.410$, comparative fit index CFI = .971, root mean square of sample approximation RMSEA = .081]. Fornell-Larcker test [21] confirmed discriminant validity as the average variance extracted (AVE), that is the mean of the squared latent variables’ loadings (health animosity: .754, general animosity: .828, ethnocentrism: .605) were greater than the maximum correlations (r^2_{max}) of the respective latent variable with the other latent variables (health animosity: .560, general animosity: .560, ethnocentrism: .399).

To support the robustness of the analysis, we ran a separate CFA for each country, which indicates satisfactory model fit in each country (Germany: $\chi^2(32) = 47.537$; $\chi^2/df = 1.486$, CFI = .958, RMSEA = .099; Brazil: $\chi^2(32) = 69.756$; $\chi^2/df = 2.180$, CFI = .900, RMSEA = .145; India: $\chi^2(32) = 52.587$; $\chi^2/df = 1.643$, CFI = .918, RMSEA = .110; U.S.: $\chi^2(32) = 40.931$; $\chi^2/df = 1.279$, CFI = .971, RMSEA = .073). The Fornell-Larcker test was largely supported, except in the Indian sample for health animosity. In the U.S. sample, ethnocentrism and general animosity are not discriminant, but this relationship is not in the focus of the present scale development.

The factor loadings of the CFA for all countries together and the four countries individually can be found in Table 1. All items of the newly developed health animosity scale loaded high on the common factor and exceeded the threshold for an acceptable level of .50 [22].

Table 1. CFA Factor Loadings

Health Animosity	Whole sample	Germany	Brazil	India	U.S.
1. The Chinese government is responsible for the fact that the corona virus has spread so quickly worldwide.	.888	.841	.898	.835	.755
2. Had the Chinese authorities reacted differently, this global catastrophe would not have occurred.	.810	.940	.713	.617	.828
3. How Chinese authorities deal with the covid-19 pandemic is irresponsible to the world.	.923	.952	.932	.820	.782
4. The Chinese government has not taken sufficient measures to prevent the spread of the corona virus.	.849	.868	.899	.763	.729

Notes. Based on confirmative factor analysis.

The descriptive statistics and internal consistencies are displayed in Table 2. Health animosity is relatively high in India and the U.S. compared to Germany and Brazil. An ANOVA analysis revealed that health animosity is higher in India and the U.S. compared to Germany and Brazil ($F(3, 211) = 19.285, p \leq .001$). Post hoc tests (LSD) indicate a significant difference of health animosity between $M_{\text{India}}(5.65)$ and $M_{\text{Germany}}(3.93)$ ($p \leq .001$), and between $M_{\text{India}}(5.65)$ and $M_{\text{Brazil}}(4.05)$ ($p \leq .001$). There was also a significant difference between $M_{\text{US}}(4.73)$ and $M_{\text{Germany}}(3.93)$ ($p \leq .001$), and between $M_{\text{US}}(4.73)$ and $M_{\text{Brazil}}(4.05)$ ($p \leq .001$).

Table 2. Descriptive statistics and internal consistency

	M	SD	α	AVE
Health animosity				
whole sample	4.734	1.627	.925	.754
Germany	3.971	1.772	.944	.813
Brazil	4.048	1.771	.921	.748
India	5.644	0.936	.845	.583
U.S.	5.278	1.161	.853	.600
Ethnocentrism				
whole sample	4.531	1.409	.855	.605
Germany	4.123	1.331	.843	.586
Brazil	3.864	1.342	.771	.501
India	5.574	0.824	.781	.481
U.S.	4.580	1.432	.871	.650
General animosity				
whole sample	4.158	2.010	.903	.828
Germany	3.010	1.771	.911	.837
Brazil	3.386	2.059	.897	.825
India	5.806	1.199	.797	.649
U.S.	4.415	1.640	.808	.712

Notes. α = Cronbach's alpha, AVE = average variance extracted.

To establish the measurement invariance, we performed multi-group CFAs to test between-group (i.e., between-country) in several steps [23]. The initial unconstrained model confirmed configural invariance, meaning that the model with the same subset of indicators performs well with the same constructs in all countries [$\chi^2(128) = 210.792; \chi^2/df = 1.647, CFI = .937, RMSEA = .055$]. In subsequent nested models, we first constrained the measurement weights [$\chi^2(149) = 248.758; \chi^2/df = 1.670, CFI = .924, RMSEA = .056$]. We followed Cheung and Rensvold [24], who state that changes in CFI for model fit comparisons with $\Delta CFI \leq .01$

indicate no significant difference, while ΔCFI between .01 and .02 indicates a marginal difference. The metric invariance model differs marginally from the baseline model ($\Delta CFI = -.013$), which indicates that the measurement models are only marginally different across the four countries. We then constrained the structural covariances [$\chi^2(167) = 367.468$; $\chi^2/df = 2.200$, $CFI = .846$, $RMSEA = .075$]. The strong decrease in CFA indicates that the structural covariances are significantly different across the four countries, that is the relationship between the constructs varies significantly across countries (Table 3).

Table 3. Correlations

	Whole sample	Germany	Brazil	India	U.S.
	r p	r p	r p	r p	r p
Health animosity \leftrightarrow Ethnocentrism	.422***	.148	.099	.712***	.610***
Health animosity \leftrightarrow General animosity	.680***	.517***	.624***	.626***	.665***
General animosity \leftrightarrow Ethnocentrism	.555***	.405**	.208	.416**	.716***

Notes. Pearson-product-moment-correlation. Level of significance: * $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$.

4. Discussion

This paper introduces the novel concept of health animosity that constitutes consumer's antipathy toward a specific country because of governmental reactions to health-related incidents or catastrophes. Extending the literature on consumer animosity, we introduce another trigger of animosity that is related to consumers' health concerns. We demonstrate that even natural disasters, which are not a result of a specific purpose of the target country—contrary to political, military or economic disputes—can result in a kind of animosity. In dealing with a natural disaster, the attribution of blame is sufficient to build up feelings of animosity.

The study introduces and successfully validates a new scale of health animosity in a multi-country study. The satisfactory model fit of the confirmatory factor analysis (CFA) and the Fornell-Larcker test confirmed suitable convergent and discriminant validity of the newly developed health animosity scale. The multi-group CFAs could confirm configural invariance and only marginal differences regarding the measurement invariance. When examining each country separately, however, it appears that discriminant validity is given for all countries except for India. One possible explanation is the language bias. Whereas the three questionnaires for Brazil, Germany, and the U.S. were translated into the predominant languages of those countries, the questionnaire for India was only translated into English. Consequently, there might be a language bias, as English certainly constitutes an official language but not the mother tongue of most Indians and Indians could hence have misunderstand certain words and phrases. India declared English and Hindi as official languages and officially approved more than 20 additional languages. Nevertheless, with more than 40% of all Indians speaking Hindi, it is the most predominant language in India. Thus, further investigations are needed to investigate the validity of this scale in India.

With regard to the long-term effects of the COVID-19 pandemic, the concept of health animosity may have strong implications for international relations and international business, which need to be explored in future studies. The consequences of animosity in general are widely confirmed in previous research. It is evident that animosity decreases the willingness to buy [25–26] and increases the intention to boycott products from a specific country [5, 27]. This link is validated in several national settings, including the U.S. consumers' animosity toward Japan [20], the Dutch consumers' animosity toward Germany [28], the Greek consumers' animosity toward Turkey [29], the Spanish consumers' animosity toward Korea [16], the British consumers' animosity toward France [30], Jewish Israeli consumers' animosity toward Germany [31], and Jordanian consumers' animosity toward Iran and Turkey [32]. Besides this link, there is evidence that the closeness of the incident [33] and the cultural similarity of the individuals' home and target country [34] function as a moderator of the relationship between animosity and the willingness to boycott. Since COVID-19 leads to a global pandemic and currently defines—and will most probably define—the daily life for the entire 2020, it seems

reasonable that the link between animosity and the willingness to buy will be strengthened instead of weakened. Moreover, the cultural similarities between China and other countries strongly vary and hence animosity may decrease the willingness to buy Chinese products especially in countries that are culturally different. The impact of increased tendencies of animosity due to a novel type of animosity will therefore most probably jeopardize the already weakened global economy.

In sum, this study sets the basis for a new understanding of consumer animosity and its various antecedents. By making use of this newly developed health animosity scale, follow-up studies could investigate the consequences relating to consumer reactions, such as willingness to buy and intention to boycott. Furthermore, it is interesting to examine how health animosity influences consumer reactions in a long-term perspective by focusing on the attitude toward products or brands from the targeted country. Thus, it is possible to investigate the indirect, negative consequences for the global economy by focusing on the damage of multilateral relationships. Future studies could use this scale to examine countervailing mechanisms to reduce feelings of animosity.

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