Co-creating value and wellbeing experiences in physiotherapy services

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Abstract

Purpose: We study the U.S. based (American) physiotherapy customers' goals to engage in value cocreation activities during their well-being experience.

Design/methodology/approach: We perform Smart PLS-SEM analysis of the primary data of physiotherapy service customers in the USA.

Findings: Our findings show that the U.S. well-being customer engages in physiotherapy for individualizing, empowering, development, concerted, and ethical motives but not for relating motives. These findings are contrasted with previous research to show that the service-dominant logic is not sufficient to account for the contextual complexity of the well-being experience and to explain the identified differences across culturally different customer segments.

Research Implications: By integrating insights from healthcare and cross-cultural literature, we highlight the importance of relationship dynamics, culture, and institutional context in well-being sector and develop a more comprehensive understanding of the cocreation behaviors in this industry. This helps advance the value cocreation research in well-being sector and promote the well-being experiences such as physiotherapy.

Originality: We draw from a variety of disciplinary perspectives and challenge the S-D logic as insufficient in explaining the value cocreation between the customer and expert in the well-being sector. We adapt physician-patient relationship model from healthcare literature and cultural values of power distance from cross-cultural literature to complement the S-D logic to account for the complexity and nuanced context of the well-being cocreation experience.

Keywords: consumer experience, knowledge sharing, value cocreation, well-being sector, physician-patient relationship dynamics, power distance, cultural values

Paper Type: Research Paper

1. Introduction

With rising healthcare costs totaling $4.01 trillion in 2020 in the United States of America (AB, 2020), the healthcare and well-being sectors are in the limelight in both academic and policy arenas. The majority of these dollars are spent on managing chronic illnesses. Emerging data show that the burden on the healthcare system can be reduced when patients are actively involved in managing their health through, e.g., collaborative care or patient-centered approaches and that these approaches come with positive health outcomes (e.g., McColl-Kennedy *et al.*, 2017b; Sweeney *et al.*, 2015). Increasing customer awareness and willingness to engage with preventive care is also reflected in the $1.5 trillion well-being market, which sees annual growth of 5-10% (McKinsey, 2021). However, despite the importance of this sector, we know very little about consumer goals in the well-being sector. Moreover, considering the continuously increasing competition in healthcare and well-being industries, it is more important for the service providers to understand consumer needs to communicate better well-being offerings that customers value.

As enhancing well-being requires a nuanced understanding of consumer psychology, recognizing the relationship context in which consumer motives to co-create value occur is critical for the advancement of the field and for designing optimal marketing stimuli to promote participation in well-being activities across various consumer segments and help engage customers in value cocreation. To do so, we first need to understand why they engage in various cocreation activities. So far, only one article (Bhatti *et al.*, 2021) explored the motivations for knowledge sharing in value cocreation by Pakistani and German patients in physiotherapy services. Their study is notable as physiotherapy as a well-being service has received scant research attention compared to general healthcare services, while the physical therapy industry in the U.S. alone was valued at $33 billion in 2019 (IBIS World 2020) and is rapidly growing, with an estimated total value to reach almost $46 billion by 2023 (Market Research, 2020), making it an important well-being sector to study as numbers of individuals suffering from chronic pain are continuously increasing.

Bhatti *et al.* (2021) study are also noteworthy as it is the first study highlighting that the country's context might influence the value of cocreation in well-being. The authors encourage future studies in other countries. With the rising importance of telemedicine, and thus country boundaries between the patient and service provider becoming less and less important, it is now important more than ever to highlight any culture-specific trends or identify generalizable patterns of value cocreation when delivering and communicating offerings and developing successful strategies to engage customers in the value cocreation activities across country boundaries. Moreover, country differences in their study encourage value cocreation researchers to go beyond commonly applied service-dominant logic and account for the context in which this cocreation occurs.

Therefore, the current paper aims to study the U.S. physiotherapy customers' goals to engage in value cocreation activities during their well-being experience. We ask what the value cocreation goals of U.S. physiotherapy patients are and whether these goals differ from those of patients from other countries? We then ask, what factors explain the differences in physiotherapy patients' motives? In particular, we build on Karpen *et al.* (2012) and Neghina *et al.* (2014) typology of cocreation interactions to explore how these goals impact customers' willingness to engage in value cocreation with the expert. We then contrast our findings with the previous physiotherapy research on value cocreation (Bhatti *et al.*, 2021) and show that the service-dominant logic (Vargo & Lusch, 2004), which has been used as a foundational basis for the majority of the value cocreation studies, is not sufficient to account for the differences in cocreation goals and behaviors across culturally different customer segments and falls short in explaining the complexity of the nuanced context of value cocreation in the well-being experience. By

integrating insights from healthcare and cross-cultural literature, namely the physician-patient relationship model by Emanuel and Emanuel (1992) and the cultural framework by Hofstede (2001), we explore the importance of relationship dynamics, culture, and institutional context in healthcare. By doing so, we help develop a more comprehensive understanding of the behaviors of American well-being consumers, which occur within complex and nuanced interlocking layers of social contexts. So far, no prior study has undertaken such an endeavor (at least to our knowledge); our study bridges a clear gap. By doing so, our study offers several contributions to services marketing, particularly value cocreation literature streams.

We show that the S-D logic cannot fully explain the value cocreation in the physiotherapy experience. We increase the explanatory value of this framework by incorporating insights from diverse disciplinary perspectives such as healthcare, cross-cultural literature, and physician-patient relationship dynamics. By doing so, we develop a more comprehensive understanding of the consumers' role in the well-being experience. We elaborate on the importance of cultural, institutional, and sector context in the value cocreation process. We also reveal how the cultural dimension of power distance and physician-patient relationship dynamics shape customers' propensity to engage in value co-creation. Our findings contribute to the research on telemedicine by being one of the first studies to specifically capitalize on patients' existing goals and expectations concerning active participation in their health management and consequent value co-creation.

2. Relationship dynamics between customer and service provider in the well-being industry

While value cocreation undoubtedly results in positive outcomes for the customer, not every relationship mode is conducive to a collaborative wellness experience. Healthcare literature differentiates four types of relationship dynamics between physician and patient: paternalistic, deliberative, interpretative and informative (Emanuel & Emanuel, 1992).

Paternalistic relationships are characterized by a passive role of the patient who does not question the physician but solely executes expert recommendations. Decisions are made independently by the expert, and communication and sharing of knowledge occur one-way with an emotional distance between the two actors (Driever et al., 2020). The key role of the patient is to consent to the intervention suggested by the physician, who is assumed to know what is in the patient's best interest. In deliberative relationships, the patients' role is limited to sharing their health status and providing feedback, which helps the physician diagnose and provide a better treatment plan.

This communication will motivate the patient to better conform to the expert's recommendations. Interpretative relationships are characterized by more interpersonal relationships between the two actors, with the physician serving as an advisor and patients playing a more active role in the decision-making process than the previous two relationship modes. In informative relationships, patients play the most active role as the two actors work together to arrive at the best treatment solution. The physician's role is to share his factual medical knowledge and professional technical expertise and options for treatment, from which the patients have full autonomy to choose at their discretion regardless of the physician's preferences.

This physician-patient model applies to the relationships between customer and expert (service provider) in the well-being sector, in general, and in the physiotherapy setting, in particular, as it is a knowledge-intensive professional service (Chen et al., 2020). Similar to the healthcare setting, there

exists knowledge asymmetry between the two actors and the well-being service provider is hired for his knowledge and 'expert position,' which can be contrasted with the customers' limited knowledge and understanding of the specific well-being or healthcare issue (Emanuel & Emanuel, 1992; Knutsson & Ulla-Karin, 2020). Moreover, as we will discuss, these four relationship dynamics have important implications for willingness and motivation to co-create value. The four customer-expert (service provider) relationship modes in the well-being sector were adapted from Emanuel and Emanuel's (1992) physician-patient relationship model and are presented in Table 1, with corresponding customer goals (patient values), obligations of the expert (physician), perceptions of customer's (patient) roles (autonomy) and the expected role of the expert (physician).

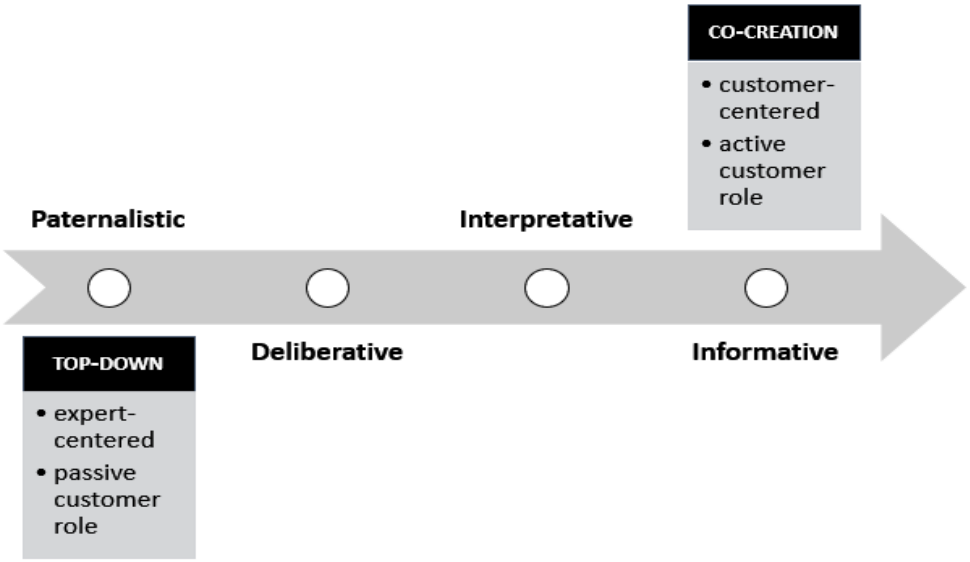
Table 1. **Four models of the customer-expert relationships in the well-being sector**

	Informative	**Interpretative**	**Deliberative**	**Paternalistic**
Customer goals	Defined, known to the patient	Requiring elucidation	Open to development and revision	As suggested by the expert
Expert obligations	Providing relevant factual information, implementing the patient's selected intervention	Interpreting patients' goals, informing and implementing the patients; preferred intervention	Persuading the customer of the most desired goals and interventions	Promoting the customer's well-being regardless of their preferences
Customer role	Choice of and control over treatment	Self-understanding relevant to the treatment	Self-development relevant to the treatment	Consent to expert goals and interventions
Expert role	Competent technical expert	Counselor	Teacher	Parent

Source**:** Modified from Emanuel, Emanuel (1992, p. 2222)

Considering the varying roles of customers and experts stemming from these relationship dynamics, in terms of implications for the value cocreation, these four relationship modes can be considered on a continuum, as presented in Figure 1, with increasing degree of collaborative care and customer (patient)-centered service.

Figure 1. **Relationship continuum and implications for value co-creation**



As the paternalistic relationship mode represents the most top-down decision-making between the customer and the expert, it represents the most expert(physician)-centered approach to well-being care, with the lowest opportunities for value cocreation, and the customer playing the most passive role. In contrast, the informative relationship mode is characterized by the most collaborative decision-making between the two actors. Consequently, it is the most customer(patient)-centered, offering the most potential for value cocreation, with customers playing the most active role in their well-being experience.

3. Cultural attitudes toward authority

As discussed above, not every relationship mode is conducive to a collaborative wellness experience. Similarly, not every cultural context in which these relationships occur favors active value cocreation. When discussing the relationships with experts, we need to recognize that attitudes toward people with authority are learned through cultural socialization (Hofstede *et al.*, 2010). Thus, one should not assume that the four relationship modes between a customer and the well-being expert or between a patient and a physician will appear across various cultures with the same degree of commonality.

The cultural value best describes the differences across cultures in relationships with people of different social statuses is 'power distance' from the widely recognized Hofstede's cultural framework (2001). Power distance is "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally" (Hofstede *et al.*, 2010, p. 61). Cultures categorized as high-power distance societies accept this inequality. People in these societies depend on the top-down decisions of those in power, whether they are bosses, politicians, teachers, parents, or physicians. On the other hand, societies with low power distance strive for equality. Relationships between subordinates, bosses, children, and parents are interdependent with more consultative decision-making (Hofstede, 2001; House *et al.,* 2004). The two cultural opposites should not be merely seen as two distinct modes of how societies operate but as a continuum (Hofstede *et al.*, 2010).

Empirical evidence confirms that power distance also shapes the relationships between physicians and patients. For example, in high power distance cultures, the time spent on consultation is shorter. Furthermore, information exchanges are minimal, with no room for building an emotional connection between the two actors (Meeuwesen *et al.* 2009). In addition, patients treat physicians as their superiors,

and the physicians control the physicians' consultations, as ‘subordinates expect to be told what to do’ (Hofstede *et al.*, 2010). On the other hand, in low power distance cultures, patients and doctors share the same status and are seen as equals and patients actively partake in the consultation (Bhatti *et al.*, 2021).

Therefore, the degree of the power distance in the culture will impact the preferred relationship mode between the physician and patient, or, in our case, the customer and the well-being expert. The top-down decision-making and reliance on the authority of the expert typical for Hofstede’s (2001) high (low) power distance cultures correspond with Emanuel and Emanuel’s (1992) paternalistic (informative) relationship mode as presented in Figure 2, integrating the two theories. Consequently, the extent of the two actors engaging in value cocreation activities with an increasing degree of collaborative care and customer-centered service will correspond to lower levels of power distance. As shown by the horizontal arrows, high power distance leads to top-down decision-making, whereas low power distance is more conductive of cocreation behaviors.

Figure 2. **Power distance continuum – patient expectations and implications for value cocreation**

4. Value cocreation motives in well-being experience

In physiotherapy, value cocreation is at the core of the wellness experience, which requires the customer’s participation in the treatment. This cocreation can range in the degree of involvement. At the very minimum, consumer involvement will include passive participation in the well-being experience, including sharing or seeking information, interacting with the expert and acting in response to the service. But often, this involvement extends to increasing customers’ awareness, education, knowledge, and skill development or empowering them to actively participate in the decision-making process, setting treatment goals, explicitly or implicitly defining their roles in the treatment plan and actions to share and coordinate necessary actions, as well as evaluating the treatment and providing feedback on its effectiveness (Hoogeboom *et al.*, 2014; Papadimitriou, 2008; Yi & Gong, 2013). In this interactive and iterative process, the consumer and the expert are thus engaging in the active sharing of knowledge and learning.

Individualistic and collectivistic cultures differ in their autonomy expectations (Oishi et al. 1999). Citizens in individualistic cultures believe in undertaking independent decisions, but persons in

collectivistic cultures are contented with decisions made by others (Iyengar & Devoe 2003; Iyengar & Lepper 1999). Furthermore, these cultures describe autonomy differently (Oishi et al. 1999). Collectivistic society citizens believe they are making autonomous decisions when they follow others' advice and are more prone to interpersonal influences (Mourali, LaRoche, & Pons, 2005; Bond & Smith, 1996).

As the expert cannot know what is going on in the patient's body, this cooperation is even more critical in the context of well-being experience. Thus, a critical question is how best we can facilitate and enhance value cocreation (Karpen *et al.* 2012). Answering this question requires understanding the motivations of participating actors (Vargo & Lusch, 2004). Neghina *et al.* (2014) proposed a set of six value cocreation actions based on the service-dominant logic (Vargo & Lusch, 2004) and the typology of strategic co-creation interactions developed by Karpen *et al.* (2012), namely (1) individualizing actions; (2) relating actions; (3) developmental actions; (4) empowering actions; (5) ethical actions; and (6) concerted motives, as defined in Table 1. Consistent with the expectancy theory (Mitchell, 1974; Vroom, 1964), these cocreation actions represent expected outcomes (values) derived from the interaction with the expert and thus translate into consumer goals to engage in value co-creation activities. These "goals are mental representations of desired outcomes to which people are committed" (Mann *et al.* 2013, p. 488).

Table 2. **Cocreation goals and corresponding customer actions in well-being experience**

	Cocreation goals	Definition	Customer cocreation actions
1	**Individualizing**	Customization of the experience and value outcome	Customization of the experience and outcome through expressing preferences for a particular treatment, sharing treatment history and previous experiences with physiotherapy, and setting the goals for the treatment
2	**Relating**	Enhancing a social and emotional connection	Establishing a personal bond with the well-being provider; sharing mutual interests, exploring similarities, getting to know each other
3	**Developmental**	Knowledge and skill development	Asking questions and sharing knowledge to improve the resource base and learn; being introduced to external partners and patient groups that can facilitate learning
4	**Empowering**	Taking partial responsibility for the experience	Taking responsibility for the outcomes of the treatment; intervening, being proactive with feedback, or requesting modifications to the treatment plan, taking charge
5	**Ethical**	Ensuring ethical treatment	Providing accurate information, seeking transparency and full disclosure from the service provider, being treated with respect
6	**Concerted**	Coordinating the experience	Adapting behaviors to each other, coordinating the behavior, establishing agreement as to the form of treatment

5. Study Hypotheses

Individualizing motives

Customization of products allowing consumers to express their individual preferences has made its way into the healthcare industry, where it is even more important that the particular service is tailored to the individual needs of a specific patient and their medical condition. Individualizing actions allow the consumer to have an 'experience of one.' Through individualizing actions, the service provider gains a better understanding of customers' individual circumstances, desired outcomes, resources, and ways in which they can contribute to the treatment plan (Karpen *et al.* 2012). This allows the expert to act

accordingly and better assist individuals by being adaptive to their individual needs (Vargo & Lusch 2004). This is critical for the satisfaction from the service, as the better the understanding of individual consumer's needs by the service provider, the better outcomes for the consumer (Karpen *et al.* 2012; Hoolbrook, 2006). This should motivate the physiotherapy customer to engage in value cocreation and related interactions with the service provider for individualizing motives. By engaging in individualizing actions such as expressing preferences for particular treatment, disclosing treatment history and previous experiences with physiotherapy, or being proactive in setting goals and desired outcomes, the individual is able to customize and shape their treatment plant and impact the behavior of the service provider. Therefore, we propose:

Hypothesis 1. Consumers' individualizing motives positively influence their willingness to co-create value.

Relating motives

Relating actions enhancing a social and emotional connection (Neghina *et al.* 2014) facilitate open communication which leads to mutual trust and loyalty between partners (Sirdeshmukh *et al.* 2002). Open communication results in the service provider having more concern and empathy toward the consumer (Hausman, 2004), and resulting encouragement and support has been linked to increased compliance in healthcare (Seiders *et al.* 2015). Positive interactions also form the basis for developing mutual trust, critical for the success of treatments (Hogarty, 2002).

In trust-based relationships, the interactions between actors serve as conduits of knowledge, which ultimately results in more positive outcomes for the consumer. A dialogue based on trust is critical for knowledge sharing and learning between interaction partners (Nambisan & Nambisan, 2009; Ballantyne 2004) and relating actions have been associated with higher levels of positivity and self-disclosure (Bradley *et al.* 2010; Gallan *et al.* 2013). On the other hand, the lack of positive relating interactions and ensuing distrust results in more anxiety for the patient and making less-informed decisions (Tran *et al.* 2014) with less positive outcomes when the treatment plan is prescribed rather than developed through mutual understanding (Hausman, 2004; Lutfey, 2004).

This should motivate the physiotherapy consumer to engage in value cocreation for relating motives. By establishing rapport with the expert through relating actions of personal connection and getting to know each other as a person, the patient is able to shift the interaction from one-way 'prescribing of treatment' to a conversation based on mutual dialogical exchange and 'developing the treatment together'. By doing so, the consumer can thus proactively shift the interactions with the service provider from transactional to a relational exchange with anticipated positive outcomes in terms of increased satisfaction from the treatment, increased compliance, better outcomes, and empathy from the service provider. Therefore, we propose:

Hypothesis 2. Consumers' relating motives positively influence their willingness to co-create value.

Empowerment motives

Patient empowerment is "a social process of recognizing, promoting, and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to control their lives" (Gibson, 1991, p. 359). Through empowering actions consumers influence the interaction outcomes (Neghina *et al.* 2014, p. 7). In the well-being setting, this democratization of power allows consumers to take charge over their treatment experience as empowerment actions shape the nature and content of the exchange (Karpen *et al.* 2012). For instance, feedback offered by the

consumers allows the expert to learn more about their partner's needs and modify their behavior accordingly (Ballantyne & Varey, 2006). Offering suggestions gives consumers control over the process and results in more involvement in the decision-making (Neghina *et al.* 2017), thus their active participation leads to increased self-efficacy and satisfaction in managing illness (Guo *et al.* 2013). This results in the service better meeting consumer specifications and context of their situation (Tuli, Kohli, & Bharadwaj, 2007), and, in healthcare settings, ultimately leads to better health outcomes and cost savings (Michie *et al.*, 2003; Edmunds *et al.*, 2019).

This should motivate the physiotherapy patient to engage in value cocreation and interactions with the service provider for empowering motives. By doing so, patients are taking responsibility for the outcomes of the treatment, intervene when needed, are proactive with feedback, or request modifications to the treatment plan when needed. By actively taking collaborative actions to negotiate the power, patients benefit from the cocreation process by receiving customized care and having better health outcomes. Therefore, we propose:

Hypothesis 3. Consumers' empowerment motives positively influence their willingness to co-create value.

Ethical motives

Ethical motives involve ensuring fair and ethical treatment of the participating actors (Neghina *et al.* 2014). This is critical for value cocreation to occur as fair treatment is a prerequisite for the engagement with the service provider (Williams and Aitken, 2011; Joosten *et al.*, 2017). Dishonest and unethical conduct is a leading cause for switching service providers (Keaveney, 1995; Joosten *et al.*, 2017). Open communication is critical for the value cocreation as it helps avoid ethically questionable conduct (Ballantyne and Varey, 2006; Edmunds *et al.*, 2019) and decreases decisional conflict between patients and their healthcare provider (Kremer *et al.* 2007).

This should motivate the physiotherapy patient to engage in value cocreation and interactions with the service provider for ethical motives. By engaging in ethical activities and taking action aimed at setting transparent interactions, the patient is able to establish expectations about the full disclosure from the service provider. This, in turn, encourages the patient to engage in more self-disclosure, provide accurate information thus resulting in collaborative cocreation of value for the patients where they feel treated fairly and with respect. Therefore, we propose:

Hypothesis 4. Consumers' ethical motives positively influence their willingness to co-create value.

Developmental motives

Consumers "need to know, understand, and make sense of their circumstances. They want information so that they are able to explain past occurrences, interpret ongoing events, predict future occurrences, and make plans accordingly" (Bradley *et al.*, 2010, p. 238). When consumers anticipate the knowledge asymmetry, they seek to ask questions and learn from the expert's body of knowledge, motivated by the expectation of improving their knowledge or developing a skill (Neghina *et al.* 2017). Therefore, they partake in actions with developmental motives which involve knowledge and competence development (Neghina *et al.* 2014).

This knowledge sharing is critical for value cocreation (Frow & Aitken, 2007) as consumers knowledge and skills determine the effectiveness and efficiency of 'resource integration and value actualization' (Karpen *et al.* 2012). The development of knowledge and skills allows the consumer to take advantage

of the available resources more efficiently and effectively (Payne *et al.* 2008; Karpen *et al.* 2012). Moreover, the more knowledge and skills they have, the better potential for reaching desired outcomes (Bell & Eisingerich 2007). Thus, service providers can enhance value cocreation through educating the customer (Norman & Raminez 1993). Moreover, when people seek developmental outcomes for themselves, they are also more willing to share their knowledge (Gagne, 2009; Tobbin, 2012; Bilgihan *et al.*, 2016). This sharing of knowledge will increase the knowledge base available to both consumer and service provider (Neghina *et al.* 2014) from which both actors draw upon to develop successful treatment plan. This patient education reduces the needs of healthcare visits and the number of days on sick leave (Gallefoss and Bakke, 2000).

Thus, physiotherapy patient motivated by developmental motives will take collaborative value cocreation actions by asking questions, learning, and engaging in knowledge sharing to support the development of the treatment plan. These developmental actions can also involve the patient learning from and potentially being connected to external partners or patient groups which can help in their learning and treatment and recovery. Therefore, we propose:

Hypothesis 5. Consumers' developmental motives positively influence their willingness to co-create value.

Concerted motives

Concerted motives involve the synchronization between customers and service providers (Neghina *et al.* 2014), which is required for their resources and capabilities to be used in a coordinated manner. These coordinating activities constitute an important cocreation capability (Madhavaram & Hunt 2008) with concerted motives having positive impact on value cocreation (Schuler *et al.* 2019). This is especially relevant in the context of physiotherapy which involves 'the interaction between the therapist and patient in a process where body and muscle movement potentials are examined and assessed' (World_Confederation_of_Physical_Therapy, 2017). In the setting of chronic diseases, collaborative interactions with the involvement of a patient has been recognized as vital for the successful management of the disease (Holman & Lorig 2000).

Thus, physiotherapy patient motivated by concerted motives will aim to adapt his/her behavior to that of the service provider, in order to coordinate their interactions during treatment and establish agreement as to the form of treatment. Therefore, we propose:

Hypothesis 6. Consumers' concerted motives positively influence their willingness to co-create value.

Cocreation behavior

Above-discussed consumer motives influence consumers' willingness to co-create value (Neghina et al. 2017). Willingness to co-create value represents consumers' attitudes and their readiness to invest their resources (in our case time and effort) into the interaction with the service provider (Arnould et al. 2006). These attitudes are a strong predictor of the intended behavior (Neghina et al. 2017). The link between consumer motives and willingness to share knowledge and co-create value has been well established in previous research (Hawkins *et al.* 2013; Neghina *et al.* 2017). This relationship has been also confirmed specifically in physiotherapy patients in the study by Bhatti et al (2021). Commitment between customer and service provider influences their willingness to co-create value, which in turn impacts value cocreation behavior (Neghina et al. 2014).

In the context of this study, the physiotherapy patient's willingness to share knowledge can be reflected in a variety of value cocreation behaviors such as sharing and learning information, pro-actively sharing

feedback regarding the progress and possible modifications of the treatment and openly communicate any arising problems. Cocreation of value can be passive or active. The former involves sharing or seeking information, whereas the latter is manifested through e.g. providing feedback, helping, or advocacy (Yi & Gong, 2013). Therefore, we propose:

Hypothesis 7. Willingness to co-create value positively influences the patients' cocreation behavior.

6. Research Methodology

In what follows, we will discuss the research methodology and the findings of our data collection in the U.S. To test the hypotheses presented above and investigate the relationships between physiotherapy customers' goals and their value cocreation behaviors, we employ quantitative research methodology and collect data for this study through an online questionnaire administered to physiotherapy service customers in the USA. We perform Smart PLS-SEM analysis of the primary data collected. We then contrast our study findings with physiotherapy service customers in Germany and Pakistan.

6.1 Data Collection Procedure

Measures in this study are adapted from the existing value cocreation research. Survey questions presented in the appendix were adopted from Bhatti *et al.* (2021), and were previously applied and tested in cocreation research (Neghina *et al.*, 2015; Neghina *et al.*, 2017). Respondents answered questions about their willingness to co-create in physiotherapy, as well as each of the individualizing, relating, empowering, ethical, developmental, and concerted motives on a 7-point Likert scale.

6.2 Study Sample

For our empirical research, we selected physiotherapy service patients in USA. The survey data from 446 physiotherapy customers was collected through research panel company Qualtrics. All respondents have participated in physiotherapy experience within the last year. Those aged 25-34 years accounted for 24%, aged 35-44 for 22% of the respondents. Most of the respondents had completed at least high school (15%) and (63%) held an academic degree. The sample mainly consists of female respondents (72%). The married respondents accounted for 47% of the respondents. The household income for the past year before tax was $100,000 and above for 26 percent while 15% percent had income below $25,000.

6.3 Measures

We employed SmartPLS to perform PLS-SEM for data analysis (Ringle, 2015) and followed Hulland's (1999) procedure for evaluating models in two stages. First, we assess the reliability of the measurement model. Second, we test the structural model. The individual-item reliabilities, convergent, and discriminant validity were assessed as recommended by Hair *et al.* (2011). The individual item reliabilities were first assessed by the loadings between the indicator and its latent variables. All the individual item reliabilities loadings fall above the 0.7 level recommended by Gotz *et al.* (2010) which affirms high degree of individual item reliability. The composite reliability was calculated with levels higher than 0.6 recommended by Gotz *et al.* (2010) indicating the discriminant validity.

As shown in table 3, all latent constructs have average variance extracted (AVE) values above the recommended minimum level of 0.5 (Fornell & Larcker, 1981), thus we can affirm the convergent validity of all latent constructs (Fornell & Larcker, 1981; Gotz *et al.* 2010). Moreover, table 3 shows

that our data complies with the discriminant validity recommendations, as the square roots of all the latent variables' AVEs are higher than the correlations of these latent variables (Chin, 1998; Fornell & Larcker, 1981; Gotz *et al.,* 2010).

Table 3. **Inter-construct correlations, Average Variance Extracted (AVE), and the square root of AVE along the diagonal**

	Constructs	AVE	1	2	3	4	5	6	7	8
1	Co-Creation Behavior	0.654	**0.809**							
2	Concerted Motive	0.635	0.828	**0.797**						
3	Development Motive	0.734	0.801	0.784	**0.857**					
4	Empowering Motive	0.694	0.778	0.728	0.749	**0.833**				
5	Ethical Motive	0.742	0.314	0.312	0.440	0.367	**0.894**			
6	Individualizing Motive	0.692	0.192	0.285	0.522	0.552	0.268	**0.830**		
7	Relating Motive	0.774	0.086	0.322	0.264	0.358	0.114	0.201	**0.886**	
8	Willingness to Share	0.746	0.469	0.216	0.382	0.333	0.216	0.321	0.035	**0.819**

We employed the full collinearity assessment approach to detect common method bias as recommended for PLS-SEM (Kock, 2015). The VIF values of the model fall below 2.0 and is thus lower that the recommended 3.3 threshold (Hair *et al.,* 2017; Kock, 2015), indicating that our model is free from the common method bias.

6.4 Analysis

The main effects of a structural model are assessed by looking at the coefficient of determination (R^2) and the overall effect F^2 (i.e., for overall effect), standardized b path loadings and levels of significance (Gotz *et al.,* 2010; Hair *et al.,* 2011). In our model the R^2 for the dependent variable of value cocreation behavior is 0.743, demonstrating that the independent variables (the six cocreation motives) explain 74.3% of the variance of the dependent variable.

The bootstrapping method of sampling by 300 bootstrapping runs generated t values (Chin, 1998). Table 4 presents the results of the structural model examining the influence of the six motives of physiotherapy consumers on their willingness to share knowledge.

Table 4. **PLS path analysis results (Standardized beta coefficients and p-values)**

Model Paths			Model		Label
			β	*p*-value	
H1	Individualizing Motive	→ Willingness to share	0.132	(0.019) **	Accepted
H2	Relating Motive	→ Willingness to share	-0.098	(0.001) ***	Not Accepted
H3	Empowering Motive	→ Willingness to share	0.111	(0.026) **	Accepted
H4	Ethical Motive	→ Willingness to share	0.429	(0.000) ***	Accepted
H5	Development Motive	→ Willingness to share	0.104	(0.075) *	Accepted
H6	Concerted Motive	→ Willingness to share	0.243	(0.000) ***	Accepted
H7	Willingness to share	→ Co-creation behaviors	0.862	(0.000) ***	Accepted
Construct ^{R2}		Co-creation behavior = 0.743			

* $p \leq 0.1$. ** $p \leq 0.05$. *** $p \leq 0.01$.

Hypothesis 1 related to customers engaging in physiotherapy with individualizing goals. Consistent with expectations, individualizing goals are positively related to willingness to share (b = 0.132; $p \leq$

0.019, is accepted). Hypothesis 2, concerning the positive impact of relating motives on willingness to share, (b = -0.098; $p \leq 0.001$, is not accepted). Hypothesis 3, regarding the influence of empowering motives on willingness to share, (b = 0.111; $p \leq 0.026$) is accepted. Similarly, hypothesis 4, concerning the influence of ethical motives on willingness to share, (b = 0.429; $p \leq 0.000$) is also accepted). Hypothesis 5, on the influence of developmental motives on willingness to share, is partially accepted (b = 0.104; $p \leq 0.075$) and H6, concerning the influence of concerted motives on willingness to share, (b = 0.243; $p \leq 0.000$), is accepted. Hypothesis H7, concerning the influence of willingness to share knowledge on cocreation behavior, (b = 0.862; $p < 0.000$), is accepted as well.

7. Discussion

This paper investigates the U.S. customers' goals to engage in value cocreation during their physiotherapy well-being experience. We asked what are the value cocreation goals of the U.S. physiotherapy patients and whether these goals differ from those of patients from other countries? We then ask, what are the factors explaining the differences in physiotherapy patients' motives?

We discuss six customers goals influencing their willingness to co-create value (based on and Karpen *et al.* (2012) and Neghina *et al.* (2014) typology of cocreation interactions), namely, individualizing, relating, empowerment, ethical, developmental, and concerted goals. In what follows we will contrast our findings with Bhatti *et al.* (2021) study and bring in interdisciplinary perspectives from healthcare and cross-cultural literature, namely physician-patient relationship dynamics model by Emanuel and Emanuel (1992), and Hofstede's (2001) cultural values of high- vs. low- power distance, to explain differences in study results and challenge the dominant in the field of value cocreation reliance on the service-dominant logic by Vargo & Lusch (2004). As we do so, we present several important future research avenues that emerge from this comparison with a potential to help advance the value cocreation research of the healthcare sector in general, and physiotherapy sector in particular.

We show that the U.S. physiotherapy customers are motivated by five of these goals and are engaging in value cocreation activities: (1-individualizing) to personalize their treatment and customize it to their particular needs; (2-empowerement) to exert influence on the treatment process; (3-ethical) to ensure a fair and honest communication; (5-developmental) to develop relevant knowledge and skills that can improve their health outcomes; and (6-concerted) to synchronize their and physiotherapist's efforts. However, the U.S. physiotherapy patients are not motivated by (4-) relating goals and, in general, do not intend to share their experience publicly or on social media.

Table 5. **Value cocreation goals – cross-country comparison**

	Motive	United States	Germany	Pakistan
1	**Individualizing**	accepted	rejected	accepted
2	**Relating**	rejected	rejected	rejected
3	**Developmental**	partially accepted	accepted	accepted
4	**Empowering**	accepted	accepted	accepted
5	**Ethical**	accepted	rejected	accepted
6	**Concerted**	accepted	rejected	accepted

In related physiotherapy study, Bhatti *et al.* (2021) investigated the aforementioned motives among patients from Germany and Pakistan and suggested the influence of the cultural values of individualism vs. collectivism as potential contextual factor that might explain the differences between the two countries. As the U.S. is often presented as an example of a very individualistic society (Hofstede *et al.*

2010; House *et al.* 2004), it constitutes a good contrast sample to their study. We contrast the findings from these three countries in Table 5 to explore the importance of customer-expert relationship dynamics, country culture, and institutional context in motivations for value cocreation in well-being experience.

As can be seen in table 5, well-being customers in none of the countries are motivated by relating motives and most of them are unwilling to share information about their treatment on social media as they believe this will not influence other consumers or experts. This is in stark contrast to previous research studies in other service industries (Ballantyne and Varey, 2006; Neghina *et al.* 2014; Karpen *et al.* 2012). This can be attributed to a very personal nature of physiotherapy and well-being and customers not wanting to disclose such intimate information on social media, which are generally used for self-promotion and self-enhancement in terms of image building. While with the rise of social media we have seen the emergence of 'selfies culture' and sharing of many of the mundane everyday activities, participants in our and Bhatti's *et al.* (2021) study do not extend this relating activity to their experiences of physiotherapy.

Patients across all three countries engage in value cocreation for developmental and empowering goals. Patients are regarded as active in learning and studying their health situation, participating in relationships with health care providers, undertaking needed resource mobilization and engaging in lifestyle changes associated with their disease (Gibson, 1991). Another highlighted patient empowerment characteristic is the significance of the patient's taking control, understanding, and taking responsibility for their disease (Anderson, 1995; Ouschan et al., 2000; McColl-Kennedy et al., 2017). This is important for telemedicine and the standardization of care across countries. Concerning the empowering goals, respondents across all three countries would like to exercise power to influence the service by supporting the findings of prior studies focusing on similar topics (e.g., Wright *et al.*, 2006; Fuller *et al.,* 2009; Edmunds *et al.,* 2019).

It is interesting that the individualizing goals to contribute with knowledge and skills to ensure aligning the treatment with patient's needs, as well as concerting goals, which depict synchronizing effort for timely and comfortable treatment were significant in the U.S. (individualistic country) and Pakistan (collectivistic country) samples, in line with findings of prior studies which confirmed the importance of these motives in healthcare services (e.g. Hogarty, 2002; Gallan *et al.,* 2013), but not in the German (individualistic) sample. Most notable is that the U.S. and German findings differ to a large degree, whereas U.S. and Pakistani patients engage in similar value cocreation practices. This puts into question whether culture, as measured through individualism-collectivism cultural values really explains these differences. Both U.S. and Pakistani customers wish to customize their course of treatment, and are willing to actively cooperate with the expert, but not the German patients. This, rather than by cultural values of individualism-collectivism, could be potentially explained by the relationship dynamics between the customer and the expert from the Emanuel and Emanuel (1992) model. The paternalistic relationship dynamics represented by Germany discourage the patient from intervening in the treatment and encourage the reliance on the expert. Whereas informative relationship style where the patient is assumed to have full control over the course of the treatment will be predominant in the U.S.

The ethical goals guided patients in the U.S. and Pakistan, but again not in Germany. Previous consumer service research also arrived at contradictory findings – the ethical motives were not significant in some of the service-dominant logic studies (e.g., Joosten *et al.,* 2017; Williams and Aitken, 2011), but significant in others (Joosten *et al.,* 2017; Keaveney, 1995). Based on the sampling data provided in the previous literature, it is not possible for us to conclude, whether country or cultural context really played a role there. These studies also focused on different service sectors. In paternalistic relationship style

between the physician and the patient, it is assumed that the physician knows best and has the best interest of the patient at heart. On the other hand, in informative relationship style, the physician is merely the source of technical factual medical knowledge (Emanuel & Emanuel 1992). Thus, the customer-expert relationship dynamics and expected roles and obligations might explain these differences. Moreover, subjective measures such as trust in the healthcare system and the perceived quality of care might explain whether or not patients actively seek ethical motives when engaging in value cocreation practices in physiotherapy. A German patient might trust the physiotherapy expert and thus does not need to seek the fair and honest provision of treatment. A patient in Pakistan, might seek to ensure such treatment due to less favorable perceptions of healthcare quality and conduct, whereas a patient in the U.S. might be very vigilant to ensure ethical treatment (or recognize when a mistake is made) considering high rates of medical malpractice lawsuits in this country. Thus, while the U.S. and Pakistani patients will both engage in ethical goals, they do so for various underlying reasons.

Theoretical contributions

We confirm the importance of patient's goals their willingness to engage in the value cocreation with their well-being physiotherapy provider. We extend Bhatti *et al.* (2021) work by further showing that cultural values of individualism-collectivism (Hofstede *et al.*, 2010) may or may not explain the differences in the significance of various motives across countries. Our findings further support their emphasis of the importance of the service context. We highlight that other cultural values such as power distance (Hofstede *et al.*, 2010), rather than individualism-collectivism, might play an important role in influencing patients' value cocreation activities, as the nature of the relationship dynamics (Emanuel & Emanuel, 1992) between patient and an expert authority figure (physiotherapy provider) is more relevant in this context than the individual's relationship with the society at large (as related to the individualism-collectivism).

Our findings offer several theoretical and practical implications. Firstly, we affirm that value cocreation in well-being sector requires, what Knolich *et al.* (2011) refers as 'shared internationality', as each co-creating actor brings in their own intentions, attitudes and motivations that will shape the value cocreation process. However, one should keep in mind that, as we argued above, the expectations concerning this shared intentionality and the roles of the customer and the expert are influenced by the relationship dynamics between the patient and the physician (Emanuel & Emanuel, 1992), as well as by the power distance between the two as influenced by the societal attitudes toward inequality and authority (Hofstede *et al.*, 2010; Meeuwesen *et al.* 2009). This shared intentionality needs to be more specifically incorporated in healthcare and well-being services theorization, in order to have a more comprehensive understanding of value cocreation in these contexts. Also, the practitioners need to be mindful of the shared intentionality aspect as it can significantly support the outcome of well-being treatments.

Our findings also suggest that expert– (physician) customer (patient) relationship dynamics (Emanuel & Emanuel 1992) rather than directly the cultural background might influence customers propensity to engage in value cocreation. This relationship dynamics, influencing the expected roles and obligations of the customer and the expert can be culturally bound as countries differ in their approaches to healthcare and the degree to which an individual patient is expected to proactively partake in their own health management and rely on the authority figure such as well-being expert. We also suggest that the institutional context and perceived healthcare quality should also be considered as potential factors influencing value cocreation in well-being industry in general and physiotherapy in particular. Our findings (especially the insignificance of the relating motives) highlight the importance of not extrapolating the findings across various service sectors, particularly to the physiotherapy or healthcare

sector which is much more personal in its very nature. Thus, we show that drawing from a variety of disciplinary perspectives, such as healthcare and cross-cultural literature, and integrating knowledge on physician-patient relationship dynamics (Emanuel & Emanuel, 1992), and cultural values of power distance (Hofstede *et al.*, 2010) with the service-dominant logic (Karpen *et al.* 2012; Neghina *et al.* 2014; Vargo & Lusch, 2004), can increase its explanatory value in future value cocreation studies and help develop a more comprehensive understanding (both theoretically and practically of the consumers' role in well-being sector.

Managerial implications

Practitioners trying to encourage value cocreation need to account for patients' goals to co-create value including individualizing, empowerment, ethical, relating, developmental, and concerted motives. They also need to consider how customer-expert relationship dynamics, country culture, and institutional context affect these motivations. Patients across all three countries (USA, Germany, and Pakistan), engage in value cocreation for developmental and empowering goals. However, caution should be applied when considering individualizing and concerting goals, as these are not a significant driver of behavior for German patients, who expect paternalistic relationship dynamics and prefer to rely on the expert. Thus, practitioners need to vary their approach across cultures taking into account how comfortable the patient is with intervening in the treatment process. They also need to consider the differences in the importance of ethical goals, which were significant for respondents in the U.S. and Pakistan samples, but not in the German sample. Practitioners must take into account that trust in the healthcare system and the perceived quality of care affect patients' ethical motives when engaging in value cocreation practices in physiotherapy. A German patient trusting the expert will not seek fair and honest provision of treatment because he/she takes it for granted. A patient in Pakistan will pursue these goals due to uncertainty about healthcare quality and conduct, and a patient in the U.S. will focus on them due to high rates of medical malpractice lawsuits in this country.

Limitations and Future Research

As we showed, physiotherapy patients do not engage in value cocreation for relating motives, and do not share information about their treatment on social media. This calls for question as to how patients can be encouraged to share their experiences with well-being experiences on social media to co-create value not only with their service providers but with the patient community at large. We have seen the emergence of this kind of communities and e.g. Facebook groups dedicated to various illnesses, including long COVID-19, however, the research in this area is lagging behind. Therefore, we call for more research investigating *the antecedents of patients engaging in relating activities on social media to co-create value with a large network of other patients*. Another related potential research avenue lies in investigating *how the healthcare service providers can use social media to encourage their patients to engage in relating activities on social media, thus engaging in multi-actor value cocreation*. While this study (and the study by Bhatti *et al.* 2021) was not able to establish a link between the *cultural values of individualism-collectivism* (Hofstede, Hofstede & Minkov, 2010) and the relating goals, comparing findings *across a more diverse sample of countries* could help confirm or reject the hypothesis as to their impact on value cocreation.

Moreover, in contrast to other service sectors (see Ballantyne and Varey, 2006; Neghina *et al.* 2014; Karpen *et al.* 2012), our study, consistent with Bhatti *et al.* (2021), shows that relating goals are not a significant driver of value cocreation in well-being sector. This shows that researchers should be careful in extrapolating research findings about cocreation goals across industries. We thus encourage further exploration of the *antecedents of value cocreation well-being industry, as well as industry comparisons*.

The differences between two individualistic countries (Germany and the U.S.) in terms of the importance of individualizing and concerting motives, put into question whether culture, as measured through individualism-collectivism cultural values really explains these differences. More relevant seem here *institutional contexts, access to healthcare, public vs. private healthcare insurance,* the importance of which should be further studied. Culture might still play an important role here, but probably not the cultural dimension of individualism-collectivism. Instead, we suggest that the cultural value of *Power distance* (Hofstede *et al.*, 2010) *in the relationship between the patient and the healthcare provider* as an expert and authority figure might play a role here and should be investigated in future studies. Future studies should also consider the impact of other cultural dimensions such as *uncertainty avoidance on concerting motives*. Moreover, related to this relationship between the patient and his/her doctor is *the physician-patient relationship continuum* – are patients in general taught to rely on the service provider (paternalistic relationship style – Emanuel & Emanuel, 1992) or are they encouraged to actively participate in managing their illness (informative relationship style). This might play a more important role than cultural values of individualism-collectivism.

Considering inconclusive findings as to the importance of the ethical motives, and previous contradictory findings from other service sectors and service-dominant logic literature (e.g., Bhatti *et al.* 2021; Joosten *et al.*, 2017; Williams and Aitken, 2011), it is of importance to *investigate factors influencing the importance of ethical motives in value cocreation activities and to explain the reason behind the contradictory findings in the existing literature*. For this purpose, we encourage future studies to undertake the metanalysis of the existing literature and consider factors such as service sector, or regulatory and institutional context. Just as with the relating motives, we encourage future studies to explore *the role of cultural values* here. Cultural values particularly *power distance* from Hofstede (2001) framework might prove most relevant to explain the *relationship dynamics between the customer and the expert* (physiotherapy service provider). As we discussed above, *trust in the healthcare system, its quality, or even a culture of malpractice lawsuits*, could influence patient's propensity to engage in value cocreation for ethical motives, which should be investigated further. Future studies should also consider the impact of other cultural dimensions such as *uncertainty avoidance on ethical motives*.

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