The Impact of Culture on the Efficiency of Healthcare Service Treatment and Value Co-Creation for Patient Well-Being

Mario Glowik

Professor

Berlin School of Economics and Law

Badensche Straße 50-51, 10825 Berlin, Germany

e-mail: mario.glowik@hwr-berlin.de

Waheed Akbar Bhatti

Associate Professor

Linnaeus University

Universitetsplatsen 1

392 31 Kalmar, Sweden

e-mail: waheed.bhatti@lnu.se

Agnieszka Chwialkowska

Associate Professor

University of West Georgia

1601 Maple St.

Carrollton, GA 30118, USA

e-mail: achwialk@westga.edu

Abstract

Current literature on value co-creation identifies motives that are fundamental drivers of knowledge sharing, service efficiency, and client satisfaction (i.e. patient well-being) during the treatment process. These motives include individualising, relating, developmental, empowering, ethical and concerted motives.

However, research conducted in different countries points to contradictory findings regarding the significance of these motives. Therefore, we argue that studying patients' motives is important, as they drive participation in the healthcare treatment process with medical experts.

We expand the predictive value of service-dominant logic by discussing the cultural dimension. The aim of this study is to encourage the development of a more efficient, culturally integrative healthcare service planning process. We explore how cultural values impact patients' motivation to engage in the co-creation of value in healthcare services. We believe this will support reducing healthcare costs for service providers and national health systems, as well as increasing patient well-being.

Keywords

- Healthcare value co-creation process
- Healthcare service efficiency
- Medical expert- and patient interaction
- Cultural dimensions
- Patient well-being

Introduction

Further global progress is required in implementing Sustainable Development Goal 3 (SDG 3), as set out by the United Nations (Glassman & Temin, 2016; Haenssgen, 2023; Sachs & Ban, 2015; United Nations, 2025). SDG 3 aims to promote healthy lives and well-being for all. SDG 3 addresses various global health challenges, as diseases and healthcare systems become increasingly interconnected, as witnessed during the recent pandemic (Prahalad & Ramaswamy, 2004; United Nations, 2025; Haenssgen, 2023). Improving patient well-being can significantly reduce healthcare costs and the financial burden on global healthcare systems, and value co-creation can contribute to this.

While previous studies have identified motives for value co-creation in the healthcare service sector (Neghina et al., 2014), more recent studies have produced conflicting results regarding the importance of customer value co-creation motives in different countries. For example, studies by Bhatti et al. (2021) and Chwialkowska et al. (2022) highlight differences in the importance of ethical, individualising, and concerted motives, which were found to be significant in the US and Pakistan, but not in Germany. Furthermore, contrasting the results of Chwialkowska et al. (2022) and Neghina et al. (2017) reveals differences in the significance of relational motives and knowledge sharing. The former were not significant in the US sample, whereas the latter were significant in a study conducted in the Netherlands. We argue that the cultural dimension of power distance significantly influences the dynamics of value co-creation between medical experts and patients during the healthcare treatment process. Consequently, our research addresses the key research question.

> *How do cultural factors and the dynamics of the medical expert–patient relationship influence co-creation activities and the importance of patients' motives in engaging in these activities?*

The purpose of this study is to achieve the following major objectives,

> (1) to explore the importance of the cultural dimension of power distance in shaping patients' motives to co-create, and to propose how these values impact medical expert–patient relationship value co-creation dynamics.
>
> (2) To propose practical implications for healthcare providers (e.g. medical experts, physicians, hospitals, and pharmaceutical firms) seeking to improve patient satisfaction and well-being.

The study encourages the development of culturally sensitive healthcare services and treatment processes that are more efficient for providers and increase patient well-being. We advocate long-lasting development approaches as a means of tackling global health challenges (McKee, 2021).

Value co-creation and service-dominant logic

Value co-creation is a process in which healthcare service providers and patients interact to create and develop value through communication, collaboration, understanding, and activity

(Prahalad & Ramaswamy, 2004; 2004a). Ideally, this results in positive health outcomes for patients (Sweeney et al., 2015; McColl-Kennedy et al., 2017; Manias & Williams, 2008; Michie et al., 2003).

Initially, the literature viewed value co-creation in light of Vargo and Lusch (2004, 2008), who considered all clients to be value co-creators. However, this perspective has been questioned by Gronroos (2012), who distinguishes between buyer value creation, which depends on client activities as they represent economic actors, and value co-creation, which requires interaction between at least two economic actors (i.e. the patient and the healthcare service provider). Gronroos's approach aligns with the work of Prahalad and Ramaswamy (2000, 2004) and Ballantyne and Varey (2006).

Randall et al. (2011) emphasise that commitment, connection, and trust are dimensions of a more comprehensive co-creation concept. Yi and Gong (2013) examine the customer viewpoint on co-creation, assessing it as a third-order factor consisting of two main dimensions: customer citizenship and customer co-creation behaviours. Only a few studies compare co-creation (focused on service industries) and co-production (focused on manufacturing industries) (Schau et al., 2009; Ple´ and Ca´ceres, 2010; Vargo & Lusch, 2008).

While the existing literature identifies various patient co-creation activities in healthcare (Gonzales, 2019; Bashar et al., 2020; McColl-Kennedy et al., 2012; Sweeney et al., 2015), it does not acknowledge that the extent of patient involvement is culture-dependent (Hofstede, 2001; Hofstede, 2010; House et al., 2004).

In summary, the literature on value co-creation in the healthcare industry mainly focuses on three major research areas. The first research stream identifies the outcomes of patient involvement. These include enhanced well-being and quality of life (McColl-Kennedy et al., 2017; Sweeney et al., 2015), improved management of chronic pain (Manias & Williams, 2008), reduced stress levels (Kremer et al., 2007), increased patient satisfaction (Loh et al., 2007), greater efficiency in treatment, as measured by a reduction in referrals and diagnostic tests (Stewart et al., 2000), and fewer conflicts between patients and healthcare providers (Kremer et al., 2007). While all these studies highlight the importance of value co-creation in the healthcare industry, they fail to discuss the importance of cultural backgrounds during the interaction process.

Value co-creation cannot be discussed without mentioning service-dominant logic (SDL), which addresses service interaction actors. Ideally, both actors benefit during the service treatment process, with the medical expert (service provider) providing benefits to the patient through their knowledge, skills, and competencies, resulting in higher service quality, better treatment performance, reputation, increased treatment satisfaction, and patient well-being. Therefore, S-D logic is based on bilateral relationships, communication, and mutual trust, resulting in a win-win situation. Due to its interactive nature and the constant adjustment of the actors involved and how they appraise value, each actor is constantly learning how to better serve and function within a complex and dynamic healthcare service environment (Joiner & Lusch, 2016).

S-D logic provides a framework through which to understand how actors co-create value through communication, learning and interaction (Vargo & Lusch, 2004; Vargo et al., 2020). According to S-D logic, value is not embedded solely within a single product or service, but is co-created 'in use' by the actors involved, which naturally requires patient involvement (Prahalad & Ramaswamy, 2004; Ballantyne & Varey, 2006; Grönroos, 2012; Grönroos &

Voima, 2013). In line with expectancy theory (Mitchell, 1974; Vroom, 1964), value co-creation activities represent expected values derived from interaction and corresponding motives to engage in co-creation. Thus, S-D logic emphasises the importance of interaction and the exchange of knowledge, skills, and technological innovations.

Considering S-D logic, we integrate insights from the physician-patient relationship model in healthcare by Emanuel and Emanuel (1992) to account for how relationship dynamics and expectations of patient and expert roles impact patient willingness to engage in value co-creation processes. The paternalistic relationship mode is expert-centred and characterised by top-down decision-making and limited expectations for value co-creation among those involved. In contrast, the deliberative relationship model is the most patient-centred, characterised by high expectations of value co-creation from both parties (Emanuel & Emanuel, 1992).

While the literature provides a value co-creation framework (Gronroos & Voima, 2013), further questions must be addressed to improve our understanding of how to achieve a more systematic, fine-grained, and efficient value co-creation process that gives patients the utmost satisfaction in the context of their cultural and national backgrounds. Consequently, as discussed in the following sub-chapter, we argue that it is necessary to combine the paternalistic and deliberative relationship modes with the cultural dimension of power distance (Hofstede, 2001; Emanuel & Emanuel, 1992).

The influence of culture on healthcare treatment relationship dynamics

As one of the cultural value orientations, power distance (PD) reflects societal attitudes towards inequality, authority, and experts (Hofstede, 2001). It is defined as 'the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally' (Hofstede et al., 2010, p. 61). High-PD cultures accept inequality as the natural order of the world, whereas low-PD cultures seek equality (House et al., 2004). These two extremes represent a spectrum of societies with varying degrees of acceptance of inequality (Hofstede, 2001). For instance, individuals in high-PD cultures anticipate top-down decision-making and do not expect to be consulted or asked for their opinions. Conversely, in low PD cultures, even relationships between supervisors and subordinates, or parents and children, are based on equality and interdependence. This results in people in these cultures expecting collaborative decision-making processes (House et al., 2004; Hofstede et al., 2010).

PD is relevant to this study because this cultural value affects relationships between medical experts and patients, as well as their mutual expectations during healthcare treatment (value co-creation) (Chwialkowska et al., 2022; Hofstede, 2001; Hofstede et al., 2010). Therefore, it impacts the expected roles in the interaction and treatment motivations. In high PD cultures, medical experts spend less time with each patient, as both parties perceive significant hierarchical distance (Goodyear-Smith & Buetow, 2001). They share less information with patients than in low PD cultures (Meeuwesen et al., 2009). The medical expert controls the interaction and is treated as superior and the owner of knowledge. The patient is expected to follow instructions without question, just as a subordinate would follow a manager in a company (Hofstede et al., 2010).

Patients in high PD cultures do not expect consultation time to be spent building rapport or an emotional connection between the parties involved (Meeuwesen et al., 2009; Goodyear-Smith & Buetow, 2001). Conversely, in low PD cultures, the two parties are considered equals (Hofstede, 2001). More time is spent on consultations and medical experts share more information with their patients (Meeuwesen et al., 2009). Patients are expected to actively participate in communication, consultations, treatment, and the feedback process (Mead & Bower, 2000; Hofstede et al., 2010) (see Figure 1).

== Please insert Figure 1 here ==

Therefore, the degree of PD impacts the preferred communication and relationship dynamics between medical experts and patients (Hofstede, 2001). Emanuel and Emanuel's (1992) paternalistic relationship dynamics align with patients' expectations in high PD cultures, as these cultures rely on authority, expert opinion, and top-down decision-making. Conversely, deliberative relationship dynamics are most prevalent in low PD cultures, where decisions are made collaboratively and both the patient and the medical expert are responsible for the patient's well-being and the success of the treatment. Consequently, the extent to which the two parties engage in value co-creation activities corresponds to lower levels of power distance.
As power distance affects the expectations and preferred relationship dynamics between the medical expert and the patient (service recipient), we propose the following:

Proposition 1: *Patients in cultures with high power distance expect and prefer more paternalistic relationship dynamics with medical experts in healthcare services.*

Proposition 2: *Patients in cultures with low power distance, however, expect and prefer more deliberative relationship dynamics with the medical expert.*

Discussion, conclusion, and outlook

While existing value co-creation studies in the healthcare sector have made significant contributions to our knowledge, there are still several gaps in our understanding. The first calls were made to consider the role of cultural values in the co-creation process and their impact on patient motives for co-creation (e.g. Bhatti et al., 2021; Chwialkowska, 2022). However, the majority of existing research focuses on the outcomes of patient value co-creation (e.g. Kremer et al., 2007; Loh et al., 2007; McColl-Kennedy et al., 2017; Manias & Williams, 2008; Stewart et al., 2000; Sweeney et al., 2015), yet does not consider the importance of patients' cultural backgrounds. This needs to be improved because culture, as expressed through communication styles, behaviours and attitudes, has a significant effect on interactions between medical experts and patients (Hofstede et al., 2001; Hofstede et al., 2010).

S-D logic (Vargo & Lusch, 2004) provides valuable insights into value co-creation behaviour during healthcare treatment processes (Karpen et al., 2012; Neghina et al., 2014; Tommasetti et al., 2017). Although S-D motivations have been well established in the literature as critical drivers of value co-creation behaviours, emerging research in the healthcare sector suggests that

S-D logic fails to account for the complexity of the co-creation experience in a cross-cultural context.

Building on the work of Chwialkowska et al. (2022), who argue that improving patient well-being and healthcare service efficiency requires an understanding of attitudes towards authority and communication dynamics through the lens of the cultural value dimension of power distance (Hofstede, 2001), we explore the impact of cultural values on healthcare interactions.

Finally, we draw researchers' attention to patients' (service recipients') expectations regarding relationship dynamics, shaped by their cultural values and attitudes towards inequality and authority. For instance, patients in cultures with high power distance (PD) are more likely to expect a paternalistic relationship and top-down decision-making. In contrast, cultures characterised by low PD expect a more deliberative relationship model and actively seek to engage in value co-creation. This patient engagement is expressed by asking questions of the medical expert rather than remaining silent and waiting for instructions, as is typical in cultures with high PD (paternalistic) cultures.

Patients from low PD (deliberate) cultures want to understand the reasons behind and the processes of medical treatments, taking into account potential negative side effects, among other things. Transparency, communication, and understanding are all crucial in low PD cultures. Once informed and convinced of the treatment, patients are ready to actively participate in the treatment and the value co-creation process, and are more willing to adjust their attitudes and behaviour. Patients in high PD cultures expect to be instructed and do not question the treatment process or the expertise of the medical expert. Hospitals that hire medical experts and hospital staff from abroad, especially from countries with different PD levels, should educate and train their employees to prioritise patient well-being.

Our study advances the value of co-creation literature in terms of the impact of culture, thereby increasing the predictive power of the S-D logic. Additionally, we shed light on potential reasons for contradictory findings in academic healthcare research by Bhatti et al. (2021) and Chwialkowska et al. (2022).

We propose that future research tests the model of cultural influences on value co-creation in relation to healthcare services and patient well-being experience through qualitative and quantitative empirical studies in countries representing different levels not only concerning power distance but also uncertainty avoidance, and individualism-collectivism. We acknowledge that Hofstede's cultural dimensions, on which our integrative model is based, have been subject to conceptual criticism. We encourage scholars to explore alternative cultural models (e.g. GLOBE, Trompenaars, and Schwartz) in relation to S-D logic and value co-creation processes within the healthcare industry. Further developed propositions also have important implications for promoting value co-creation in different cultural consumer segments.

Bibliography

Ballantyne, D. and Varey, R. J. (2006). 'Creating value-in-use through marketing interaction: the exchange logic of relating, communicating and knowing'. *Marketing Theory*, 6 (3), pp.335–348.

Bhatti, W. A., Glowik, M., and Arslan, A. (2021). 'Knowledge sharing motives and value co-creation behaviour of consumers in physiotherapy services: a cross-cultural study'. *Journal of Knowledge Management*, 25 (5), pp.1128–1145.

Chwialkowska, A., Bhatti, W. A., Arslan, A. and Glowik, M. (2022). Co-creating value and well-being experiences in physiotherapy services. *Journal of Services Marketing*, https://doi.org/10.1108/JSM-11-2021-0423.

Emanuel, E. J. and Emanuel, L. L. (1992), 'Four models of the physician-patient relationship'. *The Journal of the American Medical Association*, 267 (16), pp. 2221–2226.

Glassman, A. and Temin, M. (2016). Millions Saved: New cases of proven success in global health. Brookings Institution Press.

Goodrich, K. and de Mooij, M. (2013). How 'social' are social media? A Cross-Cultural Comparison of Online and Offline Purchase Decision Influences'. *Journal of Marketing Communications*, 20 (1/2), pp. 1–14.

Goodyear-Smith, F. and Buetow, S. (2001). Power issues in the doctor–patient relationship. *Health Care Analysis*, 9, pp. 449–462.

Gronroos, C. and Voima, P. (2013). 'Critical service logic: making sense of value creation and co-creation'. *Journal of the Academy of Marketing Science*, 41 (2), pp. 133–150.

Haenssgen, M. J. (2023). Aligning global health policy and research with sustainable development: A strategic market approach'. *Sustainable Development*, https://doi.org/10.1002/sd.2762.

Hofstede, G. (2001). Culture's consequences: Comparing values, behaviours, institutions, and organisations across nations. Sage, Thousand Oaks, CA.

Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). Cultures and organizations: Software of the mind: Intercultural cooperation and its importance for survival. McGraw-Hill Education: New York.

House, R. J., Hanges, P. J., Javidan, M., Dorfman, P. W. and Gupta, V. (2004). Culture, leadership and organizations: The GLOBE study of 62 societies. Sage, Thousand Oaks, CA.

S. I. Iyengar and S. E. DeVoe (2003). Rethinking the value of choice: Considering cultural mediators of intrinsic motivation'. In V. Murphy-Berman and J. J. Berman (Eds.), Nebraska Symposium on Motivation, 49, 129–176. Cross-cultural differences in perspectives on the self. Lincoln, NE: University of Nebraska Press.

S. I. Iyengar and M. R. Lepper (1999). 'Rethinking the value of choice: A cultural perspective on intrinsic motivation'. *Journal of Personality and Social Psychology*, 76 (2), pp.349–366.
Joiner, K. and Lusch, R. (2016). 'Evolving to a new service-dominant logic for healthcare'. *Innovation and Entrepreneurship in Health*, 3 (1), pp.25–33.

Karpen, I. O., Bove, L. L., and Lukas, B. A. (2012). 'Linking service-dominant logic and strategic business practice: a conceptual model of a service-dominant orientation'. *Journal of Service Research*, 15 (1), pp. 21–38.

Kremer, H., Ironson, G., Schneiderman, N., and Hautzinger, M. (2007). 'It's my body': does patient involvement in decision making reduce decisional conflict? *Medical Decision Making*, 27 (5), pp. 522–532.

Li, M. and Cai, L. A. (2012). 'The effects of personal values on travel motivation and behavioural intention'. *Journal of Travel Research*, 51 (4), pp.473–487.

S. Mai, S. Ketron & J. Yang (2020). 'How individualism–collectivism influences consumer responses to the sharing economy: Consociality and promotional type'. *Psychology & Marketing*, 37 (5), pp.677– 688.

Markus, H. R. and Kitayama, S. (1991), 'Culture and the self: Implications for cognition, emotion, and motivation'. *Psychological Review*, 98 (2), pp. 224–253.

McColl-Kennedy, J. R., Hogan, S. J., Witell, L., and Snyder, H. (2017). 'Co-creative customer practices: The effects of healthcare customer value co-creation practices on well-being'. *Journal of Business Research*, 70, pp. 55–66.

J. R. McColl-Kennedy, H. Snyder, M. Elg, L. Witell, A. Helkkula, S. J. Hogan and L. Anderson (2017). 'The changing role of the healthcare customer: Review, synthesis and research agenda'. *Journal of Service Management*, 28 (1), pp. 2–33. DOI: 10.1108/JOSM-01-2016-0018.

McKee, M. (2021). Drawing light from the pandemic: A new strategy for health and sustainable development: A review of the evidence. European Observatory on Health Systems and Policies.

Mead, N. and Bower, P. (2000), 'Patient-centredness: A conceptual framework and review of the empirical literature'. *Social Science and Medicine*, 51 (7), pp.1087–1110.

L. E. Meeuwesen, van de Brink-Muinen and G. Hofstede (2009). 'Can dimensions of national culture predict cross-national differences in medical communication?' *Patient Education and Counseling*, 75, pp. 58–66.

Michie, S., Miles, J., and Weinman, J. (2003). 'Patient-centredness in chronic illness: What is it and does it matter?' *Patient Education and Counselling*, 51 (3), pp. 197–206.

Mitchell, T. R. (1974). 'Expectancy models of job satisfaction, occupational preference, and effort: A theoretical, methodological, and empirical appraisal'. *Psychological Bulletin*, 81 (12), pp. 1053–1077.

Neghina, C., Caniëls, M. C. J., Bloemer, J. M. M., and van Birgelen, M. J. H. (2014). Value co-creation in service interactions: Dimensions and antecedents. *Marketing Theory*, 15 (2), pp.221–242.

Neghina, C., Bloemer, J. M. M., van Birgelen, M. J., and Caniëls, M. C. J. (2017). Consumer motives and willingness to co-create in professional and generic services. *Journal of Service Management*, 28 (1), pp. 1–44.

Oyserman, D. (1993). 'The lens of personhood: Viewing the self and others in a multicultural society'. *Journal of Personality and Social Psychology*, 65 (5), pp.993–1009.

D. Oyserman, H. M. Coon and M. Kemmelmeier (2002), 'Rethinking individualism and collectivism: Evaluation of Theoretical Assumptions and Meta-Analyses'. *Psychological Bulletin*, 128(1), pp.3–72.

Prahalad, C. K. and Ramaswamy, V. (2004), 'Co-creation experiences: The next practice in value creation'. *Journal of Interactive Marketing*, 18 (3), pp. 5–14.

C. K. Prahalad and V. Ramaswamy (2004a), 'The future of competition'. Co-creating unique value with customers. Harvard Business School Press/McGraw-Hill Professional. Rahman, S. U. (2019). 'Differences in horizontally individualist and vertically collectivist consumers' environmental behaviour: A regulatory focus perspective'.

S. U. Rahman (2019). 'Differences in horizontally individualist and vertically collectivist consumers' environmental behaviour: a regulatory focus perspective'. *International Journal of Business and Emerging Markets*, 11 (1), pp.73–88.

Sachs, J. D. and Ban, K.-M. (2015). The age of sustainable development. Columbia University Press.

Special Eurobarometer 298 (2008). 'Consumer protection in the internet market'. Available at: http://www.astrid-online.it/static/upload/protected/ebs_/ebs_298_en.pdf (accessed 13 October 2021).

Sweeney, J. C., Danaher, T. S., and McColl-Kennedy, J. R. (2015). 'Customer effort in value co-creation activities'. *Journal of Service Research,* 18 (3), pp.318–335. DOI: 10.1177/1094670515572128.

Tommasetti, A., Troisi, O. and Vesci, M. (2017). 'Measuring customer value co-creation behaviour'. Journal of Service Theory and Practice, 27(5), pp.930–950.
United Nations (2025), Goal 3: Ensure healthy lives and promote well-being for all at all ages. Department of Economic and Social Affairs. Sustainable Development. https://sdgs.un.org/goals/goal3 (accessed 3 June 2025).

Vargo, S. L. and R. F. Lusch (2004), 'Evolving to a new dominant logic for marketing'. *Journal of Marketing*, 68 (1), pp. 1–17.

Vargo, S. L. and Lusch, R. F. (2017), 'Service-dominant logic 2025'. *International Journal of Research in Marketing*, 34 (1), pp. 46–67.

Vargo, S. L., Koskela-Huotari, K., and Vink, J. (2020). 'Service-dominant logic: Foundations and applications'. In: Bridges, E. and Fowler, K. (eds.) The Routledge Handbook of Service Research: Insights and Ideas, London: Taylor and Francis.

Vroom, V. (1964). 'Expectancy theory'. Wiley, New York.

Williams, J. and Aitken, R. (2012), 'The service-dominant logic of marketing and marketing ethics', *Journal of Business Ethics*, Vol. 102 (3) pp. 439–454.

World Bank. (2021). World Databank. http://databank.worldbank.org/home.aspx (accessed 12 September 2025).

Yi, Y. and Gong, T. (2013). 'Customer value co-creation behaviour: scale development and validation'. *Journal of Business Research*, 66 (9), 1279–84.

Yi, Y., Natarajan, R., and Gong, T. (2011). 'Customer participation and citizenship behavioural influences on employee performance, satisfaction, commitment, and turnover intention'. *Journal of Business Research*, 64 (1), pp. 87–95.

Zhang, L.; Tong, H.; Demirel, H. O.; Duffy, V. G.; Yi, Y.; and Bidassie, B. (2015). 'A practical model of value co-creation in healthcare services'. *Procedia Manufacturing*, 3, pp. 200–207.

Appendix

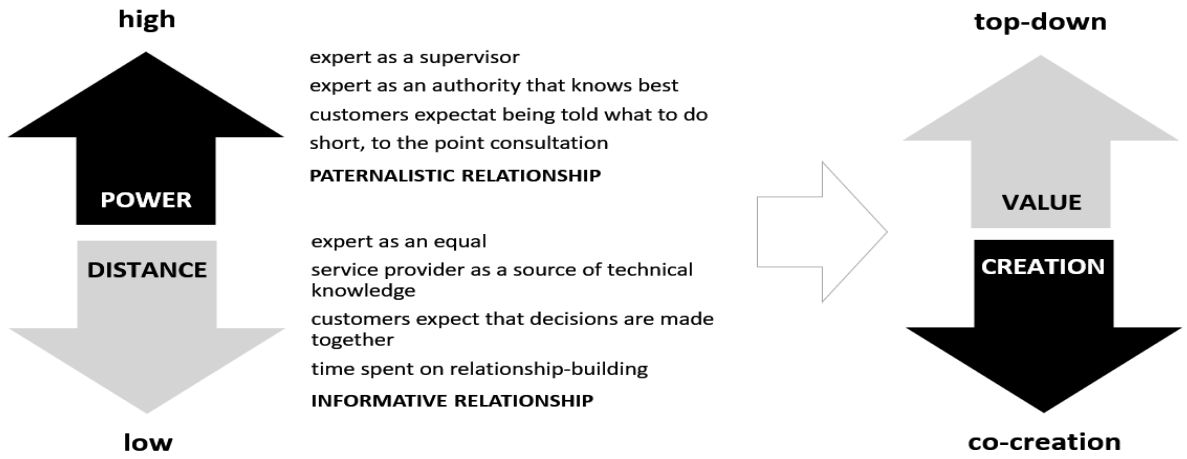

Figure 1. Patient-Physician Relationship Dynamics

Source: Chwialkowska et al., (2022)