Is perception reality in consumer dominant value creation?

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Is perception reality in consumer dominant value creation?

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1 Nadia Zainuddin is a Senior Lecturer at the University of Wollongong, Australia. Her research is situated within the broader field of social change, guided by social marketing and services marketing thinking. She is a specialist in the area of value and researches value creation and destruction. Nadia has a special interest in individual, community, and social wellbeing, and uses mixed methods in her research. She has experience working in collaborative research teams with industry partners such as the Australian Red Cross Blood Service, Queensland Health, and BreastScreen Australia.

2 Rory Mulcahy is a Lecturer of Marketing at the University of the Sunshine Coast, Australia. His research interests include gamification, serious games and other forms of technology to assist consumer wellbeing. Rory’s research has appeared in Psychology and Marketing, Journal of Services Marketing, Journal of Service Theory and Practice and Journal of Social Marketing.
**Background**

The initiation and maintenance of positive social behaviours offers significant transformative wellbeing implications for citizens in society. Social change research has demonstrated the efficacy of value creation in allowing us to encourage, support, and facilitate the performance of positive social behaviours amongst citizens (see Chell & Mortimer, 2014; Leo & Zainuddin, 2017; Zainuddin et al., 2017). However, two important gaps remain in the current body of knowledge. First, there is a lack of empirical examination for how value creation can be used to encourage behaviour initiation in social marketing, as much of the existing work has focused on behaviour maintenance. The processes of change model identifies initiation (i.e. recruitment and action) and maintenance (retention) as separate and distinct stages (Prochaska & DiClemente, 1983), each presenting different sets of challenges and considerations for social change. Second, much of the existing empirical research on value creation in social marketing has viewed value co-creation as dyadic (i.e. service provider-consumer) relationships. Anker et al. (2015) suggest a greater focus on Consumer Dominant (CD) value creation research is needed (consumer-consumer), as existing value creation ideologies (i.e. product dominant and service dominant) cannot adequately explain this. Social marketing scholars have provided tentative support for Anker et al.’s view, recognising research on the role of the individual can offer more rounded understanding of value creation in social change, adopting a consumer dominant approach in their value research (see Gordon et al., 2018; Zainuddin et al., 2016). However, despite the initial support offered by this emerging work, further research is needed to fully capture the role of consumers in value creation where little interaction with social marketing service providers takes place and how this varies at different stages of consumers’ readiness for social change.

Drawing from CD logic and value creation, the current study’s aims is to examine the differences between the imagined value creation process and outcomes for self-service non-users, relevant to issues of behaviour initiation, with the realised value creation process and outcomes of self-service users, relevant to issues of behaviour maintenance. This led to the study research question – RQ: What are the differences between the expectations and the reality of value creation processes and outcomes in CD social marketing services? A self-service context was selected to operationalise this research and address the research question, as self-services have limited service provider-consumer interaction, which is reflective of CD. Bowel screening self-service is the context used in this study for two reasons. First, health self-care management offers significant transformational wellbeing outcomes to individuals and is therefore an important area of investigation in social marketing. Second, the selection of bowel screening self-service is consistent with the health care literature which increasingly recognizes that health care does not only occur with a server provider present, nor at a health care facility, and can begin or take place in the home (Danaher & Gallan, 2016).

**Method and Analysis**

A dual cross-sectional quantitative survey was hosted online using Qualtrics, enabling data collection from users and non-users of bowel screening self-service. Men and women aged 50 years and above had never been diagnosed with bowel cancer were sampled, as this represented the primary target population of the bowel screening population health screening program in Australia (Bowel Cancer Australia, 2015). Prior to relationship testing, the constructs used subjected to reliability and validity testing and model fit was assessed. Both models indicated reasonably good fit. Average variance extracted (AVE) scores were also calculated and discriminant validity was
assessed. Multi-group analyses using invariance testing were performed using AMOS 24.0 to establish statistically significant differences between users and non-users.

### Results

<table>
<thead>
<tr>
<th>Relationship</th>
<th>χ²</th>
<th>Users β</th>
<th>Non-Users β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress Tolerance → Hedonic Value</td>
<td>1.00 (ns)</td>
<td>.017</td>
<td>.07*</td>
</tr>
<tr>
<td>Motivational Direction → Hedonic Value</td>
<td>5.01*</td>
<td>.01</td>
<td>.33***</td>
</tr>
<tr>
<td>Motivational Direction → Utilitarian Value</td>
<td>7.11**</td>
<td>.08</td>
<td>.43***</td>
</tr>
<tr>
<td>Co-Production → Hedonic Value</td>
<td>6.69**</td>
<td>21***</td>
<td>-0.03 (ns)</td>
</tr>
<tr>
<td>Co-Production → Utilitarian Value</td>
<td>2.27 (ns)</td>
<td>.22***</td>
<td>0.06 (ns)</td>
</tr>
<tr>
<td>Consumer Readiness → Hedonic Value</td>
<td>0.30 (ns)</td>
<td>.61***</td>
<td>.72***</td>
</tr>
<tr>
<td>Consumer Readiness → Utilitarian value</td>
<td>3.33(ns)</td>
<td>.66***</td>
<td>.45***</td>
</tr>
<tr>
<td>Hedonic Value → Satisfaction</td>
<td>28.10***</td>
<td>.28***</td>
<td>.92***</td>
</tr>
<tr>
<td>Utilitarian value → Satisfaction</td>
<td>34.36***</td>
<td>.73***</td>
<td>.07 (ns)</td>
</tr>
<tr>
<td>Satisfaction → Behavioural intentions</td>
<td>1.46 (ns)</td>
<td>.90***</td>
<td>.87***</td>
</tr>
</tbody>
</table>

R²
- Hedonic Value | .63 | .86
- Utilitarian Value | .82 | .66
- Satisfaction | .91 | .96
- Behavioural Intentions | .81 | .77

***p<.000, **p<.01, *p<.05, ns non-significant

The results suggest that the value creation processes are different between the two groups, but the outcomes are similar, in that perceived or expected satisfaction is a strong driver of behavioural intentions to repeat the behaviour. In terms of consumer contributions, those who have engaged in health care self-service before (i.e. users) appear to focus on the “doing”, while those who have no experience (i.e. non-users) appear to focus on the “preparing”. Motivational direction, which refers to having a clear understanding of one’s role in a consumption process (Kelley, 1992), is a more influential consumer contribution on value for non-users than for users. Perhaps, having an accurate and adequate understanding of the expectations of the role that one is required to play in a consumption situation can serve as reassurance to those who lack experience and familiarity with the process. This also explains why hedonic value is a more influential value dimension on the expected satisfaction for non-users, which is consistent with Parkinson et al. (2018). In contrast, having some experience and familiarity with the process allows an individual to focus on becoming more proficient at the self-service. This explains the greater influence of co-production and consumer readiness on value for users, as these consumer contributions tend to focus on more utilitarian, rather than hedonic aspects (Bendapudi & Leone, 2003). This also explains why utilitarian value is more influential on satisfaction for users.

### Discussion and Conclusion

The findings offer a theoretical contribution by examining consumers’ experience of CD value creation at behaviour initiation and behaviour maintenance stages. The theoretical and empirical insight of CD is an important emerging perspective for social marketing as it posits consumers as capable of being able to create value for themselves with little to no interaction from organisations. Thus, this research demonstrates the growing role consumers can take in their own healthcare and how this can be encouraged at behaviour initiation or behaviour maintenance stages. Practically, this study contributes by highlighting the need for different strategies when recruiting (behaviour initiation) versus retaining (behaviour maintenance) health self-service users, or encouraging behaviour initiation versus facilitating behaviour maintenance. This is particularly relevant in population health, which has a tendency to use population-level, rather than segmented approaches in their strategy.
References


Appendix

Note: Heavier weighted relationships signify significantly stronger relationships
**Response to Review Comments**

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Comments</th>
<th>Authors’ response</th>
</tr>
</thead>
</table>
| Reviewer 1 | I find this abstract difficult to follow and heavy on jargon.             | We apologise for the use of jargon – we sought to use correct labels for concepts which are used in the literature. Without specific examples from the reviewer highlighting problematic terms, we have reviewed the document and identified three terms that may be considered to be “jargon” but did not have the capacity to offer full definitions in the brief abstract:  
   1. Value creation/value co-creation - a process in which an organisation and customers interact at various stages of the consumption process in order to create the product/service (Prahalad and Ramaswamy, 2004)  
   2. Dyadic relationships – service provider-consumer relationships (we use this description in the paper on line 12)  
   3. Consumer Dominant logic - a view that positions the customer in the center, rather than the service, the service provider/producer or the interaction or the system (Heinonen et al., 2010) (in the paper, we have attempted to explain this by using the term “consumer-to-consumer” on line 13) |
|            | It does not state the health issue that is being investigated, methodology or any details about the target audience. | We have highlighted “bowel screening” as the study context in the second paragraph of the Background section:  
   A self-service context was selected to operationalise this research and address the research question, as self-services have limited service provider-consumer interaction, which is reflective of CD. Bowel screening self-service is the context...  
   Unfortunately, due to page limitations, we were not able to explicitly state... |
that bowel screening is aimed at minimizing the specific health issue of bowel cancer.

In the Method section, we have stated:

*A dual cross-sectional quantitative survey was hosted online using Qualtrics, enabling data collection from users and non-users of bowel screening self-service.*

*Multi-group analyses using invariance testing were performed using AMOS 24.0*

We have added the term “quantitative” (denoted in red) in the paper to clarify that the survey was quantitative in nature.

We also state that the target audience were:

*Men and women aged 50 years and above had never been diagnosed with bowel cancer were sampled, as this represented the primary target population of the bowel screening population health screening program in Australia (Bowel Cancer Australia, 2015).*

If the reviewer is referring to demographic details of the study participants, we have chosen not to include this information in the current submission in order to allow greater space to present the results of the hypothesis testing, which were pertinent to the aims of this study. We however do plan to provide such details when we attempt to publish this paper in a full journal article.
It is difficult to infer how the results can be used in practice without more information.

We agree. It is quite challenging offering meaningful practical implications given the page restrictions. We have attempted to address this by including the following statements in the Discussion and Conclusion section:

*Practically, this study contributes by highlighting the need for different strategies when recruiting (behaviour initiation) versus retaining (behaviour maintenance) health self-service users, or encouraging behaviour initiation versus facilitating behaviour maintenance. This is particularly relevant in population health, which has a tendency to use population-level, rather than segmented approaches in their strategy.*

We hope that we can expand on these implications, and more, in our presentation.

Currently this abstract is too vague.

We hope that the edits we have made and the explanations provided in this response has aided in providing greater clarity.

**Reviewer 2**

This paper presents the results of a quantitative survey of consumers on value creation around access to a bowel (self-)screening service in Australia. The paper focuses on an important and increasingly-discussed aspect of social marketing – value creation. It provides a good introduction to the theory and issue, including an explanation of the gaps and proposed solution and testing of a consumer dominant model. Choosing a self-service model raises questions of applicability to other service models where self-creation and co-creation take place. The paper does not provide sufficient explanation of the relationship variables, especially why hedonic and utilitarian were chosen. In the results and discussion, allocating hedonic mostly to non-users and utilitarian to users may restrict

Thank you for these constructive comments. We agree with the reviewer’s assessment of the applicability to other service models and contexts and will address this in our presentation.

Also, the selection of hedonic and utilitarian value was purposeful as previous research (see Zainuddin et al., 2011; 2013) has identified that these were the most salient value dimensions in health screening. Other value dimensions, such as social and altruistic value, were also found to be relevant, but not as salient in this specific context. Unfortunately, we were not able to provide this justification in the paper given the page limitations.

We are looking forward to discuss these issues further during the presentation, as the reviewer has highlighted!
understanding of how emotional and rational determinants affect behaviour in both groups. The author could mention how these issues would be explored and verified using other research techniques, especially qualitative ones. The presentation of this paper at the ISMC will provide the opportunity for the author to discuss these issues.