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Dynamics of Co-Created Wellbeing: A Psychological Ownership Perspective

ABSTRACT

Purpose–People have legal ownership of their wellbeing, yet psychological ownership (PO) might vary, depending on the dynamics of co-created wellbeing among engaged actors. The paper's two research objectives pertain to (1) explicating co-created wellbeing and (2) conceptualizing the dynamics of co-created wellbeing with consideration of the influences of engaged actors from a PO perspective.

Design/methodology/approach—To provide a new conceptualization and framework of dynamic, co-created wellbeing, this research synthesizes wellbeing, PO, and value co-creation literature. Four healthcare cases serve to illustrate the effects of engaged actors' psychological ownership on co-created wellbeing.

Findings—The derived, conceptual framework of dynamic, co-created wellbeing suggests four main propositions: (1) co-created wellbeing is the intangible target of the focal actor's and other engaged actors' PO, (2) PO over the focal actor's wellbeing is dynamic, (3) PO is reflected in collective resource integration, which is subject to but also influences resource conditions and challenges, and (4) influenced by co-created wellbeing and dependent on the extent of PO among all engaged actors.

Originality/value—This article provides a novel conceptual framework that can shed new light on value co-creation in wellbeing related service research. Through the introduction of psychological ownership, concepts such as quality of life and wellbeing can be better understood.

Keywords: Psychological ownership, value co-creation, dynamics of co-created wellbeing, healthcare, service-dominant logic, transformative service research

Paper type: Research paper

INTRODUCTION

I was outsourcing my health to somebody else. I was coming along saying, 'Here is my money. You fix me'" (Joe Cross cited in Siewierski, 2014)

Customers contribute in various ways to improve their wellbeing (McColl-Kennedy *et al.*, 2012), and ideally should adopt an active stance (Caru and Cova, 2015; Prahalad and Ramaswamy, 2004) to "take ownership of [their] health" (Saint Thomas, 2016). However, changing the customer's role cannot guarantee positive wellbeing effects in healthcare settings (McColl-Kennedy *et al*., 2017a), which vary significantly in terms of the appropriate level of patient participation and effort required during co-creation practices (Sweeney *et al*., 2015), with distinct effects on their wellbeing (McColl-Kennedy *et al.*, 2017b). The co-creation of wellbeing in healthcare settings instead demands collective resource integration by all engaged actors (Kleinaltenkamp *et al*., 2017), who include the focal actor (healthcare customer, patient), the professional service provider (healthcare practitioner, physician), and interested others (e.g., family, friends).

Empirical studies cite a wide range of healthcare customer co-creative roles and behaviors (e.g., McColl-Kennedy *et al*., 2012, 2015), though the precise routes by which wellbeing is co-created among engaged actors over time remains unclear. To address this gap, the current study draws on psychological ownership (PO) theory (Jussila *et al*., 2015; Pierce *et al*., 2003) as a lens to explore the dynamics of co-created wellbeing in this critical service context. The resulting, wide-ranging implications hold promise for transforming consumer lives (Anderson and Ostrom, 2015), by detailing psychological experiences of ownership of all engaged actors over a focal actor's wellbeing.

Accordingly, the two research objectives are (1) explicating co-created wellbeing and (2) conceptualizing the dynamics of co-created wellbeing with consideration of the influences of other engaged actor(s) from a PO perspective. In so doing, the current study contributes to

service research in four main ways. First, it recognizes the importance of wellbeing in service settings (Anderson *et al.*, 2013; Dodds *et al*., 2014, 2018; Finsterwalder *et al*., 2017; Gallan *et al.*, 2019; Hepi *et al*., 2017; Joiner and Lusch, 2016; McColl-Kennedy *et al*., 2017a,b; Ostrom *et al*., 2015) and provides a review of wellbeing literature. Second, this article conceptualizes the dynamics of co-created wellbeing from a PO perspective (Jussila *et al.*, 2015) and establishes a novel conceptual framework. Third, it provides propositions for viewing wellbeing through a co-creation and PO lens, illustrated with four cases from healthcare. Fourth, this article concludes with a research agenda and implications for service scholars, policymakers, and healthcare practitioners.

THEORETICAL FRAMEWORK

Wellbeing

Wellbeing is a growing research field (La Placa *et al*., 2013), gaining momentum in service research due to the potential impacts of policy and service provision on individual and societal wellbeing (Anderson and Ostrom, 2015). In turn, "improving well-being through transformative service" (Ostrom *et al*., 2015, p. 127) is a research priority, reflecting the transformative potential of service and the notion that wellbeing is critical to service policy and practice (Ostrom *et al*., 2015; Steptoe *et al*., 2015). In service research, subjective wellbeing (SWB) is a key outcome of value co-creation (Diener and Chan, 2011; Pera and Viglia, 2015). SWB results from happiness, pleasure, and the absence of pain (Kahnemann *et al*., 1999; Kahnemann and Krueger, 2006; Keyes *et al*., 2002; Ryan and Deci, 2001) and is a standard measure of wellbeing, along with other aspects of quality of life (Frow *et al.,* 2016; Steptoe *et al*., 2015). Aligned with Service-Dominant Logic (Vargo and Lusch, 2008), the present study adopts the definition of SWB as "people's evaluations of their lives—the degree to which their thoughtful appraisals and affective reactions indicate that their lives are desirable and proceeding well" (Diener *et al*., 2015, p. 234). Nevertheless, SWB alone cannot

explicate the dynamic nature of wellbeing (Dodge *et al*., 2012). Instead, Dodge *et al*. (2012) suggest a set point at which wellbeing exists, which requires an equilibrium between resources and challenges, even as states change (subject to the context). Dodge *et al.*'s (2012, p. 230) conceptualization of balance point wellbeing is instructive as well, in that it cites "the balance point between an individual's resource pool and the challenges faced" as the locus of wellbeing.

Extending from Dodge *et al.*'s (2012) balance point wellbeing view, an actor's wellbeing is inherently multidimensional and affected by various aspects of the person's life—health, employment, material resources, relationships, and so forth (Decancq and Lugo, 2012; Kahneman and Krueger, 2006)—that change over time. Because it is inclusive of cognitive, psychological, physical, and social aspects, wellbeing is facilitated by the interplay of the actor's circumstances, locality, activities, and psychological, economic, and social resources (La Placa *et al*., 2013; McNaught, 2011), and should consider comprising resource integration of other engaged actors (Kleinaltenkamp *et al*., 2012; 2017), such as family members and healthcare practitioners, to co-create a focal actor's wellbeing (McColl-Kennedy *et al*., 2017b). Therefore, all engaged actors must be considered in the co-creation of wellbeing (Dodge *et al*., 2012; La Placa *et al*., 2013).

An imbalance of resources and challenges may stimulate resource integration activities, so the effectiveness of balancing depends on the resource integration abilities of the focal actor and other potentially engaged actors. That is, wellbeing results from integrating cognitive, psychological, physical, and social resources and reducing cognitive, psychological, physical, and social challenges (Dodge *et al*., 2012; Smith, 2013; Vargo *et al*., 2008). Further, any improvement or deterioration reflects the level of resource integration of engaged actors. Therefore, a balance point view of wellbeing implies co-creation (Hepi *et al.*,

2017; Joiner and Lusch, 2016) suggesting that wellbeing can result from value co-creation involving resource integration of engaged actors.

Value Co-Creation

Service research has sought to conceptualize value co-creation and advance the notion of value beyond the marketing discipline (Edvardsson *et al.*, 2011; McColl-Kennedy *et al.*, 2012; Vargo and Lusch, 2016). Co-created wellbeing appears as a direct outcome of co-created value, leading to personal wellbeing (Busser and Shulga, 2018), which aligns with conceptualizations of value as wellbeing (Black and Gallan, 2015; Hepi *et al*., 2017). Further, value co-creation also entails a dynamic, iterative process (Chen *et al.*, 2017). On the one hand, value implies increased wellbeing in a system (Vargo and Lusch, 2014), and as an outcome, it manifests in quality of life and the attainment of life goals (Anderson *et al*., 2013; Black and Gallan, 2015; Hepi *et al*., 2017). McColl-Kennedy *et al.* (2012), in their study of patients' value co-creation practices, note the beneficial outcomes derived from a co-creative process in which patients integrate resources through their activities and interactions with others in the service network. By applying resources, actors can access, adapt, and integrate benefits from a range of offerings within a service ecosystem (McColl-Kennedy *et al*., 2012; Vargo *et al*., 2008), which then may enhance an actor's wellbeing.

On the other hand, during exchanges among actors, a person's wellbeing can be co-constructed and value co-created (Chandler and Vargo, 2011; Frow *et al*., 2016) or wellbeing can be co-destroyed (Chowdhury *et al*., 2016; Echeverri and Skålén, 2011; Plé and Chumpitaz Cáceres, 2010), which Vargo (2019) interprets as negative value. Further, the co-creation of wellbeing can be constrained by a lack of access to resources, a lack of connections to key actors in the service system, or contested institutional access due to tensions or conflicts with normative rules and values (Frow *et al*., 2016; Hepi *et al*., 2017). In a healthcare context, such limits might include hospital bed shortages, poor family support,

insufficient knowledge about the medical condition or cure, limited access to healthcare professionals, or restricted treatment options (e.g., due to national regulations that prohibit alternative medicine). Such constraints may prompt the duplication of effort or depletion of resources in the system, which then might stimulate focal or other engaged actors' active participation in co-creating wellbeing.

Accordingly, value co-creation is inherently dynamic, involving the experiential process of jointly creating value (wellbeing), undertaken by the focal and other engaged actors, through their integration of resources (Kleinaltenkamp *et al*., 2012; McColl-Kennedy *et al*., 2017a).

Psychological Ownership

A sense of possession is not always aligned with legal rights of ownership (Pierce *et al*., 2003). Notably, feelings of PO are not prone to "switching on and off" (Jussila *et al*., 2015). Rather, they emerge over time through three interrelated *routes* to psychological ownership (Dirks *et al*., 1996): (1) self-initiated responsibility and exercise of control, (2) investing the self in an ownership target and its evolution, and (3) intimate knowledge of the ownership target. The drive to exercise PO stems from four basic human needs that act as motivators: (1) efficacy and effectance, (2) self-identity, (3) having a place, and (4) stimulation and arousal (Pierce *et al*., 2003). These so-called *roots* are motivational conditions that may be satisfied through the evocation of PO (Jussila *et al*., 2015). Previous research suggests that PO is pivotal in facilitating positive behavioral outcomes (Hulland *et al*., 2015; Vandewalle *et al*., 1995). However, a sense of ownership can lead to territorial behaviors (Brown *et al*., 2014) that threaten to decrease wellbeing. Considering that PO can lead to both promotion and prevention outcomes (Higgins, 1998), it suggests a conceptual alignment with value co-creation and value co-destruction, as well as with the improvement and deterioration of wellbeing.

The behavioral implications of PO have long been recognized in disciplines such as anthropology, psychology, social psychology, geography, history, and philosophy (Ye and Gawronski, 2016); it also has emerged as a focus in management research (Gineikiene *et al.*, 2017) that seeks individual-level predictors and consequences of PO, such as organizational commitment (Van Dyne and Pierce, 2004) or employee job satisfaction (Avey *et al*., 2009). From a marketing perspective, PO has potential implications for consumer behavior, including positive attitudes toward target objects (Beggan, 1992; Feuchtl and Kamleitner, 2009). Jussila *et al.* (2015, p. 121) define PO as "a personal sense of possession an individual holds for a material or immaterial target (i.e., 'This is MINE!')." Identified outcomes include customer satisfaction, relational intentions, competitive resistance (Asatryan and Oh, 2008; Fuchs *et al*., 2010), product consideration (Kamleitner and Feuchtl, 2015), and product acquisition (Kamleitner, 2011). Notwithstanding these insights—and despite the presence of some notable exceptions (Asatryan and Oh, 2008) and similar construct conceptualizations (Harwood and Garry, 2010), such as sense of ownership (Ng *et al.* 2019)—PO has yet to be leveraged in service research (Jussila *et al.*, 2015), particularly to understand the co-creation of wellbeing.

Dynamics of Co-Created Wellbeing

On the basis of this literature review, the current study defines *co-created wellbeing* as a focal actor's wellbeing, subject to their challenges and resource conditions, which in turn depend on the focal actor's and other engaged actors' psychological experiences of ownership. The conceptualization accounts for (1) the balance between resource conditions and challenges of the focal actor, (2) the extent of resource integration, and (3) different routes to PO. Notably, this work includes at least two engaged actors: the *focal actor* who is central to the health and wellbeing challenges and efforts and *other engaged actors*, who can be instrumental in transforming the focal actor's wellbeing (Kleinaltenkamp *et al*., 2017).

They might be primary (e.g., healthcare practitioner, physician) or secondary (e.g., network of family and friends) actors (Finsterwalder *et al*., 2017; McColl-Kennedy *et al*., 2012). Three scenarios underpin the proposed conceptualization of the dynamics of co-created wellbeing:

First, the dynamics of co-creation are stimulated by the interplay of roles, efforts, and desire for betterment among engaged actors (Chen *et al.,* 2017). For example, a nurse may take the lead in caring for a newborn baby while also teaching new parents. This interplay highlights the dynamics of co-created wellbeing, in terms of a variety of psychological experience of ownership between the focal and other engaged actors.

Second, the degree and level of resource integration of engaged actors should depend on the interplay of the three routes to PO. For example, when patients become familiar with their health condition, they develop PO through intimate knowledge and may invest more of their own resources (e.g., spend time searching online for ways to improve their health) or decide to take more control over their health. These interplays can result in either promotion or prevention outcomes (see the illustrative cases below), which influence the challenges and resource conditions of the focal actor.

Third, the notion of co-created wellbeing allows a shift in focus from one actor to another (e.g., patient to physician, patient to family member) and as such, influence over one another's wellbeing becomes more evident. In this case, the interdependence of the other engaged actors' and the focal actor's own wellbeing in a system is subject to the interplay between their own challenges and resource conditions, which supports the dynamics of co-created wellbeing.

In summary, the dynamics of co-created wellbeing are subject to individual interpretation by the different actors and influenced by the focal and all other engaged actors' PO, which depends on their interactions. Therefore, the PO of engaged actors can improve or

deteriorate the resource conditions of the focal actor, and amplify or mitigate the associated challenges. Such interplay then determines the interpretation of co-creation of wellbeing by engaged actors and the SWB of the focal actor. Table 1 summarizes these key conceptualizations and Appendix 1 defines the key terms. Later, four propositions are presented to further support the conceptualization of the dynamics of co-created wellbeing and four illustrative cases show the application of the propositions.

--- Table 1 about here ---

PROPOSITIONS

This section presents four propositions on psychological ownership, co-created wellbeing and its dynamic nature and distinction from SWB.

Engaged Actors' Psychological Ownership

Psychological ownership can apply to tangible (e.g., physical good, physical space) or intangible (e.g., ideas, values) objects, "sensed" as being the person's own. Despite some debate about what can qualify as a target of PO (Hulland *et al*., 2015; Pierce and Jussila, 2011), consensus exists that people are motivated to engage in behaviors that "nurture, advance and protect the target of ownership" (Jussila *et al*., 2015, p. 130). Yet the *roots* of PO (i.e., efficacy and effectance, self-identity, having a place, stimulation and arousal) are not sufficient to elicit PO, but pursuing the three *routes to PO*, including a sense of control, intimately knowing a target, and investing in the target, is also required (Pierce *et al*., 2001).

In healthcare contexts, wellbeing is a multifaceted construct, and the proposed conceptualization further specifies that *co-created wellbeing* is an intangible target, subject to the three main routes that all give rise to PO. Greater control over, familiarity with, and investment of self in support of the focal actor's health thus should increase PO over the

actor's wellbeing. Specifically, when focal actors experience a heightened sense of control due to perceptions of the manageable severity of a current health condition, the affordability of treatment, and empowerment drawn from support by peer groups or families, they also experience PO. On the route created by intimate knowledge of the target, focal actors might document their own wellbeing, compare it with publically listed symptoms (e.g., on websites), and study treatment options. Such actions also imply investing in the target, in the form of devoting time to rehabilitation efforts, actively interacting with other patients and healthcare practitioners, or researching healthy living options for after the treatment is complete.

Engaged actors also voluntarily integrate their own resources to ensure a focal actor's wellbeing. For example, healthcare practitioners, such as physicians and nurses, likely develop PO over a patient's wellbeing because of their professional knowledge, skills, care provision, and control over the treatment provided. Their interpersonal relationship also may give rise to PO; a physician who treats a patient suffering from multiple chronic diseases over time gains intimate knowledge of the patient and relevant health conditions. If healthcare practitioners, family members, or close friends spend considerable time caring for the focal actor, they also may develop PO as a result of investing in the focal actor's care. This route might be particularly salient when focal actors are unable to perceive ownership of their wellbeing, for example, if they have been incapacitated or are too young to look after themselves.

Formally, we suggest:

Proposition 1: Co-created wellbeing is the intangible target of the focal actor's and other engaged actors' psychological ownership, and subject to the three routes to PO of exercising control, investing in the target, and intimately knowing the target.

Dynamics of Psychological Ownership

The rise of PO is dynamic and shifts in the level of PO held by any actors can occur at any point in time, as focal and engaged actors' PO differently contribute to the co-creation of wellbeing (Anderson *et al*., 2013; Hair *et al*., 2016). Specifically, engaged actors who invest their (cognitive, psychological, physical, and social) resources into the focal actor's wellbeing are likely to develop PO. These feelings then influence their future resource integration (cf. Frow *et al*., 2006); the more PO they perceive, the more resources they are willing to integrate (Pierce et al., 2001). Two other routes to PO (sense of control and intimate knowledge) provide further explanations beyond investment of self. Actions or inactions by others might alter another engaged actor's PO over the focal actor's wellbeing, such as when a patient refuses to share information about their wellbeing. In this case, a healthcare practitioner might develop weaker PO over this patient's wellbeing due to a lack of intimate knowing of the patient's ailments, compared with a patient who co-creates wellbeing by providing detailed information and following the practitioner's recommended treatment plan, which increases the practitioner's sense of control over the patient's wellbeing. However, these perceptions might change over time.

Moreover, the three routes to PO do not guarantee improved wellbeing; they might even weaken it. For example, misuse of alternative medicine, self-diagnosis using dubious online health forums, or overdependence on less qualified but still engaged actors might reduce a healthcare practitioner's perceived PO over the focal actor's wellbeing and thus diminish co-created wellbeing. If a healthcare practitioner invest substantial time, energy, and other resources in one customer with a complex health history, it may also leave fewer resources available to devote to others. Finally, an individual might feel burdened by a family member's extra-role behavior if that engaged actor is too emotionally invested or seeks to take charge of the focal actor's health and wellbeing.

Further, at various points in a person's healthcare journey, PO over their wellbeing varies, increasing or diminishing over time. For example, focal actors who partake in extra-role behavior and commit to and take responsibility for their health likely exhibit engagement in their own healthcare (McColl-Kennedy *et al.* 2012; Sweeney *et al*., 2015). Interactions with other engaged actors (e.g., dietician) could increase both the focal actor's and the other engaged actors' PO over the focal actor's wellbeing and thereby prompt even more engagement in health-related activities (e.g., changing their diet). However, if the focal actor reaches a wellbeing balance point (Dodge *et al.*, 2012) and no longer needs assistance to maintain wellbeing, the other engaged actors' PO over the focal actor's wellbeing might naturally diminish, while the focal actor's PO remains high. For focal actors who are unlikely to develop PO (e.g., infants, people diagnosed with severe illnesses making them unable to act), the PO of other actors has crucial influence on the challenges and resource conditions of that focal actor.

In summary, we express this as follows:

Proposition 2: Psychological ownership over the focal actor's wellbeing is dynamic and subject to the psychological experience of ownership by the focal actor and other engaged actors.

Psychological Ownership and Resource Integration

The level of engaged actors' resource integration should be associated with their evaluation of the focal actor's and their own existing resource conditions and challenges. For example, a low level of available resources to the focal actor, combined with severe challenges, might require greater integration of resources by other engaged actors to better the focal actor's health. Moreover, more challenges for a focal actor might increase their willingness to integrate others' resources. When focal actors enjoy the support of other engaged actors, they might also be better able to integrate resources and master challenges,

by bundling their own and others' resources. Collective resource integration efforts, therefore, can improve the focal actor's resource conditions and alleviate the challenges.

Moreover, a focal actor's increased PO can result from a greater understanding of their health and the need to take ownership of it, because this understanding implies an investment of some cognitive resources to comprehend and contemplate the status quo of their own wellbeing. Such comprehension exercise might benefit from the integration of other resources, such as using a Fitbit device to record health data, gather feedback on training progress, and determine sleep patterns.

However, the development of PO does not always enhance wellbeing and can deter resource integration of engaged actors. For example, tensions may arise among actors due to territoriality issues, such as when the focal actor is not equipped with sufficient resources to achieve wellbeing, thus other engaged actors might intervene and seek control over the focal actor's wellbeing. Such tensions may lead to the depletion or conservation of resources and the withdrawal of one or more engaged actors. Moreover, other engaged actors' PO over the focal actor's co-created wellbeing depend on the challenges they face and the resources they can integrate. Further, PO arising from a sense of control and intimate knowledge can lead to resource depletion or duplicated efforts that further deter resource integration, for example, when a focal actor denies or defers standard medical treatment after gaining access to the supposed resources provided in dubious online health forums where biased knowledge might prevail.

Finally, resources can be the focal actor's own or be drawn from other engaged actors. When a focal actor has a sufficient resource pool, PO can be high ("I own/can access the required resources to take charge of my health"); without it, felt PO likely decreases ("I don't have what I need to master these challenges and my wellbeing").

Formally, we propose:

Proposition 3: The extent of evoked psychological ownership over a focal actor's wellbeing is reflected in collective resource integration, which is subject to but also influences resource conditions and challenges perceived by the focal actor and other engaged actors.

Psychological Ownership and Subjective Wellbeing

People construct expectations of potential or future service experiences from different sources, including their own imagination or stories told by others (Meyer and Schwager, 2007). Life experience builds over time, through evaluations of individual or shared accounts of past, current, and future experiences with different resources, processes, contexts, and outcomes (Helkkula *et al*., 2012). Similarly, SWB perceived by the focal actor is influenced by co-created wellbeing (Busser and Shulga, 2018). In the proposed conceptual framework, cognitive, psychological, physical, and social *challenges*, relative to the cognitive, psychological, physical, and social *resources* available, influence assessments of SWB. However, the focal actor's SWB is also influenced by other engaged actors' PO over the focal actor's wellbeing, because this PO can influence the focal actor's resource conditions positively or negatively. Resource replenishment or depletion over time can increase or decrease the PO of these engaged actors and lead to the contraction or expansion of co-created wellbeing.

Further, co-created wellbeing as an outcome may be evaluated differently by engaged actors. Engaged actors form an ecosystem (Chandler and Vargo, 2011; Maglio *et al*., 2009) and contribute to co-created wellbeing if they provide resources (cognitive, psychological, physical, and social) to facilitate the improvement of the focal actor's wellbeing. Such resource integration should increase the resource pool and ease perceived challenges and this likely alters the focal actor's evaluation of their own wellbeing. However, the more challenges a focal actor faces, the faster their resources diminish as does the ability to

perform resource integration to combat the challenges. This might decrease the perceived PO over their wellbeing as well as their SWB. The focal actor's evaluation of their own health and PO over their wellbeing depends on resource conditions and challenges, however, the availability of more resources without proper resource integration capability may not always produce positive outcomes (cf. Brown *et al*., 2014). For example, a "territory battle" may prevent a focal actor from integrating their resources in an effort to maintain boundaries and control over their wellbeing. The notion of co-created wellbeing thus recognizes that the PO of engaged actors collectively influences the challenges and resource conditions of the focal actor and their SWB. Collectively, the levels of one or more engaged actors' PO (including the focal actor) influence the focal actor's perceived SWB.

In conclusion, we formulate:

Proposition 4: A focal actor's subjective wellbeing is influenced by co-created wellbeing and dependent on the extent of evoked psychological ownership among the focal actor and other engaged actors.

Figure 1 illustrates the interplay of these four propositions and reflects the different notions of wellbeing. The underlying conditions relate to individual actors' personal spheres as well as the joint value co-creation sphere. That is, (1) co-created wellbeing is multifaceted, involving the focal actor's challenges and resources and the balance point of wellbeing (Dodge *et al.*, 2012); (2) wellbeing is always co-created; (3) co-created wellbeing is determined by both the focal actor's and other engaged actors' levels of PO; and (4) a focal actor's co-created wellbeing is dynamic.

--- Figure 1 about here ---

APPLICATION OF THE FRAMEWORK TO HEALTHCARE

Four cases, derived from qualitative research undertaken by one of the authors, provide primary data pertaining to value co-creation projects, from both healthcare customers' (three cases) and practitioners' (one case) perspectives. The data analysis involved both thematic analysis and transcript code-recode procedures. The thematic analysis primarily relied on a deductive approach (Boyatzis, 1998) that identified themes related to co-creation, psychological ownership, and wellbeing. Each case was written as a narrative, with extracts from the interview transcripts serving to illustrate the four propositions. The presentation of each case reflects the following organization: First, the case is outlined and the focal actor and other engaged actors are identified with pseudonyms. Second, the issues related to PO are outlined. Third, the discussion shows how PO is managed to co-create positive wellbeing outcomes. Fourth, the outcomes of co-created wellbeing are explained. Fifth, each case is summarized in relation to the four propositions.

Case 1: The Focal Actor Has No Psychological Ownership

Case 1 is centered on a newborn baby as the focal actor, the mother (primary care giver) as the primary engaged other actor, and a nurse practitioner as a secondary engaged other actor, with services such as the Salvation Army as tertiary other actors. The focal actor (baby Karina) has no PO over her wellbeing and cannot evaluate her SWB; she is completely reliant on the engaged actors, the mother (Rae) and nurse practitioner (Jill), to co-create her wellbeing. Although Rae is the primary caregiver, both Karina and Rae receive support from Jill, who works for a healthcare service that provides resources to families who have recently had a baby. Nurse Jill integrates resources for the focal actor Karina (Proposition 3), who was born into a family with limited resources. The father is unwell and cannot work, and there is no extended family available for support. As an engaged other actor, Jill's primary concern is the wellbeing of baby Karina and also supporting Rae, such that she notes, "we give [parents] all the support we can, but we also have to say, look, you know, that baby needs …." In this

case, both Rae and Jill develop high PO over Karina's wellbeing; Jill's relatively high PO over Rae's wellbeing also reflects her awareness that Rae's wellbeing is important for the baby's wellbeing.

Issues related to the PO of baby Karina's wellbeing arose primarily due to the limited psychological, social, physical, and financial resources of the family. In this case, because the wellbeing of the baby is at stake, Nurse Jill offers extra support and organizes other actors to help, such as the Salvation Army:

> I organized a Salvation Army pack for them, because she, the baby was just wee [little], and she didn't have nappies, so I got her cloth nappies. But they just had nothing, like she [Rae] had to pay the rent and her husband was unwell, so his income wasn't coming in, and she wasn't working, so she tried to go back working, but the baby would not take the bottle. We tried to help with that. So yeah, it was just like a bigger support role than most mums would need, and our role is that we can see people more, make contacts [with other health professionals] if there is a need.

In this case, the focal actor and primary engaged actor (Rae) have limited resources, and the engaged secondary and tertiary actors (Nurse Jill and the Salvation Army), who have high PO at this point, integrate additional resources to ensure the wellbeing of the focal actor.

Once some of the challenges associated with the resource conditions of baby Karina and Rae were addressed, Jill's PO for both decreased, until she no longer needed to visit (Proposition 2), and "I had to say goodbye … you do go through a lot with people, but then you need to move on." This dynamic nature of PO over co-created wellbeing arises largely because the health practitioner provides resources (cognitive, psychological, physical, and social) up until the point that she knows the wellbeing of the focal actor is improving. However, Rae retains high PO over Karina, due to the natural intimate knowledge between

mother and baby, despite the depleted resource conditions and Rae's own diminished psychological wellbeing. With additional support from Jill, they were able to co-create wellbeing for both Rae and Karina.

In summary, co-created wellbeing in this case arises from the primary engaged other actor (Rae) as well as secondary (Nurse Jill) and tertiary (Salvation Army) engaged other actors' PO over the focal actor's (baby Karina) wellbeing (Proposition 1). PO is dynamic (Proposition 2), as demonstrated by the way that Nurse Jill's PO over baby Karina's wellbeing changes over time. The overall outcome is that the nurse practitioner facilitates co-created wellbeing for the baby (focal actor) and mother (engaged actor) by sufficiently integrating resources to improve both the baby's and the mother's wellbeing, representing the resource conditions and challenges as suggested in Proposition 3. Although primary and secondary other actors engaged in co-creation and improved the wellbeing of the focal actor (Proposition 4), the SWB of baby Karina could not be determined subjectively but only objectively by Nurse Jill, who applied other measures, such as key childhood development indicators (e.g., weight, height, heart rate). Karina's wellbeing therefore was influenced by the extent of Jill's PO over her co-created wellbeing.

Case 2: The Focal Actor Has Low Psychological Ownership

In this case, the focal actor is 91-year-old Fred, the primary engaged other actor is Fred's wife Dot (71 years of age), and other secondary and tertiary engaged actors include healthcare service providers, family, and friends. Six years ago, Fred, previously very fit and healthy, had a heart attack, and since then, he has had to "adjust to living life" with this "wretched health thing [congestive heart failure]," relying on Dot and other service providers (physicians, nurses, speech therapists, respite care) to ensure his health and wellbeing are maintained. Complications from the heart attack have confronted Fred with many challenges, both physical and mental, including confusion and memory loss. These challenges have

resulted in the reduction of Fred's PO over his wellbeing and a concomitant increase in the PO of other actors, primarily Dot, who is his main caregiver.

In particular, Fred has lost some of his sense of intimate knowledge and ability to exercise control, due to his failing memory and reduced ability to care for himself. As Dot explains, "Fred has been going through a really difficult health patch and his concentration just naturally isn't there." Dot thus assumes greater PO over Fred's wellbeing due to her intimate knowledge of Fred as her husband (Proposition 1). Despite Fred's diminishing PO, during lucid moments, he is aware of Dot's contribution and the importance of good healthcare services to his wellbeing, noting that "the service we get at our doctor [is good] … just as well, because we've needed it." Dot ensures that Fred has the resources to maintain his wellbeing, by organizing doctor's visits, visitors, social outings, and respite care as needed (Proposition 2 and 3). In this sense, Dot had taken full ownership of Fred's healthcare and believes that being involved in his health management is important:

> I like to be involved in our health management…. Whenever we see specialists, I always ask them, can we have a copy of that please, and the numbers of times that has been valuable. We had two speech therapists here the other day looking at Fred's swallowing difficulties…. I was able to give them the specialist report…. The same thing happened with the ambulance officers when he's been taken to hospital; the ambulance officers don't have the background, so I gave them Fred's file to look at.

However, as Dot took more PO over Fred's wellbeing, her own physical and psychological wellbeing suffered, due to exhaustion. As Fred's condition worsened, Dot experienced resource depletion and needed extra support to replenish her resources and reduce the challenges, with the support of other actors (Proposition 4). Fortunately, Fred and Dot have sufficient financial resources to afford respite care so that Dot could put Fred in respite care

“for a week to give me a break.” Dot is also well connected in the community and has strong social networks. She arranges for close friends or family members to stay with Fred while she shops or takes breaks. These temporary caregivers (other engaged actors) likely develop some PO over Fred’s wellbeing during these care sessions.

By carefully managing these challenges and resource conditions, Dot has been able to co-create wellbeing, ensuring that Fred has the best possible care, as well as co-creating wellbeing for herself. Dot possesses intimate knowledge that her own wellbeing is critical to ensuring her ability to support Fred and continue to manage his health and wellbeing. As a key outcome, Dot was able to integrate resources by successfully identifying and engaging other actors, including healthcare professionals, friends, and family, who could provide appropriate support and advice (Proposition 3). This case also demonstrates the dynamism of PO (Proposition 2), in that PO over Fred’s wellbeing changes continually, with various actors taking more or less PO at any given time. On a day-to-day basis, Dot is in full charge of Fred’s health, and she has high PO; when she needs a break and Fred goes to respite care for a week, Dot still retains PO, but the service provider takes full PO over Fred’s wellbeing. In this scenario, Fred’s PO also diminishes, because he feels a complete lack of control. Similarly, when Fred is admitted to the hospital, the service provider assumes high PO over his wellbeing. Thus Fred’s PO over his own wellbeing is constantly changing; when he is at home and feels coherent, he takes more PO, but when he is incapacitated, his PO diminishes.

This case in particular reveals that co-created wellbeing is an intangible target of both the focal and other engaged actors (Proposition 1); it also reflects the dynamics in PO adopted by various engaged actors over the focal actor’s wellbeing (Proposition 2). The case highlights the effect of resource integration of both focal actor and engaged actors (Proposition 3), and this empirical evidence documents how Fred’s SWB is influenced by the PO of these actors (Proposition 4).

Case 3: The Focal Actor Has High Psychological Ownership

In case 3, Margaret, who is 48 years old and suffers shoulder, neck, and back pain, turns to other engaged actors, such as her doctor and chiropractor. After trying several short-term relief options, such as anti-inflammatory medication and physiotherapy, Margaret decided to seek a longer-term solution. Despite her physical and psychological challenges, due to her health condition, Margaret displays high PO over her wellbeing (Proposition 2), explaining that "I've had issues with my shoulders, my neck, my back…. I took a lot of anti-inflammatory medication just to get me through the day…. So, yeah, I needed to do something about it." Margaret discussed her options with her doctor, who recommended that she consult with an orthopaedic surgeon. However, Margaret has decided that surgery is not a good option at this stage and sought out a chiropractor as "a last resort."

In this case, a potential tension arises between the focal actor (Margaret) and the primary engaged other actor (doctor). Both assume PO over Margaret's wellbeing, with different views of the best course of action. Margaret explains, "the doctor said that I need to go and see an orthopaedic surgeon and maybe have surgery on my shoulder and I thought no I'm not doing that…. I know of people who have had similar surgery and they're actually worse off…. [Instead] I decided to try a chiropractor." Despite her doctor's recommendation, Margaret makes a decision to consult a chiropractor and replaces the surgeon as potential secondary engaged actor with the chiropractor, and increases PO over her wellbeing, investing herself in her own wellbeing and exercising control. She explicitly explains, "I am taking responsibility for my health, for my wellbeing by looking for an alternative to surgery" (Proposition 1).

As a result of Margaret's reasonable PO and evaluation of her current SWB ("I'm just in constant pain, stiff necks, sore arms…. I needed a long-term solution"), Margaret begins to co-create wellbeing by managing the challenges and consulting alternative sources

(Proposition 2 and 4). Margaret also has sufficient financial resources to pursue alternative healthcare. Her experience with the secondary engaged other actor (chiropractor) is paramount to improving and maintaining her high PO. The consultative style of the chiropractor and shared decision making also enable Margaret to maintain a sense of control and engage in the process. The chiropractor thus facilitates co-created wellbeing by explaining her condition in-depth and working with her, such that "the chiropractor explained everything … explained how the spine worked … we discussed the treatment plan." Margaret is empowered by this experience, because "it does give you more power to actually understand what's going on."

Initially, Margaret visited the chiropractor two to three times per week for a period of six weeks; the frequency later decreased to once per week and then once per month, at which point she experienced long-term pain relief. With this treatment, Margaret managed to reduce her challenges (physical and psychological), and as an outcome, her wellbeing improved (Propositions 3 and 4). As Margaret describes, "it was a whole new beginning for me to be pain free … it's helped me mentally and physically."

This case depicts co-created wellbeing as an intangible target of the PO of both the focal actor (Margaret) and the engaged other actor (chiropractor) (Proposition 1). This PO grew as Margaret's physical and psychological challenges diminished, through her engagement with the chiropractor. She also had the financial resources to afford this specialized care. Not only did Margaret's SWB improve due to co-created wellbeing between her and her chiropractor, as a result of evoked PO through collaboration (Proposition 4), but her initially lower PO over her wellbeing increased and then remained high (Proposition 2) as she took more continuous responsibility, and further integrated resources for her health improvements (Proposition 3).

Case 4: The Focal Actor Has Varying Psychological Ownership

Case 4 revolves around Jane as a focal actor. Jane is a 51-year-old widow with a teenage son, and was diagnosed with mesothelioma, an asbestos-related lung cancer. The primary engaged other actors are her oncologist and a natural healthcare practitioner. The secondary engaged actors include family members (sister, brother, and sister-in-law); tertiary other actors are a nutritionist, and Dove House, a cancer support center.

When Jane was first diagnosed, she dipped into "a very dark black hole" and "couldn't see the way out of it." Her oncologist told her "time is not on your side" and took immediate PO over Jane's wellbeing, saying "I don't want to keep you out of my sight for too long … you need to get treatment ASAP." Initially the oncologist exercised control (Proposition 1), but after dealing with the challenge of the initial "shock," Jane began exercising more control and investing herself to maintain PO over her wellbeing. Jane realized she needed to "put everything into [beating the cancer]," so she started to "read cancer books, [study] cancer, cancer, cancer, alternative stuff and nutrition" and also enlisted her sister-in-law to help find a natural healthcare practitioner (Propositions 1 and 2). After discussions with her oncologist and meetings with the natural health practitioner, Jane decided "to do both" chemotherapy and natural therapy. Of great importance to Jane was the oncologist's and natural healthcare practitioner's preparedness to work together with her, to co-create wellbeing. An integrated approach to her healthcare was paramount, and she felt "fortunate" to have the "best of both worlds" (Propositions 2 and 4).

Jane had resources (social, financial, and psychological) to cope with the challenge of cancer, and "I was fortunate that I didn't have to hold down a fulltime job…. I had the luxury of being able to sleep when I needed to but, yeah, it was a big undertaking but I had fantastic support from my family" (Proposition 3). Despite the challenges of enormous psychological stress, due to her diagnosis and the loss of her partner in a tragic accident prior to that diagnosis, Jane did what she needed to do "to be able to get up each morning and get through

each day." Critical to her wellbeing were her relationships with the natural health practitioner, oncologist, and "amazing" family, such that she "felt supported … felt like you had hope." Jane's family was particularly important in terms of co-creating wellbeing, in that her "sister-in-law would drive [her] there [to chemotherapy]," and her brother and sister came to "every CT scan, every oncologist appointment."

Jane's co-created wellbeing in turn had a large impact on her overall SWB, due primarily to collective resource integration among the engaged actors (Propositions 3 and 4). As Jane underwent treatment, both chemotherapy and natural therapy, she maintained her high PO by continually seeking support and co-creating wellbeing with other actors, such as Dove House. According to Jane, "I was going probably once a week, it was my absolute lifeline for about six to eight months, my one little drive to Dove House, that's what kept me above water … without Dove House as well, I would have really struggled." Jane also sought advice from a nutritionist to fine-tune her diet and read texts by the author of *Crazy Sexy Cancer Survivor*, describing how "wow, like this woman [author] has just been such an inspiration to me." These other actors were critical to co-creating Jane's wellbeing and subsequent SWB. In addition, from Jane's perspective, the PO of these engaged other actors was paramount, from Dove House being a "lifeline" to the author being "incredible … she sends you little emails all the time … that's what gives you the real belief" (Proposition 4).

Jane's case illustrates all four propositions. As Jane states, "I'm living proof that it [co-creation of wellbeing] works, you know and yes, I get tired and yes, I still [have] some days [where I] have little meltdowns and feel this is so unfair, but at the end of the day I'm alive…. I'm about 19 months now [since diagnosis] and I'm really, really well."

DISCUSSION

Theoretical Contributions

Scholars have called for more research on how wellbeing is co-created (Ostrom *et al*., 2015). By drawing on existing service research to conceptualize the role of PO in co-created wellbeing, this study makes several contributions to service research. In particular, it establishes four propositions regarding the dynamics of co-created wellbeing from a PO perspective. In introducing PO to service-related wellbeing research, this study confirms its key role in how actors co-create wellbeing. Empirical illustrations demonstrate how to use PO as a theoretical construct to explain co-created wellbeing, which depends on the focal actor (e.g., patient), other engaged actors (e.g., healthcare practitioner), or both taking ownership of the focal actor's wellbeing. Various resource conditions alone may or may not evoke resource integration by different actors. The findings reflect the positive and negative consequences and dynamic nature of PO-informed co-created wellbeing, which have not previously been acknowledged or understood.

This work also extends theoretical frameworks used in prior service research applications to healthcare. In particular, the illustrative cases show that PO can explicate the effects of co-created wellbeing in terms of both the practice approach level (McColl-Kennedy *et al*., 2017b) and the individual actor level (McColl-Kennedy *et al*., 2017a). At the practice approach level, PO can serve as an additional explanation for the shift from a traditional model of care toward self-managed care, shared decision-making (SDM) and person- and people-centered healthcare (PPCHC) (Lukersmith *et al*., 2016) (see Appendix 2). The move from individual PO toward shared PO over the focal actor's wellbeing (Pierce and Jussila, 2010) also helps explain the development of practice approaches over time. Considering the limited resources in modern healthcare systems, such practice approaches are key. At the individual level, this study distinguishes between SWB and co-created wellbeing: The former is an individual evaluation of personal wellbeing, whereas the latter reflects both the focal

actor's and other engaged actors' PO and resource conditions, which then influence individual SWB. The findings demonstrate the explanatory power of PO in service research, suggesting the potential benefits of studying PO further, as outlined subsequently in the research agenda.

Practical Implications

The four illustrative healthcare cases depict the processes and impact of PO on co-created wellbeing, thereby revealing why it is important to attend to and manage PO when co-creating wellbeing. Health practitioners should account for the health and wellbeing context that surrounds their patients; beyond the challenges these focal actors face (e.g., medical conditions, financial constraints), they should evaluate available resources (e.g., time, family). In particular, the focal actor's networks of friends, family, and other types of support might need activation (Hepi *et al.*, 2017) to evoke PO and, ultimately, increase the options for improving the focal actor's wellbeing. This study provides insights into how to manage dynamic processes of PO to co-create wellbeing in terms of initiating, taking, and maintaining psychological experiences of ownership.

Notably, to facilitate wellbeing, it should be easy to leverage collective resource integration by engaged actors. For policymakers, block funding may appear effective and efficient, but they also need to recognize the dynamic nature and interrelationships of co-created wellbeing and PO. The focal actor might require support not only from healthcare practitioners but also from the immediate and personal service system. Public policy should be designed to strengthen the position of and support for other engaged actors, such as family and friends, by leveraging their resources and to ensure support exists for enabling and making ease of resource integration where it is needed. For example, subsidized taxi fares and wheelchair-accessible vehicles could be very valuable. Legal recognition of the role and position of engaged actors also might take some responsibility off government agencies, by

decentralizing health and wellbeing efforts to the individual family or reference group. Such a shift would require the redistribution of resources, away from the overall system and into private hands. Then the focal actor can draw on resources, available in the immediate environment, more easily.

Research Agenda

The proposed research agenda suggests important areas of inquiry to advance understanding of co-creation, PO, and wellbeing; it reflects the propositions of the theoretical framework, as outlined and summarized in Table 2.

--- Table 2 about here ---

In particular, by taking a PO perspective on co-creation and wellbeing, this study provides insights into emergent research domains that might benefit focal actors, through co-creation of their wellbeing. Relatively little prior research has explored the PO of intangible objects, such as wellbeing, which is highly complex, as an intangible target contingent on the type of service (e.g., disease), situational factors (e.g., patient's condition), and level of engagement of the patient and other actors (e.g., physicians, nurses, families, friends, social workers) (Fuchs *et al*., 2010). Explorations of co-created wellbeing as an intangible target of engaged actors' PO might aid with distinguishing more precisely among formal (legal) ownership, co-created wellbeing, and SWB. In some cases, an engaged actor (e.g., a grandson) may have formal ownership of the focal actor's (e.g., grandmother) wellbeing, such as in legal guardianships. Outcomes might differ if, for example, an engaged actor (e.g., the sole remaining heir) feels "entitled" to take PO of somebody else's (e.g., grandmother) wellbeing. It will be critical to specify the boundary conditions between PO versus a sense of responsibility or accountability. Because PO also indicates a sense of possession, it could be

intertwined or confused with feelings of responsibility and accountability, but distinguishing these constructs can advance understanding of the potential effects on co-created wellbeing.

Furthermore, PO depends on resource conditions, so further studies should determine how an existing pool of cognitive, psychological, physical, and social resources influence co-created wellbeing. As noted, PO can have positive outcomes, but it also might result in negative consequences (e.g., territorial behaviors). Further research should explore the resource conditions that tend to lead to the co-destruction of wellbeing.

With regard to dynamic individual PO over wellbeing, it is necessary to address whether this dynamism also applies to other types of wellbeing, such as financial wellbeing (e.g., inertia towards superannuation). Previous research on PO concurs that both roots and routes inform its generation (e.g., Jussila *et al*., 2015). Further research might explore other contextual factors associated with PO (Avey *et al*., 2009; Mayhew *et al*., 2007). In professional service settings such as medicine and finance, efficacy, identity, and belonging all might be salient factors. Patients and financial clients may lack the ability to identify key factors, especially if the target objects, such as a hospital bed or superannuation scheme, are undesirable or not psychologically owned by the focal actor. Moreover, the dynamism of PO applies not just intra-individually but also inter-individually, between a focal actor and other engaged actors. Further study thus is needed to describe intra- and inter-individual variations among different actors in service settings.

Research that goes beyond the PO of individual wellbeing (Jussila *et al*., 2015) might extend insights into wellbeing and collective PO, such as the collective PO of family members or a medical team that treats a patient. From a system view, the target of collective PO could be expanded, from co-created wellbeing for an individual actor to national or ecosystem wellbeing. In a related sense, future research should focus on actors who

demonstrate non-ownership of their wellbeing and its effects on treatment plans, time to heal, or collaboration with medical professionals.

This study thus offers several promising directions for research into the transformation of lives, according to the proposed theoretical framework that combines value co-creation, wellbeing, and PO. It calls for conceiving of value co-creation as more than just benefits, wellbeing as more than subjective evaluations by a focal actor, and PO as more than just the notion of possession.

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Figure 1: Dynamics of Co-created Wellbeing Framework

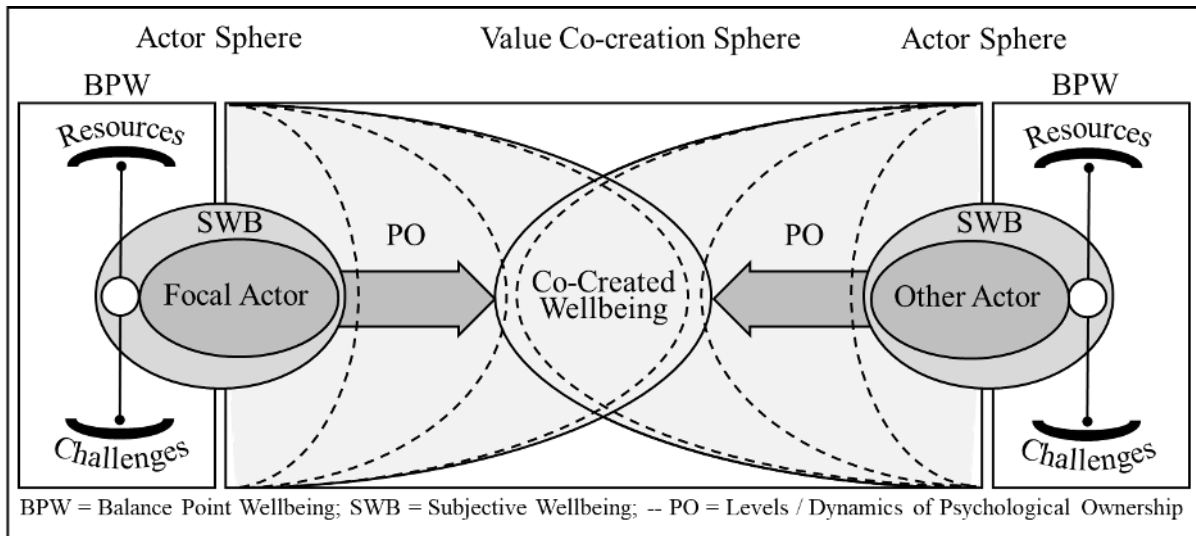

Table 1: Conceptualizations of Wellbeing

Authors / Year	Field of Study	Focal Wellbeing Construct	Definition / Conceptualization of Wellbeing	Theory	Method	Findings
This paper	Service research	Co-created wellbeing	A focal actor's wellbeing is subject to his or her own resource conditions, influenced by the focal actor's and other engaged actors' psychological ownership (PO).	Psychological ownership	Conceptual and qualitative, interviews	Co-created wellbeing is dynamic.
Diener *et al.* (2003)	Social psychology	Subjective wellbeing (SWB)	Personal outcome whereby a person thrives across multiple domains of life.	Dimensions of SWB: physical, psychological, social, existential	Review	If a person's life exceeds comparison standards, the person is satisfied and happy. If the life falls short of comparison standards, the person is dissatisfied and unhappy.
Diener *et al.* (2015, p. 234)	Social psychology	Subjective wellbeing (SWB)	"People's evaluations of their lives—the degree to which their thoughtful appraisals and affective reactions indicate that their lives are desirable and proceeding well."	Affective and cognitive bases of wellbeing.	Review	SWB is based on emotional reactions to events and cognitive judgments of satisfaction and fulfilment in life.

Dodge *et al.* (2012, p. 230)	Positive psychology	Balance point wellbeing	"The balance point between an individual's resource pool and the challenges faced" includes cognitive, psychological, physical, and social resources and challenges.	Dynamic equilibrium theory of wellbeing	Conceptual	Individuals are decision makers, with choices, preferences, and the possibility of becoming masterful or efficacious.
Kahnemann *et al.* (1999)	Hedonic psychology	Hedonic wellbeing	Hedonic wellbeing what makes experiences in life pleasant or unpleasant, through the consideration of feelings, circumstances, enjoyment, and suffering at a particular time or phase in one's life.	Experiential	Experiment	Experiences in real-time rather than retrospective evaluations of life provide richer insights into true wellbeing and happiness.
Keyes *et al.* (2002)	Social psychology	Psychological wellbeing (PWB)	PWB is distinct from SWB, concerned with human development and existential challenges of life, including resources and potential to cope with adverse life events.		Survey, quantitative, factor analysis	The probability of optimal wellbeing (high SWB and PWB) increased as age, education, extraversion, and conscientiousness increase and as neuroticism decreases.
Ryan and Deci (2001)	Humanistic psychology	Eudaimonic wellbeing	Wellbeing is optimal psychological experience and functioning, viewed from two perspectives: hedonic	Aristotle	Survey	Wellbeing is not an outcome or end state as mush as a process of fulfilling or realizing

			(presence of positive and absence of negative affect) or eudaimonic (living life in a deeply satisfying way).			daimon or true nature—that is, fulfilling virtuous potential and living as inherently intended.
Seligman (2011)	Positive psychology	Flourishing, languishing	The gold standard for wellbeing is flourishing, and the goal of positive psychology is to increase it.	PERMA (positive emotion relationships meaning affect)	Experiment, quantitative	Exercises focused on building gratitude, increasing awareness of what is most positive about the self, and identifying strengths of character.

Table 2: Research Agenda for Co-Created Wellbeing and Psychological Ownership

Propositions	Areas of Inquiry
P1: Engaged actors' psychological ownership.	▪ How are a sense of entitlement and formal ownership connected? ▪ How does the PO of wellbeing apply to different types of wellbeing?
P2: Dynamics of psychological ownership.	▪ What are the contextual factors associated with PO? ▪ How does PO vary intra- and inter-individually across focal actors and engaged other actors?
P3: Psychological ownership and resource integration.	▪ How do different resource conditions in an actor's resource pool influence a change in PO and wellbeing co-creation? ▪ How do co-creation and co-destruction of resources and interactions influence wellbeing?
P4: Psychological ownership and subjective wellbeing.	▪ How are collective PO and wellbeing intertwined? ▪ How does perceived non-ownership influence wellbeing?

Appendix 1: Key Terms

Key Term	Definition	Reference
Focal actor	The actor in the centre of wellbeing efforts.	This paper
Engaged actor	Any other actor involved in the improvement of the focal actor's wellbeing.	This paper
Value	Wellbeing.	Black and Gallan, 2015; Hepi *et al.*, 2017
Value co-creation	The dynamic and experiential process of jointly creating value (wellbeing) among the focal actor and other engaged actors through the integration of resources.	This paper
Psychological ownership	A sense of possession that may be distinct from any legal right of ownership.	Pierce *et al.* (2003)
Healthcare	"Collection of goods and services that are perceived as bearing a special relationship to health … [and are] central to the health [and wellbeing] of both individuals and populations"	Evans and Stoddart (2017, p. 27)

Appendix 2: Three Types of Healthcare Practitioner–Patient Relationships

This appendix outlines the development of healthcare practice, particularly the healthcare practitioner–healthcare customer relationship over time, from the traditional notion in healthcare practice to approaches such as self-managed care and shared decision making (McColl-Kennedy *et al*., 2017b), and more recently moving towards the development of "person- and people-centred healthcare" (PPCHC) (Lukersmith *et al*., 2016).

Traditions in Healthcare

Traditionally, interactions between the focal actor and the healthcare practitioner tend to focus on the problem, not the person (Courtney *et al*., 1996). In their role as the focal actor's guardian, the healthcare practitioner authoritatively determined what was best for the focal actor. The focal actor, to a large extent, was viewed as a passive recipient of care (Wagner *et al*., 2005). The healthcare practitioner used their knowledge and skills to determine, diagnose and make decisions about treatment and interventions (Emanuel and Emanuel, 1992). In this form of healthcare we can presume that the healthcare practitioner had PO over the focal actor's health, while the focal actor often felt that their wellbeing was owned by the healthcare practitioner. The wellbeing of the focal actor, therefore, depended on whether the healthcare practitioner's resource integration ability was sufficient to cure the focal actor, and whether the focal actor felt that the healthcare practitioner had taken PO over their wellbeing.

Self-Managed Care

Self-managed care refers to an "individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent to living with a chronic condition" (Barlow *et al*., 2002, p. 177), both inside and outside the healthcare setting. The core self-management skills include problem-solving, decision-making, resource utilization, sharing of information, and forming patient–healthcare provider partnerships

(Lorig and Holman, 2003). The role of healthcare professionals in self-managed care is educating the focal actor about their disease and teaching self-care skills, forming relationships (with patients, families, and communities), and facilitating self-care and peer education (Lorig and Holman, 2003). We therefore reason that self-managed care could potentially build a focal actor's PO over their wellbeing. However, if the challenges are much larger than the resources available or the burden of self-care is too great the focal actor's PO of their wellbeing may diminish and self-managed care may not be satisfactorily achieved. In such cases, neither the focal actor nor the healthcare practitioner has PO of the focal actor's wellbeing, and this diminishes the chances of successful health outcomes for the individual.

Shared Decision-Making

Subsequently, shared decision-making (SDM) emerged from the increased interest in more person- and people-centred healthcare (PPCHC) (Lukersmith *et al*., 2016). SDM is considered a mutual process whereby the focal actor actively engages in medical consultations, defines their preferred role in decision-making, forms a partnership with the healthcare practitioner, articulates health problems and expectations, communicates, accesses and evaluates information, and negotiates and agrees on an action plan (Frosch and Kaplan, 1999). The healthcare practitioner, in turn, must be willing to establish a relationship with the focal actor and take the time to understand their preferred role in decision-making, share expertise and evidence, identify choices, respond to the their ideas and concerns, and discuss options (Charles *et al*., 1997).

SDM and a PPCHC approach are therefore likely to evoke a healthcare practitioner's PO over a focal actor's wellbeing, and once their preferred role is successfully understood and developed, PO over their own wellbeing should emerge. When the level of PO of both actors is high, their resource integration in terms of improving the focal actor's wellbeing and co-created wellbeing is at an optimal level. In contrast to traditional healthcare and self-

managed care approaches, PPCHC and SDM have the potential to create shared PO among healthcare practitioners and their customers over the focal actor's wellbeing, thus contributing to positive co-created wellbeing. This paper bases its conceptual explorations on the notion of the development of PO through PPCHC and SDM.