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Essentials of customer experience in demanding medical rehabilitation

CASE-STUDY IN A PRIVATE PHYSIOTHERAPY CLINIC

MASTER'S DEGREE PROGRAMME IN REHABILITATION
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Essentials of customer experience in demanding medical rehabilitation. Case-study in a private physiotherapy clinic.

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The objective of this qualitative case-study originated from the upcoming changes in the health care sector, where the customers' freedom of choice will increase in the future. The role of customer experience as a competitive advantage will be noticeable. The purpose of this study was to deepen customer insight in the target organization. Customer experiences of Kela's demanding medical rehabilitation customers were explored in relation to service encounters and touch point elements. This study was conducted as part of a wider development process of the target organization. A customer panel founded for developmental purposes acted as a focus group for the interviews. Two focus-group interviews with 4-7 customers were implemented within five months in 2019. Data was analyzed by using an abductive approach, where both theory and data guided the analysis of the data.

Different touch point elements as unique combinations affected the customer experience in several service encounters. The most critical service encounter was the actual physiotherapy appointment. This core service encounter was the most meaningful to customers and created the most value for them. The meanings linked to the core service were maintaining functioning, therapy creating structure to daily life, and social support. The role of people in creating a good customer experience was highlighted over any other touch point element. An especially important issue was the therapy relationship. Moreover, the continuity of therapy and person-centeredness concerning the content of therapy were important. Accessibility was the main factor affecting the customer experience when surroundings were concerned. These experiences were dependent on the customer's functioning and changes in it over time. The customers' need for advocacy and new experiences appeared in the experiences and in multiple suggestions for possible new service encounters.

Several managerial implications were presented to the target organization. Despite that the study was done as case study, these can be used more generally when developing customer-oriented rehabilitation services.

Customer experience, medical rehabilitation, customer orientation

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1 INTRODUCTION

This research is taking place in a private outpatient physiotherapy clinic providing medical rehabilitation in the Pirkanmaa region in Finland. The rehabilitees receiving demanding medical rehabilitation are the focus of this study. In Finland, social and health care services are going through a change in the future, though it is not precisely known, how this change will eventually come true.

The regional government, health and social services reform was planned to come into force on 1.1.2021. It would have meant a change for the whole structure of health and social services by giving people the opportunity to choose between a private sector service provider and the National Health Service without a difference in price. (Finnish Government 2018a.) This would have significantly affected the private health care actors. Because of the resignation of the Finnish government, preparations for the implementation of this reform were cancelled in March 2019. A need for change still exists, even though the course of actions is not yet clear.

Kela (The Social Insurance Institution of Finland) is the biggest stakeholder providing demanding medical rehabilitation by purchasing the services from private service providers. Even if the health care reform is currently on hold, another change that is coming is that Kela is modifying its way to select demanding medical rehabilitation service providers. Currently service providers compete with price and quality to get selected by Kela and customers select the provider from Kela's list. In a couple of years, it is possible to any provider to sign in if they meet the criteria and customers can choose any registered provider they want. (Kela 2019b.) This will increase the competition between service providers, as new providers may enter the field increasing the options for customers to choose from.

For organizations working in similar fields, a competitive edge can't often be reached by price, operations or even by quality, since oftentimes these do not vary so much

between firms. Therefore, the customer's overall experience is of great importance. This is something that needs to be acknowledged in private outpatient rehabilitation clinics providing services to the same customer segments, such as rehabilitees receiving Kela's demanding medical rehabilitation.

One way to enhance customer experience is to develop more customer-oriented services. Promoting customer-orientation in health care services is one of the main topics of research- and development of the Finnish health administration (Aalto, Vehko, Sinervo, Sainio, Muuri, Elovainio & Pekurinen 2017, 1). Customer-orientation is also one key principle in Kela's demanding medical rehabilitation guidelines for service producers (Kela 2018, 4) and it was also one of the goals of the planned health and social services and regional government reform (Finnish Government 2018b).

This study acts as a part of an organization's bigger developmental process that is implemented to keep an eye on the future challenges. The developmental process focuses on co-developing the services of the organization with the customers. As part of that process, this study focuses on exploring the construction of customer experience of Kela's demanding medical rehabilitation rehabilitees. This study also aims at finding the critical issues that should be acknowledged when developing services. The study is implemented as a qualitative case study, where focus-group interview is used as part of a co-developmental customer panel founded in the organization.

In chapter 2, the Finnish rehabilitation system, rehabilitation process, and the role of the private service provider are introduced to create an understanding of the context where this study is carried out. In chapter 3, the theoretical framework is widened to include issues related to customer experience and co-development of health care services in order to provide a background for the research setting. After the theoretical background is introduced, the purpose and goals of this research and the research question is set in chapter 4.

In chapter 5, the philosophical and methodological choices are defined, and the process of data collection and data analysis are described. The results of the study are presented in chapter 6. The reflecting of results on previous research and theory and managerial

implications are presented in chapter 7. Finally, in chapter 8, the discussion about the whole research process, and suggestions for further research are presented.

2 REHABILITATION

Content of rehabilitation as a concept as well the rehabilitation system in Finland have transformed over time. In this chapter, the history of rehabilitation, current rehabilitation system and a role of private service provider in it is introduced. Additionally, the rehabilitation process linked to this is described.

2.1 The short history of rehabilitation in Finland and worldwide

As long as there has been sickness, disabilities or social exclusion, there has been some acts of rehabilitation too, but the content, goals and ways of implementing rehabilitation has changed over time. The premise of the Finnish rehabilitation lays in the 1940's and 1950's, when rehabilitation was mostly about taking care of disabled veterans, wounded in the Winter War and the Finnish Continuation War. The first law concerning care for the disabled was set in 1947. This Care of Invalid Act consisted of medical care and acts to ease working and education by means of financial assistance. At the same time, the concept of rehabilitation was rooted to use and other injuries, ones not caused by war, were started to be an equal reason for rehabilitation too. (Järvikoski & Härkäpää 2011, 8; Puumalainen 2008, 16.)

In the 1960's, the aim was to "normalize" rehabilitation and add it in the social and health care services of a welfare state as part of good treatment. This development culminated in the 1980's, when medical rehabilitation was finally included in the health-service system. The current form of Finnish rehabilitation system started to take shape in the turn of the 1990's, when the Act for Services and Assistance for the Disabled overturned the Care of Invalid Act in 1987 and when the responsibility of

medical rehabilitation for severely disabled persons was moved to Kela in 1991. (Puumalainen 2008, 17-18.)

This change in paradigm was worldwide. I this chapter, the afore mentioned change is described according to Järvikoski and Härkäpää (2011; 2008). In the early years of rehabilitation, the paradigm was deficiency and authority- oriented. the focus was more about fixing the existing injuries, for example treating and exercising an injured limb, and adapting in to living with the deficit. A person was a passive object receiving rehabilitation, which was planned and implemented by an authoritarian expert. In the 1970's, movement of the disabled started to criticize the authoritarian nature of rehabilitation. They stated, that a disability is not just a plain cause of injury or deficiency, but more created by an insufficient society's service system and authorities. (Järvikoski & Härkäpää 2011, 49-51; 2008, 57.)

As a result of this movement, the paradigm of independent living started to develop. It highlighted the special needs and goals of disabled people and their own opinions about their future. A person with a disability was started to be seen as an active subject, pursuing one's goals, understanding, interpreting and planning one's own life and its premise - as a rehabilitee, instead of a passive patient. (Järvikoski & Härkäpää 2011, 49-51; 2008, 57.) This change set the course for currently prevailing paradigm.

International response to this universal critique towards the common conception of rehabilitation resulted, when in 2001 World Health Organization (WHO) published The International Classification of Functioning, Disability and Health (ICF). It was aiming to provide a unified language and framework about health and health-related issues to be used in research and statistics, and as a common tool between different professional fields and cultures. ICF is a biopsychosocial model, that illustrates the dynamic relations between a person's health status, function and disability and contextual factors. Functioning and disability is observed from the perspective of bodily functions and structures, but also from the perspective of activities and participation. Contextual factors contain characteristics of the environment and the individual. (Järvikoski & Härkäpää 2011, 96; WHO 2011, 5,16-21.)

The ICF framework is widely used in the field of rehabilitation as a helpful tool in recognizing the issues affecting one's functioning. Especially the components of activities and participation are in the center of focus when creating goals for rehabilitation. ICF can also be used as a common ground, when planning multi-professional rehabilitation. (Järvikoski & Härkäpää, 2011, 98-99.) In addition, ICF includes an alphanumerical coding system, that could be used to assess each factor in the model and in transferring this information between professionals (WHO 2001, 3).

Despite the positive change the ICF brought for framework of rehabilitation, it has been criticized because of its authoritarian nature, where the assessment is based only on a professional's evaluation (Järvikoski & Härkäpää, 2011, 99). Some researchers, like Ueda and Okawa (n.d. in Järvikoski & Karjalainen 2008, 84) have suggested adding a subjective dimension to ICF. This opportunity is also recognized by WHO (2001, 231).

Today, in the 21st century, a rehabilitee is understood as someone in interaction between one's environment. Therefore, rehabilitation can't be just actions addressed to a person, but also actions towards the environment. This environment includes the natural, built, social and cultural environment. In this understanding, by modifying and changing the environment, and by finding both interpersonal and external resources, the rehabilitee can live a fulfilled life despite the limitations. (Järvikoski & Härkäpää 2011, 14, 50-51.)

2.2 Rehabilitation system in Finland

It might be because of the history of rehabilitation in Finland, that the first impression about rehabilitation is often linked to physical impairments and medical rehabilitation. Yet, it is important to understand that rehabilitation as a concept includes much more. According to Kuntoutusselonteko (2002, according to Järvikoski & Härkäpää 2011), rehabilitation is planned, multisectoral, preserving activity, aiming at helping a rehabilitee to control one's own life situation. It is a change process of a person or person and environment with a goal of promoting functioning, independence, well-being and employment. The need for rehabilitation is based on a recognized symptom,

condition, injury or disability, but also on decreased ability to work or risk of severe social exclusion. (Järvikoski & Härkäpää 2011, 10.)

The Finnish rehabilitation system is quite multisectoral and complicated, with different subsystems, financiers, organizers and providers. Rehabilitation can be divided into four fields: medical, vocational, social and educational rehabilitation. Vocational rehabilitation concerns actions supporting a person's ability to maintain or achieve employment. Social rehabilitation focuses on the social side of functioning and educational rehabilitation supports the education of a disabled child or adult. Medical rehabilitation means actions that are based on a medical examination and assessment. The aim of these actions is on increasing a person's physical and psychological functioning. (Kuntoutuksen uudistamiskomitea 2017, 11-12; Järvikoski & Härkäpää 2011, 20-22; Sillanaukee 2015, 8-9.) Medical rehabilitation includes rehabilitation guidance, evaluating and assessing a person's functioning, ability to work and need for rehabilitation. It includes also therapies and other needed actions, assistive devices, and different kind of rehabilitating inpatient or outpatient courses. (Kuntoutuksen uudistamiskomitea 2017, 19; Sillanaukee et al. 2015, 9.)

The Finnish rehabilitation system's functions spread over three sectors: public administration sector, private sector and the so called "third- sector". During a person's medical rehabilitation process, different sectors may work in co-operation, or the responsibility for organizing the rehabilitation may move from one sector to another. Without proper co-operation between the sectors and the professionals within them, the scattered rehabilitation service system risks achieving a seamless rehabilitation process. (Lahtela et al. 2002, 15-16, 48.) This co-operation could also be observed from the societal level -point of view, where micro, meso and macro level actors need to work in unison to gain the best benefits of rehabilitation to all stakeholders, from individual to societal level. This division is described further in the next two paragraphs.

Social reality and phenomena can be observed as interaction of three levels: the micro, meso and macro level. When applied in rehabilitation, the micro level concerns the individual and their relations to those professionals, services and actions that are encountered during the rehabilitation process. The meso level covers the organizations

providing rehabilitation, and their ways of operating. The macro level is the societal level, consisting of the rehabilitation system, social values, and laws concerning rehabilitation. The interaction between these three levels in rehabilitation can be seen in how laws and regulations define how the organizations can produce services. Also, the operation models of organizations can affect the content or quality of the rehabilitation provided to the rehabilitee. (Beirão & Patrício 2016, 234; Järvikoski & Härkäpää 2011, 19-20.)

Reasons for providing rehabilitation for individuals can also be observed through these levels. In the individual level, micro level benefits are linked to the rehabilitee's quality of life, functioning, life control, autonomy and equal right to work, standards of living and social safety. In the meso level, rehabilitation of an employee with decreased functioning limits the costs that could be caused by a person's decreased ability to work. Public interest gained by rehabilitation in the macro level is mostly economical and occurs after a longer time period. These benefits of rehabilitation are related to decreased social and health care costs, pensions, and productivity of work force. (Järvikoski & Härkäpää 2011, 24.)

Since medical rehabilitation is in the focus of this study, the system concerning it is more precisely introduced here. There are two main actors in the public administration sector: public health care and Kela (Lahtela et al. 2002, 15; Sillanaukee et al 2015, 8). Public health care carries the main responsibility about organizing medical rehabilitation services. These services are divided into two levels: primary health care and specialized health care. (Lahtela 2002, 16.) This responsibility to organize services is shared with Kela. Kela organizes demanding medical rehabilitation for persons under 65-years old, who have long-lasting, significant difficulties in working, studying or activities of daily living due to a sickness or disability (Kuntoutuksen uudistamiskomitea 2017, 22.)

Public health care usually organizes their medical rehabilitation services inside their own organization, but Kela purchases their therapies and courses from private sector service providers (Sillanaukee 2015, 10). Kela works in co-operation with public health care, and the rest of medical rehabilitation services, such as evaluation, planning, and assistive device services are still organized by public health care services

(Kela 2019c). Third sector rehabilitation and other supportive actions are arranged by associations and foundations. These have a markable role in the rehabilitation system, but it is not usually defined as medical rehabilitation. (Saarinen, Henrikson & Ala-Kauhaluoma 2012.)

2.3 A private physiotherapy clinic as a service provider for Kela

The target organization of this thesis provides physiotherapy services for Kela. As service provider, the organization operates in meso level, doing close cooperation with both the micro and macro level. In this section, the content of demanding medical rehabilitation services is observed more closely. Additionally, cooperation between Kela, public health care and a service provider is introduced using a rehabilitation process as an example.

As mentioned, Kela provides demanding medical rehabilitation for persons under 65 -years old, who have long-lasting difficulties in activities of daily living due to a sickness or disability (Kuntoutuksen uudistamiskomitea 2017, 22). Conditions leading to decreased functioning can be, for example, MS-disease, brain- or spinal cord injuries and other neurological or muscle diseases, or Cerebral Palsy. Kela provides physiotherapy, music therapy, neuropsychological therapy, psychotherapy, speech therapy, riding therapy and occupational therapy for individuals or groups. Rehabilitation can also be arranged by remote rehabilitation or as rehabilitation courses. These services Kela purchases from private service providers. (Kela 2018, 4-5, 14, 17-38.)

Currently, customers can choose the service provider from those selected and approved by Kela (Kela n.d. 7). To be selected as service provider for Kela, organizations need to participate in a tendering process, where the organizations are rated by the price, they would commit to for producing services for the next four-year period. In addition to price, the service providers are also rated by facilities and the therapists' experience. (Aalto-yliopiston taloustieteen työryhmä 2018, 9.)

Kela is planning a change in their service provider selection system. In the planned registration procedure, service providers can register themselves to provide services with set limits concerning their prices (Aalto-yliopiston taloustieteen työryhmä 2018, 14). The goal of the registration procedure is to encourage service providers to compete more with the quality of their service, by enabling new service providers easier access to market and by increasing the activity of the customers in choosing the service provider (Kela 2019b). Kela has announced, that the first testing of the registration procedure is planned to happen between 2020-2022, and the aim is to adopt this procedure to concern all demanding medical rehabilitation services (Kela 2019a). The possible change towards this kind of an acquisition method was one factor guiding the topic of this thesis.

Kela has set certain demands for the service providers, concerning the content of therapy, facilities, equipment and experience and expertise of their therapists. Obeying good rehabilitation practice and utilizing the ICF framework in rehabilitation are also included in Kela's standard for rehabilitation services. (Kela 2018, 4-5, 14.) ICF was introduced already earlier in this thesis, and good rehabilitation practice is explained next.

According to the law about Kela's rehabilitation benefits (Laki Kansaneläkelaitoksen kuntoutusetuuksista ja kuntoutusrahaetuuksista 566/2005 §9), rehabilitation organized by Kela needs to obey good rehabilitation practice and it should be based on special expertise. Good rehabilitation practice consists of concrete ways of working, but also from principles and perspectives that guide the work of professionals.

Key aspects of good rehabilitation practice are person-centeredness, multi-professional cooperation and obeying evidence-based practice in therapy, where both scientific evidence and expertise and experience of the professionals are guiding the choices made. Rehabilitation is expected to be ethically approved, efficient and successful. It should be timed right, and the person receiving the rehabilitation and/or their family or other close individuals should be engaged in the process. The ICF framework offers the needed base that can be used when mapping the persons unique situation. (Paltamaa, Karhula, Suomela-Markkanen & Autti-Rämö 2011, 35.)

2.4 The rehabilitation process of Kela's medical rehabilitation

The rehabilitation process includes several phases that should be linked seamlessly together (Paltamaa et al. 2011, 35). The process of Kela's medical rehabilitation is introduced in Figure 1, where the progress of the process, stakeholders from different social levels and co-operation between all these are shown.

In the following simplified explanation about the process, the number in parenthesis indicates the numbers in Figure 1. The process starts when the rehabilitee, after the recognition of the need for rehabilitation, contacts the doctor in public health care (1), who then makes a rehabilitation plan with the rehabilitee (2). This plan is sent or given to the rehabilitee and it can also be sent directly to Kela (broken arrow 2), if agreed so. The rehabilitee sends the application and possible attached rehabilitation plan to Kela (3). Then Kela, based on the rehabilitee's application, makes the decision about the provided rehabilitation (4). This agreement can be done for 1-3 years at a time, and it is sent to the rehabilitee and public health care. It is also sent to the selected service provider, with the added rehabilitation plan (2+4). (Paltamaa et al. 2011 30-31.)

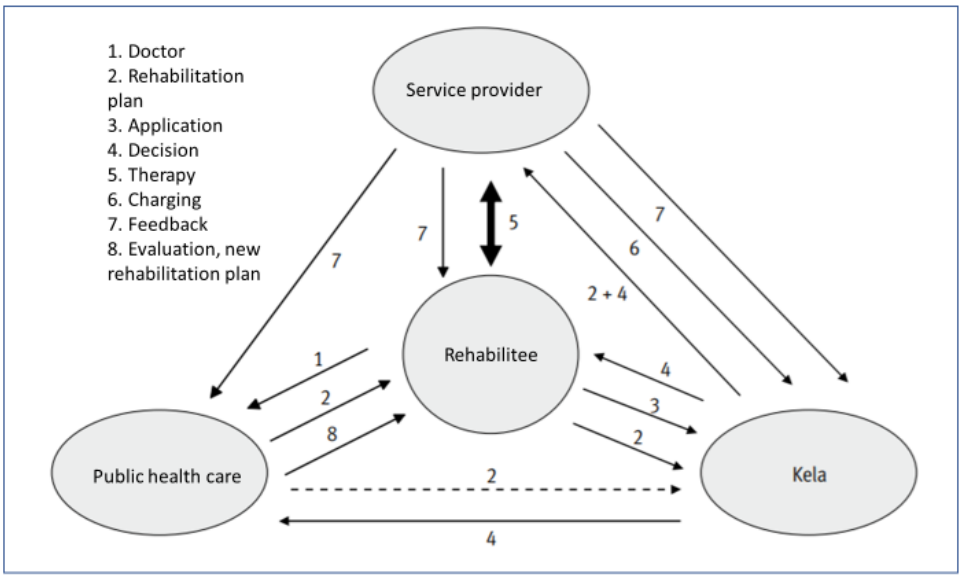

Figure 1. Kela's demanding medical rehabilitation process. (Modified from Paltamaa et al. 2011, 30.)

After this process, the actual therapy begins (5). The provided therapy can be implemented, for instance, as physiotherapy, pool therapy, home visits or rehabilitation courses – whatever is in accordance with the rehabilitation plan and decision. The service provider charges Kela for the provided services (6). After each rehabilitation period, which is usually 12 months, the service provider drafts up a rehabilitation feedback based on the evaluation and assessment made with the rehabilitee, and with family members or other close individuals if needed. This feedback, complete with a description of the realized therapy and an estimation about the future need for rehabilitation, (7) is sent to rehabilitee, public health care and Kela. The evaluation about the future need for rehabilitation is again made in public health care (8) in a rehabilitation planning meeting, and the process starts over. It is also possible that the therapist attends the planning meeting with the rehabilitee and doctor. (Paltamaa et al. 2011, 31-32.)

In the target organization, every customer gets their own therapist, who is responsible for the whole rehabilitation process. Also, a second therapist is selected to substitute the main therapist during holidays, or to share the responsibility of treatment implementation during the whole rehabilitation period. The amount of therapy that the customer receives is dependent on Kela's decision. The amounts can vary from couple of dozens therapy appointments per year up to 1-3 meetings a week. For some customers, also pool therapy or home visits are provided.

3 CUSTOMER IN THE FOCUS

In this chapter, the theoretical framework concerning the value of the service, customer experience and customer-oriented service development are introduced. Also, concepts of customer participation, co-creation and co-development are explained. These are related to the target organization's developmental process and are therefore introduced to create an understanding about the context of this thesis. In addition, the co-developmental method of a customer panel is introduced, since it is applied in the data collection of this research.

3.1 Value of the service

The purpose of this research is to create deeper customer insight in order to develop rehabilitation services to be even more valuable for the customers. Therefore, it is important to understand what is meant by value. According to Tuulaniemi (2016), the most basic mission of any organization is to create value for the customer, and by doing so, make profit. The value of the service is the customer's experienced benefit in relation to the price or effort needed to get the goods or the service wanted. For the organization, the value becomes concrete in the amount of the bought services and in how profitable the customer is for the organization. (Tuulaniemi 2016, 30-33.)

To achieve competitive advantage, organizations must aim to create extra value for the customer. This is done either by lowering the prices or adding other value for the customers. (Tuulaniemi 2016, 33, 37-38.) To be able to add extra value, customers' needs should be recognised, and information of these needs and ways to meet them, should be collected from the customers themselves. Involving the customers is crucial especially for making successful innovations. It helps to improve the service concept and pinpoint the weaknesses. Organizations with high co-creative capabilities are more agile to seeing opportunities based on customer needs and to converting them to new services that deliver value for the customers. (Storey & Larbig 2018, 101, 113.)

There is no such thing as absolute value, or the value can't be set by the organization, but it is always created based on the customer's own, subjective perception. This perception is affected by one's previous experiences and the personal meaning of the service for the individual. (Beirão & Patrício 2016, 229; Tuulaniemi 2016, 31-33.) Value is created in a process happening in the interaction between the customer and organization (Storey & Larbig, 2018,101), and between customer's expectations and realized customer experience (Tuulaniemi 2016, 31-33.), as well as through customer's experiences in different service encounters (Park, Kim, Park & Agarwal 2016, 469). In marketing, this is called *value co-creation*. This concept recognizes the active role of the customer, making decisions and interacting with the company, instead of customers just trading money for the services that are autonomously designed and offered by the company. (Prahalad & Ramaswamy 2004, 6.)

Created value can consist of quantitative value, like money and technical properties, and qualitative value like customer experience and convenience (Tuulaniemi 2016, 31-32). According to Park and colleagues (2016), another way to describe the nature of value is to divide it to dimensions of extrinsic and intrinsic value. This division describes value creation especially well in health care settings. Extrinsic value consists of functional value, like the effectiveness of the received treatment and, social value, that is created through pleasant social interactions with the employees. Intrinsic value results from the customer's perception about being treated empathetically, respectfully and in a way that honours the customer's belief systems. (Park et al. 2016, 468-469.)

There are some issues, that should be noted, when discussing value creation in health care services. Customers are often "forced" to use the services because of their condition or disability (Virtanen, Suoheimo, Lamminmäki, Ahonen & Suokas 2011, 17), and this might have an effect on the creation of value in either way. It is also important to notice that when discussing health service ecosystems, such as a rehabilitation system, there are plenty of other stakeholders in addition to the customer and service provider. These micro-, meso- and macro-level actors are creating value together for themselves and for each other. (Beirão & Patrício 2016.)

This value co-creation is presented also in Figure 1 describing Kela's medical rehabilitation process, where actions and choices made by different stakeholders have an effect on others. Park et al. (2018) also noted that health care and rehabilitation services often include the customer's family in the process, and a high amount of very individualized interactions between the customer and professionals create a unique stamp for these kinds of services. Due to these characteristics, emotional and social dimensions of customer experience and the created value are highlighted more, compared to some other services, like hotels and banking services. (Park et al. 2018, 468.)

In this research, the focus is on the value experienced by the customer, but the customer's value for the organization should not be forgotten. When observing the value creation in the context of this study, where the focus group is Kela's demanding medical rehabilitees, financial value is fixed for both the customer and the

organization. Therapy services are free for the customers and the organization gets a fixed price from Kela. Since the price of the services is not affecting the customer's selection of service provider, the meaning of qualitative value is highlighted even more.

Nowadays, there is only a limited number of service providers for the customers to choose from, especially ones that are local and near them, but this might change in the future. The amount of service providers might increase, if Kela's resignation approach is carried out and it enables new firms to enter the field easier. These issues should be recognized by organizations in order to create some added value. This can be done by creating a better customer experience throughout the service path. The concepts of customer experience and service path are introduced in the next chapter.

3.2 Customer experience throughout the service path

Customers always have an experience when they use services (Berry, Wall & Carbone 2006, 53), whether it is good, bad or neutral. This experience is the main key for value creation (Gentile, Spiller & Noci 2007, 395). According to Shaw and Ivens (2005, according to Gentile et al. 2007, 396), traditional elements like price, quality and the service or product itself are not enough to create a competitive advantage, but the customer experience rises to be the distinctive factor.

Customer experience's relation and link to other close concepts, such as service quality and satisfaction, varies in literature. Customer experience is seen to affect created value and experienced customer satisfaction, and these alongside service quality, are seen as important elements in creating customer loyalty (Worlu, Kehinde & Borishade 2016, 460). Lemon and Verhoef (2016, 74) state that instead of customer experience creating satisfaction, satisfaction could on its own be one component of customer experience, and service quality would precede customer experience. However, the consensus is that good customer experience creates loyalty, and affects other factors such as customer's profitability, word of mouth and customer lifetime value (Lemon & Verhoef 2016, 71, 74). A positive customer experience enhances the creation of an emotional bond between the customer and organization, which is seen to increase

loyalty (Gentile et al. 2007, 404) and is difficult for the competitors to break (Worlu et al. 2016, 461).

In the field of marketing, customer experience has been defined in many ways. In literature, the concept of customer experience is sometimes replaced with the term service experience, and these two are often used as synonyms, despite the slight nuance difference between them (Jaakkola, Helkkula & Aarikka-Stenroos 2015, 185). Instead, Voorhees, Fombelle, Gregoire, Bone, Gustafsson, Sousa and Walkowiak (2017, 270) used the term service experience to describe the time period, that concludes all service encounters. This period of time is yet elsewhere referred as a customer journey (Lemon & Verhoef 2016, 77) or service path (Tuulaniemi 2016, 78). These differences in nuances and the lacking consensus concerning the meaning of the concepts is acknowledged by the researcher and taken into notice when reviewing and utilizing the literature for this thesis.

In this study, customer experience is defined as a dynamic "multidimensional construct focusing on a customer's cognitive, emotional, behavioural, sensorial, and social responses to a firm's offerings" (Lemon & Verhoef (2016, 71, 74) "in any direct or indirect contact with a company" [Meyer and Schwager 2007 (in Lemon & Verhoef 2016, 70)] during the customer's entire service path (Tuulaniemi 2016, 78). In the same way as described in value creation, customer experience, too, is created in relation with the customer's expectations, and the gap between the customer's expectations and reality affects the customer's satisfaction and evaluation about service quality (O'Connor, Trinh & Shewchuk 2000). Furthermore, memories and imagination (Jaakkola et al. 2015, 186), attitudes and previous experiences can affect experience, and it can change, when a service is repeatedly used over time (Lemon & Verhoef 2016, 74).

In this research, service path, service encounters and touch point elements are concepts guiding the data collection and analysis during the study process. According to Tuulaniemi (2016, 78), a service path describes the process of a customer "using" the service during certain period of time. This is also when customer experience and value is created. Service path can be divided into smaller parts, such as service encounters and touch points. Service encounters are moments of service, including several

different touch points. Touch points can be elements such as people, operations, surroundings or objects, that the customer is in direct or indirect interaction with. These interactions entwine together and create the overall customer experience. Variety of different terms concerning these elements is used in literature. (Stein & Ramaseshan 2016, 8-9,12; Tuulaniemi 2016, 33, 78-82.) Since the service path itself should appear as one fluid process to the customer, not separate acts (Tuulaniemi 2016, 81), one might argue that the division of service encounters and touch points a bit artificial. However, this division is still useful to make so that organizations can explore these particles individually and identify the needs for development. Touch point elements, as they are handled in this research, are described in Table 1.

Table 1. Descriptions of touch point elements.

People	The people providing service, the customers themselves (Tuulaniemi 2016, 82) and direct or indirect interactions between the customer and employees or other customers (Stein & Ramaseshan 2016, 12).
Operations	Commonly agreed ways of working concerning the service. Operations can be visible for the customer or happen "behind the scenes", affecting visible operations (Tuulaniemi 2016, 82).
Surroundings	Physical or virtual surroundings that can guide the behavior or affect the mood of a customer (Tuulaniemi 2016, 81-82).
Objects	All physical objects that are used during service encounters (Tuulaniemi 2016, 82).

Another way to describe these units of touch point elements was introduced by Berry and colleagues (2006). They discussed different "clues" for the customer's perception of service quality and experience: functional, mechanic and humanic clues. They stated that a functional clue, meaning how the service meets or doesn't meet the customer's needs or acts as a solution to the customer's problem, creates the cognitive perception about service quality. They argued that these functional clues such as reliability and competence of the service are the basic level of service that needs to be achieved, otherwise the service does not even have a reason to exist. Failure in this level most often is the reason for the customer to change the service provider. (Berry et al. 2006, 44, 46-47.) If compared to the touch point elements presented, these functional clues are closest to the touch point element of operations.

Mechanic and humanic clues create more emotional perceptions of service quality. Mechanic clues create sensory responses of the service and are actual objects and environments, like the touch point elements of objects and surroundings. These mechanic clues paint the picture about the service even before the customer is using it, and the importance of them is highlighted when the customer spends a lot of time in the facilities. Humanic clues Berry and colleagues were describing as issues concerning the behaviour and appearance of the service provider, ways of speaking, dressing or enthusiasm. The role of humanic clues is bigger when the interaction between the customer and employee is in the focus of the service. (Berry et al. 2006, 45-46, 49.) Difference between the touch point element of people and the humanic clues is, that humanic clues are including only the service provider, not the customer themselves or other customers, as in the touch point element of people. This is also one reason why the concepts of touch point elements were used in this research, instead of the clues.

The customer can be in touch with several different touch points during one service encounter. In brand-owned touch points the organization has designed the interaction to suit the customer and has the control over managing it. Partner-owned touch points are managed and designed together with or by external partners. The customer's own actions that the firm can't control, which affect customer experience, are called customer-owned touch points. Social and external touch points include the interactions that the customer has, for example, with other customers or external information. Quite often there is no clear line between the "owner" of the touch point, and there are differences in how much control the organization has over these touch points. It depends on the nature of the service which touch points are most important during different phases of the service path. (Lemon & Verhoef 2016, 76-78.)

Voorhees et al. (2017, 271) divided the service path, or service experience as they call it, in three periods. The core service encounter period is the time interval where the primary service that fulfils the customer's critical need (Voorhees et al. 2017, 271), and most of the actual value for the customer (Tuulaniemi 2016, 79), is provided. The pre-core service encounter period precedes the core service encounter period and it includes all service encounters leading the customer to use the core service. The post-

core service encounter period follows the core service period. During this period, customers asses their experiences from the previous periods, and the organization reaches out to the customer in order to improve their experiences in the future and maintain customer relations. (Voorhees et al. 2017, 270-272.) The phases of a service path are not necessarily only linear, but more iterative, dynamically affecting one's experiences in other phases and service encounters. In Figure 2, some of the general service encounters in the service path of a customer in Kela's demanding rehabilitation in the target organization are shown.

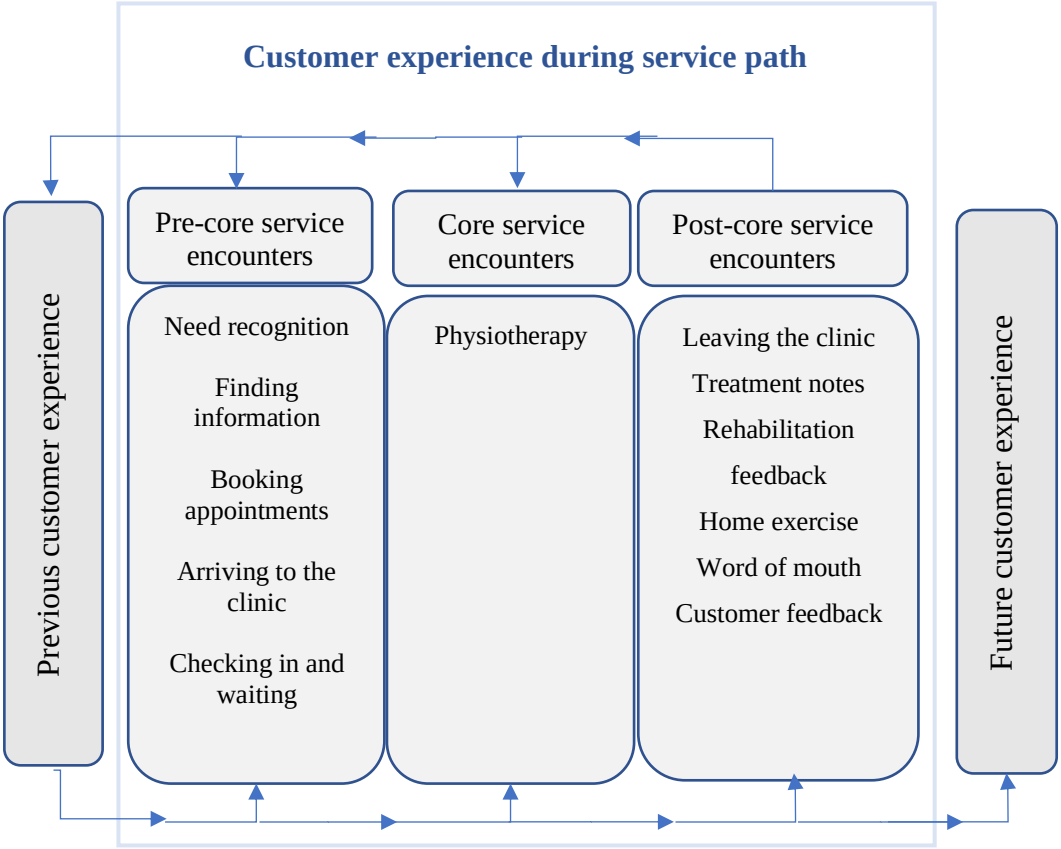

Figure 2. Service path of a demanding rehabilitation customer in the target organization. (Modified from Lemon & Verhoef 2016, 77; Voorhees et al. 2017, 271.)

The model is combined and modified from Voorhees et al. (2017, 271) conceptual model of service encounters throughout the service experience and Lemon and Verhoef's (2016, 77) process model for customer journey and experience. Figure 2 shows the iterative nature of service encounters and the impact of previous experiences about similar services (Lemon & Verhoef (2016, 75), that can have an effect on the

current customer experience. The content of the service encounters is constructed by the author of this research, based on her own knowledge from working in the organization. The pre-core service encounters include noticing the need for physiotherapy, finding information, booking appointment, arriving to the clinic and checking in and waiting. The core service is the actual physiotherapy appointment.

The post-core service encounters include leaving the clinic, viewing the treatment notes that are available in the Kanta-archive, which is a national digital archive for personal social and health care information (Kanta n.d.), and home exercise instructions. Additionally, the yearly rehabilitation feedback for Kela, word of mouth, which means speaking with others about the service or company, and customer feedback, (either spontaneous feedback, which is given proactively by the customer or reactive feedback, which is collected by the firm), can be post-core service encounters. This is not an exhaustive list and other service encounters can exist or some are not relevant for certain customers.

3.3 Development of the customer-oriented health care services

From the 1990's onward, the role of the individuals just using health care services started to move towards the individuals being more of a customer and a consumer of the services, in the sense that the provided services should meet the needs of the customers better. Traditionally, a customer can be a person, group of people or an organization, receiving services (Virtanen et al. 2011, 15-17). The target organization's customers are not only the individuals receiving therapy services, but also Kela, as purchase of the services. In this study, the customer in focus is the rehabilitee - the end-user of the services.

Health care services can be provided and developed in two ways. In the inside-out approach, development is seen from the point of view of promoting an organization's efficiency (Elg, Engtröm, Witell & Poksinska 2012, 329). This organizational inside-out perspective has been the prevailing view in national social and health care in Finland until the 21st century, when a more customer-centered and -oriented approach has been adopted (Virtanen et al. 2011, 7-8,16). This customer oriented outside-in

approach focuses on providing effective services for meeting the customers' needs (Elg et al. 2012, 329). This change from an inside-out to outside-in has slowly happened alongside the paradigm change in rehabilitation.

Customer-centeredness and customer-orientation have been often used as synonyms. However, Virtanen et al. (2011, 36) make difference between these two terms in a social and health care settings, more specifically in services development (Figure 3).

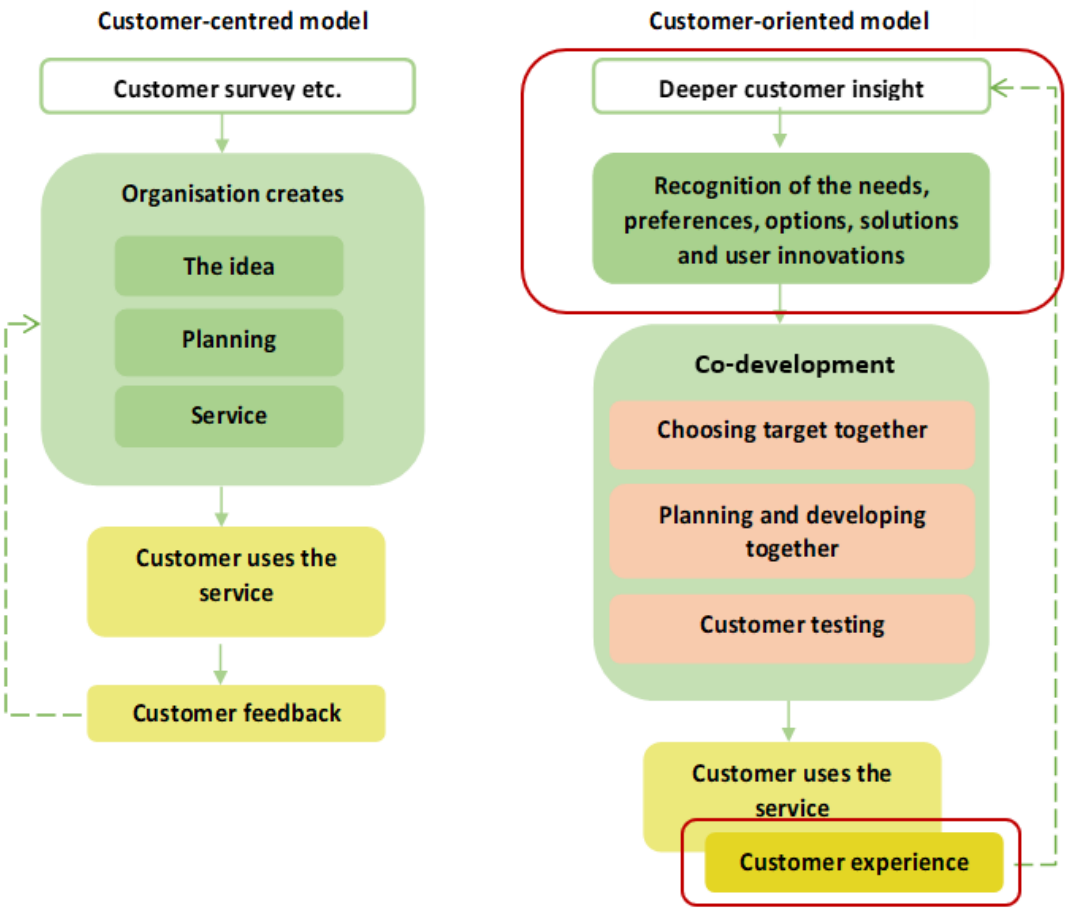

Figure 3. Differences between customer-centeredness and customer-orientation. (Translated and modified from Virtanen et al. 2011, 37.) The steps this study focuses on are circled with a red frame.

In a customer-centered model, the needs of the customers guide the service development, but the initiative for development comes from the organization and customers just use the service organization created. In this model, customers are often seen only as informants giving feedback of the service through questionnaires and

having no part in deciding what is developed or how it is done. (Virtanen et al 2011, 36-37.)

The target organization aims on promoting a more customer-oriented model (Figure 3) where, according to Ahonen (2017, 53), customers are important participants and resources of knowledge in developing and innovating services. Customers are on board from the very beginning and in every phase of the project, from planning to testing and finally evaluation. Customers are part of decision making, concerning the services they are using. (Virtanen et al. 2011, 36-37.) This is called co-development of services. Target organization implements customer-oriented co-development by founding a customer panel. The concepts of co-development and customer panel are discussed more broadly later in this report.

This study focuses on the last and first two steps (red frames in Figure 3) of a customer-oriented model. The aim is to deepen customer insight, which gives an opportunity to understand the customers' needs and desires. The customers are given the opportunity to tell their experiences and give direct suggestions about the targets of any developmental acts. This lays the groundwork for an upcoming co-developmental process implemented later in the organization.

3.4 Customer participation, co-creation and co-development

Customer participation, co-creation, co-development, and so on. All these concepts have been widely used in literature, but a lacking consensus with terminology causes confusion for the reader and researchers (Dong & Sivakumar 2017, 944). There are differences on what level of actions concepts refer to, and what outcomes can be reached from each action. These concepts and issues are introduced here in order to create an understanding about their slight differences in means they are used in this study.

The concept of customer participation can be an umbrella term to any activities to which customer take part (Sharma et al. 2014). In marketing, customer participation is seen to connect the customers more closely to the organization, increase their loyalty

and increase the organization's ability to identify the needs of the customers (Merlo, Eisingerich & Auh 2014,81, 83). Sharma, Conduit and Rao Hill (2014, 180) define customer participation in a health care service development context on a quite general level: as customers taking active role in redesigning health care services. This happens through giving feedback or taking part in conversations between the customer and organization. The common factor is that the customer is seen as an important resource, who is an expert on one's own situation and has first -hand information about living with the disability or disease, and therefore can provide superior information and insight that the service producer can't otherwise have. (Sharma et al. 2014; Virtanen et al 2011, 19, 36.)

According to Sharma and Conduit (2016, 439), value co-creation in health care aims at reaching a certain outcome by integrating the resources of customer and professional. Frow, McColl-Kennedy and Payne (2016, 26), and Leask, Sandlund, Skelton, Altenburg, Cardon, Chinapaw, Bourdeaudhuij, Verloigne, Chastin et al. (2019) describe co-creation as process, where different actors of a certain service ecosystem work together integrating their resources, such as knowledge or physical resources, when interacting with each other and takin part in collaborative actions to reach a shared goal: increased customer value.

Sharma and Conduit (2016) define co-development as co-creative behaviour, aiming at enhancing organization's service offering. Different stakeholders, such as customers, employees, volunteers or other experts participate in the development, but may not directly benefit from it themselves. This benefit to all service users is the distinctive difference that separates co-development from value co-creation, where instant benefit is gained only for individual participants, such as the customer themselves. The customer's role in co-development is seen to be a part of the whole process, as in customer- oriented service development in Figure 3, rather than just participating only in few steps of the process. (Sharma & Conduit (2016, 444, 447.)

These differences between co-creation and co-development might be easier to illustrate with more practical examples, where also the different levels of actions are also seen. Customer participation in health care can be observed in two levels: for the benefit of oneself and for the benefit of others. The more common level is participating

in one's own care, where the customer is more responsible through shared decision making in planning and management of the treatment. This way, the customer develops one's own treatment or services and affects one's own customer experience throughout the service path, co-creating value for their own benefit. (Elg et al. 2012, 330; Engström & Elg 2015, 511; Sharma et al. 2014, 180-181.) In this level, customer participation increases adherence to treatment, which leads to better clinical outcomes. In addition, it can decrease the health care costs in the macro level. (Leask et al. 2019.)

In another, less investigated (Sharma et al. 2014, 180) level, the customer participates in co-developing health-care services in an organizational or system level and co-creates value also for the benefit of other service users (Elg et al. 2012, 330). For an organization, deeper customer insight and understanding can be gained through a co-development process. This enables a more precise targeting of developmental acts (Sharma & Conduit 2016, 450) and creative innovation of new services, offering competitive advantage to an organization (Sharma et al. 2014, 179). According to Jagosh, Macaulay, Pluye, Salsberg, Bush, Henderson, Sirett, Wong et al. (2012, 324, 332), services developed in partnership are more appropriate for target group, especially concerning culture, and increase trust between stakeholders.

Sometimes participation and co-creation in either level can increase the well-being (Engström & Elg 2015, 511), social capital, skills (Frow et al. 2016, 30), or empowerment of the participants (Sharma & Conduit 2016, 451). Of course, there are down sides of customer participation too. Customers might have too many ideas on how they would like to develop the services, and these might not be in line with the organization's views. Organizations should carefully consider the suggested improvements or innovations and the real need for them. (Storey & Larbig 2018, 113.)

3.5 Examples on co-development and customer panel

As was stated by Storey and Larbig (2018, 101), involving the customer enables organizations to create better innovations and identify possible weaknesses in their services. In this chapter, a few examples of customer participation and co-development are briefly introduced. These examples show what kind of results can be achieved in

different levels of society by using co-development. One co-developmental method, the customer panel, is applied in the data collection of this research and is therefore introduced here. This application of a customer panel for data collection is discussed further later in this report. The concepts of co-creation and co-development are in some examples used a bit differently than the definitions presented in previous chapter. Despite of this slight inaccuracy, the concepts are used in way they were used in the original literature.

In their review, Greenhalgh, Jackson, Shaw and Janamian (2016) represented several cases, where co-creative model of development was claimed to contribute to a more valuable, enduring and suitable outcomes than if created solely by organizations. For example, a local capacity of primary health care was extended and service delivery across the sector was better integrated by a co-created health care practise with a shared governance by a university, local health economy and community in Australia. In the UK, priorities for mental health care improvements were recognized by interviewing the staff and service users, and in Norway, a better working electronic booking system for health care providers was created utilizing user experiences and the knowledge of technology professionals. (Greenhalgh et al. 2016.)

A customer panel is one way to promote customer-orientation and implement co-development in an organization. It enables open interaction and dialogue between the customers and the organization, and it can be used as a method for collect feedback concerning customer experience or innovating and testing new ideas. According to the chief inspector of Valvira (National Supervisory Authority for Welfare and Health), the role of a customer panel is to be an advisory body (Räsänen 2019). The purpose is to hear and acknowledge the customers' point of view and give them an opportunity to affect the planning and implementation of service development (Pieviläinen, Pyykkönen & Saukkonen 2014, 5), as in the model of customer-oriented development in Figure 3. As stated by Elg et al. (2012, 330), this is using customer participation and co-development for co-creating value for other users.

Usually the ideal size of a customer panel is 10-20 persons (Innokylä n.d.), but smaller groups of 8-10 persons can be used too (Terveyden ja hyvinvoinnin laitos 2019). A panel can consist of old, new or potential customers, depending on the goal of the

project. Representatives from the organization participate in the panel. Their role is more of asking, listening, and learning kind of role, and giving room to customers for them to be able to bring up issues on their minds. In the meeting of the panel, the chairperson of the panel leads an open conversation based on planned topics or themes, takes notes of the conversations and takes care that everyone gets to speak equally. Often the chairman of the panel is someone outside the organization. This might be beneficial in order to promote open conversation about real experiences, feelings, and projections that are not considered during typical everyday conversations. (Innokylä n.d.)

Customer panels are widely used in public health care sector. In Norway, a customer panel is founded to act as a forum of co-development between authorities of The Norwegian Board of Health Supervision and umbrella organizations of different social and health care associations (Räsänen 2019). More often customer panels are used locally, and many hospital districts and individual cities have customer panels for developing a more customer oriented and better organized public sector social and health care services. For example, according to the websites of Hospital District of Helsinki and Uusimaa (n.d.), Hospital District of Lapland (2020) and Hospital District of Pirkanmaa (2020) they have their own customer panels for different customer groups and in different profit centres. Also, cities such as Nokia and Kaarina have their own customer panels for social services (Nokia city 2020; Kaarina city 2020).

Several bachelor's and master's thesis have been written about setting up customer panels in public social and health care units. For example, Saarinen (2012) did an action research where a customer panel was founded for developing job coaching service in mental health rehabilitation and Nevalainen (2016) implemented a project, where housing services for the intellectually disabled were developed with the customers and their families.

Despite the vast use of customer panels and co-development in the public sector, there is not much reported information about co-development in the private health care sector. On the website of private medical clinic Mehiläinen, a customer panel of theirs is mentioned. In this case, the panel works through answering web-based questionnaires and no face-to-face group meetings are used (Mehiläinen n.d.). Outside

the health care sector, the use of a customer panel is reported in a bachelor's thesis, where the panel was used in the of opening of a new supermarket and where the potential customers were invited to participate in planning the stores product selection before opening and evaluating the service offering after the opening (Pelkonen 2018). In both these cases, customer panel was found to be very well received by the customers and to be a usable customer-oriented tool for developing services.

4 PURPOSE AND GOALS OF THE THESIS

Research in universities focuses on creating new theories, whereas research made in universities of applied sciences focuses on the development of working life. The goal of this kind of vocational research is to produce or develop the services or practises that are topical and currently in the focus of a certain field of business. This is done by combining theory, experience and occupational practises in a way that promotes the practical skills of the professionals and their stakeholders regionally, nationally and internationally. (Vilkka 2015.)

A practical and working life -oriented approach is guiding also this thesis throughout the whole process, from the selection of the topic to data collection and analysis. Alongside the practical approach, this study also aims at fulfilling the demands set for scientific research. These are, according to Eco (1989 according to Vilkka 2015): the object of study must be defined and recognisable, the research must produce something new, the research benefits others and it must give sufficient ground for public discussion. In addition, to these demands, Vilkka herself adds the need for a theoretical framework, reviewing previous studies and employing ethical research guidelines. (Vilkka 2015.)

The uncertain future of health care and social services, including rehabilitation, and the increased customers' freedom of choice is something service providers should already acknowledge. Alongside with quality and effectiveness of the rehabilitation services, customer-orientation of services and overall customer experience are issues

that play a big role when customers are choosing service providers in the future. From these issues arises the need for this study, which seeks to increase knowledge about customers experiences in private sector rehabilitation services. This study contributes to knowledge that already exists on customer experience in services and co-development in health care services. While these issues are quite well reported from a public health care point of view, this study adds a private sector and outpatient rehabilitation perspective to create more multidimensional picture.

As mentioned, this study is implemented as a part of a bigger developmental process, the purpose of which is to promote customer -orientation in the target organization. The purpose of this study is to deepen customer insight for service developmental purposes and for preparing for the future. The research question of this study is:

What kind of experiences have the customers had in relation to service encounters and touch point elements?

The goal of the study is to acquire information about customer experience in the target organization and to describe issues affecting the experience during the service path of a Kela's demanding medical rehabilitation rehabilitee. This information will be used in an upcoming co-creative process, which will be implemented later during the organization's development process.

5 IMPLEMENTATION OF THE THESIS

In this chapter, overall description of the research process is given. Philosophical and methodological framework guiding this research are introduced. Methods used for data collection and process of data collection are described. Finally, the process of data analysis leading to results of this study is explained.

5.1 Philosophical and methodological framework

The philosophical framework of the research guides the research position and choices made during the research process, for example what is done, why, and how. It also helps to underline the meaning of a specific study in wider context. (Carson, Gilmore, Perry & Grohaug 2001, 12.) In philosophy, ontology is the perception of what is the nature of reality, what really exists (Raatikainen 2004, 11). Epistemology is the theory of knowledge. It describes what is approved to be valid knowledge and how knowledge is created in a relationship between reality and the researcher. Methodology defines the procedures and methods used by the researcher. (Carson et al. 2001, 15-16.; Holloway & Galvin 2017, 21.)

There is a wide range of different philosophical approaches in science. On one end of the spectrum is positivism, the ontology of which observes the world as external and reality is objectively determined. Epistemology of positivism believes that the researcher is an independent observer, and that keeping facts and values clearly separated is possible. According to positivism, clear causal relationships can be explained. On the other end of the spectrum is interpretivism, where ontology accepts that different realities exists. The epistemology of interpretivism is that many perspectives to knowledge exists, depending on the actors and their interpretations of knowledge. In interpretivism, the focus is more on understanding these interpretations. As well, term relativism is used alongside interpretivism. (Carson et al. 2001, 15-16.)

Somewhere in the middle of this spectrum between positivism and interpretivism is moderate constructionism, which is applied as an approach of this study. Moderate constructionism, according to Raatikainen (2004, 45), should be separated from strict constructivism that is linked to strict relativism where it is argued that there is no such thing as common reality, but the reality is different for everyone. (Raatikainen 2004, 45.)

In strict constructivism, the world is seen as changing truths, created by scientific information and researchers. The meanings of phenomena and the world are seen as socially and culturally created structures. (Holloway & Galvin 2017, 27.) In

constructivism, it is proposed, that active agency is involved in human experience. The meanings of experiences are created through tacit, emotional processes, affected by an individual's sense of selfhood and personal identity. These processes are not structured in isolation, but in relation with social and symbolic surroundings and they develop through an individual's whole lifespan. (Mahoney 2004.)

In moderate constructivism, knowledge is seen to be created by social negotiation as in relativism and interpretivism, but only partially. Ontology of moderate constructivism is that there might be one reality, yet it is specific and local. Epistemology of constructivism claims that understanding local truths is possible through community-based knowledge, which is created by empirical observation and is bound by subjectivity. This locality of truth appears in the methodology of moderate constructionism. (Järvensivu & Törnroos 2010, 101.)

Deduction and induction are two basic models of how scientific knowledge can be achieved by a reasoning process. In deduction, theory is the starting point of research and, through hypothesis, empirical analysis is made. In induction, research starts from observed empirical findings, aiming to create more general claims and theory. In qualitative research, strict deduction is not suitable. On the other hand, pure induction is very rare or even impossible. Therefore, many social studies involve both deduction and induction, which are used iteratively in different phases of the research process. This can be referred to as abduction logic. (Eriksson & Kovalainen 2008.)

As Järvensivu and Törnroos (2010, 102) state, constructive research process uses an abductive approach, that is situated somewhere between theory driven deductive research and data driven inductive research. It accepts the existing theory, but also allows data to guide the research process. The thinking and reasoning of the researcher is also allowed to lean more on either deductive or inductive thinking during different phases of the research. (Järvensivu & Törnroos 2010, 102.) According to Dubois and Gadde (2002), by going back and forth between theory and empirical data, a researcher's understanding concerning both theory and empirical phenomena is expanded. The preliminary preconceptions of the researcher, made based on theory, evolve when empirical observations help to understand the theory. This constantly

evolving framework directs the further search of empirical data. (Dubois & Gadde 2002, 555.)

According to Lukka (2011), constructive research approach is developed in the field of business economics and research is often done as case studies, where the research creates an innovative construct, the usability of which is tested in real world. This innovative construct is an abstract concept that can be anything from a new model or a diagram, to a plan or a commercial product. The researcher and participants work closely as a team, where learning by experience is supposed to happen. (Lukka 2001.)

Case-style studies are do not aim at generalizing conclusions, but more to produce intensive, detailed information about a certain, strictly defined unit, such as an individual, community or organization (Laine, Bamberg & Jokinen 2007, 9). This is also the overall idea behind qualitative research as "in one repeats the general". And when observed closely enough, a single case can reveal what is meaningful in the phenomenon in general (Hirsjärvi, Remes & Sajavaara 2014, 182).

In case studies the focus is on understanding the relation between 4P's: place (context), process, people and period (time) (Carson et al. 2001, 93). Case studies are especially useful, when the purpose is to develop user-oriented services (Vilkka 2015). A case-study is more of a research strategy than just a method (Laine et al. 2007, 9). Case studies can be implemented with qualitative, quantitative or mixed methods, but most often the method is qualitative. A typical feature for a case study is that it is exploratory and can be a base for more extensive or quantitative research. Although the results can't be generalized, they may be transferred as ideas concerning similar cases. (Holloway & Galvin 2017, 253, 256.)

In this research, the introduced methodological and philosophical framework is implemented. In the process, both the existing theory and collected data are utilized and are iteratively and simultaneously guiding the next steps of the process. The real-life problem is the need to know the current experiences of the customers, the factors that are affecting the experiences and the critical needs for development. For this purpose, subjective customer experiences are explored. The community-based knowledge is created in a group, which in this case is the customer panel. Locality of

the truth appears under strict limitations of the group or the case and in the experiences of certain customers of a certain organization, thus making this study a case study. These findings are then reflected in light of former theory and research, aiming at creating a new construct - a solution to the problem. Despite the locality of the truth reached, it can also give insight and ideas for other similar situations and contributes to the field of study, that is in the border- line between health science and business studies.

5.2 Method of data collection

According to Hirsjärvi et al. (2014, 160-161), when a study aims at describing a phenomenon without expectations on what issues might come out, qualitative research methods can be used. Qualitative research also aims at being comprehensive and explain real life settings (Hirsjärvi et al. 2014, 161). Since the aim of this study was to explore the experiences of customers in real life situations that were not explored before, it was reasoned to use qualitative methods. In qualitative research, data is collected by a living "human instrument" which is often the researcher (Kiviniemi 2015, 74). The data is collected in ways that the real voice and perspective of the examinees can be revealed. When the aim of the research is to find out what people are really thinking, feeling or experiencing, methods like interviews and observation are most commonly used (Holloway & Galvin 2017, 87).

Interview as a method enables real dialogue between the researcher and examinees. Greatest benefit of this method is flexibility. It gives an opportunity for the examinees to tell freely about issues concerning them without any limitations and to be an active participant in the dialogue (Hirsjärvi et al. 2014, 204-205). To gain enough data, more than one interview per individual or focus group might be needed (Holloway & Galvin 2017, 88). There is no rule for the volume of data, instead the amount of collected data is seen to be adequate, when new information does not emerge anymore. This is called saturation. (Hirsjärvi et al. 2014, 182.)

According to Holloway and Galvin (2017, 130), focus-groups are often used in market and health research, both being in the focus of this study. In a focus -group interview

the topic of research is discussed together with several people. There is debate on what is the proper size of a focus group, and suggestions vary between 4 to 12 people. To gain a variety of perspectives but not being too fragmented, 6 people is seen as the optimal size of a focus group. (Holloway & Galvin 2017, 125, 130.)

To guide the conversation, the frame of a thematic interview can be used. This means that the topics are decided beforehand, but the order of questions can change to enable a natural flow of dialogue and conversation. The researcher asks questions from everyone but can address clarifying questions to individuals if needed. Participants can interact and facilitate each other too, which is one of the benefits of focus-group interview. The role of the researcher in a focus -group interview is more to guide the conversation, not so much just asking questions. (Hirsjärvi et al. 2014, 210-212.)

In this research, a focus-group interview was applied in an existing group, the customer panel, which was introduced as a co-developmental method earlier in this report. Organizing a customer panel was a part of a bigger process of the organization aiming to deepen customer insight. This knowledge was to be uses in developing the old services and innovating new customer-oriented and effective services to gain a competitive edge in the future. The purpose of the customer panel was to also engage the customers to develop the services in a new way. The customer panel was planned to meet two to three times a year and it is supposed to stay active also later if it proves to be a usable way of customer participation and co-development. There was no need to form an additional focus-group for the research, since it would have increased the workload for the customers.

The principles of a focus-group interview and customer panel are quite similar, but some differences exist too. A comparison between these two methods is presented in Appendix 1. The biggest difference between these methods is the presence of the organization representatives in the customer panel meetings. Moreover, the possibility to use the panel meetings as a co-developmental platform for a development process differs from a focus-group interview just being forum to collect information. Yet, a customer panel can be used similarly for information collection purposes too.

5.3 Process of data collection

Based on the current needs of the organization, the customer panel was limited to include only the customers of Kela's demanding medical rehabilitation. When the participants were invited, elite sampling was used. What that means is that persons who were thought to be able to give good information about the topic and express themselves well (Saaranen-Kauppinen & Puusniekka 2006) were selected to participate in the panel. Customers of different age and of different cycle lengths as customer were invited to give a wider perception of the topic.

During April and May 2019, a total of 12 participants were invited by giving them an invitation. Invitation was given by researcher, office person or customer's own physiotherapist. The invitation included information about the last date to sign up and the date for the first meeting. Additionally, participants were given an informed consent (Appendix 2) to be familiarized with beforehand. By the given date, 10 volunteers had signed up. In the end, all volunteers did not participate in the meetings. The age of those who were present varied between 20-50 years and they had been customers for 2-9 years. The participants are introduced in Table 2.

Table 2. Participants in the meetings

Participant	Age (years)	Years as customer	Present in 1st meeting	Present in 2nd meeting
P1	48	5	X	
P2	48	2	X	X
P3	29	5	X	
P4	50	9	X	X
P5	44	4	X	X
P6	42	8	X	
P7	20	2	X	X
Researcher	-	-	X	X
Office person	-	-	X	X
Manager	-	-		X
Total number of participants			9	7

Two interviews were done during customer panel meetings in June and October 2019. The meetings were kept in the facilities of the organization after office hours. The meetings lasted two hours, with a 15-minute break in the middle, which suits the recommendations for focus-group interviews (Holloway & Galvin 2017, 131) that is 1,5 to 2 hours. The meetings were recorded with two recorders to avoid any loss of data due to possible poor audibility. At the beginning of the first meeting, ethical issues and the use of collected data was gone through with the participants and they all signed an informed consent (Appendix 2), which they had received when signing up. The plan for the meetings and interview frame is presented in Appendix 3.

Since the interviews were implemented in customer panel meetings, other representatives alongside the researcher were present too (see Table 2). In both meetings, office person of the organization was present taking notes during the meeting and helping with the arrangements but avoided participating in the conversation unless directly addressed. In the second meeting, manager of the organization was present too, but did not participate in the conversation during interview until in the end, where deepening questions were asked. The managers role was to answer the customers' questions and give information about the planned developmental activities handled later during the meeting. This later section of the meeting was not included in this study.

The researcher herself was attended the meetings in a dual role of a chairperson and a researcher, even though this is not an ideal situation according to the guidelines of a customer panel, that suggest the chairperson to be a neutral person outside the organization. The researcher works as physiotherapist in the organization and the participants know the researcher at least by name. Also, some of the customers new each other beforehand. This might have had an effect on the dynamics of the meetings. According to Holloway and Galvin (2017, 131), in health care research this type of familiarity might even have positive effect by shortening the "warm-up" time needed to start the conversation.

In the first meeting seven customers were present. The first meeting imitated the form of a focus-group interview more, aiming at only collecting information, not implementing any actual co-developmental actions. Only the short introduction of

general issues related to customer panel was included (see Appendix 3) in the beginning. The focus was in open conversation about customer experiences, and this was facilitated by open questions concerning the topic (Appendix 3). The researcher was leading the conversation, taking care that everyone had a chance to speak.

The conversation was flowing quite freely, and the customers told openly about their experiences, both positive and negative. The atmosphere was relaxed, which indicates that the participants felt comfortable in the situation. Not all the questions needed to be asked, since the topics came up spontaneously but some specifying questions were asked to deepen the conversation or encouraged the quiet persons by asking their opinion. There were no issues concerning many persons speaking simultaneously or acting provocatively towards others. As was hoped to happen, customers facilitated each other to share their thoughts by asking questions and comparing experiences.

After the first meeting, the recording was transcribed and anonymized. Transcription and notes taken by the office person and researcher were studied, and a primary analysis of the results was made. Some superficial thematization was also done to give researcher first impression about themes that had emerged.

In the second meeting, four customers were present, all of whom were present also in the first meeting. The focus of the second meeting was to deepen the existing information from the first interview, but also other topics not related to the research were discussed and some co-developmental actions were kicked off. Due to these other topics, the manager of the organizations was present as mentioned earlier but they participated only at the end of the interview by asking deepening questions, as explained next.

At the beginning of the second meeting, the summary of the results of the first meeting was introduced using Power Point-presentation and the customers were given a chance to comment and give additions to the summary, but there were only few comments that gave any new information. After this, the conversation was directed by the researcher and manager to more precise issues concerning the accessibility of the entrance and ways to collect customer feedback. Up until this point, the conversation was recorded. After the conversation ended, other co-developmental actions started,

and the recording was stopped. Only the recorded part of the meeting was used as data in this study.

After the second meeting, it seemed that there wasn't any new information concerning the customer experience of this group, so the saturation of the data was reached. The presence of the manager possibly affected the conversation, which was more restricted and not as open as in the first meeting. Decision was made that only these two meetings would be used as data for the research and the customer panel would continue in the future as a separate activity, concentrating more on actual co-development.

The recording of the second meeting was transcribed partially and anonymized, excluding the presentation of the previous results by the researcher. The transcribed parts of the interviews in both meetings were transcribed as precisely as possible, including laughter or physical signals, such as nodding and showing thumbs up, to gain as rich data as possible. Only the parts clearly not related to the topic were left out, but even these parts were referred to briefly in the transcriptions so that it would be possible to return to the parts if needed.

In the transcriptions the participants were separated from each other with the marking P*n*, where P stood for participant and *n* stands for identification number. The same number was used in the transcriptions of both interviews. The researcher had a list where the identification number was connected to the participant. This list was kept in a cloud file secured with a password, accessible only by the researcher. Data handling is discussed further later in this report in ethical discussion.

In the results section of this report, quotes of the participants are marked with identification markings such as P4/2. The number after letter P represents a certain customer and the number after the backslash is the number of the interview where the quote is from. Quotes used in this report were translated from Finnish to English by the researcher as precisely as possible, aiming at not losing any information. Translation of the quotes was the final step after analysing the data and writing the results section of this report. This way, the quotes were easier to find from the original data if needed and the risk of misunderstandings was minimized.

5.4 Data analysis

In qualitative research the data analysis progresses iteratively, when the researcher moves from data collection to analysis and back to data collection (Holloway & Galvin 2017, 287). During this iterative process, interpretations made through analysis are guiding the upcoming data collection and the formulation of the final research questions. Several interesting aspects and lots of usable data might be gathered, but the final approach to a problem defines the data to be used for deeper analysis after the data collection is completed. Even if it is not relevant to bring up all information found under the scope, this information can have important role in framing the final focus of the study. (Kiviniemi 2015, 74-77, 81-82.)

The first steps of data analysis were taken already during the first interview. The content of the conversation was instantly reflected with the researcher's existing knowledge and preconceptions about the theory of customer experience, and this guided the further conversation in such way, that good quality data could be gathered. The analysis continued after the first meeting, when the primary analysis of the data collected so far was done. At this stage only rough, general themes such as wishes, importance of physiotherapy and experiences about facilities, therapy and operations were identified from the data. These primary results were presented in the organization management group, where some actions addressed to occurred issues needing immediate attention were planned. Summary of the results and planned actions was done as power point -presentation to be used in second meeting.

A preconception of the researcher was that service encounters introduced in already existing theory could be used in structuring the data. The primary analysis of the data confirmed that this could be done. In addition, this primary analysis helped to deepen the researcher's theoretical understanding about the topic, and it guided the search for more information from literature. At this point, in the iterative process between theory and empirical observations as described by Dubois and Gadde (2002, 555), the collected data guided the researcher to familiarize herself more with the concept of touch point elements (people, operations, objects and surroundings), which were

decided to be used as the theoretical base when collecting and organizing the data further.

After the second meeting and transcription of the second interview, both transcriptions were red through several times and recordings were listened at the same time and separately in order to identify emotions and true meanings of the quotes. In addition, the notes taken from both meetings were red through, but only the recordings and transcribed data were used later, since all necessary information could be taken from those.

After the data was familiar to the researcher, it was coded. Coding means labelling or marking the sections or units of data to be more easily handled (Holloway & Galvin 2017, 293). The first two steps of the organizing the data were done in a theory driven way, utilizing existing models and theory of service encounters and touch point elements (Figure 4). First, the coded units were arranged by different service encounters, creating main categories.

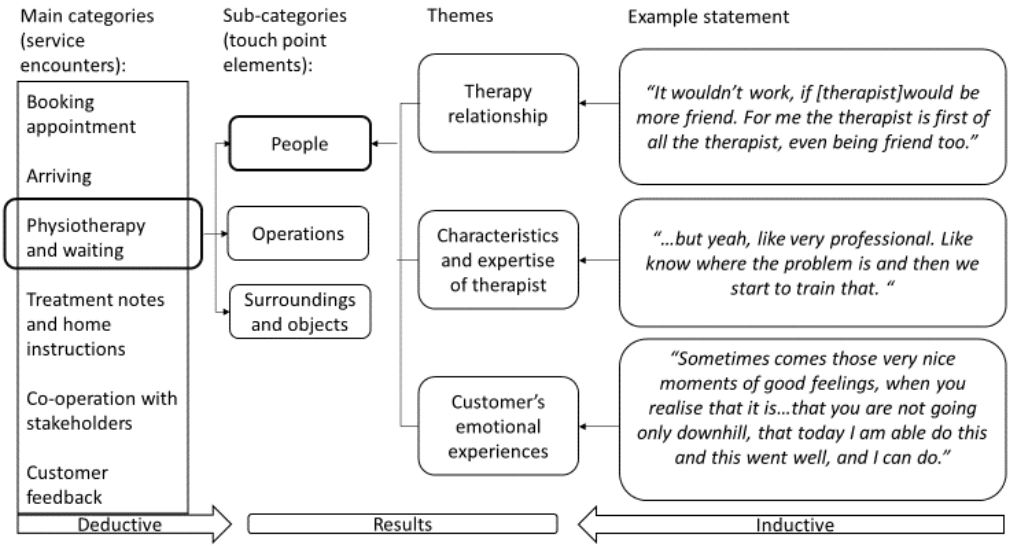

Figure 4. An example of the categorization of the statements concerning a service encounter of physiotherapy and waiting time.

Secondly, the data was explored further, arranged again and statements were organized in sub-categories based on touch point elements. The elements of surroundings and objects were combined to be handled as one touch point element, as they were often very closely linked to each other. Thus, making a differentiation between them would

have been hard and would have made introducing the results unnecessarily complicated. An example on categorization concerning service encounter of physiotherapy and waiting is illustrated in Figure 4.

In the third, data driven step of the analysis, these statement units in the sub-categories were then further explored and thematised. By these themes, issues effecting on customer experience could be identified. Only after this iterative coding and arranging, the final structure of the data was created (Kiviniemi 2015, 82-83) in the form that is presented in the results section below (tables included in Appendix 4).

6 MULTIDIMENSIONAL CUSTOMER EXPERIENCE

The results of this study give rich description of the effect of different touch point elements in different service encounters on the customer experience. From the collected data, six service encounters could be identified (Figure 5). Some service encounters were combined, since issues concerning them were so similar or they otherwise were so tightly linked together in the conversation. Not all touch point elements could be identified from every service encounter (Appendix 4).

Some of the pre-core service encounters introduced in Figure 2, such as need recognition and finding information, were not discussed. This is understandable, since all customers participating the panel had been customers for several years, and therefore these topics were not relevant to them anymore. In addition, the post-core service encounter of word of mouth didn't emerge in the conversation. However, the customers compared their experiences during the interviews, and this could be seen as word of mouth. This comparison, and the issues revealed by it, may especially affect the customers' upcoming experiences.

The customers' experiences of the core service were most critical in creating the overall customer experience. What is worth noting is that customers linked the waiting time very closely to the therapy appointments, as part of the core service encounter,

instead of them being separate service encounters. The core service encounter meets the customers' critical needs, and the service's meaningfulness to the customer was tightly linked to this service encounter. Therefore, it is reasonable to say that the core service is the most valuable service encounter during the service path.

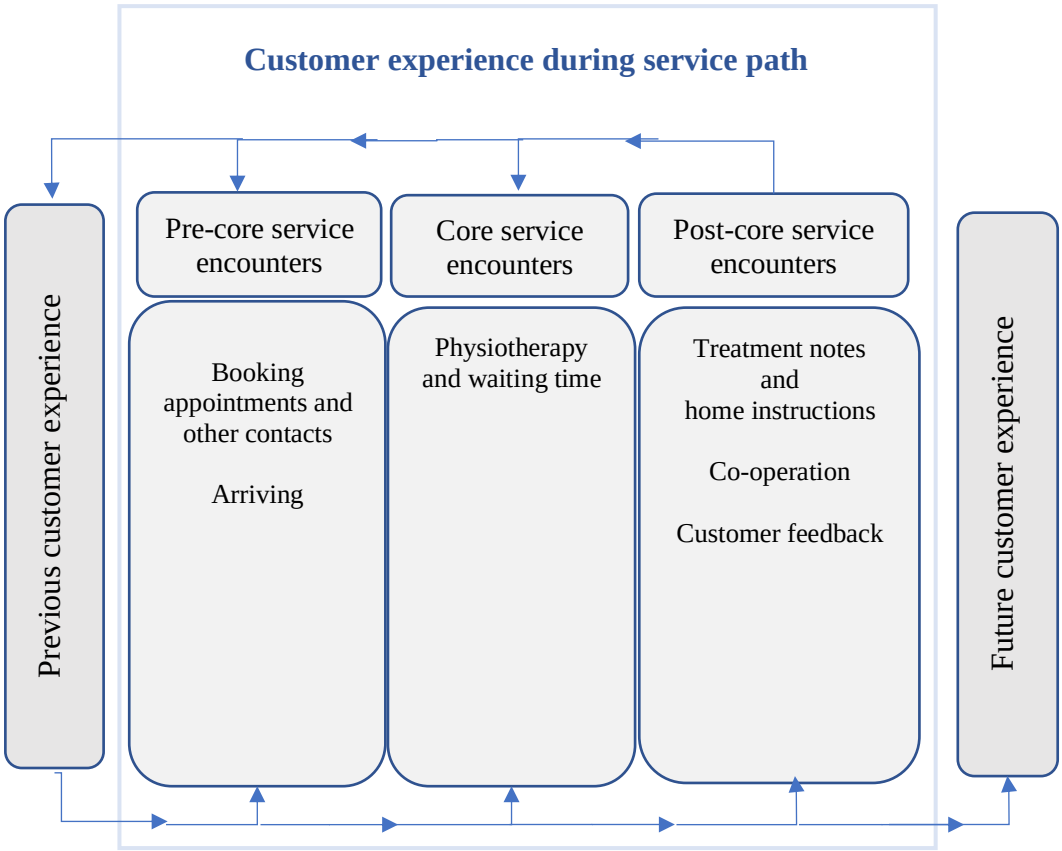

Figure 5. Service encounters identified from the data. (Modified from Lemon & Verhoef 2016, 77; Voorhees et al. 2017, 271.)

In some service encounters, the effect of previous experiences and customer's attitude were visible. Furthermore, few not yet existing service encounters were recognized. These findings are introduced in the following subchapters in more detail by each touch point element.

6.1 People – the most important element

The role of the touch point element of people was prominent in most service encounters. It appeared from the perspective of individual characteristics of the

customer and therapist, but also as interaction between them. When booking a time or contacting the organization in some other way, there was variability in the quality of the service depending on the person who was offering the services. Usually there were no problems worth mentioning, and customers liked doing business with the office person, who they highly valued:

P2/1: With [office person] everything ALWAYS works and if not during the first phone call, then I call you again. With booking a time, everything has been ok, as well as with cancelling times.

In some cases, if there were substitutes or other persons taking care of the office, problems and negative experiences had occurred, especially concerning operations linked to office services.

The role of the customer's physical characteristics was highlighted in the experiences concerning the arrival to the clinic. Experiences varied very much depending on the customer's functioning and the changes happening in it over time. One customer recalled the time when the surroundings of the organization were less accessible than currently, but it was not an issue at all back then, when their functioning was better:

P4/2: As I have steadily gotten weaker during these 10 years, it's not until now that you notice concretely what accessibility means. Back then, 10 years ago [before modifications were made in the facilities], this place was totally not accessible, but I didn't notice it back then.

This example shows very well how subjectively an experience is created, how a customer's expectations and needs affect the experience and how an experience can change over time.

The role of the element of people was especially highlighted in the core service encounter. The customer's own role in the creation of customer experience was clearly visible. Emotional experiences were visible as an attitude directed towards the service beforehand or created by the service. For example, in the early stages of a rehabilitation

process, customer's attitude towards physiotherapy can be negative, causing negative experiences. This happened to one customer:

P7/1: At first, I didn't know if I would be left in a wheelchair or using crutches, so I felt this was just going through the formalities (suom. pakkopulla). Like, again on Tuesday I had to come here. But now, when little by little it has started to dawn on me where I am going, I can value these small things more, which will eventually have an effect on how I will walk.

Additionally, the changing nature of the customer experience came visible when the attitude changed to be more positive after the true meaning of rehabilitation to the customer was revealed. In most cases, emotional experiences were created by the service when customers responded emotionally to the meaningfulness of the service. The meaningfulness of the service was often related to the customers' functioning and the benefit customers got from physiotherapy:

P4/1: I wouldn't walk, at least not in the amounts I now do, if I wouldn't come here in [name of organization].

Positive feelings of motivation and empowerment were achieved when, during therapy, the customers noticed the development that had happened despite their condition:

P1/1: On the other hand, even when there was no progress and all was just downhill, you still had the strength to come here even from a distance. And then you felt like you are at least doing something… But now when finally, there is a period that we are moving forward, yes, it is much more motivating.

P5/1: Sometimes there are those really nice moments of good feelings when you realise that it is…that you are not going only downhill, that today I am able do this and this went well, and I can do it.

Additionally, social aspects of functioning were experienced to be meaningful. Regular physiotherapy appointments gave structure and content to many of the customers' daily life:

P6/1: For me this is a social event, as I'm retired. At least I visit here, if I go nowhere else. When you are given the times beforehand, you know that you need to be there then. Otherwise it would be more difficult to go.

P7/1: This is a kind of moment of cheer in the week. The therapist asks how you are and then you can chat about whatever is on your mind. And like, you get good tips and advice and support overall.

Regular meetings also helped maintain a positive mood for some customers. Physiotherapy was also experienced as supportive especially when the condition caused drawbacks in a customer's functioning. Support received from the therapists and other staff members and customers, as well as friendships created with other customers were important too.

Another way the element of people affected the customer experience was the therapy relationship between the therapist and the rehabilitee. It was described as a balance between friendship and professionalism. Customers saw the therapist as a friend that one could talk to about everything. During the whole interview, the therapist was often called with casual nicknames like physio (suom. fysio) or "jumppari", or with the first name of the therapist, which gives an impression of a natural, open and equal relationship. On the other hand, the professional role of the therapist was something very important too:

P4/1: I don't see many of my friends as many times a week and talk about everything, like that [therapist] knows my fat percentage and everything. Like the size of my underwear and all. And for me, that is a big thing. Still, the therapist is an expert of one's own field, otherwise we just chit chat about everything.

P3/1: It wouldn't work if the therapist would be more of a friend. For me the therapist is first of all the therapist, even if they're my friend too.

P5/1: On the other hand, it wouldn't work if the therapist would only be an expert, like some physician in a health care centre… P1/1: [continuing the sentence of previous talker] …like an outsider.

It depended on the customer how they liked the emphasis between friendship and professionalism to be, but no extremes in either way were described. The importance of a good relationship was also seen in a situation, where the customer was willing to drive 45 minutes to therapy and back, even if there would have been other options closer. The reason for this was that good "chemistry" was not reached with the other therapists. In addition, notions of trust and attachment were used by customers to describe the therapy relationship:

The personal characteristics and expertise of the therapist were closely linked in the therapy relationship and in the "chemistry" that evolves between the customer and therapist. The therapists were described as sympathetic, wonderful and pleasant persons. One customer described the therapist as demanding, and highlighted it being the way that a therapist should be in order to make things work. Also, the physical strength of the therapist was valued as a feature creating safety to a customer during a therapy session. The expertise of the therapists was highly valued, and customers were happy with the overall level of it, as can be seen in the next quote:

P7/1: …but yeah, like very professional. Like they know where the problem is and then we start to train that. I am so happy that we have got things working so fast... I have been surprised on how broad this [expertise] is, like [therapist] knows what the issue is and can tackle it immediately.

The expertise of the therapists was shown also when the therapists could pinpoint the customer's achieved progress, since it could be difficult to notice otherwise. Setting limits to the customer concerning, for example, the amount of training or rest was acknowledged as expertise too.

Variation in expertise between therapists caused some negative experiences, when the therapist wasn't familiar with the diagnosis of the customer, and this led the therapy session to be not so useful:

P1/1: Some of the therapists have less knowledge about the condition than other therapists. It has, in a way, slowed the process.

In these cases, the therapist was often substituting the customer's own therapist with a short warning time due to sudden situations, such as sick leaves. On the other hand, positive experiences concerning this variety was linked to specialized expertise of different therapists:

P1/1: On the other hand, every therapist has differences in expertise and that is good. Some new perspective has been brought up every time.

If the customers had some specific issues, the customers were happy they could ask for a few meetings with a different therapist with the skills to handle this issue. The customers can have high expectations concerning the expertise of therapists, since one customer was wondering if the use of ICF was familiar to all therapists, especially when used as an evaluation tool for complex conditions. In addition, the therapist's willingness to learn and gain new knowledge and know-how concerning the customer's needs was noted and valued.

When co-operation with stakeholders was concerned, consultancy and advocacy by therapists was an important issue. While experiences concerning the procedures or the operations that the organization can't affect were negative, positive experiences and value for the customer were created by the organization when the therapist helped a customer to handle difficult issues:

P2/1: It is so difficult to do business with Kela, really. Like now when they called me about [issues related to rehabilitation], I thought that I didn't understand anything, and wanted to ask if they could contact the [target organization] directly.

P2/1: Then I brought the paper to the therapist, who guided me how to proceed…

This need for the therapist's consultancy demonstrated in the second quote was sometimes directed towards contacts not directly related to the rehabilitation process but concerning other services that still somehow had an effect on the customer's functioning, and therefore secondarily affected their rehabilitation. This need for consultation was highlighted by customers who for some reason didn't get the answers they needed from the service counsellor in public sector services.

6.2 Operations – ensuring convenient and adequate service

The role of operations was markable throughout the service path. In the service encounter of booking appointments and other contacts, convenience of the operations was important in the creation of good experiences. Flexibility with the time of the appointments and operations concerning their booking was highly appreciated. Customers felt that they could fit their therapy to their own schedules very well and had the appointments booked far ahead, which was convenient. They could have also contacted the therapist quite easily, at least by leaving a request to call back or asking the office person to pass on the message. The variability in the touch point element of people affected negatively to the element of operations:

P6/1: "You can cancel the appointment, but might not be able to book a new one, if the office person is not present"

P2/1: "Or they just forget to inform about changes."

Negative experiences and inconvenience were linked to the situations where, for example, the substitute of the office person couldn't book a new appointment for some reason or the message to the therapist was not delivered, and for that reason some prior information for the next appointment was missed. Sometimes an inconvenience was caused if changes in therapy appointments were not relayed properly to the customer, or the physiotherapist had not been informed about the cancellation.

The role of operations in the core service encounter of physiotherapy and waiting occurred in two themes: continuity of therapy and content of therapy. These issues affected the customer experience strongly. Continuity of therapy evoked a lot of conversation and there was a variety of experiences concerning it. Some persons had had the same therapist in charge the whole time they had been a customer in the organization, and they were happy with the situation. They were able to have meetings with other therapists too, but the main responsibility for the rehabilitation was maintained by one therapist the whole time. Unfortunately, totally different experiences existed as well:

P6/1: It feels that I'm thrown to any therapist who is free. This is something I could say a few chosen words about. I don't get the sustainability. In addition, I do different things with different therapists, there is no continuity. Then I may forget what is done and it all becomes a total mess, maybe.

This customer was very frustrated about a situation where the therapist treating them changed very often, even if the physiotherapist in charge remained the same officially. This clearly demonstrates a situation where errors in operations during the booking of an appointment compromised the stability of the rehabilitation process and continuity of therapy.

Even if the continuity of therapy and stability with the therapist in charge were important, sometimes meetings with different therapists created extra value for the customer. This happened when the therapy gained new perspectives, or the customer gained new information from the therapist. However, the value was added only when the change was done based on the customer's needs and hopes, and it was done in co-operation with the therapist in charge.

Another widely discussed topic was the content of therapy and operations linked to it. Some customers described their experiences through a comparison to therapy processes they had had somewhere else, either in public or private sector, before coming to the target organization. A distinctive feature in these previous experiences was that the needs of the customers were not met, which led to negative experiences.

Therefore, some customers were very happy about the possibility to change the service provider:

P2/1: I probably wouldn't walk anymore if I'd still be going there [another service provider]. They just forced me to go to the gym, just the gym. Then, when I was not able to properly walk anymore, I was allowed to come here…

It is possible that these former negative experiences affected the current experiences in the target organization and made the customers value these positive experiences even more. Customers felt that therapists in the target organization planned their therapy in a person-centered way and according to their hopes and needs:

P5/1: Like, what is important here, is that the physiotherapy stems from my own needs and what is good for me.

P2/1: Like, here they treat you as a whole.

The customers felt that the content of therapy acknowledged them as a whole, and that the methods used were valid. This was seen to be very important.

The role of the organization's operations that are not directly visible to the customers became evident through the reported experiences. For example, educating the staff members about the possible content of therapy could be such an operation. When customers discussed about the content of their therapy, differences occurred on how versatile the content of therapy was and if the therapy included any "specialities", like testing different sports. Some customers had gone outside with the therapist for the warm-up before training or visited a local gym nearby, whereas some felt they were lacking this variety. Some customers had not even heard about this opportunity to do "sport or hobby testing", which is included as a possibility in Kela's service description for demanding medical rehabilitation. Generally, variation was one thing that some customers felt was missing from the therapy. These customers hoped that the therapist would suggest something different more often.

In post-core service encounters the customers' experiences were related to the functionality of the operations. In the service encounter of treatment notes and instructions, the theme of information transfer was discussed. When customers were not aware about the operations linked to the therapist making treatment notes, they doubted the continuity of therapy. One customer was worried whether the therapist had time to write any treatment notes, because the therapist often started their next appointment right after the previous one had ended. The customer wondered if the therapist would remember later what the current state was or what was done during the therapy appointment:

P4/1: Sometimes I wonder, when the therapy ends and another customer is coming in straight away, like, when does the therapist have time to write down what we did or what was the case, or will those be forgotten?

Some customers also noted that often they would forget what was discussed during the meeting or what was recommended to be done at home. They hoped that these instructions would be written down somehow, so that the customer could recall them better later.

Experiences concerning the operations linked to co-operation with stakeholders varied. Overall experiences concerning the convenience of partner-owned procedures, such as applying rehabilitation from Kela, were negative. This was due to long handling times and complicity of the language used in applications, forms or conversations with Kela's personnel. Of the co-operation procedures where the service provider was included, experiences were more positive. For example, the preparation of rehabilitation feedback and recommendations concerning the future were seen to work well:

P6/1: For me it has worked well that together with the therapist we planned what we put or what we hope is in the next rehabilitation plan. And for the rehabilitation feedback we planned that [the therapist] will send it to the doctor.

In this example, the therapist prepared the document early enough and then went through the document with the customer before sending it to the doctor currently

treating the customer in public health care, ensuring that the process moved forward smoothly.

Variability in the operations linked especially to rehabilitation plan meetings caused negative experiences. Some customers felt that they were not informed that the therapist would have had an opportunity to participate in these meetings. There was also variation on how necessary the therapist's participation was, and when was it that customers thought the participation of the therapist was needed. One customer in particular felt that their needs were not met in this case, as can be seen from the two quotes from the same person:

P1/1: I have never had that rehabilitation planning meeting, and no one has ever said that it is possible.

P1/1: [Therapist and doctor] should meet face to face. I have doctors changing after two months and then they know nothing about anything.

The participation of the therapist was seen important especially if the doctor was new to the customer. When this didn't happen, the customer felt a bit disappointed. If the treatment relationship between the customer and the doctor was longer, the therapist's participation in the planning meetings was not necessary and the information between the professionals was successfully transferred via rehabilitation feedback.

Slowness and unclarity in operations concerning handling customer feedback caused negative experiences. Some customers were frustrated about the slow progress of the process:

P6/1: I have talked about those [equipment]so many times. I even thought I'd bring my own screwdriver with me and do the work…

Customers told that they had hoped something several times, and even if promised, nothing would happen. They hoped the organization would react quicker to feedback and stated that customers should be better informed about what actions were planned to be implemented based on their feedback and when it would happen.

6.3 Surroundings and objects – physical and social accessibility as principle

A significant theme concerning the element of surroundings and objects was accessibility. Both physical and social accessibility were important issues affecting customer experience throughout the whole service path. Customers evaluated the accessibility of the target organization in relation to their own functioning, but also by comparing the target organization to other service providers.

Concerning the service encounter of arriving, central location was experienced as a good thing, but of course this was dependent on where the customer lived. Lack of parking space, especially spaces for the disabled, caused frustration. Sometimes customers had even been late for their meetings since there were no free spaces nearby. The unevenness of the yard area made the walking or the use of a wheelchair difficult, and a handrail that was too short and narrow steps in the stairs caused negative feelings. Some customers were not able to or had severe difficulties to independently enter the building by using a wheelchair, because the ramp to the entrance was too steep and the doors opened in a difficult way. The frustration of the customers came through in a comment expressed very emphatically:

P5/1: Shouldn't this place be, like, accessible at least?

Additionally, when concerning the core service encounter, accessibility of the therapy facilities was not at the level the customers would have wanted. Poor accessibility of toilet facilities, functionality of assistive objects and accessibility of gym equipment were criticized:

P5/1: If something negative then, these facilities are not so good. Very small and cramped, very non-accessible.

Additionally, a low contrast between some ramps and their surroundings caused difficulties to customers that have problems with their sight. Moreover, the indoor temperature of the facilities affected the experience during therapy appointments. Due

to the temperature being too high, some customers were even forced to cancel their appointments, since the temperature negatively affected their functioning so much.

One customer interpreted these lacks in accessibility as a sign of poor attitude from the organization, and as expressing possible deficits in social accessibility. On the other hand, despite the limitations in physical accessibility, social accessibility was mostly experienced to be positive. This could be interpreted from comments such as:

P4/2: It says something that we stayed here after our own appointments for this interview, like we do feel like at home.

P2/2: Many times, it would have been nice to stay here after my therapy, to sit down, get a cup of coffee and catch up…

P3/1: This is like another home for me, I visit here so often.

The customers' comments revealed a positive atmosphere in the organization, the customers' familiarity with the staff, and the customers' willingness to stay and spend some time in the lobby after their therapy chatting with staff and other customers.

The crowdedness of the therapy space made it difficult to move around sometimes, and it was experienced to be very disturbing, especially in testing situations:

P4/2: Last time when the therapist made me do the walking test, and there was someone occupying every piece of gym equipment, and because I have poor eye sight and walking is difficult, I was afraid whether I can even do it if someone comes in my way.

Some therapy rooms and the open therapy space were described as small and cramped. This crowdedness, especially in the open therapy space, sometimes compromised the privacy of the customers since the discussions between the therapist and customer could be heard by others in the same space:

P5/1: It is quite a close-knit atmosphere here in the therapy space. Sometimes, often it is ok, but sometimes the intimacy is compromised since there is 4-5 customers in the room.

Sometimes the conversations concerning the customers could be heard from other spaces, for example, from the waiting area to the therapy space. Positive feedback was given for the tapings in the big windows, which blocked the view from the street to the therapy space, thus giving some more intimacy.

Some customers commented on the visual appearance of the facilities. Even though it was not seen as important as accessibility, some customers felt that the colours of the walls and treatment tables were outdated, and it created some discomfort. Also, the amount of loose and unused equipment was commented upon.

During the interview, the theme of digital solutions was brought up in relation to many service encounters. Their role in forming the current customer experience was minimal. When discussing digital surroundings for therapy, for example remote therapy, the customers' impressions towards the topic were negative. They stated it was a current trend, and that it is not suitable for everybody. The only applications they could currently accept were linked to supporting the implementation of their home exercise programs or booking an appointment. One customer thought that reminders about the home exercise schedule could be sent through mobile, but even then, there was no way to ensure that the customer would actually do the exercises:

P4/1: If it is something that reminds me to exercise, then maybe.

Online booking for appointments was not used often, but it was thought to be convenient in some cases. One customer hoped for a possibility to move the booked appointments straight to Google Calendar.

When discussing about the service encounter of customer feedback, themes of accessibility and anonymity were linked to digital solutions too. Customers were happy to give feedback, but the way it is collected should be thought over carefully. Customers stated that even if digital applications for feedback might be convenient for

the organization, those are not available for every customer due to a lack of smart devices or visual impairments making their use difficult. Additionally, based on their experiences in other contexts, customers didn't trust that the feedback collected, for example, by mobile phone would actually be anonymous:

P5/1: Of course the feedback is more open if you can do it anonymously. I don't think anyone believes that it is anonymous if you do it by your mobile phone.

Customers experienced that this possible lack of anonymity would risk the truthfulness of the feedback and that giving negative feedback might have an effect on the services offered to them. Overall, customers were pleased that the organization had an open attitude towards receiving feedback:

P5/1: It is very positive that the organization wants to hear the voice of the customers. I am happy to give feedback.

The customers appreciated the fact that a customer panel was organized, which enabled them to participate in the development of the organization by giving feedback and taking part in the development planning.

6.4 Possible new service encounters – creating extra value to the customer

In addition to the customers' experiences about service encounters during the service path, they brought up some possible, not yet existing service encounters. These service encounters could either support the rehabilitation process or produce extra value to the customer in other ways. Even if this is not directly linked to the research questions of this research, these findings are introduced here since they give a good idea about the matters the customers feel they may be lacking currently.

Some customers hoped that the organization would arrange possibilities to have new experiences, for example, to try out different special sports equipment that could be used despite their disability. This could be arranged individually, as group trips for

several customers or as events planned by the organization. The customers could also get to know each other in these meetings and get peer support.

The customers hoped that the organization would share information. This could be done by arranging themed events about topics that are related to the customers' functioning. The topics could concern issues such as new available assistive equipment or general well-being. These could be arranged in co-operation with third sector associations, the public sector or other private sector actors.

Co-operation with the public sector was also desired concerning the plans made on municipal level:

P1/1: The organizations could work together, with the municipality. That the needs [of the disabled] would be taken in to notice when building. So, this communal influencing. Or you should have some politician who could promote these issues.

In this case, the customer hoped that the expertise of the physiotherapist could be used also on a larger scale, and that the organization would lobby politicians for the issues that are important to the customers.

7 CONCLUSIONS

Based on the results of this study, customer experience in physiotherapy services is very multidimensional. Customer experience is created through different service encounters and touch points. Different touch point elements affect customer experience as unique combinations in different service encounters, which then affect experiences in other service encounters. Additionally, customers compare their current experiences to their previous experiences. Needs of the customers vary over time and between individuals. Identifying these unique, changing needs and meeting them is the key issue in creating good customer experience.

A possible new finding was that the customers hoped that the organization would work as an advocate, promoting issues important to the customers on a municipal level. Based on this finding, a conclusion can be drawn that either the customers are not aware of possible other authorities that could promote their ideas, or that this work done by these authorities is not enough. Either way, it reveals that the customers, at least the ones in this focus group, are aware of the difficulties of disabled people and expect this awareness also from the organization the services of which they are using.

In the next chapter, the main findings of this study are reflected upon theory and previous studies. Some of the issues handled in other studies are not directly observed from the perspective of customer experience but are brought up here in the sense that they show what is meaningful and important to the customers. Based on this premise, these issues are also important in the creation of customer experience.

7.1 Reflection of the results to the theory and previous research

Importance of the core service is natural, since therapy is the service that is fulfilling the critical need of the customer. While core service encounters are more widely studied, pre-core and post-core service encounters have gained less attention also in previous studies. (Voorhees et al. 2017, 270-271.) Although the role of these service encounters might not be as markable in creating a customer experience, they do have an effect on it, and therefore should not be neglected. Understanding the effect of these service encounters might even give the organization a unique opportunity to enhance their overall customer experience with just small adjustments.

In the core service meeting, the role of people was highlighted, and operations were very important too. This finding is in line with the thoughts of Berry and colleagues (2006). They stated that customer experience is influenced by the customers perception about the surroundings and objects, but the core of the experience is created by meeting the needs of the customer with the service. Moreover, human interaction is the key component to exceeding the customer’s expectations and to creating an emotional bond between the organization and customer. (Berry et al. 2006 46-48.) In this study, the role of accessibility of the surroundings was yet very important issue and it is

possible that effect of the surroundings on creation of customer experience is more important with customers with disabilities.

In this study, fulfilment of meeting an individual's needs was linked strongly to the content of physiotherapy. This recognition of different needs between individuals and treating individuals as a whole are key concepts of person-centeredness (see e.g. Plewnia, Bengel & Körner 2016; Zill, Scholl, Härter & Dirmaier 2015). Meeting the customers' needs, especially concerning the core service, evoked positive emotional experiences, such as motivation and empowerment. According to Plewnia and colleagues (2016, 2068), these positive emotions, are related to good rehabilitation outcomes as such, but also to higher patient satisfaction in a medical rehabilitation setting. These positive experiences create the highest level of customer experience (Tuulaniemi 2016, 74-75), as they create an emotional bond between the organization and customer (Gentile et al. 2007, 404).

Therapy relationship had important role in creation of customer experience. Although the perspective of previous studies has not mostly been from the customer experience point of view, Paltamaa, Erkkilä, Kanelisto, Mustonen and Nousiainen (2017) have explored Kela's medical rehabilitation and its meaning to customers. The customers recognized the role of the therapist as a professional presenting realistic point of views and noted that the trust between a customer and a therapist was seen to benefit the outcomes of the therapy. (Paltamaa et al. 2017, 51, 212.) Need for an alliance between the therapist and customer was recognised also by Holopainen, Piirainen, Heinonen, Karppinen and O'Sullivan (2017), who studied the conceptions of low back pain - patients about their encounters in health care system. They noted that a good therapeutic relationship and a person-centered approach were vital for the rehabilitation process to be successful or, in some cases, even begin. (Holopainen et al. 2017, 274.)

As seen in the example where customer was aware about the ICF, customers can be very informed about issues related to their functioning and expect certain level of knowledge from professionals too. This customers' increased knowledge and motivation to have a more active role in rehabilitation encounters (Ishikawa, Hashimoto & Kiuchi 2013, 152) and their increased motivation to seek health-related

information and use it in a value co-creation process in health care services (Osei-Frimpong, Wilson and Lemke 2016, 21) is recognized in other studies too.

When observed from the perspective of customer experience, the important role of the characteristics of the therapists, such as professionalism, skills, friendliness and caring nature, is recognised in many studies. Hush, Cameron and Mackey (2011, 32) made similar findings when they reviewed the issues affecting customers' satisfaction in the context of musculoskeletal physiotherapy. In their article, Berry et al. (2006, 50) introduced the results of National Inpatient Priority Index (2004) showing that human contacts, such as nurses informing the patients, being sensitive to inconvenience caused by the health problems and emotional support were ranked to be some of the top reasons to recommend the hospital over any issue linked to surroundings or objects. Even in luxurious contexts, where physical atmosphere is first class, the moments of care by employees and interpersonal synchrony were seen to be the most important issues affecting the customers' experience and satisfaction, as was found in a study by Kreuzer, Cado and Raïes (2019).

The importance of continuity of therapy in the sense, that the therapy is provided by the same therapist became obvious in this study. This topic is widely handled in many studies. It has been seen to be vital in building good therapy relationship (Holopainen et al. 2017, 273) and Beattie, Dowda, Turner, Michener and Nelson (2005, 1046) linked it to be associated with customer satisfaction, and argued, that organizations hoping to achieve high customer satisfaction, should ensure the continuity of care. In a study by Paltamaa et al. (2017), the customers experienced that continuity with the same therapist created security. On the other hand, they also felt that sometimes change of the therapist was welcomed. (Paltamaa et al. 2017, 46-47.) This positive effect of therapist changes was seen also in this current study, but the therapist change was only seen positive, when it was based on the needs of the customer.

Most of the negative experiences in this study were addressed towards lack of physical accessibility. According to United Nations Convention on the Rights of Persons with Disabilities (2006), "*disability results from the interaction between persons with impairment and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others*". In the ICF, functioning

of a person is defined as the interaction between individual's health condition and contextual factors (WHO 2011, 19). This interaction was visible in the results of this study, when customer's experience concerning physical accessibility was created by the customer's personal characteristics interacting with the surroundings, not by either element alone.

According to Sosiaali- ja terveysministeriö (The Ministry of Social Affairs and Health) (2010, 61), barriers in built environments are very common and they set individuals with disabilities in an unequal position. When regarding customer experience, the role of accessibility in creating a competitive edge will increase in the future due to the aging population (Sosiaali- ja terveysministeriö 2010, 165). However, the author of this research argues, that in the market field of medical rehabilitation, accessibility shouldn't be the way to compete in the market, but the axiom that the services are created from.

In this current study, issues concerning convenience were linked to operations and they emerged especially in pre-core and post-core service encounters. According to Tuulaniemi (2016, 32), convenience of the service creates qualitative value for the customer. Convenience is linked both to customer satisfaction and customer experience in the study of Srivastava and Kaul (2014, 1030) in retail context and Russell-Bennett, Glavas, Previte, Härtel and Smith (2017, 666) in a medicalized wellness service context. Another theme linked both to operations and element of people was variability. Kumar, Rajan, Gupta and Dalla Pozza (2019) proposed that variation in service experience influences the perceived satisfaction and emotional attachment. This was seen also in this study, when variability within the received service caused negative experiences for the customers. Kumar and colleagues (2019) argued that an experience enhances satisfaction and emotional bond, when the variation in perceived experience is low. Therefore, they propose that organizations should aim to reduce the variation in experiences if they aim at maintaining a high level of satisfaction. (Kumar et al. 2019, 138, 155.)

Finally, the customers brought up, that they would hope that the organization could provide them with new experiences and additional information, possibly in a co-operation with the other stakeholders. The role of the experience was recognised

already by Gentile and colleagues (2007) when they suggested that more experience-driven innovations should be developed to achieve an even better customer experience. They also suggested, to have venues for an integrated customer experience, where customers could create their own experience together with other customers. (Gentile et al. 2007, 405) These examples were given concerning more products, but could be utilized also with services. In the context of this research, some activities or informative events organized for the customers could be successful.

7.2 Managerial implications

As hoped, the results of this study highlighted which service encounters and issues related to touch point elements are affecting customer experience and are important to the customers. The experiences the customers shared during the interviews show how the organization has succeed in meeting the needs of the customers. If the expectations of the customers were met or exceeded, experiences were positive. These positive experiences show the issues where the target organization has successfully understood the needs of the customers. Negative experiences occurred, if the reality was less than what the customers' expected. These are the weak links in the target organization, and they should be developed to maintain a competitive advantage in the future. Development of these issues can be done by using the deeper customer knowledge gained during this research.

Based on the results of this study and reflecting them with theory and previous research, some managerial implications are set to highlight some critical issues, that should be acknowledged in service development.

- Ensure the quality of core service encounters. This is the encounter that matters the most. This is also the encounter, where success leads to a strong emotional bond between a customer and an organization. Failing here is most likely the reason why customers change their service provider.

- Ensure that a good therapy relationship between a customer and therapist is enabled. This relationship is most likely more important than any other element

during the whole service path. It is important that the “chemistry” between the customer and therapist work, so that a good alliance is built, and the customers have the possibility to be active participants in their own rehabilitation.

- Promote the therapists’ expertise. Ensure that the therapists have up-to-date information about methods, and that they obey good rehabilitation practise. Try to minimize the difference between basic knowledge and expertise among the therapists, but value and utilize any special expertise of individual therapists.

- Ensure and value the continuity of care. It has a markable effect in building the therapy relationship and increased customer satisfaction.

- Ensure that the content of therapy meets the needs and hopes of the customer by promoting a person-centered approach. Encourage the therapists to utilize different opportunities, like testing different sports in therapy and ensure that every customer is informed about these different possibilities.

- Pay attention to accessibility, both physical and social. Customers’ have individual special needs that should be taken in to notice in every service encounter during the service path. Customers are the best informants concerning these issues, since the issues may be difficult to identify without own experience. Acknowledge that the needs of the customers may change over time.

- Secure the privacy and intimacy of the customers by all means possible.

- Ensure that the information transfer in the organization and between organization and customer is efficient and fluent.

- Try to maintain the services as convenient for the customers as possible to increase customer satisfaction. This applies also to partner -owned touch points, like co-operation with other stakeholders.

- Minimize the variation in experience. Ensure that the quality of service is not dependent on the employee and that the offered service and experience is consistent to every customer in every encounter during the service path. Remember that customers share experiences and identified differences might lower the satisfaction. Also remember that a customer has their own role in creating an interpretation about the experience.

- Create an efficient way to collect and handle customer feedback and keep customers updated about the progress.

- Offer advices and information to customers, even when it is not directly related to rehabilitation.

- Keep an open mindset when considering the ways to create added value for the customers. Consider the possibilities of offering special experiences to customers or promote issues that are meaningful and important to them also on a wider spectrum.

Since this is a case study, suggestions are directed primarily to the target organization, but they are helpful also for other organizations, when reflecting on their own situation.

8 DISCUSSION

This study reached its goal to produce information that can be used to develop services in the field of medical rehabilitation. As part of a bigger developmental process in the target organization, this research process itself promoted customer -orientation and gave customers an opportunity to help create value not only for themselves, but for other customers too, as presented in the model of service co-development in Figure 3. Results of this research created a deeper insight on how customer experience is formed during a service path and what issues affect it. The recognition of customer needs and

preferences and suggestions made by the customers help the organization to set a more accurate focus on future development.

8.1 Evaluation of the research

As stated, aim of case-style studies is more to produce detailed information about certain, defined unit than to generalize the conclusions. The focus group of this study represents only a small portion of customers of Kela's demanding rehabilitation. Participants of this study were all adults, who don't have any or only unnoticeable limitations in cognitive functions, communication or expressing themselves. Even within this customer segment, variation between customer occurs. Other customers in this customer segment can be children or people with mental disability. In addition, the organization provides services to other customer segments too, such as geriatric customers and musculoskeletal physiotherapy.

During the interviews for this research, some very conscious and educated opinions were given by the customers about, for example, hoping for the organization's advocacy in societal issues or accessibility. It is important to notice that people who were willing to participate in this kind of research might be more aware of these issues than most of the customers. A more extensive examination about the experiences of a broader group of customers would be needed to paint the whole picture about customer experience and the importance of different elements. Therefore, it should be noted that the experiences described in this research represents only one sector of experiences, and totally different experiences, expectations and needs might be found among different customers. Yet, the theoretical framework and reflection with previous research are supporting the findings of this study from wider perspective too.

In the second meeting, summary of the topics discussed in the first meeting was presented to participants to prepare the further conversation. The participants had the possibility to correct their answers at this point, if they felt that their message was misunderstood. No corrections were made. In transcription phase, parts clearly not related to the subject of the research were left out. Included parts of recordings were transcribed as precisely as possible to increase reliability in data analysis phase. When

analyzing the data, researcher was devoted to stay objective and no data was left out, even it would reveal negative experiences about the organization's services.

The researcher's familiarity with neurological physiotherapy and the rehabilitation process of Kela's demanding medical rehabilitation is the strength of this study. Likewise, the operations of the organization are very familiar to the author. This knowledge makes the analysis of the data and the results more reliable. The weakness of this study is the researcher's lack of previous theoretical knowledge and experience in the field of business management, which is where a big part of the theoretical framework comes. The researcher attempted to fill his gap by having conversations with the person more familiar with the field during the thesis project. The researcher is also a novice as a researcher and interviewing, as well as in organizing co-developmental events like customer panels. These issues might have had an effect on the study in such way that the best possible knowledge has not been in use during data collection. Data quality was discussed in the section concerning data collection.

Methodologically this study applied an existing customer panel to be used as a focus group in interviews for a qualitative case -study. In the customer panel, the chairperson leading the conversation is recommended to come from outside the organization. This wasn't possible in this case. It is possible, that because the researcher works in the organization and is familiar with the clients, and because some of the customers knew each other beforehand, the conversation might have been affected. This effect seemed to be positive, since the atmosphere was relaxed. Although, one common limitation of the focus-group interview is that individuals might be timid to tell their real opinions in group.

In addition, participation of the representatives from organization might have affected the conversation. During the interviews, researcher and other representatives from organization refrained commenting or participating the conversation in any way that might have compromised the true opinions of the participants to be brought out. Especially the presence of the manager of the organization in the second meeting, caused possible restrictions in the conversation among customers. These issues might have caused deficit in the gained data. Therefore, the use of a group containing also other people than just the people who are in the focus of the study, like in the customer

panel, is not ideal and should be considered carefully. In this case it was logical concerning the overall context of the organization's development process. Founding a separate focus-group for just interviews would have increased the burden of the customers.

In case -studies, several data sources are often used. Here the data was collected by the interview, notes and observation, yet the role of the observation and notes in the final data analysis were very small. The analysis made based on the data is presenting the interpretations of the researcher. To enable a deeper understanding about the context of this case study, an extensive description about the Finnish rehabilitation system, Kela's demanding medical rehabilitation and co-development of health services were given in the theory section of this report. The transparency of this process and progress of this thesis project is ensured by describing it clearly in this report.

8.2 Ethicality of the research

The study was done obeying the principles of Responsible Conduct of Research by Finnish National Board on Research Integrity (TENK 2020).

The autonomy of participants was respected in every phase of the study. Participating to the customer panel was voluntary and the participants could withdraw at any time. Participation in the first meeting didn't bind the participant to take part in the other meetings. Participation or withdrawing or answers given during interview did not and does not affect the possible treatment the participant was or is having in the organization or any other interactions they had or may continue to have with the organization. Any physical, mental, social or financial harm to the participants was avoided in all phases of the process. Participants had the possibility to have their travel expenses covered by the organization.

When signing up for the customer panel, the participants were informed in writing about the content of the customer panel. The role of the included research was communicated clearly and separately in the informed consent. This information was repeated in orally at the beginning of the first meeting in a way that it can be heard in

the recordings. After this, the participants signed the informed consent as an agreement of their participation. The information was given, and the meetings were kept in Finnish. By participating in the meetings, the participants gave their consent for recording and using collected data in the way defined later in this chapter. Permission to record the meetings was asked verbally also in the beginning of the second interview.

During the thesis process and in the final thesis report, the anonymity of the customer panel participants of was protected. The participants were informed that any possible personal issues of other participants spoken in the meetings were confidential and not allowed to be discussed outside the group. The participants' personal participation in the customer panel was allowed to be discussed outside the group, but the identity of other participants was kept confidential. The organization didn't share any information about the content of the panel or share any pictures in any digital or printed media or in the facilities of the organization.

In the transcription phase, data collected during the meetings/interviews modified in a way that the participants can't be recognised from the written material or the final report. The transcription was done by the author. Anonymized data was saved for future developmental purposes and can be used either by the organization or the researcher, which was informed to the participants in informed consent.

During the research project, the digital data (recordings, transcriptions) was saved in a computer -file and secured with a password. Other data, for example handwritten notes were, kept in a locked cabin. Access to any data that was not anonymized was and is only for the researcher. Original recordings and other non -anonymized data are destroyed after the thesis report is published or latest at the end of 2021. The results of the research are published in the form of a master's thesis in Theseus-publication -archive online. The name of the organization is not published in the thesis report to protect the anonymity of the participants. The organization has the right to publish the results on their website, social media or any other way they see best, still respecting the anonymity of participants.

A permission from the ethical board was asked, even if it wasn't mandatory. The topics under discussion were planned to concern the overall customer experience and other general issues, and the participants are all adults. Bringing up any intimate/personal information was a personal choice of the participants, although the others were not permitted to discuss about this information outside the group. It was possible that another participant could cause hurt feelings with their words or gestures amidst the conversation. This possibility was discussed with the participants beforehand, but no such issues occurred during the meetings.

The thesis process was implemented in the researcher's free time. Only the actual meetings and direct preparation for the meetings were considered as paid working hours. Expenses caused by the meetings (e.g. travel or serving expenses) were also covered by the organization. Any other compensation to the participants was not offered to ensure the integrity of the participants.

8.3 Contribution

This research contributes the target organization by giving a deeper understanding on the experiences of a certain customer group. This information is usable for service development in the organization and gives competition leverage in the future. The results of this study are already used to direct the development to the weak links identified in the organization. The deeper understanding concerning the needs of the customers was utilized when the coronavirus epidemic caused a quick launching of remote therapy. Despite the negative first impressions from both the customers and personnel, the dialogue concerning the customers' needs for continuity of care and maintaining a therapy relationship motivated both the customers and staff to try this new way of implementing therapy.

Other similar service provider may utilize the report, and therefore this thesis promotes better customer experience and the development of more customer-oriented services in the outpatient medical rehabilitation sector. As is a vocational research's aims, this study also contributes to working life by giving a theoretical base that can be easily used to examine customer experience of other customer groups or other contexts.

This study contributes to the research field by supporting the previous theory and models of customer experience by showing their functionality in the outpatient rehabilitation settings. It also strengthens the image, where the interaction between a customer and professional is seen as one of the most important issues related to customer experience and satisfaction, especially in health services. A novel contribution to research concerning customer experience and needs of the customers in health care settings are the findings of possible other service encounters and the customers' need for organizational advocacy in societal issues.

Methodologically this study contributes in two ways. In working life, this study might be the first one reporting the use of a customer panel in private outpatient rehabilitation or physiotherapy setting aiming to co-develop services. Scientifically it tests the usability of this kind of an existing group, with both the subject of the research and organizational representatives. As stated, the use of this kind of a focus group should be considered carefully, since the possibilities to compromise the data are higher in these types of groups.

To the researcher themselves, this study has contributed the most. The author's knowledge about value creation, customer experience and customer-oriented service development has increased enormously. Also, the deep exploration of the history of rehabilitation and the current rehabilitation system increases the expertise of the author in the field of rehabilitation. The whole process has developed the professionality of the researcher in working-life oriented development and research, especially with regards to project and process management skills.

8.4 Future research

As stated earlier in this report, this report gives a small glimpse about the creation of customer experience in an outpatient rehabilitation setting. To gain a more generalizable picture, more research is needed. Differences on the importance of service encounters and effects of touch point elements might occur also among Kela's demanding medical rehabilitation customers. For example, the experiences and

interpretations of family members of mentally disabled customers or children could be explored, since in such cases they can be considered as customers of the organization too. In a situation, where an organization offers services to other customer groups too, the experience creation of those segments could be justified to study as well.

This study didn't reveal much about the issues that influenced the customers' choice when they selected the service provider in the beginning of their rehabilitation journey. In the future, when aiming at canvassing new customers, this information could be useful. It might be relevant to explore what pre-core service encounters and touch points, such as advertising, social media or other factors, should the organizations target.

Finally, this study slightly opened the curtain to the customers' possible other needs, like the need for advocacy in the meso and macro level of society or need for new experiences and information. This finding sprouts several questions about the topic: How important is this kind of advocacy and why do customers need it from a private service provider? Could this advocacy be obtained by developing the co-operation of different stakeholders in the health care and rehabilitation field? Are these kind of possible service encounters the key to a competitive triumph in the future?

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APPENDIX 1

Customer panel and focus-group interview comparison

	Customer panel	**Focus-group interview**
Aim	Collect information and co-develop	Collect information
Method for data collection	An open, guided conversation or an interview based on selected topics. In the co-developmental phase, also other ways are possible	Thematic interview
Group size	8-20 persons, depending on the purpose	4-12 persons
Participants and their roles	Chairperson: Guide the conversation. Customers: Informants, experts in their own field, active participants in planning, implementing and evaluating developmental acts. Organizational representatives: Listening, learning, taking notes, giving room to customers, and working with them in the co-developmental phase	Researcher: Guide the conversation Focus-group (customers): Informants

APPENDIX 2

Suostumus osallistumisesta opinnäytetyötutkimukseen

Tervetuloa mukaan tutkimukseen!
Osana asiakasraatitoimintaamme teen tutkimusta asiakaskokemuksesta Target Organization Oy:ssä. Tutkimus tehdään ylemmän ammattikorkeakoulututkintoni opinnäytetyönä.

Mitä tutkin?
Opinnäytetyössäni tutkin asiakkaidemme kokemuksia kuntoutuspalveluista Target Organization Oy:ssa. Tarkoituksena on myös selvittää, mitkä ovat asiakkaidemme mielestä tärkeimpiä kehityskohteita asiakaskokemuksen kannalta. Tutkimuksen tuloksia hyödynnämme palveluidemme kehittämiseksi. Tutkimuksen tulokset esitellään asiakasraadin myöhemmissä tapaamisissa. Valmis opinnäytetyö julkaistaan verkkojulkaisuna.

Mitä tutkimukseen osallistuminen vaatii?
Tutkimuksen aineisto kerätään asiakasraadin tapaamisissa, jotka äänitetään myöhempää käsittelyä varten. Yksittäisen tapaamisen kesto on noin 1,5-2 tuntia ja tapaamisia on korkeintaan 3 kertaa vuodessa. Tapaamiseen osallistumisesta aiheutuneet matkakulut korvataan halutessasi. Tapaamisiin osallistuminen ei vaadi ennakkovalmistautumista.
Tapaamisiin ja tutkimukseen osallistuminen on vapaaehtoista, eikä ensimmäiseen tapaamiseen osallistuminen velvoita muihin tapaamisiin osallistumista. Tapaamisiin osallistuminen tai niistä pois jättäytyminen ei vaikuta yritykseltä mahdollisesti saamiisi kuntoutuspalveluihin millään tavalla. Osallistujalla on oikeus jättäytyä pois tutkimuksesta, milloin tahansa. Jo kerättyä aineistoa voidaan kuitenkin hyödyntää tutkimuksen teossa. Tapaamisissa käsitellyt asiat ja muiden osallistujien henkilöllisyys ovat luottamuksellisia, eikä näitä saa tapaamisten ulkopuolella tuoda julki.

Mitä tallenteille tehdään?
Tutkija kirjoittaa tapaamisista nauhoitetut tallenteet puhtaaksi tekstimuotoon, jolloin niistä poistetaan mahdolliset henkilö- ja tunnistetiedot (nimi, yhteystiedot, muu tunnistamisen mahdollistava tieto). Äänitallenteita ja muita tunnistetietoja sisältävää materiaalia säilytetään salasanalla suojattuna tutkimusprosessin ajan, jonka jälkeen ne hävitetään viimeistään opinnäytetyön julkaisun jälkeen. Tallenteita tai muita tunnistetietoja sisältävää materiaalia saavat käsitellä vain tutkija ja tarvittaessa hänen mahdollisesti valtuuttamansa henkilöt, joiden osallistuminen on tutkimuksen onnistumiseksi välttämätöntä.
Tekstimuotoon tallennettu tunnistetietoja sisältämätön aineisto säilytetään yrityksessä kehittämistyötä ja mahdollista myöhempää tutkimusta varten. Myös tutkijalla on oikeus käyttää tätä aineistoa myöhempää tutkimusta varten.
Tutkimukseen liittyvissä julkaisuissa ei mainita osallistujia omilla nimillään ja muut tunnistamisen mahdollistavat seikat häivytetään niin, ettei osallistuja ole suoraan tunnistettavissa mistään tutkimukseen liittyvästä julkaisusta.

Allekirjoituksellani vakuutan ymmärtäneeni ylläolevan ja vahvistan tutkimukseen osallistumiseni.
Aika ja paikka: _____ ____/___20__

Lisätietoja: Kirsi Varonen, xxx@xxxx tai puh: xxx-xxxx

APPENDIX 3

Plan and interview frame for customer panels

First customer panel meeting.

Date: June 2019
Goal: Gather information about customer experience in organization from different service encounters.
Representatives from organization: Researcher working as interviewer and chairperson, office person taking notes, helping with arrangements (not participating in conversation)

Introduction: Welcome everyone. Short introduction concerning the customer panel as a co-developmental platform. Explain the goal of this meeting, which is gathering information about customer experience via conversation. Explain the role of the chairperson as a researcher in this meeting and go through the informed consent. Collect the signed forms.
Warm-up: Short round for introducing participants. Ask everyone to tell their name, age and number of years they have been customers in organization.
Main section, 1st part: Goal of the first question is to find out those experiences and service encounters customers bring out first.
Question 1: *What kind of experiences you have had during your time as customer in target organization?*
If needed, ask additional questions about experiences concerning different service encounters (list of service encounters in Figure 2).

15- minute break. Snacks and refreshments.

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Main section, 2nd part: Goal of next questions is to deepen the understanding about customers' expectations and meaning of physiotherapy services to them.
Question 2: *What is the meaning of the physiotherapy services to you?*
Question 3: *What is important in physiotherapy services?*
Question 4: *If no limits exists, what kind would the ideal physiotherapy service be?*
Closing: Few minutes of free speech from customers. Thanking participants and information about next meeting.

Second customer panel meeting
Date: October 2019
Goal: Deepen the information collected in the first meeting. Start co-developmental activities (not included in the research)
Representatives from organization: Researcher working as interviewer and chairperson. Office person taking notes, helping with arrangements. Manager of the organization asking deepening questions concerning collection of customer feedback and accessibility, participating in the second, co-developmental part of the meeting.

Introduction: Welcome everyone. Short introduction about goal and progress of the meeting.
Main section, 1st part: (included in research)

- Introduce the rough summary concerning the results of previous interview. Ask if issues are understood correctly and give opportunity to make corrections or additions.
- Deepening conversation concerning increasing accessibility and collection of feedback by asking examples how these could be done in target organization

15-20-minute break. Snacks and refreshments

Appendix continues on the next page

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Main section, 2nd part: (not included in the research)

- Starting co-developmental actions by touring the facilities with the customers, collecting ideas

Closing: Thanking everyone, discussion about customer panel meeting in the future.

Results organized by touch point elements

Themes within the touch point element of people in different service encounters.

Service encounter	Themes within element of people	Example quote
Booking appointment and other contacts	Variability	"With [office person] everything ALWAYS works and if not during the first phone call, then I call you again. With booking a time, everything has been ok, as well as with cancelling appointments."
Arriving	Customer's personal characteristics	"As I have steadily gotten weaker during these 10 years, it's not until now that you notice concretely what accessibility means."
Physiotherapy and waiting time	Therapy relationship	"It wouldn't work, if the therapist would be more of a friend. For me, the therapist is first of all a therapist, even if they're my friend too."
	Characteristics and expertise of therapist	"…but yeah, like very professional. Like they know where the problem is and then we start to train that. I am so happy, that we have got things working so fast."
	Customer's emotional experiences	"At first I didn't know if I would be left in a wheelchair or using crutches, so I felt this was just going through the formalities."
Treatment notes and home instructions	-	-
Co-operation	Consultancy and advocacy	"Then I brought the paper to the therapist, who guided me how to proceed."
Customer feedback	-	-

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Themes within the touch point element of operations in different service encounters.

Service encounter	Themes within element of operations	Example quote
Booking appointment and other contacts	Convenience	"You can cancel the appointment but might not be able to book a new one, if the office person is not present."
Arriving	-	-
Physiotherapy and waiting time	Continuity of therapy	“It feels like I’m thrown to any therapist who is free. This is something I could say a few chosen words about. I don’t get the sustainability.”
	Content of therapy	“Like, what is important here, is that the physiotherapy stems from my own needs and what is good for me.”
Treatment notes and home instructions	Information transfer	“Sometimes I wonder, when the therapy ends, and another customer is coming in straight away, like, when does the therapist have time to write down what we did or what was the case, or will those be forgotten?”
Co-operation	Convenience	“For me it has worked well that together with the therapist we planned what we put or what we hope is in the next rehabilitation plan. And for the rehabilitation feedback we planned that [the therapist] will send it to the doctor.”
	Variability	“I have never had that rehabilitation plan meeting, and no one has ever said that it is possible.”
Customer feedback	Handling feedback	“I have talked about those [equipment]so many times. I even thought I’d bring my own screwdriver with me and do the work.”

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Themes within the touch point element of surroundings and objects in different service encounters.

Service encounter	Themes within element of surroundings and objects	Example quote
Booking appointment and other contacts	Digital solutions	"If you could import the booked appointments directly to Google Calendar."
Arriving	Accessibility	“Shouldn’t this place be, like, accessible at least?”
Physiotherapy and waiting time	Accessibility	“It says something that we stayed here after our own appointments for this interview, like we do feel at home here.”
	Privacy	“It is quite a close-knit atmosphere here in the therapy space. Sometimes, often it is ok, but sometimes the intimacy is compromised since there is 4-5 customers in the room.”
	Visual appearance	"About these facilities, color scheme is from the 80's."
	Digital solutions	"Those won't fit everyone."
Treatment notes and home instructions	Digital solutions	"If it is something that reminds me to exercise, then maybe."
Co-operation	-	-
Customer feedback	Accessibility	“It is very positive that the organization wants to hear the voice of the customers. I am happy to give feedback.”
	Anonymity	“Of course the feedback is more open if you can do it anonymously.”