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Locked-in: the dangers of health service captivity and cessation for older adults and their carers during COVID-19

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ABSTRACT

Focusing on the government-led health service in the UK, this paper explores the experiences of family caregivers, responsible for co-ordinating the healthcare of older adults experiencing vulnerability during the pandemic. Data were collected through a 6-month covert netnography, culminating in 322 relevant forum topics and 2607 posts. The findings reveal that both ageing consumers and their carers experience service captivity, which leads to vulnerability. Furthermore, older adults experience vulnerability most when service cessation occurs, involving premature discharge from hospital, eviction from care homes and in-home caregivers withdrawing services, leaving the consumer without an essential health service. Recommendations are made to health service organisations to aid in preventing service captivity and cessation in government-led health services, especially during times of crisis.

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Transformative service mediator; service captivity; service cessation; healthcare; consumers experiencing vulnerability; older adults

Introduction

On 11th March 2020, the World Health Organization (WHO) declared the Coronavirus disease (COVID-19) a global pandemic. Since the onset of the pandemic, 517 million people worldwide have contracted COVID-19 and more than 5.42 million have died (World Health Organization, 2022). The WHO, however, believe that there are further 'excess deaths' either directly or indirectly related to COVID-19, amounting the total mortalities to over 14.91 million (World Health Organization, 2022). It is thought that the indirect 'excess deaths' may be caused by disruptions to health services, including a reduction in resources for non-COVID related specialities. As a result, 90% of countries have reported disruptions to their essential healthcare services (World Health Organization, 2021).

Within the UK, the National Health Service (NHS) is a government-led organisation that ensures free healthcare to all UK residents, as it is primarily funded by taxation (Keeling et al., 2021). Prior to the pandemic, the UK's expenditure on health was only 9.8% of its GDP, one of the lowest amongst developed countries. Furthermore, the NHS had a very low capacity with only 2.5 hospital beds per 1000 people (Maizland & Felter, 2020). During the pandemic, the NHS responded to the crisis by postponing non-emergency procedures, closing non-emergency services and redeploying specialists, which released

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necessary hospital beds (Maizland & Felter, 2020). Unfortunately, it is believed that these actions have had negative consequences on UK residents who regularly depend on the health service, such as older adults experiencing vulnerability (OAeV).

Concerns for older adults have been at the forefront of the pandemic, as in March 2020, UK residents were asked to stay at home to prevent the spread of the virus and to protect those who were experiencing vulnerability (Institute for Government, 2021). Older adults were included in the vulnerable bracket as it was discovered that age has an impact on the likelihood of hospitalisation and mortality (Webb, 2020). However, by protecting older people from the virus, the lockdown restrictions and alterations to the regular health service have created indirect adverse consequences on health and morale, alongside substantial waiting times for healthcare (Age UK, 2020; The King's Fund, 2021). Moreover, as 2 million adults in the UK are receiving care from a loved one, family member, friend or acquaintance, the pandemic not only impacts the OAEV but also their family caregiver (Office for National Statistics, 2019). The real effect of a pandemic-restricted health service on the lives of OAEV and their carers is yet to be explored in depth.

This paper therefore contributes to the services marketing literature by investigating narratives of UK-based family carers of OAEV during the pandemic. This is with a view to understanding how the UK healthcare service responds to a crisis and what impact this has on the well-being of care receivers and family caregivers. Extant literature on healthcare from a services marketing perspective tends to focus on pre-paying services (e.g. in the US) or mixed public-private healthcare systems (e.g. in Australia and New Zealand; Anderson et al., 2019; Hepi et al., 2017; McColl-Kennedy et al., 2017; Mittelstaedt et al., 2009; Sharma & Conduit, 2016; Sweeney et al., 2015; Zainuddin et al., 2016). This study therefore contributes by focussing on government-funded healthcare, which provides less freedom of choice to the consumer (Keeling et al. 2021; Ranjan et al., 2021). Furthermore, given the recentness of the pandemic, the current literature is endeavouring to explore the response of healthcare services to the crisis, but there remains a lack of empirical evidence (Berry et al., 2020; Brodie et al., 2021; Prakitsuwan & Moschis, 2020). This paper therefore contributes to services marketing literature by adopting an empirical approach to provide further in-depth insight on the pandemic.

In addition, the study contributes to Transformative Services Research (TSR) by developing a testable framework of service captivity, experienced by both healthcare consumers and their caregivers. Service captivity, a concept initially coined by Rayburn (2015), is where the consumer has a strong need for a service and due to limited alternative providers, the consumer becomes trapped within it. As a result, they feel powerless, voiceless and with limited choices of alternative services (Rayburn et al., 2020). Through qualitative analysis of netnographic data this paper reveals that service captivity is not just experienced by healthcare consumers, but also by caregivers advocating for OAEV within the health service. Moreover, caregivers experience vulnerability differently from consumers and consequently develop feelings of mistrust and resentment towards the service provider.

This paper also contributes to the TSR literature by extending the service captivity process to reveal a new construct called 'service cessation'. Service cessation is where consumers and their caregivers are prematurely discharged or evicted from a captive service provider, enhancing vulnerability, and leaving them without a future service to use. Service cessation is revealed to heighten the vulnerability felt by consumers and

caregivers experiencing service captivity. Moreover, service captivity and cessation are prominent in the UK healthcare service exchange during the pandemic and as such this paper has practical contributions to healthcare organisations and public policy. Understanding the health service experiences and subsequent vulnerability felt by older adults and their caregivers has important implications for how governments improve their health services and respond to any future health-based crises.

Literature review

Services and healthcare

Since Berry and Bendapudi (2007) highlighted the potential that marketing scholars hold for the healthcare industry, there has been an abundance of services research linked to the context of healthcare (e.g. Davey & Grönroos, 2019; Mittelstaedt et al., 2009; Tanner et al., 2020). As it currently stands, the majority of studies focussing on pre-paid healthcare systems undertake research on the US healthcare system (Anderson et al., 2019). This literature furthers our understanding of how services marketing principles can enable consumers to transition into a preferential healthcare future and how healthcare services can be designed and delivered effectively (Anderson et al., 2018, 2019). Furthermore, there is a body of literature exploring medical practices within countries, such as Australia and New Zealand, where healthcare is a mixture of public and private services (Dagger et al., 2007; Hepi et al., 2017; McColl-Kennedy et al., 2012, 2017; Sharma & Conduit, 2016; Sweeney et al., 2015; Zainuddin et al., 2011, 2013, 2016). These studies, primarily focussing on private services, social services and free screening programmes, are imperative in outlining how services concepts such as co-creation, self-creation and value creation can be applied to the healthcare context in order to improve well-being.

Considering the complexity and fast evolution of the industry, there remains unexplored avenues for future research to capture the nuances of modern-day healthcare. For instance, since the pandemic there has been increasing interest on the impact that a crisis has on healthcare services (Berry et al., 2020; Brodie et al., 2021; Prakitsuwan & Moschis, 2020). Yet, given the recentness of COVID-19, these studies are often lacking in empirical data. The exception is Berry et al. (2020), who provide an extensive account of healthcare in the US and how issues have been expounded by the current crisis.

Moreover, outside of the pre-paying and mixed public-private healthcare systems, there is a necessity for services research to be applied to a system where healthcare is primarily and solely government-funded, such as the NHS in the UK. This is because systems and services differ within government-run healthcare, often providing more stability but less freedom of choice (Keeling et al., 2021). Unlike services in the US, Australia and New Zealand, patients have no medical insurance and little access to private healthcare, hence limiting their choice of healthcare provider and reducing their control, power and voice, which can lead to service captivity (Rayburn, 2015). Studies that do focus on healthcare in the UK demonstrate the power of understanding service user experience on developing innovation in hospices and palliative care (Sudbury-Riley et al., 2020). Furthermore, Keeling et al. (2021) indicate how co-creation and co-destruction can manifest in dialogic interactions between patients and healthcare professionals. Consequently, there is scope to advance these studies to provide a holistic understanding of how

government-funded healthcare reacts during times of crisis, especially towards members of society who are experiencing vulnerability and are provided with limited healthcare options.

Transformative services research

The purpose of TSR is to develop significant alterations in services so that the well-being of consumers, service providers and other actors in the servicescape is improved (Anderson et al., 2013). It combines research on consumer behaviour and services marketing to solve practical issues within the chosen service of study, with an intention to improve well-being outcomes (Anderson & Ostrom, 2015; Anderson et al., 2013). TSR is therefore closely linked to consumer vulnerability, which is when a consumer experiences powerlessness in a consumption setting (Baker et al., 2005; Riedel et al., 2022). Studies on vulnerability have recently advanced from stating that the consumer is vulnerable towards maintaining that the consumer is experiencing vulnerability, a state that may come and go. Consequently, Riedel et al. (2022) define consumers experiencing vulnerability as 'unique and subjective experiences where characteristics such as states, conditions and/or external factors lead to a consumer experiencing a sense of powerlessness in consumption settings' (p. 1).

Within services literature, there is often an assumption that consumers have the capacity to engage actively in service exchange. It is assumed that they have a choice of service providers, control over participation in interactions, and the ability to voice partialities and concerns (Grönroos, 2011; Shah et al., 2006). However, recent debates in Transformative Services Research (TSR) indicate that some consumers are at a disadvantage and can lack control and capacity within a service context, making them vulnerable to imbalances in power and poor service experiences (Anderson et al., 2013; Rayburn et al., 2020). This paper therefore uses a TSR perspective to explore the impact of health services on consumers experiencing vulnerability, and their well-being (Anderson et al., 2013, 2018). It builds on previous studies indicating that TSR can be used effectively within the context of older adults' service consumption during the pandemic (Prakitsuwan & Moschis, 2020).

Healthcare service for consumers experiencing vulnerability

Within the body of literature focusing on consumers experiencing vulnerability and utilising healthcare, the findings often relate to the accessibility of services, the health service literacy of the actors within the service, and the vulnerability of patients' personal health records (Davey & Grönroos, 2019; Mittelstaedt et al., 2009; Sheehan, 2005; Tanner et al., 2020). Since the pandemic, it can be argued that some of these vulnerabilities have been exacerbated. For example, Brough and Martin (2021) indicate that as many offline activities are replaced by online activities, new digital records are created, which can become susceptible to attack, especially to people experiencing vulnerability. Furthermore, Berry et al. (2020) reveal the negative impact of the pandemic on the patient-clinician relationship and the overreliance on family caregivers. There is consequently an opportunity to further extend this understanding towards older patients experiencing vulnerability and utilising a government-funded health service during a global health crisis.

In reference specifically to older adults, not all are vulnerable but often older adults receiving healthcare have conditions or multi-conditions alongside other social factors that can impact their experienced vulnerability (Dahlberg et al., 2018). This can lead to negative effects such as unplanned hospital admissions and reluctance to visit healthcare professionals, primarily due to physical restrictions and the associated financial burden (Dahlberg et al., 2018; Lee et al., 2012). A further indicator of vulnerability in older adults is frailty, which can lead to an increase in utilisation of primary and secondary care (Ilinca & Calciolari, 2015). Presently, frailty is seen to be growing across Europe and so frailty prevention is imperative to reduce vulnerability, promote healthy ageing and reduce the strain on healthcare services (Ilinca & Calciolari, 2015).

Recent research into OAeV and healthcare often deduces that empowering the patient by encouraging a patient-led approach reduces the issues associated with experiencing vulnerability (Khaksar et al., 2017). Older adults are empowered by creating a positive self-image, providing enhanced access to information and providing choice, which can be achieved through encouraging social engagement in third spaces such as community centres (Meshram & O'Casey, 2013). Further solutions to improving the issues associated with vulnerability include social robots being used in elderly care, using clinically accessible criteria to identify the likelihood of an older adult contracting a serious illness, and regular appointments with disease-relevant specialists and primary care physicians (Johnston & Hockenberry, 2016; Kelley et al., 2017; Čaić et al., 2019). However, during a pandemic the required pre-planned activities and usual level of support are stretched, resulting in a potential lack of resources and consequential disempowerment for older adults experiencing vulnerability.

Family caregivers as transformative service mediators

For older consumers of healthcare who are experiencing vulnerability, often there are several actors involved in the care process, one of which is the family caregiver (Dean et al., 2014). In the extant services literature, family carers have been referred to as secondary customers, companions, interdependent actors, and significant others (Kelleher et al., 2020; Leino, 2017; Suárez-Álvarez et al., 2020; Verleye et al., 2014). Consequently, there is a body of literature on family carers within the healthcare context. For instance, Kelleher et al. (2020) discover that caregivers, interwoven in the service system, use mechanisms such as assembling, performing and brokering to co-ordinate care on behalf of the dependent. However, despite an array of knowledge development, no single definition for a carer has emerged.

Despite the lack of specific terminology, the way that healthcare services interact with the family caregiver has important implications for both the individual providing care and the care receiver (Leino, 2017; Suárez-Álvarez et al., 2020; Verleye et al., 2014). Suárez-Álvarez et al. (2020), for example, reveal that coproduction between the healthcare professional and companion is vital to increase satisfaction and if the companion is satisfied, this is more likely to have a positive impact on the patient. Furthermore, there are suggestions that secondary customers are also exposed to vulnerabilities, similar to primary consumers of healthcare, and as such their well-being is impacted by the level of care provided to their loved ones (Leino, 2017). In nursing homes, it is suggested that to encourage customer engagement and positive word of mouth, the practice must display

support and service quality towards the significant other (Verleye et al., 2014). Consequently, the service experience received by OAeV is intertwined with the experience and well-being of the family carer. It is therefore an important avenue for future research, especially within times of crisis, such as the pandemic.

To aid in developing a definition for additional actors within the service experience, Johns and Davey (2019) provide a description and a framework for a Transformative Service Mediator (TSM). A TSM is defined as 'an all-encompassing term representing the array of value co-creating activities in vulnerable consumption contexts – at times these actors are service providers, consumer advocates, service gatekeepers and risk analysts' (Johns & Davey, 2019, p. 8). There are two different types of TSM. Firstly, the intermediaries, whose role is to facilitate the service delivery from the service provider to the consumer experiencing vulnerability. Secondly, the transformative apomediarities who are involved in representing the consumer experiencing vulnerability to the service provider and other TSMs (Johns & Davey, 2019). TSMs are advancements on previous definitions such as, secondary customers and interdependent actors, as they account for both intermediaries and apomediarities, with the latter using service interaction to lead to transformative service outcomes, such as improving well-being and reducing harm (Johns & Davey, 2019). Since its conception, several studies have applied this concept to OAeV, some of which are within the context of healthcare (Amine et al., 2021; Bianchi, 2021). This paper advances these studies by investigating the role of the family carer as a transformative apomediaritey under the all-encompassing term 'TSM'.

Service captivity

Despite recent studies indicating the importance of empowering patients and their carers, many consumers of healthcare services are still experiencing service captivity (Rayburn et al., 2020). Service captivity was initially coined by Rayburn in 2015 and relates to a consumer's experiences of limited control, power, voice and choice during a service exchange. If there is limited choice, such as in a government-led health service, power is unequally allocated to the provider, as the consumer cannot threaten to end the relationship if the service is inadequate (Rayburn et al., 2020). As a result, the consumer experiences feeling confined and subsequent vulnerability in the relationship (Rayburn, 2015).

What creates service captivity is when the perceived need for a service is severe, yet the consumer's options to access the service are limited (Rayburn et al., 2020). In the case of healthcare, there is a high need for and dependency on a service, and as a result this can create vulnerability in the exchange process, especially as people have health issues, multi-conditions and other social factors affecting their health (Dahlberg et al., 2018; Mittelstaedt et al., 2009). Furthermore, for service captivity to occur there must be a lack of alternative services, which depends on the structure of the market (Rayburn et al., 2020). In a government-led health service such as in the UK, there is unlimited and free access to healthcare for all residents. This means that despite being openly available, consumers have limited choice within the service process. For a consumer to receive secondary care, which is consultant-based and specialised, they must be referred by a primary healthcare provider, such as a general practitioner. They therefore have little choice in their secondary care service and the care they do receive depends on regional differences. Consumers

can pay for private healthcare, which provides more autonomy, however in countries where government-funded healthcare is standard, these services are scarce and expensive (Keeling et al., 2021).

The danger with service captivity is that consumers may experience no power, no voice and no choice (Rayburn, 2015). Having no power emerges from feeling trapped, having few options, or entering something and not having the option to leave. These situations create a loss of control and further shift in power towards the service provider (Rayburn et al., 2020). Furthermore, service captivity can constrain the consumer voice as many people feel as if they cannot talk freely about discomfort or unhappiness with a service. Within healthcare, patients often feel dismissed, unheard and unable to complain (Rayburn et al., 2020). Finally, having no choice means that consumers cannot simply exit the service or find other possible alternatives. For example, in healthcare, service captivity is the reality as consumers have no other option other than to accept the service that they receive from their provider (Rayburn et al., 2020).

Extant literature on service captivity explores how the consumer is impacted by a sense of powerlessness (e.g. Rayburn et al., 2020; Rayburn, 2015), however there is currently no theoretical understanding of how additional actors in the servicescape equally experience service captivity. This paper therefore intends to explore i) in what ways the TSMs of OAeV experience service captivity; ii) how health service captivity is affected by the pandemic; and iii) how healthcare services, providing care for OAeV and liaising with TSMs, can avoid service captivity, especially during times of crisis. This is with a view to advancing the concept of service captivity to account for additional actors impacting the consumption of healthcare services.

Methodology

Context of the research

The research focusses on the health services used by OAeV in the UK. The healthcare market in the UK is complex with the NHS being the main care provider and available to all UK citizens. It is funded by taxation and other minor sources including consumer charges, such as prescription costs and car parking (Keeling et al., 2021). The NHS divides its funding between clinical commissioning groups (CCGs). A CCG is responsible for the healthcare within a local area of the UK and the funding they receive depends on population, demographics and deprivation. The aim of the CCG is to assess the needs of the local area and purchase the necessary services from NHS trusts responsible for hospitals, mental health and community and other providers such as General Practitioners (GPs) and social services (The King's Fund, 2020).

The health service for older adults in the UK is yet more complicated, with several different services that are all susceptible to captivity. For example, older adults are supported by the NHS through primary (e.g. GP) and secondary care (e.g. hospital), like all patients in the UK. However, when conditions worsen, older adults may also receive in-home caregivers provided or funded by social services and the local authority. This service is only available to someone who is below the income threshold, and for anyone over this threshold, in-home care must be paid for. Once in-home care is not enough, an older adult may require moving to a specialised home, for example a nursing home, in which they

receive constant care. Depending on wealth, these homes may be subsidised. This paper explores the experiences of services provided by the NHS (e.g. primary and secondary care) alongside private and subsidised services (e.g. in-home care and care homes) from the perspective of the TSM. This is to represent the ensemble of intertwining paid and non-paid care that OAeV receive from family and friends, and free and paid healthcare services (Barnhart & Peñaloza, 2013).

Data collection

The study undertook an exploratory qualitative research design to decipher in what ways the TSMs of OAeV experience service captivity, and whether this has been exacerbated by the pandemic. It was appropriate to adopt this approach, as it is a novel area of research and has potential theoretical extensions. Furthermore, within the context of government-led healthcare providers for older adults during a pandemic, there is little knowledge and understanding. Consequently, taking both an exploratory and qualitative approach allows in-depth knowledge to be gained and the opportunity for theoretical expansion.

The research took the form of a covert netnography from a pragmatic perspective. A covert netnography, rather than an overt netnography, was adopted due to the success of this method in gathering online community data created by consumers experiencing vulnerability, and discussing sensitive topics, especially within the healthcare context (Fletcher-Brown et al., 2021; Keeling et al., 2013; Langer & Beckman, 2005; Liang & Scammon, 2011; Parkinson et al., 2017). By not revealing the identity of the researcher, conversations between participants remained natural and undisturbed, which provided a true reflection of the way in which online communities were used by carers, alongside a wealth of informative data. From a pragmatic perspective, if other methods (e.g. overt netnography, interview or focus groups) were adopted, it would be difficult to gather honest data with such depth on the chosen topic due to the complexity of emotions and commitments involved in the caring process (Langer & Beckman, 2005). Furthermore, as a pragmatic study, a covert approach was necessary because there was no other way for the rich data to be obtained, especially within the current restrictions associated with the pandemic (Lee, 1993). The difficulties associated with covert research were acknowledged, and ethical procedures were instigated to protect the rights of the participants and create no harm.

The covert netnography therefore involved less engagement with the online community than Kozinets (2002) had originally suggested, but the chosen method was in keeping with the evolution of netnography research (Heinonen & Medberg, 2018). For instance, when netnography was originally coined by Kozinets (1998, 2002), consumers' online activity was limited to communities of enthusiasts, but as the Internet has advanced, many people now share their attitudes, opinions, narratives, and experiences on copious platforms through an array of devices (Heinonen & Medberg, 2018; Laing et al., 2011). This was augmented through the pandemic, as online activity became the only outlet for many consumers, especially those who were experiencing vulnerability. Consequently, there was a richness of untapped data left by consumers, which is valuable for services research.

Data were collated from two online communities that support adult carers in the UK. The communities were considered public forums where viewing the posts and forum activity did not require a login or password. Posts on these forums were therefore considered public communication and were available for data collection and analysis through covert netnography (Langer & Beckman, 2005). Data were collected for 6 months during the pandemic, from 15th March 2020 to 15th September 2020, encapsulating periods of lockdown, and when the NHS was at full capacity. Across the two forums, there were 322 forum topics and 2607 posts relating to caring for older adults during the pandemic. The sample included any adult family caregiver (aged 18+) caring for an older adult (65+) throughout the pandemic who had posted in one of the two online caregiver communities between March 2020 and September 2020.

Ethical considerations

Due to the covert nature of the netnography, ethical issues were considered during the data collection, analysis and reporting in order to prevent harm to participants. Firstly, in relation to data collection, it was ensured that the users of the online communities were aware of the public nature of their posts. For instance, each website had clear exclaimers indicating that the forums are within the public domain, openly accessible, and that posts are viewable and searchable. Users were advised by the online community that their posts should not include any private or traceable information, and any private messages should be sent in the private message function provided, which has not been accessed. Furthermore, when scraping the data, if any personal information had been posted against the advice of the forum, this information and the usernames of participants were redacted.

Secondly, when reporting the data, to mitigate the risks of participants being identifiable, all posts were anonymised through a labelling system. For example, the data was labelled as follows: F1T1P1, which represents forum 1, thread 1 (e.g. the first in the chosen time period) and post 1 (the first post in the specific thread). This redaction, anonymity and process of labelling the data avoids an individual person or prolific poster being identifiable. The forum names were also anonymised so that there was no way of identifying participants based on the online community that they engage with. Finally, to avoid any participants being identified through reverse searching, no direct quotations were replicated in the published material, and any data used as evidence was paraphrased.

Data analysis

According to Heinonen and Medberg (2018), thematic analysis is the most frequently used and robust data analysis method for netnographic data, and as a result this study adopted an inductive approach and followed the step-by-step process outlined by Braun and Clarke (2006). In step 1, the researcher familiarised themselves with the data by reading the forums, scraping relevant posts from the public online communities using NCapture, and redacting usernames and personal information. For step 2, the researcher generated initial codes on NVivo 12 by systematically working through the posts to decipher frequent features, patterns and themes in an open coding process. For instance,

‘my mother’s caregivers have said they can no longer care for her’ was coded as *at-home care_withdrawal of service*, whilst ‘I am now sickened because they are telling him that he can come home tomorrow’ was coded as *premature discharge from hospital*.

Step 3 involved the researcher searching for themes by organising open codes into overarching themes relating to the aims of the research. With the use of mind-maps, the researcher moved between the data and theoretical understanding to create themes. For example, the two open codes *at-home care_withdrawal of service* and *premature discharge from hospital* were both organised under the theme ‘Service Cessation’. In step 4, the researcher reviewed the themes by refining the initial ideas to compliment the process of service captivity. The coding and themes were cross-checked by a second researcher to ensure reliability, sense, and relation to theory. During step 5, refined themes were named and defined to represent the essence of each theme and create a narrative of analysis, and as a result a coding guide was produced (see Table 1). Finally, in step 6, the researcher started producing the report. Quotes were chosen to represent each theme and were paraphrased to avoid being reverse-searchable and revealing the identity of participants.

Findings

Service captivity for family caregivers

The findings indicate that service captivity is experienced by family caregivers, as transformative apomediaries of OAeV. As a result, the TSMs, alongside their loved ones, are subjected to being powerless, voiceless and choiceless. This has been further exacerbated by the impact of the pandemic on the UK health service. Furthermore, the data reveals that service cessation, a novel concept, heightens the impact of service captivity on consumer and TSM felt vulnerability. For instance, premature discharge from hospital, eviction from care homes and the service

Table 1. Thematic coding guide of forum data.

Thematic code	Sub-themes	Definition
Powerless	<ul style="list-style-type: none"> ● Unapproved changes to medical records ● Poor quality service but powerless to change provider 	When power resides with the service provider due to a high customer need for the service and little opportunity to exit. Customers and TSMs have a lack of control over the quality and characteristics of the service they are receiving.
Voiceless	<ul style="list-style-type: none"> ● Muted by frontline Healthcare Professionals (HCPs) ● Unable to complain 	Being unheard as a customer and TSM within a service; unable to freely express issues with service conduct and quality. Involving overly complex or non-existent complaints procedures, and frontline employees unwilling to listen.
Choiceless	<ul style="list-style-type: none"> ● Difficult to leave provider ● Scarcity of services 	Due to the constraints of the service providers and market context, consumers and TSMs cannot exit the service. A lack of choice is enhanced by the urgent customer need for the service and scarcity of competitive services in the market.
TSR Outcomes	<ul style="list-style-type: none"> ● Vulnerability of patient ● Mistrust of HCP ● Resentment of HCP 	Feelings that emerge as a result of consumers and TSMs experiencing service captivity and service cessation. Feelings include vulnerability, mistrust and resentment.
Service Cessation	<ul style="list-style-type: none"> ● Prematurely discharged ● Evicted from residence ● The service provider leaving 	When a service provider decides to prematurely end the service, leaving the consumer and TSM in a vulnerable position. The impact of which is heightened when the need for the service is paramount.

provider withdrawing care results in additional vulnerability for the older adult and leads the TSM to mistrust and resent healthcare professionals. Throughout the findings, propositions are developed, and a framework is created to represent the service captivity process (Figure 1).

Powerless

The first theme emerging from the data refers to how TSMs, alongside OAeV, experience ‘powerlessness’ within the health service. The participants express the lack of power they and their care receivers experience whilst receiving healthcare in the UK during the COVID-19 pandemic. Two sub-themes reveal *unauthorised changes made to medical records* and TSMs being *unable to initiative improvements* within the health service. For example, participants discuss how the NHS is required to prioritise patients in order to have enough capacity, with older adults being considered as a low priority because their chance of survival is less. As a result, TSMs recall situations where ‘do not resuscitate’ (DNR) is placed on care receivers’ medical records without either party being consulted:

We discovered the DNR on my husband’s medical records by pure accident and asked for it to be removed but heard nothing back. On the same day as the General Medical Council’s advice came out about prioritising care for less vulnerable adults, he received a phone call from his GP. My husband was having none of it and told his GP that he will not be disregarded just for their convenience. (F1T5P6)

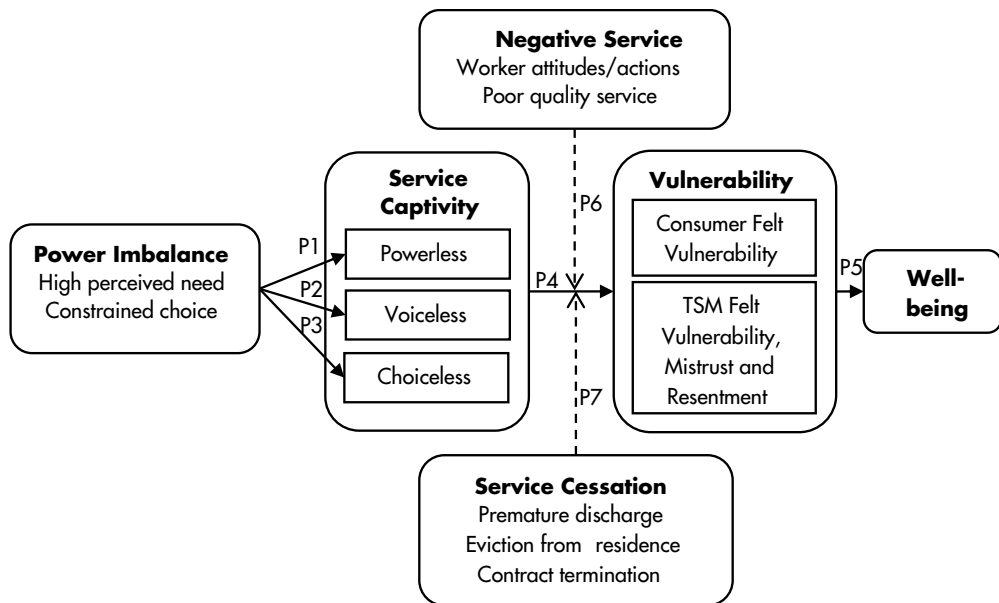


Figure 1. Framework of the service captivity process.

Furthermore, resuscitation requests are altered without either the TSM or OAeV being aware. Not only does this create mistrust of the government-led NHS by the TSM but these feelings are exacerbated by pandemic-related restrictions. In this example, the caregiver is concerned that they will not be able to observe whether care wishes are adhered to, due to limited access to the hospital:

I had a similar situation with my mother. Her records were downgraded from limited resuscitation attempts to DNR. As I have power of attorney, I rung up the GP and said it wasn't acceptable and it should be changed back to what was agreed previously. If she does go to hospital, I won't be able to go with her because of COVID and so she would be at their mercy with nobody to oversee her wishes. (F1T5P10)

Not only is powerlessness experienced by TSMs and their dependents through unexplained changes to medical records, but TSMs also feel unable to implement improvements to the care services of OAeV. Thus, the power often resides with the healthcare organisation. For instance, the quality of healthcare provided can be extremely poor but the TSM and patient have very little control over the outcome. The following example indicates how a family caregiver is unhappy with the professional in-home care service that their mother is paying for:

My mother had to change care company because the previous one could no longer do it. Social services only provide 5 hours care a day and so she now pays £300 a month to top up her care. The new company do not provide a good service, especially in comparison to her old company. In the evening, the guy arrives to give my mum her medication. He then has a chat, watches the news and leaves after half an hour. He never asks if she needs anything and never wears protective gear, which is a big concern. (F2T7P1)

Moreover, the lack of power experienced by TSMs is worsened by the pandemic and the restrictions associated with it. The following example indicates the power dynamic of formal healthcare professionals asserting their authority on the family caregiver. In this case, the in-home caregivers are using pandemic restrictions to limit the contact that the TSM has with their loved one. The care company asserts their power by threatening to withdraw their care, leaving the older adult experiencing vulnerability and without necessary support:

I care for my gran who is bed bound. She also has carers who change and wash her, but they have said to me that I cannot go and look after my gran. I like to prepare meals, make sure she takes her medication and cut her toenails, which is something the carers won't do. They told me that if I went to visit, they would withdraw their care. I spoke to Public Health England and they said it shouldn't be a problem, especially as I am self-isolating and keeping to government guidance. I mean the care team don't even use PPE! (F2T7P8)

The pandemic creates further expectations from TSMs over the quality of care from in-home caregivers. For instance, healthcare professionals must be clean and use personal protective equipment (PPE) to lower the risk of spreading the virus. Unfortunately, the lack of PPE is a common complaint, but the TSM has little power in enforcing the service provider to comply:

8 caregivers a day come to support my wife. One company told me that any caregiver getting closer than 2 metres to my wife, must wear a mask, eye protection, an apron and gloves. The other care company, the ones who wash and dress her, have said that PPE is only required if my wife starts to get symptoms. (F1T28P3)

These varying standpoints from service providers demonstrate the different ways that the regulations are construed, perhaps due to unclear government guidelines and a fundamental lack of PPE. Worryingly, the TSM has little power over the quality of the in-home care, other than threatening to cancel the service. A task which is difficult to do when there is also little choice of alternative services. Throughout the pandemic, power resides with the care provider and the little power the TSM has is thwarted. As a result, the following proposition is proposed:

P1: A power imbalance, created from a consumer's high need for a service and limited choice of alternatives, results in the consumer and TSM experiencing powerlessness within a captive service.

Voiceless

The second theme relates to TSMs and care receivers being 'voiceless' within the health service. Within this theme, several sub-themes emerge, such as being *muted by frontline employees* and being *unable to complain about poor practice*. In one situation, a participant's father is terminally ill and receiving secondary care, he then contracts COVID-19. The hospital attempts to discharge him as they have limited capacity due to the pressure of the pandemic, but the care home also does not admit him as he may infect the other residents. The worried TSM is trying to communicate their situation to the hospital but is muted by the frontline healthcare professional:

The ward manager, who is very hard work – I understand that there is a lot of pressure at the moment, but she was unnecessarily aggressive – shouted at me when she was telling me about my father's positive COVID test. She said he was taking up a bed and needed to go home. I tried to let her know that I would be happy to take him home with me, but she would not let me speak. (F2T16P1)

Being silenced within a healthcare service is experienced by numerous patients and their loved ones, resulting in many wishing to process a complaint. Unfortunately, the complaints procedure within the NHS primary and secondary care is considered complicated, once again reducing the voice of patients and their TSMs:

I tried to ask two GPs at my mum's GP surgery to provide her with an updated Mental Capacity Assessment. Mum and I were given the run around by the GPs. My mum wrote a letter of complaint, but we still haven't heard anything 3 months later. I have phoned up and been told they will ring me back but still nothing! (F1T35P1)

The elongated and complicated complaints procedure is negatively impacted by the pandemic, with the government explaining that all resources are being used to fight the virus, leaving few to handle the complaints process. However, this leaves the TSM, who already has little voice, without further capacity to be heard. On the forum, in response to the previous example, one participant mentions how the new complaints guidance from the NHS is now a centralised but less responsive service:

This is primarily because the NHS is currently re-deploying all possible resources to focus on the fight against the coronavirus, so the most effective way to deal with complaints whilst they're at maximum capacity, is to centralise the service (F1T35P1)

Issues with being unable to complain and feeling unheard do not just reside in primary and secondary NHS care, but also affect the relationship that TSMs have with private in-home care services. For example, this TSM notices issues with unhygienic care, potentially spreading the virus to their care receivers, yet the company is not responding to any complaints made by the TSM:

My first thought was that the virus came from the care company, as my mum had so many caregivers coming and going, not wearing masks and she does not leave the house otherwise. So, I tried to warn them about what had happened. I rang them, emailed them and tried their emergency support number but nobody answered. After FOUR DAYS of trying to get in touch, somebody answered the phone, told me they had received the email and would call me back . . . I am still waiting for that phone call! (F1T17P1)

It is evident that TSMs have little voice within the health services in the UK, similar to previous conceptualisations of service captivity experienced by patients receiving health-care (Rayburn et al., 2020; Rayburn, 2015). Furthermore, this difficulty in being heard spans across both government-led health services and private in-home care. It has been heightened by the pandemic, as when in crisis, the government's recommendations are to reduce the resources relating to the complaint procedure. As a result, a further proposition is stipulated:

P2: A power imbalance, created from a consumer's high need for a service and limited choice of alternatives, results in the consumer and TSM experiencing voicelessness within a captive service.

Choiceless

Often, the reason that consumers of healthcare endure being powerless and voiceless is because of the limited choice that they have for alternative healthcare services (Rayburn et al., 2020). The third theme therefore relates to TSMs being 'choiceless', with sub-themes referring to *difficulties leaving the service* and a *scarcity of alternative options*. For instance, the previous sections outline how TSMs experience a lack of power and are unable to voice complaints and concerns. In an NHS context, relating to primary and secondary care, this predicament is heightened by not being able to cancel the service due to a lack of affordable alternatives. Furthermore, relating to paid services for older adults, such as in-home care and nursing homes, services are strained and difficult to find. The following example demonstrates how encountering a private company is difficult for TSMs:

My mum, who lives alone, has carers visit her 3 times a day, minimum. We have had issues with the care company for some time with their poor standards and hygiene. As a family, we started to look for our own carers, as the original company had been provided by social services, but we didn't have much luck. (F1T13P4)

Due to the pandemic, NHS secondary care reaches capacity, which then increases the demand for private care such as in-home caregivers. This sudden increase in demand on an already strained market results in a scarcity of healthcare services. For example, TSMs feel as if they have little choice in how their loved ones are cared for, especially when further restrictions are released by the government in order to handle the pressures of the pandemic:

I read the government's guidelines on hospital discharges, where it says that the patient 'will not have a choice'. I only found the word 'carer' once. Suggesting that us carers don't have any real input into anything. Whoever wrote the document seems to think that there are multiple nurses and carers available in the community. This could not be any further from the truth. Even prior to the coronavirus, patients were kept in hospital because there wasn't enough support staff in the community. (F2T45P10)

The fragile balance of healthcare services in the UK means that pressure on one service can increase the scarcity of another service. In these examples, this paucity leads to service captivity felt by the TSM who is responsible for representing the OAeV to the service provider. The following proposition is therefore developed:

P3: A power imbalance, created from a consumer's high need for a service and limited choice of alternatives, results in the consumer and TSM being choiceless within a captive service.

Vulnerability, mistrust and resentment

From the previous examples, service captivity experienced by OAeV, evidently leaves the older adult vulnerable to poor service quality and further health degradation as the power resides with the service provider. However, for the TSM who is informally caring for the OAeV, this captive health service can create feelings of mistrust and resentment towards the whole NHS system, the government, policy makers, and even healthcare professionals. The fourth theme emerging from the data is therefore the negative outcomes associated with service captivity. The following example indicates how TSMs have developed a mistrust of healthcare professionals and the whole NHS system to care responsibly for OAeV:

The new hospital discharge rules seem to defy the Human Rights Act. I am afraid that many people are going to suffer tremendously before they take this problem seriously in the current crisis. (F1T20P6)

Furthermore, this mistrust leads to resentment, where TSMs feel anger and frustration towards NHS workers. NHS workers have been promoted as heroes of the pandemic by government and media, however the issues that TSMs and OAeV are having with the healthcare service results in annoyance at these messages:

It's a complete joke, at our expense. At the chippy yesterday, they were offering half price fish and chips to NHS staff. Fish and chips cost £4 for NHS workers and £8 for people on universal credits ... that doesn't seem fair! It's utter rubbish ... a consultant earning £100K, who doesn't work on the front line, can get their dinner half price. (F2T6P9)

The resentment moves beyond NHS workers and extends towards the institution, as TSMs also demonstrate frustrations towards the government. The following example indicates how TSMs feel ignored and unsupported by the UK government:

So our Prime Minister has joined people of the UK in clapping for the NHS, to pay tribute to the staff and the health service. Where is the clapping for private/family carers? When do we get what we deserve? (F2T6P12)

This resentment is further evident in the titles of many of the forum posts, for example 'now they are shoving palliative care on us', 'furious at care from social service, caregivers and the hospital', 'when will the clapping end' and 'COVID-19 bill – an absolute joke'. These findings demonstrate how a government-led healthcare service in crisis can result in patients and their family caregivers feeling confined within the service, vulnerable at the hands of the service, and resentment towards healthcare professionals, the NHS and the government. The following proposition is therefore proposed:

P4: Being powerless, voiceless and/or choiceless within service captivity impacts the consumer's felt vulnerability and the vulnerability, mistrust and resentment felt by the TSM.

Furthermore, as healthcare is intended to improve patient well-being, lessons must be learned from actions during the crisis, in order to avoid the issues previously stated. The final proposition of this section therefore relates to the influence of service captivity and felt vulnerability on the well-being of the consumer and TSM:

P5: Felt vulnerability created from experiencing service captivity negatively influences the well-being of both the consumer and the TSM.

Service cessation and negative service

Being held in service captivity by the healthcare services in the UK; having little power, voice, and choice, places the patient and the TSM in an extremely vulnerable position if that service provider delivers a poor service quality or prematurely ends the service agreement. This premature disruption has been labelled 'service cessation', which is a novel construct within the service captivity framework (Rayburn et al., 2020; Rayburn, 2015). The fifth theme is therefore service cessation, as the data demonstrates numerous narratives indicating the vulnerability of patients when in-home caregivers, NHS secondary healthcare or care homes remove their services. Sub-themes within service cessation include *premature discharge*, *eviction*, and *withdrawal of services*. For instance, the following example highlights how service cessation of in-home care can create disruption for both the care receiver and TSM, negatively impacting well-being:

My mother's caregivers have said they can no longer care for her because they are having staffing problems. They used to visit her four times per day. She is now living with us, but this is difficult because we don't have a downstairs bathroom and our chairs and spare beds are too low for her. (F1T34P12)

Furthermore, the impact of COVID-19 places further pressure on the issues of service cessation. The following example of an older woman experiencing vulnerability and being evicted from a care home indicates how difficult this is for the TSM as they are voiceless and powerless regarding the decision. Furthermore, their choice is restrained due to the constraints of the pandemic:

My mother is in the dementia section of a care home. She is very frail and needs help getting up and going to the toilet. The care home has said that they need two people to help her do this and as a result they can't provide the level of care that she needs. They sent us a formal

letter with a 30-day eviction notice, saying she will be charged if she doesn't leave in this time period. Should I really be moving her to a nursing home right now, with everything that is going on? (F2T16P1)

A further TSM's narrative really demonstrates the dangers of premature service cessation. The pandemic leads to hospitals desperately discharging patients to avoid spreading the virus and to have capacity for COVID-19 patients. Unfortunately, this has devastating effects on those experiencing vulnerability and suffering from illnesses. On the forum, a concerned son writes about how his 90-year-old mother contracts COVID-19 from her caregivers and is subsequently admitted to hospital. Whilst in hospital, the ward allows no visitors but keeps providing positive reports as to how his mother is progressing. The hospital decides to discharge the patient, even though she no longer has caregivers, nobody is available to collect her and there is no food or heating in the house. This decision has devastating repercussions:

My mother arrived home by ambulance and my sister was shocked at her condition – she was in pain, couldn't stand or walk. She was just dumped in a chair and left in the living room. A caregiver arrived but could not help my mum into bed, so she left and did not come back until the next day. My mum was left in the chair all night. The next day a physiotherapist arrived and called 999 . . . when the ambulance arrived, they assessed mum, agreed she was still very poorly but were reluctant to take her to hospital because of the coronavirus. The two strong ambulance men decided to lift her from the chair to her bedroom and get her into bed . . . her feet were black and swollen, she had a high temperature, a chest infection and she had soiled herself in the night. (F1T7P1).

Being subject to service captivity with little power, voice and choice makes the service receiver and their TSM vulnerable, and this vulnerability can be increased by either a negative service experience or service cessation. As is evidenced in these examples, if healthcare services prematurely withdraw their service, the outcome can be detrimental, devastating and dangerous, which negatively impacts the well-being of the older adult experiencing vulnerability, and their TSM. Consequently, the following propositions are presented:

P6: Negative Service is a moderating factor of the relationship between service captivity and felt vulnerability (mistrust and resentment) by the consumer and their TSM.

P7: Service Cessation is a moderating factor of the relationship between service captivity and felt vulnerability (mistrust and resentment) by the consumer and their TSM.

Discussion and conclusions

Theoretical implications

Through in-depth qualitative data collection and analysis, this study develops a framework of the service captivity process (see [Figure 1](#)), which was a concept initially depicted by Rayburn et al. (2020). The present investigation builds on previous interpretations of the process by producing a testable framework with 7 propositions that can be employed in future research. Similarly to extant literature, it is proposed that a power

imbalance in the service impacts the consumer's captivity within that service as they are powerless, voiceless and choiceless, which consequently increases the vulnerability felt by the consumer. To contribute to the extant TSR literature, service captivity is developed through the lens of transformative services, and consequently well-being is included in the framework as a dependent variable. Furthermore, negative service, which was originally included in the Rayburn et al. (2020) service captivity process as an independent variable, has been included in this study as a mediator. This is because the findings reveal that a negative service, such as poor quality and worker attitudes, increases the impact of service captivity on the felt vulnerability of the consumer.

The testable framework does not just account for the experiences of the consumer, but it also recognises the role of the TSM within the service experience. This is the first time service captivity has been acknowledged as a process that can be experienced by a second actor, acting on behalf of the consumer. The TSM, whose central aim is to represent the consumer in service interactions so that they can improve consumer well-being and reduce harm (Johns & Davey, 2019) is also subject to service captivity. The TSM experiences having little power, voice, and choice, comparable to the consumer, however their vulnerability is experienced differently. The TSM feels vulnerable in the situation as they are unable to help the person that they are responsible for, but they also express mistrust and resentment towards the service provider.

The main theoretical contribution of the present paper to the TSR literature is how the impact of service captivity on felt vulnerability is mediated by service cessation. Service cessation is a new construct representing the service provider withdrawing their custom, leaving the consumer without a service that they require. This heightens the felt vulnerability of the consumer and their TSM during service captivity, especially when the required service is scarce. There is a body of literature on ending service exchanges, using terms such as customer switching, termination, dissolution, and exiting (Antón et al., 2007; Halinen & Tähtinen, 2002; Tähtinen & Halinen, 2002). These papers, however, assume that the service exchange is voluntarily ended by the customer and that the customer has alternative options. Using a TSR perspective, the present study identifies situations when a service customer and their TSM are in a vulnerable situation as the service provider has the power to prematurely end a service, without which the consumer cannot cope. Within the context of older adults receiving healthcare, service cessation can have extremely detrimental effects on the consumer's health and well-being, as they can be prematurely discharged from hospital, evicted from care homes, and left by in-home caregivers. Preventative recommendations are subsequently made for health services and policy.

Health service implications

In government-led healthcare, one of the main factors influencing care receivers' and TSMs' vulnerability and resentment is the power imbalance, where the power resides with the service provider. Interestingly, extant literature on family caregivers recommends that the service provider should empower and support the caregiver to reduce vulnerability and improve the well-being of both the care receiver and the caregiver (Leino, 2017; Rosenberg et al., 2015; Suárez-Álvarez et al., 2020). For example, Rosenberg et al. (2015) conclude that in the context of End-of-Life (EoL) care, service providers should actively

facilitate and support family caregivers to develop a sustainable positive cycle. Furthermore, Suárez-Álvarez et al. (2020) demonstrate the importance of co-production between the healthcare professional and the patient's companion, and that the satisfaction of the companion is directly related to the satisfaction of the patient. Unfortunately, in the context of the present study, the government-led healthcare service has failed to empower TSMs, resulting in a negative service experience and a reduction in well-being for both the patients and the TSMs.

Additionally, when TSMs feel voiceless with regard to the care receiver's healthcare service, further feelings of resentment, frustration and mistrust emerge. In the present study, TSMs have been physically silenced by healthcare professionals and feel unable to make complaints. The pressures placed on the health service throughout the pandemic have intensified these experiences, as frontline employees are under severe pressure and healthcare resources are stretched (Voorhees et al., 2020). However, the well-being of patients and their TSMs should still be paramount. Leino (2017) discovers that the loved ones of healthcare users are also susceptible to vulnerability and reduced well-being in a health service context. These secondary customers therefore require support, communication and information, similar to supporting a patient (Leino, 2017). By hampering the voice of TSMs, not only does this increase the vulnerability of the patients within health service captivity, but it also negatively impacts the well-being of the TSMs.

A government-funded healthcare market creates service captivity, primarily due to the lack of viable options available to care receivers and their TSMs. According to Keeling et al. (2021), a government-led health service is complex, however for the older adult experiencing vulnerability there are further levels of complexity. For instance, in-home care and care homes are major components of the lives of OAeV (Barnhart et al., 2014; Verleye et al., 2014). These services in themselves are complicated as both can be privately or government-funded but the level of support that an older adult receives depends on their financial situation. As a result, many consumers utilise a mixture of private and funded care services. Due to the growing ageing population, the demand on these services is colossal, and subsequently demand is greater than supply, creating a scarcity of healthcare. These issues have been aggravated by the pandemic as restrictions have prevented consumers from switching services, even if the service is not performing to expected standards. Throughout the findings, TSMs demonstrate their frustration with not being able to find a better in-home care company or being able to move their loved one to another care home.

In a crisis such as a pandemic, a healthcare service should prioritise the health of its patients and their TSMs without marginalising the more vulnerable members of society. Firstly, no changes should be made to medical records without the consent of both the patient experiencing vulnerability and their TSM, especially to end-of-life treatment, which can be an extremely personal decision for both parties (Rosenberg et al., 2015). Secondly, the channels through which a patient and their TSM can voice their concerns should not be restricted. Patients and TSMs should be able to have a voice within the service that they are receiving, which means being able to talk to healthcare professionals and being able to make complaints, if required. Finally, the health service should protect its staff and healthcare professionals by ensuring manageable workloads, and by

providing adequate PPE and emotional support services. This would reduce the pressures placed on frontline employees and therefore reduce the emotional conflicts between healthcare professionals, patients and TSMs.

Policy implications

To enable these recommendations during times of crisis, fundamental changes need to be made to government-led healthcare, which should be instigated by policy modifications. Firstly, the scarcity of in-home services, provided both privately and publicly, needs to be addressed. To increase the number of in-home services available, business loans could be developed to encourage and support start-up care companies. Furthermore, government loans could be provided for individuals wishing to train as formal caregivers and nurses. Within in-home care companies there also needs to be a standardised expectation of quality, with clear guidance on how to comply in regular situations and during a pandemic. This would reduce the issues associated with poor care provided by in-home caregivers. Longevity in the relationship between in-home caregivers and care receivers is critical to patient well-being and formal caregiver job satisfaction (Barnhart et al., 2014). Therefore, services providing healthcare (e.g. in-home care companies, nursing homes and care homes) should legally not be able to withdraw their care during times of crisis. In regular circumstances the withdrawal of care should only be allowed once the older adult experiencing vulnerability has found suitable alternative care.

Secondly, changes need to be made to the way in which publicly-funded secondary care manages its patients and their TSMs. There needs to be more cohesion between the different actors involved in the care of an older adult experiencing vulnerability. One way to do this would be to integrate primary care, secondary care and health-based social services so that the combined services run fluidly and there are fewer disparities between local governing bodies. This would prevent patients being prematurely discharged without the necessary support from social services and/or in-home care. Furthermore, it would be easier for TSMs to manage the care of the OAeV if they were conversing with one overarching healthcare service as opposed to multiple healthcare professionals from a variety of independent services. The TSM could be officially recognised as the main caregiver for the patient, their views would be heard, and they could be adequately supported with finance, training and emotional support services. It is essential for governments and healthcare services to recognise the TSM as an orchestrator of care for consumers experiencing vulnerability and to ensure that these individuals are supported (Cardoso et al., 2020).

Limitations and directions for future research

Although this paper is paramount to understanding how OAeV and their TSMs interact with healthcare services within the UK, it is only based on one country. The research should be expanded to further countries so that it can establish if TSMs and OAeV experience service captivity and cessation in additional government-funded healthcare settings and countries where healthcare is pre-paid. The chosen method of data collection for the present study was a covert netnography, which enables natural data to be gathered during pandemic restrictions. Future research could also incorporate interviews

into the methodology, which would enable specific questions to be addressed to the TSMs. Moreover, it would be interesting to triangulate the study with narratives from the OAeV and healthcare providers within government-funded healthcare.

A further limitation is that the framework is developed from a specific context; OAeV receiving government-funded healthcare. The framework for the service captivity process could also be applied to alternative service situations where the consumer is trapped and a TSM is required to act on their behalf. For example, captive services can include automotive, cellular, financial, gym, health insurance, healthcare, internet, property management, retail, social services, and university services (Rayburn et al., 2020). Any consumers could experience temporary or longer-term vulnerability within these services and consequently require a TSM (Riedel et al., 2022). For example, children using social services, people with disabilities in the retail environment and patients with chronic conditions navigating healthcare. Future research could test the framework and propositions within these settings.

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No potential conflict of interest was reported by the author(s).

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