Reframing Prevention: How Influencers Drive Engagement Among Younger Adults

An Exploratory Qualitative Study on the Strategic Role of Influencers in Germany's §20 SGB V Digital Health Programs

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Dissertation written under the supervision of
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Abstract

This thesis investigates how social media influencers (SMIs) can be strategically embedded into certified digital preventive health courses under Germany's §20 SGB V framework to increase adoption among younger adults aged 20 to 40. Despite a robust reimbursement infrastructure and the recent expansion to digital formats, participation within this demographic remains low—mainly due to persistent psychosocial barriers such as emotional disengagement and perceived irrelevance. Grounded in the Elaboration Likelihood Model (ELM), source credibility theory, and parasocial interaction research, the study develops a conceptual framework that contrasts health-oriented influencers (who convey topical authority) with peer influencers (who foster relatability through co-learning). Each type activates distinct motivational mechanisms. To explore these dynamics empirically, four focus groups (N = 26) were conducted, using stimulus materials that systematically presented expert-only, health influencer, and peer influencer course formats. Thematic data were analyzed using structured qualitative content analysis (Mayring, 2015), combining deductive and inductive category development. Findings suggest that influencer-supported formats enhance perceived relevance, emotional accessibility, and motivational engagement—yet their effectiveness varies depending on participants' level of involvement. Health influencers were more persuasive under conditions of high involvement, leveraging perceived expertise and credibility. Peer influencers proved particularly effective in low-involvement contexts, reducing psychological entry barriers through emotional resonance and co-learning dynamics. These results support an involvement-contingent interpretation of the ELM.

This study contributes to the literature on influencer communication in behavioral interventions and provides practical guidance for public health actors and course providers seeking to modernize preventive health offerings for younger, digitally native audiences.

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Resumo

Esta dissertação investiga como influenciadores digitais (SMIs) podem ser estrategicamente integrados em cursos preventivos de saúde digitais certificados pelo §20 SGB V na Alemanha, com o objetivo de aumentar a adesão entre adultos jovens com idades entre 20 e 40 anos. Apesar de uma infraestrutura de reembolso robusta e da recente expansão para formatos digitais, a participação nesse grupo demográfico continua baixa — principalmente devido a barreiras psicossociais persistentes, como o distanciamento emocional e a percepção de irrelevância. Com base no Modelo de Probabilidade de Elaboração (ELM), na teoria da credibilidade da fonte e na pesquisa sobre interação parasocial, desenvolve-se um modelo conceitual que distingue influenciadores especializados em saúde (com autoridade temática) de influenciadores pares (com foco na proximidade emocional e aprendizagem conjunta). Cada tipo ativa mecanismos motivacionais distintos. Para explorar essas dinâmicas empiricamente, foram realizados quatro grupos focais (N = 26), utilizando materiais de estímulo que apresentavam sistematicamente três formatos de curso: apenas com especialista, com influenciador de saúde e com influenciador par. Os dados foram analisados com base na análise qualitativa de conteúdo estruturada (Mayring, 2015), combinando desenvolvimento de categorias dedutivas e indutivas. Os resultados indicam que os formatos com influenciadores aumentam a relevância percebida, a acessibilidade emocional e o envolvimento motivacional — embora sua eficácia varie conforme o grau de envolvimento dos participantes. O estudo oferece contribuições relevantes para a literatura sobre comunicação em saúde e fornece orientações práticas para atores públicos e fornecedores de cursos que desejam modernizar as ofertas preventivas para públicos digitais.

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1 Introduction

Preventive health has become a strategic necessity for modern healthcare systems, as demographic change and behavioral risk factors accelerate the global rise of non-communicable diseases (NCDs)—now the leading cause of death worldwide (World Health Organization, 2021). Many of these conditions are avoidable through early lifestyle intervention, making the promotion of healthier behaviors a core priority for improving population wellbeing (Hoskins et al., 2019).

In response, Germany established a statutory reimbursement framework under §20 SGB V to strengthen preventive health at the population level (§20 SGB V, 1988). The program enables citizens to participate in certified health courses in areas such as physical activity, nutrition, and stress management. These are delivered by private providers and subsidized by statutory health insurers (GKV-Spitzenverband, 2024b). Since 2020, legal reforms have extended the framework to include fully digital formats, thereby enhancing accessibility, scalability, and opportunities for entrepreneurial implementation. With over 74 million people eligible for reimbursement (Federal Ministry of Health (Germany), 2025), §20-certified courses represent a policy-backed mechanism with significant public health impact and market potential.

Despite this infrastructure, course participation remains disproportionately low among younger adults aged 20 to 40—a demographic that is both digitally engaged and increasingly affected by lifestyle-related stress and health risks (Jeong & Nam, 2024). Existing research highlights three core barriers to the adoption of preventive health behavior: structural access, financial burden, and psychosocial disengagement (De et al., 2024; Kelly et al., 2016). While the §20 framework effectively addresses the first two through digital access and reimbursement, it still fails to emotionally engage many individuals within this age group. Younger generations, despite being a well-suited target due to their health awareness and digital affinity, often remain disconnected from the formal and impersonal formats currently offered.

In parallel, social media influencers (SMIs) have emerged as powerful communicators in digital environments, particularly effective in engaging younger audiences. Their strength lies in fostering perceived authenticity, emotional proximity, and parasocial trust—traits that have shown to influence consumer behavior and health engagement alike (Schouten et al., 2020; Sokolova & Perez, 2021). While SMIs have become increasingly relevant in public health

campaigns and awareness initiatives, their potential within structured, behaviorally grounded and certified health interventions remains largely unexplored.

This thesis addresses this gap by exploring how SMIs can be meaningfully embedded into §20-certified digital preventive health courses to reduce psychosocial barriers and increase adoption among younger adults. Unlike promotional influencer use in marketing, this investigation focuses on their active integration within course formats—as emotional co-participants or motivational companions—rather than external endorsers.

Based on these theoretical and practical considerations, this thesis examines the strategic use of influencer collaborations to address psychosocial adoption barriers among younger demographics within digital preventive health courses under Germany's §20 SGB V framework. It is guided by the following primary research question:

RQ1: *How can influencer collaborations be used to increase the adoption of §20 SGB V-certified preventive health courses among younger demographics (aged 20–40) in Germany?*

Building on the conceptual foundations developed in Sections 2.2.1 and 2.2.2, two sub-questions further specify the scope of investigation. First, the general effectiveness of influencer integration is examined:

> **RQ2:** *Do preventive health courses that feature influencers generate higher willingness to adopt compared to traditional expert-led courses?*

Second, the influencer typology proposed in this thesis (see Section 2.2.3) provides the conceptual foundation to investigate peer dynamics—marking an original theoretical contribution by positioning peer-like influencers as co-learners within certified behavioral interventions:

> **RQ3:** *Are peer-like influencers (who learn alongside participants) more effective in driving engagement than health-oriented influencers?*

Together, these questions aim to explore not only whether, but how and why, influencer-supported digital health courses can improve engagement among younger adults—contributing to both theory-building and practical go-to-market innovation.

2 Literature Review

2.1 Preventive Health

2.1.1 Defining Preventive Health: Origins, Principles, and Modern Perspectives

Preventive health refers to strategies aimed at minimizing health risks and preventing the onset or progression of disease. The World Health Organization (WHO) defines prevention as a critical approach targeting modifiable risk factors to reduce disease burden and improve population well-being (World Health Organization, 2021). Historically, preventive health evolved from early sanitation and vaccination efforts to more comprehensive strategies encompassing lifestyle changes, early detection, and chronic disease management (AbdulRaheem, 2023). In contrast to curative medicine, which treats disease post-diagnosis, preventive care focuses on risk reduction and health promotion, offering cost-effective avenues to improve health outcomes (Bauer et al., 2014).

Preventive health is commonly divided into three levels—primary, secondary, and tertiary prevention—originally defined by Leavell and Clark (1965) and still widely used in public health frameworks (Yongu, 2022; Baumann & Ylinen, 2017). Primary prevention aims to stop disease before it starts, using measures like vaccinations, education, and lifestyle interventions. Secondary prevention involves early detection through screenings and diagnostics, while tertiary prevention focuses on managing complications in individuals with chronic conditions. These stages remain foundational in modern policy frameworks, including the WHO's Global Health Strategy 2025–2028 (WHO, 2025).

As understanding of public health has deepened, two additional levels—primordial and quaternary prevention—have been introduced (AbdulRaheem, 2023). Primordial prevention, developed in 1978, targets structural determinants of health such as poverty and urban design, aiming for long-term equity (Gillman, 2015; Yongu, 2022). Quaternary prevention focuses on avoiding overmedicalization, reducing unnecessary interventions and patient harm (Martins et al., 2018).

Among these, primary prevention has the greatest potential, especially in addressing non-communicable diseases (NCDs) like cardiovascular disease, diabetes, and cancer. These are largely driven by modifiable behaviors and are thus highly preventable (AbdulRaheem, 2023;

Kushner & Sorensen, 2013). Primary prevention combines structural interventions (e.g., policy regulations) with health promotion strategies such as education, physical activity, and smoking cessation. Evidence shows that up to 80% of chronic diseases could be prevented through such behavioral interventions, underscoring their value in both health outcomes and cost containment (Bauer et al., 2014).

With the growing recognition of behavioral risks, Lifestyle Medicine (LM) has emerged as a structured, evidence-based approach to primary prevention (Lippman et al., 2024). Unlike traditional preventive efforts that emphasize structural measures, LM focuses on individual behavioral change. According to Lippman et al. (2024), LM includes six core pillars: nutrition, physical activity, stress management, restorative sleep, avoidance of harmful substances, and social connection. This holistic model promotes sustainable habits and emphasizes mental and physical resilience through self-care and lifestyle shifts.

While primary prevention and LM provide strong foundations for long-term health and well-being, their true impact relies on effective implementation and scalability. As modern healthcare systems seek innovative approaches to support healthier populations amid rising healthcare costs, the following section examines what key opportunities arise for both public health and the private sector in developing sustainable models for large-scale adoption.

2.1.2 Strengthening Preventive Health: Key Drivers and Opportunities

The urgency to strengthen primary prevention efforts continues to grow, as demographic change and lifestyle-related risk factors drive a sharp increase in non-communicable diseases (NCDs). These chronic conditions now account for 74% of global deaths (WHO, 2021) and impose rising long-term costs on healthcare systems, particularly in high-income countries (Vandenberghe & Albrecht, 2020). In the European Union alone, major NCDs contribute to at least 25% of healthcare spending and nearly 2% of GDP (Vandenberghe & Albrecht, 2020). Since many NCDs are largely preventable through early lifestyle interventions, cost-effective and scalable prevention strategies are increasingly seen as a global public health priority.

Lifestyle-based interventions have emerged as a particularly promising approach. Although their long-term benefits can be difficult to quantify precisely, the available evidence is strong: the WHO (2021) estimates a potential sevenfold return on every dollar invested in preventive health by 2030, and Zhou et al. (2020) show that programs targeting conditions such as diabetes

are not only effective but highly cost-efficient. These findings position behavioral prevention not just as a moral imperative but as a strategic tool to reduce systemic pressure on healthcare systems.

Moreover, research confirms that lifestyle-based primary prevention is particularly effective when implemented early. A 2024 longitudinal study involving 3,013 adults by Roca-Ventura et al. (2024) highlights middle age (40–65 years) as a critical phase in which the cumulative impact of unhealthy behaviors becomes especially apparent, sharply increasing the risk of chronic conditions. The study further emphasizes that individuals aged 20 to 40 are far more receptive to long-term habit formation, as behavioral change becomes progressively harder with age. Accordingly, early preventive engagement in this age group offers not only measurable health benefits but also significant potential for long-term impact.

Digital health technologies offer new avenues to operationalize these goals. Defined broadly as the use of information and communication technologies (ICT)—such as mobile apps, wearables, and telemedicine—for health promotion (Jeong & Nam, 2024), digital tools are well suited to overcome access and scalability barriers. However, their current use in prevention remains limited. Cohen et al. (2020) find that digital health solutions are disproportionately focused on disease management rather than prevention. Interestingly, Cohen et al. (2020) observe that demand for digital prevention is largely consumer-driven: users are often the ones actively seeking out and financing these tools themselves. This finding points to a substantial unmet need in the current health technology landscape and suggests that preventive offerings are being driven more by end-user interest than by institutional supply.

Building on the previously highlighted potential of digital health solutions, younger generations—Millennials and Generation Z—are recognized as key drivers of increased interest in healthier lifestyles, longevity, and technology-driven health solutions (Statista, 2023b). However, despite their high digital literacy and strong interest, Jeong et al. (2024) identify a substantial gap in their actual use of digital health tools. In their study, they examine the "digital divide" between so-called "Digital Natives" (ages 20–39) and "Digital Immigrants" (ages 40–69), revealing that while younger adults express greater technological confidence, their engagement with digital health offerings remains comparatively low. The authors argue that this disconnect stems less from access or competence than from a lack of relevance and integration into daily routines. Hence, they emphasize the need for age-specific tailoring of

digital health interventions—an area where current solutions often fall short and where considerable untapped potential remains.

To close this gap at scale, hybrid implementation models are needed. Public-private partnerships (PPPs) offer a promising framework for delivering digital health solutions that are both high-quality and widely accessible (Fabre & Straub, 2023; Torchia et al., 2015). Defined as long-term collaborations between public and private actors, PPPs combine public oversight and infrastructure with private innovation and efficiency (Fabre & Straub, 2023). As Torchia et al. (2015) emphasize, such models are particularly well suited to address demanding behavioral challenges that require flexible, user-centric designs. However, their success largely depends on robust regulatory frameworks, stakeholder coordination and sustainable financing models (Torchia et al., 2015).

Germany's framework under §20 SGB V illustrates how PPP principles can be operationalized in preventive health (§20 SGB V, 1988; GKV-Spitzenverband, 2024b). Here, certified providers—including private firms—develop preventive courses that meet evidence-based standards and are reimbursed by statutory health insurers once approved by the Zentrale Prüfstelle Prävention (GKV-Spitzenverband, 2024b). This model aligns closely with the core principles of Lifestyle Medicine and was recently expanded to include purely digital formats (Medizinischer Dienst Bund & GKV-Spitzenverband, 2024). It thus represents a scalable template for combining medical quality with private sector innovation.

Despite this infrastructure, uptake among younger users remains low. Recent data show that the 20–39 age group is underrepresented in §20 SGB V course participation (Medizinischer Dienst Bund & GKV-Spitzenverband, 2024). Understanding how to engage this segment more effectively is therefore both a research gap and a public health opportunity. This study focuses specifically on that challenge.

While early intervention strategies, digital health solutions, and PPPs such as those under Germany's §20 SGB V framework present promising opportunities, significant challenges remain in driving adoption and sustaining behavioral change. The following section will explore key barriers to preventive health behavior adoption, with a particular focus on behavioral constraints that impact engagement and long-term adherence.

2.1.3 Barriers to Preventive Health Adoption

Despite the well-documented potential of preventive health programs—such as certified online courses under Germany's §20 SGB V—adoption and sustained engagement remain limited. Recent systematic reviews (De et al., 2024; Deslippe et al., 2023; Hoskins et al., 2019, 2019; Kelly et al., 2016; Shabir et al., 2022) consistently identify a multifaceted array of barriers to preventive health behavior (PHB). These are most often grouped into three domains: structural access issues, socioeconomic constraints, and psychosocial factors (De et al., 2024; Kelly et al., 2016). Understanding these barriers is essential for developing PHB strategies that are both scalable in reach and viable from a business perspective.

A first layer of barriers stems from limitations in access and infrastructure. Geographic disparities—especially in rural areas—can restrict the availability of preventive services (De et al., 2024; Deslippe et al., 2023), while time constraints due to work and caregiving responsibilities further hinder participation (Kelly et al., 2016). Although digital tools help reduce many of these access issues, gaps in digital literacy and technology access persist, particularly for older or disadvantaged groups (Shabir et al., 2022; Yuen et al., 2024). However, as highlighted in Section 2.1.2, these limitations are less relevant for younger users (ages 20–40), who report high levels of digital confidence (Yuen et al., 2024), making structural barriers less pressing in this demographic.

Financial constraints also play a significant role. High out-of-pocket costs, limited coverage, and general financial insecurity reduce the willingness to invest in preventive care, particularly among low- and middle-income groups (De et al., 2024; Deslippe et al., 2023; Kelly et al., 2016; Shabir et al., 2022). A systematic review by Hoskins et al. (2019) confirms that financial incentives can increase adoption by offsetting these opportunity costs. Within the §20 SGB V framework, such costs are largely mitigated through reimbursement by statutory health insurance, significantly lowering entry barriers. Nonetheless, Hoskins et al. (2019) also emphasize that while financial support facilitates initial uptake, it does not ensure long-term adherence—highlighting the need to look beyond economic incentives.

The literature consistently identifies psychosocial and behavioral barriers as particularly critical. A lack of intrinsic motivation often hinders both initiation and long-term commitment to health-promoting behaviors. De et al. (2024) point to low self-efficacy as a major obstacle,

with many individuals doubting their capacity to change habits. Deslippe et al. (2023) further emphasize the role of negative self-perceptions and disinterest in lifestyle change. Social context exacerbates these issues: in the absence of encouragement or peer role models, individuals are less likely to engage and persist in preventive behaviors (De et al., 2024). Deslippe et al. (2023) and Shabir et al. (2022) add that a lack of social reinforcement can lead to feelings of isolation and undermine motivation, but opportunities to leverage social reinforcement remain underutilized in many interventions.

Taken together, these findings suggest that while structural and financial hurdles are increasingly manageable—particularly within publicly subsidized digital formats—psychosocial constraints remain the most persistent challenge. This aligns with recent literature emphasizing the importance of motivational and social dynamics for sustainable PHB (Hoskins et al., 2019; De et al., 2024).

Given these insights, it becomes evident that overcoming psychosocial barriers, particularly motivational deficits and lack of social reinforcement, requires innovative engagement strategies. In this context, influencer collaborations represent a promising approach to leverage social influence mechanisms and strengthen long-term behavior change, especially among younger demographics. The following section explores how integrating influencers into preventive health programs may effectively address these challenges and foster sustained engagement.

2.2 Influencers in Preventive Health Promotion

2.2.1 The Role of Social Media Influencers

Over the past decade, social media influencers (SMIs) have received increasing academic attention for their ability to shape audience attitudes and behaviors (De Veirman et al., 2017). As part of the broader domain of social influence and electronic word-of-mouth (eWOM), SMIs serve as powerful intermediaries in digital communication (Balaban et al., 2022; Cialdini, 2021). Studies show that interpersonal sources often exert stronger effects on consumer decision-making than traditional advertising, especially when perceived as authentic and relatable (De Veirman et al., 2017). Supporting this, Lou and Yuan (2019) reference a Twitter study in which consumers reportedly place trust in influencers comparable to that of friends—highlighting their persuasive potential as peer-like figures. This trust is nurtured through

emotional engagement and the sharing of personal narratives, fostering closeness and credibility.

The academic literature offers multiple definitions of SMIs. One of the most frequently cited comes from Freberg et al. (2011), who define them as "a new type of independent third-party endorser who shapes audience attitudes through blogs, tweets, and the use of other social media." Traditionally, a distinction has been made between celebrities—who gain influence through mainstream exposure—and SMIs, who grow organically through niche content on platforms like Instagram or YouTube (Leung et al., 2022; Wei et al., 2022). However, this distinction is becoming blurred. As Lou and Yuan (2019) point out, even celebrities can function as influencers if they consistently produce content and build direct audience relationships. Thus, this thesis adopts a broader, behavior-oriented definition: an influencer is any individual who consistently engages in authentic, audience-centered digital communication—regardless of their origin. The defining features are not fame, but personal content sharing, continuous engagement, and perceived authenticity.

While SMIs have been widely studied in the context of low-involvement products, recent research has also demonstrated their effectiveness in high-involvement domains like health and well-being (Folkvord et al., 2020). Balaban et al. (2022) emphasize that influencers function as digital opinion leaders and trust agents who shape consumption patterns, attitudes, and lifestyles. Folkvord et al. (2020) further show that when content aligns with audience values, SMIs can affect health-related attitudes and behaviors. This is particularly relevant for younger audiences, who engage with social media habitually and perceive influencers as relatable role models (Lou & Yuan, 2019).

Despite this relevance, the role of influencers in regulated, high-involvement settings such as certified §20 SGB V health courses remains underexplored. As Section 2.1.3 illustrates, psychosocial barriers—like low motivation or lack of social reinforcement—often impede adoption. Integrating influencers may offer a strategic way to activate social mechanisms and enhance engagement. The next section investigates the psychological processes underlying this persuasive potential.

2.2.2 Psychological Mechanisms of Influence

To understand how social media influencers (SMIs) can increase the adoption of preventive health courses among younger adults, it is essential to examine the psychological mechanisms that underlie their persuasive power. These mechanisms are particularly relevant in preventive health, where traditional communication strategies often fail to overcome motivational and social barriers (see Section 2.1.3). In §20 SGB V-certified courses, instructors typically possess formal expertise but lack social influence. Co-created formats—featuring both SMIs and certified experts—may amplify trust, emotional resonance, and social influence, offering new avenues for self-initiated behavior change.

A foundational framework is the **Source Credibility Model**, which argues that persuasive effectiveness depends on perceived expertise, trustworthiness, and attractiveness (Hovland & Weiss, 1951; Ohanian, 1990). While originally applied to celebrity endorsements, more recent studies show that SMIs are often perceived as more credible than institutional sources (De Veirman et al., 2017; Lou & Yuan, 2019). This credibility enhances message acceptance and facilitates trust transfer—especially in high-involvement contexts (Schouten et al., 2020). SMIs thus act not only as endorsers but as perceived experts whose views serve as heuristics, particularly when identity and values align with their audience.

Complementing this is the concept of **Parasocial Relationships (PSRs)**. Introduced by Horton and Wohl (1956), PSRs describe one-sided yet emotionally meaningful relationships between media figures and audiences. On social media, storytelling and behind-the-scenes content foster intimacy often perceived as personal recommendation (Labrecque, 2014; Tukachinsky & Stever, 2019). In the case of fitness influencers, Sokolova and Perez (2021) found that parasocial bonds significantly increase engagement, particularly among non-exercising individuals. Although direct links to behavior were not established, the sustained engagement may support motivation through emotional proximity.

The **Elaboration Likelihood Model (ELM)** adds a cognitive dimension. It proposes that persuasion occurs via either a central route—characterized by analytical message processing—or a peripheral route, which relies on heuristic cues like likability or emotional appeal (Petty & Cacioppo, 1986). SMIs frequently influence via the peripheral route, particularly among unmotivated or uninformed users—common in preventive health (Audrezet et al., 2020). Their

perceived authenticity and relatability serve as shortcuts to facilitate decision-making. Still, SMIs can also activate central processing through educational content, testimonials, or in-depth narratives, engaging users on a deeper level.

Social Learning Theory (SLT) introduces a behavioral lens, emphasizing that people learn by observing others—especially those perceived as relatable or admired (Bandura, 1986). Applied to SMIs, this suggests influencers serve as role models whose behaviors guide follower actions via observational learning (Farivar & Wang, 2022). The modeling effect strengthens when followers perceive high similarity and authenticity, enhancing self-efficacy and behavioral intent (Farivar & Wang, 2022; Schouten et al., 2020). As discussed in Section 2.1.3, low self-efficacy remains a key barrier in preventive health.

Finally, **Social Proof** highlights the role of perceived popularity and social consensus (Cialdini & Goldstein, 2004). Under uncertainty, individuals often rely on social validation. On social media, likes, comments, and testimonials signal peer approval and encourage behavioral conformity (Munnukka et al., 2016; Reinikainen et al., 2020). This is especially relevant for §20 SGB V courses, where visible social engagement can drive participation.

Taken together, these models demonstrate how SMIs activate both emotional and cognitive pathways. Their ability to generate trust, closeness, modeling effects, and social validation makes them compelling communicators—particularly in preventive health, where motivation and social reinforcement are often lacking. The next section explores whether different influencer types—namely health experts and relatable peers—engage distinct psychological mechanisms and thereby shape user perceptions and engagement patterns differently within the preventive health context.

2.2.3 Health vs. Peer Influencers: A Typological Comparison

Building on the psychological foundations outlined in the previous section, this study introduces a novel conceptual distinction between two types of social media influencers (SMIs) within the preventive health context: health influencers and peer influencers. To the author's knowledge, no prior research has systematically theorized this typology providing an original contribution to theory-building in digital health communication. While adjacent models in peer communication exist the definition of influencers as ‘peers’ in the sense of co-learning, non-expert public figures has not been formally theorized.

In certified §20 SGB V courses, the influencer does not replace the certified expert but complements them within a hybrid course design. This integration raises a strategic consideration: whether the influencer should be selected based on perceived expertise and topic fit, or instead on emotional proximity and audience relatability—each activating distinct persuasive mechanisms. The following section explores the psychological mechanisms each type activates—and under which conditions they may best support adoption.

Health influencers—such as fitness creators or mental health advocates—derive their persuasiveness primarily through perceived domain authority and topic-specific credibility (Sokolova & Perez, 2021). Based on the Source Credibility Model (Hovland & Weiss, 1951; Ohanian, 1990), their effectiveness hinges on expertise, trustworthiness, and message-content fit (Lou & Yuan, 2019). These figures lend educational legitimacy to the course and act as aspirational role models within the logic of Social Learning Theory (Bandura, 1986). From the perspective of the Elaboration Likelihood Model (Petty & Cacioppo, 1986), their presence activates the central route of persuasion, particularly for health-aware users who evaluate the course based on substantive arguments. However, this expert framing may also lead to psychological distance. Prior studies highlight that health influencers can intimidate or demotivate low-involvement users who lack prior health engagement or self-efficacy (Folkvord et al., 2020; Munnukka et al., 2016). Hence, health influencers tend to reinforce pre-existing intentions more effectively than they initiate motivation.

Peer influencers, in contrast, peer influencers are not defined by expertise but by relatability, authenticity, and emotional closeness (Munnukka et al., 2016; Schouten et al., 2020). They appear not as instructors but as co-learners, who visibly go through the course and share their journey. This framing could, in theory, enhance perceived similarity and a sense of closeness, particularly among hesitant or skeptical users (Farivar & Wang, 2022; Schouten et al., 2020). Through frequent personal storytelling and perceived interactivity, they are assumed to foster strong parasocial bonds (Tukachinsky & Stever, 2019), which may in turn support trust and emotional engagement. Under the ELM, peer influencers would likely activate the peripheral route of persuasion—appealing through heuristic cues such as likability and social resonance. While they may not convey substantive expertise, they could serve as motivational catalysts. Research suggests that in unfamiliar or low-involvement domains, similarity and trust—not expertise—are often the dominant drivers of message acceptance (Munnukka et al., 2016).

Moreover, by potentially reducing emotional barriers such as fear of failure or perceived inaccessibility, peer influencers may lower the threshold to engage.

Taken together, these two archetypes may activate distinct psychological mechanisms: health influencers activate central processing and convey legitimacy; peer influencers trigger peripheral cues and provide social reinforcement. In hybrid course formats—where certified experts ensure credibility—the incremental value of the influencer may lie not in expertise, but in motivational and emotional engagement. This perspective justifies the strategic use of peer influencers, particularly in §20 SGB V contexts, where preventive health often suffers from low involvement and uptake.

Figure 1 illustrates the proposed conceptual model, mapping the differential effects of health versus peer influencers within this hybrid design.

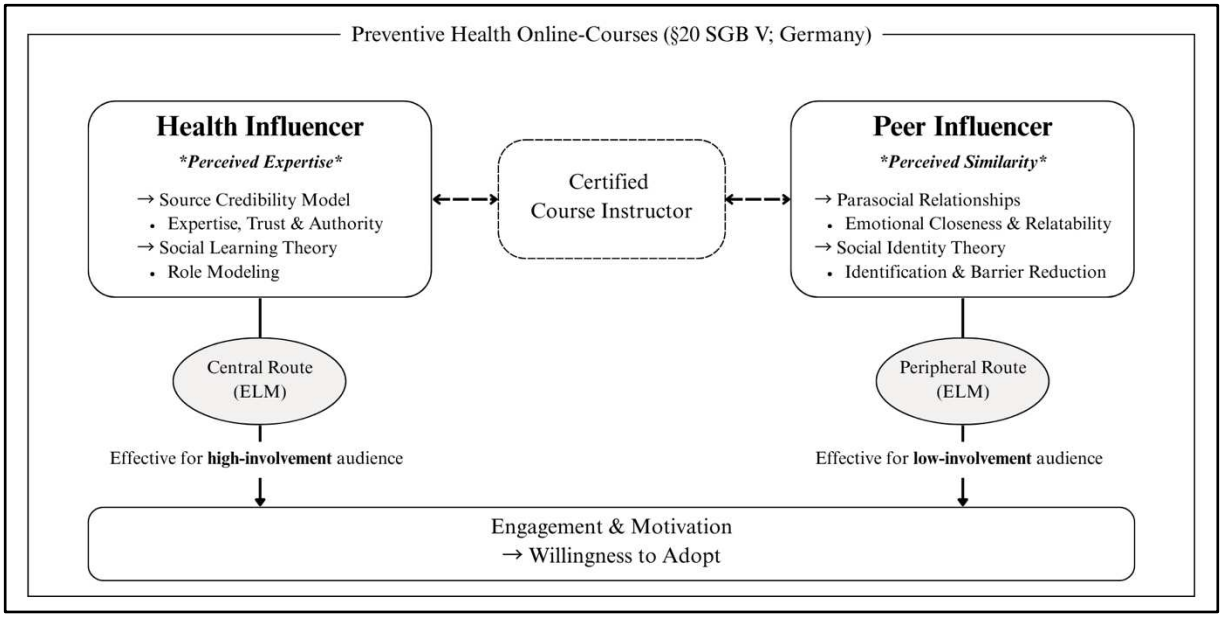

Figure 1 *Conceptual model of influencer typologies and their persuasion mechanisms*

Note. Original model developed by the author

While the assumed effects of both influencer types are grounded in existing literature, no prior study has systematically examined or compared their relative psychological effectiveness within hybrid learning environments that combine certified instruction and influencer integration. This thesis thus offers an initial theory-driven proposition to fill this gap.

The following chapter outlines the regulatory and industry context of the study, situating the proposed model within Germany's digital preventive health market under the §20 SGB V framework.

3 Industry and Market Analysis

3.1 The §20 SGB V Framework: Preventive Health Courses

As part of Germany's Social Code Book V (SGB V), §20 provides the legal foundation for a nationwide public–private partnership (PPP) model in preventive health promotion (see 2.1.2). Introduced in 1989 and expanded through the Prevention Act of 2015 (*Präventionsgesetz*), this provision mandates statutory health insurers to fund structured interventions, such as prevention courses, that foster health-promoting behaviors among their insured members (§20 SGB V, 1988; PrävG, 2015). Ultimately, §20 SGB V seeks to reduce lifestyle-related health risks and address social and gender-based disparities in health opportunities. Today, approximately 90% of the German population—around 74.7 million citizens (Federal Ministry of Health (Germany), 2025)—are eligible to participate in these subsidized preventive health programs, making the framework highly relevant from both a public health and market access perspective.

Under the §20 framework, private providers are authorized to conceptualize, develop, and market preventive health courses. Central to the operational structure is the *Zentrale Prüfstelle Prävention* (ZPP), a regulatory body jointly established by Germany's 170 statutory health insurance funds. The ZPP certifies these course programs according to central guidelines, ensuring alignment with scientific evidence, structured delivery, and measurable health promotion outcomes (GKV-Spitzenverband, 2024b).

Private providers submit their eligible course concepts to the ZPP for evaluation. Once certified, providers can market their programs directly to the public. Participants register for the courses independently and pay the course fee upfront. Upon successful completion, they receive a certificate that can be submitted to their statutory health insurer. Depending on the insurer's reimbursement policy, between 80% and 100% of the participation fee is then refunded to the participant. By appointing the ZPP as the centralized certifying authority, the insurers guarantee quality assurance across all preventive programs while facilitating broad accessibility (GKV-Spitzenverband, 2024b). Figure 2 summarizes the operational flow and stakeholder interaction within §20 SGB V-certified programs.

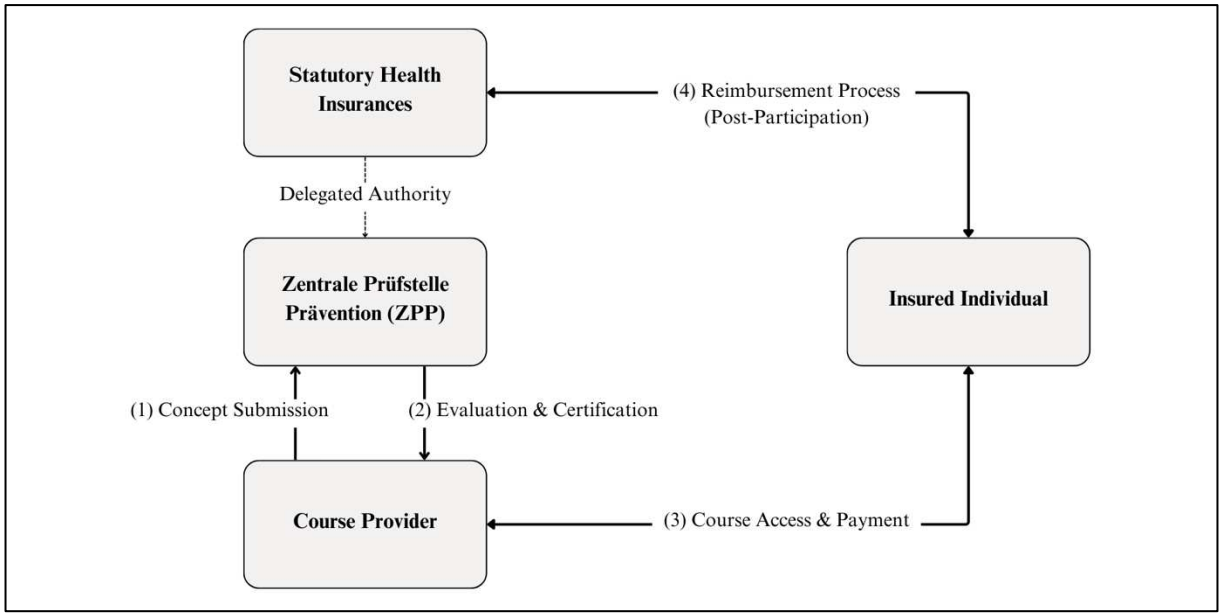

Figure 2 *Germany's §20 SGB V framework: Operational model & stakeholder roles*

Note. Own representation.

To qualify for approval, course concepts must adhere to a structured educational format—consisting of eight or ten weekly modules—and are explicitly designed to promote sustainable behavioral change by enabling participants to gradually integrate health-promoting routines into their daily lives (GKV-Spitzenverband, 2024a, 2024b). This objective closely aligns with the principles of Lifestyle Medicine discussed in Section 2.1.1, emphasizing not only knowledge transfer but the long-term adoption of healthier habits. In this context, the thematic scope of certified course programs is clearly defined by the *ZPP* across the four areas of primary prevention: physical activity, nutrition, stress and resource management, and substance use prevention. Table 1 provides a practical overview of these fields and examples of eligible course topics.

Table 1 *Overview: Certifiable Interventions Across §20 SGB V Prevention Areas*

Prevention Area	Principle	Sample §20 Interventions
(1) PHYSICAL ACTIVITY	Reducing physical inactivity	→ (Functional-) full-body training → Cardio & running programs
	Preventing & reducing health-related risks	→ Back-strengthening training → Pilates-based core training
(2) NUTRITION	Avoiding nutrient deficiencies & poor dietary habits	→ Nutrition for busy professionals → Vegetarian and pregnancy-specific nutrition
	Preventing & reducing overweight	→ Nutrition coaching for weight management → Metabolic training and dietary planning
(3) STRESS & RESOURCE MANAGEMENT	Multimodal stress & resource management	→ Mindfulness-based Stressreduction (MBSR) → Work-life balance and burnout prevention
	Promoting relaxation & recovery	→ Promoting healthy sleep → Hatha Yoga, Qigong, Tai Chi
(4) SUBSTANCE USE PREVENTION	Promoting non-smoking	→ Structured tobacco cessation coaching
	Responsible use of alcohol / Reducing alcohol consumption	→ Strategies for reduced alcohol consumption

Note. Adapted from ZPP classification criteria as outlined by GKV-Spitzenverband (2024a, 2024b). Own representation.

Beyond the course concept, a central requirement for certification is the involvement of an accredited and certified course instructor (GKV-Spitzenverband, 2024a). Contingent on the specific area of prevention, instructors must demonstrate verifiable expertise—typically through relevant academic degrees, professional qualifications, or accredited continuing education. According to the official certification guidelines, the following responsibilities are explicitly assigned to the course instructor: delivering educational content, motivating participants, facilitating reflection, and tailoring the course experience to individual needs (GKV-Spitzenverband, 2024b; Medizinischer Dienst Bund & GKV-Spitzenverband, 2024). Ultimately, this mandate ensures both didactic integrity and credible domain expertise, making the instructor a central pillar of §20 SGB V-certified programs.

Notably, the scope of the §20 SGB V framework was, until recently, limited to the certification of preventive health courses delivered in in-person group settings. A significant shift occurred only in 2020, when regulatory adjustments—introduced in response to the COVID-19

pandemic—allowed for the development and certification of fully digital course formats, commonly referred to in the German regulatory context as "IKT-courses" (Information and Communication Technology) (GKV-Spitzenverband, 2024b; Medizinischer Dienst Bund & GKV-Spitzenverband, 2024). While still relatively new, this regulatory shift represents a substantial innovation, allowing for more scalable, flexible, and barrier-reduced access to preventive health education. It also opens new strategic opportunities for private providers operating within the certified §20 framework.

Building on this institutional and regulatory foundation, the following section explores the emerging market of certified digital preventive health courses, highlighting current developments, demographic reach, and strategic growth opportunities for private providers.

3.2 §20 SGB V Online-Courses: Market Insights, Gaps and Strategic Opportunities

The introduction of digital course formats represents a notable expansion of Germany's highly regulated §20 SGB V framework, creating new opportunities for established providers and new market entrants. With more than 74 million individuals eligible for insurance reimbursement (Federal Ministry of Health (Germany), 2025), the framework now offers considerable potential for scalable, digital-first health promotion. Until recently, however, official participation data did not distinguish between traditional and online formats, limiting transparency around the scope, reach, and performance of this emerging submarket. For the first time, the latest *Prevention Report 2024* provides a systematic breakdown by delivery mode (Medizinischer Dienst Bund & GKV-Spitzenverband, 2024), offering valuable insights into how younger demographics engage with digital formats, informing the design of more targeted go-to-market strategies.

Early-Stage Market with Potential for Scale

This newly available data highlights the digital segment as an emerging but high-potential component of the broader market. The report reveals that in 2023, a total of approximately 110,000 certified prevention courses were registered across all formats (Prevention Report, 2024, p. 99). However, only 3,000 of these—less than 3%—were certified as digital offerings, highlighting the early-stage development of the online segment. Yet despite limited supply, online formats accounted for 22% of all 1.6 million participations recorded in 2023 (Prevention Report, 2024, p.12). Given their marginal share of total course offerings, this disproportionate

uptake indicates strong commercial viability through digital scalability. Notably, overall course participation increased by 25% between 2022 and 2023 —suggesting a broader growth trend and rising demand within the preventive health sector. Considering the total size of the eligible population, however, the market remains far from saturated.

Overrepresentation of Older Demographics in §20 Courses

A closer look at age-specific participation patterns reveals critical insights into the current reach, and limitations, of certified courses. Overall participation data, combining both delivery modes, reveal a pronounced age imbalance, as illustrated in Figure 2. In 2023, 57% of all course participants were aged 50 and above, with the 50–59 and 60–69 segments each representing more than 20% of the total user base (Prevention Report, 2024, p. 95). Compared to their respective population shares of 15% and 13.8% respectively (Statista, 2023a), these age segments are systematically overrepresented. In contrast, the 20–29 age group is notably underrepresented relative to its 11.1% share of the general population.

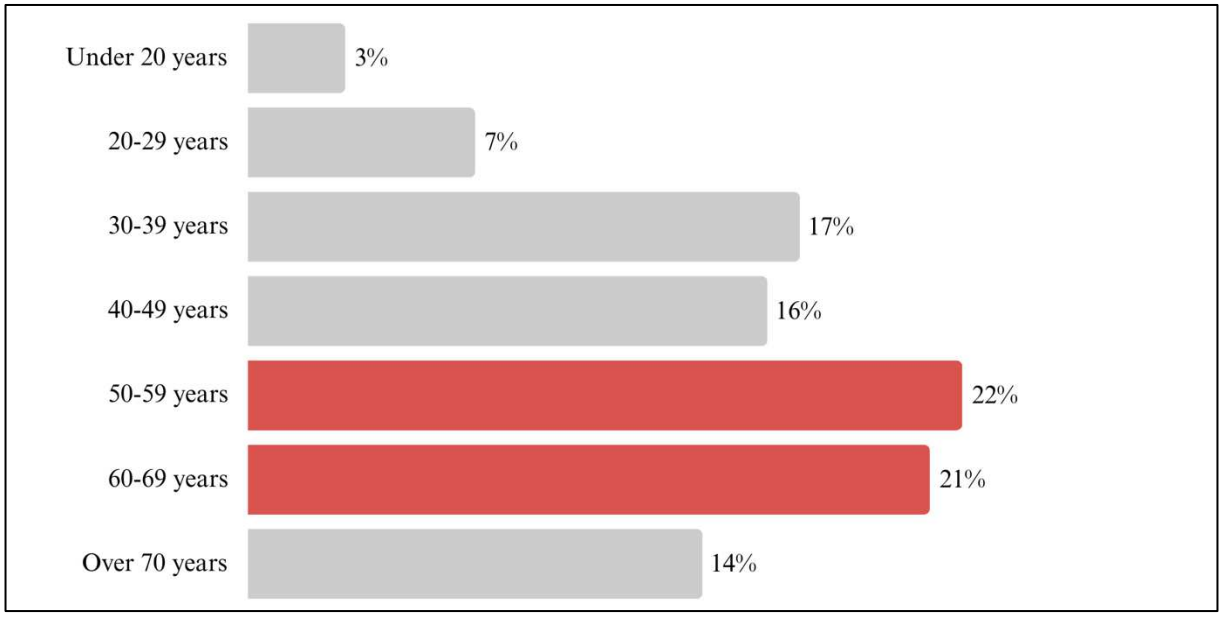

Figure 2 *Participation in §20 SGB V courses by age group (2023)*

Note. Based on data from Medizinischer Dienst Bund & GKV-Spitzenverband (2024), Präventionsbericht 2024.

This skewed pattern is critical in light of Section 2.1.2, where younger adults—especially those aged 20–40—were identified as a particularly high-impact group for early lifestyle interventions (Roca-Ventura et al., 2024).

Digital Formats: Increased Adoption Among Younger Audiences

A differentiated view by delivery mode reveals a more nuanced picture: the data reveal an encouraging demographic trend for digital offerings. For the first time, the Prevention Report (2024, p. 95) differentiates between digital and in-person course formats, revealing a significant shift in demographic adoption patterns. In 2023, 68% of all online participants were between 20 and 49 years old, with the 30–39 segment alone accounting for 29%. As illustrated in Figure 3, in-person formats remain the dominant delivery channel across all age groups. However, especially the segment aged 20–39 stands out with the highest relative adoption rate of online courses.

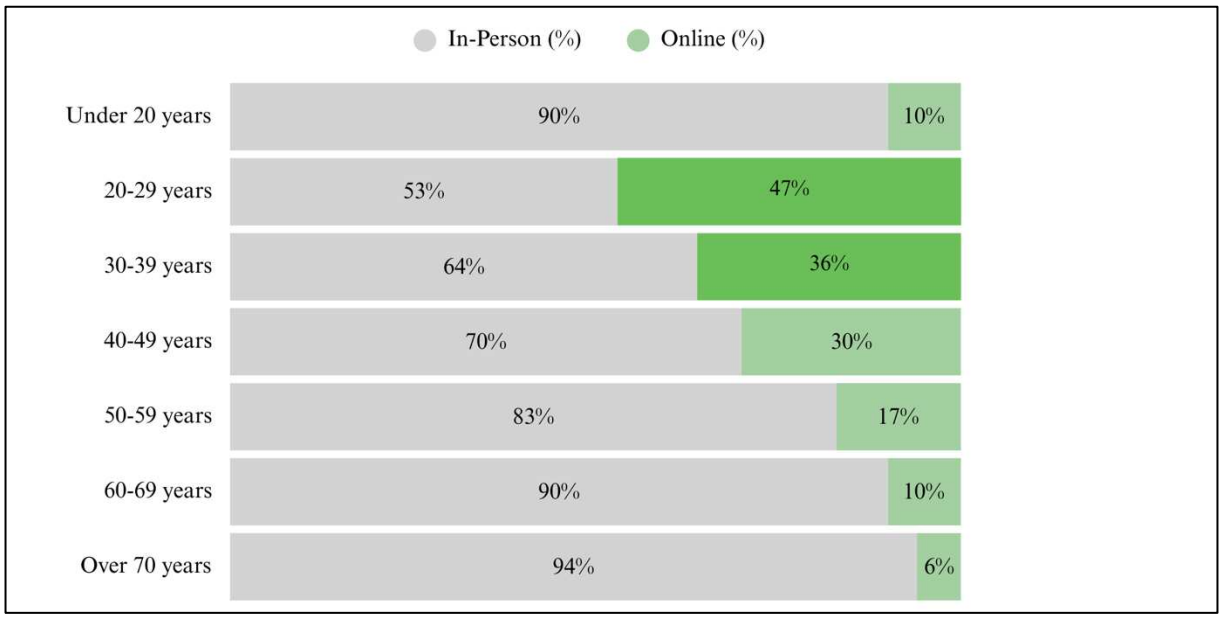

Figure 3 *Participation in online vs. in-person §20 SGB V courses by age group (2023)*

Note. Based on data from Medizinischer Dienst Bund & GKV-Spitzenverband (2024), Präventionsbericht 2024.

For practitioners, these patterns underscore the strategic relevance of younger adults as a distinct target segment in digital preventive health—supporting the theoretical foundations laid out in Sections 2.1.2 and 2.2.1 regarding their digital literacy, lifestyle preferences, and media habits.

Untapped Market Meets Behavioral Bottleneck

Despite these promising signals and inherent scalability, digital formats have yet to reach their potential in terms of market volume and adoption. The structural and financial access barriers

traditionally hindering PHB adoption—such as time constraints, geographic limitations, and out-of-pocket costs—have been largely addressed in the online segment through flexible access and insurance reimbursements (see Section 2.1.3). Therefore, the remaining adoption gap seems less a question of accessibility, and more a matter of psychological and motivational constraints.

As discussed in Section 2.1.3, low intrinsic motivation, lack of social reinforcement, and low self-efficacy remain key barriers of PHB (De et al., 2024; Hoskins et al., 2019). Together, this substantiates the need for innovative engagement strategies that effectively leverage digital formats to reach younger adults.

Regulatory Design with Embedded Opportunity

This creates a distinct opportunity for innovation within the regulatory boundaries of §20 SGB V. While the inclusion of a certified instructor remains mandatory—as discussed in Section 3.1—this role encompasses not only knowledge transfer, but also participant motivation, reflection, and personalization. In doing so, central psychosocial barriers are already partially addressed. However, the framework does not exclude the addition of complementary figures.

In this context, the integration of social media influencers (SMIs) offers a promising design innovation. As outlined in Sections 2.2.1 to 2.2.3, SMIs are particularly well suited to act as motivational companions—enhancing engagement via parasocial trust, relatability, and social reinforcement. Within co-learning environments, this role remains underexplored but could help overcome key motivational bottlenecks and increase adoption, particularly among younger adults aged 20–40 (see Sections 2.1.2 and 2.2.1).

To the best of the author's knowledge, such co-creation formats have not yet been implemented within certified digital prevention programs, nor systematically examined in academic research. While adjacent industries—such as digital learning platforms like *MasterClass* (n.d.) or *BBC Maestro (n.d.)*—have successfully introduced expert-led course formats in lifestyle and health topics, these models predominantly rely on authoritative instructors and reinforce the health influencer logic. In contrast, peer-based co-learning models remain largely untapped in both practice and research. This observed gap in both implementation and scholarship provides a compelling rationale for the empirical exploration that follows, laying the groundwork for the methodological framework presented in the next chapter.

4 Methodology

4.1 Research Design

This study applies a qualitative research design to explore how, whether and under what conditions SMIs can influence the perception and adoption of certified prevention courses among adults aged 20–40 in Germany. Given the psychological complexity and situational factors of the mechanisms involved, from emotional engagement to behavioral intentions, a qualitative approach is particularly suited to uncover dynamics behind participants' perceptions and decision-making (Silverman, 2017).

The analysis follows a structured qualitative content analysis according to Mayring (2015), which emphasizes theoretical relevance instead of statistical representativeness, enabling detailed, context-sensitive insights into the research problem. This approach was favored, as it allows for structured categorization of both deductive and inductive elements: pre-defined categories derived from the literature (Section 2) are combined with codes that emerged inductively during group interaction. It enables both theory-driven interpretation and openness to context-specific insights, essential given the exploratory aim of this study.

To examine these dynamics, focus groups were chosen as the primary method (Krueger & Casey, 2015). The group format encourages reflective engagement, contrasting views, and co-construction of meaning, making it effective for identifying participant perceptions, hidden barriers, and emotional reactions (Morgan, 1997). Each session followed semi-structured interview guidelines and included a sequence of visual stimulus mockups to compare the effects between course formats (standard expert-only, health influencer, peer influencer). The use of structured stimuli is recommended to provide a consistent framework for participant reflection and guide discussion in a focused but non-restrictive manner (Krueger & Casey, 2015; Mayring, 2015). This ensured comparability across groups while allowing spontaneous reactions and emergent insights.

4.2 Sampling Strategy

To capture diverse and relevant perspectives within the target demographic of younger adults in Germany, a purposive sampling strategy was applied (Patton, 2015). While statistical representativeness was not pursued, the selection aimed for theoretical relevance and

conceptual depth in line with qualitative research standards (Mayring, 2015). Inclusion criteria required participants to be aged 20 to 40, currently residing in Germany, and to reflect a balanced gender composition across groups. Prior experience with §20 SGB V programs was not questioned before the discussions, allowing for both uninformed and informed viewpoints to emerge.

A total of 43 individuals were contacted through the extended personal and professional network of the researcher by informal outreach. While this convenience-based access limits statistical generalizability, the selection logic followed clear purposive criteria aligned with the research aim.

Sampling was explicitly structured to ensure two groups per age segment (20–29 and 30–40), with a gender-balanced composition maintained within each group. A total of 26 individuals participated across four groups. Group sizes ranged from 5 to 8 participants, allowing for a balance between thematic breadth and conversational depth. The inclusion of larger and smaller groups was deliberate as larger groups enabled broader thematic coverage, while smaller sessions fostered more in-depth discussion and individual reflection (Krueger & Casey, 2015; Morgan, 1997). An overview of group composition is provided in Table 2.

Table 2 *Overview of focus group composition*

Focus Group	Age Group	Participants (n)	Female (n, %)	Male (n, %)
FG1	20-29	8	4 (50 %)	4 (50 %)
FG2	30-40	7	4 (57 %)	3 (43 %)
FG3	20-29	5	3 (60 %)	2 (40 %)
FG4	30-40	6	3 (50 %)	3 (50 %)
Total		26	14 (54 %)	12 (46 %)

The number of groups was guided by the principle of thematic saturation. As Krueger and Casey (2015) note, around 80% of themes typically emerge within two to three groups, and up to 90% within three to six groups. Based on this guidance, four focus groups were conducted to ensure broad thematic coverage and validate pattern stability (Guest et al., 2017). All participants joined voluntarily, provided informed consent, and were briefed on confidentiality and data protection in line with institutional standards.

4.3 Data Collection

All four focus groups were conducted online via Zoom between April and May 2025, each lasting approximately 90 minutes. To ensure accessibility and natural interaction, discussions were held in German. All sessions were recorded in audio and video and subsequently transcribed using the AI-based tool Turboscribe. The transcripts were then manually reviewed and cleaned to correct potential transcription errors and ensure verbatim accuracy, ensuring a reliable data basis.

Each session, moderated by the author, followed a semi-structured discussion guide (Appendix A) developed in accordance with the principles of structured qualitative content analysis (Mayring, 2015). The guiding questions were primarily derived deductively—based on relevant theoretical constructs as well as the specific research questions of this study—while also leaving space for new developments and spontaneous contributions. This combination allowed for the emergence of inductive insights in line with the methodological approach recommended by Mayring. This flexible yet systematic format is particularly suitable for exploratory research with complex subject matter (Kuckartz, 2014; Mayring, 2015).

To provide a shared frame of reference and stimulate reflection on the central phenomena, each session included a stimulus-based presentation. This consisted of a brief overview of the §20 SGB V framework, key preventive areas (exercise, nutrition, stress management), and typical course structure. The presentation further introduced three systematically varied course models (expert-only, health influencer, peer influencer). These formats are summarized in Table 3 and visually presented as neutral mockups (Appendix B). The moderator ensured that all three course model stimuli were discussed in equal depth. The use of structured stimuli is recommended to support understanding, ensure consistency across sessions, and guide group discussion without restricting spontaneous feedback (Krueger & Casey, 2015). The visual design was deliberately kept abstract to isolate the perceived roles without biasing responses through brand or aesthetic cues, and no real individuals were shown to avoid activating personal associations or pre-existing attitudes.

Table 3 *Overview of stimulus conditions*

Stimulus Condition	Description
(1) Standard	Course led solely by a certified course instructor (§20 SGB V); no influencer present.
(2) Health Influencer	Course led by a certified course instructor (§20 SGB V); supported by a health-focused influencer (e.g., fitness or mental health creator) who complements personal knowledge and acts as a motivational partner.
(3) Peer Influencer	Course led by a certified course instructor (§20 SGB V); joined by a non-health influencer (e.g., content creator or lifestyle figure) who learns alongside users as a relatable co-learner.

To avoid overextending the scope and introducing additional complexity, the addiction prevention domain was excluded from the stimuli to maintain thematic focus and comparability. The resulting transcripts served as the empirical basis for the qualitative content analysis detailed in Section 4.4.

4.4 Data Analysis

The analysis followed Mayring's (2015) structured qualitative content analysis, which combines theory-driven deduction with openness to inductive emergence. This method was chosen to systematically examine how different course formats influenced participant perceptions while remaining sensitive to unexpected, context-specific insights.

The material basis consisted of full transcripts from all four focus groups. Sentences and short paragraphs representing meaning-bearing units—defined by Mayring (2015) as self-contained semantic segments relevant to the research question—served as coding units. Transcripts were analyzed using NVivo software. An initial coding system was developed deductively, drawing from the study's research questions, theoretical framework (including the Elaboration Likelihood Model, source credibility, and parasocial interaction theory), and the discussion guide. These deductive categories were implemented as parent nodes (C0–C5, C7, C8). During coding, inductive subcategories were added whenever the material revealed new, recurring themes.

In line with Mayring's (2015) recommendation to revise the category system after 10–50% of the material has been reviewed, the framework was refined after analyzing 1.5 transcripts. This led to the creation of two additional main categories (C6 and C9). All previously coded material was revisited and revised where necessary to ensure conceptual clarity, theoretical coherence, and consistent application of coding rules. As illustrated in Figure 4, the final coding system comprised ten main categories and seventeen subcategories, organized hierarchically in NVivo.

MAIN CATEGORY	SUBCATEGORY (CODE LABEL)	CONTEXTUAL CODING
C0 - Prevention in Everyday Life	C0.1 - Conceptual & Emotional Associations with "Prevention" C0.2 - Relevance of PHB in Daily Life	
C1 - Contact to §20 PHB Programs	C1.1 - Awareness & Experience with Certified Programs C1.2 - Evaluation of §20 Course Model	
C2 - Barriers to PHB Adoption	C2.1 - Structural Barriers C2.2 - Socioeconomic Barriers C2.3 - Psychological & Behavioral Barriers	
C3 - Relatability & Identification	None.	S1, S2, S3
C4 - Trust & Credibility	None.	S1, S2, S3
C5 - Authenticity & Sincerity	None.	S1, S2, S3
C6 - Motivational Impact	C6.1 - General Engagement Drivers C6.2 - Involvement-Based Motivation	S1, S2, S3 S1, S2, S3
C7 - Comparison of Course Models	C7.1 - Influencer vs. Standard C7.2 - Standard C7.3 - Health Influencer C7.4 - Peer Influencer C7.5 - Strategic Model Fit (ELM-Based)	
C8 - Adoption Willingness	None.	S1, S2, S3
C9 - Emerging Adoption Drivers	C9.1 - Structural Motivation Features C9.2 - External Incentives & Value Triggers C9.3 – Format & Content Innovation	

Figure 4 *Overview: Final category system (C0-C9)*

To differentiate responses by course format, an additional layer of contextual stimulus coding (S1–S3) was applied in selected categories. These model-specific markers—used in parallel with thematic codes—enabled a comparative analysis across the three stimulus conditions and align with best practices in multidimensional coding (Kuckartz, 2014). A detailed overview—including category definitions and exemplary anchor quotes—is provided in Appendix C in

accordance with Mayring's (2015) procedure. Coding reliability was enhanced through repeated reviews and theoretical cross-checks, allowing for overlapping codes when contextually justified and ensuring a valid analytical basis for the findings presented in Chapter 5.

5 Empirical Findings

5.1 Framing of "Prevention" Among Young Adults

All statements analyzed in this section were given before the presentation of any stimulus materials, reflecting participants' baseline attitudes toward the concept of prevention. Findings from categories C0.1 and C0.2 show that the term "Prävention" in the German context elicited indifference or rejection, particularly among younger adults (20–29), despite widespread endorsement of health-conscious behaviors.

Across all focus groups, the term was perceived as abstract, institutional, or associated with older generations. While many participants actively pursued health-related habits, they did not identify them as "preventive". Instead, they associated the term itself with bureaucracy, illness, and aging:

> "Prevention to me sounds like something from an insurance brochure—some kind of buzzword, but not something that plays a role in my actual life." (FG2, 30–40)

> "Mainly older people—I associate it with age. And I'm young, so I feel like I don't need it." (FG1, 20–29)

Rather than a lack of relevance, this disconnect appeared to stem from a linguistic and emotional mismatch. Many participants described behaviors like exercising, cooking at home, or taking mental breaks as essential to their wellbeing—just not as "prevention":

> "I work out regularly, try to eat healthy and sleep well. But I'd never call that prevention." (FG2, 30–40)

Notably, participants across age groups expressed a preference for framings focused on emotional benefits and functionality over risk avoidance:

> "They should say what it's actually good for—like helping with stress or just feeling better." (FG3, 20–29)

Younger adults in particular emphasized the importance of feeling balanced and staying functional, but distanced themselves from the formal connotation of prevention:

> "It helps me stay balanced. But I wouldn't call it preventive health." (FG1, 20–29)

> "If you say 'do this because it's preventive,' people immediately think about diseases. But if you say, 'you'll feel better afterwards,' then people might actually listen." (FG4, 30–40)

In sum, preventive behaviors were common but not labeled as such. The institutional framing of prevention failed to resonate emotionally or semantically, highlighting a critical communication gap in reaching younger demographics.

5.2 Perception of the Certified Course Model & Adoption Barriers

This section analyzes participants' perceptions of the certified online course model presented during the focus groups. All statements were made after a brief explanation of the structure and reimbursement logic of §20 SGB V. The analysis integrates insights from C1.1 (awareness and experience), C1.2 (evaluation), and C2 (barriers).

Awareness and Evaluation of the Certified Model (C1.1 & C1.2)

Awareness of certified §20 programs was generally low. Most participants had no direct contact with such offerings:

> "I'm honestly not in touch with that at all. Maybe something about it from the health insurance once, but otherwise not really." (FG1, 20–29)

If awareness existed, it was often tied to older family members or traditional offline formats:

> "I know my mom once did one of those courses, but that was offline—still reimbursed by insurance, though." (FG4, 30–40)

Online versions were unfamiliar to most:

> "I know these kinds of things exist offline. But I didn't know you could do that online too." (FG4, 30–40)

However, participants reported frequent exposure to unregulated wellness content on social media:

> "Everyone's selling online courses these days. You see ads everywhere—but never for certified prevention programs." (FG2, 30–40)

While unfamiliar, the certified model was positively evaluated once explained. Participants perceived official certification and reimbursement as trust-building features that distinguished it from commercial offerings:

> "There's so much out there on YouTube, but this feels official. That stamp matters." (FG3, 20–29)

Yet trust alone was seen as insufficient. Relevance, content quality, and usability were emphasized:

> "If it's just 120 healthy recipes, I'm out. But if it teaches me how to build habits, then I'm in." (FG2, 30–40)

The digital format offered flexibility but also raised concerns about discipline and screen fatigue:

> "After a day at the screen, I don't want more Zoom fatigue." (FG1, 20–29)

Participants also noted practical frictions, such as upfront payments and reimbursement procedures:

> "The refund is great in theory, but having to pay upfront and do paperwork later feels a bit much." (FG4, 30–40)

In sum, the certified course model was perceived as credible and fair—but not inherently motivating. Emotional connection and ease of integration were seen as essential.

Adoption Barriers and Participation Hurdles (C2)

While participants expressed openness toward preventive health behaviors, they also identified a range of barriers that hindered actual engagement. These included structural, socioeconomic, and—most dominantly—psychosocial constraints. As discussed in Section 2.1.3, behavioral inertia, low urgency, and limited perceived self-efficacy are well-documented inhibitors of preventive action. The current findings clearly align with these theoretical insights (Table 4).

Table 4 *Summary of barriers to preventive health behavior by type*

Barrier Type	Coded References	Core Themes
Structural (C2.1)	16 (30%)	Time pressure, competing priorities
Socioeconomic (C2.2)	12 (22%)	Upfront payment, bureaucracy
Psychosocial / Behavioral (C2.3)	26 (48%)	Motivation, urgency, self-efficacy, social context

Time constraints and life stress were commonly cited as limiting factors, particularly among full-time workers and students. Even though the digital format was appreciated for its flexibility, it did not fully mitigate these challenges:

> "I'd love to do something like this, but I just don't have the time to sit down regularly for eight weeks." (FG1, 20–29)

Participants described their days as overloaded, leaving little space for planned self-care routines. Nevertheless, online access was seen as a helpful enabler, especially for those in rural areas or with changing schedules.

Financial and Administrative Frictions

While reimbursement was viewed positively, several participants found the administrative process daunting. The requirement to pay upfront and complete the course before receiving a refund created hesitation:

> "You have to pay first, finish everything, upload proof, and then hope it gets refunded. That just puts me off." (FG3, 20–29)

Such frictions were not seen as deal-breakers, but as disproportionate hurdles given the perceived effort required—especially among those unfamiliar with health system procedures.

Psychosocial and Behavioral Bottlenecks

By far the most prominent theme, psychosocial barriers revealed deep-seated motivational challenges. Participants frequently mentioned a lack of urgency or emotional immediacy:

> "I know I should do something, but it never feels urgent enough." (FG3, 20–29)

"There’s no instant benefit in prevention. You don’t feel anything right away—that makes it hard to commit." (FG4, 30–40)

Even those with generally health-conscious lifestyles questioned whether a course felt necessary:

> "I do sports regularly, eat well. Why would I need a course unless something happens?" (FG3, 20–29)

Another barrier was the absence of social reinforcement. Without external motivation or peer involvement, engagement felt fragile:

> "If you don’t have someone pushing you or doing it with you, it’s easy to just drop out." (FG2, 30–40)

These observations underline a central insight: while structural and financial factors may shape access, the real bottleneck lies in internal activation. The data confirm that without emotional salience, social support, and a strong sense of personal relevance, preventive behavior remains aspirational rather than habitual.

5.3 Evaluation of Stimulus-Based Engagement Factors

This section analyzes stimulus-specific reactions to the three presented models: (1) the standard course model with a certified expert, (2) the health-influencer model, and (3) the peer-influencer model. It draws on categories C3 (Relatability & Identification), C4 (Trust & Credibility), C5 (Authenticity & Sincerity), and C6 (Motivational Impact). To enable structured comparison, all statements are contextualized based on the referenced model.

Relatability & Identification (C3)

Relatability emerged as a central factor influencing emotional connection and psychological accessibility. The standard model was perceived as competent but remained emotionally distant. Health influencers were seen as aspirational and familiar, yet their high competence could create a sense of separation.

> "It would be cool if the influencer wasn’t acting like a teacher, but more like a learner—getting the input and trying it out, just like I would." (FG1, 20–29)

This desire for shared experience was fully realized in the peer-influencer model, which consistently received the highest scores for emotional closeness. The idea of "learning together" resonated deeply with participants:

> "I would personally feel more supported. If I'm struggling, it helps to see someone else struggle too." (FG2, 30–40)

> "You feel like you're doing it together. When the influencer is also new to it, I feel less intimidated and more seen." (FG3, 20–29)

In summary, peer influencers activated identification more effectively than the other models, which participants described as a key condition for initial motivation—especially for less health-experienced users.

Trust & Credibility (C4)

Trust was primarily anchored in certified expertise. Regardless of the model, participants emphasized the importance of a qualified expert to ensure professionalism and legitimacy:

> "I think it's fundamentally important. I wouldn't do it if there wasn't a certified person behind it, otherwise I could go back to YouTube." (FG1, 20–29)

However, influencers introduced an additional layer of emotional credibility. Health influencers were perceived as more trustworthy than peers due to thematic alignment and domain knowledge:

> "A food blogger might give me more confidence that the meals will actually work in everyday life. I'd trust that more than a nutritionist who's just into the science." (FG2, 30–40)

By contrast, peer influencers triggered concerns about competence and structure:

> "If you put someone there who's completely lost […] and they just keep saying how hard it is […] then I feel like I'm not actually learning anything." (FG3, 20–29)

Still, their inclusion was accepted—if clearly positioned as learners, not leaders:

> "As long as the peer influencer joins in but isn't the one leading it, I don't really see a problem." (FG2, 30–40)

Overall, certified experts remained the primary trust anchor. Health influencers enhanced trust through topic alignment; peer influencers required clearer framing to avoid confusion.

Authenticity & Sincerity (C5)

Authenticity referred to emotional sincerity and perceived motive. The standard model was not questioned in this regard. Health influencers benefitted from reputational pressure and thematic coherence:

> "A health influencer has more to lose. If they talk nonsense, it damages their whole brand." (FG3, 20–29)

Peer influencers required additional justification. Their authenticity depended on visible motivation and consistency:

> "It's important to me that I take it from the person that they also have this struggle […] I'd believe that he really wants to change something." (FG4, 30–40)

> "If they've done five different partnerships in five weeks, I won't buy it. But if they stick with something, it feels more real." (FG1, 20–29)

In short, health influencers were presumed authentic; peer influencers had to demonstrate it through narrative alignment and continuity.

Motivational Impact (C6)

Unlike the prior sections, which focused on individual dimensions of persuasion, this section explores the motivational pull of each model. Two subcategories emerged: general engagement drivers across all groups (C6.1) and motivation patterns depending on user involvement and topic readiness (C6.2).

General Engagement Drivers (C6.1)

Influencer presence consistently made the course feel more engaging and emotionally accessible. Participants described the expert-only model as dry or overly didactic:

> "If it's just one expert talking at me, I zone out. But if there's someone reacting or asking things, I stay with it." (FG2, 30–40)

The co-presenter format—with either health or peer influencers—was likened to familiar online formats such as YouTube or podcasts:

> "Especially [for] our generation, this could give it more of a YouTube character, which would make it easier to consume, I believe." (FG1, 20–29)

> "It feels more fun and less like a lecture when two people are involved." (FG3, 20–29)

This was particularly true for the peer-influencer model, which felt lighter and more relatable:

> "I'm definitely with the peer influencer. Professionalism [with health influencers] is a hurdle for me, because it quickly becomes very dry for me [...]. I can now understand the point about the funny element more and more —it's becoming increasingly important to me. If it's a person from outside the field, then this high-quality prevention course feels like more than just work; it might actually be a bit more entertaining." (FG4, 30–40)

While entertainment was valued, participants stressed the importance of maintaining educational substance:

> "It shouldn't turn into a show. It still has to teach something real." (FG2, 30–40)

Involvement-Based Motivation (C6.2)

Participants' motivational responses varied based on prior involvement and topic sensitivity. Health influencers were most effective for already engaged users:

> "If I'm already into fitness or healthy eating, I want someone who brings more experience—not someone learning with me." (FG2, 30–40)

Peer influencers were considered more suitable for hesitant or new users:

> "If someone's also struggling or just starting out, I don't feel so alone. It makes it easier to get going." (FG3, 20–29)

A key insight was the peer model's potential to reach hard-to-reach segments:

> "But if you take [a peer influencer] who doesn't really have anything to do with it, then you're actually reaching exactly the people you want to reach. Namely those who haven't really had any interest in it yet and should actually be doing something. They're harder to convert, of course, but they're actually the ones you want." (FG1, 20–29)

In summary, peer influencers lowered psychological entry barriers and fostered emotional accessibility, while health influencers appealed to competence-oriented audiences. Effective engagement strategies should match influencer type to user readiness and motivational profile.

5.4 Adoption Readiness and Model Preferences

Influencer Integration as a Relevance Catalyst (C7.1)

Across all focus groups, the integration of influencers was not only well received but seen as a critical lever to increase relevance and awareness among younger demographics. Participants consistently described traditional preventive health formats as invisible or emotionally distant—whereas influencer-led models sparked attention, reduced psychological entry barriers, and created an initial sense of connection:

> *"I think it's generally really good to combine this with some kind of influencer, because I think that's the best way to reach the younger target group and create more awareness. And I think such an approach is great."* (FG3, 20–29)

While health-related credibility remained anchored in the certified expert, the influencer's role was widely understood as an emotional bridge—enhancing discoverability, motivation, and narrative engagement.

Model Preferences and Contextual Fit (C7)

When asked to evaluate the presented models directly, participants overwhelmingly favored influencer-based formats over the traditional expert-only approach. However, preferences between **health** and **peer** influencers were highly context-sensitive. Health influencers were generally seen as credible and aspirational—especially in domains like exercise or nutrition, where participants already had routines or pre-existing knowledge. In contrast, peer influencers were perceived as more approachable and emotionally resonant in areas of low involvement or stigma—most notably mental health.

> *"I'd probably split it by topic. For fitness and nutrition, I'd prefer a health influencer. But for mental health, it needs to feel safe—more like someone I can relate to."* (FG2, 30–40)

This distinction mirrored the involvement-based dynamics previously observed (C6.2): peer influencers lowered the barrier to action and appealed to hesitant users, while health influencers reinforced existing motivation in already engaged individuals.

Willingness to Participate: A Conditional Commitment (C8)

When prompted explicitly about their intention to participate in a certified course, most participants expressed conditional openness. While many welcomed the concept in principle, actual adoption hinged on topic relevance, perceived self-efficacy, and individual need. Some participants felt "too advanced" or not sufficiently targeted:

> *"Honestly, I already work out and eat well. I don't think I need a course."* (FG3, 20–29)

Others, particularly those struggling with stress or lacking structure, showed high willingness to engage—especially when the influencer format offered emotional resonance and accessibility:

> *"For stress, absolutely. That's where I actually need help."* (FG1, 20–29)

Importantly, topic choice influenced not only interest, but model preference. In more distant domains such as mental health, the peer influencer was repeatedly named as the most suitable figure to inspire action:

> *"I'd say 90–95% of the time, I'd probably go for the peer influencer."* (FG1, 20–29)

While individual comments varied in tone and emphasis, there were no systematic differences in model preferences or adoption willingness between the 20–29 and 30–40 age groups. Both groups expressed comparable engagement patterns, with only minor nuances regarding entertainment value and structure preferences.

In sum, while influencer integration was broadly endorsed, actual behavioral intent remained segmented. Relevance, timing, and personal readiness were decisive, underscoring the importance of fit between influencer type, topic, and user profile. These dynamics offer a practical foundation for the discussion that follows, which integrates these findings into broader strategic and theoretical implications.

6 Discussion

6.1 Addressing RQ1: How SMIs Bridge the Gap in Preventive Health Adoption

To understand how influencer collaborations might increase the adoption of §20 SGB V-certified preventive health courses among younger adults (aged 20–40) in Germany, it is essential to first clarify the underlying problem. As outlined in the literature (Section 2.1.3), preventive health behaviors are often hindered by structural, financial, and psychosocial barriers. While the §20 SGB V framework and its recent digitization addresses many structural and financial challenges—especially for digital-native younger audiences (see Section 3.1)—actual participation within this group remains markedly low (Section 3.2).

The focus group findings confirm that psychosocial barriers remain the central bottleneck. Participants across all groups reported a fundamental lack of identification with the term “prevention” and an emotional distance from the topic itself (see Section 5.1). In addition, awareness of certified digital courses was remarkably low, and the programs were rarely seen in personal media environments (see Section 5.2). This underscores the need for a mechanism that not only informs but emotionally connects and motivates.

In this context, Section 2.2.2 outlines that social media influencers (SMIs) possess a unique set of psychological persuasion mechanisms—such as parasocial closeness (Horton & Wohl, 1956), social learning (Bandura, 1986), and trust-based credibility (Lou & Yuan, 2019; Schouten et al., 2020)—which are particularly powerful in high-resistance domains like preventive health. Notably, this thesis does not view influencers as mere marketing tools. Instead, it explores a novel co-experience model, in which influencers are integrated directly into the course format to complement the mandatory role of the certified instructor—either by offering peer-level relatability or by enhancing thematic engagement.

Focus group data suggests that this integration allows influencers to activate precisely those mechanisms theorized in the literature. Compared to the standard course model, both the health influencer and peer influencer formats scored higher in perceived relatability and identification (Category C3, see Section 5.3). This emotional proximity appears to lower psychological entry barriers and helps reframe the course as accessible and personally relevant.

Importantly, trust in the overall course did not diminish through influencer involvement. On the contrary, many participants described a diffuse sense of increased trust when influencers were present—especially when those were perceived as authentic and value-driven (Category C4 & C5). While health influencers benefited from topic credibility, peer influencers required a clearer display of intrinsic motivation to be perceived as sincere (see Section 5.3).

Where these conditions were met, the motivational effect—an essential precondition for adoption—was consistently higher across both influencer models (Category C6). In addition, participants overwhelmingly preferred these formats over the traditional model (see Section 5.4). Beyond motivational uplift, participants also described the influencer as a kind of “translator” or “emotional anchor” who could contextualize the abstract idea of prevention and increase its personal resonance (Section 5.4).

This interpretation is further supported by inductive insights: participants frequently stated that they had never seen or heard of such programs before, but that they would likely engage with them if introduced by a familiar figure in their digital ecosystem (see Section 5.2). Thus, the influencer may serve as both a mental entry point and an emotional motivator.

In sum, while this thesis does not claim causal proof, the alignment between psychological theory, observed participant reactions, and adjacent market precedents suggests that the integration of influencers into preventive health courses represents a highly promising lever to address motivational, emotional, and perceptual barriers among younger adults.

6.2 Addressing RQ2: Adoption Willingness in Influencer-Based Formats

Secondly, this chapter examines whether the integration of social media influencers (SMIs) into certified preventive health courses increases willingness to adopt among younger adults (aged 20–40) compared to traditional expert-led models. Building on the psychosocial mechanisms outlined in 6.1, this section focuses specifically on declared motivation and expressed adoption intent among participants. While barriers such as limited perceived need and lack of motivation remain central constraints (see Section 5.2; Category C2), the question here is whether influencer-enhanced formats can activate willingness to adopt despite underlying motivational frictions.

From a theoretical perspective, the elevated willingness to adopt observed in the focus groups can be linked to established mechanisms of social influence. Parasocial interaction theory (Horton & Wohl, 1956; Tukachinsky & Stever, 2019) helps explain why participants felt a stronger emotional connection and perceived support in influencer-integrated models. This sense of familiarity and non-judgmental presence reduced psychological resistance. Additionally, concepts such as observational learning (Bandura, 1986) and social proof (Cialdini & Goldstein, 2004) shed light on how influencers can normalize participation and model behavior in a way that lowers internal barriers. This effect was particularly pronounced in the peer influencer condition, where perceived similarity and shared struggles lowered internal barriers and evoked reactions such as: “If they can do it, so can I.” While the elaboration likelihood model (Petty & Cacioppo, 1986) was not the focus here, it is relevant in the background insofar as SMIs appear to activate peripheral motivational pathways—particularly for audiences with low initial involvement.

Empirical findings from the focus groups strongly support the notion that SMI formats are perceived as more engaging, relatable, and emotionally resonant than the standard course model (see Categories C6.1 and C7.1). Participants described these models as less formal, more dynamic, and closer to the kind of digital environments they engage with in everyday life. Particularly the peer influencer format was seen as humorous and accessible—provided the influencer's motivation was perceived as authentic (see Category C5). Across groups, participants emphasized that the SMI presence introduced a sense of entertainment and narrative that contrasted positively with the "lecture"-like feel of the standard model.

Importantly, this perceived motivational uplift translated into clear model preferences: participants consistently favored the two influencer-integrated versions over the traditional expert-only model (see Section 5.4). However, preference alone does not equate to willingness to adopt. To probe this more explicitly, participants were asked at the end of each session whether they would consider participating in the respective formats. As shown in Category C8, willingness to adopt was indeed significantly higher for the influencer models—but only under the condition that participants perceived a personal need or relevance. For individuals who expressed no health concerns or change motivation, even SMIs could not shift intent. However, among those with a basic interest in the topic or a latent desire for change, the influencer formats clearly increased declared willingness to act—across both age groups.

In sum, while SMIs are not a universal solution to overcome all adoption barriers, they demonstrably raise willingness to adopt when there is a pre-existing motivational foundation. Their ability to reshape course perception, increase emotional resonance, and create social proximity appears to enhance not only model preference but also adoption intent. Given the additional reach and visibility that influencers can offer, especially among digitally immersed younger adults, it is reasonable to assume that their integration meaningfully increases the likelihood of adoption in relevant segments.

Beyond these model-specific findings, the focus groups surfaced several participant-driven ideas for increasing adoption willingness—captured inductively in Category C9. These suggestions clustered around three domains: motivational design features (e.g., gamification elements), social formats (e.g., completing courses with friends or shared challenges), and tangible incentives to enhance perceived course value. As one participant noted:

> "If I received something physical for signing up—like a yoga mat or a healthy eating kit—that would feel like a bundle I'd actually be really excited about." (FG3, 20–29)

While not directly related to the influencer-driven formats, these ideas reflect broader structural expectations and value-based adoption drivers. Given the bureaucratic effort—particularly around reimbursement in §20 SGB V courses—highlighted as a minor yet recurring barrier, such nudges and structural features may help tip the balance from passive interest to actual adoption, especially among younger adults.

6.3 Addressing RQ3: Engagement Pathways – Health and Peer Influencers

This section explores the comparative effectiveness of peer influencers and health influencers in fostering engagement within §20 SGB V-certified preventive health courses. While Chapters 6.1 and 6.2 established the overall effectiveness of influencer integrations, this chapter specifically addresses differences between the two influencer typologies. As theoretically assumed in Section 2.2.3 and empirically validated through the focus groups, each influencer type leverages distinct psychological mechanisms of persuasion. In the following comparative analysis, the theoretical model is examined from two complementary perspectives: a top-down approach based on identified psychological mechanisms (Section 5.3), and a bottom-up approach based on participants' varying involvement levels (Section 5.4).

The conceptual model proposed in Section 2.2.3 suggests that peer influencers primarily operate through peripheral routes of persuasion, characterized by high relatability and parasocial interactions (Petty & Cacioppo, 1986; Tukachinsky & Stever, 2019). In contrast, health influencers leverage central routes involving credibility, expertise, and perceived authority (Lou & Yuan, 2019; Schouten et al., 2020). The empirical findings from the focus groups (Categories C3–C6, Section 5.3) strongly confirm this theoretical differentiation. Participants consistently described peer influencers as more relatable, approachable, and authentic, provided their intent was perceived as sincere. These observations strongly reflect the mechanisms described by Horton and Wohl (1956) concerning parasocial connections. Health influencers, conversely, were predominantly recognized for their expert status and credibility, aligning closely with central-route processing as proposed by Petty and Cacioppo (1986).

Critically, the comparative effectiveness of each influencer type varied substantially depending on participant involvement levels. Participants demonstrating higher prior knowledge or existing interest in preventive health topics expressed a clear preference for health influencers, attributing their choice to the influencers' expertise and credibility, which align closely with central processing mechanisms (Lou & Yuan, 2019). Conversely, participants with lower involvement levels—characterized by limited prior knowledge, reduced self-efficacy, and emotional detachment from preventive health—responded more positively to peer influencers. The peer influencers' relatability and emotional accessibility evidently lowered psychological entry barriers and enhanced initial engagement, as evidenced by clear participant preferences and adoption readiness expressed in Section 5.4.

Combining these insights, the theoretical model developed in this thesis finds strong empirical support and provides a useful way to segment audiences based on their level of involvement. Strategically, however, the greater potential impact lies not with individuals already motivated or knowledgeable but with previously disengaged audiences. It is precisely in these low-involvement segments where peer influencers demonstrate their unique strategic value. By providing emotional accessibility and relatability, peer influencers effectively bridge the motivational gap, converting passive interest into active participation. While benchmark models in adjacent industries, such as *MasterClass* or *BBC Maestro* (Section 3.2), predominantly utilize influencers that leverage central routes of persuasion (aligning with health influencer typologies), the validated peer-influencer model presented here constitutes an original contribution with significant potential for expanding the reach of preventive health initiatives.

This strategic potential is captured succinctly by one participant:

> “But if you take [a peer influencer] who doesn’t really have anything to do with it, then you’re actually reaching exactly the people you want to reach. Namely those who haven’t really had any interest in it yet and should actually be doing something. They’re harder to convert, of course, but they’re actually the ones you want.” (FG1, 20–29)

In conclusion, both influencer typologies prove effective in driving engagement but under different scenarios. Yet, given the distinct demands of behavioral change in preventive health—often marked by low self-efficacy, limited intrinsic motivation, and low involvement—the peer influencer emerges as particularly effective in reaching the disengaged audiences that traditional models struggle to activate.

6.4 Theoretical Contributions

This thesis advances the theoretical understanding of how social media influencers can be embedded into certified preventive health programs—not only as promotional figures, but as integral elements of the intervention design. While previous research has explored the persuasive power of influencers in lifestyle and consumer health settings, their structured use in regulated programs like §20 SGB V remains largely unexplored.

To address this gap, the thesis proposes and empirically supports a new conceptual model that suggests two distinct influencer typologies: health influencers as expert-driven communicators and peer influencers as emotional co-learners. Building on established theories, most notably the Elaboration Likelihood Model (Petty & Cacioppo, 1986) and parasocial interaction theory (Horton & Wohl, 1956; Tukachinsky & Stever, 2019), the model helps to explain and frame psychological mechanisms of persuasion in preventive health contexts, where behavior change is highly contingent on psychological readiness, perceived relevance, and contextual fit.

The resulting typology not only clarifies how different influencer formats activate distinct routes of persuasion but also introduces a segmentation logic based on audience involvement levels. The model was developed and tested specifically among younger adults (aged 20–40), a digitally native demographic that has proven particularly difficult to engage in preventive health behaviors. This focus enhances the model's conceptual relevance for examining consumer psychology in health interventions targeting historically under engaged populations.

By conceptualizing influencers as embedded co-creators within certified public health programs—and translating this role into a theoretically grounded model—this thesis contributes a new perspective to the literature on digital health communication. It reframes influencers as strategic facilitators of access and motivation, particularly for hard-to-reach audiences, and offers a foundation for future research across adjacent domains.

6.5 Managerial Implications

The findings of this thesis offer clear guidance for providers of certified online preventive health courses under §20 SGB V—particularly those aiming to engage younger adults between 20 and 40 years of age. Despite this group's growing health awareness, they remain largely disconnected from traditional prevention offerings, which are often associated with

older demographics and illness-focused framing. Existing courses frequently fail to create emotional relevance or motivational pull for this audience, leaving a wide gap between intention and participation.

This study demonstrates that the integration of social media influencers into preventive health formats can help close that gap. Influencers act as attention drivers, create emotional access, and help reduce psychological entry barriers. Across all focus groups, courses featuring influencers—regardless of type—were consistently preferred over the traditional expert-only model. This indicates a clear need for supply-side innovation in how courses are designed and communicated.

At the same time, the results underline the importance of strategic segmentation. Health influencers work best for target audiences who already have a connection to the topic and are looking to deepen their engagement. Peer influencers, in contrast, offer a low-threshold entry point and are particularly effective for those who have engaged little with the topic themselves—be it mental health, nutrition, or physical activity—and feel distant from traditional health communication.

Providers are therefore advised to tailor their course concepts to the involvement level of their target group. By adding a suitable influencer alongside the certified expert, they can increase both the reach and emotional impact of their offerings—making them more relatable, motivating, and ultimately more likely to drive adoption.

6.6 Limitations and Future Research

While this thesis offers important insights into the integration of influencers in certified preventive health courses, several limitations should be noted. First, the study is based on a qualitative focus group design. It was intended to generate exploratory insights; statistically generalizable effects cannot be inferred. The results offer strong indications but require further empirical validation.

Second, while participants were purposively selected to reflect the target group (20–40, living in Germany), the sample was recruited via the author’s extended personal network. Most participants had higher education backgrounds and strong digital literacy, and none came

from socioeconomically disadvantaged groups. This may have introduced selection bias and limits the transferability to other population segments.

Third, the stimulus materials used were simplified visual mockups rather than actual course experiences. Participant responses were therefore based on perceived impressions, which may have overstated or understated certain effects.

Fourth, the study did not analyze gender differences in the perception or effectiveness of the models. Given the existing gender gap in preventive health participation—especially the underrepresentation of men—future research should explore whether different influencer formats resonate differently across genders.

Finally, the study was not conducted in a real-world behavioral context. Future research could build on these findings through experimental or longitudinal designs to better understand actual adoption and long-term engagement.

7 Conclusion

This thesis examined how influencer collaborations can increase the adoption of §20 SGB V-certified digital preventive health courses among younger adults (20–40 years) in Germany. Building on the Elaboration Likelihood Model (ELM), it proposed a differentiated conceptual model that distinguishes between health and peer influencers—each triggering distinct psychological mechanisms in persuasive health communication. Health influencers primarily activate central-route processing via credibility and topic authority, while peer influencers function as relatable co-learners who engage users through emotional proximity and social resonance.

The qualitative focus group study confirmed that both archetypes can reduce key psychosocial barriers to adoption, such as low perceived relevance, lack of motivation, and weak social reinforcement. Participants viewed influencer-supported formats as more engaging, relatable, and emotionally accessible than traditional expert-only courses—highlighting the added value of SMIs as motivational catalysts.

Importantly, the relative effectiveness of influencer types was shown to depend on the audience's motivational readiness. Health influencers were favored by those with pre-existing interest, whereas peer influencers proved especially impactful for low-involvement users by

lowering entry thresholds and fostering identification through shared experience. In this way, the peer model addresses a persistent bottleneck in preventive health adoption.

By conceptualizing SMIs not merely as promoters but as integrated co-learners within certified formats, this thesis introduces a novel application of influencer logic in regulated health contexts. It highlights how carefully designed collaborations—anchored in theory and adapted to user needs—can bridge the intention-action gap in preventive health. These insights lay the groundwork for more inclusive, digitally scalable interventions and inform the empirical agenda for health communication innovation.

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Appendix

Appendix A

Semi-Structured Focus Group Discussion Guide (translated from German)

1. INTRODUCTION

- Briefing on study goals
- Emphasis on confidentiality and anonymity
- Consent for recording
- Note on open discussion, no right or wrong answers

2. WARM-UP

- Name, age, current occupation
- General associations with "prevention"
- Personal health routines (e.g., sports, nutrition, mental balance)

General perception of preventive health courses (after provision of context)

- Have you heard of or participated in certified preventive health courses before?
- What is your opinion of such programs?
- What would motivate or discourage you to join one?

3. STIMULUS-BASED DISCUSSION

Stimulus 1 – Standard Model (certified course instructor only)

- What is your first impression of this course format?
- Does this model seem credible and trustworthy to you?
- Would you join this kind of course? Why (not)?

Stimulus 2 – Health Influencer Model

- How did your impression change when the influencer was added?
- What role does the influencer play—trust, motivation, identification?
- Does it feel more appealing or motivating? Why (not)?

Stimulus 3 – Peer Influencer Model

- How did your impression change in this format?
- How does the influencer affect your perception?

- Did it change your motivation to participate? Why (not)?

Comparative Discussion – All Three Models

- Which of the three models appeals to you the most-and why?
- Please rank the three models in order of personal preference.
- For which model could you realistically imagine signing up-and what would be your main reason (or hesitation)?

4. CLOSING ROUND

- Any final thoughts or additions?

Note:
Moderation followed an open and adaptive approach, aimed at including a wide range of perspectives. Follow-up questions were asked as needed to prompt clarification, examples, reasoning, or emotional reactions.

Appendix B

Stimulus Materials Used in Focus Groups (translated from German)

Figure B1

Stimulus 1: Standard Course Model

Figure B2

Stimulus 2: Health Influencer Model

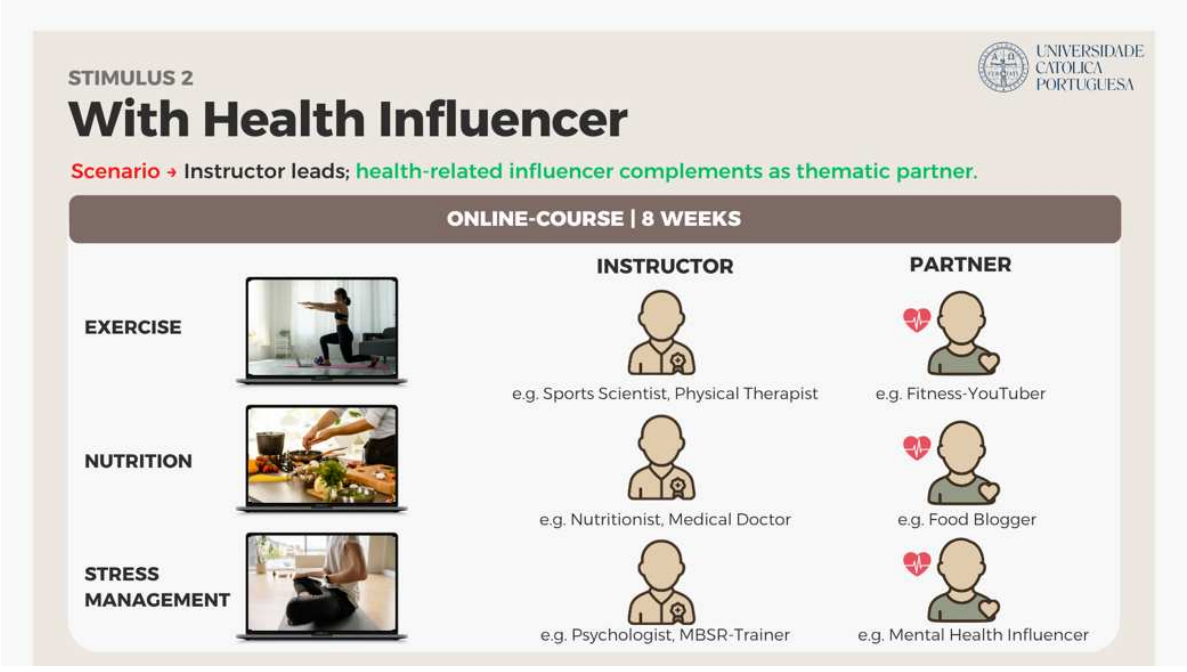
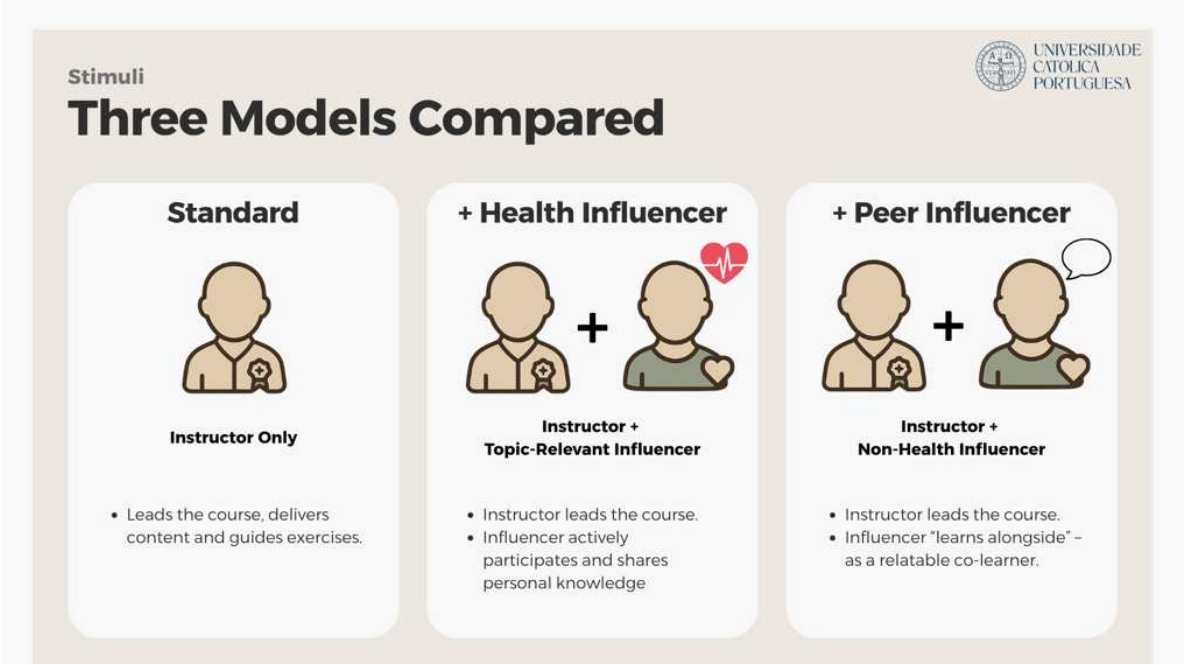


Figure B3

Stimulus 3: Peer Influencer Model

Figure B4

Overview: Comparison of All Three Stimulus Models.



Appendix C

Table C1

Category System: Qualitative Content Analysis According to Mayring (2015)

CODE	CATEGORY	DEFINITION	ANCHOR EXAMPLE	CONTEXT / DERIVATION
C0	**Prevention in Everyday Life**	Captures participants' spontaneous associations, emotional reactions, and intuitive beliefs about the term "prevention," as well as the implicit role of preventive health behaviors (PHBs) in daily life.	*Serves as a thematic umbrella for the subcodes below.*	Deductive
C0.1	Conceptual & Emotional Associations with "Prevention"	Associations, definitions, and emotional reactions related to the concept of prevention—such as perceived tone, stereotypes, or semantic distance.	*"For me it also feels very government-like. Old office buildings, gray, dusty, full of bureaucracy—people sitting behind a desk all day telling others what to do." (FG2, 30–40)* *"Prevention feels negative, because you immediately associate it with some kind of illness." (FG1, 20–29)* *"They should say what it's actually good for—like helping with stress or just feeling better." (FG3, 20–29)*	Deductive

C0.2	Relevance of PHB in Daily Life	Describes how preventive behaviors (e.g., physical activity, nutrition, stress management) are integrated into everyday life—regardless of whether participants explicitly label them as "prevention."	*"I work out regularly, try to eat healthy and sleep well. But I'd never call that prevention." (FG2, 30–40)*	Deductive
C1	Contact to §20 PHB Programs	Refers to participants' awareness, prior exposure, and evaluation of structured §20 SGB V programs.	*Serves as a thematic umbrella for the subcodes below.*	Deductive
C1.1	Awareness & Experience with Certified Programs	Whether participants have heard of, experienced, or are familiar with certified preventive health courses under §20 SGB V.	*"I know my mom once did one of those courses, but that was offline—still reimbursed by insurance, though." (FG4, 30–40)*	Deductive
C1.2	Evaluation of §20 Course Model	Participants' general evaluation of the certified §20 model—especially in terms of structure, reimbursement, and perceived credibility (after explanation).	*"It's actually a cool idea. You don't really pay anything, and it's all certified. That gives it some weight." (FG1, 20–29)*	Deductive
C2	Barriers to PHB Adoption	General obstacles to adopting preventive health behavior, independent of any specific course model. Includes perceived barriers towards §20 SGB V participation.	*Serves as a thematic umbrella for the subcodes below.*	Deductive

C2.1	Structural Barriers	Barriers related to time constraints, access, logistics, or format complexity.	*"I'd love to do something like this, but I just don't have the time to sit down regularly for eight weeks." (FG1, 20–29)*	Deductive
C2.2	Socioeconomic Barriers	Financial burden, reimbursement uncertainty, or mismatch with cultural/educational background.	*"The refund is great in theory, but having to pay upfront and do paperwork later feels a bit much." (FG4, 30–40)*	Deductive
C2.3	Psychological & Behavioral Barriers	Internal blocks such as low motivation or self-efficacy, lack of social reinforcement, or perceived missing relevance.	*"There's no instant benefit in prevention. You don't feel anything right away—that makes it hard to commit." (FG4, 30–40)*	Deductive
C3	Relatability & Identification	Perceived emotional similarity or shared experience with the person in the course—especially the influencer. Includes feelings of being represented or understood.	*"You feel like you're doing it together. When the influencer is also new to it, I feel less intimidated and more seen." (FG3, 20–29)*	Deductive, Context Categories Used for Differentiation (S1-S3)
C4	Trust & Credibility	Perceived expertise, legitimacy, and authority of the person or course format.	*"I think it's fundamentally important. I wouldn't do it if there wasn't a certified person behind it, otherwise I could go back to YouTube." (FG1, 20–29)* *"A person you follow in that case still gives you a different kind of trust, I would say,*	Deductive, Context Categories Used for Differentiation (S1-S3)

			and that might also help." (FG3, 20–29)	
C5	Authenticity & Sincerity	Whether the model appears honest, intrinsically motivated, and emotionally sincere in its intent.	*"A health influencer has more to lose. If they talk nonsense, it damages their whole brand." (FG3, 20–29)* *"If I follow someone who usually does something totally unrelated, and then suddenly they're promoting a fitness course, I'd probably assume it's just well paid—not that they really care." (FG2, 30–40)*	Inductive, Context Categories Used for Differentiation (S1-S3)
C6	Motivational Impact	Perceived emotional or cognitive engagement effects of the course model on motivation to participate and feeling addressed.	*Serves as a thematic umbrella for the subcodes below.*	Deductive

C6.1	General Engagement Drivers	Factors that broadly increase appeal and motivation of the course format, including tone, entertainment, and emotional connection.	*"Especially [for] our generation, this could give it more of a YouTube character, which would make it easier to consume, I believe" (FG1, 20–29)*	Inductive, Context Categories Used for Differentiation (S1-S3)
C6.2	Involvement-Based Motivation	Model preference depending on prior involvement, topic readiness, and personal context—closely aligned with the Elaboration Likelihood Model (ELM).	*"If I'm already into fitness or healthy eating, I want someone who brings more experience—not someone learning with me." (FG2, 30–40)* *"But if you take [a peer influencer] who doesn't really have anything to do with it, then you're actually reaching exactly the people you want to reach. Namely those who haven't really had any interest in it yet and should actually be doing something. They're harder to convert, of course, but they're actually the ones you want." (FG1, 20–29)*	Inductive, Context Categories Used for Differentiation (S1-S3)
C7	Comparison of Course Models	Comparative judgments and clear preferences between the three course formats (standard, peer influencer, health influencer).	*Serves as a thematic umbrella for the subcodes below.*	Deductive

C7.1	Influencer vs. Standard	Statements contrasting influencer-based models with expert-only formats (regardless of type).	*“I think it's generally really good to combine this with some kind of influencer, because I think that's the best way to reach the younger target group and create more awareness. And I think such an approach is great.” (FG3, 20–29)*	Deductive
C7.2	Standard	Specific perceptions of the standard expert-only course format.	*"One and three. I wanted to say that the peer influencer and this additional entertainment factor wouldn't necessarily be the deciding factor for me to do this course. I'm primarily doing it because my goal is to get fit and that's why I would choose exactly one or three." (FG3, 20-29)*	Deductive
C7.3	Health Influencer	Specific perceptions and comparison of the health-influencer format.	*“I’d probably split it by topic. For fitness and nutrition, I’d prefer a health influencer.” (FG2, 30–40)*	
C7.4	Peer Influencer	Specific perceptions and comparison of the peer-influencer format.	*"Because I would have the feeling that these are more realistic things that are being offered to me. Because there's a person there who's like me. And not that it takes place directly at this super high level." (FG1, 20-29)*	Deductive

C7.5	Strategic Model Fit (ELM-Based)	Strategic judgments about which model works best for whom—based on topic familiarity, involvement level, and psychological barriers.	*"I'd probably split it by topic. For fitness and nutrition, I'd prefer a health influencer. But for mental health, it needs to feel safe—more like someone I can relate to." (FG2, 30–40)*	Inductive
C8	Adoption Willingness	Statements reflecting explicit openness or intent to participate in one of the course models.	*"For stress, absolutely. That's where I actually need help." (FG1, 20–29)* *"Honestly, I already work out and eat well. I don't think I need a course." (FG3, 20–29)*	Deductive, Context Categories Used for Differentiation (S1-S3)
C9	Emerging Adoption Drivers	Participant-driven suggestions for improving engagement and perceived value in certified courses.	*Serves as a thematic umbrella for the subcodes below.*	Inductive
C9.1	Structural Motivation Features	Suggestions for features such as gamification, reminders, or community components.	*"What would also motivate me a lot would be if I could do the course together with friends. A kind of social component, so that I can also compete. I do the sports course with two or three other friends." (FG1, 20-29)*	Inductive

C9.2	External Incentives & Value Triggers	Mentions of financial, material, or organizational incentives to increase adoption willingness.	*"What would excite me would be if I had something more haptic. If I take a sports course, I would get a mat to take home on which I can do my sports exercises. Something like that would incentivize me. It's a direct benefit you can touch." (FG1, 20-29)*	Inductive
C9.3	Format & Content Innovation	Proposals to improve storytelling, entertainment, or personality-driven presentation in the course model.	*What just came to my mind is that I always find extreme examples very interesting, when it comes to addiction for example, when you have a person, who perhaps smoked a lot and then somehow managed to quit and then tells you about the methods and somehow inspires you to try this and that" (FG4, 30-40)*	Inductive