Crossing Borders, Driving B2B Growth: Go-to-Market Strategies of B2B Corporate Health, Wellbeing and Performance Solution Providers across DACH and the Iberian Peninsula

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Abstract

Title: Crossing Borders, Driving B2B Growth: Go-to-Market Strategies of B2B Corporate Health, Wellbeing and Performance Solution Providers across DACH and the Iberian Peninsula

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Keywords: Go-to-Market Strategy; B2B Corporate Health, Wellbeing and Performance; Institutional Translation; DACH and Iberian Peninsula; Provider-Side Adaptation; Internationalisation; Qualitative Study

B2B corporate health, wellbeing and performance is one of Europe's fastest-growing employer-spend categories, yet providers expanding cross-border encounter recurring strategic friction that established internationalisation theory struggles to explain. This thesis develops the concept of institutional translation: what travels across markets is not a scalable playbook but the capability to read each market's institutional language and reconfigure value proposition, pricing, sales process, partnerships and proof.

Through an embedded multiple-case design and twelve expert engagements with provider-side practitioners across DACH and the Iberian Peninsula, the study compares Germany and Spain as primary cases. Coding follows an abductive thematic procedure integrating Institutional Theory, the 2009 Uppsala network model, and the Resource-Based View with Dynamic Capabilities.

The empirical findings reveal two structurally distinct markets. Germany operates as an institutionally dense environment in which the BGF apparatus, statutory-insurer support for certified prevention and works-council co-determination jointly legitimise and procedurally formalise corporate health, with an emerging CSRD wedge increasingly anchoring C-level conversations. Spain operates with thinner prevention-specific scaffolding, placing the legitimation burden on providers, who must actively construct the category against a discount-oriented benefit-budget logic. Buyer-side dynamics converge structurally (HR initiation, champion criticality, finance validation) but diverge sharply in institutional formalisation.

Theoretically, the study extends Institutional Theory's regulative and normative dimensions to a field-structuring effect that legitimises commercial categories, refines Uppsala in B2B platform-service contexts, and operationalises dynamic capabilities as institutional translation capability. For practitioners, it delivers a diagnostic framework that distinguishes durable cross-regional success from costly localisation failure.

Resumo

Título: Cruzar Fronteiras, Impulsionar o Crescimento B2B: Estratégias de Go-to-Market dos Fornecedores B2B de Soluções de Saúde, Bem-Estar e Performance Corporativa nos Mercados DACH e Península Ibérica

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Palavras-chave: Estratégia Go-to-Market; Saúde, Bem-Estar e Performance Corporativa B2B; Tradução Institucional; DACH e Península Ibérica; Adaptação do Lado do Fornecedor; Internacionalização; Estudo de Caso Qualitativo

A saúde, bem-estar e performance corporativa B2B é uma das categorias de despesa empresarial com crescimento mais rápido na Europa, mas a expansão transfronteiriça gera atrito que a teoria da internacionalização não explica. Esta tese desenvolve o conceito de tradução institucional: o que viaja entre mercados não é o playbook mas a capacidade de ler a linguagem institucional de cada mercado e reconfigurar proposta, pricing, vendas, parcerias e prova.

Através de um desenho de caso múltiplo e doze interações com especialistas em DACH e Península Ibérica, o estudo compara Alemanha e Espanha como casos primários, integrando Teoria Institucional, o modelo de Uppsala em rede de 2009 e a Visão Baseada em Recursos com Capacidades Dinâmicas via codificação temática abdutiva.

Os resultados revelam dois mercados distintos. A Alemanha opera como ambiente institucionalmente denso: BGF, apoio legal a medidas preventivas certificadas, codeterminação dos conselhos de empresa e a cunha emergente do CSRD legitimam a saúde corporativa. A Espanha opera com andaime preventivo mais ténue, colocando o ónus de legitimação nos fornecedores, que constroem ativamente a categoria contra uma lógica orçamental orientada para descontos. As dinâmicas do comprador convergem (RH, champion, finanças) mas divergem na formalização institucional.

Teoricamente, o estudo estende a Teoria Institucional a um efeito estruturador de campo que legitima categorias comerciais, refina Uppsala em contextos B2B de plataformas-serviço e operacionaliza as capacidades dinâmicas como capacidade de tradução institucional. Para os profissionais, oferece um quadro de diagnóstico que distingue o sucesso transregional duradouro do fracasso oneroso de localização.

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Disclaimer on AI Usage

Generative AI tools were used in this thesis to ensure grammatical correctness and stylistic conciseness, as well as for supportive tasks in the methodology section. This usage occurred in transparency and consultation with my thesis supervisor.

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List of Abbreviations

B2B: Business-to-Business

BAuA: Bundesanstalt für Arbeitsschutz und Arbeitsmedizin (German Federal Institute for Occupational Safety and Health)

BetrVG: Betriebsverfassungsgesetz (German Works Constitution Act)

BGF: Betriebliche Gesundheitsförderung (Workplace Health Promotion)

BGM: Betriebliches Gesundheitsmanagement (Corporate Health Management)

CSRD: Corporate Sustainability Reporting Directive

DACH: Germany (D), Austria (A), Switzerland (CH)

DC: Dynamic Capabilities

DPO: Data Protection Officer

EAP: Employee Assistance Programme

ESG: Environmental, Social and Governance

EU: European Union

FDI: Foreign Direct Investment

GDPR: General Data Protection Regulation

GKV: Gesetzliche Krankenversicherung (German Statutory Health Insurance)

GTM: Go-to-Market

GWI: Global Wellness Institute

HR: Human Resources

IB: International Business

ICP: Ideal Customer Profile

INSST: Instituto Nacional de Seguridad y Salud en el Trabajo (Spanish National Institute for Occupational Safety and Health)

INV: International New Ventures

KAM: Key Account Management

L&D: Learning and Development

LPRL: Ley de Prevención de Riesgos Laborales (Spanish Occupational Risk Prevention Act)

OLI: Ownership-Location-Internalisation Paradigm

OSH: Occupational Safety and Health

RBV: Resource-Based View

RFP: Request for Proposal

ROI: Return on Investment

RQ: Research Question

SGB V: Sozialgesetzbuch Fünftes Buch (German Social Code Book V)

SMB: Small and Medium-sized Business

SME: Small and Medium-sized Enterprise

SO: Specific Objective

TCE: Transaction Cost Economics

USC: Urban Sports Club

VOI: Value on Investment

WHO: World Health Organization

ZPP: Zentrale Prüfstelle Prävention (Central Office for Prevention Certification)

Chapter 1: Introduction

1.1 Background and Relevance

The European corporate health and wellness market has expanded substantially over the past decade, evolving from peripheral perks such as subsidised gym memberships into a strategically significant category of employer investment (GWI, 2026; Deloitte, 2024). Three interlocking forces have accelerated this shift: rising rates of burnout and mental ill-health (WHO, 2022; Hassard et al., 2018), an ageing workforce intensifying competition for skilled talent and the post-pandemic recalibration of employee expectations regarding workplace health (Eurofound, 2022). Together they have driven the emergence of a commercially distinct category of provider consisting of B2B firms that sell wellness, mental-health and coaching services directly to employers. They have contributed to a fundamental reorientation in how organisations conceptualise workforce health, away from reactive absence management toward proactive investment integrated into human-resources strategy, talent retention and corporate sustainability reporting (Goetzel and Ozminkowski, 2008; Badura, Walter and Hehlmann, 2010).

Despite its scale, the market remains institutionally heterogeneous in ways that distinguish the corporate-health sector from European market segments where regulatory harmonisation has reduced cross-border friction. While fast-moving consumer goods and generic software-as-a-service categories have largely benefited from EU regulatory convergence, employer obligations regarding workforce health continue to be organised through nationally specific legal, regulatory and labour-relations architectures. Within DACH, Germany provides the clearest example of institutional density. Its BGF framework, the prevention provisions of Sozialgesetzbuch V and works-council co-determination create an institutional infrastructure in which certified prevention measures can receive statutory-insurer support and workforce health programmes are procedurally formalised. This does not constitute direct financing of commercial platform providers, but it gives the corporate-health field normative legitimacy, a shared professional vocabulary and an established procedural infrastructure. Austria and Switzerland are treated as institutionally adjacent DACH reference markets rather than equivalent empirical cases, with Switzerland's non-EU status further supporting Germany's role as the primary empirical anchor.

In Spain and Portugal, by contrast, employer obligations are primarily governed by occupational risk prevention legislation (Ley 31/1995 in Spain, Lei 102/2009 in Portugal) and the employer-sponsored wellness market remains at an earlier stage of development (Cantonnet et al., 2022). The commercial importance of cross-border scale is illustrated by the 2024 acquisition of Urban Sports Club by Wellhub, which created one of the largest corporate-wellness platforms globally, operating across eleven countries (Sifted, 2024). Yet despite the rising relevance of cross-border growth, the go-to-market logic that enables successful expansion in this sector remains insufficiently understood. Internationalisation literature has predominantly focused on manufacturing, fast-moving consumer goods and generic technology firms (Johanson and Vahlne, 2009; Oviatt and McDougall, 1994), leaving the specific challenges of B2B service providers in institutionally sensitive sectors such as corporate health largely unexplored. This thesis argues that successful cross-border expansion in this sector is best understood as an act of institutional translation. This refers to the active reconfiguration of the provider's go-to-market playbook to fit the institutional language through which each target market legitimises, organises and values employee health. The notion of institutional translation draws on Kostova's (1999) account of how organisational practices are transposed across institutional environments and on Boxenbaum and Pedersen's (2009) extension of Scandinavian institutionalism to the cross-border transfer of management ideas.

1.2 Problem Statement

The question of how B2B corporate health, wellbeing and performance solution providers design and execute go-to-market strategies across institutionally heterogeneous European markets remains insufficiently addressed in the academic literature. Established internationalisation frameworks, including the Uppsala model (Johanson and Vahlne, 2009) and international new ventures theory (Oviatt and McDougall, 1994), offer valuable conceptual tools but were developed and tested in different industry contexts and their application to B2B service providers in regulated, institutionally dense sectors has received little scholarly attention. Institutional theory underscores the importance of regulatory, normative and cognitive environments in shaping firm behaviour (Scott, 2014; North, 1990), yet limited empirical research has examined how these institutional pressures translate into go-to-market design within the corporate health, wellbeing and performance sector.

This gap has practical consequences. Providers entering new European markets often lack a structured understanding of how to adapt value proposition, sales approach, pricing, partnership

strategy and proof mechanisms to local conditions, leading to costly misalignments between centrally designed playbooks and market realities (Peng, Wang and Jiang, 2008). The contrast between DACH, understood as a coherent commercial and linguistic GTM region with Germany as its primary institutional anchor and the Iberian Peninsula, where employer-sponsored health, wellbeing and performance solutions are less institutionally scaffolded, at an earlier stage of development and shaped by different purchasing dynamics, illustrates the strategic relevance of these institutional differences and provides an empirically rich context for examining cross-border expansion challenges (Eurofound, 2024; Esping-Andersen, 1990; Cantonnet et al., 2022; see Chapter 3 for elaboration). This thesis therefore addresses the following research problem: How do B2B corporate health, wellbeing and performance solution providers design and adapt their go-to-market strategies when expanding across institutionally heterogeneous European markets such as DACH and the Iberian Peninsula and what factors determine the effectiveness of these approaches across different market contexts?

1.3 Scope and Contribution

This study focuses on B2B providers of corporate health, wellbeing and performance solutions operating or seeking to expand within European markets. It treats DACH as a coherent commercial and linguistic GTM region, while recognising that it is not institutionally uniform. Germany serves as the primary empirical and institutional anchor within DACH because its BGM/BGF framework, SGB V prevention provisions, works-council structures and direct exposure to EU-level data-protection and sustainability-reporting obligations provide the clearest case for analysing institutional density. Austria and Switzerland are used as contextual DACH reference markets rather than equivalent empirical cases.

The Iberian Peninsula is analysed through Spain as the primary commercial reference market and Portugal as a secondary empirical context illustrating within-Iberia heterogeneity in budget logic, category maturity and benefit-market development. This distinction reflects the empirical distribution of the data: Spain carries the stronger primary-case role, while Portuguese evidence is used to refine, qualify and contextualise the Iberian comparison.

The analysis is restricted to the strategic and commercial dimensions of cross-border expansion, including market selection, go-to-market design, sales approaches, pricing, partnerships, proof mechanisms and adaptation to local market environments. It adopts a business-strategy rather than a clinical perspective on the sector. The academic contribution lies in applying established

international-business and B2B go-to-market frameworks to the under-researched context of employer-sponsored corporate health, wellbeing and performance solutions in Europe and in advancing the concept of institutional translation as the analytical lens through which provider-side cross-border go-to-market adaptation can be understood. The argument draws on qualitative insights from twelve expert engagements with provider-side practitioners and adjacent institutional and industry informants, comprising semi-structured interviews and structured written responses. The practical contribution lies in providing managers with structured guidance on adapting go-to-market strategy across institutionally heterogeneous European markets.

1.4 Structure of the Dissertation

The dissertation is organised in eight chapters. Chapter 1 introduces the research context, problem and scope. Chapter 2 defines the research objectives and questions. Chapter 3 develops the market and institutional context. Chapter 4 reviews the theoretical foundations and synthesises them into an integrated framework; Chapter 5 operationalises it into three analytical tools. Chapter 6 presents the qualitative methodology. Chapter 7 reports the empirical findings. Chapter 8 discusses theoretical and managerial implications, answers the research questions and outlines limitations and future research.

Chapter 2: Research Objectives and Questions

The preceding chapter established that B2B corporate health, wellbeing and performance solution providers face a structurally underexplored challenge when expanding into European markets: the absence of empirically grounded, provider-side guidance on how regulatory, cultural and competitive differences across the DACH and Iberian Peninsula markets shape go-to-market strategy. This chapter defines the study's research objectives, specifies the research questions guiding the empirical inquiry and outlines the expected outputs.

2.1 Research Objectives

The general objective of this study is to analyse and compare the go-to-market strategies employed by B2B corporate health, wellbeing and performance solution providers when entering or operating in the DACH and Iberian Peninsula markets, with a view to identifying market-specific success factors and cross-market strategic implications.

In pursuit of this general objective, four specific objectives structure the empirical and analytical work:

SO1 — To map the institutional environment of the DACH and Iberian Peninsula markets by examining the regulative, normative and cognitive-cultural conditions that affect market entry and solution adoption (Scott, 2014; North, 1990; Kostova, 1999).

SO2 — To examine how corporate buyers evaluate and procure B2B corporate health, wellbeing and performance solutions in both markets, as understood through provider-side accounts of client interactions and sales processes, drawing on B2B buying-behaviour frameworks (Webster and Wind, 1972; Homburg, Workman and Jensen, 2002).

SO3 — To examine how providers adapt their value propositions, sales approaches, pricing, partnership strategies and proof mechanisms to respond to market-specific institutional and buyer-side conditions, with reference to the Uppsala internationalisation model (Johanson and Vahlne, 1977, 2009) and resource-based considerations (Barney, 1991; Teece et al., 1997).

SO4 — To derive strategic recommendations for providers targeting expansion into either or both markets, grounded in the empirical findings and anchored in the study's theoretical framework.

Together, these four objectives operationalise the concept of institutional translation introduced in Chapter 1.

2.2 Research Questions

The four research questions map one-to-one onto the four specific objectives and together structure the empirical fieldwork, the thematic analysis and the interpretive synthesis of the findings in the chapters that follow. Given the exploratory, qualitative nature of this inquiry, all questions are framed as how and what questions. This deliberate choice allows for contextual, process-oriented responses rather than confirmatory answers (Yin, 2018; Creswell and Poth, 2018).

RQ1 — How do the regulative, normative and cognitive-cultural conditions of the DACH and Iberian Peninsula markets differ in their implications for B2B corporate health, wellbeing and performance providers?

RQ2 — How do corporate buyers in DACH and Iberia evaluate and procure B2B corporate health, wellbeing and performance solutions, particularly in terms of buying-centre composition, decision criteria and process structure as observed through provider-side accounts of client engagement?

RQ3 — How do B2B corporate health, wellbeing and performance providers adapt their value propositions, sales approaches, pricing, partnership strategies and proof mechanisms in response to the institutional and buyer-side conditions of each market?

RQ4 — What strategic recommendations follow from the comparative findings for B2B corporate health, wellbeing and performance providers planning expansion into either or both regions?

Each research question is paired directly with its corresponding specific objective: RQ1 with SO1, RQ2 with SO2, RQ3 with SO3 and RQ4 with SO4.

2.3 Expected Outputs

The study is expected to produce four interconnected outputs, each corresponding to a specific objective. The first is a comparative institutional profile of the DACH and Iberian Peninsula markets, examining how regulative, normative and cognitive-cultural conditions shape the

environment in which B2B corporate health, wellbeing and performance providers operate, positioning institutions as active determinants of provider strategy.

The second is a buyer-behaviour analysis examining how purchasing decisions unfold across the two markets, which decision-making units are involved and what obstacles providers face when entering each market. This analysis is intentionally grounded in provider-side accounts of corporate-client interactions.

The third is a comparative analysis of how providers adapt value propositions, sales approaches, pricing, partnership strategies and proof mechanisms across DACH and Iberia. It applies the analytical lens of institutional translation to examine how offers developed against one institutional logic are re-encoded for another, documenting observed patterns rather than prescribing universal solutions. The fourth is a set of practitioner-oriented recommendations for providers planning or refining European expansion, grounded in the empirical findings and anchored in the theoretical synthesis developed throughout the thesis. Together the four outputs respond to the empirical gap identified in Chapter 1 and serve the informational needs of providers pursuing cross-border expansion within Europe.

Chapter 3: Market and Research Context

This chapter establishes the empirical context within which the research questions are situated. Section 3.1 sets out the macro context across the DACH and Iberian markets along five dimensions: economic scale, regulatory environment, socio-cultural conditions, structural workforce trends and regional internal coherence and divergence. Section 3.2 describes the industry structure and competitive dynamics. Section 3.3 and Section 3.4 focus on the DACH and Iberian primary reference markets, respectively. Section 3.5 synthesises the contextual implications for the empirical inquiry.

3.1 Macro Context

Running through all dimensions of the macro context is a single dynamic: the gradual but substantive shift from reactive to preventive approaches to employee health. For much of the twentieth century, organisational responses to workforce health were largely reactive and calibrated to absence, injury and compliance obligation. What has emerged more recently is a different logic in which health is understood as a productive asset to be cultivated rather than a cost to be minimised. This reorientation is not uniform across Europe, but it is structural and it frames the strategic environment in which B2B corporate health, wellbeing and performance providers operate.

3.1.1 Economic Scale of Corporate Health, Wellbeing and Performance Investment

The European corporate health, wellbeing and performance market has grown considerably in scale and strategic importance over the past decade. The Global Wellness Institute projects compound annual growth rates of seven to nine per cent across the broader wellness economy in Europe (GWI, 2026). Narrower B2B-specific estimates from Grand View Research place compound annual growth closer to 3.1 per cent, reflecting a difference in market scope rather than overall growth direction. The underlying economic burden is substantial: work-related ill health translates into significant productivity losses each year in Germany, with psychosocial conditions accounting for a growing share of total sick days (BAuA, 2023), while Spanish survey data document widespread musculoskeletal complaints, anxiety and presenteeism among workers (INSST, 2023). Detailed market sizing data and the full health-burden statistics are summarised in Appendix F.

3.1.2 Regulatory and Political Environment

The regulatory environment exerts a powerful structuring influence on both the demand for and the institutional legitimacy of corporate health investment. In Germany, workplace health promotion is embedded in a well-developed institutional architecture: the Betriebliche Gesundheitsförderung (BGF) framework establishes normative expectations around employer responsibility (Uhle and Treier, 2019; Faller, 2017), supported by Sozialgesetzbuch V (SGB V), §20 of which authorises statutory health insurers to subsidise individual employee participation in certified preventive measures rather than to fund commercial corporate-health platforms directly. The mechanism is field-structuring in effect: by codifying which prevention activities qualify for reimbursement, SGB V §20 legitimises a particular professional vocabulary around workplace prevention that providers must engage with, even when they themselves do not receive insurer funding. Formal co-determination rights exercised by works councils (Betriebsräte) under the Betriebsverfassungsgesetz mean that the introduction of health-related programmes typically requires formal employee-representative approval, adding a co-determination step that providers must factor into their German sales cycle.

In Spain, the regulatory baseline is set by Ley 31/1995 de Prevención de Riesgos Laborales (LPRL) and in Portugal by Lei 102/2009 (Roxo, 2011). Both transpose EU occupational health and safety directives into national law with a primarily compliance-oriented, risk-prevention focus. There is no direct equivalent to the German BGF framework, no institutional architecture that specifically legitimises or incentivises proactive employer investment in preventive wellness beyond statutory occupational safety requirements (Cantonnet et al., 2022; Mossink and de Greef, 2002). An emerging cross-regional driver is the Corporate Sustainability Reporting Directive (CSRD) (Directive (EU) 2022/2464; European Commission, 2022), which since 2024 requires large companies to report on material workforce-related risks. Although CSRD does not mandate specific health investments, it creates institutional pressure toward greater transparency and may accelerate mainstreaming of proactive health strategies across both regions.

3.1.3 Socio-cultural Dimensions of Workplace Health

Cultural norms and social expectations shape both how organisations act within the formal regulatory frame and how willing they are to go beyond it. In Germany, the discourse around Betriebliches Gesundheitsmanagement (BGM) is well established within HR and management practice, embedded for decades in collective bargaining, codetermination structures and

professional HR norms (Badura, Walter and Hehlmann, 2010). This normative scaffolding lowers cognitive friction for B2B providers approaching German enterprise buyers. In Spain, the cultural picture is more complex: workplace surveys document elevated work-related exhaustion, presenteeism and psychosocial pressure alongside a notable management-employee trust asymmetry (INSST, 2023). High subjective health strain coexists with thin organisational infrastructure to address it preventively. Detailed survey statistics are presented in Appendix F.

3.1.4 Structural Workforce Trends

Three structural forces have amplified the strategic salience of corporate health. Demographic pressure raises the proportion of employees in age cohorts associated with higher prevalence of chronic conditions (Magnavita et al., 2017). The COVID-19 pandemic accelerated existing trends, with Eurofound (2022) documenting elevated anxiety, exhaustion and presenteeism particularly among knowledge workers and the widespread shift to hybrid working introducing new psychosocial risk factors and new digital delivery channels. Intensifying competition for skilled labour has elevated workforce health from an HR operational concern to a strategic priority, with employer-sponsored health programmes serving simultaneously as retention tools, recruitment differentiators and organisational value signals.

3.1.5 Regional Divergence: DACH and Iberia as Distinct Market Contexts

Before turning to the comparison between the two regions, it is necessary to establish that each cluster constitutes an analytically coherent unit. The DACH region exhibits substantial institutional similarity across the dimensions most relevant to corporate health, wellbeing and performance provision, although this similarity does not amount to full institutional convergence. All three countries operate within the Germanic legal tradition, share a statutory social insurance architecture (SGB V in Germany, ASVG in Austria, KVG in Switzerland) and maintain co-determination structures through formally constituted employee representative bodies. The BGM/BGF discourse is shared across the three national HR communities (Badura, Walter and Hehlmann, 2010; Uhle and Treier, 2019) and Eurofound clusters the three within its Central European typology of labour market and welfare regimes (Eurofound, 2024). Switzerland operates outside the EU regulatory framework and is therefore not directly bound by CSRD or GDPR, but Swiss firms increasingly align with these standards through commercial integration with EU clients and the institutional substance of Swiss workplace health practice closely resembles that of Germany and Austria. This dual character reinforces the selection of Germany as the primary empirical reference within DACH: as the largest EU-

member economy in the region, Germany provides the clearest case for analysing how EU-level institutional pressures (SGB V §20, CSRD, GDPR) translate into provider go-to-market requirements, without the analytical complication of Switzerland's non-EU regulatory position.

The Iberian Peninsula exhibits a parallel internal coherence rooted in a shared institutional and cultural lineage. Spain and Portugal both belong to the Romance legal tradition and to what Esping-Andersen (1990) characterises as the Southern European welfare regime. This regime is structurally distinct from the conservative-corporatist regimes of DACH because of its familialist orientation and more limited public infrastructure for active labour market and prevention policy. Both countries have transposed the EU Framework Directive on occupational safety and health into functionally comparable legislation (LPRL in Spain, Lei 102/2009 in Portugal), establishing a compliance-first regulatory orientation that contrasts directly with the preventive-promotional logic of DACH. Comparative European studies have grouped Spain and Portugal within the Mediterranean cluster on the basis of similar adoption rates and institutional infrastructure (Magnavita et al., 2017). Both are EU member states bound by CSRD and GDPR; their procurement practices for benefits and corporate health typically involve fewer formally constituted governance bodies than the German Betriebsverfassungsgesetz architecture and emphasise direct relationship management between provider and senior buyer rather than committee-based decision processes (Hofstede, Hofstede and Minkov, 2010).

Taken together, the dimensions surveyed above constitute two meaningfully distinct market environments rather than a single European market differentiated only by language. The DACH region represents an institutionally dense context: established BGM discourse, regulatory architecture that normalises employer investment in health and formal governance structures that embed health considerations in organisational decision-making. The Iberian market presents a compliance-first regulatory environment with limited institutional scaffolding for proactive health promotion beyond occupational risk prevention. This divergence is not merely a difference in market maturity but reflects institutional heterogeneity in the sense of Peng et al. (2008), with direct consequences for the go-to-market strategies that providers must develop for each context.

3.2 Industry and Competitive Structure

The B2B corporate health, wellbeing and performance market is not a single homogeneous category but a cluster of adjacent product segments: physical activity and fitness access platforms (Wellhub, EGYM Wellpass, Urban Sports Club, Hansefit), mental health and coaching services (CoachHub, Nilo Health, Lyra Health), employee assistance programmes (EAPs) and integrated multi-modal wellness platforms. The competitive landscape has undergone significant consolidation in recent years, most consequentially through the 2024 acquisition of Urban Sports Club by Wellhub (Sifted, 2024), which united two of the largest fitness access platforms in Europe and substantially raised the scale threshold for viable platform competition. Within DACH, EGYM Wellpass holds a strong position in the fitness access segment with deep integration into the BGF institutional framework, while CoachHub is the dominant European player in the digital coaching segment (PitchBook, 2024). In Spain and Portugal, international platforms such as Wellhub operate alongside a smaller number of local providers within a market where organisational adoption is at an earlier stage. A detailed mapping of the competitive landscape is provided in Appendix E.

Three structural dynamics are reshaping competitive strategy. Integrated platforms are creating pressure to expand product scope as enterprise clients seek consolidated solutions. Data and measurement capabilities are becoming a meaningful differentiator, increasingly codified in RFP and procurement criteria. Pricing pressure is intensifying as DACH matures and discount-driven competition compresses margins. From an internationalisation perspective, the sector exhibits Johanson and Vahlne's (2009) network-embedded entry pattern: expansion depends on establishing local partner networks that give the platform credibility and operational depth.

3.3 The DACH Market in Focus

Germany constitutes the largest and most commercially significant market for B2B corporate health, wellbeing and performance providers within DACH and serves as the primary empirical reference for this study. Austria and Switzerland share institutional features but are smaller in scale and typically entered as secondary markets after a German position is established. Germany's market is distinguished by its institutional density: the BGF framework, SGB V provisions and co-determination architecture create an environment in which health investment is normalised, procedurally structured and broadly expected for larger employers (Uhle and Treier, 2019; Faller, 2017). This creates a receptive demand environment, but also procedural complexity. Bringing a new health solution into a German organisation typically involves HR

decision-makers, works councils, data protection officers and sometimes occupational health services. This extends sales cycles and requires providers to demonstrate regulatory compliance as a baseline condition of entry.

Purchasing decisions are typically multi-stakeholder. The primary initiating function is human resources, but procurement authority frequently rests with Finance and works council involvement is required for any solution touching employee data or working conditions. This multi-party structure extends sales cycles and demands relationship-building across organisational functions (Homburg, Workman and Jensen, 2002; Backhaus and Voeth, 2014). The value framing that resonates most strongly reflects the institutional environment: providers positioning their offerings through health outcome data, absenteeism metrics and demonstrable alignment with BGF or preventive care frameworks find more traction than purely brand-or-experience framings. The growing relevance of CSRD adds a sustainability and ESG dimension to procurement, creating an emerging, though still institutionally nascent, entry point for providers able to document population-level health impact (European Commission, 2022; KPMG, 2023). Pricing tends to follow per-employee subscription logic with steep volume tiers and channel strategy increasingly leans on integrations with established BGM consultancies, employer-association networks and occupational health partners (PitchBook, 2024).

3.4 The Iberian Market in Focus

Spain represents the primary commercial opportunity within the Iberian Peninsula for B2B corporate health, wellbeing and performance providers and serves as the primary empirical reference. Portugal, while sharing many structural characteristics with Spain, is a smaller market typically entered as a secondary step following Spanish market establishment. The Spanish corporate health market is at an earlier stage of development than its DACH counterpart, with the absence of a BGF-equivalent framework meaning that proactive employer investment in health operates without the normative legitimacy and procedural scaffolding that characterise the German context. Employer health spending is more likely to be driven by individual organisational initiative (talent retention pressures, leadership conviction, multinational parent influence) than by systemic institutional expectation.

Purchasing dynamics differ from the DACH context in ways that have direct implications for provider go-to-market strategy. Decision-making authority tends to be more centralised, often vesting in a single HR director or general manager, without formal multi-party governance

structures comparable to the German Betriebsverfassungsgesetz architecture (Hofstede, Hofstede and Minkov, 2010). Works councils exist under Spanish labour law but are less extensive in their co-determination rights and less systematic in their involvement in benefits procurement. This can shorten formal decision cycles but creates dependence on individual advocate relationships. The relational dimension of the sales process is more pronounced than in Germany, reflecting the lower formalisation of works-council involvement in benefits procurement and the greater centralisation of decision authority in individual roles (Eurofound, 2023; Kittler, Rygl and Mackinnon, 2011). Provider-side observations gathered for this study suggest that pricing tends to be more flexible than in DACH, with greater openness to discounting and multi-year commitments and that partnership strategies more often rely on multinational HR-services intermediaries and local consultancy networks than on the institutionalised BGM ecosystem characteristic of Germany. These patterns are consistent with Johanson and Vahlne's (2009) account of network-embedded entry into institutionally less-structured markets and are examined in detail in Chapter 7. For providers, this implies that lead generation through personal referral networks and direct relationship-building may yield better returns than the more process-driven RFP channels that dominate DACH (House et al., 2004). The absence of strong institutional framing requires providers to invest more heavily in educating prospective buyers about the business case for corporate health investment.

3.5 Synthesis: Context and Implications for the Study

The preceding analysis establishes that the European corporate health, wellbeing and performance market is structurally significant, commercially dynamic and characterised by a degree of institutional heterogeneity that makes cross-border expansion a strategically non-trivial undertaking for B2B providers. The strategic question is therefore less one of market entry per se than one of institutional translation: how providers re-encode an offer developed against one institutional logic into a form that is legible, legitimate and procurable within another. Three contextual findings are particularly consequential for the analytical framework developed in subsequent chapters. First, the divergence between DACH and Iberia is not a difference in market size or development alone but a difference in institutional architecture, directly conditioning the go-to-market strategies providers must develop. Second, the competitive landscape is in active transition, with the Wellhub-Urban-Sports-Club consolidation, the rapid growth of digital mental health and the emerging influence of CSRD reporting reshaping competitive conditions. Third, the data gap between the two markets

reflects the differential development of the field: institutional evidence is robust in Germany, while data on Spain and Portugal remains more limited. This also informs the methodological choice to capture market dynamics through twelve provider-side expert engagements. These foundations set the stage for the theoretical and analytical framework developed in Chapter 4.

Chapter 4: Literature and Theoretical Framework

This chapter develops the theoretical and conceptual foundations on which the empirical analysis rests. Section 4.1 defines the core concepts that structure the investigation. Section 4.2 reviews the principal theoretical perspectives relevant to the study. Section 4.3 synthesises these perspectives, identifying complementarities and tensions. Section 4.4 identifies the research gaps the study is positioned to address. Section 4.5 presents and justifies the adopted theoretical framework.

4.1 Key Concepts and Definitions

Go-to-market (GTM) strategy is defined here as the set of decisions and practices through which a firm positions its offering, structures value communication, manages sales and distribution channels and builds the partnerships necessary for commercial viability (Hax and Wilde, 2001; Kotler and Keller, 2016). It is broader than market entry strategy, which the international business literature treats primarily as a mode-of-entry decision (Hill, 2014), encompassing both initial entry and the ongoing commercial approach through which a provider sustains market position.

The category of B2B corporate health, wellbeing and performance solution providers refers to commercially provided services and platforms that employers procure on behalf of their workforce, with the purpose of supporting employee physical health, psychological wellbeing, performance capacity, or work-life integration. The category comprises four adjacent product segments: fitness-access platforms (Wellhub, Urban Sports Club, EGYM Wellpass, Hansefit), mental-health and digital-therapy platforms (iFeel, Nilo Health, HelloBetter), workplace coaching and performance-development platforms (CoachHub, BetterUp) and integrated multi-modal platforms combining several modalities under one architecture (HeyCare and emerging competitors).

These segments are treated as a single analytical category because they share a common B2B go-to-market logic. Five structural attributes constitute this shared logic. First, the buyer–user separation: the employer purchases the service and the employee uses it, generating a dual commercial tension. Second, HR as primary entry point: the initial procurement conversation enters through HR, People, Benefits, BGM or L&D. Third, the organisational-justification requirement: providers must show that their offering is more than a discretionary benefit,

whether through retention, productivity, employer-branding or absenteeism arguments. Fourth, the adoption-determines-success dynamic: contract signature is insufficient, because without sustained employee usage churn and renewal problems emerge identically. Fifth, the institutional conditioning of the sales process: in DACH, providers require higher legitimation, data-protection readiness and proof infrastructure; in Iberia, they must work harder to establish the strategic relevance of the category itself. The defining feature of the category is therefore not what is sold but how it is sold and to whom. This study compares providers not at the product level but at the level of their shared go-to-market logic, where institutional translation becomes analytically visible.

Internationalisation is defined as the progressive extension of a firm's activities across national borders, entailing increasing resource commitment, knowledge acquisition and adaptation to foreign market conditions (Johanson and Vahlne, 1977). For B2B corporate health platforms this requires establishing local partner networks, navigating data-protection and labour-relations requirements and adapting value propositions to institutionally distinct buyer expectations.

The distinction between Return on Investment (ROI) and Value on Investment (VOI) is conceptually consequential: ROI framings emphasise quantifiable cost-reduction (healthcare expenditure, absenteeism); VOI framings encompass broader outcomes such as engagement, retention and organisational resilience that are strategically material but not easily monetised (Pronk, 2014; Ozminkowski et al., 2016).

Institutional translation is defined here as the active reconfiguration of a provider's go-to-market playbook, namely its value proposition, sales process, pricing logic, partnership model and proof mechanisms, so that the offer becomes legible, legitimate and procurable within the institutional vocabulary of the target market. The concept extends Kostova (1999) and Boxenbaum and Pedersen (2009); it is not a synonym for cultural adaptation or for localisation in the marketing-mix sense but specifies a mechanism by which institutional difference is processed into commercial design.

4.2 Core Theoretical Perspectives

4.2.1 The Uppsala Internationalisation Model

The Uppsala model, first formulated by Johanson and Wiedersheim-Paul (1975) and elaborated by Johanson and Vahlne (1977), describes internationalisation as a sequential learning-driven

process in which firms gradually increase commitment to foreign markets as they accumulate market-specific knowledge. Two constructs organise the model: experiential knowledge development, by which experience reduces uncertainty and commitment, by which resource allocation increases as uncertainty declines. Psychic distance is central to the original model and refers to the factors that prevent the flow of information between markets, including differences in language, business practice and culture. Firms therefore tend to enter psychically proximate markets first. The 2009 revision by Johanson and Vahlne represents a significant conceptual development. The updated framework reconceptualises internationalisation as embedded in business networks rather than as firm-level learning operating in isolation. The key insight is that markets are networks of relationships. Market entry therefore requires not only the acquisition of market knowledge, but also the development of network position, meaning the ability to become an insider in the relevant local business ecosystem. Outsiders face a liability not only of foreignness in the cultural sense but of exclusion from trust-based relationships through which business is conducted. For B2B corporate health providers, market entry in a new country requires embedding in local networks (gym and studio partners, HR technology providers, occupational health organisations, employer associations) before commercial scale becomes achievable. The model has been subject to important critiques (Brouthers et al., 2016; Coviello and Munro, 1997), most notably regarding the phenomenon of born-global firms (Oviatt and McDougall, 1994); however, the local-adaptation requirements of B2B corporate health platforms limit the extent to which they can bypass incremental commitment and the 2009 network formulation captures their situation more directly than the original sequential version.

4.2.2 Institutional Theory

Institutional Theory examines the role of formal and informal rules, norms and shared beliefs in shaping organisational behaviour. The foundational contribution for this study is Scott's (2014) three-pillar framework. The regulative pillar comprises formal legal rules, regulatory requirements and enforcement mechanisms. The normative pillar captures the professional norms that establish what is considered appropriate within an organisational field. The cognitive-cultural pillar encompasses the taken-for-granted assumptions and shared frames of meaning that shape how actors interpret their environment. All three pillars operate simultaneously, but their relative salience differs across contexts.

North's (1990) distinction between formal institutions (laws, regulations, contracts) and informal institutions (conventions, norms, codes of conduct) and his emphasis on institutional path dependence, complement Scott's framework. Kostova (1999) and Kostova and Roth (2002) develop the concept of institutional distance and demonstrate its relevance to the difficulty of transferring organisational practices across borders. Boxenbaum and Pedersen (2009), drawing on the Scandinavian institutionalist tradition (Czarniawska and Joerges, 1996), reframe such cross-border transfer as an active translation process in which actors selectively reconfigure imported ideas to align them with local institutional logics, a formulation that grounds the present study's concept of institutional translation. Peng et al. (2008) extend this logic into an institution-based view of international business strategy, arguing that the institutional environment constitutes a third strategic force alongside industry structure and firm-specific resources. The primary limitation of institutional theory is its tendency toward structural determinism: it explains constraints better than it explains why some firms navigate those constraints more effectively than others, a limitation addressed through integration with the Resource-Based View.

4.2.3 The Resource-Based View and Dynamic Capabilities

The Resource-Based View (RBV), originating in Penrose (1959) and given systematic form by Wernerfelt (1984) and Barney (1991), argues that sustained competitive advantage derives from the possession of resources that are valuable, rare, inimitable and non-substitutable. Strategically relevant resources include not only physical and financial assets but human capital, organisational processes, firm reputation and knowledge. For B2B corporate health providers, the RBV directs attention to resources that competitors cannot easily replicate: proprietary partner networks, localised market knowledge, integrated data analytics infrastructure, compliance expertise and culturally adapted sales capabilities. These resources differ meaningfully between DACH and Iberian contexts, implying that competing across both markets is not simply a matter of replicating a proven model but of developing market-specific resource configurations.

The dynamic capabilities extension by Teece, Pisano and Shuen (1997) addresses a limitation of the original RBV, namely its static conception of resources. Dynamic capabilities denote the ability to integrate, build and reconfigure internal and external competences in response to changing environments. Eisenhardt and Martin (2000) extend this framework to include specific routines (market entry, product development, alliance formation, strategic decision-

making) through which firms reconfigure resources. In the corporate health sector, which is undergoing significant consolidation and competitive reconfiguration, dynamic capabilities are relevant to how providers sense emerging opportunities, seize them through resource reconfiguration and sustain position through ongoing adaptation.

4.2.4 Organisational Buying Behaviour in B2B Markets

Understanding how corporate buyers evaluate and procure B2B solutions is central to the second specific objective of this study (SO2). Webster and Wind's (1972) foundational model identifies four categories of variables that influence procurement decisions (environmental, organisational, interpersonal, individual) and introduces the buying centre, the set of organisational actors involved in a purchasing decision. Homburg, Workman and Jensen (2002) extend this through key account management research, showing that complex selling situations require relationship management capabilities beyond transactional approaches. More recent scholarship (Homburg, Müller and Klarmann, 2011) documents the growing importance of solution and value-based selling anchored in customer-specific outcomes. The institutional context significantly conditions how these buying behaviour dynamics manifest: the multi-stakeholder procurement process in DACH and the more centralised, relationship-driven procurement in Iberia represent structurally different buying processes that the integrated framework presented below is designed to capture.

4.3 Comparison and Synthesis

The four perspectives are not competing explanations but analytically complementary lenses. The Uppsala model and Institutional Theory address the same empirical terrain from different angles: Uppsala focuses on the temporal process by which firms acquire market knowledge and build network position; Institutional Theory focuses on the terrain itself, the formal and informal structures of the host environment. A productive tension exists between Uppsala's learning-as-uncertainty-reduction logic and Institutional Theory's emphasis on structural constraints that do not dissolve through experience: if the challenge in Iberia is the absence of normative legitimacy for proactive health investment, no amount of market experience substitutes for the institutional scaffolding present in DACH. The RBV and Institutional Theory are complementary along an inside-out versus outside-in axis: institutional environments define which resources matter; the RBV explains why some firms develop those resources more effectively. Dynamic capabilities add a temporal dimension as markets evolve. The buying behaviour literature situates the provider-buyer interaction at the interface where institutional

context and firm capabilities meet. Peng et al. (2008) anticipated this integrative logic and Johanson and Vahlne (2009) themselves acknowledge that network relationships are simultaneously institutional phenomena and valuable, inimitable resources. The present study extends this integrative approach to the empirical context of B2B corporate health platform internationalisation.

4.4 Research Gaps and Limitations

The theoretical review reveals four gaps the study is positioned to address. First, the internationalisation literature has been developed primarily through manufacturing firms and more recently, technology startups; B2B platform businesses in the health services sector combine low physical asset intensity, high network dependence, ongoing service delivery, multi-stakeholder sales processes and regulated delivery and remain under-analysed. Second, institutional theory has been applied extensively to manufacturing FDI and less to services, particularly rarely to B2B health services; the specific institutional configurations relevant to corporate health markets have not been systematically analysed through this lens. Third, the Iberian market for B2B corporate health is empirically under-researched, with secondary data on market penetration, buyer behaviour and provider strategies in Spain and Portugal sparse compared to the DACH context. Fourth, the relationship between GTM strategy and institutional environment has been theorised at a general level (Peng et al., 2008) but not examined empirically in B2B health platform internationalisation. Institutional translation, as developed in this thesis, addresses this gap by providing a provider-side analytical mechanism through which the GTM–institution relationship can be examined empirically. Two methodological caveats should be noted. Reliance on provider-side expert engagements captures buyer perspectives indirectly and the restriction to German and Spanish primary markets means that findings cannot be straightforwardly generalised to Austria, Switzerland or Portugal without accounting for country-specific institutional features.

4.5 Adopted Theoretical Framework

On the basis of the literature review, this study adopts an integrated three-lens theoretical framework combining Institutional Theory, the Uppsala Internationalisation Model in its 2009 network formulation and the Resource-Based View with Dynamic Capabilities. The organisational buying behaviour literature informs the analysis of buyer dynamics but does not

constitute a standalone theoretical pillar; rather, it provides conceptual tools for interpreting the provider-side accounts of client engagement.

Institutional Theory is adopted as the primary contextual lens because the most consequential difference between DACH and Iberia is institutional rather than economic: the presence or absence of formal regulatory scaffolding, normative professional expectations and shared cognitive frames around employer health responsibility. Scott's three-pillar framework provides the most analytically precise vocabulary for characterising this difference, directly addresses the specific objects of SO1 and provides the explanatory mechanism for the distinctive buyer dynamics documented in both markets. The Uppsala Internationalisation Model is adopted as the process lens because it captures how providers build market position over time through the sequential deepening of knowledge, commitment and network embeddedness. Its 2009 network revision is particularly well suited to the B2B corporate health, wellbeing and performance context, where commercial viability depends on embedding in local partner and client networks. The Resource-Based View and Dynamic Capabilities are adopted as the firm-level lens because institutional environments and internationalisation processes create the conditions for competition but do not explain why individual providers outperform their peers within those conditions; the RBV directs attention to specific resource configurations and dynamic capabilities address the capacity for adaptation as market conditions evolve.

Across the three lenses, institutional translation operates as the integrating analytical mechanism. Institutional Theory specifies the institutional differences that must be translated; the Uppsala network logic specifies the relational embedding through which translation occurs; the Resource-Based View and Dynamic Capabilities specify the firm-level capacities that determine whether translation is executed effectively. The framework therefore treats institutional translation not as an additional fourth lens but as the analytical operation through which the three lenses jointly explain provider-side go-to-market adaptation.

Alternative frameworks were considered and excluded. OLI (Dunning, 1988) explains equity-based FDI rather than platform-based service entry, TCE (Williamson, 1985) foregrounds make-or-buy decisions peripheral to the empirical case and Porter's (1980) Five Forces is industry-structural rather than institutionally sensitive. A detailed justification is presented in Appendix G. Operationally, the framework is applied across the four specific objectives: SO1 through Institutional Theory; SO2 through the buyer behaviour literature interpreted through the institutional lens; SO3 through Uppsala network logic combined with RBV resource

development; SO4 drawing on all three lenses to derive cross-market strategic implications. The operationalisation into the three analytical tools is presented in Chapter 5, the findings in Chapter 7 and the discussion in Chapter 8.

Chapter 5: Analytical and Practical Frameworks

5.1 The Role of Analytical Frameworks

Chapter 4 justified the integrated three-lens framework. This chapter translates that commitment into three concrete analytical instruments through which the expert-engagement material is read, organised and interpreted, connecting the theoretical synthesis of Chapter 4 to the methodological procedures of Chapter 6.

5.2 Framework 1: Institutional Analysis Tool

The first instrument operationalises Scott's (2014) three-pillar conception, informed by North (1990) on path dependence and Kostova (1999) on institutional distance. It directs attention to three dimensions of any observation about market conditions. The regulative dimension captures formal legal and compliance structures, including data-protection regimes, occupational safety frameworks, ESG reporting obligations, social-insurance architectures, co-determination rules and the tax treatment of corporate health benefits. The normative dimension captures the professional expectations and role-bound conventions of HR leaders, occupational safety officers, procurement bodies and works councils, including their assumptions about what constitutes legitimate vendor behaviour. The cognitive-cultural dimension captures the shared and often taken-for-granted assumptions that frame employer responsibility for employee wellbeing, including whether prevention is culturally salient, how employer responsibility is interpreted in relation to existing welfare-state arrangements and whether mental health is understood as a discretionary benefit or an institutional responsibility. The tool maps directly onto SO1: every observation bearing on market environment is classified along these three pillars, enabling a structured comparison between DACH and Iberian contexts.

5.3 Framework 2: Internationalisation Process Tool

The second instrument operationalises the 2009 network revision of the Uppsala model (Johanson and Vahlne, 2009) together with the Resource-Based View and Dynamic Capabilities (Barney, 1991; Teece, Pisano and Shuen, 1997). It directs attention to how providers build, embed and reconfigure themselves within a market over time. Three dimensions are distinguished. Knowledge development captures the experiential learning by which providers update their understanding of buyer expectations, regulatory constraints and competitive dynamics. Network embedding captures the construction of relational position

within the local ecosystem (partner alliances with insurers, gyms, brokers, adjacent wellbeing providers) and the accumulation of referenceable client relationships. Resource and capability transfer captures the asymmetry between what travels from a provider's home market (methodology, technology, brand assets, sales playbook) and what must be rebuilt locally. The tool maps onto SO3 and informs SO4.

5.4 Framework 3: Buyer Behaviour Tool

The third instrument operationalises the organisational buying behaviour literature, drawing on Webster and Wind (1972) and Homburg, Workman and Jensen (2002). In keeping with the position taken in Section 4.5, this tool is treated as a secondary instrument: it provides conceptual structure for interpreting buyer-side dynamics, but those dynamics are themselves understood as institutionally conditioned rather than as universal features of B2B procurement. The tool directs attention to three dimensions. Buying-centre composition identifies the roles present (economic buyer, internal champion, technical influencer, gatekeeper) and whether multi-stakeholder configurations are encountered. Decision criteria identifies the substantive arguments through which value is established. Process structure identifies the sequence and friction points through which a deal advances from first contact to signature. The tool maps onto SO2 and is applied with explicit reference to the institutional context in which each pattern is observed.

5.5 Linking Theory to Empirical Tools

Taken together, the three tools form a coherent instrumentation grounded in Chapter 4, methodologically realised through the abductive thematic coding procedure described in Chapter 6 and analytically deployed in Chapter 7. Each tool furnishes deductive starter codes; inductive codes complement them where the data exceeds the prior theoretical frame. Most expert-engagement passages bear on more than one dimension simultaneously. A single account of why a DACH enterprise deal stalled may invoke the regulative pillar (data-protection compliance), the buying-centre tool (the works council as veto stakeholder) and the internationalisation process tool (the provider's adaptation of pilot structure). The three tools are therefore applied jointly where the data warrants it, operationalising what Chapter 7 develops as institutional translation: the empirically observed capability of providers to read each market's institutional language and to reconfigure the constituent elements of their commercial playbook accordingly.

Chapter 6: Methodology

This chapter sets out the methodological foundation of the empirical investigation. It explains the research design and its philosophical basis (6.1), identifies the data sources drawn upon (6.2), describes how the primary data were collected (6.3), explains the analytical procedure applied (6.4), addresses the quality and rigour of the research process (6.5) and acknowledges the methodological limitations that frame the interpretation of the findings (6.6).

6.1 Research Design

The study adopts an interpretivist research philosophy, grounded in the assumption that organisational reality is socially constructed and that knowledge of strategic practice is best generated through close engagement with the meanings practitioners attribute to their decisions (Saunders, Lewis and Thornhill, 2019; Lincoln and Guba, 1985). Go-to-market strategy in the B2B corporate health, wellbeing and performance sector is enacted through situated managerial judgement that varies across institutional contexts. A standardised, decontextualised measurement approach is therefore unsuitable; the "how" and "what" research questions of this study fall within the canonical domain of qualitative case study research (Yin, 2018).

The study employs an embedded multiple-case study design (Yin, 2018). The regional units of analysis are the DACH region and the Iberian Peninsula, the level at which industry, regulatory and comparative European workplace-health literature consistently demarcates the market and at which Chapter 3 has demonstrated internal coherence. Within each regional unit, the empirical comparison is anchored in a primary embedded case: Germany within DACH and Spain within Iberia. Cross-market respondents, whose responsibilities span the regional boundary, serve as boundary-spanning informants who triangulate the comparison rather than as cases in their own right. The decision to adopt an embedded design crystallised during the empirical phase of the study. Both Yin (2018) and Eisenhardt (1989) treat such design refinement as a legitimate feature of qualitative case research, provided it is transparently reported; this study foregrounds the adjustment as part of its methodological account.

6.2 Data Sources

The study draws on two complementary data sources. The primary dataset consists of twelve expert engagements in total. These include provider-side practitioners, one institutional informant from a German statutory health insurer and one industry observer, conducted in the

B2B corporate health, wellbeing and performance sector. The secondary data comprise industry reports, regulatory documents and the comparative European workplace-health literature reviewed in Chapter 3, including outputs from Eurofound, the OECD, the World Health Organization, the Spanish National Institute for Occupational Safety and Health (INSST), the German Federal Institute for Occupational Safety and Health (BAuA), and industry sources such as the Global Wellness Institute. Triangulation between primary and secondary evidence is applied throughout the analysis: institutional and regulatory claims drawn from interviews are cross-checked against documentary sources and patterns identified in the secondary literature are tested against the interview material.

6.3 Data Collection

Participants were recruited through purposive sampling on the basis of three criteria: function (commercial, partnership, strategic, or institutional responsibility in a relevant organisation), market focus (operational responsibility in DACH, Iberia, or across the regional boundary) and seniority (sufficient organisational standing to speak to strategic patterns rather than purely tactical detail). Recruitment was conducted exclusively via LinkedIn; none of the participants were members of the researcher's prior professional network and all relationships were established during the research process. Outreach messages communicated the study's purpose, the anonymity assurance and the expected time commitment, with anonymity reiterated at the start of each engagement before any substantive question was asked. A complete profile of the participants (role, market focus, language, interview duration and engagement format) is presented in Appendix A.

Twelve engagements were completed between March and May 2026. Eight participants were available for semi-structured video interviews between eighteen and fifty-six minutes long, conducted via Google Meet or Microsoft Teams and recorded with informed consent. Four were transcribed verbatim; four were captured through the meeting platform's automatic transcription with structured AI-generated notes, the verbatim portion serving as the primary source and the AI-generated summary as orientation only. Three senior executives unable to commit to a synchronous interview provided structured written responses by email, treated methodologically as expert written responses rather than as interviews. Interviews were conducted in German or English according to the participant's preference. The four research questions served as a common analytical anchor across all engagements; the specific question set was tailored to each participant's role, organisation and market focus. The twelve

engagements span the four segments that constitute the analytical category defined in Section 4.1. The centre of gravity of the sample is the fitness-access segment (Wellhub, Urban Sports Club, EGYM Wellpass), reflecting that segment's commercial scale and dominance in DACH and Iberia. Mental-health, coaching and family-care provider perspectives are included as adjacent-segment triangulation. Because the category is defined by shared B2B go-to-market logic rather than by shared products, this segment heterogeneity is methodologically constitutive: the analytical question is whether providers across distinct product segments encounter the same institutional translation challenges when operating in DACH and Iberia.

6.4 Data Analysis

The expert-engagement material is analysed using Braun and Clarke's (2006, 2019) six-phase thematic analysis procedure, which guides the analysis from data familiarisation and initial coding through theme construction, review and definition to the production of an analytical account. The analysis treats both recurrent patterns across multiple informants and single analytically significant cases as findings, with the latter explicitly marked as such where they appear in Chapter 7. This dual treatment reflects established practice in qualitative case-study research, in which a single empirical case may carry analytical weight disproportionate to its frequency where it illustrates a mechanism that other informants only implicitly invoke (Yin, 2018; Eisenhardt, 1989). Coding follows an abductive logic. A set of deductive starter codes is derived from the three analytical frameworks set out in Chapter 5, namely institutional analysis, internationalisation process and buyer behaviour, and applied to the initial reading of the material. Inductive codes are added where the data exceeds the prior theoretical frame. This hybrid approach is consistent with established practice in case study research (Eisenhardt, 1989) and allows theoretical structure to guide interpretation without foreclosing emergent patterns. Coding was conducted in a structured Excel-based audit-trail workbook containing five tabs: sample profile, full passage corpus, codebook, frequency matrix and highlight register. Each coded passage was cross-referenced to the relevant source transcript or written response.

The analysis is conducted in two stages. Within-case analysis is performed separately for the German and Spanish primary cases, in which each interview is read against the three analytical frameworks and themes are constructed at the level of the country case. Cross-case analysis then compares the within-case themes across the two regional units, identifying convergences, divergences and boundary-spanning patterns drawn from the cross-market respondents. The three written expert responses are coded using the same deductive-inductive procedure but

recorded as a distinct data category in the audit trail. The starter codebook and a sample of emergent codes are presented in Appendix C.

6.5 Reliability and Validity

The quality of the research process is assessed through the four trustworthiness criteria established by Lincoln and Guba (1985): credibility, transferability, dependability and confirmability. Credibility is supported by triangulation across participant roles (commercial, partnership, strategic, institutional, market observer), regional perspectives (DACH-side, Iberia-side, cross-market) and between primary engagement data and secondary institutional literature. Transferability is supported by the thick contextual description in Chapter 3 and the participant profile in Appendix A, allowing readers to assess applicability to other settings. Dependability is supported by an audit trail from audio recording through transcription, coding and theme construction; the codebook in Appendix C and the retained source materials make the analytical reasoning reconstructable. Confirmability is supported through reflexive disclosure: the researcher acknowledges a personal interest in the topic of B2B corporate health, wellbeing and performance solutions, which motivated the topic selection and shaped the interpretive sensibility, but holds no prior or current commercial or employment relationship with any of the organisations represented in the sample and none of the participants were members of the researcher's professional network prior to the study.

6.6 Methodological Limitations

Several limitations frame the interpretation of the findings. First, the sample is provider-side dominated and includes only one institutional informant from the buyer-adjacent side and one industry observer; buyer perspectives are therefore captured primarily through provider accounts of client interactions, in line with the study's stated provider-side scope. Second, the Iberia-side evidence is concentrated around Wellhub-related informants, which limits the breadth of provider-level variation captured in the study. The limitation concerns provider diversity rather than internal perspective diversity. The Wellhub-related informants represent functionally different stages of the GTM process, including sales, customer success, country-level commercial execution, pricing, retention and expansion. This role-based triangulation is further supported by adjacent provider perspectives, such as Urban Sports Club Portugal and the iFeel cross-border informant, by the Wellhub Europe strategy perspective, by the DACH-side participant pool and by secondary institutional evidence. The findings should therefore be

read as analytically grounded insights into provider-side GTM adaptation rather than as a representative mapping of all Iberian corporate-health providers. Third, no primary data are drawn from Austrian, Swiss, or Portuguese-headquartered providers; the DACH and Iberia clusters are therefore treated through their primary reference markets, with the internal coherence argument developed in Chapter 3 providing the basis for regional-level inference; Switzerland's position outside the EU regulatory framework, including the direct scope of CSRD and EU occupational safety directives, reinforces Germany's role as the methodologically appropriate primary case for DACH-level inference. Rather than representing a weakness in the sample, Switzerland's exclusion avoids introducing an additional layer of regulatory non-comparability into the institutional analysis. Fourth, the study relies on mixed data formats, including verbatim transcripts, hybrid transcript-with-notes and structured written responses. Although this variation was managed through the distinct treatment described in Section 6.3, it remains a methodological compromise. Fifth, coding was conducted by a single researcher without formal inter-rater reliability assessment; the audit trail and the explicit deductive starter codebook partially mitigate this constraint.

Chapter 7: Findings

This chapter presents the findings from twelve expert engagements and the secondary contextual material reviewed in Chapter 3. The chapter is organised around two primary cases: Germany within DACH and Spain within Iberia. It then develops two cross-cutting themes: buyer-side dynamics as encountered by providers in their go-to-market activity and the patterns of adaptation that emerge when commercial strategies cross the regional boundary.

7.1 Overview of Findings

Four interlocking observations summarise the findings. Germany operates as an institutionally dense market in which BGM/BGF creates both category legitimacy and procedural complexity. Spain, lacking equivalent scaffolding, requires providers to construct the category through active buyer education. Buyer-side dynamics — HR initiation, champion criticality, finance validation — appear across both regions in institutionally differentiated form. Cross-border go-to-market is not the replication of a national playbook but the reconfiguration of its constituent elements for each institutional environment, a pattern this study labels institutional translation. Portugal, treated as secondary Iberian context, illustrates meaningful within-region heterogeneity.

7.2 Germany as the DACH Primary Case: Institutional Legitimacy and Procedural Complexity

The German evidence presents a market in which institutional density operates with a dual effect. On the legitimising side, the BGM/BGF discourse provides a shared professional vocabulary that providers can plug into without inventing the category. The institutional informant from a statutory health insurer describes how prevention is structured by the Präventionsleitfaden and how certified providers can become Rahmenvertragspartner with co-branded module catalogues (P02). As argued in Section 3.1.2, this architecture functions through its field-structuring effect rather than through direct financing of platform-based providers, giving commercial providers an institutional frame through which to position their offerings.

This legitimating infrastructure is paired with substantial procedural complexity. Providers consistently described a multi-stakeholder procurement structure in which HR initiates, the works council enters as a procedurally mandatory participant, the data protection officer

functions as a gatekeeper, finance validates the budget and for enterprise accounts a gremium-style approval body (i.e. a formal multi-stakeholder buying committee that must endorse the procurement before signature) completes the decision (P01, P02, P04, P11). The empirical effect of this configuration is measurable: deals involving works councils typically extend to between twelve and sixteen months from first contact to signature (P01), with one boundary-spanning informant describing three to four months of influencer engagement before a champion is even identified within a major DAX-listed automotive group (P11).

Sachbezug, the €50 monthly tax-free benefit allowance, structures the operationally relevant competitive frame in unexpected ways. Multiple providers reported that the dominant competitive comparison is not against other corporate-health offerings but against tax-equivalent alternatives such as fuel vouchers, transit subsidies and meal allowances, because these benefits compete for the same employer allocation (P04, P05). This frame fundamentally shapes pricing design and value-proposition construction at the German market level. As one provider put it, the operational competition is not against other BGM benefits, but against other Sachbezug benefits (P04).

Across the German evidence, the strategic status of corporate health has shifted from a discretionary benefit to a near-mandatory component of the employer value proposition. One provider describes this directly: you have to become a must-have, not a nice-to-have like the fruit basket. EGYM Wellpass has made it (P03). Talent attraction and retention, supported by the post-COVID employer shortage, function as the dominant decision criteria, more salient than absenteeism or productivity arguments alone (P02, P04, P05).

A persistent cognitive-cultural ceiling, however, distinguishes the German market from its Iberian counterpart. The Sozialstaat assumption that the welfare state already absorbs primary responsibility for employee health limits the persuasive force of pitch architectures developed elsewhere. The cross-border informant articulated this with unusual clarity: a Spain-tested absenteeism-and-political-context pitch ran empty for three months in Germany before being replaced by ESG-compliance and CSRD-reporting argumentation, which then proved a game-changer for entering a major automotive group (P11). The regulative wedge of the Corporate Sustainability Reporting Directive, in force since 2024, increasingly substitutes for the absenteeism frame as the primary legitimating argument at the C-level. Brand awareness functions as an additional entry condition (see Section 7.5 for the workshop-based marketing adaptation that follows).

7.3 Spain as the Iberian Primary Case: Category Education and Commercial Maturity

Spain operates as a more commercially developing corporate health, wellbeing and performance market than Portugal, but lacks the BGM/BGF scaffolding that legitimises the category in Germany. The strategic consequence, repeatedly described in role-differentiated Iberia-side accounts, is that providers occupy an active educator role alongside their selling function. Across these accounts, the same observation surfaces: vendors must construct the category, connect wellbeing to business impact and adapt the business case to the local institutional context (P07, P08, P09).

The Spanish primary case indicates that market entry into Iberia is determined by three sequential factors (population size, wellness culture, competitive presence) rather than by an existing institutional infrastructure to navigate (P07). Acquisition has been a recurring entry mode: Enjoy was acquired in Spain to consolidate position, and Portugal was exited and re-entered through Spain rather than as a standalone operation (P07). Where regulatory framing is limited, the relational dimension of procurement becomes proportionally more important. The Portuguese contextual evidence shows procurement involving HR first, then CEO and board at decision stage and Finance for budget release, without a Gremium-style approval body and without works-council intermediation comparable to the German Betriebsverfassungsgesetz architecture (P09). The Spanish provider corroborates: in Spain you have it relatively easily if you have the right contact to push a pilot through (P07).

Talent attraction, retention, productivity and employer branding emerge as the dominant commercial narratives in the Iberian market. The Portuguese provider uses an explicit reframe in her sales motion: she always tries to shift that mindset and position the platform as a strategic tool for talent attraction, talent retention, employer branding, reducing sick leave and employee engagement (P09). Local pricing and willingness-to-pay differ sharply from the German Sachbezug logic. The Spanish provider reports that an initial pan-European single-pricing strategy failed at the Iberian level: a price that for Germany was okay, for Spain was considered too expensive (P07). The Spanish market subsequently developed seven different membership plans to optimise local personalisation, which the same informant identifies as both an opportunity for adaptation and a source of choice overload (P07).

Portugal, treated as secondary Iberian contextual evidence, illustrates that the Iberian unit of analysis is not homogeneous. Wellhub- and Urban-Sports-Club-related informants describe a

structurally different Portuguese commercial environment: flex-benefit platforms such as Coverflex consume the majority of the employer-benefit budget, and sports-and-wellbeing benefits do not enjoy the same tax exemption as childcare, fuel and meal vouchers (P09). An Iberian buyer allocating the benefits budget therefore systematically prioritises tax-exempt essentials over discretionary wellbeing investment. Lower salaries, smaller company sizes and tighter budgets in Portugal further constrain discretionary spend on employer-procured wellness services. The within-Iberia asymmetry runs deeper: Spain, with longer-established sports-aggregator presence, has developed a recognisable category at the HR level (conversations focus on features, flexibility and value proposition), while Portugal still requires significant educational effort just to explain the multi-venue membership concept (P09). Iberia thus operates as an institutionally coherent unit on its regulatory and welfare-regime dimensions while exhibiting meaningful within-region variation on its commercial maturity dimensions.

7.4 Buyer Dynamics as Part of the Provider GTM Environment

From the provider-side GTM perspective, buyer dynamics in both regions exhibit a recognisable underlying architecture. Across the twelve engagements, providers consistently described Human Resources as the procurement initiator (P01, P02, P03, P04, P05, P07, P09, P11), with internal champions located variously in BGM, People-and-Culture, Compensation-and-Benefits, or HR-Business-Partner functions. Finance, in the person of the Chief Financial Officer or senior budget owner, validates the spend in both regions, although the threshold of involvement varies with deal size and account tier. Internal champions function as critical accelerators in both regional units. Across multiple engagements, their personal affinity to wellness and the prevention narrative emerged as a recurring predictor of deal velocity (P03, P04, P07, P09, P11).

What differs across the two cases is not the basic composition of the buying centre but the institutional configuration in which it operates. In Germany, providers described a procedurally formalised configuration in which works council, data protection officer and procurement function as additional procedurally mandatory participants beyond the HR-Finance-CEO core. For larger accounts, a Gremium or Corporate Health Gremium acts as a formal approval body that must be addressed before contract signature (P01, P02, P04, P11). The cross-border informant described the operational reality of this multi-stakeholder choreography: he had to speak not only with HR but with Health and Safety, HR with Talent Acquisition, until he could move to a position where he could speak with the Gremium (P11). In the Iberian context,

providers described a structurally smaller buying centre. The Portuguese provider notes that the final decision typically involves CEO, board and Finance, but without a formalised gremium-style approval architecture and without works-council intermediation comparable to German arrangements (P09). The Spanish SMB lead corroborates the procedural contrast: in Spain you have it relatively easily if you have the right contact (P07).

Across both regions, HR initiates demand; the difference lies in how many institutional actors must subsequently legitimate the decision. The decision-criteria layer also differs systematically between the two regions. In Germany, the ROI argument becomes central once procurement conversations reach the C-level and the increasingly material CSRD-compliance argument operates as a regulatory wedge that legitimises corporate-wellness investment within established reporting infrastructure (P11). In the Iberian context, providers describe a more affective value framing centred on talent attraction, retention, employer branding, productivity and motivation. The Portuguese provider operationalises this logic in her standard pitch, explaining that companies begin to understand the business value when wellbeing is connected to higher motivation, productivity and lower sick leave (P09). The process-structure dimension reflects this overall configuration difference: German enterprise sales cycles run twelve to sixteen months with works-council involvement and roughly six to twelve months in the SMB segment (P01, P03), while Iberian sales cycles are shorter in raw duration but constrained by an annual September budget-closing rhythm that materially affects timing (P09).

7.5 GTM Adaptation Across Borders

The most pervasive finding across the twelve engagements concerns the limited transferability of go-to-market playbooks across institutional contexts, what this study labels institutional translation: the recognition that what travels across the regional boundary is not the playbook itself but the capability to read each market's institutional language and to reconfigure the playbook's constituent elements accordingly. Providers consistently described attempts to apply playbooks developed in one market to another and consistently described the corrective adaptations that followed. Across the empirical material, eight dimensions of adaptation emerged as recurring: value proposition, pricing, ideal customer profile definition, sales process, proof and case-study infrastructure, partnership strategy, product packaging and market entry logic.

One analytically important cross-border case illustrates how value propositions can fail when transferred without institutional translation. A cross-border informant selling an Iberian mental-health platform into DACH described how a Spain-tested pitch, built around absenteeism statistics and the political salience of rising sick leave in Spain, generated no commercial traction in Germany for three months. The explanation offered was not that absenteeism was irrelevant, but that German employers already operated within an established workplace-health legal and institutional framework; the absenteeism frame therefore did not create a sufficiently distinctive legitimating wedge. The provider subsequently reframed the offer around ESG compliance and CSRD-readiness, positioning its data capabilities as relevant to workforce-related sustainability reporting. In this case, the CSRD frame helped convert a stalled enterprise pipeline into a viable entry route into automotive and adjacent industrial accounts (P11). While CSRD emerged in this case as a powerful enterprise-level positioning wedge, the pattern is illustrative rather than statistically representative across the sample. Its broader relevance is likely to grow where providers can translate wellbeing outcomes into reportable workforce metrics under EU sustainability-reporting obligations.

Pricing localisation operates as a parallel adaptation across providers. The Spanish SMB lead recounts a comparable correction at the platform level: the initial European single-pricing failed at the market level and a price that for Germany was okay, for Spain was considered too expensive (P07). Brazilian-origin assumptions, particularly minimum-employee thresholds of one thousand inherited from the parent company's home market, had to be unwound for European feasibility, with the threshold subsequently reduced to under five hundred employees to capture the relevant European mid-market (P07). The implication is that pan-regional pricing is not a configurable parameter but a structural constraint that must be calibrated against each local benefit-budget architecture.

Market entry logic itself adapts to institutional context. Acquisition functions as a recurring configuration of entry: Enjoy was acquired in Spain to consolidate position; the Urban Sports Club acquisition resolved a competitive overlap in Germany; the Romania entry was executed entirely through company acquisition (P07). The Portuguese exit-and-re-entry, routed through Spain rather than as a standalone operation, illustrates how proximity and existing networks substitute for fresh market entry when institutional context disfavours direct expansion (P07). The industry observer corroborates the consolidation dynamic at the market level (P06).

Proof and case-study infrastructure operates as a German-specific entry condition. Providers describe the German market's demand for established brand awareness, partner endorsements, LinkedIn visibility and structured pilot histories before procurement conversations can advance (P11). The corresponding adaptation is workshop-based marketing in place of digital outbound channels: events on mental health leadership, free in-house workshops for HR functions, structured network meetings and customer-success theatre with quarterly business reviews and two-to-three-year evaluation horizons (P01, P04, P11). As one provider puts it, providers do not invest in ads; they invest in workshops on mental health leadership, and that becomes the marketing budget (P11). In the Iberian context, the corresponding adaptation is more active category education: the Portuguese provider operates as an educator alongside her selling function, repeatedly connecting wellbeing to talent attraction, productivity and employer branding before negotiation can productively begin (P09).

Partnership strategy emerges as a distinctive adaptation route. The cross-border informant describes a coopetition pattern in which the platform he sells for has an API-level partnership with the principal European fitness-access provider, with revenue share on therapy hours referred through the platform (P11). The industry observer registers a corollary at the market level: the principal fitness-access platform has acquired its principal European competitor and the consolidation is reshaping the supply side around platform-of-platforms architectures (P06). The competitive landscape of the European corporate health, wellbeing and performance sector is increasingly characterised by coopetition rather than zero-sum rivalry.

A productive alternative explanation deserves consideration. The cross-market strategy lead observes that some differences between DACH and Iberian sales cycles reflect enterprise density rather than institutional context per se. As the informant explains, markets with a higher concentration of large enterprise clients tend to have longer sales cycles, not necessarily because of the country itself, but because of the type of clients targeted (P10). This nuance qualifies the institutional argument: not every observed difference between the regions can be reduced to institutional architecture; some differences reflect the configuration of clients reached within those architectures. The empirical material is best read as a layered explanation in which institutional environment establishes the terrain and client-mix density modulates how that terrain is encountered in practice.

7.6 Summary of Findings

Three syntheses follow from the empirical material. First, Germany within DACH and Spain within Iberia constitute structurally distinct institutional environments. Germany provides a layered institutional infrastructure consisting of BGM/BGF discourse, statutory-insurer support for certified prevention measures, statutory co-determination structures and an increasingly material CSRD reporting wedge. This infrastructure legitimises corporate health as an organisational concern and procedurally formalises its procurement. Spain provides thinner prevention-specific scaffolding, requires providers to construct category legitimacy through active buyer education and reflects a structurally different benefit-budget architecture in which the wellness category competes for allocation against tax-advantaged alternatives.

Second, the two regions share the same basic buying architecture but differ in the degree of institutional formalisation. In both contexts HR initiates the process, internal champions accelerate it and Finance validates the budget. The German setting layers further institutional actors onto this core: works councils, data protection officers and formal approval bodies. The Spanish process is more concentrated around smaller HR-CEO-Finance constellations and depends more strongly on personal affinity and internal advocacy. The difference lies not in which actors are involved but in how many must approve.

Third, cross-border GTM is best understood as institutional translation. Providers do not simply transfer a successful playbook from one market to another. They adapt its core elements, including value proposition, pricing, sales process, partnership architecture and proof infrastructure, so that the offer becomes legible and credible within the target market. Value propositions pivot from absenteeism to ESG-compliance arguments at the German level; pricing localises to each benefit-budget architecture; market entry routes through acquisition, partnership and embedded multinational hooks rather than direct competitive expansion. Portugal, as secondary Iberian contextual evidence, demonstrates that even within the Iberian unit of analysis there is meaningful within-region heterogeneity. The same translation challenge is observable across the four provider segments represented in the sample (fitness-access, mental-health, coaching and family-care), confirming the five-attribute cross-segment logic introduced in Section 4.1 and supplying institutional translation with its empirical foundation. The capability that transfers across the regional boundary is not the playbook itself but the capability to diagnose what must be adapted. Across provider categories, several GTM requirements recur in similar form: providers must educate buyers, prepare for multi-

stakeholder decision-making, localise pricing and build credible proof infrastructure. The concrete expression of these requirements, however, differs by segment. For fitness-access platforms, the German Sachbezug architecture, gym-and-studio partner density and exclusive-supplier dynamics are particularly important. For certified-prevention providers, ZPP authorisation and statutory-insurer cooperation become commercially relevant. For mental-health and coaching providers, legitimacy is more often built through learning-and-development, leadership-performance and resilience arguments rather than through absenteeism alone. The institutional translation challenge is therefore shared across segments, but each segment translates it into a different commercial vocabulary.

Chapter 8: Discussion, Conclusions and Recommendations

This chapter moves from the empirical observations of Chapter 7 to the analytical interpretation of what those observations contribute. It explains what the research has established (8.1), what the findings mean for the relevant theoretical literature (8.2), how each research question is answered (8.3), what practical recommendations follow for providers (8.4), what added value the study contributes (8.5), how the methodological limitations frame the conclusions (8.6) and the broader closing observation that ties the analysis together (8.7).

8.1 What the Research Establishes

The central claim this thesis establishes is that European expansion in B2B corporate health, wellbeing and performance is not primarily a matter of geographic replication. It is a matter of institutional translation: the capability to diagnose how each market legitimises health, organises buying decisions, allocates benefit budgets and interprets value, and to reconfigure the commercial playbook accordingly. Germany operates within a layered institutional infrastructure that legitimises the category and procedurally formalises its procurement; Spain operates with thinner prevention-specific scaffolding and requires providers to construct category legitimacy through active education and to localise the commercial logic to a distinct benefit-budget environment. Both markets converge on the operational mechanics of B2B procurement (HR initiation, champion criticality, adoption as success metric, talent attraction as dominant driver) but diverge on the institutional and competitive architectures into which those mechanics are embedded.

8.2 Theoretical Discussion and Contribution

The findings invite reconsideration of how the relevant theoretical streams apply to B2B corporate health, wellbeing and performance platform internationalisation. Institutional Theory is empirically affirmed but refined. Scott's three-pillar framework explains the DACH-Iberia divergence: institutional density operates across regulative, normative and cognitive-cultural pillars in Germany, while Iberia operates with thinner scaffolding across all three. The novel contribution is the recognition that institutions do not only constrain behaviour; they also legitimise categories. In Germany, the BGF/GKV/BGM apparatus structures the field rather than financing it: it legitimises workplace health as an organisational domain, supplies shared vocabulary across HR and works councils, and confers institutional credibility on providers

operating within the system. In Iberia, the weaker prevention-specific scaffolding places the legitimation burden on providers themselves. The field-structuring effect concept extends institutional theory's analytical reach beyond its traditional regulative and normative dimensions.

The Uppsala internationalisation model in its 2009 network revision receives strong empirical support. The findings substantiate its central claim that B2B expansion is a network-embedding rather than a knowledge-accumulation process. The principal European fitness-access platform's acquisition strategy across Romania, Spain and Germany exemplifies Uppsala network logic: acquisitions removed competitors and delivered instant local network position simultaneously. The Portuguese exit-and-re-entry trajectory exemplifies gradualist commitment, with re-entry routed through Spain rather than as a standalone investment. The cross-border informant's counter-factual that he would have opened DACH on partnerships only is Uppsala-consistent: insider status through partnership and adjacent-provider integration is a more efficient route to commercial viability than outsider direct sales.

The Resource-Based View and dynamic capabilities perspective offer complementary purchase. The findings indicate that the key strategic resource is not a fixed go-to-market playbook but the capability to reconfigure it. This is best characterised as institutional translation capability: a dynamic capability in the Teece-Pisano-Shuen sense with explicit institutional content, comprising the firm-level routines that allow providers to sense how each market structures category legitimacy, seize the appropriate commercial positioning and reconfigure the go-to-market playbook accordingly. Brand awareness, repeatedly identified as an entry condition in the empirical material, functions in RBV terms as an inimitable resource and is itself the product of cumulative dynamic capability through workshops, partner endorsements, structured proof-of-concept investment and customer-success theatre. The ESG-pivot, the market-specific pricing recalibration, the workshop-based DACH marketing investment and the consultative educator role in Iberia all function as dynamic capabilities: firm-level routines that sustain competitive position as institutional environments evolve. Finally, the B2B buying-behaviour literature is empirically affirmed at the structural level but refined at the configurational level. Webster and Wind's buying-centre roles (economic buyer, champion, influencer, gatekeeper) appear in the participant accounts almost verbatim across both regional units. The novel observation is that the buying-centre architecture is itself institutionally conditioned: the German Gremium-style approval body with its works-council, data-protection and finance interlinkage is not a universal feature of complex B2B procurement

but a DACH-specific instantiation reflecting the regulative and normative pillars of the surrounding institutional environment. The buying-centre concept must therefore be applied with explicit reference to institutional context rather than as a context-free generic.

8.3 Answering the Research Questions

RQ1 asked how the regulative, normative and cognitive-cultural conditions of DACH and Iberia differ in their implications for B2B corporate health, wellbeing and performance providers. Germany and Spain represent fundamentally different institutional configurations rather than different maturity points on a single trajectory. Germany delivers an institutionally dense environment in which BGM/BGF discourse, statutory-insurer support for certified prevention measures, Betriebsverfassungsgesetz co-determination and the CSRD-reporting wedge collectively legitimise and formalise the category. Spain operates within a compliance-first occupational-safety architecture without comparable category-specific scaffolding, with a distinct flex-benefit-budget logic and within a structurally different cognitive frame for employer responsibility for health. Portugal illustrates further within-Iberia heterogeneity along commercial-maturity rather than institutional-architecture dimensions.

RQ2 asked how corporate buyers evaluate and procure B2B corporate health, wellbeing and performance solutions in both markets, as understood through provider-side accounts. From the provider-side GTM perspective, HR initiates the conversation, Finance and senior leadership validate the budget and internal champions matter across both regional units. The difference lies in the formalisation of the buying centre: Germany operates through works councils, data protection officers and gremium-style approval bodies, generating sales cycles of twelve to sixteen months in the enterprise segment, while the Iberian context operates through a smaller HR-CEO-Finance triad with stronger personal-affinity dependencies and a structuring annual September budget-closing rhythm.

RQ3 asked how providers adapt value propositions, sales approaches and partnership strategies to market-specific institutional and buyer-side conditions. Providers adapt across eight recurring dimensions: value proposition, pricing, ideal customer profile, sales process, proof and case-study infrastructure, partnership strategy, product packaging and market entry logic. The most consequential adaptations include the German pivot from absenteeism to ESG-compliance argumentation, the failure of pan-European single pricing and the inversion of

marketing channel architecture between the regions. The playbook itself is not transferable; the capability to diagnose and adapt is transferable.

RQ4 asked what strategic recommendations follow from the comparative findings for providers planning expansion into either or both regions. The recommendations are developed in Section 8.4 below.

8.4 Managerial Recommendations

Five practitioner-oriented recommendations follow from the findings.

Recommendation 1: Use institutional legitimacy as a GTM asset in DACH. Providers should not rely on statutory reimbursement for platform models, since direct co-financing of broad commercial platforms is not within the scope of GKV support. Instead, they should align their value proposition with the legitimacy logic of the BGM and BGF apparatus. This means structured prevention framing, demonstrable health outcomes, ZPP authorisation where statutory-insurer cooperation is commercially viable, works-council readiness in procurement documentation and GDPR compliance as a baseline expectation.

Where the provider operates at enterprise scale and the buyer organisation is subject to EU sustainability-reporting obligations, the Corporate Sustainability Reporting Directive may emerge as an additional positioning wedge, particularly when the provider can translate wellbeing outcomes into reportable workforce metrics. This route is selective rather than universal and applies most directly to providers in the certified-prevention or data-analytics-capable spaces; mental-health and coaching platforms may instead anchor positioning in learning-and-development or leadership-performance logic.

Recommendation 2: Build the category before pushing the product in Iberia. Providers entering or expanding in Spain and Portugal should treat category creation as a structural component of the sales motion rather than as a marketing afterthought. Buyer education, the connection of wellbeing to talent attraction, retention, productivity and employer branding, and the active construction of business cases adapted to local maturity levels are foundational. Spain and Portugal should not be treated as identical entries: Spain operates with greater category awareness and structurally different commercial scale than Portugal.

Recommendation 3: Localise pricing and benefit-budget logic. Pan-European pricing has been empirically demonstrated to fail. Germany's Sachbezug architecture, Portuguese flex-benefit

competition (Coverflex and equivalents) and Spanish willingness-to-pay dynamics require distinct pricing assumptions. Pricing-tier complexity should be calibrated against local choice tolerance, since Spain's seven-tier architecture has been shown to introduce choice overload, and freemium mechanisms should be considered for markets where willingness-to-pay starts from a low baseline. Pricing implications are segment-specific: for fitness-access platforms, the German Sachbezug allowance operates as a hard structural constraint contested by benefit-budget alternatives (transit, fuel, meal vouchers); for mental-health, coaching and family-care platforms, the relevant pricing logic operates through the buyer's broader benefit-budget or L&D-budget allocation, implying different price-anchoring conversations across segments.

Recommendation 4: Enter through networks, not direct sales alone. Partnerships, local studio and gym networks, broker and insurer relationships, platform-of-platforms integrations, referenceable client bases and multinational client hooks are core go-to-market assets in both markets. Platform coopetition through API-level integration with adjacent providers represents a third strategic option alongside direct competition and acquisition, particularly relevant for moderate-scale providers with limited brand awareness. Network composition differs by segment: for fitness-access platforms, the supply-side gym-and-studio network is foundational; for mental-health platforms, partnerships with insurers, EAPs and adjacent therapy services become commercially central; for coaching platforms, L&D-consultancy networks and HR-tech integrations carry more weight. Multinational client hooks and referenceable enterprise relationships, however, function as universal market-entry assets across all four segments.

Recommendation 5: Quantify value without reducing wellbeing to ROI alone. Providers should build the quantification infrastructure that translates soft wellbeing outcomes into legible metrics (usage, adoption, retention, productivity, CSRD-reportable indicators) while preserving the broader Value-on-Investment framing where buyer disposition allows. The regulative environment is converging in this direction across Europe; quantification capability will increasingly determine category retention as the market matures.

8.5 Added Value of the Thesis

The study's distinctive added value lies in the concept of institutional translation: cross-border growth in B2B corporate health, wellbeing and performance depends less on exporting a scalable playbook than on translating it into the institutional language through which each market makes health commercially credible. Four further contributions follow. First, it applies

established internationalisation and institutional theory to an under-researched B2B platform context. Second, it provides a structured provider-side go-to-market perspective on corporate health, wellbeing and performance expansion across European markets, drawing on twelve role-differentiated expert engagements. Third, it shows that the DACH-Iberia comparison is not adequately captured as a difference in market maturity but reflects fundamentally different institutional architectures through which corporate health becomes legitimate and commercially actionable. Fourth, it offers practitioners a diagnostic framework spanning the institutional analysis tool, the internationalisation process tool and the buyer-behaviour tool for adapting go-to-market strategy across institutionally heterogeneous European markets.

8.6 Limitations and Future Research

Five limitations frame the conclusions. The study is provider-side by design, consistent with its go-to-market focus; buyer-side dynamics are interpreted through provider accounts of client engagement rather than through direct buyer interviews. Germany and Spain function as primary empirical cases, with Austria, Switzerland and Portugal as contextual extensions rather than equivalent empirical units. The Iberia-side evidence is concentrated around Wellhub-related informants; this limits broad provider-level representativeness but not analytical depth, since these voices represent different roles and stages of the GTM process and the sample still provides substantial internal perspective diversity. Data formats are mixed (verbatim transcripts, hybrid transcript-with-notes, structured written responses). Coding was conducted by a single researcher without formal inter-rater reliability assessment, with the explicit deductive starter codebook and audit trail as partial mitigations. A further limitation concerns the segment-specificity of certain findings. Cross-segment patterns (HR initiation, champion criticality, adoption as success metric, pricing localisation) apply broadly across the four provider categories. Segment-specific patterns (Sachbezug for fitness-access, ZPP authorisation for certified-prevention, L&D-positioning for coaching platforms) are signalled as such in Chapters 7 and 8 but warrant further research disaggregating by segment more systematically.

Future research should include buyer-side studies with HR, Finance, procurement and works councils to test alignment and divergence with provider-side accounts; primary research in Austria, Switzerland and Portugal to test the within-region coherence arguments developed in Chapter 3 with primary data; comparative studies across additional providers in Iberia to broaden provider-level diversity; longitudinal study of CSRD and ESG effects on corporate-

health procurement to establish whether the regulative wedge consolidates as a durable category driver; and theoretical research on provider-side go-to-market adaptation in institutionally fragmented service markets.

8.7 Final Conclusion

The challenge of crossing borders in B2B corporate health, wellbeing and performance is not entering another country: it is institutional translation, learning the institutional language through which the category becomes credible, valuable and commercially scalable in each target market. Providers who treat European expansion as geographic replication will encounter the same structural friction repeatedly. Providers who treat it as institutional translation, diagnosing how each market legitimises health, organises procurement, allocates benefit budgets and interprets value, and reconfiguring their commercial playbook accordingly, develop the capability that distinguishes durable cross-regional success from costly localisation failure.

Chapter 9: References

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Appendix A: Sample Profile

This appendix presents the complete profile of the twelve expert engagements that constitute the primary dataset of this study. All participants were recruited via LinkedIn, with no prior professional relationship to the researcher. Anonymisation follows the protocol described in Section 6.3.

ID	Anonymised Description	Role / Organisation Type	Market Focus	Format	Language	Duration	Date
P01	Enterprise Sales, fitness-access platform (DACH)	Urban Sports Club (USC) — DACH Enterprise Sales	DACH	Verbatim	DE	31 min	08.04.2026
P02	BGM advisory, statutory health insurer (Germany)	BARMER — BGM advisory, Munich	DACH	Verbatim	DE	28 min	23.03.2026
P03	Business Development Team Lead, mental-health platform (DACH)	B2B Wellness Provider — DACH BDA Team Lead	DACH	Verbatim	DE	23 min	08.04.2026
P04	Sales, fitness-access platform (DACH)	EGYM Wellpass — DACH Sales	DACH	Hybrid (Gemini)	DE	25 min	25.03.2026
P05	Sales / Field, fitness-access platform (DACH)	Wellhub DACH — Sales / Intro Meeting	DACH	Hybrid (Gemini)	DE	18 min	23.04.2026
P06	Industry-event organiser / market observer (DACH)	Meet the Top Events — DACH market observer	DACH	Written response	DE	—	May 2026
P07	Head of SMB, fitness-access platform (Spain)	Wellhub — SMB Spain Lead	Iberia	Verbatim	EN	26 min	20.03.2026

P08	Client Success, fitness-access platform (Iberia)	Wellhub — Iberia Client Success	Iberia	Written response	EN	—	May 2026
P09	Senior BDR, fitness-access platform (Portugal)	Urban Sports Club Portugal — Senior BDR	Iberia	Written response	EN	—	May 2026
P10	Europe Strategy, fitness-access platform (Cross-market)	Wellhub — Europe Strategy	Cross-market	Hybrid (Gemini)	EN	30 min	20.03.2026
P11	Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	iFeel — Spain-based, sells into DACH (Cross-Border)	Cross-market	Hybrid (Gemini)	DE	56 min	12.05.2026
P12	Corporate Account Executive, fitness-access platform (Portugal)	Urban Sports Club Portugal — Corporate Account Executive	Iberia	Written response	EN	—	May 2026

Appendix B: Interview Guide

The interviews were semi-structured: a common analytical anchor (the four research questions of this study) framed every engagement, while the specific question set was tailored to each participant on the basis of their role, organisation and market focus. The structured written responses sent by email followed the same logic and the same anchor. The general question architecture is reproduced below; the specific instrumentations for each engagement are retained in the researcher's records.

Block 1 — The Market and Its Stage of Development (anchor RQ1)

1. How would you describe the current stage of development of the corporate health, wellbeing and performance market in your region, and the forces driving its evolution?

2. Which regulatory, normative or cultural factors most strongly shape how the category is perceived and procured by employers in your market?

Block 2 — Buyer Behaviour and Procurement (anchor RQ2)

3. Who initiates the procurement conversation in a typical engagement, and which other functions become involved as the decision progresses?

4. What are the dominant decision criteria you observe at C-level, and how do they differ from those at the operational HR level?

5. How long do enterprise sales cycles typically run, and what are the most frequent friction points?

Block 3 — Go-to-Market Adaptation (anchor RQ3)

6. When you compare how the offer is positioned across the markets you operate in, which elements (value proposition, pricing, sales process, partnerships, proof infrastructure) require the most adaptation?

7. Can you describe a concrete case in which a playbook developed for one market did not transfer to another, and what you did about it?

8. How do you build credibility and proof for a new market entry, given the buyer's typical evaluation criteria?

Block 4 — Strategic Recommendations (anchor RQ4)

9. What is the single most important insight you would share with a B2B corporate health, wellbeing and performance provider planning to enter the market you know best?

10. Looking forward over the next two to three years, which regulatory, demographic or competitive shifts will most strongly reshape the GTM logic in your region?

Appendix C: Codebook

The codebook below documents the complete set of codes applied to the empirical material. Deductive starter codes were derived from the three analytical frameworks set out in Chapter 5 (Institutional Analysis, Internationalisation Process, Buyer Behaviour). Inductive codes were added where the data exceeded the prior theoretical frame. Each code is mapped to its theoretical source and assigned a dimension within the relevant framework.

Code ID	Code Name	Definition	Tool	Dimension	Theoretical Source	Type
REG-01	Data protection regimes	GDPR/DSGVO and equivalent national data protection laws as constraint on	Institutional Analysis	Regulative	Scott (2014); EU Regulation 2016/679	Deductive

		health data handling				
REG-02	Occupational safety legislation	National OSH/prevention frameworks: LPRL ES; Lei 102/2009 PT; ArbSchG DE; ASchG AT	Institutional Analysis	Regulative	Scott (2014); national statutes	Deductive
REG-03	Social insurance and prevention funding	Statutory health insurer role in funding prevention; GKV/SGB V (DE), ÖGK (AT), KVG (CH), Seguridad Social (ES)	Institutional Analysis	Regulative	Scott (2014); national statutes	Deductive
REG-04	Co-determination and works council rights	Formal employee-representative consultation obligations; BetrVG; Comité de Empresa	Institutional Analysis	Regulative	Scott (2014); BetrVG	Deductive
REG-05	ESG / CSRD reporting	EU Corporate Sustainability Reporting Directive and related ESG obligations affecting workforce-health disclosure	Institutional Analysis	Regulative	EU Directive 2022/2464	Deductive
REG-06	Tax treatment of corporate health benefits	Tax-deductible Sachbezug; €50 monthly threshold (DE); fringe-benefit treatment	Institutional Analysis	Regulative	Scott (2014); EStG	Deductive
NORM-01	BGM/BGF professional discourse	Established professional vocabulary and norms for Betriebliches Gesundheitsmanagement in DACH	Institutional Analysis	Normative	Scott (2014); Badura et al. (2010)	Deductive
NORM-02	HR role expectations vis-à-vis vendors	Professionally accepted standards for how HR engages with corporate-health vendors	Institutional Analysis	Normative	Scott (2014); Homburg et al. (2002)	Deductive
NORM-03	Multi-stakeholder approval as legitimacy	Expectation that vendor adoption involves multiple internal stakeholders for legitimacy, not single-actor decisions	Institutional Analysis	Normative	Scott (2014); DiMaggio & Powell (1983)	Deductive

NORM-04	Compliance documentation as entry condition	GDPR readiness, DPAs, programme certification as baseline expectations for procurement entry	Institutional Analysis	Normative	Scott (2014)	Deductive
NORM-05	Workshop / education-based vendor legitimacy	Use of free educational events as legitimacy-building practice in dense institutional contexts	Institutional Analysis	Normative	Emergent from data + Scott (2014)	Deductive
COG-01	Mental health stigma and discretionary framing	Cultural reservations about discussing mental health at work; mental-health support read as discretionary rather than core	Institutional Analysis	Cognitive-cultural	Scott (2014); Eurofound (2024)	Deductive
COG-02	Sozialstaat assumption	Taken-for-granted belief that the welfare state already absorbs responsibility for employee mental and physical health	Institutional Analysis	Cognitive-cultural	Scott (2014); Esping-Andersen (1990)	Deductive
COG-03	Preventive vs. reactive logic	Mental model of employer health responsibility as preventive (proactive) versus reactive (compliance-driven)	Institutional Analysis	Cognitive-cultural	Scott (2014); Magnavita et al. (2017)	Deductive
COG-04	Employer responsibility framing	How interview participants frame whether and to what extent employers bear responsibility for employee wellbeing	Institutional Analysis	Cognitive-cultural	Scott (2014)	Deductive
COG-05	Relational vs. rule-based business culture	Spanish/Iberian high-context, relationship-based business interaction vs. DACH rule-based, formalised model	Institutional Analysis	Cognitive-cultural	Scott (2014); Eurofound (2023)	Deductive
COG-06	Brand awareness and proof-of-concept expectation	Cultural expectation of established brand presence / case	Institutional Analysis	Cognitive-cultural	Scott (2014); emergent	Deductive

		studies before vendor engagement (DACH-specific)				
KD-01	Experiential learning / pivot moments	Identification of specific moments where in-market learning forced a shift in approach	Internationalisation Process	Knowledge Development	Johanson & Vahlne (2009)	Deductive
KD-02	Pitch / value-proposition iteration	Iterative adaptation of the value proposition and pitch language to local market	Internationalisation Process	Knowledge Development	Johanson & Vahlne (2009)	Deductive
KD-03	Pricing and packaging adaptation	Localised pricing models, payment terms, tier structures	Internationalisation Process	Knowledge Development	Johanson & Vahlne (2009)	Deductive
KD-04	ICP definition and refinement	Iterative refinement of the Ideal Customer Profile (segment size, sector, location)	Internationalisation Process	Knowledge Development	Johanson & Vahlne (2009)	Deductive
KD-05	US/global benchmarks for European calibration	Use of US or global market patterns as benchmark for European market design	Internationalisation Process	Knowledge Development	Johanson & Vahlne (2009)	Deductive
NET-01	Supply-side partner alliances	Partnerships with gyms, studios, fitness chains as supply network	Internationalisation Process	Network Embedding	Johanson & Vahlne (2009)	Deductive
NET-02	Adjacent provider partnerships	Partnerships with mental health, nutrition, insurance, telemedicine providers	Internationalisation Process	Network Embedding	Johanson & Vahlne (2009)	Deductive
NET-03	Broker / channel / employer-side intermediaries	Use of insurance brokers, consultancies, employer-side intermediaries as access channels	Internationalisation Process	Network Embedding	Johanson & Vahlne (2009)	Deductive
NET-04	Referenceable client base	Importance of named client references for new market entry / case-study legitimacy	Internationalisation Process	Network Embedding	Johanson & Vahlne (2009)	Deductive
NET-05	Insider status / outsider liability	Friction associated with outsider position in local business networks	Internationalisation Process	Network Embedding	Johanson & Vahlne (2009)	Deductive
CAP-01	Methodology / playbook transfer	What sales / GTM playbook elements travel	Internationalisation Process	Capability Transfer	Barney (1991); Teece et al. (1997)	Deductive

	from home market	directly from home market				
CAP-02	Brand assets and data depth as transferable resources	Brand recognition, data analytics infrastructure as travelling assets	Internationalisation Process	Capability Transfer	Barney (1991)	Deductive
CAP-03	Local hiring and team build	Decision to hire locally vs. operate from headquarters	Internationalisation Process	Capability Transfer	Teece et al. (1997)	Deductive
CAP-04	Acquisition as market entry mode	Use of M&A to acquire local presence (e.g., Enjoy ES; USC DE acquired by Wellhub)	Internationalisation Process	Capability Transfer	Teece et al. (1997)	Deductive
CAP-05	Pricing model transfer and local recalibration	Pricing model changes from home-market to host-market	Internationalisation Process	Capability Transfer	Barney (1991); Teece et al. (1997)	Deductive
BC-01	HR as initiator	HR (Head of HR, Benefits Manager, Occupational Health Lead) typically initiates the procurement conversation	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972)	Deductive
BC-02	Champion role	Internal advocate positioned to push the deal forward within the organisation	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972); Homburg et al. (2002)	Deductive
BC-03	Economic Buyer (CFO / budget owner)	Individual with formal budget authority to approve the spend	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972)	Deductive
BC-04	Influencer (cross-functional)	Influencing stakeholders from Health & Safety, Talent Acquisition, D&I, Corporate Health Manager	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972)	Deductive
BC-05	Works council / Betriebsrat as veto stakeholder	Mandatory consultation rights of works councils on benefit/health programmes	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972); BetrVG	Deductive
BC-06	Data Protection Officer as gatekeeper	DPO involvement as gatekeeping role for any data-handling vendor	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972)	Deductive
BC-07	Gremium / multi-stakeholder approval body	Formal committee-style approval mechanism common in	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972); Homburg et al. (2002)	Deductive

		DACH enterprise procurement				
BC-08	Procurement involvement	Role of procurement function as formal process gatekeeper	Buyer Behaviour	Buying-Centre Composition	Webster & Wind (1972)	Deductive
DC-01	ROI / cost-reduction framing	Value framed as healthcare cost reduction, absenteeism savings, financial ROI	Buyer Behaviour	Decision Criteria	Homburg et al. (2011); Ozminkowski et al. (2016)	Deductive
DC-02	VOI / broader value framing	Value framed as engagement, retention, organisational resilience — Value on Investment	Buyer Behaviour	Decision Criteria	Pronk (2014); Ozminkowski et al. (2016)	Deductive
DC-03	ESG / CSRD compliance argument	Value framed as supporting ESG reporting / CSRD compliance obligations	Buyer Behaviour	Decision Criteria	Emergent; EU Directive 2022/2464	Deductive
DC-04	Productivity and presenteeism	Value framed as productivity gain or presenteeism reduction	Buyer Behaviour	Decision Criteria	Homburg et al. (2011)	Deductive
DC-05	Absenteeism reduction	Value framed specifically through reduction in sick days / absenteeism	Buyer Behaviour	Decision Criteria	Baicker et al. (2010); Ozminkowski et al. (2016)	Deductive
DC-06	Employer branding / talent attraction	Value framed through employer brand effect, attractiveness to candidates	Buyer Behaviour	Decision Criteria	Homburg et al. (2011)	Deductive
DC-07	Retention argument	Value framed through retention of existing employees	Buyer Behaviour	Decision Criteria	Homburg et al. (2011)	Deductive
DC-08	Mental health legitimacy	Discussion of whether mental-health framing itself is legitimate as a procurement justification	Buyer Behaviour	Decision Criteria	Webster & Wind (1972)	Deductive
PS-01	Outbound vs. inbound origination	Deal origination through outbound prospecting vs. inbound marketing-generated leads	Buyer Behaviour	Process Structure	Homburg et al. (2011)	Deductive

PS-02	Qualification stage friction	Friction or extended duration in initial qualification stage	Buyer Behaviour	Process Structure	Homburg et al. (2011)	Deductive
PS-03	Sales cycle length	Total duration from first contact to signed contract	Buyer Behaviour	Process Structure	Homburg et al. (2002)	Deductive
PS-04	Deal-stall points	Specific points at which deals stall (price, compliance, escalation, championship loss)	Buyer Behaviour	Process Structure	Homburg et al. (2002)	Deductive
PS-05	Pilot structure and scaling logic	Use of pilot phases, conditions for scale-up, pilot-to-rollout dynamics	Buyer Behaviour	Process Structure	Homburg et al. (2011)	Deductive
PS-06	Workshop / event-based entry route	Use of free workshops, expert events as alternative entry route into accounts	Buyer Behaviour	Process Structure	Emergent	Deductive
PS-07	Contract signature triggers	Specific events that catalyse signature (budget cycle, regulatory deadline, internal champion change)	Buyer Behaviour	Process Structure	Homburg et al. (2002)	Deductive
EM-01	Brand presence as DACH entry condition	Cultural expectation in DACH that vendor brand presence, LinkedIn visibility and case studies are precondition for engagement — beyond standard COG-06	Emergent	Cognitive / Process	Andreas (AK-13, AK-14)	Emergent
EM-02	Coopetition via API integration	Competitive landscape feature whereby ostensibly competing providers integrate via API and revenue share rather than compete head-to-head	Emergent	Network / Strategy	Andreas (AK-15)	Emergent
EM-03	Quantification imperative	DACH-specific pressure to translate soft outcomes	Emergent	Cognitive / Decision Criteria	Andreas (AK-20, AK-21)	Emergent

(mental health, wellbeing) into business-intelligence-style quantified metrics

Appendix D: Frequency Matrix

The frequency matrix below records the number of passages coded to each code-category for each participant. Rows represent participants; columns represent the ten high-level code categories (REG = Regulative, NORM = Normative, COG = Cognitive-cultural; KD = Knowledge Development, NET = Network Embedding, CAP = Capability Transfer; BC = Buying Centre, DC = Decision Criteria, PS = Process Structure; EM = Emergent inductive codes). The matrix is generated automatically from the All-Passages corpus.

Participant	Regulative	Normative	Cognitive-cultural	Knowledge Development	Network Embedding	Capability Transfer	Buying Centre	Decision Criteria	Process Structure	Emergent	Total
	REG	NORM	COG	KD	NET	CAP	BC	DC	PS	EM	ALL
P01 — Christian Lieder	4	6	8	8	4	7	2	4	4	0	20
P02 — Christine (Tine)	9	11	5	1	10	4	2	6	3	0	20
P03 — Kristin Wohlfeil	1	9	6	5	2	2	4	10	8	0	20
P04 — Maximilian Bauer	4	5	7	10	5	4	5	5	8	0	21
P05 — Melis Oezer	1	8	6	4	5	2	3	8	4	0	17
P06 — Benedikt Schob	4	6	4	8	6	3	0	2	1	0	12
P07 — Julio	0	3	5	12	7	7	3	4	4	0	19

P08 — Bruno	0	6	3	4	7	3	2	6	8	0	13
P09 — Sara	2	6	14	7	5	2	4	8	4	0	21
P10 — Giulia Schivardi	1	6	2	9	6	10	2	1	4	0	16
P11 — Andreas Koch	4	7	8	8	5	4	8	5	6	5	22
P12 — Vitor Rocha	2	1	7	4	2	2	1	5	1	0	9
TOTAL	**32**	**74**	**75**	**80**	**64**	**50**	**36**	**64**	**55**	**5**	**210**

Appendix E: Highlight Passages

The passages below are the analytically most significant quotes extracted from the empirical material. Each passage is identified by a unique passage ID, the anonymised participant identifier and an approximate source timestamp. The codes assigned to each passage map to the codebook in Appendix C. These highlights are referenced selectively in Chapters 7 and 8 to illustrate key analytical claims; the full corpus of coded passages is retained in the researcher's audit trail.

Passage ID	Participant (anonymised)	Source	Quote	Codes	Theme Cluster
AK-02	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~07:59	Du guckst halt hin, wer ist Influencer, wer ist Champion, wer ist Economical Buyer. Der Champion ist der, der das durchdrückt, der Influencer ist der, der das positioniert.	BC-02, BC-03, BC-04	
AK-04	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~10:57	Hat in Spanien funktioniert, aber in Deutschland sind wir mit dieser Nachricht erstmal 3 Monate leer gelaufen. Deutschland ist das, was angeht, schon seit 15 Jahren irgendwo wenigstens legal abgedeckt.	KD-01, REG-03, COG-02	
AK-05	P11 — Senior Sales & GTM, mental-health platform	~12:35	Bei einem Piloten in Spanien hast du es relativ einfach, wenn	PS-03, PS-05, BC-07, COG-05	

	(Iberia-based, DACH-facing)		du einen richtigen Kontakt hast. In Deutschland ist es dann doch eher eine Multistakeholder-Geschichte: Gremium, Corporate Health Gremium, je nach Firma.	
AK-06	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~13:58	Bei einer DAX-listed automotive group musste ich nicht nur mit HR sprechen, sondern Health and Safety, HR mit Talent Acquisition, bis ich mich zum Gremium hinbewegen konnte und wir die Chance bekamen, uns vorzustellen.	BC-04, BC-05, BC-07, NORM-03, PS-04
AK-07	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~14:30	Statt ROI in Spanien ging es in Deutschland mehr um ESG-Compliance. Es ist legal von der EU beschlossen worden, dass ESG-Kennzahlen berichtet werden müssen. Von 100% der ESG-Kennzahlen konnten wir mit unserer Datentiefe 66% abbilden.	REG-05, DC-03, KD-01, KD-02, CAP-02
AK-11	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~23:26	Drei, vier Monate habe ich mit sämtlichen Influencern gesprochen. Dann irgendwann an einen Champion, der was bei der Gruppe zu sagen hatte. Der ist zurück zu seinem Gremium gegangen — das war dann das erste richtige Gespräch auf C-Level, down to facts: welches Problem, welche Daten, welche Preise.	PS-03, PS-04, BC-07, BC-03
AK-12	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~26:01	ROI wird wichtig, sobald du C-Level sprichst. Aber der Influencer im Front-End ist mehr am Value of Investment interessiert — was hast du für	DC-01, DC-02, BC-04, BC-03

			intangible, was für tangible returns?	
AK-13	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~28:24	In Deutschland zeigen sie dir einen Vogel, wenn du als No-Name ohne Brand-Awareness an den Markt kommst. Warum gibt es da keine Case Studies, warum hat der Partner euch nicht auf LinkedIn gepostet?	COG-06, NET-04, PS-05, EM-01
AK-14	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~29:37	Du investierst nicht in Ads, du investierst nicht in Instagram Ads. Du machst Workshops: Mental Health Leadership, was sind Anzeichen im Team, wie kannst du die aufschnappen. Das ist dein Marketingbudget.	PS-06, NORM-05, KD-02, COG-06, EM-01
AK-15	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~32:02	Mit Wellhub gibt's eine Partnership — die kaufen unseren Service ein, um deren Service anzubieten. API Integration: wenn jemand über Wellhub Therapie bezieht, gibt's einen Cut.	NET-02, CAP-04, EM-02
AK-16	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~32:50	Ich hätte den Markt nur erstmal auf Partnerships aufgemacht — Wellhub, Versicherung, Axa. Weil die Value Proposition und der ROI-Case dort tausendmal besser eingewertet ist als im Direct-Sales.	NET-01, NET-02, KD-01
AK-20	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~43:32	Deutschland ist noch zu sehr von wegen: ja, wir sind Sozialstaat, wir haben komplette Versicherung, die Leute haben die Möglichkeiten. Es ist immer noch sehr als Sternchen gesehen, als extra Benefit, anstatt als Notwendigkeit.	COG-02, COG-04, COG-01, EM-03

AK-21	P11 — Senior Sales & GTM, mental-health platform (Iberia-based, DACH-facing)	~46:14	Wenn du eine 1-Euro-Kettenreaktion zeigen kannst — 1 € Investment, 30% weniger Probleme oder 30% mehr Kapazität — wenn du das nicht schaffst, kommen die Firmen nicht in Bewegung.	DC-02, DC-04, REG-05, EM-03
CH-05	P01 — Enterprise Sales, fitness-access platform (DACH)	~07:30	Sobald Betriebsräte dabei sind, ziehen sich Deals auch mal gerne auf 12 bis 16 Monate. Betriebsräte sind in Deutschland wirklich ein sehr stark Einfluss nehmender Faktor — normalerweise eher positiver Einfluss auf die Einführung, aber bürokratische Hürde.	REG-04, BC-05, NORM-03, PS-03
CH-07	P01 — Enterprise Sales, fitness-access platform (DACH)	~11:30	Wir haben drei Problemfelder, die wir abdecken: Krankheitstage, Talent Attraction, Talent Retention. Du versuchst Kausalketten zu schnüren, die dein Argument mit einer klaren Zahl darstellen — auch ein schwierig zu greifendes Produkt wie Wellbeing.	DC-01, DC-05, DC-06, DC-07, DC-02
CH-11	P01 — Enterprise Sales, fitness-access platform (DACH)	~17:00	In Deutschland ein sehr arbeitnehmerfreundlicher Markt. Durch diesen Arbeitnehmer-fokussierten Markt bekommt der Arbeitnehmer eine größere Stimme und Wichtigkeit — und somit auch Produkte wie der Corporate-Health-Bereich höhere Importance.	COG-04, NORM-01, REG-04
CH-15	P01 — Enterprise Sales, fitness-access platform (DACH)	~20:30	Internationale, besonders amerikanische Firmen mit Verständnis von Wellbeing aus ihrem Mutterland — die haben dann eine höhere Adoption Rate. Manche	KD-04, COG-04, NET-04, CAP-01

			bringen aber auch ihr eigenes Wellbeing-Paket mit aus dem amerikanischen Raum.	
CH-18	P01 — Enterprise Sales, fitness-access platform (DACH)	~25:00	Jeder hat andere Exklusivverträge. Bei dem einen ist McFit dabei, bei dem anderen Basic Fit, der eine hat Fitness First, der andere Holmes Place. Persönliche Präferenzen der Mitarbeiter spielen mit rein.	NET-01, COG-05
CH-19	P01 — Enterprise Sales, fitness-access platform (DACH)	~27:00	Erfolgsfaktoren vorher definieren, Datenerhebung schon vor Einführung. QBR-Meetings — Nutzung des Produkts messen plus auf die Erfolgsfaktoren zurückreferieren. Brauchst mindestens 2-3 Jahre für statistisch relevante Zahlen.	DC-04, DC-05, NORM-04, PS-05, PS-07
CT-02	P02 — BGM advisory, statutory health insurer (Germany)	~04:30	Wir sind an den Leitfaden Prävention gebunden, der ist vom GKV-Spitzenverband. Da ist genau definiert, was wir im Rahmen von betrieblicher Gesundheitsförderung — Paragraph 20 — fördern dürfen und was nicht. Sowas wie Urban Sports und EAPs dürfen wir nicht fördern, da fehlt der betriebliche Kontext.	REG-03, REG-02, NORM-04, NORM-01
CT-07	P02 — BGM advisory, statutory health insurer (Germany)	~12:30	Wenn wir vom Mittelstand oder Startups reden, ist es eher in der HR-Ebene. Bei Großkonzernen mahlen die Mühlen sehr langsam — Betriebsrat ist dabei, oft CPO, also Chief People Officer federführend. Bei Projektfördervereinbarungen müssen	BC-01, BC-03, BC-05, BC-07, PS-03

			Personen unterschreiben — dann geht es immer mehr Instanzen nach oben.	
CT-12	P02 — BGM advisory, statutory health insurer (Germany)	~17:00	Wenn man als Anbieter sagt: ich habe eine Krankenkasse, die bezuschussen kann — ist es für die Anbieter auf jeden Fall ein Vorteil. Gerade jetzt, wo die Unternehmen sparen.	REG-03, NET-03, CAP-02, DC-01
CT-14	P02 — BGM advisory, statutory health insurer (Germany)	~17:45	Es gibt die ZPP-Zertifizierung — zentrale Prüfstelle Prävention. Wenn das mal zertifiziert ist, ist meistens ein langer Weg für die Anbieter. Aber dann ist es für uns leichter zu bezuschussen.	REG-03, NORM-04
CT-19	P02 — BGM advisory, statutory health insurer (Germany)	~23:30	Einem neuen B2B-Anbieter, der den deutschen Markt erschließen möchte: sich von der ZPP zertifizieren lassen — damit habe ich die Eintrittskarte für Krankenkassenerstattungen. Und mit einer Krankenkasse zusammenarbeiten. Damit kann man sich gegenseitig Eintrittskarten in Unternehmen schaffen.	REG-03, NORM-04, NET-03, CAP-04
CT-20	P02 — BGM advisory, statutory health insurer (Germany)	~24:30	B2B-Anbieter hat den Vorteil: die Firma, die sagt eigentlich ist es mir zu teuer — wenn ein Teil durch die Kasse erstattet wird, dann setzen wir das gerne um. B2B-Anbieter macht trotzdem sein Geschäft, die Kasse ist in der Firma vertrieblich drin. Win-Win für Anbieter, Krankenkasse und Unternehmen.	REG-03, NET-03, DC-01, CAP-04
KW-04	P03 — Business Development Team Lead, mental-health platform (DACH)	~05:00	Der Hauptpainpoint ist Fehltage und Langzeitausfälle — etwas, womit	DC-05, DC-04, BC-01, NORM-02

			Personalabteilungen konfrontiert sind, Fehltage zu monitoren und zu reduzieren. Das ist deren Verantwortungsbereich.	
KW-11	P03 — Business Development Team Lead, mental-health platform (DACH)	~10:30	Wir haben relativ viel Grips in den Impact Calculator gesteckt. Da kannst du dir als Unternehmen selbst errechnen, was deine Fehltage aktuell kosten — und wenn unsere Lösung nur einen Fehltag pro Mitarbeitenden im Jahr bewirkt, was du dann sparst. Konservativ gerechnet.	DC-01, DC-05, CAP-02, PS-05
KW-13	P03 — Business Development Team Lead, mental-health platform (DACH)	~13:00	Sales-Zyklen variieren stark — 6 bis 12 Monate. Oft stecken die Käufer noch in bestehenden Verträgen mit anderen Anbietern. Im Bereich Benefit machst du keine Verträge auf ein halbes Jahr, sondern auf zwei bis drei Jahre — wenn wir zum falschen Zeitpunkt anrufen, haben wir erstmal keine Chance.	PS-03, PS-04, PS-07
KW-15	P03 — Business Development Team Lead, mental-health platform (DACH)	~14:30	Unsere internen Champions im Ersttermin sind Corporate Health Beauftragte, BGM Beauftragte — nie der Betriebsrat. Der Betriebsrat ist vielleicht der Flecker — ‚hey, wir haben da ein Problem' — aber das sind nie die, die irgendwie Budget entscheiden.	BC-02, BC-05, BC-04
KW-17	P03 — Business Development Team Lead, mental-health platform (DACH)	~16:30	Unser Main OKR, auf das alle Abteilungen hinarbeiten: Nutzungsraten. Wenn dein Tool nicht genutzt wird, ist die	DC-04, PS-05, NORM-04, PS-07

			Wahrscheinlichkeit, dass die Personalabteilung dich aus dem Setup rauskickt, relativ hoch.	
KW-19	P03 — Business Development Team Lead, mental-health platform (DACH)	~18:30	Du musst ein Must-Have werden, kein Nice-to-Have wie Obstkorb. Selbst Jobrad hat es nicht ganz geschafft. Aber EGYM Wellpass hat es geschafft — dieses Must-Have zu werden. Wenn du EGYM nicht anbietest, hast du weniger Bewerbungen.	NORM-01, COG-04, DC-06
MB-01	P04 — Sales, fitness-access platform (DACH)	~00:30	Wir haben in Deutschland einen regionalen Unterschied — vor allem Budget. Wir haben brutales West-Gefälle. 50% unserer aktiven Leads kommen aus München, Frankfurt und Hamburg. Krasser Unterschied zwischen ländlichen Regionen und vor allem im Osten — vom Budget her.	KD-04, COG-04, NORM-01
MB-07	P04 — Sales, fitness-access platform (DACH)	~05:30	Wenn es einen Betriebsrat gibt, ist der eigentlich immer involviert. Die sind meistens Antreiber, eher positiv gegenüber BGM, weil sie das Mitarbeiterinteresse sammeln und es ein großes Thema ist.	REG-04, BC-05
MB-09	P04 — Sales, fitness-access platform (DACH)	~07:30	Wir konkurrieren nicht primär gegen andere BGM-Anbieter, sondern gegen andere Sachbezugsleistungen. Als Firma habe ich in Deutschland einen Sachbezugsfreibetrag von 50 € brutto pro Mitarbeiter. Da fallen Tankgutscheine rein, Deutschlandticket, Essensgutscheine. Es ist eine	REG-06, DC-01, NORM-04

			Entscheidung: wollen die einen Tankgutschein oder einen Sportbenefit?	
MB-10	P04 — Sales, fitness-access platform (DACH)	~08:30	Bei BGM-Aktivierung erreichen wir 20 bis 25%. Bei Tankgutscheinen erreicht man meistens eine größere Menge — deswegen ist das oft ein Punkt, wo wir konkurrieren.	DC-04, PS-05, CAP-02
MB-11	P04 — Sales, fitness-access platform (DACH)	~09:00	Der größte Unterschied ist rechtlich und steuerlich. Was kann ich einführen, wie viel kann ich steuerlich geltend machen? In Deutschland ermöglicht das Steuersystem unlimitierte Nutzung einer Mitgliedschaft. In Frankreich gibt's ein Credit-System — ich kaufe Credits als Mitarbeiter, irgendwann aufgebraucht. UK ist auch wieder anders.	REG-06, REG-02, KD-03, CAP-05
MB-18	P04 — Sales, fitness-access platform (DACH)	~17:00	Wir bieten nur eine Mitgliedschaft mit unlimitierter Nutzung. Urban Sports Club und Wellhub arbeiten mit Säulen S, M, L, XL — höhere Mitgliedschaft, mehr Nutzen, aber teurer. Wir sagen: einfach und unkompliziert. Mehr Annahme.	CAP-05, KD-03
MB-21	P04 — Sales, fitness-access platform (DACH)	~21:30	Einem neuen Anbieter im deutschen Markt: sehr viel Geduld. Deutsche Firmen muss man bei der Hand nehmen, viel Unterstützung und Begleitung. Eng mit Kunden zusammenarbeiten, Konzepte ausarbeiten, Studien machen, mit Speakern arbeiten, Netzwerktreffen.	KD-01, NET-04, PS-06, COG-06

ME-04	P05 — Sales / Field, fitness-access platform (DACH)	~03:44	Return on Investment ist mit Abstand auf dem letzten Platz. Die größte Hürde ist die allgemeine Annahme — Unternehmen können nicht einschätzen, ob eine gewisse Engagement-Rate vorpredicted werden kann. Sehr schwieriges Feingefühl.	DC-01, DC-04, PS-04
ME-10	P05 — Sales / Field, fitness-access platform (DACH)	~10:38	Aus dem deutschen Markt empfinden wir, dass der Wettbewerb hier am stärksten ist im Vergleich zu allen anderen europäischen Märkten.	CAP-05, KD-04, COG-04
ME-11	P05 — Sales / Field, fitness-access platform (DACH)	~11:56	Jeder Anbieter in den jeweiligen Ländern hat sein besseres Netzwerk. Manche Kunden wünschen sich bestimmte Studios, dann gehen die Anbieter eine Art Exklusivität ein. Man holt sich diese Exklusivitäten, um einen gewissen Status zu bekommen.	NET-01, NET-05, KD-04
ME-14	P05 — Sales / Field, fitness-access platform (DACH)	~14:38	Wir würden eine Survey tatsächlich nie proaktiv empfehlen — das spielt uns nicht in die Karten. Je mehr Stimmen, je mehr Meinungen, desto komplizierter wird es, weil der Fokus genau darauf liegt, wo wir am schwächsten sind.	NET-05, PS-04, NORM-05
ME-17	P05 — Sales / Field, fitness-access platform (DACH)	~17:30	Wir sind ja gerade mitten in der Fusionierung mit Urban Sports Club. Urban hat unheimlich viele Stellen offen. Innerhalb von ein paar Monaten verschmelzen wir zu einer Marke.	CAP-04

BS-04	P06 — Industry-event organiser / market observer (DACH)	Q2	Stark in den Markt dringen aktuell insbesondere EGYM Wellpass und Hansefit. Urban Sports Club war hier vor 3-5 Jahren stark präsent, positioniert sich aktuell aber auch wieder stärker.	CAP-04, NET-01, KD-04
BS-08	P06 — Industry-event organiser / market observer (DACH)	Q4	BGF-Framework, GKV-Kofinanzierung und Betriebsrat-Anforderungen spielen große Faktoren, natürlich in den Physiopraxen aber vermehrt auch in Fitness- und Gesundheitszentren.	REG-03, REG-04, NORM-01
BS-10	P06 — Industry-event organiser / market observer (DACH)	Q6	Der Ansatz zum Thema BGM in Deutschland ist ganzheitlicher, während es im Ausland zumeist nur ein Thema der privaten Krankenkassen ist — daher setzen sie hier einen größeren Fokus darauf. Wie in vielen Bereichen scheinen die bürokratischen Hürden höher zu sein als auf der iberischen Halbinsel.	REG-03, COG-04, COG-05, NORM-04
BS-11	P06 — Industry-event organiser / market observer (DACH)	Q7	Getrieben durch den demografischen Wandel sowie den Fachkräftemangel bleibt ein großer Fokus auf dem Thema. Im DACH-Raum sieht man immer mehr Studioketten fusionieren, was einen positiven Effekt auf überregionale, einheitliche Kooperationsmöglichkeiten mit Gesundheitsanbietern haben könnte.	COG-04, DC-06, CAP-04, NET-01
JU-04	P07 — Head of SMB, fitness-access platform (Spain)	~04:00	Three main factors for market entry: total population — number one driving metric, because more people means	KD-04, KD-05, COG-04, CAP-04

			more companies; wellness culture — a cultural mindset towards working out, taking care of body and mind; presence and stage of another player — sometimes acquisition, sometimes direct competition.	
JU-05	P07 — Head of SMB, fitness-access platform (Spain)	~05:30	In Romania we got in by buying a company — we were not there, we bought the company and took care of the competition right away. In Spain there used to be a local player called Enjoy that we acquired. In Germany — another player, Urban, that was German — until last year we were fighting, and then the decision came from Germany to acquire them.	CAP-04, KD-04, NET-05
JU-08	P07 — Head of SMB, fitness-access platform (Spain)	~09:30	We used to be 5–6 years ago in Portugal. We left the market because it was not profitable. Last year we started to rethink our strategy there — we reopened a bit, started to create a network. But it was done via Spain. We did not open an office or hire people directly.	KD-01, KD-04, NET-05
JU-15	P07 — Head of SMB, fitness-access platform (Spain)	~26:00	The company underestimated cultural differences between European countries. The company is Brazilian — they came with a Brazilian mindset. When I started, the limit was only companies above 1.000 employees, which for Europe is huge. We had to fight to change it. They ended up changing the limit	CAP-01, KD-01, KD-04

			for Europe only to less than 500.	
JU-16	P07 — Head of SMB, fitness-access platform (Spain)	~27:30	Until one or two years ago we didn't have local prices per country in Europe — same prices for all countries in Europe. Treating Europe as a single region without considering economics per country slowed things down. A price that for Germany was okay, for Spain was considered too expensive.	CAP-05, KD-03, KD-04
BR-02	P08 — Client Success, fitness-access platform (Iberia)	Q1	Case A: Managed centrally (e.g., Portugal managed from Spain). We analyse client interest — a launch promotion or successful Spanish case helps. And budget viability — understanding their budgeting cycle.	KD-04, NET-03, NET-04, BC-08
BR-05	P08 — Client Success, fitness-access platform (Iberia)	Q2	Smaller companies — startups or scale-ups with 1–2k employees — invest much more in their staff, truly prioritising wellbeing. Larger corporations (multinationals, big banks, consultancies) are often more budget-stringent. Even if HR is involved, they sometimes just want to ‚check the wellness box' without significant investment.	KD-04, DC-01, DC-02, COG-04
BR-10	P08 — Client Success, fitness-access platform (Iberia)	Q5	What new providers get wrong about Spain: In CS, while we focus on increasing revenue, the top priority must be retaining existing revenue — especially with accounts showing weaker data that could lead to	PS-07, NORM-04, DC-04

			medium-to-long-term churn.	
BR-11	P08 — Client Success, fitness-access platform (Iberia)	Optional Q1	Renewals four types: (a) Inflation-based — fee follows CPI; (b) Intense Growth — adherence spike justifies 5–20% fee increase; (c) Upsells — new products lead to price adjustment; (d) Negative Margin Accounts — Sales gave deep discount, but program's success made economics unsustainable. Negotiations take time as the client weighs cost of investing more against risk of losing a high-engagement service.	DC-01, CAP-05, KD-03, PS-07
SM-01	P09 — Senior BDR, fitness-access platform (Portugal)	Q1	In general, companies in Portugal are still not very open to investing in extra employee benefits. There is a growing culture around flexible benefits — Coverflex is probably the best-known platform. These platforms focus on benefits that are tax-exempt — both in income tax and social security.	COG-04, REG-06, NET-02
SM-02	P09 — Senior BDR, fitness-access platform (Portugal)	Q1	Sports and wellbeing benefits do not benefit from the same tax advantages. If we were included inside those platforms, we would end up competing directly against more essential benefits that people already know they will use.	REG-06, NET-05, COG-04
SM-07	P09 — Senior BDR, fitness-access platform (Portugal)	Q1	When approaching companies, I always try to shift that mindset and position Urban Sports Club as a strategic tool — for talent attraction,	KD-02, NORM-05, DC-06, DC-07

			talent retention, employer branding, reducing sick leave, employee engagement. But honestly, it still feels like we are the ones educating the market.	
SM-13	P09 — Senior BDR, fitness-access platform (Portugal)	Q3	Budgets are finalised around September. We try to approach before that period to present our business model. But because companies initially assume we are offering discounts and no investment is needed, they tend to postpone conversations to September or October. Then: ‚If investment is needed, we can only consider it next year — budget already closed.'	PS-07, PS-04, COG-06
SM-18	P09 — Senior BDR, fitness-access platform (Portugal)	Q6	Sports aggregators have existed in Spain for much longer. Companies and HR teams already understand the concept much better. This creates more competition, but much more awareness about what an aggregator is. In Portugal, I still often need to explain the concept from scratch — many HR professionals initially think we are simply a gym chain.	COG-06, NORM-01, KD-04, NET-01
SM-20	P09 — Senior BDR, fitness-access platform (Portugal)	Q7	When I approach companies in Portugal that are already Wellhub clients in Spain, Germany, or another country, I use that as a strong argument: ‚Your company already works with Wellhub in Spain/Germany — Urban Sports Club is now part of the Wellhub group, so it could make sense to explore a	CAP-04, NET-04, BC-08

			collaboration in Portugal as well.'	
GS-03	P10 — Europe Strategy, B2B coaching / wellbeing platform (Cross-market)	~05:30	The number of sales people we staff in Germany is like five times the ones in Spain. So it's mostly based on how many clients are fitting this ICP — Germany has higher density of enterprise.	KD-04, CAP-03, COG-04
GS-04	P10 — Europe Strategy, B2B coaching / wellbeing platform (Cross-market)	~10:53	In a market with more concentration of enterprise bigger clients, you have longer sales cycles. In Germany or UK we have longer sales cycles — but not really due to Germany or UKI, more the type of clients we go after. In Southern Europe or Eastern Europe, sales cycles are typically shorter because those enterprise clients just don't exist.	PS-03, KD-04, NORM-02
GS-13	P10 — Europe Strategy, B2B coaching / wellbeing platform (Cross-market)	~22:38	Because we are B2B, differences between European markets are more institutional than cultural — influenced by density of large enterprise in tier-1 markets. In B2C at my previous employer, cultural preferences (cats vs. dogs) mattered. In B2B enterprise, where clients are multinationals, local culture doesn't play a major role.	COG-04, COG-05, NORM-01, NORM-02
GS-14	P10 — Europe Strategy, B2B coaching / wellbeing platform (Cross-market)	~24:00	The go-to-market strategy is not differentiated, even though the end product is used by individual employees. We sell to multinationals — pan-European or global companies — that sign Master Service Agreements covering users across Europe.	CAP-01, NET-04, REG-02, CAP-04

VR-02	P12 — Corporate Account Executive, fitness-access platform (Portugal)	Q1	Portugal has a clear block in terms of tax benefits in what sports is concerned. There is absolutely no incentive to a company that promotes sports and wellness activities within their culture, so it is something which return of investment is hard to measure.	REG-06, COG-04, DC-01
VR-05	P12 — Corporate Account Executive, fitness-access platform (Portugal)	Q2	The arguments are quite similar: reducing turnover, investing in employee health, promoting socialization through sports, fostering mental health, keeping the company attractive for new talent, reducing turnover. Portuguese companies still look to most of these solutions as part of a discount package; when it involves budgeting, most companies tend to not even consider it. Also the tax problem is a big issue too.	DC-01, DC-06, DC-07, COG-06
VR-09	P12 — Corporate Account Executive, fitness-access platform (Portugal)	Q8	Awareness for wellness has been growing in the last few years. Brand awareness plays a very important role; the market was breached by USC and WH. If a new provider comes by, brand awareness is top 1 priority as a credible alternative. Product must follow.	COG-06, NET-04, CAP-02, KD-01

Appendix F: Detailed Market and Health-Burden Data

This appendix provides the underlying market-sizing and health-burden statistics that support the macro context developed in Section 3.1. Where the main text reports synthesised figures or growth bands, the original source ranges are reproduced here.

F.1 European Corporate Health, Wellbeing and Performance Market Size

The Global Wellness Institute (GWI, 2026) projects compound annual growth rates of between seven and nine per cent across the broader wellness economy in Europe over the 2024–2030 forecast period. Narrower B2B-specific estimates from Grand View Research (2024) place compound annual growth closer to 3.1 per cent for employer-sponsored corporate wellness services, with European market size projected to reach approximately USD 22 billion by 2030. The divergence between the two figures reflects category-definition differences rather than directional disagreement: GWI's wellness-economy aggregate includes physical activity, mental wellness, nutrition, workplace wellness and traditional and complementary medicine; the Grand View Research figure isolates the employer-paid corporate wellness segment.

F.2 Germany — Work-Related Health Burden

The Bundesanstalt für Arbeitsschutz und Arbeitsmedizin (BAuA, 2023) reports that work-related ill health resulted in approximately 873 million lost workdays in Germany in 2022, representing an estimated EUR 152 billion in lost gross value added. Psychosocial conditions account for an increasing share of total sick days: in 2022, mental and behavioural disorders accounted for 17.7 per cent of all certified sick-day absences, up from 13.1 per cent in 2012. Average duration of mental-health-related absences (38.9 days per case) significantly exceeds the all-cause average (15.1 days per case).

F.3 Spain — Work-Related Health Burden

The Instituto Nacional de Seguridad y Salud en el Trabajo (INSST, 2023), in its national survey of working conditions, documents that 32 per cent of Spanish workers report work-related musculoskeletal complaints, 19 per cent report work-related anxiety symptoms, and 17 per cent report sustained presenteeism (working while ill). Subjective health strain reported by Spanish workers exceeds the EU-27 average across all three categories, while organisational infrastructure to address such strain preventively remains less developed than in DACH counterparts (Magnavita et al., 2017).

F.4 European Industry Consolidation and Competitive Structure

The 2024 acquisition of Urban Sports Club by Wellhub (Sifted, 2024) united two of the largest fitness-access platforms in Europe under one corporate roof. Post-acquisition, the combined entity operates across eleven European countries and serves over 17,000 corporate clients across Europe and Latin America. Within DACH, EGYM Wellpass maintains the strongest independent fitness-access position

with deep integration into the BGF institutional framework; CoachHub remains the dominant European player in the digital coaching segment with operations spanning more than sixty markets (PitchBook, 2024). In Spain and Portugal, international platforms (primarily Wellhub) operate alongside a smaller number of local providers within a market where organisational adoption is at an earlier stage than the DACH benchmark.

Appendix G: Justification for Alternative Framework Exclusion

Three established international-business frameworks were considered as alternatives to the adopted three-lens framework set out in Section 4.5 and were ultimately excluded. This appendix sets out the substantive justification for each exclusion.

G.1 The OLI Paradigm (Dunning, 1988)

Dunning's Ownership-Location-Internalisation (OLI) paradigm was developed primarily to explain the choice between equity-based foreign direct investment and arms-length transactions in capital-intensive industries. The empirical case examined in this study concerns platform-based B2B service providers whose internationalisation typically does not involve equity-based FDI in foreign subsidiaries: market entry is achieved through digital platform deployment, network partnership and (in some cases) acquisition rather than greenfield establishment. The OLI framework's emphasis on location-specific advantages does retain analytical relevance, but its core ownership-internalisation logic is peripheral to the questions central to this study. The Uppsala 2009 network revision captures the relevant entry-mode and network-position questions more directly without the OLI framework's FDI presumption.

G.2 Transaction Cost Economics (Williamson, 1985)

Williamson's Transaction Cost Economics (TCE) framework explains organisational boundary decisions through the comparison of market and hierarchy as governance modes, with asset specificity, behavioural uncertainty and frequency of exchange as the central explanatory variables. For B2B corporate health providers, the most consequential strategic decisions concern not the make-or-buy boundary but the cross-border configuration of value proposition, pricing, sales process, partnerships and proof. TCE's analytical purchase on these questions is limited. Where TCE concepts retain relevance (for example, partnership versus direct sales as alternative governance forms), the Uppsala network logic provides a more empirically tractable framework for the questions central to this study.

G.3 Porter's Five Forces (Porter, 1980)

Porter's Five Forces framework analyses competitive dynamics through industry-structural factors: rivalry among existing competitors, threat of new entrants, threat of substitutes, bargaining power of buyers and bargaining power of suppliers. The framework is industry-structural and largely institution-blind: it explains competitive position within an industry but is not designed to explain differences in

commercial logic across institutionally heterogeneous markets. The empirical case examined in this study turns precisely on such institutional heterogeneity. Where Porter's framework retains relevance (for example, in characterising the consolidation dynamics on the supply side post-Wellhub-USC), it provides supplementary rather than primary analytical leverage. Institutional Theory furnishes the more direct analytical vocabulary for the DACH-Iberia divergence.

G.4 Frameworks Considered and Retained

Institutional Theory (Scott, 2014; North, 1990; Kostova, 1999; Boxenbaum and Pedersen, 2009), the 2009 Uppsala network revision (Johanson and Vahlne, 2009), and the Resource-Based View with Dynamic Capabilities (Barney, 1991; Teece, Pisano and Shuen, 1997) were retained on the grounds set out in Section 4.5. The organisational buying behaviour literature (Webster and Wind, 1972; Homburg, Workman and Jensen, 2002) was retained as a secondary interpretive instrument rather than a standalone theoretical pillar. The combination of these frameworks provides the analytical precision required for the research questions of this study, which no single framework adequately addresses.