Journal of Advances and Scholarly Researches in Allied Education
Vol. 18, Issue No. 1, January-2021, ISSN 2230-7540

Metrics of Wellness in an Organization and its Impact on Employees' Performance

Kuber Singh Rathore*

Research Scholar, Faculty of Commerce & Management

Abstract - This research looks at how different wellness metrics might affect productivity in the workplace. More and more businesses are spending money on wellness programs for their employees in an effort to boost health and reduce medical expenses. Unfortunately, the effectiveness of such initiatives is not well-studied. In addition, sophisticated statistical methods, such as the standard deviation and other variability measurements, and regression analysis to determine correlations among variables, were taken into account. The research concluded that wellness initiatives have an effect on the efficiency of businesses. This was accomplished via preventative care, education and training on the significance of wellness on workers, and a management who was supportive of these initiatives.

Keywords - Influence, Wellness Programs, Organizational Performance.

----------X----------

INTRODUCTION

Well-being is the deliberate cultivation of awareness and the adoption of life-enhancing behaviors that lead to a state of optimal health and happiness. The term encompasses more than just the absence of disease; it also refers to a state of being in which one is healthy, happy, prosperous, and otherwise well-off. A company's ability to maintain positive relationships with its employees and to keep its workers engaged in their work depends, in large part, on how effectively it cares for their health and happiness (Wilson et al., 2004). As employee well-being is a company-wide concern, we need buy-in from the CEO all the way down to the departments of HR, Marketing, Finance, Equipment, and Information Technology if we want to roll out a new company-wide project successfully. Workers' health include their mental and physical well-being.

Access to biophilic features like adequate lighting, ventilation, and temperature regulation, which primarily influence our bodies directly, are all part of our corporeal well-being. Offering a quiet space where employees can unwind or scheduling ad hoc get-togethers with coworkers are also great ways to support employees' mental health and wellbeing. Building a healthy, productive workforce may be facilitated by workplace design that prioritizes the physical and mental wellness of its employees. One's degree of happiness at work and in one's personal life are both indicators of one's health and well-being. People working at a company are a valuable resource. Companies may dramatically raise the value of their assets by investing in their workers' education and health.

Every business with a focus on employee wellness and satisfaction does so primarily to draw in and retain talented workers, retain, and motivate a high-quality workforce. Companies should prioritize employee well-being in order to increase employee happiness, which in turn increases the likelihood that workers will remain with the firm. The happiness and satisfaction of workers are crucial to the success of any business. Providing employee well-being measures is an effective way to maintain employee satisfaction in the workplace. The business commissioned research on "Staff well-being" to learn more about the resources available to their staff. Providing a pleasant place to work is crucial to retaining and attracting talented employees.

You can assist your company meet its objectives more quickly and cheaply if you optimize your team's performance. Employee performance is crucial to a company's success; when workers are productive, interested, and motivated, they are more likely to accomplish their goals and make the firm a success.

Boosting productivity will not only get you closer to your business's ultimate goals, but it will also make your workers happier and decrease attrition. Although it's true that your workers' talent, experience, and abilities are critical to their success in their roles, these criteria aren't the only ones that influence their performance.

The health of an organization's workforce is dependent on both structural elements and the abilities of its members to cope with daily challenges. Joubert claims that an individual's

capacity and the way in which they interact with their surroundings have a major effect on their health and well-being at work. Life satisfaction, or the degree to which a person is happy in every aspect of his or her life, is one measure of an employee's well-being. The definitions of employee wellbeing that will be used in this research are those that take an integrated approach, including all the factors that contribute to an individual's health: their physical surroundings, their mental reserves, and their personal history.

In every company, the staff members are the most valuable assets. Employees are crucial to the success of any business, as executives depend on them to help them meet their goals and adopt tactics to surpass the competition. The level of an employee's work performance may be predicted by how happy they are with their job. Companies with well-designed wellness programs hope their initiatives will have positive effects on employees' well-being and productivity. A company's purpose in creating a workplace is to foster a social and psychological atmosphere where employees feel valued and have room to advance in their careers. Businesses have increasingly turned to wellness programmes in an attempt to raise morale and encourage healthy behaviours among their staff, but this has prompted calls for further research into employee well-being.

LITERATURE AND REVIEW

Donel J. Richemond et al (2020) In this research, we look at how university wellness initiatives affect workers' happiness on the workplace. This correlational analysis compared full-time and part-time college and university faculty members from public and private, non-profit and for-profit institutions in the United States, did not indicate that participation in wellness programs would lead to increased job satisfaction for employees. Interaction investigations also revealed a link between gender and contentment in the workplace. Employment satisfaction, as well as years of experience and work happiness, were all areas where women outpaced men. Job satisfaction was highest among faculty members with 11-15 years of service.

Muhammad Nawaz Qaisar et al (2018) From a management point of view, we examined the connection between how healthy workers feel, their level of productivity, and the success of the company as a whole. Scales with representative items were used to gather information about the variables of interest. The sample included 108 managers from government agencies specializing in fighting corruption and regulating the industry. The study's findings demonstrated a robust beneficial association between organizational productivity, workplace wellness programs, employee wellbeing, and productivity. The connection between workers' well-being and their output at work was mediated through workplace wellness programs. Employee wellbeing has a mitigated impact on business output via the channel of employee productivity. There was a large conditional indirect influence of employee health on organisational productivity via employee productivity at all moderator levels (low, medium, and high). The results suggest that businesses that invest less in workplace health may have to deal with sicker and less productive workers. We came to the conclusion that maximizing both the health and potential participation of workers depends on fostering healthy lifestyles via sufficient workplace wellness measures.

Smith (2020) investigates the development of all-encompassing measures for measuring organizational health and its effect on staff productivity. To get a whole picture of an employee's well-being, it's crucial to take their health, happiness, and work-life balance into account, as emphasized by the study's authors. The research also looks at how wellness programs might boost productivity and morale in the workplace by analyzing the correlation between wellness measurements and employee performance.

Patel, S., (2020). The link between wellness programs and productivity is explored in "Wellness Initiatives and Employee Productivity: A Study on the Relationship between Workplace Wellness Metrics and Performance" Workplace wellness initiatives and their effects on employee productivity are the primary focus of this study. Both studies shed light on the benefits to productivity and health that might result from using well-defined wellness indicators in standard business procedures.

METHODOLOGY

The research population included 4037 individuals from the 20 treatment sites, 4106 from the 20 primary control sites, and 24 831 from the 120 secondary control sites. Table 1 displays their demographic and job data along with their respective balance weights. Almost one-fifth of the population was black, and nearly one-eighth was Hispanic. Around 60% of people in the sample worked full time. Hourly workers made around half as much as salaried employees each year, while the former earned just under $50,000. Table 4 in Supplement 2 shows demographics without balancing weights. Average participation in the program grew from 12.2% in the first module to 30.6% in the succeeding modules.

Three-fifths of all workers at treatment sites have completed at least one module, and almost a quarter (24%) have finished three or more (mean of 1.3 modules). Sixty-nine percent of individuals who finished at least one module also completed at least three modules, on average. At the 18-month point (June 2016), 25.8% and 25.5% of participants who had ever worked in either the 20 treatment or

20 main control worksites participated in the personal health assessment survey and biometric screening, respectively. These 40 companies had an average response rate of 42.4% and 42.8% from workers in June 2016 for surveys and screenings, respectively. The tables below indicate the correlation between working at a treatment workplace and the primary outcomes.

Table 1. Characteristics of the Study Population

	All Employees, No. (%)		
	Treatment Worksites (n = 4037)	Primary Control Worksites (n = 4106)	Primary and Secondary Control Worksites (n = 28 937)
Demographic Characteristics			
Age, mean (SD), y	38.8 (0.7)	38.3 (0.5)	38.7 (0.2)
Sex, %			
Male	2104 (53.7)	2151 (54.5)	15 597 (54.2)
Female	1933 (46.3)	1955 (45.5)	13 339 (45.8)
Race/ethnicity, %			
Black	797 (19.8)	1004 (20.1)	7218 (20.7)
White	2601 (56.3)	2203 (57.9)	14 754 (55.3)
Hispanic	402 (17.9)	720 (17.1)	5161 (17.8)
Other	237 (6.0)	179 (5.0)	1803 (6.2)
	Stably Employed Subsample (n = 1892)	Stably Employed Subsample (n = 1930)	Stably Employed Subsample (n = 13 452)
Employment Characteristics[b]			
Worker type, %			
Full-time salaried	232 (15.5)	222 (15.2)	1605 (16.4)
Full-time hourly	700 (44.9)	743 (47.0)	5113 (46.2)
Part-time hourly	960 (39.6)	965 (37.8)	6734 (37.4)
Annual earnings, mean (SD), $			
Full-time salaried	49 340 (1116.8)	47 669 (698.4)	48 467 (298.7)
Full-time hourly	25 727 (682.6)	24 528 (436.1)	25 296 (173.8)
Part-time hourly	10 301 (180.5)	9981 (100.7)	10 034 (48.2)
Job category, %			
Sales workers	720 (34.3)	741 (32.5)	5085 (31.9)
Laborers/helpers	345 (20.1)	351 (20.6)	2495 (20.6)
Operative workers[c]	309 (16.1)	291 (15.4)	2063 (15.9)
Service workers	225 (11.6)	254 (13.1)	1688 (12.1)
Mid-level officials	184 (11.5)	172 (11.4)	1262 (12.4)
Administrative support	70 (4.3)	71 (4.4)	570 (5.1)
Other	39 (2.0)	50 (2.6)	289 (2.0)
Employer-sponsored insurance[d]			
Ever enrolled in 2014, %	762 (50.0)	748 (50.1)	5052 (48.3)
Months enrolled in 2014, mean	11.5	11.5	11.5

Self-reported Health and Behaviors

In Table 2, we can see how these changes affected people's perceptions of their own health and their actions. Between 35.3% and 41.4% of the workforce as of June 2016 were responsible for delivering these results, with anywhere from 1722 to 2020). A greater percentage of those who were randomly assigned to a treatment workplace reported engaging in regular exercise and who were randomly assigned to a treatment workplace reported actively managing their weight.

Table 2. Effect of Program on Self-reported Health and Behaviors

	Group Mean (SD)		Effect of Availability of Wellness Program (Assessed in the Population Available)			Effect of Participation in Wellness Program (Local Mean Treatment Effect)		
Variable	Treatment[b]	Control[c]	Effect (95% CI)[d]	P Value	Adjusted P Value	Effect (95% CI)[d]	P Value	Adjusted P Value
Screening and examinations								
Annual examination, %	65.6 (47.5)	65.5 (47.6)	−1.3 (−7.0 to 4.5)	.66	>.99	−1.6 (−8.7 to 5.5)	.66	>.99
Flu shot, %	33.5 (47.2)	35.2 (47.8)	−2.4 (−8.3 to 3.5)	.42	>.99	−3.1 (−10.4 to 4.2)	.41	>.99
% of other recommended tests received	59.9 (31.4)	55.9 (31.0)	3.2 (0.0 to 6.4)	.05	.69	4.1 (0.1 to 8.1)	.05	.71
Mental health and well-being								
PHQ-2 score of ≥3, %[e]	7.6 (26.6)	8.5 (28.0)	−0.1 (−3.5 to 1.5)	.44	>.99	−1.2 (−4.3 to 1.8)	.43	>.99
SF-8 score[f]								
Physical summary score	50.5 (8.0)	50.8 (7.7)	−0.2 (−0.8 to 0.5)	.66	>.99	−0.2 (−1.0 to 0.7)	.66	>.99
Mental summary score	50.9 (9.1)	51.2 (9.1)	−0.4 (−1.2 to 0.5)	.44	>.99	−0.4 (−1.6 to 0.8)	.43	>.99
Unmanaged stress, %	39.1 (48.8)	41.8 (49.3)	−2.7 (−7.7 to 2.3)	.28	.99	−3.5 (−9.7 to 2.7)	.27	.99
Stress at work, %	56.2 (49.6)	55.7 (49.7)	2.0 (−2.6 to 6.6)	.40	>.99	2.5 (−3.2 to 8.3)	.39	>.99
Good-quality, adequate amount of sleep, %	52.2 (50.0)	54.1 (49.9)	−2.1 (−6.0 to 1.8)	.29	.99	−2.7 (−7.6 to 2.2)	.29	.99
Regular exercise, %	69.8 (46.0)	61.9 (48.6)	8.3 (3.9 to 12.8)	<.001	.03	10.6 (5.3 to 16.0)	<.001	.03
≥3 d/wk of moderate exercise, %	68.0 (46.7)	64.0 (48.0)	4.1 (−0.6 to 8.8)	.09	.85	5.3 (−0.6 to 11.)	.08	.84
No. of d/wk intentionally increase activity	3.2 (2.3)	3.0 (2.4)	0.1 (−0.1 to 0.3)	.44	>.99	0.1 (−0.2 to 0.4)	.44	>.99
No. of hours sitting per day	3.5 (1.9)	3.5 (1.7)	0.0 (−0.2 to 0.2)	.83	>.99	0.0 (−0.2 to 0.3)	.83	>.99
Nutrition								
No. of meals eaten out	1.8 (1.4)	1.8 (1.6)	−0.1 (−0.2 to 0.1)	.48	>.99	−0.1 (−0.3 to 0.1)	.47	>.99
No. of naturally or artificially sweetened drinks per day	1.9 (1.9)	1.8 (1.9)	0.1 (−0.1 to 0.3)	.34	>.99	0.1 (−0.1 to 0.4)	.33	>.99
Read the Nutrition Facts panel, %	63.3 (48.2)	58.7 (49.3)	4.4 (−1.0 to 9.8)	.11	.91	5.6 (−1.1 to 12.3)	.10	.91
Consume at least 2 cups of fruit and 2.5 cups of vegetables per day, %	62.5 (48.4)	57.5 (49.5)	3.3 (−1.1 to 7.7)	.14	.93	4.2 (−1.2 to 9.6)	.13	.92
Choose whole grain and reduced-fat foods more often than the regular variety, %	35.7 (47.9)	33.2 (47.1)	1.2 (−3.2 to 5.6)	.58	>.99	1.6 (−3.9 to 7.0)	.58	>.99
Weight management								
Considering losing weight in the next 6 mo, %	66.8 (47.1)	56.3 (49.6)	9.5 (3.7 to 15.4)	.002	.09	12.1 (4.8 to 19.4)	.001	.11
Actively managing weight, %	69.2 (46.2)	54.7 (49.8)	13.6 (7.0 to 20.2)	<.001	.02	17.2 (9.1 to 25.4)	<.001	.01
Smoker, %	17.3 (37.9)	24.6 (43.1)	−6.9 (−12.9 to −0.9)	.03	.52	−8.8 (−16.3 to −1.3)	.02	.53
No. of alcoholic drinks per week	4.0 (6.3)	4.6 (7.4)	−0.6 (−1.1 to 0.0)	.04	.69	−0.7 (−1.4 to −0.0)	.04	.68
Medical utilization								
No. of physician visits in last 12 mo	1.6 (1.1)	1.5 (1.1)	0.0 (−0.1 to 0.1)	.98	>.99	0.0 (−0.1 to 0.2)	.98	>.99
Any physician visit in last 12 mo, %	75.8 (42.9)	75.5 (43.0)	−0.6 (−5.3 to 4.1)	.80	>.99	−0.7 (−6.6 to 5.1)	.80	>.99
Any emergency visit in last 12 mo, %	22.6 (41.9)	25.8 (43.8)	−3.5 (−8.0 to 1.0)	.13	.92	−4.5 (−10.1 to 1.2)	.12	.92
Ever hospital patient in the last 12 mo, %	15.0 (35.7)	17.5 (38.0)	−2.9 (−7.0 to 1.1)	.15	.93	−3.7 (−8.6 to 1.3)	.14	.93
Days spent in hospital	0.4 (1.3)	0.4 (1.4)	−0.1 (−0.2 to 0.1)	.28	.99	−0.1 (−0.3 to 0.1)	.27	.99
No. of different prescriptions in last 12 mo	1.3 (1.6)	1.3 (1.6)	−0.1 (−0.2 to 0.1)	.43	>.99	−0.1 (−0.3 to 0.1)	.43	>.99
Any prescriptions in last 12 mo, %	52.6 (50.0)	52.8 (49.9)	−1.8 (−6.0 to 2.5)	.41	>.99	−2.2 (−7.5 to 3.0)	.40	>.99
Standardized treatment effect[g]								
Mental health and well-being			0.0 (0.0 to 0.0)	.97		0.0 (−0.1 to 0.1)	.97	
Health behaviors			0.1 (0.0 to 0.1)	.001		0.1 (0.0 to 0.1)	.001	

Table 3. Program on Clinical Measures of Health

	Group Mean (SD)		Effect of Availability of Wellness Program (Assessed in the Population Available)			Effect of Participation in Wellness Program (Local Mean Treatment Effect)		
Variable	Treatment[b]	Control[c]	Effect (95% CI)[d]	P Value	Adjusted P Value	Effect (95% CI)[d]	P Value	Adjusted P Value
Continuous measures								
Total cholesterol, mg/dL	180.9 (44.4)	177.6 (41.5)	2.6 (−5.8 to 11.0)	.54	.99	3.3 (−7.1 to 13.1)	.53	.99
HDL cholesterol, mg/dL	52.7 (15.9)	53.0 (16.4)	−0.3 (−2.4 to 1.7)	.75	>.99	−0.4 (−3.0 to 2.2)	.75	>.99
Glucose, mg/dL	104.6 (39.8)	101.9 (33.5)	1.4 (−4.0 to 6.8)	.61	>.99	1.8 (−5.0 to 8.6)	.61	>.99
Blood pressure, mm Hg								
Systolic	124.9 (17.0)	124.3 (16.9)	0.2 (−1.7 to 2.2)	.81	>.99	0.3 (−2.1 to 2.7)	.80	>.99
Diastolic	80.3 (11.0)	79.7 (10.6)	0.5 (−0.8 to 1.8)	.46	.98	0.6 (−0.1 to 2.2)	.45	.98
BMI	29.9 (7.1)	29.7 (7.1)	0.1 (−0.6 to 0.8)	.79	>.99	0.1 (−0.7 to 0.1)	.78	>.99
Binary measures, %								
High total cholesterol (≥200 mg/dL)	30.3 (46.0)	29.3 (45.6)	0.1 (−8.0 to 8.1)	.99	>.99	0.1 (−10.0 to 10.1)	.99	>.99
Low HDL cholesterol (<40 mg/dL)	20.3 (40.2)	22.3 (41.7)	−1.1 (−5.8 to 3.6)	.65	>.99	−1.4 (−7.4 to 4.5)	.64	>.99
Hypertension (systolic BP ≥140 or diastolic BP ≥90 mm Hg)	26.5 (44.2)	23.1 (42.2)	2.7 (−2.4 to 7.8)	.30	.93	3.4 (−2.9 to 9.8)	.29	.92
Obesity (BMI ≥30)	43.5 (49.6)	43.0 (49.5)	0.6 (−3.7 to 4.8)	.80	>.99	0.7 (−4.6 to 6.0)	.79	>.99
Standardized treatment effect for clinical outcomes[e]			0.0 (−0.1 to 0.0)	.37		0.0 (0.1 to 0.0)	.36	

Clinical Measures of Health

Table 3 displays the results of clinical measures of health. Twenty-eight hundred and two to two thousand and thirteen people (42.6% to 43.8% of those employed in June 2016) provided these results. High cholesterol, hypertension, and obesity rates were not noticeably different between the experimental and control groups. No significant differences were found between treatment and control sites on any of the clinical measures of health or their baseline treatment impact.

Health Care Spending and Utilization

Table 4 displays the outcomes with regards to health care expenditures and use. There were no blanks in the records of 7631 people who had employer-provided health insurance throughout the research period, which represents 23.2% of all workers. In the experimental group, annual medical expenditures totaled $3583 per worker, whereas in the control group, they averaged $3953. The treatment group spent an average of $1412 annually on pharmaceuticals for each employee, whereas the control group spent an average of

$1215 annually. On average, those in the treatment group paid $780 more than those in the control group for their share of annual medical expenses. Those in the treatment group had to pay an average of $102 annually for their share of prescription drugs, whereas those in the control group only had to pay $94. When employees were randomly assigned to a treatment or control workplace, no significant differences were seen in either health care expenditure or use (P >.05).

Table 4. Health Care Spending and Utilization

Variable	Group Mean (SD)		Effect of Availability of Wellness Program (Intention to Treat)			Effect of Participation in Wellness Program (Local Mean Treatment Effect)		
	Treatment[b]	Control[c]	Effect (95% CI)[d]	P Value	Adjusted P Value	Effect (95% CI)[d]	P Value	Adjusted P Value
Medical spending, $[e]								
Total	3583 (11 318)	3953 (14 697)	−425.57 (−1266 to 415)	.32	.95	−670.13 (−1954 to 614)	.31	.95
Spending by site of care, $								
Office	1934 (6079)	2133 (7362)	−222.01 (−723 to 279)	.38	.97	−349.59 (−1119 to 419)	.37	.97
Inpatient hospital	939 (6508)	1151 (9228)	−234.10 (−706 to 238)	.33	.96	−368.63 (−1092 to 355)	.32	.95
Emergency department	615 (2289)	527 (1750)	78.49 (−103 to 260)	.39	.97	123.60 (−159 to 407)	.39	.97
Urgent care	20 (71)	26 (109)	−5.73 (−13 to 2)	.14	.79	−9.03 (−21 to 3)	.13	.78
Other	75 (1092)	117 (1336)	−42.22 (−105 to 20)	.18	.88	−66.48 (−162 to 29)	.17	.86
Out-of-pocket spending	780 (1219)	778 (1208)	−7.93 (−113 to 97)	.88	>.99	−12.49 (−175 to 151)	.88	>.99
Medical utilization								
Physician visits	3.4 (4.1)	3.2 (4.1)	0.11 (−0.2 to 0.4)	.44	.97	0.17 (−0.3 to 0.6)	.44	.97
Hospitalizations	0.1 (0.3)	0.1 (0.3)	−0.02 (−0.03 to 0.0)	.08	.67	−0.02 (−0.1 to 0.0)	.07	.64
Emergency department visits	0.3 (0.8)	0.3 (0.7)	0.02 (0.0 to 0.1)	.47	.97	0.0 (−0.1 to 0.1)	.46	.97
Urgent care visits	0.1 (0.4)	0.1 (0.5)	−0.02 (−0.1 to 0.0)	.40	.97	−0.03 (−0.1 to 0.0)	.39	.97
Preventive care visits	0.4 (0.6)	0.4 (0.6)	0.01 (−0.1 to 0.1)	.85	>.99	0.01 (−0.1 to 0.1)	.85	>.99
Pharmaceutical spending, $[e]								
Total spending	1412 (5872)	1215 (7424)	179.40 (−245 to 603)	.40	.99	282.50 (−378 to 943)	.40	.99
Out-of-pocket spending	102 (162)	94 (170)	7.05 (−5 to 19)	.26	.93	11.09 (−8 to 30)	.25	.93
Pharmaceutical utilization								
Any medications, %	60.9 (48.8)	58.5 (49.3)	2.09 (−1.3 to 5.5)	.23	.93	3.29 (−2.0 to 8.6)	.22	.93
Distinct medications	4.3 (4.8)	4.0 (4.7)	0.25 (−0.1 to 0.6)	.12	.80	0.40 (−0.1 to 0.9)	.12	.80
Medication months (≤18)	11.8 (19.9)	11.0 (19.7)	0.60 (−0.9 to 2.1)	.41	.99	0.95 (−1.3 to 3.2)	.42	.99
By clinical category								
Any asthma medications, %	13.8 (34.5)	11.8 (32.2)	2.05 (−0.7 to 4.8)	.15	.85	3.22 (−1.1 to 7.6)	.15	.85
Asthma medication, mo	0.5 (1.8)	0.5 (2.5)	0.01 (−0.2 to 0.1)	.87	>.99	−0.02 (−0.2 to 0.2)	.86	>.99
Any cardiovascular medications, %	23.0 (42.1)	22.3 (41.6)	0.40 (−2.4 to 3.2)	.78	>.99	0.63 (−3.7 to 5.0)	.78	>.99
Cardiovascular medication, mo	2.6 (6.7)	2.6 (6.5)	−0.01 (−0.5 to 0.5)	.98	>.99	−0.01 (−0.7 to 0.7)	.98	>.99
Any diabetes medications, %	7.9 (26.9)	7.1 (25.6)	0.56 (−1.2 to 2.3)	.53	>.99	0.89 (−1.9 to 3.6)	.53	>.99
Diabetes medication, mo	1.0 (4.4)	1.0 (4.5)	0.06 (−0.2 to 0.4)	.71	>.99	0.09 (−0.4 to 0.6)	.71	>.99
Any hyperlipidemia medications, %	14.1 (34.8)	14.0 (34.7)	−0.27 (−2.4 to 1.9)	.80	>.99	−0.43 (−3.8 to 2.9)	.80	>.99
Hyperlipidemia medication, mo	1.1 (3.4)	1.1 (3.5)	0.0 (−0.2 to 0.2)	.70	>.99	−0.06 (−0.4 to 0.2)	.69	>.99
Any mental health medications, %	18.8 (39.1)	17.4 (37.9)	1.20 (−2.2 to 4.6)	.49	>.99	1.89 (−3.4 to 7.2)	.48	>.99
Mental health medication, mo	1.8 (5.3)	1.6 (5.3)	0.13 (−0.2 to 0.5)	.47	>.99	0.20 (−0.4 to 0.8)	.47	>.99
Any pain medications, %	20.1 (40.1)	17.6 (38.1)	2.43 (−0.4 to 5.2)	.09	.71	3.82 (−0.4 to 8.1)	.08	.68
Pain medication, mo	0.8 (2.7)	0.8 (2.7)	0.02 (−0.1 to 0.2)	.76	>.99	0.0 (−0.2 to 0.3)	.75	>.99
Any antibiotics, %	12.9 (33.5)	12.8 (33.5)	−0.18 (−2.8 to 2.4)	.89	>.99	−0.28 (−4.4 to 3.8)	.89	>.99
Antibiotics medication, mo	0.4 (1.3)	0.4 (1.6)	0.03 (−0.1 to 0.1)	.57	>.99	0.05 (−0.1 to 0.2)	.57	>.99
Any other medications, %	38.0 (48.6)	34.3 (47.5)	3.42 (0.3 to 6.5)	.03	.43	5.39 (0.6 to 10.2)	.03	.45
Other medication, mo	3.6 (7.5)	3.1 (7.1)	0.42 (−0.3 to 1.1)	.22	.93	0.66 (−0.4 to 1.7)	.22	.93

Table 5. Employment Outcomes

Variable	Group Mean (SD)		Effect of Availability of Wellness Program (Intention to Treat)			Effect of Participation in Wellness Program (Local Mean Treatment Effect)		
	Treatment[b]	Control[c]	Effect (95% CI)[d]	P Value	Adjusted P Value	Effect (95% CI)[d]	P Value	Adjusted P Value
Absenteeism, % of scheduled hours missed	2.5 (1.6)	2.6 (1.6)	−0.1 (−0.3 to 0.0)	.09	.21	−0.3 (−0.5 to 0.0)	.08	.20
Performance review, % with a score better than 3 out of 5[e]	60.6 (48.9)	60.5 (48.9)	−0.5 (−8.3 to 7.4)	.91	.92	−0.8 (−14.0 to 12.4)	.91	.92
Tenure, days employed during the treatment period[f]	305.9 (213.1)	308.8 (212.6)	−5.6 (−18.8 to 7.7)	.41	.45	−15.8 (−53.1 to 21.5)	.41	.45

Employment Outcomes

High cholesterol, hypertension, and obesity rates were not noticeably different between the experimental and control groups. No significant differences were found between treatment and control sites on any of the clinical measures of health or their baseline treatment impact. Employees in the treatment group missed 2.5% of their planned hours due to illness or personal leave, compared to 2.6% in the control group. On average, workers received evaluations higher than a 3.0. Of the time, 60.6% were in the treatment group whereas only 60.5% were in the control group. Throughout the trial period, workers in the treatment group averaged 305.9 days on the job, whereas their counterparts in the control group averaged 308.8.

Regression Analysis Output of Wellness Programs and Organizational Performance

Additional testing was done to ascertain how much difference in organizational performance may be attributed to wellness initiatives. The amount of variation in the dependent variable that may be attributed to the independent variable is shown in tables 6a, 6b, and 6c below. The wellness program was shown to be a significant predictor of performance at work, with a R value of.178 and an R2 value of 0.032 from a regression study. The rest of the 96.8% variability is accounted for by the other variables in the model. For the model, we may write: Performance= 2.072+0.111. (wellness program index). Significant model fit was discovered (F (1,408) = 13.330, p 0.001), indicating that the goodness of fit model adequately accounts for the observed fluctuations in the dependent variables.

This proves that wellness programs are an accurate predictor of business success, suggesting that companies with wellness programs tend to have more productive workers. When questioned about the importance of wellness programs in their jobs, respondents gave the following account, which represents 40.5% of the total: The health initiatives provided by my bank have made me feel respected and encouraged. A similar percentage of respondents also said that "health and fitness education improves their organization's performance of their bank." (57.3%) Regression study showed a favorable and statistically significant link (= 0.178, p 0.001) between wellness initiatives and business success. In other words, the possibility (probability) of the regression model making an incorrect forecast is less than 0.001. As a result, we can trust the regression model with 95% certainty.

Table 6a Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.178[a]	.032	.029	.42389

Table 6b ANOVA

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	2.395	1	2.395	13.330	.000[a]
	Residual	73.309	408	.180		
	Total	75.704	409			

Table 6c Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients		Sig.
		B	Std. Error	Beta	T	
1	(Constant)	2.072	.093		22.373	.000
	Wellness programs	.111	.030	.178	3.651	.000

CONCLUSION

There were no significant changes in clinical indicators of health, health care expenditure and usage, or employment outcomes among workers of

a big warehouse retail firm 18 months following exposure to a workplace wellness program. The impact of wellness initiatives on business success has not diminished. There was a linear relationship between providing wellness programs, such as those that emphasize preventative care, offer wellness-related education and training, and have managers who are supportive of wellness initiatives in terms of their employees' satisfaction, productivity, and job satisfaction.

REFERENCE

1. Richemond, D.J. and Needham, C. (2020) The Impact of Wellness Programs on Employee Job Satisfaction in Colleges and Universities. Open Journal of Business and Management, 8, 569-599. https://doi.org/10.4236/ojbm.2020.82035.

2. Qaisar, Muhammad & Mariam, Shahida & Ahmad, Farooq. (2018). Employee Wellness as Predictor of Productivity from Public Sector Management Perspectives: Conditional Process Analysis. 13. 104-116.

3. Richemond, D.J. and Needham, C. (2020) The Impact of Wellness Programs on Employee Job Satisfaction in Colleges and Universities. Open Journal of Business and Management, 8, 569-599. https://doi.org/10.4236/ojbm.2020.82035

4. Smith, J. (2020). "Measuring Wellness: Developing Comprehensive Metrics for Organizational Well-being and Employee Performance." Vol. 10, No. 1, 2020, pp. 13-19. doi: 10.11648/j.ajhr.20221001.13

5. Patel, S. (2020). "Wellness Initiatives and Employee Productivity: A Study on the Relationship between Workplace Wellness Metrics and Performance."-25. 10.15239/j.brcacadjb.2022.12.01.ja01.

6. Adams JM. The Value of Worker Well-Being. Public Health Reports. 2019;134(6):583-586. doi:10.1177/0033354919878434

7. Yamada, A., Subica, A.M., Kim, M.A., et al. State of Spirituality-Infused Mental Health Services in Los Angeles County Wellness and Client-Run Centers. Administrative Policy Mental Health (2014), 41, 835–844

8. WHO. Stress at the workplace, 2015. Retrieved on February 2016 from http://www.who.int/occupational_health/topics/stressatwp/en/

9. WHO (2016). Mental health: strengthening our response. Fact sheet. Retrieved on April 2016 from http://www.who.int/mediacentre/factsheets/fs220/en/

10. Collymore B. Leaders Africa, 2015. Retrieved on March 19, 2015 from http://www.leaders-africa.com/ceo-of-safaricom/

11. CDC. Benefits of Health Promotion Programs (2013). Retrieved on March 19, 2016 from http://www.cdc.gov/workplacehealthpromotion/businesscase/benefits/

12. Philips, J.M. & Gully, S. M. Human Resource Management, International edition., USA, South-Western, Cengage Learning, 2014. [18] Pelletier, B., Boles, M. & Lynch, W. Change in health Risks and Work Productivity Over Time. Journal of Occupational & Environmental Medicine (2004), 46 (7), pp. 746 – 754.

13. Doyle K. L'Estrange J. & Bauman A. Healthy Workplace Guide: Ten Steps to implement a workplace health program. 2nd Edition. The National Heart Foundation of Australia, 2016. Retrieved on October 30, 2016 from https://www.heartfoundation.org.au/images/uploads/main/4669_HF_-_Healthy_Workplace_guide_booklet_update_2016_Web_Email_FINAL.pdf

14. Bray, I. Healthy Employees, Health Workplace. Rotman Management Magazine, 2016

15. Merrill, R.M., Aldana, S.G, Vyhlidal, et al. (2011). The Impact of Worksite Wellness in a Small Business. Journal of Occupational & Environmental Medicine, 53(2), 127-131.

Corresponding Author

Kuber Singh Rathore*

Research Scholar, Faculty of Commerce & Management