Why Don't Employees Participate in Well-being Programs? A Research-Informed Systems-Based Model

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Objective: Employee nonparticipation in well-being programs is common, but not well understood. Development of a systems-based framework to characterize reasons for nonparticipation can inform efforts to enhance engagement. **Methods:** Following literature review and building on previous research, a systems-based model was developed to contextualize participation barriers. **Results:** Well-being program nonparticipation is more frequent among low-wage workers as well as minority subpopulations. Contributors include employer factors, such as inequitable benefits design, and employee factors, such as lack of perceived relevance, barriers to access, and lower prioritization of personal health needs. **Conclusions:** A systems-based approach to evaluating well-being program nonparticipation can help identify factors contributing to employee nonparticipation and lead to targeted policy and practice changes that encourage greater employee engagement.

Keywords: well-being programs, employee benefits, health inequities, employee participation

LEARNING OUTCOMES

- Discuss the contextual/organizational and personal factors contributing to employee nonparticipation in well-being programs
- Formulate a plan to elicit employee feedback as to reasons for nonparticipation in well-being programs
- Outline a framework of the approaches to mitigating organizational and personal factors that contribute to employee nonparticipation in well-being programs

Since their popularization in the second half of the 20th century, worksite health and well-being programs have been focused on participant engagement and outcomes. Early evaluation efforts explored the difference between participant and nonparticipant outcomes, with the understandable goal of measuring program value.[1] Given that the preponderance of programs has been vendor sponsored, it is easy to appreciate the importance of this objective for the sake of maintaining existing employer clients and attracting new ones. However, the emphasis on program outcomes has significantly—and unfortunately—shifted the focus of both vendors and employers away from program nonparticipants. As a result, employers and vendors alike have become accustomed to accepting middling participation rates as an acceptable "normal." At the same time, efforts to quantify return on investment suggest that comparing participants to nonparticipants does not accurately capture the value provided by the program.[2] Instead, it likely reflects built-in limitations of the research design, such as healthy participants' self-selection into well-being programs.[2]

Growing awareness of health inequities in the United States—and particularly among individuals with employer-sponsored insurance—has prompted a critical evaluation of inequities in workforce well-being[3] and employer-provided program offerings.[4,5] Are these programs accessible and relevant to all employees? Do they provide equitable value for participants? Or do they inadvertently worsen health inequities? To reach the employees who could benefit most from these programs, organizations may want to examine how they can develop policies and structures to facilitate participation among the employee groups who could benefit the most.

The goal of this article is to present a theoretical framework from existing literature about the reasons why some employees do not participate in workplace well-being programs and to bring attention to nonparticipants by providing insight into their perspectives and experiences. Included is an exploration of reasons for nonparticipation, as well as a discussion of the implications of nonparticipation in relation to workforce health equity. We present a business rationale for employer and vendor stakeholders to broaden their engagement efforts and provide a series of suggested action steps to foster greater engagement of current nonparticipants.

Theoretical Framework: Factors Affecting Employee Participation

Engaging in workplace well-being programs is often framed as a personal decision, even though structural factors often impede participation. Given that employees have autonomy to decide whether and how to address their health, some organizations find it sufficient to provide access to programs or benefits, pushing the responsibility of prioritizing health and finding the time to engage in available programs onto employees. If access to and value of workplace well-being programs were truly equitable, then nonparticipation should be somewhat random across different work and demographic characteristics, including occupation, work schedule, race/ethnicity, and gender. At the very least, it should be closely aligned with need, such that employees who have more to benefit from the programs are more likely to participate in them. However, previous research suggests that this is not the case and that employees who may benefit most from participation are often less likely to use workplace well-being programs.[6]

Many variables influence employee participation in well-being programs. In a 2003 discussion, Linnan et al[7] describe the "Political Economy of Health" as a theoretical perspective that extends beyond the social-ecological framework to characterize larger social, political, and economic factors influencing wellness program participation. At the employer level, factors including organizational culture, the organization's

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focus on workforce health equity, and the program's perceived alignment with business objectives also play an important role.[8,9] For each specific offering, aspects influencing participation may include program design, marketing and communication approaches, and employee accessibility, as well as alignment with employee values and required participant literacy level. Perhaps the most compelling factors influencing participation are employee considerations, including alignment with personal well-being priorities, accessibility, and perceived value. More work is needed to understand and characterize the factors associated with nonparticipation.

This analysis leverages Andersen's Behavioral Model of Health Services Use[10] as a conceptual framework for understanding the factors influencing employees' nonparticipation in employer-sponsored well-being programs. As shown in Figure 1, the model highlights three sets of factors at both contextual and individual levels of analysis, which can impact health behaviors and ultimately individual health outcomes: predisposing factors, enabling factors, and need. Here, we describe context in terms of the workplace, to characterize organizational and/or work-related factors that influence employee well-being program participation. Individual factors include not only employee characteristics but also the social determinants of health they experience outside of the organization that influence their engagement in available well-being programs. Finally, we extend this framework to include not only individual health outcomes but also organizational outcomes. There is a compelling business case for promoting employee health and well-being, most notably for employees who do not often participate in employer-sponsored well-being programs.

Predisposing Factors

Predisposing factors represent existing features of the workplace or employee characteristics that influence employee decisions regarding well-being program participation status.

Context

At the contextual level, predisposing factors include organizational culture as well as the organization's emphasis on workforce health equity, both of which can impact employee beliefs. Organizational culture provides a foundation for employee perceptions of the importance of well-being programs and, if supportive, may foster greater levels of employee involvement.[9] Similarly, greater leadership support may also increase participation levels.[11] A recent analysis of employee perceptions of supervisor response to employee health concerns revealed wage-based differences, with more supportive supervisor responses to higher income employees, and negative responses to lower income employees.[12] In addition, when employees perceive that the organizational culture (or social norms) de-emphasizes benefit utilization, they may be less likely to use their benefits.[13] Importantly, and discussed later in more detail, is the extent to which an organization is focused on workforce health equity, which almost certainly impacts the relevance and perceived value of programming for employees.[4] Some employers remain unsure how to develop programs for all employees while also recognizing and addressing factors that might prevent some people from participating.[14] Similarly, limited data on the impact of nonparticipation makes it difficult for organizations to decide whether well-being programs are truly aligned with their business objectives.

Employees

At the individual level, predisposing factors include existing beliefs about health and well-being, including about one's personal responsibility for well-being and comfort with using or receiving employer-sponsored benefits offerings. Predisposing factors also include demographic characteristics, employees' social determinants of health and unmet social needs, as well as their genetic predisposition to certain diseases. At a subpopulation level, and broadly acknowledged in the context of healthcare services use,[15] systemic racism and medical mistrust are likely contributors to low workplace well-being program participation rates among Black employees.[16]

Enabling Factors: Financing and Benefit Design

Context

At a tactical level, employer benefit design considerations may determine employee eligibility for well-being program participation. Some employers have extended eligibility to all employees irrespective of health plan enrollment, while others restrict well-being program eligibility to only those enrolled in the employee health plan. Some employers work to innovate with their benefits, while others offer more standardized or off-the-shelf benefits offerings. In addition, employer willingness to elicit employee feedback to understand unmet needs and personal well-being priorities can be helpful but may not be a common practice beyond use of well-being risk assessments to gather population-level responses and insights.[17] The extent to which well-being program leaders make decisions primarily based on their own experience with less input from employees raises the potential for in-group bias,[18] which may reduce the relevance and value of well-being programming to more diverse populations.

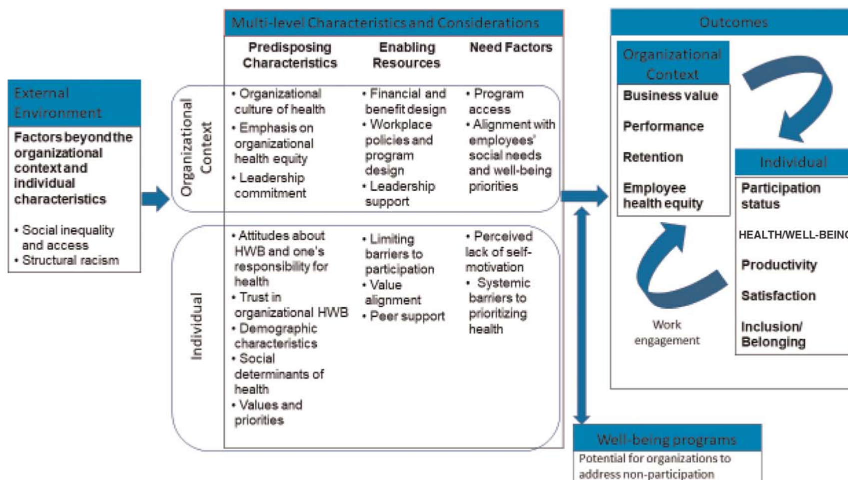

FIGURE 1. Model of employee nonparticipation in HWB initiatives in organizations. HWB, Health and well-being.

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Individual

For employees, financial considerations can impact participation in employer-sponsored well-being programs. For instance, out-of-pocket costs associated with well-being programs may prevent individuals with limited financial resources from participating, particularly low-wage workers. A typical scenario might involve a fitness center membership or weight loss program where employees make the initial payment and receive a partial rebate based on achievement of a participation threshold. Low-wage workers may not be able to afford the necessary financial outlay and consequently decline participation. Some insurance plans offer financial discounts or reimbursements for engaging in healthy behaviors, like completing an annual physical. However, the implicit assumption that employees know how to do so and can find an approved provider in the allotted time may not be the case. A lack of perceived cultural alignment may also diminish employee interest in well-being programs, as may language or literacy barriers to employee understanding. Personal motivation is an important determinant, but systemic barriers also warrant attention. If an individual works multiple jobs, finding time to exercise may be difficult, even if the person is motivated, and may involve trade-offs with sleep or family time.

Enabling Factors: Workplace Policies and Program Design

Work Context

Other research has touched on some of the barriers to participation that arise as a result of the program itself. Some of these include scheduled time, duration of individual sessions and overall program length, means for delivery (in-person vs digital), and effectiveness of marketing, which can all play a role in program accessibility, perceived value, and participation levels.[19,20] Appropriate matching with employee health literacy and cultural and socioeconomic considerations can enhance perceived employee value and increase engagement, while insufficient alignment can reduce employee perceptions of value and substantially lower participation rates.[21]

There is also a tension between work and health. In some cases, they intersect—in others, they do not. For instance, some organizations offer employees on-site access to healthy food options. However, these may not be available to all employees, such as when food service areas are closed to employees working overnight shifts or when healthy food vending machines are only accessible to certain employees. Similarly, some employees talk about how they are on their feet all day, doing tasks that should count as exercise. At the same time, physical exhaustion and wear and tear on the body can undermine health. For instance, some employees are so exhausted when they get home that they eat snack foods that are more convenient, yet potentially less healthy.[20]

Needs

Ultimately, many employer-sponsored well-being offerings push the responsibility for employee participation onto individual employees. While access barriers may exist,[19] alignment of personal employee priorities and values with available employer-sponsored well-being offerings likely represent a significant determinant of participation. Employees with unmet social needs, including financial or caregiving stressors, may be less likely to engage in because of more pressing personal priorities. In their book, *Scarcity: Why Having So Little Means So Much*, the authors note that perceived lack of essential assets—including money, time, love, or others—results in a compelling focus or "tunneling" on the subject of scarcity.[22] In addition, the authors note that a "bandwidth tax" further limits individuals experiencing scarcity from appreciating opportunities that may be helpful but are peripheral to the subject of scarcity.[22] From a practical perspective, individuals without the money to spend on a well-being program, as mentioned earlier, or insufficient available time, may also not participate because of limited resources.

Some employees suggest that the biggest barrier to their use of health benefits is themselves—if they wanted it more, they would make time for it. Although low-wage workers have fewer resources to access or use well-being programs, when asked about the barriers to using them, some employees point to their own lack of motivation or unwillingness to put their health first.[20] They note that if they wanted to take advantage of their health, they would fit it into their schedule—by not fitting it in, there is a sense that maybe they do not prioritize it. However, prioritizing health and wellness often involves deprioritizing other personal needs.

What Do Available Data Tell Us?

In light of these considerations along with review of published research, we present some key findings and inferences, along with additional supportive evidence.

1. Nonparticipants are disproportionately represented by low-wage workers.

Low-wage workers are less likely to participate in employer-sponsored well-being programs.[6,23,24] Paradoxically, these individuals have a greater prevalence of chronic conditions as well as less healthy lifestyle behaviors that likely contribute to their disease burden.[25] In addition, because low-wage workers exhibit significantly greater use of the emergency department for low-acuity care, have substantially higher hospitalization rates, and exhibit significantly lower compliance with preventive services even after adjusting for illness burden,[26] targeting these individuals for health improvement initiatives would make particular sense from a healthcare cost-containment perspective.

2. Nonparticipants are generally more reactive users of healthcare, with likely focus on other personal priorities, including unmet social needs.

Consistent with the "scarcity" construct, employees who do not participate in well-being programs seem less likely to use preventive services or have primary care visits and are more likely to use the emergency department for care or be hospitalized. In an unpublished analysis of private exchange enrollee data from 45,000 employees and spouses/partners, we show that in comparison with individuals participating in employer-offered biometric screening, nonparticipants had more frequent emergency department visits and hospitalizations and comparatively lower primary care use, as shown in Table 1. In addition, despite similar concurrent risk scores, healthcare costs per member per year were more than $1400 greater for the biometric screening nonparticipants. These data suggest that program nonparticipation may be an indicator of a more significant issue—that personal attention to health issues may be a lower personal priority among this subpopulation.

3. When used for population health management planning, health risk assessment results are skewed toward participant responses and do not necessarily reflect the needs of the broader population.

Indent this line for consistency. Evidence for low well-being program participation among low-wage workers seems to be broadly recognized.[6,24] Similar findings have been observed in relation to low-wage worker participation in health risk assessments with 30% lower participation rate among low-wage workers relative to their higher-wage counterparts, even in the setting of a financial incentive for completion.[23] As a result, use of these tools to inform population-level well-being offering selection may inadvertently result in program offerings that do not adequately reflect the needs and interests of low-wage workers.

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TABLE 1. Difference in Healthcare Utilization and Cost Patterns by Biometric Participation Status Among 45,000 Employees and Spouses Enrolled in a Private Exchange Offering During 2015

	Biometrics Participation	Biometrics Nonparticipation	IBM Watson MarketScan Benchmark
Relative risk score–concurrent	1.43	1.40	
Allow amt PMPY med and Rx	$6,578	$8,261	$5,969
Net pay PMPY med and Rx	$5,130	$6,570	$5,014
Admits per 1,000 acute	60.23	91.75	60.32
Admits per 1,000 acute avoidable	4.99	9.18	
Days LOS admit acute	3.42	4.63	4.00
Scripts per 1,000 Rx	14,057	12,630	12,177
Visits per 1,000 office med	6,610	5,788	6,924
Visits per 1,000 prevent adult	456.91	344.95	424.20
Visits per 1,000 ED	283.49	590.10	227.51
Ambulatory sensitive ED visits per 1,000	23.48	53.62	—

ED, Emergency Department; LOS, Length of Stay; PMPY, Per Member Per Month.

4. Outcomes-based incentive programs have the potential to worsen health inequities.

Low-wage employees who participate in outcomes-based incentive programs receive fewer financial rewards, potentially exacerbating health inequities.[27] This suggests that wellness program costs, including incentives, are effectively borne by low-wage workers, while the benefits are enjoyed by higher-earning employees who are already healthier before participating.[28]

5. Nonparticipants are less engaged with their employers and, as a result, are more likely to leave employment.

Participation in health and well-being is not only beneficial for employees but can have business implications for employers, too. For instance, lower engagement in well-being programs has been associated with higher levels of absenteeism and eventually turnover.[29] In contrast, employees derive value from employers taking an interest in their health,[24] which may well enhance employee retention. A nationwide labor shortage, especially in industries that rely on front-line workers, highlights the value of employee retention.

6. Broader employee participation in well-being offerings can yield business value.

Employers may benefit from expanding their approach to quantifying the value of well-being initiatives. As previously noted, there are significant limitations with simply comparing participant versus nonparticipant outcomes. Instead, employers can use existing internal metrics and data sources to understand better the relationship between employee health, work engagement, and the associated business consequences of workforce retention, productivity, and performance,[30] even though physical health parameters may not significantly change.[28]

Importantly, well-being initiatives that foster greater participation because of perceived value—especially among diverse employee subgroups—can also help improve workforce health equity. By ensuring that diverse employee perspectives are elicited during the well-being program planning process, employers can have greater confidence that their program offerings are meeting the diverse needs of their employees. A data-driven approach to linking employee participation in well-being initiatives and the effect on health, well-being, engagement, and measures of business performance may be particularly insightful.[31]

Potential Action Steps for Stakeholders

Employers

While employers have traditionally focused on well-being program participant outcomes, future efforts should work to expand the analysis of nonparticipant health and well-being data. In addition, it is important for employers to understand the reasons for nonparticipation. As mentioned previously, employers could examine predisposing organizational or employee-associated factors that limit participation. They could also invest in gaining a better understanding of the unmet health and well-being needs of their employees, as well as the enabling factors that may enhance participation. Some considerations include eliciting input from employee resource groups or focus groups of nonparticipants to understand perceived participation barriers.[32]

Importantly, employers can—and perhaps should—incorporate health equity measures into their well-being program evaluations. Effective well-being initiatives should target a diverse array of unmet subpopulation health and well-being needs across the workforce, with the goal of equitably improving health. If certain subpopulations are not participating, employers should take steps to understand and address the contributory factors. Inclusion of measures of health equity into employer diversity, equity and inclusion (DEI) initiatives will likely enhance organizational DEI outcomes and impact.[4]

When organizations focus on employee health, there is a need to focus at a system/strategic level rather than simply at an employee level. In addition to thinking about how to change people's attitudes and behaviors to increase their readiness and willingness to engage in health and well-being, there is a need to embed health and wellness into the infrastructure, too. Employers can implement organizational policies and practices that are aligned with workforce well-being objectives, including healthy food options, supportive leave policies, or wage-based subsidies for health benefits. By so doing, they reinforce support for the organization's commitment to a culture of health, which may help lower threshold for employee participation in employer-sponsored well-being programs.

Vendors

Well-being program vendors have a perhaps unparalleled opportunity to take a leadership role in enhancing workforce health equity for their employer clients. To start, vendors will benefit from incorporating individual level employee race, ethnicity, and perhaps wage (or wage band) data from clients to characterize program participation rates by demographic subcategories. Ongoing reporting can be used to inform collaborative employer-vendor efforts to understand barriers to participation as well as unmet subpopulation well-being needs. These insights can then be incorporated into strategic program planning, with at least quarterly reporting to evaluate the impact on program participation, with timely modifications in the event participation is not as desired.

Vendors can also play a more active role in promoting health equity. For clients, vendors can provide subpopulation-specific program participation and outcomes data as a measure of the vendor's impact. At a book-of-business level, vendor reporting can highlight the extent to which vendors are meaningfully addressing health equity concerns and fostering diverse employee involvement in programs. Finally, vendors can use these and other reports to support their roles as strategic planning partners for their clients by understanding health equity priorities and potential solutions.

Researchers and Program Evaluators

There is an urgent need for systematic and thoughtful evaluation of well-being programs to ensure they deliver equitably beneficial health and well-being outcomes. Both researchers and program evaluators can use the provided framework to broaden their analyses to include program nonparticipants. Only with a clear understanding of the needs and concerns of these individuals will there be an opportunity to reduce health inequities in the workforce. After all, the value of a well-

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being offering should be viewed through its impact on the entire population, and not solely on those who participate.

CONCLUSIONS

As employers continue to invest in workforce health benefits, optimizing the business value of those investments has become increasingly important. However, employees in low-wage categories or belonging to racial or ethnic minorities are often not using the benefits available to them, limiting program effectiveness and potentially exacerbating workforce health inequities. A thoughtful strategic planning approach to workforce health and well-being has the potential to foster greater involvement of individuals in these subpopulations, improving health equity and business outcomes.

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