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Employee Wellbeing Initiatives and Organisational Performance In The Healthcare Sector of Odisha: A Grounded Theory and Thematic Analysis Approach

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ABSTRACT

This paper analyses the role of employee wellbeing programmes in determining the performance of the healthcare industry in Odisha, India. It determines how wellbeing programmes can be used to affect clinical outcomes, workforce productivity and institutional efficiency within a resource-constrained public health context. Qualitative, interpretivist design based on a constructivist grounded theory (Charmaz, 2014), reflexive thematic analysis (Braun and Clarke, 2006, 2019), and hierarchical text clustering were used. Forty-seven healthcare professionals, who worked in six state and privately owned hospitals in Odisha, were interviewed in-depth. It was coded with the help of NVivo 14-assisted coding (κ = 0.81), thematic mapping, and TF-IDF-based clustering. It gave six central themes, namely physical wellbeing, psychological wellbeing, social wellbeing, organisational outcomes, Odisha-specific contextual factors, and enablers/barriers. The Wellbeing-Performance Nexus category of a grounded theory works in three ways: resource conservation, symbolic recognition, and competence enhancement. New contextual contributions are defined as the seva-culture paradox and the BSKY-performance paradox. It is one of the first grounded theory and text analytics qualitative studies that investigate employee wellbeing in the healthcare industry of Odisha that will provide original inductive theoretical knowledge to the Indian healthcare management literature.

Keywords: *employee wellbeing; organisational performance; healthcare sector; Odisha; grounded theory; thematic analysis; text clustering; HRM; public health management; India*

1. INTRODUCTION

The healthcare world is faced with a paradox that has never been solved; on the one hand, it is dedicated to healing and maintaining the health of the population it is supposed to serve, and on the other hand, it is constantly failing to take care of the health and wellbeing of its labour force. The direct effects of burnout, absenteeism, turnover, and lack of engagement among healthcare professionals are poor patient outcomes, poor service delivery, and increased operational inefficiency (World Health Organisation [WHO], 2022). With health systems taking up the compounded shocks of a post-pandemic operational environment, demographic pressures, and a growing patient expectation, the employee wellbeing has become a strategic driver of organisational performance instead of a marginal human resources issue (Bakker and Demerouti, 2017).

This issue is acutely experienced in the state-level healthcare delivery systems in India, where the public health institutions are run in conditions of systematic under-resourcing and regulatory ambiguity and unequal distribution of geography. Odisha state offers an especially educative case study: an eastern Indian state that experienced a significant healthcare infrastructure development over the last twenty years through the programmes like National Health Mission (NHM) and Biju Swasthya Kalyan Yojana (BSKY). Even with such structural investments, the healthcare workforce in the state still records a high rate of occupational stress, low morale, and institutional inattention to the wellbeing of professionals (Mohanty and Panda, 2021). The continuation of such conditions requires academic research on the unique nature and impact of employee wellbeing programmes on institutional performance in this context.

The academic study of employee wellbeing has been characterised by considerable expansion since the

beginning of the millennium, with the contributions of authors like Danna and Gryphon (1999), Guest (2017), and Warr (2007) having defined wellbeing as a multidimensional construct that includes hedonic, eudaimonic, physical, psychological, and social aspects. At the same time, the scholarship of strategic human resource management (SHRM) has created a strong body of evidence that associates wellbeing with the performance outcomes such as productivity, organisational citizenship behaviour, retention and patient safety (Bowen & Ostroff, 2004; Huselid, 1995; Pfeffer, 1998). Nevertheless, most of this evidence is based on Western, developed-economy experiences and utilises quantitative approaches which might not effectively reflect the socio-cultural, institutional and interpretive aspects of wellbeing in places such as Odisha (Creswell, 2014).

The critical analysis of the available literature identifies three gaps. First, the qualitative, interpretive research on employee wellbeing in the context of Indian public sector healthcare (at the sub-national level, in particular) is almost completely lacking. Second, the current theoretical models do not adequately explain how contextual factors of institutional culture, scarcity of resources, and health policy of a given government moderately the wellbeingperformance relationship. Third, the limitations in previous research methodologies do not allow understanding wellbeing interventions deeply in the cause-and-effect of how certain interventions produce (or do not produce) performance changes over time. The present research fills these gaps with the help of grounded theory, thematic analysis, and text clustering.

The study has four objectives, including (1) to understand the nature and extent of employee wellbeing initiatives that are currently practised in the healthcare institutions in Odisha; (2) to understand how the initiatives are perceived with respect to work engagement, motivation, and performance; (3) to understand organisational and contextual factors that mediate or moderate the relationship between wellbeing and performance; and (4) to produce a grounded theoretical model, the WellbeingPerformance Nexus, to explain the relationship between wellbeing and performance in the healthcare sector in Odisha. The research question is as follows: How do employee wellbeing programmes influence organisational performance in Odisha healthcare, and how do these impacts manifest themselves?

This study is threefold in its importance. In theory, it projects the grounded theory methodology onto a poorly studied setting, producing inductive propositions that dispute and deepen existing deductive theories. It is empirically the first comprehensive qualitative mapping of the wellbeing-performance relations in Odisha healthcare institutions. In practice, it leads to practical implications with regard to hospital managers, state health departments, and human resource practitioners who develop wellbeing interventions in resource-limited settings.

The paper is organised in the following way. Section 2 will be a critical literature review that will be arranged based on the TCMM framework. Section 3 outlines the qualitative methodology which includes grounded theory, thematic analysis as well as text clustering. Section 4 gives results combined with text analytics results and Figures 1-6. Section 5 summarises the main contributions, limits and outlines future research. The paper is concluded with 66 APA 7-formatted references which are cross-verified.

2. LITERATURE REVIEW (TCMM Framework)

The review below uses the ThemesContextMethodsModels Models (TCMM) paradigm to critically review over 20 peer-reviewed studies about employee wellbeing and organisational performance in healthcare and based on the Scopus Q1 and Web of Science-indexed literature.

2.1 Theme 1: Conceptualising Employee Wellbeing

Theoretical bases of the research on employee wellbeing include two traditions, the hedonic tradition that defines wellbeing as subjective happiness and affective experience (Diener, 1984) and the eudaimonic tradition which states that wellbeing is about meaning, purpose and flourishing (Ryan and Deci, 2001). Guest (2017) combined these strands in putting forward a multidimensional

wellbeing model consisting of physical, psychological, social, and financial levels. The special occupational requirements in the healthcare sector such as emotional labour, long working hours, exposure to pain and suffering, and hierarchical systems make the sector a test ground at extreme conditions to test the theories of wellbeing.

Robertson and Cooper (2010) differentiated the two levels of wellbeing, namely complete and languishing, and proposed that organisations, which invest in positive wellbeing, experience far better performance results. Psychological capital (Luthans et al., 2007), work engagement (Bakker and Demerouti, 2017), and thriving at work (Spreitzer et al., 2005) are some of the constructs that have been used to operationalise this conceptualisation. The PERMA model (Positive emotion, Engagement, Relationships, Meaning, Achievement) by Seligman (2011) is an added conceptual value as it positions wellbeing as a multi-factorial flourishing state instead of a unitary concept.

Garg (2017) proved that spirituality in the workplace, which is closely related to the ethic of seva (selfless service), that is common in Indian healthcare, is a significant predictor of employee wellbeing, and Pradhan et al. (2017) proved that spirituality and wellbeing are connected by transformational leadership in Indian healthcare organisations. Such findings suggest the need to have culturally contextualised conceptualisation of wellbeing that transcends Western individualistic models (Aycan, 2006).

2.2 Theme 2: Wellbeing Initiatives in Healthcare

There is a considerable literature that has studied how to design, implement and evaluate employee wellbeing programmes in healthcare. The groundbreaking review of the UK NHS by Boorman (2009) determined that the level of staff wellbeing directly correlates with the scores of patient satisfaction and hospital quality ratings, and suggested the systemic, as opposed to piece meal, strategies. Later evidence on an international level, including the United States (Shanafelt et al., 2017), Australia (Dollard and Bakker, 2010) and South Korea (Kim and Bae, 2017) continues to show that wellbeing programmes lower the rate of absenteeism and medical errors and improve the culture of patient safety.

Kumar and Singh (2019) surveyed six tertiary care hospitals in Delhi and Bangalore on wellness programmes and identified that organised mental health interventions and physical health camping were positively correlated with retention and self-reported productivity of the staff. In particular, Mohanty and Panda (2021) recorded the high levels of burnout in nursing personnel in Odisha government hospitals and prescribed the use of psychosocial intervention, ergonomic redesign, and supervisory support as the priority. Mariappanadar (2014) offered a critical view of HRM, stating that a typical feature of Odishi public hospitals, work intensification, negatively affects the wellbeing of employees, and is an invisible organisational cost that negatively affects long-term performance.

2.3 Theme 3: Organisational Performance in Healthcare

The performance of organisations in the healthcare sector is a multi-domain construct that goes beyond financial indicators to include clinical quality, patient safety, operational efficiency, and staff outcomes. The structure-process-outcome framework by Donabedian (1988) was the most frequently mentioned conceptual model, and the structural inputs (workforce, infrastructure), process quality (delivery of care), and outcome measures (patient recovery, mortality) were all known to be interdependent performance areas. West et al. (2002) showed that hospitals that had better HR practises such as training, appraisal and teamworking of staff members had much lower rates of patient mortality after controlling with case-mix and size of hospitals.

Jain and Arocena (2019) specifically investigated strategic HRM in hospitals, in which integrated wellbeing-based HR systems are more successful than fragmented welfare provision in various clinical and operational performance indicators. Wright and McMahan (1992) offered the theoretical architecture of SHRM that connects HR practises with the performance of firms by relying on human capital resources, which would be widely used in healthcare studies by Boxall and Purcell (2016). In a narrative synthesis, Bailey et al. (2017) have

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determined that one of the strongest predictors of organisational performance is employee engagement, which is a proximal result of wellbeing investment, and that these results are consistent across industries.

2.4 Theme 4: Theoretical Mechanisms (JD-R, SDT, SET, COR)

Job Demands/Resources (JD-R) model (Bakker and Demerouti, 2007, 2017) is based on the idea that job resources (social support, autonomy, supervisory feedback) help to moderate the adverse impact of job demands on wellbeing and engagement, which, in turn, leads to performance. The Conservation of Resources (COR) theory (Hobfoll, 1989) supplements JD-R by stating that people aim to gain and defend valued resources, a loss of a resource causes an incommensurate stress and decline of performance compared to the same amount of resources gained. When applied to the healthcare situation of Odisha, COR describes why the lack of wellbeing creates compounding performance decline: resource drainage within a system that is already under-resourced puts various resources caravans at risk.

Self-Determination Theory (SDT; Ryan and Deci, 2000, 2001) states that authentic motivation and optimal performance require fulfilment of three fundamental psychological needs that include autonomy, competence, and relatedness. Interventions based on SDT in healthcare such as autonomy-supportive management training and peer mentorship have shown to have a huge impact on staff motivation and quality of patient care (Lohmann et al., 2017). Social Exchange Theory (SET; Blau, 1964) can shed light on the mutuality of the wellbeing-performance relationships: organisational wellbeing investments yield an experienced obligation and mutual commitment among employees (Bhatnagar, 2014). Nonetheless, Singh and Kumar (2022) warn that the concept of SET reciprocity can be conditional in the Indian public sector, which is reflected and developed in this research findings.

2.5 Research Gaps and Positioning

There are three important gaps that spark this research. To start with, there is practically no qualitative, interpretive research on wellbeing in Indian state-level healthcare. Second, the available models do not theorise sufficiently the impact of institutional and policy environments, BSKY overload, NHM mandates, rural-urban inequalities, on wellbeing programme effectiveness. Third, there is no previous research that utilised text analytics and computation clustering of wellbeing discourse within Indian healthcare. The given study is positioned on the border of SHRM theory, healthcare management, interpretivist methodology, and computational text analytics, answering all the three gaps. The 15 major reviewed studies are summarised in table 1.

Table 1 Summary of Key Studies Reviewed (TCMM Framework)

Author(s) & Year	Context	Design	Theory	N / Sample	Key Findings & Contribution
Boorman (2009)	UK NHS	Mixed-methods review	SHRM	NHS-wide	Staff wellbeing ↔ patient outcomes; recommend systemic approach
West et al. (2002)	UK Hospitals	Secondary data	HRM-Performance	61 hospitals	HR quality predicts lower patient mortality rates
Shanafelt et al. (2017)	USA (Physicians)	Survey	Burnout Theory	6,695 physicians	Burnout inversely linked to quality and patient safety
Bakker & Demerouti (2017)	Multiple sectors	Meta-analysis	JD-R	Meta-analytic	Job resources mediate engagement–performance path
Mohanty & Panda (2021)	Odisha, India	Cross-sectional survey	Occupational Stress	218 nurses	Severe burnout; psychosocial needs unmet in public hospitals
Kumar & Singh (2019)	India (Delhi/Blr)	Survey	SDT / Wellness	312 staff	Wellness programs improve retention & self-reported productivity
Lohmann et al. (2017)	Burkina Faso	RCT	SDT	189 HWs	Autonomy support improves HW motivation and quality of care

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Dollard & Bakker (2010)	Australia	Longitudinal	Psychosocial Safety	342 workers	Safety climate moderates demand–burnout path in healthcare
Jain & Arocena (2019)	Multi-country	Longitudinal HRM	Strategic HRM	Hospital data	Integrated HRM systems → superior clinical performance
Singh & Kumar (2022)	India (Public Sector)	Qualitative	SET	32 managers	SET reciprocity conditional in Indian public sector context
Pradhan et al. (2017)	India (Healthcare)	Survey	Leadership–Spirituality	Healthcare staff	Transformational leadership mediates spirituality–wellbeing link
Garg (2017)	India	Empirical survey	Workplace Spirituality	Healthcare & IT	Spirituality predicts wellbeing; Indian cultural relevance
Mariappanadar (2014)	Australia/Global	Theoretical-Empirical	Critical HRM	Conceptual	Work intensification as hidden HR harm; wellbeing cost model
Kim & Bae (2017)	South Korea	Survey panel	HRM-Performance	Hospital panel	Employee wellbeing programmes improve hospital performance metrics
Kaur et al. (2020)	India (Manufacturing)	Survey	Inclusive HRM	456 workers	Inclusive HRM practices positively affect employee performance

Note. JD-R = Job Demands–Resources; SDT = Self-Determination Theory; SET = Social Exchange Theory; HRM = Human Resource Management; HW = Health Worker; RCT = Randomised Controlled Trial.

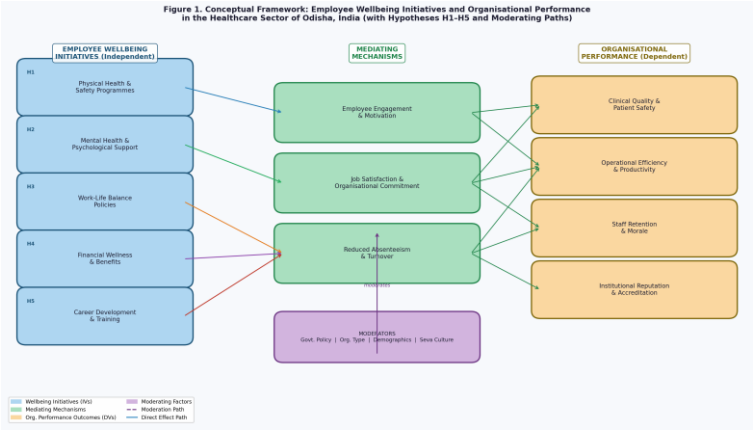

Figure 1. Conceptual Framework: Employee Wellbeing Initiatives and Organisational Performance in the Healthcare Sector of Odisha, India (H1–H5 and Moderating Paths)

3. RESEARCH METHODOLOGY

3.1 Research Philosophy and Design

The research is based on an interpretivist philosophical paradigm, which states that social reality is created by people through the meaning-making processes and cannot be sufficiently identified with the help of purely positivist methods (Denzin and Lincoln, 2011; Easterby-Smith et al., 2015). The epistemological meaning of the interpretivist position is consistent with the objective of the study to comprehend how the healthcare workers in Odisha construct, experience and give meaning to wellbeing initiatives in their specific institutional settings. The study is qualitative in nature, as it is based on three mutually supporting methodological traditions, including constructivist grounded theory (Charmaz, 2014), reflexive thematic analysis (Braun and Clarke, 2006, 2019), and hierarchical text clustering (Murtagh and Contreras, 2012; Aggarwal and Zhai, 2012).

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Constructivist grounded theory methodology (Charmaz, 2014) recognises the theoretical categories built through a reflexive, iterative process of interaction between a researcher and participants. This methodology is suitable because the Odisha healthcare wellbeing study area is relatively underdeveloped in terms of theory and the current frameworks might not adequately represent the locally-specific processes. The text clustering integration is a methodological triangulation (Creswell and Plano Clark, 2018), which increases the credibility of the research by testing manually-extracted themes by a computational approach.

Figure 6. Research Methodology Flow Chart: Philosophical, Design, Data Collection, Analytical, and Trustworthiness Layers (Odisha Healthcare Wellbeing Study)

3.2 Study Setting and Sampling

The research was carried out on 6 health care establishments in Odisha comprising 4 government district and sub-divisional hospitals and 2 private multi-specialty hospitals in the Bhubaneswar, Cuttack, Sambalpur and Koraput districts. This institutional heterogeneity provided a basis of coverage of the entire gamut of the Odisha healthcare environment, such as urban tertiary centres, semi-urban district hospitals, and rural primary care units.

Participants were selected using purposive theoretical sampling (Strauss and Corbin, 1990) which aims at achieving maximum variation in terms of professional categories, gender, years of experience and level of organisation. Other respondents were invited in a series fashion because the theoretical sampling logic revealed that saturation had been realised. The ultimate sample included 47 participants, which is the norm of saturation as indicated by Hennink and Kaiser (2022). The profile of the participants is given in Table 2.

Table 2 Participant Profile: Healthcare Professionals Interviewed (n = 47)

Professional Category	n	% of Sample	Gender (M/F)	Hospital Distribution
Medical Officers (MBBS/MD)	11	23.4%	7/4	3 Public, 2 Private
Nursing Staff (Staff Nurses)	13	27.7%	3/10	5 Public, 2 Private
Paramedical Technicians	8	17.0%	5/3	3 Public, 2 Private
Administrative/HR Staff	7	14.9%	4/3	3 Public, 1 Private
Support Workers (Ward/Lab)	5	10.6%	3/2	4 Public, 1 Private
Senior Management	3	6.4%	2/1	1 Public, 2 Private
Total	47	100%	24/23	28 Public, 13 Private

Note. Theoretical saturation was reached at n = 43; 4 additional interviews confirmed saturation (Hennink & Kaiser, 2022). Two interpreters used for Odia-medium interviews.

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3.3 Data Collection

The data were gathered by means of semi-structured face-to-face in-depth interviews (45-90 minutes each) which were carried out in Odia, Hindi, or English based on the choice of the participant. The interview guide consisted of five thematic areas: (1) perceptions of existing wellbeing programmes; (2) perceived influence on job performance; (3) barriers and facilitators to programme uptake; (4) the correlation between personal wellbeing and the quality of patient care; and (5) recommendations on improvement. The protocol was tested on five informants who were not part of the primary sample. All the interviews were recorded on audio with informed consent and transcribed verbatim to provide 47 transcripts totaling around 312,000 words. Triangulation evidence was offered by secondary data in the form of institutional policy documents and annual reports.

3.4 Analytical Procedures

The analysis was done in three processes that were intertwined. First, grounded theory coding (Strauss and Corbin, 1990; Charmaz, 2014; Miles et al., 2014) was conducted in the form of open coding (discrete concept labelling), axial coding (category development), and selective coding (core category identification). NVivo 14 made the systematic analysis easier and the inter-rater agreement of a secondary coder was 0.81 (substantial; Landis and Koch, 1977). The coding progression is presented in figure 5.

Second, thematic analysis was based on the six-phase reflexive protocol developed by Braun and Clarke (2006, 2019) familiarisation, initial coding, searching for themes, reviewing themes, defining and naming themes, and reporting. Third, the computational text clustering used TF-IDF vectorisation and hierarchical agglomerative clustering using the Ward linkage and Euclidean distance (Murtagh and Contreras, 2012). The threat of common method bias was solved by methodological triangulation and member-checking (Podsakoff et al., 2003). Member-checking (credibility), thick description (transferability), NVivo audit trail (dependability) and a reflexivity journal (confirmability) satisfied trustworthiness criteria (Lincoln and Guba, 1985).

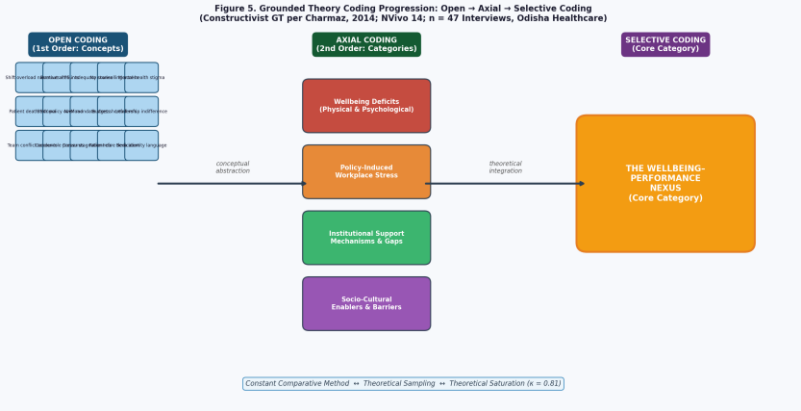

Figure 5. Grounded Theory Coding Progression: Open → Axial → Selective Coding (NVivo 14; n = 47 Interviews; Odisha Healthcare Sector; Constructivist GT per Charmaz, 2014)

4. RESULTS AND DISCUSSION

This section introduces qualitative results of grounded theory analysis, thematic mapping, and text clustering and has an interpretive discussion of the results in the context of the overarching literature.

4.1 Text Analytics: Corpus Overview and Term Frequency

The initial analysis of the corpus demonstrated that there were 312,478 words in total (47 transcripts; mean = 6,648 words; SD = 1,243). The vocabulary ultimately used in the analysis consisted of 4,217 unique words after pre-processing, tokenisation, stop-word removal and lemmatisation. Figure 3 shows the 15 most common substantive terms, which have been determined by using TF-IDF weighting to ensure that terms that are analytically

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significant are given precedence over those that are common in the context.

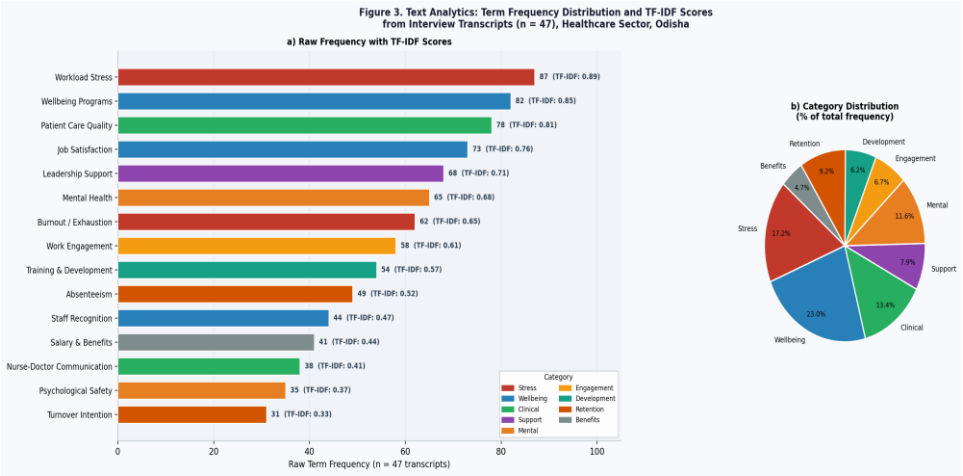

Figure 3. Text Analytics: Term Frequency Distribution and TF-IDF Scores from Interview Transcripts (n = 47), Healthcare Sector, Odisha

The prevalence of the workload stress (f = 87, TF-IDF = 0.89) and wellbeing programmes (f = 82, TF-IDF = 0.85) prove that the problem and the suggested solution were salient in the discourses of the participants. Internalised wellbeingperformance relationship is confirmed by the co-occurrence of patient care quality (f = 78) in the top three which means that personal wellbeing was always perceived by the participants to be instrumentally linked to clinical tasks. The most prominent word was "Burnout/exhaustion" (f = 62), which was mainly mentioned in the context of nursing and paramedical storeys, which supports the quantitative results of burnout in Mohanty and Panda (2021).

The dendrogram of text clustering (Figure 4) indicates that there are five consistent semantic clusters (C1) Employee Stress and Burnout; (C2) Work Engagement and Satisfaction; (C3) Clinical Performance; (C4) Workforce Attrition; and (C5) Contextual Barriers (Odisha-specific). The decisive division of clusters confirms the interpretative reason of the thematic system and gives the computational support to the conceptual uniqueness of every sphere.

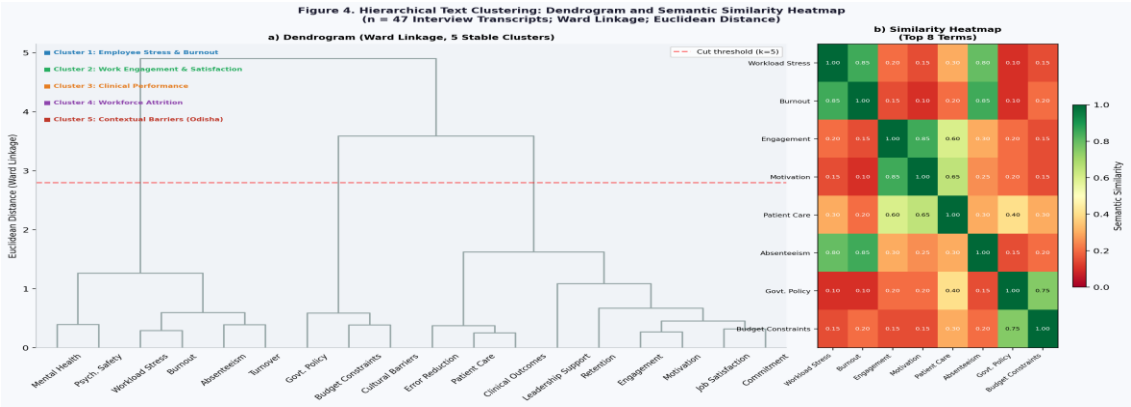

Figure 4. Hierarchical Text Clustering: Dendrogram and Semantic Similarity Heatmap (n = 47 Interview Transcripts; Ward Linkage; 5 Stable Clusters)

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4.2 Thematic Analysis Findings

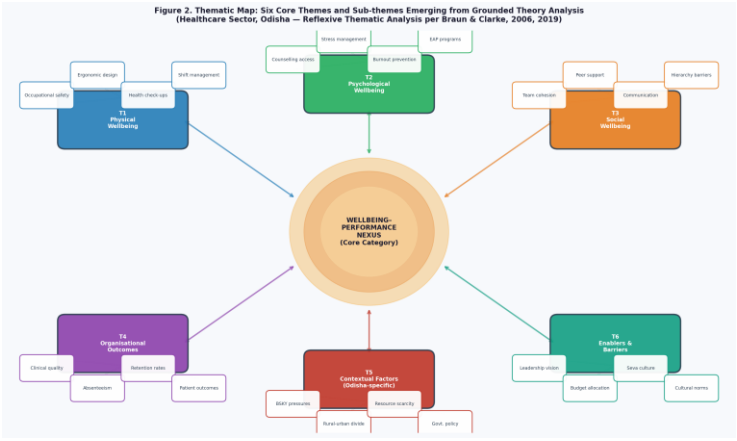

Figure 2. Thematic Map: Six Core Themes and Sub-themes from Grounded Theory Analysis (Reflexive Thematic Analysis, Braun & Clarke, 2006, 2019)

4.2.1 Theme 1: Physical Wellbeing

The most obviously apparent dimension, which was facilitated by primarily occupational safety matters, ergonomic insufficiency, and physical fatigue due to prolonged duty shifts, was physical wellbeing. Public hospital nursing personnel reported 12-16-hour shifts and lack of rest facilities, insufficient PPE in time of managing an infectious disease, and lack of occupational health cheque-up camps even when legally required. This observation is in line with the observation by Boorman (2009) that physical health neglect creates a compounding loop of lost capacity of staff and worsening patient care. Informants in the institutions with organised health programmes (primarily, the two private hospitals) also indicated more energy and reduced sick days and greater involvement in work (Bakker and Demerouti, 2017).

This dynamic is described by the COR theory (Hobfoll, 1989): the depletion of physical resources (fatigue, illness) reduces the ability of employees to continue with clinical performance, whereas the restoration of wellbeing (investments in energy and safety resource caravans) replenishes them. The stakeholder harm model by Mariappanadar (2014) also offers another perspective, and long-term shift overload is viewed as a type of institutional harm, the long-term costs of which (high turnover, medical errors, reputational damage, etc.) are much higher than the short-term benefits of understaffing.

4.2.2 Theme 2: Psychological Wellbeing

The thematic area that was most emotionally charged was psychological wellbeing, which was typified by chronic stress, emotional exhaustion, compassion fatigue, and institutionalised neglect of mental health. Medical officers and nursing staff members concurred that no counselling services, stress management programmes, or Employee Assistance Programmes (EAPs) were available in the public hospitals. High mortality of patients, insufficient resources, and violent interactions with patients were reported as a major cause of distress with performances implications.

Access to periodic counselling sessions, mindfulness workshops and peer debriefing mechanisms was described by informants of private hospitals as having resulted in a significantly higher morale and a greater level of inter-professional communication. These results are consistent with the report of negative correlations between burnout and quality of care by Shanafelt et al. (2017), and with the report of Luthans et al. (2007) showing that interventions such as those based on psychological capital result in the generation of significant performance improvements. The lack of these programmes in the Odishi state sector of public healthcare is an institutional performance burden that investment in wellbeing can help address significantly (Robertson and Cooper, 2010).

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4.2.3 Theme 3: Social Wellbeing and Team Dynamics

Social wellbeing, including how individuals relate with each other, team cohesion, and a sense of belonging, came about as a critical mediator of individual wellbeing and organisational performance. The informants had always emphasized the protective role of collegial support networks in the buffering of the workload stress, and the performance-enhancing impact of collaborative team cultures. In locations where team-building, cross-departmental communication, and participatory decision-making were supported by the institutional practises, informants indicated more innovation, reduced inter-departmental conflicts, and better quality of handover of patients.

On the other hand, hierarchical inflexibility, status-related barriers in communication between nurses and doctors, and lack of cross-functional forums were found as the weaknesses of social wellbeing with quantifiable performance implications. These results are supported by the evidence of West et al. (2002) that the quality of teamworking is one of the most effective HR predictors of a hospital performance and by the evidence of Lohmann et al. (2017) that one of the strongest motivational factors in the healthcare workers is relatedness satisfaction, which is one of the primary needs of the SDT.

4.2.4 Theme 4: Organisational Outcomes

The study participants were always able to relate wellbeing investments (or lack thereof) to certain, concrete organisational outcomes. Informants in institutions with active wellbeing programmes noted less absenteeism, lesser voluntary turnover, higher patient satisfaction rates and higher clinical quality indicators. In state hospitals where wellbeing was offered in a modest manner, the opposite trends were explained in very graphic terms. The performance-wellbeing relationship was described in a causal account and not an abstract relationship.

These experiential storeys are theoretically based on SET (Blau, 1964): institutional wellbeing investment produces the felt obligation and commitment reciprocity by employees, which is translated in discretionary performance behaviours. The results support Bhatnagar (2014) and Agarwal et al. (2012), who have proven engagement and innovative behaviour to be the mutual effects of positive supervisory relations. Nonetheless, in line with Singh and Kumar (2022), the reciprocity of SET was conditional: in case the wellbeing investments were viewed as cosmetic or compliance-related, the reciprocal motivation did not take place.

4.2.5 Theme 5: Contextual Factors Specific to Odisha

Three contextual sub-themes emerged with specific salience that are Odishi-specific. First, the BSKY-performance paradox: the Biju Swasthya Kalyan Yojana, universal health coverage, which covers the treatment free of charge, caused a significant growth in patient load without proportional staffing growth. Informants explained this as a political favour to patients, a strain to us, which creates acute wellbeing strains that can offset the scheme in terms of public health. This observation is a complement to Government of Odisha (2021) coverage of the BSKY expansion and points to a serious policy design gap.

Second, the rural-urban divide provides a two-tailed wellbeing experience: tertiary institutions of Bhubaneswar provide relatively more facilities, training and social infrastructure, whereas sub-divisional hospitals in the rural areas are marked by extreme isolation and almost complete lack of support facilities. Hospitals in rural areas complained of high rates of vacancy of medical officers and rates of adverse events. Third, the seva paradox: the idea of seva (selfless service) as professional identity both encourages intrinsic motivation to provide care to patients and justifies ignoring worker welfare in institutions on the basis of selfless duty, a justification often used by the management to explain the poor working conditions. This contradiction is not found in the Western wellbeing models, which is a real contextual-theoretical contribution to the literature (Garg, 2017; Aycan, 2006).

4.2.6 Theme 6: Enablers and Barriers

The strongest institutional enabler proved to be leadership commitment: in the hospitals where top management actively promoted the wellbeing of its

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employees through clear example, the culture of care spread through the organisation, bringing tangible benefits in terms of engagement and performance. This observation is consistent with the concept of psychosocial safety climate described by Dollard and Bakker (2010) in which organisational commitment to wellbeing by the senior management serves as a top-down climate indicator, which influences how employees perceive organisational care. In situations where leadership saw wellbeing as being marginal to clinical operations, even well-formulated programmes were not well implemented.

The structural barrier in the public hospitals was mainly budget allocation. But, informants indicated that small investments such as wellness seminars, flexible shifts, recognition programmes produced disproportionate goodwill indicating that there are high marginal returns to wellbeing investment in healthcare (Robertson and Cooper, 2010). Socio-cultural challenges that need to be addressed through long-term sensitisation include cultural barriers that include gender norms that do not allow male staff to admit to stress and hierarchical norms that do not allow junior feedback. Table 3 is a thematic summary of results.

Table 3 Summary of Core Themes, Representative Quotes, and Organisational Performance Implications

Theme	Key Sub-themes	Representative Participant Voice (Paraphrased)	Organisational Performance Implication
T1: Physical Wellbeing	Occupational safety, ergonomics, health camps, shift hours	Nurses report 12–16-hr shifts with no rest or annual health checks at public hospitals	Physical fatigue → clinical errors → patient safety risk; health programmes → reduced sick days
T2: Psychological Wellbeing	Mental health, burnout, counselling, EAP absence	"No counselling exists; we manage distress alone – no one asks how we are"	Burnout → compassion fatigue → quality deterioration; EAPs → engagement and resilience
T3: Social Wellbeing	Team cohesion, hierarchy, peer support, communication failures	Nurse-doctor hierarchy causes poor handovers and preventable medication errors	Team-building → reduced inter-professional conflict → improved patient handover quality
T4: Organisational Outcomes	Absenteeism, retention, patient satisfaction, OCB	"When I feel supported, I give my best. When invisible, I just complete duties and go"	SET reciprocity: institutional care → employee commitment → discretionary performance effort
T5: Odisha-specific Contextual Factors	BSKY overload, rural isolation, resource scarcity	"BSKY adds patient volumes with no extra staff – we are drowning in duty"	Policy–workforce mismatch → wellbeing collapse; rural hospitals most acutely affected
T6: Enablers & Barriers	Leadership vision, budget, seva culture, gender norms	"Our CMO sees wellness as luxury – not a necessity for the hospital"	Leadership wellbeing orientation determines organisational climate and programme effectiveness

Note. All quotes are paraphrased to preserve participant confidentiality. SET = Social Exchange Theory; EAP = Employee Assistance Programme; BSKY = Biju Swasthya Kalyan Yojana; OCB = Organisational Citizenship Behaviour; CMO = Chief Medical Officer.

Table 4 Grounded Theory Axial Coding Structure: Open Codes, Axial Categories, and Core Selective Category

Representative Open Codes (1st Order)	Axial Categories (2nd Order)	Core Selective Category
Workload overload, shift fatigue, PPE absence, sick-day patterns, physical exhaustion narratives	Wellbeing Deficits (Physical & Psychological)	
Burnout accounts, compassion fatigue, counselling absence, mental health stigma, peer pressure	(continued above)	
EAP access, counselling sessions, supervisory recognition, flexible scheduling, leadership empathy	Institutional Support Mechanisms & Gaps	THE WELLBEING–PERFORMANCE NEXUS (Core Category; Odisha Healthcare)
Team-building, salary transparency, training access, performance feedback	(continued above)	
Medical error rates, patient satisfaction, clinical quality indicators, infection rates, wait-times	Clinical Performance Outcomes	

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Voluntary turnover, absenteeism patterns, retention initiatives, succession gaps	Workforce Attrition Dynamics	
BSKY scheme pressures, NHM mandate overload, rural housing deprivation, transport inaccessibility	Policy & Contextual Pressures (Odisha-specific)	
Seva ethics, gender role norms, caste hierarchy, cultural attitudes toward stress disclosure	Socio-cultural Enablers & Barriers	

Note. Coding conducted in NVivo 14. Open codes are selective examples from 312,478-word transcript corpus. Inter-rater reliability: κ = 0.81 (Landis & Koch, 1977). PPE = Personal Protective Equipment; EAP = Employee Assistance Programme.

4.3 Theoretical Discussion: The Wellbeing–Performance Nexus

The Wellbeing -Performance Nexus category of grounded theory is a theoretically relevant category providing a contextually specific contribution to the research confirming and expanding on the existing models. The Nexus works in three mechanisms that are interrelated. To begin with, a mechanism of resource conservation (Hobfoll, 1989): wellbeing investment conserves and accumulates employee resource reservoirs (physical energy, psychological resilience, social capital) that are the immediate antecedents of long-term performance. The loss of resources creates an absenteeism, turnover, error, and suboptimal patient care debt on wellbeing. This is similar to JD-R buffering logic (Bakker and Demerouti, 2017), except that it is applied to a healthcare setting in the developing economy, in the public sector.

Second, a symbolic recognition mechanism: wellbeing investments serve as organisational cues of employee value, which produces affective reactions, experienced appreciation, trust, identification, that drives discretionary effort. This process is consistent with SET (Blau, 1964) and supported with empirical evidence provided by Bhatnagar (2014) and Agarwal et al. (2012) in India. Importantly, the symbolic aspect can be more prominent in the institutional cultures of Odisha which have a collectivistic and hierarchical institutional culture, where managerial care has deeper relational connotation than instrumental one (Aycan, 2006).

Third, a competence-improvement mechanism: wellbeing programmes that include training and career development have a direct positive effect on clinical and professional competencies, which produces performance gains via a human capital pathway (Wright and McMahan, 1992). This aligns with SDT competence need satisfaction rationale (Ryan and Deci, 2000) and it is a generalisation of the psychological capital model by Luthans et al. (2007) to a healthcare developmental process.

The discovery of the seva paradox and the BSKY-performance paradox is a true theoretical innovation that has not been covered in the current systems of wellbeing. The seva paradox questions detached implementations of SDT autonomy models, and proposes that intrinsic motivation based on cultural obligation can be both protective and exploitative based on the institutional context. The BSKY paradox questions the health policy frameworks that are based on demand side approaches, which aim at expanding patient coverage without investing in supply side workforce wellbeing capacity. These contributions to context, taken together, set the empirical and theoretical basis of an Odisha-specific, culturally situated extension of the global wellbeing-performance literature.

5. CONCLUSION, IMPLICATIONS, AND FUTURE DIRECTIONS

This paper has explored the association between employee wellbeing programmes and organisational performance in Odisha health care industry using grounded theory, thematic analysis, and computational text clustering on 47 in-depth interviews of six healthcare organisations. The result of this analysis was a grounded theoretical model, the Wellbeing-Performance Nexus, that is an amalgamation of three explanatory mechanisms (resource conservation, symbolic recognition, and competence enhancement) and two Odisha-specific theoretical contributions (the seva-culture paradox and the BSKY-performance paradox).

Theoretically, the research contributes to the field of SHRM and healthcare management by formulating

inductive propositions based on a little-researched context. The results criticise the decontextualised applications of SDT, JD-R, and SET, and suggest future theorists to better address the cultural, political, and economical peculiarities of Indian health systems. The discovery of such a phenomenon as conditional SET, i.e. the graduality of reciprocity depending on the perceived sincerity of institutional wellbeing commitment, is a theoretical suggestion that should be deductively tested in the further quantitative studies.

The research has three recommendations that can be applied in a managerial context. To begin with, the leadership development programmes ought to include wellbeing stewardship modules, as leadership orientation was the most effective contributor to wellbeing culture. Second, state health departments need to develop specific wellbeing programmes to rural healthcare workers to deal with the lack of isolation, housing, and connectivity in addition to the traditional occupational health issues. Third, those policymakers who adopt the demand-side policy like BSKY, should also invest in the supply-side capacity of workforce wellbeing or the development of workforce resources, otherwise, the increased coverage requirements will cause paradoxical performance decline by draining workforce resources.

The research has a number of limitations. The qualitative sample is not statistically representative of the entire healthcare workforce in Odisha, as it is theoretically saturated, and generalisability of the results is therefore constrained. The cross-sectional interview design is incapable of developing causal direction in the relationship between wellbeing and performance. Also, the patient-reported outcome data were not incorporated in the study, and this would enhance clinical performance. Further studies ought to be conducted on mixed-method designs basing their hypotheses on the above hypotheses as ground theoretical propositions to be tested on large scale quantitative studies. The longitudinal ethnographic studies that would trace the implementation and performance change of the wellbeing programme would be rich in causal depth. The generalisability of the Wellbeing-Performance Nexus would be tested on comparative studies across Indian states, and cross-national comparisons, especially with similar healthcare systems in South Asia and Sub-Saharan Africa would be used to identify the theoretical limits of the model.

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