McKinsey Health Institute

Workforce Interventions Database: Supplemental methodology

From potential to practical: Fueling performance with proven workplace health interventions

January 2026

Context

The benefits of improving employee health and well-being are well established—ranging from stronger performance and productivity to a more adaptable and resilient workforce. Yet many employers still struggle with where to start and which interventions truly make a difference.

To help address these questions, the McKinsey Health Institute (MHI) developed the Workforce Interventions Database—a curated starting point that brings together existing evidence on actions employers can take to improve workforce health and performance. The database is designed to make the research more accessible and actionable, translating a broad and sometimes fragmented evidence base into insights that can guide employer decision-making.

About the database

Grounded in research and informed by real-world practice, the Workforce Interventions Database provides an evidence-based starting point for employers seeking to improve workforce health and performance. Rather than serving as a systematic review, it represents a curated synthesis, bringing together credible evidence from diverse sources to highlight interventions with demonstrated potential impact. It summarizes what has been tested and shown promise, not everything that exists.

To clarify its scope and limitations, this database is as follows:

— *An evidence synthesis—not a meta-analysis:* The database summarizes workplace evidence but does not conduct statistical comparisons or pooled effect-size analyses. It represents a synthesis designed to help employers identify actionable opportunities based on available research.

— *Representative but not exhaustive:* The database includes a curated sample of interventions that meet basic relevance and quality criteria; it is not a full catalog of all possible interventions. The exclusion of an intervention doesn't mean it's ineffective; it may simply not have been captured within the sources or scope used to build the database.

— *Workplace-specific:* Only studies conducted in occupational settings were included to ensure findings reflect employed adult populations.

— *Evidence-based but nonprescriptive:* The database summarizes what has been tested and shown results; it does not prescribe what every organization should do. Decisions about selection and implementation should be guided by local context and priorities.

— *Context-dependent:* Impact scores reflect study results in specific contexts; a lower score may reflect limited data or context-specific factors (for example, workforce segments, geography) rather than ineffectiveness.

Note: Success ultimately depends on local factors, including employee participation, organizational readiness, and the surrounding cultural and regulatory context.

Note: Updated as of January 2026.

Purpose of this supplemental methodology

This document serves as a methodological supplement to "From potential to practical: Fueling performance with proven workplace health interventions." It outlines the approach used to build the database, detailing how interventions were identified, scored, categorized, and evaluated based on how they can help improve employee health and well-being.

Our methodology

Overview: The approach to developing this database followed five key steps:

— *Step 1: Defined the goal* by framing a guiding question for the intervention search.

— *Step 2: Gathered relevant evidence* from both academic and practice-based sources to identify studies and programs addressing employee health and well-being.

— *Step 3: Selected interventions for inclusion* from the evidence collected, identifying 115 that met broad relevance and quality criteria.

— *Step 4: Scored interventions for impact and feasibility* using a defined rubric (1–6 scale) to position them on a 2×2 impact–feasibility matrix.

— *Step 5: Categorized interventions* by health dimension, target organizational level, gender applicability, and workforce objective to enable deeper organizational insights.

Detailed methodology: The following sections summarize each step in greater depth.

Step 1: Defined the goal

The guiding question is, "Which workforce interventions are shown to improve employee health and well-being, and what evidence exists on their relative impact, feasibility, and contextual effectiveness?"

How was the search question defined? The question was framed to identify what interventions worked and what was practical under which conditions. The search was intended to complement previous research on the predictors of holistic health and burnout, extending that work toward practical, actionable solutions for employers.

Step 2: Gathered relevant evidence

To balance academic insights with practical relevance, MHI drew on evidence from multiple disciplines—including psychology, management science, and organizational behavior.

Evidence was gathered through a hybrid search approach, combing academic articles and targeted business or expert sources—including 13 contributions from the World Wellbeing Movement.

Academic sources. Searches focused on peer-reviewed research (for example, experimental and observational studies) related to employee health, well-being, and workplace context. The intent was to capture a broad range of relevant studies rather than conduct a formal systematic review.

Targeted sources. Complementary searches drew from management literature and practitioner reports (such as *Harvard Business Review*) to identify emerging or practice-based interventions with demonstrated relevance in real organizational settings.

Step 3: Selected interventions for inclusion
After gathering the evidence, MHI reviewed and filtered studies to identify those most relevant to employee health and well-being. Studies were screened using a few broad inclusion parameters to guide selection:

— *Setting:* Focused on interventions implemented in workplace or organizational contexts. Studies conducted solely among students, retirees, or general populations were excluded to ensure relevance to employed adults.

— *Design quality:* Prioritized peer-reviewed studies published after 2000, reflecting more contemporary approaches and reasonably sound methods.

— *Focus and outcomes:* Included studies that evaluated at least one workplace intervention aimed at improving measurable health outcomes (such as stress, blood pressure) and performance outcomes (such as productivity, absenteeism).

The resulting 115 studies span a range of industries (for example, healthcare, manufacturing, education, technology).

While care was taken to capture a diverse and credible sample, this database reflects only the evidence available at the time of review. Its intent is practical rather than exhaustive, offering employers a well-grounded starting point for action, not a comprehensive catalog of all possible interventions. *The absence of an intervention in the database does not imply a lack of importance or impact; it simply reflects that it was not captured through the methodology or the evidence reviewed at the time of analysis.*

Step 4: Scored interventions for impact and feasibility
MHI assessed impact and feasibility for implementation in workplace settings. Each intervention was given scores using a structured evidence rubric. The rubric was developed with expert input and informed by practical considerations from real-world use.

— *Impact:* Scores reflected indicators of effectiveness such as the strength and consistency of outcomes reported in the literature and the robustness of study design.

— *Feasibility:* Scores captured real-world implementation factors, including resource needs, operational simplicity, and scalability across organizational settings.

Results were plotted on a 2×2 impact–feasibility matrix, offering a practical, at-a-glance view of which interventions may deliver the greatest value for effort. This visualization serves as a synthesis tool to distill a large and diverse evidence base into insights useful for portfolio design and prioritization.

How should the intervention quadrants be interpreted? The impact–feasibility matrix organizes the interventions into four quadrants, illustrating their relative potential and implementation requirements. These categories are designed to inform prioritization and portfolio design, rather than prescribe specific actions.

Prioritize: No-regret interventions. These interventions demonstrate measurable improvements in employee well-being and productivity, often with modest investment. They typically reinforce key enablers of well-being (such as supervisor support), integrate naturally into day-to-day workflows, and address multiple dimensions of health with clearly defined outcomes.

Evaluate: For strategic investments. These interventions demonstrate high impact but require greater organizational readiness (for instance, investment) and coordination (for example, policy alignment) to succeed. While their impact is evidenced through research, execution requires enabling conditions such as senior leadership sponsorship, integrated systems, or culture change to achieve their full effect. When implemented under the right conditions, strategic investments can deliver transformational results, but without sustained commitment, their potential may remain unrealized.

Consider: Based on context. These interventions are practical and easy to adopt, with the potential to achieve meaningful outcomes in the right context, though overall evidence remains mixed or context-dependent. Rather than being ineffective, these interventions can be seen as *selecti*vely effective, with success often depending on contextual factors. With appropriate adaptation and supporting enablers, they could deliver outcomes for specific populations or roles.

Deprioritize: Niche approaches. These interventions show limited impact or low feasibility for broad implementation. They may be highly specific to a study population, heavily resource intensive, or unproven outside pilot conditions. Because the broader literature often favors positive findings (that is, "survivor bias"), the number of studies in this quadrant is limited. These approaches should generally not be prioritized as entry points for well-being investment, as they may divert resources from interventions with stronger and more generalizable evidence. They may, however, offer insights for future experimentation if redesigned or tested under new conditions.

Step 5: Categorized interventions

To support deeper interpretation, interventions were also categorized by health dimension, workforce objective (namely, workplace factor), level of action, and gender applicability (that is, women's and men's health). While many interventions addressed multiple dimensions or workplace factors, each was assigned a primary focus for clarity. Secondary or cross-domain outcomes were noted but not used for categorization, which may mean some broader effects are underrepresented. Additionally, this methodology represents the scoring and categorization of interventions as they were implemented, rather than within the context of a specific organization. Therefore, it is important that contextual factors (for instance, available resources, population characteristics) are integrated into intervention design.

These classifications help reveal patterns across interventions and highlight where different types of solutions may be most applicable.

1. Health dimension. Each academic study was assigned a primary health dimension based on the end point that the authors most emphasized in their results and discussion—that is, the most prominently reported finding. The same end point also informed the intervention's impact score on the 1–6 rubric.

Why one "primary" dimension was used? Many high-quality studies, including randomized controlled trials, assess multiple outcomes across different health dimensions. However, assigning more than one dimension per study would create ambiguity about which result the impact score reflects. To preserve interpretability, each intervention was linked to the domain most emphasized in its reported findings. For example, "digital hourly-break nudges" most emphasized sedentary behavior and was therefore categorized as a physical-health intervention. However, other measured outcomes included mental well-being, depression, anxiety and stress, and work engagement. This approach ensured consistency in categorization, avoiding assumptions about an intervention's intent or design.

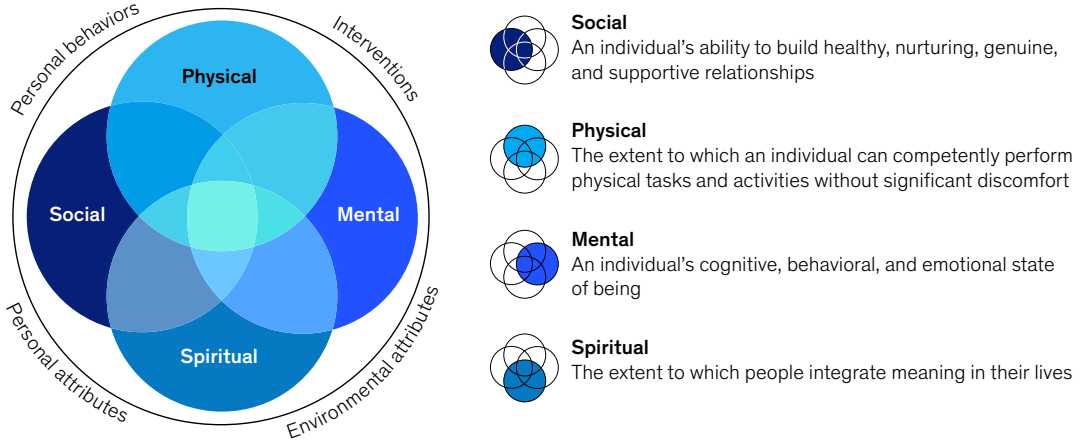
This approach inevitably meant that some cross-cutting or less tangible domains—such as spiritual health (for example, purpose or meaning at work)—were underrepresented. MHI found that these outcomes are less often the focus of workplace studies and are difficult to measure consistently. While some interventions indirectly touched on these elements, they typically appeared as secondary effects rather than the primary outcomes reported. Still, this gap points to an opportunity for future research, as evidence increasingly links purpose and meaning to other dimensions of well-being, particularly among younger workers.

For more information regarding the dimensions of holistic health, see "Adding years to life and life to years" (Exhibit 1).

Exhibit 1

Holistic health includes four dimensions of health.

Holistic health: An integrated view of an individual's physical, mental, spiritual, and social functioning[1]



[1]Grounded in WHO definition of "health": "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
Source: McKinsey Health Institute analysis

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2. Workforce objective and target organizational-level assessment. MHI's previous research explores how employees perceive their health and how workplace factors influence mental, physical, spiritual, and social health.

Workplace factors fall into two main types (see Exhibit 2)[1]:

— *Demands* are factors that require sustained cognitive, physical, or emotional effort (for instance, work pressure).

— *Enablers* are factors that provide support, resources, or a sense of control and can mitigate the impact of job demands (for example, psychological safety).

Understanding these two categories provides a framework for identifying *where* and *how* employers can act. To connect the challenges employees face with potential interventions, MHI categorized the interventions under corresponding workplace factors. In the tool, these appear as "workforce objectives," helping employers easily pinpoint the specific areas they aim to address.

Additionally, each workplace factor is also linked to a target organizational level, reflecting where the intervention is being implemented—from individual to organizational levels. The target level for each intervention is therefore determined by the workplace factor with which it was associated.

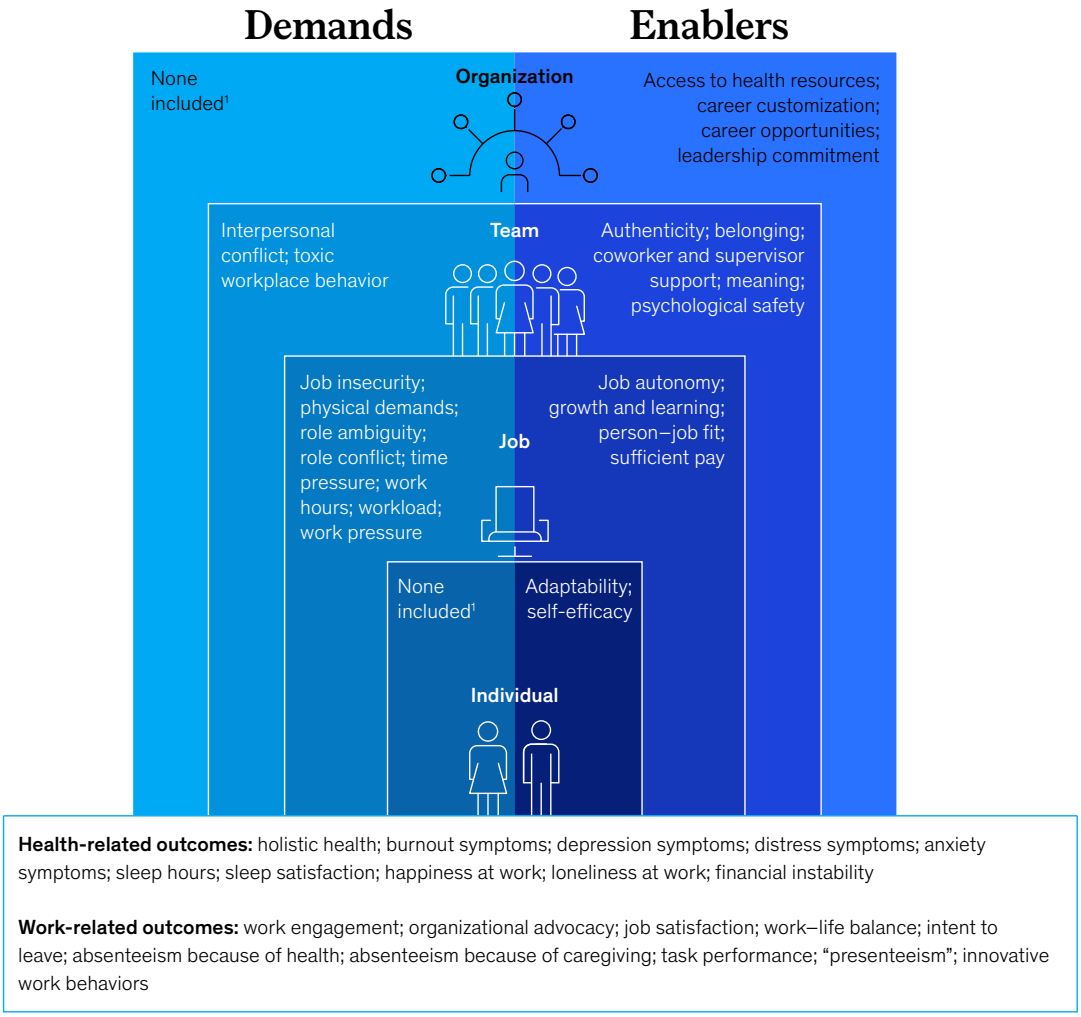
[1] Arnold B. Bakker, Evangelia Demerouti, and Ana Sanz-Vergel, "Job demands–resources theory: Ten years later," *Annual Review of Organizational Psychology and Organizational Behavior*, 2023, Volume 10.

For more information regarding the impact of these workplace factors on employee holistic health and burnout, see "Reframing employee health: Moving beyond burnout to holistic health."

Exhibit 2

Workplace factors can affect health- and work-related outcomes.

Workplace factors measured for analysis of health- and work-related outcomes



[1]While demands at this level can be measured, the McKinsey Health Institute research model prioritized what employers have the most ability to change.
Source: McKinsey Health Institute Employee Holistic Health Survey, 30,392 participants at all levels of the organization, Apr–Jun 2023

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3. Gender applicability. To assess how interventions address the needs of specific groups, MHI conducted a focused analysis of *women's health* and *men's health* interventions. These tags were applied to interventions explicitly designed for gender-specific populations in the workplace (such as menopause programs).

Definition and scope

MHI defines "women's health" and "men's health" interventions as those that specifically targeted either women or men and only included either women or men in the study sample. Interventions with a majority of one sex (such as 90 percent) but not explicitly designed for that group were not tagged.

Inclusivity note

The authors use the terms "sex" and "gender" as reflected in the original studies to align with their language and maintain accuracy. They also recognize the importance of inclusive research that encompasses transgender, nonbinary, and gender-fluid communities. The authors acknowledge that not all individuals who identify as women or men were born biologically female or male, and that approaches must reflect the diverse needs of these populations, who are often underrepresented in workplace studies.

Why this matters

Sex- and gender-specific differences can influence how employees experience and respond to health interventions. Yet many studies do not report results separately by gender, limiting insights into potential variations in outcomes. Recognizing these differences can help employers identify where tailored approaches may be needed to ensure equitable impact.

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