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ORIGINAL RESEARCH

Unlocking the Power of Inclusive Leadership: The Moderating Role of Climate for Inclusion on Job Satisfaction and Perceived Care Quality

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Importance: Inclusive leadership (IL) is posited to strengthen employee wellbeing and patient-centered outcomes, yet findings in healthcare remain mixed.

Objective: To test direct effects of IL on job satisfaction (JS) and perceived quality of care (PQC) and to examine whether climate for inclusion (C4I) and cultural competence (CC) moderate these relationships.

Design, Setting, and Participants: Cross-sectional survey of US healthcare managers recruited via a commercial opt-in Email frame and professional networks (June–November 2024). N=209; complete-case N=144.

Main Outcomes and Measures: JS (2-item short index) and PQC (10-item) on 5-point Likert scales; predictors IL (8 items), C4I (16 items), CC (7 reverse-coded items).

Results: Regression models supported H1–H6 ($p<0.001$). The three-way IL×CC×C4I term was marginal for JS (H7a; $p=0.064$) and significant for PQC (H7b; $p<0.001$). Measurement reliability was excellent for IL ($\alpha=0.950$), C4I ($\alpha=0.948$), CC ($\alpha=0.930$), JS ($\alpha=0.873$), and PQC ($\alpha=0.923$).

Conclusions and Relevance: Inclusive leadership and cultural competence are associated with higher JS and PQC, with stronger effects under supportive inclusion climates. Programs that develop inclusive leaders and institutionalize inclusive norms may yield workforce and care benefits.

Plain Language Summary: We surveyed US healthcare managers about leadership behaviors, how inclusive their workplace feels, and the quality of care. Inclusive leaders made the biggest difference when the overall climate felt less inclusive. Building both inclusive leaders and inclusive norms may boost staff morale and the care patients receive.

Keywords: inclusive leadership, climate for inclusion, cultural competence, job satisfaction, perceived quality of care

Introduction

Healthcare organizations invest heavily in diversity initiatives, yet frontline professionals continue to report feeling unseen, unheard, or marginalized—experiences linked to burnout, turnover, and avoidable adverse events.[1]

Inclusive leadership (IL)—defined by accessibility, openness, and proactive solicitation of diverse views—has been proposed as a relational remedy able to transform such climates.[2] However, extant healthcare studies rarely move beyond simple main-effect tests; they overlook contextual boundary conditions that determine whether IL "sticks" in day-to-day practice.[3]

Climate for inclusion (C4I) is one such boundary; theory predicts that IL matters most where inclusive norms are weak and least where they are already strong, yet empirical tests inside healthcare settings are sparse.[4]

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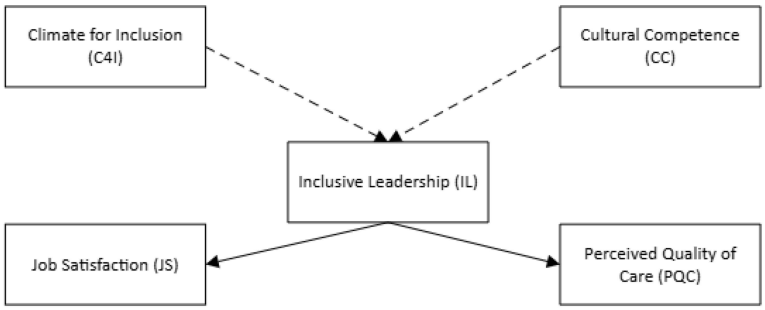
Graphical Abstract



Graphical Abstract. Conceptual framework summarizing tested paths

Design: Cross-sectional survey of US healthcare managers (N=209; complete-case N=144).

Main findings: IL→JS and IL→PQC supported; C4I moderates both; CC shows positive main effects; three-way interaction significant for PQC.

Implications: Develop inclusive leaders and institutionalize inclusion norms; pair with CC training.

Outcome measures: 2-item Job Satisfaction; 10-item Perceived Quality of Care; reliabilities ≥0.87 for all multi-item constructs; CC α=0.93 after reverse-coding.

Cultural competence (CC)—employees' ability to recognize and bridge cultural differences—may further shape how IL translates into engagement and care outcomes.[5]

Study Aims

We examine whether IL relates to job satisfaction (JS) and perceived quality of care (PQC), and test whether these relationships are contingent on climate for inclusion (C4I) and employees' cultural competence (CC). By integrating Social Exchange and Social Identity theories, we offer a boundary-condition model (Figure 1) and test seven hypotheses (H1–H7) in a national sample of US healthcare managers.

Literature Review

Inclusive leadership, a style that values each team member's unique contributions, boosts employee engagement and facilitates open communication with external stakeholders, fostering inclusive care delivery.[4–6]

We hypothesize that (H1) IL significantly enhances JS and (H2) IL improves PQC. Additionally, inclusive behaviors can mitigate discrimination-related dissatisfaction and foster a respectful, cohesive workplace.[7–9]

Theoretical Foundation

Social exchange theory (SET) and social identity theory (SIT) provide a lens for understanding how belonging and identity affirmation undergird the effects of IL and inclusive climates.[4] SET posits that reciprocal, inclusive behaviors by leaders enhance employee engagement, loyalty, and innovative behaviors. SIT highlights the importance of group membership, in which organizational socialization and loyalty increase when employees feel included and aligned with organizational values. This study explores how these theories underpin inclusive leadership's impact on healthcare team cohesion and quality outcomes.[4]

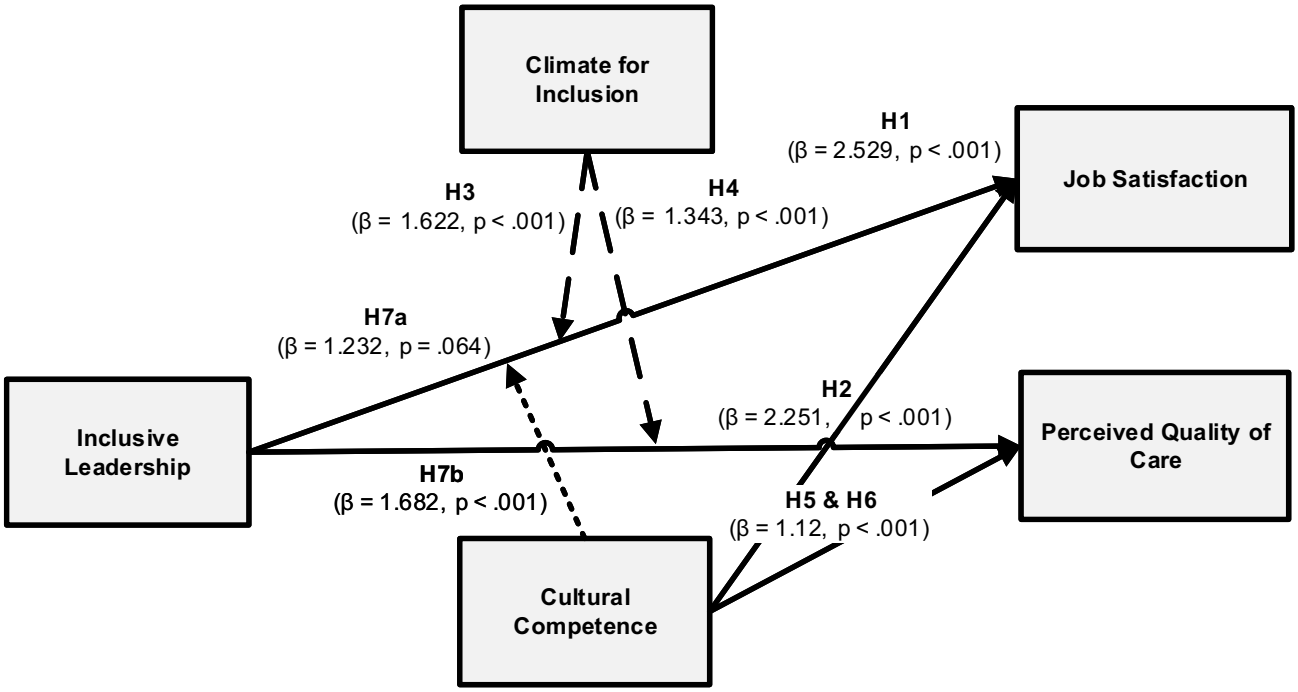


Figure 1 Conceptual framework model.

Notes: Conceptual framework model depicting hypothesized relationships among Inclusive Leadership, Climate for Inclusion, Cultural Competence, Job Satisfaction, and Perceived Quality of Care; path labels H1–H7b display the estimated coefficients (β) and p-values as shown in the figure Path estimates: H1 (β = 2.529, p <.001), H2 (β = 2.251, p <.001), H3 (β = 1.622, p <.001), H4 (β = 1.343, p <.001), H5 & H6 (β = 1.12, p <.001), H7a (β = 1.232, p =.064), and H7b (β = 1.682, p <.001). All paths are statistically significant at p <.001 except H7a, which is marginal.

Inclusive Leadership and Cultural Competence

In diverse healthcare settings, IL shapes a culture that values collaboration and diversity, directly influencing team effectiveness and patient outcomes.[5,6] Inclusive leaders prioritize empathy, openness, and appreciation, which promotes a positive culture and enhances patient care outcomes.[10]

Inclusive climates also facilitate creativity and reduce stressors, fostering an environment conducive to high job satisfaction and well-being.[8,11]

Cultural competence ensures services respect patients' cultural backgrounds and aligns care with community needs.[12] Ongoing work evaluates whether structured CC training or broader leadership development is most effective.[13]

The Anomaly of Climate for Inclusion

Policy-practice decoupling highlights gaps between inclusive policies and real-world application; leaders must align actions with policy to create authentic inclusion climates.[13]

A climate for inclusion likely moderates IL→JS (H3) and IL→PQC (H4) by embedding norms that value diversity.[14]

When employees perceive their workplace as inclusive, they are more satisfied and motivated, positively affecting PQC; evidence suggests the climate for inclusion is a vital moderator of IL effects.[10,11,27]

Studies indicate that supportive, inclusive climates strengthen the effectiveness of IL and improve satisfaction and care quality.[7,12]

Job Satisfaction and Perceived Quality of Care

A positive work environment influences JS and patient care quality; administrative support, growth opportunities, recognition, and meaningful work reduce turnover and improve outcomes.[15–17]

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The Role of Leadership Policy–Practice Decoupling

Bridging the policy–practice gap is critical for IL to improve JS and PQC through genuine inclusivity.[13]

Methods

Sampling and Recruitment

We employed a purposive, multi-stage strategy. A pilot in a senior-living community (n=47) ensured item clarity. The refined Qualtrics link was posted to healthcare leadership groups on LinkedIn. Finally, we purchased a single-use Email frame (5000 addresses) from a vendor maintaining an all-opt-in database of licensed US healthcare managers. Recipients received one invitation with an opt-out hyperlink; no unsubscribes were recorded. Data were collected June–November 2024; 209 completes were returned (4.2% completion). A priori power analysis (G*Power v3.1, f^2=0.10, α=0.05, 1-β=0.80, predictors=6) indicated 123 cases; complete-case N=144 exceeded this threshold.

Instrumentation

The study used (Appendix 1) Inclusive Leadership (IL), the Cultural Competence Assessment Instrument (CCAI-UIC), the Climate for Inclusion (CiD), the Short Index of Job Satisfaction (SIJS), and the Healthcare Quality Perception (HQP) scales. The survey included leadership behavioral items, cultural competence, job satisfaction, and perceived importance up to the adequate or good level of patient care quality, addressing effective communication with sociodemographic diversity.[15,18–21]

Eligibility

Participants were US-based, currently employed healthcare managers (≥1 direct report) aged ≥25 years. Exclusion criteria: incomplete surveys and duplicate IP hashes.

Nonresponse Bias

Early versus late responders did not differ beyond |d|=0.15 on study variables, suggesting limited nonresponse bias.

Scale Diagnostics and Remediation Steps

Cronbach's α met or exceeded.87 for IL (8 items) and C4I (16 items). Negatively worded items in the original Cultural Competence Assessment Instrument[19] produced a suppression artifact prior to correction. After reversing keying and dropping two low item-total indicators, the 7-item CC scale showed excellent internal consistency (α=0.930). The PQC scale is a 10-item instrument used in healthcare quality-perception research.[21] The 2-item JS index follows guidance on short scales.[22] Complete reliability can be seen in Table 1 and loading summaries appear in Table 2; residual diagnostics for JS and PQC appear in Figures 2 and 3.

Table 1 Survey Instruments and Reliability (α)

Construct	Original	Adopted	Scale	Cronbach Alpha
Inclusive Leadership	13	8	5-pt	0.950
Cultural Competence (Reverse Coding)	24	7	5-pt	0.930
Social Desirability	7	4	5-pt	0.290
Climate for Inclusion	16	16	5-pt	0.948
Job Satisfaction	5	2	5-pt	0.873
Perceived Quality of Care	5	5	5-pt	0.923

Notes: *Construct* = latent variable measured; *Original* = number of items in the source instrument; *Adopted* = number of items retained in this study; *Scale* = response format (5-point (pt) Likert-type); *Cronbach's α* = internal consistency of the adopted items in this sample. Items in the Cultural Competence scale were reverse-coded so that higher scores reflect greater competence before computing α and composite scores. As rules of thumb, α ≈ 0.70 is acceptable, ≥ 0.80 good, and ≥ 0.90 excellent; the Social Desirability scale, highlighted in yellow, (α =0.29) shows poor reliability and should be interpreted with caution.

Table 2 Regression Analysis Results

Hypothesis	N	F	df	ß	t	adj. r2	p
H1	141	7.035	8	2.529	8.040	2.56%	<0.001
H2	141	12.337	8	2.251	9.826	3.93%	<0.001
H3 (m)	140	7.194	21	1.622	5.058	4.86%	<0.001
H4 (m)	140	12.123	21	1.343	5.748	6.27%	<0.001
H5	142	6.12	7	1.12	13.20	1.68%	<0.001
H6	142	6.89	7	1.12	13.26	1.83%	<0.001
H7 (m and Int) JS	139	5.669	28	1.232	1.873	4.86%	0.064
H7 (m and Int) PQC	139	9.969	28	1.682	3.808	6.45%	<0.001

Notes: N = sample size; *F* = omnibus F-statistic for overall model fit; *df* = degrees of freedom (for the corresponding test; where relevant, numerator and denominator df); *ß* = unstandardized regression coefficient; *t* = t-statistic testing *ß* (H_0: *ß* = 0); *adj. r²* (adjusted R^2) = proportion of variance explained, adjusted for number of predictors; *p* = exact two-tailed p-value unless otherwise noted.

Common-Method Bias Controls

Predictors and outcomes were placed in separate survey blocks with a timed transition (mean ≈46 s). A 5-item social desirability marker was included as a covariate; it was non-significant in all models. Harman's single-factor test indicated 29% of variance; adding a latent CMV factor changed item loadings by <0.02 (ΔCFI=0.002).

Results

Confirmatory factor analysis supported the five-factor structure ($\chi^2(335)=453.2$, CFI=0.92, TLI=0.91, RMSEA=0.046). Exploratory factor loadings indicated well-behaved measurement for C4I (0.63–0.87), CC (0.74–0.84), IL (0.75–0.91), JS (0.886–0.979), and PQC (0.47–0.86), with a single low PQC loading (0.47).

Hypotheses Testing

Hierarchical (moderated) regressions supported direct effects of IL on JS (H1) and PQC (H2) and of CC on both outcomes (H5–H6), all p<0.001. C4I moderated IL→JS (H3) and IL→PQC (H4), p<0.001. The IL×CC×C4I three-way

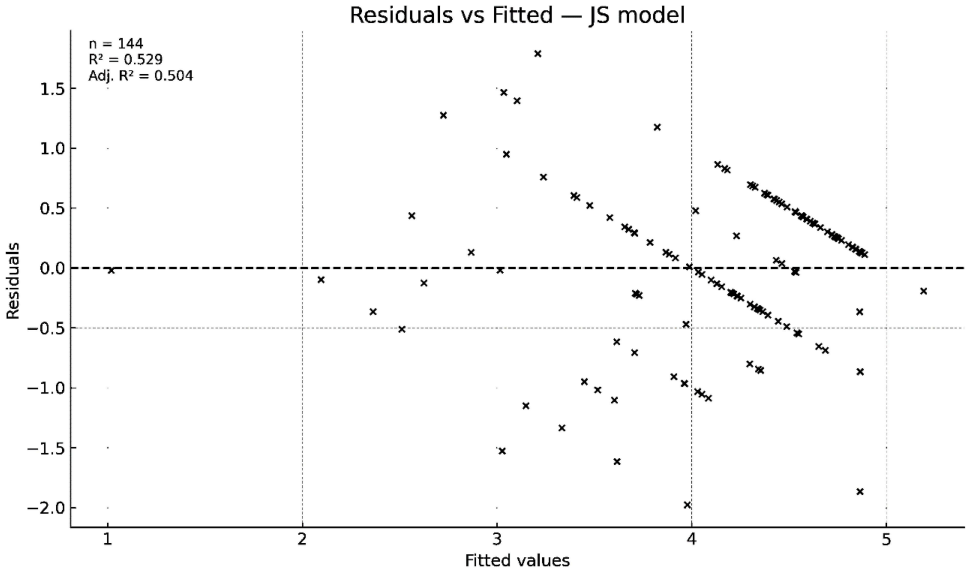

Figure 2 Residuals vs fitted — Job Satisfaction model.

Notes: Residuals vs fitted values for the Job Satisfaction (JS) model (n = 144; R^2 = 0.529; adjusted R^2 = 0.504). The dashed line marks zero residual. Points are centered near zero with fairly constant spread across the fitted range (~1–5). The visible vertical banding reflects discrete (Likert-scale) predictions; no strong curvature or funneling is evident, and only a few moderate residuals (≈ −2 to +1.5), suggesting linearity and homoscedasticity are reasonably satisfied.

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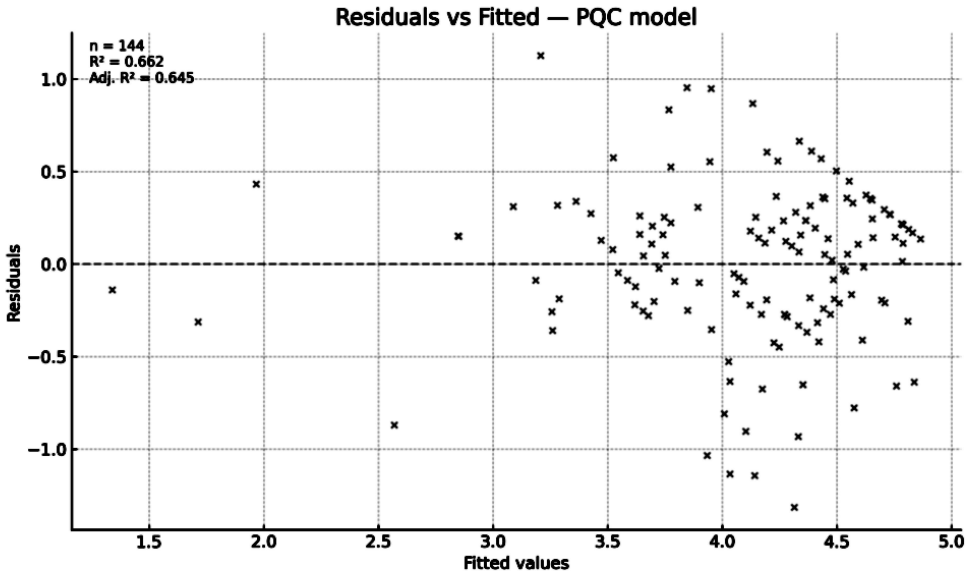

Figure 3 Residuals vs Fitted PQC model.

Notes: Residuals vs fitted values for the Perceived Quality of Care (PQC) model (n = 144; R^2 = 0.662; adjusted R^2 = 0.645). Each point is an observation; the dashed line marks zero residual. Residuals are centered around zero across the fitted range (~1.5–5.0) with no obvious curvature or funneling and only a few moderate residuals (≈ ±1), indicating no strong violations of linearity or homoscedasticity.

term was marginal for JS (H7a, p=0.064) and significant for PQC (H7b, p<0.001). See Table 3 for F-tests, coefficients (B), t-statistics, adjusted R^2, and p-values.

Construct Validity and Reliability

The Inclusive Leadership scale had excellent reliability (Cronbach's α = 0.950). In uncorrected scoring, CC showed weaker internal consistency, underscoring the need for refinement.[19,21]

Table 3 Factors Matrix (EFA) — Loading Ranges

C4I	CC	IL	JS	PQC
0.812	0.78	0.801	0.979	0.629
0.704	0.82	0.872	0.886	0.778
0.652	0.8	0.911	0.9325	0.676
0.777	0.74	0.902		0.78
0.874	0.76	0.905		0.747
0.844	0.79	0.749		0.721
0.847	0.84	0.788		0.76
0.76	0.79	0.785		0.47
0.763		0.839125		0.855
0.814				0.853
0.781				0.7269
0.723				

(*Continued*)

Table 3 (Continued).

C4I	CC	IL	JS	PQC
0.748				
0.63				
0.823				
0.749				
0.7688125				

Notes: The loadings indicate a well-behaved measurement structure for the five reflective constructs. Climate for Inclusion "C4I" (16 items) loads between **0.630–0.874**; Cultural Competence "CC" (reverse-coded, 7 items) between **0.740–0.840**; Inclusive Leadership "IL" (8 items) between **0.749–0.911**; Job Satisfaction "JS" (2 items) at **0.979** and **0.886**; and Perceived Quality of Care "PQC" (10 items) between **0.470–0.855**. The single low loading is **PQC_7 =0.470**; all other PQC indicators are ≥ 0.629. The two interaction composites (C4I × IL; CC × IL) show **1.000** self-correlations as expected for computed products and are not treated as reflective latent factors. The colored text significance is Green = strong / acceptable; Red = weak / problematic; Black = calculated averages or neutral reference values.

Descriptive Statistics

Among the 144 complete cases, age clustered at 45–54 (32.6%) and 55–64 (31.9%); 25–34 and 35–44 formed smaller shares (8.3%, 14.6%). The sample was predominantly female (70.8%) and mostly full-time (95.8%). Education was high (62.0% graduate/professional; 25.7% bachelor's). Household income skewed higher (56.3% ≥$150,000; 23.6% $100,000–$149,999). The dataset[23] reflects the composition of respondents described in Figure 4.

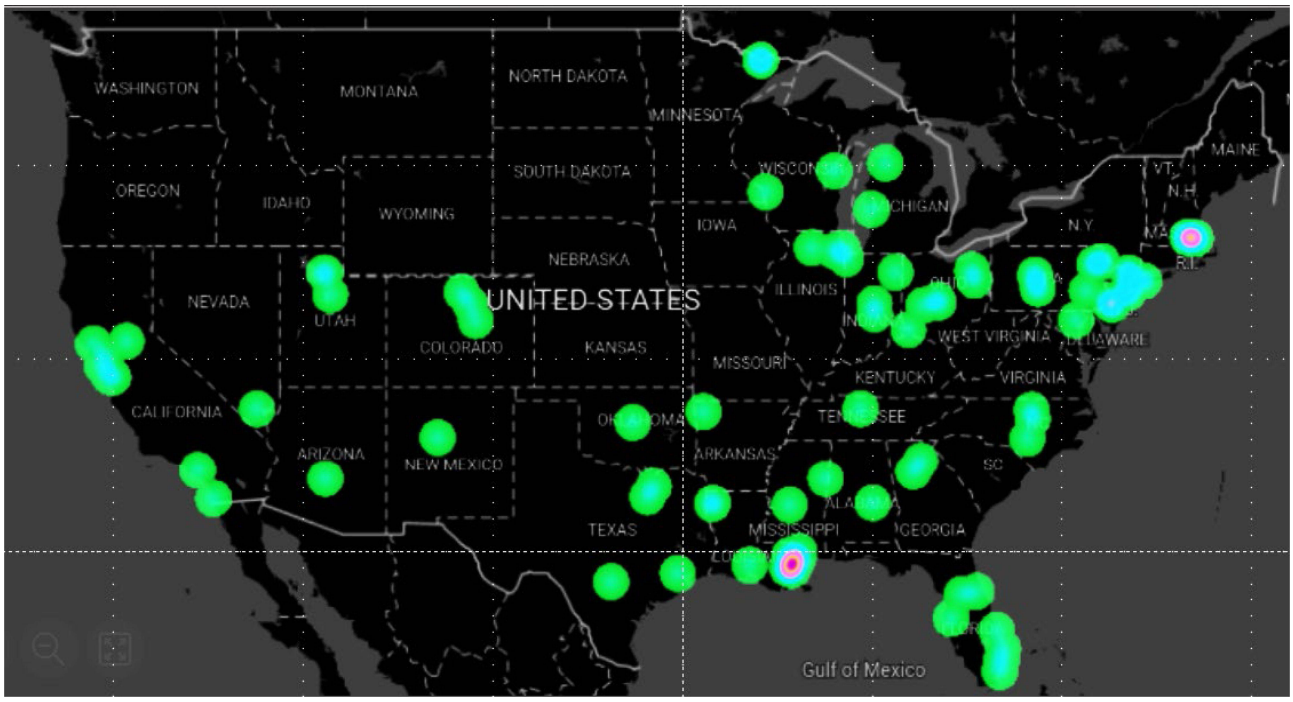

Figure 4 Respondent heat map.
Notes: Heat map of respondent ZIP codes across the United States (N = 143; 100%). Most ZIP codes appear once (~0.7% each), indicating wide geographic diversity with limited clustering. A few ZIP codes show modestly higher representation—70458 (6, 4.4%), 70,461 (5, 3.6%), and 70460 (4, 2.9%)—and several others, including 70124, 70447, and 84037, appear twice (1.5% each). Overall, the distribution is broad, with the majority of ZIP codes unique in the dataset.

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Discussion

Inclusive leadership and cultural competence each showed positive associations with JS and PQC, and C4I strengthened these linkages. A diminishing-returns pattern emerged for IL when C4I was already high, consistent with simple-slope probing of the IL×C4I interaction. Practically, organizations should develop inclusive behaviors and sustain evidence--based CC training[18,19] aligned with national standards.

These practices align with national and federal guidance (CLAS Standards, Healthy People 2030, and HRSA workforce programs).[24–26]

Limitations and Future Research

Cross-sectional design and a 2-item JS scale limit causal inference and content breadth. Self-selection and single-source data may introduce bias despite CMV checks. Future longitudinal, multi-source studies with team-level diversity metrics are warranted.

Conclusions

IL is a salient antecedent of JS and PQC. CC contributes positively and, together with a strong inclusion climate, yields synergistic benefits—especially for PQC. Joint investments in leader behavior and inclusive systems are pragmatic levers for workforce engagement and patient-care improvement.[13,19–22]

Data Sharing Statement

Anonymized data and codebooks will be made available in a public repository upon publication (see dataset[23]).

Ethics Approval and Consent to Participate

This study received an exempt determination (Category 2) from the University of New Orleans institutional review board protocol number 04APR2024 electronic informed consent was obtained from all participants.

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Disclosure

The authors declare no competing interests.

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