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The Impact of Inclusive Leadership on Job Satisfaction and Care Quality: Moderating Effects of Inclusion Climate and Cultural Competence

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Abstract

Inclusive leadership (IL) is expected to boost employee well-being and improve patient-focused results, yet research findings within healthcare continue to produce conflicting conclusions. To evaluate the straight-line effects of IL on job satisfaction (JS) and perceived quality of care (PQC), and to determine if climate for inclusion (C4I) and cultural competence (CC) serve as moderating factors in those links. Cross-sectional survey conducted among US healthcare managers who were sourced from a commercial opt-in email database and various professional networks from June to November 2024 (n = 209; complete-case n = 144). JS was assessed using a 2-item brief scale, and PQC using a 10-item instrument, both rated on 5-point Likert scales. The key predictors consisted of IL (8 items), C4I (16 items), and CC (7 reverse-coded items).
Regression analyses provided strong support for H1–H6 ($P < 0.001$). The three-way interaction of IL×CC×C4I showed marginal significance in relation to JS (H7a; $P = 0.064$) and reached statistical significance for PQC (H7b; $P < 0.001$). Internal consistency was strong across all measures: IL ($\alpha = 0.950$), C4I ($\alpha = 0.948$), CC ($\alpha = 0.930$), JS ($\alpha = 0.873$), and PQC ($\alpha = 0.923$). Inclusive leadership, together with cultural competence, correlates with elevated levels of JS and PQC, and these relationships intensify notably when a positive inclusion climate is present. Interventions aimed at training inclusive leaders and embedding inclusive practices organization-wide could generate meaningful gains for staff retention and patient care delivery. We collected responses from US healthcare managers regarding their leaders' approaches, the sense of inclusiveness in their daily work environments, and their views on care quality. Inclusive leadership showed the strongest positive influence in environments where the broader climate felt relatively non-inclusive. Combining leadership development with efforts to create inclusive workplace standards may enhance employee satisfaction and elevate the standard of care patients receive.

Keywords: Inclusive leadership, Climate for inclusion, Cultural competence, Job satisfaction, Perceived quality of care

Introduction

Healthcare organizations allocate large budgets to diversity efforts, but staff working directly with patients often feel overlooked, dismissed, or excluded—conditions tied to exhaustion, high turnover, and avoidable negative incidents [1].

Inclusive leadership (IL), marked by approachability, receptiveness to feedback, and deliberate efforts to gather differing opinions, is often viewed as a key interpersonal strategy for reshaping difficult work environments [2]. Still, current studies in healthcare seldom advance beyond basic direct-effect analyses and often ignore the surrounding conditions that determine whether IL actually functions daily [3].

Climate for inclusion (C4I) functions as one critical condition. Theoretical models propose that IL delivers its greatest value in settings where inclusive standards are underdeveloped and offers limited additional value where such standards are already robust; empirical validation of this pattern in healthcare remains uncommon [4].

Cultural competence (CC), referring to personnel's ability to detect and manage cultural differences, may

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further determine the extent to which IL influences staff engagement and care effectiveness [5].

We explore the connections between IL and both job satisfaction (JS) and perceived quality of care (PQC), while testing whether climate for inclusion (C4I) and employees' cultural competence (CC) alter the strength of those connections. Integrating principles from Social Exchange Theory and Social Identity Theory, we introduce a moderated framework **(Figure 1)** and examine seven hypotheses (H1–H7) using responses from a national group of US healthcare managers.

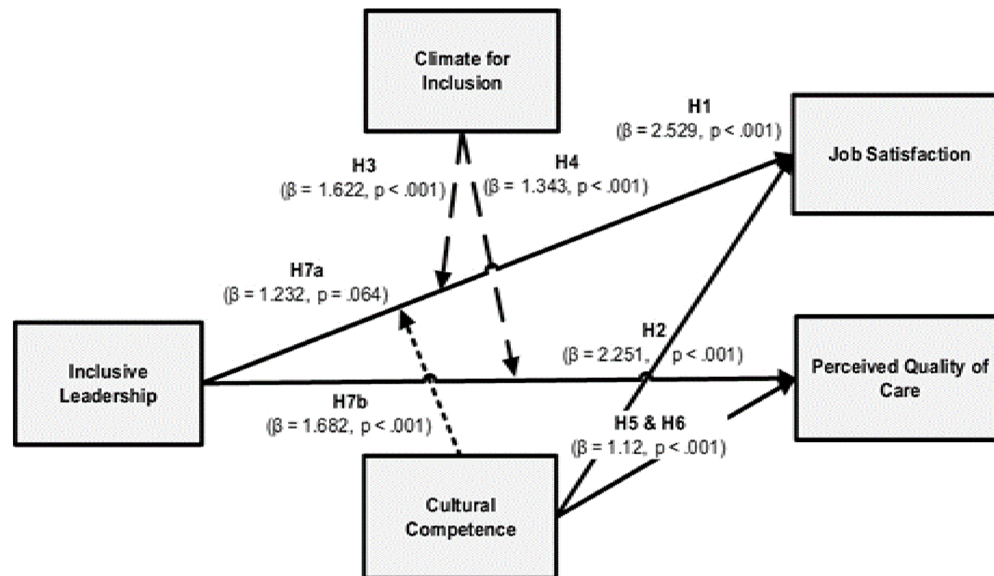

Figure 1. Conceptual framework model. Notes: Conceptual framework model depicting hypothesized relationships among Inclusive Leadership, Climate for Inclusion, Cultural Competence, Job Satisfaction, and Perceived Quality of Care; path labels H1–H7b display the estimated coefficients (β) and p-values 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.

Literature review

Inclusive leadership is a leadership approach that recognizes and appreciates the distinct contributions of every team member. It strengthens employee engagement, encourages transparent dialogue with outside parties, and supports the delivery of truly inclusive patient care [4–6].

We propose that (H1) IL substantially raises job satisfaction (JS) and (H2) IL enhances perceived quality of care (PQC). Moreover, such inclusive practices help lessen dissatisfaction stemming from discrimination and help build a workplace characterized by mutual respect and strong teamwork [7–9].

Theoretical foundation

Social exchange theory (SET) and social identity theory (SIT) offer valuable frameworks for explaining how feelings of belonging and affirmed identity support the influence of inclusive leadership and inclusive work environments [4]. SET suggests that when leaders demonstrate reciprocal and inclusive conduct, employees respond with greater engagement, commitment, and creative problem-solving. SIT emphasizes the role of group belonging, noting that employees develop stronger organizational attachment and loyalty when they feel valued and share the organization's core principles. The present study investigates how these two theories explain the role of inclusive leadership in promoting teamwork and superior performance outcomes in healthcare [4].

Inclusive leadership and cultural competence

Across varied healthcare environments, inclusive leadership helps establish a culture that prizes teamwork and diversity, which, in turn, directly affects how well teams function and how effectively patients are served [5, 6]. Leaders who practice inclusivity emphasize empathy,

receptiveness, and genuine appreciation; these qualities nurture a constructive atmosphere and lead to better patient care results [10].

Inclusive work climates further encourage innovative thinking and lower stress levels, creating conditions that promote greater job satisfaction and overall employee well-being [8, 11].

Cultural competence involves delivering services that honor patients' cultural identities and tailoring care to meet the specific requirements of local communities [12]. Current research continues to assess whether targeted cultural competence training programs or wider leadership development initiatives produce superior results [13].

The anomaly of climate for inclusion

The frequent gap between official policies and daily practices reveals significant discrepancies; leaders need to ensure their behavior aligns with stated policies if they wish to build genuine climates of inclusion [13].

A strong climate for inclusion is expected to moderate the relationships between IL and JS (H3) and between IL and PQC (H4) by reinforcing organizational norms that celebrate diversity [14].

When staff members view their workplace as inclusive, they tend to report higher satisfaction and motivation, which in turn contributes to improved perceived quality of care. Available evidence indicates that the climate for inclusion is a key moderating influence on the effects of inclusive leadership [10, 11].

Research shows that positive, supportive inclusion climates amplify the benefits of inclusive leadership, leading to greater staff satisfaction and higher standards of care [7, 12].

Job satisfaction and perceived quality of care

A healthy work setting plays a major role in shaping job satisfaction and the overall standard of patient care. Factors such as strong administrative backing, opportunities for professional development, recognition for effort, and meaningful work all help reduce staff turnover and improve results [15–17].

The role of leadership policy–practice decoupling

Closing the divide between written policies and everyday practice is essential if inclusive leadership is to genuinely elevate job satisfaction and perceived quality of care through authentic inclusiveness [13].

Materials and Methods

Sampling and recruitment

A purposeful, multi-stage recruitment approach was adopted. First, a pilot test was conducted at a senior living facility ($n = 47$) to verify that the survey items were clear and understandable. The updated survey link was then shared within healthcare leadership communities on LinkedIn. In the final stage, a single-use email list containing 5000 addresses was acquired from a reputable vendor that maintains a fully opt-in database of licensed US healthcare managers. Each recipient received one invitation email that included an easy opt-out link; no recipients chose to unsubscribe. Data collection took place from June to November 2024, yielding 209 completed responses (4.2% completion rate). An a priori power analysis conducted with G*Power v3.1 ($f^2 = 0.10$, $\alpha = 0.05$, $1\text{-}\beta = 0.80$, predictors = 6) determined that 123 cases would be sufficient; the final complete-case sample of $N=144$ surpassed this requirement.

Instrumentation

The survey (see Appendix 1) incorporated the inclusive leadership (IL) scale, the cultural competence assessment instrument (CCAI-UIC), the climate for inclusion (CiD) scale, the short index of job satisfaction (SIJS), and the z healthcare quality perception (HQP) scale. Items covered leadership actions, cultural competence, job satisfaction levels, and respondents' views on the importance of achieving adequate or good patient care quality, with particular attention to effective communication across sociodemographic differences [15, 18–21].

Eligibility

Study participants had to be healthcare managers working in the United States, actively employed, responsible for supervising at least one direct report, and 25 years of age or older. Individuals were excluded if they submitted incomplete questionnaires or showed duplicate IP addresses.

Nonresponse bias

Analyses comparing early and late survey responders found only trivial differences on key study variables (all $|d| \leq 0.15$), suggesting little evidence of nonresponse bias.

Scale diagnostics and remediation steps

Cronbach's α values were at or above 0.87 for the IL scale (8 items) and the C4I scale (16 items). The original

cultural competence assessment instrument [19] contained negatively worded items that initially produced a suppression effect. After these items were properly reverse-coded and two poorly performing indicators were removed, the revised 7-item CC scale achieved excellent internal consistency (α = 0.930). The PQC measure consisted of a 10-item tool frequently used in studies of healthcare quality perceptions [21]. The JS measure was a brief 2-item index developed in line with recommendations for short-form scales [22]. Detailed reliability statistics for all scales appear in **Table 1**, while factor loading summaries are shown in **Table 2**. Residual diagnostics for the JS and PQC models are displayed in **Figures 2 and 3**.

Table 1. Survey instruments and reliability (α)

Construct	Adopted	Original	Cronbach alpha	Scale
Inclusive leadership	8	13	0.950	5-point
Cultural competence (reverse coding)	7	24	0.930	5-point
Social desirability	4	7	0.290	5-point
Climate for inclusion	16	16	0.948	5-point
Job satisfaction	2	5	0.873	5-point
Perceived quality of care	5	5	0.923	5-point

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 a rule of thumb, α ≈ 0.70 is acceptable, ≥ 0.80 good, and ≥ 0.90 excellent; the Social Desirability scale (α = 0.29), highlighted in yellow, shows poor reliability and should be interpreted with caution.

Table 2. Regression analysis results

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

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 (H0: ß = 0); adj. r² (adjusted R²) = proportion of variance explained, adjusted for number of predictors; p = exact two-tailed P-value unless otherwise noted.

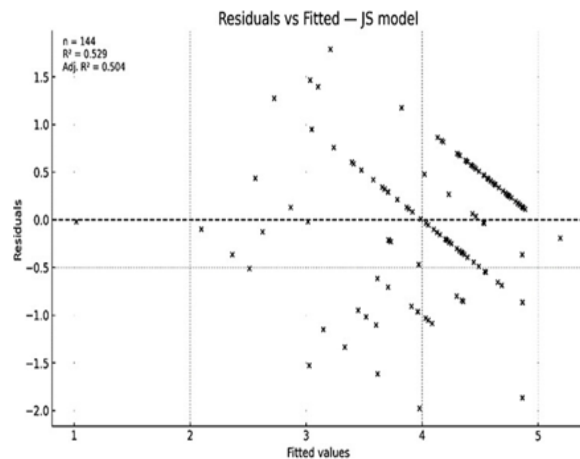

Figure 2. Residuals vs fitted—Job Satisfaction model. Notes: Residuals vs fitted values for the job satisfaction (JS) model (n = 144; $R^2 = 0.529$; adjusted $R^2 = 0.504$). The dashed line marks zero residual. Points are centered near zero with fairly constant spread across the fitted range (~1–5). 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.

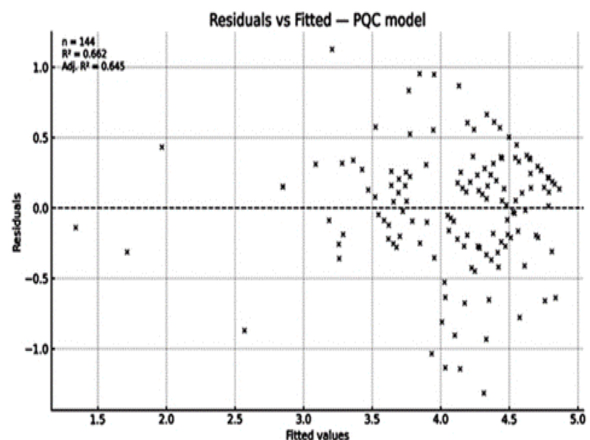

Figure 3. Residuals vs fitted PQC model.Notes: Residuals vs fitted values for the perceived quality of care (PQC) model (n = 144; R2 = 0.662; adjusted R^2 = 0.645). Each point is an observation; the dashed

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.

Common method bias controls

All predictor variables and outcome variables were separated into different sections of the survey and divided by a timed break (average ≈46 s). A 5-item social desirability indicator was included as a control variable and remained non-significant across all models tested. Harman's single-factor test explained 29% of the total variance; when a latent common method variance factor was added, item loadings shifted by less than 0.02 (ΔCFI=0.002).

Results and Discussion

Confirmatory factor analysis confirmed an acceptable fit for the proposed five-factor measurement model ($\chi^2(335)=453.2$, CFI=0.92, TLI=0.91, RMSEA=0.046). Exploratory factor analysis revealed generally strong and clean loadings 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), except for one lower loading on a single PQC item (0.47).

Hypotheses testing

Hierarchical moderated regression models confirmed the direct positive influences of inclusive leadership on job satisfaction (H1). They perceived quality of care (H2), along with the direct positive influences of cultural competence on both outcomes (H5–H6), all of which reached significance at $P < 0.001$. Climate for inclusion acted as a moderator in the pathways from inclusive leadership to job satisfaction (H3) and to perceived quality of care (H4), also at $P < 0.001$. The three-way interaction among inclusive leadership, cultural competence, and climate for inclusion approached significance for job satisfaction (H7a, $P = 0.064$) and achieved full significance for perceived quality of care (H7b, $P < 0.001$). Complete details on F-tests, unstandardized coefficients (B), t-statistics, adjusted R^2 values, and exact p-values are provided in **Table 3**.

Table 3. Factors matrix (EFA)—loading ranges

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

Construct validity and reliability

The scale measuring inclusive leadership exhibited outstanding reliability (Cronbach's $\alpha = 0.950$). Before any adjustments, the cultural competence instrument showed comparatively lower internal consistency, confirming the value of targeted improvements [19, 21].

Descriptive statistics

Among the 144 valid complete responses, the largest age brackets were 45–54 years (32.6%) and 55–64 years (31.9%), whereas the 25–34 years and 35–44 years age groups accounted for smaller proportions (8.3% and 14.6%). Participants were mostly women (70.8%), and nearly all worked full-time (95.8%). The sample showed strong educational backgrounds: 62.0% held graduate or professional qualifications, and 25.7% held bachelor's degrees. Annual household income was elevated, with 56.3% earning \$150,000 or more and 23.6% earning between \$100,000 and \$149,999. The overall profile of respondents [23] aligns with the geographic distribution illustrated in **Figure 4**.

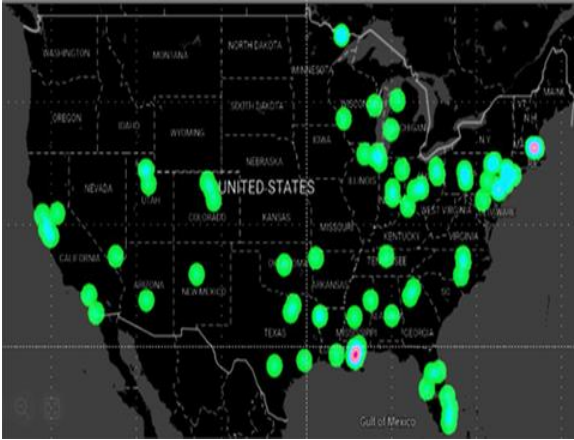

Figure 4. Respondent heat map.Notes: Heat map of respondent ZIP codes across the United States (n = 143; 100%). Most ZIP codes appear once (~0.7% each), indicating wide geographic diversity with limited clustering. A few ZIP codes show modestly higher representation—70458 (6, 4.4%), 70,461 (5, 3.6%),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

Inclusive leadership and cultural competence were both positively associated with job satisfaction and perceived quality of care, and a supportive climate for inclusion further strengthened these associations. Simple-slope analyses of the inclusive leadership × climate for inclusion interaction revealed a clear pattern of diminishing returns for inclusive leadership once the inclusion climate was already strong. In practical terms, healthcare organizations are encouraged to actively build inclusive leadership capabilities and deliver well-evidenced cultural competence training programs [18, 19] that conform to recognized national guidelines.
Such approaches are fully consistent with existing national and federal recommendations, such as the CLAS Standards, Healthy People 2030, and various HRSA workforce initiatives [24–27].

Limitations and future research

Because the study used a cross-sectional design and relied on a short 2-item measure of job satisfaction, firm conclusions about causality cannot be drawn, and the breadth of the job satisfaction construct remains limited. Self-selection into the sample and the use of single-source self-reported data could still introduce some bias, despite the steps taken to address common method variance. Subsequent research would benefit from longitudinal designs, multi-informant data collection, and the inclusion of actual team-level diversity indicators.

Conclusion

Inclusive leadership is an important predictor of both job satisfaction and perceived quality of care. Cultural competence also contributes, and its impact becomes especially powerful when paired with a strong climate for inclusion—particularly when it comes to perceived quality of care. Making coordinated investments in developing inclusive leader behaviors and strengthening inclusive organizational practices offers a realistic and effective route toward greater workforce engagement and better patient care delivery [13, 19–22].

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Conflict of Interest: None

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