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The Importance of Diversity and Inclusion in Healthcare Settings: Benefits for Healthcare Workers and Patients

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Abstract

1. Introduction

Health is a basic human right, as outlined in the World Health Organization constitution. The benefits of health are defined in its preamble as “not merely the absence of disease or infirmity, but the best attainable state of physical, mental, and social well-being”. Despite these principles, marginalized groups are less likely to reap the health benefits of these ideals and experience poorer mental and physical health outcomes compared to more privileged groups of the same societies. Health inequities are defined as “differences in health which are unnecessary and avoidable but are also considered unfair and unjust”. Those who have different cultural backgrounds and speak languages other than English are more likely to be disadvantaged and judged inappropriately by existing health and healthcare systems, a double disadvantage costing individuals to pay a hidden price for their cultural safety in terms of health outcomes. While various campaigns assist in raising awareness of these injustices, attention should also be given to those who are historically induced to experience worse health consequences because of socially determined physical conditions As recognized in the Ottawa Charter for Health Promotion, there is a causal cycle between disadvantages due to the social determinants of health and the poor health outcomes. Those who have poor health are limited in terms of education and work opportunities. This in turn leads to an ever-increasing gap in income and wealth levels, with the consumption of unhealthy food and the

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use of harmful substances and energy-density food and obesity, and reduces the physical capacity for paying the price of better health. Corresponding to the deleterious actions in all dimensions, individual and community productivity is reduced, which can lead to unskilled and low-income jobs and limited access to healthcare services. Unable to pay health insurance, some people do not access health services when needed, leading to premature death, disability, and loss of dignity. Such healthcare services may not be inclusive of diverse populations, including hard-to-reach groups with a temporary visa. The costs of non-inclusive practices in healthcare in the country are clear and can contribute to avoidable health inequities. Given the awareness of such adverse consequences, there has been a change in approach to the 1980s and 1990 to review the provision of healthcare, and rather focus on health promotion and prevention strategies more broadly. Healthcare practice becomes more active in the management plan and includes legislation, policy, and practice regardless of health. Sweden is a pioneer in this revolutionary shift, implementing “inclusive health and safety measures” based on the Ottawa Charter action areas including public policy, community coalitions, and services needed to make healthier choices easier for citizens. Since then, awareness of health inequities has generated inclusive and person-/patient-centered healthcare practices rooted in socio-ecological and life-course approaches tailored to individual identities, beliefs, and needs. However, despite several decades of implementation of such principles, inequities in health and healthcare are still a serious matter in most countries.

Methods

A comprehensive multidisciplinary search was conducted. Major electronic databases were searched from the beginning of indexing of the databases till March 2021. Search terms were related to heterogeneous terms for "diversity" and "inclusion," and the second string of terms for "healthcare." Eligibility criteria included quantitative, qualitative, as well as mixed-methods study designs. The data search, screening, identification, and retrieval process were conducted following guidelines, and two independent reviewers assessed the quality of the studies. Quality was assessed using a modified version of the appropriate checklist for each study design. Disagreements were solved by consensus.

The descriptive design involved rigorously scrutinizing and objectively synthesizing a range of articles and identifying the best pieces of evidence contextualizing the central issue of this review on the impact of diversity and inclusion in healthcare. Data collection was performed in an accurate, consistent, and transparent approach, followed by increasing reproducibility and transparency of the review results. The thematic analysis ensured rigorous, reliable, and credible evidence and interpretation regarding the role of diversity and inclusion in healthcare and the present occupational and health-related outcomes, maximizing the review's clarity and concision, laying the foundations for future evidence-based policy making. The studies'

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quality was investigated under a dual-proportionate approach other than applying stringent exclusion criteria and justified rationales for the outcomes. Other measures were also taken into account. This is especially important due to the novel nature of the objectives related to a debated and central concept that in itself represents a personal and professional value-based approach more than a paradigm.

Conclusion

Lord Nigel Crisp, former Chief Executive of the English National Health Service, argued that "Diversity and inequality are the healthcare issue of our time." Health is a fundamental human right. Yet marginalized subpopulations, such as People of Color, LGBTQIA+ individuals, People with Disabilities, and People of Marginalized Religious or Socio-Economic Backgrounds, consistently experience more negative mental and physical health outcomes. Other forms of systemic social inequality in the Global North also pertain to Australia: socioeconomic differences in health, the richer are healthier; rural versus urban disparities, regional, rural, and remote children and young people are significantly differentially underprivileged compared to urban children; access to basic services, availability of services determines health outcomes; and 'transport disadvantage' significantly hinders regional Australians from accessing healthcare. Such subpopulations are not only found in the broader community but also in all health settings. Yet diverse healthcare settings have been shown to provide exponential benefits over solely homogenous environments. As such, 'inclusive' healthcare workers and settings are urged to actively be transformative by embracing and understanding the broader community's inherent diversity and complexity. It is no longer enough to simply 'do no harm.' Healthcare workers and settings must embrace a proactive, 'person-/patient-centered care' and mitigating potential or existing problematic backgrounds.

2. Understanding Diversity and Inclusion in Healthcare

Health is a basic human right and the highest attainable state of health is a fundamental right of every human being. However, marginalized groups, because of their identity, may experience poorer mental and physical health outcomes due to health inequities. A key driver of health inequities are the social determinants of health, which include education, social exclusion, and access to health services. Poor health status additionally subjects people to disadvantages in order to obtain education and engage in work, often resulting in limited access to healthcare services (Marjadi et al., 2023). One important factor in this lack of access is the historical notion that healthcare services may not be inclusive of the very populations who need them the most. However, the awareness of health inequities has led to the development of new inclusive, patient-centered healthcare practices that are tailored to individual identities, beliefs, and needs.

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Diversity and inclusion in healthcare are multi-faceted and complex issues, which may be overwhelming to address simultaneously. While many individual simple steps can be taken independently, a more effective and comprehensive approach involves combining and normalizing their practices. An inclusive framework does this by normalizing practices across seven bedrooms, which fit within the scopes of practice or control of key healthcare professions. This inclusive framework provides infinitely-tailored, contextually-assistive guides to healthcare workers, managers, and practitioners.

3. Benefits of Diversity and Inclusion for Healthcare Workers

Having a diverse and inclusive workforce can of benefits to all parties involved. Research showing health benefits of workforce diversity has the potential to facilitate policy and organizational change but is currently undermined by measurement and design weaknesses. These benefits can also add incentives to inch closer to creating a more diverse workforce. It drives an appreciation for the different experiences and perspectives of both workers and clients. Furthermore, it can decrease health problems caused by work-related discrimination or lack of health care. Workers would also feel safer in talking to someone who can better address their health needs. A major incentive for employers is it also brings in 33 million more customers a year (Thomas, 2014). Training to improve in this area makes it a win-win for the company and its workers. It also works wonders within the company culture. Workers feel like they are part of a family, and that the company cares about the social status of its workers. This creates a solid base of employee loyalty, and workers who want the best for their company. Organization health is also affected by these programs. Companies are also becoming more fertile and responsive to the different demographics of the modern healthcare workforce.

Recent studies affirm that minorities become most sympathetic when adequate attention is provided to them. In response to this delineation, health care initiations are striving to uphold a fair and just relationship with patients and staff of varied cultural backgrounds. It has been seen that having a staff of diversified cultural enrichment will in return attract a variety of patients. If such an adaption is conducted, patients and bystanders won't feel the bitterness of how some health care providers put them off. In many cases, it has also been seen that medical staff sometimes doesn't whole-heartedly assist patients feeling they treat them as a burden in the first place. In times like this, a person of the same background can promptly communicate the situation to a superior immediately seeking proper medication in an emergency issue. It is understood that people have their doubts whenever they visit a doctor's chamber, majority of them suffer from a syndrome of apprehension. With the clinical staff comes an added pressure, adaptation and inclusive training will make the atmosphere more relaxing and easy-going between staff and patients.

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3.1. Enhanced Workforce Satisfaction and Retention

A diverse workforce is a rich source of cultural and linguistic competence, which has long been identified as one of the basic requirements of modern health service provision. The Employment Opportunities for People with Care Responsibility National Working Group in its response to the Royal Commission on Long-Term Care commented that its membership represented 18 minority ethnic groups and that its comments related particularly to race and culture. Only by acknowledging the links between race, inequality, poverty, and social exclusion could these issues be addressed in a fuller context. The national mosaic was reflected in every local health service as doctors, nurses, health visitors, porters, laboratory technicians, and care assistants. COVID-19 has again starkly highlighted long-standing racial disparities in health outcomes, with higher rates of morbidity and mortality among people of Black, Asian, and minority ethnicity compared to White populations. Discrimination is part of the fabric of British society just as much as it is in any other country (Bullas, 2003). Statistically, someone of minority ethnicity living and working in England today is more likely to be infected, be re-infected, be made redundant and remain unemployed partly or wholly due to their ethnicity. The British government in 2020 inadvertently demonstrated the extent of institutional racism in employment by succinctly revealing the daily decisions to promote and protect the lives of the "White other". Japanese, Moroccan, and Vietnamese are just some of the many groups that comprise the BAME cohorts in any local health care population.

3.2. Improved Cultural Competence and Communication Skills

Cultural competence is the ability to work well with patients, families, and other members of different cultures. It involves being aware and taking steps to learn about each patient. Cultural Factors. Every person's culture is different due to beliefs, experiences, and ways they learn to interact. Country of origin may affect views toward health. A patient's country may have a different way of treating illnesses. The United States is a country that tends to treat illnesses with Western medicine, while other countries treat illnesses with traditional roots. Preferred language. Patients should be encouraged to use their own language. Reading or writing in a different language is a barrier that should be overcome. Communication style. Culture may affect nonverbal and verbal responses. For example, while eye contact signifies respect in Western cultures, it can be seen as a sign of disrespect in some Asian cultures (Blonigen-Heinen & Basol, 2015). Views of health. Illness may not be viewed as best treated by Western medicine. An illness that may be seen as preventing the body from living in balance place is treated with therapies that bring the body back in balance, such as special diets, teas, or massages. Religion. Religion may affect consents, schedules, room arrangement, and what a patient can do during treatments. Food preferences. Cultural practices may affect foods a patient may eat or avoid.

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Some ways to build cultural competencies with each patient include: not assuming that patients or families speak English if they observe them speaking English, not asking a lot of questions about culture, not avoiding questions because thinking it is rude, not expecting patients to speak for an entire race, asking questions to learn about customs, building a relationship by introducing themselves, and asking if the patient prefers to be called by a different name. Some ways to effectively communicate include: listening to how the patient talks about their condition, using indirect questions, asking what the patient believes caused the condition, asking how the patient prefers to receive information, educating about lifestyle, environmental, and social factors that may affect their health, considering patient factors that may affect their care such as age, gender, sexual orientation, and socio-economic status, and offering culturally appropriate care (R. Devine, 2014). Cultural competencies are the skills used to work well with patients of all cultures, which involves considering every patient's culture when giving care and treating every patient as an individual. Health-care culture is providing care that fits all races; however, it is important to provide care that fits the individual. Learning about cultural competencies benefits everyone by improving care, meeting the standards of The Joint Commission, and enhancing job performance. Effective communication is essential for reaching the community served and advancing health equity.

4. Benefits of Diversity and Inclusion for Patients

Health is a basic human right in which everyone worldwide should benefit equally (Marjadi et al., 2023), regardless of their social, political, religious, or economic status. However, this is not the case, as systematic inequities exist where marginalized groups experience poorer mental and physical health outcomes than the general population. This situation has been exacerbated by the COVID-19 pandemic. Marginalization includes "refugees," "asylum seekers," "migrants," "homeless," "genders and sexualities diverse (GSD)," "culturally and linguistically diverse (CALD)," "those from and in rural settings," "those living with a socio-economic disadvantage," and "people with a disability," among diverse other categories. These health inequities are largely driven by social determinants of health (Thomas, 2014); the conditions in which people are born, live, grow, work, and age. Poor health status then exposes marginalized populations to additional disadvantages, limiting their ability to obtain education and engage in work. Such perpetuation of a cycle of disadvantage often results in these groups having limited access to, experiencing bias in, and frequently overlooking their rights to healthcare services. One key identified factor underlying this issue is the concerns that healthcare services may not be inclusive of the diverse populations most in need of healthcare. There is an ever-increasing awareness of the existence of such health inequities, and in response, various healthcare providers have, to diverse extents, developed practices that are inclusive and per—or patient—centered; services that see each person as an individual who is so much more than their health conditions. Such practice offers a dignified and respectful care across powerful environments, where each person's unique identity is

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considered from entry to exit. Unfortunately, such practices are not universal. Public services, including healthcare services, are on the rise to essentially hone to this population, which could further exasperate the existing issues around inclusivity and care of marginalized populations.

4.1. Enhanced Trust and Patient Satisfaction

Health is a basic human right; the right to the enjoyment of the highest attainable state of health is a fundamental right of every human being. This includes access to quality healthcare services, facilities, and information, free from gender, age, socioeconomic, and other types of discrimination (Marjadi et al., 2023). However, this right is often compromised for the most vulnerable within societies. Marginalized groups experience both poorer mental and physical health outcomes. Inequitable health outcomes in marginalized or minoritized populations are largely driven by health inequities, dominated by social determinants of health. Poor health status subjects people within these social groups to a variety of additional disadvantages, greatly limiting their access to the benefit of healthcare services (Thomas, 2014). Healthcare services that do not account for the full spectrum of diversity within populations invariably contribute to these health inequities.

To bring awareness to this issue, healthcare practice needs to be both reflective and responsive to the social identities of patients/populations being accommodated, centered on individual narratives, beliefs and needs. Specifically, these practices should subscribe to the provision of specific care that appreciates and sensitively responds to individual preferences, ancestral, cultural and language practices, social and religious beliefs, and needs. Equitable healthcare practices consider and take into account potential social inequities that impact a patient's ability to maintain good health and overall well-being. Adult learning theory takes on many different forms, which the clinical educator can apply to foster better retention of gained knowledge. These strategies include, but are not limited to, hands-on training, auditory interaction, games, and storytelling.

4.2. Improved Health Outcomes

Health is a basic human right. The universal right to health is enshrined in the constitutions of WHO member countries. Within ethically responsible healthcare systems, there is a shared duty to facilitate and preserve the unrestricted access to timely, good quality, medical care, while respecting individual choices, beliefs, autonomy, and dignity. It should be accessible to all, irrespective of race, sex, religion, political orientation, socio-economic status, or age. The recognition of social determinants of health has heightened the awareness that health inequities drive disadvantaged groups into poorer mental and physical health outcomes, when compared to the general population. An intertwined relationship exists between those disadvantages and poor health outcomes (Marjadi et al., 2023). Social and environmental

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circumstances contribute decisively to create the entry pathways into a vicious cycle. Poor health status is known to be a strong limiting factor, restricting the chances to access work, educational training and professional development, which, in turn, impedes a wide and easy access to healthcare services. Poorer education and lower income – often the result of lower educational attainment – were shown to be associated with higher mortality and morbidity rates, due to a poorer health behavior and to restricted access to healthcare services. The latter is particularly relevant also in terms of health literacy, since one of the main effects of educational level on health could be to provide tailored cognitive skills to promote good health habits and to better navigate the health system. On the faulting side, the health system might end up discriminating an already disadvantaged population, through its own organizational structures, filtering capacities and the awareness encoded in its culture. It is against this interpretation that, from the late 80's onwards, there has been a burgeon of studies and healthcare interventions playing on a perspective that foregrounds a person-centered, very inclusive model of healthcare, where multiple aspects – cultural, ethnic, socio-economic – that contribute to shape patients and caregivers' behavior should be actively singled out and monitored in order to tailor the intervention as much as possible. More recently, the reference has been widened to an audience approach, a twofold initiative meant to improve on one side the outcomes of healthcare intervention and on the other to enhance the empowerment of patients: on the one hand, it implies a solidaristic action to fight health inequities, by fostering the foundations of healthy environments in deprived districts; on the other hand, it activates professionals through a series of continuous and targeted training initiatives. In this climate of increasing awareness and sharing, the work leading to this paper took place under the mediating presence and the auspices of the Diversity, Equity, and Inclusion Special Interest Group of a national Public Health Association. This circumstance led to a need to reflect more deeply upon the concepts so far somewhat complacently taken for granted—diversity, equity, inclusion, intersectionality—and on the methodology underpinning the distribution of available funds—a strength-based approach to community development empowering the local agents. A turning point was marked by a consultation session with an opening duet between social psychologist and a linguistic expert there coalesced into a comprehensive list of twelve tips, which the attended seminar was devised to disseminate and upon which the Doctors writing group has been striving to sensitize both professionals and managers within the healthcare system.

5. Challenges and Barriers to Achieving Diversity and Inclusion in Healthcare

INTRODUCTION Health is a basic human right, yet marginalized groups experience poorer mental and physical health outcomes supported by linguistic and cultural disconnects and by health inequities. Health inequities generally show socio-economic gradients and are largely driven by social determinants of health such as socio-economic status, physical environment, education, social support network, and social and community context. Health inequities are

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exacerbated by limited access to health care services, which may not be inclusive of the populations who are disadvantaged on other axes (Marjadi et al., 2023). People that are not well may become more disadvantaged, e.g. reduced capability to work, limited access to education and work activities, and difficulty in accessing information and benefits. Inclusive care is defined as a comprehensive, person-orientated approach to care that takes into account how diverse patient populations experience diseases and healthcare. Inclusive care requires the systematic actions of removing barriers, fostering an environment with the resources to create opportunities for patients to meet their basic requirements, and channelling resources and services to those in greatest need. It covers diverse concepts including but not limited to cultural and linguistic appropriateness, shared decision-making model, quality standards in healthcare delivery, and early disease detection. BACKGROUND The awareness of health inequities has led to the development of inclusive, person-/patient-centered practices. Most guidelines on inclusivity in healthcare practices are limited to one diversity aspect, e.g. cultural competence or barriers to healthcare access relating to language or physical disabilities, and a language model. An important endeavor in creating inclusive practices involves patient-/person-centered care approaches that allow sick people to become effective in maintaining their own and their families' health and working with healthcare services to come to get them. Although a number of guidelines on inclusive healthcare practices have been developed, they are predominantly related to a single diversity aspect and thus do not cover all diversity aspects and their intersections. Moreover, this guideline mainly focuses on potentially modifiable indicators of inpatient care and lacks attention to the nature of specific service barriers and systemic inequities or fragmentation.

6. Best Practices and Strategies for Promoting Diversity and Inclusion in Healthcare

When Differences Are Embraced, the Marginalized Feel Healed. People from marginalized groups face structural, interpersonal, and internalized oppression. Policies, societal narratives, and institutional practices condone these differences as the norm. This marginalization results in unconscious bias and systemic discrimination at every stage of the patient journey. Healthcare workers from marginalized groups also face institutional oppression. Lack of inclusion can make work settings unsafe for these workers. For instance, they may experience xenophobia, criminalization, tokenism, and financial insecurities. Inclusive work settings have been shown to reduce burnout and improve mental health outcomes. Social identity-defensive motivational theory - underachieving marginalized individuals experience feelings of exclusion from academic spaces, generating defensive motivation. If individuals feel troublemaker ideology directed at them is a threat to their social identity, internalized stress can result, perpetuating lower achievement. Resilience interventions can reduce defensive motivation, reversing the achievement gap for low income racial/ethnic minority students. (Woodhead et al.2022)(Cubrich et al.2022)(Marjadi et al.2023)(Wallace et al.2021)

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Equity and inclusion are interdependent concepts. Equity involves substantive measures to redress imbalances from the past and enable diverse groups to be on equal footing. It goes beyond artificial numerical targets, promoting reach over representation. Intersectionality focuses on the interactions between different social categories. When these intersections are considered, groups are recognized performance-based race gender stereotypes depress the achievement of women and Blacks. When the intersection is ignored, policies intended to promote diversity and inclusion can instead exacerbate existing inequalities. A strength-based approach considers the dignity, resilience, and strengths of individuals, families, and communities. As of the end of 2020, over 100,000 Americans have died of COVID-19, a continuation of the health disparities experienced by racial and ethnic minorities.

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