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A Systematic review protocol on workplace equality and inclusion practices in the healthcare sector

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ABSTRACT

Introduction While equality and inclusion practices in healthcare have been advanced from a service user perspective, little is known about the application of workplace equality and inclusion practices in healthcare on upper-middle-income and high-income countries. In the developed world, the composition of the healthcare workforce is changing, with nationals and non-nationals working 'side-by-side' suggesting that healthcare organisations must have robust and meaningful workplace equality and inclusion practices. Healthcare organisations who welcome and value all their employees are more creative and productive, which can lead to better quality of care. Additionally, staff retention is maximised, and workforce integration will succeed. In view of this, this study aims to identify and synthesise current best evidence relating to workplace equality and inclusion practices in the healthcare sector in middle-income and high-income economies.

Methods and analysis Using the Population, Intervention, Comparison and Outcome (PICO) framework, a search of the following databases will be made—MEDLINE, CINAHL, EMBASE, SCOPUS, PsycInfo, Business Source Complete and Google Scholar—using Boolean terms to identify peer-reviewed literatures concerning workplace equality and inclusion in healthcare from January 2010 to 2022. A thematic approach will be employed to appraise and analyse the extracted data with the view to assessing what is workplace equality and inclusion; why it is important to promote workplace equality and inclusion in healthcare; how can workplace equality and inclusion practices be measured in healthcare; and how can workplace equality and inclusion be advanced in health systems.

Ethics and dissemination Ethical approval is not required. Both a protocol and a systematic review paper are to be published concerning workplace equality and inclusion practices in the healthcare sector.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Identifying and synthesising workplace equality and inclusion practices relating to staff development in healthcare.
⇒ The search strategy incorporates up-to-date research based on a timeframe that ranges from 2010 to 2022.
⇒ Research in relation to all healthcare employees will be included in the evaluation of workplace equality and inclusion practice literature.
⇒ Only peer-reviewed articles published in English will be included. We are cognisant that relying on English-language studies may not represent all of the evidence as it can create a language bias; however, recent studies have shown minimal effect on the effect estimates and the overall conclusions of systematic reviews.
⇒ The first of its type, this review will make academic findings into this area more accessible to academic and organisational decision-makers.

INTRODUCTION

Across the globe, countries and societies are becoming increasingly diverse, a phenomenon that is having a significant impact on workplace practices. For instance, in 2020 the US healthcare workforce comprised of more than 50% white, approximately 20% Asian, 7% black and less than 1% Hispanic and native American workers[1] relative to the turn of the century whereby less non-natives participated in the health labour force. Moreover, the commentators (Tayaben and Younas, p2220)[2] note 'the increase in migration of nurses has an effect on healthcare systems'. As a result, working with employees from a variety of backgrounds, mangers should understand differing cultural perspectives and styles of thinking[3] as employees who are treated fairly and have equal opportunity are better able to contribute socially and economically to the community, and to enhance growth and prosperity within the organisation.[4] In particular, embedding robust workforce equality and inclusion practices in healthcare leads to mutual desired benefits for health systems. Health professionals who are treated fairly and are included in the decision-making process are engaged and motivated which impacts on the quality of service. At the same time, these strategies support the workforce to treat the myriad of needs and populations that the health systems serve.[1] In Europe, the principle of equality is deeply rooted in the European Union (EU). In more recent times, EU laws have been strengthened to guarantee

equal opportunities in employment by banning discrimination in employment on the grounds of religious beliefs, age, sexual-orientation, and disability.[5] These developments aim to encourage member states within the EU framework to advance robust equality and inclusion practices in their societies.

The purpose of this paper is to present a protocol for a systematic review which is concerned with classifying and synthesising workplace equality and inclusion practices in healthcare with respect to staff development. This is motivated by a healthcare system that is considered to have one of the most ethnically diverse, highly skilled professional workforces driving the need for effective equality and inclusion practices.[6] Additionally, constructive equality and inclusion practices in the workplace is an important aspect of good people management. While the equality legislative framework, covering race, religion, gender, sexual orientation among others sets a minimum standard, robust equality and inclusion practices add value to the organisation, contribute to employee well-being and engagement and impact on service delivery.[7] These practices include, good communication based on open dialogue and active listening to all employees; learning and development programmes; continuous professional development (CPD) for all subordinates but, in particular for leaders and managers as their behaviour advance and strengthen equality and inclusion in the healthcare arena. Delivering patient safety care is dependent on the coordination of actions between doctors, nurses and other allied health professionals within a team. The commentators,[8] note that teamwork requires a number of core competencies, including leadership, mutual support and communication. These core competencies are supported by trust and a shared vision of patient care among healthcare professionals. Training and development can improve the team performance upwards by 20%,[9] thus it is imperative that all healthcare employees across the different areas and levels of healthcare, have an opportunity to engage with CPD programmes.

Developed economies can provide resources—such as money, knowledge, education and economic opportunities which can increase an individual's aspirations to migrate rather than remain in the local economy.[10] While western Europe has become a global destination of migrants, it is important to note 'global migration has not accelerated' (De Haas *et al*, p889).[10] Instead, the demand for skilled labour in specialised labour markets has become more accelerated. In terms of healthcare, health systems need health professionals to deliver health services, however there is a significant shortage of labour supply in this domain. In their study, the WHO[11] notes 'there is a chronic worldwide need for some 2.4 million more physicians, nurses and midwives, and for almost two million more pharmacists and other paramedical workers' (p1). This implies that middle-high income countries might need to source labour supply from outside of its native shores to delivery medical services. For example, in the UK the proportion of non-British nationals in the healthcare workforce has remained broadly stable since 2012, but at the same time the numbers have increased from 155 000 to 227 000, with EU nationals accounting for most of the increase. Similarly, in the Irish healthcare system it is reliant on non-Irish personnel to deliver health services. For instance, of the '4684 newly registered nurses and midwives in Ireland in 2017, almost 33% were trained outside the EU and 37% in other EU states' (Cullen, p1, para 2).[12] This shows that native and international staff are working side by side to deliver quality medical services. To advance and promote a harmonious and collaborative working environment, it is imperative that healthcare organisations put in place meaningful workplace equality and inclusion practices. Furthermore, it is also important to note that while the recruitment of international health personnel provides the destination country with healthcare staff, the WHO Code of practice on international recruitment of health personnel advocates that recruiting countries have a responsibility to strengthen the health workforce of less developed countries as building a sustainable workforce leads to a reduction inequality.

Global migration can create many challenges in the provision of healthcare as native and foreign health-professionals need to be culturally sensitive of each other.[13] This implies differences should be respected and appreciated. Moreover, 'those who can identify shared goals that lie underneath the cultural differences are likely to have the greatest success and value' (Fabian, p67).[4] Nonetheless, 'overseas nurses do face many different forms of discrimination from their managers, patients and healthcare colleagues at some point during their professional life' (Kritsotakis *et al*, p436).[14] As a result, this can impact on staff morale, productivity and organisational performance.

Having a globalised workforce in the healthcare arena in the western world is likely to continue going forward, thus, to improve workforce integration,[15] informs us that both national and international healthcare personnel need to recognise that two-way understanding and adaptation is necessary to build inclusivity. The authors[16] suggest that collaboration and teamwork lead to enhanced staff well-being and better patient care. Effective interprofessional collaboration and teamwork requires coordination across the professions, boundaries and a sense of openness from each of the multiple professions.[17] As a result, inclusive and well-functioning teams can improve health outcomes.

Moreover, work environments that show a willingness to understand employee differences in terms of thinking, working styles, forms of communication (both verbal and non-verbal) are high in psychological safety and engender high engagement among personnel.[18] Furthermore, 'institutional theory proposes that an organisation is influenced by its institutional environment which consists of formal and informal institutions' (Kemper *et al*, p57).[19] The former referring to 'binding rules, such as laws' and the latter relating to 'culture and conventions'

(Kemper *et al*, p57).[19] In Ireland, the Employment Equality directive prohibits discrimination on several grounds including gender, marital status, age, disability, sexual orientation, race and religion.[20] As regards culture and the advancement of equality and inclusion principles, healthcare professionals must be aware of their 'own cultural beliefs, values, attitudes before learning about other cultures. This need for awareness is predicated on the fact that cultural beliefs, values, attitudes and practices may vary considerably, and practitioners ought to be respectful of these differences. Being sensitive and adaptive to individual cultural differences relies on the professional's self-awareness and reflection and can lead to greater interpersonal cultural awareness' (Brooks *et al*, p385),[13] minimisation of unconscious bias, and effortless respect for people regardless of physical, mental, social, religious, political, educational and professional differences. Thus, health practitioners need to reflect on five factors that may lead to 'greater awareness of cultural competence: (1) valuing diversity, (2) developing the capacity for cultural self-assessment, (3) being conscious of interculture interaction, (4) establishing institutionalised cultural knowledge and (5) developing adaptations of service delivery that reflect an understanding of cultural diversity' (Rittle, p532).[3] If these elements are implemented in interactions between healthcare professionals, inter-professional collaboration and teamwork will succeed in delivering care that is culturally sensitive.[21]

One of the most researched and documented manifestations regarding equality and inclusion practices in healthcare organisations is related to gender. Appropriate equality and inclusion practices are historically driven by the fundamental need for gender equality. Traditionally, the medical profession was dominated by men, however since the 1970s the number of women doctors entering this profession has increased dramatically in the developed world. Despite these advancements, the quest for gender equality remains elusive as women remain under-represented in certain specialties in medicine and in top leadership positions in healthcare. Possible reasons for the continuation of gender inequality for these women might include (1) the glass ceiling, (2) little or no mentoring, (3) the culture and (4) the responsibilities of domestic, clinical and leadership roles which can lead to higher burnout rate.[22 23] Thus, to recruit, retain and promote female doctors' healthcare organisations must develop meaningful inclusive strategies that support and value these people. Furthermore,Boylan *et al*[24] suggest that to advance equality and inclusion its about challenging the structures that entrench inequality, but also about challenging our own behaviour and attitudes, and those we experience every day. That said, Kemper *et al*[19] surmise that improving gender equality can be arduous as changing organisational culture can be demanding. While the Treaty of Rome was instrumental in establishing the principle of equal treatment in relation to access of employment, working conditions and training, the implementation of equality and inclusion varies in different contexts owing to different interpretations of these principles, perhaps explaining why there continues to be a substantial lack of female representation in positions of executive management and decision-making.[18]

Women constitute almost 78% of the health workforce; however, the majority of female posts relate to the operations side of healthcare.[25] While women have a central role in the delivery of healthcare, their representation in positions of greater responsibility and decision-making is very limited,[26] suggesting that to advance gender parity in leadership positions in healthcare it is imperative that workplace equality and inclusion practices are infused into the workplace culture. In summary, there is quite a growing body of literature on the female–male workforce ratio and the gender wage gap as measures of gender equity, we would be interested to find out more from the systematic review about the impact of culturally sensitive approaches to inclusive work practices which are often less researched.

Inclusive and strategic leaders try and get the best of their followers so that the organisation can reach its goals and objectives. Transformational leadership calls for collaboration and engagement among healthcare colleagues and a two-way approach in terms of communication. These behaviours can lead to greater sense of well-being among team members, which in turn leads to more effective outcomes for service users. Interestingly, when examining workplace practices concerning equality and inclusion in healthcare much less attention is given to these issues among healthcare staff in contrast to service users, where inequalities in healthcare delivery are well researched.[27] Thus, this paucity in the research on equality and inclusion workplace practices supporting workforce integration in the delivery of health services must be addressed. Specifically, organisational leaders in healthcare must deliver a more culturally sensitive, inclusive environment to retain medical personnel, enhance job satisfaction and increase organisational commitment. Practitioners in the healthcare industry must be encouraged to examine their own cultural biases and behaviours as a foundation for progressing toward becoming culturally competent both in individual practice and at an organisational level.[13]

It is imperative that all healthcare systems worldwide have workforce integration, which is conditioned by egalitarianism and intercultural understanding[15] that incorporates principles of pluralism, equality and inclusion so that future healthcare needs can be catered for by native and international health professionals working side by side. The growing responsibility of healthcare organisations to design systems that target equality and inclusion practices for their employees requires a sound evidence-based approach in the development process. *Thus, the research question of this study is: what is the current best evidence relating to workplace equality and inclusion practices in healthcare?*

METHODS AND ANALYSIS

This study uses the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.[28]

Study design

To summarise workplace equality and inclusion practices in healthcare we use the PICO framework to facilitate the literature search.

1. In the (population) segment we are concerned with identifying equality and inclusion practices among the healthcare employees.
2. In the (Intervention) aspect, we assess what promotes equality and inclusion among practitioners compared (Comparison) to exclusion and inequality.
3. The outcome seeks to focus on enhanced interprofessional collaborations, teamwork and engagement in the organisation, equality of access across the different areas and levels of healthcare for CPD and career advancement.

Inclusion/exclusion criteria

We will *include* studies that satisfy all of the following criteria:

1. Studies that describe workplace equality and inclusion practices in healthcare.
2. Studies that focus on equality and inclusion workplace practices that relate to workforce integration, interprofessional collaborations, teamwork and an engaged workforce.
3. Studies which discuss the cultural context of healthcare with respect to the impact of the culture on equality practices. It is important to note gender could be a variable that impacts on work culture, however other elements of culture (such as the belief system of the employee/communication patterns) must be considered too to ensure all healthcare employees feel included in the organisation.
4. Given that the momentum for equality and inclusion has occurred since the late 2000, studies from 2010 onwards are included in this systematic review.

We will *exclude* papers where any of the following apply:

1. Studies that describe equality and inclusion from a service user perspective as the focus of this work is on workplace equality and inclusion practices.
2. Reviews, letters and personal correspondence.
3. Articles in a language other than English.

Search methods

Studies will be identified by searching the medical literatures using Medline (Pubmed and Ovid), Business Source Complete, Cinahl Complete, Embase, PsycINFO and Scopus to identify primary articles reporting on workplace equality and inclusion practices in healthcare. We will use different combinations of the Boolean phrases outlined in box 1 to identify current best evidence relating to workplace equality and inclusion practices in healthcare.

Box 1 Boolean phrases

Equality AND Inclusion; Equality AND Inclusion AND Healthcare; Staff Equality AND Inclusion AND Leadership/Professional Development/ Training and Development/Staff Development/ Mentoring; Healthcare Employees AND Equality AND Culture.

Additionally, citation lists of previous protocols (relating to workplace equality and inclusion in healthcare) and the reference list of papers identified in the above search will be reviewed to ensure all relevant medical literature are captured in evaluating the evidence regarding workplace equality and inclusion practices in healthcare.

Moreover, it is also important to note that we will use Google Scholar as a control to ensure all relevant literature are detected in relation to workplace equality and inclusion practices in healthcare.

Study timeframe

Anticipated start time: March 2023
Anticipated end date: June 2023.

Patient and public involvement

No patient or public are involved in this study.

Study selection and quality appraisal

First, the titles, abstracts and key words of all the selected medical literature will be read by two members of the team to ensure these works are relevant to workplace equality and inclusion practices in healthcare. The inclusion principles outlined above will guide the reader's decision-making process in ensuring the literature is within the scope of this research project. Papers that do not centre on workplace equality and inclusion practices in healthcare are removed from the process. To ensure that a fair, balanced and transparent approach are employed in the study selection process, a third reviewer is available to consult, should there be differences of opinion between the primary readers as regards what literature should be included or excluded in the process.

Following this, the full text of the relevant literature will be read in detail to ensure it is within the scope of this study. It is important to note the third reviewer is always available to discuss, should there be divergences of opinion between readers one and two, as it is crucial that all eligible relevant works are incorporated in evaluating workplace equality and inclusion practices in healthcare.

Finally, all stages of the study selection process (identification; screening; eligibility and inclusion) will be outlined in a flow diagram (ie, PRISMA).

Analysis

Thematic analysis will be employed to evaluate and appraise the data in relation to the following themes:

1. Motivation for assessing workplace equality and inclusion practices in healthcare
2. Definition of equality and inclusion principles

3. A review of how equality and inclusion are measured.
4. Discussion on how we can promote and advance equality and inclusion practices.

ETHICS AND DISSEMINATION

Ethical approval is not required. In terms of dissemination, the focus of summer 2022 is to publish both a protocol and a systematic review of workplace equality and inclusion practices in the healthcare sector.

Contributors SNL, NR and RL conceptualised the study together. All authors engaged in research to support the writing of the paper. SNL compiled the research in the form of the protocol paper. NR and RL proof-read and edited the paper.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting or dissemination plans of this research.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

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