

TRANSFORMATIONAL LEADERSHIP FOR DISABILITY-INCLUSIVE HEALTHCARE: A CONCEPTUAL FRAMEWORK FOR NURSING AND HEALTHCARE WORKFORCE EMPOWERMENT

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Abstract

People with disabilities experience persistent healthcare inequities linked to communication, accessibility, workforce competency, and organizational barriers. Transformational leadership is associated with workforce and organizational outcomes in healthcare, particularly nursing, but its role in disability-inclusive healthcare remains underexamined. This narrative review examines how transformational leadership may support disability-inclusive healthcare, with explicit attention to nursing, and proposes a conceptual framework. Structured searches of PubMed/MEDLINE, the WHO publications repository, and publisher and journal platforms (September 1–15, 2026) identified 19 English-language sources meeting explicit inclusion criteria. Sources were synthesized thematically; no meta-analysis or formal quality appraisal was performed. Review-level evidence, drawn largely from nursing, links transformational leadership with staff empowerment, job satisfaction, organizational commitment, and safety culture, while the disability literature documents persistent workforce, communication, and organizational barriers. No study directly tested transformational leadership as an intervention for disability-inclusive outcomes. The proposed Transformational Leadership for Disability-Inclusive Healthcare (TLDIH) Framework hypothesizes that leadership contributes to disability-inclusive care primarily by empowering a disability-competent workforce, with co-production with people with disabilities as a cross-cutting principle and contextual conditions as moderators. Transformational leadership is not a stand-alone solution to disability-related health inequity but may strengthen the organizational capacity,

including nursing management capacity, needed to translate inclusion policy into practice.

Keywords: *Organizational culture; Workforce empowerment; Accessibility; Health equity; Patient-centered care*



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1. Introduction

Disability-inclusive healthcare is an essential component of health equity and universal health coverage. Approximately 1.3 billion people, or 16% of the global population, experience a significant disability. Yet people with disabilities continue to experience poorer health outcomes and avoidable barriers to healthcare, with inequities arising from conditions within and beyond health systems (World Health Organization [WHO], 2022). These inequities are not attributable solely to underlying impairments. They are also shaped by inaccessible environments, communication barriers, stigma and discrimination, financial constraints, inadequate service organization, and insufficient health-worker knowledge and skills (Clemente et al., 2022; Gréaux et al., 2023).

Healthcare professionals, including nurses, physicians, and allied health staff, occupy the point at which health-system policy is translated into patient experience. Clinical encounters require healthcare workers to communicate effectively, obtain informed consent, assess individual needs, provide appropriate accommodations, and support participation in treatment decisions. Nurses in particular are frequently the frontline professionals coordinating disability-related care, patient education, and referral, making the nursing workforce central rather than incidental to disability inclusion. Consequently, disability inclusion cannot be achieved solely through physical infrastructure or formal policy; it also requires a workforce that has appropriate knowledge, skills, attitudes, and organizational support.

These findings indicate that disability-inclusive healthcare is simultaneously a clinical, workforce, and organizational challenge. Healthcare professionals require the capability to provide disability-inclusive care, while healthcare organizations, and the nurse managers and administrators who operationalize their policies, must create conditions that allow that capability to be translated into practice.

Leadership is therefore relevant to disability inclusion. In healthcare, leadership influences organizational priorities, professional norms, workforce development, teamwork, and quality-improvement activities. Transformational leadership has attracted substantial attention because it emphasizes shared vision, motivation, intellectual stimulation, individualized consideration, and development of followers (Bass, 1985; Bass & Riggio, 2006).

The intersection between transformational leadership and disability-inclusive healthcare, however, remains insufficiently developed as a distinct area of scholarship. Leadership studies have generally examined workforce, organizational, and broad patient outcomes, whereas disability research has focused on access barriers, health inequities, workforce competency, professional attitudes, and accommodations. With the exception of preliminary, practice-focused commentary specifically addressing learning-disability nursing (King, 2024), rigorous empirical integration of these two literatures remains limited. This separation creates an opportunity to integrate the two literatures and develop a testable model of how leadership, and nursing leadership in particular, may support disability inclusion.

Accordingly, the objective of this narrative review is to examine the potential contribution of transformational leadership to disability-inclusive healthcare, with explicit attention to its implications for nursing practice and management, and to propose a testable conceptual framework — the Transformational Leadership for Disability-Inclusive Healthcare (TLDIH) Framework. The framework links leadership behavior with organizational culture, workforce empowerment, disability competency, accessible clinical practice, and health equity, and it distinguishes relationships supported by existing evidence from those that remain hypotheses.

Four terms are used consistently throughout. Disability-inclusive healthcare refers to the system- and organization-level goal of equitable and accessible healthcare for people with disabilities. Disability-inclusive care refers to the care that individual patients with disabilities receive in clinical encounters. Disability competency refers to the knowledge, communication skills, attitudes, and confidence of individual health workers. Workforce inclusion refers specifically to the participation, accommodation, and retention of healthcare professionals who themselves have disabilities.

2. Literature Review

2.1 Disability-Inclusive Healthcare and Workforce Barriers

A global scoping review of barriers and interventions found that health-worker limitations were prominent within the evidence on disability-related access barriers. Limited human resources, inadequate training and skills, negative attitudes, and insufficient confidence were repeatedly identified as barriers to equitable healthcare for people with disabilities (Gréaux et al., 2023). Similarly, Clemente et al. (2022) identified communication failures, attitudinal and behavioral barriers, organizational limitations, physical barriers, inadequate resources and technology, and lack of professional training among barriers affecting access to healthcare services. In the Indonesian context, access to medical rehabilitation has also been described as uneven, with barriers involving facilities, human resources, insurance coverage, service standards, and referral systems (Putra & Lany, 2025).

2.2 Transformational Leadership in Healthcare and Nursing

Evidence from healthcare leadership research, concentrated heavily in nursing, suggests that transformational leadership is associated with important workforce and organizational outcomes. Hult et al. (2023), in a systematic review of reviews, found that transformational leadership was the most studied leadership style among the included nursing leadership literature, with staff outcomes, particularly job satisfaction, more frequently examined than patient outcomes. Ystaas et al. (2023) similarly reported that transformational leadership was associated with nurses' work environments and identified structural empowerment, organizational commitment, and job satisfaction among relevant mediating factors. An integrative review by Gebreheat et al. (2023) found predominantly positive associations between transformational leadership and nurses' job satisfaction. Complementing this evidence, nurse managers' transformational leadership has also been linked to the quality of patient care (Alanazi et al., 2023) and to nurses' adoption of safety practices through the mediating role of patient safety culture (Hamdan et al., 2024), while an integrative review found that transformational leadership supports nursing staff retention largely through enhanced job satisfaction and organizational commitment (Goens & Giannotti, 2024).

Recent research also suggests that organizational and personal factors influence the capacity of leaders to enact transformational leadership. In a scoping review of acute healthcare, Considine et al. (2024) identified manager preparation, experience, traits, organizational culture, manager support, and organizational processes among factors associated with transformational leadership. These findings suggest that transformational leadership should be understood within an organizational context rather than as a characteristic of an individual leader alone.

2.3 Workforce Inclusion and Organizational Context

At the same time, disability inclusion increasingly requires attention to the healthcare workforce itself. Physicians and other healthcare professionals with disabilities may encounter barriers during education, training, employment, accommodation, and career progression. Nouri et al. (2021) estimated that 3.1% of practicing U.S. physicians reported a disability. Among U.S. medical students reporting disabilities, Meeks et al. (2022) found that approximately one in five students who reported needing accommodations had not requested them for reasons other than not needing accommodations. Pereira-Lima et al. (2023) further found that fear of stigma or bias and lack of a clear institutional process were among reported reasons that resident physicians did not request needed accommodations.

These findings are relevant to leadership because an inclusive healthcare organization must support both people who receive healthcare and the professionals who provide it. A healthcare system cannot reasonably be described as fully disability-inclusive if qualified healthcare professionals with disabilities face avoidable barriers to participation, development, or retention.

2.4 Integrating Leadership and Disability Inclusion

Read together, the two literatures converge on a shared intermediate level of analysis. The leadership literature identifies the mechanisms through which transformational leadership is associated with outcomes: structural empowerment, organizational commitment, job satisfaction, and safety culture (Ystaas et al., 2023; Goens & Giannotti, 2024; Hamdan et al., 2024). The disability literature identifies barriers at the same level: insufficient training and confidence, negative attitudes, limited human resources, and unclear institutional processes (Clemente et al., 2022; Gréaux et al., 2023; Pereira-Lima et al., 2023). Several of these barriers correspond to specific transformational leadership dimensions. Intellectual stimulation addresses habitual, unexamined routines that make services inaccessible; individualized consideration addresses unmet accommodation needs among staff; and inspirational motivation and idealized influence address attitudinal norms and the priority given to accessibility (Bass & Riggio, 2006). This correspondence is conceptual rather than empirical, but it provides the rationale for examining whether leadership mechanisms documented in general healthcare settings could be directed toward disability-specific barriers.

The conceptual model developed in this review positions transformational leadership as an upstream organizational influence rather than as a direct determinant of patient health outcomes. The proposed framework links leadership behaviors with inclusive organizational culture, an empowered and disability-competent healthcare workforce, accessible and patient-centered clinical practice, and health equity and quality outcomes. These pathways are treated as hypotheses derived from converging evidence, because direct intervention studies linking transformational leadership to disability-inclusive outcomes were not identified.

3. Research Method

This article is a narrative review. Its purpose is conceptual: to integrate two literatures that have developed largely separately — transformational leadership in healthcare (particularly nursing) and disability-inclusive healthcare — and to derive a testable framework from them. Narrative reviews are suited to this kind of interpretive, theory-building synthesis (Greenhalgh et al., 2018; Sukhera, 2022). A systematic review was not appropriate because the review did not address a focused effectiveness question, and direct evidence connecting the two domains was limited and heterogeneous, making quantitative pooling inappropriate. A scoping review was also not appropriate, because the aim was not to map the full extent of either literature but to select and interpret sources relevant to proposed mechanisms. Structured search and screening procedures are nonetheless reported below to make the evidence base traceable and reproducible. These procedures do not make the review systematic or scoping in design: no protocol was registered, searching was limited to one bibliographic database supplemented by the WHO repository and selected publisher platforms, and no formal risk-of-bias or certainty appraisal was undertaken.

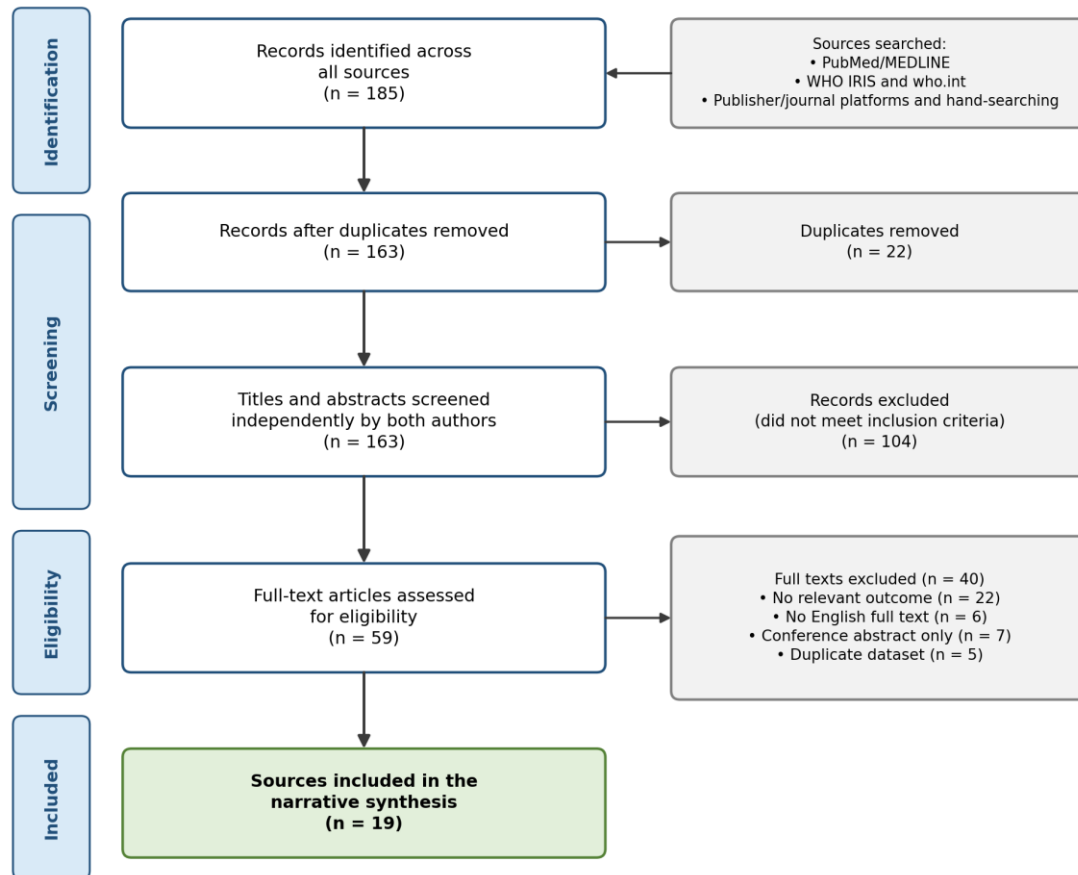
3.1 Search Strategy

Targeted searches were conducted between September 1 and September 15, 2026, in PubMed/MEDLINE and in the World Health Organization's official publications repository (WHO IRIS and who.int). The following Boolean search string was applied to titles and abstracts in PubMed: ("transformational leadership" OR "nursing leadership" OR "leadership style") AND ("disability" OR "disabilities" OR "persons with disabilities" OR "disability-inclusive") AND (healthcare OR "health system" OR "health service*" OR nursing). Searches were limited to English-language records published between January 2015 and September 2026; foundational leadership texts (Bass, 1985; Bass & Riggio, 2006) were identified separately and were not date-limited, as they establish the theoretical basis of transformational leadership rather than empirical findings. Supplementary hand-searches of publisher and journal platforms (including JAMA Network, SAGE Journals, Taylor & Francis Online, BMC, and MDPI) were conducted to verify publication details, retrieve full texts, and identify additional eligible sources not indexed in PubMed, including systematic or scoping reviews and the foundational leadership texts. Records from all sources were pooled before de-duplication and screening (Section 3.2).

3.2 Study Selection

Searches across all sources — PubMed/MEDLINE, the WHO publications repository (WHO IRIS and who.int), and publisher and journal platforms, including hand-searching — identified 185 records, which were pooled before screening. After removal of 22 duplicates, 163 titles and abstracts were screened independently by both authors against the inclusion criteria below; disagreements ($n = 9$, 5.5%) were resolved by discussion and consensus. At this stage, 104 records were excluded as not meeting the inclusion criteria, and 59 records proceeded to full-text review. Of these, 40 were excluded: no outcome relevant to the review domains ($n = 22$), not available in English without translation ($n = 6$), conference abstract without an associated full-text article ($n = 7$), or duplication of a dataset already represented by an included source ($n = 5$). Nineteen sources therefore met the inclusion criteria and are synthesized in this review. Full-text review was not performed in duplicate (see Section 4.7). The selection process is summarized in Figure 1. Methodological and measurement references cited in Sections 3 and 4.6 (Edmondson, 1999; Greenhalgh et al., 2018; Sukhera, 2022) support the review approach and are not part of the synthesized evidence base. Similarly, two Indonesian sources (Prayuti et al., 2024; Putra & Lany, 2025) were not identified through the structured search; they were cited purposively to provide national context and to strengthen the argument for the Indonesian setting, and they are not part of the synthesized evidence base.

Figure 1. Flow of Source Identification, Screening, and Inclusion



Source: Developed by the Authors (2026)

3.3 Inclusion and Exclusion Criteria

Sources were included if they (a) empirically or theoretically examined transformational leadership in healthcare or nursing settings; (b) reported organizational or workforce outcomes associated with transformational leadership; (c) examined barriers to healthcare access among people with disabilities; (d) addressed disability competency or training among health workers; (e) examined inclusion, accommodation, or disclosure among healthcare professionals with disabilities; or (f) constituted official WHO guidance on disability-inclusive health systems. Priority was given to systematic reviews, scoping reviews, and peer-reviewed empirical studies; foundational leadership texts were included to establish the theoretical basis of transformational leadership. Conference abstracts without an associated full-text article, non-English sources without an available translation, opinion or editorial pieces without empirical or theoretical grounding, and duplicate reports drawn from the same dataset were excluded.

3.4 Synthesis Approach

Sources were not pooled statistically and no effect size was calculated. Findings were synthesized thematically around eight recurring constructs: organizational culture, empowerment, psychological safety, disability competency, workforce inclusion, accessibility, patient participation, and health equity. Evidence from the two literatures was then combined component by component. For each framework component, the leadership literature was examined for a mechanism associated with transformational leadership, and the disability literature for a barrier or enabling condition at the same level (Section 4.2). Because no formal quality appraisal (for example, GRADE) was performed, Table 1 does not grade the certainty of evidence. Instead, it describes the level of support in the reviewed literature using explicit descriptive criteria: (a) consistent review-level support, meaning two or more systematic, scoping, or integrative reviews reporting associations in the same direction; (b) single-review support, meaning one review-level synthesis; (c) primary-study support, meaning consistent findings from two or more primary studies without a review-level synthesis; (d) limited support, meaning a single primary or practice-based source; and (e) institutional guidance, meaning normative WHO recommendations without empirical testing. Relationships with no direct supporting study are labeled conceptual propositions. All relationships in the resulting framework should therefore be interpreted as hypotheses derived from converging, and mostly indirect, evidence rather than as demonstrated causal effects.

4. Results and Discussion

4.1 Evidence Synthesis

The evidence synthesis identified a consistent distinction between two bodies of evidence. The healthcare leadership literature, concentrated substantially in nursing, provides evidence that transformational leadership is associated with important staff and organizational outcomes, while the disability literature documents substantial barriers involving healthcare access, workforce competency, attitudes, accommodations, and system design. Direct studies testing transformational leadership specifically as an intervention for disability-inclusive healthcare were not identified in the 19 sources synthesized in this narrative review; this absence is treated explicitly as a limitation of the evidence base rather than obscured within the synthesis (see Table 1).

Consistent with Section 2.2, the leadership evidence was strongest for staff and organizational outcomes and was drawn predominantly from nursing populations. Across the included reviews, the outcomes most consistently associated with transformational leadership were job satisfaction, organizational commitment, structural empowerment, and retention (Hult et al., 2023; Ystaas et al., 2023; Gebreheat et al., 2023; Goens & Giannotti, 2024). Patient-level outcomes were examined less often and were limited to general care quality and safety practices (Alanazi et al., 2023; Hamdan et al., 2024); none concerned patients with disabilities specifically. Considine et al. (2024) added that

transformational leadership in acute healthcare depends on personal and organizational attributes, including culture and managerial support.

The disability literature showed the opposite pattern: it documented barriers in detail but rarely examined leadership. Both scoping reviews identified workforce-related barriers, including limited training, skills, confidence, and human resources and negative attitudes, alongside communication, physical, financial, and organizational barriers (Clemente et al., 2022; Gréaux et al., 2023).

Training represents one potentially modifiable workforce factor. Rotenberg et al. (2022) synthesized global evidence and found that disability training can improve health workers' knowledge, confidence, competence, and self-efficacy. Approaches involving people with disabilities, community placements, simulations, and interactive learning were among the approaches associated with favorable educational outcomes.

Workforce inclusion emerged as a distinct domain. The prevalence, accommodation, and disclosure findings described in Section 2.3 (Nouri et al., 2021; Meeks et al., 2022; Pereira-Lima et al., 2023) were extended by Sheets et al. (2026), who found that physicians with disabilities were more likely than physicians without disabilities to report considering leaving medical practice or reducing clinical participation. Among physicians with disabilities, those who received accommodations were less likely to report an intention to leave. Because the study was cross-sectional, these findings demonstrate associations rather than causal effects. All workforce-inclusion evidence identified concerned physicians and medical trainees; no comparable nursing data were found.

WHO guidance provides a complementary health-system perspective. The WHO Global Report on Health Equity for Persons with Disabilities identifies leadership and governance, workforce competency and training, inclusion of people with disabilities in the health workforce, physical and digital accessibility, quality of care, and monitoring and evaluation among strategic areas for action (WHO, 2022). The subsequent Health Equity for Persons with Disabilities: Guide for Action provides a practical process, including foundational workforce training resources, for integrating disability inclusion into health-system governance, planning, implementation, and monitoring (WHO, 2024). For national context, Indonesian law defines the legal relationship between doctors and patients, including their rights and obligations, which adds a further governance consideration for healthcare delivery (Prayuti et al., 2024).

Taken together, these findings support the plausibility of an organizational pathway linking transformational leadership to disability-inclusive healthcare. However, as summarized in Table 1, the evidence does not establish that transformational leadership directly improves health outcomes among people with disabilities; this specific pathway remains a conceptual proposition rather than an empirically demonstrated effect. The proposed contribution of this article is therefore a mechanism-based framework that identifies intermediate organizational and workforce processes through which leadership

may influence disability-inclusive care, and that explicitly flags which of its components are evidence-supported versus inferred.

Table 1. Evidence Domains Informing the Proposed Framework and Level of Support in the Reviewed Literature

Evidence domain	Representative evidence	Level of support in the reviewed literature	Implication for TLDIH framework
Transformational leadership → staff/organizational outcomes	Multiple reviews link transformational leadership to staff satisfaction, empowerment, and organizational commitment (Hult et al., 2023; Ystaas et al., 2023; Gebreheat et al., 2023).	Consistent review-level support (two or more reviews)	Leadership positioned as an upstream organizational influence.
Nursing-specific transformational leadership	Nurse-manager transformational leadership is linked to patient-care quality (Alanazi et al., 2023), safety practices (Hamdan et al., 2024), and staff retention (Goens & Giannotti, 2024); disability-specific application discussed by King (2024).	Consistent review-level support for general nursing outcomes; limited support (single practice-based source) for disability-specific application	Strongest available basis for the framework's nursing-specific relevance.
Healthcare access barriers for people with disabilities	Communication, attitudinal, organizational, physical, financial, and training-related barriers are documented (Clemente et al., 2022; Gréaux et al., 2023); Putra and Lany (2025) provide Indonesian context.	Consistent review-level support (two scoping reviews)	Disability-inclusive care requires system-level rather than patient-level solutions.
Disability training	Training improves health workers' knowledge, confidence, competence, and self-efficacy (Rotenberg et al., 2022).	Single-review support (global evidence synthesis)	Leadership may help institutionalize disability competency.
Workforce inclusion (professionals with disabilities)	Healthcare professionals with disabilities report accommodation, disclosure, and retention-related barriers (Nouri et al., 2021; Meeks et al.,	Primary-study support (cross-sectional studies of physicians and medical trainees only)	Individualized consideration is proposed to extend to workforce accessibility.

Evidence domain	Representative evidence	Level of support in the reviewed literature	Implication for TLDIH framework
Organizational context supporting transformational leadership	2022; Pereira-Lima et al., 2023; Sheets et al., 2026). Culture, manager support, and organizational processes shape leaders' capacity to enact transformational leadership (Considine et al., 2024).	Single-review support (scoping review)	Leadership effects depend on organizational capability.
Health-system governance	WHO recommends disability inclusion across governance, workforce, accessibility, quality, and monitoring (WHO, 2022, 2024).	Institutional guidance (non-empirical)	Provides a governance rationale for integrating inclusion into routine accountability.
Direct link: transformational leadership → disability-inclusive outcomes	No study in the reviewed evidence directly tested transformational leadership as an intervention for disability-inclusive healthcare outcomes.	Conceptual proposition (no direct studies identified)	This pathway is the framework's central, empirically untested hypothesis.

Source: Developed by the Authors (2026)

Note: Levels of support describe the type, number, and consistency of sources in this review. They are not formal certainty-of-evidence grades. Criteria are defined in Section 3.4.

4.2 Proposed Transformational Leadership Framework for Disability-Inclusive Healthcare

The synthesis informed the development of the Transformational Leadership for Disability-Inclusive Healthcare (TLDIH) Framework (Figure 2). The framework is intended as a conceptual and testable model rather than a validated instrument. It proposes that transformational leadership may influence disability-inclusive healthcare through organizational and workforce mechanisms, including nursing management mechanisms specifically, rather than through a direct effect on patient health outcomes.

The framework consists of five interconnected domains: (1) transformational leadership; (2) inclusive organizational culture; (3) an empowered and disability-competent healthcare workforce; (4) accessible and patient-centered clinical practice; and (5) health equity and quality outcomes. These domains are complemented by a parallel pathway (workforce inclusion of professionals with disabilities), a cross-cutting principle (co-production with people with disabilities), and contextual moderators, each described below and shown in Figure 2.

Primary mechanism. Although the framework contains several components, it has one central story. Transformational leadership is hypothesized to contribute to

disability-inclusive care mainly by empowering frontline staff, most often nurses, to recognize and remove accessibility barriers in routine care. Empowerment here combines authority and resources, disability competency, and the psychological safety to raise problems. Inclusive organizational culture is the condition that sustains this mechanism, and workforce inclusion of professionals with disabilities forms a parallel pathway. This choice reflects where the two evidence streams meet most directly: structural empowerment is among the best-documented correlates of transformational leadership in nursing (Ystaas et al., 2023), while limited training, confidence, and human resources are among the most frequently reported barriers to care for people with disabilities (Gréaux et al., 2023).

Transformational leadership forms the upstream domain. Each of its four dimensions is proposed to act mainly through particular downstream components (Table 2). Idealized influence models respectful, non-discriminatory behavior and is linked chiefly to organizational culture. Inspirational motivation establishes an equity-oriented vision and links accessibility to organizational priorities. Intellectual stimulation encourages staff to question and redesign inaccessible routines and is linked chiefly to empowerment and accessible practice. Individualized consideration supports professional development and individual needs, including accommodations for staff with disabilities (Bass & Riggio, 2006).

Inclusive organizational culture is the enabling condition for the primary mechanism. Leaders, including nurse managers and unit-level supervisors, are hypothesized to signal whether disability inclusion is regarded as a core component of healthcare quality or as an optional initiative. A culture that values respect, non-discrimination, accessibility, patient autonomy, psychological safety, and staff voice may make inclusive behaviors more sustainable. Evidence that transformational leadership is associated with nurses' safety practices through patient safety culture (Hamdan et al., 2024) provides an indirect analogue for this culture-mediated pathway; its application to disability inclusion has not been tested.

An empowered and disability-competent healthcare workforce is the primary mechanism. Empowerment means more than autonomy; it includes knowledge, resources, authority, and psychological support to identify and address accessibility problems. The association between transformational leadership and structural empowerment is supported at review level in nursing (Ystaas et al., 2023). Disability competency includes knowledge, communication skills, confidence, and the ability to adapt care to individual needs. Evidence that disability training improves these attributes supports the potential value of this pathway (Rotenberg et al., 2022). Whether empowered staff act on disability-related barriers specifically is a proposition that requires testing.

Accessible and patient-centered clinical practice represents the point at which organizational and workforce capabilities become visible to patients. This includes accessible communication, appropriate accommodations, informed consent, shared decision-making, accessible appointment and referral processes, and coordination across

professional disciplines. Transformational leadership has been associated with general care quality and safety practices (Alanazi et al., 2023; Hamdan et al., 2024), but not yet with accessibility outcomes.

The final domain concerns health equity and quality. Potential outcomes include patient-reported experience, perceived respect, communication quality, participation in decisions, continuity of care, and selected safety and quality indicators. Workforce outcomes, including staff satisfaction, psychological safety, retention, and inclusion, should also be measured because they may represent important intermediate outcomes.

Co-production with people with disabilities is a cross-cutting principle of the framework rather than a separate downstream step. People with disabilities are positioned not only as recipients of care but as partners at every level: in setting leadership priorities, shaping organizational culture, co-delivering workforce training, assessing accessibility, and defining and evaluating outcomes. This principle is grounded in WHO recommendations emphasizing empowerment and meaningful participation of people with disabilities (WHO, 2022, 2024) and in evidence that training involving people with disabilities was among the approaches associated with favorable educational outcomes (Rotenberg et al., 2022). In Figure 2, it is shown as a band spanning all domains.

The parallel pathway is the explicit inclusion of healthcare professionals with disabilities. The framework treats workforce inclusion as part of organizational capability. This is supported by primary studies showing that disability-related accommodation, disclosure, and retention barriers can affect medical education and professional practice (Meeks et al., 2022; Pereira-Lima et al., 2023; Sheets et al., 2026). Because these studies concern physicians and medical trainees, the application of this pathway to nursing workforces is an extrapolation.

Contextual moderators. The framework should not be interpreted as a linear deterministic pathway. Five groups of contextual conditions are specified as moderators that may strengthen or weaken each relationship: (a) organizational resources and staffing, which determine whether empowered staff can act on identified barriers; (b) healthcare setting, such as acute, primary, community, or rehabilitation care; (c) policy and legal environment, including national disability and health legislation and patient-provider legal protections (Prayuti et al., 2024); (d) disability type and the accommodations it requires; and (e) socioeconomic and health-system conditions, including financing and service availability (Putra & Lany, 2025; WHO, 2022). Treating these conditions as moderators, rather than only as limitations, means the framework predicts that its relationships will differ in strength across settings and should be tested accordingly (Section 4.6).

Nursing-specific and healthcare-wide components. The framework distinguishes components specific to nursing from those that apply across the healthcare workforce (Table 2, final column). Nursing-specific components are those for which the evidence base is drawn from nursing and nurse managers are the most likely enactors: unit-level empowerment and psychological safety, nurse-manager role modeling, nursing

education, and nurse-coordinated referral and communication. Healthcare-wide components are organizational culture, governance and accountability, accessibility of physical and digital environments, and interprofessional practice. Workforce inclusion is healthcare-wide in principle, but its current evidence base is limited to physicians.

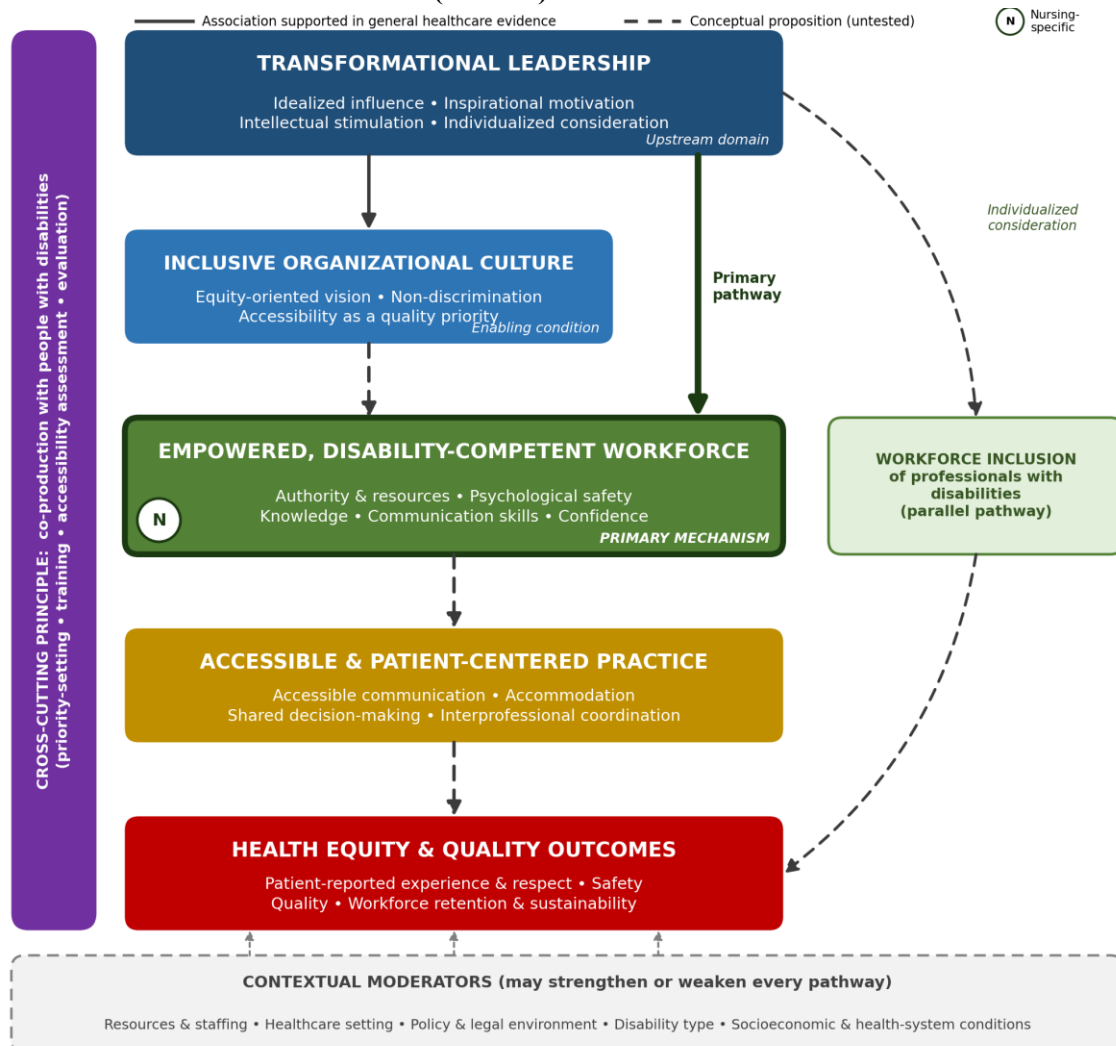
Table 2. Derivation of TLDIH Framework Components From the Two Evidence Streams

Framework component (role)	Leadership-literature basis	Disability-literature basis	Main TL dimension(s)	Scope; status in framework
Inclusive organizational culture (enabling condition)	TL associated with safety practices via patient safety culture (Hamdan et al., 2024); culture and manager support enable TL (Considine et al., 2024)	Attitudinal and organizational barriers (Clemente et al., 2022; Gréaux et al., 2023)	Idealized influence; inspirational motivation	Healthcare-wide, enacted at unit level by nurse managers; conceptual proposition
Workforce empowerment and psychological safety (primary mechanism)	Structural empowerment and organizational commitment as correlates of TL (Ystaas et al., 2023; Goens & Giannotti, 2024)	Limited human resources, skills, and confidence (Gréaux et al., 2023)	Intellectual stimulation; individualized consideration	Nursing-specific; TL → empowerment supported in nursing; empowerment → disability-inclusive action proposed
Disability competency (part of primary mechanism)	TL associated with quality of patient care (Alanazi et al., 2023)	Training improves knowledge, confidence, competence, and self-efficacy (Rotenberg et al., 2022)	Intellectual stimulation; individualized consideration	Healthcare-wide, with nursing-education implications; training effect supported; leadership role proposed
Workforce inclusion of professionals with disabilities (parallel pathway)	Individualized consideration in TL theory (Bass & Riggio, 2006)	Accommodation, disclosure, and retention barriers (Nouri et al., 2021; Meeks et al., 2022; Pereira-Lima et al., 2023; Sheets et al., 2026)	Individualized consideration	Healthcare-wide in principle; evidence limited to physicians; leadership link proposed
Accessible and patient-centered practice	TL associated with care quality and safety practices (Alanazi et al., 2023; Hamdan et al., 2024)	Communication, physical, and process barriers (Clemente et al., 2022; Gréaux et al., 2023)	All four dimensions	Interprofessional, with nurse-coordinated elements; conceptual proposition
Health equity and quality outcomes	Patient outcomes rarely studied in TL research (Hult et al., 2023)	Persistent health inequities (WHO, 2022)	—	Healthcare-wide; untested
Co-production with people with disabilities	Shared vision and follower participation in TL	Meaningful participation (WHO, 2022, 2024);	Inspirational motivation;	Healthcare-wide; institutional guidance and

Framework component (role)	Leadership-literature basis	Disability-literature basis	Main TL dimension(s)	Scope; status in framework
(cross-cutting principle)	theory (Bass & Riggio, 2006)	training involving people with disabilities (Rotenberg et al., 2022)	intellectual stimulation	single-review support
Contextual moderators	Organizational attributes shape TL (Considine et al., 2024)	Legal, financing, and service-availability conditions (Prayuti et al., 2024; Putra & Lany, 2025; WHO, 2022)	—	Healthcare-wide; proposed moderators

Source: Developed by the Authors (2026). TL = transformational leadership.

Figure 2. Proposed Transformational Leadership for Disability-Inclusive Healthcare (TLDIH) Framework



Source: Developed by the Authors (2026)

Note: Solid arrows indicate associations supported in general (non-disability-specific) healthcare evidence; dashed arrows indicate conceptual propositions not yet tested. N marks the component whose evidence base and enactment are primarily nursing-specific.

4.3 Implementation Strategies

Transformational disability-inclusive leadership could be operationalized through existing healthcare governance and quality systems. The WHO Guide for Action emphasizes preparation, assessment, design, implementation, and monitoring as continuous elements of disability inclusion in health systems (WHO, 2024). At the organizational level, this process can be translated into a leadership accountability cycle. To keep the basis of each strategy visible, strategies are labeled evidence-informed when the reviewed literature or WHO guidance directly supports them, and proposed when they are implementation ideas derived from the framework that have not been evaluated.

First, leaders should establish disability inclusion as a strategic priority, incorporated into strategic planning, quality improvement, patient safety, workforce development, patient-experience measurement, and organizational performance rather than isolated within a separate program (WHO, 2022, 2024) [evidence-informed: institutional guidance]. Second, organizations should assess accessibility across physical, communication, digital, and organizational domains, examining appointment systems, communication support, examination equipment, health information, physical environments, referral pathways, and accommodation processes, because disability-related barriers occur across multiple levels of healthcare delivery (Clemente et al., 2022; Gréaux et al., 2023) [evidence-informed].

Third, healthcare organizations, including nursing departments specifically, should institutionalize disability competency through longitudinal training that combines knowledge with practical learning; interactive approaches and involvement of people with disabilities have been associated with improved knowledge, confidence, competence, and self-efficacy (Rotenberg et al., 2022) [evidence-informed]. Fourth, leaders could establish psychologically safe mechanisms for reporting accessibility barriers, so that staff can identify problems involving communication, equipment, workflows, or accommodations without fear that reporting will be interpreted as personal failure. This strategy extrapolates from evidence on safety culture (Hamdan et al., 2024) and has not been evaluated for disability-related barriers [proposed].

Fifth, organizations should develop clear and confidential accommodation pathways for healthcare professionals, since stigma, uncertainty, and unclear institutional processes may discourage accommodation requests (Meeks et al., 2022; Pereira-Lima et al., 2023), and receipt of accommodations is associated with lower intention to leave (Sheets et al., 2026) [evidence-informed for physicians; proposed for nursing]. Sixth, people with disabilities should be meaningfully involved in service design and quality improvement, extending beyond consultation to participation in priority-setting, training, accessibility assessment, research, and evaluation (WHO, 2022, 2024) [evidence-informed: institutional guidance].

Seventh, organizations could monitor disability inclusion using indicators such as staff disability competency, psychological safety, accommodation satisfaction, resolution of accessibility barriers, and patient-reported communication, respect, participation, and experience [proposed]. These are candidate indicators rather than validated standards; Section 4.6 describes how they could be operationalized. Finally, leaders could use a continuous improvement cycle — assess, prioritize, co-design, implement, measure, learn, adapt, and reassess — adapted from the WHO process (WHO, 2024) and aligned with the transformational emphasis on intellectual stimulation, shared vision, staff participation, and organizational learning [proposed]. Table 3 illustrates how each leadership domain might translate into practice. It is an illustrative matrix, not a validated organizational assessment tool, and every indicator in its final column is proposed.

Table 3. Illustrative Leadership-to-Practice Implementation Matrix

Dimension or component	Mechanism	Staff behavior	Disability-inclusive practice	Proposed indicator (not yet validated)
Idealized influence	Role modeling	Respectful, non-discriminatory behavior	Patient dignity and autonomy	Patient-reported respect
Inspirational motivation	Shared equity vision	Commitment to inclusion	Inclusion in strategic goals	Strategic plan indicator
Intellectual stimulation	Critical reflection	Identifies system barriers	Accessibility-focused improvement	Completed QI projects
Individualized consideration	Staff development	Responds to individual needs	Workforce accommodation	Accommodation satisfaction
Empowerment	Staff participation	Reports and solves barriers	Responsive systems	Staff empowerment score
Psychological safety	Safe communication	Speaks up about barriers	Earlier problem identification	Psychological-safety score
Disability competency	Workforce education	Applies disability-informed care	Accessible communication and care	Competency assessment
Collaboration	Shared responsibility	Coordinates across professions	Integrated care	Teamwork measure
Co-production with people with disabilities	Co-design	Engages people with disabilities	Services informed by lived experience	Participation indicator

Source: Developed by the Authors (2026)

Note: The matrix is illustrative and has not been validated as an organizational assessment tool. Indicators are proposed for future development and testing (Section 4.6).

4.4 Contribution to Nursing Practice, Management, and Health Science

Although the TLDIH Framework draws on literature spanning multiple healthcare professions, it has particular implications for nursing. Nursing constitutes the largest healthcare workforce globally and is frequently positioned at the frontline of disability-related clinical encounters, care coordination, and patient advocacy. The healthcare

leadership evidence synthesized in this review is also drawn disproportionately from nursing populations: Hult et al. (2023), Ystaas et al. (2023), Gebreheat et al. (2023), Alanazi et al. (2023), Hamdan et al. (2024), and Goens and Giannotti (2024) each examined transformational or related leadership within nursing management and nursing care delivery. King (2024), a practice-focused article, is one of the few sources that explicitly connects transformational leadership behaviors with disability-specific nursing care.

For nursing practice, the TLDIH Framework proposes that nurses' disability competency, communication skills, and accommodation practices may be strengthened when nurse leaders enact idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration; this proposition has not yet been tested. For nursing management, the framework positions head nurses, charge nurses, and nurse executives as likely intermediaries who translate organizational disability-inclusion policy into unit-level practice through empowerment, psychological safety, and staff development. This role is consistent with evidence that nurse-manager transformational leadership is associated with patient-care quality and safety practices (Alanazi et al., 2023; Hamdan et al., 2024).

For nursing education, the framework suggests integrating disability competency and inclusive-leadership content into pre-registration and continuing nursing education curricula, consistent with evidence that structured disability training improves health-worker knowledge, confidence, and self-efficacy (Rotenberg et al., 2022). For community health nursing and health services more broadly, the framework highlights nurse-coordinated accessible referral pathways and interprofessional collaboration as practical extensions of the accessible-practice domain.

The framework does not treat “medical staff” and “nurses” as interchangeable. Where evidence specifically concerns physicians (e.g., Nouri et al., 2021; Meeks et al., 2022; Pereira-Lima et al., 2023; Sheets et al., 2026), this review uses “physicians” explicitly; where nursing-specific evidence is available, “nurses” or “nursing” is used; and “healthcare professionals” or “healthcare workforce” is reserved for statements intended to apply across disciplines. This terminological distinction is maintained throughout the manuscript to make the framework's nursing-specific contribution explicit while preserving its applicability beyond nursing.

4.5 Discussion

This article proposes that transformational leadership may function as an upstream organizational enabler of disability-inclusive healthcare. The central argument is not that transformational leadership directly eliminates disability-related health inequities; rather, leadership, and nursing leadership in particular, may influence the organizational conditions that determine whether healthcare workers can consistently provide accessible, respectful, and patient-centered care. This interpretation is consistent with the finding that leadership research has examined workforce outcomes more often than patient outcomes,

which suggests that leadership effects may operate through intermediate organizational and staff mechanisms (Hult et al., 2023).

What the framework adds is a specification of where leadership could act on disability-related barriers. Because many of these barriers are organizational rather than individual (Section 4.1), they cannot be addressed solely by asking individual healthcare professionals to behave differently. They require organizational systems that provide resources, training, accessible processes, and accountability.

Transformational leadership may be particularly relevant because it combines vision with organizational learning. Intellectual stimulation may encourage staff to question why a clinical process disadvantages people with disabilities; inspirational motivation may connect accessibility with the organization's mission; idealized influence may establish inclusive behavior as a professional norm; and individualized consideration may support healthcare workers who require accommodations.

Staff empowerment is the framework's primary mechanism, and it also carries the framework's main risk. A healthcare professional may identify an accessibility barrier but lack the authority or resources to address it. Transformational leadership may increase the likelihood that staff concerns are heard and incorporated into quality-improvement processes. However, empowerment without resources can create an unrealistic expectation that individual employees should solve structural problems.

Disability competency is another potential mechanism. Leadership may strengthen the sustainability of disability training (Rotenberg et al., 2022) by integrating disability competency into continuing professional development, orientation, supervision, and quality improvement. Training alone, however, should not be considered sufficient when organizational systems remain inaccessible.

The workforce inclusion pathway extends the framework beyond patient care. The physician studies reviewed in Section 4.1 suggest that workforce accessibility should be treated as an organizational capability rather than an individual exception. The same principle plausibly applies to nursing workforces, but nursing-specific data on accommodation and retention were not identified, and this remains an important evidence gap.

Positioning co-production as a cross-cutting principle has theoretical consequences. It challenges a purely provider-centered model in which organizational leaders alone define what disability-inclusive care should look like (WHO, 2022, 2024). In the TLDIH Framework, transformational leadership is therefore exercised with, rather than on behalf of, people with disabilities.

A leadership-centered approach nonetheless has important limitations. Disability-related health inequities are influenced by poverty, transportation, education, employment, housing, social exclusion, healthcare financing, national policy, and other determinants beyond organizational leadership (WHO, 2022); a transformational leader cannot independently overcome these structural conditions. There is also a risk of symbolic inclusion, in which an organization establishes a disability committee or

provides awareness training without changing clinical workflows or patient experience. For this reason, the TLDIH Framework emphasizes measurable outcomes and accountability rather than leadership rhetoric alone.

The theoretical contribution of the framework is therefore its integration of leadership, and nursing leadership specifically, with disability inclusion at the organizational level. Instead of asking only whether transformational leadership is effective, the framework asks through which mechanisms leadership may create the conditions for disability-inclusive practice — a mechanism-oriented approach that provides a clearer basis for empirical testing and that, as summarized in Table 1, explicitly separates evidence-supported mechanisms from the framework's central untested hypothesis. Overall, the available evidence supports the plausibility of the TLDIH Framework but does not establish its causal validity; the proposed relationships should be regarded as hypotheses requiring empirical evaluation.

4.6 Operationalizing and Testing the Framework

Each construct in the framework can be operationalized with existing or adaptable measures. Transformational leadership can be measured with established multi-rater instruments such as the Multifactor Leadership Questionnaire, which captures the four transformational dimensions (Bass & Riggio, 2006). Structural empowerment can be measured with the empowerment scales used in nursing research on transformational leadership (Ystaas et al., 2023), and psychological safety with established team-level scales (Edmondson, 1999). Disability competency can be assessed with the knowledge, confidence, and self-efficacy measures used in disability-training evaluations (Rotenberg et al., 2022). Workforce inclusion can be captured through items on accommodation need, request, receipt, and satisfaction, similar to those used in national physician and trainee surveys (Meeks et al., 2022; Sheets et al., 2026). Disability-inclusive care can be assessed through patient-reported communication, respect, participation in decisions, and accessibility among patients with disabilities, together with organizational indicators such as resolved accessibility barriers. Where adequate measures do not yet exist, particularly for disability-inclusive organizational culture, they will need to be developed and validated with people with disabilities as co-researchers.

Relationships should be tested in order of their current support. First, the association between transformational leadership and staff empowerment and psychological safety should be confirmed in units serving high proportions of patients with disabilities, using multilevel designs with staff nested in units. Second, and most importantly, studies should test the framework's central untested link: whether empowerment, psychological safety, and disability competency mediate a relationship between leadership and disability-inclusive staff behaviors, such as reporting and resolving accessibility barriers or providing accommodations. Third, designs linking staff surveys to patient-reported experience among patients with disabilities should test whether unit-level practice is associated with patient outcomes. Fourth, longitudinal and controlled intervention designs, such as a stepped-wedge evaluation of a leadership-

development program co-designed with people with disabilities, should test whether changes in leadership precede changes in workforce and patient outcomes. Across all stages, the contextual moderators shown in Figure 2 should be tested explicitly, for example by comparing settings with different staffing levels, policy environments, or disability populations.

4.7 Limitations

This article has several limitations. First, it is a narrative review. Notwithstanding the structured search and screening procedures reported in Section 3, it searched a limited set of sources (one bibliographic database, the WHO repository, and selected publisher platforms), did not perform duplicate independent screening beyond the title/abstract stage, and did not include formal risk-of-bias assessment or quantitative synthesis; some selection bias therefore cannot be excluded. The levels of support in Table 1 are descriptive and should not be read as certainty-of-evidence grades. Second, the available transformational leadership evidence is heterogeneous and disproportionately concentrated in nursing populations, which strengthens the framework's nursing relevance but limits generalizability to other professions. Third, direct research linking transformational leadership specifically to disability-inclusive healthcare remains limited to a single practice-focused source (King, 2024) in the evidence reviewed for this article.

Fourth, disability is heterogeneous, and barriers differ across physical, sensory, intellectual, developmental, psychosocial, and multiple disabilities; a single framework cannot capture all disability-specific requirements. Fifth, much of the evidence concerning leadership is observational, limiting causal inference. Sixth, the proposed indicators within the framework have not yet been validated as a unified measurement system. Seventh, all workforce-inclusion evidence concerned physicians and medical trainees, so the parallel pathway's application to nursing is untested. These limitations do not invalidate the framework but define its appropriate status as a hypothesis-generating model requiring validation through longitudinal, mixed-methods, and intervention research.

5. Conclusion and Suggestions

Disability-inclusive healthcare requires transformation at the level of clinical encounters, healthcare organizations, and health systems. People with disabilities continue to encounter barriers related to communication, accessibility, provider attitudes, workforce competency, and health-system organization (Clemente et al., 2022; Gréaux et al., 2023; WHO, 2022). At the same time, transformational leadership, particularly in nursing, is associated with important workforce and organizational outcomes in healthcare (Hult et al., 2023; Ystaas et al., 2023; Alanazi et al., 2023). This article proposes the Transformational Leadership for Disability-Inclusive Healthcare Framework as a conceptual bridge between these fields. Its central hypothesis is that leadership contributes to disability-inclusive care mainly by empowering a disability-

competent workforce within an inclusive culture, with co-production with people with disabilities as a cross-cutting principle, workforce inclusion as a parallel pathway, and contextual conditions as moderators. This hypothesis has not yet been tested. Transformational leadership should not be regarded as a substitute for legislation, financing, accessible infrastructure, workforce resources, or broader social policy. Its potential contribution lies in strengthening organizational, and specifically nursing-management, capacity to translate inclusion from policy intention into routine practice. In the Indonesian setting, this distinction is important because disability-inclusive healthcare also depends on legal protections and on addressing documented rehabilitation-access barriers (Prayuti et al., 2024; Putra & Lany, 2025).

Nursing practice and management: Integrate disability-competency expectations and accommodation-reporting pathways into unit-level nursing supervision, performance review, and quality-improvement structures, led by nurse managers exercising transformational leadership behaviors. Nursing and health-professions education: Embed disability competency and inclusive-leadership content into pre-registration and continuing nursing education curricula, drawing on evidence that structured training improves knowledge, confidence, and self-efficacy (Rotenberg et al., 2022). Health services: Establish accessible, nurse-coordinated referral and communication pathways, and formally involve people with disabilities in service design and quality-improvement processes. Policy and governance: Embed disability inclusion into routine organizational governance, accountability, and performance indicators rather than treating it as a standalone program, consistent with WHO guidance (WHO, 2022, 2024). Future research: Test the framework in the sequence set out in Section 4.6, beginning with the leadership-empowerment link in settings serving people with disabilities and then the framework's central untested link between empowerment and disability-inclusive staff behavior. Studies should prioritize multidisciplinary and nursing-inclusive samples, involve people with disabilities as research partners, and include both patient-reported outcomes and health-management outcomes, enabling health-system and nursing leaders to evaluate disability inclusion as both an equity obligation and an organizational-performance priority.

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