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Realising the Business Case for Diversity: A Realist Perspective on the British National Health Service

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This article takes a novel approach to exploring the business case for diversity (BCD) as it has been adopted in the British National Health Service (NHS), principally in terms of 'race' and ethnicity for the sake of clarity and manageability. It draws on realist perspectives that consider issues of context, mechanism and outcome. It concludes that transferring policies from other countries and sectors is problematic, and consequently that the application of the BCD to the NHS must be treated with extreme caution.

Keywords: Diversity, business case for diversity (BCD), equal opportunity and diversity (EOD), National Health Service, realistic evaluation.

Introduction

This article provides a realist perspective on the relevance of the 'Business Case for Diversity' (BCD) (Cox and Blake, 1991; Schneider and Ross, 1992) to the British National Health Service (NHS). We broadly discuss the BCD in relation to race, not least because the BCD was originally developed here. The BCD has been broadly promoted in the UK for some time by a number of organisations inside and outside government (for example, Rutherford and Ollerearnshaw, 2002; DTI, 2003; NAO, 2004; Jones, 2006; Cabinet Office, 2008; Chartered Institute for Personnel Development (CIPD), 2005; Equality and Human Rights Commission (EHRC)/Trades Union Congress (TUC)/Confederation of British Industry (CBI), 2008), and also in the NHS (Esmail *et al.*, 2005; NHS Employers, 2009).

While the BCD underpins many recent proposals and initiatives (for example, Shah, 2009; Davies, 2011), it has been little discussed in social policy. Bagilhole (2009) contrasts the moral, economic or business and social cohesion cases, and presents a chronology of five eras of equal opportunity and diversity (EOD) (but see Powell *et al.*, 2013). She writes that the business or economic case argues that EOD brings greater efficiency and economic growth to organisations and society in general. She views the 2000s as the 'fairness tempered with economic efficiency era'.

However, we argue that there are major problems with the BCD. First, it may not be as strong as some of its supporters suggest (for example, Schneider and Ross, 1992; Robinson and Dechant, 1997; Kandola and Fullerton, 1998; Centre for Strategy and Evaluation Services (CSES), 2003). This article does not, however, examine in any detail the empirical evidence for the BCD (see Milliken and Martins, 1996; Ryan *et al.*, 2002; Anderson and Metcalf, 2003; Kochan *et al.*, 2003; Dreachslin *et al.*, 2004; Awbrey, 2007; Curtis and Dreachslin, 2008; Shore *et al.*, 2009; Pitts, 2009; Bleijenbergh *et al.*, 2010; Heres

and Benschop, 2010; Haas, 2010). Instead, we focus on the contingent nature of the BCD (Kochan *et al*., 2003). Even if the empirical evidence for the BCD stands in one context, it does not necessarily follow that these findings are transferable to other contexts (cf. Ram *et al*., 2007). We argue that the BCD has been stretched far beyond its original setting to cover a range of very diverse contexts. For example, the original claim was that increasing the ethnic workforce in for-profit companies in the USA would increase profits (for example, Cox and Blake, 1991). However, translating empirical evidence on the BCD from for-profit business in the USA to a public service such as the NHS in Britain is problematic. Moreover, it has been stretched to cover issues as diverse as parliamentary representation, board membership, workforce diversity and leadership diversity. Mechanisms may be rather different for workforce diversity compared to leadership or 'top team' or boardroom diversity. Similarly, outcomes may be rather different for parliamentary representation (for example, more inclusive and better legislation) as compared with workforce diversity (such as, higher sales or share value). Finally, the BCD as applied to (say) 'race' and ethnicity may operate rather differently when applied to gender or disability.

Pawson and Tilley (1997) provide basic guidance about Programme Theory and CMO configurations. Theories must be framed in terms of propositions about how mechanisms (M) are fired in contexts (C) to produce outcomes (O): what might work for whom in what circumstances. In other words, the relationship between causal mechanisms and their effects is contingent rather than fixed. This article reports on a conceptually driven evidential review and it employs the CMO framework as a theoretical device to explore the relevance of the BCD for the British NHS. First it examines the BCD in general terms, and then turns to diversity in the NHS. It then moves to consider issues of context, mechanism and outcomes related to the BCD by interlacing the general case with specific illustrations drawn from the NHS. While the conclusions support those produced in much of the available literature, the use of realistic evaluation as conceptual frame allows the separate elements of the limitations of the BCD in this setting to be clearly identified for the first time.

The business case for diversity

During the late 1980s, diversity rhetoric in the USA shifted to a business case for supporting workforce diversity (Dickens, 1999; Riley *et al*., 2008; Herring, 2009; Pitts, 2009). The BCD has developed more slowly in Europe, but is gaining ground (Jones, 2006). Cox and Blake (1991) argue that diversity can result in competitive advantage via six routes:

- resource acquisition: companies develop reputations as diversity employers;
- marketing: a diverse workforce understands diverse market segments;
- system-flexibility: tolerance for different cultural viewpoints leads to greater openness to new ideas;
- creativity: organisations with diverse perspectives are more creative;
- problem-solving: diversity promotes better decision-making;
- cost reduction: such reductions include lower staff turnover, reduced absenteeism and increased productivity.

Subsequent commentators give broadly similar sets of explanations, but sometimes in differing numbers, contexts and emphases (see Robinson and Dechant, 2007; Catalyst, 2004). The important point is that diversity is not about doing what is right, but rather achieving organisational results. It accepts that 'social justice' is insufficient, and that

equal opportunities and diversity (EOD) initiatives have to appeal to self-interest. As Dickens (1999) maintains, BCD arguments are inevitably contingent, variable, selective and partial. Perriton (2009) argues that it works to frame, restrict and depoliticise the discussion of gender in the workplace, and downplays issues of discrimination (see also Wrench, 2005; Bagilhole, 2009).

Diversity in the NHS

Diversity in employment has been on governmental agendas since the passage of the Disabled Persons (Employment) Act in 1944, but the New Labour government took the biggest active step towards employment diversity, with impetus from the Macpherson Report (Macpherson, 1999). The Race Relations Amendment Act 2000 was supplemented by positive action for key government departments. While some organisations were seen to be inadequately diverse, the NHS was regarded as a public sector exemplar (Straw, 1999).

There has been a long history of diversity initiatives in the NHS (Law, 1996; Oikelome, 2007; Crisp, 2010; Bach and Kessler, 2012). According to the NHS Institute for Innovation and Improvement (NHS III) (2009), since the Race Relations (Amendment) Act 2000 there has been a plethora of NHS initiatives designed to promote workforce and managerial diversity. In 2000, *The Vital Connection* was published, outlining governmental expectations of the NHS in terms of equal opportunities, and was operational until 2010 (NHSE, 2000). This was supported by a framework strategy, and backed by national development programmes such as *Positively Diverse* (DoH, 2000a) and the *Improving Working Lives Standard* (DoH, 2000b). In 2004, a ten-point Race Equality Plan was implemented and an Equality and Human Rights Director was appointed. Diversity initiatives have also been established under the 'Breaking Through' programme, the National Leadership Council, the Equality and Diversity Council, NHS Operating Statements, the NHS Constitution and the Equality Delivery System. The NHS also features in wider initiatives aimed at diversifying the level of public boards across government (GEO, 2009) and is subject to the Equality Act 2010, which has very significant implications. However, while there has been a long history of gender and black and minority ethnic (BME) diversity in the NHS (Kalra *et al.*, 2009), this 'proportional' version of diversity, where workforces are broadly representative, was never matched by 'structural' diversity at senior levels (Esmail *et al.*, 2005; Johns, 2006; NHS III, 2009; Crisp, 2010). As Trevor Phillips stated in *The Guardian* in 2004:

> People from [BME] communities make up 35 per cent of its doctors and dentists, 16.4 per cent of the nurses and 11.2 per cent of non-medical staff. However at the top of each NHS organisation, the boss is almost always White. There are more than 600 NHS trusts, health boards, local health boards and health and social services boards in England, Scotland, Wales and Northern Ireland, and fewer than 1 per cent of them have a Black or minority ethnic chief executive. The contrast between snow-capped summit and the mountain base could hardly be more stark. (Carvel, 2003)

CMO perspectives in the BCD

Milliken and Martins (1996) write that research on diversity is challenging because it spans disciplinary boundaries, assesses the effects of various types of diversity, focuses on many

different dependent variables and employs a wide range of groups and settings. In short, the diversity literature is diverse. Realist perspectives stress that even if strong evidence exists to support BCD in different contexts, it does not follow that it 'works' for the NHS. In this section, we explore a number of issues concerned with context, mechanisms and outcomes.

Context

There are two main contextual issues. First, most of the literature is based on for-profit businesses, with few studies focusing on the public sector and health care. Little published research has considered the link between diversity management processes and public sector performance (Naff and Kellough, 2003). Pitts (2009) claims that a handful of studies have addressed the diversity–performance link in public agencies. Most 'case studies' and 'top tips' are taken from the private sector (Cabinet Office, 2008; NHS III, 2009). According to Weech-Maldono *et al*. (2002), research on diversity management practices in healthcare organisations is scarce, numbering three studies.

In 1995, the Commission for Racial Equality (CRE) shaped the BCD to the requirements of the public sector via the 'quality case' (CRE, 1995). Its core was that where business is about profit in a competitive marketplace, this does not reflect the public service ethos. The motivating agenda for the quality case was the quality of provision to a diverse population, in effect serving diversity *requires* diversity. A related development for local government is the concept of 'representative bureaucracy'. It is much wider, taking into account other identity dimensions than 'race' and ethnicity and using democratic rights as its principal justification (Andrews *et al*., 2005). It is assumed that 'passive representation' (mirroring the service area demography) will lead to active representation, i.e. that people will actively represent 'their' communities. This may have underpinned New Labour's adoption of all-women short-lists in 1997 (the practice of fielding female candidates in safe parliamentary seats). However, this is a notion that has been questioned (Cashmore, 2002; Johns, 2006).

A further contextual factor is that most studies are from the USA. There are few studies in Europe (CSES, 2003) and the UK (Rutherford and Ollerearnshaw, 2002; Riley *et al*., 2008). It is difficult to transfer findings based on the different ethnic population structures of the USA and Britain, and their different historical constructions (Ram *et al*., 2007). Census data are obviously flawed, carrying combinations of 'racial', ethnic and national origin categories; nevertheless, they are the best sources available. According to the 2010 census conducted in the USA, the population included 79.6 per cent classed as 'White', with 12.9 per cent 'Black', 4.8 per cent 'Asian', 'Native Hawaiian' and 'Pacific Islanders', 1.0 per cent 'American Indian' and 'Alaskan Native' and finally 1.7 per cent reported as two or more 'races' (July 2009, US Census Bureau). By contrast, the UK in 2001 was constructed in the following way: 92.1 per cent 'White', 3.5 per cent 'Asian', 2.0 per cent 'Black', 1.2 per cent 'Chinese and Other' and 1.2 per cent 'Mixed' (see Craig *et al*., 2012 for more details). A smaller BME population, differently constructed and with different historical relationships mean a quite distinct context, which suggests transferring policy initiatives is risky.

In addition, the legislative history and policy development is very different when we compare the UK with the USA. Affirmative Action (AA) which was initiated during the 1940s was arguably much more radical than the legislative responses to equal

opportunities in the UK, although the AA apparatus has been eroded since the 1980s (Cohen and Sterba, 2003).

By contrast, the UK has followed a path guided by formal equality of opportunity underlined by equal treatment; positive action was available from the 1970s but remained virtually latent (Bagilhole, 2009; Craig *et al.*, 2012). While Saunders (2011) has argued that positive discrimination is common in the UK, the reality is that until the Disability Discrimination Act 1995 it was illegal to treat people differently except via positive action (outreach recruitment, goals and targets, and targeted training programmes). In the wake of the Macpherson Report (Macpherson, 1999), there was an intensification of positive action efforts and the Equality Act 2010 promoting identity as a tie-break criterion is taking the UK along a more radical path. It is clear that there are important contextual differences in population structures and very different legal and policy traditions that may hamper policy transfer between the US and the UK.

Mechanisms

Much of the BCD literature is unclear on mechanisms, and so specifying clear CMO configurations is problematic. The first issue is the extent to which routes to competitive advantage (Cox, 1991; Cox and Blake, 1991) developed in the context of for-profit business, apply to public service. Robinson and Dechant (1997) report a survey in which human resource executives from fifteen Fortune 100 companies were asked to identify the primary business reasons for diversity management. The top five reasons were: better utilisation of talent (93 per cent); increased marketplace understanding (80 per cent); enhanced breadth of understanding in leadership positions (60 per cent); enhanced creativity (53 per cent); and enhanced team problem-solving (40 per cent).

The BCD has increasingly been embraced in the NHS (Esmail *et al.*, 2005; Crisp, 2010). It is strongly supported by NHS Employers (2009) who suggest that the evidence for the BCD and its NHS relevance continues to grow. According to NHS Employers (2009), diversity enhances:

- an organisation's reputation – this attracts talent from all communities, helping to meet service delivery needs;
- staff recruitment and retention – valuing diversity enables employers to recruit and retain the best people;
- productivity – staff perform better in diversity organisations that are committed to employees' well-being; and
- mitigating organisational risks – effective diversity management limits the risk of legal challenges.

The benefits of a more diverse leadership have been identified as improving morale and productivity, exploiting latent creativity and also generating trust within service populations (Kalra *et al.*, 2009). According to the NHS III (2009), interviews with Primary Care Trust (PCT) staff and workshops identified a variety of potential benefits of applying the BCD to the NHS. These benefits focused on financial gains (including reduced litigation), improved performance (better quality of provision) and a potential reduction in health inequalities.

> If you speak to the finance director, emphasise the pure business case. If it is the public health representative then emphasise the impact on health inequalities. If you are speaking to frontline staff delivering the service, then emphasise making a difference to the way care is delivered; there is a business case for workforce diversity, but it is sold to different people in different ways. (Interview reported in NHS III, 2009: 21)

NHS Employers (2009) refer to a case study by University College London that claimed an NHS employer with 3,000 staff and a turnover of £150 million, treating 500,000 patients a year would save £3.8 million annually using policies informed by the BCD.

There are no obvious reasons why 'labour' factors (supply, talent, recruitment and retention, morale) should be irrelevant for the BCD in public services. However, the marketing argument – that a diverse workforce understands diverse market segments – may be more problematic. Companies with more BME employees that increase sales to BME customers will maximise revenue. The same might be true for an NHS Trust with more BME employees that treated more BME patients. Yet a commissioner (PCT or CCG) with more BME employees that tapped unmet needs in BME communities would increase its costs (at least in the short term NHS horizon). This would meet the NHS's equal access mission, but it also indicates that the simplistic transfer of the BCD is problematic for a public service.

The second issue involves the contested conceptualisation of diversity (Butt, 2006; Bagilhole, 2009; Herring, 2009; Craig *et al.*, 2012). Dandeker and Mason (2001) point out that the concept of representativeness conceals four distinct ideas: the statistical, the delegative, the symbolic and the value. 'Diversity' is often used to mean different things (Dudau and McAllister, 2010), for example cultural diversity, linguistic diversity, ethnic diversity and gender diversity. It is also often used interchangeably with 'race equality' (Butt, 2006). According to the CSES (2003), a 'diverse workplace' is difficult to define. There is no accepted way of distinguishing between diverse and non-diverse workplaces; similarly, the CIPD (2005) states that the definition of diversity is almost as diverse as the subject itself, making the interpretation of findings highly judgemental.

Broadly, there is a difference between identity and cognitive diversity (Page, 2007). Diversity is usually defined as a 'variation of social and cultural identities among people existing together in a defined employment or market setting' (Cox, 1991) and separated into observable and non-observable characteristics (Milliken and Martins, 1996). The former includes characteristics such as gender, 'race', ethnicity and age. Non-observable characteristics include cultural, personality traits, cognitive, functional and technical differences. Thus, the concept of diversity in the workplace is increasingly represented as 'the varied perspectives and approaches to work that members of different identity groups bring' (Thomas and Ely, 1996).

Working on a joint project, the EHRC/TUC/CBI (2008) carried out forty-five in-depth interviews with employers, and found that the majority defined diversity in terms of workforce headcounts. Conversely, a minority said it did not matter how many BMEs or women they employ, rather it is the way people are treated and that procedures are non-discriminatory that are important – one employer conceded: 'Just because the numbers are right it doesn't mean the culture is sorted.'

This leads to problems in the relationships between identity and cognitive diversity, and in examining dimensions in isolation. For example, would an all-female white

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workforce be 'diverse'? If workforce diversity is examined in terms of the wider population benchmark, can a 'minority' group be 'over-represented' or a workforce 'too diverse'?

Third, many national and regional documents (for example, DoH, 2009) are unclear about whether the benchmark for diverse leadership is the local population or the workforce. To use the example of gender, benchmarks would be different if they are based on population (about 50 per cent female) or NHS workforce (about 70 per cent female). A further problem concerns the benchmark of national or local population. Government benchmarks for public boards reflect uniform national figures (GEO, 2009), but most NHS documents use local figures. Gauss and Jessamy (2007) argue that the best means of justifying diversity is to link it to local demography; employers should aim to reflect the local service population (what Johns (2006) referred to as local proportional diversity). However, they go on to say that if a local area is not diverse, for instance is essentially 'White', then there remains a moral duty to achieve workforce diversity. Yet, if it is about morality, the BCD becomes unnecessary.

Fourth, it is not clear whether the key mechanisms relate to workforce or leadership diversity. It appears unlikely that a diverse workforce alone delivers organisational benefits; otherwise, the NHS would already be reaping them. If leadership diversity is the key, it is not clear if diversity is more important in the executive and non-executive directors on boards or senior managers in general. According to Roberson and Park (2007), both researchers and practitioners have also assumed that leadership diversity equals financial success. They suggest that diversity in senior management helps to align business strategies with demographic and market trends to achieve organisational growth. According to upper echelons theory, a firm's leaders significantly determine performance given their organisational power (Finkelstein and Hambrick, 1996). However, they state that little attention has been given to the performance effects of 'racial' diversity in top management teams. In short, it is not clear if different or similar mechanisms underscore the competitive advantage of a diverse workforce and a diverse leadership.

Even if the broad BCD is accepted, we do not know what works or why (cf. Pawson and Tilley, 1997). We require clearer 'programme theory' about specific interventions that work to deliver specified outcomes in particular contexts. Kalev *et al*. (2006) write that lists of diversity management 'best practices' have proliferated recently, but that these are best guesses. We know a lot about the disease of workplace inequality, but not much about the cure. Similarly, Curtis and Dreachslin (2008) argue that the literature on diversity interventions is too limited to provide significant human resources guidance. Although advocates of diversity management contend that interventions work and cite best practices, empirical support is lacking.

There are only a few high-quality academic studies that predominantly focus on the USA. Kalev *et al*. (2006) examined the effects of seven common diversity programmes: AA plans, diversity committees and taskforces, diversity managers, diversity training, diversity evaluations for managers, networking programmes and mentoring programmes on the representation of 'White' men, 'White' women, 'Black' women and 'Black' men in private sector management. They claim that diversity committees and diversity staff have been quite effective. On the other hand, diversity training was not very effective and showed adverse effects among non-contractors. Kalev (2009) provides strong support for the argument that restructuring work to weaken job segregation improves the access of women and minorities to management. Both self-directed work teams and cross-training programmes have significant positive effects on the odds that managers are

'White' women, 'Black' women and 'Black' men, and a negative effect on 'White' men's odds of being in management. In contrast, programmes that do not expand workers' opportunities to transcend job boundaries, problem-solving teams and job training do not have these effects. The results also indicate that 'racial' barriers are more resistant to change than gender barriers. However, there are few comparable studies in the UK. Moreover, programmes tend to be used in combination rather than in isolation, and there are debates surrounding the differences and different level of effectiveness between EOD and 'Managing Diversity' approaches (for example, Liff, 1996; Kirton and Greene, 2007; Bagilhole, 2009; Ashley, 2010).

Outcomes

There are two major problems relating to outcomes. First, it is not clear whether outcomes refer to (process, intermediate) outcomes relating to the workforce or final outcomes relating to the population. The BCD refers to the 'bottom line' of organisational performance, which suggests that relevant outcomes should be seen in terms of greater efficiency, or effectiveness in terms of increasing population health or reducing health inequalities. According to the NHS III (2009), diversity of senior management should be seen as a means to an end, rather than an end in itself: unless such links between diverse senior management and successful health organisations are made, it will be difficult for the barriers described to be overcome. However, some commentators point to the outcome of greater leadership diversity, which can be seen as a means to an end rather than an end in itself.

Second, unlike the research on the effects of diversity on individual and group-level performance, where there are a large number of studies, there are relatively few studies assessing the relationship to the performance of the organisation (Jayne and Dipboye, 2004). Similarly, according to Kochan *et al.* (2003), there is little research conducted in actual organisations that addresses the impact of diversity or diversity management practices on financial success. While there are several laboratory experiments that test specific diversity–performance hypotheses, there are few real world studies and fewer still that use objective performance measures.

A number of studies have explored the relationship between leadership diversity and organisational performance (for example, Catalyst, 2004; Krishnan and Parsons, 2008). Richard *et al.* (2004) suggest that, rather than a simple linear relationship, management of diversity and firm performance may have a curvilinear relationship moderated by elements of strategic stance. Roberson and Park (2007) claim that previous research that has examined the relationship between top management team diversity and organisational performance has found equivocal results; they used longitudinal data for 100 US firms to test hypotheses related to the effects of diversity reputation and leader 'racial' diversity on financial outcomes. The results showed a positive relationship between diversity reputation and book-to-market equity, and a curvilinear, *U*-shaped relationship among leader diversity and revenues, net income and book-to-market equity, with the low point at about 22 per cent. In short, firm performance declines with increases in the representation of 'racial' minorities in leadership up to a point beyond which further increases in diversity are associated with increases in performance.

In the UK, Esmail *et al.* (2005) claim that in order to improve the quality of services to BME patients the NHS needs to embrace diversity as a central facet of its business

plans. However, this is a very narrow claim – that leadership diversity would *only* benefit BME patients. They claim that there are three dimensions for an NHS BCD: improved patient care, improved performance and demographic imperatives, and that one of the strongest reasons to adopt a diversity approach is to reduce ethnic health inequalities. Yet no evidence is presented for this claim. Moreover, it is too vague: much of the BCD focuses on the workforce, and arguably the currently diverse NHS workforce has not fully delivered this objective.

Discussion

Cox and Blake (1991) argued that the logic of 'valuing diversity' is rarely made explicit. Richard and Johnson (2001) term it a 'theoretical abyss' (but see Curtis and Dreachslin, 2008). Pitts (2006) points to the atheoretical nature of diversity research. Very few scholars have attempted to establish theoretical frameworks for diversity in public sector organisations (Thomas and Ely, 1996). In addition, much of the work on diversity stems from a normative view that any diversity leads to positive consequences, and the 'diversity-as-panacea' view has crept into the scholarly literature. With few exceptions (Wise and Tschirhart, 2000), research has not attempted to assess the real value of diversity.

Esmail *et al.* (2005) argue that the diversity approach is organisationally universal, but most of the literature claims that diversity is contextual, which suggests that a simplistic policy transfer is untenable. Many commentators argue that organisational context is crucial (Richard, 2000; Richard *et al.*, 2004; Andrews *et al.*, 2005; Awbrey, 2007). This has a number of implications. Shore *et al.* (2009) state that research on different dimensions of diversity has mostly evolved independently. We do not know if conclusions for one dimension (for example, gender) can be applied to others (such as disability), or how the dimensions interact (for example, BME women) (cf. Pitts, 2009). Most research examines diversity at the workforce level, and less at the leadership level. It is not clear whether conceptual arguments or empirical conclusions can be applied to the different levels. Most work has been carried out in the USA, and the relevance for the UK is unclear. Most work has been on business, with few studies on public services and health care. This suggests that the work on representative bureaucracy might form a more solid theoretical foundation than the BCD, and that more stress should be placed on studies in public services and health care. In short, context truly matters (Haas, 2010; Bleijenbergh *et al.*, 2010). As Riley *et al.* (2008) put it**,** whether diversity results in net benefits or costs will vary by organisational context.

Conclusions

Our main conclusion is that, in addition to being complex and elusive (cf. Shapiro and Allison, 2007), the relationship between diversity and the 'bottom line' is contextually contingent, which means that a simplistic policy transfer from US evidence on the for-profit sector to UK public services, which is often – at least implicitly by ignoring contextual issues – asserted, is unwise.

In short, we argue that more consideration is required on the 'context–mechanism–outcome configurations' or 'programme theory' (Pawson and Tilley, 1997) associated with the BCD. Put another way, we argue that it is necessary to develop contingent 'best fit'

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practices *(if* and *where* the BCD works) rather than *assume* a universal 'best practice' approach to 'what works'. This fits with the concerns of some commentators on the BCD (such as, Ryan *et al.*, 2002; Bleijenbergh *et al.*, 2010; Heres and Benshop, 2010; Johns *et al.*, 2013). Noon (2007: 781) puts it nicely when he says: 'the argument for the moral case based on the human rights of all employees and job seekers must not be abandoned for the current fashion of diversity and the business case'. This is certainly true for the NHS, where Esmail *et al.* (2005) underline that the BCD alone will not be enough to drive forward diversity as an outcome. We suggest a research agenda that draws on realistic perspectives in order to critically explore how policy makers develop (implicit) programme theory in policy and practice documents that seeks to examine how the mechanisms of the BCD are linked with particular outcomes on particular circumstances.

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