Review Article

Diversity and performance in health care: A systematic review of the evidence base

Davide Trinchese[a], Manuela Furlan[b], Milena Vainieri[c], Gianluca Veronesi[d]

Background: Diversity in the health care sector has been put forward as a key factor for improving organizational performance; however, the evidence based on this assumed positive impact is still fragmented.
Purpose: Adopting a narrative and critical approach, this systematic review investigated the relationship between surface and deep-level diversity and performance in the health care sector. Performance is categorized into two main dimensions: relational performance, arising from interactions between groups of individuals within organizations, and organizational performance, which refers to outcomes related to the overall organizational activity.
Methodology/Approach: This systematic review focused on scientific papers published in English in international peer-reviewed journals, retrieved from the ISI Web of Science citation and search database. In addition, citation snowballing was employed to identify further relevant studies. A total of 58 papers were identified as meeting the research criteria.
Findings: The analysis of the 58 selected studies indicates that at the organizational level, diversity has a generally positive effect on performance. At the team level, however, diversity is frequently linked with mixed or negative relational performance outcomes. Undesired consequences of diversity specifically relate to the emergence of homogeneous subgroups, so-called faultlines, in groups of individuals, ultimately leading to a negative impact on relational and organizational performance. At the board level, where the extant literature has mainly focused on gender diversity, increasing female representation appears to yield positive effects, except when it is already comparatively high.
Practice Implications: Policymakers and practitioners should recognize both the benefits and challenges of diversity in health care. While diversity is essential in such a complex sector, it may produce unintended negative consequences, particularly when diversity is at high levels or faultlines emerge. This highlights the importance of effective management strategies and human resource policies to optimize its impact.

Key words: diversity, health care, performance, workforce

Background

In recent years, policymakers, scholars, and practitioners have increasingly emphasized the importance of workforce diversity in public administration as a strategic performance asset (Ding & Riccucci, 2023; Gomez & Bernet, 2019). At the policy level, both the European Commission and the United Nations have introduced measures aimed at reducing the diversity gap through the implementation of diversity, equity, and inclusion (DEI) initiatives like the Horizon Europe Guidance and the Sustainable Development Goals. From a scholarly perspective, some studies in the health care field have shown that diversity can positively influence organizational performance by introducing a wider range of perspectives, experiences, and problem-solving approaches, which foster creativity and innovation (Gomez & Bernet, 2019; Schmidt et al., 2023). However, despite its assumed benefits, the extant literature has also highlighted the potential drawbacks associated with diversity, including increased communication barriers, cultural misunderstandings, heightened interpersonal conflicts, and the risk of team fragmentation (Hillman et al., 2009; Leslie, 2019; Van Knippenberg & Schippers, 2007; Von Bergen et al., 2002). This ambivalence has contributed to a growing characterization of diversity as a "double-edged sword," a concept emphasizing its dual capacity to generate both positive and negative outcomes depending on organizational and contextual factors (Horwitz & Horwitz, 2007). The salience of this debate is particularly apparent in the health care sector, where diversity is seen as essential to addressing the needs of increasingly heterogeneous patient populations, ensuring high-quality, safe care, and

[a]Davide Trinchese, PhD, Scuola Superiore Sant'Anna di Pisa. E-mail address: davide.trinchese@santannapisa.it.
[b]Manuela Furlan, PhD, Scuola Superiore Sant'Anna di Pisa.
[c]Milena Vainieri is Full professor, Scuola Superiore Sant'Anna di Pisa.
[d]Gianluca Veronesi is Full Professor, University of Bristol; and University of Verona.

The authors have disclosed that they have no significant relationship with, or financial interest in, any commercial companies pertaining to this article.
Supplemental Digital Content is available for this article. Direct URL citations are provided in the HTML and PDF versions of this article on the journal's website, www.hcmrjournal.com.
Health Care Management Review (2026) 00:e00
http://dx.doi.org/10.1097/HMR.0000000000000478

promoting equitable access to service provision (Placide et al., 2023; Stanford, 2020).

The health care sector represents a particularly interesting field for investigating the relationship between diversity and performance. First, health care organizations are characterized by intrinsic complexity: they rely heavily on interprofessional collaboration, a multiplicity of highly specialized and differentiated roles, and operate under constant time and resource pressures with potential direct consequences for patient outcomes (McLaney et al., 2022; Rawlinson et al., 2021). In such a context, workforce diversity has become increasingly critical for addressing staff shortages and demographic shifts, especially in the aftermath of COVID-19, as professional diversity facilitates knowledge exchange and supports task shifting (Goode & Landefeld, 2018). Conversely, diversity may also undermine coordination, slow down decision-making, and increase the risk of miscommunication and misunderstanding (Dreachslin et al., 2000; Rawlinson et al., 2021).

Second, health care provides a particularly fertile context for examining diversity across multiple organizational levels. At the organizational level, workforce diversity is especially significant because day-to-day interactions with patients occur here, where demographic, cultural, and professional differences among staff directly influence the quality of care. A diverse workforce brings a wider range of skills, knowledge, and perspectives, which enhances problem-solving and, ultimately, improves organizational performance (El Chaarani & Raimi, 2022; Naciti et al., 2022; Trinchese et al., 2024). At the team level, diversity shapes the effectiveness of daily communications among members, influences the integration of different types of professional knowledge, and affects the coordination of roles and responsibilities in practice. These dynamics, in turn, impact the degree of trust and mutual respect that either enables or constrains collaboration (Mitchell et al., 2011). At the board level, diversity is not only a matter of ensuring adequate representation of the workforce but also serves as a strategic lever. Diverse boards contribute a broad range of perspectives that can influence organizational priorities, shape governance processes, and prioritize the allocation of resources in ways that affect both employees and overall organizational performance (Blanco-Oliver et al., 2018; Romano et al., 2024).

Third, health care organizations offer a distinctive context for studying the potential adverse consequences of diversity, such as the emergence of faultlines. These are defined as hypothetical dividing lines that split teams into internally homogeneous but mutually distant subgroups, increasing the risk of fragmentation, conflicts, and reduced cohesion (Lau & Murnighan, 1998). This issue is particularly salient in health care because effective service delivery relies heavily on collaborative, interprofessional teamwork, requiring close coordination among professionals to ensure high-quality and safe care (Nawaz et al., 2022).

Hence, despite the growing adoption of DEI initiatives in health care globally, the relationship between diversity and performance remains underexplored, lacking both a comprehensive analytical framework and a robust evidence base. This review aligns with broader theoretical developments that conceptualize diversity as multidimensional and context-dependent (Harrison & Klein, 2007) and responds to recent calls for advancing diversity theory to better capture complexity and organizational dynamics (Nkomo et al., 2019). By engaging with these perspectives and applying them to health care delivery organizations, this study seeks to bridge conceptual advances in organizational research with the practical challenges of managing diverse workforces in high-stakes service environments.

Theory

In the literature, diversity has been theorized across multiple academic disciplines and research streams, each emphasizing distinct mechanisms and outcomes linked with a more heterogeneous workforce. Following Harrison et al. (1998), we distinguish between surface-level diversity and deep-level diversity. Surface-level diversity refers to observable characteristics such as gender, age, and ethnicity, whereas deep-level diversity encompasses nonobservable attributes such as values, beliefs, attitudes, and personality that typically emerge through interaction. In line with the classification of Martins and Sohn (2022) as well as Jansen and Searle (2021) and according to the dichotomization of team diversity from Horwitz and Horwitz (2007), we categorize tasks related to diversity as a deep-level characteristic depending on cognitive orientations, individuals' beliefs, expertise, and experience. In general terms, diversity theory assumes organizational benefits such as increased creativity, innovation, and problem-solving stemming from the combination of different perspectives, backgrounds, and experiences (Gomez & Bernet, 2019).

From economic and strategic management perspectives, most theories adopt a general positive view of diversity, highlighting its role as a valuable organizational asset. For instance, resource dependence theory posits that a heterogeneous workforce enables organizations to attract employees with higher levels of human and social capital. This reinforces connections with the external environment, facilitates access to information and resources, and improves adaptability and contextual fit (Pfeffer & Salancik, 2015). Similarly, signaling theory sees diversity as a signal of openness to multiple perspectives, capable of reducing information asymmetry and enhancing organizational legitimacy and reputation (Spence, 1978, 2002).

By contrast, research in social psychology and organizational behavior has especially emphasized the potential risks associated with diversity. In this sense, social identity theory and self-categorization theory explain how individuals classify themselves and others into social groups, generating in-group favoritism, stereotyping, and intergroup bias that can fragment collaboration and reduce performance (Tajfel et al., 1979). Aligned to this, the similarity-attraction perspective reinforces these dynamics by suggesting that individuals prefer to collaborate with those perceived as similar, thereby intensifying interpersonal tensions (Byrne, 1997). On a positive side, optimal distinctiveness theory—an extension of social identity

theory—posits that while individuals categorize themselves into groups based on attributes such as race, ethnicity, or gender, they also seek to balance the dual need for assimilation and differentiation (Brewer, 2012). Building on these psychological insights, faultline theory argues that the alignment of diversity attributes can divide teams into homogeneous but mutually distant subgroups, undermining cohesion and decision-making. Conversely, weaker faultlines can foster cross-cutting ties that allow diversity to be leveraged productively (Lau & Murnighan, 1998). Specifically, Lau and Murnighan (1998) differentiate between "demographic group faultlines, such as age" and "non-demographic characteristics, such as personal values or personality" (p. 328).

At the governance level, diversity is theorized as shaping both the monitoring and decision-making functions of boards of directors. Upper echelons theory argues that the demographic characteristics of top executive teams and boards influence strategic choices and subsequent organizational outcomes, with diversity in leadership teams improving decision quality and alignment with environmental demands (Hambrick & Mason, 1984). Complementarily, agency theory emphasizes the monitoring benefits of diversity, suggesting that heterogeneous boards strengthen oversight, mitigate agency costs, and reinforce accountability (Fama & Jensen, 1983). Meanwhile, stakeholder theory posits that more diverse governance structures enhance legitimacy, trust, and responsiveness by representing a broader range of constituencies (Freeman et al., 2010).

In health care, applying and comparing these theories is especially important due to the sector's reliance on multidisciplinary collaboration and the proliferation of empirical studies across diverse organizational contexts. Collectively, these theoretical perspectives highlight the absence of a definitive answer regarding the impact of diversity on performance outcomes. Hence, this systematic review aims to critically examine and synthesize existing evidence on workforce diversity and its relationship to performance outcomes across multiple levels within health care organizations. Specifically, it seeks to address the following research question:

RQ: What is the impact of diversity on performance in health care at the team, board, and overall organizational levels?

Method

Search Strategy

The review employed a rigorous methodological framework grounded in the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. PRISMA represents an internationally recognized standard featuring 27 specific criteria aimed at ensuring methodological rigor, transparency, and comprehensive documentation in systematic reviews (Page et al., 2021). Article extraction was conducted using the Web of Science database, strategically selected for its capacity to ensure access to high-impact, methodologically robust research, thereby enabling a comprehensive and reliable evidence-based mapping (Catuogno et al., 2016; Sarto & Veronesi, 2016).

The research protocol was constructed through a structured, algorithmic approach that incorporated key terminology and linguistic variants. Search string construction was informed by two specialized librarians from the medical and social sciences, ensuring the integration of two core thematic domains: diversity and health care sector performance. The final search configuration was: ("diversity" OR "gender diversity" OR "age diversity" OR "tenure diversity" OR "workforce diversity" OR "team diversity" OR "faultlines") AND ("healthcare" OR "healthcare management" OR "healthcare services" OR "healthcare organizations") AND ("performance" OR "individual performance" OR "organizational performance"). Database interrogation was conducted on April 09, 2025, followed by retrospective and prospective citation tracking for included articles using Google Scholar until July 11, 2025.

Study Selection

The search targeted peer-reviewed scholarly publications available in international journals, with a time limit constraint from the year 2000 onward. This year marked the introduction of the Millennium Goals, which elevated diversity as a priority across multiple research agendas. The initial search generated 952 publications, which were subsequently evaluated the following inclusion parameters: (1) empirical investigations reporting quantitative or qualitative empirical findings, thus excluding editorials, reviews, and pure theoretical analyses; (2) studies conducted within the health care context; (3) explicitly examination of workforce diversity and its relationship to performance, ensuring thematic relevance; and (4) publication in the English language.

Study selection proceeded through a three-phase protocol illustrated in Figure 1:

(a) First, bibliographic information from algorithmically identified records was screened to ensure compliance with the inclusion parameters related to publication type, language, and year of publication.
(b) Subsequently, the title and abstract of the remaining studies were evaluated for thematic relevance, study design, and target population.
(c) Finally, full-text documents of the remaining records were retrieved and assessed for eligibility.

All three phases were conducted independently by two authors, with disagreements resolved through discussion at regular intervals; persistent discrepancies were resolved by a third author. The systematic search initially generated 952 records. Of these, 75 were eliminated in the initial phase for being published before 2000 ($n = 7$) or not appearing in peer-reviewed international journals ($n = 68$). Subsequently, 805 records were removed during title and abstract screening due to nonempirical design ($n = 58$) or thematic irrelevance ($n = 747$). The remaining 72 records underwent full-text review, resulting in the exclusion of two studies for lacking an empirical approach and 35 for thematic irrelevance. Additional studies were incorporated through backward and forward citation tracking ($n = 23$).

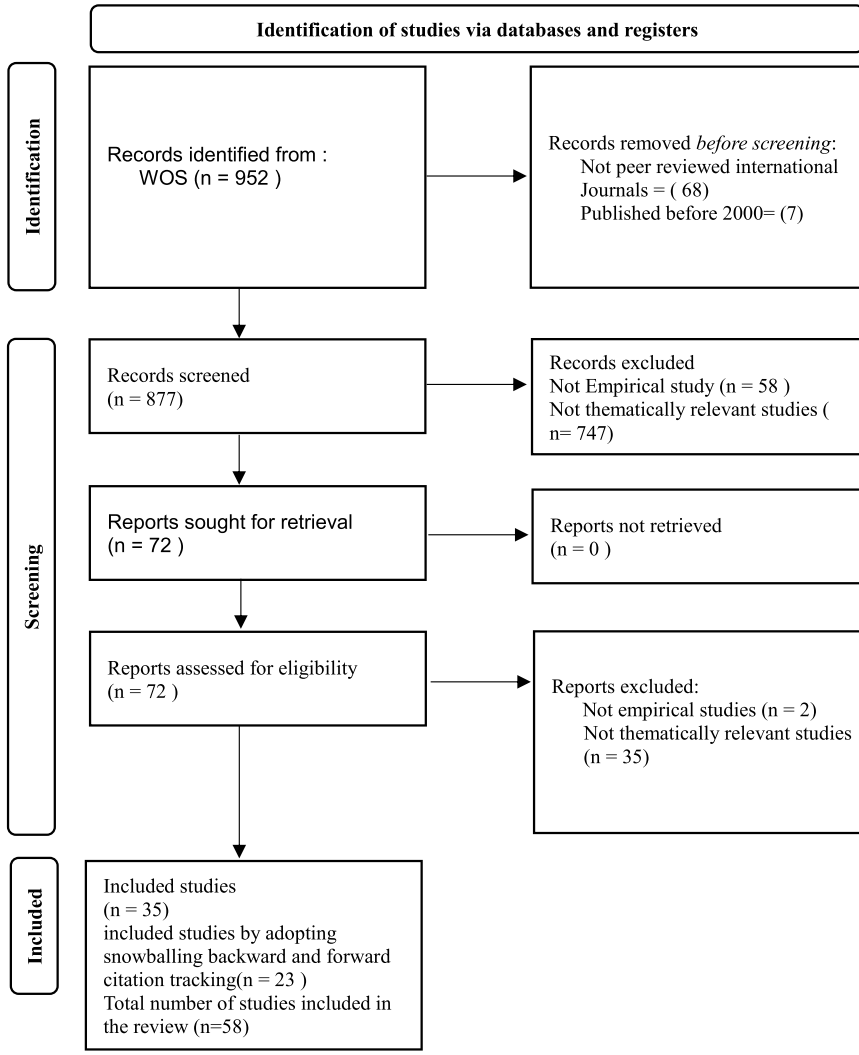

FIGURE 1. PRISMA flow chart of study selection.

Ultimately, 58 studies met all the inclusion parameters and were retained for the review.

Quality Assessment

Methodological and reporting quality assessment of the included studies was conducted following Hermes et al. (2025) and utilized a modified QuADS instrument originally developed by Harrison et al. (2021). The adapted scale encompassed 11 criteria grouped into four dimensions: study concept and design (Items 1–4), transparency of methodological procedures (Items 5–7), methodological appropriateness (Items 8–10), and limitations (Item 11). Each criterion was scored on a 0–3 scale, with 3 indicating the highest quality. Two authors independently assessed each study's methodological and reporting quality. Assessment disagreements were discussed and resolved bilaterally. Based on total scores, the studies were categorized into three quality categories: low (score $<60\%$), moderate (60–79%), and high ($\geq 80\%$). In reporting the review findings, we emphasized high-quality studies, while low-quality studies were retained to preserve valuable insights and adhere to QuADS principles (Harrison et al., 2021).

The quality assessment overview for each study, including individual criteria, overall ratings, and reporting quality, is reported in Supplemental Digital Content Table 1 (http://links.lww.com/HCMR/A188).

Study Characteristics

Table 1 provides an overview of the selected articles (see Digital Content Table 2, Supplemental Digital Content, http://links.lww.com/HCMR/A188 for a detailed overview). Based on a comprehensive analysis of 58 studies included in this systematic review, the temporal distribution reveals a concentrated publication pattern with 60% of studies ($n = 35$) published between 2020 and 2025, indicating a marked increase in scholarly interest in diversity research within health care settings in recent years. The publication peak was in 2024 ($n = 11$), further indicating growing academic attention in the postpandemic period.

TABLE 1

Summary of the literature on diversity and health care performance

References	Year	Country and period	Setting	Type of diversity	Theoretical framework	Unit of analysis	Type of analysis	Type of performance	Outcome
Goradia and Byron (2025)	2025	United States (2016–2019)	Hospitals	Workgroup diversity	Diversity theory	Organizational level	Longitudinal data analysis	Organizational performance	Patient outcome (+)
Houston et al. (2025)	2025	United States (NF)	Health care teams	Racial diversity	Social cognitive theory, categorization-elaboration model	Organizational level	Cross-sectional analysis	Relational performance	Follower evaluation of leader effectiveness (+)
Uman et al. (2025)	2025	Sweden (2022–2023)	Health care training observations	Ethnic diversity	Diversity theory	Team level	Qualitative (Fuzzy test)	Relational performance	Team performance. (+,–)
Yoo and Kang, 2025	2025	United States (2019)	Health care teams	Expertise diversity	Information processing theory	Team level	Cross-sectional analysis	Organizational performance	Project efficiency (+,–) and project creativity (–)
Achiro et al. (2024)	2024	United Kingdom (2014–2018)	Hospitals	Gender diversity	Agency theory, resource dependence theory, stakeholder agency theory, upper echelons theory	Board level	Longitudinal data analysis	Organizational performance	ROA (–)
Alta'any et al. (2024)	2024	United Kingdom (2014–2018)	Hospitals	Gender diversity	Resource dependence theory, upper echelons theory, stakeholder-agency theory	Board level	Longitudinal data analysis	Organizational performance	Cancer waiting time target (not significant)
Bao et al. (2024)	2024	China (NF)	Health care teams	Faultlines	Faultlines theory, self-categorization theory, and social identity theory	Team level	Cross-sectional analysis	Relational performance	Team performance (–)
Gregor, S (2024)	2024	Canada (NF)	Hospitals	Gender, age, race, and professional diversity	Diversity theory	Organizational level	Qualitative (interviews)	Organizational performance	Trasformational change (+)
Hallet et al. (2024)	2024	Canada (2009–2019)	Hospitals	Sex diversity	Diversity theory	Team level	Longitudinal data analysis	Organizational performance	Major morbidity (+)
Martikainen et al. (2024)	2024	Finland (2022)	Health care organizations	Cultural and linguistic diversity	Diversity theory	Organizational level	Cross-sectional analysis	Relational performance	Perceived integration (low–high) (–)
Molina et al. (2024)	2024	Spain (NF)	Health care organizations	Faultlines	Faultline theory, social identity theory, dispersion theory	Team level	Cross-sectional analysis	Relational performance	Team justice climate and performance (–)
Monteiro et al. (2024)	2024	European (2017–2021)	Hospitals	Gender diversity	Resource-based theory, institutional theory, and legitimacy theory	Board level	Longitudinal data analysis	Organizational performance	ESG performance reporting (+)
Romano et al. (2024)	2024	Europe (2020)	Health care organizations	Gender diversity	Resource-based view and upper echelons theory	Board level	Cross-sectional analysis	Organizational performance	Cost of debt (+)
Tietschert et al. (2024)	2024	United States (2019)	Health care organizations	Cultural heterogeneity	Repertoire theory	Organizational level	Cross-sectional analysis	Relational performance	Organizational culture (U-shaped)
Trinchese et al. (2024)	2024	Italy (2016–2021)	Health care organizations	Gender diversity	Resource dependence theory, signaling theory, agency theory, and social identity theory	Organizational level	Longitudinal data analysis	Organizational performance	Average length of hospital stay (LOS) (+)
Wang et al. (2024)	2024	China (2022)	Hospitals	Generational diversity	Similarity attraction theory, social identity theory, and self-categorization theory	Team level	Cross-sectional analysis	Relational performance	Team functioning (quality of care, namely speaking up, silence, and knowledge sharing) (not significant)

TABLE 1

(*Continued*)

References	Year	Country and period	Setting	Type of diversity	Theoretical framework	Unit of analysis	Type of analysis	Type of performance	Outcome
Aly et al. (2023)	2023	United Kingdom (2016)	Hospitals	Gender diversity	Agency theory, stakeholder theory and stewardship theory, and resource-based theory	Board level	Cross-sectional analysis	Organizational performance	Profitability, effectiveness, financial and nonfinancial indicators (+,–)
De Klerk and Singh (2023)	2023	Multicountry (2015–2019)	Health care organizations	Cultural and gender diversity	Agency theory, differences-behavior theory, social identity theory, and critical mass theory	Board level	Longitudinal data analysis	Organizational performance	Sustainability performance (environmental, social governance) (+)
Garcia-Lacalle et al. (2023)	2023	United Kingdom (2013)	Hospitals	Gender diversity	Upper echelons theory, stakeholders theory	Board level	Cross-sectional analysis	Organizational performance	Financial performance and service quality (not significant)
Han et al. (2023)	2023	China (2022)	Health care teams	Informational team faultline	Complex adaptive system theory, conservation of resources theory, faultline theory	Team level	Cross-sectional analysis	Relational performance	Team resilience. (–)
Sheffer Hilel et al. (2023)	2023	Israel (2019)	Health care teams	Faultlines	Professional identity theory, faultline theory, and leadership theory	Team level	Cross-sectional analysis	Organizational performance	Quality of care (+,–)
Lee et al. (2023)	2023	United States (2017)	Hospitals	Racial diversity	Stakeholder theory; contingency theory	Organizational level	Cross-sectional analysis	Organizational performance	Operational efficiency (+)
Van Zijl et al. (2023)	2023	Dutch (2017–2018)	Health care teams	Functional diversity	Self-categorization theory	Team level	Cross-sectional analysis	Relational performance	Team innovation (U-shaped)
El Chaarani and Raimi (2022)	2022	Lebanon (2021)	Hospitals	Gender diversity, age diversity, and value diversity.	Social Identity theory, social dominance theory, behavioral theory, information processing theory, knowledge-based theory, and resource-based theory,	Organizational level	Cross-sectional analysis	Organizational performance	Innovation (+) and patient satisfaction (+)
Mitchell et al. (2022)	2022	United States (NF)	Health care teams	Professional diversity	Social categorization theory	Team level	Cross-sectional analysis	Relational performance	Suspicion and Counterproductive work behavior (CWB) (–)
Mitchell et al. (2022)	2022	United Kingdom	Health care teams	Faultlines	Faultlines theory	Team level	Cross-sectional analysis	Relational performance	Multidisciplinary team innovation (U-shaped)
Naciti et al. (2022)	2022	Italy (2012–2018)	Hospitals	Gender diversity	Diversity theory	Organizational level	Longitudinal data analysis	Organizational performance	Liquidity index (+) and return on sales (+)
Nawaz et al. (2022)	2022	Pakistan (NF)	Health care organizations	Surface-level diversity; deep-level diversity	Social identity theory	Team level	Cross-sectional analysis	Relational performance	Task conflict (–)
Chen et al. (2021)	2021	Taiwan (2006–2017)	Hospitals	Gender diversity	Agency theory and resource dependence theory	Board level	Longitudinal data analysis	Organizational performance	Gross operating profit margin, net operating profit margin, net income before tax, net income after tax (not significant)
Kim et al. (2021)	2021	Korea (NF)	Health care organizations	Group tenure diversity	Diversity theory	Organizational level	Cross-sectional analysis	Relational performance	Workplace gossip (+)
Mitchell and Boyle, 2021	2021	United Kingdom (NF)	Health care teams	Professional faultlines	Faultline theory	Team level	Cross-sectional analysis	Organizational performance	Innovation (+)
Uyar et al. (2021)	2021	Multicountry (2011–2018)	Health care organizations	Gender diversity	Agency theory, stakeholders theory, complexity theory	Board level	Longitudinal data analysis	Organizational performance	Financial performance (+); CSR performance (+)

Van Zijl et al. (2021)	2021	The Netherlands (2016–2017)	Health care teams	Functional heterogeneity	Diversity theory	Team level	Longitudinal data analysis	Relational performance	Team performance (+)
Yang et al. (2021)	2021	China (2019–2020)	Health care teams	Reputation diversity and experience diversity	Signaling theory, similarity attraction theory, social identity theory	Team level	Longitudinal data analysis	Relational performance	Team performance (number of online consultations of the team per week in the data collection period) (+)
Mitchell et al. (2020)	2020	China (NF)	Health care teams	Functional diversity	Upper echelons theory	Team level	Cross-sectional analysis	Organizational performance	Firm performance and adaptive capability (+,–)
Bass (2019)	2019	United States (2013–2017)	Health care organizations	TMT gender diversity	Upper echelons theory	Team level	Longitudinal data analysis	Organizational performance	Innovation (+)
Li, JY (2019)	2019	China (2017–2018)	Health care teams	Team heterogeneity	Upper echelons theory and social exchange theory	Team level	Longitudinal data analysis	Organizational performance	Online team-based medical service (+,–)
Mitchell et al. (2019)	2019	United Kingdom (NF)	Health care teams	Cognitive diversity	Diversity theory	Team level	Cross-sectional analysis	Relational performance	Team effectiveness (+)
van Zijl et al. (2019)	2019	Dutch (2016–2017)	Health care teams	Functional heterogeneity	Diversity theory	Team level	Cross-sectional analysis	Relational performance	Team processes (information elaboration, boundary management, and team cohesion) (–)
Blanco-Oliver et al. (2018)	2018	United Kingdom (2011)	Hospitals	Board heterogeneity	Upper echelons theory	Board level	Cross-sectional analysis	Organizational performance	Hospital performance (+)
Bouncken et al. (2018)	2018	German (2014)	Hospitals	Cross-cultural diversity (nationality, language, cultural background)	Social identity theory	Organizational level	Cross-sectional analysis	Organizational and relational performance	Employee job satisfaction (–) and productivity (–)
Ibidunni et al. (2018)	2018	Nigeria (NF)	Health care organizations	Workforce diversity	Diversity theory	Organizational level	Cross-sectional analysis	Relational performance	Job satisfaction (+) and organisational commitment (+)
Johnson et al. (2018)	2018	Australia (2011)	Health care teams	Functional diversity	Diversity theory	Team level	Cross-sectional analysis	Relational performance	Role conflict (–)
Schrand et al. (2018)	2018	United States (2005–2015)	Trusts linked to health care environment	Gender diversity	Decision-making theory, stakeholders theory, and critical mass theory	Board level	Longitudinal data analysis	Organizational performance	Market performance (PRICE/NAV) (+) and operating performance (FFO/SHARE) (U-shaped relationship)
Mitchell et al. (2017)	2017	Australia (NF)	Health care teams	Cognitive diversity	Social identity theory, the similarity attraction paradigm theory	Team level	Cross-sectional analysis	Relational performance	Debate (+)
Ancarani et al. (2016)	2016	United Arab Emirates, UAE (2012)	Units	Religious diversity	Social categorization theory, self categorization theory, faultline theory	Team level	Cross-sectional analysis	Organizational performance	Ward's efficiency (U-shaped)
Mitchell et al. (2016)	2016	China (NF)	Health care teams	Functional and national diversity	Resource allocation theory, information processing theory, and upper echelons theory	Team level	Cross-sectional analysis	Relational performance	Decision comprehensiveness (–)
Rupert et al. (2016)	2016	The Netherlands (NF)	Health care teams	Informational faultlines	Faultline theory	Team level	Cross-sectional analysis	Relational performance	Team learning (+,–)
Mitchell, R (2015)	2015	United Kingdom (NF)	Health care teams	Professional diversity	social identity theory	Team level	Cross-sectional analysis	Organizational performance	Innovation (+,–)
Ellwood and Garcia-Lacalle (2015)	2015	United Kingdom (2009–2011)	Hospitals	Gender diversity	Agency theory, stakeholders theory, stewardship theory, and upper echelon theory	Board level	Longitudinal data analysis	Organizational performance	Return on assets, clinical negligence costs (not significant)
Curşeu (2013)	2013	The Netherlands (NF)	Health care teams	Age diversity, educational diversity	Diversity theory	Team level	Cross-sectional analysis	Relational performance	Face-to-face communication (–), frequency of virtual communication (–)
Drach-Zahavy and	2013	Israel (NF)	Units	Team diversity (age,	Social categorisation theory	Team level	Cross-sectional	Relational	Intrapersonal agression relationship

TABLE 1
(Continued)

References	Year	Country and period	Setting	Type of diversity	Theoretical framework	Unit of analysis	Type of analysis	Type of performance	Outcome
Trogan (2013)				sex)			analysis	performance	(+, –)
Gates and Mark (2012)	2012	United States (2003–2004)	Hospitals	Value diversity, age diversity, ethnicity diversity, gender diversity	Social identity theory	Organizational level	Longitudinal data analysis	Relational performance	Job satisfaction (+, –) and intention to stay (+, –)
Gover and Duxbury (2012)	2012	Canada (NF)	Hospitals	Organizational faultlines	Social identity theory and faultline theory	Team level	Qualitative (Interviews)	Relational performance	Intergroup dynamics and job satisfaction (–)
Mitchell et al. (2011)	2011	Australia (NF)	Health care teams	Professional diversity	Social identity theory, similarity attraction theory, and self-categorization theory	Team level	Cross-sectional analysis	Relational performance	Team effectiveness (+)
Andrew H (2008)	2008	United States (NF)	Health care organizations	Diverse organizing models	Diversity theory	Organizational level	Longitudinal data analysis	Organizational performance	Clinic revenue, productivity, and patient satisfaction (+)
Laditka (2004)	2004	United States (1984–1990)	Health care organizations	Physician diversity	Diversity theory	Organizational level	Longitudinal data analysis	Organizational performance	Ambulatory care sensitive conditions (+)
Janice L. Dreachslina (2000)	2000	United States (NF)	Hospitals	Race, ethnicity, gender, age, and sexual orientation diversity	Diversity theory	Team level	Qualitative (focus group)	Organizational and relational performance	Team communication, patient care (–)

Studies spanned multiple disciplinary fields, with organizational behavior and human resource management accounting for the largest share (31%), followed by health policy and management (29%), public administration and public sector management (15%), psychology (14%), and other fields (11%), reflecting the interdisciplinary nature of diversity research in health care.

Geographically, the studies showed substantial international scope, with the United States having the largest research output (21 studies), followed by the United Kingdom (17%) and China (12%). This indicates a multicountry academic engagement with health care diversity research. The predominant research settings were health care teams (38% of studies), followed by hospitals (33%), and other health care organizations (22%).

Sample sizes varied across reviewed studies, ranging from small qualitative samples of 14 participants to large-scale data sets encompassing over 26,000 employees. This variation mirrors the adoption of diverse methodological approaches tailored to distinctive research questions. Methodologically, the field demonstrates a predominantly quantitative orientation, with 93% of studies (65% cross-sectional and 35% longitudinal) employing quantitative designs, while only 7% used qualitative methods. With reference to the dimensions of diversity examined, gender-related diversity was the most frequently investigated category (31% of studies), followed by faultlines (14%).

To structure the analysis, we grouped performance outcomes into two levels: relational and organizational. Relational outcomes include studies focusing on interpersonal interactions and relationships, while organizational outcomes refer to broader measures of performance achieved at the organization level.

Regarding the findings, 24 studies (40%) reported a positive effect, 15 (26%) a negative effect, 9 (16%) a mixed effect, 5 (9%) a U-shaped effect, and 5 (9%) found no significant effect. As explained, we categorized these studies along two dimensions: relational performance outcomes (47%), which capture effects from interpersonal interactions such as communication, conflict management, and organizational climate; and organizational performance outcomes (50%), which relate to broader organizational activity, such as financial performance, innovation, efficiency, and quality of care. Only two studies (3%) addressed both relational and organizational outcomes simultaneously.

Theoretical Orientations and Application

Of the 58 studies investigating the relationship between diversity and performance in health care settings, 44 (76%) articulated specific theoretical explanations for the observed relationships, whereas 14 studies (24%) relied solely on generic diversity theory without specifying a distinct theoretical framework. Across all levels of analysis, social identity theory emerged as the most frequently employed theoretical framework (14 applications), followed by faultline theory (8 applications).

Among the 15 organizational-level studies, 7 (46%) articulated specific theoretical frameworks on diversity, whereas 8 (54%) relied exclusively on generic diversity theory. Among those specifying a framework, social identity

theory and resource dependence theory were the most frequently applied (50% and 27%, respectively). The theoretical perspectives were employed to explain how demographic differences, such as gender, age, and cultural diversity, affect both relational and organizational outcomes, including innovation, employee satisfaction, and quality of care (Bouncken et al., 2018; El Chaarani & Raimi, 2022; Gates & Mark, 2012; Trinchese et al., 2024). Ethnic diversity was examined through a distinct theoretical framework. For example, Lee et al. (2023) adopted a contingency theory perspective, highlighting how an organization can achieve a competitive advantage by adapting its structure to align effectively with changing environmental conditions. In this case, the study illustrated how labor shortages were addressed through a targeted recruitment strategy, specifically by increasing ethnic diversity via the hiring of foreign medical staff. Another theoretical lens is offered by Houston et al. (2025), who draw on social cognitive theory to explain the moderating role of ethnic diversity in leader–follower dynamics. Their findings indicate that leaders' diversity self-efficacy is more strongly associated with followers' evaluations of leader effectiveness when workgroups exhibit higher levels of ethnic diversity. Furthermore, repertoire theory was used to explain how cultural diversity can improve organizational "toolkits," generating "new ideas and practices that advance care quality and make work more meaningful and manageable for employees" (Tietschert et al., 2024; p. 2). Rather than a tactic to mitigate the potential negative effects of diversity, the toolkit represents an intrinsic organizational resource that broadens cognitive and practical capacities, thereby conferring advantages in terms of care quality and employee experience.

Among the 31 team-level studies, most (74%) were grounded in specific theoretical frameworks, while a smaller portion (26%) drew exclusively from generic diversity theory. Forty-two percent applied at least one socio-psychological theory: social identity, social categorization, self-categorization, and similarity attraction. These theories were adopted to examine biodemographic diversity as well as to explore functional diversity (Mitchell et al., 2017; Mitchell et al., 2022; Van Zijl et al., 2023). Notably, Ancarani et al. (2016) applied these theories to analyze the relationship between religious diversity and health care team efficiency. Faultline theory was also extensively employed (26%), appearing in studies addressing both demographic (Bao et al., 2024; Molina et al., 2024; Rupert et al., 2016) and professional faultlines (Gover & Duxbury, 2012; Mitchell et al., 2022; Mitchell & Boyle, 2021; Sheffer Hilel et al., 2023). Two studies adopted information processing theory to explore how diversity affects complex information integration and impacts decision-making and project efficiency (Mitchell et al., 2016; Yoo & Kang, 2025).

At the board level, all 12 studies adopted specific theoretical foundations. Board gender diversity was the predominant theoretical lens (83%), but also cultural (De Klerk & Singh, 2023) and professional background diversity (Blanco-Oliver et al., 2018) were investigated in the papers identified. Board diversity is frequently theorized through the lenses of stakeholder theory and agency theory, as greater heterogeneity within boards of directors is assumed to enhance the representation of multiple interests while mitigating agency conflicts (Achiro et al., 2024; Chen et al., 2021; de Klerk & Singh, 2023; Ellwood & Garcia-Lacalle, 2015; Uyar et al., 2021). This perspective is often complemented by resource dependence theory, since "from a resource dependency point of view, ensuring a diverse and multidisciplinary board is crucial in safeguarding the public interest" (Aly et al., 2023, p. 2; see also Alta'any et al., 2024). Moreover, upper echelons theory offers a similar lens, suggesting that "greater heterogeneity in individual backgrounds of senior executives leads to better outcomes" (Blanco-Oliver et al., 2018, p. 393; see also Garcia-Lacalle et al., 2023).

Organizational Diversity and Performance

At the organizational level, diversity is mostly frequently analyzed in relation to surface-level characteristics. Specifically, due to growing shortages of health care professionals, the increasing complexity of health care systems, and equity and inclusion-oriented considerations, several studies highlighted the importance of diversity in terms of gender, age, and culture. In this sense, El Chaarani and Raimi (2022) argued that "diverse workforce is an important tool than can be employed by executives in medical centers during the COVID-19 pandemic period" (p. 15). Here, diversity is viewed not only as a strategy to address workforce shortages but also as a driver of positive organizational outcomes (Gates & Mark, 2012; Naciti et al., 2022; Trinchese et al., 2024).

Empirical evidence consistently shows a positive effect of gender diversity on health care performance at both the relational level and the organizational level. For example, El Chaarani and Raimi (2022) find that gender diversity positively affects patient satisfaction. Gates and Mark (2012) also identify a positive impact on satisfaction (see also Ibidunni et al., 2018), as well as on employees' intention to leave the organization. Other studies highlight a positive impact of gender diversity on organizational outcomes such as efficiency, financial performance, and innovation (El Chaarani & Raimi, 2022; Naciti et al., 2022; Trinchese et al., 2024). Consistent with these findings, Goradia and Byron (2025) observe that departments with greater gender diversity exhibit superior overall performance.

Similarly, age diversity and cultural diversity are generally associated with positive effects on relational outcomes, such as organizational culture, patient satisfaction, employee satisfaction, and intention to stay (Bouncken et al., 2018; Gates & Mark, 2012; Ibidunni et al., 2018; Tietschert et al., 2024) as well as on organizational outcomes such as operational efficiency and innovation (El Chaarani & Raimi, 2022; Lee et al., 2023). In addition, Houston et al. (2025) highlight the role of leaders' diversity self-efficacy, showing that its positive association with follower evaluations is amplified in contexts characterized by greater racial diversity within workgroups. They describe diversity self-efficacy as "an essential cognitive resource that can motivate leaders of racially diverse workgroups to

persist in their efforts to effectively execute their leadership duties" (p. 1006). Nonetheless, some evidence also points to negative effects; in this sense, cultural or linguistic diversity has been linked to weaker integration, lower satisfaction, and diminished hospital performance (Bouncken et al., 2018; Gates & Mark, 2012; Martikainen et al., 2024).

Few studies have examined deep-level diversity within health care organizations. Research suggests several positive effects, such as the role of professional diversity in driving transformational change, the contribution of physician diversity to improved quality of care, revenue, productivity, and patient satisfaction (Goradia & Byron, 2025; Gover & Duxbury, 2012; Laditka, 2004; Van De Ven et al., 2008). Kim et al. (2021) further illustrate that higher levels of tenure diversity are linked to lower levels of workplace gossip. Conversely, Gates and Mark (2012) investigate value diversity and report that nurses who perceived greater dissimilarity in values compared with their colleagues expressed lower job satisfaction and were less likely to intend to remain in their current positions.

Team Diversity and Performance

At the team level, scholars have extensively investigated the impact of deep-level diversity on relational performance. Overall, the reviewed studies identified a negative relationship between functional diversity and outcomes such as intra-team conflicts, communication challenges, counterproductive work behavior, team processes, and team effectiveness (Johnson et al., 2018; Mitchell et al., 2022; Nawaz et al., 2022; van Zijl et al., 2019), with some evidence pointing to a curvilinear impact (Mitchell et al., 2016).

Deep-level diversity has also been linked to adverse organizational outcomes, including lower efficiency and reduced quality of care (Li et al., 2019; Yoo & Kang, 2025), or found to be insignificant in relation to organizational performance and adaptive capability (Mitchell et al., 2020). Accordingly, Van Zijl et al. (2023) showed that beyond a certain threshold, the relationship between functional diversity and team innovation becomes more complex and may even turn negative. Similarly, religious diversity was associated with a curvilinear (inverse U-shaped) relationship with ward efficiency, suggesting that moderate levels of religious diversity may be beneficial (Ancarani et al., 2016).

Conversely, fewer other studies indicate positive outcomes, such as improved team performance and effectiveness (Mitchell et al., 2011; Yang et al., 2021; Van Zijl et al., 2021). In this sense, cognitive diversity, defined as "differences in knowledge and perspective" (Mitchell et al., 2017, p. 47), has been associated with enhanced team effectiveness and higher-quality debate (Mitchell et al., 2017, 2019). Similarly, Yang et al. (2021) identified a positive relationship between reputation diversity and team performance.

Surface-level diversity in a team context offers mainly mixed evidence. Some studies found a negative relationship between team communication and patient care (Curşeu, 2013; Dreachslin et al., 2000; Nawaz et al., 2022). Other scholars reported mixed or statistically insignificant effects (Drach-Zahavy and Trogan, 2013; Uman et al., 2025; Wang et al., 2024). Positive outcomes were observed in the quality of care and innovation performance (Bass, 2019; Hallet et al., 2024).

Studies examining faultlines generally report negative effects on relational performance, particularly regarding outcomes such as knowledge sharing and team climate. In turn, a positive team climate is associated with enhanced team performance, resilience, and quality of care (Bao et al., 2024; Han et al., 2023; Molina et al., 2024). Similarly, several authors have highlighted the detrimental impact of faultlines on organizational performance outcomes, including organizational change, innovation, and quality of care, mostly through the disruptions of intergroup dynamics (Gover and Duxbury, 2012; Mitchell et al., 2022; Sheffer Hilel et al., 2023). However, some evidence suggests conditional benefits. For example, Rupert et al. (2016) argued that faultlines "can boost team learning, through an accurate development of transactive memory based on different prior educational and work experiences, as long as subgroups are not too far apart" (p. 285). In line with this, Mitchell and Boyle (2021) observed a positive relationship between faultlines and team innovation, but only when mediated by interprofessional differentiation.

Board Diversity and Performance

At the board level, gender diversity has been the primary focus, reflecting the persistent underrepresentation of women in senior leadership positions. Most studies highlight a positive relationship between board gender diversity and sustainability performance, including ESG reporting (de Klerk and Singh, 2023; Monteiro et al., 2024; Uyar et al., 2021) as well as financial outcomes (Romano et al., 2024; Uyar et al., 2021). Accordingly, Romano et al. (2024) found that board gender diversity "fosters the decrease of the cost of debt. This feeds interesting cues upon the influence of gender dynamics in a firm's decision-making process concerning environmental initiatives" (p. 1929). In addition, Uyar et al. (2021) identified a positive influence of board gender diversity on firm value, return on assets, and ESG scores.

However, we also identified several mixed findings. Schrand et al. (2018) observed that gender diversity positively impacts market performance but not operating ones, where a U-shaped relationship emerges, requiring a critical mass of ~30% female executives to achieve positive effects. Other studies found no significant association between board gender diversity and financial performance or quality of care (Alta'any et al., 2024; Aly et al., 2023; Chen et al., 2021; Ellwood & Garcia-Lacalle, 2015; Garcia-Lacalle et al., 2023). Conversely, Achiro et al. (2024) reported a negative impact of board gender diversity on ROA.

Relatively few studies have focused on other forms of diversity. De Klerk and Singh (2023) found a positive relationship between boardroom cultural diversity and sustainability performance. Similarly, Blanco-Oliver et al. (2018) conceptualized board diversity as a "composite construct that measures diversity with respect to several indicators related to the background of board members" (p. 397). Unlike studies focused on single dimensions, this multidimensional approach captures a broader range of deep-level attributes, including tenure, professional

expertise, and educational background. Their findings indicated a positive relationship between board diversity and hospital performance, emphasizing the potential of diverse boards to strengthen organizational performance.

Discussion

This systematic review highlights the predominantly positive impact of diversity as a strategic resource that enhances relational and organizational performance. At the same time, it acknowledges that diversity can also bring challenges that require recognition and careful management. This duality calls for theoretical frameworks that transcend single-lens perspectives, acknowledging the complexity of diversity as both an opportunity and a source of potential tension that should be managed in combination.

A significant proportion of the studies included in this review adopt resource-oriented theoretical perspectives that conceptualize diversity as an organizational asset, resulting in predominantly positive outcomes: ranging from reductions in operational costs and debt burdens (Romano et al., 2024; Trinchese et al., 2024) to improvements in ESG performance and innovation (El Chaarani & Raimi, 2022; Monteiro et al., 2024). From a governance perspective, studies drawing on the upper echelons theory, frequently applied at the board level (Bass, 2019; Blanco-Oliver et al., 2018), emphasize that greater leadership diversity enhances the quality of strategic decision-making. Similarly, research grounded in stakeholder theory positions diversity as critical for effective stakeholder engagement and organizational legitimacy (Lee et al., 2023; Schrand et al., 2018; Uyar et al., 2021). In contrast, the majority of the studies employing faultlines theory and social identity-based psychological frameworks generally report negative effects of diversity on relational outcomes, including diminished team performance and resilience (Bao et al., 2024; Han et al., 2023; Molina et al., 2024), increased task conflict (Nawaz et al., 2022), and greater employee dissatisfaction (Bouncken et al., 2018; Gover & Duxbury, 2012).

Several studies identify a curvilinear (U-shaped) relationship between workforce diversity or faultlines and performance across multiple organizational dimensions, including organizational culture, ward efficiency, innovation, and operating performance (Ancarani et al., 2016; Mitchell et al., 2022; Schrand et al., 2018; Tietschert et al., 2024). Rupert et al. (2016) illustrate this mechanism, noting that faultlines can produce positive effects when subgroup divisions are "not too far apart," but generate negative outcomes when these divisions become extreme. In a similar vein, Van Zijl et al. (2023) underline this pattern for functional diversity and team innovation, observing that "from a certain degree of functional diversity, the relationship between functional diversity and team innovation becomes more complex and even turns negative" (p. 235). These findings suggest that diversity effects depend on achieving optimal balance points where benefits outweigh costs. This dynamic also appears at the board level, where negative effects of gender diversity on performance are primarily reported in studies conducted in the United Kingdom, a context characterized by comparatively high levels of board diversity (Achiro et al., 2024; Ellwood & Garcia-Lacalle, 2015; Garcia-Lacalle et al., 2023).

This systematic review further reveals that the impact of surface and deep-level diversity varies significantly depending on the type of performance examined. Studies focusing on organizational performance generally report positive effects, especially at the organizational and board levels. Most of these investigations have been conducted on financial and sustainability outcomes, innovation, and quality of care (Blanco-Oliver et al., 2018; El Chaarani & Raimi, 2022; Naciti et al., 2022; Romano et al., 2024; Trinchese et al., 2024). Conversely, research centered on relational performance more often identifies negative effects. These studies, typically conceptualized at the team level, often report adverse or curvilinear relationships between workforce diversity or faultlines and relational outcomes like conflict, communication, team efficiency and effectiveness, organizational climate, and team resilience (Ancarani et al., 2016; Han et al., 2023; Johnson et al., 2018; Molina et al., 2024; Rupert et al., 2016). These findings underscore a critical consideration for policymakers and human resource managers: managing diversity and faultlines is inherently complex, particularly with respect to relational performance outcomes. However, a possible interpretation of these findings may lie in the methodological design. Most studies examining relational performance rely on cross-sectional data, thus overlooking the temporal dynamics of diversity. From a relational perspective, such dynamics are particularly relevant, as time may attenuate unintended negative consequences of diversity through processes of adaptation and the development of shared understanding. Hence, these patterns suggest that surface and deep-level diversity do not exert uniform effects across the levels but interact with contextual and temporal factors.

This systematic review makes several key contributions to the literature. First, it provides a comprehensive theoretical mapping that reveals how different theoretical lenses have been applied to examine diversity in health care. Second, it advances understanding of diversity's multi-level complexity by underlining how its effects vary across organizational levels. Third, with over 60% of the reviewed studies published after COVID-19, it captures the evolution of diversity research in contexts where diversity is increasingly recognized as both essential for addressing critical workforce shortages and as a potential source of organizational challenges requiring targeted management strategies and practices. Fourth, by identifying curvilinear relationships as theoretical bridges between opposing perspectives, it highlights the importance of determining the optimal diversity levels where benefits outweigh costs, rather than assuming that diversification is beneficial per se. Finally, it highlights that effective diversity management requires integrated approaches that leverage diversity's resource advantages while proactively mitigating its relational challenges.

Several management techniques have been identified as facilitators for mitigating the potential negative outcomes of diversity. Inclusive and strong leadership (Houston et al.,

2025; Mitchell, Boyle, et al., 2022; Sheffer Hilel et al., 2023) appears crucial in reducing conflicts and fostering cohesion within heterogeneous teams. Structured communication and coordination processes (Curşeu, 2013; Johnson et al., 2018; van Zijl et al., 2019) support effective information and minimize role ambiguity. Cultural integration practices (Bouncken et al., 2018; Martikainen et al., 2024), alongside governance mechanisms such as board independence and stakeholder engagement (Aly et al., 2023; Ellwood & Garcia-Lacalle, 2015), enhance the effectiveness of diversity at higher organizational levels. Moreover, training and knowledge-sharing initiatives (Wang et al., 2024) help reduce stereotypes, while fostering a psychologically safe climate (Bao et al., 2024; Han et al., 2023; Molina et al., 2024; Tietschert et al., 2024), amplifying the positive effects of diversity or mitigating the negative effects of faultlines. The importance of inclusion is also recognized. For example, Schrand et al. (2018) suggest that a critical mass of around 30% women is necessary to move beyond token representation toward significant influence, enabling women's voices to shape board dynamics. These findings show that inclusion demands fundamental changes in governance and organizational culture to fully realize the benefits of diverse perspectives.

Study Limitations

While this systematic review offers valuable insights into the effect of diversity on performance in health care settings, some limitations should be acknowledged. First, the majority of the included studies adopted a cross-sectional design, which limits the ability to draw causal inferences. While correlations between diversity and outcomes are informative, they do not capture temporal dynamics or potential lag effects through which diversity may influence team, board, or organizational performance over time. Second, although the review encompasses studies from multiple countries, it does not systematically account for contextual differences such as national regulations, cultural norms, or health care system structures. This limits the generalizability of the findings, as the mechanisms through which diversity operates may differ significantly across institutional contexts. Third, despite addressing diversity at multiple levels—organization, team, and board—the operationalization of diversity varies widely across studies. Variations in measurement approaches (e.g., demographic vs. functional diversity, perceived vs. objective indicators) may affect comparability and complicate synthesis. Fourth, this study relied exclusively on the Web of Science database for literature identification. Although snowballing techniques were employed to retrieve additional sources, it is possible that some relevant articles were not captured. Finally, while this review draws on multiple theoretical perspectives to interpret the findings, the diversity of conceptualizations and frameworks across studies poses challenges for integration and direct comparison. Consequently, understanding the mechanisms by which diversity affects health care performance remains a fertile area for further study.

Directions for Future Research

The systematic review provides several promising avenues for future investigation. First, while there exists abundant evidence on the impact of diversity on performance outcomes, there is comparatively less attention to the temporal and contextual dynamics of these effects. Most studies conceptualize diversity as a static condition, yet its influence may vary depending on when diversity is introduced (e.g., during crisis management, organizational change initiatives, or growth phases) and the duration of collaboration among employees, teams, or boards. Future research should therefore incorporate a temporal lens, examining whether the benefits of diversity accumulate, diminish, or even reverse over time. This would deepen our understanding of the conditions under which diversity enhances performance versus when it may lead to inefficiencies or conflict.

Second, there is a pressing need for a deeper investigation into diversity at the team and middle-management levels. As our review shows, the evidence in this domain remains inconsistent, with studies frequently reporting curvilinear and negative effects. Diversity within health care teams, such as interprofessional clinical units, presents unique challenges as variations in training, role identity, and professional power dynamics can exacerbate faultlines. Exploring how leadership styles, communication structures, and boundary-spanning roles influence the capacity of diverse teams to collaborate effectively would provide important insights into the consequences of diversity. Moreover, comparative analyses between homogenous occupational groups (e.g., nurses working with nurses) and multidisciplinary teams (e.g., physicians, nurses, and allied health professionals) could reveal the conditions under which diversity is more likely to be beneficial.

Third, future research could focus on the mechanisms and boundary conditions under which diversity generates positive versus negative outcomes. For example, the faultlines theory suggests that subgroups can lead to conflict and negative performance, yet little is known about strategies that can mitigate these risks. Initiatives like interprofessional training, cross-boundary mentoring, and formalized conflict resolution warrant closer attention. Similarly, the relational dynamics within diverse teams require further scrutiny: while diversity may lead to more heterogeneous perspectives, it can also trigger mistrust or frustration if not actively managed. Understanding the interplay between emotional climate, psychological safety, and the functioning of diverse teams could thus yield critical insights for theory and practice. In this regard, research that identifies and evaluates evidence-based practices to strengthen diverse teams across organizational levels would be particularly valuable. In addition, future studies could examine whether sharing surface-level characteristics between clinicians and patients (e.g., race, gender, language) is sufficient to foster connection and trust, and why different forms of diversity might influence outcomes in distinct ways.

Fourth, research at the board level could extend beyond the dominant focus on gender diversity. While gender remains a critical dimension, other forms of surface and deep-level diversity, including cultural, professional,

generational, and experiential diversity, are increasingly salient for governance structures and decision-making in complex health care environments. Future studies should explore how these different dimensions interact and whether specific configurations of board composition are more conducive to effective decision-making and stakeholder engagement. Moreover, cross-country comparative work is essential to explain the mixed results reported in the United Kingdom compared with other contexts, which would enable a better understanding of the influence of institutional, cultural, and regulatory environments.

Fifth, future research could pursue methodological advancements through sophisticated multi-level and longitudinal designs that capture the evolving impact of diversity across organizational layers and over time. Embracing an interdisciplinary approach could further enrich theoretical development and lead to more comprehensive models of diversity effects in health care delivery. In addition, our review reveals differences between articles published in health care-specific journals and those appearing in general management journals. The latter typically draw on well-established theoretical frameworks and devote substantial effort to conceptual development, whereas health care-specific journals tend to prioritize shorter, empirically oriented papers focused on reporting results. Moreover, general management journals usually place less emphasis on detailed clinical outcomes and instead focus on organizational, managerial, or policy-level implications. In this context, future research should aim to translate organizational and managerial theory into practical health care policies and management interventions, thereby bridging the gap between theoretical development and clinical impact, and fostering integrative frameworks that combine diverse theoretical perspectives.

Lastly, there are opportunities to integrate analyses across multiple levels to develop a truly multilevel perspective on diversity within health care organizations. Current research tends to isolate diversity effects at either the organizational, team, or board level. Less attention is given to how dynamics at one level shape or constrain outcomes at another. For example, how does board-level diversity influence organizational culture, which in turn shapes the experiences of diverse employees and teams? Conversely, how do grassroots experiences of diversity among frontline staff may inform governance and strategic decision-making? Addressing these questions would advance both theoretical and practical understanding of diversity, enabling policymakers and managers to leverage diversity as a systemic resource rather than a fragmented phenomenon.

Practical Implications and Conclusion

Adopting a narrative and critical approach, this systematic review synthesizes evidence on the relationship between diversity and performance in health care settings. The health care sector represents a particularly distinctive context due to persistent workforce shortages and the growing complexity of care demands, challenges that have become especially pronounced in the aftermath of the COVID-19 pandemic (Ahmed et al., 2022; Poon et al., 2022). Notably, 60% of the reviewed studies were published in the post-pandemic period, reflecting the evolving significance of diversity in health care. Given the varied dynamics associated with diversity, a multilevel approach was required. Hence, we examined the literature at the organizational, team, and board levels.

The findings suggest that at the organizational level, diversity, often referred to as surface characteristics, is generally associated with enhanced performance. A more diverse workforce generally fosters openness, constructive dialogue, and collaboration, both internally among employees and externally in interactions with patients. From a managerial perspective, recruitment and workforce planning can deliberately integrate dimensions of diversity, such as age, gender, culture, and professional background, which have been shown to have positive effects on the performance of health care organizations.

At the team level, however, our results, mainly focused on deep-level characteristics, are more nuanced. At this level, authors focused more on the relationship between diversity and relational performance, often evidencing negative or curvilinear results. While diversity has the potential to stimulate innovation and broaden perspectives, it may also lead to relational challenges and negative performance outcomes if not effectively managed. Evidence on the emergence of faultlines is particularly illustrative of this risk. Integration strategies that merely co-locate individuals with heterogeneous characteristics, without adequate human resource support and training, are unlikely to succeed. Effective diversity management at this level requires deliberate team design, proactive planning, and leadership practices that facilitate cohesion and collaboration (Rawlinson et al., 2021).

At the governance level, most studies concentrate on the surface characteristics of gender within boards of directors. The findings largely indicate positive associations with organizational performance, although these effects are less pronounced in contexts where gender diversity is already well established.

The findings have important implications for policymakers and practitioners. Diversity should be strategically managed within health care organizations rather than left to evolve organically. Developing internal capacity through specialized human resource functions and tailored training programs at all organizational levels is crucial to consolidate the benefits of diversity and mitigate potential drawbacks. Recruitment and workforce planning should deliberately incorporate dimensions such as age, gender, culture, and professional background to strengthen organizational performance. Furthermore, leadership practices should foster team cohesion and proactively address challenges related to diversity faultlines to prevent negative outcomes. By institutionalizing these practices, health care organizations can transform diversity into a strategic asset rather than a source of fragmentation.

References

Achiro L. O., Tauringana V., Alta'any M. (2024). Corporate governance and financial performance: The case of English NHS hospitals. *International Journal of Public Sector Management*, 37(7), 896–912.

Ahmed F. R., Bani-Issa W., Timmins F., Dias J. M., Al-Yateem N., Subu M. A., Alzahmi S. M., Saqan R., Abdul Rahman H., AbuRuz M. E. (2022). Managing during the COVID-19 pandemic: A cross-sectional study of health care workers' perceived organizational support and its consequences on their compassion, resilience and turnover intention. *Journal of Nursing Management*, 30 (7), 2642–52. https://doi.org/10.1111/jonm.13824

Alta'any M., Tauringana V., Achiro L. O. (2024). The impact of corporate governance on the cancer waiting time target of the English National Health Service hospitals. *Corporate Governance: The International Journal of Business in Society*, 25, 1363–84. https://www.emerald.com/insight/content/doi/10.1108/CG-02-2024-0107/full/html

Aly D., Abdelqader M., Darwish T. K., Scott K. (2023). The impact of healthcare board characteristics on NHS trust performance. *Public Money & Management*, 43(6), 594–601. https://doi.org/10.1080/09540962.2021.2022272

Ancarani A., Ayach A., Mauro C. D., Gitto S., Mancuso P. (2016). *Does religious diversity in health team composition affect efficiency? Evidence from Dubai*. Accessed September 15, 2025. https://onlinelibrary.wiley.com/doi/10.1111/1467-8551.12184.

Bao X., Dai Y., Wu Q., Nie W., Tao H. (2024). Primary health care team faultlines and team performance: The mediating role of knowledge sharing. *Frontiers in Psychology*, 15, 1362520.

Bass A. E. (2019). Top management team diversity, equality, and innovation: A multilevel investigation of the health care industry. *Journal of Leadership & Organizational Studies*, 26(3), 339–51. https://doi.org/10.1177/1548051819849008

Blanco-Oliver A., Veronesi G., Kirkpatrick I. (2018). Board heterogeneity and organisational performance: The mediating effects of line managers and staff satisfaction. *Journal of Business Ethics*, 152 (2), 393–407. https://doi.org/10.1007/s10551-016-3290-8

Bouncken R. B., Reuschl A. J., Barwinski R. W., Viala C. (2018). Cross-cultural diversity management in service firms. *European J of International Management*, 12(5/6), 510. https://doi.org/10.1504/EJIM.2018.094496

Brewer M. B. (2012). Optimal distinctiveness theory: Its history and development. *Handbook of theories of social psychology*, 2, 81–98.

Byrne D. (1997). An overview (and underview) of research and theory within the attraction paradigm. *Journal of Social and Personal Relationships*, 14, 417–31. https://doi.org/10.1177/0265407597143008

Catuogno S., Saggese S., Sarto F., Viganò R. (2016). Shedding light on the aim of stock options: A literature review. *Journal of Management & Governance*, 20(2), 387–411.

Chen K.-C., Hsieh F.-C., Hsiao Y.-J. (2021). Hospital board of directors' composition and financial performance: Empirical evidence from Taiwan. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 58, 00469580211024897. https://doi.org/10.1177/00469580211024897

Curşeu P. L. (2013). Demographic diversity, communication and learning behaviour in healthcare groups. *The International Journal of Health Planning and Management*, 28(3), 238–47. https://doi.org/10.1002/hpm.2130

de Klerk K., Singh F. (2023). *Does gender and cultural diversity matter for sustainability in healthcare? Evidence from global organizations. Sustainability 2023, 15, 11695*. https://pdfs.semanticscholar.org/36b1/b989d1bf6b9855b9b71918365f05756fd9f4.pdf

Ding F., Riccucci N. M. (2023). How does diversity affect public organizational performance? A meta-analysis. *Public Administration*, 101 (4), 1367–93. https://doi.org/10.1111/padm.12885

Drach-Zahavy A., Trogan R. (2013). Opposites attract or attack? The moderating role of diversity climate in the team diversity–interpersonal aggression relationship. *Journal of Occupational Health Psychology*, 18(4), 449.

Dreachslin J. L., Hunt P. L., Sprainer E. (2000). Workforce diversity: Implications for the effectiveness of health care delivery teams. *Social Science & Medicine*, 50(10), 1403–14.

El Chaarani H., Raimi L. (2022). Diversity, entrepreneurial innovation, and performance of healthcare sector in the COVID -19 pandemic period. *Journal of Public Affairs*, 22(S1), e2808. https://doi.org/10.1002/pa.2808

Ellwood S., Garcia-Lacalle J. (2015). The influence of presence and position of women on the boards of directors: The case of NHS foundation trusts. *Journal of business ethics*, 130(1), 69–84.

Fama E. F., Jensen M. C. (1983). Agency problems and residual claims. *The Journal of Law and Economics*, 26(2), 327–49. https://doi.org/10.1086/467038

Freeman R. E., Harrison J. S., Wicks A. C., Parmar B. L., De Colle S. (2010). *Stakeholder theory: The state of the art*. https://books.google.com/books?hl = it&lr = &id = xF8-WN1QlIMC&oi = fnd&pg = PR7&dq = stakeholder+theory+freeman+1984&ots = ZYz1Q1uu5M&sig = cxF-bSzlNU--AuxJhUgYQIJrAmw

Garcia-Lacalle J., Royo S., Yetano A. (2023). Boards of directors and performance in autonomous public sector entities. *Public Money & Management*, 43(2), 85–94. https://doi.org/10.1080/09540962.2021.1896131

Gates M. G., Mark B. A. (2012). Demographic diversity, value congruence, and workplace outcomes in acute care. *Research in Nursing & Health*, 35(3), 265–76. https://doi.org/10.1002/nur.21467

Gomez L. E., Bernet P. (2019). Diversity improves performance and outcomes. *Journal of the National Medical Association*, 111(4), 383–92. https://doi.org/10.1016/j.jnma.2019.01.006

Goode C. A., Landefeld T. (2018). The lack of diversity in healthcare. *Journal of Best Practices in Health Professions Diversity*, 11(2), 73–95.

Goradia D., Byron K. (2025). Made better by others? When having more diverse colleagues improves individual outcomes. *Production and Operations Management*, 34(3), 356–81. https://doi.org/10.1177/10591478241238973

Gover L., Duxbury L. (2012). Organizational faultlines: Social identity dynamics and organizational change. *Journal of Change Management*, 12(1), 53–75. https://doi.org/10.1080/14697017.2011.652375

Gregor S., Mulholland A.D., Brydges R., Bulmer B., Kangasjärvi E., Onyura B., Ng S. (2024). Distinct journeys and unique stories: how individuals from multiple professions cultivate careers in healthcare leadership. *BMJ leader*.

Hallet J., Sutradhar R., Flexman A., McIsaac D. I., Carrier F. M., Turgeon A. F., McCartney C., Chan W. C., Coburn N., Eskander A., Jerath A., Perez d'Empaire P., Lorello G., Eskander A. (2024). Association between anaesthesia–surgery team sex diversity and major morbidity. *British Journal of Surgery*, 111(5), znae097.

Hambrick D. C., Mason P. A. (1984). Upper echelons: The organization as a reflection of its top managers. *The Academy of Management Review*, 9(2), 193. https://doi.org/10.2307/258434

Han Y., Tang B., Li X.-M., Yang G.-S.-R., Yang L. (2023). Research on the relationship between informational team faultline and team resilience—team leader member exchange and team member exchange as mechanism. *Journal of Multidisciplinary Healthcare*, 16, 3585–97. https://doi.org/10.2147/JMDH.S436618

Harrison D. A., Klein K. J. (2007). What's the difference? Diversity constructs as separation, variety, or disparity in organizations. *Academy of Management Review*, 32(4), 1199–228. https://doi.org/10.5465/amr.2007.26586096

Harrison D. A., Price K. H., Bell M. P. (1998). Beyond relational demography: Time and the effects of surface- and deep-level diversity on work group cohesion. *Academy of Management Journal*, 41(1), 96–107. https://doi.org/10.5465/256901

Harrison R., Jones B., Gardner P., Lawton R. (2021). Qualityassessment with diverse studies (QuADS): An appraisal tool for methodological and reporting quality in systematic reviews of mixed- or multi-method studies. *BMCHealth Services Research*, 21 (1), 144. 10.1186/s12913-021-06122-y

Hermes M., Winter V., Wild E.-M. (2025). Predictors and effects of hospital chief executive officer turnover: A systematic review. *Health Care Management Review*, 50(3), 197. https://doi.org/10.1097/HMR.0000000000000441

Hillman A. J., Withers M. C., Collins B. J. (2009). Resource dependence theory: A review. *Journal of Management*, 35(6), 1404–27. https://doi.org/10.1177/0149206309343469

Horwitz S. K., Horwitz I. B. (2007). The effects of team diversity on team outcomes: A meta-analytic review of team demography. *Journal of Management*, 33(6), 987–1015. https://doi.org/10.1177/0149206307308587

Houston L., Kraimer M., Schilpzand P. (2025). The motivation to be inclusive: Understanding how diversity self-efficacy impacts leader

effectiveness in racially diverse workgroups. *Group & Organization Management*, 50(3), 983–1019. https://doi.org/10.1177/10596011231200929

Ibidunni A. S., Falola H. O., Ibidunni O. M., Salau O. P., Olokundun M. A., Borishade T. T., Amaihian A. B., Peter F. (2018). Workforce diversity among public healthcare workers in Nigeria: Implications on job satisfaction and organisational commitment. *Data in brief*, 18, 1047–53.

Jansen A. E., Searle B. J. (2021). Diverse effects of team diversity: A review and framework of surface and deep-level diversity. *Personnel Review*, 50(9), 1838–53.

Li J., Wu H., Deng Z., Lu N., Evans R., Xia C. (2019). How professional capital and team heterogeneity affect the demands of online team-based medical service. *BMC Medical Informatics and Decision Making*, 19:119.

Johnson A., Nguyen H., Groth M., White L. (2018). Reaping the rewards of functional diversity in healthcare teams: Why team processes improve performance. *Group & Organization Management*, 43(3), 440–74. https://doi.org/10.1177/1059601118769192

Kim A., Shin J., Kim Y., Moon J. (2021). The impact of group diversity and structure on individual negative workplace gossip. *Human Performance*, 34(1), 67–83. https://doi.org/10.1080/08959285.2020.1867144

Laditka J. N. (2004). Physician supply, physician diversity, and outcomes of primary health care for older persons in the United States. *Health & place*, 10(3), 231–44.

Lau D. C., Murnighan J. K. (1998). Demographic diversity and faultlines: The compositional dynamics of organizational groups. *The Academy of Management Review*, 23(2), 325. https://doi.org/10.2307/259377

Lee C. C., Cho Y. S., Breen D., Monroy J., Seo D., Min Y.-T. (2023). Relationship between racial diversity in medical staff and hospital operational efficiency: An empirical study of 3870 US hospitals. *Behavioral sciences*, 13(7), 564.

Leslie L. M. (2019). Diversity Initiative Effectiveness: A Typological Theory of Unintended Consequences. *Academy of Management Review*, 44(3), 538–63. https://doi.org/10.5465/amr.2017.0087

Martikainen R.-M., Kuivila H.-M., Koskenranta M., Kamau S., Oikarainen A., Matinlompolo N., … Mikkonen K. (2024). Exploring the integration of culturally and linguistically diverse nurses and nursing students in healthcare: A cross-sectional study. *Nurse education in practice*, 80, 104129.

Martins L. L., Sohn W. (2022). How Does Diversity Affect Team Cognitive Processes? Understanding the Cognitive Pathways Underlying the Diversity Dividend in Teams. *Academy of Management Annals*, 16(1), 134–78. https://doi.org/10.5465/annals.2019.0109

McLaney E., Morassaei S., Hughes L., Davies R., Campbell M., Di Prospero L. (2022). A framework for interprofessional team collaboration in a hospital setting: Advancing team competencies and behaviours. *Healthcare Management Forum*, 35(2), 112–7. https://doi.org/10.1177/08404704211063584

Mitchell R., Boyle B., Hughes L. (2015). Professional diversity, identity salience and team innovation: The moderating role of open-mindedness norms. *Journal of Organizational Behavior*, 36(6), 873–94.

Mitchell R., Boyle B. (2021). Professional faultlines and interprofessional differentiation in multidisciplinary team innovation: The moderating role of inclusive leadership. *Health Care Management Review*, 46(4), 332. https://doi.org/10.1097/HMR.0000000000000276

Mitchell R., Boyle B., Nicholas S. (2020). The interactive influence of human and social capital on capability development: The role of managerial diversity and ties in adaptive capability. *Personnel Review*, 50(3), 865–79. https://doi.org/10.1108/PR-08-2019-0410

Mitchell R., Boyle B., Nicholas S., Maitland E., Zhao S. (2016). Boundary conditions of a curvilinear relationship between decision comprehensiveness and performance: The role of functional and national diversity. *Journal of Business Research*, 69(8), 2801–11.

Mitchell R., Boyle B., O'Brien R., Malik A., Tian K., Parker V., Giles M., Joyce P., Chiang V. (2017). Balancing cognitive diversity and mutual understanding in multidisciplinary teams. *Health care management review*, 42(1), 42–52.

Mitchell R., Boyle B., Snell L. (2022). The curvilinear effect of professional faultlines on team innovation: The pivotal role of professional identity threat. *Applied Psychology*, 71(1), 296–311. https://doi.org/10.1111/apps.12322

Mitchell R., Boyle B., Von Stieglitz S. (2019). Professional commitment and team effectiveness: A moderated mediation investigation of cognitive diversity and task conflict. *Journal of Business and Psychology*, 34(4), 471–83.

Mitchell R., Gu J., Boyle B. (2022). What do they think of me? Professional diversity, meta-stereotype negativity, suspicion, and counterproductive work behaviour. *Human Resource Management Journal*, 32(4), 864–89. https://doi.org/10.1111/1748-8583.12476

Mitchell R. J., Parker V., Giles M. (2011). When do interprofessional teams succeed? Investigating the moderating roles of team and professional identity in interprofessional effectiveness. *Human Relations*, 64(10), 1321–43. https://doi.org/10.1177/0018726711416872

Molina A., Valls V., Martínez-Tur V., Cropanzano R. (2024). Team Justice as a consequence of demographic faultlines: Climate level and strength. *Group & Organization Management*. https://doi.org/10.1177/10596011241238492

Monteiro A. P., Cepêda C., da Silva A. F. (2024). Does the workforce and sustainability reports strengthen the relationship between gender diversity and sustainability performance reporting? *Administrative Sciences*, 14(6), 105.

Naciti V., Noto G., Vermiglio C., Barresi G. (2022). Gender representation and financial performance: An empirical analysis of public hospitals. *International Journal of Public Sector Management*, 35(5), 603–21. https://doi.org/10.1108/IJPSM-01-2022-0004

Nawaz M. R., Ishaq M. I., Ahmad R., Faisal M., Raza A. (2022). Team diversity, conflict, and trust: Evidence from the health sector. *Frontiers in psychology*, 13, 935773.

Nkomo S. M., Bell M. P., Roberts L. M., Joshi A., Thatcher S. M. B. (2019). Diversity at a critical juncture: new theories for a complex phenomenon. *Academy of Management Review*, 44(3), 498–517. https://doi.org/10.5465/amr.2019.0103

Page M. J., McKenzie J. E., Bossuyt P. M., Boutron I., Hoffmann T. C., Mulrow C. D., Shamseer L., Tetzlaff J. M., Akl E. A., Brennan S. E., Chou R., Glanville J., Grimshaw J. M., Hróbjartsson A., Lalu M. M., Li T., Loder E. W., Mayo-Wilson E., McDonald S., McGuinness L. A., Stewart L. A., Thomas J., Tricco A. C., Welch V. A., Whiting P., Moher D., Brennan S. E. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *bmj*, 372. https://www.bmj.com/content/372/bmj.n71.short

Pfeffer J., Salancik G. (2015). External control of organizations—Resource dependence perspective. In *Organizational behavior 2* (pp. 355–370). Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9781315702001-24/external-control-organizations%E2%80%94resource-dependence-perspective-jeffrey-pfeffer-gerald-salancik

Placide V., Brown R. A., Blavos A., Grover O., Chubb C. S. (2023). The importance of diversity in the healthcare workforce. In *Handbook of research on exploring gender equity, diversity, and inclusion through an intersectional lens* (pp. 374–396). IGI Global https://www.igi-global.com/chapter/the-importance-of-diversity-in-the-healthcare-workforce/324459

Poon Y.-S. R., Lin Y. P., Griffiths P., Yong K. K., Seah B., Liaw S. Y. (2022). A global overview of healthcare workers' turnover intention amid COVID-19 pandemic: A systematic review with future directions. *Human Resources for Health*, 20(1), 70. https://doi.org/10.1186/s12960-022-00764-7

Rawlinson C., Carron T., Cohidon C., Arditi C., Hong Q. N., Pluye P., Peytremann-Bridevaux I., Gilles I. (2021). An overview of reviews on interprofessional collaboration in primary care: Barriers and facilitators. *International journal of integrated care*, 21(2), 32.

Romano M., Netti A., Corvino A., Intenza M. (2024). Environmental innovation in healthcare industry: The moderating role of women on board in cost of debt. *Corporate Social Responsibility and Environmental Management*, 31(3), 1921–33. https://doi.org/10.1002/csr.2678

Rupert J., Blomme R. J., Dragt M. J., Jehn K. (2016). Being different, but close: How and when faultlines enhance team learning. *European Management Review*, 13(4), 275–90. https://doi.org/10.1111/emre.12083

Sarto F., Veronesi G. (2016). Clinical leadership and hospital performance: Assessing the evidence base. *BMC Health Services Research*, 16(S2), 169. https://doi.org/10.1186/s12913-016-1395-5

Schmidt M., Steigenberger N., Berndtzon M., Uman T. (2023). Cultural diversity in health care teams: A systematic integrative review and research agenda. *Health care management review*, 48(4), 311–22.

Schrand L., Ascherl C., Schaefers W. (2018). Gender diversity and financial performance: Evidence from US REITs. *Journal of Property Research*, 35(4), 296–320. https://doi.org/10.1080/09599916.2018.1549587

Sheffer Hilel G., Drach-Zahavy A., Endevelt R. (2023). The paradoxical effects of professional stereotypes on the quality of care by interprofessional teams: The contingent effects of team faultlines, team stereotypes, and championship behaviors. *Frontiers in Psychology*, 14, 1135071.

Spence M. (1978). Job market signaling. In *Uncertainty in economics* (pp. 281–306). Elsevier https://www.sciencedirect.com/science/article/pii/B9780122148507500255

Spence M. (2002). Signaling in Retrospect and the Informational Structure of Markets. *American Economic Review*, 92(3), 434–59. https://doi.org/10.1257/00028280260136200

Stanford F. C. (2020). The importance of diversity and inclusion in the healthcare workforce. *Journal of the National Medical Association*, 112(3), 247–9.

Tajfel H., Turner J. C., Austin W. G., Worchel S. (1979). An integrative theory of intergroup conflict. *Organizational identity: A reader*, 56 (65), 9780203505984–16.

Tietschert M., Bahadurzada H., Kerrissey M. (2024). Revisiting organizational culture in healthcare: Heterogeneity as a resource. *Social Science & Medicine*, 356, 117165.

Trinchese D., Vainieri M., Cantarelli P. (2024). Gender diversity and healthcare performance: A quantitative analysis from the Italian health system. *Health Policy*, 146. https://doi.org/10.1016/j.healthpol.2024.105117

Uman T., Steigenberger N., Nichitelea D., Berndtzon M., Schmidt M. (2025). A configurational approach to the relationship between ethnic diversity, leadership, and performance in health care teams. *Health Care Management Review*, 50(4), 285–95.

Uyar A., Kuzey C., Kilic M., Karaman A. S. (2021). Board structure, financial performance, corporate social responsibility performance, CSR committee, and CEO duality: Disentangling the connection in healthcare. *Corporate Social Responsibility and Environmental Management*, 28(6), 1730–48. https://doi.org/10.1002/csr.2141

Van De Ven A. H., Rogers R. W., Bechara J. P., Sun K. (2008). Organizational diversity, integration and performance. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational and Organizational Psychology and Behavior*, 29(3), 335–54. https://doi.org/10.1002/job.511

Van Knippenberg D., Schippers M. C. (2007). Work group diversity. *Annual Review of Psychology*, 58(1), 515–41. https://doi.org/10.1146/annurev.psych.58.110405.085546

van Zijl A. L., Vermeeren B., Koster F., Steijn B. (2019). Towards sustainable local welfare systems: The effects of functional heterogeneity and team autonomy on team processes in Dutch neighbourhood teams. *Health & Social Care in the Community*, 27(1), 82–92. https://doi.org/10.1111/hsc.12604

Van Zijl A. L., Vermeeren B., Koster F., Steijn B. (2023). Functional diversity and team innovation: A study on the mediating role of social cohesion in primary care teams. *Health Care Management Review*, 48(3), 229–36.

Von Bergen C. W., Soper B., Foster T. (2002). Unintended negative effects of diversity management. *Public Personnel Management*, 31 (2), 239–51. https://doi.org/10.1177/009102600203100209

Wang H., Buljac-Samardžić M., van Wijngaarden J., van de Klundert J. (2024). Do generational diversity and perceived similarity improve team functioning in rural Chinese hospitals? A cross-sectional survey study. *BMJ Open*, 14(11), e086451.

Yang H., Yan Z., Jia L., Liang H. (2021). The impact of team diversity on physician teams' performance in online health communities. *Information Processing & Management*, 58(1), 102421.

Yoo S., Kang J. Y. (2025). The effects of expertise diversity on efficiency and creativity in healthcare project teams. *European Journal of Training and Development*, 49, 1–2155–74.

Zijl A. L. V., Vermeeren B., Koster F., Steijn B. (2021). Interprofessional teamwork in primary care: The effect of functional heterogeneity on performance and the role of leadership. *Journal of Interprofessional Care*, 35(1), 10–20. https://doi.org/10.1080/13561820.2020.1715357