What comes after strategy: Moving beyond statements and open letters – An analysis of three Toronto hospitals’ diversity, equity and inclusion (DEI) plans

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ABSTRACT

Introduction The murders of Breonna Taylor and George Floyd in 2020 forced institutions to publicly acknowledge systemic racism. In the Canadian healthcare sector, some hospitals used this pivotal moment to create strategic equity plans to address anti-Black racism and ongoing health inequities.

Methods Through a case study approach, we selected three hospitals in Toronto, Canada and analysed their most recent publicly available diversity, equity and inclusion (DEI) strategic plans.

Results All three hospitals released new DEI strategies following 2020 that covered similar grounds: incorporating DEI into HR practices, cultural adaptations of services, race-based data collection and investments in training. While two out of three hospitals reported progress on their anti-Black racism commitments, specific actions to be taken and metrics to monitor and track progress varied.

Conclusions DEI plans analysed are set to reach maturity as early as 2023 and as late as 2025. We provide high level recommendations to guide this work beyond these timelines. Antiracism reform and reconciliation is not a one-time event, but requires thoughtful planning, collaboration with communities, investment in labour (ie, resources and staff), reflection and deep reckoning.

BACKGROUND

In the early days of 2020, COVID-19 was thought by many to be the great equaliser; an airborne virus that would not discriminate on the basis of race, class or gender. Three years later, the data show otherwise. A recent study by Statistics Canada2 reported that COVID-19 mortality rates were significantly higher for racialised populations (31 deaths per 100 000) compared with non-racialised and non-Indigenous populations (22 deaths per 100 000), with Black people having the highest age-standardised COVID-19 mortality rate (49 deaths per 100 000), followed by South-Asians (31 deaths per 100 000). These findings are consistent with results from studies conducted in the USA and elsewhere.1 The onset of COVID-19 also saw the dramatic increase in anti-Asian racism worldwide (reminiscent of the 2003 SARS CoV outbreak), with people of Chinese descent or those perceived to be Chinese targeted and blamed for the pandemic.4–7 Against the backdrop of the pandemic was the continued struggle for self-determination and Indigenous rights to self-governance as Wet’suwet’en Nation land defenders organised against the Canadian government to oppose the construction of the Coastal GasLink pipeline into their traditional territories.10, 11 While solidarity movements across the nation took place in support of the Hereditary Chiefs of Wet’suwet’en in early 2020, this historical struggle largely faded from public consciousness as attention turned to the pandemic.12

If the global pandemic was the pile of hay and the ensuing spike in anti-Asian racism and rhetoric was the trail of gasoline, then the murder of Breonna Taylor in Louisville, Kentucky, and George Floyd in Minneapolis, Minnesota by state police officers served as the match, forcibly ushering in a long-overdue social reckoning and igniting a global sense of urgency among organisations and institutions to express their commitment to social justice and anti-racism.13 In the months and years since, many have questioned the commitments and impacts of these public statements, open letters and strategies; skeptical of their performative nature while being hopeful of the potential to address
systemic issues and move the needle towards a more equitable world.\textsuperscript{14}

**Diversity, equity and inclusion: Moving beyond statements**

Institutions often communicate commitments to anti-racism reform alongside mentions of diversity, equity and inclusion (DEI).\textsuperscript{14} Although DEI is by no means new to the healthcare lexicon, prior to 2020, DEI was by and large operationalised as a sub-function of human resources (HR).\textsuperscript{15} Post-2020, DEI has become perceived by many organisations as a key business function related to social citizenship, advocacy and justice.\textsuperscript{15} In the USA, between May and September 2020 alone, the number of DEI-related job postings increased by 123%.\textsuperscript{16} In Canada, at the 2022 National Health Leadership Conference, healthcare leaders, organisations and patients called on the federal government to help address key root causes of the healthcare crisis, one of which included a commitment to DEI through funding that would embed DEI training into healthcare workers educational curricula.\textsuperscript{15}

With the explosion of interest in DEI, how does one assess whether expressions of interest by healthcare leaders and organisations translate into tangible investments, structural change and health equity, or whether expressions of interest remain simply that—expressions of interest?

Strategic plans provide material evidence of the priorities of institutions, providing a window into their aspirations, values and metrics. Recognising the renewed interest in DEI across Canada’s healthcare system, we review the strategic DEI plans and initiatives of three prominent hospitals in Canada’s most racially and ethnically diverse urban centre, Toronto, Ontario.

We offer a critical analysis of the role and limits of DEI plans and initiatives for advancing structural change and equity within healthcare organisations and systems.\textsuperscript{17}

**METHODS**

Employing a case study approach,\textsuperscript{18} we describe the evolution of DEI commitments and associated strategies at three prominent Toronto hospitals. The intent of this paper is not to point to any single institution as an example to strive towards or disavow, but to critically assess the efforts of healthcare institutions as they work towards advancing equity through the umbrella of DEI. Therefore, the hospitals in our analysis will be referred to as: hospital 1, hospital 2 and hospital 3. The sampling strategy and selection criteria for documents to be reviewed are detailed in figure 1. Refer to online supplemental files for all DEI plans and related documents.

**Authors’ reflexivity and positionality**

We are a diverse group of multidisciplinary researchers at a Toronto Academic Health Science Network (TAHSN) hospital with marginalised and privileged identities committed to anti-racism and anti-oppression. Our social identities include: a Pakistani-Muslim queer cis-gender man who identifies as a settler living with a chronic mental illness; a Black cis-gender female who identifies as African and an immigrant to Canada; a straight white cis-gender woman who is a second-generation settler with European ancestry living with a chronic illness; a Vietnamese cisgender woman who is a settler from refugee parents; and an Indo-Canadian cis-gender woman who is a second-generation settler. As researchers embedded in academia and health, we are critiquing a space that has over time afforded us privilege and power. Despite these juxtapositions, we are individually and collectively committed to advancing anti-racism and anti-oppression within our spheres of influence. Two authors co-founded and co-chaired a departmental equity committee within our institution which is currently under the leadership of two other authors. One author is a senior researcher dedicated to equity in their research.

**CASE STUDIES OF THREE TAHSN HOSPITALS**

In this section, we present a structured but non-exhaustive analysis of the organisational DEI strategies of the three selected case studies. We report the analysis according to: (1) the process of their strategy development, (2) which communities (if any) are explicitly addressed in the strategic plans, (3) the different components of each plan and (4) accountability structures or measures that have been developed by each hospital to monitor and report on progress.

**Figure 1** Sampling Strategy and Selection Criteria for Hospitals and Documents

Using a convenience sampling approach, we identified three hospitals that have publicly available equity-related strategic plans. Throughout this article we refer to these as DEI (diversity, equity, inclusion) plans.

Selection of hospitals and their equity-related strategy plans was based on two criteria and one distinctive feature. Criteria included: 1) membership in the Toronto Academic Health Sciences Network (TAHSN), a network of academic health organizations and Canadian leaders in research, teaching, and clinical care and 2) DEI plans were publicly available. To narrow our selection to 3 hospitals from the 15 member organizations within the TAHSN network, we opted to select hospitals that serve a distinct population or deliver distinct types of healthcare services specifically those focused on children, mental health, and women.

We reviewed the most recent organization-wide and publicly available strategy documents and DEI plans at each hospital. Where necessary, we leveraged pre-existing networks and relationships with colleagues at the three institutions to confirm the descriptions and titles of their DEI documents which helped us refine our search on Google and on each hospital’s website. Given that many institutions began formally addressing DEI following the outcries against systemic racial violence in 2020 it is possible that many hospitals were in the middle of planning their next cycle of strategic plans and pivoted to include or develop a DEI-specific strategy as a timely response. Therefore, any publicly available DEI strategies or documents (e.g., reports) released post-2020, even if not stated as officially part of the official hospital-wide strategy, were also reviewed.
Strategy overview and DEI timelines

Hospital 1 is a paediatric hospital serving children and youth under 17 years old. Their DEI strategy was released in 2022, with a 3-year implementation period nested within the larger institutional strategy spanning from 2020 to 2025. This is their first DEI strategy to be developed. Hospital 2 is a mental health and addiction service provider. Their 3-year strategic plan (2020–2023) focuses on redefining mental health. Hospital 2 also released a Truth and Reconciliation (TRC) action plan and Anti-Black Racism (ABR) action plan with actions that correspond with the 3-year strategic plan. Hospital 3 specialises in women’s health and provides specialised care for various groups, including trans people, refugees, sexual assault/domestic violence survivors, and people with problematic substance use. Their institutional strategic framework (2022–2023) focuses on improving care after COVID-19. Hospital 3 also released several public-facing documents, including an ABR strategy and a HR equity plan for staff. It is unclear how these two later documents link to the institutional strategic framework.

Process: Development of DEI strategy

All three hospitals employed similar approaches in developing their DEI strategies and action plans, which included reviewing organisational policies and processes, consulting existing DEI literature and resources, and gathering insights from various groups such as staff, patients, trainees, community leaders and experts in DEI. Hospital 1’s 3-year (2022–2025) DEI strategy was developed with support by an external advisor and aligns with Ontario Health’s Equity, Inclusion, Diversity, and Anti-Racism (EIDA-R) framework, as mentioned previously, this is the first DEI strategy released by this hospital. Hospital 2’s 3-year strategy (2020–2023) was developed in collaboration with internal and external experts from the mental health and addictions community and is described as explicitly linking to corresponding TRC and ABR action plans. Hospital 3’s HR equity plan for staff is a corresponding deliverable that stems from their 2-year institutional strategic framework (2022–2024) and it is unclear how the ABR plan released in 2021 is connected to the strategic framework. Hospital 3 hired an external expert in ABR to lead the development of the plan which included conducting data collection with internal Black identified staff and physicians.

Spotlight: Communities addressed in DEI strategy

The strategic plans of all three hospitals emphasise DEI, with each hospital recognising the varying quality of access to care and care outcomes for certain communities based on personal characteristics such as gender, race/ethnicity, geographic factors and socioeconomic status. All three hospitals acknowledged the gaps in equitable care for Indigenous, Black and other marginalised communities and described their aims to reduce barriers to care access and to develop culturally appropriate and safe services. Only Hospital 2 developed a TRC Action Plan addressing Indigenous Nations which acknowledges how Canada’s colonial history continues to be embedded within institutional structures and highlights support for Indigenous-led initiatives and tailored clinical services. While TRC in partnership with Indigenous communities is mentioned within hospital 1’s plan, there is no elaboration on how TRC recommendations will be addressed. Among the three documents reviewed for hospital 3, Indigenous peoples are mentioned in the HR Equity Plan for staff in relation to inequities in hiring, retention and promotion. In this document, Indigenous peoples, persons with disabilities, racialised persons, LGBTQ2+ individuals and women are specifically named as having experienced barriers to employment.

Hospital 2 and 3 both developed specific action plans to address ABR. For both hospitals 2 and 3, ABR commitments aim to educate and address how ABR had negatively impacted the experiences and career trajectories (including hiring practices and promotion opportunities) of staff members who identify as Black, often leading to emotional and psychological harms. In addition, both strategies aim to assess ABR in the design and delivery of healthcare services for Black identifying patients. Both hospitals released at least one follow-up progress report or communications to share how they have advanced on their ABR journey or commitments. While hospital 1 has made noticeable efforts to incorporate DEI language in their strategy, their acknowledgement of systemic oppression could be strengthened by connecting their goals to past and ongoing racial injustices and discriminatory practices. Due to the paediatric population, it serves, hospital 1’s strategy includes a focus on increasing access to in-hospital and postdischarge care for vulnerable children.

Nuts and bolts: Review of action plans

Our review of the DEI plans and companion documents from the three hospitals show that areas of focus outlined in their various documents cover similar grounds. DEI strategies aimed to enhance (1) data collection and disaggregated measurements, (2) inclusive HR practices related to retention, recruitment and equity, (3) culturally adapted service models, (4) investments in training and capacity-building, staff education and organisational advocacy and (5) ensuring funding and resources for implementing DEI strategies. Figure 2 provides an overview of the strategies identified in the analysis of the hospitals.

All three hospitals committed to carrying out internal data collection efforts, including internal sociodemographic employee surveys and reviewing/revising existing organisational HR policies as needed. To cater to diverse and marginalised patient populations and understand where current health service offerings may need to be culturally adapted, all three hospitals also committed to reviewing current services offerings and collection of sociodemographic data on patient populations. While all hospitals committed to collection sociodemographic and race-based data on patients to understand service reach, only hospital 2 recognised the current barriers to collecting race-based data and the distrust between racialised communities and the wider health system that needs to be addressed to achieve these data-driven goals. Lastly, all three hospitals also committed to developing educational resources for staff to increase knowledge on DEI, with hospital 2 and 3 committed to develop specific educational resources on ABR and reconciliation.

Hospital 1 also had specific objectives around creating a public-facing scorecard to measure staff diversity, developing key performance indicators (KPIs) and benchmarks to measure DEI progress, integrating DEI analysis in the design, training and application of research and education, and establishing a DEI Steering Committee. However, some proposed actions from hospital 1 illustrate gaps in understanding complex sociohistorical dynamics that have created inequities. For example, plans to remove barriers that inhibit diverse representation among volunteers and staff focus solely on candidates’ qualifications and fail to consider the real barriers marginalised communities face.

Hospital 2’s ABR strategy, with 22 action points, aims to enhance equitable access to care, training and education, hiring and retention, partnership and collaboration, reporting and support structures for racist incidents, quality improvement...
strategies, culturally adapted services, and institutional advocacy. The TRC action plan for hospital 2 includes creating a psychologically safe workplace for Indigenous staff, using land acknowledgements, Indigenous cultural safety and anti-racism training for all staff, systems for safely reporting and addressing incidents of racism, ethnoculturally sensitive forms of programme delivery and collecting race-based data.

Specific activities to be carried by hospital 3 appear to be in the process of being developed by separate steering groups or committees. The only publicly available document available was the internal HR equity plan, which as previously mentioned, outlines activities such as an internal and external workforce and service analysis.

Brass tacks: Accountability structures and key performance indicators

All three hospitals developed or committed to developing measures and KPIs to ensure accountability and track progress on DEI commitments.

Hospital 1 initiated efforts to collect sociodemographic data on staff and trainees and state that this data will aid in establishing benchmarks and developing a scorecard with KPIs to enhance diversity within their workforce. While they also mentioned the application of a DEI analysis in the design, training and application of research and education, there was no specific information on what the DEI analysis would entail. Although there
was acknowledgement that achieving DEI goals will be resource intensive, there was no publicly available disclosure on sustainable funding and resources for to support its’ DEI goals.

Hospital 2 developed an ABR strategy with 22 actions at the organisational, staff and clinical level, with corresponding measures and metrics of progress. The strategy places a strong emphasis on providing resources, support and channels for staff to serve Black patients and their families equitably. While the operational details of this emphasis are not as explicitly stated, hospital 2 plans to measure and monitor improvements in DEI starting in 2020, with a timeline for action on its ABR plan until the end of 2022.

Hospital 3 recently released a progress report outlining the hospital’s corporate commitments to address and dismantle ABR, along with an implementation plan to carry it out and a monitoring and evaluation framework. The report includes a commitment to develop quantitative and qualitative KPIs for future initiatives. The plan emphasises the importance of attaching time frames and accountability measures for DEI activities and describes specific goals for staff, volunteers and physicians, with related deliverables. The plan lists key success factors, internal and external potential partnerships to operationalise it, and a system for monitoring and revising the plan.

**DISCUSSION**

Given the renewed interest in DEI in Canada’s healthcare system, we examined the strategic plans and initiatives of three major hospitals in Toronto, Ontario. While DEI are not the same as anti-racism and social justice efforts, the decision to analyse the strategic plans were based on the premise that institutional strategies provide a glimpse into institutional aspirations, values and metrics, serving as material evidence of institutional priorities. While all three hospitals addressed racism and reconciliation in their strategic plans following the events of early 2020, hospital 2’s long-standing commitment to equity stood out. However, it is important to note that strategic documents are a vehicle for organisational leadership to express their views and commitments, and staff may have long-standing commitments to equity that predate public acknowledgement at the organisational level. The timeline for these plans are subject to end as early as 2023 and as late as 2025, as such the fruits of these plans are yet to be fully realised.

While all hospitals mentioned Indigenous, Black and other marginalised communities at a high level, only hospitals 2 and 3 developed specific action plans to address ABR, anti-Indigenous racism and integrate TRC principles into research, hiring practices and organisational policies. However, there was more concrete action and transparency in reporting progress on ABR than anti-Indigenous or TRC commitments, with progress reports released a year following the launch of their ABR strategies. Additionally, there was no clarification on who or what other communities are
lumped under ‘other marginalised groups’, potentially indicating a cherry-picked approach to equity. Rather than treating equity, anti-racism reform and reconciliation as checkbox exercises, organisations need to demonstrate a critical understanding of how power, privilege and oppression operate to uphold oppressive systems. True transformative movements towards anti-racism and reconciliation require concerted effort to understand how strategies of liberation and justice for one group may run in conflict for another group and the courage to reckon with these complexities.

All three hospitals shared a goal of increasing diversity in their workforce. However, it is important to recognise that merit-based hiring and promotion practices may have limitations. HR policies are often bureaucratic and procedural to prevent bias, but leadership and policies need to consider the structural barriers that marginalised communities face in obtaining professional experience and higher education, which affects their competitiveness in the hiring pool and their compensation if hired. These communities may have been historically excluded from entering these institutions, leading to a lack of diversity. Adopting an equity lens to hiring and promotion practices means understanding that not everyone has had equal opportunities and taking steps to address these disparities.

In a recent review, Rahman-Shepherd et al. analysed the anti-racism statements and commitments among the highest-ranked public health universities, academic journals and funding agencies and found that of the 45 institutions that were sampled, only 19 had issued some sort of anti-racism statement following the events of 2020. Of these 19, only 4 made a follow-up statement each year after their first public statements, and even fewer developed actionable metrics of accountability. While actionable metrics (eg, KPIs) provide a level of assurance and accountability, it is important to keep in mind the long-term vision of this work rather than get lost in metrics. Well-intentioned words and language without accountability reproduces racism, power differentials and hierarchical thinking. This is highlighted in Brown et al’s critical discourse analysis of public statements released by Canadian and American academic medical organisations in response to the demand for collective action against racial injustices and police brutality. Public-facing organisational documents that lack critical reflection and commitment are harmful, performative and do not lead to transformative actions to abolish racism and discriminatory institutional practices and processes.

Ella F. Washington, a DEI consultant, describes how an organisation’s DEI progress follows a predictable developmental cycle: awareness, compliant, tactical, integrated and sustainable, with most organisations being stuck in the compliant stage as they aim consciously or not to appease funders and regulatory bodies. While being at the compliant stage may be better than not being on the trajectory at all, we need to be wary of how the prime motivation and accountabilities for organisations stuck at this stage may be misplaced, deprioritising the communities impacted. In the spirit of reflection and accountability and following our analysis, we proffer the following high-level recommendations to healthcare institutions and other organisations in general seeking to move beyond expressions of interest and perforfny DEI plans in figure 3.

To our knowledge, ours is the first paper to conduct a review of the DEI plans and strategies of TAHSN hospitals taking a case study approach. This case study approach offers important insight and reflection into how institutions with a mandate to serve the public good, specifically hospitals, are proactively thinking about and acting to address systemic and structural injustice within and outside their walls. However, as our sample only represents a subset of hospitals in the Toronto area (3 out of 15 TAHSN member hospitals), a broader sample may yield more insights. Second, as we only reviewed strategic plans that were publicly available, it is possible that more detailed versions of DEI-related documents may exist but are internal facing. Ultimately, the purpose of this paper is not to suggest that there is a one-size-fits-all approach to doing meaningful work in this space; often, targeted and specific recommendations are most helpful. This analysis provides high-level recommendations, recognising that different institutions are at different places in their trajectory. The authors would also like to note that the existence of a detailed or robust DEI plan does not necessarily mean that all the work in the plan is being meaningfully executed. In contrast, the absence of a strategic plan focused on DEI, ABR, or TRC does not necessarily mean that no good work is being done. As more hospitals and health organisations begin to publicly release DEI strategic plans and integrate DEI-specific goals, a broader systems-level analysis with national scope would be beneficial to understand DEI efforts in different jurisdictions with their own unique contexts and considerations.

CONCLUSION

As our collective consciousness around injustice continues to expand, Canadian hospitals and healthcare organisations must acknowledge institutional responsibility to dismantle structural violence against historically and present-day marginalised communities. This requires more than just well-crafted statements, but deep reflection and reckoning on our collective complicity of harm caused, whether through explicit exclusionary policies and practices or silence in the face of such practices. Our team analysed the equity strategies of three major hospitals in Toronto and provided high-level recommendations to guide the continuation of this work beyond the 3–5 years stated timelines. Developing effective equity-oriented strategic plans requires thoughtful planning, collaboration with communities, and the investment in labour (ie, resources and staff) needed to push this work forward. Action plans and strategic documents, with their clean lines, professional typesetting, editing, and emotive imagery and colour, often belie the demanding work and labour that underpin transformative anti-racism and anti-colonialism reform—labour that we know is still largely being borne by the impacted communities. To go forward, we also need to look back and reflect, sharing progress and inviting others to learn from what we have learnt. This should be a part of public accountability and may accelerate progress on our collective reconciliation pathway as a society.

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REFERENCES


Original research

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