Pathways for Internationally Educated Health-Care Professionals

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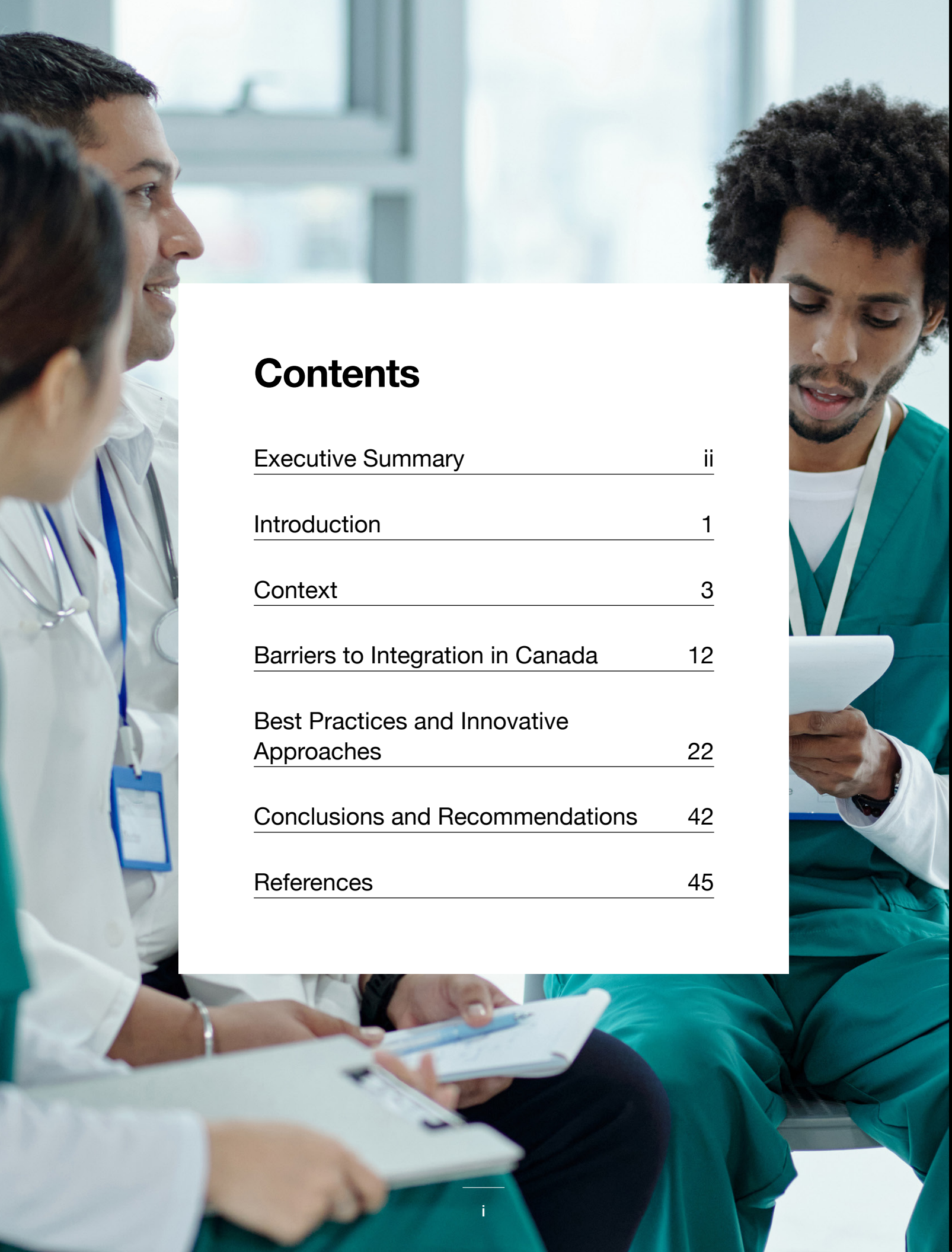

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Executive Summary

According to the World Health Organization, there is a global shortage of health-care workers. One in five Canadians already experiences this scarcity through a lack of access to a family physician. But the gaps, strains and shortages go well beyond physician care. They have wide implications for accessibility, wait times and the quality of care that people receive.

A solution is hiding in plain sight: Integrating internationally educated health-care professionals (IEHPs) into Canada's health-care system can alleviate workforce shortages and strengthen the system's overall performance.

However, Canada's integration of these professionals, much-needed across many health-care fields, is hampered by the convoluted process they must endure to share their skills. Obsolete and contradictory requirements are among the significant barriers that are shaped at societal, organizational and individual levels.

Drawing on Canadian and international examples, this report explores effective strategies and promising practices for bolstering IEHP participation in Canada's health-care mosaic.

Context

As of 2021, IEHPs accounted for 13% of post-secondary graduates within health-related fields in Canada. These professionals hold diverse educational backgrounds, from undergraduate degrees to advanced qualifications in medicine, dentistry, pharmacy, nursing and other fields.

Despite Canada's increasing health-care needs, IEHPs continue to encounter significant barriers to securing employment that aligns with their qualifications. Although 76% of IEHPs are employed, only 58% work in roles

related to health care, with many taking on positions that do not match their expertise.

This comes at a time when Canada's health-care staffing shortages are deepening, leading to delays in procedures and a decline in public trust. Rural areas face severe shortages in primary care, underlining the urgent need to address barriers preventing IEHPs from fully contributing to the workforce.

Comparing Canadian to OECD data gives us a picture of how similar countries with differing relicensure requirements are faring toward this goal. The United Kingdom, Irish and Australian experiences provide additional relevant and instructive comparisons.

Although 76% of IEHPs are employed, ***only 58%*** *work in roles related to health care, with many taking on* ***positions that do not match their expertise.***

Barriers to integration in Canada

The integration of IEHPs into Canada's health-care system is hindered by compounding barriers at societal, organizational and individual levels, and requires a multi-level approach.

Societal level

Proof of recent work experience, evidence of settlement funds, and other requirements can exclude qualified professionals. At the same time, temporary work permits further restrict professional integration by limiting job roles, mobility and access to licensure. Canada's decentralized health-care system also results in inconsistent policies, licensure requirements and standards across jurisdictions.

Global best practices indicate better health-system outcomes occur where these barriers are eliminated. However, the Atlantic Registry, launched in 2023, demonstrates that innovation is possible in Canada's federal system as well. The registry allows physicians licensed in the four Atlantic provinces to practise across those jurisdictions without relicensure.

Building on this, a pan-Canadian licensure framework was endorsed by health ministers (excluding Quebec) in October 2023 to facilitate national mobility for physicians. This could significantly improve IEHP employment flexibility and tackle regional labour shortages.

In January 2024, the federal government committed $86 million to support 15 organizations in streamlining foreign credential

recognition for 6,600 IEHPs. This includes simplifying credentialing processes, providing relevant work experience with wraparound supports, and enhancing the supply of health-care workers where they are needed most.

Organizational level

Additional licensure regulations and the lack of coherent IEHP employment practices hinder the integration of international professionals into workplaces. The absence of meaningful equity, diversity and inclusion (EDI) implementation enables discrimination in hiring and promotion. Workplaces often equate familiarity with local health-care systems, communication styles, and workplace norms with competence, sidelining the skills and experiences of internationally trained professionals.

These issues are layered with specific challenges for different professional roles.

For example, international medical graduates (IMGs) face limited residency opportunities, inconsistent access to more streamlined licensure pathways such as practice-ready assessment programs, and systemic bias in licensure. Internationally educated nurses (IENs) report racism, heightened scrutiny from supervisors, and costly, time-consuming recertification processes. International pharmacy graduates (IPGs), though well-represented in the workforce, frequently start in entry-level positions and face restricted access to clinical placements and hospital jobs.

Several effective approaches to streamline pathways are well-positioned for broader scaling and implementation.

- **Pre-arrival licensure preparation** is essential for helping newcomers understand the steps required to regain professional standing in Canada. Promising practices, including pre-arrival counselling and credential guidance, can inform IEHPs about their career pathways, reduce uncertainty and enable better employment outcomes.
- **Mutual recognition agreements** are formal arrangements through which Canadian regulatory bodies accept the credentials, examinations and training standards of select international jurisdictions as meeting local requirements. These agreements facilitate entry into regulated health professions, eliminating unnecessary relicensing requirements for IEHPs. It reduces entry barriers, lowers costs and processing times, and supports faster integration into the health-care workforce.

- **Bridging programs** integrate classroom instruction with hands-on learning through clinical placements or practicums. This combination is highly effective, as IEHPs who gain relevant workplace experience during the credentialing process are more likely to secure employment after licensure. Despite these benefits, many programs face challenges in securing placements due to limited employer engagement and misconceptions about the level of support IEHPs require.
- **Practice-ready assessment programs** are 12-week, clinical-based programs that offer streamlined, competency-based evaluations for IMGs who have completed residency and independent practice abroad. By allowing participants to work in the health-care system, these programs help address physician shortages in underserved communities.
- **New licensing categories** introduced in some Canadian provinces enable IEHPs to practise in supervised roles while completing their licensure requirements. This approach allows them to gain Canadian work experience and earn an income during the licensing process, simultaneously reducing entry delays and strengthening health-care system capacity.
- **Competency-based credential recognition** offers a more equitable and flexible pathway to licensure by evaluating what IEHPs know and can do, rather than where they were trained. It assesses whether individuals possess the knowledge, skills and judgment required to practise safely and effectively within Canada's health-care system. By emphasizing demonstrated ability over training origin in this way, the approach helps remove unnecessary barriers to licensure and supports more inclusive integration.
- **Reducing redundancies in language proficiency testing** is essential to improving access to licensure for IEHPs. Requiring repeated standardized exams creates unnecessary barriers, including financial and emotional strain, and can delay licensure even when individuals have already demonstrated proficiency. To address this, some regulators have begun accepting recent education or professional experience in English-speaking jurisdictions as sufficient evidence of language competence.

To support IEHP integration, EDI should be embedded across five key dimensions:

- **Governance and leadership:** Diverse leadership is crucial for shaping inclusive policies and practices.
- **Human resources:** Recruitment, professional development, mentorship programs, and extended orientation are essential for effective IEHP integration.
- **Workplace culture**: An inclusive workplace culture plays a critical role in supporting IEHPs. Equity-focused practices within the workplace foster a culture of respect, belonging and job satisfaction. This enhances retention and engagement among diverse staff.
- **Measurement and tracking EDI progress:** This is vital for ensuring accountability and continuous improvement. Disaggregated data, especially related to IEHPs, helps organizations tailor their interventions to address specific challenges and ensure equity.
- **Outreach and expanding the pool:** Healthcare employers can extend their efforts beyond internal diversity by collaborating with educational institutions, regulatory bodies, and community organizations to enhance pathways for IEHPs, ultimately expanding opportunities for these professionals to enter and succeed in the workforce.

Individual level

At the individual level, IEHPs can face challenges with English or French language proficiency, difficulties adapting to cultural and professional norms, and the emotional distress of leaving their home countries and rebuilding their lives in a new place. Many arrive in Canada seeking better opportunities for themselves and their families, often at the cost of established careers, support networks, and social standing in their home countries, leading to significant emotional strain. In addition, adapting to socio-cultural nuances in health care, as well as workplace norms and expectations, can create misunderstandings and hinder IEHPs' ability to integrate effectively.

Successful integration of IEHPs into the Canadian workforce would be bolstered by integrating the following best practices training into these professionals' preparation for work in the Canadian health-care system:

> **Mentorship programs** that provide personalized support can help IEHPs navigate language barriers, adapt to workplace cultures, and improve their understanding of Canadian health-care practices. By providing tailored guidance on professional roles and responsibilities, these programs enhance confidence, facilitate smoother integration, and contribute to stronger retention within the workforce.

> **Trauma-informed approaches to training** are crucial, as some IEHPs may have experienced trauma before migrating, and the migration journey itself can also be emotionally distressing. This approach focuses on a training environment that is safe, supportive and aware of the risks of environments that can cause retraumatization. They ensure that all participants feel secure, respected and empowered in their learning and professional environments.

> **Technologies** such as virtual reality (VR), micro-credentialing platforms, and artificial intelligence (AI) provide innovative solutions for bridging gaps in language proficiency, cultural competencies, and credential recognition.

> **Wraparound supports**, including financial aid, career counselling, mental health services, and assistance with child care and housing, are essential for addressing the unique challenges faced by IEHPs and round out the trauma-informed approach.

> **Socio-emotional skills training** is essential for IEHPs, who often face challenges related to communication, team dynamics, and professional norms in Canada's health-care system.

Trauma-informed approaches to training *are crucial, as some IEHPs may have experienced trauma before migrating, and the* ***migration journey*** *itself can also be* ***emotionally distressing.***

Conclusion and recommendations

To effectively address the barriers faced by IEHPs, a combination of systemic reforms, organizational practices, and individual strategies must be implemented.

At the societal level, government initiatives to rationalize licensure requirements and bolster targeted immigration approaches need to be strengthened and scaled. Regulators need to be part of the conversation and tie competencies to skill rather than location of training.

At the organizational level, employers need to implement wraparound integration methods that include standardized professional equivalencies. Implementing robust EDI strategies throughout the workplace can create an accepting work culture that embraces the skills and talents IEHPs bring to Canada's health-care system. Regarding recruitment, employers could work with governments to ensure a streamlined approach to targeted work permits and immigration streams.

Recognizing, supporting and advancing the skills of IEHPs will address the gaps in their Canadian experience and increase participation – without miring people in the Catch-22 situation of needing Canadian employment to land a Canadian job.

A strong commitment to addressing the structural and cultural aspects of the integration of IEHPs into Canada's health-care system can yield a strengthened Canadian health-care model and sustainable work for these badly needed international professionals.

Introduction

The World Health Organization has projected a global shortage of more than 14 million health-care workers by 2030.[1] To address this critical issue, the organization adopted the *Global Strategy on Human Resources for Health: Workforce 2030*. The strategy aims to establish key milestones and performance indicators to strengthen health workforce planning in member countries.

These milestones include the creation of health workforce registries and effective health human resource (HHR) planning strategies by 2030. The goal is to ensure there are enough health-care workers with the necessary knowledge, skills and qualifications to effectively perform their roles and achieve the objectives of a health system.[2] At its core, effective HHR planning seeks to align the current and future health needs of the population with workforce capacity and equitable distribution of resources.

A critical element is leveraging the potential of internationally educated health-care professionals (IEHPs). These are people who have completed their education, training and accreditation in a country other than the one in which they are seeking to practise.

The number of these professionals coming to Canada has grown substantially. By 2021, an estimated 259,695 IEHPs between the ages of 18 and 64 were living in Canada, making up 13% of the population in that age group with post-secondary health education.[3] This group includes physicians, nurses, dentists, pharmacists, and highly skilled professionals in other health-care-related disciplines.

Despite their expertise and experience, IEHPs face barriers to practising in their fields. Many are either unemployed or working in roles that fail to reflect their qualifications and training.[4]

The underutilization of IEHPs highlights critical inefficiencies in the health-care system, especially as workforce challenges continue to intensify. For instance, Canadian clinicians and health-care professionals are experiencing high rates of burnout, depression and physiological distress.[5, 6, 7] These issues contribute to increased levels of absenteeism and low retention rates, particularly among members of regulatory bodies.

These issues have been exacerbated by the COVID-19 pandemic.[8, 9] A report by the Registered Practical Nurses Association of Ontario indicated that 62% of registered

practical nurses in the province had considered or were intending to leave the profession in 2023.[10] The College of Nurses of Ontario reported that 7,795 nurses did not renew their licence or moved to the non-practising class in 2024, up from 7,215 in 2023.[11] Family doctors are in short supply, with one in five Canadians lacking access to a regular physician.[12] These gaps have implications for the accessibility, wait times and overall quality of care.

Broader systemic responses to burnout must factor in adequate training for less experienced staff, improved role distribution, regulated work hours, and supportive organizational practices.[13] However, another important strategy is to leverage the skills and experience of IEHPs.

Effective integration of international professionals would reduce the strain on existing workers and enhance the overall quality of care. They contribute specialized expertise, cultural knowledge and linguistic diversity that can enhance the delivery of patient-centred care, particularly in diverse communities.[14, 15] For example, research has shown that when health-care practitioners demonstrate greater cultural competence, it is associated with higher patient satisfaction, better adherence to treatment plans, and more open exchange of information.[16]

By integrating IEHPs in a more streamlined fashion, Canada can foster a more inclusive health-care workforce that can better meet the health needs of its diverse population,[17] while mitigating the global challenge of adequate system-wide professional health-care staffing.

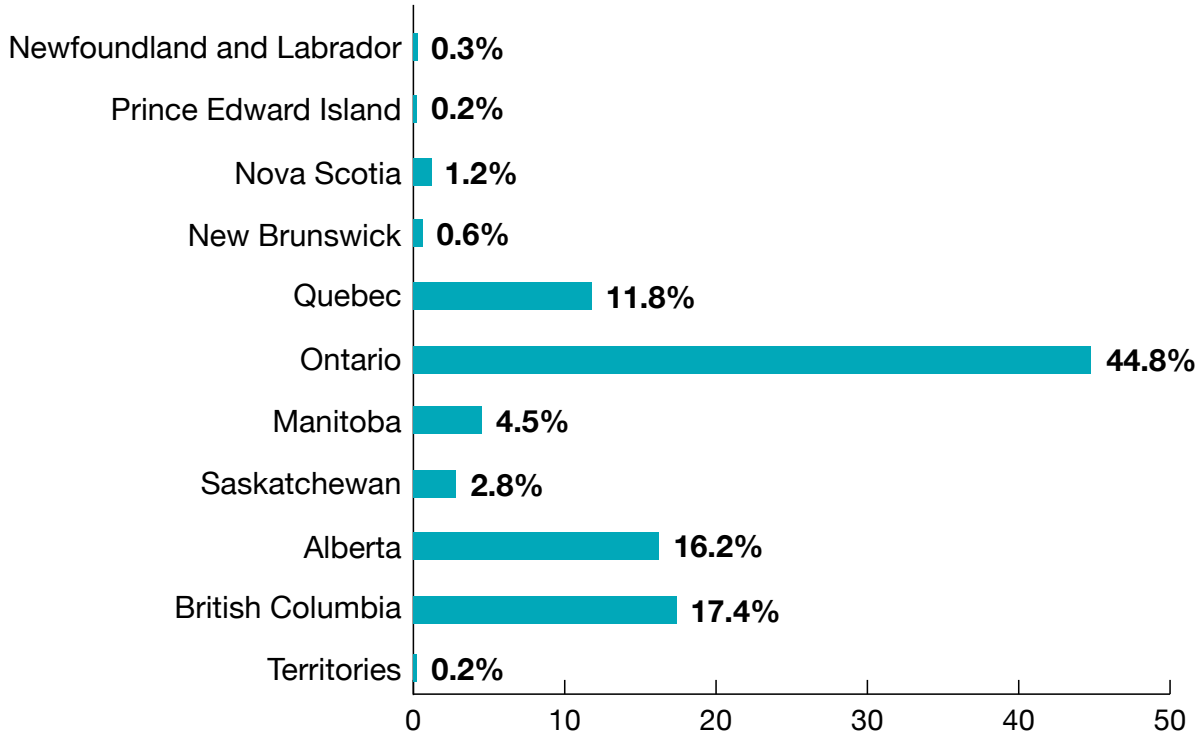
Context

Demographics in Canada

As Figure 1 shows, nearly one-half of IEHPs in Canada reside in Ontario (44.8%), followed by British Columbia (17.4%), Alberta (16.2%) and Quebec (11.8%). Women make up more than 70% of this group. More than one-third (33.5%) of IEHPs in Canada are 50 years of age and older, while those aged 30 to 39 represent 31.1% of the total, and 29.3% are between the ages of 40 and 49.[18]

Figure 1

Distribution across Canadian provinces and territories

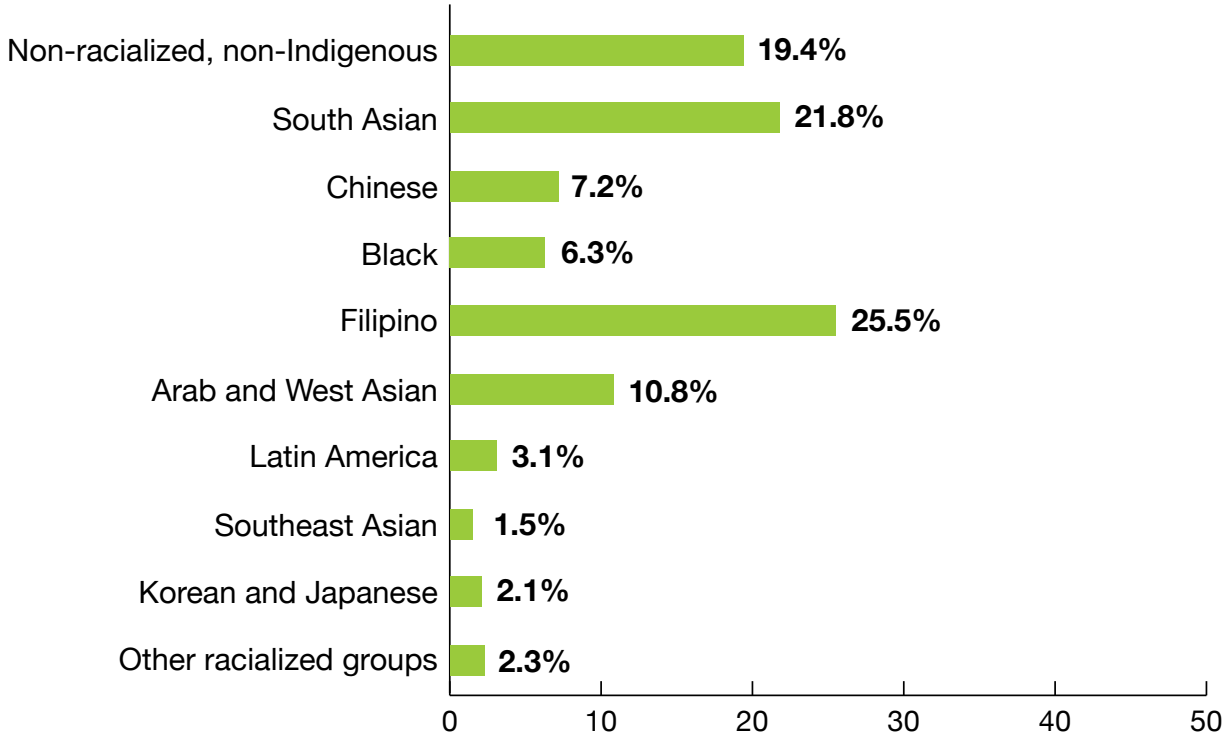


Source: Frank, K., Park, J., Cyr, P., Weston, S., & Hou, F. (2023). *Characteristics and Labour Market Outcomes of Internationally Educated Health Care Professionals in Canada.* Health Canada. https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/characteristics-labour-market-outcomes-internationally-educated-health-care-professionals-canada.html

Most IEHPs are racialized persons, and considerable research suggests that systemic discrimination presents an obstacle in their pathways to professional practices.[19, 20] Overall, the largest ethnic groups among IEHPs are Filipinos (25.5%) and South Asians (21.8%), followed by Chinese, Black, Arab and West Asian populations.[21] The proportions vary by occupational group. For example, the majority of nurses are Black and come from African and Caribbean countries.[22] Figure 2 provides a detailed breakdown.

Figure 2

Representation across ethnic groups



Source: Frank, K., Park, J., Cyr, P., Weston, S., & Hou, F. (2023). *Characteristics and Labour Market Outcomes of Internationally Educated Health Care Professionals in Canada.* Health Canada. https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/characteristics-labour-market-outcomes-internationally-educated-health-care-professionals-canada.html

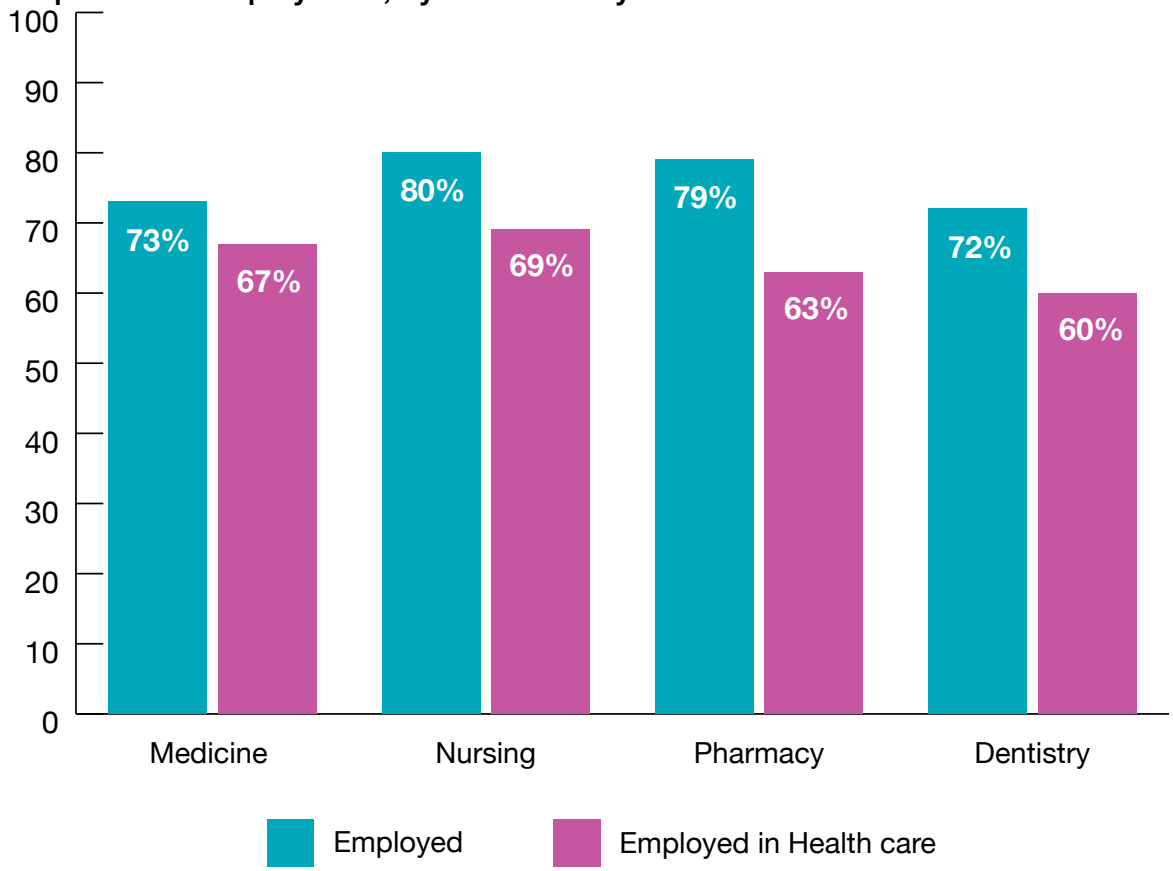
More than one-third hold undergraduate degrees, while about 25% have post-secondary certificates or diplomas below the bachelor's degree level. In addition, 20% have professional degrees in fields such as medicine, dentistry or optometry. About one-third of IEHPs in Canada have studied nursing, followed by 15% in medicine, and 8% each in pharmacy and dentistry.[23]

Labour market outcomes

Despite the growing demand for health-care services in Canada, IEHPs face persistent challenges in securing employment aligned with their training and expertise. About 76% of IEHPs in Canada are employed, but only 58% of those who are employed are working in health occupations.[24] Figure 3 breaks these figures down by area of training.

Figure 3

Proportion of employment, by field of study



Source: Frank, K., Park, J., Cyr, P., Weston, S., & Hou, F. (2023). *Characteristics and Labour Market Outcomes of Internationally Educated Health Care Professionals in Canada.* Health Canada. https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/characteristics-labour-market-outcomes-internationally-educated-health-care-professionals-canada.html

*Note – Those counted as "employed in health care" above may not necessarily be working in their field of study. For example, a dentistry graduate could be working in nursing and still count as employed in health care for the purpose of this figure.

Health-care labour force shortages in Canada

Some evidence suggests that physicians in Canada are reducing hours for a variety of reasons, including aging physician cohorts and burnout.[25]

The COVID-19 pandemic has also profoundly affected Canada's health-care system, exposing and exacerbating critical staffing shortages. In fact, many health-care professionals have been prompted to reconsider their career paths. For example, a survey by the Ontario Hospital Association revealed a 45% increase in resignation rates at Ontario hospitals between 2020 and 2021.[26]

A 2023 report from the House of Commons on the health workforce crisis highlighted how these shortages caused delays in diagnostic and surgical procedures, eroding public trust in the health-care system.[27] The report also warns of escalating job vacancies, particularly in regions with an already limited supply of health-care professionals. Rural and remote areas, such as northern Ontario, face acute challenges.[28] In addition to physicians, job vacancies are beginning to rise in nursing, pharmacy, occupational therapy, and medical laboratory fields.[29]

This emphasizes the importance of evaluating the structural barriers that impede IEHPs from contributing their skills, education and expertise to Canada's health-care workforce.

International comparisons

Global comparisons of IEHP integration are challenging due to variations in data definitions, reporting practices, and availability across countries.

The OECD's 2023 *Health at a Glance* report offers valuable insights into international migration trends for doctors and nurses, using data on where they obtained their first medical or nursing degree.[30] However, comparability is limited by inconsistencies in data coverage and workforce activity status. For example, while some countries update registries to include only actively practising professionals, others report all licensed individuals, regardless of whether they are currently working. Further complexities arise from exclusions, such as data that only include professional nurses in Finland and Slovenia or hospital-employed nurses in Switzerland, as well as Germany's use of nationality instead of training location.

The 2023 OECD report highlights a growing reliance on internationally trained health-care professionals to meet increasing workforce demands around the world. In 2021, 19% of doctors and 9% of nurses across OECD countries obtained their first degree abroad, up from 15% and 5%, respectively, a decade earlier. This growth occurred alongside increases in domestically trained graduates, reflecting rising demand for health-care professionals globally.

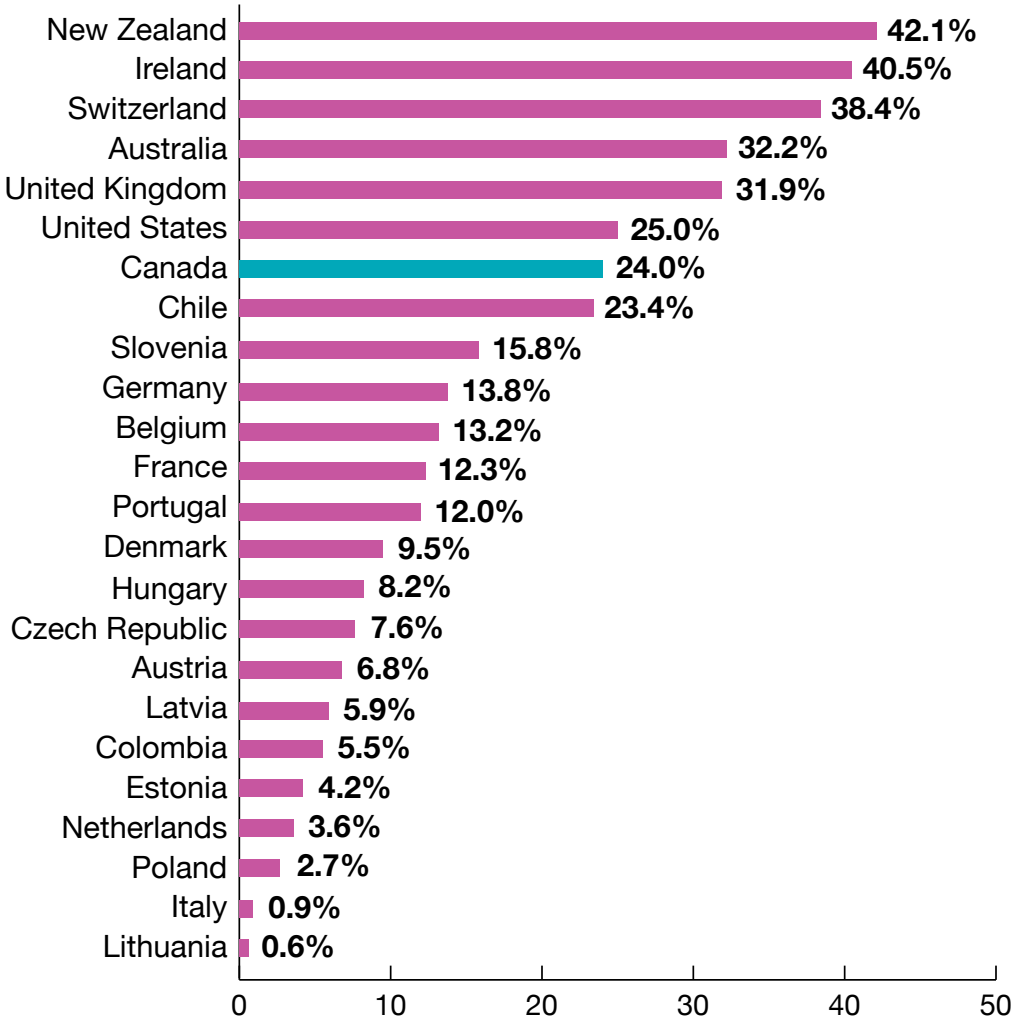
*The 2023 OECD report highlights a **growing reliance on internationally trained health-care professionals** to meet increasing workforce demands around the world.*

The share of internationally trained physicians varies significantly, from 3% or less in Lithuania, Italy and Poland to more than 40% in Switzerland, Ireland, Norway and New Zealand. The proportion in Israel reaches nearly 60%. However, it should be noted that, in countries like Israel, Norway, Sweden and Finland, a sizeable portion of internationally trained physicians are citizens who studied abroad before returning to practise.[31]

Figure 4 illustrates the proportion of internationally trained physicians across OECD countries. Canada ranks seventh among those OECD nations examined, with internationally trained physicians accounting for 24% of all licensed physicians in 2021. This places Canada just below the United States (25%) and well above the OECD average of 18.9%.[32]

Figure 4

Share of internationally trained physicians, 2021 or nearest year



Source: OECD. (2023). Health at a Glance. Chapter: International migration of doctors and nurses. https://www.oecd.org/en/publications/health-at-a-glance-2023_7a7afb35-en.html

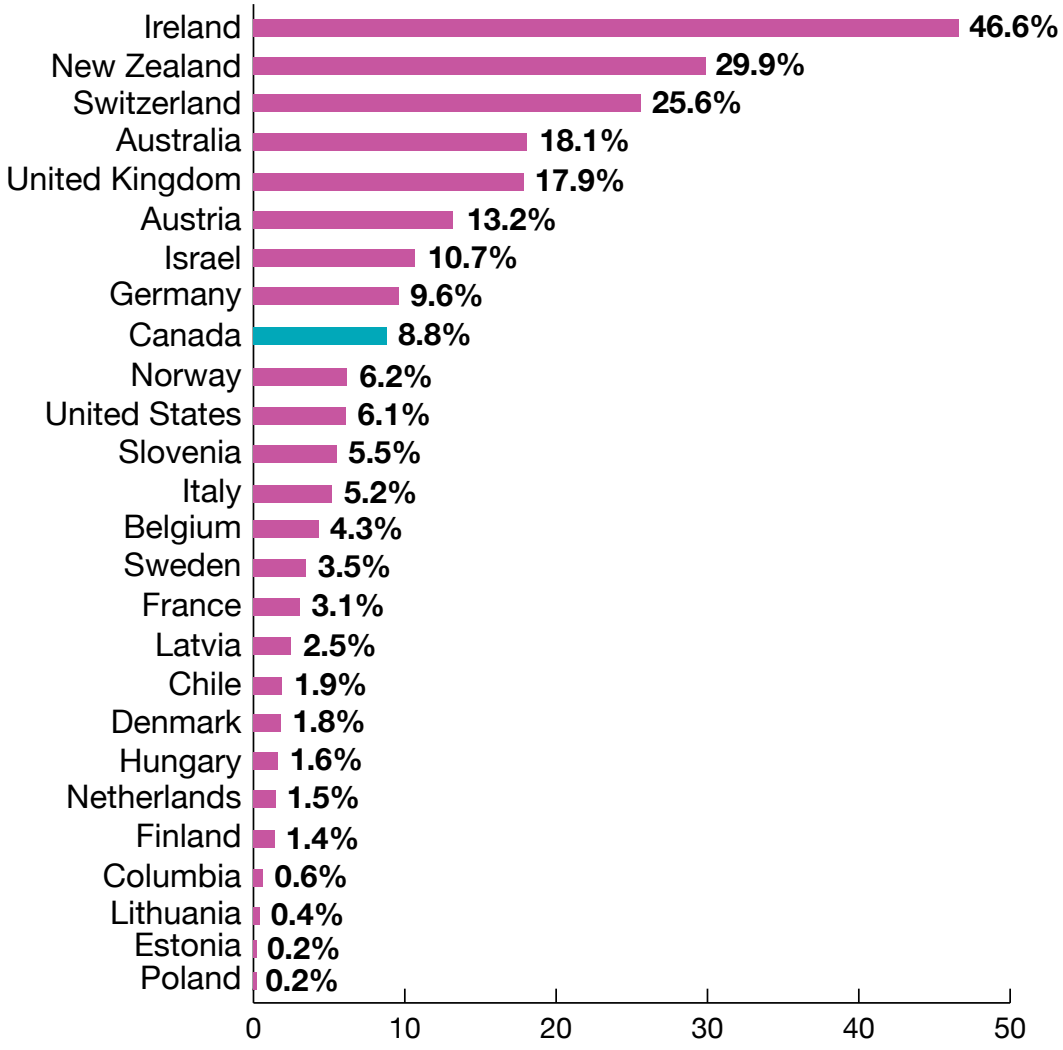
Note: Israel, Norway, Sweden and Finland are excluded from the analysis, as a notable share of their internationally trained doctors are citizens who studied abroad before returning to practise. Germany's data reflects nationality rather than place of training. Data for Portugal is from 2017 and data for the United States is from 2016.

Figure 5 highlights the proportion of internationally trained nurses across OECD countries. Ireland leads with 46.6%, followed by New Zealand (29.9%) and Switzerland (25.6%). In the United Kingdom, international nurse recruitment reached record levels in 2021-22, and 17.9% of its nursing workforce is now internationally trained.

While recruitment from European Union (EU) countries declined post-Brexit, this was counterbalanced by increased hiring from the Philippines, India, Nigeria, Ghana and Zimbabwe. In Canada, there has been progress in the international recruitment of nurses,[33] but the share still stands at 8.8%, only slightly above the OECD average of 8.7%.

Figure 5

Share of internationally trained nurses, 2021 or nearest year



Source: OECD. (2023). Health at a Glance. Chapter: International migration of doctors and nurses. https://www.oecd.org/en/publications/health-at-a-glance-2023_7a7afb35-en.html

Note: Germany's data reflects nationality rather than place of training

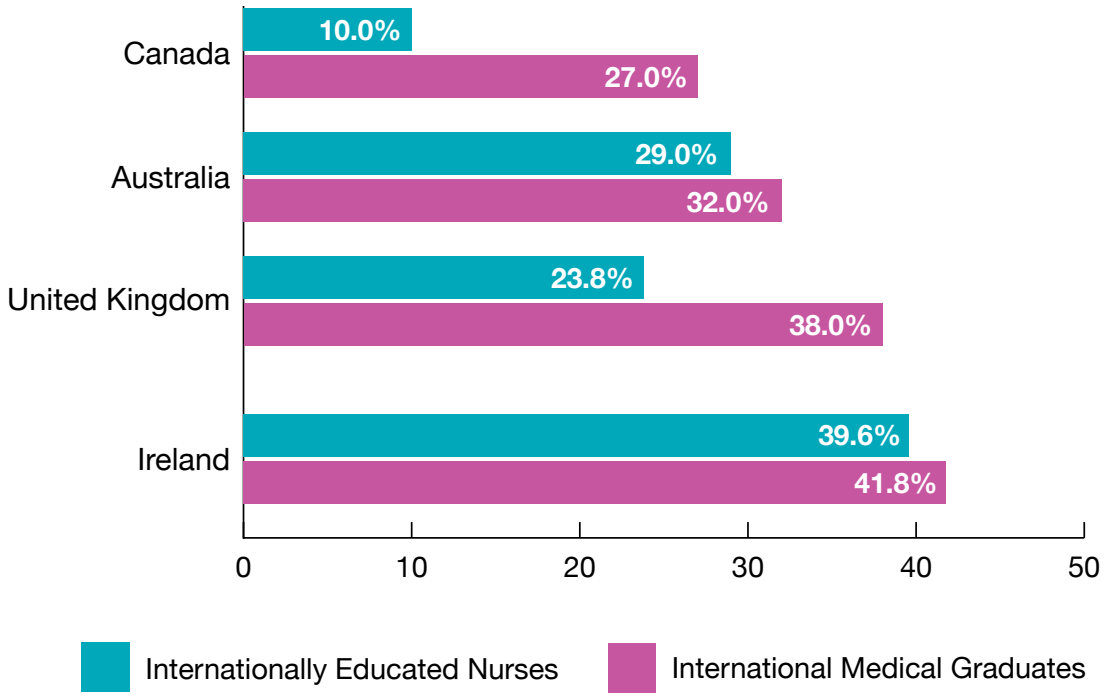
In Canada, IEHPs from ***non-EU countries face significantly more complex pathways*** *to credential recognition and workforce integration.*

While OECD data offers valuable insights, it combines IEHPs from EU and non-EU source countries. This may be misleading, as EU-trained professionals benefit from aligned regulatory frameworks, mutual recognition agreements and geographic proximity, all of which facilitate their integration. For example, in Switzerland, the increasing share of internationally trained physicians and nurses is largely attributable to professionals coming from neighbouring EU countries such as France, Germany and Italy.[34]

In Canada, IEHPs from non-EU countries face significantly more complex pathways to credential recognition and workforce integration. Therefore, this report focuses on the United Kingdom, Ireland and Australia to offer more meaningful comparisons to Canada's experience with IEHPs. While Ireland is part of the EU, its health workforce is shaped by a significant reliance on non-EU professionals. For instance, more than one-half (52%) of the 7,120 internationally educated nurses (IENs) newly registered with Ireland's Nursing and Midwifery Board in 2024 were trained in India, followed by the Philippines (12%), the U.K. (4%) and Ghana (3%).[35] For the U.K., this report draws on post-Brexit data from 2023-24. While data collection varies by jurisdiction and profession, Figure 6 presents more recent trends than those cited in the OECD figures referenced above.

Figure 6

Integration of internationally educated nurses and international medical graduates



Note. Data collection dates for international medical graduates (IMGs) and internationally educated nurses (IENs) vary: **Ireland** (2021 for IMGs and 2024 for IENs); **U.K.** (2023 for IMGs and 2024 for IENs); **Australia** (2022 for IMGs and 2018 for IENs); and **Canada** (2022 for IMGs and 2022 for IENs).

Data sources are as follows:

Ireland:

Irish Medical Council. (2021). *Medical workforce intelligence report 2021*; and Nursing and Midwifery Board of Ireland. (2024). *State of the register 2024*.

Australia:

Australian Institute of Health and Welfare. (2023). *Health workforce*; and Tie, Y. C., Birks, M., & Francis, K. (2018). Playing the game: A grounded theory of the integration of international nurses. *Collegian, 26*(4), 470–476.

U.K.: General Medical Council. (2023). *The state of medical education and practice: Workforce report 2023*; and Nursing and Midwifery Council. (2024). *Nursing and Midwifery Council Register UK mid-year update*.

Canada: Canadian Institute for Health Information. (2022). *Internationally educated health professionals: The state of the health workforce in Canada, 2022*

Barriers to Integration in Canada

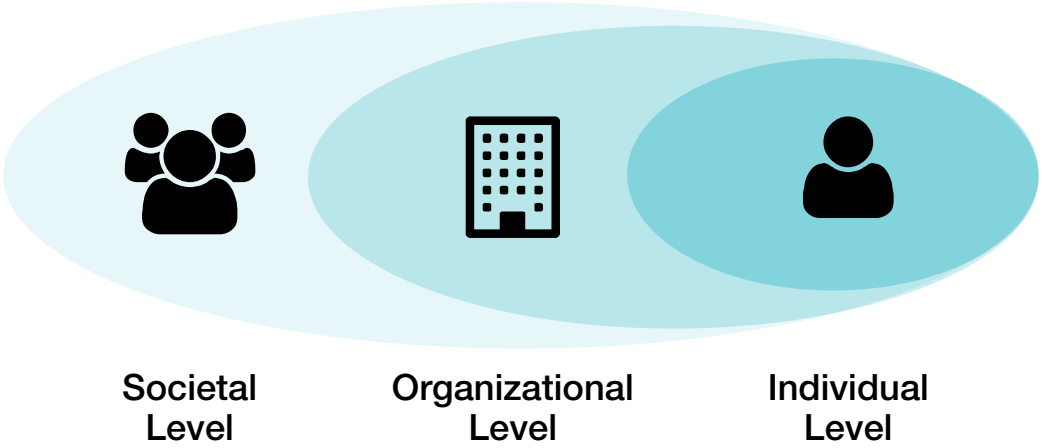
The integration of IEHPs into the Canadian workforce is influenced by a complex interplay of barriers that span societal, organizational and individual levels.[36]

At the macro level, demographic trends, governmental policies, cultural norms and other societal factors influence the legal and social environment in which IEHPs navigate. These influences can sustain inequities, including discrimination and stereotypes.

The meso level focuses on organizational practices among educational institutions, professional associations, employers and other organizations. These can either create pathways or reinforce barriers to meaningful employment and advancement. They include internal policies, credential recognition processes, hiring practices and workplace cultures.

At the micro level, the focus is on the knowledge, skills and behaviours of IEHPs, as well as the individuals who hold gatekeeping roles.

Figure 7
Ecological model



Source: Cukier, W., Gagnon, S., Mae Lindo, L., Hannan, C., & Amato, S. (2014). "A [critical] ecological model to enabling change: Promoting diversity and inclusion." In V. Malin, J. Murphy & M. Siltaoja (Eds.), *Getting things Done: Dialogues in Critical Management Studies* (pp. 245-275). Bingley: Emerald.

Societal level barriers

Societal-level barriers are systemic, rooted in policies, governance frameworks, and cultural norms that collectively shape the access and opportunities available to IEHPs. These barriers influence the border context within which IEHPs attempt to enter and advance their professional careers within the healthcare system.

Immigration policies

The immigration status of IEHPs significantly influences their ability to access pathways, such as professional registration, employment opportunities, and sustained practice within Canada's healthcare workforce. Immigrants arrive through various pathways, including as permanent residents, often through the Federal Skilled Worker Program (FSWP), or as refugees and family-sponsored immigrants.[37] Some IEHPs also enter Canada on a temporary basis, typically through restrictive work permits, which can create additional challenges for professional integration.

About one-third of IEHPs arrived in Canada between 2016 and 2021, with most having immigrated through the FSWP or provincial nominee programs.[38] Although designed to attract skilled workers, the FSWP includes criteria that can inadvertently exclude qualified health-care professionals. Requirements such as recent, continuous, paid work experience and substantial proof of settlement funds often create barriers for IEHPs, particularly those from lower-income countries or with non-linear career paths.[39]

Further, IEHPs who immigrate under the family class or as refugees often encounter challenges that limit their ability to fully integrate into their professions. They are less likely to secure employment in higher-skilled health occupations, more likely to take on lower-skilled roles, and tend to earn lower incomes compared to IEHPs who immigrate through economic streams.[40]

Research shows that Canadian immigration policies are built on three assumptions: that immigrants inherently provide value to Canada, they do not require support to find work, and they will secure employment regardless of whether it aligns with their previous experience.[41] However, those entering Canada on temporary permits face severe challenges due to restrictive work arrangements. For example, nurses from the Philippines who arrive on temporary work permits as personal support workers or in-home caregivers are often confined to these roles.[42] These permits typically prevent

*Nurses from the Philippines who arrive on **temporary work permits** as personal support workers or in-home caregivers are **often confined to these roles**.*

them from meeting the requirements of health regulators, who restrict registration to Canadian citizens, permanent residents, or holders of "open" work permits that allow broader employment opportunities.[43] This limitation prevents many qualified health professionals from practising in their trained professions.

Canada's *2025-2027 Immigration Levels Plan* emphasizes transitioning individuals already residing in the country, such as international students and temporary foreign workers, into permanent residents. More than 40% of permanent resident admissions expected to come from this group by 2025.[44]

While this strategy creates pathways for those already in Canada, it raises concerns about the potential corollary reduction in overall immigration levels and limits opportunities for newcomers. In the health-care sector, where workforce shortages are dire, IEHPs play a critical role in addressing service gaps. Restricting immigration risks exacerbating these shortages and undermining efforts to build a resilient and inclusive health-care system.

Health-care governance and regulation

Another major barrier to integration can be attributed to Canada's decentralized health-care system. Under the Canada Health Act, health-care delivery is the responsibility of provincial and territorial governments, resulting in a fragmented system in which each jurisdiction operates independently.[45]

While there are similarities in practice patterns among regulatory bodies, the lack of national standardization creates challenges for IEHPs navigating the system. Across Canada, there are 13 regulatory jurisdictions with numerous colleges overseeing health services.[46] Although the federal government has repeatedly emphasized the need to increase the utilization of IEHPs, provincial health policies often complicate their integration into the workforce.[47]

One of the primary challenges is the variation in educational and licensure requirements across jurisdictions. For example, IENs must write the NCLEX-RN exam to obtain licensure

as registered nurses in all provinces except Quebec, which has its own licensing process. Yet additional provincial requirements vary. All provinces require proof of language proficiency in either English or French, but the type of language test accepted, the required scores, and when or how often results must be submitted can vary by province and regulatory body.

Experience requirements also differ. Ontario generally requires applicants to demonstrate nursing practice within the past three years, whereas many other Canadian provinces have specific hour-based requirements to demonstrate currency of practice – typically 1,125 hours of nursing practice within the past five years.[48]

These licensure and practice requirements are not only extensive and costly but also lack transferability across provinces. An IEHP who meets the requirements in one province may face additional hurdles if they decide to relocate, as they would need to fulfil the licensure criteria of the new jurisdiction. This lack of standardization adds friction to the process of entering and remaining in the health-care workforce, further limiting the ability of IEHPs to contribute effectively to Canada's health-care system.[49, 50]

Organizational level barriers

These obstacles arise from practices and policies that limit IEHPs' ability to navigate licensure, integrate into the workplace, and advance professionally. The requirements for licensure vary across professions but typically include formal training, examination and work experience. Internationally educated professionals face barriers at every stage.

Education

The processes for assessing and evaluating international credentials in Canada vary considerably across professions. They are also often inefficient and cumbersome without, for example, block transfers or equivalencies, relying on individual course-by-course assessments. While many post-secondary institutions have created bridging programs for IEHPs, they often lack the

*The requirements for licensure vary across professions but typically include **formal training**, **examination** and **work experience**. Internationally educated professionals face **barriers at every stage**.*

elements required to ensure licensure. For example, these programs tend to focus on standardized examination requirements, but do not provide opportunities for the requisite work experience.[51]

Canadian work experience for licensure

For years, the requirement for Canadian work experience posed a significant barrier within the registration processes of many health regulatory colleges across provinces. Given the shortage of internship and residency spaces, even for Canadian-trained physicians, the prospects of gaining the employment experience necessary to practise medicine has been a significant barrier for IMGs.

In a notable policy shift, Ontario introduced legislative changes in January 2023 under the Fair Access to Regulated Professions and Compulsory Trades Act that prohibit regulated professions from requiring Canadian work experience for licensure, unless such requirements can be demonstrated as necessary.[52]

However, these reforms do not fully resolve the issue in practice. For example, internationally trained subspecialists (physicians who completed specialized training in a narrower field) seeking licensure through the Practice Eligibility Route (PER) must still complete a period of approved work experience in Canada to qualify for Royal College certification, an essential step for provincial licensure.[53]

Even though provincial policies may formally remove Canadian experience requirements, national certification processes and institutional norms continue to reinforce them.

Profession-specific barriers

This section explores the unique challenges faced by IEHPs within their respective fields, focusing on physicians, nurses and pharmacists. These professions were selected as they represent the top areas of study for IEHPs and the highest areas of demand in Canada's health-care system.[54] While many of the challenges discussed are systemic, they are examined here to illustrate how these broader issues intersect with the specific requirements, expectations and dynamics of each profession.

Physicians

International medical graduates (IMGs) play a valuable role in addressing physician shortages in Canada, as they bring linguistic and cultural competencies that improve the quality of health-care delivery for immigrant populations. However, IMGs face significant challenges in entering the health-care workforce. They often lack access to information about licensure requirements, preparation materials for exams, and avenues to gain Canadian experience, all of which are essential for securing residency positions.[55, 56]

Even after passing qualifying exams, the competitive nature of the field remains a major obstacle. In 2022, only 23.9% of IMGs, including Canadians who studied abroad, were matched to a residency position through the Canadian Resident Matching Service (CaRMS). This compares to a 92% match rate for graduates of Canadian medical schools. Practice-ready assessment programs offer a faster pathway for those who have already completed residency abroad. However, they are not available nationwide and remain underutilized, as only 124 IMGs were licensed through this route in 2021.[57]

*In 2022, only **23.9% of IMGs**, including Canadians who studied abroad, **were matched to a residency position through the Canadian Resident Matching Service (CaRMS)**.*

A recent Mosaic report classifies six forms of discrimination reported by IMGs:

1. **Limited access to licensure due to fewer available positions in a restricted number of disciplines compared to Canadian medical graduates**
2. **Additional hurdles for IMGs, including mandatory return-of-service contracts limiting their job choice and the requirement to retake the English fluency examination every two years**
3. **Experiences of racial and religious descrimination**
4. **Age-based discrimination, affecting older graduates**
5. **An assumption that Canadian-trained students are more competent than IMGs**
6. **A licensure process that relies heavily on personal connections, which disadvantages immigrant physicians.[58]**

Nurses

Internationally educated nurses (IENs) are an essential part of Canada's health-care workforce and represent about one-third of IEHPs who came to Canada between 2016 and 2021.[59] Despite recognition of their importance, IENs encounter substantial barriers to integration.[60, 61, 62, 63] They undergo an extensive and costly recertification process, which often involves enrolling in bridging programs to meet Canadian standards.[64]These programs, combined with living expenses, impose significant financial burdens, particularly on IENs who arrive in Canada without familial support or must also support family members in their home countries. These burdens undermine and destabilize the contributions that IENs can make to Canada's health-care staffing crisis.

Research further indicates that IENs often face racism and discrimination for being perceived as less qualified than their Canadian-born counterparts, leading to disparities in their upward mobility and the scope of their practice.[65, 66, 67] These nurses often report that racial discrimination plays a significant role in the challenges they face in advancing their careers and attaining leadership positions.[68] A lack of trust in IENs by those supervising daily operations has also been shown to contribute to heightened levels of monitoring, a practice not typically applied to Canadian-trained nurses. These dynamics can evoke feelings of fear, powerlessness and stress among IENs, undermining their self-esteem and potentially compromising the quality of patient care.[69]

Pharmacists

Despite accounting for nearly one-third of Canada's pharmacists and almost one-half in Ontario,[70] international pharmacy graduates (IPGs) continue to face barriers to professional integration. For many IPGs, practising in Canada often requires starting at entry-level positions, such as a pharmacy assistant. In a qualitative study exploring the experiences and perceptions of IPGs in Canada, many identified this process as "discouraging."[71] This sentiment was especially pronounced for IPGs who were regarded with the same esteem as doctors in their home country. While many IPGs recognized some sacrifices are necessary to practise in Canada, they found being treated as students difficult.[72]

Evidence suggests that IPGs are less likely to secure employment in hospital settings due to barriers such as the limited availability of clinical placements in pharmacy bridging programs. Residency, which significantly enhances employment opportunities in hospitals, is also financially burdensome and often inaccessible for many IPGs. The lack of residency opportunities not only limits their practical experience but also reduces their chances to build professional networks, further curtailing career advancement.[73]

Lack of EDI practices and workplace discrimination

Many Canadian employers continue to explicitly or implicitly stress Canadian experience as a requirement for employment, despite clear sanctions through human rights legislation. This creates an added barrier for IEHPs who are expected to gain Canadian experience to secure employment but are unable to do so without first being employed.[74] Employers may see Canadian experience as a proxy for professional readiness, ensuring familiarity with the health-care system, workplace expectations and communication styles.[75] But these qualities can be more effectively met and measured in other ways.

Another issue is the lack of equity, diversity and inclusion (EDI) practices in health-care settings.[76] This obstructs the employment and retention of IEHPs and undermines the overall effectiveness of Canada's health-care system.[77] These barriers exist in health-care leadership and governance, hiring and promotion practices, and culture.[78] Racialized health-care professionals, for example, encounter discrimination that hinders their integration into the workforce and their opportunities for career progression. Studies have shown that racialized nurses, many of whom are internationally educated, are less likely than their white colleagues to receive promotions, as they are often viewed as less competent.[79]

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Furthermore, qualitative findings reveal that IEHPs often feel excluded, alienated or unfairly treated in many hospital settings, including being assigned disproportionately longer and more demanding shifts.[80] They also often experience discrimination from their patients.

Notably, these experiences are more pronounced for IEHPs who are racialized and particularly those who are Black.[81] Anti-Black racism likewise results in disproportionately poor health outcomes for Black communities.[82, 83] Employing and supporting Black IEHPs could therefore have the added benefit of promoting Black community health outcomes, in addition to fortifying skilled staffing pools.[84]

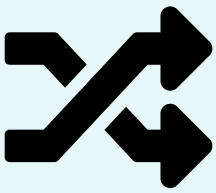
Individual-level barriers

Individual barriers stem from personal circumstances, such as language proficiency, cultural adaptation, and Canadian work experience. These can all affect IEHPs' ability to navigate systemic and organizational challenges.

Language and communication skills

Limited proficiency in an official language can pose a significant barrier for IEHPs. Although a uniform requirement across most regulatory bodies is the language proficiency exam, the passing scores vary by jurisdiction.

Strong language skills are not only essential for meeting licensure requirements, but also for effectively preparing for and passing complex licensing examinations.[85] However, the challenges extend well beyond test performance. Even when IEHPs demonstrate adequate knowledge of phonology, vocabulary and grammar, they may struggle with the nuanced socio-cultural aspects of workplace communication.[86] Arguably more critical to job performance in clinical settings than formal language knowledge, these aspects include understanding idiomatic expressions, navigating indirect communication styles, and interpreting context-specific cues. Such communication gaps can lead to misunderstandings with colleagues or patients and, in some cases, be used to reinforce existing xenophobic or racial biases.[87] Additionally, some evidence suggests that language proficiency is not necessarily correlated with employment for immigrants, and considerable discrimination is based on accent rather than comprehensibility.[88]



Many IEHPs encounter difficulties adapting to workplace norms, patient-centred care models, and interprofessional dynamics that ***differ from those in their countries of origin****.*

Canadian socio-cultural competencies

Many IEHPs encounter difficulties adapting to workplace norms, patient-centred care models, and interprofessional dynamics that differ from those in their countries of origin. These include initiating informal small talk with patients or engaging in collaborative decision-making that involves challenging hierarchical norms.[89, 90] While not tied to clinical competence, these socio-cultural expectations are critical to workplace success.

Research highlights that many IEHPs move through the licensure process without fully acquiring the socio-cultural competencies needed for everyday clinical practice. When misalignments occur in the workplace, they are too often interpreted as personal deficiencies rather than contextual learning

needs.[91] In some cases, these differences are cited as grounds to deny progression toward licensure, rather than being addressed through orientation, coaching or mentorship.[92]

Importantly, these barriers should not be viewed as the sole responsibility of IEHPs to overcome. Framing integration challenges exclusively around the perceived deficits of IEHPs ignores the fact that health-care professionals trained in Canada also face limitations in navigating cross-cultural interactions. They too may be unprepared to support the health-care needs of diverse patients, as well as the unique learning and personal needs of IEHPs.

As a recent study highlights, educators themselves often feel ill-equipped to teach IENs and gain valuable insight through reciprocal learning. This reveals that integration is a shared process that requires reflection and institutional support.[93] Internationally educated professionals bring distinct assets to the health-care system that are often undervalued. Their cultural backgrounds, languages and lived experiences can reflect those of diverse patient populations. This enables IEHPs to bridge communication gaps while fostering greater trust, comfort and understanding among patients.[94]

Personal loss and emotional distress

Beyond seeking appropriate employment or career growth, many IEHPs migrate to build a better life for their families. This involves significant personal sacrifices, including the loss of higher social status, better quality of life, and stronger support networks in their home countries. Even those without children may see these sacrifices as investments in the well-being of their families' futures.[95]

Sense of self for IEHPs often is deeply entwined with their professional standing,[96] making discrimination at work particularly damaging to their emotional well-being. The inability to secure residency placements, for instance, can be deeply distressing for IMGs and IPGs.[97] Alongside the demanding nature of their professions, many IEHPs must contend with inadequate financial and emotional support, further thwarting their ability to succeed. These challenges foster feelings of doubt and regret about their decision to migrate, compounding the emotional toll of their migration journey.[98]

Best Practices and Innovative Approaches

This section highlights international and Canadian examples of successful interventions for workplace integration that can be adapted to improve labour market outcomes for IEHPs in Canada.

Innovation, as this report sees it, is a holistic process. Value is created by addressing unmet needs, solving problems, and seizing opportunities through new and improved approaches. It extends beyond technological advancements to include enhancements in processes, organizational models and social practices that drive meaningful change. By embracing diverse perspectives, fostering collaboration, and encouraging creative solutions, innovation offers the potential to improve pathways for IEHP integration and address labour shortages.

Societal

At the societal level, policies and governance structures play a pivotal role. Effective, coordinated and forward-thinking policies are essential for removing barriers and establishing pathways that allow IEHPs to contribute meaningfully to the health-care system.

International best practices

Countries that have excelled in integrating IEHPs have adopted innovative strategies to streamline credential recognition and create structured pathways for workforce integration. This section examines best practices from Australia, Ireland, and the U.K., which offer valuable lessons through their successful models for attracting and integrating IEHPs.

Australia

When considering income earnings as a measure of integration, Australia surpasses Canada for newcomers holding medical and nursing degrees.

A 2021 study assessing the outcomes of permanent migration programs in both countries highlights significant disparities.[99] In Australia, fewer than 5% of international nursing degree holders and about 10% of medical degree holders earned below the median income for all individuals in their respective fields, regardless of the arrival period.

In contrast, among medical degree holders who arrived in Canada between 2009-2016, 70% earned less than one-half of the median

income of Canadian-born individuals in the same fields. Earlier arrivals, between 2001 and 2008, performed slightly better, with less than 50% of newcomers earning below this threshold. For nursing degree holders, the proportion was 20%.

The report goes on to outline the key factors contributing to Australia's relative success. These include:

> **Centralized leadership:** Australia's federal government has demonstrated greater capacity to drive national migration reform over the last three decades. Strong centralized leadership enabled the establishment of the National Office of Overseas Skills Recognition in 1989. This office promotes national standards for skill recognition, competency-based assessments and bridging pathways. While licensure in Australia is technically governed by state and territory laws, all jurisdictions adopted a shared Health Practitioner Regulation National Law that established a single regulatory framework. This is administered nationally by the Australian Health Practitioner Regulation Agency in partnership with profession-specific boards. This cooperative model allows health professionals, once registered, to practise across the country. Pre-migration assessments of qualifications and English language proficiency are mandated and aligned with occupational standards. In contrast, Canada's highly decentralized system has led to fragmented policies and slower reforms. Significant provincial autonomy poses challenges in implementing uniform national standards for credential recognition and language assessment.

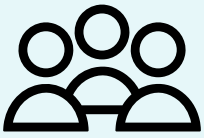
> **Employer-driven selection and demand-driven migration:** Australia has prioritized a demand-driven system, enabling employers to nominate skilled newcomers for pre-arranged jobs, which are fast-tracked through priority processing. By 2016, employer-nominated immigrants exceeded the employment rates and earnings of those selected through independent points-based systems. Australia's two-point immigration system, which allows temporary workers to transition into permanent residency, further enhanced outcomes by addressing labour shortages and assuring pre-arranged employment.

> **Bridging programs and early credential recognition:** Australia invested early in comprehensive bridging programs, which include examination preparation, modular training, and industry partnerships for temporary and permanent migrants. In contrast, Canada has struggled to provide consistent bridging programs, which remain intermittent, difficult to access, and restricted to permanent residents.

Ireland

Ireland has emerged as a leader in attracting IMGs, who make up more than 40% of the country's physicians. This success results from a combination of strategic recruitment campaigns, supportive policies, and an innovative licensure process. Together, these create an environment conducive to attracting highly skilled international health-care professionals:

> **International recruitment campaigns:** Ireland's growth in IMGs has been driven by well-orchestrated recruitment campaigns. Between 2010 and 2013, Ireland actively recruited physicians from India, Pakistan and South Africa.[100] Notwithstanding the issue of Irish-born medical professionals leaving Ireland in significant numbers, this model can inform Canadian practice.[101]



__Ireland__ has emerged as a leader in attracting IMGs, who make up __more than 40%__ of the country's physicians. This success results from a combination of strategic recruitment campaigns, supportive policies, and an innovative licensure process.

> **Facilitative policies:** Skilled worker immigration streams, a 2012 regulation permitting non-EU health-care professionals with prearranged positions to work without a visa, and other policies have enhanced the attraction and integration of IMGs.[102]

> **Streamlined licensure:** Ireland has an innovative licensure process that waives exams for IMGs who meet specific criteria. The Medical Council of Ireland accepts internships from various countries, including Malaysia, Pakistan, South Africa and the U.K., as equivalent to Irish internships. Eligible applicants with recognized internships or higher qualifications (e.g., specialization in pediatrics), English proficiency, a certificate of good standing, and a medical degree from a recognized institution can validate their credentials and obtain a licence without further testing. Those not meeting these criteria can take the Pre-Registration Examination System (PRES) to assess their knowledge and practical skills.

Despite these efforts, some challenges persist. Many non-EU immigrant doctors find themselves confined to junior hospital positions that offer limited opportunities for career advancement. This lack of upward mobility often results in deskilling, as these roles may not fully utilize their qualifications or expertise, ultimately contributing to frustration and high turnover rates.[103] Ireland's heavy reliance on these junior roles underscores the critical need to address systemic barriers to career progression.

United Kingdom

The U.K. has established robust pathways for integrating internationally trained physicians into its health-care system. According to recent reports, 38% of doctors in the U.K. received their medical education outside the country.[104] Central to the U.K.'s success in this area is its structured and transparent physician licensure process, overseen at the national level by the General Medical Council (GMC). The GMC ensures rigorous standards while offering clear and accessible pathways for international applicants' entry into the country's health-care workforce:

> **Eligibility and degree verification:** To be eligible for licensure in the U.K., non-EU medical graduates must hold a degree from an institution listed in the World Directory of Medical Schools. The degree must be verified with the issuing institution(s) by the Educational Commission for Foreign Medical Graduates. While transcripts are not required as part of the process, specialists may need to provide additional evidence to validate their qualifications. The GMC maintains a list of medical qualifications that are not accepted, offering transparency and clarity to applicants.[105]

> **National assessment:** International applicants must pass the Professional and Linguistics Assessment Board test, which evaluates medical knowledge and clinical skills. The process consists of two parts. First, a three-hour, multiple-choice exam is designed to assess the applicant's theoretical understanding of core medical practice. Then, an objective structured clinical examination tests clinical skills, communication abilities and decision-making in practical settings with 16 scenarios.[106]

> **Clinical experience requirements:** To qualify for registration, applicants must complete either Year 1 of the U.K. Foundation Programme or an equivalent internship outside the country. This internship must last at least 12 months, with a minimum of three months each in medicine and surgery. If applicants provide evidence of an acceptable internship experience, no further training, practice assessments or residencies are required.[107]

> **English language proficiency:** The GMC offers multiple pathways for demonstrating English proficiency. These options include:

1. **Passing an approved English language exam, such as the International English Language Testing System (IELTS) or the Occupational English Test (OET)**
2. **Providing a letter from a health-care employer confirming two or more years of medical practice conducted in English**
3. **Submitting evidence that the applicant's medical degree was taught in English**
4. **Submitting an offer of employment from a U.K. health-care institution, with the employer completing the required validation form to confirm the applicant's language competence.**[108]

Since 2016, recruitment and integration of non-European Economic Area (EEA) nurses in the U.K. have changed significantly, due to Brexit and new English language requirements.[109] This led to a decline in EEA nurse recruitment, while increasing registrants trained in non-EEA countries. For instance, new nurse registrants trained in non-EEA countries reached a 32-year high in England in 2022-23, with about 24,300 new entrants.[110] Similarly, 2018 data show that 35.6% of all internationally trained nurses across the U.K. were from outside of the EU.[111] These changes were supported by bilateral agreements, a rigorous national licensure process, and a focus on efficiency.

> **Bilateral agreements:** The U.K. has established formal agreements with several countries, including the Philippines, India, Malaysia, Kenya, Nepal and Sri Lanka.[112] These agreements outline key conditions for recruiting IEHPs and emphasize collaboration in health-care workforce planning. A significant feature of these agreements is the development of systems to mutually recognize skills, qualifications and educational credentials.

> **National licensure process:** The licensure process for IENs mirrors the structured approach for physicians, with defined steps to maintain high standards while being accessible to international applicants. For nurses, credential validation ensures qualifications meet U.K. standards. English proficiency can be shown through education, work experience, or approved tests like IELTS or OET, similar to the pathways for physicians. Nurses must complete a computer-based test to assess theoretical knowledge and an objective structured clinical examination for practical skills, paralleling the two-part Professional and Linguistics Assessment Board test for physicians.[113, 114]

- **Timelines, costs and efficiency:** The process is designed for efficiency, with credential evaluation completed within 14 days and licensure finalized within 30 days after passing required assessments and, if necessary, a language test. The minimum timeline for licensure is about five months, with total costs amounting to the equivalent of C$1,975. Applicants who fail the credential evaluation and withdraw from the process are eligible for reimbursement. The expedited 14-day credential assessment suggests that bilateral agreements and established precedents play a key role in streamlining the process.[115]

Germany

While Germany may not exhibit the same level of success in integrating IEHPs as the countries mentioned above, its Federal Recognition Act offers valuable insights into addressing credential recognition challenges. Introduced in 2012, the act establishes a standardized framework for evaluating foreign qualifications. This creates a federally coordinated approach that ensures consistency and transparency across Germany's states and professions, including health care.[116] The act grants non-EU immigrants the legal right to have their credentials reviewed, and mandates completion within three months.[117]

The Federal Recognition Act has significantly enhanced the integration of non-EU immigrants into Germany's labour market. A study by the Institute of Labour Economics found that the act led to a 15% increase in the workforce share of immigrants with recognized foreign qualifications.[118] This improvement facilitated a rise in employment and wages for non-EU immigrants in licensed occupations, helping to reduce disparities in employment levels and wages. Notably, the study found no evidence of negative impacts on employment or wages for workers already in the domestic labour force.

Recent initiatives in Canada

Centralized leadership and national frameworks have proven essential in providing pathways for IEHPs across various international contexts. The examples mentioned above highlight how coordinated policies and systems can establish clear, streamlined routes to licensure and employment. They help to ensure consistency, efficiency and alignment with labour market needs.

In contrast, Canada faces significant challenges in integrating IEHPs, largely due to its decentralized health-care system. While the federal government sets broad national standards and provides funding under the Canada Health Act, the administration and delivery of health-care services and the regulation of health professions are managed independently by each of the 13 provinces and territories. This results in a complex and fragmented regulatory environment.

Ultimately, licenses to practice are issued by provincial regulatory bodies. However, IEHPs in many disciplines must also meet national certification requirements. For example, medical specialists need certification from the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, or must pass national exams administered by bodies like the Medical Council of Canada. As a result, IEHPs often face overlapping or duplicative assessments, unclear timelines and inconsistent standards, all of which hinder timely integration into the health-care workforce.

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Inter-provincial discrepancies in licensure continue to pose significant barriers for IEHPs, complicating their employment. Recent collaborative initiatives demonstrate that greater alignment is feasible. The Atlantic Registry, launched in May 2023, is one example. It was designed to allow physicians licensed in Nova Scotia, New Brunswick, Prince Edward Island or Newfoundland and Labrador to practise across all four provinces without undergoing relicensure. According to a recent evaluation, the Atlantic Registry marked a significant step toward breaking down provincial silos, showing that regulators can collaborate to recognize one another's licensees. The evaluation also revealed that while licensure portability is an important advancement, it is not a standalone solution for addressing physician distribution or improving health-care access.[119]

In October 2023, federal, provincial and territorial health ministers (excluding Quebec) committed to developing a pan-Canadian framework that would allow physicians in good standing to practise across jurisdictions.[120] A pan-Canadian licensure framework would significantly improve employment mobility for IEHPs. This flexibility could help address regional workforce gaps by enabling provinces to recruit licensed IEHPs from other jurisdictions. It also makes Canada a more attractive destination for skilled health professionals, offering access to a national job market through a single licence.

Given the concern about staff shortages in the health-care workforce, the federal government has made efforts to improve the integration of IEHPs. In January 2024, Canada's employment minister announced an investment of up to $86 million for 15 organizations across Canada to enhance the recognition of foreign credentials for 6,600 IEHPs.[121] The integration of IEHPs would be advanced in three key areas:

> Reducing the barriers to foreign credential recognition by simplifying the steps in credentialing and improving access to practice

> Providing IEHPs with work experience in their intended field of practice, while incorporating wraparound supports such as child support and transportation

> Facilitating cross-jurisdictional labour mobility for IEHPs by reducing the systemic barriers for those who want to work in different provinces.

Organizational

Improving how IEHPs enter and fare in Canada's health-care system requires action on several fronts. Licensure shapes whether IEHPs can practise in their fields. Employment pathways influence how they enter the workforce and grow within it. Inclusive health-care employers determine if IEHPs thrive in their employment.

The following section highlights promising models already in place, and points to steps that employers and regulators can take to build more inclusive, equitable health-care environments.

Licensure

Internationally educated health-care professionals often confront fragmented, opaque and inconsistent licensure processes that delay or prevent their ability to practise. A growing number of organizational and regulatory innovations address these challenges, such as pre-arrival preparation, mutual recognition agreements, and supervised licensing categories. It is important to assess IEHPs based on their demonstrated competencies through competency-based credential recognition and technology-enabled, prior learning assessment and recognition (PLAR). Approaches such as employer-engaged bridging programs and practice-ready assessments create opportunities for IEHPs to build skills and demonstrate readiness in employment settings, leading to workforce integration.

Pre-arrival licensure preparation

Early access to licensure information and support services plays a key role in the creation of transparent steps to professional standing. Pre-arrival counselling and credential guidance reduce uncertainty and support better employment outcomes. One Canadian example of a pre-arrival program that offers this type of support is ACCES Employment. This organization provides approved immigrants with customized e-learning, targeted webinars, employer connections, and one-on-one coaching tailored for pre-arrival.[122]

Mutual recognition pathways

Mutual recognition pathways can ease entry into Canada's regulated health professions by reducing duplicative licensing requirements. These are formal agreements through which Canadian regulatory bodies recognize the credentials, exams and training standards of select jurisdictions as meeting local requirements. Rather than requiring IEHPs to undergo full credential reassessment or bridging programs, regulators may accept verified qualifications from trusted countries. These arrangements lower entry barriers, reduce costs and processing times, and support faster integration into the health-care workforce.

The College of Registered Nurses of Alberta (CRNA) recently introduced licensure amendments that streamline the process for IENs from countries such as the Philippines, India, the U.S., the U.K., Australia, Nigeria, Jamaica, New Zealand and Ireland.[123] Applicants from these countries are no longer required to undergo credential assessments. Instead, the CRNA focuses exclusively on document validation. This shift toward a mutual recognition model has produced immediate results: In the first month, the CRNA registered 1,413 IENs — more than 2.5 times the number of IENs registered over the previous four years combined.[124]

Bridging programs

Bridging programs address gaps in education, professional standards, language, and health-care system familiarity. A defining feature is the combination of classroom learning with hands-on experience, typically through clinical placements or practicums. However, many programs struggle to secure placements due to limited employer engagement and misconceptions about the supports IEHPs require.[125] The ensuing lack of practical experience can delay licensure and employment. Evidence shows that IEHPs who gained related work experience during credentialing were significantly more likely to find employment post-licensure (65% vs. 41%), highlighting the importance of expanding placement opportunities.[126]

Leveraging technology for prior learning assessment and recognition

Bypassing redundant and inefficient licensure requirements, prior learning assessment and recognition (PLAR) technology recognizes the existing skills and knowledge of IEHPs. It values formal, informal and experiential learning. While PLAR has often been criticized for being resource-intensive, technology is beginning to transform PLAR into a more scalable and accessible practice. A pilot study of an online PLAR tool for IENs demonstrated promise in objectively assessing eligibility for licensure exams.[127] Platforms driven by artificial intelligence offer significant potential to improve PLAR by streamlining evidence collection, identifying skills gaps, and enhancing decision-making through data-driven insights. They have the capacity to reduce subjectivity, support personalized and accessible learner experiences, and improve administrative efficiency.[128]

*Across Canada, provinces have introduced s**pecial licensure pathways** that allow IEHPs to begin practising in **supervised roles** while they complete remaining licensing requirements.*

Practice-ready assessment programs

These assessments are 12-week, clinical-based programs that place participants under the supervision of licensed physicians. This allows IEHPs to demonstrate their ability to provide safe, effective care within the Canadian health-care system. Beyond offering a pathway to licensure, practice-ready assessment programs also help address physician shortages in underserved communities. Candidates who successfully complete the assessment typically enter into a return-of-service agreement, committing to work in areas with limited access to health care.[129] Despite their promise, practice-ready assessment programs remain underutilized and inconsistently implemented.

New licensing categories

Across Canada, provinces have introduced special licensure pathways that allow IEHPs to begin practising in supervised roles while they complete remaining licensing requirements. For example, Temporary Class from the College of Nurses of Ontario lets nursing applicants work as nurses while finishing requirements for full registration.[130] For IENs, this means they can earn income and obtain Canadian work experience while finalizing their licensure. Likewise, the associate physician licence from the College of Physicians and Surgeons of B.C. is a restricted class that permits IMGs to practise under supervision when they are not yet eligible for licensure.[131] Such programs enable IEHPs to start using their skills in Canada before all exams or training equivalencies are

finalized. Administered by regulatory bodies, these licensure models are designed to ease delays for IEHPs and strengthen health system capacity by filling critical staffing needs.

Competency-based credential recognition

These approaches assess whether applicants possess the knowledge, skills and judgement required to practise safely and effectively within the Canadian health-care system. These models enable regulators to evaluate IEHPs based on demonstrated ability, regardless of where their training occurred. This is valuable for professionals whose qualifications do not align perfectly with Canadian academic standards, but have extensive clinical experience. By focusing on what applicants can do, rather than where they train, competency-based assessments can reduce exclusion and accelerate entry into the workforce.

Examples include Inspire Global Assessments in British Columbia, which offers a platform that employs a combination of computer-based and simulation lab assessments to evaluate candidates' skills, knowledge and competencies. These assessments are designed to identify strengths as well as areas needing improvement, providing a clear roadmap for IENs on their path to licensure. The results are shared with the candidates and regulatory bodies, leading to informed decisions regarding further training or readiness for practise.[132]

Reducing redundancies in language proficiency testing

Repeated standardized language testing imposes financial and emotional strain and can delay licensure despite evidence of proficiency. Some regulators have introduced greater flexibility. The College of Nurses of Ontario accepts recent nursing education or practise in English or French within the past two years as sufficient evidence.[133] Similarly, Alberta and British Columbia recognize professional experience or education completed in English-speaking jurisdictions when evaluating language requirements for licensure. Internationally, regulators such as the U.K.'s General Medical Council and Medical Council of Ireland accept verified practise in English or confirmation from employers. Expanding these practices in Canada can reduce duplication, accelerate workforce entry, and better acknowledge IEHPs' prior training and experience.

The role of health-care employers

Health-care employers can create inclusive environments that integrate IEHPs and generate workplace loyalty. The following subsections explore EDI policies and practices across five dimensions: governance, human resources, workplace culture, measurement and tracking, and outreach and expanding the pool.

Governance

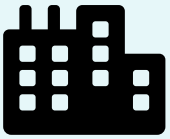
At the leadership level, EDI strengthens strategic decision-making by incorporating a wide range of perspectives, and fosters a culture of belonging that resonates throughout an organization.[134, 135, 136] In health care, diverse leadership is crucial for fostering cultural competence, delivering equitable care, and addressing the needs of diverse communities.[137]

Despite these recognized benefits, equity-deserving groups are underrepresented in health-care leadership. Research indicates that racialized individuals, particularly first-generation immigrants, encounter substantial barriers to advancement, including systemic challenges such as race-based discrimination.[138] Governance representation differs across regions, with some hospital boards actively reflecting their communities' diversity.[139] Encouragingly, Toronto has several organizations leading by example.

In 2019, William Osler Health System became the first Canadian hospital named one of Canada's Best Diversity Employers for nine consecutive years, reflecting strong commitment to accessibility, equity and inclusion.[140] Central to this achievement is the Diversity Advisory Council, with 50 to 60 change champions, including senior leaders. The council meets bi-monthly to promote an inclusive environment, address key issues, and gain insights from expert speakers.[141]

The Scarborough Health Network is another example of EDI in governance. It established an organizational development and diversity department, led by a dedicated director, to support its diverse community. Its Leadership Development Program includes mandatory bias-awareness training. Also, in 2016, all leaders completed a 360-degree leadership assessment developed with MIT Sloan School of Management, featuring a Diversity Index to evaluate inclusivity and drive innovation.[142]

Sunnybrook Health Sciences Centre demonstrates similar leadership commitments through its Internationally Educated Professionals Committee. This group helps shape Sunnybrook's human resources strategy, focusing on attracting, training and retaining internationally educated professionals, while developing targeted programs for their integration.[143]



*Pinecrest-Queensway Community Health Centre has cultivated a workforce where almost **40% of staff reflect the multicultural population** it serves.*

Human resources

Proactive and intentional recruitment efforts demonstrate significant success in building diverse and inclusive workforces. Pinecrest-Queensway Community Health Centre has cultivated a workforce where almost 40% of staff reflect the multicultural population it serves, according to 2015 data.[144] This achievement resulted from deliberate efforts to recruit internationally trained individuals, with careful attention to language requirements, staffing needs, and the diversity of clients. Staff involved in the hiring process receive training to ensure that interviews are welcoming and inclusive for all candidates. Employers can also address labour shortages by partnering with recruitment services and support organizations that connect IEHPs with health-care organizations.

Extended orientation and onboarding are pivotal for integrating IEHPs into the Canadian health-care system, equipping them with the knowledge and resources needed to adapt to unfamiliar workplace cultures and health-care practices. To achieve meaningful results, these processes must be comprehensive, incorporating critical information packages, job-specific training, and regular opportunities for feedback and engagement. To support this, the Ontario Ministry of Health has introduced the Nursing Career OrIENtation program.[145] This initiative offers up to 26 weeks of funding to help employers overcome resource constraints and enables robust onboarding processes that support the seamless integration of IEHPs into the workforce. It has been embraced by St. Michael's Hospital and Hamilton Health Sciences.

Effective strategies for retaining IEHPs and supporting career progression should focus on providing robust professional development opportunities and creating well-defined avenues for advancement. In Australia, health-care employers have partnered with Monash University to provide leadership development opportunities through the Women in Leadership program. The program is offered to women working in nursing or allied health, women working in a rural or remote area, and women in clinical academics.[146]

Workplace culture

Policies and practices play a key role in shaping an inclusive organizational culture that respects, values and supports employees from equity-deserving groups.[147] Such a culture enhances employee satisfaction and retention while strengthening an organization's

ability to address strategic challenges and achieve its goals.[148] However, as discussed earlier in this report, health-care settings often lack EDI policies and practices that foster truly inclusive organizational environments. Internationally educated health professionals frequently encounter barriers such as workplace discrimination, resulting in job dissatisfaction and poor retention.[149, 150] By contrast, organizations that implement equity-oriented practices create more respectful and inclusive environments for health-care workers and community members.

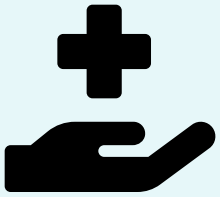
Returning to the example of William Osler Health System: Its efforts illustrate the symbiotic and mutually reinforcing relationship between EDI leadership and the cultivation of an inclusive workforce culture. Osler initiatives, such as employee wellness programs, resource programs, and partnerships with community organizations to increase access to care for underserved communities, help to foster inclusivity.[151, 152] In this way, Osler's culture of belonging encourages diverse engagement and participation at all levels, including on the board of directors. The initiatives have contributed to increased engagement among board members, a growing number of applicants for board and council positions, and the creation of new volunteer opportunities.[153]

King's College Hospital in London exemplifies how a strong focus on EDI can shape an inclusive and vibrant workplace culture. Informed by the priorities outlined by the General Medical Council,[154] including fairer employer referrals, fair training cultures, and inclusivity as an employer, the hospital's comprehensive EDI strategy translates these priorities into tangible initiatives that foster meaningful cultural change. Central to its approach is the establishment of staff diversity networks, which serve as a pillar of the hospital's inclusive environment. These networks organize workshops, events and celebrations, creating opportunities for connection and engagement among staff. With more than 3,500 members participating as of 2024, these networks have proven instrumental in cultivating a culture of belonging and mutual respect.[155]

Measurement and tracking

Metrics and benchmarking are important tools for employers to assess the effectiveness of their initiatives. Establishing clear targets and measuring outcomes not only drives the advancement of EDI efforts, but also reinforces accountability.[156] Employers can track diversity through anonymous surveys and interviews, then publish their results to reaffirm their EDI commitment and transparently communicate the impact of their interventions. These metrics serve a dual purpose: They provide the benchmarks for year-over-year progress within an organization while facilitating comparisons with other organizations in the sector or industry.[157]

For example, Royal Melbourne Hospital in Australia developed its EDI action plan using a comprehensive baseline audit analysis that included a gender audit, payroll data analysis, and findings from its annual People Matter survey.[158] These data-driven insights informed the implementation of initiatives in a wide range of areas, including harassment cases, pay equity, and flexible work arrangements. By 2021, the hospital achieved a workplace culture satisfaction rate of 78% among survey respondents, exceeding its initial target of 62%.[159]



By 2021**, the hospital achieved a **workplace culture satisfaction rate of 78%** among survey respondents, **exceeding its initial target of 62%.

While aggregated metrics provide a high-level overview, disaggregated data is crucial for uncovering disparities faced by employee groups, such as IEHPs. This granular approach is important in health care, where IEHPs often encounter unique challenges related to adapting to new workplace cultures and overcoming biases. By isolating data related to IEHPs, organizations can tailor their initiatives and ensure that interventions are equitable and effective for all employees.

Outreach and expanding the pool

Health-care employers can extend their influence beyond internal diversity efforts by leveraging partnerships to promote EDI externally. Collaborations with educational institutions, immigrant-serving organizations, and regulatory bodies can strengthen the ecosystem around IEHPs, providing targeted opportunities for licensure, mentorship and professional development.[160]

Hamilton Health Sciences' comprehensive integration program for IENs is a collaboration between local educational institutions, regulatory bodies and community organizations. It offers clinical assessments, mentorship and supervised clinical

placements.[161] These placements allow IENs to work under the supervision of licensed professionals, helping them meet local practice standards and ensuring they are fully prepared for licensure. From 2009-19, the program has supported more than 890 participants, with more than 524 IENs securing employment as professional nurses.[162]

Unity Health Toronto, through its involvement in the Supervised Practice Experience Partnership with the College of Nurses of Ontario and Ontario Health, showcases effective employer outreach. By providing funded clinical placements to IENs, Unity Health enhances their clinical skills, language proficiency and licensure readiness while tackling workforce integration barriers. Similarly, Women's College Hospital in Toronto offers the Emily Stowe Scholar program. The initiative supports students and mid-career to senior scientists from equity-deserving groups with tailored programming and networking to advance their careers.[163] In Australia, seven teaching hospitals and community facilities within the mental health network provide clinical work experience for IMGs.[164] These efforts help participants adapt to local health-care environments and successfully contribute to the workforce.

Individual

In conjunction with structural improvements that address systemic inequities, individual-level interventions, including mentorship programs, trauma-informed training, technologies, wraparound supports, and socio-emotional skills training offer personalized approaches to the successful integration of IEHPs into the Canadian workforce.

Programming

Many promising practices help IEHPs navigate the transition into the Canadian health workforce.

While represented as distinct for the purposes of analysis, training programs and licensure are deeply connected. Often the most effective strategies for improving access to licensure depend on employer engagement and work-integrated learning opportunities.

Mentorship programs

Research shows that IEHPs often face significant challenges when adapting to the Canadian health-care environment. These challenges include overcoming language barriers, as well as unfamiliar medical practices, models and technologies, while learning the nuances of workplace expectations and communication styles.[165] Mentorship programs offer a personalized approach to overcome these obstacles, improving the confidence and retention rates of IEHPs within the health-care workforce.[166, 167]

The CARE Centre's mentorship program delivers positive outcomes by pairing IENs with experienced professionals to help them navigate a foreign health-care environment.[168] The program helps IENs understand their role and their scope of practice in Canadian health-care settings. They connect with potential employers and expert nurses to answer their questions, and job-shadow to understand Canadian health-care workplace culture.[169] In 2023-24, 71 IENs participated in the program.[170] Of these, 45 completed mentorship assignments, while 13 updated their practice and language skills through the structured practice experience program, enhancing their readiness for integration into the health-care system by aligning their skills with current Canadian standards.[171]

While not exclusive to IMGs, the needs of Black physicians experiencing anti-Black racism in their training process in the Canadian health-care system has also received attention in the form of a specialized mentorship program offered by the Black Physicians of Canada (BPC).[172]

Established in 2021, the BPC mentorship program is the first national race-concordant mentorship program in Canada providing one-on-one mentorship for Black residents, fellows and early career physicians. In the past year, the program has had 89 mentor-mentee pairs. The program also offers workshops on topics relevant to Black learners and physicians including microaggressions, hidden curriculum and finances.

Trauma-informed training

The immigration journey can involve significant disruption, loss of professional identity, and emotional distress. Some IEHPs migrate to Canada to escape conflict or instability in their home countries. Unresolved trauma from these experiences may impede learning and adaptation, particularly when access to trauma-informed resources are limited.[173] Many employers are ill-equipped to accommodate individuals with traumatic histories, creating further barriers to successful employment and settlement.[174]

Creating trauma-informed career pathways is a relatively new but vital approach in Canada. Drawing from the foundational model of trauma-informed care established by Harris and Fallot, these programs emphasize five guiding principles: safety, trustworthiness, choice, collaboration and empowerment.[175] Such principles support recovery and foster resilience among individuals with traumatic experiences.

Organizations like the Ontario Council of Agencies Serving Immigrants have advanced this approach by developing trauma-informed guidelines[176] that acknowledge the intersections among various forms of violence, trauma and adverse life outcomes. This model supports resilience and self-care by incorporating four key principles:

1. **Generalist practice:** Recognizing the potential for invisible trauma in everyone
2. **Preventing retraumatization:** Ensuring a do-no-harm approach underpins all policies and practices
3. **Fostering safety:** Committing to emotional, physical, psychological, interpersonal, social, cultural and systemic safety for all individuals
4. **Continuing growth and community building:** Adopting a strengths-based approach that fosters choice, collaboration and connection to promote recovery and resilience.

Leveraging technology

Virtual reality (VR) and artificial intelligence (AI) offer potentially transformative solutions to persistent challenges, such as cultural competency gaps and biases in hiring. Virtual reality has shown impressive potential, offering immersive, realistic training environments that allow participants to practise communication, leadership and teamwork.[177] A pilot program for socio-emotional skills training showed that participants completed training four times faster than in classroom settings and were 275% more confident in applying their acquired knowledge.[178] The integration process is further enhanced by AI, which can enable more nuanced assessments of workers' abilities. Through machine-learning algorithms and psychometric testing, AI evaluates a range of competencies, including non-quantifiable skills like leadership, time management, and empathy, which are often overlooked in traditional hiring practices.[179] This approach has the potential to better capture the full scope of IEHPs' talents and support more equitable recruitment and improved job matching.

Heeding cautions about potential racial biases in AI and machine learning, technology can also be leveraged to support language learning. Such instruction is mainly carried out through five types of technology: mobile learning, multimedia learning, socialized learning, speech-to-text and text-to-speech recognition, and digital game-based learning.[180] Evidence shows that compared to non-technological instruction, these modalities have a greater impact on language learning and teaching, particularly when delivered through mobile phone applications.[181]

*By 2023, the IEN Pathway program had **supported 174 IENs**, with **115 successfully hired** into roles at the hospital.*

Wraparound supports

Emerging evidence emphasizes the importance of wraparound supports, often identifying them as being as critical as training itself.[182] Supports help mitigate barriers such as financial constraints, caregiving responsibilities, transportation challenges, and access to essential resources. Key interventions include direct financial aid, employment placement programs, career counselling, mental health support, and practical assistance with child care and transportation. Wraparound supports could also include mentorship, professional networking opportunities and language assistance, which are provided in conjunction with the core training. These types of supports are most effective when they are tailored to the unique needs and experiences of individuals. For example, IENs may require a combination of financial assistance, child care, housing, and settlement services to overcome the distinct challenges they face in returning to practice.

The IEN Pathway program at Sunnybrook Hospital offers customized assistance to participants, including child care, financial aid, settlement services, and housing.[183] By 2023, the program had supported 174 IENs, with 115 successfully hired into roles at the hospital.[184] Similarly, New York-Presbyterian Hospital's returnship program provides coaching, networking opportunities, reskilling and credentialing, and employer training on the benefits of hiring IEHPs. Since its inception in 2021, the program has supported more than 100 immigrants and refugees in reestablishing their health-care careers,[185] suggesting that short-term investment is offset by longer-term results.

Soft skills training

Fostering informal peer support can ease the integration of IEHPs into the Canadian health-care system. Canadian-born professionals who volunteer as mentors or buddies help bridge gaps in understanding clinical practices and workplace expectations. Informal check-ins, answering questions, or simply being a friendly and approachable colleague can reduce feelings of isolation and build confidence in daily practice.[186]

Mentorship plays a significant role in facilitating smoother transitions for IEHPs, as mentors enhance the learning capacity of international students in clinical settings.[187] The presence of a mentor has been linked to lower stress levels among international medical students in new environments.[188] Peer mentors can also play a role in helping IEHPs navigate credentialing processes, workplace dynamics, and cultural differences while providing emotional and professional support during the integration process.[189] Health-care providers also benefit from reflecting on their own assumptions and remain open to the varied training backgrounds of IEHPs. Canadian-trained staff can share local best practices while also benefiting from the diverse insights and clinical practices IEHPs offer. Studies note that IEHPs integrate best when they can embrace their culture of origin as well as that of Canada.[190]

Conclusions and Recommendations

Internationally educated health professionals play a vital role in supporting Canada's health-care system. They help to address workforce shortages and enrich the quality of care.

However, despite their value, IEHPs often encounter significant barriers that hinder their full participation in the workforce. To unlock their potential, targeted solutions that harness their skills and expertise must be identified.

Advancing their integration will strengthen Canada's health-care system while promoting equity and better addressing the needs of a diverse population. This section outlines recommendations for policymakers, employers and immigrant-serving organizations to improve IEHP integration.

Societal

The federal system in Canada introduces complexities in integrating IEHPs due to decentralized health-care governance. Recommendations at this level emphasize collaborative and context-sensitive approaches.

> Standardize licensure requirements across provinces and territories to promote fairness, transparency and consistency in the recognition of international qualifications. This would support more efficient and equitable integration of IEHPs and align with international best practices. A pan-Canadian licensure agreement would also enable IEHPs licensed in one jurisdiction to practise elsewhere without recertification.

> Increase federal funding through the Canada Health Transfer tied to provincial and territorial bridging programs, work-integrated learning opportunities, and practice-ready assessments. This funding should reflect a long-term commitment from the federal government to improve disparities in health-care needs, prioritize support for rural and underserved areas, and incentivize employer partnerships to enhance IEHP integration and retention.

> Establish a national data strategy on IEHP pathways and outcomes, incorporating disaggregated demographic data to reveal systemic gaps and inform more responsive program and policy development aimed at addressing disparities.

Organizational

Licensure

> Invest in pre-arrival programs that provide IEHPs with timely, profession-specific licensure information and career guidance.

> Develop mutual recognition agreements to streamline licensure processes from trusted countries based on comparable training and standards.

> Increase funding and employer engagement in bridging programs that combine classroom instruction with clinical placements.

> Expand practice-ready assessment programs across provinces to offer IMGs an alternative licensure pathway that does not require repeating residency training.

> Expand the use of temporary or conditional licences that allow IEHPs to begin working in supervised roles while completing their full licensure requirements.

> Adopt competency-based credential recognition models that evaluate applicants based on demonstrated skills and knowledge, rather than training location or rigid equivalency standards.

Enhancing equity, diversity and inclusion

Health-care employers can foster inclusive workplaces by embedding EDI principles across all organizational practices to create supportive environments for IEHPs.

> Increase diversity in leadership roles by actively recruiting equity-deserving groups, including IEHPs, and establishing EDI councils to guide inclusive policies and monitor progress.

> Adopt EDI-focused human resources practices. These include tailored hiring strategies, such as partnerships with IEHP-serving organizations, comprehensive onboarding, and professional development opportunities, to support IEHP recruitment, retention and career advancement.

> Foster inclusive workplace cultures through equity-oriented policies, employee wellness programs, staff diversity networks, and community partnerships that enhance engagement and belonging.

> Use metrics and benchmarking to assess EDI initiatives, collect disaggregated data to uncover disparities, and publish results to drive accountability and inform targeted interventions.

- Integrate EDI principles across core organizational functions, including marketing, research and development, and patient care (e.g., tailoring services to meet diverse linguistic and cultural needs).
- Build partnerships with educational institutions, regulatory bodies, and community organizations to support IEHPs through clinical placements, mentorship, licensure preparation, and outreach initiatives that encourage engagement and long-term retention.

Individual

- Connect IEHPs with experienced professionals through mentorship programs offering one-on-one guidance, shadowing opportunities, and networking to support their adaptation to Canadian health-care practices, communication styles, and workplace norms.
- Embed trauma-informed principles in training and workplace practices by fostering safe environments, training staff to address trauma, and leveraging strengths-based approaches to support IEHP resilience and successful integration.
- Leverage technology, including VR simulations, online micro-credentialing, and AI-driven assessments to provide targeted training, familiarize IEHPs with Canadian health-care dynamics, and improve recruitment and job matching.
- Provide wraparound supports in training that address IEHPs' challenges with financial aid, career counselling, child care, transportation, mental health services, mentorship, networking, and language support.
- Integrate structured socio-emotional skills development as a core component of all IEHP training programs. This should include approaches such as simulation-based learning, mentorship, and work-integrated opportunities to help IEHPs better navigate Canadian workplace norms, enhance professional communication, and improve employment outcomes.

Internationally educated professionals could play an important role in addressing Canada's health-care workforce shortages and contribute to advancing health equity and improving population health. Yet Canada's systems of recruitment, licensure, integration and long-term career options for these health-care professionals lack coherence and efficiency.

Effective practices have been tested in similar international settings, and some are being piloted here at home. Attention and commitment to these opportunities could be an answer to the gaps Canadians are experiencing in what they regard to be one of the most valued aspects of their national identity.

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