Signal49 RESEARCH

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# From Newcomers to Game Changers

## Immigrant Skill Utilization in the Healthcare Sector

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Future Skills Centre | Centre des Compétences futures

The Future Skills Centre (FSC) is a forward-thinking centre for research and collaboration dedicated to driving innovation in skills development so that everyone in Canada can be prepared for the future of work. We partner with policymakers, researchers, practitioners, employers and labour, and post-secondary institutions to solve pressing labour market challenges and ensure that everyone can benefit from relevant lifelong learning opportunities. We are founded by a consortium whose members are Toronto Metropolitan University, Blueprint, and Signal49 Research, and are funded by the Government of Canada's Future Skills Program.

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# Contents

# Key findings

- Immigrant healthcare professionals are more than twice as likely to be overeducated for their jobs than their Canadian-born counterparts. This gap is widest for those with university education above the bachelor's level.
- The immigration system prioritizes high-skilled immigrants based on education and language proficiency, but it does not ensure their credentials will be recognized in Canada. For internationally trained healthcare professionals, this creates a gap between who gets in and who can actually work in healthcare.
- Canada's fragmented licensing system across provinces and territories creates delays and costs that disproportionately affect internationally trained healthcare professionals, contributing to their skill underutilization. This fragmentation also limits the mobility of immigrant healthcare practitioners who wish to move outside of their province of licensure.
- Bridging opportunities for internationally educated healthcare professionals—such as training courses, clinical placements, and other work-integrated learning opportunities—are limited, leaving many immigrants without clear pathways into the healthcare roles that they're trained for.

# Healthcare worker shortages limit essential care

Canada's healthcare system is facing acute labour shortages, but the sector is failing to leverage many internationally trained healthcare workers already in the country. In 2021, only 67 per cent of immigrant physicians worked in the healthcare sector, compared to 95 per cent of their Canadian-born counterparts.[1] Even fewer immigrant healthcare professionals—58 per cent—held any health-related occupations.

Beyond the serious health consequences this has for Canadians,[2] there is a profound economic cost: In 2024 alone, the Canadian economy lost $2.6 billion due to a shortage of 64,000 skilled workers, with healthcare accounting for nearly half of this loss at $1.2 billion.[3]

Canada plans to address these shortages by dedicating 64 per cent of total permanent resident admissions to the economic immigration category by 2028, prioritizing key sectors like healthcare.[4] This class comprises immigrants admitted to meet identified labour market needs. But the core issue isn't the supply of healthcare workers—it's that their skills aren't being used effectively and, in some cases, aren't being used at all.

Drawing on Labour Force Survey data from 2022 to 2024, we examined how well immigrants' skills are utilized in the healthcare sector. We also spoke with 20 employment and settlement service providers and six healthcare employers to better understand the skill utilization gap and learn how we can solve it.

1 Frank and others, *Internationally educated health care professionals in Canada*.
2 Zhang, *The Doctor Dilemma*; Pelley, "Canadian ERs keep closing this summer — but there's no easy fix"; Moir and Baura, *Waiting Your Turn*.
3 Signal49 Research, *From Shortages to Solutions: Tackling Canada's Critical Gaps in Healthcare, Trades, and Tech*.
4 Immigration, Refugees and Citizenship Canada, *2026-2028 Immigration Levels Plan*; "Canada's immigration levels."

# Part of a series

This issue briefing is one of three examining immigrant skill utilization in healthcare, construction, and hospitality.

For a cross-sector view of immigrant skill utilization, see our online experience: From Newcomers to Game Changers: A Scorecard for Immigrant Skill Utilization. Read our construction and hospitality issue briefings to learn about other sector-specific barriers and recommendations.

## How we measured skill underutilization

Skill underutilization takes two forms: mismatch and wastage.

People experience skill *mismatch* when they're employed below their education level, such as a physician working as a lab technician. We measured this as the share of workers who were overeducated for their jobs.

People experience skill *wastage* when they can't find employment, when they're in precarious jobs, or when they work fewer hours than they want to. We measured this as the share of working-age people who were unemployed, in temporary jobs, or worked part time involuntarily.

See our methodology in Appendix A for more information.

## Measuring immigrant overeducation and unemployment in healthcare

Our healthcare data only includes people who worked in the healthcare sector at some point while in Canada. This creates a gap when measuring overeducation and unemployment among immigrants.

Consider two examples: An internationally trained physician who has only worked as a bartender in Canada would be counted in our hospitality data as overeducated but they wouldn't appear in our healthcare data because they never worked in the sector. An internationally trained physician who has been unemployed since arriving in Canada wouldn't appear in any of our sector-specific data because they never worked in Canada.

Both individuals, however, would be captured in our industry-wide skill utilization results, which track employment outcomes across the full labour market rather than linking them to a specific sector.

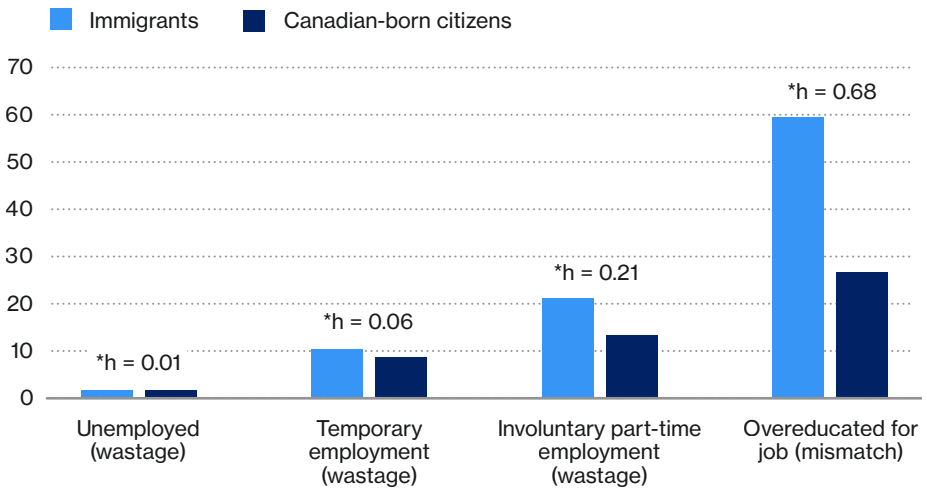
This data limitation means we likely underestimate the number of internationally trained healthcare professionals who are either unemployed or overeducated for their job.

# Immigrants tend to be mismatched for their jobs

In 2024, the primary way immigrants' skills were underutilized in healthcare was through overeducation, or *skill mismatch*. (See Chart 1.) Immigrants also faced involuntary part-time employment—a form of *skill wastage*—but this challenge was much less pronounced than overeducation.

Comparing the rates in Chart 1, immigrants were 2.2 times more likely to be overeducated for their jobs than Canadian-born citizens. Immigrants were also 1.6 times more likely to have faced involuntary part-time employment. There were also statistically significant differences in rates of unemployment and temporary employment; these differences were trivial in size; thus, their meaningfulness is limited.[5]

**Chart 1**
In 2024, overeducation was the biggest skill utilization challenge for immigrants in healthcare
(percentage underutilized)




Note: Cohen's *h* is an effect size metric that measures the magnitude of the difference between two proportions. Values below 0.20 represent trivial differences. Values between 0.20 and 0.49 represent small differences. Values between 0.50 and 0.79 represent medium differences. All differences were statistically significant (*). See our methodology for more details.
Sources: Statistics Canada; Signal49 Research .

5 These differences between immigrants and Canadian-born citizens were statistically significant but varied in size. There was a medium difference in overeducation (*h* = 0.68), a small difference in involuntary part-time employment (*h* = 0.21), and trivial differences in temporary employment (*h* = 0.06) and unemployment (*h* = .01). See Appendix A for our methodology.

# Skill mismatch

## Skill mismatch disparities exist at higher education levels

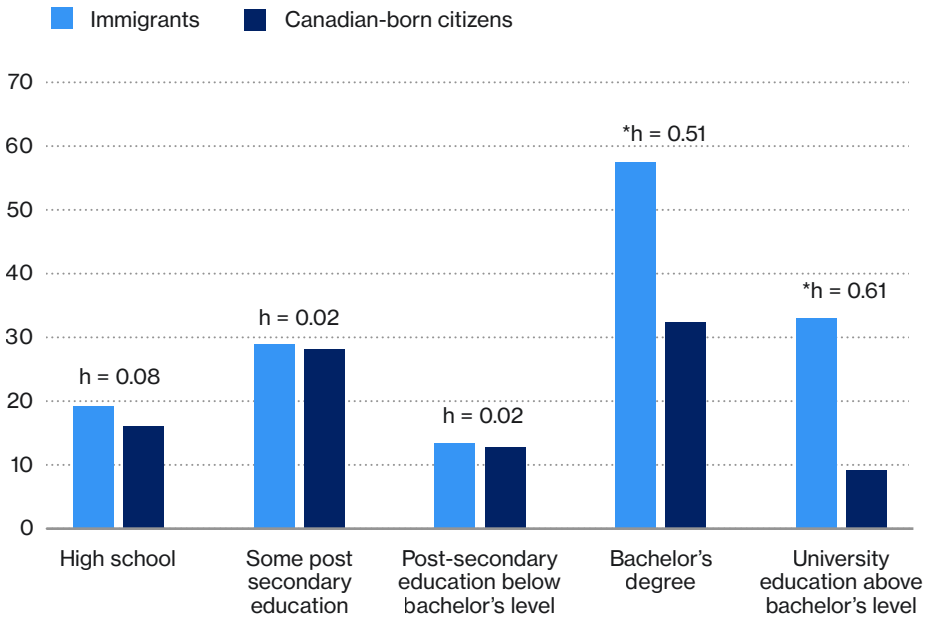
In 2024, overeducation was the primary way immigrants' skills were underutilized in the healthcare sector. (See Chart 1.) When we broke this down by level of educational attainment, we found that immigrants with bachelor's degrees had the highest overeducation rates. This was also true for Canadian-born citizens. (See Chart 2.)

Comparing immigrants to Canadian-born citizens, the largest difference appeared among those with higher than a bachelor's degree. Immigrants in this group were 3.7 times more likely to have faced overeducation than their Canadian-born counterparts. At the bachelor's level, immigrants were 1.8 times more likely to have been overeducated for their jobs.[6] (See Chart 2.)

**Chart 2**

In 2024, overeducation in healthcare was highest among immigrants with bachelor's degrees

(percentage overeducated)




Note: Cohen's *h* is an effect size metric that measures the magnitude of the difference between two proportions. Values below 0.20 represent trivial differences. Values between 0.50 and 0.79 represent medium differences. Statistically significant differences are marked with an asterisk (*). See our methodology for more details.
Sources: Statistics Canada; Signal49 Research .

6 These group differences were statistically significant and medium in size (*h* = 0.51 and 0.61). The other group differences were nonsignificant and trivial in size (*h* = 0.02 to 0.08). See Appendix A for our methodology.

# Barriers to immigrant skill utilization

Interviews with employers and employment and settlement service providers revealed three key barriers to immigrant skill utilization:

- The lack of interprovincial coordination and recognition of licensing standards across provinces and territories
- Limited access to bridging programs for internationally trained healthcare workers
- A lack of coordination between immigration selection criteria and healthcare workforce priorities

## Fragmented licensure standards delay healthcare sector entry

Everyone wanting to work in a regulated healthcare profession in Canada must be licensed. But internationally trained professionals face an extra barrier—they must navigate Canada's credential recognition process first.[7] This process can require a substantial financial investment. Licensing fees range from hundreds to several thousand dollars, depending on the profession.[8] Internationally educated healthcare professionals must also factor in costs for English or French language testing.[9]

Further, licensing regulations are fragmented across provinces and territories.[10] For instance, for nursing there are 22 regulatory bodies across 10 provinces and three territories. Requirements for training, examinations, and demonstrated practice experience vary between jurisdictions and regulatory bodies.[11] This fragmentation limits professional mobility between jurisdictions and contributes to skill underutilization for immigrant healthcare practitioners.[12]

A settlement service provider in Saskatchewan described both of these challenges.

> **"The cost for doing the process is a barrier for our clients because it's not just a mere hundred. It can cost maybe a couple of hundred or even thousands to get through the process. And not an easy process. It's not very quick. Also, it's not transferable to other provinces. So, we have seen healthcare professionals that have gotten their credential recognition here in Saskatchewan but cannot work elsewhere in Canada or vice versa.... The bodies that do these credential recognitions per province, they have their own set of rules.... It's not really mobile."**
>
> **Settlement service provider**, Saskatchewan

7 Walton-Roberts, "The ethics of recruiting foreign-trained healthcare workers."
8 Kaur, "A Complete Breakdown of NCLEX Test Cost & Policies; PracticeMed, "Fees for Examinations and Services."
9 Cukier and others, *Pathways for Internationally Educated Health-Care Professionals*.
10 Leslie and others, "Pan-Canadian Registration and Licensure of Health Professionals."
11 Cukier and others, *Pathways for Internationally Educated Health-Care Professionals*.
12 Cukier and others, *Pathways for Internationally Educated Health-Care Professionals*; Leslie and others, "Regulating health professional scopes of practice."

A survey by the Canadian Medical Association (CMA) found that 95 per cent of physicians in Canada are in favour of issuing medical licenses that are valid throughout Canada, and 73 per cent think this will make Canada more appealing to international medical graduates.[13] The CMA is not the only professional body urging Canada to standardize healthcare licensing across the country. There have been many calls over the years for a pan-Canadian licensure process,[14] or smaller-scale licenses for multiple jurisdictions (e.g., in 2023, a single occupational license for physicians in Atlantic Canada was introduced).[15]

A healthcare employer in British Columbia told us that there is no reason for "lowering our standards or reducing safety for patient populations, but having a reasonable, clearly definable, and—I would argue—pan-Canadian sort of process ... shouldn't be that difficult."

13 Canadian Medical Association, *Time for pan-Canadian licensure*.
14 Bartman and others, "Facilitating the Path to Licensure and Practice"; Bosco and others, "Pan-Canadian licensure"; Leslie and others, "Pan-Canadian Registration and Licensure of Health Professionals."
15 Sweatman, "Models in Professional Regulation"; College of Physicians and Surgeons of Nova Scotia, "Atlantic Registry."

## Why territorial regulation poses extra barriers

For newcomers who settle in Canada's territories, the licensure situation is even more challenging because regulation takes different forms depending on the territory and occupation. For instance, instead of colleges or other regulatory bodies, some medical licenses are overseen by territorial governments, such as those for physicians in Nunavut and the Northwest Territories.[16] Other professions, like occupational therapists, are not regulated in the territories at all, leaving candidates to register either with a national association or with another provincial regulatory body, as requested by some employers.[17]

**"For regulated professions, ... you have to get registered twice. You always have to get registered with a province before you can get recognized in the territories, because the territories don't have the infrastructure. The regulation bodies are just there to recognize another provincial credential .... So, being in a territory has that added barrier, that added obstacle, that you need to be registered with a province. And sometimes you can only get registered in a province if you are a resident of that province."**

**Employment services manager**, Yukon

A 2023 Statistics Canada profile of immigrants who are internationally trained healthcare workers found that the territories lag behind all provinces in employment rates, with only 46 per cent of internationally educated healthcare professionals residing in the three territories employed in the healthcare sector as of 2021.[18]

16 Nunavut Physicians, "License and Registration"; Health and Social Services, "Medical Licence."
17 Canadian Institute for Health Information, *Occupational Therapists in Canada, 2024 — Methodology Notes*.
18 Frank and others, *Internationally educated health care professionals in Canada*.

## Bridging programs help skilled immigrants get healthcare jobs

The experience of high-skilled immigrants in "survival jobs"—positions that are low-skill, low-wage, often temporary, and outside their field of training[19]—came up frequently in our interviews. A recruitment specialist in Ontario provided an example of a newcomer radiologist, with 10-15 years of experience at a large hospital, asking for customer service jobs because they needed any job, adding, "There is nothing in between for them. There is no bridging."

"Bridging" refers to programs that offer training to enter or re-enter a regulated profession to overcome education or practice gaps,[20] often by combining coursework with practical experience.[21] While these programs can help immigrants gain valuable experience, they're often confined to urban centres and are limited in scope, capacity, and funding.[22] They are also often costly, with tuition sometimes reaching tens of thousands of dollars.[23]

The settlement service providers we spoke to repeatedly mentioned structured, hands-on workplace integration as an effective onboarding strategy. For instance, they recommended "shadowing" practices and extended onboarding periods to offer internationally trained professionals the opportunity to acclimatize to Canadian healthcare settings, to build confidence in their skillset, and to practice routinely. In Ontario, for example, the Trillium Health Partners' Licensure and Career Integration Bridging Program includes observerships (i.e., shadowing) alongside a five-week course and continued mentorship.[24]

Beyond bridging programs, some provinces facilitate workplace integration through provisional licenses, such as those from the Colleges of Physicians and Surgeons of Ontario[25] or British Columbia.[26] These allow internationally trained professionals to practice under supervision with limited scope until they gain full licensure.[27]

19 Baumann and others, "Diversifying the health workforce"; Raihan and others, "Low Job Market Integration of Skilled Immigrants in Canada"; Shuva, "Information experiences of Bangladeshi immigrants in Canada."
20 Baumann and others, "Diversifying the health workforce"; Connelly and others, "Learnings from nursing bridging education programs"; Covell and others, "Scoping review about the professional integration of internationally educated health professionals."
21 Cukier and others, *Pathways for Internationally Educated Health-Care Professionals*.
22 Covell and others, "Scoping review about the professional integration of internationally educated health professionals."
23 Canadian Imperial College, "Bridging Pathway for Internationally Educated Healthcare Professionals (BPIEHP)"; Mohawk College, "Canadian Health Care for Foreign Trained Professionals (International Only)"; Conestoga College, "Enhanced Practice for Internationally Educated Nurses."
24 Trillium Health Partners, "Internationally Educated Health Professionals (IEHPs)."
25 College of Physicians and Surgeons of Ontario, "Provisional Certificate of Registration for Exam Eligible Candidates."
26 College of Physicians and Surgeons of British Columbia, "International Medical Graduates."
27 Cukier and others, *Pathways for Internationally Educated Health-Care Professionals*.

**"If you [weren't] able to practice nursing in the last five years, ... you have now a practice gap.... You need to be enrolled [in] that [bridging] program and then work as a nurse.... It's the last part for the license. So, they applied for the license, and then the last thing would be ... instructor-led training within the hospital and ... preceptorship-led training, like around 600 hours.... They will be working as [a] kind of graduate nurse. This is the last part. And then they will be having the board exam and getting the license to practice."**

**Healthcare employer**, New Brunswick

## Immigration policy clashes with healthcare sector needs

We heard from employers that the structure of Canada's immigration system contributes to the challenge of integrating internationally educated professionals into healthcare roles. While Express Entry prioritizes education, language proficiency, and financial resources in selecting high-skilled immigrants, it does not sufficiently account for the realities of integrating these immigrants into the labour market and meeting its demands:

**"I do think that the way that the immigration [system]—especially the Express Entry system—is designed; simply said, it's set up for failure because it's not tied to employment. It is tied to language proficiency, it's tied to money, it's tied to education levels, previous experience, but previous [foreign] experience is not recognized here in Canada. So, we end up with a lot of people coming to Express Entry who are very, very skilled, but who end up working in positions that they shouldn't be working in."**

**Healthcare employer**, Nova Scotia

Some jurisdictions in Canada, including Nova Scotia, are becoming more deliberate in applying targeted international recruitment to address local healthcare shortages.[28] A healthcare employer in Nova Scotia told us that, with provincial support, they look to increase recruitment of trained healthcare workers from countries in which they have had recruitment successes.

Other provinces and healthcare recruiters can draw from these lessons. The goal for Canada's immigration system is not only to recruit internationally educated healthcare professionals but also to ensure that they thrive within the Canadian healthcare system.

28 Nova Scotia Health, *Physician Recruitment Strategy 2024 - 2027*; Hampshire, "Jordan-trained pharmacists arrive in N.S. following international recruitment."

# Actionable insights

Provincial policy-makers, regulatory bodies, employers, and service providers seeking to leverage immigrant skills in the healthcare sector can consider the following:

## Provincial policy-makers and regulatory bodies

**Expand interprovincial licensure agreements gradually toward a coordinated, pan-Canadian licensure framework that makes healthcare credentials portable across the country.**
Licensing regulations are fragmented across provinces and territories. While mutual recognition agreements exist between some jurisdictions, gaps remain: Not all professions are covered, standards vary, and credentials recognized in one province may not be valid in another. Provinces, territories, and regulatory bodies can work together to harmonize standards progressively across professions, using existing agreements as a foundation and surveying regulatory bodies to identify where further alignment is possible. The Atlantic Provinces, for example, already have an interprovincial, Atlantic registry for physicians.[29] A gradual progression toward a pan-Canadian framework would allow internationally trained professionals to obtain recognition once and practice anywhere in the country, reducing delays and costs.

**Expand provisional licensure to all provinces and territories so that internationally trained healthcare workers can practice under supervision while completing full licensure.**
The licensing process for internationally trained healthcare professionals can take months or, in some cases, years. Without income or clinical work during this period, professionals face financial pressure and practice gaps. Some regulatory bodies, such as the College of Physicians and Surgeons of Ontario and also of British Columbia,[30] currently address this through provisional licenses, which allow internationally trained professionals to practice under supervision while completing full licensure. The Government of British Columbia also offers compensation for supervisors of provisional licensees practicing in rural areas.[31] Other provinces and territories and healthcare licensing bodies can adopt equivalent frameworks to keep internationally trained professionals in clinical settings on arrival, preventing practice gaps and skill wastage.

29 College of Physicians and Surgeons of Nova Scotia, “Atlantic Registry.”
30 College of Physicians and Surgeons of Ontario, “Provisional Certificate of Registration for Exam Eligible Candidates.”
31 Government of British Columbia, “Supervisors for Provisionally Licensed Physicians.”

## Provincial governments and healthcare employers

**Involve employers in targeted recruitment missions that assess internationally trained health professionals, match them to in-demand roles, and transition them directly into these positions on arrival in Canada.**

Immigrants with education above the bachelor's level are 3.7 times more likely to be overeducated for their healthcare job than Canadian-born peers. This is because Canada selects immigrants for their credentials without tracking whether those credentials are used here. One fix is to pair selection with direct pathways into employment: Immigrants are assessed for their skills and job suitability overseas, receive a job offer from an employer, and then transition directly into these roles upon arrival in Canada. Provinces such as Saskatchewan, Nova Scotia, Manitoba, and Newfoundland and Labrador have already created targeted recruitment initiatives to assess and hire internationally educated healthcare professionals in this way.[32] Other provincial governments and employers can develop and scale their own international recruitment missions to match the successes experienced in these initiatives. By addressing overeducation at the outset of the immigration process, skill shortages can be filled quicker, reducing the risk of both skill mismatch and skill wastage.

## Service providers (settlement, employment support, training institutions) and healthcare employers

**Establish more bridging programs that offer early, hands-on training for international healthcare professionals across specializations.**

While many internationally trained professionals arrive with strong credentials, there is no clear entry point into regulated roles. This often leaves them in positions below their education and skill levels. To carve a path toward commensurate employment, service providers can develop bridging training courses targeting professions where the shortages are the most acute , while employers can provide clinical placements, observerships, and structured mentorships to help professionals adapt to Canadian healthcare settings and become workforce-ready sooner. Expanding access to such bridging programs gives internationally trained professionals a clear, supported pathway into regulated roles. This reduces skill mismatch and moves immigrant professionals with in-demand skillsets into the healthcare positions and facilities where they are needed most.

32 Saskatchewan Healthcare Recruitment Agency, *Annual Report 2024-25*; Province of Manitoba, "Manitoba Government Launches Campaign to Recruit Health Professionals from the United States"; Nova Scotia Health, *Physician Recruitment Strategy 2024 - 2027*; Gates, Faith, "Global Talent, Local Impact."

Appendix A

# Methodology

## About the research

We conducted this research to better understand the extent of immigrant skill utilization in three in-demand sectors: healthcare, hospitality, and construction. We used a mix of quantitative and qualitative methods to explore three research questions in each of these sectors:

1. At what rates do immigrants versus Canadian-born citizens experience skill underutilization?
2. What barriers prevent employers from utilizing immigrants' skills?
3. How can municipalities, employers, and settlement service providers improve the utilization of immigrants' skills?

## Literature review

The first phase of this research involved a literature review to inform the quantitative study design and qualitative interview questions. To be included in our review, publications had to be from 2015 onwards and be related to immigrant employment and immigrant skill utilization in the Canadian labour market.

We identified and reviewed 14 publications, produced by academic journals, research institutes, and Statistics Canada, that provided broad insights on the definitions and implications of immigrant skill utilization, employment and settlement supports that enhance immigrant skill utilization, and barriers to the labour market integration of immigrant workers.

We also consulted sector-specific sources to understand industry challenges and the extent of labour shortages. We found four publications on labour shortages in the construction sector produced by Signal49 Research, news agencies, and an industry association. For the healthcare sector, we consulted a news release by Employment and Social Development Canada that provided an estimate of labour shortages. At the time of the literature review, we identified no sector-specific studies on the hospitality sector that projected labour shortages in accommodation and food services.

We identified and consulted additional sources over the course of the project, as the initial literature review was not meant to be an exhaustive list.

## Quantitative data analysis

### Data

We used custom tabulations of Statistics Canada's Labour Force Survey for the quantitative component of this study.[1] Our analysis spanned 2022 to 2024 survey years and covered the 38 census subdivisions with relevant data. *Census subdivision* is the general term for municipalities or areas treated as municipal equivalents for statistical purposes.[2]

The following five tables were requested from Statistics Canada:

1. Labour force characteristics by immigrant status, educational attainment, selected industries, and North American Industry Classification System (NAICS) 2022, Canada, provinces, territories and selected census subdivisions, annual average (persons x 1,000)
2. Employed employees by job permanence, immigrant status, selected industries, NAICS 2022, and type of work, Canada, provinces, territories and selected census subdivisions, annual average (persons x 1,000)
3. Persons employed part-time by main reason for part-time employment at their main job, immigrant status, selected industries, and NAICS 2022, Canada, provinces, territories and selected census subdivisions, annual average (persons x 1,000)
4. Persons not in the labour force by reason for not looking for work, immigrant status, selected industries, and NAICS 2022, Canada, provinces, territories and selected census subdivisions, annual average (persons x 1,000)
5. Employed population by TEER category, National Occupational Classification (NOC) 2021, educational attainment, immigrant status, selected industries, and NAICS 2022, Canada, provinces, territories and selected census subdivisions, annual average (persons x 1,000)

Our analysis focused on working-age individuals (15–64 years) who were Canadian-born citizens, permanent residents, or naturalized citizens. We excluded temporary residents because the Labour Force Survey does not disaggregate temporary foreign workers and international students. These groups are too distinct from each other to make valid inferences when treated as a single category. In addition, not all underutilization indicators we used capture temporary foreign workers' labour market experience. Many of these individuals can only enter Canada with a full-time job offer, which is likely to be time-limited given the nature of work permits.

1 Statistics Canada, "Guide to the Labour Force Survey."
2 Statistics Canada, "Dictionary, Census of Population, 2021 – Census Subdivision (CSD)."

## Skill utilization indicators

We measured two dimensions of skill utilization separately for immigrants and Canadian-born citizens: skill mismatch (one indicator) and skill wastage (three indicators).

We used all available skill underutilization indicators from the Labour Force Survey except *worker discouragement*—another form of skill wastage. This captures people who want to work but don't seek employment because they're discouraged by the reality or their perception of the labour market.[3] We excluded this indicator because Statistics Canada had flagged much of it as unreliable.

**Skill mismatch: overeducation**

Overeducation represents the share of workers whose primary jobs require less education than they hold.

We measured overeducation by comparing an individual's highest education level (foreign or Canadian) to the Training, Education, Experience and Responsibilities (TEER) classification of their job.[4] For instance, a bachelor's degree holder working in a position requiring only a high school diploma would be considered overeducated for their job.

The overeducation rate represents the number of overeducated workers as a percentage of all individuals employed in the sector.

**Skill wastage: unemployment**

People were considered unemployed if, during the reference week of the Labour Force Survey, they were without work, had actively looked for work in the past four weeks, and were available for work.[5] This included individuals on temporary layoff and those set to start a new job within four weeks.

The unemployment rate was only measured for people who worked in the sector at some point while in Canada, either as a temporary or permanent resident. It represents the number of unemployed individuals who used to work in the sector as a percentage of the sector's labour force (employed plus unemployed individuals).

**Skill wastage: temporary employment**

A temporary job has a predetermined end date or will end once a specified project is completed.[6] This includes seasonal jobs, term or contract jobs (including those done through temporary help agencies), casual jobs, and other temporary work arrangements.

Seasonal jobs have specified hours and a predetermined end date but recur on an annual basis. Term and contract jobs have specified hours and a predetermined end date. Casual jobs have no specified hours or set work periods. Other temporary work arrangements include jobs outside these categories but of a similar nature.

The temporary employment rate represents the number of temporary sector workers as a percentage of all individuals employed in the sector.

**Skill wastage: involuntary part-time employment**

Involuntary part-time workers are those who work fewer than 30 hours per week due to poor business conditions or because they couldn't find full-time work (this includes those who actively searched for full-time work in the past four weeks and those who did not).[7] In contrast, voluntary part-time workers cite other reasons for their reduced hours, though these may include situational constraints that aren't truly voluntary, such as caring for children, attending school, or managing a personal illness.

The involuntary part-time employment rate was only measured for people whose part-time job was their main job in the sector. It represents the number of involuntary part-time sector workers as a percentage of all part-time sector workers.

3 Banerjee and others, "Use it or lose it."
4 Immigration, Refugees and Citizenship Canada, "Find Your National Occupational Classification (NOC)."
5 Statistics Canada, "Guide to the Labour Force Survey."
6 Statistics Canada, "Guide to the Labour Force Survey."
7 Statistics Canada.

## Data analysis

**Skill utilization in immigrants vs. Canadian-born citizens**

To determine whether immigrants experienced significantly worse skill underutilization than Canadian-born citizens, we used two-proportion z-tests. Statistically significant differences are marked with an asterisk (*). This indicates there is less than a 5 per cent probability that the group difference occurred by chance.

The number of people in an analysis can impact statistical significance.[8] If the sample is too small, meaningful differences can be missed. If the sample is sufficiently large, trivial differences can be statistically significant.

While the Labour Force Survey estimates are representative at granular geographic scales, this is not the case within each analytic cell. When we narrow analyses to specific sectors and further split by immigration status, cell sizes (sample size used in the z-tests) can become small. Constructing skill-utilization indicators within each sector can further reduce the number of available cases and increase the sampling variability.

We therefore present Cohen's *h* alongside our significance tests. Cohen's *h* is an effect size metric that measures the magnitude of the difference between two proportions.[9] Values of 0.20, 0.50, and 0.80 represent small, medium, and large differences, respectively. Values below 0.20 represent trivial differences.

# Qualitative data analysis

We interviewed 36 individuals for the qualitative component of this study. This included the following:

- 20 employment and settlement service providers
- 16 employers (five in hospitality, five in construction, six in healthcare)

## Interviews

All participants were granted confidentiality. We developed an interview guide based on the reviewed literature and in conjunction with the Research Advisory Board (members listed in Acknowledgments). To answer the research questions, the interview guide focused on understanding the following:

- Challenges in hiring immigrants to fill specific skill gaps or roles
- Barriers to effective immigrant skill utilization (with further prompts aimed at identifying barriers in each sector)
- Motivations for improving immigrant skill utilization (e.g., economic contribution of immigrants, workforce diversity, talent retention)
- Implemented programs and practices to improve immigrant skill utilization
- Success stories for effective utilization of immigrants' skills
- Collaboration with stakeholders to improve immigrant skill utilization (e.g., governments, employers, sector associations, community organizations)
- Opportunities to improve immigrant skill utilization broadly and in the three study sectors

To qualify as an employment or settlement service provider, participants had to be an employee of an immigrant-serving organization that runs employment programs and counselling or offers settlement services with an employment component. Employers had to be professionals in a human resources, hiring management, or training or development capacity at an organization under one of the three sectors.

We recruited participants both indirectly and directly. Indirect recruitment involved asking the relevant parties to disseminate our research invitation letter. These parties included members of our research centres, councils, and Research Advisory Board members, as well as sector associations and immigrant employment councils. Direct recruitment involved identifying potential participants and emailing them. This strategy was reserved for employers because we exceeded our participant targets for employment and settlement service providers using the indirect approach.

8 Sullivan and Feinn, *Using Effect Size—or Why the P Value Is Not Enough*.
9 Lee, "Alternatives to P value."

We conducted our interviews via Microsoft Teams from July 7 to November 20, 2025. Participants lived and worked in all provinces and territories except Quebec and Nunavut.

Interviews were transcribed by ScribeWire, a third-party transcription service. Interviews ranged from 28 to 66 minutes long, for a total of 26.3 hours. This resulted in 430 pages of transcripts that totaled 224,843 words.

We analyzed the interview transcripts using NVivo. Following the grounded theory approach, we let codes emerge from the data through an exploratory analysis of the interviews instead of using a pre-developed codebook.[10] We conducted inter-coder reliability on randomly selected interviews from each participant group to ensure coding was consistent across researchers. Across participant groups, we achieved 96.3 per cent agreement in our codes.

Codes were compared and grouped into themes. Themes were examined based on how frequently they were noted, as well as the intensity of the observation.

## Limitations

### Quantitative data limitations

We could not measure all types of skill underutilization. For instance, we could not account for immigrants who changed sectors involuntarily, those who were discouraged from seeking employment,[11] or those who worked below their non-educational qualifications.

Our analysis only captures immigrants who worked in the sector at some point in Canada, either as a temporary or permanent resident. This underestimates the unemployment rate.

Every month the Labour Force Survey will sample 56,000 households nationally in a rotating six-month panel – approximately 100,000 persons are sampled across Canada. The survey uses a probability sample that is based on a geographically stratified multi-stage design. Although the sample is representative at different geographic scales, the sample of immigrants and Canadian-born citizens becomes small when we narrow our analysis to the healthcare, construction, and hospitality sectors. It becomes even smaller when we create the skill utilization indicators within each of these sectors.

### Qualitative data limitation

We aimed to interview 10 employers in each of our three study sectors but reduced this to five employers due to the low response rate. While this reduces the variety of insights on immigrant skill underutilization, the overlap in employers' interviews showed sufficient data saturation.

Due to the small sample size, we cannot generalize the findings of this research.

10 Charmaz, *Constructing Grounded Theory.*
11 Banerjee and others, "Use it or lose it."

Appendix B

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