Pan-Canadian Health Workforce Data Strategy

Health Workforce Canada | Effectif de la santé Canada

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Land Acknowledgement and Recognition

We acknowledge that we live and work on the traditional territories of many diverse First Nations, Inuit and Métis peoples. We are grateful to the people who have cared for the land for centuries and the current stewards who care for it today. We recognize and celebrate the strength and resilience of Indigenous health workers, and we embrace the opportunity to support the advancement of cultural safety for all those who provide care and those they care for.

Message From The CEO

Every day, Canada's health workforce shows up with skill, compassion, and resolve. To support and strengthen their work today and tomorrow, Canada needs a coordinated, future-ready approach to collect, govern, share, and use health workforce data.

Health Workforce Canada is pleased to present the Pan-Canadian Health Workforce Data Strategy. The first of its kind, the data strategy is co-designed with partners across jurisdictions with the intent of strengthening health workforce planning now and into the future.

It offers a pan-Canadian lens that builds on and enhances the rich local, provincial, territorial, and employer-level data that drive service delivery. Shared outcomes and detailed recommendations align, connect, and elevate what already exists, and clarify where national coordination adds value, while respecting custodianship and governance across the health system.

We are committed to a path of progress over perfection: starting with practical steps, learning quickly, iterating, and growing trust through incremental change. We embrace a learning health system mindset and design for evergreening, knowing that needs and technologies will evolve. This approach allows the data strategy to remain relevant over time, without waiting for ideal conditions to begin.

Our desired future state is clear: comprehensive, timely, interoperable data that empowers evidence-informed health workforce decisions across Canada, governed together with Indigenous partners and accessible to those who need it to improve care and outcomes.

Meaningful progress only happens when the people who generate, use and are affected by data work together to shape solutions. To everyone across the health workforce ecosystem, thank you for your leadership, your candour, and your commitment. Together we will build the data foundation that our health workforce and the people of Canada deserve.

Sean Chilton,
Chief Executive Officer, Health Workforce Canada

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Co-Design Approach

The Pan-Canadian Health Workforce Data Strategy (data strategy) was co-designed through a collaborative, multi-jurisdictional process involving federal, provincial, and territorial representatives with the leadership of Health Workforce Canada.

A co-design approach was selected for the data strategy development to establish a working partnership with a subset of those who will generate, use or be affected by health workforce data. Early engagement with partners helped to ensure recommendations are feasible, relevant across jurisdictions, and supported through shared ownership.

At the core of the co-design process was the Pan-Canadian Health Workforce Data Strategy Advisory Group. The group was comprised of members from 24 organizations spanning multiple jurisdictions, including ministries of health, health regions, regulatory colleges, professional associations, key data stewards and researchers. The advisory group was convened from February 2025 to February 2026.

Prior to convening the advisory group, input was gathered from other Health Workforce Canada advisory groups and consultations. This was to ensure alignment on key data gaps, challenges and opportunities. Subject matter experts were engaged throughout the process to ensure the applicability of the data strategy's areas of focus.

The co-design approach is committed to respecting and upholding Indigenous rights to data sovereignty and self-determination. This includes aligning with needs and priorities defined by First Nations, Inuit and Métis organizations, guided by a distinctions-based, rights-affirming approach that upholds the principles of cultural safety and trust.

To ground the data strategy in evidence and inclusiveness, Health Workforce Canada conducted environmental scans of existing health workforce data practices, engagement sessions, workshops, and expert consultations. These efforts helped ensure the data strategy reflects diverse perspectives across Canada's health workforce environment and draws on prior work and lessons learned.

Shared accountability is central to implementation, recognizing that progress depends on collective responsibility across jurisdictions, sectors, and partners.

Health Workforce Canada

is an independent organization established in 2023. Funded by Health Canada, Health Workforce Canada unites health workforce experts, policymakers, researchers, health workers, patients and caregivers to strengthen health workforce data and planning.

Working together ensures health workers can provide the care people need within a cost-effective and sustainable health care system.

Members of the Advisory Group

We gratefully acknowledge the Pan-Canadian Health Workforce Data Strategy Advisory Group for their expert guidance and support throughout this work. Their contributions have been critical to advancing a comprehensive and collaborative pan-Canadian health workforce data strategy and reflect the value of working together to build a stronger, more connected health workforce data ecosystem.

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Executive Summary

- The Pan-Canadian Health Workforce Data Strategy will help build comprehensive, timely, and interoperable health workforce data that supports evidence-informed decision-making across jurisdictions.

The Pan-Canadian Health Workforce Data Strategy (data strategy) offers a shared and coordinated approach to strengthen how Canada collects, governs, shares, and uses health workforce data.

Developed through a collaborative, multi-jurisdictional co-design process led by Health Workforce Canada, the data strategy responds to clear and persistent challenges across Canada's fragmented workforce data ecosystem. Challenges such as inconsistent standards, limited interoperability, untimely data, and gaps in coverage and connectedness, constrain the ability of health system partners, including Indigenous governments to plan effectively and respond to evolving population health needs.

Importantly, the data strategy clarifies how pan-Canadian data can complement—rather than replace—local, provincial, territorial, and employer-level data that are essential for workforce planning and service delivery.

This data strategy is not intended to serve as a detailed roadmap or workplan for any given organization. Rather, it is designed as a guide that supports incremental progress, offering practical steps for partners, organizations, and jurisdictions to collectively strengthen the health workforce data ecosystem in Canada.

The data strategy is organized around three core pillars.

Desired Future State:

It builds towards a future state where comprehensive, timely, and interoperable health workforce data supports evidence-informed decision-making across jurisdictions. Data will be consistently collected, comparable, accessible, and governed in collaboration with Indigenous partners. This will enable planning that supports a thriving and supported health workforce across Canada.

Guiding Principles:

Throughout the co-design process, several key principles consistently emerged as priorities in creating alignment and sustaining progress across the health system. These guiding principles anchor the data strategy, provide direction, and complement existing pan-Canadian health data principles related to governance, privacy, and stewardship:

1. **Progress over perfection** comes from collaborative and continuous learning, iteration, and building trust over time.
2. **Indigenous Data Sovereignty:** Recognizes and respects First Nations, Inuit and Métis peoples' rights to data sovereignty and self-determination in data sharing that supports reciprocity and strengthens relationships.
3. **Incremental change** builds momentum, confidence and trust through achievable, phased improvements and creates a foundation for impactful transformation.
4. **Evergreen to remain current** promotes adaptability, flexibility and sustainability to evolve with new technologies, infrastructure, needs, and priorities.
5. **Readiness for critical events** recognizes the need to establish a strong foundation in high-quality health workforce data and planning.
6. **Learning health system culture** embraces a shared culture of continuous learning and improvement with data driving accountability, innovation and adaptation.

Shared Outcomes and Recommendations:

Shared outcomes describe the common goals for the health workforce data ecosystem, articulating what success looks like across jurisdictions, while recommendations outline how to make progress toward those goals.

A total of five shared outcomes and 40 recommendations identify practical, incremental actions to advance towards the desired future state. They are designed to respect jurisdictional differences, existing governance structures, and varied capacities for implementation. While some actions may require new investment, many build on existing work, national frameworks, and established data standards.

Recommendations are organized across short-, medium-, and longer-term horizons based on anticipated complexity.

The following table summarizes the five shared outcomes and associated recommendations.

Shared Outcomes				
1. Equity-driven, high-quality data for decision-making	**2.** Partnerships with First Nations, Inuit, and Métis organizations	**3.** Efficient, interoperable data flow	**4.** Strengthened domestic workforce supply through education data	**5.** Improved data on internationally educated health professionals
Recommendations				
1.1 *CIHI, regulatory colleges* – Adopt CIHI's HWI MDS Data Standard **1.2** *CIHI, MCC, regulatory colleges* - Align existing national registries to CIHI's HWI MDS Data Standard **1.3** *CIHI, CAF, Veterans Affairs, Correctional Services, health facilities, organizations, and employers* - Partner with federal agencies to establish an approach for identifying and reporting on health professionals providing these services **1.4** *Health facilities, organizations, employers, CIHI, P/Ts* - Adopt MIS standards **1.5** *CIHI, P/Ts* - Open access to microdata files **1.6** *CIHI, P/Ts* - Update Insured Persons Registry data to capture preferred language of service **1.7** *HWC, StatCan, ESDC* - Improve level of detail in health-related occupation classification codes **1.8** *Health facilities, organizations, employers* - Implement Health Standards Organizations Global Health Workforce survey **1.9** *HWC* - Review of data suppression practices in rural and remote communities **1.10** *HWC, CIHI, StatCan, P/Ts* - Convene discussion on what constitutes timely data **1.11** *HWC, CIHI, StatCan* - Expand Health Workforce Canada's Data Catalogue **1.12** *CHWN, StatCan, CIHI* - Promote health workforce data literacy initiatives **1.13** *HWC* – Develop a monitoring framework for data strategy	**2.1-2.4** *PCHOs, health facilities, organizations, and employers* - Ensure distinction-based approach to First Nations, Inuit and Métis health workforce data initiatives **2.5** *PCHOs, health facilities, organizations, and employers* - Build relationships with and learn from First Nations Information Governance Centre **2.6** *PCHOs, health facilities, organizations, and employers* - Engagement with Indigenous health professional associations **2.7** *PCHOs, health facilities, organizations, and employers* - Work with First Nations, Inuit and Métis partners to identify and use the most timely and relevant data sovereignty frameworks and references to support respectful collaborative activities	**3.1** *CIHI, CHI* - Enhance Pan-Canadian Interoperability Roadmap to include flow of health workforce data **3.2** *CIHI, P/Ts, regulatory colleges* - Promote adoption of CIHI HWI MDS Data Standard and align existing ministries' health workforce databases with the standard, where applicable **3.3** *CIHI, MCC, regulatory colleges* - Enable access to National Registry of Physicians data **3.4** *CIHI, P/Ts* - Enable real-time data flow of hospital staffing indicators **3.5** *FPT CHW* - New sub-committee on legislative and regulatory frameworks **3.6** *Health facilities, organizations, employers* - Align with existing best practice data use guidelines and frameworks **3.7** *HWC* - Enhance and expand Health Workforce Canada's data and information dashboards **3.8** *HWC, HSO* - Share Global Health Workforce Survey to enhance Health Workforce Canada's data and information dashboards **3.9** *CIHI, health information system vendors, P/Ts* - Include health delivery and health workforce data into the pan-Canadian Health Data Content Framework and work with health system vendors to adopt the standard	**4.1** *CIHI* - Define minimum data set for health workforce related education data **4.2** *CIHI, CHI, holders of education data* - National discussion on implementation of a health profession agnostic national unique identifier **4.3** *CIHI, holders of education data* - Institutions of education to implement national education standard once defined **4.4** *Health professional associations, regulatory colleges and/or appropriate organizations as decided upon by professions* - Uniformly define profession-specific competencies on a pan-Canadian scale **4.5** *HWC* - Enable accessible professional competency-based information within Health Workforce Canada's Digital Front Door **4.6** *HWC* - Continuous conversations that strengthen infrastructure and governance of health workforce education data	**5.1** *CIHI, regulatory colleges, MCC, CAPER* - Ensure standardized data capture for internationally educated health professionals including international medical graduates and Canadians trained abroad – include in education MDS **5.2** *Relevant health organizations and data stewards, P/Ts, regulatory colleges* - Develop standardized data collection and reporting across provinces, territories, and regulatory bodies on licensure and registration by immigrant status - link with census and national administrative data **5.3** *HWC* - Expand and enhance data sources on internationally educated health professionals in the internationally educated health professionals' module of the Health Workforce Canada's data and information dashboards **5.4** *HWC, CAPER, AFMC* - Advance the availability and integration of physician education data into Health Workforce Canada's data and information dashboards **5.5** *HWC, IRCC* - Increase collaboration opportunities with Immigration, Refugees and Citizenship Canada to improve internationally educated health professionals' pathways

The work in this data strategy builds on earlier pan-Canadian health data initiatives that establish shared expectations for data governance, privacy, stewardship, and responsible data use. Rather than restating these broader foundations, the data strategy focuses on health workforce-specific priorities where additional clarity, alignment, and coordinated action are needed.

The data strategy is intended to be a living, evolving resource and is supported by a monitoring framework that emphasizes learning, adaptation, and shared leadership. Working with partners across the country will help the data strategy remain responsive to emerging needs, technological changes, and opportunities for collaboration over time.

AFMC - Association of Faculties of Medicine of Canada

CAF - Canadian Armed Forces

CAPER - Canadian Post-M.D. Education Registry

CHI - Canada Health Infoway

FPT CHW - Federal/Provincial/Territorial Committee on Health Workforce

CHWN - Canadian Health Workforce Network

CIHI - Canadian Institute for Health Information

ESDC - Employment and Social Development Canada

HSO - Health Standards Organization

HWC - Health Workforce Canada

HWI MDS - Health Workforce Information Minimum Data Set

IRCC – Immigration, Refugees, and Citizenship Canada

MCC - Medical Council of Canada

MDS - Minimum Data Set

MIS - Management Information System

PCHO – Pan-Canadian Health Organizations

P/Ts - Provinces and Territories

StatCan - Statistics Canada

For more details, including proposed organizations to action the recommendations, see Appendix A: Summary of Pan-Canadian Health Workforce Data Shared Outcomes and Recommendations.

Pan-Canadian Health Workforce Data Strategy

Canada's health workforce is the backbone of our health system, yet the current data ecosystem that supports the health workforce is fragmented and incomplete.

Inconsistent data standards and definitions, fragmented infrastructure and systems, and untimely or outdated data all limit the capacity to monitor trends in workforce supply, distribution, mobility, and well-being. This makes it challenging to answer critical current and future health workforce planning questions.

Health Workforce

refers to both regulated and unregulated workers who deliver or support health services. This data strategy is guided by the World Health Organization (WHO) definition, which describes the health workforce as "…all people primarily engaged in actions with the primary intent of enhancing health. This includes doctors, nurses, midwives, pharmacists, dentists, physiotherapists, laboratory professionals, as well as workers trained in other professions but working in the health sector—such as managers, economists, accountants, information technologists, and other administrative support workers." (WHO EMRO, n.d.).

This strategy also recognizes the essential contributions of formal and informal caregivers whose roles support the health and well-being of individuals and communities.

An opportunity for change

Starting in May 2024, Health Workforce Canada launched extensive engagement with partners across the health workforce ecosystem to address these longstanding challenges.

Consultations generated several insights that pointed to an urgent need for a coordinated, pan-Canadian approach to improve timeliness, comprehensiveness, and interoperability of health workforce data:

- A significant volume of health workforce data exists across the country.
- Data availability and accessibility vary considerably across jurisdictions and professions.
- Timeliness of data and near-real time data processing is a significant barrier to generating necessary insights.
- Persistent gaps in data coverage/ timeliness/connectedness limit the ability to plan effectively and to model and forecast future workforce needs for a growing and aging population.

These data limitations are underscored by the need to keep the person at the centre of all health workforce planning and decision-making initiatives. See Use Case 1: Why Workforce Data Matters.

Timely Data

is essential to understanding workforce pressures, responding to emerging needs, and informing policy decisions. Long lag time and infrequent updates limit the ability to monitor health workforce supply, distribution, inflows/outflows and well-being, and can constrain modeling and forecasting. Advancements in interoperability and data integration are key drivers of more timely data availability.

While this document focuses on developing a pan-Canadian health workforce data strategy, it is recognized that lasting and effective policy change requires data to be supported by strategic and coordinated health-workforce planning. This data strategy should therefore be viewed as a first step toward supporting the longer-term pan-Canadian health workforce planning strategy—which is a critical piece of infrastructure that will strengthen Canada's health workforce for the future. Such planning efforts are intended to address pan-Canadian challenges and opportunities and will not duplicate planning work already underway within individual jurisdictions.

A shared, coordinated approach

The Pan-Canadian Workforce Data Strategy was co-designed through a collaborative, multi-jurisdictional process involving federal, provincial, and territorial representatives with the leadership of Health Workforce Canada.

At the core of the co-design approach was the Pan-Canadian Health Workforce Data Strategy Advisory Group. It was comprised of members from 24 organizations across multiple jurisdictions (see Co-Design Approach). The group's first deliverable was the release in 2025 of the Primer for a Pan-Canadian Health Workforce Data Strategy, which described priority areas for improvement and the need for a new approach to health workforce data. The group went on to provide guidance and input to Health Workforce Canada as it developed the data strategy.

The result is a coordinated, pan-Canadian approach to collecting, managing, and using health workforce data. It sets out a desired future state, guiding principles, shared outcomes and recommendations to improve the timeliness, comprehensiveness and connectedness of health workforce data over time.

The data strategy highlights shared standards and definitions to strengthen usability across jurisdictions and spans all regulated and unregulated professions in public, private, Indigenous and community-based settings, while respecting jurisdictional authority and data sovereignty. Importantly, it clarifies how pan-Canadian data can complement, rather than replace, local, provincial, territorial and employer-level data necessary for workforce planning and service delivery.

Central to the data strategy is prioritizing timely, near real-time data and linking workforce information to population health outcomes, which is critical to building a strong foundation for responsive planning and decision-making. These considerations ensure that data can be used when it matters most and guide investments that improve health workforce sustainability and adaptability.

Using the Data Strategy

The data strategy is designed to serve the health system and other partners who rely on, contribute to, or are affected by health workforce data. This may include federal, provincial and territorial ministries of health, health authorities and service delivery organizations, regulatory colleges, professional associations, Indigenous governments and organizations, employers, unions, educational institutions, researchers, and users of the health system.

Health system partners can use the data strategy to:

- Learn about known/existing standards, definitions, and ongoing initiatives to improve comparability and usability of data.
- Support a common understanding of gaps, incremental improvements, and where alignment creates the most value.
- Work toward a connected, timely, and equitable health workforce data ecosystem.

This data strategy is not intended to serve as a detailed roadmap or workplan for any given organization. Rather, it is designed as a guide that supports incremental progress, offering practical steps for partners, organizations, and jurisdictions to collectively strengthen the health workforce data ecosystem in Canada.

Health Workforce Canada's Role

Health Workforce Canada's role is to provide national coordination, shared insights, and a pan-Canadian perspective grounded in broad engagement. It is to act as a convenor and unifying anchor of the health workforce ecosystem, bringing key players together and working with partners to clearly identify priority areas, gaps, and potential solutions.

Health Workforce Canada does not administer funding, exercise regulatory authority, or direct implementation within jurisdictions. Rather it serves as a convener, collaborator, and knowledge partner, identifying, unifying and elevating shared priorities and enabling collective progress.

By providing a national view of needs, challenges, and recommended actions, Health Workforce Canada supports a more coherent and collaborative approach across Canada. This approach respects local priorities while enabling jurisdictions and partners to see themselves within a broader, shared direction. Implementation remains distributed across the ecosystem and respects existing custodianship and governance.

See Appendix B: Existing Roles and Responsibilities of Partners in the System.

A Note on Funding

The recommendations in this data strategy identify areas where collective action and alignment can strengthen the pan-Canadian health workforce data foundation. Some actions may require new or sustained investments by federal, provincial, and territorial governments or partners to be fully implemented, while others may rely on stable operational funding.

This data strategy does not allocate or commit funding, rather, it offers shared direction to guide coordinated planning, prioritization, and decision-making across Canada. It is not intended to prescribe funding decisions or replace jurisdictional planning processes, but to provide a common framework that supports collective progress.

Health Workforce Data

refers to quantitative and qualitative information needed to understand, plan for, and support the health workforce across Canada.
This includes:

- **Standardized quantitative data on supply, distribution, mobility, education and training, employment patterns, and workforce characteristics.**
- **Qualitative insights that describe experiences, conditions, and contexts that shape how health workers enter, stay in, or leave the system.**

See Appendix C: Infographic on Health Workforce Data in Canada.

USE CASE 1: Why Workforce Data Matters

Jenna is a Canadian Medical Association Patient Voice member from Halifax, Nova Scotia. As a young adult living with complex, chronic illness, health workforce data is deeply personal to her. *"It's the reason some of us get care in time and the reason others fall through the cracks completely."*

When Jenna turned 18 and "aged out" of pediatric care, there was no data showing which providers were accepting new patients or trained for her conditions. *"It felt like falling off a cliff… all because the data wasn't there."* Staffing shortages and long waits weren't surprises – *"the warning signs were there; we just didn't track them."*

Jenna's experience highlights why patients must be co-creators in workforce data solutions and why up-to-date, transparent provider information is essential for equitable access. As she puts it: *"Data should help us plan, not panic. It should help us intervene early, not react late. It should create trust, not confusion."*

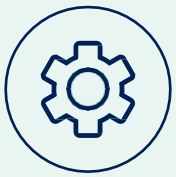
Three Pillars

Desired State

Description of what is desired as the ideal state for health workforce data to support planning.

Guiding Principals

Core values to act as a compass for action to create a solid health workforce data foundation.



Shared Outcomes and Recommendations

Concrete actions, immediate and long-term to reach the desired state. Beyond aspirational.

Desired Future State

Health Workforce Canada, working collaboratively with advisory group members and other subject matter experts, developed a statement for a desired future state of pan-Canadian health workforce data. This statement is a clear and inspiring picture of what the data strategy aspires to achieve, describing the optimal outcome and end goals.

The desired future state includes:

Comprehensive, timely and trusted data that powers a thriving and supported health workforce for Canada: A nimble, interoperable health workforce data system that delivers consistent, high-quality, and timely data for multiple users, enabling evidence-based planning and decision-making across jurisdictions. The data collected is purpose-driven, timely, comprehensive, and accessible, capturing information from publicly- and privately-funded parts of the health system, governed, protected, and used in accordance with applicable privacy laws in each jurisdiction, and in a manner that respects Indigenous Data Sovereignty inherent rights. This data is used in conjunction with other health system and population health outcome data to achieve full planning optimization in the future. This will ensure Canada's health workforce is equipped to meet the needs of people in every region and supports Indigenous-led health systems, reflecting the distinct realities and needs of First Nations, Inuit, and Métis peoples.

Private Sector Data

A comprehensive workforce data system must include data from privately delivered health services, as many professions (e.g., oral health, chiropractic care, physiotherapy, optometry, pharmacy, and others) operate largely in private settings. Without data, important gaps remain in understanding overall workforce capacity and service availability. Access to private sector data is currently limited, particularly where information is held by insurers. Publicly available data is the primary focus for the data strategy with opportunities to engage private sector sources like private electronic medical records (EMR) and insurer data as areas for future exploration.

A recent advancement is inclusion of "Provider Employment Funding Source" data within the 2025 CIHI Health Workforce Information (HWI) Minimum Data Set Data Dictionary. This will generate greater insight on the public and private funding sources for the healthcare provider's employment.

Guiding Principles

To achieve the desired future state for health workforce data, **six guiding principles** anchor the data strategy and complement existing pan-Canadian health data principles related to governance, privacy, and stewardship.

The guiding principles focus on health workforce data, the need to strengthen evidence-based policy and planning, and to support a thriving health workforce that can meet the care needs of Canadians.

1. Progress Over Perfection:
Meaningful progress comes from learning, iteration, and building trust over time, with an approach that values collaboration and continuous improvement and not waiting for ideal conditions or complete data before taking action.

2. Indigenous Data Sovereignty:
Recognizes and respects First Nations, Inuit and Métis peoples' rights to data sovereignty and self-determination in data sharing that supports reciprocity and strengthens relationships.

3. Incremental Change:
Building incremental momentum and trust through achievable, phased improvements rather than large-scale system change reduces risk, improves confidence and creates a foundation for more impactful transformation.

4. Evergreen to Remain Current:
Designing for adaptability and flexibility so that the data ecosystem evolves with new technologies, infrastructure, needs, and priorities. Ensuring selected recommendations and outcomes can be sustained over time. This includes preparing for a future where AI will play an increasing role that depends on high-quality data.

5. Readiness for Critical Events:
Recognizing the importance of establishing a strong foundation in health workforce data planning to ensure readiness for critical or unprecedented events. See Use Case 2: Canadian Forces Health Workforce Surge Planning.

6. Learning Health System Culture:
Embracing a culture of continuous learning and improvement where data is used not only for accountability but also for improvement, innovation and adaptation across the health workforce ecosystem.

Work That's Come Before

The data strategy draws from and builds on a series of national initiatives that laid important groundwork for improving the way health data is collected, shared, and used across Canada.

- Foundational among these is the Pan-Canadian Health Data Charter that outlines shared principles for equitable access, transparency, accountability, and trust in health data (Health Canada, 2023b). The charter provides a unifying vision for how health data should serve the public good, ensuring people, providers, and policymakers have access to high-quality, secure, and comparable data to inform decisions.
- Another key initiative is the Pan-Canadian Health Data Content Framework, developed by the Canadian Institute for Health Information (CIHI). This framework establishes consistent data elements and standards across jurisdictions to reduce fragmentation in data capture and reporting, and to enable interoperability and comparability over time and across regions (CIHI, 2025c).
- CIHI's Hallmarks of Health Data Stewardship provides the ethical and operational foundation for data governance—emphasizing responsible use, privacy protection, and collaboration among partners (CIHI, n.d.).

Together these initiatives continue to advance Canada's health data infrastructure. They also highlight the need to address persistent health workforce data gaps, including fragmented systems and limited real-time visibility into workforce supply, distribution, mobility, and other critical factors needed for evidence-based planning.

The data strategy draws from these established frameworks and seeks to address the persistent data and coordination gaps they have revealed and build upon lessons learned. The following recommendations detail how the strategy seeks to work towards an integrated and future-ready data ecosystem that enables timely, accessible, person-centered and system-level insights to be generated across the health workforce landscape.

USE CASE 2: Canadian Forces Health Workforce Surge Planning

The need to respond quickly and effectively to routine care and emergencies highlights the critical value of accurate, real-time health data for planning and decision-making.

Canadian Forces Health Services Group is creating a flexible plan to make sure the health workforce can respond to any situation-from everyday care to large-scale conflicts. Their plan uses lessons learned from past military missions, pandemics, and emergencies in Canada.

As demands increase, the need for people, facilities, and coordination grows quickly. Good surge planning depends on strong teamwork between military and civilian health systems, backed by coordinated leadership and national-level guidance to ensure a unified “Team Canada” response.

Recent national exercises showed the importance of managing patient flow between federal and provincial authorities to keep care running smoothly during high-demand periods.

The surge planning framework leverages civilian health workforce data to match patient needs with available capacity, providing decision-makers with a clear, real-time view of system pressures.

This use case illustrates how timely, connected data can support preparedness, resilience and coordinated national response in routine work, emergencies, and wartime situations.

Shared Outcomes & Recommendations

Reliable, comparable health workforce data is critical for effective planning and system transformation. The Pan-Canadian Health Workforce Data Strategy brings together shared outcomes and a set of actionable recommendations to improve how health workforce data is collected, governed, and used across Canada. These recommendations are intended to be shared, practical, incremental, and grounded in existing system capacity.

The shared outcomes and recommendations that follow are intended to create an evergreen guide to support progress in a complex and constantly evolving health workforce system.

Recognizing that implementation will vary across jurisdictions and contexts, and the need to respect local priorities and partnerships, the recommendations are incremental and build on existing work. They are grounded in the understanding that strengthening the health workforce is a shared responsibility across partners and jurisdictions.

The intent is to identify tangible places to start, enabling flexibility while maintaining alignment with guiding principles. By aligning specific recommendations to one of five shared outcomes, the data strategy creates a clear structure that supports measurable progress for the future.

The five shared outcomes are as follows:

1. **Equity-driven, high-quality data for decision-making:** Data collected supports equity-driven decision-making to plan for and manage a thriving health workforce that meets population needs and health system needs, generating quality outcomes.
2. **Partnerships with First Nations, Inuit, and Métis organizations:** Distinctions-based, Indigenous-led partnerships and mechanisms are established with First Nations, Inuit and Métis peoples' organizations to govern, direct, and oversee the collection, sharing, protection, and use of First Nations, Inuit and Métis health workforce data, in a manner that meets their priority needs, supports cultural safety, and respects Indigenous Data Sovereignty rights.
3. **Efficient, interoperable data flow:** Health workforce data flow is maximized for efficiency to reduce data collection and reporting burden, reduce cost and improve timeliness, leveraging secondary use of data where possible.
4. **Strengthened domestic workforce supply through education data:** Enable seamless sharing, integration and access to privacy-appropriate data across relevant sources to strengthen the domestic health workforce pipeline from education to the delivery of service.
5. **Improved data on internationally educated health professionals:** Enable seamless sharing, integration and access to data across relevant sources to strengthen immigration pathways for health workers and ensure these individuals can work to their full scope of practice and education level in Canada.

Shared outcomes and recommendations are intended to supplement what's been established by the Pan-Canadian Health Data Strategy and CIHI's Hallmarks of Health Data Stewardship. This includes recommendations related to concepts such as privacy, governance and interoperability along with Indigenous data sovereignty. However, some recommendations outlined below are intended to complement these foundations by focusing specifically on health workforce data needs.

While organizations and players are mentioned in the recommendations below, it is important to note that this data strategy respects existing custodianship and governance frameworks that are currently at play within the health workforce data ecosystem. Regulators, provinces, employers, and Indigenous organizations are the custodians and rights-holders of their respective data under current legislation. Health Workforce Canada, CIHI, Statistics Canada, and other data partners are focused on connecting systems, aligning standards, improving data integration and enabling collaboration, without assuming ownership of data. See Appendix B: Existing Roles and Responsibilities of Partners in the System.

Finally, recommendations are categorized across short-, medium- and long-term time horizons based on the level of complexity required for implementation, and to assist with prioritization for implementation. Short-term recommendations are expected to be implementable within approximately one year, medium-term within 18 months, and longer-term within two years of the strategy's publication.

It is important to note that recommendations within shared outcomes 4 and 5 represent emerging priorities. Due to the complex linkage between education, immigration, and health workforce data, current recommendations are intended as a starting point to offer opportunities for collaboration and innovation as implementation progresses.

See Appendix A: Summary of Health Workforce Data Strategy Shared Outcomes and Recommendations.

Shared Outcome 1

Equity-driven, high-quality data for decision-making

- Data collected supports equity-driven decision-making to plan for and manage a thriving health workforce that meets population needs and health system needs, generating quality outcomes.

Advancing the comprehensiveness, completeness, timeliness and accessibility of data is central to achieving a thriving health workforce that provides the care Canadians need. Informed decision making and sustainable workforce planning depend on high quality data. By strengthening and leveraging data that Canada already collects, we can better support effective and efficient health system planning. Existing data provide a strong foundation for planning, however, full potential for usage is limited by inconsistencies in definitions, formats, timeliness and reporting across jurisdictions.

Implementation and widespread adoption of CIHI's Health Workforce Information Minimum Data Set (HWI MDS) Data Standard is a critical step toward improving data comparability and interoperability across jurisdictions. While CIHI establishes the pan-Canadian standard, ongoing academic research on inter-professional health workforce minimum data sets offers valuable insights that could inform future enhancements to the HWI MDS Data Standard (Zagrodney et al., 2026).

Linking Workforce Data with Health Service and Population Outcomes

Health workforce data becomes most powerful when it is connected to how care is delivered and the outcomes experienced by patients and communities. Workforce counts alone cannot show whether people are getting timely care, or whether existing staffing models are meeting local needs. Connecting workforce data with health service use and population health outcomes would provide a fuller picture of where pressures exist and what investments are needed.

Ensuring data can be linked, in privacy-appropriate contexts and using a distinctions-based approach when working with Indigenous partners, is essential for jurisdictions to make evidence-informed decisions that strengthen both the workforce and the health system. The ability to link existing data sources leveraging the consideration of 'collect once, use many times' would improve integration, reduce duplication, and create steps towards the unified foundation needed for health workforce planning (Public Health Agency of Canada, 2022).

Recommendations

1.1

Health professional regulatory colleges are encouraged to adopt CIHI's Health Workforce Information Minimum Data Set (HWI MDS) Data Standard (CIHI, 2025a) to produce standardized, comparable and interoperable data across professions and jurisdictions. The CIHI standard is mapped to the HL7 Fast Health Interoperability Resources specifications.

CIHI's HWI MDS Implementation Toolkit offers practical guidance and tools to support consistent and scalable implementation of the standard.

Note: *Mandatory collection of a core set of data elements is needed to ensure sustainability of data over time. Unregulated professions and/or other health related professions including public health professions, oral health professionals, etc. are encouraged to consider using the CIHI standard. See Use Case 3: Paramedic Association Implementing CIHI HWI MDS Data Standard.*

1.2

Where national registries exist and collect data from regulatory colleges, such as the National Registry of Physicians (Medical Council of Canada, 2024), alignment to the CIHI HWI MDS Data Standard would be beneficial. Establishing this alignment would help ensure that physician data can be compared consistently with other health professions, which is essential for planning, monitoring, and evaluating the health workforce as a whole. CIHI to work with the Medical Council of Canada to ensure the HWI MDS Data Standard response sets reflect the physician profession, including specialties.

1.3

As part of the HWI MDS Data Standard, it would be beneficial for CIHI to partner with the Canadian Armed Forces (CAF) and other federal agencies such as Veterans Affairs, Correctional Services, etc. to determine how to clearly identify health professionals providing services for these agencies (both regular and reserved service) and include this with their reporting.

1.4

All health facilities, organizations, and employers should consider adopting the CIHI Management Information System (MIS) standards to enable greater disaggregation of staffing indicators such as sick time, over time, and worked hours broken down by health profession and functional centre (CIHI, 2025b)[1].

[1] *As stated in the MIS standards, a functional centre refers to "A subdivision of an organization used in a functional accounting system to record the budget and actual direct expenses; statistics; and/or revenues, if any, which pertain to the function or activity being carried out." (CIHI, 2025b).*

Recommendation Length: Short Term | Medium Term | Long Term

Recommendations Continued

1.5

CIHI to assess the feasibility of providing open access to microdata files for health workforce-related data, in addition to curated data tables. The assessment should consider alignment with privacy, legal, security, and Indigenous data governance requirements, including adherence to distinctions-based Indigenous data sovereignty principles.

1.6

CIHI to work with provinces and territories to explore the feasibility of updating the Insured Persons Registry data to capture preferred language of service.
The aim is to support population data needs for health workforce modelling and would require consistent implementation across jurisdictions and regular data flow back to CIHI, contingent on the availability of these elements in source data systems.

1.7

Health Workforce Canada will continue the joint project with Statistics Canada (StatCan) and Employment Services Development Canada (ESDC) to explore potential approaches to enhancing the level of detail available for health-related occupations in existing data sources. Work may include examining ways to distinguish subgroups within broad occupational categories to support more targeted health workforce analyses, as well as determining the best approach for distinguishing professional caregivers from informal caregivers.

1.8

Facilities and organizations that employ health care providers should explore the feasibility of implementing Health Standards Organization's (HSO) Global Health Workforce Survey, if in alignment with their organizational mission and purpose (Health Standards Organization, 2025).

Recommendation Length: Short Term | Medium Term | Long Term

1.9

When convening with major stewards and relevant partners, Health Workforce Canada should explore feasibility of reviewing data suppression practices that impact data access for rural and remote communities and hold targeted conversations about legislated/policy barriers and requirements.

1.10

Health Workforce Canada and its advisory groups, with participation from CIHI and StatCan, are encouraged to convene discussions around what constitutes timely, fit-for-purpose data, including which data elements should be collected, how frequently, and for whom. Not all data needs to be available in real time; efforts should focus on investments and strategies to improve efficiency of existing data flows and efficient use of resources.

Note for actions 1.9 and 1.10:

Any review or discussion of data access considerations must consider legislated confidentiality obligations, disclosure control frameworks, and the foundational principle of protecting respondent privacy.

1.11

Health Workforce Canada, in partnership with CIHI and other data stewards, to evolve the Health Workforce Data Catalogue to include broader coverage of data sources that currently exist. Enhancement will continue as the data foundation improves. Developed in collaboration with CIHI and Statistics Canada, the Data Catalogue guides users to health workforce related data and how to access it.

1.12

Joint efforts to continue across data stewards, Health Workforce Canada, the Canadian Health Workforce Network (CHWN) and others to promote health workforce data literacy through communications, product releases, micro-credentials, and engagement activities, including topic specific workshops and roundtables that incorporate data components.

1.13

Health Workforce Canada will establish a monitoring framework that tracks and shares progress on the implementation of the data strategy, along with its evergreening as the health system evolves.

Recommendation Length: Short Term | Medium Term | Long Term

USE CASE 3: Paramedic Association Implementing CIHI HWI MDS Data Standard

The Paramedic Association of New Brunswick (PANB) took a proactive step toward modernizing health workforce data by exploring implementation of CIHI's HWI MDS Data Standard before being designated as a priority profession or receiving dedicated funding. Recognizing the value of standardized data, the PANB aimed to improve consistency and comprehensiveness of paramedic workforce information across the province.

By adopting the HWI MDS Data Standard, PANB sought to align data collection with national standards. This decision was driven by the understanding that standardized data on the profession would strengthen not only local workforce planning but also enable future integration with broader data sets. This integration would enable better tracking of labour mobility, student registration, and inform evidence-based policy decisions.

Early work towards adopting this standard by PANB demonstrates how regulatory bodies can leverage existing standards to help build out a connected health data ecosystem, one that supports better planning and enhances patient care and health outcomes.

Shared Outcome 2

Partnerships with First Nations, Inuit, and Métis organizations

Distinctions-based, Indigenous-led partnerships and mechanisms are established with First Nations, Inuit and Métis peoples' organizations to govern, direct, and oversee the collection, sharing, protection, and use of First Nations, Inuit and Métis health workforce data, in a manner that meets their priority needs, supports cultural safety, and respects Indigenous Data Sovereignty rights.

This shared outcome focuses on data about the First Nations, Inuit, Métis and Indigenous health workforce, recognizing the significant and persistent disparities in health outcomes between Indigenous peoples and the non-Indigenous population, and the critical role that culturally appropriate, Indigenous-led health workforce data plays in addressing these inequities. It further acknowledges that colonial practices in the collection, use, and governance of data about Indigenous peoples have caused great harm and have profoundly undermined trust (Public Health Agency of Canada, n.d.). In this context, Indigenous Data Sovereignty–recognized as an inherent right grounded in self-determination–emerges not as an abstract principle, but as a necessary condition for restoring trust, ensuring accountability, and enabling First Nations, Inuit and Métis peoples to govern data in ways that support their health priorities and cultural safety.

Karhinéhtha´ Cortney Clark, a Mohawk woman from Wáhta Mohawk Territory and Indigenous health researcher, contributed the Indigenous Health Workforce Section in the Caring for Canadians: Canada's Future Health Workforce – The Canadian Health Workforce Education, Training and Distribution Study (Health Canada, 2025), which was approved by the federal, provincial and territorial health ministers (except Quebec) in January 2024. The report recommends that collaborative efforts be made to co-develop data collection processes, forecast workforce needs, and create culturally appropriate health programs and services for the Indigenous health workforce. Regular monitoring and reporting on recruitment, retention, and educational outcomes are crucial for accountability (Health Canada, 2025).

Any recommendations determined to advance data on the Indigenous health workforce will be developed in partnership with First Nations, Inuit and Métis organizations and partners, respecting and applying established Indigenous data governance processes wherever they apply, as part of the data strategy's evergreen process.

The data strategy recognizes that partnership development occurs at different stages and reflects distinct data governance contexts. Health Workforce Canada is currently further along in relationship building with First Nations partners and is committed to a distinctions-based approach across all Indigenous partnerships, ensuring that Indigenous data sovereignty frameworks such as OCAP®, OCAS, and the National Inuit Strategy on Research (NISR) are respected and applied in Indigenous led, context appropriate ways. This first version of the data strategy acknowledges that relationships must be built and sustained over time.

Recommendations below reflect this early stage. It should also be noted that shared outcome two of the data strategy will not be achievable unless First Nations, Inuit and Métis partners are equipped with the necessary capacities and supports to enable meaningful and sustainable engagement and contributions, including through distinctions-based data governance strategies. At present, these capacities are lacking, and without addressing this gap, meaningful progress on this shared outcome will be at risk. This is a broader, cross-jurisdictional issue that must be addressed collectively.

Note: *Timelines of recommendations are to be determined in collaboration with First Nations, Inuit, Métis and Indigenous partners.*

Recommendations

2.1

Health Workforce Canada and other partner organizations, including Canada's major data stewards, are encouraged to ensure, in collaboration with First Nations, Inuit and Métis peoples' organizations, that they are taking a distinctions-based approach to First Nations, Inuit and Métis health workforce data (if not already considered) and continue to do so throughout ongoing and new initiatives, as appropriate including through the implementation of Canada's UNDRIP Act Action Plan (Department of Justice Canada, 2025).

2.2

Health Workforce Canada and other organizations, including Canada's major data stewards, are encouraged to continue building relationships with the First Nations Information Governance Centre (FNIGC) and other distinctions-based data organizations or tables.

2.3

Health Workforce Canada and other partner organizations, including Canada's major data stewards, are encouraged to collaborate in, support, and draw on distinctions-based, Indigenous-led data governance strategies–as enabling solutions to help address information gaps or barriers impacting equity-driven First Nations, Inuit and Métis health workforce planning and outcomes–including the First Nations Data Governance Strategy (FNDGS); the National Inuit Strategy on

Recommendations Continued

Research (NISR) and the forthcoming national Inuit data strategy; and the Métis Nation's Organizing Committee on Data and Statistics.

2.4

Health Workforce Canada and other partner organizations, including Canada's major data stewards, are encouraged to develop (if not already considered) distinctions-based engagement plans on their respective health workforce data initiatives–in advance of critical decision points and in collaboration with First Nations, Inuit and Métis partners–to ensure greater visibility and predictability of engagement and to provide sufficient time for meaningful and respectful engagement.

2.5

Health Workforce Canada and other partner organizations, including Canada's major data stewards, are encouraged to collaborate in, and draw on, across jurisdictions, the advancement of First Nations, Inuit and Métis-led, distinctions-based data governance mechanisms, established at local, regional, and/or national levels to exercise Indigenous Data Sovereignty rights and to ensure that they can–in a sustainable and equitable manner–contribute to, and benefit from the broader pan-Canadian public health data modernization initiatives, inclusive of health workforce.

2.6

Health Workforce Canada and other partner organizations, including Canada's major data stewards, are encouraged to engage Indigenous health professional associations as part of engagement initiatives.

2.7

Health Workforce Canada will work with First Nations, Inuit and Métis partners to identify and use the most timely and relevant data sovereignty respectful collaborative activities to advance mutually agreed upon goals.

Shared Outcome 3

Efficient, interoperable data flow

Health workforce data flow is maximized for efficiency to reduce data collection and reporting burden, reduce cost and improve timeliness – leveraging secondary use of data where possible.

Canada is quite data rich when it comes to health workforce data. However, data is fragmented across many sources and jurisdictions and lacks interoperability in how data flows among data stewards and users.

Support for secondary data use, such as repurposing data for planning, quality improvement, or policy development, can be hindered by differing policies and processes that exist across jurisdictions and organizations alike (OECD, 2025).

Other challenges arise due to variability in the interpretation of legislative frameworks (OECD, 2025). Examples exist where there are multiple interpretations within a single jurisdiction. One professional regulatory college may share data for secondary use while another may perceive that legislation and/or regulatory frameworks preclude them from doing so.

A modern data architecture for health workforce planning in Canada emphasizes the use of interoperable data pipelines, which automate data collection, processing, and reporting. This approach, while well underway in some areas, remains siloed and lacks national coordination.

Adopting common data content and exchange standards in Canada can enable flexible and sustainable data flows that support real-time analytics and fit-for-purpose planning (Bourcier and Simkin, 2024).

Several interoperability initiatives are underway, including the collaborative Connected Care work between CIHI and Canada Health Infoway (Canada Health Infoway, n.d.). In February 2026, the Government of Canada introduced the Connected Care for Canadians Act (Bill S-5), which proposes to strengthen the secure, interoperable exchange of health information across health systems. This data strategy supports continued advancement of Connected Care initiatives and recognizes the potential role of Bill S-5 in shaping conditions that enable interoperable health workforce data.

Recommendations

3.1

CIHI and Canada Health Infoway are encouraged to enhance the Pan-Canadian Interoperability Roadmap to include the flow of health workforce data to support use for care delivery and reuse for planning and monitoring.

3.2

CIHI to continue collaboration with federal, provincial and territorial ministries of health and regulatory colleges to enhance health workforce data flow by promoting adoption of the CIHI HWI MDS Data Standard across jurisdictions. Where ministries maintain health workforce databases, aligning with CIHI standards can support streamlined, lower-burden data sharing.

Note: *A future-ready, interoperable system would enable regulatory colleges to transmit standardized data in near real-time to both CIHI and ministries in parallel, improving timeliness and consistency. Over time, data flows should be increasingly automated to support efficient and sustainable exchange.*

3.3

CIHI to continue collaboration with the Medical Council of Canada and provincial and territorial regulatory colleges to enable access to National Registry of Physicians data, supporting comparability across professions and jurisdictions. Efforts should focus on enabling timely data flow through interoperable and, over time, automated means.

3.4

Jurisdictions with CIHI are encouraged to explore the feasibility of enabling near real-time data flow capability of hospital staffing indicators.

3.5

The Federal-Provincial-Territorial Committee on Health Workforce is encouraged to assess opportunities for provinces and territories to share and gain clarity on the legislative and regulatory frameworks within each jurisdiction. Conversations would support learning from each other on how to move forward in creating environments that improve data flow. See Use Case 4: Changing Legislative Frameworks

Recommendation Length: Short Term | Medium Term | Long Term

Recommendations Continued

3.6

All organizations and employers who work with or produce health workforce data should align with and apply existing frameworks and guidelines such as CIHI's Health Data Stewardship Framework (CIHI, n.d.) and Digital Governance Standards Institute's Data Governance: Health Data and Information Capability Framework (Digital Governance Standards Institute DGSI, 2023) to guide stewardship roles, transparent governance, and accountability to maintain public trust.

3.7

Health Workforce Canada will continue to enhance and expand its data and information dashboards in fit-for-purpose formats to improve access to various data sources and support planning for an efficient and effective health care system.

3.8

Health Standards Organization (HSO) is encouraged to continue sharing its Global Health Workforce Survey results with Health Workforce Canada to enhance the Provider Wellness module of its data and information dashboards.

3.9

CIHI is encouraged to include health delivery and health workforce data in the pan-Canadian Health Data Content Framework (national data standard for Connected Care) and to collaborate with health system vendors to adopt and implement health delivery and health workforce data in electronic medical records, health information systems, and other sector systems.

Recommendation Length: Short Term | Medium Term | Long Term

USE CASE 4: Changing Legislative Frameworks

In 2017, the government of New Brunswick enacted legislation allowing government and public authorities to share person-level data with the provincial research platform, DataNB (then NB-IRDT). A 2019 update expanded the scope for data matching across post-secondary education, bridging programs, licensing authorities, and health services. Together these changes enabled detailed research linking education, licensure, employment, and residence for regulated health occupations.

This integrated data environment supports analysis of critical workforce questions relating to transitions from education to employment, retention, and mobility of health professionals. An example of this is DataNB linking university and college graduation records with Medicare and payroll data to study the career paths of registered nurses and licensed practical nurses.

Work is expanding to include all licensed nurses, as well as social workers and paramedics. Future research will also examine health and wellness outcomes using health service and workers' compensation data, offering valuable insights for workforce planning and policy decisions.

Shared Outcome 4

Strengthened domestic workforce supply through education data

Enable seamless sharing, integration and access to privacy-appropriate data across relevant sources to strengthen the domestic health workforce pipeline from education to the delivery of service.

The report Caring for Canadians: Canada's Future Health Workforce highlights that "…health workforce data focuses on data collected at the time of registration or licensure with less emphasis on health workforce data prior to or during their education and training" (Health Canada, 2025).

The inconsistency and lack of information on education and training for non-physician providers creates significant challenges for broader health workforce planning to strategically design a domestic supply of health workers that meets the needs of Canadians now and into the future. This includes building in stretch capacity for flexibility, adaptive models of care, and crises.

Some of the recommendations in Caring for Canadians include:

- A minimum data standard on health profession students and their education programs should be created and required for all health profession programs to complete and report on.
- Data on health profession students and their education programs should be available to those who undertake health workforce planning.
- Health profession students should have a unique identifier that will not change through their entire professional career to facilitate monitoring of location and practice patterns for health workforce planning purposes.

There is limited formalized data sharing between educational institutes and health workforce planning teams across the country. Data sharing from Ministries of Education and Advanced Education to health workforce planning teams in ministries of health varies by jurisdiction and is often a result of relationship building that is person-dependent.

In strengthening these connections, there is an opportunity to integrate existing national education datasets, such as Statistics Canada's Postsecondary Student Information System (PSIS), which already provides standardized administrative data on postsecondary enrollments and completions across Canada (Statistics Canada, 2025b).

Incorporating PSIS into future discussions will help ensure that foundational education pipeline data is leveraged alongside emerging, profession-specific data needs (e.g., clinical placements, competencies, and transitions to practice). Work should be done to better understand PSIS imitations for health provider groups with smaller memberships, as well as explore data sources that are complementary to PSIS, and how they can be integrated and used for health workforce planning.

Within most professions across jurisdictions, there also remains limited access to standardized information on competencies that define the skills or abilities a health worker requires to perform a job. It is essential to understand competencies and the evolving scopes of practice, particularly as many professions expand their scope over time while data systems continue to reflect outdated assumptions about roles, responsibilities, and skills.

National competency frameworks such as CanMEDS and CanMEDS-FM highlight important dimensions of professional capability. However, these frameworks do not always translate uniformly across practice environment, for example due to geographic variation. Applying a rural lens to competency expectations, whether for family physicians or specialists, can be challenging, as rural practice often requires broader skill sets and different service models (Canadian Patient Safety Institute, 2020).

Relationship and bridge building across the two sectors of health and education is encouraged as a first step to developing proper governance. As data linkages expand across multiple sources, it will also be important to ensure that any new approaches respect privacy and remain consistent with existing legislative and regulatory frameworks.

Recommendations

4.1

CIHI to define what constitutes a minimum data set for health workforce related education data elements and incorporate this into its HWI MDS Data Standard.

4.2

Considering the CIHI HWI MDS Data Standard has a placeholder for a national unique identifier and is establishing the Pan-Canadian Health Data Content Framework (CIHI, 2025a), CIHI is best positioned to convene a national discussion on how to move forward development and implementation of a health profession agnostic national unique identifier. Discussion should bring together partners from health and education across jurisdictions and include any organization that holds education data, even those without a formal role in compiling education data but with interest in supporting future collection initiatives. See Use Case 5: Personal Education Identifier.

4.3

Organizations who currently hold a role in compiling pan-Canadian education data (e.g., Canadian Association of Schools of Nursing (CASN) and Canadian Post-MD Education Registry (CAPER)) are encouraged to explore opportunities to work with institutes of education to implement the CIHI education standard once defined, and to share standardized data with CIHI.

4.4

Health professional associations, regulatory colleges, and/or appropriate organizations, many of which are actively defining profession- and specialty-specific competencies, are encouraged to work collectively toward a coordinated, pan-Canadian articulation of competencies. Existing and ongoing work should be made publicly available, where appropriate, to support consistent measurement, planning, and evaluation across jurisdictions.

4.5

Health Workforce Canada will enable easily accessible professional competency-based information through its AI-powered Digital Front Door and continue to expand available resource partners as necessary.

4.6

Where possible, Health Workforce Canada will support a continuous, collaborative pan-Canadian conversation to define plausible next steps for opportunities to work towards infrastructure and governance in this space.

Recommendation Length: Short Term | Medium Term | Long Term

USE CASE 5: Personal Education Identifier Linking Pathways

A national unique identifier for healthcare professionals has been discussed for over two decades with several profession-specific identifiers created to track credentials, licensure, and workforce participation. These efforts highlight the value of being able to follow individuals' pathways over time, while respecting privacy and jurisdictional authority.

In British Columbia, a provincial Personal Education Number (PEN) was developed to track individuals from education to employment. The PEN is a unique nine-digit identifier assigned to each student when they enter the provincial education system (K-12) and is used by the Student Transitions Project to link student data across K-12 and public post-secondary education.

The project uses these PENs (after encryption) as the linking device between K-12 records and public post-secondary institution records, enabling longitudinal tracking of transitions, mobility, and outcomes across the education system. The data reported are aggregated, and strict privacy protocols ensure that individual students cannot be personally identified or have decisions made about them using this data.

Data is used to understand regional demand for new health programs. If linked to workforce data, it could provide a more complete picture of an individual's journey from education through to employment and career progression.

By connecting education and workforce data, tools like PEN demonstrate the potential for evidence-informed policy and strategic workforce planning, ensuring the health system has the skilled professionals it needs today and in the future.

Shared Outcome 5

Improved data on internationally educated health professionals

Enable seamless sharing, integration and access to data across relevant sources to strengthen immigration pathways for health workers, and ensure these individuals are able to work to their full scope of practice and education level in Canada.

Internationally educated health professionals (IEHPs) have been an important part of Canada's health workforce for many years, contributing across many roles and making up a significant portion of the workforce. While the COVID-19 pandemic brought more attention to their contributions and led provinces and territories to rely on newly arriving and already-resident IEHPs, this amplified efforts that were already underway rather than marking a new shift in policy.

While a great deal of IEHP data exists, sources remain incomplete and siloed, making linkage and tracking individuals over time challenging or not possible. For example, Census and Labour Force Survey data from Statistics Canada show numbers of IEHPs living in Canada and employed in health occupations but lack record-level licensing information for those eligible to practice. Tracking immigration pathways (e.g., express entry and provincial nominee programs) is often inconsistent, and few sources collect information on foreign credential recognition despite long-standing interest.

Current federal immigration systems are not designed to reliably track how many internationally trained workers are in Canada but not working in the health sector, or where they encounter barriers along the pathway. As immigration processes assess education credentials for selection, rather than practice readiness, the resulting data may not fully reflect how many IEHPs are eligible to work in regulated professions once they arrive. These tracking issues and limited data granularity across systems make it challenging to answer questions such as whether IEHPs can find appropriate employment in their field of study, and if not, which barriers are preventing this (Health Canada, 2023a; Statistics Canada, 2023). Changes to licensure and training requirements over time further complicate trend analysis.

The broader category of IEHPs also includes Canadians who pursued health education abroad and are seeking to return and practice in Canada. These repatriating Canadians face many of the same credentialing challenges and are also not well reflected in data collection. Several studies have leveraged data that does exist to tell the IEHP story, but accessing the data requires time, research skill and integration of multiple sources (see Table 1). Even then, a complete picture does not exist.

Through the data strategy engagements to date, it has been highlighted that these challenges are discussed across federal and intergovernmental tables and forums. Such mechanisms provide an avenue for federal, provincial, and territorial partners to consider system-level challenges such as data fragmentation, misalignment between federal immigration data and provincial and territorial regulatory processes, and clearer tracking of IEHPs across the full pathway, from selection to assessment, licensure, and employment.

Much like the interface between education and health, immigration and health are similarly complex, spanning challenges with licensure pathways, integration into Canadian society, retention efforts, and ethical recruitment practices.

IEHPs play many different roles within the health care system in Canada, from direct clinical care to healthcare administrative roles. One additional consideration is thinking more broadly about who comprises the IEHP health workforce, and the various roles that they play in the health ecosystem. Academic partners indicate that international students comprise a substantial portion of enrollment in some accredited health and medical administrative service programs across Canada (Statistics Canada, 2025c). Health information professionals from these programs play a critical role as producers of clinical data, and without explicit, high- quality data on these roles, there can be unintended consequences of immigration policy on professions. See Use Case 6: Health Information Professionals.

Table 1:

Recent studies focused on Internationally Educated Health Professionals

- Statistics Canada and Immigration, Refugee, Citizenship Canada's, Immigrant nurses in Canada: Alignment between intentions and employment outcomes (Statistics Canada, 2025a).
- Conference Board of Canada's, The Leaky Bucket 2024: A Closer Look at Immigrant Onward Migration in Canada (Monteiro, Guccini, and Hamman, 2024).
- Government of Canada's, Characteristics and Labour Market Outcomes of Internationally Educated Health Care Professionals in Canada (Health Canada, 2023a; Statistics Canada, 2023).
- World Education Services (WES), Addressing the Underutilization of Internationally Educated Health Professionals in Canada: What the Data Does and Doesn't Tell Us (WES, 2022).

Recommendations

5.1

CIHI to work with regulatory colleges, the Medical Council of Canada, and relevant organizations such as the Canadian Post-M.D. Education Registry (CAPER) to ensure standardized data capture for IEHPs including international medical graduates and Canadians trained abroad. This should be part of the augmented education minimum data set (see Recommendation 4.1), with data collected and made accessible in alignment with Recommendation 1.3.

5.2

Relevant health organizations and data stewards are encouraged to develop standardized data collection and reporting processes across provinces, territories, and regulatory bodies on licensure and registration by immigrant status, and to link the standardized data with census and national administrative data housed at StatCan.

5.3

Health Workforce Canada will continue consolidating data from above sources into the IEHP module of its data and information dashboards.

5.4

Health Workforce Canada will continue to collaborate with CAPER and the Association of Faculties of Medicine of Canada (AFMC) to advance the availability and integration of physician education data into its data and information dashboards. This includes maintaining conversations and exploring opportunities for shared standards, reporting, and linkage to support health workforce planning.

5.5

Health Workforce Canada to explore the opportunity to work with Immigration, Refugees and Citizenship Canada (IRCC) to bring this data strategy forward to relevant federal and intergovernmental forums related to immigration data.

Recommendation Length: Short Term | Medium Term | Long Term

USE CASE 6: Health Information Professionals – International Student and Post-Graduate Work Permit Program Changes

Recent federal immigration changes raise the importance of considering who the Canadian health workforce is in a much broader sense, and how failing to do so could cause unintended health system impacts.

As of November 1, 2024, only students in select Classification of Instructional Programs codes remain eligible for the Post-Graduate Work Permit (PGWP). Most health information programs, which are critical to digital health, data quality, and analytics fall under the 51.07 subseries, which is now excluded. As a result, many institutions are no longer able to admit international students to these programs, reducing enrollment and limiting the future supply of graduates entering these roles.

Medical Informatics was deemed an eligible field of study for the PGWP until June 2025 when it was removed from the list—but then re-added back as of July 2025. This rapid policy change illustrates how policy decisions outside the health sector can affect essential health workforce segments. The exclusion list is next updated in early 2026.

Domestic graduates do not meet current demand for health information professionals, and needs will increase as health systems expand digital platforms, data governance, AI oversight, and analytics capacity. Shortages in these roles affect virtual care, documentation quality, system performance reporting, and population-health planning.

This use case demonstrates the need for system-wide, cross-profession workforce data to inform policy decisions. Without timely, connected labour market intelligence, policy changes made outside the health sector may inadvertently constrain health system capacity. Health partners continue to engage federal, provincial, and territorial colleagues to advocate for policy alignment that supports a sustainable, well-trained health workforce.

Monitoring Progress

Health Workforce Canada will continue to work with partners across the health system to lead and coordinate efforts that ensure the data strategy remains relevant, continues to evolve and is responsive to emerging needs.

Continuous learning and feedback will be important to this process. Partners including jurisdictions, organizations, and First Nations, Inuit and Métis organizations will have opportunities to share insights, challenges and emerging priorities through streamlined channels. These conversations will help identify where support, new approaches, or additional actions are needed, ensuring the data strategy remains inclusive and effective.

Together, this approach will keep the data strategy as a living resource that evolves with health system needs, technological advancements including AI, and practices and principles related to Indigenous data sovereignty.

Monitoring Framework

To support progress in strengthening Canada's health workforce data foundation, Health Workforce Canada will develop a monitoring framework in 2026 to help partners to learn together how the data strategy is functioning in practice and where refinement may be valuable.

Rather than serving as a tool for oversight or compliance, the framework will prioritize shared learning, reflection, and adaptation. It will help partners understand how implementation of the data strategy's recommendations is unfolding, surface barriers and enablers, and inform ongoing evolution of priorities over time.

Monitoring will focus on two areas:

- Progress made towards the data strategy's shared outcomes as jurisdictions and organizations advance the short-, medium- and long-term recommendations.
- Contextual conditions such as data governance, capacity, collaboration and engagement that shape the ability of organizations and jurisdictions to move the work forward.

Together, this learning-focused approach provides a practical and adaptable monitoring framework that supports shared leadership, highlights where adjustments may be needed and helps align decisions over both immediate and longer planning horizons. It also ensures the data strategy remains responsive opportunities emerge.

Next Steps

Health Workforce Canada recognizes that implementing some of the recommendations across jurisdictions is dependent on resources and partner organizational priorities. Some pan-Canadian organizations' funding agreements do not currently include these recommendations, meaning new commitments may be necessary to realize the data strategy's shared outcomes and recommendations. Therefore, this data strategy aims, where possible, to provide shared outcomes and recommendations that build off and leverage existing work and projects.

As the Pan-Canadian Health Workforce Data Strategy Advisory Group is time-limited, Health Workforce Canada's role as a convener and knowledge sharer will be critical in sustaining progress. By fostering collaboration, supporting champions of change, and creating spaces for shared learning, Health Workforce Canada can help ensure this work continues.

Considerations for Future Iterations

While the data strategy establishes a starting point for improving the foundation of health workforce data in Canada, future iterations will be required to keep up with emerging priorities in the space.

The use of AI and advanced analytics are just two examples of emerging areas that should be further explored when using health workforce data to support planning.

It is important to note that before considering the integration of machine learning or deep learning to health workforce data, organizations should first create or adopt policies on data privacy and the ethical use of AI (World Health Organization, 2024).

Future iterations of this data strategy will also need to explore development of 'intermediary goals' to be embedded within each of the five shared outcomes and corresponding recommendations. This refinement will help establish a more targeted and actionable monitoring framework over time.

Looking Ahead

The Pan-Canadian Health Workforce Data Strategy sets out to be more than a set of recommendations. It is a shared responsibility and commitment to building a stronger, more connected health workforce data ecosystem.

By aligning efforts and embracing collaboration, jurisdictions and partners can create a foundation that supports better planning, informed decision-making, and resilience in the face of future challenges and crises. This work is essential to ensuring Canada's health workforce is equipped to meet the needs of today and tomorrow.

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Appendix A:

Summary of Pan-Canadian Health Workforce Data Strategy Shared Outcomes & Recommendations

Shared Outcome 1

Equity-driven, high-quality data for decision-making

Recommendations and Proposed Organizations to Action

1.1 *CIHI, regulatory colleges* - Adoption of CIHI's HWI MDS Data Standard

1.2 *CIHI, MCC, regulatory colleges* – Align existing national registries to CIHI's HWI MDS Data Standard

1.3 *CIHI, CAF, Veterans Affairs, Correctional Services, health facilities, organizations, and employers* - Partner with federal agencies to establish an approach for identifying and reporting on health professionals providing these services

1.4 *Health facilities, organizations, employers, CIHI, P/Ts* - Adoption of MIS standards

1.5 *CIHI, P/Ts* - Open access to microdata files

1.6 *CIHI, P/Ts* - Update Insured Persons Registry data to capture preferred language of service

1.7 *HWC, StatCan, ESDC* - Improve level of detail in health-related occupation classification codes

1.8 *Health facilities, organizations, employers* - Implement Health Standards Organizations Global Health Workforce survey

1.9 *HWC* - Review of data suppression practices in rural and remote communities

1.10 *HWC, CIHI, StatCan, P/Ts* - Convene discussion on what constitutes timely data

1.11 *HWC, CIHI, StatCan* - Expand Health Workforce Canada's Data Catalogue

1.12 *CHWN, StatCan, CIHI* - Promote health workforce data literacy initiatives

1.13 *HWC* – Develop a monitoring framework for data strategy

Shared Outcome 2

Partnerships with First Nations, Inuit, and Métis organizations

Recommendations and Proposed Organizations to Action

2.1-2.4 *PCHOs, health facilities, organizations, and employers* - Ensure distinction-based approach to First Nations, Inuit and Métis health workforce data initiatives

2.5 *PCHOs, health facilities, organizations, and employers* - Build relationships with and learn from First Nations Information Governance Centre

2.6 *PCHOs, health facilities, organizations, and employers* - Engagement with Indigenous health professional associations

2.7 *PCHOs, health facilities, organizations, and employers* - Work with First Nations, Inuit and Métis partners to identify and use the most timely and relevant data sovereignty frameworks and references to support respectful collaborative activities

Shared Outcome 3

Efficient, interoperable data flow

Recommendations and Proposed Organizations to Action

3.1 *CIHI, CHI* - Enhance Pan-Canadian Interoperability Roadmap to include flow of health workforce data

3.2 *CIHI, P/Ts, regulatory colleges* - Promote adoption of CIHI HWI MDS Data Standard and align existing ministries' health workforce databases with the standard, where applicable

3.3 *CIHI, MCC, regulatory colleges* - Enable access to National Registry of Physicians data

3.4 *CIHI, P/Ts* - Enable real-time data flow of hospital staffing indicators

3.5 *FPT CHW* - New sub-committee on legislative and regulatory frameworks

3.6 *Health facilities, organizations, employers* - Align with existing best practice data use guidelines and frameworks

3.7 *HWC* - Enhance and expand Health Workforce Canada's data and information dashboards

3.8 *HWC, HSO* - Share Global Health Workforce Survey to enhance Health Workforce Canada's data and information dashboards

3.9 *CIHI, health information system vendors, P/Ts* - Include health delivery and health workforce data into the pan-Canadian Health Data Content Framework and work with health system vendors to adopt the standard

Shared Outcome 4

Strengthened domestic workforce supply through education data

Recommendations and Proposed Organizations to Action

4.1 *CIHI* - Define minimum data set for health workforce related education data

4.2 *CIHI, CHI, holders of education data* - National discussion on implementation of a health profession agnostic national unique identifier

4.3 *CIHI, holders of education data* - Institutions of education to implement national education standard once defined

4.4 *Health professional associations, regulatory colleges and/or appropriate organizations as decided upon by professions* - Uniformly define profession-specific competencies on a pan-Canadian scale

4.5 *HWC* - Enable accessible professional competency-based information within Health Workforce Canada's Digital Front Door

4.6 *HWC* - Continuous conversations that strengthen infrastructure and governance of health workforce education data

Appendix A Continued

Shared Outcome 5

Improved data on internationally educated health professionals

Recommendations and Proposed Organizations to Action

5.1 *CIHI, regulatory colleges, MCC, CAPER* - Ensure standardized data capture for internationally educated health professionals including International Medical Graduates and Canadians trained abroad – include in education MDS

5.2 *Relevant health organizations and data stewards, P/Ts, regulatory colleges* - Develop standardized data collection and reporting across provinces, territories, and regulatory bodies on licensure and registration by immigrant status - link with census and national administrative data

5.3 *HWC* - Expand and enhance data sources on internationally educated health professionals in the internationally educated health professionals' module of the Health Workforce Canada's data and information dashboards

5.4 *HWC, CAPER, AFMC* - Advance the availability and integration of physician education data into Health Workforce Canada's data and information dashboards

5.5 *HWC, IRCC* - Increase collaboration opportunities with Immigration, Refugees and Citizenship Canada to improve internationally educated health professionals' pathways

AFMC - Association of Faculties of Medicine of Canada

CAF - Canadian Armed Forces

CAPER - Canadian Post-M.D. Education Registry

CHI - Canada Health Infoway

FPT CHW – Federal/Provincial/Territorial Committee on Health Workforce

CHWN - Canadian Health Workforce Network

CIHI - Canadian Institute for Health Information

ESDC - Employment and Social Development Canada

HSO - Health Standards Organization

HWC - Health Workforce Canada

HWI MDS - Health Workforce Information Minimum Data Set

IRCC – Immigration, Refugees, and Citizenship Canada

MCC - Medical Council of Canada

MDS - Minimum Data Set

MIS - Management Information System

PCHO – Pan-Canadian Health Organizations

P/Ts - Provinces and Territories

StatCan - Statistics Canada

Appendix B

Existing Roles and Responsibilities of Partners in the System

Convenors and Coordinators (e.g., Health Workforce Canada)

- Unifying anchor across the health workforce ecosystem
- Integrate sources; align standards and partners
- Facilitate advisory groups and working tables
- Support collaboration, data literacy and monitoring

Indigenous Partners (Rights-holders and Governance Authorities)

- Ensure Indigenous data sovereignty and application of distinctions-based approach (e.g., OCAP®, OCAS, and the National Inuit Strategy on Research (NISR))
- Define Indigenous-led protocols for data collection, sharing, access, and use
- Co-design governance and access pathways with system partners

Data Steward Entities (e.g., CIHI, Statistics Canada)

- Manage pan-Canadian standards (e.g., HWI-MDS Data Standard)
- Operate secure data pipelines, aggregate and publish the data
- Enable comparability and interoperability

Data Users and Planners (e.g., ministries, regions, employers, modelers, analysts, policymakers, funders, researchers)

- Use data to support operational and strategic planning
- Apply advanced analytics to analyze trends
- Use workforce trends to design and evaluate policies, programs, investments

Data Custodians (e.g., regulators and provinces/territories)

- Collect/maintain licensure, human resources and practice data under legislation
- Ensure compliance, privacy, reporting
- Share with data stewards (e.g., via agreements)

Appendix C

Infographic on Health Workforce Data in Canada

Strengthening health workforce data improves planning and helps support informed decision-making for evolving health systems and population needs.