

Making New Yorkers Healthier

Immigrant Health Professionals' Untapped Potential

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Executive Summary

New York State's health-care system, like many across the country, is under mounting pressure. An aging population is driving up demand for care while the health-care workforce itself is aging, with nearly one in five physicians and registered nurses in the state within ten years of retirement. At the same time, geographic mismatches leave rural and underserved communities without adequate health-care professionals. By one estimate, 8 million New Yorkers live in federally designated Health Professional Shortage Areas and would benefit from better access to primary care physicians, dentists, or mental health specialists. Workforce studies have found that New York State has a shortage of more than 5,000 registered nurses, and such shortages are projected to grow. By 2038, for example, for every five family medicine doctors needed to meet patient demand in the state, only about three will be available.

These challenges, while not new, are now colliding with sweeping federal immigration policy changes that are restricting the international pipeline of health-care workers upon whom New York has long depended. In this time of significant demographic change and unprecedented immigration restrictions on future arrivals under the Trump administration, underemployed immigrant health-care professionals already living in New York represent an underutilized pool of talent that could be more fully deployed. U.S. and international experiences present a range of policy models that could help mobilize this workforce to address shortages in medicine, nursing, and mental health.

Underemployed immigrant health-care professionals already living in New York represent an underutilized pool of talent that could be more fully deployed.

This report describes key demographic and health-care workforce trends in New York State, focusing in particular on the number and characteristics of the 24,000 immigrant health-care professionals who were underemployed as of 2024—that is, immigrant college graduates with degrees in medical and health sciences and services who were employed in low-skilled jobs, unemployed but seeking employment, or out of the labor force. Based on Migration Policy Institute (MPI) analysis of the Census Bureau's 2024 American Community Survey (ACS), supplemented by a unique MPI methodology for estimating the legal status of immigrants in ACS data, and drawing on interviews with New York State stakeholders, the report examines who these underemployed immigrants are, what barriers they face, and what other U.S. states and countries have done to reduce brain waste among health-care professionals.

Key findings of the study include:

- **New York's health-care system depends heavily on immigrants.** Immigrants accounted for 37 percent of the state's physicians and 29 percent of its nurses in 2024—among the highest shares in the country. Moreover, nearly one in five international medical graduates (internationally trained physicians completing their residency in the United States) does so in New York, more than any other state. New York's deep reliance on immigrant health-care professionals exposes the state to policy

changes that narrow international pathways into the health sector, including recent extensive changes to J-1 and H-1B visas and longer application processing times.

- **Yet at least 24,000 immigrants in the state who have health and medical college degrees were underemployed.** These immigrants accounted for 32 percent of New York State's total of 75,000 underemployed professionals (both U.S. and foreign born) with degrees in medical and health sciences and services in 2024. In New York City, 52 percent of all underemployed health-care professionals were immigrants.

  Nationwide, there were 310,000 underemployed immigrant college graduates with medical and health-related degrees in 2024, representing 24 percent of all 1.3 million underemployed health-care professionals in the United States. Notably, underemployment is not limited to immigrants: Nearly 1 million U.S.-born college graduates with medical and health-related degrees were underemployed across the country, including 52,000 in New York State. A number of policies that would boost employment of immigrant health professionals would benefit underutilized U.S.-born professionals as well.

- **Long-tenured residents, women, and U.S.-trained immigrants make up large shares of underemployed health-care workers in New York State.** Most of New York's underutilized immigrant health-care professionals (71 percent in 2024) had lived in the United States for more than ten years, compared to 58 percent nationally. Women accounted for the vast majority of underutilized health-care professionals both in New York and nationally (76 percent and 81 percent, respectively), in part because women are more likely to have left the labor force to manage child-care responsibilities. Notably, 54 percent of underemployed immigrant health-care professionals in New York obtained their degrees in the United States—a share higher than the national average of 39 percent—suggesting that barriers extend well beyond recognition of foreign-earned credentials.

- **While legal status is a key factor in brain waste among immigrants, most of those who are underemployed are legally present in the country.** Only 13 percent of underutilized immigrant health-care professionals in New York as of 2023 were unauthorized immigrants, lower than the nationwide share of 18 percent. Meanwhile, 87 percent of underemployed immigrant health-care professionals in the state held legal status as either a naturalized U.S. citizen, lawful permanent resident (i.e., green-card holder), or temporary visa holder, and therefore are allowed to work in most jobs. Still, anecdotal evidence suggests that fear of immigration enforcement has a chilling effect on workforce development and education program participation even among immigrants with legal status.

- **Underemployed immigrants represent a linguistic asset to the health-care workforce that could help better meet the care needs of New York's diverse patient population.** Most underemployed immigrant health-care professionals in New York (68 percent in 2024) are fully proficient in English. Many also speak other languages that are common in the state's most underserved patient populations, such as Spanish, Chinese, Bengali, Russian, Haitian Creole, and Arabic. This linguistic profile represents a significant, unrealized asset for improving culturally and linguistically competent care delivery across New York State.

A wide range of policy models from the United States and other countries could be adapted to help New York reduce brain waste among immigrant health-care professionals. These include scaling up contextualized English-language programs; accepting evaluations from multiple credential-evaluation providers; creating clearer pathways from temporary to permanent licensure for physicians; providing financial support during relicensing and exam preparation; and improving data collection on licensing and placement outcomes. Taken together, these approaches frame reforms not as an immigration issue, but as a workforce strategy. At a time of deepening workforce shortages and tighter federal immigration restrictions, such reforms could help New York make better use of talent already in the state while expanding access to care in rural and other underserved communities.

1 Introduction

New York State's health-care system is one of the largest employers in the state, employing close to 1.2 million workers in 2024 and serving a racially and linguistically diverse state population of nearly 20 million.[1] The system is under mounting pressure from converging forces: a rapidly aging population driving up demand for care, an aging health-care workforce approaching retirement, persistent geographic mismatches that leave rural and underserved communities without adequate access to health care, and long-standing racial gaps between health professionals and patients that limit the system's ability to deliver culturally competent care.[2] About 8 million New Yorkers live in federally designated Health Professional Shortage Areas,[3] including 5.4 million in areas with primary care shortages as of 2026.[4]

About 8 million New Yorkers live in federally designated Health Professional Shortage Areas.

These structural challenges are not new. What is new is their collision with a set of federal immigration policy changes that threaten to limit New York's ability to recruit a key group of health-care professionals—immigrants—who currently represent 37 percent of all health-care workers in the state.[5] At the same time, some immigrants already residing in the state have medical and health-related degrees but are underemployed, either working in jobs below their skill level or unemployed. Activating this underutilized pool of talent will become even more important as health-care workforce pressures continue to intensify.

1 Migration Policy Institute (MPI) tabulation of data from the U.S. Census Bureau's 2024 American Community Survey (ACS).
2 Robert Martiniano and Jean Moore, *Trends in New York Registered Nurse Graduations, 2015-2024* (Albany, NY: Center for Health Workforce Studies, College of Integrated Health Sciences, University at Albany, State University of New York, 2026); Robert Martiniano et al., *The Healthcare Workforce in New York State: Trends in the Supply of and Demand for Healthcare Workers* (Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York, 2026); Shen Wang, Robert Martiniano, and Kristen Stiegler, *Assessing the Characteristics of New York State Dentists Serving Medicaid Beneficiaries* (Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York, 2022).
3 Carmen Renée Green, "The Doctor Shortage Begins in the Classroom, Not the Clinic," *City and State New York*, February 23, 2026.
4 U.S. Department of Health and Human Services, "Designated Health Professional Shortage Areas Statistics: Third Quarter of Fiscal Year 2026," accessed July 10, 2026.
5 "Immigrants" refers to persons who were not U.S. citizens at birth. This population includes naturalized U.S. citizens, lawful permanent residents (i.e., green-card holders), refugees and asylees, certain legal nonimmigrants (including those on student, work, or other temporary visas), and persons residing in the country without authorization. The term "U.S. born" refers to those born in the United States and those born abroad to at least one U.S.-citizen parent.

This study examines this population, the changing policy context, and what it means for New York. The report offers insights for policymakers, licensing agencies, health-care employers, workforce development funders, community-based organizations, and others that are or could be engaged in reducing barriers to practice for underemployed health-care professionals.

A. New Policy Context

Since reentering office nearly two years ago, the Trump administration has changed both immigration policy and health-care financing policy (Medicaid cuts, for example) in ways that are likely to simultaneously reduce the supply of health-care workers, destabilize the institutions that employ them, and restrict patient access to care.[6] As of late 2026, relevant immigration policy changes include:[7]

- A final rule limiting J-1 visa duration to four years rather than the actual duration of the residency or fellowship program for international medical graduates (IMGs), which is often longer.[8] The policy is currently blocked in court.[9]
- A revised H-1B lottery favoring higher-wage applicants,[10] a $100,000 fee on certain new H-1B petitions filed for workers abroad (vacated in court), and a proposed $103,265 fee on H-1B petitions filed for workers abroad or in the United States.[11] Certain nonprofit institutions, including some hospitals, are excluded from these fees.

6 The Center for Migration Studies, The Mother Cabrini Health Foundation, and The New School's Zolberg Institute for Migration and Mobility, "Supporting & Protecting Immigrant Home Care Workers in New York City" (event, July 17, 2025).

7 Jeanne Batalova and Michael Fix, *Physicians in an Era of Changing Immigration Policy: The Case of Nephrology* (Washington, DC: MPI, 2026); Julia Gelatt, "Trump Restrictions on Legal Immigration Could Sharply Reduce U.S. Population Growth" (commentary, MPI, Washington, DC, April 2026); Cecilia Esterline, "Legal Immigration in Numbers: August 2026 Status Update" (commentary, Niskanen Center, Washington, DC, October 2026).

8 The J-1 visa is the primary pathway for international medical graduates (IMGs) entering U.S. medical residency programs, but it is also used by researchers, professors, and other exchange visitors. The new rule was set to take effect on September 15, 2026. A day earlier, a federal judge in Massachusetts issued a nationwide preliminary injunction blocking its implementation. Litigation continues as the government is expected to appeal. See Jeanne Batalova, "A New DHS Rule Just Made Life Significantly More Complicated for International Students on F-1 Visas and J-1 Exchange Visitors, Including Scholars and Internationally Trained Physicians" (LinkedIn post, July 2026).

9 Presidents' Alliance on Higher Education and Immigration, "Duration of Status Litigation," accessed September 21, 2026.

10 On December 29, 2025, the Department of Homeland Security (DHS) published a final rule replacing the H-1B random lottery with a wage-based selection system (the lottery is applicable only to employers subject to the annual visa cap). The wage offered to a foreign worker by a petitioner (employer) is categorized using wage levels set by the Department of Labor, and these categories determine how many entries an application receives in the lottery: Applications at a level IV wage (the highest level) receive four lottery entries, whereas those with a level I wage receive one entry, reducing their selection odds. This rule particularly affects health-care professionals at the start of their careers.

11 As of this writing, two employer-paid fees for new H-1B workers have been introduced. The first, a $100,000 fee imposed by presidential proclamation, took effect on September 21, 2025, and applied to petitions for workers outside the United States. On June 8, 2026, a federal judge vacated the policy as an unconstitutional tax, and on July 24 the First Circuit declined to stay that ruling, pending the government's appeal. On September 18, 2026, the White House extended the proclamation through September 2027. At the end of September 2026, a federal district court judge granted preliminary injunction and invalidated both the original $100,000 fee and the September proclamation. See Stuart Anderson, "Judge Strikes Down Latest Version of $100,000 H-1B Immigration Fee," *Forbes*, October 1, 2026. Separately, in August 2026, DHS proposed a $103,265 fee on all cap-subject H-1B petitions, including for workers already in the United States. Petitions from cap-exempt employers and for physicians with Conrad 30 waivers would be exempt. Public comments closed September 24, 2026. As of this writing, the fee has not been finalized or implemented. See Jeremy Neufeld et al., *Explaining the Proposed $103k H-1B Fee* (Washington, DC: Institute for Progress, 2026).

- A proposal to eliminate the 60-day grace period allowing H-1B workers who lose their jobs to remain in the country to find new employment, change status, or depart.[12]
- The end of automatic work permit extensions for H-4 spouses of H-1B workers.[13]
- Mandatory in-person visa renewals, which mean applicants must return to their home countries and have led to longer visa processing times at embassies.[14] These policy changes occur at a time when U.S. Citizenship and Immigration Services (USCIS) has a backlog of more than 12 million applications.[15]
- A ban on entry for nationals of 39 countries, mostly from Africa, Latin America, and the Middle East, along with a related USCIS freeze on applications from nationals of those countries already in the United States (vacated in court in June 2026).[16]
- Cancellation of humanitarian protections for an estimated 1.5 million people (as of early 2026), which included sizeable numbers of health- and elder-care workers, such as many Haitians who held Temporary Protected Status (TPS).[17]

These policies reach nearly every category of immigrant worker. Some have not been fully implemented, and others are being contested in court, but some effects are already visible. Both permanent and temporary visa issuances fell in 2025 and early 2026 compared with 2024.[18] And in the period when the $100,000 H-1B fee was in effect (between September 2025 and July 2026), rural hospitals and community clinics across the nation reportedly struggled to recruit internationally trained staff, deepening existing geographic disparities in care.[19] At the same time, physicians from the 39 countries covered by the entry ban could not extend their status or work permits, and many were placed on leave or stopped working.[20]

12 Unlike the weighted lottery and the proposed $103,265 fee, this rule would affect all H-1B workers (employed by cap-subject and cap-exempt employers alike), including physicians in teaching hospitals during and after training. It also includes workers on other temporary visas such as O-1, L-1, E, and TN workers. See Reddy Neumann Brown PC, "DHS Proposes to Eliminate the 60-Day Grace Period for H-1B, L-1, O-1, E, and TN Workers," accessed September 21, 2026; DHS, "Eliminating the Discretionary 60-Day Grace Period," *Federal Register* 91, no. 175 (September 11, 2026): 57807.

13 DHS eliminated the automatic 540-day extension of employment authorization documents in October 2025. Before that, H-4 visa holders were eligible for work authorization when the H-1B worker had an approved immigrant petition or had extended status beyond six years. The population affected by this change consists largely of families well along the path to permanent residence. See FWD.us, "Ending Automatic Work Authorization Extensions Will Cost Billions," updated April 9, 2026.

14 *Times of India*, "H-1B Visa Stamping Delays Continue in India, Interview Dates Now Being Deferred to 2027," *Times of India*, January 22, 2026.

15 Julia Gelatt, "USCIS Published Its Latest Processing Data Yesterday" (LinkedIn post, August 2026).

16 In May 2026, following significant pressure from medical organizations and a bipartisan group of lawmakers, U.S. Citizenship and Immigration Services (USCIS) exempted physicians already in the United States. A federal judge then found the USCIS policies unlawful on June 5, 2026, ordering the agency to resume processing applications from all nationals of the affected countries. The government has appealed to the First Circuit, and on July 15, 2026, the court declined to pause the ruling during the appeal, so processing continues while the case proceeds. However, the entry ban still holds for those abroad, including physicians and medical residents. See USCIS, "Court Order on Hold Policies," updated June 12, 2026.

17 Jeanne Batalova, "Frequently Requested Statistics on Immigrants and Immigration in the United States," *Migration Information Source,* March 12, 2026; Miriam Jordan and Madeleine Ngo, "Employers Fear Labor Shortage as Many Immigrants Lose Protected Status," *New York Times*, July 26, 2026.

18 Julia Gelatt, "New Data from the State Department Show Legal Immigration Falling" (LinkedIn post, March 2026); Sunaina Sunda and Jeanne Batalova, "Temporary Visa Holders in the United States," *Migration Information Source*, October 21, 2026.

19 Miriam Jordan, "Trump's Immigration Policy Sidelines Foreign Doctors Amid Shortage," *New York Times*, April 4, 2026; Madeleine Ngo, "Trump's Changes Lock Some Employers Out of H-1B Visa Program," *New York Times*, April 10, 2026.

20 Arielle Zionts, "Delays in Visa Program Threaten Placement of Hundreds of Doctors in Underserved Areas," CBS News, May 1, 2026.

These policy changes have deepened the challenges of recruiting internationally trained health-care professionals and made long-term workforce planning difficult for hospitals and other health-care institutions that have long relied on them. These immigration-side pressures are amplified by federal education financing changes. For instance, the 2025 *One Big Beautiful Bill Act* capped federal student loans at $200,000 total—a threshold likely to deter lower-income students from pursuing medical and dental degrees,[21] narrowing the domestic pipeline into health professions. Taken together, these developments make it more important than ever to leverage the skills of immigrant health professionals already in the United States.

B. The New York Case Study

New York State presents a critical case study for understanding the urgency of and how to more fully tap into the skills of resident immigrant health professionals. With approximately 4.6 million immigrants, New York has the fourth-largest immigrant population in the nation, and immigrants comprise 23 percent of the state population, far exceeding the national average of 15 percent.[22]

The state's many multilingual and multicultural communities create both high demand for culturally and linguistically competent care and a large pool of health-care workers with those very competencies.

This demographic reality is reflected in the make-up of the health-care workforce: Immigrants have long been essential to sustaining New York's health-care system, accounting for 37 percent of physicians and 58 percent of home health and personal care aides statewide—shares far exceeding their 23 percent share of the total state population.[23] The state's many multilingual and multicultural communities create both high demand for culturally and linguistically competent care and a large pool of health-care workers with those very competencies. Trump administration policy changes are poised to have substantial effects in New York State, where safety-net institutions serving large immigrant populations face intersecting pressures from sweeping immigration enforcement actions, health-care financing cuts, and mounting workforce recruitment challenges.

New York's importance as a case study extends beyond demographics to state policy innovation. At the onset of the COVID-19 pandemic in March 2020, New York became the first state in the nation to issue executive orders adjusting licensing requirements in order to rapidly expand the health-care workforce and to allow internationally trained physicians to practice with temporary licenses.[24] Although these emergency measures were temporary and led to relatively small additions to the state's health-care workforce, these policies offer valuable lessons about the feasibility of accelerated credentialing.[25]

21 Ezekiel Emanuel, Emily Kim, and Vitor de Souza, "Make Medical School Three Years," *New York Times*, November 10, 2025.
22 MPI tabulation of 2024 ACS data.
23 MPI tabulation of 2024 ACS data.
24 Jeanne Batalova, Michael Fix, and Sarah Pierce, "Brain Waste among U.S. Immigrants with Health Degrees: A Multi-State Profile" (fact sheet, MPI, Washington, DC, 2020).
25 Institute on Immigrant Integration Research and Policy, Rockefeller Institute of Government, State University of New York, "Engineering Cohesive Communities: Social Integration of Foreign-Born Americans" (conference summary, July 2025).

C. *Research Questions and Methodological Approach*

Building on extensive work by the Migration Policy Institute (MPI) on skill underutilization among immigrants in the health sector,[26] this multi-method study examines demographic and workforce trends in health care in New York State and New York City. The research addresses four animating questions:

1. What are the key demographic and workforce trends affecting New York State, New York City, and the state's rural areas?
2. What role do immigrant health-care workers currently play in the New York health-care system?
3. Who are the underemployed college-educated immigrants with medical and health-care degrees in New York?
4. Drawing on the experiences of other U.S. states and other countries, what policies and practices should New York policymakers consider to improve recruitment, credential recognition, and retention of underemployed immigrant health-care professionals?

To answer these questions, MPI researchers analyzed the U.S. Census Bureau's 2024 American Community Survey (ACS), with a focus on New York State, New York City, and the state's other urban areas and rural counties. This report describes key characteristics of underemployed immigrant health-care professionals, including place of education, English proficiency, and languages spoken at home. The analysis also leverages a unique MPI methodology for estimating the legal status of immigrants in ACS data to examine the status breakdown of underemployed immigrant health-care professionals.

In addition to this quantitative analysis, the research team also conducted semi-structured interviews with stakeholder organizations in New York State and New York City, including community colleges, organizations serving underemployed immigrant professionals, and New York policy researchers to document local perspectives on credentialing barriers, program models, workforce trends, and the effects of federal policy changes on immigrant professionals seeking training and employment. Finally, the researchers reviewed federal legislation, executive orders, and agency regulations and guidance between January 2025 and September 2026 to highlight policies likely to affect the supply of health-care professionals, and they examined approaches in other U.S. states and countries that aim to reduce brain waste. (See Appendix A for details on the study methodology and key definitions.)

26 See, for example, Batalova and Fix, *Physicians in an Era of Changing Immigration Policy*; Jeanne Batalova, Michael Fix, and José Ramón Fernández-Peña, "The Integration of Immigrant Health Professionals: Looking beyond the COVID-19 Crisis" (policy brief, MPI, Washington, DC, 2021); Jeanne Batalova and Michael Fix, "Leveraging the Skills of Immigrant Health-Care Professionals in Illinois and Chicago" (policy brief, MPI, Washington, DC, 2021).

2 Key Trends Shaping Demand for and Supply of Health-Care Services

The United States is undergoing a profound demographic transformation. A recent Census Bureau report revealed a striking slowdown in population growth along with a rapidly aging population.[27] The number of people ages 65 and older grew by 47 percent between 2010 and 2024, while the total U.S. population grew by only 8 percent.[28] Coupled with immigration restrictions, these trends have far-reaching implications for the country's labor market and health-care delivery systems, and can be clearly seen in New York State and New York City.

A. Demographic Shifts in New York

Between 2010 and 2024, the total New York State population increased by about 1 percent while the population ages 65 and older grew by 39 percent. The number of older residents in New York City grew even faster, by 49 percent.[29] Other urban and rural New York communities are experiencing stagnant total population growth and rapidly graying demographics as well. Serving a growing population of older residents with existing health- and elder-care systems is thus a statewide challenge.

The health-care workforce, which includes workers across skill and education level, is aging alongside the patient population it serves. Nearly one in five physicians and registered nurses in the state are within ten years of retirement (ages 55 to 64), as shown in Table 1. The share of New York State physicians ages 55 and older (33 percent) exceeded the national average (30 percent), and in rural New York the share was even higher (41 percent).

These demographic trends put growing pressure on the health-care workforce. Projections indicate that the United States will face a shortage of about 39,000 family medicine physicians by 2038. The estimated "percent adequacy" for this profession is 76, which means that for every four family medicine doctors needed to meet U.S. patient demand, only about three will be available.[30] Adequacy levels for this specialty will be even lower in New York State. For every five family medicine doctors needed to meet patient demand in the state in 2038, only three will be available.[31] Shortages are also projected for several other health professionals in the state, including mental health counselors and pharmacists. Already in 2026, New York State is facing a shortage of more than 5,000 registered nurses. However, faculty shortages in nursing schools have led some institutions to limit admissions.[32]

27 U.S. Census Bureau, "U.S. Population Growth Slows Due to Historic Decline in Net International Migration" (press release, January 27, 2026).
28 MPI tabulation of 2024 ACS data.
29 MPI tabulation of 2024 ACS data.
30 National Center for Health Workforce (NCHW), *State of the U.S. Health Care Workforce, 2025* (Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services, 2025). See also NCHW, "Workforce Projections," accessed March 19, 2026. According NCHW projections, the total percent adequacy is the projected number of doctors active in the workforce divided by the number of doctors required to provide a level of services. For details on definitions and the microsimulation model that projects the current and future supply of and demand for health-care workers by occupation, geographic area, and year, see NCHW, "Health Workforce Projections Dashboard," accessed March 19, 2026.
31 The percent adequacy for family medicine doctors in New York State in 2038 is projected to be 61 percent, with a shortage of about 3,200 physicians. See NCHW, "Workforce Projections."
32 Martiniano and Moore, *Trends in New York Registered Nurse Graduations.*

TABLE 1

Age Breakdown of Employed Health-Care Professionals, by Geography and Selected Occupations, 2024

	Number	Share by Age Group			
		Under 25	25–54	55–64	65+
All health-care workers					
United States	16,584,000	10%	68%	16%	7%
New York State	1,159,000	7%	66%	19%	8%
New York City	514,000	5%	66%	20%	9%
Other urban areas	372,000	8%	65%	19%	8%
Rural counties	273,000	9%	65%	18%	8%
Physicians					
United States	1,076,000	0%	70%	17%	13%
New York State	84,000	0%	67%	17%	16%
New York City	35,000	0%	76%	12%	12%
Other urban areas	33,000	0%	62%	20%	18%
Rural counties	17,000	0%	59%	20%	21%
Nurses					
United States	3,708,000	5%	72%	17%	6%
New York State	220,000	5%	70%	18%	7%
New York City	70,000	4%	73%	16%	8%
Other urban areas	88,000	6%	68%	20%	6%
Rural counties	62,000	4%	70%	19%	7%

Notes: In this table, the category "all health-care workers" includes physicians and surgeons, registered nurses, health-care practitioners and technical occupations, and workers in health-care support occupations such as home health aides and personal care aides.
Source: Migration Policy Institute (MPI) tabulation of data from the U.S. Census Bureau's 2024 American Community Survey (ACS).

Moreover, national and state-level projections do not tell the full story. The uneven geographic distribution of health-care professionals in many specialties, particularly in primary, dental, and mental health care, constrains patients' access to care in many rural and underserved areas. The Office of the New York State Comptroller estimated that 16 of the rural counties examined in its 2025 report had 4.0 primary care physicians per 10,000 people, roughly half the rate of New York State (8.1) and the United States overall (8.4), with similarly low population-to-provider ratios for pediatric physicians and obstetrician-gynecologist physicians.[33]

B. Racial and Ethnic Composition of the State Population versus Health-Care Workforce

As a long-standing destination for immigrants of diverse national origins, the racial and ethnic composition of the New York health-care workforce is significantly more diverse than health-care providers in the nation overall. Approximately 42 percent of health-care workers in the state identify as White, followed

33 Office of the New York State Comptroller, *The Doctor Is … Out: Shortages of Health Professionals in Rural Areas* (New York: Office of the New York State Comptroller, 2025).

by 22 percent as Black and 18 percent as Latino (see Table 2). New York City's health-care workforce is considerably more diverse than those in other urban counties, while the workforce in rural counties remain overwhelmingly White.

TABLE 2

Race/Ethnicity of the Total Population and Employed Health-Care Professionals, by Geography and Selected Occupations, 2024

		Share by Race/Ethnicity				
	Number	Latino	Black	Asian American and Pacific Islander	Other (non-White)	White
Total population						
United States	340,111,000	20%	14%	8%	3%	56%
New York State	19,867,000	20%	15%	10%	2%	52%
New York City	8,478,000	29%	22%	16%	2%	31%
Other urban areas	6,161,000	16%	12%	7%	2%	63%
Rural counties	5,228,000	11%	8%	4%	3%	74%
All health-care workers						
United States	16,584,000	15%	17%	11%	2%	55%
New York State	1,159,000	18%	22%	16%	2%	42%
New York City	514,000	24%	30%	23%	2%	20%
Other urban areas	372,000	13%	18%	12%	2%	55%
Rural counties	273,000	12%	12%	6%	4%	67%
Physicians						
United States	1,076,000	8%	6%	25%	2%	59%
New York State	84,000	9%	7%	29%	2%	52%
New York City	35,000	10%	9%	29%	3%	49%
Other urban areas	33,000	7%	7%	29%	3%	55%
Rural counties	17,000	12%	4%	27%	2%	55%
Nurses						
United States	3,708,000	10%	14%	12%	2%	62%
New York State	220,000	9%	21%	15%	2%	54%
New York City	70,000	12%	33%	26%	2%	26%
Other urban areas	88,000	8%	17%	12%	1%	62%
Rural counties	62,000	6%	12%	6%	3%	73%

Notes: In this table, the category "all health-care workers" includes medical doctors, nurses, health-care practitioners and technical occupations, and workers in health-care support occupations such as home health aides and personal care aides. Latinos can be of any race. The other racial groups refer to non-Latinos. Black refers to non-Latino persons who reported their race as "Black alone" or "Black in combination with other race." Asian American and Pacific Islander (AAPI) refers to non-Latino persons who reported their race as "AAPI alone" or "AAPI in combination with other race" except Black. White refers to non-Latino persons who reported their race as "White alone."
Source: MPI tabulation of 2024 ACS data.

Nonetheless, one pattern seen across all New York State geographies is that Latino and Black individuals tend to be underrepresented among physicians. In New York City, for example, approximately 29 percent and 22 percent of the total population identified as Latino and Black, respectively, yet only 10 percent and 9 percent of the city's physicians were Latino and Black. By contrast, Asian American and Pacific Islander (AAPI) doctors were overrepresented relative to their share of the total state population and the population of New York City. Even in rural counties, where AAPI residents made up only 4 percent of residents, they represented 27 percent of physicians. Looking at the New York nursing workforce, a notably larger share of nurses identified as Black than did members of the overall population at all geographic levels.

C. *Immigrants in the New York Health-Care Sector*

Immigrant health-care professionals have long been an integral part of New York's health-care system, with foreign-born individuals a far greater share of health professionals than the general population. Immigrants accounted for 23 percent of the total state population in 2024 but made up 37 percent of physicians and 29 percent of nurses statewide (see Table 3). Immigrants are also overrepresented among physicians and nurses in New York City and other urban counties. Even though the absolute number of immigrant doctors is relatively low in rural areas, their share of all doctors is high, accounting for one in three doctors in rural New York.

Immigrants accounted for 23 percent of the total state population in 2024 but made up 37 percent of physicians and 29 percent of nurses statewide.

New York's reliance on immigrant health-care workers is greater than that of any other state. One in ten U.S. immigrant doctors and nurses live and practice in New York State; one in twenty live in New York City specifically.[34] The share of health-care workers overall who are immigrants is higher in New York (37 percent as of 2024) than in any other state in the country, while the immigrant share of physicians (37 percent) is exceeded only by the share in Maryland (39 percent). The immigrant share of nurses in New York (29 percent) ranks sixth nationally. In each case, shares are much higher in New York City than in the state overall.

Data on IMGs—physicians who obtained their medical education abroad—tell a similar story. IMGs account for a larger share of active medical residents in New York (37 percent) than nationally (23 percent).[35] Moreover, nearly one in five IMGs completing a residency in the United States does so in New York—the largest share of any state. These figures underscore both how deeply embedded immigrants are in New York's health-care system and how vulnerable that system is to policy changes that restrict international pathways into medicine and other health-care professions.

34 MPI tabulation of 2024 ACS data.

35 See Table C.17 in Accreditation Council for Graduate Medical Education (ACGME), *Data Resource Book: Academic Year 2023-2024* (Chicago: ACGME, 2024).

TABLE 3

Number of Immigrants and Their Share of the Total Population and Employed Health-Care Professionals, by Geography and Selected Occupations, 2024

	All	Immigrants	Immigrant Share
Total population			
United States	340,111,000	50,281,000	15%
New York State	19,867,000	4,642,000	23%
New York City	8,478,000	3,119,000	37%
Other urban areas	6,161,000	977,000	16%
Rural counties	5,228,000	546,000	10%
All health-care workers			
United States	16,584,000	3,119,000	19%
New York State	1,159,000	429,000	37%
New York City	514,000	289,000	56%
Other urban areas	372,000	93,000	25%
Rural counties	273,000	47,000	17%
Physicians			
United States	1,076,000	304,000	28%
New York State	84,000	31,000	37%
New York City	35,000	15,000	41%
Other urban areas	33,000	12,000	35%
Rural counties	17,000	5,000	32%
Nurses			
United States	3,710,000	631,000	17%
New York State	220,000	64,000	29%
New York City	70,000	33,000	48%
Other urban areas	88,000	19,000	22%
Rural counties	62,000	11,000	19%

Note: In this table, the category "all health-care workers" includes medical doctors, nurses, health-care practitioners and technical occupations, and workers in health-care support occupations such as home health aides and personal care aides.
Source: MPI tabulation of 2024 ACS data.

3 Underemployed College-Educated Health-Care Professionals in New York

Like the nation overall, New York has long benefited from highly skilled immigration. Yet not all immigrants are able to restart their careers after arrival. "Brain waste," also called underemployment, refers to college graduates who work in jobs well below their skill level or who cannot find work at all. The barriers immigrants face vary depending on how they came to the United States, among other factors. Those who arrive through employer-sponsored visas or formal training programs (e.g., medical residencies) typically

have built-in institutional support and a clearer pathway to continued practice in their field. In contrast, immigrants who arrive through family, humanitarian, or other pathways not based on employment or training must navigate the credentialing process and labor market on their own and tend to face more obstacles to resuming their careers.

Past research and the interviews conducted for this project highlight a range of barriers immigrant professionals encounter, including:

- difficulty obtaining diplomas and licensing credentials from institutions in their countries of origin (an issue of particular significance for humanitarian migrants, who may have had to flee without these documents and who may be unable to replace them);
- lack of recognition of international credentials by U.S. professional bodies and employers;
- unfamiliarity with the U.S. labor market and lack of professional networks;
- employer skepticism about the quality of internationally earned degrees and strong preference for U.S. work experience;
- limited familiarity among employers, licensing agencies, and workforce training program administrators with the complexity of visas and immigration statuses; and
- a shortage of bridging programs[36]—training and support programs designed to close the gap between the technical and English language skills immigrants bring with them and what U.S. employers and licensing bodies require.[37]

This underutilization carries substantial costs for immigrants, employers, and U.S. communities alike, encompassing lost earnings and tax revenue as well as the waste of critical expertise at a time of skill shortages.[38]

Consistent with earlier research, MPI analysis of ACS data shows that immigrants are overrepresented among underemployed adults with health or medical degrees. Nationwide, the 310,000 underemployed immigrant college graduates with a degree in these fields represented 24 percent of the total 1.3 million underemployed health-care professionals in the United States in 2024. In New York State, approximately 24,000 immigrants with a medical or health-related degree were underemployed, representing 32 percent

36 Batalova, Fix, and Fernández-Peña, "The Integration of Immigrant Health Professionals"; presentation by Rey Koslowski, *Reducing "Brain Waste" among Refugees in New York State*, at the conference "Engineering Cohesive Communities: Social Integration of Foreign-Born Americans," hosted by the Institute on Immigrant Integration Research and Policy, Rockefeller Institute of Government, State University of New York, June 16, 2025; Institute on Immigrant Integration Research and Policy, Rockefeller Institute of Government, State University of New York, "Credentialing and Licensing of Foreign-Obtained Degree Holders and Workforce Development for Foreign-Born New Yorkers" (webinar, March 19, 2024).

37 Bridging programs are training and support programs that help internationally trained professionals bridge gaps between their internationally earned credentials and work experience and the requirements to practice in a new country. They do so by integrating vocational content with contextualized language training, providing wraparound support, and helping participants find employment. Contextualized language instruction is particularly valuable because many internationally trained professionals have adequate general English proficiency but lack the specialized professional vocabulary their field requires.

38 Jeanne Batalova and Michael Fix, *Leaving Money on the Table: The Persistence of Brain Waste among College-Educated Immigrants* (Washington DC: MPI, 2021).

of all underemployed health-care professionals in the state. The immigrant share was even higher in New York City, at 52 percent (see Table 4).

TABLE 4

Total and Underutilized Adults (ages 25–64) with Medical or Health-Related Degrees, by Nativity and Geography, 2024

	Total		Immigrants		Immigrant Share of	
	All	Underutilized	All	Underutilized	Total	Underutilized
United States	7,111,000	1,289,000	1,434,000	310,000	20%	24%
New York State	445,000	75,000	133,000	24,000	30%	32%
New York City	159,000	31,000	75,000	16,000	47%	52%
Other urban areas	162,000	27,000	36,000	6,000	22%	22%
Rural counties	99,000	18,000	18,000	3,000	18%	17%

Notes: The universe in this table is persons with a college degree in medical and health sciences and services.
Source: Data in this table for the United States and New York State are based on MPI tabulation of 2024 ACS data. Pooled 2020–24 ACS data were used to generate robust estimates for the smaller geographies of New York City, other urban areas, and the state's rural counties.

Immigrants are more likely to experience underemployment than their U.S.-born counterparts with health or medical degrees. In the United States overall and in New York City, approximately 22 percent of immigrant health-care professionals were underutilized, compared to 17–18 percent of their U.S.-born peers (see Table 5). In New York State, underemployment rates do not vary significantly by nativity. (For data on underemployment in other states, see Appendix B.) The data highlight that underemployment is not a phenomenon experienced only by immigrants, as nationwide nearly 1 million U.S.-born college graduates with medical and health-related degrees, including 52,000 in New York State, are also stuck in low-skilled jobs or out of employment, in some cases because of difficulty matching to medical residency positions.[39]

TABLE 5

Immigrant and U.S.-Born Underutilized Adults (ages 25–64) with Medical or Health-Related Degrees, by Geography, 2024

	All Immigrants		U.S. Born	
	Number Underutilized	Share Underutilized	Number Underutilized	Share Underutilized
United States	310,000	22%	979,000	17%
New York State	24,000	18%	52,000	17%
New York City	16,000	22%	15,000	18%
Other urban areas	6,000	17%	21,000	17%
Rural counties	3,000	16%	15,000	19%

Note: The universe in this table is persons with a college degree in medical and health sciences and services.
Source: Data in this table for the United States and New York State are based on MPI tabulation of 2024 ACS data. Pooled 2020–24 ACS data were used to generate robust estimates for the smaller geographies of New York City, other urban areas, and the state's rural counties.

39 Emma Goldberg, "'I Am Worth It': Why Thousands of Doctors in America Can't Get a Job," *New York Times*, February 23, 2021.

A. Labor Force and Demographic Characteristics of Underemployed Immigrant New Yorkers

In interviews, New York professional and policy stakeholders emphasized that underemployed immigrant health-care professionals are not a monolithic group. They include recently arrived immigrants still navigating the credentialing process, longer-term residents who have become disconnected from their fields after taking low-wage jobs, and professionals who are fully credentialed but face employer bias or lack access to professional networks. Interventions are most effective when tailored to each group's needs.

One notable characteristic of the population of 24,000 underemployed immigrant New Yorkers with health and medical degrees is that 52 percent were not engaged in the labor force at all in 2024 (see Table 6). This group has stopped looking for work. There are several common explanations for labor force withdrawal, including child-care and elder-care responsibilities (disproportionately affecting women), prolonged periods without practice, and discouragement after repeated credential rejection. Among immigrant health-care professionals in New York State who were employed in low-skilled jobs, 57 percent were personal care aides, receptionists, taxi drivers, office clerks, babysitters, warehouse workers, and cashiers. None of these top seven jobs are health-care occupations.[40]

TABLE 6

Labor Force Status of Underutilized Immigrant Health-Care Professionals (ages 25–64), by Geography, 2024

	Total Underutilized Immigrants	Out of Labor Force	Unemployed	In Low-Skilled Jobs
United States	310,000	52%	6%	42%
New York State	24,000	52%	7%	41%
New York City	16,000	55%	10%	35%
Other urban areas	6,000	56%	8%	36%
Rural counties	3,000	61%	7%	32%

Note: The universe in this table is persons with a college degree in medical and health sciences and services.
Source: Data in this table for the United States and New York State are based on MPI tabulation of 2024 ACS data. Pooled 2020–24 ACS data were used to generate robust estimates for the smaller geographies of New York City, other urban areas, and the state's rural counties.

Nearly half (46 percent) of underutilized health-care professionals living in New York State in 2024 obtained their education abroad (see Table 7). As MPI and others' research has consistently demonstrated, internationally educated immigrants and refugees often find it difficult to restart health-care careers in the United States.

One interviewed program director emphasized that credentialing processes can be a particularly difficult barrier for some national-origin groups. Students from Cuba, for example, are often unable to obtain official academic credentials from their universities—in some cases, the most practical solution has been

40 MPI tabulation of 2024 ACS data.

for the student to travel to Cuba and mail the documents back to the United States.[41] The Board of Nursing (part of the New York State Education Department's Office of the Professions[42]) strongly encourages internationally trained nurses to submit credential evaluations conducted by the single state-approved institution: TruMerit, formerly the Commission on Graduates of Foreign Nursing Schools. The only alternative is to request that credentials be verified by the applicant's own foreign nursing school, an even more difficult and time-consuming option.[43] By contrast, other states such as Texas, Illinois, and New Mexico accept evaluations from multiple providers, allowing applicants more flexibility in how they meet this requirement.[44] At the same time, New York's Board of Nursing does not require passing a separate language test as it assumes that passing the nursing licensing exam, which is only in English, is sufficient.[45]

The other 54 percent of underemployed immigrant health-care professionals in New York obtained their degrees in the United States, a share higher than the national average of 39 percent (see Table 7). This finding suggests that credential recognition issues alone do not explain the full scope of underemployment, and that other factors, including labor market discrimination, professional network gaps, and employer bias, play important roles as well. These U.S.-educated immigrants may face challenges similar to those encountered by their U.S.-born counterparts, and both groups could benefit from similar strategies. Interviewees noted the importance of counseling about alternative careers that could utilize their knowledge, skills, and experience in an adjacent sector, for instance, public health analysts, community health workers, researchers in biochemistry labs, and medical insurance analysts and adjudicators.

Most (71 percent) of underutilized immigrant health-care professionals in New York have lived in the United States for more than ten years, compared to 58 percent nationally (see Table 7). Unlike recently arrived immigrants who may still be navigating initial credential processes, those with a longer U.S. tenure may have been out of professional practice for so long that reentry becomes increasingly difficult. Extended time out of the field erodes skills, clinical confidence, professional networks, and familiarity with current standards of care.

Women account for the vast majority of underutilized health-care professionals in New York State (76 percent) and across its cities and rural areas (77–83 percent), in part because women are more likely to have left the labor force to manage child-care responsibilities.[46] Of the total 24,000 underemployed immigrants with medical and health degrees in the state, women with children under age 18 at home accounted for 43 percent.[47] Recent policy efforts in New York State and New York City to subsidize child care[48] may help address this problem by enabling female health-care professionals to reenter the labor market.

41 Authors' interview with a stakeholder in charge of an education and training program in an institution of higher education, March 13, 2026.
42 New York State Education Department, Office of the Professions, "Registered Professional Nurse," accessed March 1, 2026.
43 New York State Education Department, Office of the Professions, "RN Pathway #5 - Graduates of Foreign Nursing Schools (Outside of the U.S. and U.S. Territories)," accessed April 1, 2026.
44 Lysa Balboa, "Licensure Pathways for Internationally Educated Nurses in the United States (2026 Outlook)," NEAC Medical Exams Application Center (blog), January 15, 2026.
45 Balboa, "Licensure Pathways."
46 North Carolina Hospital Association, "Child Care Issues Are Driving Women Out of Healthcare: Benefits Can Bring Them Back." (white paper, 2023); Shruti Jolly et al., "Gender Differences in Time Spent on Parenting and Domestic Responsibilities by High-Achieving Young Physician-Researchers," *Annals of Internal Medicine* 160, no. 5 (March 4, 2014): 344–353.
47 Among the 52,000 U.S.-born underemployed health-care professionals in New York State, women with children under age 18 at home accounted for 33 percent.
48 Benjamin Oreskes, Eliza Shapiro, and Grace Ashford, "Hochul and Mamdani Announce Plan to Make N.Y. Child Care Universal," *New York Times*, January 12, 2026.

Asian immigrants were the largest regional group among underemployed health-care workers in New York City and New York State, with the top countries of origin being the Philippines, China (including Hong Kong), and India.

TABLE 7

Educational and Demographic Characteristics of Underutilized Immigrant Health-Care Professionals (ages 25–64), by Geography, 2024

	United States	New York State	New York City	Other Urban Areas	Rural Counties
Underutilized immigrants	**310,000**	**24,000**	**16,000**	**6,000**	**3,000**
Internationally educated	61%	46%	53%	44%	55%
Time in the United States					
0–5 years	28%	16%	21%	11%	25%
6–10 years	15%	13%	14%	11%	10%
11 or more years	58%	71%	66%	78%	66%
Female	81%	76%	77%	82%	83%
Age: 55–64	23%	19%	27%	26%	28%
English proficient	62%	68%	65%	67%	78%
Top 3 countries of origin					
Country 1	Philippines	Philippines	Philippines	India	Philippines
Share of total	14%	9%	14%	11%	13%
Country 2	Mexico	China	China	Philippines	Jamaica
Share of total	8%	6%	10%	9%	11%
Country 3	India	India	India	China	Canada
Share of total	8%	6%	9%	7%	6%

Notes: The universe in this table is persons with a college degree in medical and health sciences and services. In this table, China includes Hong Kong.
Source: Data in this table for the United States and New York State are based on MPI tabulation of 2024 ACS data. Pooled 2020–24 ACS data were used to generate robust estimates for the smaller geographies of New York City, other urban areas, and the state's rural counties.

B. Legal Status

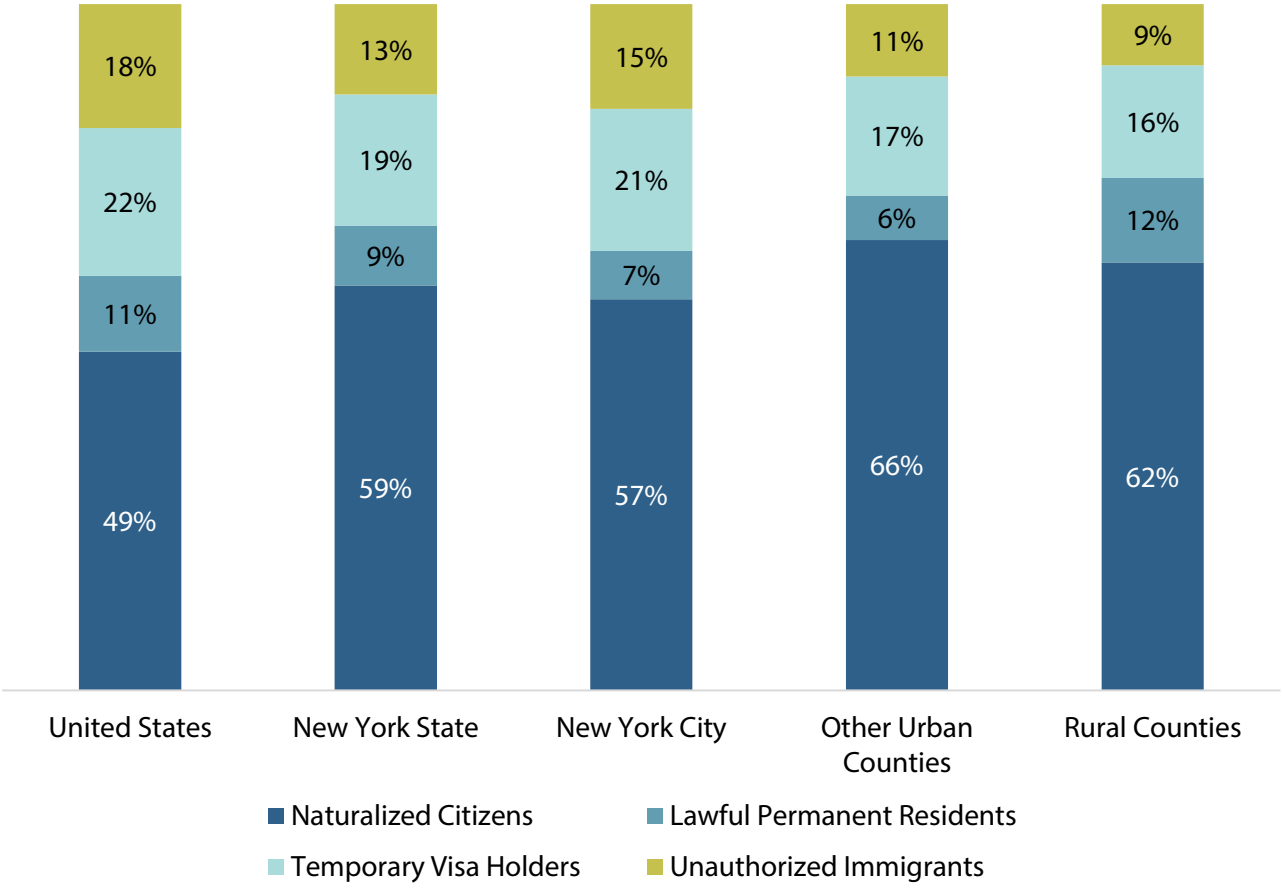
Immigration status is another key determinant of skill underutilization. Naturalized U.S. citizens, lawful permanent residents (i.e., green-card holders), workers on temporary visas (such as J-1 or H-1B visas), and immigrants with approved refugee or asylee status generally face a lower risk of underemployment because they are authorized to work. By contrast, unauthorized immigrants who are ineligible for work permits and some humanitarian migrants, such as TPS holders, whose status (and thus their eligibility for work authorization) has been revoked in recent months face significantly greater obstacles to finding jobs commensurate with their education and skills.

In New York State, 87 percent of underutilized immigrant health-care professionals in 2023 were naturalized U.S. citizens, lawful permanent residents, or holders of various temporary visas (a group likely to include

both temporary visa holders and their spouses, some of whom face work restrictions), as shown in Figure 1. Approximately 13 percent of underutilized immigrant health-care professionals in New York were unauthorized immigrants,[49] lower than the nationwide share (18 percent).

FIGURE 1

Legal Status of Underutilized Immigrant Health-Care Professionals (ages 25–64), by Geography, 2023



Note: The universe in this figure is persons with a college degree in medical and health sciences and services.
Source: These 2023 estimates result from MPI analysis of data from the 2019–23 ACS, pooled, and the 2023, 2022, and 2008 Survey of Income and Program Participation, weighted to 2023 unauthorized immigrant population estimates provided by Jennifer Van Hook of The Pennsylvania State University. For more on the methodology used in this analysis, developed by MPI researchers in partnership with Van Hook and James Bachmeier of Temple University, see MPI, "MPI Methodology for Assigning Legal Status to Noncitizen Respondents in U.S. Census Bureau Survey Data," accessed August 2, 2026.

Work authorization can be a determining factor for many immigrant professionals. Even when immigrants are professionally qualified and have made progress through credentialing processes, employer and worker uncertainty about work authorization—particularly for individuals whose status is in flux or has been terminated—can derail employment opportunities.

49 In this analysis using MPI's legal status methodology, unauthorized immigrants refer to persons who entered the United States illegally, generally by crossing the border with Mexico, or who overstayed or otherwise violated the terms of their visas. MPI estimates of the unauthorized immigrant population include some groups with temporary forms of protection from deportation, sometimes called "liminal" or "twilight" status, that are discretionary and can be revoked. These groups include recipients of Temporary Protected Status (TPS) and Deferred Action for Childhood Arrivals (DACA), humanitarian parolees, recipients of deferred action other than DACA, and those with pending asylum applications.

At the same time, the presence of large cohorts of naturalized citizens and lawful permanent residents among the underemployed underscores the fact that legal status alone does not resolve barriers to professional employment; credential recognition, language barriers, and employer bias operate independently of legal status. One program manager commented that fear of immigration enforcement has also emerged as a significant barrier since early 2025, observing that immigrant participants, including those with a valid legal status, have expressed anxiety about attending classes, participating in public programs, or sharing their stories publicly[50]—a "chilling effect" that may suppress participation in training and language programs even among those who are legally authorized to work.

C. *English Proficiency and Languages Spoken*

Representatives of programs serving internationally trained professionals have reported that the biggest challenges their students face are achieving English proficiency and gaining familiarity with the culture and organization of the U.S. health-care system. One program director noted that bilingual and bicultural competencies are in high demand by employers, but that candidates often need structured support to translate those competencies into the U.S. professional context.[51]

As of 2024, 32 percent of underemployed immigrants with medical and health-related degrees in New York State were limited English proficient (LEP) and therefore likely to face difficulties navigating complex licensing processes, competing in job interviews, and using professional vocabulary in English.

Several interviewees called for more contextualized English language instruction specifically designed for health-care professionals, emphasizing medical vocabulary, patient interaction scenarios, and U.S. clinical culture. As one program director observed, the pool of applicants who meet minimum English language requirements for bridge programs is far smaller than the total population of internationally trained professionals seeking help.[52] A major challenge is the shortage of English as a Second Language courses in adult education programs nationwide, especially for those seeking language instruction geared toward high-skilled professionals.[53] This shortage of programs serving adult English learners limits access to bridge programs for professionals who cannot meet the minimum language requirements. The consequences worsen over time: The longer professionals remain outside their field, the harder it becomes to reenter it, as employers tend to favor candidates with recent work experience.

A major challenge is the shortage of English as a Second Language courses in adult education programs nationwide, especially for those seeking language instruction geared toward high-skilled professionals.

50 Authors' interview with a stakeholder who manages a program that supports adults pursuing health-care careers, March 17, 2026.
51 Authors' interview with a dean in an institution of higher education, March 9, 2026.
52 Authors' interview with a stakeholder in charge of an education and training program in an institution of higher education, March 13, 2026.
53 Jacob Hofstetter and Margie McHugh, "Leveraging Data to Ensure Equitable and Effective Adult Skills Programming for Immigrants" (policy brief, MPI, Washington, DC, 2023); Benjamin M. James et al., *Adult Education ESL in the United States: A Systematic Literature Review* (New York: Teachers College, Columbia University, Community College Research Center, 2026).

TABLE 8

Linguistic Profile of Underutilized Immigrant Health-Care Professionals (ages 25–64) and Limited English Proficient (LEP) Residents of Selected Geographies, 2024

	United States	New York State	New York City	Other Urban Counties	Rural Counties
Top 7 languages spoken by underemployed immigrant health-care professionals					
Total underemployed	310,000	24,000	16,000	6,000	3,000
Language 1	**Spanish**	**Spanish**	**Spanish**	**Spanish**	**Spanish**
Share	25%	19%	19%	14%	19%
Language 2	**Tagalog**	**Chinese**	Tagalog	**Chinese**	**Tagalog**
Share	12%	7%	7%	8%	13%
Language 3	**Chinese**	Tagalog	**Russian**	Tagalog	**Russian**
Share	5%	7%	7%	7%	5%
Language 4	**Arabic**	**Bengali**	**Chinese**	**Haitian Creole**	**Chinese**
Share	3%	6%	5%	5%	147
Language 5	**Korean**	**Russian**	**Bengali**	**Arabic**	Amharic
Share	3%	5%	4%	4%	3%
Language 6	Portuguese	**Haitian Creole**	Korean	**Bengali**	German
Share	2%	5%	3%	3%	3%
Language 7	Russian	**Arabic**	Urdu	Malayalam	Portuguese
Share	2%	3%	3%	3%	3%
Top 7 languages spoken by LEP residents					
Total LEP population	28,883,000	2,707,000	1,871,000	568,000	268,000
Language 1	**Spanish**	**Spanish**	**Spanish**	**Spanish**	**Spanish**
Share	64%	48%	46%	50%	57%
Language 2	**Chinese**	**Chinese**	**Chinese**	Yiddish	**Chinese**
Share	7%	15%	19%	11%	6%
Language 3	Vietnamese	Yiddish	**Russian**	**Chinese**	Arabic
Share	3%	4%	5%	7%	2%
Language 4	**Tagalog**	**Russian**	**Bengali**	**Haitian Creole**	**Russian**
Share	2%	4%	5%	4%	2%
Language 5	**Korean**	**Bengali**	Yiddish	**Bengali**	Penn. Dutch
Share	2%	4%	3%	3%	2%
Language 6	**Arabic**	**Haitian Creole**	Haitian Creole	Urdu	**Tagalog**
Share	2%	3%	2%	2%	2%
Language 7	Haitian Creole	**Arabic**	Arabic	**Arabic**	Italian
Share	2%	2%	2%	2%	2%

Notes: The universe in the top panel of this table is persons with a college degree in medical and health sciences and services. Bolded languages highlight where there is overlap in the top languages spoken by a geography's underutilized immigrant health-care professionals and its LEP residents. "Chinese" includes Mandarin, Cantonese, and Chinese; "Tagalog" includes Filipino; and "Amharic" includes other Ethiopian languages.

Sources: The top panel of the table is based on MPI tabulation of 2024 ACS data for the United States and New York State. Pooled 2020–24 ACS data were used to generate robust estimates for the smaller geographies of New York City, other urban areas, and the state's rural counties. Data for the bottom panel are from the 2024 ACS for all geographies.

Yet if these issues can be addressed, immigrant professionals' linguistic diversity can be a major boon for health-care systems. Research shows that LEP patients are more likely to have difficulty communicating their symptoms to English-only health-care professionals. Communication difficulties increase the risk of misdiagnosis[54] and are more likely to lead patients to disregard medical advice.[55] Underemployed immigrant professionals speak a broad array of languages that could be an asset for New York's health-care system. Spanish, Chinese, Bengali, Russian, Haitian Creole, and Arabic are among the most common languages spoken by underemployed immigrant health-care professionals in New York and also feature among the top languages spoken by the state's LEP population (shown in bold in Table 8).

4 Reducing Brain Waste in New York: Lessons from Other States and Countries

The challenges New York faces to unlocking the potential of underemployed immigrant health-care professionals are not unique. Other U.S. states and other countries with large numbers of skilled immigrants have grappled with similar pressures: growing demand for health-care workers, a substantial pool of internationally trained professionals already living within their borders, yet credentialing, licensing, and other structural barriers that often keep those professionals out of practice.

The Organization for Economic Cooperation and Development (OECD) has reported that internationally trained individuals have higher rates of brain waste than their native-born counterparts across countries and professions.[56] Over the past decade, numerous U.S. states and countries have developed models to address this challenge. As of mid-2026, 27 U.S. states, including New York, had legislation creating alternative licensure pathways for internationally trained physicians.[57] At the same time, countries such as Canada and some EU Member States have invested in building broader institutional capacity to smooth the transition of internationally trained health-care workers into practice.

These efforts offer approaches that New York and other states could consider. Promising models fall into the following categories: (1) alternative pathways to licensure; (2) expedited credential recognition; (3) supervised practice as a bridge to full licensure; (4) bridging programs combining vocational and language training; and (5) linking licensure to service in underserved areas.

54 George Contreras, "Hispanic Heritage Month Spotlight," *Journal of Emergency Medical Services*, October 15, 2024.

55 Elisabeth Wilson et al., "Effects of Limited English Proficiency and Physician Language on Health Care Comprehension," *Journal of General Internal Medicine* 20, no. 9 (2005): 800–06; Emma M. Steinberg et al., "The 'Battle' of Managing Language Barriers in Health Care," *Clinical Pediatrics* 55, no. 14 (2016): 1318–27.

56 See Organization for Economic Cooperation and Development (OECD), *International Migration Outlook* (Paris: OECD Publishing, various years).

57 Of the 27 states, 25 enacted this type of legislation between 2021 and 2026, while two other states (New York and Montana) had legislation to allow internationally trained physicians to apply for state licenses prior to 2021. It is important to note that enacted legislation does not mean that internationally trained physicians can immediately access these pathways, as the regulatory rulemaking process required to implement new licensing procedures can be lengthy. See World Education Services (WES), "27 States Expand Pathways for Internationally Trained Physicians in 2026," accessed September 20, 2026. See also WES and Council of State Governments (CSG), *From Policy to Practice: Why States Need Better Data to Advance the Impact of Alternative Pathways to International Physician Licensure* (N.p.: WES and CSG, 2025); WES, "Legislative Strategies: How Three States Responded to Physician Shortages," accessed March 18, 2026.

A. Alternative Pathways to Full Licensure

The traditional pathway to medical practice in the United States for internationally trained physicians is long, demanding, and costly. It involves completing medical school abroad, obtaining Educational Commission for Foreign Medical Graduates certification, and similar to U.S. medical students, passing multiple licensing examinations and completing a U.S.-based medical residency of two to four years.[58] This process often excludes large numbers of internationally trained physicians who have already practiced abroad because it would require them to retake licensing exams, this time in the United States, and repeat residency training to gain U.S.-based experience, regardless of their prior record. In practice, this process requires professionals to devote extra time and financial resources to exam preparation and generally low-paid residencies—barriers that delay or prevent many from entering the health-care workforce. A growing number of states have sought to create alternative pathways that maintain rigorous standards while reducing unnecessary barriers for experienced professionals.

BOX 1
New York's Pathways for Internationally Trained Physicians

On the surface, internationally trained doctors appear to have options to practice in New York because there are three routes to medical practice: (1) the standard international medical graduate (IMG) pathway to a full license (i.e., through demonstrating completion of equivalent post-graduate training); (2) endorsement of a license granted by a country other than the United States or Canada; and (3) a two-year (renewable once) limited license to practice under the supervision of a New York State-licensed physician in a certain setting.

In practice, however, each pathway is narrow and rigid. The first requires three years of U.S. residency or substantial equivalency—an often-insurmountable barrier for experienced physicians who have already completed postgraduate training and years of independent clinical practice abroad. An estimated 80 to 90 physicians obtain full licenses through this route each year. The second route is used by a small number of physicians, primarily those sponsored by hospitals arriving directly from abroad on temporary visas. The third offers no pathway to permanent licensure after four years of practice (two years on the initial temporary permit, with an option to extend it for two more years). As of 2025, roughly 3,000 IMGs held such provisional permits in New York.

Assembly Bill A7319, introduced by Assemblywoman Catalina Cruz in 2025 and amended in February 2026, would create a supervised pathway to full licensure for internationally trained physicians practicing in shortage areas. As of late 2026, the bill remains in the Assembly Higher Education Committee, as does its Senate companion (S7840A), which has bipartisan sponsorship. Neither advanced during the 2026 session.

Note: The 2025 bill would establish "an internationally trained physician licensure pathway program to allow qualified, foreign-trained physicians and physicians trained and/or licensed to practice medicine in a territory or possession of the United States to contribute to the health-care system through supervised practice in designated shortage areas, ultimately leading to full licensure." See New York State Senate, "Assembly Bill A7319A: Establishes an Internationally Trained Physician Licensure Pathway Program," 2025–2026 Legislative Session, March 25, 2025.
Sources: World Education Services (WES) and Council of State Governments (CSG), *From Policy to Practice: Why States Need Better Data to Advance the Impact of Alternative Pathways to International Physician Licensure* (N.p.: WES and CSG, 2025); New York State Education Department, "License Requirements for Physicians," updated November 30, 2020.

58 Welcome Back Centers, "U.S. Licensing Process for Foreign-Trained Physicians" (fact sheet, revised March 2016).

Alternative Pathways for Physicians: U.S. State Models

Illinois was among the first states to enact legislation to create a formal alternative pathway to full physician licensure. Eligible IMGs may apply for a limited license and progress to full licensure after meeting specific qualifications and completing a supervised practice period. Other states have enacted similar legislation, including Arkansas, Florida, Iowa, Louisiana, Massachusetts, Texas, Virginia, and Wisconsin.[59] For example:

- Arkansas has established an alternative pathway to licensure for internationally trained physicians that allows eligible candidates to practice under a provisional license for up to two years with a licensed health-care provider serving a medically underserved area. After completing two years of provisional practice, the internationally trained physicians may apply for a full medical license without completing a U.S. residency. Separately, the statute requires three consecutive years of employment with the sponsoring provider, establishing a retention and continuity expectation beyond the provisional period.
- Wisconsin's newly implemented alternative pathway to licensure for internationally trained physicians allows eligible candidates to practice under supervision with a provisional license. After three years of full-time consecutive practice, they may convert their provisional license to a full, unrestricted license without completing a U.S.-based medical residency.
- Colorado established a reentry license pathway for internationally trained physicians, requiring only one year of U.S. supervised practice—compared to the standard three years—for physicians returning to clinical work after a period out of practice.[60]

Expanding Alternative Pathways Beyond Physicians

While most policy attention has focused on physicians, a growing number of states are extending alternative pathways to nurses, dentists, mental health professionals, and allied health practitioners. Hawaii and Kentucky, for example, have created temporary permits for internationally trained nurses completing licensure requirements. Massachusetts now has a Limited Dental License for internationally trained dentists who face many of the same structural barriers as physicians but have received far less legislative attention.[61]

B. Expedited Credential Recognition

Several EU countries, including Ireland, Germany, and Latvia, have sought to speed up recognition procedures for "frequently seen qualifications"—that is, qualifications from non-EU countries with a history of positive recognition decisions. For instance, Ireland introduced in 2023 a sample qualification assessment for nurses from India and the Philippines.[62] This approach to licensing applies to all general nursing qualifications issued by the two countries and removes the need for a case-by-case assessment. The Nursing and Midwifery Board of Ireland does a review to ensure that applicants from India and the

59 Authors' interview with a stakeholder in an organization that focuses on federal and state advocacy for policies reducing barriers to employment for college-educated immigrants, April 15, 2026.
60 Denise Bell, *Opportunity by Design: How States Turn Immigration into Economic Advantage* (Washington, DC: Niskanen Center, 2025).
61 Bell, *Opportunity by Design.*
62 Maria Vincenza Desiderio, *Verifying and Benchmarking Non-EU Nursing Qualifications Against EU Standards: Advanced Tools and Support Mechanisms* (Brussels: TruMerit, 2026).

Philippines meet basic criteria (e.g., having three years of full-time training, meeting minimum theory and clinical placement thresholds) before issuing a letter that enables candidates to then apply for a short-term work permit and complete the registration procedure by either passing a competency test or working for a short 6–12 week (paid) adaptation period.[63] Germany and Latvia have adopted similar approaches, applying expedited sample assessments to qualifications from trusted institutions with an established track record of recognition.

C. *Supervised Practice as a Bridge to Full Licensure*

One feature of many models is a period of supervised practice in lieu of traditional post-graduate clinical training, such as a medical residency program. This approach recognizes that many internationally trained professionals have years of training and independent clinical practice abroad and need an opportunity to demonstrate competence within the destination-country health-care system, rather than being required to repeat training they have already completed.

Canada's Practice-Ready Assessment (PRA) programs offer rigorous frameworks for reducing unnecessary barriers. Nine provinces in Canada have their own PRA programs, which provide licenses to internationally trained doctors who have completed their postgraduate training and worked in independent clinical practice outside of Canada.[64] All nine programs offer a clinical workplace-based assessment period of up to 12 weeks, most focused on family medicine. On completing this assessment period, participants then sign a "return of service" agreement to work in an area of high need for three to five years, before receiving their full license to practice anywhere in the province. Although the exact model varies by province, PRA programs further several goals simultaneously: They provide a credible competency assessment, protect patient safety, generate outcome data, and help address the uneven geographic distribution of health-care workers.

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D. *Bridging Programs: Combining Vocational and Language Training*

Even where alternative licensure pathways exist, internationally trained health-care professionals frequently need structured support to prepare for licensing examinations, build familiarity with the destination-country health-care system and workplace culture, and develop the specialized professional language skills their field requires. Examples of programs from the United States, Canada, and Europe that seek to address these needs include:

- **United States:** One well-established model is the Welcome Back Initiative, a network of centers across the nation founded in 2001. New York is home to two of these centers, the New York City Welcome

63 Desiderio, *Verifying and Benchmarking Non-EU Nursing Qualifications*.
64 Medical Council of Canada, "Practice-Ready Assessment," accessed March 10, 2026.

Back Center at LaGuardia Community College in Long Island City and the Syracuse-area Healthcare Advancement Resource Center hosted by Le Moyne College.[65] Drawing on both public workforce-related funding and private foundation support, these centers focus on individualized educational case management: Case managers assess each participant's educational and professional background, comparing it with U.S. standards for that profession, and then develop a career pathway plan that builds on the participant's existing skills and experience.[66] To address some employers' reluctance to hire immigrant and refugee health-care professionals, the Welcome Back Centers in New York and Upwardly Global, a nonprofit that also supports internationally trained immigrants seeking to restart their careers, help build alumni networks that connect program graduates with potential employers.[67]

- **Canada:** Canadian provinces and territories offer an array of bridging programs for health-care professionals, often delivered in partnership with educational institutions, with funding available from the federal government through its Foreign Credential Recognition Program.[68] Immigration, Refugees, and Citizenship Canada also funds the Pre-Arrival and Post-Arrival Supports and Services program for internationally trained nurses, which includes some online communication courses and guidance on navigating the recognition process.[69] The province of Ontario offers:[70]
  - → *For nurses,* the STARS program (Supports, Training, and Access to Regulated-Employment Services), funded by the province, offers a combination of mentorship, one-on-one case management, and courses to help nurses prepare for the licensing exam and build associated communication and technical skills.[71] The Ontario Internationally Educated Nurses Course Consortium runs a competency bridging program (also funded by the province) that covers orientation, transition to practice requirements, technical skills, clinical placement, and a professional practice course. Completion allows graduates to sit for the entry-to-practice exam for registered nurse.[72]

65 LaGuardia Community College, "NYC Welcome Back Center," accessed March 1, 2026; Le Moyne College, "Healthcare Advancement Resource Center (HARC)," accessed March 1, 2026.

66 With support from the Mother Cabrini Health Foundation, LaGuardia has recently expanded the New York City center beyond its traditional focus on nurses to serve a wider range of internationally trained health-care professionals, enrolling eligible participants in contextualized health-care bridge courses for English learners and piloting an alumni outreach project to create a professional network that helps participants navigate barriers and achieve their language, training, and employment goals. See LaGuardia Community College, "LaGuardia Receives $1.2 Million Grant from Mother Cabrini Health Foundation to Enhance Program for Internationally-Trained Healthcare Professionals," updated January 22, 2025.

67 See, for example, Upwardly Global, "Welcome to the UpGlo Alumni Network," updated April 21, 2026.

68 The program provides funding to provinces and territories and other eligible entities (e.g., regulatory bodies, credential association agencies, national associations) as well as providing some direct support through loans that can cover related expenses. Starting in 2026–27, Employment and Social Development Canada will spend CAD 97 million over five years on the Foreign Credential Recognition Action Fund, which will work with provinces and territories on improving and expediting credential recognition procedures, particularly in construction and health care. See Employment and Social Development Canada, "Employment and Social Development Canada's 2026 to 2027 Departmental Plan," updated March 16, 2026.

69 CARE Centre for Internationally Educated Nurses, "Services," accessed April 30, 2026.

70 The Ontario Bridge Learning Program compiles many of these programs as a central resource. See, for example, related courses in home health care and health-care data, as well as programs geared toward other licensed professions (e.g., early childhood education, engineering, and construction). See Government of Ontario, "Adult Learning: Ontario Bridge Training Program," updated November 4, 2025.

71 CARE Centre for Internationally Educated Nurses, "Supports, Training, and Access to Regulated-Employment Services (STARS)," accessed April 1, 2026.

72 Ontario Internationally Educated Nurses Course Consortium, "Overview," accessed March 5, 2026.

- → *For pharmacists*, the International Pharmacy Graduate Program at the University of Toronto provides 23 weeks of online training on pharmacy practice and the Canadian health-care system,[73] with financial assistance of up to CAD 5,000 to help cover tuition costs.[74]

- **Sweden:** Sweden's Fast Tracks program covers more than 30 professions, including doctors, nurses, dentists, teachers, builders, and social workers.[75] Medical professionals seeking a license in Sweden can sign up for a course in Swedish designed for medical professionals. These courses last for up to 18 months, depending on the candidate's Swedish proficiency, and combine intensive Swedish language classes with professional courses on medical Swedish, the Swedish health-care system and surrounding culture, medical record keeping, and medical law and training.[76] The program is geared toward new arrivals (those who have been in Sweden for less than three years), but it is also open to longer-term residents.

E. Linking Licensure to Service in Underserved Areas

One finding across states and nations is that by linking access to newly created pathways to practice in geographic areas experiencing a shortage of health-care workers, policymakers can help solve two problems at once: They create a pathway for professionals to practice in the field for which they were trained while directing them to where they are most needed.

Canada's PRA programs, described above in Section 4.C., are among the most developed examples of this model. By requiring a three-to-five-year service commitment in an underserved area, these programs ensure that a province's publicly subsidized investment in health professionals' licensure produces a visible public benefit. Along similar lines, as of 2026, Washington State has 50 internationally trained physicians who are licensed through the state's alternative pathway, and most of them provide care in designated Health Professional Shortage Areas.[77] Similarly, legislation in Nevada and Minnesota requires internationally trained physicians eligible for an alternative licensure pathway to first complete service in a rural or medically underserved area.[78]

These models are instructive for New York and other states because they demonstrate that licensing and other workforce reforms benefiting immigrant professionals—a topic that might seem politically fraught—can attract bipartisan legislative support.

Overall, these models are instructive for New York and other states because they demonstrate that licensing and other workforce reforms benefiting immigrant professionals—a topic that might seem politically

73 Leslie Dan Faculty of Pharmacy, University of Toronto, "International Pharmacy Graduate Program," accessed April 15, 2026.
74 Government of Ontario, "Ontario Bridging Participant Assistance Program," accessed March 15, 2026; Leslie Dan Faculty of Pharmacy, University of Toronto, "Tuition and Financial Assistance," accessed May 15, 2026.
75 United Nations Educational, Scientific, and Cultural Organization, "Lifelong Learning Toolkit—Fast Track Initiative in Sweden," accessed March 10, 2026.
76 Svenska för Yrkesutbildade, "Svenska för Medicinsk Personal," accessed March 19, 2026.
77 WES, "27 States Expand Pathways."
78 WES, "Legislative Strategies."

fraught—can attract bipartisan legislative support, in part because of these policies' broad public health benefits.

F. Data Collection as a Strategic Necessity

Robust data can be indispensable when designing and refining workforce policies such as these. Yet a 2025 study found that of seven surveyed U.S. states with alternative physician licensure pathways, nearly all lacked data systems to track how many internationally trained physicians had been licensed through alternative routes, where they practiced, how many patients they treated, and what patient outcomes were.[79] Washington State, the exception, was able to demonstrate that most IMGs had been placed in underserved areas—data that have become powerful evidence used to advocate for expanding the program.[80]

Some other states have also collected data to inform how they address underemployment. Pennsylvania and Utah conducted a survey of internationally trained professionals to understand the composition of this population and the key barriers to employment these professionals face.[81] In contrast, the New York State Board of Medicine (part of the New York State Education Department's Office of the Professions)[82] does not disaggregate licensure data by pathway, making it difficult to assess the scale or impact of existing routes for internationally trained physicians to practice in the state.

5 Conclusion and Recommendations

New York State's health-care system faces a convergence of demographic, workforce, and policy pressures that together threaten the state's ability to ensure access to quality care for its diverse and aging population. The number of New Yorkers ages 65 and older grew by 39 percent between 2010 and 2024, steadily driving up demand for health-care services. At the same time, the state health-care workforce itself is aging, with nearly one in five physicians and registered nurses within ten years of retirement. Shortages already exist, particularly in rural areas and underserved communities, and are projected to grow.

New York has long relied on immigrant professionals to sustain its health-care system. Immigrants account for 37 percent of the state's physicians and 29 percent of its nurses—among the highest shares nationwide—and that dependence is not diminishing. What is changing is the availability of new internationally trained professionals to enter the state's workforce. Trump administration immigration policies, including those focused on high-skilled workers as well as broader measures, are likely to significantly constrict the flow of health-care professionals from abroad. The effects are already being felt in rural areas. At the same time, federal health-care financing changes are intensifying the pressures on health-care systems and patients.

79 WES and CSG, *From Policy to Practice*.
80 Washington State, which created a temporary license option for internationally trained physicians in 2021, updated this policy to permit such physicians to transition to full licensure in 2026.
81 Bell, *Opportunity by Design*; Pennsylvania Department of State, *New Pennsylvanians Licensure Survey: Results & Analysis* (Harrisburg: Pennsylvania Department of State, 2021).
82 New York State Education Department, Office of the Professions, "Medicine," accessed March 1, 2026.

A. Summary of Key Findings

This study's analysis of 2024 ACS data indicates that at least 24,000 immigrant New Yorkers with college degrees in health and medical sciences are either employed in low-skilled jobs, unemployed but seeking work, or out of the labor force entirely. There are two important caveats to keep in mind. First, because the ACS records only undergraduate degree fields, this figure is likely to be an underestimate: Individuals who hold advanced clinical degrees, but whose undergraduate majors were outside the health sciences, are not captured, meaning the true population of underemployed immigrant New Yorkers with clinical training is likely larger. Second, not all members of this population are equally recruitable. The 52 percent of underemployed immigrant New Yorkers with health and medical degrees who are not in the labor force include some who have retired or face limitations that preclude returning to the workforce. Effective intervention will require the kind of targeted professional survey that Pennsylvania has conducted,[83] assessing motivation, readiness, and the specific barriers these professionals face.

Stakeholder interviews and quantitative analysis point to the following set of common barriers:

- **Credentialing and licensing barriers.** For the 52 percent of underemployed immigrants not in the labor force, reasons may include child-care responsibilities, prolonged periods not in practice, or discouragement after repeated credential rejection. About 71 percent of underutilized immigrant health-care college graduates have lived in the United States for more than ten years, and extended absence from professional practice can make reentry difficult. The standard U.S. pathway to physician practice requires a minimum of three years of U.S. medical residency—a process that is long, competitive, costly, and out of reach for many older professionals and those with competing family responsibilities, including U.S.-born individuals who obtained their medical education abroad. New York has pathways to full licensure for some internationally trained physicians, but in practice they serve relatively few: An estimated 80 to 90 physicians obtain full licenses each year, while roughly 3,000 hold time-limited practice permits with no pathway to permanence once those permits expire. Nurse credentialing in New York relies on a single recognized evaluation service. In contrast, other states accept evaluation reports from multiple evaluation services.
- **Limited English language instruction.** Among New York State's underemployed immigrant health-care professionals, 32 percent are limited English proficient. Yet the state's adult education system, like many around the country, serves only a small share of adult English learners. Moreover, most courses address the needs of lower-level English learners, not more advanced students seeking to learn field-specific English. Without foundational language support, underemployed professionals cannot access bridge programs that could prepare them for licensing exams, since those programs require higher levels of English proficiency.
- **Employer bias.** An estimated 46 percent of underemployed immigrant health-care professionals in New York obtained their degrees abroad. Recruitment agencies and hospital human resources departments tend to favor U.S.-trained candidates, a preference that can disadvantage internationally trained professionals and prevent their qualifications from reaching hiring decisionmakers.

83 See Section 4.F. of this report and Pennsylvania Department of State, *New Pennsylvanians Licensure Survey*.

- **Inflexible funding mechanisms.** In New York State, 76 percent of underemployed immigrant health-care professionals are women, reflecting in large part the disproportionate burden of caregiving responsibilities that pushes some women out of the labor force. In addition, 19 percent are between ages 55 and 64. Several community college programs in the state serve the underemployed professional population effectively, but their funding is often tied to strict employment-outcome requirements that older, nontraditional students and those with competing family responsibilities—regardless of their place of education—cannot reliably meet within the allotted timeframes, limiting who can be served and how.
- **Fear and legal uncertainty.** An estimated 13 percent of underemployed immigrant health-care professionals in New York are unauthorized immigrants or hold precarious statuses such as Temporary Protected Status (TPS) or Deferred Action for Childhood Arrivals (DACA). This translates to roughly 3,000 individuals with extremely limited pathways to licensure, regardless of their clinical skills, in part because the federal government has moved to terminate programs such as TPS and DACA that grant work authorization and protection from deportation. Beyond those directly affected, state stakeholders have reported that a broader chilling effect may be suppressing immigrants' participation in community college courses and that even participants with valid legal status have expressed anxiety about enrolling in public training institutions.

B. Recommendations

The consistent lesson from both other states and international experience is that addressing these barriers will require not isolated program interventions but a coherent strategy that coordinates regulatory reform, language support, employer engagement, and financial support for professionals during their reentry into the health-care workforce.[84] Five priorities for action are:

- **Invest in contextualized English language instruction at scale.** Countries such as Sweden and Canada invest heavily in contextualized language training. New York State could consider funding integrated health-care language programs through the State University of New York, City University of New York, and community-based providers on a broad scale.
- **Accept credential evaluation reports for internationally trained nurses from multiple providers.** Several states, including Texas and Illinois, accept reports from multiple credential-evaluation providers as part of internationally educated nurses' licensing application, reducing costs and wait times. At the same time, other states could adopt New York's approach to language testing for nurses, in which passing a separate English language test is not required because passing the English-only nursing licensing exam is considered sufficient.
- **Create a pathway from temporary to full licensure for physicians.** New York could consider revising its existing pathways to allow a greater number of internationally trained physicians who currently hold temporary practice permits and work under supervision to convert those permits to permanent licensure, along the lines of what has been proposed in Assembly Bill A7319, put forward by

84 Institute on Immigrant Integration Research and Policy, Rockefeller Institute of Government, State University of New York, "Engineering Cohesive Communities."

Assemblywoman Catalina Cruz. This would involve replacing the current license that terminates in four years with a defined pathway to permanent practice that could be modeled on the provisional license frameworks enacted in Illinois, Washington, and more than a dozen other U.S. states.

- **Provide financial support during the reentry period.** Stipends or bridge grants during intensive exam preparation and credentialing phases would help health-care professionals in low-wage survival employment to focus on their licensing exams. Multiple interviewed stakeholders identified this support as a particularly effective near-term intervention for the population of internationally trained health-care workers already living in New York.
- **Improve data collection.** New York's current inability to disaggregate licensure data by the pathway health-care professionals used to obtain their license is an obstacle to evidence-based reforms to improve licensing options. By contrast, Washington State's ability to demonstrate that most of its alternative-pathway physicians practice in parts of the state experiencing health-care shortages has become a powerful tool for program expansion and more informed policymaking.

C. *The Path Forward*

Enabling more internationally trained professionals to practice does not require lowering standards. Early evidence from Washington State suggests that supervised practice periods, combined with structured competency assessment, can address patient safety concerns while also creating the U.S. clinical experience that employers and licensing boards require.[85] Progress in peer states has typically required aligning at least three elements: a legislative champion willing to persist across multiple sessions, a workforce crisis visible enough to create a sense of political urgency, and employer support. New York has the first in Assemblywoman Cruz's sustained legislative effort. The second is arriving—slowly in New York City and other urban areas, more urgently in rural upstate communities already losing physicians to retirement and seeing facilities close. At the same time, the federal government's immigration restrictions are likely to aggravate the crisis these shortages represent. Building the third element—employer support—will require deliberate engagement with hospital associations on terms that address their interests, including liability frameworks, supervision structures, and the demonstrated safety record of supervised practice in states that have already moved forward with reforms.

At the heart of all three elements is whether the state treats its underemployed health-care professionals as a strategic asset to be activated. An estimated 8 million New Yorkers live in federally designated Health Professional Shortage Areas and would benefit from better access to primary care physicians, dentists, mental health specialists, and other health-care professionals. Underemployed immigrant health-care professionals, beyond adding to the number of health-care workers in the state, could help meet its need for linguistically and culturally competent care: These immigrants speak the languages of New York's limited English proficient patient populations, such as Spanish, Chinese, Bengali, Russian, Haitian Creole, and Arabic. The benefits are thus clear. To access them, New York can leverage its well-established and connected higher education and workforce institutions, and build on promising models from other states and countries.

85 Authors' interview with a stakeholder in an organization that focuses on federal and state advocacy for policies reducing barriers to employment for college-educated immigrants, April 15, 2026.

Appendices

Appendix A. Research Approach and Key Definitions

This report draws on both quantitative and qualitative research methods.

Quantitative research. To estimate the extent of skills underutilization among college-educated immigrants with health and medical degrees by state and county and the characteristics of these underutilized professionals, Migration Policy Institute (MPI) researchers analyzed data from the U.S. Census Bureau's 2024 American Community Survey (ACS). To ensure the robustness of estimates for smaller geographies—New York City, other urban areas, and rural counties—the researchers used pooled 2020–24 ACS data.

The study population is adults ages 25–64 who have degrees in medical and health sciences and services and who were employed in low-skilled jobs, unemployed but seeking employment, or were out of the labor force. The analysis differs from earlier MPI work on immigrant skill underutilization by including college-educated immigrants of prime working age (ages 25–64) who are not engaged in the labor force as part of the pool of untapped talent.

Definitions used in this data analysis:

- **Medical and health-related degrees:** Although many of the immigrants in this sample may also hold advanced degrees, the ACS collects information only on respondents' undergraduate degree majors. Degrees in medical and health sciences and services include nursing; treatment therapy professions; pharmacy, pharmaceutical sciences, and administration; communication disorders sciences and services; health and medical administrative services; medical technology technician professions; and community and public health.
- **Low-skilled jobs.** Drawing on O*NET, the U.S. Department of Labor's online database of occupational profiles, MPI researchers assigned occupations as "low skilled" if they require a high school degree or less and little-to-moderate on-the-job training (for example, home-health aides, construction laborers, and taxi drivers).
- **Legal status:** The MPI estimates of immigrants' legal status presented in this report are as of 2023 and are the product of a proprietary MPI methodology that imputes unauthorized status using analysis of U.S. Census Bureau data from the pooled 2019–23 ACS and the 2023, 2022, and 2008 Survey of Income and Program Participation. The results are weighted to 2023 unauthorized immigrant population estimates provided by Jennifer Van Hook of The Pennsylvania State University.[86]
- **Geographies:** In this analysis, *New York City* comprises its five boroughs (counties): the Bronx, Brooklyn (Kings), Manhattan (New York), Queens, and Staten Island (Richmond). *Rural counties* follow the New

86 For a description of MPI's methodology for assigning legal status to noncitizens in Census Bureau data, see MPI, "MPI Methodology for Assigning Legal Status to Noncitizen Respondents in U.S. Census Bureau Survey Data," accessed August 2, 2026.

York State Department of Health definition, which classifies any county with a population smaller than 200,000 as rural; 44 counties meet this threshold statewide.[87] However, because only 12 of those 44 rural counties could be individually identified in the ACS dataset, the rural counties category in this analysis includes those 12 counties plus a residual "county unspecified" group. *Other urban areas* encompasses the remaining 11 identifiable counties in the dataset, including the most populous ones outside New York City, such as Suffolk, Nassau, and Erie.

Qualitative research. MPI researchers cataloged and reviewed changes in federal policy (e.g., federal legislation, executive orders, agency regulations and guidance) in immigration and health-care financing areas issued during 2025 and the first nine months of 2026.

In addition to conducting a policy and research literature review, MPI researchers interviewed representatives of several New York stakeholder organizations between August 2025 and April 2026. This included representatives of community colleges, organizations that serve underemployed immigrant professionals, New York policy researchers, and an international expert on credential recognition. The purpose of these interviews was to better understand the challenges behind the underemployment of immigrant health-care professionals as well as opportunities to more fully leverage the skills of this pool of workers.

87 New York State Department of Health, "New York State Rural Counties and Towns" (Solicitation of Interest No. 20283, Nurses Across New York, August 2021).

Appendix B. State-by-State Data

TABLE A–1

Number of Total and Underutilized Adults (ages 25–64) with Medical or Health-Related Degrees in Selected States, by Nativity, 2024

	All Immigrants			U.S. Born		
	Total	Number Underutilized	Share Underutilized	Total	Number Underutilized	Share Underutilized
United States	**1,434,000**	**310,000**	**21.6%**	**5,677,000**	**979,000**	**17.2%**
Alabama	7,000	2,000	26.2%	84,000	17,000	20.3%
Arizona	22,000	5,000	24.6%	113,000	25,000	21.9%
California	257,000	52,000	20.0%	439,000	82,000	18.6%
Colorado	14,000	4,000	26.3%	117,000	21,000	18.0%
Connecticut	17,000	4,000	22.0%	62,000	10,000	15.7%
Florida	159,000	38,000	23.8%	364,000	76,000	20.8%
Georgia	36,000	8,000	21.1%	165,000	33,000	20.2%
Hawaii	7,000	2,000	26.8%	22,000	4,000	18.5%
Illinois	58,000	11,000	18.4%	213,000	36,000	16.8%
Indiana	13,000	3,000	23.3%	127,000	22,000	17.0%
Iowa	5,000	1,000	30.8%	51,000	8,000	15.4%
Kentucky	6,000	2,000	29.1%	83,000	14,000	17.2%
Maryland	43,000	8,000	17.9%	99,000	15,000	15.6%
Massachusetts	39,000	7,000	18.5%	134,000	21,000	15.6%
Michigan	27,000	6,000	22.1%	172,000	32,000	18.9%
Minnesota	15,000	3,000	20.8%	114,000	16,000	14.2%
Missouri	11,000	2,000	21.4%	115,000	18,000	15.6%
Nevada	16,000	4,000	27.2%	37,000	8,000	20.3%
New Jersey	77,000	16,000	21.3%	148,000	20,000	13.8%
New York	133,000	24,000	17.9%	312,000	52,000	16.5%
North Carolina	27,000	7,000	25.3%	194,000	40,000	20.4%
Ohio	23,000	5,000	20.1%	233,000	38,000	16.2%
Oregon	9,000	2,000	22.6%	70,000	13,000	19.1%
Pennsylvania	38,000	7,000	19.2%	259,000	41,000	15.8%
South Carolina	8,000	3,000	29.8%	94,000	19,000	20.2%
Tennessee	12,000	3,000	20.9%	129,000	25,000	19.5%
Texas	142,000	35,000	24.9%	433,000	80,000	18.5%
Utah	6,000	2,000	38.3%	60,000	14,000	22.5%
Virginia	32,000	8,000	23.2%	139,000	27,000	19.2%
Washington	31,000	9,000	28.1%	113,000	21,000	18.5%

Notes: The universe in this table is persons with a college degree in medical and health sciences and services. Data are provided for states for which the sample size was large enough to provide reliable estimates.
Source: Estimates for the United States and the six largest states (e.g., California, Florida, Illinois, New Jersey, New York, and Texas) are based on MPI tabulation of 2024 ACS data. Estimates for the other states are from MPI analysis of pooled 2020–24 ACS data, used to generate robust estimates for smaller geographies.

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