The NEW ENGLAND JOURNAL of MEDICINE

Perspective

JULY 10, 2025

# Who Will Care for America? Immigration Policy and the Coming Health Workforce Crisis

Patricia Mae G. Santos, M.D.,[1,2] Reshma Jagsi, M.D., D.Phil.,[1] and Carlos Irwin A. Oronce, M.D., Ph.D.[3]

Since taking the oath of office on January 20, 2025, President Donald Trump and his administration have unleashed a torrent of executive actions as part of an "America First" agenda. Central among these are policies to facilitate mass deportation, including the rescission of the Department of Homeland Security's guidance on "sensitive areas" — an Obama-era rule that prohibited Immigration and Customs Enforcement (ICE) agents from arresting people in houses of worship, schools, and university campuses, along with hospitals, clinics, and other health care settings. With these restrictions lifted, ICE raids have since escalated in both frequency and intensity nationwide, even as U.S.–Mexico border crossings dropped to historic lows.

But what happens when immigrants who work in the U.S. health care system are forced to leave? Just 4 days after the inauguration, 25 undocumented Filipino direct care workers were arrested in an ICE raid at a senior care facility in Chicago; at least 8 have since been deported.[1] Weeks later, Dr. Rasha Alawieh, assistant professor of medicine at Brown University, was denied reentry after a return flight from Lebanon. Despite a court order barring removal without due process, Alawieh had her H-1B visa revoked and was deported on March 14.[2] Alawieh was one of only three transplant nephrologists in Rhode Island, and her forced departure left a critical gap in a highly technical specialty, further limiting access to lifesaving care for patients with end-stage kidney disease.

As physicians, we have witnessed firsthand the harms that such policies pose to patients and health care workers alike. In one case we know of, an older patient with metastatic cancer fell at home and lay on the floor for days before being found by a family member; he died shortly after being admitted to a local hospital. Though it's uncertain whether he would have lived had he been found sooner, his home health aide had stopped coming to work for fear of deportation.

Such tragedies illustrate the dangers that the current political climate pose to immigrants (whether documented or undocumented) who interact with the U.S. health care system. As the federal government seeks to curb immigration of all forms, immigrant health care workers and their patients will inevitably find themselves caught in the dragnet, which will have seri-

ous consequences for the system at large. The United States has already been grappling with severe health care worker shortages, which are projected to worsen over the next few years. According to the Bureau of Health Workforce, the physician shortage is expected to increase from 12% (124,180 physicians) in 2027 to 16% (187,130 physicians) in 2037. Among primary care physicians, the projected gap is even wider — growing from 18% (50,100) to 27% (87,150) in that time frame.

For aging populations, the forecast is especially dire. Medical advances have allowed Americans to live longer than ever. In 2020, approximately 56 million U.S. adults were older than 65 years of age, according to U.S. Census Bureau data. By 2030, this number is expected to balloon to 80 million, with the total population share increasing from 16% to 21%. Meanwhile, there has been a shift toward "aging in place," with more older adults seeking to live their last days at home. As more Americans reach retirement age, the demand for direct care workers — home health aides, personal care aides, and certified nursing assistants — is expected to skyrocket. Current estimates suggest that the direct care worker shortage will grow to 860,000 by 2032. Factoring in turnover and retirement, one analysis suggests that 8.9 million positions will need to be filled over the next decade to meet demand.[3]

Moreover, these projections were made before Trump's second term and therefore don't account for the potential downstream effects of the administration's anti-immigrant policies. Yet immigrants are a vital part of the U.S. health care system: at least one in five U.S. health care workers is foreign-born, including 29% of physicians, 17% of nurses, and 24% of direct care workers.[4] With anti-immigrant rhetoric and policy likely to deter foreign-born workers from entering or staying in the health care sector, labor shortages may be even worse than projected.

Data suggest that most (if not all) foreign-born physicians and nurses are naturalized U.S. citizens or lawfully permanent residents. In contrast, of the 37% of foreign-born direct care workers who are noncitizens, nearly half may be undocumented.[4] This divergence is at least partly attributable to policies that streamline pathways to legal permanent residency or citizenship for some but not all immigrants. Foreign-born, foreign-trained doctors often enter the workforce through structured programs (e.g., J-1 or H-1B visas) and benefit from accommodations such as Conrad 30 waivers, which exempt J-1 visa holders from mandatory returns to their home country for 2 years. Many direct care workers are excluded from these pathways, however, which makes them more vulnerable to deportation. For example, although some direct care workers have temporary protected status, the termination of programs authorizing this status is already under way.

As federal policies threaten to further destabilize the direct care workforce, nonimmigrants are unlikely to fill the resulting void. Direct care workers assist with household chores as well as bathing, dressing, and toileting — thereby enabling frail, older adults and those with disabilities to live safely at home. Yet despite the importance of these roles, people who fill them are often subject to exploitative work practices, including wage theft. The physically demanding nature of direct care work, combined with low pay and high susceptibility to exploitation, makes these roles unattractive to U.S.-born and highly skilled foreign-born workers. Health systems and the long-term care industry have therefore increasingly looked toward immigrants, particularly undocumented workers, to meet demand.

This is not the first time that immigrants have helped fill critical health care roles that were unattractive to U.S.-born workers. At the end of World War II, low wages and deplorable working conditions led to large-scale resignations by American nurses.[5] In response, the federal government established the Exchange Visitor Program in 1948, allowing Filipino nurses to obtain temporary work visas. Later, the Immigration and Nationality Act of 1965 allowed Filipino nurses to stay in the United States permanently. By 1967, the Philippines became the world's largest supplier of nurses. Today, 1 in 25 nurses in the United States is Filipino, and the nursing workforce gap is projected to close over the next decade.[5]

What the success of these policies demonstrates is that by offering meaningful pathways to work authorization and citizenship, the United States can become better equipped to meet the needs of its growing and aging population. Federal officials could effectuate immigration reform in a way that secures our borders while addressing labor shortages. Instead, current policies threaten to further shrink this essential workforce, maligning and driving out hard-working immigrants at the expense of an aging America. Though immigration reform must balance border security with economic priorities, indiscriminate mass-deportation policies not only infringe on basic civil liberties but may also exacerbate existing work-

er shortages, compromising care for older adults and the health care system at large. Even if domestic training programs were expanded today, the potential increase in workers would not be enough to meet current demand.

In the face of anti-immigrant rhetoric, health care leaders must find the courage to advocate for policies that support, rather than marginalize, immigrant health care workers. Workforce research to identify gaps in supply and demand, institutional policies that increase visa sponsorships, and coalitions supporting pro-immigrant policies, such as Schedule A expansions (allowing expedited green-card approvals for people entering high-need occupations) can help address shortages, while shielding workers from exploitation. Although much remains uncertain, it's clear that immigrants are — and have always been — a vital part of the United States and its health care system. Immigration policy must therefore protect the dignity of people who dedicate their lives to caring for others. The recent deportation of immigrant health care workers is our canary in the coal mine: policymakers must act swiftly, or risk endangering the health of us all.

*An audio interview with Patricia Santos is available at NEJM.org*

The views expressed in this article are those of the authors and do not necessarily represent the positions of Emory University, the University of California, Los Angeles, the Department of Veterans Affairs, or the U.S. Government.

Disclosure forms provided by the authors are available at NEJM.org.

[1] Division of Health Services, Outcomes, and Policy, Department of Radiation Oncology, Winship Cancer Institute, Emory School of Medicine, Atlanta; [2] Department of Health Policy and Management, Emory Rollins School of Public Health, Atlanta; [3] Division of General Internal Medicine and Health Services Research, University of California, Los Angeles, Los Angeles.

This article was published and updated on July 5, 2025, at NEJM.org.

1. Visaya MG. Filipino advocates condemn ICE detention conditions, call out PH gov't for inaction. Asian Journal News. February 7, 2025 (https://asianjournal.com/immigration/filipino-advocates-condemn-ice-detention-conditions-call-out-ph-govt-for-inaction/).
2. Goldstein D. Brown University professor is deported despite a judge's order. New York Times. March 16, 2025 (https://www.nytimes.com/2025/03/16/us/brown-university-rasha-alawieh-professor-deported.html).
3. PHI National. Direct care workers in the United States: key facts 2024. September 2, 2024 (https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2024/).
4. Azaroff LS, Woolhandler S, Touw S, Bor D, Himmelstein DU. Deporting immigrants may further shrink the health care workforce. JAMA 2025 April 3 (Epub ahead of print).
5. Santos PMG, Chino F, Torres M, Deville C Jr, Vapiwala N. Asian representation in the US physician workforce. In: Deville C Jr, ed. Physician workforce diversity: trends, barriers, and solutions. Cham, Switzerland: Springer International, 2024;361-76 (https://link.springer.com/10.1007/978-3-031-63050-7_22).

DOI: 10.1056/NEJMp2504949


# Exclusion of Elective Care from Hospital Financial Assistance Policies — Arresting a Troubling Development

Mark A. Hall, J.D.,[1] and Judith Garber, M.P.P.[2]

Recent research has revealed substantial variability in hospital charity care and other financial assistance (FA) policies.[1] This lack of standardization makes it much more difficult for patients and anyone assisting them (including clinicians) to ascertain their likely eligibility for free or discounted care. Past research has focused on key aspects of FA policies, such as income and asset thresholds, presumptive eligibility, and the process for determining eligibility. Hospital FA policies also vary a good deal in terms of residency requirements, whether patients must be uninsured, and other factors.

But an issue that has largely escaped attention so far is the range of services that hospital FA policies cover. Conventionally, nonprofit hospitals have covered essentially the full range of "medically necessary" services that health insurers typically cover. But we have noticed a troubling development: some hospitals now offer assistance only if care is urgently needed, thereby excluding a broad range of necessary care.

Hospitals offer free and discounted care in several ways, as outlined in their FA policies. One way is simply to discount or cap charges for "self-pay" (i.e., uninsured) patients regardless of financial need, if the patients either pay the entire bill promptly or adhere to a structured payment plan. Hospitals also provide FA based on a patient's financial need, either waiving charges entirely or discounting them substantially.

These discounts are often offered on a sliding scale based on the patient's household income,