cy prevention programs, an ominous sign of the deprioritization of evidence-based reproductive health policy.

More research is needed to explore the reasons for the United States' suboptimal and inequitable maternal outcomes and to clarify the effect of insurance coverage before, during, and after pregnancy. The ACA is not perfect: there are still gaps in insurance coverage and care for pregnant and postpartum women, including for undocumented immigrant women and women who become eligible for Medicaid only because of pregnancy. Furthermore, expanding insurance coverage won't eliminate all inequities in maternal outcomes; comprehensive approaches to poverty and discrimination will also be required. Recent Republican proposals would indisputably have been a step backward. However, other efforts to erode access to primary and reproductive health care are ongoing and will worsen inequities in maternal health. Health in pregnancy affects the long-term well-being of women and their families, and maternal outcomes are a key indicator of a health care system's effectiveness. Improving maternal outcomes in the United States will require increased study and investment and renewed focus in health care policies.

An audio interview with Dr. Molina is available at NEJM.org

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1. Martin N, Montagne R. The last person you'd expect to die in childbirth. ProPublica, National Public Radio. May 12, 2017 (https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system).
2. Alkema L, Chou D, Gemmill A, et al. Trends in maternal mortality: 1990 to 2013 — estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations population division. Washington, DC: World Bank Group, May 6, 2014 (http://documents.worldbank.org/curated/en/937281468338969369/Trends-in-maternal-mortality-1990-to-2013-estimates-by-WHO-UNICEF-UNFPA-the-World-Bank-and-the-United-Nations-population-division).
3. MacDorman MF, Declercq E, Thoma ME. Trends in maternal mortality by sociodemographic characteristics and cause of death in 27 states and the District of Columbia. Obstet Gynecol 2017;129:811-8.
4. Creanga AA, Bateman BT, Kuklina EV, Callaghan WM. Racial and ethnic disparities in severe maternal morbidity: a multistate analysis, 2008-2010. Am J Obstet Gynecol 2014;210(5):435.e1-435.e8.
5. Daw JR, Hatfield LA, Swartz K, Sommers BD. Women in the United States experience high rates of coverage 'churn' in months before and after childbirth. Health Aff (Millwood) 2017;36:598-606.

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Dreams Deferred — The Public Health Consequences of Rescinding DACA

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After months of conflicting statements, President Donald Trump has announced that the Deferred Action for Childhood Arrivals (DACA) program, a landmark immigration program introduced during the Obama administration, will be rescinded as of March 2018. The announcement was made in the face of threats by nine Republican state attorneys general (one has since withdrawn) to sue the Trump administration over what they perceived as the executive branch's unconstitutional implementation and administration of immigration policy. Like many other elements of the administration's immigration platform, the termination of DACA also appeared to be driven by a belief that rescinding economic benefits granted to undocumented immigrants would enhance economic opportunities for native-born people.

Since June 2012, when the program was established by executive order by President Barack Obama, DACA has provided freedom from deportation and access to work permits for young undocumented immigrants who were brought to the United States before 16 years of age. The program required current school attendance, completion of at least high school or high school equivalency certification (GED), or military service. Persons with significant criminal records were not eligible. To date, more than 800,000 people — predominantly from Mexico, Guatemala, El Salvador, South Korea, and Honduras — have benefited from the program. Although the program did not provide a pathway to citizenship, it granted beneficiaries — known as "Dreamers" (after the Development, Relief, and Education for Alien Minors Act, a bill that has been introduced and reintroduced in various forms since 2001 but has failed to pass) — access to opportunities for socioeconomic advancement that might otherwise have been out of their reach.

The recent policy debates about DACA have centered on the program's economic consequences, while its substantial public health benefits have been less discussed.

A recent quasi-experimental study compared changes in mental and physical health outcomes among persons who were eligible for DACA with those of a similar group of noncitizens who did not meet at least one of the eligibility criteria.[1] The study showed that rates of moderate or severe psychological distress in the DACA-eligible group fell by nearly 40% relative to rates in the DACA-ineligible group after DACA's passage. Similarly, descriptive studies of DACA beneficiaries have revealed remarkable improvements in psychological well-being after the program's implementation.[2] The most recent contribution to this literature has shown, using data on Emergency Medicaid beneficiaries in the state of Oregon, that the mental health benefits of DACA extended across generations: among the children of DACA-eligible mothers — the majority of whom are U.S. citizens by birth — rates of adjustment and anxiety disorders fell by more than half after DACA was implemented.[3]

The evidence clearly indicates that rescinding DACA will have profound adverse population-level effects on mental health. Moreover, these effects will most likely be potentiated by the broader hostile political climate surrounding immigration. In addition to rescinding DACA, other elements of the Trump administration's immigration platform include enhancing authority and providing means to implement existing immigration policies, banning or reducing immigration by specific population groups, and strengthening border security. These policies could further increase the risk of deportation for Dreamers and their family members, which could reinforce any adverse mental health consequences of DACA's termination. That DACA has been repealed in the context of the increasingly divisive and nativist rhetoric that has infected many ongoing public conversations — which itself may have independent adverse effects on mental health[4] — will only exacerbate its negative health effects.

The potential mental health fallout from DACA's termination will be immensely challenging to address through our formal health care and public health systems because it is likely to be a silent and unseen problem. Removing legal protections from deportation will reduce the likelihood that Dreamers will seek help from physicians, nurses, educators, or social workers, given the very realistic fears of coming under scrutiny by immigration authorities. Such fears and isolation will make it difficult to deploy mental health treatment and public mental health resources where they will be needed most. These effects are likely to manifest even in states that provide more generous benefits to undocumented immigrants (e.g., Massachusetts and California) and in "sanctuary cities," because federal authorities have stepped up raids to identify and deport undocumented immigrants in these areas. Moreover, Dreamers who do seek help may have fewer avenues for obtaining it if the loss of work permits leads to unemployment (or forced withdrawal from school due to loss of financial aid) and subsequent loss of health insurance.

With DACA slated to be terminated in 6 months, the fate of its beneficiaries will most likely rest in the hands of Congress. Proposals introduced to date include the Bridge Act, which effectively extends the present DACA program by 3 years; the Recognizing America's Children (RAC) Act, which would allow persons meeting DACA eligibility criteria to apply for conditional permanent residence with a path toward citizenship; and the American Hope Act and the updated version of the DREAM Act, both of which propose broader eligibility criteria and faster pathways to citizenship. Both Democratic and Republican legislators have expressed support for one or more of the proposed policies — as well as for the general concept of providing Dreamers with a definitive legal status. Over the past several months, DACA has gained broad public and bipartisan support because of the relative youth, ambition, and productivity of Dreamers. It remains unclear, however, whether any of these bills, or any other policy action supporting DACA beneficiaries, can garner sufficient votes to pass through Congress. The coming legislative battle may also have unintended consequences for other immigrant groups: successful passage of a bill benefiting Dreamers might require deals that involve tightening immigration restrictions for people who do not fit the DACA profile. In the meantime, the attorneys general of 15 states and the District of Columbia have sued the Trump administration to block DACA rescission.

The next few months present a critical opportunity for health care and public health professionals, who have traditionally advanced public health through three mechanisms: caring for patients, engaging in public advocacy, and subverting the (biologic or structural) vectors contributing to public health harm. As they have done historically, health care providers will continue to care for vulnerable patients despite myriad institutional barriers and possibly even threats to their personal safety.

They now have a limited window of opportunity to engage policymakers about protecting Dreamers through legislative action, the public health benefits of doing so, and the potentially dire mental health consequences of failing to enact a definitive legal remedy. Advocates can also make clear that protecting Dreamers — and other immigrant groups — would have few, if any, economic disadvantages for native-born workers[5] and that legislation like the RAC Act or the American Hope Act would have broad support in the business sector. In this vein, partnering with organizations outside the health sector that are advocating for DACA would amplify all contributing voices.

If a legislative solution cannot be found to provide DACA's former beneficiaries with a definitive legal status, health care and public health institutions will need to work together to ensure that the people under threat do not bear the burden of mental distress alone. In such an environment, organizations would need to proactively reach out to undocumented immigrants to keep open lines of communication and reassure them of ongoing efforts to establish a firewall between health care policy and immigration policy. Clinicians will continue to ensure the delivery of high-quality health care despite immigration status. Providing Dreamers with information about public resources that can be safely used in the case of severe mental distress will be critical. On a broader systems level, tracking health care utilization and health outcomes will help organizations monitor health at the population level and provide hard data to policymakers seeking to implement other supportive remedies.

The DACA program in many ways reflects the American ideal: people who first came to the United States as children were given a chance to pursue the American dream. DACA was never intended to be a public health program, but its population-level consequences for mental health have been significant and rival those of any large-scale health or social policies in recent history. Rescinding DACA therefore represents a threat to public mental health, and it is a humanitarian imperative for health care providers and public health officials to take an active role in countering that threat.

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1. Venkataramani AS, Shah SJ, O'Brien R, Kawachi I, Tsai AC. Health consequences of the US Deferred Action for Childhood Arrivals (DACA) immigration programme: a quasi-experimental study. Lancet Public Health 2017;2(4):e175-e181.
2. Patler C, Laster Pirtle W. From undocumented to lawfully present: do changes to legal status impact psychological wellbeing among latino immigrant young adults? Soc Sci Med 2017 March 9 (Epub ahead of print).
3. Hainmueller J, Lawrence D, Martén L, et al. Protecting unauthorized immigrant mothers improves their children's mental health. Science 2017 August 31 (Epub ahead of print).
4. Williams DR, Medlock MM. Health effects of dramatic societal events — ramifications of the recent presidential election. N Engl J Med 2017;376:2295-9.
5. Chassamboulli A, Peri G. The labor market effects of reducing the number of illegal immigrants. Rev Econ Dyn 2015;18:792-821.

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Primary Care Spending Rate — A Lever for Encouraging Investment in Primary Care

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Why doesn't the United States invest more in primary care? A large body of evidence suggests that greater investment in primary care is good for patients and health systems. Greater use of primary care has been associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.[1] Within the United States, health care markets with a larger percentage of primary care physicians (PCPs) have lower spending and higher quality of care.[2]

Despite this evidence, the United States continues to undervalue primary care. A recent Commonwealth Fund analysis identified underinvestment in primary care as one of four fundamental reasons that the U.S. health system ranks last among high-income countries.[3] Compared with peer countries, the United States has fewer primary care clinicians than specialists — along with larger income disparities between the two groups — and provides fewer services in the primary care setting.[3,4] Although the Affordable Care Act introduced a number of payment and regulatory changes that offer incentives to invest in primary care, they have not been