Disparities in Access to Prenatal Care: Perpetuation of Poverty and Inequality through the Healthcare System

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Abstract

This analysis addresses the disparity in prenatal health outcomes between the City of Paterson and Wayne Township in New Jersey. It guides the reader through the experiences of a hypothetical pregnant woman living in Paterson to examine the institutional and non-institutional factors that prevent this pregnant woman, and others like her, from accessing appropriate prenatal care. This paper also discusses the relationship between the inability to access proper prenatal care and the perpetuation of poverty and inequality. Lastly, it calls for local reforms to concentrate efforts in deconstructing community barriers.

Introduction

Health outcomes for people of different racial backgrounds in the United States are widespread, affecting minorities even before they are born. Several studies show health outcome disparities between minorities and whites: national statistics highlight that minority groups have poorer health, i.e., blacks have higher infant mortality rates (Brooks, 1998; Bach, 2003; as cited in Johnson, 2011), and white, black, and Hispanic expectant mothers receive vastly different prenatal care (Stewart, 2008). Race and ethnicity, as indicators of health status in the United States, raises many issues—yet few health research studies have delved into this dilemma's less obvious factors: community resources and location.

Infant mortality is preventable. The Prenatal Care Task Force (2008) reported that infant mortality is one outcome of inappropriate, or lack of, prenatal care; other outcomes are low-birth-weight babies and pre-term births (p55-56). These outcomes are related and often precede each other: premature births highly lead to low birth weight in newborns, which in turn, contributes to infant mortality (Prenatal Care Task Force, 2008, p. 55-56). When a prematurely born baby survives, they are at higher risk of developing lifetime medical complications such as

cerebral palsy, breathing problems, visual and hearing impediments, intellectual disability, cognitive delays, and behavioral problems (Martin, 2012; Prenatal Care Task Force, 2008, p.56). Despite these medical outcomes, premature birth in the United States prevails. The American Congress of Obstetricians and Gynecologists (ACOG) stated that in 2008 "more than half a million babies were born prematurely" (Martin, 2012).

Researchers observe that race and economic resources frequently align with outcomes of prenatal care. The Maternal and Child Health Journal published an article in 2003 attesting that the percentage of black women giving birth to low weight babies was almost twice the percentage of low-birth-weight babies born to white mothers (Reichman, Hamilton, Hummer & Padilla, 2008). Researchers often attribute health birth outcomes to the mother's socioeconomic status, level of education, number of prenatal visits, and the trimester in which she entered prenatal care (Dobie, Hart, Fordyce, Andrilla, Rosenblant, 1998, p 51). These inferences highlight individual-level barriers to proper health care, suggesting that individuals' financial stability dictates, to a certain extent, their level of health.

The relationship between pregnant women's socioeconomic status and their race and ethnicity indicates a minority-majority health outcome disparity expectation since a higher percentage of minorities, namely blacks and Latinos, live in concentrated poverty (Badger, 2015). This relationship between financial and health status provides sufficient evidence to support that living in poverty is a prominent risk factor for preventable poor health. However, it does not explain (1) the under-representation of poor whites in poor birth outcome statistics such as infant mortality, (2) the role of external factors, such as neighborhood, and the impact it has in accessing proper health care, and (3) infant mortality primarily concentrated in areas of concentrated poverty.

This paper furthers the research on the relationship between socioeconomic status, race, and prenatal care outcomes through a case study of the City of Paterson and Wayne Township in Passaic County, New Jersey. It demonstrates the complexity of this relationship, analyzing the role that place plays in its residents' ability to access proper and timely prenatal care. Despite their proximity, these two municipalities are remarkably different communities; separated by only 4.1 miles, Paterson and Wayne's residents' racial background, financial, and health status could not be more different. This evaluation examines the impact of place—locally based institutional and non-institutional factors that facilitate or impede access to prenatal care—on pregnant women. This comparative analysis sheds light on the influences of place-based factors, such as insurance coverage, medical accessibility, and the quality of treatment contributing to greater racial health disparities, specifically prenatal care and birth outcomes disparities between races. With the purpose of investigating these factors at the individual level, suppose we analyze the experiences of a hypothetical pregnant woman living in Paterson, let's name her Sandra.

Background

Sandra is a 29-year-old single female born in Paterson, New J. Her parents immigrated to the United States from their native country, Peru, in 1980 as a result of chain migration–the legal migration of extended family members due to their relation to a US citizen or lawful permanent resident. Sandra grew-up in a working-poor family; her father was a factory worker and her mother a school bus aide. She, along with her two older siblings, attended Paterson public schools. During her senior year in high school, Sandra decided to not pursue college due to the financial burden it would bring to her family. Upon high school graduation, she started a full-time job in sales at a local clothing store. Throughout the years, she has continued working in sales, changing employers a few times seeking a better compensation. Eventually, Sandra

obtained a job at a well-established retail company at a nearby mall. Although Sandra was hired as a full-time employee, one year after her start date her work hours were reduced to part-time status. Despite this change, Sandra stayed with the company because of the hourly pay-rate, bonuses, and the opportunity for advancement she was promised during her hiring interview. Unfortunately, after seven years working for this company, she is still a part-time employee—doing over-time occasionally and seasonal jobs at other department stores.

With a $25,000 annual income, Sandra falls in the lower income class (Pew Research Center, 2016). She rents a small studio in Paterson, hoping to move to a neighboring town in the future. Until then, Sandra abides by the regulations of her city, including the process of accessing prenatal care services. Sandra recently found out that she is 7 weeks pregnant; sadly she will encounter barriers along her way to a healthy pregnancy.

Navigating the prenatal healthcare system in Paterson will post challenges for Sandra in receiving adequate prenatal care, i.e. entering prenatal care in her first trimester (up to 13 weeks of pregnancy) and attending all scheduled prenatal visits, crucial to her overall health of that of her baby. In addition, Sandra will face obstacles obtaining health insurance coverage on time to choose her own obstetrician with a flexible schedule. Instead, all through her pregnancy Sandra will face hurdles in scheduling prenatal visits that won't jeopardize her availability to work. After giving birth, Sandra will be reminded that obtaining insurance is not affordable for her. Moreover, Sandra will have to battle with attending her prenatal care visits and risking being mistreated by members of the medical staff due to assumptions made about her or avoiding prenatal visits completely. Since these barriers are unique to Paterson residents, we will consider next the history and demographics of Paterson and Wayne.

History and Demographics

By the time Sandra's parents arrived in Paterson, in 1980, Paterson went from ranking 47th among the "nation's poorest cities" to be among the top 5 (Owusu, 2014, p.5). Paterson's high poverty rate and unemployment rate is attributed to residents' lack of access to jobs and lack of mobility. After the Great Depression, businesses relocated from cities to suburbs—Paterson workforce lacked immediate access to the jobs established in Wayne and other suburban areas (Wayne Township Historical Commission, n.d.). In the event that Paterson residents secured a job outside the city, greater transportation cost was expended (Owusu, 2014, p.5). It was not easy for city residents to follow the newly established companies because of town regulations. For example, in the case of Lionshead Lake, Inc. v. Township of Wayne, 1952, the Court of Appeal determined that in order to preserve "the general welfare of the community," Wayne Township had the right to impose new zoning ordinances requiring a minimum dwelling size. This ruling attracted affluent individuals to Wayne, providing greater access to the local job market and contributing to future financial stability—leaving behind those who could not afford to relocate. In 2014, Paterson's population was estimated at 146,753, almost triple the population estimate of Wayne for that same year, due mainly to Paterson's affordable housing (U.S. Census Bureau, 2015a; Census Bureau 2015b; Owusu, 2014, p.5).

Sandra has no hope of living in Wayne. As of 2014, Wayne's average family income was $151,079—almost three times more than Paterson's average family income of $51,797 (U.S. Census Bureau, 2014c). The percentage of individuals living below the poverty line in Paterson is nearly 7 times more than Wayne and almost 10 times more for families with children under the age of 18 (U.S. Census Bureau, 2014a; U.S. Census Bureau, 2014b). Sandra, with only a high school diploma, has no prospects of a high-paying job. This is not unusual for Paterson residents,

whose higher education achievement is 5 times lower compared to Wayne's constituents (U.S. Census Bureau, 2014b).

Throughout the past years Wayne has kept a consistent average of 80 percent white population, while its Hispanic population has accounted for less than 10 percent and blacks have constituted, on average, merely 2 to 3 percent (U.S. Census Bureau, 2014a). In comparison, more than half of the individuals residing in Paterson are Hispanic, like Sandra (U.S. Census Bureau, 2014b). Blacks have kept an average of 28 percent of Paterson's population whereas whites have continued to leave the city: in 2010 whites represented 11 percent of the population and in 2014 they constituted only 8 percent (U.S. Census Bureau, 2014b). The stark differences between both municipalities transcend to their health status. Paterson has become a low-income city with a high percentage of risk health factors, as we will discuss over the next sections.

Health Care and Prenatal Health

Prenatal care is vital for Sandra and her child's health. Guidelines for the care of pregnant women advise that "the content and timing of prenatal care should be varied according to the needs and risk status of the woman and her fetus" (The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 2007). In accordance with these recommendations, the Kotelchuck Index is used to measure the adequacy of prenatal care utilization. Determinations are based on: (1) the gestational month in which prenatal care was entered, noting the earlier access to care the better, and (2) the amount of expected prenatal care visits from the time care started versus the actual amount of visits from the time care started (New Jersey Department of Health, 2015). The index gives a final score based on these two determinants and it is further categorized as one of the following: inadequate, intermediate, adequate, and adequate plus (New Jersey Department of Health, 2015). Although this

measurement does not consider the content of each prenatal visit, it is still crucial since inadequate prenatal care, as determined by the Kotelchuck Index, is highly correlated with preterm birth, which contributes to infant mortality (Krueger & Scholl, 2000). This demonstrates that infant mortality is related to late prenatal care entrance and having few prenatal care visits. The ACOG strongly recommends early access to prenatal care (Martin, 2012). Its priority is clear: reduce infant mortality and increase healthy babies and mothers through proper medical assessment. The early access to care enables providers to assess the medical need of a patient, establish a care plan, and provide timely medical procedures, some of which depend on the pregnant women's gestational age (i.e., age of the fetus). For instance, if Sandra is able to enter prenatal care during her first trimester (up to 14 weeks of gestation), she can have a non-invasive first trimester screening to detect the risk of fetus chromosomal disorder, including Down Syndrome (Womenshealth.gov, 2010).

In an effort to highlight nationwide gaps in access to care, the National Women's Law Center ranked states based on pregnant women early entrance to care—New Jersey was ranked 40th (as cited in Prenatal Care Task Force, 2008). Although alarming for all women living in New Jersey, this report highlights the experiences of pregnant women, who like Sandra, live in cities and urban areas. For instance, the New Jersey Department of Health (2017) indicates that from 1990 to 2014, despite proximity and belonging to the same county, the amount of women in Wayne who entered prenatal care in the first trimester was significantly higher than the number of pregnant women who entered early prenatal care in Paterson. Also, for those same years, the average number of prenatal visits is higher for residents of Wayne than it is for women living in Paterson (New Jersey Department of Health, 2017). Thus, the proportion of pregnant women in Wayne who received adequate care, measured by the Kotelchuck Index, during 1990 to 2014

was 21.2 percent more than the proportion of pregnant women receiving Kotelchuck's adequate care in Paterson (New Jersey Department of Health, 2017). Similarly observed was the overall difference on the percentage of infants born with low weight (less than 2500 grams) from 1990 to 2014—Paterson's was higher (New Jersey Department of Health, 2017). Lastly, differences in infant mortality rates are shocking: Between 2000 and 2014, Paterson had almost 7 times the percentage of infant death than Wayne (New Jersey Department of Health, 2017). From 2012 to 2014, every 173 live births in Paterson led to 1 infant death compared to 1 infant death every 685 births in Wayne (New Jersey Department of Health, 2017). These prenatal care and birth outcome statistics are appalling for Sandra and her unborn child.

Despite the many health care reforms to increase prevention, education, and outreach services, under the U.S. Department of Health and Human Services and the New Jersey Department of Health, these disparities have persisted throughout the years. The New Jersey Infant Mortality Reduction Initiative of 1985, the Racial and Ethnic Health Disparities Initiative established in 1998, Eliminating Health Disparities Initiative of 2004, and its consecutive Strategic Plan to Eliminate Health Disparities in New Jersey of 2007 reveal the complexity of the issue—factors other than socioeconomic status affect health disparity (Denk, 2012; Brooks, 1998; NJ Department of Health and Senior Service, 2010). Even the Patient Protection and Affordable Care Act (ACA) of 2010, the most comprehensive healthcare reform of recent years, has yet to eliminate health status inequality (Medalia, 2016). In the years following the ACA, the total number of visits that residents of Paterson made to the Emergency Room (ER) was 8 times more than the total number of visits Wayne residents made to the ER (New Jersey Department of Health, 2015). This number includes all the visits in which patients entered the hospital seeking

medical attention but were not admitted—suggesting a high need for treatable medical attention not met by a primary medical physician (PCP).

Despite all of the reform attempts, place-based access to health care continues to cause health outcome disparities. The cause of this persistent inequality is the *underestimation of the impact that place has*. Barriers other than insurance eligibility and health awareness are seldom addressed. Although health insurance eligibility is imperative, the process of obtaining insurance and the access such insurance provides into the healthcare system have become more significant. We will examine next the relevant health insurance provision to determine its impact in accessing the healthcare system during pregnancy.

Insurance

Although the ACA was signed in 2010, a number of its provisions did not go into effect until years later (Medalia, 2016). New Jersey was one of the states that chose to implement the expansion of Medicaid earlier than the projected date of 2014, however, the law did not affect healthcare coverage income eligibility for pregnant women nor helped to decrease the uninsured gap between Paterson and Wayne (Department of Health and Human Services, Center for Medicare and Medicaid Services, 2013; U.S. Census Bureau, 2015). Before the ACA implementation, the income limit for pregnant women eligibility was 200 percent of the federal poverty level (FPL) with additional deductions for those who were slightly over the limit; after the ACA the limit increased 5 percent—including all deductions (Department of Health and Human Services, Center for Medicare and Medicaid Services, 2013). Thus, the implementation of the ACA did not affect the income eligibility limit for expectant mothers looking for health coverage.

Sandra, a single working pregnant woman living with no children in New Jersey qualifies for Medicaid because her monthly gross income does not exceed $2,737 (New Jersey Family Care, 2013). Since the "median earning for female full-time, year-round worker" in Paterson is $28,647, the average pregnant worker in the city tends to qualify for Medicaid insurance (U.S. Census Bureau, 2014b). Following Medicaid regulations, Sandra's future baby will be granted Medicaid coverage for one year but Sandra's coverage expires 60 days after giving birth (New Jersey Family Care, 2013). At that time, Sandra needs to re-submit an application under a new income level eligibility—up to138 percent of FPL or up to $1,843 monthly gross income for a family of two (e.g. single mother and her newborn) (New Jersey Family Care, 2013). Since Sandra's income goes over the limit ($2,077 monthly gross income) she will be referred to purchase her own health insurance in the marketplace (Compilation of Patient Protection and Affordable Care Act of 2010). Based on income and age, a non-pregnant Sandra—who does not qualify for Medicaid due to $234 "excess income"—will receive a tax-credit of $150 monthly for buying her own insurance (Healthcare.gov). However, she will not receive this credit until she files her tax return the following year, which means that she needs to pay a monthly premium of $246 out of pocket (Healthcare.gov). Although this is the most inexpensive plan, it has a deductible of $3,000, increasing potential total cost to almost $6,000 for the first year of health coverage (Healthcare.gov). For a low-income individual like Sandra, this is an unaffordable expense. Many will not enroll—including her. This is not uncommon in Paterson where the full time male worker earns a median income of $32,880, [primarily resulting from a history of inaccessibility to work and low level of education attainment]. It is not surprising that the percentage of insured individuals in the city has not increased significantly between 2012 and 2014 (data for prior years is not available) (U.S. Census Bureau, 2014b). Paterson's uninsured

population under the age of 65 is still higher than Wayne's—3.5 times more (U.S. Census Bureau, 2015).

These statistics are more compelling when taking into consideration the high number of undocumented individuals living in the "city shadows" (R. Nieves, personal communication, July 14, 2016). This population, ineligible for regular Medicaid, is not accurately represented in health statistics. At best, undocumented pregnant women in New Jersey can apply for Charity Care, a program providing reduced or free health coverage, excluding some physician fees, anesthesiology fees, radiology interpretations, and prescriptions drugs (New Jersey Department of Health, 2013).

Despite all the reforms, Paterson residents have not seen many benefits: they are not poor enough to receive Medicaid, not financially well off to afford buying private insurance, or have legal status restrictions. This is apparent in that the number of infant deaths under one year of age, although stagnant at 15, has not decreased from 2010 to 2014 [the latest available data] (NJ Department of Health, 2017). The ones who are able to benefit from health insurance regulations encounter other barriers to proper and timely health care: the institutional system.

Prenatal Visits

Lack of insurance coverage and lack of access to medical providers deters many from seeking medical attention. Although without success, Wayne and Paterson have established health care and social assistance institutions to address this problem; as of 2012 Wayne had a total of 291 institutions and Paterson had 232 (U.S. Census Bureau, 2012). Currently, the city has two major prenatal clinics serving the community whereas Wayne offers residents with access to a private clinic. Surprisingly, a web search shows both municipalities have almost the same amount of private obstetric providers despite the fact that Wayne has 1/3 of Paterson's

population. This means that pregnant women in Wayne have a higher probability of finding an available obstetrician than Paterson's pregnant women do. Usually, a sexually active woman will suspect pregnancy after she misses her first menstrual cycle; a home pregnancy test will either confirm or negate those suspicions (American Pregnancy Association, 2015). With a positive home pregnancy test result, the average women in Wayne could call her gynecologist's private office for an appointment and prenatal care initiation. The average woman in Paterson would have much more difficulty.

When Sandra finds out she is pregnant, she immediately calls Family Health Center (FHC) to start prenatal care but the operator re-directs her to get a pregnancy test confirmation from Healthy Mothers, Healthy Babies Coalition (HMHB) (FHC, personal communication, May 10, 2016). Sandra believes that she is sent to obtain a blood test confirmation of her pregnancy, which is useful for medical purposes (American Pregnancy Association, 2015). But instead she is sent to get another urine test. HMHB provides free pregnancy tests and a paper form as proof of pregnancy. Sandra must possess an official proof of pregnancy to schedule her initial prenatal care visit at the center; a home test is not sufficient as it would be for a private medical office in Wayne. This process is problematic as it subjects Sandra to abide by another institution's regulations for a procedure she could do at home.

Given the high volume of Paterson pregnant women looking for health services, it is understandable that FHC takes the extra step to ensure appointment slots are not given to false positive home pregnancy tests since home pregnancy tests have a 3 percent error (American Pregnancy Association, 2015). Whether the center believes women cannot properly administer the test, believe they do not take the test at all, or don't feel confident with the 97 percent home pregnancy test accuracy, when done correctly, the center can only benefit from this procedure

(American Pregnancy Association, 2015). The extra precaution FHC takes to dissuade any false positive pregnancy tests is an effort to alleviate its overcrowded waiting room area. The center's obstetrics and gynecology (OB/GYN) department waiting area often resembles an emergency waiting room at a busy night. The otherwise spacious area becomes insufficient to welcome the amount of patients scheduled every day.

The proof of pregnancy rule contributes to delayed entrance into care. Paterson HMHB Coalition provides services Monday through Friday up to 4:00 PM; however, the specific test is only done from 2:00 PM to 4:00 PM (HMHB, personal communication, May 10, 2016). Although an appointment is not necessary for the pregnancy test, it is not provided every day—Sandra must call ahead of time to confirm it is being provided. Despite the convenience of walk-in appointments, it is not the most suitable situation for Sandra as it entails risking having a longer wait and jeopardizing work, or tampering with a tight schedule.

To obtain the required pregnancy proof, Sandra contemplates whether she can use her lunch break to get the pregnancy test. Luckily she owns a car now, which she had to get in order to be at work on time and spend less time traveling. Seven years ago, Sandra accepted her current job position, despite being located away from Paterson, because the pay offer was greater than the available jobs in her city. She started as a full-time employee, but within a year, around the time the ACA was signed into law, her status changed to part-time, making her ineligible for insurance benefits through her employer. Unfortunately, after the ACA was enacted this practice was not uncommon. In an effort to avoid mandatory employee's benefits, some companies reduce employees' working hours (Casselman, 2015).

The commute from Sandra's residence to work is approximately 23 minutes, the average commute for a worker who resides in Paterson (U.S. Census Bureau, 2014d). She estimates that

the pregnancy test will not take more than 15 minutes. However, she realizes that the time she plans to go coincides with school dismissal—increasing traffic. Her second option is to take half a day off, but the thought of future absences from work due to medical appointments quickly diminishes this option. In the end, Sandra decides to wait until her scheduled day off next week and hope that it coincides with Paterson HMHB Coalition schedule.

Once Sandra obtains her proof of pregnancy from HMHB Coalition, she calls FHC right away to set up her initial appointment. The scheduler informs Sandra that the first available appointment slot is in three weeks. (FHC, Personal Communication, May 10, 2016). Although this waiting time is not unusual at the center, it was not always the case. In 2008 the Prenatal Care Task Force reported FHC OB appointments waiting time was 1-2 weeks (p. 72). This change is attributed to a mismatch between demand for prenatal care and providers' availability. In 2008, FHC had 5 OB/GYN attending physicians and 4 OB/GYN resident physicians (i.e. physicians in training) (Prenatal Care Task Force, 2008, p. 72). As of 2015, the center compensated the upsurge of patients by increasing medical residents, yet the attending physicians supervising those residents and the number of midwives has slightly decreased (FHC Staff, Personal Communication, July 22, 2016). The main reason: Medicaid reimbursement rates are far less than private insurance rates (Livio, 2015). Doctors are not equally compensated for attending Medicaid patients than for attending privately insured patients. This explains the inability of FHC to attract and keep attending physicians and the limited number of OB providers in the city. Since a greater percentage of Paterson residents rely in public transportation than other residents in the state; traveling long distances outside the city for healthcare services is not much of an alternative to waiting lengthier times to schedule healthcare visits in their own community (DMJM HARRIS-AECOM, 2008, p. 14).

The waiting around for Sandra, nonetheless, has just started. When she finally makes it to her first prenatal appointment, six weeks after she originally intended to enter care and 13 weeks pregnant, she is displeased to find out that she needs to call out of work. Contrary to her appointment slip showing a 45-minute session, Sandra's initial intake includes a medical examination, lab work, nutritionist screening, psychosocial assessment and an insurance eligibility screening—lasting all day. Although not happy, she feels lucky that her appointment was given during the morning time; the afternoon first-time patients are most likely to return another day to complete the process. The implementation of comprehensive intake assessments for low-income pregnant women has been a major focus of health reforms. Nutrition education and social services are critical to enhance the overall quality of health for low-income women. This was the original purpose of its implementation at the center but due to the overflow of patients and shortage of personnel, it is instead creating a burden for patients (FHC Staff, Personal Communication, July 22, 2016). In a recent interview, a FHC staff reported that a lot of patients do not complete all the process because they just do not have the time (Personal communication, July 22, 2016). The logistics are just far too complicated: pregnant women in Paterson need to plan for (1) issues with transportation (2) request time off from work since FHC is open during office hours only, and (3) arrange child care because most of the day will be spent at the center. For instance, Sandra had major issues with her prenatal visits due to work schedule conflicts. After years of working the night shifts and weekends, Sandra was promoted to work during the daytime, Monday thru Friday, allowing her to work a second job at the mall during high season. Several times she was compelled to cancel her prenatal visit or choose between a well visit at the center and a screening test at the hospital to reduce the numbers of absences at work. Since Paterson residents primarily hold jobs in production, transportation, material

moving, and retail, pregnant women are dispensable at work (U.S. Census Bureau, 2014a). The stark reality is that prenatal care for Paterson women has become a luxury and not a necessity—many chose to visit the ER in a need basis instead.

Regardless of the ordeal, FHC continues to be in high demand for prenatal care services, mainly attributed to the center's policy and grant requirement: the center cannot deny service to any residents of Passaic County (FHC Staff, Personal Communication, July 22, 2016). The great majority of their patients are Medicaid recipients and Paterson's uninsured, who can apply for insurance coverage at the center (U.S. Census Bureau, 2014b; U.S. Census Bureau, 2014b). For instance, during Sandra's initial visit, she met with a case manager and completed a presumptive Medicaid application granting her temporary coverage for nearly 45 days. In the meantime, a county Medicaid worker reviews her case, requests paperwork, and approves her insurance coverage. Because of high volume of patients and few workers, Sandra's presumptive Medicaid will expire before she gets Medicaid extension approval. She can continue services at FHC while waiting for the approval, which could take 3 to 4 months, and in some cases more (FHC Staff, Personal Communication, July 22, 2016). The process is complex and may require Sandra to follow up several times with her caseworker. Three months after her initial application, Sandra still does not have Medicaid coverage in spite of her eligibility. She has followed up various times, asking time off from work, yet Sandra is only one case of the hundreds of cases assigned to this insurance worker—Sandra is told to wait.

Sandra receives her Medicaid approval when she is 26 weeks pregnant and wants to transfer to a private obstetrician offering late night and weekend appointments but she is unable to. Medicaid alone does not cover services at a private office (FHC Staff, Personal Communication, July 22, 2016). She needs to have a Medicaid Managed Care (HMO), which

usually arrives 4 to 6 weeks after Medicaid is approved. Sandra will receive her HMO when she is at least 30 weeks pregnant and will have a hard time trying to enter care at a private doctor's office because of her gestational age. Sandra's case is not exceptional; very few patients at the center receive HMO early during their pregnancy; most do not get HMO coverage before giving birth. This means that even when women start early prenatal care and are eligible for Medicaid/HMO insurance, they must continue services at the center because options in the city are limited or non-existent.

There is no denying that centers such as FHC are critical for the care of women like Sandra: it enables women to receive prenatal care free of charge before having insurance coverage. Centers also care for the undocumented population through the Charity Care program but these women go through the same ordeal. Paterson pregnant women, already struggling with poverty, need to work so much harder to receive prenatal care because of the hurdles that institutions create for them. It is not surprising that women in Paterson have significantly higher numbers of late entrance to prenatal care and lower prenatal care visits than Wayne, where making an obstetric appointment is easily accomplished in a matter of a 3-minute phone call (Newman, MD, Personal Communication, August 6, 2016). Even when barriers on logistics are dealt with, pregnant women in Paterson encounter other deterrent: differential treatment.

Treatment Quality

The literature on whether privately insured patients receive better quality of care than Medicaid patients is not clear. The NJ Department of Health regulates all family planning facilities under the same guidelines with the goal that women across the state receive the same standard of care (NJ Department of Health, 2016). However, the quality of treatment women receive at their healthcare providers is often overlooked. Interactions at the doctor's office

immensely impact the continuation of care. For instance, if a Wayne pregnant woman feels uncomfortable at a doctor's office, is not satisfy with the service, or feels offended, she will simply change doctors. FHC staff report that their patients often undergo microaggressions, i.e., verbal and nonverbal "indignities that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, Esquilin, 2007, p.271). Although these demeaning interactions are mostly subtle, women internalize them but unlike women in Wayne, Paterson residents do not have the choice of changing providers. The only alternative is to stop prenatal services.

Of particular importance is that these belittling interactions from some of the staff are not uncommon and are not always deliberate Assumptions about the poor, and particularly about recipients of public assistance, stimulate this behavior. The assumption of self-sufficiency and the culture of poverty interlace to create a fictitious reality of the poor. The assumption attributes a person's lifelong success to the efforts put in improving one's situation (Troutt, 2013, p. 41-61). The belief is that if women, like Sandra, devote themselves to becoming financially stable, they do not have to put up with all these barriers. But because Sandra and others like her are still in this situation, they are lazy and others should not sympathize with them. Common perceptions of the poor reinforce this assumption: "Poverty results from poor decisions and weak values" (Troutt, 2013, p.153). For instance, professionals who interact with Sandra might judge her decision of becoming pregnant in spite of not having insurance coverage or means to pay for health care or even judge her decision of keeping the pregnancy amid her financial situation.

Furthermore, FHC staff reported that when a woman miss prenatal care appointments, she is usually looked at as a 'bad mother' or as if this behavior is expected from her. Paterson women get labeled non-compliant if there is no insurance coverage after a couple of months,

disregarding the long waits for approval (FHC Staff, Personal Communication, July 22, 2016). The reality is that although some of these women might inadvertently miss appointments, the great majority receive other public services and their requirements are also complicated to navigate. Often women pick and choose between appointments, especially if they work. If a woman needs to choose between going to her food stamp appointment or prenatal visit, she will choose to eat.

Assumptions about the poor are not limited to FHC or Paterson. A 2006 study conducted throughout the state by Pregnancy Risk Assessment Monitoring System (PRAMS) reported that women with Medicaid insurance were educated "15 to 30 percent more on use of illegal drugs, tobacco, alcohol, breast feeding, and physical abuse" whereas women privately insured were 10 percent more likely to be educated on "screening for birth defects and safe medications during pregnancy." While PRAMS encourages health education as part of prenatal care, it strongly advises that it should be "universal rather than selective" (PRAMS, 2006). This health education disparity implies that medical providers hold assumptions about the behavior of low-income women during pregnancy, which might disengage women from accessing the care system—contributing to inadequate care and a high health risk.

Perpetuation of Poverty and Inequality

All the barriers women in Paterson encounter when trying to access prenatal care contribute to the perpetuation of poverty. Inadequate prenatal care can lead to medical complications and developmental delays causing life-long disabilities or death, which in turn creates financial burden for families. Sandra missed several prenatal appointments due to work and health clinic schedule conflict—delaying detection of gestational diabetes during her pregnancy that led to pre-term labor and breathing complications for her newborn.

Outcomes similar to Sandra's are not uncommon for Paterson which has a higher number, than Wayne, of people under the age of 65 living with a disability (U.S. Census Bureau, n.d.). From 2011 to 2013, the average age of death in Paterson was 66 whereas residents of Wayne were expected to live until age 80 (U.S. Census, 2014a and b). These factors contribute to the high number of individuals needing public assistance in the city, where residents already struggle to find jobs. Throughout the decades, the city has more than double the unemployment rate reported for Wayne, occasionally reaching almost four times more (NJ Department of Labor and Workforce Development, n.d.). The result is that newborns do not have the same opportunities to a healthy development because they are born in Paterson. Throughout their lives, they will have higher probabilities of developing a medical condition, or dying, and will most likely be unable to find jobs causing them to stay in poverty. With the exception of those who are afforded the opportunity to escape the city—whites, according to the U.S. Census (2014b), the same will be true for their children and grandchildren, the cycle of poverty will continue unless these local barriers are reformed.

Conclusion

Place-based regulations strongly contribute to prenatal health outcome inequality targeting the most vulnerable: pregnant women and infants. Low-income residents tend to lack the means to influence decision makers on community regulations, exposing them to implementations of laws and regulations that exacerbate their current situation. This explains the over-representation of infant mortality in areas of concentrated poverty.

The case of Sandra is just one of many in the city of Paterson and other urban areas. She was able to overcome some of the barriers to access prenatal care. However, the challenge for her was the continuance of care, resulting in inadequate care based on the Kotelchuck Index. Her

outcome could have been prevented if she had proper and reasonable access to prenatal care (i.e., an obstetrician with evening and weekend appointments or shorter waiting time at the center.) To prevent these outcomes and the perpetuation of health inequality, leaders must evaluate how local institutional factors interact with each other to cause further impediments to women seeking prenatal care while paying close attention to women's experiences with these institutions. Local reforms addressing these unique experiences are a step in the right direction.

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