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Commentary

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Lessons Learned From 25+ Years of Universal Health Care Provision: Where Is the Voice of Correctional Health Care?

Roberto Hugh Potter, PhD[1]

For more than a quarter century, correctional facilities across the United States have provided a form of universal health care. Although the care may be only adequate and reactive in many cases, jail and prison systems have had to develop at least emergent health care capacity. In the present debates over health system transformation, however, there appears to be little or no utilization of the lessons learned from more than 25 years of providing the only universal health care option available in the United States. One is left to wonder why?

Is it because many of those who process through jails and prisons come from communities with poor access to health care and, more often than not, have led less than healthy lifestyles in the community, resulting in higher than expected health problems in these settings? After all, whether it is psychiatric disorder, infectious disease, or chronic disease, a disproportionate burden of poor health winds up "in jail." This situation has led to health costs becoming one of the fastest growing costs of incarceration in the United States. Spreading the low cost of healthy young people across the higher costs of aging and more diseased and disabled individuals does not seem to be making much of an impact on correctional health costs.

Correctional systems have experimented with a variety of ways to reduce "unnecessary" utilization of health services by inmates, such as co-pays for nonscheduled clinic visits. To many of us, a $5 co-pay sounds better than our current co-pay. But when you make less than $1 an hour for your work, this is considered by many a disincentive to seek necessary care, especially preventive care.

An approach to managing health care costs popular with many correctional systems and consultants is the "defined benefits plan." In essence, on entry to the correctional system, an inmate receives a booklet that details the standard medical services available to all inmates. The booklet details the cost of nonscheduled visits and explains how those fees will be deducted from inmate

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accounts, as well as the exemptions from having to pay. Most of these service schedules follow the same guidelines in the health insurance program you have, probably through your employer.

Correctional health has become big business, whether run by public agencies or by the various nonprofit and for-profit health care providers. Finding ways to reduce costs has also become a concern for legislators and correctional officials. After all, this is a public cost funded by taxpayers who want their money spent wisely. So are Medicaid and Medicare, the two systems most likely to fund health care for those elderly inmates who might be released on medically compassionate grounds. Like the old Fram oil filter commercial said, ‘‘Pay me now or pay me later.’’ Health care is not free, and so far it has been mostly a shell game of cost shifting by various levels of government using tax dollars.

Another dimension to correctional health care unfamiliar to most citizens is the ‘‘formulary.’’ This is a schedule of drugs available in the correctional pharmacy system. If a drug is not on the formulary, it may not be available to the inmate. Arguments ensue among physicians, pharmacists, and administrators about whether the newest, costlier drug will provide any better results or fewer side effects than the drugs on the formulary. When academic medical providers are involved, these arguments about ‘‘cutting edge’’ and/or ‘‘academic community standards’’ and drugs utilized can be quite heated.

Regardless of where one sits on the issue of transforming the public health system or the health care delivery system in the United States, the reality is that it will cost money. Ideally and hypothetically, if we invest more money in prevention that includes behavioral and commercial changes by individuals and profit-making companies, we will reduce the ‘‘downstream’’ costs of health care. Even inside the jail or prison, we still see those with chronic diseases on special diets stocking up on canteen items that counteract the best efforts of health care staff. Those of us who do the same thing in the free world know who we are.

Correctional health care provides us with a glimpse into the mechanisms that can be used to transform the ways in which public health and health care are delivered. Inmate behavior in a highly controlled environment shows us the ways in which individuals can still resist the best health care engineering efforts. Transforming the health care system will require a new level of social control in areas of behavior that extend beyond simply what is available at your local fast-food outlet. In the end, transforming health care is as much about social change and resistance as it is about individual health and party politics. We can learn a great deal about this from observing the health-promoting and health-defeating behaviors of inmates—and we have a lot of those, unfortunately.

Given the experiences and the expertise in developing, managing, and maintaining the only universal health care system in the United States, why has the voice of the correctional health care sector been silent in this debate? Is it because those of us associated with it do not believe we do a good job? Is it because the constituency directly served by correctional health is so stigmatized that we do not want to mention the work done? Or, is it because the issues raised between control of a population required to achieve certain health outcomes and notions of freedom held by Americans are incompatible?

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