A MESSAGE FROM THE PRESIDENT

Gayle Burrow, BSN, MPH, CCHP-RN

The transition time from winter to spring is filled with starts and stops. The weather is still unpredictable and the energy that the sun and warm weather brings is still not felt. Our trees are starting to bud and some are flowering but most are still waiting. We should not just wait for things to happen, as health care professionals we have things to do. Why not take this transition time to review our educational and membership goals? Why not take time to evaluate what more we can contribute to our own professional development and others’ practice advancement? January is the time we usually think of making goals for ourselves, but spring can be that rejuvenation time.

As I have mentioned in previous letters from the president, ACHSA is taking time out from the annual conference and evaluating education options and partnerships. One of missions of ACHSA is to provide education, skill development and support for personnel, organizations and decision-makers involved in correctional health services. The members and leadership of ACHSA has been doing this since 1976, with an annual conference and state/regional chapter conferences. Our website is being upgraded and our new newsletter editor, Mark Rowles is dedicated to making news special for all our membership. Our state and regional chapters are preparing for their annual conferences (Oregon has two) to bring you new advances in clinical practice and trends in correctional health care.

An area of ongoing communication is with the Academy of Correctional Health Professionals. It is the other membership organization and they usually have a membership meeting at NCCHC conferences. Their website is www.correctionalhealth.org. Discussion has involved each organization’s board members, but we do need our members to join the discussion of these two membership organizations merging to make a strong organization for education and support for those practicing correctional health care. Use your transition time from winter to spring to give us feedback on our website www.achsa.org.

The next ongoing board discussion topic is about having a 2017 conference. We would like to have your input into the benefit of having a national conference and its relationship to the 5 chapter conferences that occur during the year. Is a conference valuable to you and is there a location that interests you?

The other day I read a quote by Antoine de Saint-Exupery—“A goal without a plan is just a wish.” The board of ACHSA would like you to assist us in making a solid plan for the future of ACHSA. We can wish all we want, but that will get us to stay in place. Please take time to give us your input. You can go to the website, you can e-mail Stephen Mitchell, Executive Director of ACHSA, at achsa@earthlink.net or me at gfburrow@comcast.net. We will share your information with the rest of the board as we take time to look at the future picture of our great organization and the professionals who look to us for support and educational opportunities.

Attend the South East Regional Chapters Educational Conference

“One Team, One Mission”

Hotel Indigo - Athens, Georgia         September 16 - 18, 2016
Health Care for Inmates: a Right or a Privilege?

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Abstract

This paper examines whether health care for inmates is a right or a privilege. One of the conclusions emerging from the findings is that health care is a right, but it is being treated as if it were a privilege. Our criminal justice system is providing health care, but at a minimal level which places our society at higher risk of being infected and burdened with the cost of treating these diseases upon inmates’ release from prison. Research needs to be done on the relationship of healthcare expenditures for patients while in the correctional system versus the cost for society if healthcare is not provided for these adjudicated individuals.

Health Care for Inmates: a Right or a Privilege?

Prison programs that include health care are to help individuals to adjust their behavior; so that, they can live within their prospective community in a way that is socially acceptable. However, some individuals argue that “a criminal is a criminal” or that prison inmate programs are teaching criminals to be better criminals. The average offender is physically and psychologically atypical in various respects, not necessarily to a pathological degree but enough so that normal prohibition against crime is relatively ineffective. Individuals in prison are not just criminals but being labeled a criminal by the criminal justice system marks a person for further arrest and convictions and that rather than any personal traits explains the apparent continuity of criminal lives. Those individuals who have been adjudicated to the Department of Corrections have lost many of their fundamental rights; however, the right to access rehabilitative / health care is a fundamental and inalienable right to all citizens incarcerated or not.

View 1: Access to Health Care is a Right for All Inmates

The 8th Amendment to the Constitution provides that excessive bail shall not be required, nor excessive fines imposed nor cruel and unusual punishment inflicted (Exworthy, et al, 2012; Kellogg, 2009). This amendment has been applied to the right to health care (Kellogg, 2009); thereby, the 8th amendment is the motivation in establishing appropriate standards of health care for those who have been adjudicated to the Department of Corrections (Exworthy, et.al, 2012; Kellogg, 2009). Many of those inmates housed in a state correctional facility are plagued with complex and multiple illnesses and usually with greater intensity than those found in the general public (Exworthy, et.al, 2012; Kellogg, 2009 & Paris, 2008). This became evident in the landmark case in 1976 Estelle v. Gamble in the state of New York. The courts found the intentional neglect of health care needs for those incarcerated with serious medical needs is unconstitutional and therefore violates their constitutional rights. This case has later been used as the foundation to many other cases (Wright, 2008). In another case, Rhodes v. Chapman (1981), the court noted that deliberation as to whether conditions or confinement are “cruel and unusual... must draw its meaning from the evolving standards of decency...of a maturing society” (Wright, 2008, p. 32). In common everyday language this means as our society continues to evolve, so must our health care for those who are incarcerated.

Many inmates were reared in and have a very dysfunctional lifestyle which contributes to high risk health problems. Paris (2008) reaffirms this type of social learning theory: “prisoners include a larger share of risk taking individuals...statistics show that they have a larger proportion of the health problems associated with risk taking” (para. 6). Inmates’ lack of social learning contributes to high risk behavior (Hackett & Stevens,
1998; Paris, 2008). The health care programs are not only healing programs, but also teaching programs (Kellogg, 2009). If we do not provide these inmates with adequate medical services and education, in a few years they will be dumped right back out into society with the same problems, if not worse. This statement is in agreement with Paris (2008): providing inmates with the needed care enhances the inmate’s ability to function outside the penitical walls in pursuit of gainful employment. This action lowers the liability and overloading of the current health care system outside the prison walls. According to Paris (2008), the best interest of society is preserved by providing health care to inmates and promoting the public interest for everyone. J. Porter, who is an ex-inmate, affirms this by stating, that if he had not received health care while incarcerated, he would have been sicker upon his release and unable to find gainful employment. Health care is a right while incarcerated, but elective medical procedures are a privilege (J. Porter, personal communications, June 5, 2013).

View 2: Those who are convicted and sentenced to prison have lost all rights and should earn the privilege of rehabilitative / health care.

There are those who believe once you are incarcerated you have lost all rights and one must earn the privileges of rehabilitative programs within the correctional facilities. A vast majority of the American public imagine individuals incarcerated in penitentiaries are either lifting weights, stamping license plates or doing senseless labor along the highways to occupy time, while the world outside continues to grow, flourish and earn a living. The public also thinks once offenders are incarcerated, their behavior is controlled and continues to be controlled until they are released. (Hackett, & Steven, 1998). Most Americans believe health care should be a privilege to those who have become wards of the state. Inmates are just “on the take” from the taxpayers with all these free rehabilitative programs. In fact, according to Morkovsky (2012) who wrote in to The Frederick, Va. Free Lance-Star on September13, 2012, “As cold as it may sound, Health care is a privilege, not a right...We must pay the co-pay and the deductible while the aforementioned get it for free...we are not responsible for those who can work but don’t, and why should they? After all, if they sit back and do nothing, it will be handed over to them on a silver platter, taken right out of my husband’s wages that he worked for!”

Many of our correctional administrators and politicians have been listening to the public outcry to have inmates pay their own way and earn the privilege of health care. According to Paris (2008) & Awofeso (2005), many correctional facilities have started programs whereby inmates pay their fair share or at least part of their medical expenses. However, does the program allow for those who are destitute to be allowed to receive emergency medical services? Paris (2008) & Awofeso (2005) state, yes, inmates can because even our own very poor free citizens are provided free emergency medical services. Morkovsky (2012) implies that taxpayer’s money is being wasted on health care; as well as, the implied argument that prison inmate programs are teaching criminals to be better criminals by just doing nothing. This implication by Morkovsky (2012) that correctional free handouts teach criminals to be better criminals goes beyond the scope of this paper. However, Young (1996) was already discussing the concept that the real reason for the rising cost for providing care to inmates is due to the rising inmate population. This appears to be the case even today. The Department of Justice reports inmate population grew from 371,522 inmates in 1982 to 1,316,858 in 2010 (Kyckelhan, 2012).

Personal View:

Those who are adjudicated to the custody of the state have the right to receive health care. Health care for inmates helps to alleviate the pressures of a costly and overcrowded health care system outside the walls of prison, while at the same time providing society with the protection and justice rightly deserved. Correctional health care provides individuals with an opportunity to be healthy and successful prior to reintegratio into society.

The health care system in a correctional institution for incarcerated individuals is not allowing incarcerated individuals to have a free ride on the taxpayer’s dime as implied by Morkovsky (2008). In fact, as the prison population continues to increase, the operating budgets have remained the same or decreased (Kyckelhan, 2012). The Department of Justice provides the following state government average expenditures which were allocated as follows: education received 29 to 33%, public

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Recent news has been full of stories about the rising cost of prescription medications and how it contributes to the cost of health insurance. Those of us who are responsible for managing drug budgets in jails and prisons also have to deal with these issues, but our ability to address them is constrained by legal and ethical considerations. People with private health insurance are being required to pay an increasingly larger share of expenses out-of-pocket, but we are only able to charge our inmate/patients co-pays to a very limited extent. Furthermore, our patient population has a large proportion of people with chronic illnesses, often related to their previous lifestyles, and is increasingly becoming geriatric. This means, among other things, that we have a large number of patients who are candidates for treatment for Hepatitis C. Occasionally we are required to provide medications for patients with rare conditions such as Fabry’s disease, the treatment for which costs approximately $200,000/year.

Historically we have kept costs low by using generic drugs whenever possible, but now generic drug manufacturers are buying up their competitors and jacking up prices. Thorazine, which for decades cost only pennies per tablet, has now gone up to $6/dose, forcing many states to remove it from the formulary and substitute cheaper, often newer, antipsychotics.

In order to provide a constitutional level of care and follow community standards many states have begun providing the new, safer, but very expensive (initially $1000/pill) medications for Hepatitis C. Last year the Federal Bureau of Prisons spent $13,665,112 on HCV medications for 222 prisoners. While these medications have significant advantages over the old treatments for Hepatitis C, namely shorter duration of therapy, oral administration, fewer side effects and high cure rates, it has been a struggle to find the funds to pay for them. One strategy has been to prioritize which patients should be treated first, although patients with more advanced disease may be less likely to have long-term benefits. For some patients medical reprieve or compassionate release may be an option, but many are not eligible because of their crimes or lack of available community resources.

Most jails and prisons have established formularies which limit the use of expensive medications to patients who have failed to respond to cheaper ones, when such alternatives are available. For some medications we are able to negotiate reduced prices with manufacturers. Sometimes we are able to obtain medications at reduced costs by use of the 340B program. Our patients are generally unable to participate in manufacturers’ indigent care programs until they are released.

Our pharmacists and medical administrators are struggling diligently to provide the best and most effective medications to our patients at costs we can manage within our budgets. Please try to be understanding when there are changes in “preferred” medications or they ask questions about whether patients really require certain expensive medications.

I would be delighted to hear your comments or alternative points of view. Please send them to me at jrowles@mhm-services.com.
Health Care for Inmates: a Right or a Privilege? continued

welfare received 22% to 25%, highways received 5.7 to 8.6%, and health care received 6.2 to 7.5% (Kyckelhahn, 2012). These figures demonstrate that health care for the imprisoned is being provided at the minimal rate.

According to the statistics for Medicaid, North Carolina spends approximately 28.18% of its budget on helping the citizens of North Carolina who are not incarcerated (Medicaid, n.d.). However, the U.S. Department of Justice, which receives information from each of the state governments, reports that on average each state spends approximately 1.9% to 3.3% percent of the total budget on the total correctional operational budget (Kyckelhahn, 2012). This summarization is modest, but it helps a person realize how these programs are strictly managed with efforts to comply with the 8th Amendment and correctional health care.

Ethical Concept

In fact, this is utilitarianism at its best. According to Cherry & Jacobs (2014) this ethical concept “is right if it leads to the greatest possible balance of good consequences or the least possible balance of bad consequences” (p. 174). Does it make sense to dump these individuals out onto the streets ill prepared with disabling diseases to infect and afflict more harm onto our society? The more inmates are isolated from a free society and deprived of its amenities, the more likely the offenders will reject those lifestyles and will inflict more harm on the society as a whole while costing everyone more money. This is not saying utilitarianism is the complete and total answer; however, an ounce of prevention within the Department of Corrections health care system is definitely more valuable than a pound of cure later after their release, which will be at the taxpayer’s expense.

Summary / Conclusion

As society continues to move forward and our penitentiaries continue to become overcrowded, the 8th Amendment will be at the forefront for health care for those incarcerated within the walls of our prison system. There will always be those, who like Mrs. Morkovsky, are screaming about how inmates are getting a free ride. The Departments of Corrections will be trying to balance the greatest possible good against the least possible bad consequences, while not affecting the burdens of the taxpayers, and those with serious illnesses will receive the health care appropriately determined by the Court in support of the 8th amendment. The American Correctional Health Care System is in need of indemnification. This article has shown that health care is a right for those incarcerated behind the walls away from a free society. Again, an ounce of prevention is more valuable than a pound of cure after their release. However, research of new alternatives and implementation of them are required. Crime and health care for those who commit these crimes will always be debated, but how we confront the issues of health care for these individuals is as important as the correctional facilities which house them. Some programs may be less efficient than others regarding health care and various other programs for these inmates, but they are necessary in the development of a more complete and comprehensive correctional system, which is to provide equal protection and justice for all.

REFERENCES


The Spring Conference of ACHSA’s Oregon Chapter went to the Intake Center at Coffee Creek Correctional Facility, for its one-day conference. Of the 32 attendees, we had eight counties represented along with the Oregon Youth Authority and the Department of Corrections. The adjustment of having a conference in a correctional facility was that we had to leave our phones in a locker or car and had to go through the security clearance process. But we were all used to those things in our daily work, no matter what facility you work in.

The room was full of excitement as old and new friends met and exchanged stories. There were great snacks and a catered lunch. We had good vendor support for speakers and meals. Oregon was trying a one-day forum for our spring conference in order to provide education to more people. This was the largest attended conference in many years. The feedback was good to continue this central location and one-day format to contain costs and time away from work and family.

The day was accentuated by a great session on wound care and a meaningful discussion on how to talk to someone who may be suicidal. We all came away with tools in our professional toolbox. We learned about the DOC’s inmate/peer-taught program for chronic disease self-management and the community and facility focus of Janssen with mental health care. The afternoon included a discussion about components of the discharge planning process and a review of CQI. But the highlight was a tour of the DOC Intake/Receiving Center. The county nurses were excited to see what happened so they could better prepare their inmate/patients with what to expect when they went to prison. Even some of the DOC staff had not toured the intake center before.

The Oregon Chapter is beginning to plan our Fall Conference which will be in October at the Beach in Newport Oregon. We have also received suggestions for the next one-day conference, maybe in Portland. Our goal is to provide educational opportunities for correctional health care professionals and also networking with each other.

**Membership has an advantage!**

If you plan on joining us at any of our regional educational conferences, you will always qualify for a reduced registration fee if you are an active member of the national ACHSA organization.

Becoming a member is easy….simply print the following page of this newsletter (page 7) and mail the completed form along with your check. You should receive your new membership package within a couple weeks from your submission.

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