

Healthcare in Prisons: reflections on the inertia of systems and the low effectiveness of health policies in Spain

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ABSTRACT

The blockage in implementing transfer of prison health care to regional governments is a problematic social and health care issue, and also brings to light major institutional and political weaknesses. This article considers the power dynamics between administrations and levels, highlighting the subordinate nature of the health care agendas with regard to political and economic ones, as well as the sizeable capacity for blockage created by the environment itself. Within this context, some strategies are proposed to improve the future feasibility of the integration of prison health into the National Health System, based on the awareness of the need to accumulate power and influence, promote service improvements to increase the attractiveness and desirability of prison health, and the acceptance of more extended time scales so that cultural changes may take root.

Keywords: Health system; Prisons; Health care reforms; Policy; Political Systems; Decentralization; Spain.

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INTRODUCTION

Health is an asset that should be protected extensively and comprehensively; the proposal of universal health coverage by World Health Organization (WHO) faces the fact that large groups of the population worldwide are not able to access highly effective services in healing, controlling or alleviating the effects of disease¹ on the basis of a lack of solidarity. A silent yet visible aspect regarding insufficient universal health coverage is the lack of access to quality care for the imprisoned population, a fact which is especially insidious in developed countries which provide coverage for virtually all the rest of the population. The Madrid Recommendation² approved in 2009 in a Meeting including representatives from 65 countries, Euro-WHO and a wide range of agencies and entities, called for “*the development of a comprehensive program regarding the protection of health in all prisons*”.

Arguments include equity and efficiency regarding the provision of healthcare services: Indeed the imprisoned population remains strongly related to the general population contacting and returning to it periodically and eventually when the sentences have been served. We can find a concentration of pathologies in prisons, which offer a particular intervention opportunity to control certain diseases and promote health among a sector of population with a poorer health capital, less health education and a heavier burden of disease and risk factors. As we already know, a professional and sensible intervention regarding the prevention, treatment and care of HIV³ would have entailed a very different story of AIDS in Spain.

The provision of health care services in prison has specific and problematic aspects but for most it seems clear that as far as the integration with other health services is concerned, it offers broader and better possibilities.

From an ethical point of view, it seems convenient that health care services in prison do not depend from the direction of such establishments, since there is a major conflict of interest between custody matters (and the risks of malpractice in this regard) and the tasks of providing health care to inmates. Obviously, there has to be a structured functional relationship but an organization firewall needs to be introduced to avoid what Hernandez pointed out: *“the provision of health care services in prison depends from the director and therefore, since custody matters have primacy over health care issues, all health interventions are subject to the regimen of the establishment. Hence, health care services will never be autonomous”*⁴.

It is also naive to conceive a typically clientelist relationship. Physicians and nurses providing care to prisoners have a dual agency relationship, just like primary care physicians who develop clinical tasks (aware of costs and the effects on public health) and whose decisions certify events with implications regarding certain benefits (sick leave, invalidity). However, in this case in particular such relationship is clearly unbalanced in favour of the authority function (as a representative of society and public interest). That is why it would be particularly useful to lay a clear line of independence from local authorities in prison and build bridges with network organisms, both within prison health and with the National Health System (NHS). A strong dual agency relationship would entail further legitimacy and authority before inmates, their families and society as a whole. Prison health care professionals have stated their opinion all throughout this period: a paper by the Spanish Society of Prison Health makes clear and documents that they agree on the integration of such services within health care services of the corresponding Autonomous Community⁵. From a professional perspective, the Spanish Organization of Medical Colleges (OMC) has clearly stated its position in the document *“Prison Health: discrimination for inmates and health care providers”*⁶.

As far as its organization is concerned, prison health has tried to follow the guidelines of the National Health System to facilitate the attachment of both systems. In this sense, it conceives the provision of services as prison primary care, it has set a “portfolio of services”⁷ and it has created commissions to enable interinstitutional approximation among other initiatives⁸. It has also counted upon economical arguments which seem to promote the outcome of integration such as the existence of economies of scale and scope.

In a coda to this political, technical, healthcare, ethical, professional, organization and economical approach, the regulatory framework clearly defined the

horizon of integration of prison healthcare in health services within the autonomous communities. It is worth noting the resounding second paragraph of the Act on Cohesion and Quality of the NHS of 2003: *“Additional sixth disposition on the transfer of healthcare services and facilities depending of Penitentiary Institutions to Autonomous Communities. The provision of healthcare services now depending of Penitentiary Institutions will be transferred to the corresponding autonomous community as to achieve their complete integration in the corresponding autonomic healthcare services”*.

This Act defines too a rigorous implementation period: *“To this end, in a period no longer than 18 months after the entry into force of this Act and by means of the corresponding Royal Decree, prison healthcare services will be integrated in the National Health System, according to the transfer system established by the autonomic regulations”*.

After such an unequivocal mandate from the legislative to the executive, supported by a vast majority of representatives from all political parties, we are currently close to ten years late in this integration process so solemnly established.

The objective of this paper is to elaborate on the political dynamics as to better understand the hold-up in the development of this organization transformation process, by understanding that it has not been the only but yet another exponent of the difficulties of health authorities to lead the process of institutional change. On the basis of this understanding we will explore what changes in governance or strategy would enable the desired final result.

1. THE ESSENTIAL DILEMMAS

First, we must consider several dilemmas impossible to solve rationally. The functions of support, custody and reinsertion form part of the difficult balance of prison health. Due to the restriction in movement and the features of the imprisoned population, the achievement of equivalent care implies positive discrimination; and this is not easily accepted by the general population, especially if the economic crisis and the weakness of equitable values lead to limiting solidarity. Moreover, the territorial fragmentation of the NHS conflicts with the institutional centralization of the prison system.

Dilemmas should be approached by aiming at balances that would minimize entropy or disorder; yet this always entails tension supported by different agents. Each model has advantages and disadvantages:

the most important thing to do is to explore both and avoid fantasies and mythification". In this sense, it is worth saying that the transfer of prison health to autonomous health services would not make all problems disappear, nor would it represent the Happy Arcadia for healthcare professionals and prisoners. It could be beneficial as long as advantages were maximized and costs minimized. A good study case would be the comparison between Catalonia and the Basque Country (where prison health has been transferred) with the rest of autonomous communities in Spain.

Yet this paper is not aimed at the essential dilemmas, but at the paradoxes of the process of policy implementation, since in Spain there is a clear decision, as it has been previously stated.

2. THE INSERTIA OF THE PROCESS OF INSTITUTIONAL CHANGE

If you run before a pack it is difficult to tell whether you lead it or you are trying not to get run over by the stampede. Many stories allow an epic and a pragmatic version, including the Spanish transition to democracy. And since human beings need myths, especially foundational, we tend to turn complex and dirty processes into linear and shining dynamics. The bad thing about the comfortable self-delusion is that it leaves us unprotected before the following evolutionary challenges of society, preventing us from learning from experience and perfecting the governance and management of complex political economic and social systems.

Even the General Health Act 14/1986 forms part of the creation myths of the National Health System. Yet the Spanish public health followed an evolutionary and incremental path with regard to what the *Instituto Nacional de Previsión* (National Institute of Social Provision) had developed throughout the 50s of the last century⁹.

An example: healthcare financing started coming exclusively from taxes in 1999, therefore abandoning the contributions of Social Security. This could be attributed to the change of model defined by the General Health Act but it would be interesting to doubt the primarily healthcare nature of the measure, since the newly redesigned system retained the contributory money benefits and got rid of benefits in kind or non-contributory benefits (healthcare and social services).

The decentralization of healthcare is another example: the transfer of health services to autonomous communities was part of a design by the Spanish Constitution to empower a new institutional

level with a series of tasks and responsibilities. Such vigorous decentralization process can be understood from the political conviction or viewed as a convenient measure for central economic authorities for whom such inflationary and loss-making services had always been a budgetary and fiscal nightmare.

It is worth formulating an inertia principle regarding the processes of institutional change: they all need an initial political energy to overcome the resistance to change. Therefore, only when there is enough power and resources in favor of transformation this can take place effectively. In the new institutional economy this inertia is explained by means of the so called "path dependence" created by the historical course of a system or technology and which opposes any transformation¹⁰.

From this less epic perspective, the Spanish healthcare model can be described as a matrix inherited from the Social Security system, which became universal in the transition to democracy (yet incompletely and in a biased way), financed by taxes as to match the logic of economic authorities and which became autonomic due to the logical policy of the transition process into democracy.

3. BALANCE OF POWER IN THE TRANSFERENTIAL PROCESS

If we analyze the political and institutional dynamics, the transference of resources and powers between different institutional levels, organizations or agencies is ultimately the result of the vector sum of forces between that who transfers and that who receives. Let's take into consideration both perspectives:

a) The perspective of that who transfers powers and resources

It seems necessary that the issuer governmental level must be authentically and firmly committed to get rid of the centers, services and powers so that the process may move forward overcoming any institutional inertia.

However, there are no homogeneous levels; there are political authorities (general); economical authorities (economy and finance) and staff authorities (public service) which clearly prevail over the specific agendas of the rest of Ministries and Regional Governments (sectoral administrations).

In the specific case of prison health, it seems clear that political authorities don't see much of a problem in transferring it and therefore have given the green

light to several regulatory frameworks that empowered transference. We should seek what the real positions of economical and public service authorities have been, which may have not been as clearly facilitating as we may assume.

Yet, where probably most of the objection has taken place is at the sectoral level of prison authorities, since the role of assistive devices in prisons outweighs the healthcare role and entails an essential resource to support the functionality of prisons themselves. The limitation of resources (absolutely or relatively due to an increase of the imprisoned population) works against any facilitation of the process and will imply that prison sectoral authorities activate silent but effectively the institutional blockage.

b) The perspective of that who receives the new powers and resources

It is also necessary that the receiving institutional level accepts very positively (or at least without great reservations) the transference process. Possibly the strengths and weaknesses of the issuer may be compensated if the recipient provides energy and determination.

In the case of healthcare powers, there was a desperate need to receive the transference of INSALUD by autonomic governments who sought further legitimacy; particularly since 1991 when ten “slow lane” communities were left behind (with 40% of the population) and had to wait for ten more years to complete their schedule and become “first division” communities (as the seven who already had).

This healthcare transference also implied a 70% budgetary increase (and a basis to commit financial transactions for this and other purposes). Moreover the transference of tens of thousands of public employees nourished public service corps and salary scales. The three main institutional agents won (general policy, economy-finance and public service) and therefore, although the Act 21/2001 (autonomic financing) and transference negotiations were less than satisfactory from the healthcare point of view, they took place with unusual diligence and enforceability.

It is therefore essential to know how the transference is considered from the recipient’s point of view: Do political, economical and labor advantages prevail? Or do burdens, problems and cost remain?

In the case of prison healthcare it seems that we are talking about the second part of the equation. None of the major agents considers it very interesting. And what about the autonomic healthcare administration...?

There is a somewhat dissenting case, that of Catalonia, which can be a good counterpoint to reinforce the argument. In Catalonia the transference of prison administration took place long ago (RD 3482/83) and we could put forward the hypothesis that this transference was sought by politicians on the basis of a nationalist identity ideology which considered a positive advance any outflow of powers from the government of Spain (no matter how unattractive in terms of burdens, problems and costs).

The same process limited to prison healthcare took place in 2011 in the Basque country with the transfer to Osakidetza ¹¹. It should be taken into account that there is great sensitivity and political conflict regarding the issue of political prisoner in the Basque Country and that this may have encouraged the desire to assume functions by the autonomic administration.

Anyhow, we reaffirm the interest of both experiences as to evaluate the real impact of the integration of services in the relevant results for all actors (and especially for the health of the imprisoned population).

4. THE DECISION DYNAMICS: PROBLEMS, SOLUTIONS, AGENTS AND TIMING

In policy analysis, the United States School usually uses the garbage can model¹², where problems, solutions and participants (in the process of decision making) come together in the garbage to create action opportunities; but with time the garbage is collected and everything is taken away. Then the cycle is reinitiated and another decision making process has to mature.

Our institutional rules set electoral calendars for the central and autonomic administrations which usually differ in one year yet some autonomous communities can hold elections and usually introduce further variability. This asynchrony leaves a small interval for technical work between electoral promises and the implementation of real and operational governmental agendas. Furthermore, such agendas require the harmonization of different perspectives inherent to policies: service sectors, public service, finance and other entities involved. Together with institutional share-holders there are also economical and social agents involved and stake-holders which act and influence through more or less open lobby activities. This affects any of the inter-administration agreements and particularly the transference of major powers (healthcare, education and social services).

According to Freire's thesis¹³ (which many of us share), healthcare policies have had a poor consideration and role ever since the transition to democracy, including in the Spanish Constitution. Many of the institutional changes (transference to autonomous communities) may be explained by the political desire or the economical convenience of general policymakers or economic authorities. If this hypothesis was true, the real regulatory force of agreements or healthcare sectoral rules would be very low unless it counted on the endorsement or interest of the leading administrations. Anyhow, it would be difficult to overcome the resistance and any involved agent could easily block the development of the process.

Apart from the aforementioned domination of major institutional agents (policymakers, economical and public service) over sectoral ministries it is necessary to draw a map of closer potential blockages: a stick in a wheel requires little energy yet closer proximity.

As we mentioned before, if the directive technos-structure of prison institutions lives the transference of "its" physicians and nurses as a real and tangible loss that is not offset by the supposedly improved service (a bird in the hand is worth two in the bush) it will inevitably create resistances that although concealed will act effectively.

Frequently problems are even closer than it seems. Even prison healthcare officers may be prone to ambivalent professional and personal feelings. After long years of considering a happy final destination the integration and escape from the National Health System, agoraphobia can be as disruptive as claustrophobia. Perspectives may vary throughout the years of professional career and previous working experience of physicians and nurses. Yet the relevant thing is that the position of healthcare officers directly involved may be very effective since their proximity implies further opportunities to create opinions and influence explicit or implicitly in policy or institutional agents.

5. FROM PROBLEMS TO SOLUTIONS

Ever since 2010 Spain suffers the effects of a severe economic and financial crisis which threatens the financing of public services (therefore creating new problems) and yet shakes off the political agenda, creating new opportunities for change, although only those in accordance with the objectives of austerity are prioritized. Economical authorities have assumed a determining role and the Royal Decree-Law has been

entrenched as the dominating model for express regulations. Has this new scenario promoted the creation of new opportunities to reform structures in the NHS which have been long postponed? It doesn't seem so¹⁴. Times of crisis undermine prospects of change without a solid financial and fiscal basis. Austerity has also irritated everyone and it has destroyed the capital of confidence needed for intelligent and medium term transactions. Furthermore, the hasty regulation, with low quality manufacture, has complicated the legal jungle creating a situation of deregulation and legal uncertainty.

Anyway, from the perspective of prison health it is urgent to move from problems to solutions. We already know the unbearable lightness of formal politics, empty declarations and ignored rules. We have already learnt that institutional changes are slow and require talent and skills. We usually say that culture scoffs a policy for lunch and a strategy for dinner. Measures must be taken regarding values and visions although it may imply more time and effort and well focused energy.

Nevertheless new examples of good governance, democratic regeneration and organizational reformism are emerging with force in our political horizon. This entails a challenge to the domination of institutions by the hidden logic of economical authorities and external agents and it also implies new tools to improve the governance and management of public organizations. Politics (with capital letters) and Sectoral Politics (with capital letters too) can count upon a renewed strength and capacity to influence.

This is why it would all lay on the intelligent and tenacious design of a strategy leading to the desirable and desired objective. This would improve the feasibility for example by improving the service, more politically and economically integrable (by autonomous communities) granting to prison authorities that the provision of local care, administration and regimental services are not going to be challenged, financing care devices and resources that would complement the services provided by autonomous communities and building alliances with social and political agents to consolidate a new culture favorable to the National Health System not staying outside prisons. In other words: to claiming a new concept of global and inclusive "healthcare citizenship" that includes the imprisoned population and avoids the segmentation and fragmentation of the care system.

CONCLUSIONS

We are facing a complex situation, where the advance of institutional changes encounters important dilemmas and resistance. This is why we sum up as conclusions several areas of work which consider the impaired power of health care administrations and the weaknesses of the political agenda regarding the transference of prison health. The goal is to look for medium term opportunities: so that the following strategies to create the conditions for a real end effective change in the institutional arena are proposed to promote their debate.

1. To improve the current situation of prison health and clearly set a difference with prison administration: in times of crisis a challenged conflictive amalgamated service without clear organizational cleavage planes is unacceptable.
2. To force the economic desirability of prisoners for autonomic administrations. For example, that the per capita income that the community receives in concept of inmate's residence, be reassigned to the prison system so that it is reinvested in the healthcare service in accordance with the service provided. To this penalization, incremental financing may be added to achieve equivalent care and reinforce the preventive and restoring action.
3. To unblock the reluctance of prison authorities. To differentiate more specialized functions such as administrative tasks from clinical tasks, by granting prison authorities that the first are efficiently developed by specific personnel sufficiently trained to execute their duties in combination with assistance activities developed by Health care Services in the Autonomous Communities. By doing this with the necessary talent and management intelligence, the desertion and desertification of prison health would be prevented.
4. To promote the interest of autonomous communities by means of investment that enables the continuation and consolidation of reference hospitals and services to receive prisoners. It would entail not only facilitating money but also by providing expert advice with regard to safety and patient management issues.
5. To create or consolidate current operational coordination systems. A subsidy for those autonomous communities which organize and maintain an office for the coordination of care for detainees and prisoners may help stabilize an organizational need in a permanent way.
6. To look for social coalitions promoting change.

7. To articulate alliances between parties to adopt calendars for improvement measures in a roadmap that avoids excessive optimism for short terms (18 months) and which focuses on measures which already imply an advance in the provision of services as well as preparing for the desired institutional changes.

Against the institutional weakness of healthcare administrations only more intelligence, stronger alliances, obstinate and resilient leadership and longer timing for those strategies to become effective in times of impaired power and resources can be used. Anyway, it is convenient to know that a good "Plan B" (improvement of prison health) can open the road for the "Plan A" of its transference and integration.

CORRESPONDENCE

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