

LETTERS TO THE EDITOR

INTEGRATION OF PRISON HEALTH CARE: A CHALLENGE THAT WE MUST ALL TAKE ON

The integration of Prison Health care within Autonomic Services of the National Health System (NHS) represents for the Spanish Society of Prison Health (SESP in Spanish) an inherent demand ever since its creation in 1997. This is so, because the SESP believes that Public Health Care- in order to ensure its fairness- should not undergo any kind of fragmentation and should compulsorily be a sole entity, both for professionals and users. Since 2003, such opinion has acquired a legislative condition, after the Spanish Parliament passed the Act 16/2003 on Quality and Cohesion in the National Health System, whose sixth additional disposition literally states that *“Health care services depending from Penitentiary Institutions will be transferred to autonomous communities so that they are fully integrated in the corresponding autonomic healthcare services”*.

Back in 1998, the SESP submitted a report where integration was assessed as a future key element for improving Prison Health. Ever since that moment, and with such main aim, the Society has had numerous contacts to promote the process. The first approach concerned the General Direction of Penitentiary Institutions (currently, the General Secretary of Penitentiary Institutions), which has progressively been showing a more favorable behavior towards the integration process, even though efforts have not been taken on equally nor fully by all its departments or services, therefore leading to a lack of greater will towards the achievement of such objective. It is therefore enough to check the lack of advance achieved in the process almost seven years after its achievement was legally observed. As far as the Autonomic Administrations are concerned, these have shown almost no interest at all in taking on this responsibility.

Another usual contact –it could not have been otherwise- has been with the Ministry of Health, Social Policy and Equality, who entered the commitment of creating an inter-department work group with the participation of the SESP several years ago. Unfortunately, such participation was eventually rejected by the Deputy Direction of Prison Health, who claimed a series of reasons which we never shared but with which we complied so that we would

not hold the evolution of a process which was being initiated at that time. All the members of that work group, except for the representative of INSALUD, supported the integration approach, even though, until now, it has not lead to any relevant outcome.

We have also been in contact with the main political stakeholders, members of parliament and senators belonging to all parliamentary groups, so that the Health Commission of the Spanish Parliament passed a motion, published in December 1999, concerning the integration of public officers belonging to Prison Medical Entities and Healthcare Technical Assistants in the Public Healthcare Network, by means of the framework statute for professionals belonging to the National Health System.

Interviews and meetings have also been held with professionals through the Official Medical Association (OMC in Spanish) and the Nursing Association. As far as this is concerned, on March 17th 2010, the first Prison Health Conference was held in the WHO headquarters, and its conclusions included that the current situation created a doubly discriminatory situation. On one hand, patients suffer from such discrimination when their right to the same healthcare than the general population is provided with, is sometimes breached. On the other hand, professionals providing such healthcare must develop their job in different working and professional conditions, which are sometimes worse than those of their counterparts of the National or Autonomic Health System.

What are the reasons inspiring the Spanish Society of Prison Health to demand so insistently the integration of Prison Health in the relevant Autonomic Health Systems?

Firstly, the SESP considers that health prevention and healthcare must be designed, estimated, managed and assessed by Health Authorities. Otherwise, its aims, activities and the provision of services can be severely questioned. Therefore, the fact that prison Healthcare Services organizationally depend from National Offices, such as the Home Office, amongst whose main objectives the promotion and care of health are not contemplated, makes such Services poorly credible, despite the efforts made by both professionals and the Public Administration.

Second, the SESP believes that an integrated healthcare structure in the Secretary General of Penitentiary Institutions, divided into several departments (surveillance, order, security and prison treatment), makes it an isolated entity, alien to the rest of the prison network and set apart from outer healthcare resources with which it must compulsorily keep in contact and coordinate their work. We strongly believe that this situation leads to a prison healthcare model which can be classified as independent at the expense of poor operation or even a lack of it as far as some healthcare levels are concerned, apart from being poorly effective.

Third, the SESP estimates that the current prison healthcare system is not feasible, as it can't ensure a fair access of the population assisted both to specialized medicine and outer healthcare services. It also lacks proper economical resources which allow covering its elemental needs. The main features of this obsolete structure belong to another political era, which we have successfully overcome, when Prison Administration was the only provider of services and counted with its own teachers, doctors and even priests- set apart from the normal network and with a strict sense of property. Such principles, based upon the isolation of prisons, belong to past centuries and non-democratic cultures, and are currently hardly justifiable, even though the healthcare structure which was then created is still invariable in most of the Spanish territory.

Finally, the SESP considers that the current situation is unacceptable because most of the professionals have repeatedly stated their disagreement and a will for changing it. Disagreement concerns the hierarchic dependence that can pollute professional activity, the lack of professional career, the administrative career, which is not based upon antiquity, merit and

capability; the obstruction to research, the professional isolation and an overall strong will to belong once more, to the Healthcare Community. Can the Administration keep on turning a deaf ear to a demand with such characteristics? If integration means greater credibility, transparency, fairness as far as assistance is concerned and greater management efficiency, and it is also a legal imperative, what are the reasons for the Administration's slowness in carrying it on? Why is there such a lack of social sensitivity towards a population which is already enough isolated? Why imprisoned citizens do not have the right to enjoy healthcare in the same conditions than the rest of the population? What is jeopardizing that prison professionals depend from the same Authorities that manage Healthcare provided to the rest of citizens in this country? The society should know, briefly and thoroughly, what are the reasons for the Royal Decree responsible for the legislative compliance, not being passed and published seven years after the enforcement of the Act. What is it for such delay?

The SESP believes that it is high time the Act was implemented. At the end, the only way to solve the double discriminatory situation which affects the imprisoned population and prison healthcare professionals is to transfer Prison Healthcare competences to Health departments in autonomous communities. Such process can't be delayed and must be implemented at once, without exceptions all throughout Spain. We appeal, once more to our political class, so that the process is stimulated and irreversibly implemented, so that we put a definite end to inequality created by the current system.

**Board of Directors of the Spanish Society of
Prison Health**

LETTERS TO THE EDITOR

INTEGRATION OF PRISON HEALTH CARE: A CHALLENGE DECISIVELY TAKEN ON BY SOME

I have attentively read the letter that the Board of Directors of the Spanish Society of Prison Health (SESP in Spanish) has sent to the Editorial of the Spanish Journal of Prison Health and the Medical Journal and, even though I agree with it in the main, I believe it is interesting to send these reflections, just in case they are worth publishing.

As far as I am currently concerned, as Head of Prison health in the State, except for Cataluña, and mainly because most of the opinions included in the letter are targeted at the management of the Secretary General of Penitentiary Institutions, of whose Board of Directors I am a member, I believe that I must explain certain actions so that they are not misunderstood nor doubly interpreted.

I have been aware for over two decades of the importance of the integration of prison health in the community's healthcare services. My entrance on the Board of directors of the Secretary General has only strengthened that belief. Therefore, in the main I completely agree with the letter sent to this Journal by the Board of Directors of the SESP. In the end, it is all about ensuring the rights of inmates as users of healthcare services, the access of this group to health resources, the quality of prison health provided and a fair access to care.

I have had the chance to discuss thoroughly this issue with all the presidents of the SESP who have been in charge of such responsibility and with many members of its Board of Directors throughout the 13 years of existence of the Spanish Society of Prison Health, and I am certain that we do not think differently.

Probably, those who have followed the history of Prison Health will believe with me that such transfer represents a watershed in the future of this highly specialized part of public health. There have been previous moments of greater or the same importance, dates such as December 13th 1886, when the figure of prison doctor was created, therefore acknowledging the need of providing standardized public assistance in prisons. Since then, our work has undergone a series of changes, but has always remained an isolated system inherent to the penitentiary environment. So that even the 1986 General Act on Health, which

observed a National Health System for all the population, whose essential aim was to implement the constitutional right to the protection of health, made no reference at all to this assistance which was being provided, and which is still provided, for the most disadvantaged groups of population, when besides they are in prison.

In the early 80s, a combination of factors led to Prison Health experiencing certain take off as far as an improved structure is concerned. On one hand, we must take into account the raising awareness about the spreading of AIDS in prisons, which in Spain reached one of the most important rates in Europe. This fact, allowed that a great deal of resources were transferred immediately, and on a regular basis during following years, to strengthen health staff in prisons. Technicians from the Ministry of Health took the lead over the General Directorate of Penitentiary Institutions and started to lay the foundations of what today has become an organization of reference for European prison health services, both due to the high professionalism of its members and the effectiveness of public health policies which were then implemented and which continue to be reinforced. Another determining factor for the development of prison healthcare was the creation of the Spanish Society of Prison Health at the end of the 90s. The impulse of a new technical society always leads to unified objectives and interests in any professional association. I am certain that the SESP with both its good and bad moves, has helped the assistance level in Spanish prison, which can always be improved, be above the European average.

What is the next quality change that prison health must undergo in our country? Obviously, the transfer shyly suggested at the end of the 2003 Act on Quality and Cohesion. It could seem that at the time legislators had not a clear idea of what was being heralded in one of the final sections of that Act. Something of such importance would have obviously been worth of the main section of the legislative text, but was attended to with a few lines in one of the final sections and contemplated a period of time, which would have been estimated as formidably optimistic by anyone acquainted with the situation.

Yet there remain a series of severe inconveniences for the achievement of this transfer, beginning with the transfer mechanism established for any competence from the central government to autonomous administrations. A great deal of potentially transferable competences are regarded as financially deficient by Autonomous Communities. Funds used by the central government for such competences are estimated insufficient by autonomous governments when they have to meet such responsibility with autonomous management, therefore requiring a cost overrun for the central government. This is far more frequent as the autonomous government grows uninterested in assuming such competence.

The management of prison health, due to its specificity, is poorly known by those responsible of health in Autonomous Communities. Prejudice and interested opinions about it being a rambling task, take the lead over the very different reality.

In short, any situation in real life won't be properly managed because an Act sys so and even less when a period is established, without taking into account the involved parties. So, what the Act on Quality and Cohesion established has not been accomplished yet. Then, how could this situation be unblocked?

In my opinion, anyone who thoroughly and passionlessly analyses the problems which prevent the transfer from coming to fruition will realize the following:

In order to introduce changes in public management, prior political impulse which comes to an agreement with all the parties involved, must take place. Later, all technical issues entailed by such change must be approached.

As far as the Secretary General of Penitentiary Institutions is concerned, during the last two terms of office, there has always been a political will to move on in this area. Nevertheless, such will was never found in political health representatives in the Autonomous Communities which were contacted to initiate the transfer process.

Yet, advance regarding technical problems after any transference, once the political process has ended, can be initiated regardless the later. If the aim is for prison health services to work as primary care services do in each Autonomous Community, why not take a lead in the harmonization of both services? Why wait until a political agreement is entered, if we can already begin the process which follows such agreement? Moreover, if we initiate that process no one is harmed; an improved coordination between prison health services and those from the community can only be beneficial for prison and hospital professionals, for an

improved care of inmates and to bring the reality of prison health services closer to health authorities in Autonomous Communities.

From Health Coordination, this approach has already been considered and Healthcare Harmonization Commissions have been proposed in different Autonomous Communities as to unite primary care working procedures, both inside and outside prisons. Coinciding on the assistance model, raising awareness on prison health and allowing that it be offered as a tool within the services of each community, enables further integration in outside-prison assistance resources.

What are the technical issues which we should be solving? Some of them have systematically appeared in all commissions:

- The difficulty of explaining a very particular assistance model, different from health centers, primary care facilities, hospitals and residences, all of which share some common aspects.
- The customer relationship established with the prison administration since Prison Health provides services which are generally, although not exclusively, derived from medical and legal obligations legally observed.
- The professional situation of transferred staff.
- The isolation of the prison environment itself, which promotes prejudice and stigma, both for professionals and prisoners.

Finally, such transfer would entail the administrative problems of any transfer whatsoever; this is the negotiation with third parties, between departments alien to such transfer. These departments must come to an agreement on administrative and budgetary issues, financing models, the adjustment of administrative structures in different departments, the professional situation of transferred staff, etc. This involves the Technical Secretary General of the Spanish Home Office and the Deputy Directorate General of Transfers of the Ministry of Territorial Policy, as far as the central government is concerned, and the Presidency of the Autonomous government. Several bodies completely alien to healthcare are in charge of reaching the necessary agreements to achieve the administrative and political part of any transfer. On the other hand, health representatives must negotiate the actual assistance issues of the transfer. Once both negotiations are done, it is manifested through

an Act (therefore one act per autonomous community is needed and not a general one as it has been misinterpreted so many times), where technical parts are included. These must have been previously agreed by agents, who play an active role in the respective transfer, in this case prison health, so that technical negotiation must involve both Health Coordination and the respective Health Autonomous Government.

It is such a complex process, where its development can be blocked at so many and so different bottlenecks, that it is important that the bonds of all involved social bodies be declared and made public: our colleges from prison health represented by the SESP, health professional syndicates, both Medical and Nursing Associations, international organizations, political representatives, etc. However, it is also true, that the Ministry of Health, probably because it holds no longer assistance competences, has always remained extremely neutral and has never supported nor promoted one approach over the others.

Unease among prison health professionals due to the lack of professional career can be shared by all the officers of the General Administration, where professional promotion simply does not exist. I strongly dissent with the statement that the Board of the SESP holds about the "obstruction to research" of which the Secretary General is accused. I firmly believe that there has not been a person in charge of the Prison Health department as aware as I am on the importance of research as a part of the daily tasks of a good professional, especially if it is a medical one we are talking about and probably even more if he/

she works in the penitentiary environment, which is so isolated and so poorly studied. As a co-editor and founder, three years ago, of the Spanish Journal of Prison Health, which has recently been indexed by the most prestigious biomedical database in the world-Medline, I believe this conviction is sufficiently proved. However it is true that there is a lack of objective and lawful regulation, from which clear conditions about the research in the penitentiary environment be established, save for arbitrary interpretations on what, how and when to research. Active works are being currently developed in the publication of such regulations in close cooperation with the Spanish Drug Administration.

In conclusion, the transfer of prison health services to the community is the unresolved evolution. It won't be easy to complete it but I believe that the strategy developed by Health Coordination authorities in this term of office will allow firm and continuing advance in the integration of prison health services in the rest of public health, as to put an end to the structural rift which currently exists between primary care inside prison and the rest of assistance provided outside.

We have worked very hard this year with the aim of achieving this transfer in some Autonomous Communities before the end of the term of office. I hope that we succeed in doing so and that the first one will pave the way for the rest.

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