

A new prison health care model: the experience of the Basque Country

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ABSTRACT

A year after the transfer of prison health care functions and services from the State Administration to the Autonomous Community of the Basque Country, the process up to completion of the transfer, the current status of the transferred services and remaining challenges are described.

Key words: delivery of health care; primary health care; clinical governance; health policy; resources management; prisons; public administration; Spain.

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LEGAL SCENARIO OF THE PRISON HEALTH CARE MODEL

It is inevitable to refer to the legal background when talking about prison health care, a term taken from legal texts to define any activity promoted by prisons to prevent and restore the health of those hosted within. In Spain this term first appears in the 19th century's legal system, when prison health care is first referred as a proper element of penitentiary organization ¹. Thanks to the leading role of a series of ideological principles of a humanitarian and progressive nature which were then enhanced, the need of an appropriate health care provided in Spanish prisons was first established by means of an Order as of December 13th 1886.

The Penitentiary Institution is ever since then responsible for ensuring the inmates' life, integrity and health ², and therefore provides in its facilities the health coverage corresponding to Primary Care. The Ley General de Sanidad (General Law on Health) ³ grants the inmates' rights and their access to health-care provisions on the basis of effective equality and

the organization and development of all preventive and assistance actions conceived within a comprehensive healthcare system are the responsibility of the Administrations.

On general terms, all throughout Europe laws on this matter consider that those hosted in prison must have the same rights and healthcare provision than the rest of the population with the limitations related to its performance, not to its content, derived from this situation. The main objective is to grant the rights of inmates as users of health care services, their access to health care resources, the quality of prison health care and equal access to health care ⁴.

THE CLIMATE BEFORE TRANSFER

The WHO established in its 2003 Moscow Declaration the essential need to establish close links between —or to integrate— public health care services and those in prison ⁵. That same year, the Ley de Cohesión y Calidad del Sistema Nacional de Salud (Act on Cohesion and Quality of the National Health Sys-

tem)⁶ established that those health care services within Penitentiary Institutions were to be transferred to the corresponding Autonomous Community to be fully integrated in the corresponding health care autonomous services. On March 17th 2005, the Congress of Deputies passed a parliamentary discussion document which urged all Autonomous Communities to carry out the transfer process.

In 2005 several briefings were held attended by joint committees of representatives from the Departments of Public Administration, Economy and Finance, Health, Interior and the 17 autonomous communities.

Each community had a specific basal situation and different improvement opportunities; however some of them were common to all of them, regarding the isolation of prison health care from the rest of public health care services in the community, including specialized and hospital assistance⁷. Some of the conclusions of those committees were the following: the need to agree on care protocols between prison health care services and the reference hospital, to enhance telemedicine devices or to reinforce specialized mental health care.

In this context, the Secretary General of Penitentiary Institutions approached the difficulties identified to progress in the transfer process, therefore requesting the Counsel of legal representation of the State to issue an opinion on the legal aspects of funding and having already requested technical reports on the situation of the assurance of those hosted in prison and on the responsibility of the Ministry of Interior regarding this aspect.

An evaluation of the changes needed to improve the coordination between both health care systems (prison and community) entails four different groups of actions:

1. Initiatives regarding the integration of organizational structures

By first considering that prison health care services are part of the community primary care network leads to proposing technical commissions on the harmonization of the work developed by both health care networks.

2. Initiatives regarding the integration of health care information systems

By providing an easier access to the community's management and information services provides the

opportunity of better monitoring the patient, both in prison and outside. A computerized clinical documentation system common to all assistance devices enables to streamline patient care, management of specialized consultation agendas, to cut waiting lists and to reduce the number of unattended consultations.

3. Initiatives regarding an increased resolution capability.

Higher diagnostic resolution levels are achieved by means of echography, spirometry, ambulatory blood pressure monitoring, etc within the resources available in Primary Care. Prison health care services are supported by means of the generalization of specialized consultation conducted for the most frequent pathologies found in prison. A higher resolution level is also achieved for nursing care issues.

4. Initiatives regarding the reinforcement of Primary Care and more autonomy for health care professionals

This intends to enhance "filtering" activities developed by Primary Care physicians and specialist consultants, so that Primary Care professionals can count upon an improved autonomy to organize their activities and to achieve higher levels regarding equity and efficiency with limited resources.

There is still some leeway to progress in the harmonization of care models which now work in parallel in assisting the needs of those hosted in prison, to provide primary care to the community and to provide care in prisons.

THE TRANSFER OF PRISON HEALTH CARE IN THE BASQUE COUNTRY

The proposal of creating harmonization care committees was accepted by some autonomous communities, among which the Basque Country. From the relationship established through that committee in Euskadi, the cooperation approach quickly led to more formal approaches which concerned the structural integration of all the prison health care service.

On July 1st 2011 the transfer of prison health care took place in the Basque Country⁸. The Order on prison health Transfer makes a revision of all the set of laws on which this integration is based and its Addendum includes the rules of transfer, the functions

assumed by the Autonomous Community, those which remain in the central State and those which will be shared. By means of this order a Coordination Commission is also created so that all joint functioning details are regulated by means of the approval of the corresponding protocols as well as three technical commissions, one per prison, which are submitted to the regulation of the Coordination Commission.

The Basque Health Service is a public agency governed by private law which counts upon 18 hospitals, 7 Primary Care health regions, 320 health centers and 3 outpatient mental health networks with a total number of 34,500 health professionals among statutory staff, contract staff and public servants, both permanent and temporary. In previous years it had received different health transfers, the largest in 1988 (Insalud).

On the behalf of Penitentiary Institutions three facilities were transferred. The prison of Nanclares (transferred in December 2011 to the new facility in Zaballa) which hosted 721 inmates and the prisons of Basauri and Martutene with 392 and 380 inmates respectively. The number of staff transferred was 43: 22 in Nanclares-Zaballa, 10 in Martutene and 11 in Basauri. 16 were doctors, 19 nurses, 1 pharmacist and 7 clinical assistants.

HOW IS THE PRISON HEALTH CARE SERVICE REGARDED FROM A COMMUNITY HEALTH ORGANIZATION POINT OF VIEW?

The opinion of Osakidetza on prison health care follows a twofold component. On one hand, health professionals in prisons are fully adapted to the environment in which they develop their activities and have a lot of experience in the most prevalent diseases such as communicable diseases (HIV, Hepatitis B and C, and Tuberculosis), mental health and drug abuse, as well as in prison regime and medical and legal related procedures.

Nevertheless there is a counterpart: isolation. Prison health care is provided in an environment and with an organization in which safety and not health care is the main priority. Currently staying apart of a health care organization, with all its diagnostic, therapeutic and training potential, is a disadvantage.

As to integrate prison health within the Basque Health Service as it had been conceived, a reference could be very helpful. The English and Scottish experiences were very useful. The transfer process in England and Wales took place between 2000 and 2006, when it was finally completed^{9, 10}. The transfer of prison health care in Scotland was initiated in Novem-

ber 2011 but work had already been done regarding its design and organization since 2007¹¹, when the report that recommended such transfer was published¹².

On the other hand, in Catalonia, prison administration responsibilities have been transferred ever since 1983 although it was in 2006 when the formal process of transferring healthcare professionals to the Department of Health was initiated^{13, 14}, something which has not concluded yet- prison health care remains a system of their own, far from the integration system developed by Osakidetza and Penitentiary Institutions.

THE ROUTE TO TRANSFER

From an organization and administrative point of view the structure of health care and of the activities developed by healthcare professionals in prison does not have an equivalent in the Basque Health Service hence this was the first question to be made: what is comparable to prison healthcare resources? And among such resources, where should it be integrated?

Healthcare activities developed in prisons are mainly three:

- Mainly Primary Care assistance. In this aspect it can be compared to a health center. Moreover, doctors in prisons are family doctors.
- Chronic Centre. Prison health care has a considerable component of long-term centre targeting chronic patients. It also counts upon storage and dispensing of medicines, hospitalization beds and clinical assistants, which obviously do not exist in health centres. As far as its organization is concerned, this is closer to a long-term centre than to a primary care facility, maybe even closer to a social and healthcare centre belonging to the community network.
- Medical legal, judicial and prison regimen related aspects. Prison health care is an activity which crosses medicine with law, and a lot of aspects of daily life in prison, including those related to the provision of health care and a healthy environment, are regulated by penitentiary rules and need of a specific health care action. There is also continuous interaction with the judicial system. All of this constitutes a considerable part of the daily activity of the facility, which is completely different from health care in the community.

Upon these premises, the first decision was to turn all transferred prisons into health centres, hence equating with community health centres both from a

health care and administration related point of view and therefore integrating them in every way (human resources, care protocols, occupational health, dental consultation, provision of material, waste collection, etc.) in the corresponding primary care area. The centres were called alike the rest of facilities by adding the acronym CP (Spanish for penitentiary facility): Zaballa Health Centre CP, Martutene Health Centre CP and Urbi-Basauri Health Centre CP. They were also allocated a reference hospital, with all its inherent diagnostic and therapeutic capability (specialist, pharmacy services, diagnostic devices, testing, radiology, etc.). With regards to all this and other aspects of the transfer process, the section on prison health care in the web site of Osakidetza ¹⁵ gives further information.

HEALTH CARE PROFESSIONALS

Alike previous transferring processes from the Central Government, health care professionals were fully integrated in Osakidetza, both servants and workers, with the same position. And like in the rest of health centres, those responsible for the units were appointed (Head of the Primary Care Unit), as well as a nursing supervisor in Nanclares-Zaballa. Since then the three medical heads of the units take part in the area's meetings.

Some months after the transfer, the official integration of professionals in Osakidetza took place. This led to the participation of professional in public tender for relocation in primary care centres within Osakidetza. A pending issue is the offer of statutory positions for these workers.

The transfer of prison health care entails the coverage of vacancies and substitutions. Therefore one of the responsibilities of Osakidetza is to train professionals who will eventually join prison health centres. Prison health care has a series of specific functions and activities, derived from the environment in which professionals must develop their work and of the prevalent pathology of the patients. That is why these professionals must be appropriately trained, since they are acquainted with family medicine, contagious diseases, mental health and drug abuse, as well as prison regimen and medical and legal related issues.

To this end, in March 2012 in Bilbao the First Course on Prison Health for professionals of Osakidetza was held ¹⁵. As a means of practical complementary training during May and June 24 professionals (12 doctors and 12 nurses) took part in a three day

rotation in prison health centres. The general opinion was very positive, both by the centres which hosted doctors and nurses with another mentality and different training, and by the attending professionals who discovered another health care reality.

The training process of professionals will follow this twofold route. On one hand professionals transferred are included in the training programs of Osakidetza and on the other, training activities on prison health will still be developed for all those professionals interested in developing their activity in prisons.

In a longer-term approach, agreements are being established with those responsible of the training of Family Medicine residents so that they can rotate in prison facilities, as to better know their reality and therefore contribute to a fuller integration of prison health centres. The same process is being developed with Nursing University Schools.

COMPUTERIZATION OF PRISON HEALTH CENTRES

Health care provided in prison health centres must be coordinated with care provided in the community and in hospitals so that a real continuity of care is achieved. Therefore, it seems reasonable that there is only one electronic clinical record available to all professionals in charge of a patient. This is how professionals in prison have real time access to the complete record of their patients through Osabide, Osakidetza's software, including the evolution of those assisted in emergencies, admitted to reference hospitals, those who have pursued specialized consultation as well as the results of tests, radiology, alike the rest of primary care facilities.

To this end, by the end of 2012 a pilot experience was launched in Nanclares-Zaballa. A new computer and telephone cabling network was installed within the prison, independent from the facility itself due to safety reasons; computers including the trial model of the Osabide software used in primary care centres were installed and health care professionals were trained to that end. This is how in July 1st 2011, when the transfers were finally implemented, the same clinical documentation system that any health centre within Osakidetza counts upon was available in this prison.

Through this pilot experience improvement issues and several dysfunctional aspects were identified and corrected, therefore enabling its more efficient implementation in the rest of prisons.

Through this process the fact that keeping two different records —Osabide and Sanit— is unfeasible has been confirmed and therefore Sanit will disappear from prisons in the Basque Country to all purposes and intents. This had already happened in the Health Service of Navarra (osasunbidea) and the Prison of Pamplona, which share the same electronic clinical record. The data gathered by Sanit is available in the digital clinical record of both Osakidetza and the Health Service in Navarra, so that one of the main requirements established by the Transfer Order can be fulfilled: the availability of each facility's epidemiological data so that the Secretary general of Penitentiary Institutions can keep on executing its responsibility as far as public health issues within prisons are concerned. Software incompatibility is a similar problem to what is happening in the rest of the National Health System, in which each autonomous community has implemented different software and electronic clinical records.

TELEMEDICINE:

Within the strategy of the Basque Health Service one of the most relevant aspects is the development of new technologies. Among them, telemedicine is a very useful tool which enables prison health centres to pursue specialized hospital consultation without the patient needing to be displaced. The transfer of an inmate from prison to hospital for consultation is a very complex procedure which entails resources and time and is sometimes unpleasant for the inmate himself/herself.

The holding of the II Meeting on Telemedicine in prison in Bilbao in October 2010 was very useful in the implementation of this technology, through the pioneering telematic experience of the Health Service of Extremadura.

In June 2011 a pilot experience was launched concerning telematic consultation on HIV between the prison health centre of Nanclares-Zaballa and the University hospital of Alava, its reference centre¹⁵. Thus telephonic lines installed to access Osakidetza's software and electronic clinical records were used and cameras and screens were installed in both centres.

This year's experience regarding HIV consultation has been extremely positive. The implementation of teleconsultation in other areas of specialization and in other prisons is currently being assessed.

On the other hand, the new digital X-ray machine in Zaballa has been connected to the University Hospital in Alava, although it is not working yet. This device,

both regarding administration and functioning aspects, depends of the hospital's Department of Radiology.

PHARMACY:

The transfer process showed the need to regulate, within the territory of the Autonomous Community of the Basque Country, the legal and administrative situation of medicine storage within prisons, similarly to community pharmacies or hospital pharmacy services, as well as to organize and arrange all actions concerned with this. The first step was to assign in October 2011 prison pharmacy deposits to Pharmacy Services within the reference hospitals. Since then, the purchasing of medicines is done through hospital pharmacies. On the other hand, the prescription of medicines is based on Osakidetza's vademecum, including the policy of generic drugs. Second, the Basque Department of Health and Consumer Affairs is currently drafting an Order on Medicine Storage in Prisons of the Autonomous Community of the Basque Country and is expected to be published by the end of 2012. It will establish the features of such deposits, their functioning, dependency, etc.

Other equally relevant issues have also been approached such as the improvement of prescription quality and the testing of pharmacological prescription through the Osabide software and the monitoring of clinical safety as far as the implementation of single-dose holders is concerned.

In short, it would be intended that all prisons work as another ward of their reference hospitals.

REGIME AND MEDICO-LEGAL PROCEDURES

It has been previously stated that some of the functions of the healthcare staff in prison —regime and medico-legal issues— are specific of prison health and outside prison healthcare professionals are not acquainted with them¹⁶.

As to solve this situation the Guidelines on Healthcare-Administrative Procedures within the Penitentiary Environment¹⁵ have been published, an updated version of the work developed in Penitentiary Institutions several years ago and which collected a series of different procedures some of which were exclusively health care related (general medicine evolution form, consultation request form, ...) and some of which were of a more administrative and medico-legal nature (medical report on the monitoring of inmates

on hunger strike, regime isolation application, summary sheet on conduction, injury reports, ...)

In 2012, a Work Group of Osakidetza and Penitentiary Institutions has adapted this to the current situation in transferred prisons, where electronic clinical records, as in the rest of the National Health System, is the main core of community health care and in our case, of prison health care too.

So that all that regarding purely clinical issues (clinical record, evolution, complementary test results, consultation request form, etc.) will be recorded in Osabide's electronic clinical record. Administrative and medico-legal documents, specifically belonging to penitentiary activities will be those issued by Penitentiary Institutions¹⁵ and will also be included in the electronic clinical record.

In short, these Guidelines constitute a document which has tried to describe in a clear and simple way the main regime administrative and medico-legal functions which healthcare professionals must be responsible for, so that when a community health care professional starts developing his/her activities in prison he/she is acquainted with them. Anyway, the functions and responsibilities of healthcare professionals in prisons are legally defined by the LGOP, its Regulations and all its complementary legal dispositions.

MENTAL HEALTH AND DRUG ABUSE

While in the 80s and 90s HIV infection and the abuse of cocaine and heroin were the most relevant health problems in prisons, currently mental health and drug abuse are the leading issues.

Mental health care in Osakidetza is provided through two different structures: outpatient (Mental Health Networks in Araba, Bizkaia and Gipuzkoa) and hospital based structures. From an organizational point of view, and as in the rest of health centres, mental health care in every prison has been assigned to its corresponding Mental Health network.

On the other hand, and since this serious problem is our priority, a work group has been created to start thoroughly analyzing the situation by showing which are the solutions proposed by health services in other communities and countries, so that improvement measures are suggested.

THE RELATIONSHIP BETWEEN OSAKIDETZA AND PENITENTIARY INSTITUTIONS

One of the consequences of transfer has been a change in the relationships of organic dependency

among prison health care professionals. Until now these depended of the General Sub-Directorate of Prison Health Coordination and the Heads of different penitentiary facilities. The responsibility of the inmates' health and the organization of prison health care is now in the hands of the Basque Health Service, although there is certain functional dependency with the direction of facilities.

This has implied a new type of interaction, both centrally as well as in the prisons, and specially as far as the direction of facilities and medical representatives are concerned.

During twelve months after the publication of the Order of Transfer, we have specially taken care of such relationship, and therefore the coordination has been very good, without any decision being taken unilaterally and having sought the agreement of all steps affecting both organizations.

REMAINING CHALLENGES

A year after the formal transfer of prison health care to Osakidetza, there is a very positive balance for both institutions.

- The coordination has been one of the most successfully achieved aspects at all levels.
- There have been no remarkable incidences in the provision of care.
- Professionals have enabled the organizational transition and their commitment with the institutions and the patients has been unaltered.
- The Heads of prisons have stated a high level of satisfaction with the service.

However the transfer of health care serviced from the Ministry of Interior to healthcare authorities in each community remains a challenge in many ways:

- The excessively demanding attitude of the convicted population, partially explained by their profile, with a high prevalence of mental disorders, frequently multi-pathological, submitted to emotional stress and at risk of social exclusion.
- The provision of an evaluation model specifically designed for prison health care needs apart from the demands, and able to establish the beginning of an improvement cycle, to enable the monitoring of quality care and even to integrate, if appropriate in excellence models such as EFQM17.
- The impaired fulfillment of health care documentation according to judicial standards, far more

rigorous than clinical standards. This is part of the conciliation effort between legal and medical aspects that prison health professionals must learn.

- The lack of systematization between health promotion protocols, essential in this area.
- In short, the creation of a new care model which will define the prison health resource as part of the global structure of public health care.

We are therefore developing this model of prison health care on the basis of a community health manager and with the support of the powerful organizational tools provided by Osakidetza, with a perfect cohesion between the three care levels.

The experience gathered also provides useful information on what remains to be done in other autonomous communities where transfer has not been implemented. With a moderate investment prisons in any community can become functional centres of the corresponding Health Service with considerable benefits for both patients and health care professionals.

In summary, we want to underline that the integration process of prison health in an autonomic health system is very complex since it must bring together two different realities, structures and mentalities but whose result, at this stage, is being very positive.

Both Penitentiary Institutions and Osakidetza have entered a commitment so that this experience will keep up with the currently existing functioning standards and will achieve the best possible results with a better coordinated, more quality and more equal provision of health care for patients so that it can lead the way for other communities to follow.

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