Global Prison Health Care Governance and Health Equity: A Critical Lack of Evidence

The large and growing population of people who experience incarceration makes prison health an essential component of public health and a critical setting for reducing health inequities. People who experience incarceration have a high burden of physical and mental health care needs and have poor health outcomes. Addressing these health disparities requires effective governance and accountability for prison health care services, including delivery of quality care in custody and effective integration with community health services.

Despite the importance of prison health care governance, little is known about how prison health services are structured and funded or the methods and processes by which they are held accountable. A number of national and subnational jurisdictions have moved prison health care services under their ministry of health, in alignment with recommendations by the World Health Organization and the United Nations Office on Drugs and Crime. However, there is a critical lack of evidence on current governance models and an urgent need for evaluation and research, particularly in low- and middle-income countries.

Here we discuss why understanding and implementing effective prison health governance models is a critical component of addressing health inequities at the global level. (*Am J Public Health*. 2020;110:303–308. doi:10.2105/AJPH.2019.305465)

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See also Jimba et al., p. 282.

On any given day, more than 10.7 million people are incarcerated worldwide.[1] In many countries, reliance on systems such as bail and remand result in a large proportion of the prison population being incarcerated for weeks or months rather than years. As such, the number of people moving through prisons each year is undoubtedly much higher. Although the United States distinguishes between prisons and jails, most countries do not. Some countries also have separate youth detention centers for the incarceration of adolescents. In this article, we use the term prison to refer to all types of custodial correctional facilities.

The burden of mental illness and substance use disorder,[2,3] communicable disease (including HIV, tuberculosis, and hepatitis[4]), noncommunicable disease,[5–7] and cognitive disability[8] is greater among people who experience incarceration than in the general population. People who experience incarceration are also less likely to have had a regular health care provider prior to incarceration and are disproportionately affected by the social determinants of health.[6,9] Although this increased burden of disease in prisons is likely universal, the lack of basic epidemiological data on many health conditions, particularly in low- and middle-income countries,[10] means that the potential for prison health services to contribute to global health efforts cannot yet be quantified.

Prisons are a setting in which the health needs of people from underserved populations can be diagnosed and treated and in which public health interventions may reduce disease burden and improve health equity.[11] Prisons also provide an important opportunity to establish connections with sources of community support such as substance use services, health care facilities, and social services that can promote health and well-being among people after their release.[12,13] The Lisbon conclusions from the World Health Organization (WHO) 2017 international meeting on prisons and health emphasized the importance of acknowledging "the role of prisons as important settings to address health inequalities and to recognize the status of people in prison as a disadvantaged group in terms of health and well-being."[14]

Investing in the health and health care of people who experience incarceration is important on human rights, public health, public safety, and economic grounds.[15] International bodies such as the United Nations (UN) Human Rights Committee and the European Court of Human Rights have affirmed that to protect the rights of people who are incarcerated, including the right to personal security and the right to be free of torture and ill treatment, states have an obligation to provide access to adequate health

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services, including preventive services.[16]

International standards such as the UN's Mandela Rules[17] and Bangkok Rules[18] affirm the responsibility of the state to ensure that people who are incarcerated are provided health care that is, at a minimum, equivalent to that available in the community (an affirmation known as the principle of equivalence). According to Mandela Rule 24.1, people who are incarcerated "should enjoy the same standards of health care that are available in the community, and should have access to necessary health care services free of charge without discrimination on the grounds of their legal status."[17] States have a special duty of care to those who are incarcerated, because people in prisons have no alternative access to care and their living conditions are entirely controlled by the state.[16,19] The higher burden of health needs among people who experience incarceration means that health care equivalent to that available in the community is likely insufficient to achieve equivalent health outcomes.[20,21]

The movement of people between correctional facilities and communities and the overrepresentation of underserved populations in prisons make prison health a critical component of public health. This has been highlighted repeatedly by international standards such as WHO's 2003 Moscow Declaration[22] and 2010 Madrid Recommendation.[23] Promoting strong, seamless connections between prison and community health care services is an essential part of providing adequate services and ensuring continuity of care. This is important for managing health conditions such as HIV or diabetes as well as for ongoing access to resources such as contraceptives or harm reduction services.

Addressing disparities in prison health is important not only for managing communicable diseases and the burden of untreated chronic conditions but also for efforts to reduce social inequalities and improve the health of communities.[24,25] Nosrati et al. estimated that for each additional person imprisoned per 1000 residents, there is a reduction in population life expectancy of 6 months among people in the lowest income quartile.[25] The health of people who are released from custody also has an impact on the health of their families[12,24,26] and plays a role in long-term success after release, given that health can influence housing, employment, and reincarceration.[15]

Realizing the public health potential of prison health services is contingent on effective identification of health needs, delivery of quality care in custody, and integration of prisons as part of the continuum of care in community health services. Despite substantial public investments in prison health services in many countries, little is known internationally about the governance of these services. Although there are many definitions of governance, in health care systems it is most often framed in responsibilities and principles of not only the formal administrative structures involved in health service delivery but also the relationships and power dynamics among stakeholders.[27] For example, the responsibilities of governance laid out in WHO's Action Plan: Health Systems Governance for Universal Health Coverage[28] include formulating policy and strategic plans, generating intelligence, putting in place levers and tools for implementing policy, building collaboration and coalitions, and ensuring accountability.

There are critical, global gaps in our understanding of how prison health services are structured, the funding they receive, and the processes by which they are made accountable. Here we explore the arguments and evidence for different models of prison health care governance and why there is an urgent need for evidence and understanding of such governance to guide improvements in prison health services and improve health outcomes among people who experience incarceration.

DEBATES IN PRISON HEALTH GOVERNANCE

In recent years, there has been growing debate around models of governance for prison health care service delivery, particularly around whether some or all responsibilities and accountability for prison health care services should be under health ministries rather than ministries of justice. WHO and the United Nations Office on Drugs and Crime recommend that "health ministries. . .provide and be accountable for health care services in prisons and advocate healthy prison conditions."[19] An important argument in support of this recommendation is the potential for role conflict among health care providers employed by a correctional authority and the imperative for clinical independence.[29] Health care providers under the authority of correctional services may experience competing loyalties between their responsibilities to their patients and their obligations to their employer. For example, medical assessments after a use of force[30] or patients disclosing illegal activities such as drug use place health care providers employed by correctional services in an ethically complex position.

Clinical independence is essential to care that is consistent with the principles of privacy, confidentiality, and consent.[31] It is also essential to ensuring that medical staff do not participate in custodial actions such as body cavity searches, capital or corporal punishment, or assessments of fitness for solitary confinement.[19,29,30] In addition, perceptions of dual loyalty may adversely affect relationships and trust between care providers and the people for whom they care. This is of particular importance in the prison setting, where people are unable to choose their care provider and may not engage with treatment or health examinations by choice but rather through compulsory procedures.[29]

A second argument in support of making health ministries responsible and accountable for prison health care services is that it may facilitate continuity of care between prisons and the community. The importance of continuity of care is recognized in Mandela Rule 24.2: "Healthcare services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence."[17]

Some jurisdictions that have transferred responsibility to their ministry of health report that they have seen benefits such as raised clinical standards and greater transparency.[32,33] Including prisons under the mandate of health care services may also help foster the inclusion of people in prison in broader public health initiatives.[34] However, some jurisdictions in which health care is under the ministry of health note

remaining challenges, such as those related to financial and human resourcing for health care services[32] and differences in organizational culture between corrections and health care.[35] Although prisons are likely perceived as a small component of the mandate of health ministries, their continuing responsibility for the health of individuals after their release provides a structural incentive to invest in prison health.

There are also arguments for maintaining health care services in prisons under the ministry responsible for corrections. In a policy briefing for WHO Europe, Hayton et al. suggested that separating health care from corrections could lessen the influence of health professionals in prison management. As the determinants of health include the conditions in which people live, there may be disadvantages to structurally separating accountability for health care and accountability for the conditions that affect health, such as nutrition, sanitation, and solitary confinement.[36] In addition, if health care priorities are seen as separate from corrections priorities, this could lead to deprioritization[37] and, in some cases, underfunding of prison health services.

Although clinical independence and structural incentives for ministries of health provide compelling arguments for accountability and administration of prison health care to be the responsibility of ministries of health, there are plausible counterarguments and diverse opinions in this sector. Furthermore, framing governance of health care services in prisons as a binary choice may fail to capture the complexity of arrangements in many countries. There is a need to understand existing and potential models of shared responsibility between ministries of health and ministries of justice. Rigorous evaluations of existing as well as novel governance models are required to inform evidence-based decision-making.

EVIDENCE

Despite the importance of effective prison health care governance, there is a lack of basic information on prison health care governance arrangements in most jurisdictions, and these data have never been collated at a global level. In an initial effort to address this knowledge gap, the WHO (Europe) Health in Prisons Program and the UK Collaborating Centre for the WHO Health in Prisons Program conducted a survey in 2016–2017 of prison health in European member states. The data, collected as part of the Health in Prisons European Database (HIPED), were published by the WHO Global Health Observatory and provide new information on prison health governance, systems, and administration in 39 European countries[38] (Table 1[39–44]).

The data, although limited to the European region, highlight the diversity of governance models. Seven jurisdictions (Cyprus, Finland, France, Italy, Norway, Slovenia, and the United Kingdom) reported that both authority for and administration of prison health care budgets were governed by the ministry of health. Ten countries (Albania, Armenia, Czechia, Denmark, Iceland, Lithuania, Malta, Slovakia, Spain, and Switzerland) reported that responsibility for prison health care services was shared between the ministry of health and another ministry (such as the ministry of justice, the ministry of the interior, or the health care department of the prison system). In some jurisdictions, this may indicate shared responsibility; in others, however, it may reflect a transfer of responsibility in only some jurisdictions.

Beyond these European states, other jurisdictions, including Afghanistan,[44] Kosovo,[29] Taiwan,[39] some Australian states,[40] and some Canadian provinces,[41] have transferred governance and accountability for prison health care services to the ministry of health. In Argentina, Montenegro, and Turkey, prison health care has been partially integrated within the national health system.[29] In Brazil, states and municipalities can choose to be a part of the National Policy of Comprehensive Health Care for Persons Deprived of Liberty in the Prison System under the ministry of health.[42] In Zambia, a memorandum of understanding articulates shared responsibilities for health care in prisons between the Zambian Correctional Service and the ministry of health.[43] In its current 10-year strategic plan, the Ghana Prisons Service lists the ministry of health and the National Health Insurance Authority as stakeholders in the delivery of health care in prisons.[45]

Although national-level data are important in understanding global trends in prison health, prison health care is organized partly or entirely at a subnational level in many countries. This means that data collection exclusively at the national level will fail to adequately capture current arrangements or the complexity and diversity of arrangements within and between countries.

Among national and subnational jurisdictions that have moved responsibility for prison health services to the ministry of health, research and evidence on this transfer and its impact on health outcomes and health equity are extremely limited. We were able to identify 3 evaluations available as published reports[32,46,47]; however, they were retrospective and, for the most part, relied on limited survey or interview data. In addition, Bengoa et al. compared the availability and use of resources in a correctional facility in which health care is under the Basque Health System with the situation in 4 facilities in other parts of Spain in which health care is under the department of corrections.[48]

In Zambia, document reviews and interviews were used to evaluate governance and other outcomes of the Zambian Prisons Health System Strengthening Project.[43,49] With this notable exception, there is currently little evidence regarding the relative merits of different prison health care governance arrangements in low- and middle-income countries. This is a critical gap in our understanding, as the majority of the world's incarcerated population resides in such countries.[1] It is also essential to understand prison health care governance in contexts of severe resource limitations and overburdened community health care systems. In most countries, there is little publicly available information on how health care is delivered in prison or what entities are responsible for prison health care. There is an urgent need for research and evaluation to document and understand models of governance in the delivery of health care services in prisons in all jurisdictions, but particularly in low- and middle-income countries.

CONCLUSIONS AND FUTURE DIRECTIONS

Prison health is an important part of public health, and good governance in prison health care is essential to reducing health inequalities at the population

level. Yet, there is very limited published evidence about either current prison health care governance arrangements or the impact of various governance arrangements on health outcomes. Multiple and multifaceted efforts from researchers, policymakers, governments, and international bodies are needed to address this knowledge gap. For example, although there are limitations in the data self-reported by participating countries, adaptation of the HIPED[38] initiative in other WHO regions, along with expansion and refinement of data collection in the future, will lay the groundwork for the research and monitoring that are essential to implementing effective governance models.

Focused inquiries could include systematic reviews of information available on the Web sites of governments and nongovernmental organizations and from key informants. In addition, the development of global, standardized indicators will facilitate understanding of prison health across varied contexts, including identification and examination of global trends over time, comparisons between countries and regions, and knowledge regarding effects on other global targets such as the Sustainable Development Goals (SDGs). There is a high degree of variability in both health care and criminal justice systems between regions, so in addition to global measurements there is a need for local measures and indicators. These tools will generate critical context-specific evidence and understanding of prison health, facilitating comparisons between health services in prisons and those in communities, a better understanding of the health and needs of people who experience incarceration, and data to initiate

TABLE 1—Authority Responsible for Prison Health Care as Reported in the Health in Prisons European Database, and Countries Reported to Have Full or Partial Responsibility Under the Ministry of Health

Country	Ministry of Health	Ministry Other Than Health System	Shared or Mixed Governance
Afghanistan[44]	X		
Albania			X
Argentina[29]			X
Armenia			X
Australia[40]			X
Azerbaijan		X	
Belgium		X	
Bosnia and Herzegovina		X	
Brazil[42]			X
Bulgaria		X	
Canada[41]			X
Croatia		X	
Cyprus	X		
Czechia			X
Denmark			X
Estonia[a]			X
Finland	X		
France	X		
Georgia		X	
Germany		X	
Iceland			X
Italy	X		
Kosovo[29]	X		
Latvia		X	
Lithuania			X
Luxembourg		X	
Malta			X
Monaco		X	
Montenegro[29]			X
Netherlands		X	
Norway	X		
Poland		X	
Portugal		X	
Republic of Moldova		X	
Romania		X	
Russian Federation		X	
Serbia		X	
Slovakia			X
Slovenia	X		
Spain			X

Continued

TABLE 1—*Continued*

Country	Ministry of Health	Ministry Other Than Health System	Shared or Mixed Governance
Sweden		X	
Switzerland			X
Taiwan[39]	X		
Tajikistan		X	
Turkey[29]			X
Ukraine		X	
United Kingdom	X		
Zambia[43]			X

Note. With the exception of the reference citations listed in the table, data are from the World Health Organization's Global Health Observatory Health in Prisons European Database (HIPED). Ministry of health includes countries reporting ministry of health, ministry of public health, or another public health authority as the authority responsible for prison health care. Ministry other than health system includes countries reporting ministry of justice, ministry of the interior, health care department of prison system, or "other" as the authority responsible for prison health care. Shared or mixed governance includes countries reporting that the ministry of health and another ministry share responsibility or that the ministry of health is responsible in only some jurisdictions.

[a]Reported in the 2017 HIPED survey that responsibility was under the ministry of justice or ministry of the interior; reported in Pont et al.[29] to be partially integrated with the ministry of health.

and examine prison health system responses to those needs.

In addition to data collection and monitoring, rigorous and independent research on prison health care governance is required to capture the diversity and complexity of governance arrangements worldwide and to provide a sufficiently nuanced understanding of what arrangements are most effective for positive health outcomes, in what settings, for whom, and why. For example, linked administrative data could be used to quantify the impact of policy changes on health service use, health outcomes, and health care expenditures. Case studies of effective or novel governance arrangements including relevant policies and funding arrangements could help elucidate the effects of changes in policies, accountability mechanisms, and prison health care expenditures on health outcomes.

In addition, qualitative and participatory studies involving people who have experienced incarceration will be essential to understanding the experience, availability, accessibility, acceptability, and quality of health care services[50] in the correctional context. Given the rapid churn of people through custodial settings, this research must consider not only the health of people who are incarcerated and people working in these settings but also that of people released from custody, their families, and their communities. Underpinning research and efforts to assess governance models must be the recognition that one size does not fit all and that evidence generated in high-income Western countries may not be applicable in low- and middle-income countries.

Addressing the complex health needs of people who experience incarceration is a critical component of addressing health inequities at the population level. It is also essential in working toward realizing the SDGs of reducing inequalities (SDG 10), eliminating poverty (SDG 1), and promoting good health and well-being (SDG 3). Realizing the potential of good prison health services requires collaborative, integrative, whole of government approaches to prison health along with a foundation of robust indicators and ongoing research and monitoring. AJPH

CONTRIBUTORS

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this analysis because no human participants were involved.

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