Review of Health Services in Correctional Facilities in the United States

GROWING PUBLIC AWARENESS of the multitude of abuses to which inmates of prisons, jails, and other detention facilities are subjected has become manifest over the past several years. Among these abuses are severe health hazards, mental as well as physical, that are inflicted upon prisoners by the prison environment itself. Prisoners with serious medical problems are frequently denied access to needed medical care, and the care that is provided is often grossly inadequate in quality and accessibility and is given without basic considerations of human dignity.

An examination of prison health services should be based on a framework of knowledge about some basic characteristics of persons who are held in correctional facilities throughout the country. At any one time, close to half a million persons are held in State and Federal prisons, local jails, and juvenile detention facilities across the country. This number includes persons convicted and serving sentences as well as those awaiting arraignment or trial. In 1970, the distribution of inmates, by type of facility, was as follows (*1, 2*):

Facility	*Number*	*Percent*
Local jail inmates	160,863	38.0
Adults	153,063	36.1
Juveniles	7,800	1.9
State prison inmates	176,391	41.6
Federal prison inmates	20,038	4.7
Detention facilities for juvenile offenders	66,457	15.7
Total	423,749	100.0

The composition of the inmate populations reflects the disproportionately high rates of arrests and convictions among the poor and members of minority groups, as indicated in this tabulation of data on the 141,600 inmates of local jails in 1972 (*2*):

Characteristic	*Number*
Race:	
White	79,900
Black	58,900
Unknown	2,800
Years of schooling:	
0–8 years	32,200
9–12 years	94,500
More than 12 years	14,300
Unknown	600
Pre-arrest annual income:	
Less than $2,000	61,800
$2,000–2,999	16,100
$3,000–7,499	44,400
More than $7,500	15,100
Unknown	4,200

More than 40 percent of jail inmates were black, and more than 50 percent of all inmates had prearrest incomes of less than $3,000 per year. The vast majority of all prisoners, 97 percent, are male (*1, 2*).

Reflective of their disadvantaged backgrounds, prisoners are more likely than the general population to harbor serious, undetected health problems. Alcoholics, who need medical treatment rather than incarceration, make up one-third of all persons arrested (*3*). Despite these circumstances, jail inmates are rarely given medical examinations, and State prisoners may be held for years without medical care.

The United Nations, National Advisory Commission on Criminal Justice, American Correctional Association, and other organizations have set forth

☐ *Mr. Newport is a research associate at the School of Public Health, University of California at Los Angeles.* *The article is based on a paper presented at the 103d annual meeting of the American Public Health Association in Chicago, Ill., on November 20, 1975. The research it describes was supported by U.S. Public Health Service grant No. HS 00874 (principal investigator Milton I. Roemer, MD) from the National Center for Health Services Research, Health Resources Administration.*

Tearsheet requests to John Newport, University of California School of Public Health, Division of Health Services and Hospital Administration, Los Angeles, Calif. 90024.

standards listing minimal criteria for prison health services (*4*). A common theme of these standards is that medical care for prisoners should be equivalent to "mainstream" care in both quality and accessibility. At present, however, these standards are merely innocuous recommendations that carry no legal sanction for enforcement.

Health Services in Local Jails

In most parts of the country, persons convicted and sentenced for relatively short terms, generally 6 months or less, serve their sentences in municipal or county jails; those sentenced for longer terms are generally transferred to State-operated prisons. It should be pointed out, however, that local jails do not function exclusively as short-term holding facilities; it is not uncommon for inmates who are unable to post bail to be detained in jail for several months awaiting trial.

Actual conditions characterizing the health service programs in local jails contrast sharply with the published standards which call for services of a scope and quality equivalent to prevailing community norms. In the National Jail Census conducted by the Department of Justice in 1970, it was reported that 49 percent of the nation's 4,037 local jails maintained no medical facilities (*5*). As a followup to this census, in 1972 the American Medical Association (AMA) conducted a nationwide survey to assess more precisely the medical resources and types of care available in U. S. jails (*6*).

The AMA survey, conducted by mail, yielded 1,159 usable responses—slightly less than 30 percent of the nation's jails. It appears reasonable to assume that jails from which usable responses were returned were likely to have more "adequate" medical programs than those not responding. With this caveat in mind, the following findings of the AMA survey are striking in the paucity of medical care resources which the data reflect:

1. In more than 80 percent of the jails medical facilities, if available, were limited to basic provisions for first aid.
2. Only 6 percent reported that inmates are given medical examinations upon entry. Most likely this percentage is an overstatement, as in many instances these "examinations" are conducted by jail attendants without health care training.
3. In 77.8 percent of the jails there were no formal arrangements for medical coverage or surveillance. Although virtually all jails reported that prescription drugs are dispensed, these drugs are dispensed by persons without health care training. Illicit drug traffic in a major problem in most large jails.
4. A sizable number of jails had no arrangements for hospitalization of prisoners; in less than one-quarter, inmates requiring psychiatric care are referred to psychiatric facilities.

In-depth studies conducted in various locales shed further light on the dearth of medical services in relation to inmates' needs. For example, tuberculosis case rates 3 to 7 times the rate among the general population are not uncommon (*7*). When the county health department in Albany, N. Y., initiated a screening program, 22.6 percent of the first 500 county jail inmates screened were found with conditions requiring immediate medical attention. Seven percent required hospitalization (*7*).

State Prisons

State prisons, which collectively held more than 175,000 prisoners in 1970, are the furthest removed from any semblance of "mainstream" medical care. Typically set in isolated locations, these facilities house inmates convicted of serious offenses and sentenced to long terms—often several years and even life. Although there have been no nationwide surveys of health services in State prisons, several local investigations shed light on the nature and magnitude of the dearth of health care.

Health services of Pennsylvania's State prisons, which house some 5,500 inmates, were investigated in the Health Law Project of the University of Pennsylvania Law School in 1972. Major deficiencies uncovered by the investigators, who described the system as one of the nation's better prison systems, included the following (*8*):

1. Entering prisoners were given only cursory medical examinations, with no provision for ongoing medical surveillance.
2. Access to "sick call," the only point of entry to medical care, was often barred by guards who lacked training in medical triage.
3. Special diets were virtually nonexistent—diabetics were simply told to "select their food from regular meals," and given no instructions or assistance.
4. Provisions for psychiatric services were grossly inadequate. For example, a convict who tried to hang himself was simply cut down, given medication, and returned to his cell without psychiatric evaluation.
5. Basic quality controls, medical audits for example, were lacking. Also lacking were provision for informed consent and a mechanism through which prisoners could question care provided or voice their grievances.
6. Allocation of health care personnel and equipment throughout the system was largely unplanned and not reflective of actual needs. Although serious deficiencies were noted at the system's two major medical facilities, other facilities contained equipped but unused operating rooms and laboratories. One major prison had no registered nurses on its staff, and prisoners whose backgrounds qualified them to perform useful health care tasks were often given work assignments as janitors.

As a result of the study team's findings and recommendations, a Task Force on Corrections, with both government officials and prisoner representatives among its members, was appointed to develop a comprehensive health care system for the Bureau of Correction. Among the initial reforms was the hiring of two registered dietitians to improve the prisons' dietary and food services.

Although the Federal courts have traditionally assumed a hands-off posture regarding prisoners' rights to medical care, the 1972 *Newman* v. *Alabama* ruling may well be an important turning point. In this class action suit brought by State prisoners against the Alabama correctional system, the U.S. District Court ruled that, by failing to provide sufficient medical facilities and staff, the corrections agency had violated the prisoners' 8th- and 14th-amendment constitutional rights barring cruel and unusual punishment. Some of the more severe deficiencies documented in the plaintiffs' testimony were (*4a*):

1. Prisoners without formal training routinely dispensed dangerous drugs, extracted teeth, operated X-ray equipment, and even performed minor surgery. Medical coverage was extremely sparse, and nursing coverage throughout the entire system, which houses 4,000 men and women, consisted of only three registered nurses.
2. Hospital facilities consisted of an 80-bed unit with no full-time medical staff and no nursing coverage at night or during weekends, regardless of the severity of patients' conditions. Accommodations for pregnant women consisted of a delivery table with no restraints, located beneath a ceiling with peeling paint.

There were flagrant abuses of individual prisoners. A 19-year-old epileptic who unsuccessfully petitioned for treatment died due to lack of regular medical supervision. A quadriplegic in the hospital unit received no intravenous feeding during the 3 days preceding his death.

Ruling in favor of the plaintiffs, the court ordered major reforms, including greatly augmented staffing by physicians and other qualified personnel, a requirement that all prisoners be examined by a licensed physician at least once every 2 years, and an order that the hospital unit be brought into compliance with the U.S. Department of Health, Education, and Welfare's regulations for Medicare participation.

Discussion

Although most health services for prisoners are grossly inadequate, some notable exceptions should be mentioned. The medical care program of the Federal Bureau of Prisons, which operates with an annual budget of $700 per inmate, is far ahead of most, if not all, State and local correctional systems in levels of care provided. This health care program, serving 23,000 prisoners, has 17 hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) and an intensive system of outpatient care. In some areas, such as dental care, the per capita volume of service is greater than that provided to the general population (*9*).

Another noteworthy innovation is the New York City Department of Corrections' affiliation with Montefiore Hospital, which became effective in 1973. The city contracted with a major teaching hospital to provide comprehensive medical services for 7,000

prisoners at the Riker's Island facility. Onsite services provided under hospital auspices include a 24-hour emergency service, medical examinations at entry, a medically staffed daily sick call, and primary care and specialty clinics. In addition to a salaried medical staff, resident physicians are rotated through the prisoner health service (*4b*).

In other parts of the country, such as Cook County, Ill., and Dade County, Fla., specially trained nurse practitioners and former military medical corpsmen are employed to provide a more adequate range of primary care services for prisoners than was previously available.

The innovative programs such as those mentioned indicate that adequate prison health services can be developed when the needed commitment is present, but the services of most prisons and jails are abysmally poor. This is indeed ironic, for as most prisoners come from socioeconomically disadvantaged backgrounds and tend to lead rather transient lifestyles when not behind bars, they are more likely than the general population to harbor undetected serious health problems.

In most localities, inadequate financial support has been a major block in the development of adequate and humane health care services for prisoners. Officials of city, county, and State governments claim that their treasuries are caught in a crunch between limited revenue-producing capabilities and increasing demands for public services of many forms. Realistically, funding for correctional facility programs gets a low priority, and a conscientious health services administrator who is attempting to upgrade levels of service is likely to confront a pervasive, below-the-surface mind set in which prisoners are viewed as "bad people" who should be punished.

In most State and local prison systems, allowable rates of reimbursement to physicians for services rendered to prisoners are substantially lower than that for the same type of service if provided under Medicare or Medicaid or in a federally assisted neighborhood health center program. Even before the present crisis in malpractice insurance, allowable reimbursement for performing surgery on a prisoner has often not been high enough to pay the proportionate cost of malpractice insurance needed to cover the operation.

In short, in most instances physicians who are willing to work in prison settings receive rock-bottom remuneration to care for a group of patients who are generally extremely difficult to treat. From the prisoner's standpoint, prison health services can rightly be called a "third class" level of care; for in terms of both accessibility and quality, our health care system essentially can be divided into three classes of care:

> First class—"mainstream" or private sector care, available to patients paying for private physicians.
> Second class—public programs for the indigent, including public hospitals, clinics, and services subsidized through public assistance programs, Medicaid, for example.
> Third class—health services programs for "captive populations" who have no recourse—prisoners and patients committed to mental institutions, for example.

One can safely state that, in most instances, mental health services for prisoners are inadequate by any standard. Even in the relatively well-funded medical care program of the Federal prison system, officials report that existing mental health services are inadequate in relation to the needs of the estimated 15–20 percent of prisoners requiring psychiatric treatment. In the *Newman* v *Alabama* case, plaintiff's testimony indicated that 10 percent of all prisoners in that State were judged to be psychotic and another 60 percent were seriously disturbed and in need of psychiatric treatment (*4a*).

The milieu of the correctional institution often, if not always, poses severe threats to the inmate's psychological well-being. The report of the University of Pennsylvania's Health Law Project describes these threats (*8*):

> General prison conditions expose an incarcerated person to daily boredom, loneliness, frustration and tension. The threat of sexual assault weighs heavily; there is no opportunity for heterosexual fulfillment . . . Privacy and self-determination end at the prison entrance . . . Educational and work-training programs generally fail to hold promise for good jobs upon release.

Ironically, while drug abuse on the outside may lead to arrest and imprisonment, inside many prisons various mood-altering drugs are prescribed freely in an attempt to counteract the very real problems of intense frustration, anxiety, boredom, and tension which inmates experience as part and parcel of life in the prison environment.

For prisoners, emergency medical services are as inadequate as mental health services. Even in the larger prisons with hospital units, nursing coverage may not be continuous. A prisoner in a cell block who is suffering a heart attack may be able to gain the attention of a sympathetic guard, if he is lucky. However, bureaucratic encumbrances or lack of an arrangement for emergency medical services may

make it impossible to get the prisoner to the care that he needs.

Prisoners also sorely lack health education services. If resources were allocated realistically in accordance with needs, there would be extensive health education programs inside prisons. Prisoners' transient pre-arrest lifestyles have frequently resulted in serious, untreated medical problems. Yet in most prisons and jails, even rudimentary education in personal hygiene and nutrition is lacking; indeed one wonders how many prisoners even have a toothbrush and toothpaste.

As documented in the AMA survey's findings, the majority of local jails do not have adequate arrangements for medical coverage. It is probably not realistic to expect that everyone who is arrested and booked at a local jail should be given a medical examination by a licensed physician. Persons arrested for minor offenses are often released in a few hours.

It might be more practical to require that all prisoners be given a medical screening by a skilled nurse or paramedic upon booking, and that prisoners held for more than 48 hours should be examined by a physician. In small jails which do not have a physician to hold a daily sick call, arrangements could be made to take prisoners to a private physician's office or a hospital outpatient department for medical evaluation. Initial medical screening of newly arrested prisoners might be conducted by registered nurses or other skilled personnel, such as former medical corpsmen, who might be retained on a part-time or on-call basis or, in metropolitan jail systems, deployed as circuit riders from the system's medical infirmaries.

In some parts of the country, significant improvements have been effected through transferring authority for operation of the jail health service program to the local public health agency. Such an arrangement can make available health department resources, including clinical staff and hospital facilities, to take care of prisoners. Also, the fiscal and administrative separation between health and security staffs allows physicians to exercise greater objectivity in medical decisions to protect the health of inmates.

Although desirable, operation of jail health programs by public health authorities is by no means free of problems. For example, in the Cook County, Ill., jails, the Health and Hospital Governing Commission's medical director in charge of health services for the 5,500 inmates reported that he has not been able to insure that inmates needing special diets because of their medical conditions receive them. The health agency has authority over medical services for inmates, but the food service program is operated by corrections agency staff.

Conclusion

Despite the emphasis over the past decade on the right to health care, this right is not a reality for close to half a million persons incarcerated in correctional facilities throughout the country. While as yet untested, denial of prisoners' rights to health care benefits, which had previously been available through private insurance, Medicare, Medicaid, and other sources, may well be in violation of constitutional rights barring cruel and unusual punishment.

If problems of inertia and legal and bureaucratic hurdles could be overcome, the problems of prison health services could be attacked by creating health maintenance organizations (HMOs) for correctional facilities. Such organizations could provide comprehensive health services to prisoners by tapping funds which would need to be pried loose from such sources as private health insurance, Medicare, and Medicaid, and supplemented by governmental funds. Basic components of a correctional facility HMO for the inmate population of a relatively large jail or prison would include:

- A full-time, adequately salaried health care staff, including physicians, nursing staff, technicians, and other needed personnel.
- Medical evaluation and followup care for all incoming prisoners, entailing:

1. Intake medical evaluation.
2. Onsite primary care services, with provision for ready access to more sophisticated care.
3. Basic mental health services that would most likely emphasize group therapy modalities and be closely linked to the facility's rehabilitation program. The mental health program should also be directly concerned with the impact of the institution's physical and psychosocial environment on inmates. Comprehensive drug abuse services should be provided directly or by referral.
4. Contractual arrangements for hospital care, specialized outpatient services, and other services which cannot be provided conveniently onsite on a day-to-day basis.
5. A health education program, with heavy emphasis in such areas as personal hygiene and nutrition.
6. Nutritionist-dietitian services to insure that nutritional requirements of all prisoners are adequately met, and that prisoners requiring special

diets, for example, diabetics and persons with cardiac problems, receive them.

7. Dental services, including preventive dentistry (toothbrushes, education in oral hygiene, and so forth) for all prisoners and emergency dental care and restorative treatment for long-term prisoners.

8. Followup services, for example "exit health interviews" upon the prisoner's release to impress upon him the importance of obtaining followup care for conditions detected in prison and to aid him in obtaining such care through resources in the community.

Financing of the correctional facility HMO might be on a modified capitation basis, taking into account the rapid turnover of inmate population in many jails.

Some form of national health insurance seems imminent. We should strive to insure that whatever program is adopted includes adequately financed, comprehensive health care services for inmates of prisons and jails, as well as for mental patients and other institutionalized segments of the population.

References

1. U.S. Department of Justice, Bureau of Prisons: National prisoner statistics: prisoners in State and Federal institutions for adult felons 1968, 1969, 1970. NPS Bulletin No. 47, April 1972.
2. U.S. Department of Justice, Law Enforcement Assistance Administration: Survey of inmates of local jails 1972: advance report. U.S. Government Printing Office, Washington, D.C., 1974.
3. Federal Bureau of Investigation: Uniform crime reports for the United States. U.S. Government Printing Office, Washington, D.C., 1972, p. 119.
4. American Bar Association in conjunction with the American Medical Association: Medical and health care in jails, prisons, and other correctional facilities: a compilation of standards and materials. Chicago, Ill.; (*a*) pp. 229–237; (*b*) pp. 293–302. Undated.
5. U.S. Department of Justice, Law Enforcement Assistance Administration: 1970 national jail census. National Criminal Justice Information and Statistics Service, Series SC-No. 1. U.S. Government Printing Office, Washington, D.C., February 1971.
6. Medical care in U.S. jails: a 1972 AMA survey. American Medical Association, Chicago, Ill., 1973.
7. Whalen, R.P., and Lyons, J.J.A.: Medical problems of 500 prisoners on admission to a county jail. Public Health Rep 77: 497–502, June 1962.
8. Health care and conditions in Pennsylvania's State prisons. Health Law Project, University of Pennsylvania Law School, Philadelphia, August 1972.
9. U.S. Bureau of Prisons, Health Services Division: Federal prison medical program—Bureau of Prisons. U.S. Government Printing Office, Washington, D.C., January 1973.

SYNOPSIS

NEWPORT, JOHN (University of California School of Public Health, Los Angeles): *Review of health services in correctional facilities in the United States. Public Health Reports, Vol. 92, November-December 1977, pp. 564–569.*

At any one time more than 400,000 prisoners are incarcerated in State and Federal prisons, local jails, and juvenile detention facilities. Disadvantaged socioeconomic classes are disproportionately represented in the populations of correctional facilities; more than 40 percent of all jail inmates are black, and more than 50 percent have pre-arrest incomes of less than $3,000.

Reflective of their disadvantaged backgrounds, prisoners are more likely than the general population to harbor serious, undetected health problems. Alcoholics, who should be given medical treatment rather than being incarcerated, comprise one-third of all persons arrested. Despite these circumstances, jail inmates rarely receive medical examinations of any sort, and State prisoners may be held for years without medical care. Prisoners' access to sick calls is often barred by guards who lack training in medical triage.

A common theme of the standards for prison health care services developed by various organizations, including the United Nations and the American Correctional Association, is that medical care for prisoners should be equivalent to "mainstream" care in both quality and accessibility. In contrast to these standards, however, recent surveys conducted by the Department of Justice and the American Medical Association indicated that 49 percent of all local jails lack even basic provisions for first aid and that more than three-fourths of all jails have no arrangements for regular medical coverage.

The 1972 U.S. District Court ruling in *Newman* v. *Alabama* declared that failure to provide adequate medical care is a violation of prisoners' constitutional rights. The health care program for Federal prisoners with an annual budget of $700 per inmate indicates that adequate prison health services can be provided when the necessary commitment is present. In short, the abysmal state of health services in State prisons and local jails reflects lack of both motivation and resources. While yet untested, the denial of inmates' rights to health care benefits previously afforded by private insurance, Medicare, and Medicaid may be in violation of their constitutional rights.