Commentary

Prison Health: The Breaking Point

Alan Berkman, MD

Introduction

> Recognizing that prisons disproportionately confine sick people, with mental illness, substance abuse, HIV disease among other illnesses; and that prisoners are subject to further morbidity and mortality in these institutions due to lack of access and/or resources for health care, overcrowding, violence, emotional deprivation, and suicide . . . [the American Public Health Association] condemns the social practice of mass imprisonment.[1]

When the American Public Health Association's Governing Council adopted this policy statement in 1991, I was about to be released after serving more than 8 years in prison for politically motivated criminal acts. When I entered a federal detention center in 1982, there were slightly more than 400 000 men and women in US prisons ("prison" defined here as an institution for people serving more than 1 year),[2] the first reports of a new immune deficiency disease in gay men were beginning to circulate, and tuberculosis was only dimly remembered as an infectious disease. When I left a federal prison hospital in 1992, there were 900 000 men and women in prison and another 400 000 in jails (defined as short-term institutions).[2] The aggregate acquired immunodeficiency syndrome (AIDS) incidence rate for federal and state prison systems was 362 per 100 000, 20 times the rate for the United States as a whole.[3] Several prison systems had reported tuberculosis epidemics, including ones in which the organism was multiple-drug resistant.

During my time in prison, I twice developed Hodgkin's disease and became intimately familiar with the health care available to prisoners. The limited improvements in prison health care made during the 1970s in response to prisoner rebellions and class action suits crumbled in the face of a rapidly expanding patient population with serious illnesses. Sick call, usually conducted by the most poorly trained health care providers, almost never involved taking a pulse or blood pressure. Prison physicians, most of whom had little or no prior experience with HIV or infectious disease, found themselves in the forefront of the AIDS epidemic, and many simply threw up their hands. Prison officials often saw HIV-positive prisoners as simply a threat to the orderly running of their institutions and responded by placing them in isolation. The health care crisis in prisons led the National AIDS Advisory Council in 1991 to warn that the prison system could become "a charnel house in which inmates sentenced to reform and punishment are consigned to a tragic and hastened death, in pain and isolation."[4]

Increasingly, the warning is becoming reality. The heated rhetoric surrounding debates about imprisonment creates a hostile environment in which to make arguments about the human and health care tragedy being played out in our nation's prisons and jails. Yet, as public health professionals, we must continue to demand a role in formulating policy and allocating resources. To be effective, our proposals need to be rooted in the reality of prisoners' lives and the dynamics of correctional facilities.

Prisoners Are People

The buildup in the prison population has been accompanied by a systematic

The author is with the Highbridge-Woodycrest Center, Bronx, NY.

Requests for reprints should be sent to Alan Berkman, MD, Highbridge-Woodycrest Center, 936 Woodycrest Ave, Bronx, NY 10452.

campaign to dehumanize those in prison. Politicians and policymakers increasingly use terminology such as "animals" and "subhumans" to describe street criminals. The historic racial implication of this language is widely understood but rarely challenged. The intended result is to demonize those in prison, implicitly relieving society of any obligation to supply decent living conditions or medical care. President Clinton, while avoiding the most charged rhetoric, contributed to this dynamic during the debate over health care reform in 1994. His canned stump speech inevitably contained one variant or another of the following quote: "You want better health care for sure? Get on welfare, go to jail, get elected to Congress, or get rich. Be a federal employee. Be the president."

The cynicism of equating presidential health care with that of prisoners may be obvious, but the subtext is that prisoners either get better than they deserve or deserve as bad as they get. While it may now be a moot point, it was striking that all of the health care reform proposals put forward in 1994 excluded prisoners. This ensured that funding for prison health would remain part of the "law and order" debate and not part of global health care planning. Politicians vie with each other to allocate more money to build prisons, but none argue for more money for health care services. The result is that proportionately less money is being spent each year to care for greater numbers of sick prisoners. The public health implications are obvious.

Prisons Are for the Poor

There are a wide range of penal institutions, but the demographics are essentially the same: almost all of the inmates are from the poorest strata of society, and they are disproportionately from communities of color. It is fatuous for politicians or social planners to deny the relationship between rising unemployment, deepening poverty, and the parallel growth in the prison population.

So, too, must prison health care be seen as a growing part of the health care offered to the poor. The New York State Department of Corrections may well be the single largest provider of health care to HIV-positive patients in the United States. Substandard care in prisons undoubtedly contributes to the morbidity and mortality of the diseases that afflict the poor. The lives of those citizens of New York State who died of resistant tuberculosis in 1991 should count for no less because they died in prison rather than in a city hospital. The fact that prisoners with HIV die faster than people with AIDS in the street is a function of the health care they receive, not a function of the social label they happen to bear during some period in their lives. If we as a society are to continue to believe that the poor are entitled to health care, health care planners must see that that entitlement extends into the largest and most rapidly growing congregate housing for the poor.

Some of the best prison health providers have used this understanding when attempting to get reluctant elected officials to allocate sufficient resources. They argue that "most prisoners will get out some day, and if we don't treat their tuberculosis (HIV, etc.) now, they will spread it to others later." The implication is that it is the "others" who matter, not the prisoners themselves. This reasoning may shake loose some much-needed funding in the short term, but it inadvertently promotes a view of prisoners as vectors of disease and a danger to society. Policies to keep people imprisoned for longer and longer terms are the unfortunate but logical outcome of such a view.

Public health is premised on the valuing of human life, and no effective planning will be done until those in prison are viewed as part of the community.

Prisons Are for Men

The discipline of penology and virtually every aspect of prison life are premised on the prisoners being men. The vast majority of prison personnel are men. The physical plants of most prisons were designed for men. Only a handful of institutions make any accommodation to the fact that the lack of privacy that characterizes all prisons often becomes a form of sexual harassment in women's prisons. Most relevant to the current discussion, prison health services have myopically refused to recognize the unique health needs of women in prison.

The last 15 years have seen a qualitative change in the absolute and relative numbers of women in prison. According to the Bureau of Justice Statistics,[2] the percentage of women in prison tripled during the 1980s. Nationally, there are now 100 000 women in prisons and jails on any single day, and these women are at higher risk than the men for serious illness, including HIV. The New York State Department of Correctional Services' 1992 seroprevalence survey showed that 20% of incoming female prisoners tested positive; approximately 12% of the male prisoners had positive tests.[5]

Prison health services are totally inadequate in the face of this reality. In almost all systems, the prisons for women do not receive a proportionate share of the budgeted health care dollars. Women's prisons have traditionally been unable to supply even routine gynecological care; the HIV epidemic now demands that women have ready access to frequent Pap tests, colposcopy, and other specialized procedures. It is essentially impossible for HIV-infected women to receive the community standard of care for their disease while in prison.

Prisons Are Bad for Your Health

The vast majority of prison systems now define their mission as the "warehousing" of rapidly growing numbers of convicts. The "rehabilitation" model, which paid lip service to the social, educational, and medical needs of the inmate, has virtually disappeared from penological and public discourse. Warehousing, with its image of neatly packaged, stationary crates and boxes, emphasizes rigid discipline and unvarying routine. It is most successful when men and women are reduced to being as machinelike as possible. In such an environment, health care delivery and health education are seen as disruptive by prison authorities.

Health care has always stirred great passions among prisoners. The prison rebellions of the 1960s and 1970s always had improved health care as a leading demand. In response to these disturbances and the prisoner-initiated class action suits that followed, significant improvements in some systems were made. The 1980s brought the war on drugs, geometric growth in the prison population, and the total dominance of the warehousing model. It also brought the HIV epidemic and, subsequently, tuberculosis. Prisoners are now faced with literally a life and death crisis in prison health care and have less support than before in the community and in the federal courts. Faced with these conditions, prison activists have focused their efforts on self-empowerment, educating themselves and other prisoners about HIV and tuberculosis. A small number of outside grass-roots organizations and prison health providers have responded to these prisoner initiatives and the deepening crisis.

Important lessons can be learned from the last decade of experience gained by those who challenge both the AIDS epidemic and traditional prison health practices. The first lesson is that health care systems in prison should be autonomous. Numerous health experts have commented on the conflict between care and custody in prison. The best response to date has been to separate the two functions as much as possible, with health care being directed by an independent medical center or local medical association. Medical providers in prison share the established ethical obligation of all physicians to place the health of the individual patient first. Corrections may be the context in which care is given, but it should not dictate the content. Examples of this model include the New York City Department of Corrections/Montefiore Medical Center and the Rhode Island Department of Corrections/Brown University Hospital.

The second lesson is that health education/HIV prevention should be peer based. Public health professionals dealing with HIV prevention have recognized the need to develop interventions that are relevant to the target population. The race, class, gender, and nationality differences that constitute the enormous diversity of US society are all present in prisons. Transforming them all is the prison setting itself.

Prisoners are confined against their will. Hostility and deep distrust define the relationship between the prisoner and the institution. In such a setting, education, no matter how well intentioned, can rarely be effective.

Activists in a number of prisons have responded by setting up peer education groups. One of the first was ACE (AIDS Counseling and Education) at Bedford Hills Correctional Facility for Women in New York State. Consistent work over years has created an environment in which HIV-positive prisoners are accepted into the larger community of women without fear or hostility. HIV education/prevention is offered to the entire population, and it is reasonable to assume that staff have also been influenced by the work done by prisoners. Released women have since formed ACE-Out to continue the work and mutual support in the community.

Unfortunately, prison administrators have often opposed such efforts. Self-empowerment and self-awareness among prisoners are viewed by the authorities as a threat to the orderly functioning of the institution. Public health planners must be aware of and be willing to address this potential conflict when developing prevention efforts in prison.

The third lesson involves harm reduction. Prisons have had "zero tolerance" for sex and drugs for years, a policy that has been no more effective there than in the community. Public health planners who fight for the harm reduction model in the community at large cannot stop at the prison wall. A small number of prisons and jails have initiated condom distribution, and these efforts need to be evaluated. Prisoners are people and should be helped to minimize their risk of HIV infection.

The final lesson involves HIV testing. A number of prison systems have experimented with mandatory testing of all incoming inmates. Fortunately, the expense involved, as well as the realization that knowing the HIV status of all prisoners might well result in greater health care expenditures, dissuaded most systems from continuing to test.

Many public health professionals call for widespread voluntary testing of prisoners. While this is a good idea in the abstract, it can be a threat to the well-being of prisoners who test positive. Some prison systems continue to put HIV-positive prisoners in isolation or special units, depriving them of the limited programs and recreation available to others.

Anonymity is a practical impossibility in a system in which correctional officers have access to health records or escort prisoners to sick call to receive azidothymidine (AZT), bactrim, or other HIV-identified medications. I have personally been in a number of institutions where known HIV-positive prisoners were not isolated, but guards wore gloves when searching them or their cells. This practice not only identified these prisoners but labeled them as dangerous. It heightened the fears of the other prisoners and made violence against the labeled prisoners more likely.

Voluntary HIV testing will become more accepted by prisoners only when institutional discrimination is prohibited and effective education of both staff and inmates is in place.

The Human Cost

Beneath the talk of health care systems and public health planning, there is the stark reality of individuals grappling with illness and possible death in an inhumane environment. During my second bout with cancer, I was almost totally paralyzed from the neck down, able only to breathe and minimally use my hands. Yet, I was kept shackled to the bed, the guard coming by regularly to check the restraints. Prisoners struggle to live, or die, surrounded by people whose primary responsibility is to confine them, not care for them. There is no comforting touch, no human solidarity in the face of suffering or death.

Prison health care should make all of us uneasy. On a philosophical level, it raises the question of whether "antisocial behavior" should deprive an individual of humane care. On a societal level, it confronts us with the realities of poverty and racism and how we value human life. On the personal level, we are forced to look at extreme human suffering and ask ourselves if anyone deserves such treatment.

These are not popular questions in the era of budget crises and penological nostrums such as "three strikes and you're out." Yet, I am convinced that until we confront them, there will be no answer to the health care crisis in prison or in the country as a whole. The chain of common humanity is only as strong as its weakest link, and for the current generation of public health planners, prisons are the breaking point. □

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