Correctional Healthcare — an Engine of Health Inequity

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Between April 2020 and April 2021, American jails reported an estimated 2555 COVID-19-related deaths, with a standardized mortality rate of nearly 200 per 100,000 people — almost 2.5 times that of the broader US population.[1] While striking, these data likely underestimate the extent to which COVID-19 has ravaged prison populations across the nation. Misreporting and delays in data, as well as inconsistencies in testing rates between prisons and the general public, compromise the veracity of these jail COVID-19 reports.[1] Such inconsistencies in these vital jail health statistics should naturally concern epidemiologists who study the nature of this pandemic and how best to curb its spread — but deficient COVID-19 reporting in jails also points to a much more alarming reality of jail healthcare that is relevant to clinicians more broadly: vast disparities in standards and oversight persist between correctional and mainstream healthcare, fueling health disparities.

HISTORICAL DETERMINANTS OF DEFICIENT CORRECTIONAL HEALTHCARE STANDARDS

The absence of federal oversight for correctional healthcare was cemented with the Social Security Act (SSA) Amendments of 1965, which authorized the creation of Medicare and Medicaid but specifically prohibited these federal programs from subsidizing healthcare in jails and prisons.[2] Although other healthcare providers who receive Medicaid and Medicare reimbursements must meet minimum standards of care under the SSA, this inmate exception exempted correctional healthcare systems from these external quality oversight mandates. Federal organizations, such as the Centers for Disease Control and Prevention (CDC) and the American Medical Association (AMA), can set forth broad guidance for certain correctional healthcare procedures, but their limited enforcement power has resulted in a largely standardless correctional healthcare landscape.

As the COVID-19 pandemic has made evident, this unstandardized environment has allowed jail healthcare systems to diverge substantially in vital pandemic mitigation protocols. A 2021 analysis of US state departments of corrections (DOC), for instance, furnished sobering results. None (0%) of the state DOCs analyzed met all the COVID-19 quarantine recommendations as set forth by the CDC.[3] A substantial proportion of state DOCs studied (19%) failed to meet any of the CDC quarantine recommendations. This divergence in policy persists in the age of COVID-19 vaccinations. A recent analysis of state COVID-19 vaccination policies reported that approximately 15 of 36 US states analyzed did not prioritize incarcerated populations for COVID-19 vaccination.[4] Crucially, the failure to prioritize incarcerated people in state COVID-19 vaccination policies reduces access to this vital prophylactic, which raises incarcerated populations' susceptibility to infection and serious illness. Indeed, states that prioritized COVID-19 vaccination for incarcerated populations in early 2021 exhibited higher vaccination rates among incarcerated people relative to those that prioritized vaccinating this population later or not at all.[4] Jails and prisons have long been plagued by other factors conducive to COVID-19 transmission and mortality, including overcrowded congregate living settings and poor underlying health among their populations.[5] Divergent compliance with COVID-19 quarantine protocols, as well as inadequate prioritization of vaccination among incarcerated populations, only exacerbates these extant issues.

CARCERAL-COMMUNITY EPIDEMIOLOGY

Further studies will be necessary to elucidate the long-term effects of incarceration on COVID-19 health outcomes, but minimal correctional healthcare standards have already engendered critical disparities in broader health outcomes. Incarcerated populations have significantly higher prevalence of

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debilitating chronic conditions, including tuberculosis, cardiovascular disease, and substance-use disorders — illnesses exacerbated in correctional settings that often lack the necessary resources or trained health staff to provide adequate care.[5] Importantly, these poor health outcomes are not distributed equally across all racialized groups. Due to historically discriminatory policing policies and practices in the US, Black, Indigenous, and Hispanic people are incarcerated at a disproportionately high rate.[5] This inordinate exposure to the carceral system underscores the disproportionate effect of mass incarceration — a structural determinant of individual and population health — on communities targeted for marginalization. In the absence of external oversight and standards of care in the carceral system, it is predominantly people from racialized groups historically targeted for marginalization who lack the vital healthcare they need to treat their chronic illnesses, which only widens racial health disparities.

Furthermore, given that most incarcerated individuals return to society, it is critical to address poor healthcare delivery in correctional facilities to reduce burdens on the broader American healthcare system. Because incarcerated individuals are more likely to be from low-resource communities and lack stable housing and health insurance at higher rates than the general population, correctional facilities may provide many incarcerated Americans with their first access to preventive and chronic medical care.[5] However, no universal standards have been established for continuity of care upon carceral release. Resultantly, the integration of formerly incarcerated individuals into mainstream healthcare systems is often obstructed by distrust, discrimination, and poor communication; thus, correctional facilities become disease multipliers for surrounding communities.[6] Health inequity pervades these epidemiological pipelines as well. In one study, the spread of COVID-19 from a single jail accounted for approximately 16% of all Illinois cases in Spring 2020; nearly all these cases appeared in majority-Black or -Latino ZIP codes.[6] Indeed, the COVID-19 pandemic highlights carceral-community epidemiology: the inseparability of carceral conditions from community and population health.

FUTURE DIRECTIONS AND THE ROLE OF THE INTERNIST

Extant issues in correctional healthcare, which the COVID-19 pandemic has brought to the fore, exacerbate broader trends in racial health disparities that have captured the attention of the healthcare profession in recent years. Reducing disparities in medical outcomes, therefore, must include measures to ensure parity between correctional and mainstream healthcare. The first, long-overdue step along this path is straightforward yet critical: the medical community must recognize correctional and mainstream healthcare as unitary.

More specifically, effective correctional health systems require proactivity, not the "legal reactivity" with which many currently operate.[7] Facilities need enforceable healthcare standards and the same rigorous accreditation processes required of mainstream hospital systems. A federal repeal of the SSA's inmate exception for Medicaid reimbursements and external oversight may prove critical for establishing this unity across correctional healthcare and mainstream medicine. In the interim, however, states can pass individual waivers that temporarily halt Medicaid for eligible incarcerated persons, rather than eliminate coverage altogether. Moreover, medical and public health professionals can advocate for their county and state representatives to explicitly encourage or require correctional facilities to receive accreditation for their healthcare services. These approaches may assist in the establishment of quality healthcare standards, which will likely improve care coordination and the exchange of health information between correctional healthcare and mainstream medical providers.

Such short-term changes to correctional healthcare represent much-needed analgesics, but the ultimate cure more likely lies in enacting systemic criminal justice reform. In particular, meaningful efforts to reduce the flow of individuals entering the carceral system and focus on rehabilitation of incarcerated individuals are necessary to address the deleterious health effects of incarceration. The internist is instrumental on both fronts. Firstly, internists can leverage their substantial social and political capital to advocate for evidence-based policies that reduce jail and prison populations by creating alternatives to incarceration and addressing the socioeconomic conditions that induce individuals to violate the law. Reframing decarceration proposals as a matter of collective health can redirect attention away from bad-faith arguments that these policies eliminate accountability for criminal offenses. Additionally, thought leaders in the field of internal medicine can dedicate greater time and resources to studying the unique challenges of correctional healthcare. The establishment of a more robust evidence base can help catalyze the development of healthcare policies, protocols, and training materials that ensure the continuity of quality care between non-incarcerated and incarcerated settings. Such continuity of care is critical to the principles of restorative justice, which hold that people who experience incarceration emerge better off than when they enter the criminal justice system.

To be sure, the path toward improved correctional healthcare is long and complex. The profound bias against people who are incarcerated, in particular, proves a formidable obstacle to galvanizing internists and policymakers alike. However, the ethos of healthcare commands persistence: the central tenets of the medical profession leave no room for stigma nor prejudice. Indeed, physicians cannot merely resign to poor healthcare so long as it exists behind bars.

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