

COMMENTARY

Health Status in US and Russian Prisons: More in Common, Less in Contrast

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It has been 17 years since I began working in correctional health care. During that time, I managed the health services at Rikers Island (New York City's jail), supervised the health services for New York State's prison system, and, for the past 10 years, had a consulting practice focused on public policy, public health, and quality of health services in US jails, prisons, and juvenile facilities. I have examined the conditions of confinement and health services in more than 100 correctional facilities in 27 states. My work is about assuring access to high-quality health care for the 2.2 million people in US prisons and jails (1), protecting public health through prevention and early intervention, and assuring vital health services linkages for the 95% of inmates who return home to their communities.

Reading the Bobrik *et al.* paper about the health status and health care for inmates in Russian prisons (2), it is easy to imagine the conditions: cells packed tightly with 30 sweaty bodies, milling aimlessly; hungry folks; rank odors and clamor; and air that is still and dank, all the more disagreeable with airborne droplets so likely to be carrying *Mycobacterium tuberculosis*. Not pleasant thoughts.

Tuberculosis in Russian prisons is redolent of conditions in prisons in the United States a century ago. In 1894, Dr. Julius Ransom, a prison physician, reported that 25% of the 1,000 inmates at the prison in Dannemora, NY, had active tuberculosis (3). In his report to Congress in 1907, the rates were unchanged, with high mortality, more than half of which was attributed to tuberculosis (4). One

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hundred years later, despite the availability of modern diagnostics, knowledge about containment and multidrug regimens for tuberculosis, Russian prisons are currently incubators of this same scourge. But outside of tuberculosis, Russian prisons mirror our own, with rather striking parallels to the correctional population in the United States.

PARALLELS

US prisons have so much more in common with Russian prisons than in contrast:

- Only three countries in the world have incarceration rates that exceed 139/100,000 population. In 2003, the United States led the pack with a rate of 715/100,000 (5). Russia followed close behind at 628/100,000 population, and South Africa with 400/100,000 population. Italy, The Netherlands, Germany, France, Sweden, and Japan have incarceration rates $\leq 100/100,000$ population (6). In the case of the United States, the excess incarceration is not due to more violent crime. Rather, it is due to higher incarceration rates and longer sentences for property crimes and drug offenses (6, p. 8).
- The United States and Russia similarly incarcerate young men (predominantly) who are poor and undereducated. In our case, we disproportionately imprison minorities. Although at current incarceration rates, 6.6% of United States residents born in 2001 will go to prison at some time in their lifetime, roughly one in three black males and one in six Hispanic males will go to prison during that time (7). One out of every eight black males is currently behind bars (6, p. 3).
- Other than tuberculosis, the morbidity of inmates in the United States and Russia is similar, especially the rates of major mental illness, sexually transmitted disease, viral hepatitis, HIV infection, and other chronic illness (8,9).
- Perhaps less crowded generally, some United States prisons and jails get similarly crowded to those in Russia. As recently as May 2004, the Fulton County (Atlanta, Georgia) jail housed more than 3,000 inmates in a facility built for half that number; 500 were sleeping on mats on the floor of the day rooms because there were not enough bunks in the cells. In 2003, the Julia Tutwiler Prison

for Women in Alabama housed more than 1,000 women in a facility, without air-conditioning, built for 364.

- Both the United States and Russia have insufficient valid and reliable data on the health status of inmates, due to inadequate surveillance and research (9, p. 59).
- In both countries, there are clear opportunities to improve the health status of inmates through focused attention to primary prevention, early detection, and evidence-based clinical interventions (8, p. 59–64). Seizing these opportunities will not only accrue to the benefit of the inmates themselves, but also to the benefit of the public health. Of course, acting on these clear opportunities takes political will and resources.

PROTECTIVE EFFECTS AND INVISIBLE PUNISHMENTS

Bobrik *et al.* discuss the protective effect of incarcerating young men, citing the fact that 60% were unemployed prior to incarceration. Russian inmate mortality is only 40% of an age-adjusted cohort of Russian males who are not behind bars. We do not have similar comparative data for US prisons and jails, but it would be no surprise to find lower mortality among incarcerated young men. Behind bars, they are at least partly protected from external causes of death, such as accidents, violence, and drug overdose. In the United States, for males of all races aged 20–44 years, accidents, homicide, and suicide account for 33–78% of all deaths, depending on age (10).

But incarceration as a type of protective custody for young men in harm's way is neither rational nor legal. It is not the American way. There must be other, less coercive, means to keep poor young people out of harm's way.

Whatever protection prison may afford, there are other, less visible, consequences of excess incarceration: personal, social, and economic. On a personal level, there is the anger, loss of self-esteem, and isolation from family and community. At the same time, there are other risks, such as prison violence. In 1997, 22% of inmates report that they were injured while in prison. Nearly half of state inmates who had served six or more years reported that they had been injured after admission (11).

Psychological trauma from crowding constitutes another invisible consequence. Data are scant, but there is some compelling research on crowding. Crowding, such as double and triple “celling” or dormitory housing, is associated with increased rates of death, suicide, disciplinary infractions, and psychiatric commitment (12).

The released inmate also faces serious difficulties with housing, employability, and workforce participation, substance abuse, and health care (13). Depending on the state, a person convicted of a felony drug offense may be barred for life from receiving welfare benefits, prohibited from living in public housing, permanently lose the right to vote, and be denied access to financial aid for higher education (6, p. 14). Because of low workforce participation, released inmates are unlikely to have health insurance. Without health insurance they are more likely than those with health insurance to receive too little medical care and receive it too late; they tend to be sicker and die sooner, and receive poorer care when they are in the hospital, even for acute situations like a motor vehicle crash (14). The Institute of Medicine estimates that 18,000 Americans die prematurely each year due to the effects of lack of health insurance coverage (15). The uninsured are as much as four times more likely than the insured to experience an expensive, avoidable hospitalization or require emergency care (16). Owing to tight eligibility standards, however, most released inmates are not entitled to Medicaid coverage (state programs for the poor).

Inadequate treatment planning and prerelease planning for inmates with chronic disease, communicable disease, and mental illness compounds these problems and compromises opportunities for successful community reintegration (17).

Excess incarceration has a social impact on families and neighborhoods, given that 1.5 million children have a parent in prison (18). There is an uneven gender ratio in some African-American communities consequent to high incarceration rates of young black men.

Recently, the political will has continued to be “tough-on-crime”. While this tough-on-crime policy has, arguably, hurt urban communities, the policy has been a boon to poor rural communities that get the construction and workforce benefits of new prisons. Overall, with tax cuts on many political minds, the cost of corrections

competes directly with support for higher education and vital public health services.

LESSONS LEARNED

Russia and the United States share high incarceration rates. Inmates in both countries enter the systems with high morbidity, especially substance abuse, mental illness, and communicable diseases such as tuberculosis, HIV, viral hepatitis, and sexually transmitted diseases. Inmate medical care varies in quality from place to place, but, overall, there are insufficient resources to take full advantage of the personal and public health opportunities during the period of incarceration for this high-risk, vulnerable group. Inmates in the United States are released without adequate health care coverage and linkages to medical care and mental health and public health services. With mental illness and communicable disease, these inadequate linkages pose public health and public safety risks. They have economic consequences for the community. Similarly, inadequately treated chronic disease has economic consequences for the community.

A WINDOW TO OUR SOCIETY: INMATES AS PUBLIC HEALTH SENTINELS

A view of the health status of inmates is a view through a window to our society at large. Because of whom we incarcerate, especially drug users and the mentally ill, inmate morbidity is highly concentrated with people who have mental illness, communicable disease, and the consequences of alcohol and substance abuse.

The concentration of these illnesses is remarkable. In the United States, one out of every seven inmates has major mental illness such as schizophrenia, bipolar disorder, major depression, or post-traumatic stress disorder. Most are decompensated when they arrive behind bars. In 1996, 17% of HIV-infected Americans passed through a correctional facility; 12–15% of those with hepatitis B and 30% with hepatitis C infection were released; and an estimated 35% of Americans with active tuberculosis were released inmates (9, p. xi). Inmates are public health sentinels, whether in Russia or the United States.

The view through this window on our society is a clear one. It is a window of vast opportunity to protect public health cost-effectively. With a focus on seven areas, I believe public policy-makers can achieve substantial benefit, cost-effectively.

- *Primary and secondary prevention:* As a high-risk group, because of poverty and lifestyle, the majority of inmates are yet uninfected, but susceptible to, HIV, viral hepatitis and sexually transmitted disease. Up to 25% have latent tuberculosis infection. Inmates are prime candidates for cost-effective interventions in these areas, such as counseling, screening, prophylaxis, treatment, and immunization against vaccine-preventable illnesses such as hepatitis A, hepatitis B, influenza, and pneumococcal pneumonia.

Wouldn't an ounce of communicable disease prevention be worth a pound of cure behind bars?

- *Alcohol and drug treatment:* Despite its effectiveness and utility in preventing crime and recidivism, there is too little alcohol and drug treatment in prisons and jails in the United States. Eighty percent of incoming inmates report excess alcohol or illicit drug use in the 30 days prior to incarceration. More than 25% are incarcerated on drug charges.

Doesn't it make sense to intervene behind bars, in a controlled environment, where there is such a high concentration of alcohol and drug addiction?

- *Evidence-based treatment:* Too few correctional health care programs use nationally accepted guidelines for the diagnosis and treatment of chronic disease and mental illness. Diabetes, hypertension, coronary artery disease, hyperlipidemia, and asthma are examples where there are clear cost-effective consensus guidelines to reduce morbidity and mortality. There is no good reason not to implement these guidelines. Without them, there is excess morbidity, mortality, and cost. There are nationally accepted performance measures, such as HEDIS[®]; when used, performance improves.

Why shouldn't correctional clinicians follow nationally accepted guidelines for the most prevalent conditions behind bars, especially when they are cost-effective for society?

- *Preparation for re-entry:* Community reintegration depends in large part on successful linkages with community providers for

treatment of chronic diseases, mental illness, and communicable diseases. For communicable diseases, collaboration with public health departments is obligatory. It does not make sense to treat conditions without a plan for continuity of care. Continuity of medication is especially critical for those with diseases like tuberculosis and HIV, where medication lapses can cause drug resistance, and for mental illness where medication lapses can lead to mental decompensation and subsequent re-incarceration. Correctional systems, public health departments, and community organizations can redirect energy into building these linkages. States can extend Medicaid benefits to re-entering inmates to provide continuity of medication and affordable access to care.

After spending so much money to incarcerate and treat people, wouldn't it be sensible to provide these community linkages and health care coverage?

- *Barriers:* There are a multitude of barriers to effective implementation of correctional health care and public health policy. We would all benefit from an examination of at least four of these barriers and the implementation of effective programs to reduce the barriers.
 - *Leadership:* There is a lack of leadership to advocate for inmate health care, in part because some correctional administrators do not believe that inmates are “entitled” to good care. These administrators are not sufficiently educated about the potential benefits to staff and their own communities that derive from improved health services for inmates.
 - *Funding:* Correctional systems should be sufficiently funded to fulfill a public health agenda. Too often, public health is not on the minds of correctional administrators when they negotiate their budgets.
 - *Logistics:* There are logistical barriers, such as short periods of incarceration for many inmates in jails. As a result of this turnover, facilities with routine screening policies typically delay comprehensive assessments for up to 14 days. As a result, for the 50% of inmates who will stay longer than 14 days, there are lost opportunities, for example, with the early diagnosis of contagious tuberculosis. And for those who stay less than 14 days, there is no benefit at all. Custody is often short-staffed, causing problems with timely distribution of medication. Discharge

planning is often compromised because of inadequate communication between courts, parole boards, custody staff, and health care staff.

- Correctional policies themselves are barriers to care. For example, jurisdictions too often fail to specify minimum levels of care required in contracts with private health care vendors. Contracts often fail to require explicitly evidence-based clinical guidelines. Communication with public health agencies is often poor.
- *Research and evaluation:* There is a paucity of data on inmate health status and evaluation of program effectiveness. There is insufficient information on what works and what does not work. How do correctional systems compare in performance, where intervention is known to improve outcome? How do they compare where there are cost-effective interventions? How do they compare in risk management, that is, avoiding litigation? Correctional systems should have surveillance systems and performance measurement using nationally accepted measures, for example, HEDIS[®], a tool developed by the National Committee for Quality Assurance to measure and compare the performance of managed care organizations on clinical and access measures.
- *Consequences of incarceration:* There are too few data on the personal and social consequences of incarceration. What happens to people psychologically and socially when they are incarcerated? What are the adverse or salubrious effects of living in a prison community? And what are the effects on families and communities? Further research in this area might help drive public policy toward reducing unnecessary incarceration and decreasing recidivism.

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