National Commission on Correctional Health Care

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POSITION STATEMENT

Charging Inmates a Fee for Health Care Services

Background

Based on 40 years of intensive evaluation of health care systems in jails and prisons, the National Commission on Correctional Heath Care recognizes that lack of access to health care is a serious problem in detention and correctional institutions. Charging inmates for health services may contribute to the problem of access to health care.

Clearly, there are reasons one might argue either for or against the imposition of charges for health care services provided to inmates, although research on the efficacy of such programs is limited. Some of the arguments for charging inmates a fee are as follows:

- The cost of medical care is an increasingly heavy burden on the financial resources of the facility, state, or county. The cost needs to be controlled legally without affecting needed care.
- Sick call can be and is abused by some inmates. This abuse of sick call places a strain on available resources, making it more difficult to provide adequate care for inmates who really need the attention.
- Inmates who can spend money on a candy bar or a bottle of shampoo should be able to pay for medical care with the same funds—it is a matter of priorities.
- It will do away with frivolous requests for medical attention.
- It cuts down on security problems in transporting inmates to and from sick call by reducing utilization.
- It instills a sense of fiscal responsibility and forces the inmate to make mature choices on how to spend money.

Arguments against charging inmates a fee for health care services include the following:

- Access is impeded. A fee-for-service program ignores the significance of full and unimpeded access to sick call and the importance of preventive care.
- Inmates are almost always in an "indigent" mode. They seldom have outside resources and most have no source of income while incarcerated. They most often rely on a spouse, mother, or other family member to provide funds they can use for toiletries, over-the-counter medications like analgesics and antacids, telephone calls, writing paper and pens, sanitary napkins, candy, etc. These "extras" become extremely important to one who is locked up 24 hours per day. The inmate may well choose to forgo treatment of a medical problem in order to be able to buy the shampoo or toothpaste.
- The program sets up two tiers of inmates: those who have funds to get medical care and commissary privileges, and those who have to choose between the two.
- Avoiding medical care for "minor" situations can lead to serious consequences for the inmate or inmate population, since the minor situation can deteriorate to serious status or lead to the infection of others.
- Crowded conditions increase the risk of spreading infections, and effective measures need to be taken to reduce this risk. Daily sick call should be encouraged rather than discouraged. Co-pay has been identified as a contributing factor for outbreaks of methicillin-resistant *Staph aureus* (Centers for Disease Control and Prevention, 2003).

- A properly administered sick-call program keeps costs down through a good triage system, which has a lower level of qualified staff see the complaining inmate first, with referral to higher levels of staff only as medically indicated.

- Charging health service fees as a management tool does not recoup costs; rather, when looking at the increased administrative work involved or the long-term effect of the program, charging health service fees can cost more to implement than what is recovered.

- Inmates frequently have low health literacy and may not understand the difference between medically significant and medically insignificant symptoms nor when it is important to seek medical services. Thus, it may be ineffective to expect inmates to determine when to pay for medical services.

Position Statement

The National Commission on Correctional Health Care strongly believes that access to health care is at the foundation of any acceptable correctional health services program. Such access should not be obstructed, because without ready access to necessary health care services—as determined by qualified health staff—the health of the inmate population, as well as that of the staff and the public, may be jeopardized.

NCCHC recognizes that lack of access to health care remains among the most significant characteristics of jail, prison, and juvenile correctional systems in the United States. Because of their disproportionate poverty and incidence of drug use, inmates have higher morbidity and mortality from treatable serious medical problems. Therefore, NCCHC is opposed to the establishment of a fee-for-service or co-payment program that restricts patient access to care.

However, NCCHC recognizes that in some locales, legislation mandates fee-for-service programming, while in other locales, co-pay policy is largely a nonmedical decision. If a fee-for-service program is to be implemented, NCCHC recommends that it be founded on the principle that access to health services will be available to all inmates regardless of their ability to pay. To ensure that access to care is not impeded, the following guidelines should be followed:

1. Before initiating a fee-for-service program, the institution should examine its management of sick call, use of emergency services, system of triage, and other aspects of the health care system for efficiency and efficacy.

2. Facilities should track the incidence of disease and all other health problems before and after the implementation of the fee-for-service program. Statistics should be maintained and reviewed. The data should demonstrate that infection levels and other adverse outcome indicators, as well as incidents of delayed diagnosis and treatment of serious medical problems, are either consistent with or lower than the levels before implementation. Data that show an increase in infection levels or other adverse outcomes may indicate that the program is unintentionally blocking access to needed care.

3. All inmates should be informed of the details of the fee-for-service program on admission, and it should be made clear that the program is not designed to deny access to care. Inmates should have a full working knowledge of the situations in which they will or will not be assessed a fee as well as any administrative procedures necessary to request a visit with a health care provider.

4. Only services initiated by the inmate should be subject to a fee or other charges. No charges should be made for the following: admission health screening (medical, dental, and mental) or any required follow-up to the screening; the health assessments required by facility policy; emergency care and trauma care; hospitalization; infirmary care; perinatal care; in-house lab and diagnostic services; pharmacy medications to maintain health; diagnosis and treatment of contagious disease; chronic care or other staff-initiated care, including follow-up and referral visits; and mental health care, including drug abuse and addiction.

5. The assessment of a charge should be made after the fact. The health care provider should be removed from the operation of collecting the fee.

6. Charges should be small and not compounded when a patient is seen by more than one provider for the same circumstance.

7. No inmate should be denied care because of a record of nonpayment or current inability to pay for same.

8. The system should allow for a minimum balance in the inmate's account, or provide another mechanism permitting the inmate to have access to necessary hygiene items (shampoo, shaving accessories, etc.) and over-the-counter medications.

9. The facility should have a grievance system in place that accurately tracks complaints about the program. Grievances should be reviewed periodically, and a consistently high rate of grievances should draw attention to the need to work with staff to address specific problems that may have accompanied the fee-for-service program.

10. The continuation of any fee-for-service health care program should be contingent on evidence that it does not impede access to care. Such evidence might consist of increased infection rates, delayed diagnosis and treatment of medical problems, or other adverse outcomes.

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October 2005 — reaffirmed
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References

Centers for Disease Control and Prevention. (2003). Methicillin-Resistant *Staphylococcus aureus* Infections in Correctional Facilities — Georgia, California, and Texas, 2001–2003. *Morbidity and Mortality Weekly Report, 52*(41), 992-996.