MANAGING HEALTH CARE IN A MULTI-PROVIDER ENVIRONMENT
- PRISONER & OFFENDER HEALTH CARE SERVICES - P&OHCS

MICHAEL BOSWELL - GENERAL MANAGER, BUSINESS SERVICES
DEPARTMENT FOR CORRECTIONAL SERVICES

*Paper presented at the Australian Institute of Criminology Conference
Privatisation and Public Policy: A Correctional Case Study*

*Melbourne, 16 & 17 June 1997*
1. BACKGROUND

The Minister of Health is responsible for the provision of health care services to all SA residents.

The Chief Executive and all staff of the Department for Correctional Services (DCS) has a duty of care to all people in custody.

The South Australian Health Commission (SAHC) provide nursing, general medical practitioner and some other health care services to all prisoners, other than those at Mt Gambier. At Mt Gambier Prison health services are covered by the contract for management of the prison.

DCS directly provides some services - most programs and some specialist services (eg psychology).

DCS use contracted service providers for some component services - psychology, dental, transport and some specialist services.

2 years ago SAHC privatised the actual service providers - Prison Medical Service (PMS) - parent, namely Modbury Hospital.

DCS and SAHC negotiated an interim Service Level Agreement (SLA) to ensure continuity of services.

DCS are examining alternative models of managing P&OHCS for strategic decision.

2. THE INTERIM SLA

The interim SLA was intended to facilitate:

◊ continuity of service delivery;
◊ identification and assessment of strategic options, eg competitive tendering;
◊ preparation for competitive tendering; and
◊ a move from medical and nursing services to a holistic model of health care.

The interim SLA provides for prevailing services by:

◊ SAHC, also representing Forensic Mental Health Services;
◊ Modbury Hospital Inc (principally PMS);
◊ South Australian Dental Service (SADS); and
◊ Drug and Alcohol Services Council (DASC).
3. P&OHCS

The services comprise:

<table>
<thead>
<tr>
<th>Initial Reception:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- brief health assessment before prisoners are allowed into the prison proper;</td>
</tr>
<tr>
<td>- detailed health assessment within 4 hours of admission, including:</td>
</tr>
<tr>
<td>* retrieval of past medical records, with details of ongoing treatment;</td>
</tr>
<tr>
<td>* routine examination;</td>
</tr>
<tr>
<td>* mental health assessment;</td>
</tr>
<tr>
<td>* screening for ectoparasites - scabies, lice; &amp;</td>
</tr>
<tr>
<td>* history of drug &amp; alcohol abuse.</td>
</tr>
<tr>
<td>- comprehensive health assessment by a doctor within 3 working days.</td>
</tr>
<tr>
<td>Induction:</td>
</tr>
<tr>
<td>- detailed health assessment as above;</td>
</tr>
<tr>
<td>- information outlining hazards of prison life, health services available &amp; how to access them; &amp;</td>
</tr>
<tr>
<td>- retrieval of past medical records.</td>
</tr>
<tr>
<td>Health Promotion &amp; Illness Prevention, including:</td>
</tr>
<tr>
<td>- specific programs (such as substance abuse, cognitive skills therapy, sex offender treatment, fitness &amp; exercise, conflict resolution etc.);</td>
</tr>
<tr>
<td>- periodic review of cyclic menu, recipes &amp; standard of food preparation;</td>
</tr>
<tr>
<td>- development of peer prisoner educators for health promotion programs; &amp;</td>
</tr>
<tr>
<td>- pre-imprisonment &amp; pre-release liaison with community organisations.</td>
</tr>
<tr>
<td>Primary Care - care that a patient receives at first contact with the health care system:</td>
</tr>
<tr>
<td>- X “on site” hours per week for doctors, nurses &amp;/or other service providers;</td>
</tr>
<tr>
<td>- ‘sick parade’ - triage by nurses ie sorting &amp; classification of prisoner complaints to determine specific priorities for prisoner health care activities;</td>
</tr>
<tr>
<td>- infirmary facilities;</td>
</tr>
<tr>
<td>- daily health assessment of prisoners in segregation;</td>
</tr>
<tr>
<td>- distribution of medication;</td>
</tr>
<tr>
<td>- immediate care of prisoners with behavioural disability &amp;/or a mental disorder;</td>
</tr>
<tr>
<td>- purchase &amp; maintenance of prothesis (eg glasses, dentures &amp; hearing aids) using defined policy;</td>
</tr>
<tr>
<td>- mandated periodic medical examinations by a doctor for specific prisoners or groups of prisoners;</td>
</tr>
<tr>
<td>- counselling services; &amp;</td>
</tr>
<tr>
<td>- alternative &amp; complimentary therapies (eg aromotherapy, herbal medicine)</td>
</tr>
<tr>
<td>Secondary &amp; Tertiary Care - treatment given by specialists to a patient referred by primary care providers:</td>
</tr>
<tr>
<td>- X hours of service or Y episodes of service;</td>
</tr>
<tr>
<td>- referrals by nurse &amp;/or doctor to others, such as:</td>
</tr>
<tr>
<td>* Surgeons;</td>
</tr>
<tr>
<td>* Medical &amp; mental health specialists;</td>
</tr>
<tr>
<td>* Therapists (physio, speech etc); &amp;</td>
</tr>
<tr>
<td>* Podiatrists.</td>
</tr>
</tbody>
</table>
MODELS FOR MANAGING HEALTH CARE SERVICES

− longer term care of specific prisoners, including:
  * mentally disordered; &
  * convalescence from surgery, including therapy.

Custodial Staff Health Related Training:
− management of behaviourally disturbed (c/f mentally disordered) prisoners;
− management of common chronic medical conditions such as diabetes, epilepsy, asthma;
− conflict resolution/ mediation;
− care of substance abusers; &
− infection control.

Occupational Health, Welfare & Safety for Custodial Staff:
− Hepatitis B immunisation, record keeping & booster reminder;
− senior first aid accredited instruction, certification & re-certification; &
− blood & body fluids post occupation exposure counselling, treatment & follow up.

Policy Development:
− contracted health care providers’ participation in policy formation, such as:
  * cost containment guidelines; &
  * harm minimisation, including infection control.

Information, Quality Management & Research:
− computerised health information system;
− quality control systems & accreditation by independent agencies;
− research of health issues in a custodial environment, in particular epidemiological research from prison based data base; &
− Performance Indicators (PI’s) based on results.

Relationship with DCS:
− open communication between prisoner health care service providers & custodial staff;
− collegiate collaboration, integration & sharing of information for best management of each prisoner;
− input & participation in decisions associated with:
  * prisoner assessment committee (PAC);
  * case management; &
  * through care.

Other services:
− pharmaceutical supplies, medical consumables & equipment;
− disposal of bio-hazards according to OH&S legislation;
− periodic inspection & report on health implications of prison facilities & systems; &
− provision of reports to courts etc.

Provider will provide all own clerical services & other support.

4. FUNDING

In 1994 health services for prisoners ‘cost’ the SAHC $6.35m:

◊ medical services $3.0m
◊ drug and alcohol treatment services $0.25m
◊ dental services $0.1m
◊ forensic mental health services $3.0m
These ‘costs’ are the internal costs to SAHC in the context of a $1.3b budget for the provision of health services for all SA.

Some costs such as optometry and pathology are not included or even differentiated for prisoners. These costs do not include DCS costs at all.
Data and documentation is poor and incomplete in terms of:
◊ description of services;
◊ number of services and/or people needing treatments; and
◊ standards of service.

Accounting for particular services is problematic and highly variable, depending on specific circumstances. Cost shifting between one component service provider and another may happen consciously or by accident.

5. PRIMARY AND SECONDARY MEDICAL CARE

Prisoners have no choice of health care provider. P&OHCS are provided by the State in which they are imprisoned.

Under section 19(2) of the Commonwealth Health Insurance Act, 1973 - Australian prisoners are ineligible for Medicare benefit coverage.

“In(2) Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:

(a) the Commonwealth;
(b) a State;
(c) a local governing body: or
(d) an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.”

This provision reaffirms the traditional interpretation that P&OHCS are the responsibility of the States and Territories.

6. IN-HOSPITAL BASED HEALTH CARE

Funding in-hospital based health care is an issue.

In-hospital treatment has been traditionally funded by SAHC, in public hospitals.

Occasionally invoices for in-hospital services were presented to and paid by DCS.

Earlier this year SAHC interpreted section 19(2) to cover all in-hospital based health care, at a rate said to reflect ‘actual’ costs to SAHC. These costs are higher than Medicare costs but lower than those charged to private patients.

The Commonwealth Grants Commission allocates hospital funding grants for in-hospital care on a per capita basis for each state.

This matter is complex and is being resolved by DCS and SAHC with help from Department of Treasury and Finance and from service providers.

7. PRACTICES IN OTHER STATES

There is an intriguing mix of departments, commissions and private providers for health and for corrections among the various states and territories.
Doctors and nurses working in public prisons are employed by the correctional services agency itself in:

◊ Queensland       Western Australia
◊ Tasmania          Australian Capital Territory

Doctors and nurses working in public prisons are employed by the health agency (or by a non-correctional agency) in:

◊ South Australia   New South Wales
◊ Victoria          Northern Territory

Private prison operators provide health care services (to some extent) and in accordance with policies and standards in:

◊ South Australia   Victoria
◊ Queensland        New South Wales

8. VALUE MANAGEMENT - VISION DAYS

To assist identify strategic alternatives DCS organised 2 ‘vision days’.

DCS brought together:

◊ local and interstate executives and managers from correctional and health administrations;
◊ existing and potential health care services providers; and
◊ representatives from legal, cultural and academic groups.

Key points discussed included:

◊ the information base for strategic decision making;
◊ balancing needs of individual prisoners with population;
◊ the numbers of prisoners with drug abuse problems;
◊ prisoners with mental disorders and behavioural problems;
◊ communicable diseases;
◊ subgroups with specific special needs; and
◊ attracting, developing and retaining quality staff.

9. GENERAL CHARACTERISTICS REQUIRED OF P&OHCS

DCS require P&OHCS to:

◊ be results oriented - rather than inputs (ie X hours of nursing) or processes (ie adhere to XYZ standard);
◊ be based on the needs of prisoners both individually and collectively;
◊ be based on sound epidemiological data and good management information;
◊ follow a strategic plan towards health status rather than tactics such as saving life or easing pain; and
◊ recognise the role of correctional officers and prisoners themselves in achieving results.
10. SOME ISSUES TO BE RESOLVED

There are a number of significant issues to be resolved, sufficient to ensure P&OHCS as described, including:

◊ how to describe ‘health’? - how to describe the ‘results’ required, particularly from the perspective of the prisoner or offender?;
◊ medical autonomy - in a secure environment;
◊ confidentiality - with DCS and the service provider sharing key information;
◊ tensions with other DCS outsourcing initiatives - how would contracts for prison/s and prisoner movement interact with a contract for P&OHCS?;
◊ which ‘prisoners’ are to be excluded? - some are not in prison; and
◊ which ‘offenders’ are to be included? - some are required to take specific medication as a condition of non-imprisonment/

11. HURDLES TO ANY HEALTH SERVICE AGREEMENT

The desired result and purpose are problematic.

There are a myriad of people involved and/or entities with an interest in the health of prisoners and offenders. Some conflict is inevitable.

The merits of available basic approaches are hotly disputed by ‘experts’.

There is a lack of agreed definitions and service standards.

The language/jargon is complex and is not robust.

The financial arrangements are complex and involve several levels of government. Costs are rising above CPI.

Prisons tend to adversely affect the health of prisoners. However prison can have a positive impact on basic health causal factors including shelter, nutritious food and medical attention for individual prisoners. Offenders are not subject to the stresses of prison life.

DCS has duty of care to prisoners. Separation of health services from correctional services is recommended by many protocols even though they both bear on the health of prisoners individually and collectively.

Developing a cohesive approach thus far has been like herding cats.

12. THE ALTERNATIVES

Key alternatives, for DCS, include:

◊ all funds are reallocated to DCS:
  – DCS provides and manages all services in-house; or
  – all services provided on contract/s managed by DCS.
◊ all services managed (and some provided) by SAHC.

These were considered in the framework of the ROCS analysis.
13. RISKS TO DCS OF FUNDING TRANSFER

The risks to DCS include:

◊ financial risks - what are prospects of competitive tendering beating the costs incurred by SAHC for existing services, particularly in an environment of poorly recognised component services;
◊ uncertainty - the absence of data and documentation and the possible high costs of obtaining such information;
◊ interaction with other contracts - will P&OHCS be across all prisons or only some, perhaps even for each prison? How will the public and private sector interaction be properly managed and at what levels; and
◊ managerial skills - how will DCS manage health services, which are not and have not been its core business.

The combination of these uncertainties suggests that:

◊ providing its own P&OHCS is high risk strategy for DCS; and
◊ a competitive tendering process resulting in DCS managing P&OHCS is also a high risk strategy for DCS.

DCS doing nothing is a higher risk strategy.

14. PROPOSED STRATEGY FOR SOUTH AUSTRALIA

DCS is in the process of negotiating a Memorandum of Understanding (MoU) with SAHC for all non-DCS provided components of P&OHCS.

The MoU will include a requirement for:

◊ services as at the present - no change;
◊ data, information and policy as framework for a business relationship between DCS and SAHC; and
◊ DCS, SAHC and Service Provider, through a ‘Board’, will plan and manage for improved value for money services.

The business relationship will facilitate:

◊ consideration of strategic options;
◊ managed risk exposure;
◊ unravelling the funding arrangements;
◊ delivery of improved value for money across all P&OHCS; and
◊ development of arrangements for a mix of component service providers - health and corrections.

15. MEMORANDUM OF UNDERSTANDING

The MoU will set out:

◊ purpose;
◊ SAHC obligations; and
◊ DCS obligations.
The MoU will establish:
◊ agency executive, who are delegated to deliver the required results;
◊ term of the MoU;
◊ services to be provided on day one;
◊ management infrastructure - reporting, policy framework and decision making processes;
◊ intellectual property rights;
◊ default and termination;
◊ variations; and
◊ processes to resolve ‘issues’ at various levels of difficulty.

16. HEALTH SERVICES AGREEMENT (HSA)

The MoU will be given effect in terms of P&OHCS actually provided by a HSA between the SAHC and the Royal Adelaide Hospital (RAH) - the actual service provider and/or manager of services.

The HSA will describe, among other things:
◊ specific services - as per the table above, and standards for their provision;
◊ financial arrangements - between the SAHC and the RAH;
◊ policy and procedure base - for normal operational and for emergency situations;
◊ management information;
◊ performance information; and
◊ management arrangements.

17. KEY PERFORMANCE INDICATORS

◊ Number and nature of requests for intervention.
◊ Cost containment.
◊ Physical health indicators for individuals and for the prisoner population as a whole.
◊ Episodes of self harm/death.
◊ Changes in the prison environment.
◊ Increased personal responsibility for health taken by prisoners.

18. THE MODELS

DCS has examined the models available, in particular those already used in other administrations, which might be used for P&OHCS locally.

The model selected by DCS is the one outlined, namely:
◊ SAHC as the provider and/or manager of medical component services - implicitly providing the same services as are available to the community;
◊ DCS as the provider and/or manager of other health related component services - implicitly realising the duty of care; and
◊ a business relationship between the parties - so that on-going improvement in value for money of P&OHCS are identified and realised.

After we have more and better information we will be able to more fully assess other strategic possibilities.