A STUDY OF WOMEN PRISONERS’ USE OF CO-PAYMENTS FOR HEALTH CARE

Issues of Access

Anastasia A. Fisher, RN, DNSc\textsuperscript{a,⁎}, and Diane C. Hatton, RN, DNSc\textsuperscript{b}

\textsuperscript{a}San Francisco State University, School of Nursing, San Francisco, California
\textsuperscript{b}San Diego State University, School of Nursing, San Diego, California

Received 2 June 2009; revised 30 November 2009; accepted 4 January 2010

Objectives. We sought to analyze women prisoners’ use of co-payments for health care; how co-payments affect their access to health care; and how they view the impact of co-payments on their health.

Methods. Using a community-based participatory research approach, we conducted six focus groups with 31 previously incarcerated women. Data were analyzed using qualitative field research methods, grounded theory, and consensual qualitative research strategies to construct a shared understanding of the data.

Results. Co-payments hindered women prisoners’ access to health care. Women reported inequitable implementation of the policy and foregoing care because of the financial burden of the co-payment. Co-payments contributed to delays in treatment, avoidance of health care professionals, unnecessary suffering, and poor health outcomes. In response, women used self-advocacy skills to manage their health care needs and deal with the prison health care system.

Conclusion. Co-payments place an unfair burden on prisoners who are poor, limit access to health care, and contribute to needless suffering and potentially to preventable deaths.

Managed care strategies such as co-payments for prisoner health care were instituted in the mid 1990s in many jails and state prisons to help reduce unnecessary use of health care resources and spiraling health care costs. The Federal Prisoner Co-Payment Act of 2000, modeled after the states initiative, introduced co-payments for prisoner health care into the federal prison system (Stana, 2000; The Federal Prisoner Healthcare Co-Payment Act, 2000). Today, all U.S. federal prisons and about 70% of state prisons have a co-payment, collecting a fee of between $2 and $10 for each request for health care made by a prisoner (Awofeso, 2005a; Stoller, 2001). Prisoners are permitted treatment for one health problem per visit and cash withdrawals are made from their accounts at the time requests are made (Stoller, 2001). For poor prisoners, debits accrue and funds are withdrawn from their accounts when money is “put on their books” by family or through work done while incarcerated (Stoller, 2001). In California, where this study was conducted, prisoners’ earn on average 7 to 13 cents per hour for their work; for a prisoner earning seven cents an hour, a $5 co-payment requires 9 days of work. Using a similar formula, a person earning $60,000 year would make a co-payment of $2,000. Co-payments, therefore, place an unfair burden on the poor and their families (Chandler, 2003).

The fastest growing segment of the U.S. jail and prison population, women prisoners are typically poor. They come to jail or prison with serious health concerns, including human immunodeficiency virus (HIV) infection, hepatitis C, tuberculosis (TB), methicillin-resistant \textit{Staphylococcus aureus}, and sexually transmitted infections (National Commission on Correctional Health Care [NCCHC], 2002). They have higher pregnancy rates than their nonincarcerated cohorts in the general population and histories of violence, depression, substance abuse, and other mental

Funded by a grant from the American Nurses Foundation (ANF).
* Correspondence to: Anastasia A. Fisher, RN, DNSc, San Francisco State University, School of Nursing, 1600 Holloway Ave., San Francisco, CA 94132; Phone: 510-922-9024; Fax: 415-338-0555.
E-mail: anastasf@sfsu.edu.

Copyright © 2010 by the Jacobs Institute of Women’s Health. Published by Elsevier Inc.
illness (Fogel & Beylea, 1999, 2001; Haywood, Kravitz, Goldman & Freeman, 2000). These conditions are often intensified in jail or prison because women have had limited access to quality primary and preventive health care before their incarceration and receive inadequate health care during their incarceration (Freudenberg, 2002; Magee, Hult, Turalba & McMillan, 2005; Treadwell & Nottingham, 2005). Prisoner’s untreated health problems expose other prisoners, prison staff, and the public to infectious diseases and burden local health care services in the communities to which many return each year (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005).

Women often leave jail or prison sicker than when they entered; their incarceration adversely impacting families, children, and neighborhoods, leading some to declare that inadequate prison health care is a public health crisis (Freudenberg, 2002; Restum, 2005; Richie, 2001). Not only do women experience multiple, serious health problems, research indicates that women prisoners use more health care services than male prisoners, as is true of women in the general population (Ezzati-Rice & Rohde, 2005). Access to care is, therefore, one of the most pressing problems facing incarcerated women.

The primary purpose of jails and prisons is control and punishment rather than provision of health care. Although these differing priorities contribute to problems of health care access (Stoller, 2001), jails and prisons also present an opportunity to provide quality screening and preventive care, as well as follow-up treatment to a population at risk for negative health outcomes (Freudenberg, 2002; Freudenberg et al., 2005). The U.S. Supreme Court mandated health care for prisoners, recognizing indifference to their serious health problems as a violation of the Eighth Amendment of the U.S. Constitution, prohibiting cruel and unusual punishment (National Commission on Correctional Health Care [APHA], 2003; Estelle v Gamble, 1976). Yet, problems of negligent care in jails and prisons continue (Henderson, 2005); these problems are often problems of access (Restum, 2005; Stoller, 2001).

A study of three women’s prisons in California found that “co-pays discourage utilization of services, create a bureaucratic burden to the health service and an economic burden to the very poor prisoner, while providing no documented economic gain to the Department of Corrections” (Stoller, 2001, p. 10). In a study of the impact of co-payments on the prison health care budget conducted by the California State Auditor, it was found that co-payments generate no revenue for the Department of Correction and that there had been no analysis of the program’s impact on physician visits. This report concluded that “the department can not demonstrate that the program is cost-effective, so we recommend it should be eliminated” (California State Auditor, 2000, p. 2). The Centers for Disease Control and Prevention (2003) in a study to evaluate the cause of methicillin-resistant Staphylococcus aureus outbreaks in Georgia, California, and Texas prisons between 2001 and 2003, singled out co-payments as a significant contributor to the spread of infection because they discouraged prisoners from seeking care. In a recent study of health among women prisoners, co-payments were identified as a barrier to access (Hatton, Kleffel, & Fisher, 2006). Since 1976, national and international public health and prison health organizations have discouraged the use of disincentives, including co-payments (APHA, 2003; Brownlee & Goodwin-Gill, 2002; NCCHC, 2002).

Proponents of the use of co-payments in jails and prisons argue that they reduce “unnecessary” or “recreational” use of health care, instill inmate responsibility, and contain escalating health care costs (Hyde & Brumfield, 2003; Kinder, 2002; Kinsella, 2004; Vogt, 2002). Hyde and Brumfield (2003) examined the initiation of small co-payments ($3.00 for a sick care visit and $2.00 for a prescription) in Idaho prisons in 1998. Not surprisingly, the number of sick care requests declined by about 40%. Research in 36 states shows that co-payments reduce sick calls between 16% and 50% (Stana, 2000). Such findings, however, have not been convincing; some conclude that “it is impossible to devise a co-payment program that does not erect barriers to care that could put the health of individuals in jeopardy, lead to the spread of disease, and cost more in the long run” (Gibbons & Katzenbach, 2006, p.49).

Despite recommendations to discontinue their use and limited, inconsistent research findings on the impact of co-payments in jails and prisons, co-payments for health care continue. The debate about co-payments in jails and prisons, largely fueled by differing ideologies of criminal justice and prisoner advocacy, remains unresolved owing to the scant research examining the prisoner co-payment policy. The current investigation sought to address this gap in knowledge by focusing attention on women prisoners’ use of co-payments. Theirs is a perspective often absent in debates about policies that directly impact their lives. The aims of this study were to 1) examine women prisoners’ use of co-payments for health care, 2) examine how co-payment affects women prisoners’ access to health care, and 3) identify how women prisoners view the impact of co-payment on their health.

**Methods**

This exploratory study used focus groups in a qualitative, community-based participatory research design (Minkler & Wallerstein, 2003). During the project, as is congruent with community-based participatory research, the investigators maintained contact with Community Advisory Board members from a local...
advocacy agency that assists women transitioning from jail or prison to the community. A co-investigator hired from this agency participated in each phase of the project (Flasketrud & Anderson, 1999). She reviewed phrasing of focus group questions, recruited subjects, participated in discussions of the analysis, and co-presents findings with the investigators to relevant community officials.

Sample
Thirty-one women, who were recently released from jail or prison, were recruited to participate in the study. Having a co-investigator from the agency was critical to the recruitment process because she was familiar with the participants, knew their schedules, and made arrangements for their transportation when necessary.

The average age of study participants was 38 years—the mean age of incarcerated women in the literature (Sabol & Couture, 2007). The mean number of years of education was 12 and the average number of children was two. Participants reported having had an average of six incarcerations in a local jail and an average of one incarceration in prison. Fifty-five percent of the sample was non-White. Table 1 summarizes these demographic characteristics.

Participants in this study described making co-payments for physical, and mental and dental health problems. These included, diabetes, hypertension, asthma, seizures, dental caries and pain, musculoskeletal problems, pregnancy, mental health issues (acute and chronic), and testing for infectious diseases such as TB and HIV. These concerns are consistent with reports on the health of U.S. prisoners (Haywood et al., 2000; NCCHC, 2002). Co-payments were made in a variety of facilities: local county jails and state and federal prisons.

Measures/instruments
Participants completed a brief demographic form that included the characteristics noted above. Four open-ended questions guided the focus groups: 1) “Please tell us about a time when you used a co-payment while in jail or prison,” 2) “Tell us about a time when you decided not to see the doctor or nurse because of the co-payment. What happened?” 3) “How do you think these experiences have affected your health?” and 4) “Is there anything else you want to tell us about getting health care in jail or prison?”

Procedure
Data collection took place during six focus groups with formerly incarcerated women residing in the community. Each woman participated in one focus group. Focus groups were conducted at a mutually convenient location, including the offices of the advocacy organization or sober living residences where participants lived. After obtaining informed consent, the investigators discussed data collection procedures in detail. Groups began with an explanation about the process itself (e.g., confidentiality and audio-recording). At the conclusion of each focus group, major themes were summarized and verified (Flasketrud & Anderson, 1999). All sessions were audio-taped. Completion of the consent process, demographic form, and focus group discussion took 60 to 90 minutes. To acknowledge their contribution, all women received a $30 gift certificate to a local merchant.

Table 1. Characteristics of Participants (n = 31)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Age (mean, range)</th>
<th>Education (mean, range)</th>
<th>Children (mean, range)</th>
<th>Past incarcerations/jail (mean, range)</th>
<th>Days incarcerated/jail (mean, range)</th>
<th>Past incarcerations/prison (mean, range)</th>
<th>Months incarcerated/prison (mean, range)</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>38.48 (20–59)</td>
<td>12.32 (6–16)</td>
<td>2.47 (0–5)</td>
<td>6.13 (0–30)</td>
<td>530.77 (0–7,200)*</td>
<td>1.29 (0–13)</td>
<td>29.03 (0–468)</td>
<td></td>
</tr>
<tr>
<td>Days incarcerated/jail (mean, range)</td>
<td>530.77 (0–7,200)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months incarcerated/prison (mean, range)</td>
<td>29.03 (0–468)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African/American (n, %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6 (19%)</td>
</tr>
<tr>
<td>Hispanic/Latina (n, %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8 (26%)</td>
</tr>
<tr>
<td>White (n, %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14 (45%)</td>
</tr>
<tr>
<td>Other (n, %)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 (10%)</td>
</tr>
</tbody>
</table>

* Days calculated rather than months because jail stays are typically ≤1 year.

Data analysis
Quantitative data from the demographic form were entered into SPSS (SPSS, Inc., Chicago, IL) and analyzed using descriptive statistics. All focus group recordings were transcribed verbatim. Informed by grounded theory and qualitative field research methods (Glazer & Strauss, 1967; Schatzman & Strauss, 1973; Strauss, 1987; Strauss & Corbin, 1998), two investigators used a strategy known as consensual qualitative research to construct a shared understanding of the data. Consensual qualitative research uses three steps to analyze data (Hill, Thompson & Williams, 1997). First, the two academic investigators read all transcriptions line by line and systematically coded the data, developing domains that consist of rationaIly derived topics. We checked these out with each other and revised as necessary. Next we developed key categories and noted the participant verbalizations that fell into each domain. We made categorical decisions by consensus and verified decisions about what constituted a category by systematically checking them with the raw data (Hill et al., 1997). The two co-investigators verified the plausibility of the findings and wrote memos to document analytic schemes. The convenience sample of 31 participants allowed for theoretical saturation of the data; at the conclusion of the sixth focus group, participants discussed no new topics or categories. The processes of data collection and analysis proceeded concomitantly, as is the tradition of this
method. Findings were then discussed and verified with the team’s community co-investigator.

Limitations and potential difficulties in conducting the study
A limitation of this study is that it provides only the perspective of former prisoners and does not include administrators or staff working in jails or prisons. The views of the latter, however, are better documented in the literature. Thus, the investigators chose to focus on recipients of care in jail and prison because their voice is missing from the debate and typically excluded from the dialogue on policies that impact their lives (Magee et al., 2005); their testimony is often the only way to document conditions in settings where punishment takes precedence (Chandler, 2003). This limitation also provides direction for future research. Important to a comprehensive analysis of the policy’s impact on access is a study that includes multiple stakeholders such as legislators, prison administrators, and prison health care professionals directly responsible for implementation and maintenance of the co-payment policy. A second potential limitation is the study’s reliance on formerly rather than currently incarcerated women. Concern for the vulnerability of imprisoned women, including retribution for participation and problems of researcher access to this population, limited the feasibility of conducting this exploratory study in jail or prison (Stoller, 2001). A third potential limitation is that study participant’s were most recently incarcerated in California and, although a number had been in jails and prisons outside the state, their experience may be more reflective of health care in California facilities and may not accurately characterize the situation in other states, facilities, or systems. Poor quality and access to health care in U.S. jails and prisons is well-documented; co-payments are common in jails and prisons in many states; and jail and prison health care systems in other states have been under receivership, as is the current situation in California. All of this suggests that the problem of access to quality care is not limited to California jails and prisons (Freedberg, 1999; Lamb-Mechanick & Nelson, 2000; Sterngold, 2005; Wilper et al., 2009).

Human subject protection
Before starting the focus groups, the investigators read the consent form aloud and participants were encouraged to ask questions. The investigators discussed confidentiality and privacy at the beginning of each group and encouraged participants to use a pseudonym if they felt more comfortable (Morgan, 1998). A Certificate of Confidentiality was obtained from the National Institutes of Health to further protect the privacy of participants (National Institutes of Health, 2006). After signing the consent, participants completed the demographic form, noted previously, and then participated in the focus group. All were informed that participation was voluntary and they could quit the study at any time; all women who arrived at the designated meeting place agreed to participate.

Findings
Findings reveal that for the vast majority of women in this study co-payments hinder/limit access. Women reported inequitable administration of the co-payments made care more costly and cost contributed to decisions to forego care. Obviously, access to health care is more complex than co-payments alone; other factors related to access emerged in this study. These include quality and timeliness of care. Together these factors contributed to avoidance of health care professionals, unnecessary suffering, and poor health outcomes. In response, women prisoners used self-advocacy to deal with their health care needs and manage the challenges faced in the prison health care system.

Inequitable administration of the policy
Federal prisoners and those in California’s jails and state prisons are exempt from co-payments for diagnosis or treatment of contagious conditions, mental disorders, and follow-up visits; yet, women reported that requests to be seen for these conditions resulted in a co-payment of $3 in jail or $5 in prison for each visit (State of California Code of Regulations, 2008; The Federal Prisoner Healthcare Co-payment Act, 2000). They stated:

There was a TB scare and I put in an inmate request to get a TB test. I was in a room with two people who tested positive for TB. I had to pay a co-payment for my TB test (Focus Group 2).

Every time I see the psych doctor, even if it’s for the same reason, like follow-up on whatever medication; they still charge me $5 (Focus Group 3). They give you the Tylenol for three or four days, then they cut you off. You have to put in another slip to see the doctor or nurse again, pay the co-payment, and then they restart the Tylenol (Focus Group 6).

Prisoners also reported having to see multiple providers and pay multiple co-payments for the same request:

When you put in a co-pay to see the doctor you gotta see the nurse first, that’s $5; then the nurse schedules you to see the doctor, that’s another $5. There are layers of co-payments (Focus Group 2). I have mental issues and I really needed to see a psychiatrist but they charged me twice to go see him. The first time I went, they told me to read this piece of paper, it might help you. It took me another month to be seen again and I had to make another co-payment (Focus Group 3).
Women holding key positions in the kitchen or laundry facilities indicated they received priority treatment consideration and often made no co-payments for their visits to health care providers. Women working in essential prison services noted:

When you work trustee you get a lot more, they come to the trustee dorm every day, they have a certain time for meds, the med line is short; I see a doctor right away. I never see a nurse; I go right to the doctor (Focus Group 2).

I was a cook so when medical sees my name, I’m there like that. I don’t have a big problem (Focus Group 4).

The practice of forgoing the co-payment for women holding valued positions within the institution, when these jobs are so scarce, furthers inequity in access (Aday & Andersen, 1981). It is the authors’ position that health care services be provided on the basis of need rather than some other criteria.

In addition to those holding valued positions within the institutions, a few of our participants did not identify co-payments as a barrier to health care access. These women indicated,

As long as I’m up under their roof, I can’t complain about nothing they do to me, because I don’t have no say; I’m a criminal (Focus Group 1).

When I go to the doctor outside, they charge me; it is the same in here (Focus Group 3).

The woman making this last statement acknowledged she had not spent much time inside the prison system nor had she suffered from a serious illness, two conditions she said might make a difference in her experience of co-payments.

Co-payments and the decision to forego care
The majority of women in this study reported making decisions to forego seeking health care because of the financial burden of the co-payment. They often decided to forego care because they lacked funds and resented paying for what they considered to be poor quality and untimely care.

Financial burden. The women in this study were poor and had few opportunities to earn money once inside jail or prison. They typically came from poor families and incarceration left them with financial obligations to pay as restitution. Women in jail or prison earn between 8 cents an hour for jobs in the laundry or kitchen to $1 a day for their work on the fire crew, one of the highest paying positions. Most were not fortunate enough to have a job and had to rely on their families to put money on their books. For a woman earning 8 cents an hour, one $5 co-payment requires 7 days of work. A $5 co-payment, therefore, represents a significant expense and sacrifice. Several women noted:

I didn’t want to spend the money I had because I knew I needed it for bus fare when I was released (Focus Group 1).

I didn’t have much money. I didn’t want to be charged again for something. So, I opted not to sign up to see the doctor but I’ve got an infection and I know it’s not getting proper treatment (Focus Group 5).

I just sat there and coughed on a cell wall; I was sick but I didn’t have any money. So, I just suffered (Focus Group 6).

Quality of care. Although some women felt their care was acceptable, many resented paying for what they considered to be poor health care. As one woman stated, “it is not worth what you are paying for it.” Many respondents reported that often their requests were not taken seriously. When these situations occur in the general population, individuals have the option to try another provider. This is not the case for prisoners. Several noted:

I’ve been in jail so many times that unless I’m deeply ill, I don’t go. Water and Motrin are their answers for everything, they won’t answer my questions. I don’t go (Focus Group 2).

I went to see the psychiatrist, I didn’t get anything. I saw him through the glass barred window, and he asked me a couple of questions and that’s it. It is $3 for that (Focus Group 4).

I have asthma so when I went in I said, “I need my inhalers; I’m on two different inhalers.” They listened to my lungs and kicked me out of the room. They said they weren’t going to give me my inhalers. Well, you know your lungs can sound clear one minute and then all of a sudden they can get real tight. You need your inhalers (Focus Group 6).

This last statement is particularly concerning because preventable deaths from asthma, in the California prisons, are well-documented; a recent report noted six preventable deaths from asthma in 2006 (Imai, 2007). Data on the causes of prisoner deaths from asthma and other conditions are difficult to obtain; it was not possible to determine how many of the deaths in the 2006 report were women. Legislation recently passed in the U.S. House of Representatives aims to correct this by requiring states that receive federal grants for law enforcement to report to the Justice Department details about prisoners who die while in custody (Death in Custody Reporting Act, 2009). At this time, the measure has gone to the U.S. Senate.

Timeliness of care
Co-payments are deducted from prisoner’s accounts at the time they make a request to be seen by medical staff; yet, prisoners reported waiting weeks, months, or even years to receive an appointment. As one woman said, “it still takes entirely too long to be
seen. If they are going to take my money immediately why can’t they see me immediately?”

Prisoners with chronic medical and psychiatric conditions taking medications before their incarceration reported waiting weeks or longer to be seen by a physician who may or may not provide a prescription for their medication. As they noted:

I would go into jail and they would charge me $3 to see the psychiatrist, it would take a week or two to get in to see him, he’d tell me to drink some warm milk and maybe put a little honey in it or something to calm me down. He’d just try to put me off a little and not really give me anything (Focus Group 4). I went the whole time I was incarcerated (3 years) without taking my psychiatric medications and I’d been taking those medications since I was 12 years old (Focus Group 6).

Cost, quality and timeliness of care are all elements of access (Aday & Andersen, 1981). Although it is difficult to untangle the cost of co-payments from issues of quality and timeliness of care, it is clear from these data that co-payments placed a significant economic burden on poor prisoners who often decided to forego care in lieu of other needs. The women resented paying for poor quality care and waiting months or longer to see a health care provider. As a consequence of their limited access to quality health care, women prisoners often avoided providers and suffered in isolation.

Consequences
Limited access to quality health care in jail and prison contributed to some women’s avoidance of health care professionals, unnecessary suffering, and poor health outcomes. They noted:

Now I think all doctors are less caring, very untrustworthy because of my experiences there. They don’t really care so it makes me shy back from them and not want to go (Focus Group 1). I was pulling out my own teeth in my cell because I was scared to go to the dentist in there. I felt better pulling out my own teeth and that’s something I never in my whole life would imagine myself doing (Focus Group 3). I still have high blood pressure; I never got the proper diet, or any medications for it. It still affects me (Focus Group 4).

Strategies
In an effort to manage their health care needs and the challenges faced by the prison health care system, the women developed their capacity for self-advocacy. Some prisoners advocated directly with the authorities for the rights of others, whereas others advocated through bearing witness to neglectful care and providing comfort to those suffering serious health care problems. As they noted:

You have to fight for your rights (Focus Group 2). I have to fight for women, because I was a representative for the women in prison. I had to fight for other women who were epileptic or whatever. I’d have to say we’ve got somebody sick here; they need to see a doctor (Focus Group 3). I’ve lived in the dorm with girls kicking heroin and they are so sick. You have to keep bugging medical; telling them she’s really, really sick, someone has to come take care of her (Focus Group 5). We lost Ms. Ross (pseudonym), medical let her go back to the dorm, but she died right there on the floor with two inmates helping her. We were all in the dorm; locked down with her while she died (Focus Group 6).

Women’s use of self-advocacy as a strategy to manage their health needs and deal with the challenges of the prison system are similar to findings from an earlier study of preventive care for women prisoners (Magee et al., 2005). Although these acts of advocacy are admirable, leaving women prisoners to deal with these conditions is unacceptable.

Implications
Prison health care cannot be separated from the wider considerations of the nature of imprisonment and its use (Coyle, 2003). The aim of imprisonment in the United States is punishment and health care policies that impact access within such an environment run the risk of doing significant harm. Although the co-payment policy has not met the legal standard for cruel and unusual punishment (Awofeso, 2005b), we know from the most comprehensive study of health care co-payments in the general population that co-payments have an adverse impact on the health of the poor (Newhouse, 1994). It follows then that co-payments will adversely impact the health of women prisoners who are most often poor and lack funds. For participants in our study, co-payments were a financial burden that led to their decisions to forego health care, contributing to their suffering and poor health outcomes. Others have identified co-payments as a barrier to health care access that cause prisoners with legitimate concerns to delay or forego care and contribute to the spread of aggressive skin infections. They conclude that co-payments cost states more in the long run than is saved (APHA, 2003; Brownlie & Goodwin-Gill, 2002; Centers for Disease Control and Prevention, 2003; Gibbons & Katzenbach, 2006; NCCHC, 2002).

Findings from this study raise important policy questions relevant to prisoner health care co-payments and issues of health care access for women prisoners. The decision to collect a co-payment for treatment of conditions like mental illness and asthma diverges from both state and federal prisoner co-payment policies that exempt them and raise questions about
adequate care. Co-payment implementation in jails and prisons suggest inequity and potential abuse, with participants reporting paying multiple co-payments for the same health care request and waiting months to see a doctor for a health problem they had when they requested the appointment but no longer experience by the time they are seen. The detrimental impact of the co-payment policy on prisoner access to health care is difficult to deny. Our participants often endured health problems or sought care as a last resort only after a problem worsened because they lacked sufficient funds to make co-payments. Although it is commendable that women prisoner’s self-advocacy skills assisted them to deal with their health care needs and manage challenges faced in the prison health care system, the quality of and access to prison health care needs improvement. It is critical we find the political will to make the necessary improvements in jail and prison health care. As has been noted in California, “the prison medical system in the State is broken beyond repair and the harm done to California’s prison population could not be more grave. The threat of future prisoner injury and death is virtually guaranteed in the absence of drastic action” (Henderson, 2005, p. 1).

These findings about this relatively unexamined cost sharing policy have the potential to inform the national debate about the prison health care crisis as well as prisoner and public health. In addition to the issue of justice, raised by the unfair economic burden co-payments place on prisoners, are basic public health concerns regarding the spread of communicable diseases and untreated substance abuse and other mental disorders. Health problems that remain untreated during incarceration, whether they are infectious disease or substance use disorders, not only impact prisoners but eventually impact the general population. Thus, as public health experts have argued, “risk reduction policies implemented by correctional policymakers to advance the health and well-being of incarcerated populations will ultimately benefit the community at large” (Braithwaite, Treadwell & Arriola, 2005, p. 1680).

References


Author Descriptions

Anastasia A. Fisher, RN, DNSc, is an Associate Professor in the School of Nursing at San Francisco State University.

Diane C. Hatton, RN, DNSc, is Professor and Associate Director for Research at San Diego State University. Our book, Women Prisoners and Health Justice: Perspectives, Issues and Advocacy for an International Hidden Population, was recently published by Radcliffe Publishing Company.