Health Insurance in the Prison — A Solution that Created its Own Problems

Michael S. Chen*
Department of Social Welfare, National Chung Cheng University, Taiwan

Abstract
The Second Generation Reform of Taiwan's universal National Health Insurance (NHI) extended the coverage to inmates in the prison, beginning on January 1, 2013. Taiwan is unique among the few countries that had mainstreamed healthcare in prison because it takes the principle of insurance into the prison in its totality. While the application of insurance principle in the prison without distinction from that for the general public appears to be a manifestation of equal footing for the inmates, it imparts a sense of entitlement on the one hand, and imposes cost-sharing on the other. Both may contravene the principle of incarceration. Throughout the world with very few exceptions, healthcare in prison is based on need, instead of entitlement, and is funded by the general tax without cost-sharing.

Introduction of the NHI into the prison proved to be an effective solution to healthcare problems entrenched in the prison, yet taking the insurance principle in its totality into the prison may also create its own problems.

ABBREVIATIONS
NHIA: National Health Insurance Administration (Taiwan); MHW: Ministry of Health and Welfare

INTRODUCTION
A far-ranging reform of the National Health Insurance (NHI) in 2011, dubbed the Second Generation reform, extended insurance coverage to the some 65,000 inmates in Taiwan's 49 prisons. This amendment took effect in 2013, making the supposedly universal NHI a genuinely universal program, and pushing Taiwan into the rank of the few countries that had mainstreamed healthcare in the prison [1]. Taiwan, however, went beyond that by taking the principle of social insurance into the prison. While application of the insurance principle appears to be a manifestation of "equal footing" for inmates, it imparts a sense of entitlement on the one hand, and imposes cost-sharing on the other [2]. The sense of entitlement may encourage inmates to seek health care based on demand, instead of need; the cost-sharing may constitute a barrier to care for the inmates without financial sources. Both may contravene the principle of incarceration throughout the world: in-prison healthcare is provided based on inmates' needs, and funded by government budget without cost-sharing [3].

Like many other countries, health care in Taiwan's prisons used to be under the jurisdiction of Justice Authorities and was under-staffed and under-funded. The quality of care was notoriously poor and often became the target of censure by human rights groups. Problems of the in-prison health care included the following: under-staffed medical personnel, lax control of contagious diseases, poor management of medical records and specimens, slow reactions to emergency, and obsolete facilities and equipment [4]. The amendment was adopted as a solution to redress these problems.

According to the annual surveys conducted by the NHIA, the policy to cover the incarcerated people proved highly welcomed by the inmates, prison's families, and prison staffs, and has contributed to prisoners' health. However, application of the principle of health insurance also created its own problems. While our own survey conducted in May, 2015 on 1,556 inmates in the 22 prisons also confirmed that the this policy was well received by the inmates, the surveyed inmates complained that the imposition of the cost sharing, which they had to pay to the providers at the point of service, had become a barrier for them to seek in-prison care. Our site visits to the prisons also revealed the unpaid expenses had cut into the mutual trust between the medical team and the prison.

Based on an analysis on the major policy parameters and international comparison, and supported by the utilization data released by the NHIA, this article is to argue that the clash between sense of entitlement and confinement of freedom may spell a dilemma for the health authorities and the correctional authorities; and the collision between the entitlement-based and needs-based care provision may constitute another quandary for the prison and the medical team serving in it.
CASE PRESENTATION

Sixteen years into its implementation, the NHI Act went through a major reform that was concluded in the first week of 2011. As a result of this reform, the jurisdiction of providing health care in prison was transferred from the Agency of Corrections, Ministry of Justice, to the National Health Insurance Administration (NHIA), Ministry of Health and Welfare (MHW). The NHIA, in collaboration with the Agency of Corrections, invited the medical institutions to team up and set up clinics in the prison. The medical team and the prison, mediated by the local branch of the NHIA, would negotiate for the exact schedule of the in-prison service. The participating hospitals are required to establish a special ward to accommodate the need for escorted hospitalization. As the establishment of the in-prison clinics must fulfill the requirements laid out by the health authorities in terms of the location (must be separated from the rest of the prison), lighting, ventilation, seating, and other sanitary conditions, this new policy has fundamentally improved the setting for medical care in the prison.

A special budget is earmarked from the NHI global budget for this purpose. The budget is assessed based on the product of per-capita NHI expenses multiplying the total number of inmates. To encourage participation in providing care in the prison, there is a 10% markup for the consultation fee and a 20% markup to cover the extra medication costs, such as unit dosage packing. In cases where the correctional facility is located in the remote area, the team is reimbursed an extra payment.

As the NHI is a compulsory and universal program, virtually 100% of the inmates are eligible either by carrying their insurance status to the prison or by being enrolled on the NHI by the correctional institution, who is inmates’ guardian legally. Less than 1% of inmates, mainly foreigners without valid immigration certificates, are not eligible.

The premiums for inmates enrolled at the correctional institutions are provided by the Ministry of Justice from the government budget. One critical change occurred in the out-of-pocket expenses. Unlike the free care provided prior to the NHI, cost-sharing is now applicable to inmates. The out-of-pocket expenses, such as co-payment, registration fee (a fee charged by the provider to cover administrative costs), or items or services not covered by the NHI, are borne by the inmates. Although these out-of-pocket expenses are in most cases less than US $5 for a visit, they can constitute a formidable financial barrier for inmates without financial support from outside the prison. While the cost sharing for in-prison service increased from nothing to about US $5, the self-paid cost for escorted service decreased substantially: the cost of escorted visits or hospitalizations has changed from inmates having to bear the full costs for any escorted service prior to the NHI to now just having to pay a co-payment (and registration fee), which is normally approximately 8% for escorted visits and 10% for escorted hospitalizations; this is a substantial reduction in the financial burden for inmates. This asymmetric shift in the financial burden for in- and out-of-prison care has entailed skewed utilization in terms of the locations where inmates prefer to receive care.

According to the utilization data released by the NHIA, as consequences of the changed incentives, the first year of implementation saw a 37.86% decline in in-prison care, and a 26.14% increase in escorted visits outside the prison; number of escorted hospitalization even shot up by 30.82%. The decreased in-prison visits can be partially explained by the better defined performance guidelines of the NHI, which demand reasonable justification of the visit, or the payment will be denied. Yet, these figures still suggest that in-prison care might have been suppressed by the increased co-payment, and the increased escorted visits and hospitalization may have been encouraged by a lowered cost, and the sense of entitlement might have contributed to the increased escorted services, too. Although the entitlement may not be legalistic in the strict sense, it may well be a psychological one, as argued by Super [2].

DISCUSSION

Taiwan mainstreamed healthcare in its prisons after France, Norway, England, Scotland, and a couple of provinces of Canada [5]. As illustrated in Table 1, Taiwan is unique in that it may well be the only country that fully applies the principle of health insurance in the prison: due premium is assessed the same way as that for the general public, though paid by tax dollars through

<table>
<thead>
<tr>
<th>Features of Public Health Insurance</th>
<th>France</th>
<th>Germany</th>
<th>Japan</th>
<th>USA</th>
<th>Taiwan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population covered by all programs</td>
<td>Plural social insurance</td>
<td>Plural social insurance</td>
<td>Plural social insurance</td>
<td>Social insurance for certain segments of population</td>
<td>Single social insurance</td>
</tr>
<tr>
<td>Has mainstreamed healthcare in prisons?</td>
<td>Yes, since 1994</td>
<td>Not yet</td>
<td>Not yet</td>
<td>Not yet. The Affordable Care Act makes it easier to enroll inmates on Medicaid</td>
<td>Yes, since 2013</td>
</tr>
<tr>
<td>Financial source for in-prison healthcare</td>
<td>Social insurance</td>
<td>Government (Länder) budget</td>
<td>Government budget</td>
<td>Government budget</td>
<td>Social insurance</td>
</tr>
<tr>
<td>Cost sharing</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes in some of the state prisons</td>
<td>Yes, same co-payments apply to inmates as well as to the general public</td>
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Table 1: Comparison of Healthcare in the Prison in Selected Countries.
the budget of the Ministry of Justice; inmates must pay same amount of co-payment (and registration fee) as all the general public do. One fundamental problem with the insurance principle in the prison is that the role of needs assessment is marginalized. In the countries where in-prison healthcare is provided by the allocated general budget, needs assessment is the core of the correctional health system, for government’s responsibility is to meet the need of inmates, instead of the demand [6]. Insurance principle, however, introduces cost-sharing on the one hand, and sense of entitlement on the other. As suggested by Table 1, even where social health insurance serves as the backbone of its healthcare system, such as in France, healthcare in the prison is based on needs, instead of entitlement, much less on demand. And therefore, the service can be legitimately paid by the general budget without cost-sharing [7]. Also shown in Table 1, the only exception is found in some of the state prisons in the US where inmates pay certain amount of cost-sharing for in-prison care. This is not quite a comparable example, because the co-payment in those state prisons is not a result of health insurance. This practice remains a hotly debated issue, though the court has ruled that that is not in violation of the Eighth Amendment of the US Constitution, which prohibits “cruel and unusual punishments”, and is in line with the judicial precedent set in the Estelle v. Gamble case [8].

Under the principle of insurance, it is the financial incentive, or price elasticity, that determines the care-seeking behavior, as so vividly seen in Taiwan’s inmates. While the prison staff still reserve the power not to approve escorted visits or hospitalization, our site visits to prisons found that both the prison staff and medical practitioner serving in prison were reluctant to decline the inmates’ plea for doing such, because now they are “clientele” of the NHI, not just prisoners under stiff custody of the correctional system, and because expenses are less a concern for the main part of the expenses will be paid by the NHI anyway. Another problem ensued is the arrears that accumulated in some of the prisons as the inmates failed to pay the co-payment and registration fee. Our site visits also found that the median income from in-prison laboring was only around US $6 per month, and many inmates rather spend the money on cigarettes or batteries (for their personal radios) than on the self-pay medical expenses. The owing fee may become a bone of contention between the medical team and the prison, and discourage participation by the medical team in the future.

The conclusion is now in order: while the application of social insurance seems to have redressed some of the entrenched healthcare problems in the prison, carrying the principle of social insurance in its totality into the prison may create its own problems. The cost-sharing will lead to more and more unpaid expenses, which may undermine the cooperative relationship between the medical team and the prison; the demand for escorted services lent by the sense of entitlement will be difficult to control, and the escorting burden on the prison will be mounting.

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REFERENCES