The Right to Health, the Power to Punish, and the Duty to Advocate

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The Right to Health, the Power to Punish, and the Duty to Advocate

A dissertation presented

by

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to

The Committee on Higher Degrees in Health Policy

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in the subject of

Health Policy

Harvard University
Cambridge, Massachusetts
April 2018
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The Right to Health, the Power to Punish, and the Duty to Advocate

Abstract

Paper 1: The Right to Health and the Power to Punish

If prisoners have a moral right to health (RTH), then why should this be so? Moral rights do not depend on any legal systems or other social institutions; instead, they place demands on what laws and institutions we should have. They are shown to exist by moral argument. What arguments or rationales might justify a moral RTH for prisoners?

How one may answer this question depends on whether we should generally see all people as having a RTH. If one believes that people do not generally have this right, then one needs to explain why protecting health is of such moral importance that we should have obligations to meet prisoners’ health needs when we do not owe them similar obligations in relation to other needs. Furthermore, one also needs to explain why prisoners should have a RTH while other people should not. The standard argument offered by those on this side is that prisoners are a special case of people to whom we owe assistance meeting their health needs because certain health needs may lead to harms and suffering so serious that not assisting them would constitute cruel or inhumane punishment, or torture. They argue that since people have a right to be free from torture, then society has obligations to protect and promote prisoners’ health. I show that this argument is self-defeating: either it cannot adequately explain the obligation to assist prisoners in meeting health needs, or it cannot explain why non-prisoners should not also be owed similar assistance.
By contrast, if one believes that people generally do have a RTH, then one is called on to justify this view by showing that a RTH follows from a general theory of justice and health, such as that developed by Norman Daniels. Provided such a theory, then the burden of showing that it is permissible to punish people in ways that involve restricting this right is on those who contend as much. In this context, the strongest objections to the view that prisoners have a RTH involve claims that the principles of justice that ground our RTH also allow punishments that involve imposing restrictions on it. I show that these objections to a theory like Daniels's are either unsound, or overstated.

**Paper 2: Health and Health System Reform in the Colombian Prison System Between 1998 and 2015**

Background: The WHO Regional Office for Europe (WHO/Europe) recommends that responsibility for prison health should be transferred from the ministries of justice or interior to the national health authority, and that the provision of healthcare in prison should be contracted to the general health system. There is little evidence to support these recommendations, however, and it is not obvious that they are applicable to contexts beyond Europe. Colombia introduced reforms to its prison health systems similar to those recommended by the WHO/Europe between 1998 and 2016, making it an interesting case to study.

Methods: We evaluated these reforms using a mixed-methods approach comprising documentary analysis of secondary sources, institutional-ethnographic research, key-informant interviews, and a health survey among a probability sample of inmates in a large prison located in Bogota. Using WHO's “building blocks” framework, we analyzed changes to the prison health system's organization and governance, financing, health workforce, accessibility of essential medicines, and the delivery of health services.
Results: Between 1998 and 2015, Colombia integrated the prison and general healthcare systems — which historically were independent from each other with parallel governance, financing, and healthcare delivery mechanisms — by transferring the responsibility for prisoners’ healthcare from the National Institute of Prisons and Correctionals (INPEC) to insurance agencies and service providing institutions contracted from the general health system. Most of the changes that were introduced during this period were reversed in 2016: the prison health system was once again segmented from the general health system and a new institutional arrangement was created to take charge of it.

Conclusions: None of the reforms appear to have achieved progress towards the realization of prisoners’ right to health. Instead, our findings suggest that the reforms may have been retrogressive.

Paper 3: Justice and Medical Professionalism: Should Doctors be Accountable Patient Advocates?

Medical professionalism has traditionally been thought to require a kind of partisanship that bars doctors from giving weight in their clinical decision-making to considerations other than about their own patients’ best interests. This traditional view implies that doctors should not be required to play the role of steward of shared health-system resources, since stewards are accountable to all those who have a stake in how those resources are used for the reasonableness and fairness of their resource-allocation decisions. A division of labor is often proposed to preserve doctors’ role as their patients devoted advocates by assigning the role of steward to administrators or policymakers. Stewards must restrict doctors’ clinical autonomy and authority as necessary to ensure they stay within the limits required by justice. However, many doctors believe that these restrictions impinge on their ability to pursue their patients’ best interests, and thus necessarily pose a threat to what is valuable in medical professionalism.
It appears that we face a dilemma: justice requires stewardship, yet medical professionalism allegedly rules it out. Some commentators have suggested that the right response to this dilemma is to make a direct claim that justice should be primary in guiding the design of social institutions, including professional roles and their norms. This implies that we must rethink the traditional view that doctors’ clinical-decision making must be guided exclusively by a concern for their own patients’ bests interests. Yet many people believe that the traditional conception of medical professionalism captures the kind of doctor-patient relationships that we would ideally want. So, they might worry that revising this conception necessarily means that we must instead settle for a less desirable version of medical professionalism. My goal in this essay is to address this worry.

My central thesis is that it is possible to articulate a conception of medical professionalism that is worth valuing, but whose requirements do not clash with those of justice in the way the traditional view suggest. I shall try to show that the conflict between the role of patient advocate and that of steward of shared resources is largely overstated by the traditional view, because it ignores that the values that underlie the requirements of patient advocacy also depend on the value that underlies the need to set limits to it, namely, justice.
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Acknowledgements

My heartfelt thanks to:

my dissertation committee. To Norman Daniels for the commitment and generosity you show your students, from which I have benefitted greatly. And for teaching me, through discussion and example, much of what I know about ethics. To Alicia Yamin for your guidance and encouragement throughout my doctoral studies. And for helping me to better understand human rights, why so many still lack them, and what to do about it. To Alan Zaslavsky for your patience and kindness while I tried to learn how to develop theories, constructs, and measures; and for you inspiring activism.

to the Interfaculty Initiative in Health Policy. To Debbie Whitney for your indispensable help getting though the first year of the program, as well as the second, third, fourth, fifth, and sixth. To Ayres Heller, Christy Colburn, Jessica Livingston, Kristin Collins and Colleen Yout. To my program cohort and Ethics track-mates.

to the David Rockefeller Center for Latin American Studies and Erin Goodman for your support and friendliness; to the Petrie Flom Center.

to the Ash Center for Democratic Governance and Innovation, Archon Fung, and the other Democracy fellows for an illuminating and exhilarating year.

to my parents and siblings.

to Cristina, my love.
1. Introduction

In this essay, I wish to examine what rationale might justify the claim that prisoners have a moral right to health and healthcare — for brevity’s sake, hereafter I shall use only “right to health”— and what are the implications of such a rationale for what can be said about the content and limits of this right. (I will explain how I understand the idea of a right to health below, in 1.2.) The idea that prisoners have some such right is not controversial; in other words, that some actors have some duties towards prisoners to protect and promote their health and to refrain from interfering with it. Yet there is little agreement about why they should have a right to health, that is, about its grounds or justification. There is also disagreement about what this right includes, about the specific details of what we owe to prisoners in relation to their health. To such disputes on these important practical issues, we need an account of which considerations and rationales count as adequate justification for answers to questions such as these. In other words, the lack of an acceptable rationale that explains why we should view prisoners as having a right to health may prevent us from making headway on disagreements about what this right includes.

Broadly speaking, claims asserting that prisoners have a right to health can be separated into two categories. On the one hand, it might be claimed that we do not in general have a moral right to health and that prisoners are a “special case”. On the other hand, one might claim that we do in general have such a right and that prisoners are not an exception. To support a claim of the first kind, one must not only justify the assertion that prisoners have a moral right to health, one must also justify the distinction between prisoners and other people in general. That is, one must offer a compelling rationale addressing both the non-comparative question of why we should view prisoners as having a right to health, as well as the comparative question of why they should have this right when people in general do not. In the first half of this
paper, I will consider the argument that the United States Supreme Court used to justify its decision in *Estelle v. Gamble* (1976), where it established that prisoners have a legal right to have their medical needs provided for at the public’s expense — a right that the Court does not in general recognize for people outside of prisons. This claim about prisoners’ legal rights is analogous to the first kind of claims that I just described about their moral rights. I wish to assess the objections facing attempts to justify this position on prisoners’ moral right to health by appealing to a similar rationale as that employed by the Court in *Estelle*.

More specifically, I shall attempt to show that accepting the Court’s answer to the non-comparative question just described would prevent us from being able to offer a satisfactory answer to the comparative question. In other words, that if we accept the Court’s argument for the claim that prisoners have a right to health, then we should reject the claim that non-prisoners do not have a similar right: the justification for the one extends to the other, and the other considerations that may be relevant to the case are not good enough reasons to justify unequal treatment. However, to support the judgment that *people in general* have a right to health, we would need (but have not yet been offered) a systematic account of the foundations — and limits — of such a right; an account that enables us to answer the difficult question of what this right includes.

In the second half of the paper, I consider one such general theory of justice and health — namely, that developed by Norman Daniels, who borrows from John Rawls’s framework of justice as fairness — and its justification for the claim that we (i.e. all the members of a given society) indeed have a moral right to health (Daniels, 2008; Rawls, 1971). If we accept Daniels’s account, then in the first instance we would not be called on to provide further arguments for the claim that prisoners in particular also have this right. For once it has been established that individuals in a society normally have a right to health, the burden of showing that a particular group of these individuals, like prisoners, are an exception rests on those who contended as much. But those of us who subscribe to Daniels’s and Rawls’s ideas may still have to grapple
with the problem of justifying this right in the particular case of prisoners, since it is at least arguable that punitive measures involving the deprivation of this right can be shown to be justifiable from within their theories. I shall address two different allegations to this effect.

The first is that measures which restrict freedom of motion or of association also restrict opportunity, so any justification for punitive measures involving a deprivation of these liberties will undermine, a fortiori, an opportunity-based justification for prisoners’ health rights. If this allegation were correct, it would pose a difficult problem for Daniels’s theory, since it would imply that those who subscribe to it must either revise the judgment that punishments involving custodial sentences are permissible or the judgment that prisoners have a right to health — but neither seems plausible. The second allegation that I wish to address contends that Rawls’s theory justifies punishing those who commit certain crimes by taking away their right to health. A contention of this sort arguably finds support within Rawls’s framework, so those of us who accept his theory and Daniels’s extension of it to health must show that this challenge can be addressed. To do so, I will attempt to show that the argument for the first allegation is invalid, and that the argument for the second is not sound. The former turns on fallacious premises, and the latter depends on empirical claims which suffer from being (at best) speculative or (more commonly) simply immaterial to the presumptive justification for taking prisoners’ right to health away.

1.1 Background

More than 10 million people are incarcerated worldwide, and about 30 million pass through some form of detention each year (Walmsley, 2016). These individuals bear a greater burden of physical and psychiatric disease than the general population in their respective countries, yet most have little or no access to adequate care — even though many jurisdictions recognize a legal right to health for inmates. (Das & Horton, 2016; Dolan et al., 2016; Fazel & Baillargeon, 2011; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Herbert, Plugge, Foster,
In many such contexts, the existing state of affairs with respect to prisoners’ health and access to healthcare is regarded as constituting a violation of this right. For instance, Rubinstein and colleagues (2016, p. 1202) argue that certain failures on the part of governments to adopt laws, policies and practices to provide prisoners with adequate “prevention, care, and treatment upon detention, throughout imprisonment, and upon release” constitute the violation of their human rights under international law. Indeed, even in countries with very different legal systems, such as the United States and Colombia, courts have reached similar conclusions by ruling that risks to health and lack of adequate healthcare in prisons constitute violations of prisoners constitutional rights: reasoning along these lines, in *Plata v Brown* the US Supreme Court found that conditions in California violated prisoners Eight Amendment constitutional rights, and on two separate occasions the Colombian Constitutional Court has declared the existence of an “unconstitutional state of affairs” in the country’s penitentiary system (*Brown v. Plata*, 2011; Corte Constitucional, 1998, 2015).

Yet what counts as “adequate” is a matter of intense debate. For instance, in Ireland, public debate ensued around the question of whether allowing prisoners to initiate a methadone maintenance regime would be unfair to individuals outside of prisons who were on a waiting list for this treatment (Lines, 2006). Similar debates are taking place around the world in relation to whether inmates should be offered the new and highly effective, though extremely expensive, treatments for hepatitis C; a disease that is especially common among prisoner populations (in the U.S., it is estimated that one in three persons with hepatitis C have served prison sentences). The “principle of equivalence” enjoys broad support among international health and human rights instruments and organizations, which states that individuals in prison have a right to a standard of health care “equivalent” to that available outside of prisons. But how this should be interpreted is hotly disputed: some people may believe that equivalence is the most that prisoners can demand, but some insist that it is only a minimum acceptable standard,(Lines, 2006) and others believe that this principle is of little practical use in the light of the (often
extreme) differences between prisoners and the general population and their needs and the challenges to meeting them (Jotterand & Wangmo, 2014). Moreover, in some countries, the general thrust of the principle is rejected altogether: in the United States, for instance, constitutional jurisprudence has established that prisoners have “the right to access to care, the right to care that is ordered, and the right to a professional medical judgment” — yet people outside of prisons do not in general have such rights (Rold, 2008, p. 23). Finally, disagreements exist not only on the question of what care is owed to prisoners, but also on that of what must be done if this care cannot be assured to them: for instance, in the cases mentioned earlier, while the US Supreme Court ordered the state to release prisoners if it was unable to reduce overcrowding within an allotted period of time, the Colombian Court merely ordered the government to allocate resources to expanding infrastructure.

My goal in the last two paragraphs was to describe some of the different positions and practices that have been adopted in different contexts with respect to the content and limits of prisoners’ health rights, so as to give the reader a sense of the problem and of its practical significance. No doubt, many of these differences are explained by differences in the legal, political, institutional, and socioeconomic contexts of the various settings. I am not in a position to comment on the empirical explanation for these differences. Nor can I comment on whether, in any given setting, a particular judgment about the content and limits of prisoners’ rights can be justified from a legal standpoint. Rather, I am interested in investigating the question of which considerations and rationales count as adequate moral justifications for claims about what prisoners’ rights to health and healthcare should include.
1.2. Conceptual Basics

Drawing on Wesley Hohfeld’s (1917) conceptual framework,¹ I shall understand the claim that a person has a moral right to health and healthcare as being equivalent to the claim that certain actors owe this person the performance of various actions that promote, maintain, or restore the right-holder’s health, and must refrain from actions that interfere with it.² The duty-bearing actors may include individuals, groups, or society as a whole. And the duties may span a broad range of social controllable actions beyond simply providing medical care, such as designing certain institutions and distributing various kinds of goods and services beyond medical care, such as broader forms of health care, public health measures, as well as non-health-sector goods and other social determinants of health (hence the expression “right to health and healthcare”). As I shall use the term, the “content” of the right consists of the specific duties that the relevant actors have towards the right-holder.

2. The View that People Do Not in General Have a Right to Health, and that Prisoners Are a Special Case

In Estelle v. Gamble, the US Supreme Court established that prisoners have a legal right to have their medical needs provided for at the public’s expense — a right that it does not recognize for people in general outside of prisons. In this section, I wish to examine the argument that the Court used to ground its view, and assess the challenges facing attempts to use a similar rationale to justify the analogous claim that prisoners have a moral right to health even though people outside of prisons do not in general have such a right. I will be particularly concerned to identify how this argument relates the following ideas, and the moral significance it

¹ See also Leif Wenar’s (2005) elaboration of this framework.

² I do not take a stand on whether rights are in any sense prior to their correlative duties (or vice-versa); for a general discussion of this question, see Francis Kamm (2004).
ascribes to them: namely, those pertaining to the kind of good that health is; to the nature of the relationship between prisoners and the authorities; and to the notion that people have a right not to be treated in cruel or inhumane ways and what constitutes such treatment. Consider the central argument articulated by the late Justice Thurgood Marshall in the majority opinion in *Estelle v. Gamble* (1976, p. 104f):

An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical “torture or a lingering death” .... In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in contemporary legislation codifying the common law view that “it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself.” We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the “unnecessary and wanton infliction of pain,” proscribed by the Eighth Amendment.

2.1. The Nature of the Relationship Between Prisoners and the Authorities: Dependency

Consider first the Court’s observation that inmates are dependent upon prison authorities for their medical needs. This way of putting the matter understates the extent of prisoners’ dependency: in addition to medical care, inmates are dependent upon public authorities for a wide range of health needs including adequate nutrition, unpolluted drinking water, safe and sanitary living conditions, exercise and rest, a salutary social environment, and other social determinants of health. If the authorities fail to exercise their power over prisoners’ lives in a way that is conducive to meeting these health needs, then those needs will not be met. To the extent that prison authorities have the power to determine whether and on what terms inmates have access to the goods, services, and other socially controllable factors that are necessary to promote, maintain or restore health, it is accurate to say without abuse of language that inmates are dependent upon prison authorities for their health needs, broadly understood.

How does this fact help explain why we owe prisoners assistance in protecting and promoting health? What relevance should we attach to it? Some people argue that dependency
and vulnerability relations in general give rise to special obligations to assist those in need. For example, Robert Goodin (1985: p34) argues that “the simple fact that a person is… [dependent upon and thus] vulnerable to you imposes upon you special responsibilities in respect of him”. He concludes from this that “the rich and powerful… [are required to give] to the less powerful or the particularly vulnerable: to children, to the mentally and physically handicapped, to the poor, to the infirm aged” (p. 38). Now, the Court does not hold the view that the poor, the mentally and physically handicapped, or other vulnerable people in general are owed assistance for meeting their health needs. It therefore cannot be construed as agreeing, tout court, with an account like Goodin’s; it would be inconsistent if someone who shares the Court’s view attempted to justify a duty to assist prisoners by appealing merely to their dependency and vulnerability in the way Goodin does.

2.2. Claims of Compensation

Can the grounds of the public’s duties towards prisoners be traced to the public’s responsibility for causing prisoners’ dependency? When we deliberately restrict people’s liberty, we make it the case that they cannot provide for themselves, which in turn causes them to depend on us for their basic needs, including those related to health. It may be tempting to think that we can use this fact to ground the view that prisoners have a special claim of compensation against society while some other vulnerable people (e.g. the aged or those with certain disabilities) do not. This seems to be the thrust of the Court’s assertion that “it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself” (Estelle v. Gamble, 1976, p. 104f). This rationale explicitly addresses only the non-comparative\(^3\) question of the grounds of prisoners’ right to the public’s assistance.

\(^3\) For a general discussion on the distinction between comparative and non-comparative justice, see Joel Feinberg (1974).
But it can perhaps be interpreted as suggesting (albeit implicitly) the following answer to the
comparative question of the justification for the inequality between prisoners and non-prisoners
in the assistance that is allegedly owed to each group (when neither can afford meeting their
own needs). Namely, that non-prisoners do not have a similar claim of justice on the public’s
because, unlike prisoners, they have not been deliberately subjected to measures which restrict
their ability to provide for themselves. I take up each in turn.

There are, I think, several problems with this account of the answer to the non-
comparative question. To assume that prisoners’ claims on the public’s assistance can be
justified with reference to a claim of compensation is to beg the question against the
presumptive justification for punishments that involve custodial sentences. Being deprived of
liberty may prevent someone from being able to meet not only his or her health needs, but many
other kinds of important needs such as those for meaningful ways of occupying one’s time, for
self-expression, for closeness to family and loved ones, for long-term financial security. etc. Yet
we do not ordinarily think that we have an obligation to assist them in meeting all of those
needs. Quite the contrary, the unpleasantness of being rendered unable to meet such needs is
part of what makes incarceration unpleasant, and its unpleasantness is an essential part of the
reason for relying on it as a method of punishment; as Carlo Nino (1983, p. 292f) observes, “to
offer compensation to the people who are subjected to punishment would, obviously, be
incompatible with the reason for imposing it.”

2.3. Cruel or Inhumane Treatment and the Special Moral Importance of Health

It may be tempting to think that this problem is averted if we all acknowledge that people
have a right to be free from cruel or inhumane punishments, and that restricting people’s ability
to meet certain especially morally important needs without offering compensation is
unacceptably cruel or inhumane; it follows that we owe it to prisoners to meet their health
needs. But even if we take these ideas for granted, appealing to them does not carry us very far
towards answering the question at hand, since it simply replaces the problem of justifying the
duty to assist prisoners in meeting especially important needs in general with a problem of
explaining what is so special about health or health needs in particular. What looks like a
promising way of accounting for the obligation to protect prisoners’ health by connecting it to the
notion of cruel and inhumane punishments encounters the problem that it presupposes a
particular view of why we should ascribe special moral importance to health needs, which in turn
is something that stands in need of justification.

Perhaps because it recognized this problem, the Court mentions the fact that failing to
meet certain health needs results in pain, suffering, and “in the worst cases, [it] may actually
produce physical ‘torture or a lingering death’” (Estelle v. Gamble, 1976, p. 104f). I do not
believe, however, that this adequately explains the moral importance of health (let me
emphasize that I should not be construed as commenting on whether it explains its legal
importance). Many serious diseases, such as chronic hepatitis C infections or greatly elevated
blood pressure (e.g. 160/100 mHg), are often completely asymptomatic (i.e. do not cause pain
or suffering), and although they substantially reduce overall life expectancy, it would be an
abuse of language to say that they produce a “lingering” death. Moreover, people who have
extremely serious diseases or disabilities, such as quadriplegia, often report happiness or
satisfaction in life comparable to people without disease (Daniels, 2008). Now, it is clearly not
plausible that these health needs should be excluded from the set of possible objects of a right
to health simply because they do not produce these effects; yet if they are included, the account
in question cannot explain why. (More generally, such an account faces this difficulty with
respect to needs that are only related to risks to health.) Similarly, though it is not plausible that
the set of possible objects of a right to health should necessarily fail to include those related to
health conditions that are only moderately severe (e.g. depression, or myopia), especially when
they are inexpensive to treat or easy to prevent; but we cannot use the notions of pain,
suffering, or danger to life to explain why we should ascribe such importance to them that failing
to meet them could constitute cruel or inhumane punishments. This problem is perhaps more apparent when one considers that failing to meet some of the other needs that I mentioned earlier is not ordinarily thought to constitute cruel or inhumane treatment (i.e. for meaningful pursuits, self-expression, closeness to family and loved ones, long-term financial security), even though such failure may produce greater suffering compared to failing to failing to meet the health needs just mentioned. Daniels (2008, p. 35n) notes, “Advocates of this view must be willing to weigh the reduction of pain and suffering against the satisfaction of all other kinds of preferences. It is this empirical estimate of the strength of the tendency that makes health care special: The specialness disappears when the estimate changes.”

2.4. Equal Concern

To make matters worse, it seems to me that if we pursue the strategy just sketched, having a satisfactory account of the special moral importance of health needs (whatever such an account may be) from which to draw creates more difficulties than it solves. Although having such an account might ease the task of answering the non-comparative question of the justification for the obligation to meet prisoners’ health needs (by allowing us to ground this justification in the right to be free from inhumane punishment), it makes it harder to answer the comparative question of why this obligation does not extend to similarly needy people in general. By acknowledging that the interest at stake (i.e. health) is sufficiently important to justify providing for the needs of those in one group (i.e. prisoners) at the public’s expense, we open the door to the following question: If health needs are so important that failing to help prisoners meet them should be seen as cruel and inhumane, then why should we not see failing to help non-prisoners as also being cruel or inhumane?

The mere fact that prisoners, but not other people, have had restrictions on their ability to provide for themselves deliberately imposed on them is not, I think, a sufficiently relevant difference, morally speaking, to ground a satisfactory answer to the comparative question.
Consider the issue from the perspective of non-prisoners who cannot afford meeting their own health needs: these individuals could complain that the failure on the part of society to offer them similar assistance as it does to prisoners is an objectionable form of unequal treatment. They can appeal to the idea (which no plausible liberal theory of justice would deny) that everyone’s needs and interests must be given equal weight in the design and administrations of major social institutions — no one has a claim to preferential treatment from society in the absence of compelling reasons.\(^4\) We may call this a requirement of “equal concern”. If in general nobody has a (non-comparative) right to have their health needs met at the public’s expense, then providing this benefit to prisoners but not similarly to individuals outside prisons (when neither can afford meeting their own health needs), without a good reason to justify the inequality, is a violation of this requirement of equal concern.

2.5. The Significance of External Restrictions on the Ability to Provide for Oneself

Now, it is perhaps plausible that the fact that incarceration involves a restriction on the opportunity to provide for oneself would be sufficient to justify this inequality if we could assume that the circumstances facing individuals outside prisons are generally favorable enough to ensure that, in the absence of external interference, those who exercise their liberty appropriately will be able to afford meeting their health needs. If this were the case, then it would perhaps be plausible that the comparative objection could be responded to by arguing that individuals have no legitimate complaint against society for misfortunes that they could have avoided by exercising their liberty appropriately.\(^5\) (I say “perhaps plausible” because it seems to me that this response to the comparative objection also works as a rebuttal to

\(^4\) For these matters, consult Scanlon (2016), whom I follow here.

\(^5\) For a general discussion about the relevance of choice in connection to responsibility, see Scanlon (1998). Scanlon credits the inspiration for his account to HLA Hart’s (2008) seminal work on the topic, whose discussion is more directly focused on punishment:
argument about the grounds of prisoners’ non-comparative claims on society, on the assumption that the liability to punishment is reserved for actions that individuals can avoid committing.) But if the assumption does not obtain then we cannot reasonably respond to the comparative objection in this way. When liberty does not translate into a substantive opportunity to attain the goods one needs — that is, if liberty does not generally have this sort of “worth” — then we cannot justify the inequality between prisoners and others in the goods that they are provided at the public’s expense by alleging a duty to compensate prisoners for the worth of the liberty of which they, but not non-prisoners, have been deprived.6

To be clear, I am not contesting the view that we can justify the obligation to make the goods required for meeting health needs available to prisoners by appealing to the fact that incarceration involves a restriction on the ability to seek these goods. It seems to me that this would indeed be a plausible way to account for the noncomparative obligation to make the relevant goods available to prisoners. My contention is that unless we make a strong assumption about the “worth of liberty”, we cannot appeal to the fact that incarceration involves a restriction on the opportunity to provide for oneself (viz., to generate the income and wealth needed to pay for care) in order to justify the inequality that would exist if prisoners, but not other needy people in general, had their health needs provided for at the public’s expense.7

Let me turn to some other considerations that might be thought to justify the inequality.

In what follows, I shall aid myself by referring to the following example:

Rich, Penniless, and Laborer have an incurable but treatable chronic health condition that causes greatly distressing symptoms and eventually causes permanent disability unless a drug is taken regularly. The drug is not very expensive, and it is available for purchase in the community. Rich is quite wealthy, and Laborer has a steady income, so they are both able to afford the drug and take it regularly. In contrast, Penniless is unemployed for reasons beyond her control (e.g. because all of the skills she has

6 I borrow the expression, “worth of liberty” from Rawls (1971).

7 The distinction I draw between making care available to prisoners vs. providing is analogous to that drawn in international law between States’ duty to respect vs. fulfill individuals’ human rights. See for instance Committee on Economic, Social, and Cultural Rights (2000).
acquired in life are no longer marketable due to unforeseeable changes in the economy). Therefore, she cannot afford the drug. One day, they are all caught committing similar crimes and are arrested, tried, and justly sentenced to many months in prison. The medicine is available in prison on the same terms as it is in the community (i.e. it is provided to someone if and only if the person pays for it).

Once it is acknowledged that the interest at stake (i.e. health, in the example) is sufficiently important to justify providing a benefit (i.e. medicine) at the public’s expense to prisoners, then failing to provide it to non-prisoners when both are similarly needed (think of Penniless before she was detained and Penniless after she was detained) is a violation of the requirement of equal concern unless it is shown that there is a difference between prisoners vs. non-prisoners that is a “good reason” for this inequality. The key feature of this example is that being detained will only make a difference to whether Laborer gets the medicine; it will not make a difference to whether Rich and Penniless get it. So, we cannot justify the inequality between Penniless and similarly poor non-prisoners (or that experience by Penniless between the two points in her life) solely with reference to the mere fact that she, but not others, is detained. The mere fact that she is detained is not a sufficiently “good reason” to justify the inequality; that is, we cannot satisfactorily answer the question of what is the relevant difference between her and non-prisoners by appealing to this fact alone.

To provide a satisfactory answer to this question, the response must not turn solely on definition. For instance, it would be wrong to argue that failing to provide for the health needs of non-prisoners does not violate their right to be free from cruel or inhumane punishment because, by definition, cases of “punishment” must involve an actual or supposed offender who has been duly tried, convicted, and is currently serving the sentence imposed. (I assume that non-prisoners typically do not satisfy this definition). As HLA Hart (2008, Chapter 1) pointed out, this “definitional stop” prevents us from answering the very question that is being raised: namely, that of the justification for a social arrangement in which there is a social obligation to address the health needs of individuals only if they are being subjected to punishment.
2.6. Allowing Harm to Happen vs. Cruel or Inhumane Treatment

To be able to use the notion of a right to be free of cruel or inhumane punishments to justify an inequality in the benefits that are owed to prisoners relative to non-prisoners, we would need a criterion that allows us to distinguish between (1) cases where failing to assist someone meet a health need (which is an instance of merely allowing harm to happen) counts as punishment (which is ordinarily understood to involve the infliction of harm), and (2) cases where such failure does not count as punishment. In other words, we need a criterion that would allow us to correctly classify cases like the Tuskegee syphilis study, where failing to treat was cruel and inhumane but it was not punishment. In the absence of such a criterion, we cannot explain why failing to provide for someone’s health needs should count as a violation of his or her right to be free from cruel or inhumane punishment in the case of prisoners, but not in the case of non-prisoners. Returning to the scenario introduced earlier: if failing to provide treatment to Penniless when she is detained should be seen as an infliction of inhumane treatment, then why should we view this failure differently when she is free?

In Estelle, the Court appealed to the notion of "deliberate indifference" as the criterion for making this distinction. It held that only “deliberate indifference” to (serious medical) needs constitutes the infliction of (cruel or inhumane) punishment. There are several problems with this criterion. To begin with, it is not at all obvious why the intent of the agency inflicting the punishment is relevant. As Justice Stevenson notes in his dissenting opinion, “whether the [Eight Amendment] has been violated should turn on the character of the punishment, rather than the motivation of the individual who inflicted it.” Moreover, there is a problematic ambiguity in the term “deliberate”: it can mean either “intentionally” or merely “knowingly”. That is, we can

8 Between 1932 and 1972, approximately four hundred of African-American individuals who did not know they had syphilis were enrolled in a study to investigate the long-term effects of untreated syphilis. They did not receive therapy with penicillin even after it had become widely available by the 1950’s as the preferred treatment for the syphilis (Brandt, 1978).
use the term “deliberate” to characterize an agent’s (A) failing to assist someone, intending that the person suffers harm, which differs from (B) failing to assist despite recognizing that the person will suffer harm (but not intending this consequence). And we can contrast both of these with (C) failing to assist without realizing that the person will suffer harm. The examples that the Court provides in *Estelle v. Gamble* (1976, p. p104f) to illustrate the difference between cases that evince deliberate indifference and those that do not are examples only of the difference between (A) and (C): “prison guards… intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed” vs. “inadvertent failure… [to prevent] an “unforeseeable accident”. But these examples do not cover the kinds of cases discussed so far, such as that of Penniless and Laborer, which fall into category (B) (i.e. cases where failing to provide health care will foreseeably result in serious harm). Now, if the notion of “deliberate indifference” is construed in a way that excludes cases where failing to provide health care to someone will foreseeably result in harm to that person (but where causing harm is not the intended goal of failing to provide the care), then the right not to suffer cruel or inhumane punishment would not explain a duty to provide the treatment in cases like that of Penniless or Laborer. If, however, the notion is construed in a way that covers failing to prevent (merely) foreseeable harm, such that a society’s indifference to their medical needs violates their right not to be subjected to cruel or inhumane punishments, then this calls the question as to why we should have a moral right protecting us against deliberate indifference to our medical needs when we are in prison even if we have no such right when we are free.

2.6. Summary

To justify the view that prisoners are a special case, in the sense that they have a moral right to health that people outside of prisons normally do not have, one needs to address the following (comparative) question: If we do not in general have a social obligation to address the health needs of someone who cannot afford the care she needs, then why would we acquire
such an obligation towards this person when she is deprived of her liberty? In other words, if health is so important that failing to protect and promote prisoners’ health needs is morally unacceptable, then why is failing to protect and promote people’s health in general not also wrong? I examined the argument that US Supreme Court used in *Estelle v. Gamble* to justify the analogous view the prisoners have a *legal* right to health that people outside of prisons do not normally. I have tried to show that the Court’s reasoning would face significant objections if one tried to use to address the question of the justification for prisoners’ *moral* right to health.

Specifically, I have tried to show that the justification for the (non-comparative) obligation to meet prisoners’ health needs is grounded in the following argument: (i) if the public does not provide for prisoners’ health needs, then those needs will not be met and serious harm will happen to prisoners’ (ii) when serious harm will happen to someone unless we assist her, failing to assist her is to treat her in a manner that is cruel and inhumane; (iii) people have a right not to be treated cruel or inhumane ways; therefore (iv) failing to provide for prisoners’ health needs at the public’s expense would violate their right not to be treated in cruel and inhumane ways. But this justification extends to people outside of prisons, which raises the comparative question described above. To address this questions, one would need to offer a good reason that shows why the third premise in the rationale above is true in the case of prisoners but not in the case of non-prisoners: that is, why failing to assist someone avoid serious harm is to treat them in a cruel way if this person is a prisoner but not if the person is not a prisoner. The fact that prisoners, but not non-prisoners, have had restrictions on their ability to provide for themselves deliberately imposed is not sufficient to justify this unequal treatment, when it cannot generally be assumed that in the absence of external restrictions people who choose appropriately will be able to afford the goods they need. It follows from these two conclusions — that is, conclusions that the justification for prisoners’ right to health extends to non-prisoners and that we cannot offer acceptable grounds for drawing a distinction between them — that both groups should be seen as having similar health-related rights. But this broader claim amounts to the view the
people in general have a right to health. This brings me to the second type of claims that I mentioned in the introduction.

3. The View that People in General Have a Right to Health, and that Prisoners are Not an Exception

At the beginning of this essay I said that rather than viewing prisoners as a special case, it might instead be claimed that we should generally see each other as having a moral right to health. In the remainder of this essay, I wish to consider one prominent justification for a position of this kind — namely, that proposed by Daniels (2008) — and defend it against two potential challenges arguing that it leaves the door open to the permissibility of taking a prisoners’ right to health. The first alleges that his argument is either incompatible with viewing custodial sentences as permissible, or it does not support the judgment that prisoners in particular have a right to health. The second contends that Rawls’s theory justifies an institutional practice of depriving those who commit certain crimes of whatever right to health they might normally have, which would in turn undermine the support that Daniels’s argument derives from Rawls’s theory. In what follows, I shall describe Daniels’s account of the importance of health and his extension of Rawls, and then take up each of these two allegations in turn.

3.1. Daniels’s Opportunity-Based Account of Justice and Health

Daniels argues that we should see the right to health as a special instance of a broader right to fair equality of opportunity. His central argument can be summarized as follows: (1) Since meeting health needs promotes health, and since health helps to protect opportunity, then meeting health needs protects opportunity. (2) If justice requires society to protect opportunity, then justice gives special importance to meeting health needs. He substantiates (1) by providing an analysis of the kind of good that health is, which he in turn uses to show the kind of
importance we should attach to factors affecting health. Drawing on Boorse’s “biostatistical” account of health, Daniels conceptualizes health as normal species functioning, and defines health needs as “those things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning”. His account of the moral importance of health, and thus of meeting health needs, rests on the concept of a “normal opportunity range” for a given society, which he defines as “the array of life plans reasonable persons are likely to develop for themselves.” Departures from normal functioning reduce our shares of the normal range because they reduce some of our capabilities, which in turns renders unreasonable some of the life plans for which we are otherwise suited.

To support (2), Daniels (2008) proposes that we can broaden Rawls’s notion of opportunity, which allows him to then borrow support from its justification for the principle assuring fair equality of opportunity: “The impairment of normal functioning by significant pathology restricts individuals’ opportunity relative to the portion of the normal range that their skills and talents would have made available to them were they healthy. If individuals’ fair shares of the normal range are the life plans they may reasonably choose, given their (corrected) talents and skills, then disease and disability shrink their shares from what is fair.”

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9 More precisely, Daniels (2008, p. 37) understands health as the absence of pathology, where pathology refers to “any deviation from the natural functional organization of a typical member of the species [within an appropriate reference class, such as age and sex]. Pathology… takes place at various levels (genetic, organelle, cell, tissue, organ, systemic) with different consequences, ranging from innocuous to fatal.”

10 Daniels (2008, p. 37f) adds, “The normal range thus depends on key features of the society – its historical development and its material wealth and technological development, as well as important cultural facts about it. In this sense, the notion of a normal opportunity range is socially relative.”

11 For Rawls discussion of the FEO principle, see Rawls (1971), especially section 14.
3.2. An Objection to the Opportunity-Based Account

The objection to this account that I wish to discuss is grounded in the observation that freedom of the person is a crucial parameter affecting the range of exercisable opportunities from which individuals may construct their plans of life. The claim is that since punitive measures involving restrictions on individuals’ freedom of motion or of association drastically reduce the range of life plans that they may reasonably choose, then any justification for restricting these freedoms will undermine, *a fortiori*, an opportunity-based account such as Daniels’s of the justification for these individuals’ right to health. More specifically, the argument is the following: (1) If it is permissible to restrict someone’s liberty of the person, with all of its implications for what opportunities are open to her, then we must see this person as having forfeited her claim to the protection of those opportunities. (2) The right to health is a special instance of a broader right to fair equality of opportunity, so if someone has forfeited her broader right to the protection of those opportunities, then we cannot appeal to this broader right in order to explain why this person should be seen as having a more specific right protecting those opportunities against departures from normal functioning. (3) Therefore, if it is permissible to restrict a given person’s liberty, then we cannot claim that this person should be seen as having a right to health unless we provide some other grounds to support this claim, which Daniels’s opportunity-based account does not do. This in turn suggests that if we accept Daniels’s account, then we must either withdraw the judgment that punitive measures involving restrictions on liberty of the person are permissible, or we must withdraw the judgment prisoners have a right to health assuring them protection against departures from normal functioning.

This is not a valid argument. To begin with, the inferences in the first and second premises are invalid. Though it is true that deprivation of liberty is a drastic curtailment of opportunity, it does not follow from the permissibility of restricting someone’s opportunity by restricting their freedoms of the person that it is also permissible to restrict their opportunity in
other ways. And the fact that restricting someone’s liberty shrinks her opportunity does not pose a problem from an opportunity-based explanation of the moral importance of meeting her health needs. For instance, addressing a health condition that may impair her ability to read or to concentrate (such as astigmatism or depression) helps to preserve her opportunity to pursue certain forms of education or self-fulfillment that may be available in prisons. Similarly, addressing conditions that may cause disability later in life if left untreated (such as syphilis) helps to protect the range of exercisable opportunities that will be open to her after she regains her freedom. If she has a fundamental interest in protecting these opportunities, then she will have a pressing interest in meeting those health needs.

Finally, even if it is permissible to restrict someone’s liberty, with all of its implications for what opportunities are open to him, this in no way commits us to viewing him as having forfeited his right to his fair share of the normal range, which we can still define as the array of life plans he may reasonably choose, given his (corrected) talents and skills and the fact that he is detained. Since impairments of normal functioning shrink his opportunity beyond relative to the portion of the normal range that his (corrected) talents and skills would have made available to him were he healthy, it shrinks his share beyond what is fair. The burden of showing that, in addition to restricting their liberty, it is permissible to deprive lawbreakers of their right protecting their fair share of the normal range against loss of functioning rests on those alleging that this is the case.

3.3. A Challenge from Within Rawls’s Theory: Proportionality and Necessity

This brings me to the objection that Rawls’s theory can be found to justify an institutional practice of punishing those who commit certain crimes by annulling their right to health. The idea is that from the perspective of the parties to the original position, it is rational to agree to punishments involving the loss of any given right whenever these punishments are necessary in order to prevent even greater evils. I shall refer to this as the “claim of justification” underlying
this objection. Let me present more explicitly the two elements of this claim of justification, and identify the contribution that each element makes to that justification.

This claim consists of the conjunction of the following two principles: The first is a principle allowing the use of penalties that involve the deprivation of a given right if and only if the interest that this right is designed to protect is of lesser moral importance compared to those threatened by the crimes to which they are attached. We may call this a “weak principle of proportionality”.\textsuperscript{12} Support for this principle can arguably be found from within Rawls’s theory, according to which the laws, policies, and constitutional principles that define rights’ citizens and the powers of the government are just if rational self-interested contractors behind the “veil of ignorance” would agree to them.\textsuperscript{13} To see this, consider the two parts of the biconditional that the principle articulates. It allows punishing those who commit crimes X by depriving them of right Y only if the interest right Y is designed to protect is of lesser moral importance relative to the interest threatened by crime X (i.e. this is a necessary condition). This is because it is not rational to agree to jeopardize fundamental interests for the sake of relatively trivial ones.\textsuperscript{14}

\textsuperscript{12} By contrast, a stronger version of such a principle would require that the crimes and punishment be of strictly equal severity; I mention this only to illustrate the sense in which the principle in discussion is “weak”. For a general discussion of the way in which different versions of the principle of proportionality might be justified from within different theories of punishment, see Von Hirsch (1992).

\textsuperscript{13} The veil of ignorance stipulates that the parties are prevented from knowing particular facts about their own social position, natural attributes, and particular interests (i.e. they are behind a “veil of ignorance”). For a discussion of how the principles of justice are to be applied, see Rawls (1971), section 31, where he introduces the idea of the “four-stage sequence”.

\textsuperscript{14} Now, it might be thought this condition would be unnecessarily demanding if the liability to penalties is limited to actions which citizens can avoid, and they are assured adequate protections of due process and other such safeguards associated to precepts of the rule of law. It might even be claimed been tempting to think that punishments that are more severe than the crimes to which they are attached can sometimes be justified with reference to the difference principle, since crime typically has a disproportionate impact on the communities that are already the most underserved. This would be mistaken, however, as can be shown by connecting Daniels’s analysis of the moral importance of health with Rawls’s arguments for the priority of the principles of equal liberty and of fair opportunity over the difference principle and with his argument about the rationality of the parties: it would be irrational for the parties to the
Turning to the other part of the biconditional: the fact that the interests that right Y protects are less important relative to those that crime X threatens is a *sufficient* condition for punishing crime X by taking away right Y. The reason is that it is not rational to insist on certain protections of an interest if these come at the expense of a more important interest.

The force of the challenge derives from the fact that this weak principle of proportionality is sometimes satisfied. Certain types of crimes (e.g. murder) are indeed worse relative to having one’s right to health taken away: being deprived of one’s life is generally worse than being deprived of the assurance that one’s health needs will be addressed (reasonable resource-constraints permitting). This opens the door to the conclusion that it is indeed permissible to punish those who commit such crimes in this way. It is important to note, however, that the fact that justice gives special importance to meeting health needs implies that taking somebody’s right to health away is a very severe penalty. Therefore, the week principle of proportionality implies that it is only permissible to attach this form of punishment to very serious crimes, such as those that pose a significant threat to life or limb, or those which can be seen as representing a greater danger to the liberty of the representative citizen. (An example that Rawls (1971, p. 242) provides of the latter is that of “members of rival sects who, [aroused by sharp religious antagonism], are collecting weapons and forming armed bands in preparation for civil strife.”)

The second part of the claim of justification is a principle *forbidding* penalties that are more severe than required for the prevention of the crimes in question. This constraint follows from the forward-looking nature of the justification for punishment on the grounds of social protection, which is in turn the only rationale for hard punishments that the parties to the original original position to jeopardize their liberty or the protection of their opportunity for the sake of social or economic gains, even if the risk of being wronged punished are small. The condition also seems controversial when the crimes in question endanger important *collective* interests or have important aggregate effects but only cause relatively minor harms to any given individual (e.g. certain environmental or financial crimes). For reasons of space, I leave these matters aside.
position can accept. Any other rationale for punishment (such as retributivist one) depends on moral or religious views that the contracting parties cannot assume they share.\textsuperscript{15}

If it has not been shown that the severity of punishment has been kept to the minimum necessary, then those who are on the receiving end have grounds for complaining that they are being made to suffer deprivations for reasons that are irrelevant to the legitimate purpose of such a practice. (Notice that this is a clear sense in which the punishments in question could be said to be cruel and inhumane. So, in contrast to the account discussed in the previous section, the idea that depriving criminals of their right to health is cruel or inhumane is a consequence of the argument for determining which forms of punishment are justifiable, rather than a premise in that argument.)

Now, there are two senses in which it might be said that punitive measures involving the deprivation of a given right are “necessary” or “required” in order to prevent worse crimes. The first is in connection to the \textit{effectiveness} of the institution of punishment as a mechanism of deterrence. That is to say, that the unpleasantness of having this deprivation imposed is crucial to the effectiveness of the institution of criminal punishment as a mechanism of deterrence. That eliminating this unpleasantness would render the institution incapable of preventing the crimes in question. Any claim alleging that taking away offenders’ right to health is necessary in this sense suffers from being at best speculative (to my knowledge, there is no evidence about the effect on the incidence of crime of taking away health-related benefits from offenders) or at worst false (what evidence exists about the effects of harsher punitive practices, in general, suggests that beyond a certain point harsher penalties have little or even undesirable effects on the incidence of crime).\textsuperscript{16}

\textsuperscript{15} For instance, Scanlon (2011) has argued (convincingly, in my view) that we should reject retributivists rationales for punishment.

\textsuperscript{16} An example of a sentencing practice that has falsely been justified on the grounds that it contributes to the effectiveness of punishment are the so-called “habitual offender” or “three-
The other sense in which it might be said that taking a given right away from lawbreakers is “necessary” has to do with the feasibility of upholding this right in their case. That is to say, that the constraints that this right imposes on the powers of the government to punish lawbreakers impose an unacceptable cost to other important interests. For instance, it might be claimed that penalties involving incarceration are necessary in the previous sense (i.e. that it is crucial if future crimes are to be effectively prevented), but that it is not possible to incarcerate individuals at an acceptable cost without relaxing the limitations that a right to health normally imposes on the discretion of government actors to act in ways that might expose individuals to certain health risks (such as those that inevitably result from living in close quarters with many other people or from having few opportunities to exercise). Or it might be claimed that, due to certain features particular to penitentiary settings, providing goods and services in prisons is more expensive relative to providing them in the community, to the point where providing these benefits to prisoners would be unacceptably costly. To assess such claims, we need an account of how to determine what counts as “unacceptable costs”, and it is important to bear in mind what is the relevance of such claims to the argument at hand. I shall address the latter issue first.

For this general approach to understanding rights, see for instance Scanlon (2008, p. 603), who argues that “the claim that there is a right is a claim that certain limitations on the discretion to act of individual and institutional agents are necessary if important interests are to be adequately protected, and feasible as a way of providing this protection. This claim of feasibility is that the cost these limitations impose on our other interests is acceptable given the importance of the interests being protected.”
Assertions that the right to health is not feasible in the case of prisoners because the requirements it would impose are “unacceptably costly” are of limited significance to the justification for depriving inmates of this right: the significance of such claims is bounded by above by the limits to justifiable penalties imposed by the weak principle of proportionality. For instance, suppose that the weak requirement of proportionality allows incarcerating burglars but does not allow punish them in ways that pose serious risks to their health. If this were so, then the fact that it is not feasible to protect prisoners against serious health risks would not in the least support the claim that incarcerating burglars is justifiable. (Though it would, obviously, support the opposite claim — viz., that it is not justifiable.) Complaints about the “unacceptable cost” of upholding our normal duties to protect and promote health in the case of prisoners are a red herring whenever failing to uphold these duties would result in a punishment that is more severe than the crime to which it is attached, since the weak principle of proportionality disallows disproportionate penalties.

Now, the problem is clearly more nuanced than my preceding remarks might initially suggest: In a given society, the right to health might include entitlements to treatments for health needs that are arguably not very important even if they are desirable (e.g. glasses for mild myopia). So, denying these specific entitlements would not be very severe punishment. Similarly, failing to protect inmates against moderately severe pathologies is arguably not a very severe punishment, especially if the pathology is curable and leaves few sequelae (e.g. non-severe depression). Moreover, I said that it is at least arguable that taking away all the protections and provisions that a right to health might normally include is less severe compared to some very serious crimes (e.g. murder). Therefore, if it would be unacceptably costly to uphold prisoners’ entitlement to the protections and provisions in question, then the failing to do would be justifiable (assuming, that is, that the evaluation of the relative severity the crimes and punishments is not in question).
But once the objection has been reduced to this last problem, it would be an overstatement to cast it as a “challenge” to the claim that prisoners have a right to health: it is simply an instance of the general problem of distributive justice and health. Whether or not the right to health in a given society includes an entitlement to have a given health need met depends on comparing the moral importance of the need in question relative to the importance of the alternative goals that could be achieved instead. In other words, in general, an answer to the question of the content of the right to health depends on a comparison of the “opportunity costs” of meeting people’s various needs. If assisting certain people to meet certain needs would require forgoing more important goals — such as meeting more important needs, or from reducing unjustifiable inequities in whose needs are met — then justice does not require that we offer this assistance.

The prisoners’ case is no different in this regard to any other case. The fact that providing certain goods or protections to prisoners is more expensive relative to providing those things to people in the general community is not exceptional: meeting certain health needs for people in rural areas is also generally more expensive compared to meeting those same needs for people in urban areas; pregnant women generally have greater and more expensive needs compared to non-pregnant women; etc. Difference between groups of individuals — be they prisoners vs. non-prisoners, urban vs. rural dwellers, pregnant vs. non-pregnant women — in their needs and in the cost of meeting those needs can, and should, be taken into account when deciding the content of the right to health. The crucial point to notice is that the mere fact that some individuals are prisoners is not in itself a relevant consideration for deciding what their right should include. In all cases, the only relevant considerations are those about health needs, their distribution in the population, and the costs, effectiveness, and fairness of different strategies for meeting them.
4. Conclusion

At the beginning of this essay I contrasted a variety of views and practices with respect to the health-related rights that are recognized for prisoners in different contexts. This variety is a reflection of the disagreements that exist about what society owes to those who break its laws. My goal in this essay has been to improve our understanding on the question of which principles and considerations count as adequate justifications for positions on these important practical disputes. I approached this task by considering two general, mutually-exclusive judgments that someone who accepts the idea that prisoners have a moral right to health could make — either that prisoners have this right but people in general do not, or that we all normally have this right and prisoners are not exception — and then examined what rationales might be offered to support them. The answers these gave to some initial questions brought new questions in their train about what we owe to prisoners, and to each other more generally, and why. I wish to conclude by contrasting the central components of the two accounts, and offer some remarks on the extent to which either of them arrives at a “reflective equilibrium” that achieves an acceptable coherence between the answers to the various questions that came up (Daniels, 1996; Rawls, 1971).

The argument that the US Supreme Court developed in *Estelle* attempts to derive the conclusion that the public is required to care for prisoners’ health needs from principles that are specific to cases of punishments. In particular, it attempts to ground this obligation in an appeal to the constitutional principle proscribing the infliction of cruel punishments in connection with the observation that if the state does not meet prisoners’ serious medical health needs, then they will suffer severe harms. However, there is a gap between these two considerations: the first is a form of treatment that consists in *allowing harm to happen*, while the second is a principle proscribing treatments that consist in *inflicting harm*. This invites two questions: First, what is so important about the bad associated to having unmet health needs in relation to other
values, that failing to prevent the former in particular may be wrong? Second, why does failing to provide public assistance to someone avoid harm when she cannot avoid the harm without some assistance constitute inflicting harm if she is a prisoner but not otherwise? The first question cannot be answered with reference to principles that are specific to the case of prisoners; and indeed, the Court answers it by offering a general account of the importance of meeting health needs (though I offer reasons for disagreeing with the account the Court offers). But this makes the second question even more pressing, since it implies that avoiding this kind of harm has special importance for people in general, not just for prisoners. There are only three distinguishing factors between prisoners and non-prisoners to which one might appeal: that prisoners are prevented from seeking the assistance they need; that the public caused prisoners need for assistance; or the mental state of the authorities acting on the public’s behalf when they decide not to assist prisoners. The first might explain a duty to make the needed care available, but it cannot explain a duty to provide it. The second two do not provide a satisfactory answer to the question of why a free person, who, through no fault of her own, cannot meet her own needs without assistance would suddenly be owed this assistance by the public if she were detained, even though being detained would neither increase her need nor change her capacity to meet her needs without assistance.

It is interesting to note that, in a sense, the argument I considered in the second half proceeds in the opposite direction. Rather than attempting to arrive at the conclusion that prisoners’ have a right to health from the premise that we must refrain from inflicting cruel punishments, it starts from the premise that people in general have a right to health and arrives at the conclusion that taking this right away from lawbreakers when doing so is not necessary to prevent greater evils would be cruel. The important point, however, is how it derives the normative force for this conclusion. The premise that people in general have a right to health is itself a consequence of a general theory of distributive justice for health-related goods. The theory provides a general account of why health is of special moral importance that we can use
to answers the question of why health is of special importance in the case of prisoners. It also
gives us a systematic way of determining which claims about rights and duties are justified, and
which complaints about inequalities, are justifiable. This allows us to determine which demands
for protection are legitimate, and what means for providing that protection are acceptable. The
theory also yields surprising conclusions: for example, it implies that failing to protect prisoners’
opportunity against relatively unimportant pathologies, such as mild myopia, may be wrong even
though if it is permissible to drastically curtail their opportunity by incarcerating them. Finally, it
gives us a systematic way of identifying certain considerations as relevant and others as
irrelevant for settling disputes about the content and limits of prisoners’ moral right to health.
5. Bibliography


1. Introduction

Globally, more than 10 million people are in prison at any given time — or approximately 144 out of every 100,000 individuals — and each year approximately 30 million pass through some form of incarceration (Open Society Foundation, 2011; Walmsley, 2016). Even without the United States, the prisoner population in the Americas is the second largest in the world, with more than 1.5 million prisoners, or nearly 250 per 100,000 people. It is also the fastest growing, having doubled in size between 2000 and 2015 while the rest of the population grew by less than 17% (Walmsley, 2016).

Prisoners typically bear a greater burden of physical and mental illness than the general population, yet most have little or no access to adequate care (Dolan et al., 2016; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Fazel & Baillargeon, 2011). This is in flagrant disregard of prisoners' human rights since, restrictions on their liberty notwithstanding, detainees retain their right to health as enshrined in Article 4 of the International Covenant of Economic, Cultural, and Economic Rights (International Covenant on Economic, Social and Cultural Rights, 1966; Lines, 2008; Rubenstein et al., 2016; Sander & Rick Lines, 2016). Moreover, several provisions in other widely ratified international human rights treaties — such as the absolute prohibition on torture — as well as various “soft-law” instruments specifically protect prisoners’ right to health.

In the light of this situation, the World Health Organization’s Regional Office for Europe (WHO/Europe) created the “Health in Prisons Programme” (HIPP) to provide technical advice to WHO Member States in the European Region on how to create “health promoting prisons” (Galea, Enggist, Udesen, & Møller, 2014; Møller, Gatherer, Jürgens, Stöver, & Nikogosian, 2007; “WHO Health in Prisons Programme (HIPP),” n.d.) Its cornerstone recommendations have been summarized as follows:
The management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners is a whole-of-government responsibility. Health ministries should provide and be accountable for health care services in prisons. […] The most effective way [to achieve this] is for the provision of health care in prisons to be contracted to the general health-care system (Good governance for prison health in the 21st century, 2013, p. 9).

The WHO/Europe HIPP’s recommendations are explicitly addressed only to “WHO Member States in the European Region” (Good governance for prison health in the 21st century, 2013). Furthermore, by WHO/Europe’s own admission, its recommendations are grounded in very little evidence.

Colombia recently introduced reforms to its prison health systems similar to those advocated by the WHO/Europe, making it an interesting case to study. Colombia is the northernmost country in South America. As of 2016, it had an estimated population of 49.7 million and more than 121 thousand prisoners (i.e. roughly 244 inmates per 100,000 people) — which is nearly three times as many compared to 1998, when there were more than 43

Figure 1.

![Graph showing total prisoner population and overcrowding between 1998 and 2016]
thousand prisoners while the country’s estimated population was 39.2 million (i.e. roughly 109 per 100,000), as shown in Figure 1 (“Colombia | World Prison Brief,” n.d.).

A number of analyses have been written about criminal and penitentiary policies in Colombia (Ariza, 2011). Additionally, studies have explored the epidemiology of certain diseases among the prisoner population and evaluated specific healthcare and public health interventions (Castañeda-Hernández, Martínez-Ramírez, Bolivar-Mejía, & Rodríguez-Morales, 2013). To our knowledge, this is the first study to adopt a holistic approach to analyzing the performance of the prison health system as a whole and the reforms that have been introduced in the last twenty years.

The analytical framework used in this study (Figure 2) builds on the framework developed by the WHO and IHP+ (2011, 2010) by wedding it to a human rights-based approach to health (HRBA). This framework describes health systems in terms of six core components or “building blocks”: (i) organization and governance, (ii) health information, (iii) financing, (iv) health workforce, (v) access to essential medical products and technologies, and (vi) service delivery.

Figure 2.
Additionally, it models the relationships between these various health-system components functionally, in terms of a “results chain” (Figure 3) that shows how inputs to the health system (e.g. financing, infrastructure, human talent) are reflected in its key outputs (e.g. availability and utilization of goods and services), which in turn translate into important intermediate outcomes (e.g. adequate coverage of key interventions) and to a final impact (i.e. improvements in level and distribution of health). Organization and governance as well as health information are cross-cutting components, in the sense that they provide the basis for decision-making and regulation across the entire health system. The financing, health workforce, and essential medicine components cover key inputs to the health system, while the service delivery component covers the immediate outputs and intermediate outcomes of the health system. The six building blocks and their respective contributions to the results chain are discussed in greater detail in section 4.

Figure 3.
Wedding this analytical framework to a human rights-based approach (HRBA) to health provides a way to ground the standards against which the prison health system’s performance in the Colombian and international legal frameworks for human rights. This study uses the understanding of a (HRBA) adopted by WHO and the Office of the High Commissioner for Human Rights (OHCHR), which aims to realize the right to the highest attainable standard of health (or “right to health”) and other health-related rights (WHO & OHCHR, 2003). This right to health is enshrined in the International Covenant of Economic, Social, and Cultural Rights (ICESCR), and it is also recognized by the Colombian domestic legal system as a fundamental, justiciable right (CESCR, 2000). A HRBA to health is based on the following principles, which are key elements either of human rights in general or of the right to health in particular: progressive realization and non-retrogression; maximum available resources; availability, accessibility, acceptability and quality of facilities and services (AAAQ); participation, equality and non-discrimination; and accountability (Bustreo, Hunt, & Organization, 2013; Hunt, 2016; Alicia Ely Yamin, 2013a, 2013b). The performance of the prison health system shall thus be evaluated in terms of the extent to which it is compliant with these principles’ requirements, which are discussed in greater detail in the discussion section (i.e. section Error! Reference source not found.).

2. Methods

We examined changes in the organization and governance of the prison health system between 1998 – 2016, and analyzed the penitentiary-sector health system performance between 2010– 2016. The analysis relied on both primary and secondary research. The latter consisted in a documentary analysis of key legal instruments and policy documents, reports published by government and multilateral actors, and academic as well as press articles. Primary research relied on a mix-methods approach combining qualitative and quantitative methods (Creswell & Clark, 2007).
Qualitative data-collection occurred between December 2013 and January 2016, and involved two components: (i) Ethnographic observation during 208 person-hours of fieldwork in one of Colombia’s largest prisons, described below, and during 200+ hours of multi-stakeholder meetings convened by government as well as multilateral agencies involved in setting policy for the prison health system. (ii) Semi-structured interviews with a “snowball” sample of 37 key informants who were involved with the penitentiary system at different levels, including inmates, prison healthcare workers, prison custodial and administrative staff, and functionaries from a number of government agencies, multilateral institutions, NGO’s, civil society groups, and academia. Interviews were documented through contemporaneous note taking, and ethnographic observations were documented through field notes written at the end of each day of fieldwork. The resulting data was grouped iteratively by emerging themes and subthemes, and subsequently validated through triangulation with information from secondary sources (Pope, Ziebland, & Mays, 2000).

Quantitative primary research comprised a cross-sectional survey conducted between December 2013 and September 2014 among a probabilistic sample of inmates (n = 148) in an all-male, high-security, correctional facility located in Bogotá D.C. with an average prisoner population of >4,500. The study population consisted of all adult, male inmates detained in the correctional facility in Bogota who were not subject to special security measures. The prison census was used as the sampling frame. The required sample size was calculated assuming a binary variable with a 25% prevalence, a confidence of 95%, and standard error of 7%, which yielded a minimum sample size n = 147. To allow for non-response, 239 inmates were selected to be included in the sample using systematic sampling with equal probability of selection.

In total, 148 individuals agreed to participate in the survey and completed the survey, 33 declined, and 58 could not be reached either because they had already been released or because they had been transferred to a different prison. Per IRB requirements, no information
whatsoever was recorded about individuals who either could not be reached or declined to participate; these observations were treated as missing completely at random.

The proportion of individuals in the sample who were awaiting trial (45%) was lower compared to that in the population (55%); there were also some small differences in the age distribution of the sample compared to that of the population. To correct for these discrepancies, we used iterative proportional fitting to adjust the original sampling weights. Data were analyzed using the svy functions in STATA 14. Data-collection methods are described in section 4.6.

3. Background

Historically, the prison health system and the general health system were almost entirely independent from each other, with separate sources of financing, different governance structures, and disjoint healthcare delivery systems. Prior to 1993, the general health system was itself segmented into several vertically-integrated, parallel subsystems (OECD, 2015; Plaza, Barona, & Hearst, 2001; A E Yamin, Parra-Vera, & Med, n.d.), each of which served a different segment of the population. Private insurers and providers served the wealthy, various social security institutes covered different groups of workers, and public hospitals and clinics assisted the poor. Against this background, the independence of the prison health system from the rest of health system was unexceptional.

In 1993, the general health system underwent major reforms to create the Sistema General de Seguridad Social en Salud (SGSSS, or General System of Social Security in Health), which horizontally integrated the previously parallel subsystems into a single one to provide universal access to a two-tiered health benefits plan, called the Plan Obligatorio de Salud (POS, or Mandatory Health Plan). The upper tier of the POS, known as the contributory regime, covered those formally employed or who earned more than twice the minimum wage. Meanwhile, the lower tier, called the subsidized regime, covered the remainder of the population
and included approximately one-half of the benefits of the contributory regime. (The two tiers were eventually to be unified in 2016.)

The system was organized according to a model of “structured pluralism” (Londoño & Frenk, 1997), in which each of four basic health-system functions—financing, purchasing, delivery, and governance—would be performed by different institutions that together would serve the entire population, except prisoners. Financing came from a newly-created Social Security Fund, which would be responsible for collecting resources from various sources and pooling them into a single national pool. Responsibility for organizing and insuring the provision of services included in the POS was assigned to a mix of private and public managed care organizations (Empresas Promotoras de Salud — EPS), which acted as surrogate purchasers of healthcare on behalf of their enrollees. They would obtain their revenue through a system of capitated payments form the social security fund. The delivery of healthcare was assigned to service-providing institutions (Instituciones Prestadoras de Servicios — IPS), such as hospitals, clinics, an individual clinical practices, which could be either contracted or owned by the EPS; IPS were reimbursed primarily through fee-for-service. Governance was retained by the central government through various agencies such as the Ministry of Health and the Health Superintendence.

These reforms notwithstanding, the prison health system continued to exist as a parallel, vertically-integrated subsystem. Financing came entirely from general tax appropriations for INPEC. Responsibility for the management of the prison healthcare system was largely devolved to the directors of INPEC’s regional headquarters and the prison wardens who reported to them. Most health workers within the prison system were salaried employees of INPEC. Contracts with third-party service providers were limited to those for the delivery of extramural services and to a few, exceptional “carve-out” arrangements for the care of specific groups of patients, such as those with HIV, severe mental illness, or chronic renal failure.
Towards the end of the 1990’s the penitentiary system came under intense judicial scrutiny as a result of litigation involving violations of prisoners’ human rights caused by overcrowding, poor sanitation, and lack of adequate healthcare. The first major judicial interventions came in 1998 when the Constitutional Court handed down rulings T-153, T-606, and T-607 (M.P.: Eduardo Cifuentes, 1998; M.P.: José Gregorio Hernández, 1998). It was the first time the Court declared the existence of an “unconstitutional state of affairs” (USoA) within the country’s penitentiary system and ordered the “Institute of National Penitentiaries and Correctionals (INPEC) [along with various Ministries] … to initiate the administrative, budgetary, and contractual procedures to create a subsidized system of social security in health for prisoners… or to enroll this population in the General System of Social Security in Health” (M.P.: Eduardo Cifuentes, 1998, para. 53). (These rulings are discussed in greater detail in Annex 2).

4. Results

This section is divided into six parts, each of which covers one of the six health system components or “building blocks” (2010) mentioned in the analytical framework that we used for this study (Figures 2 and 3). Each subsection begins with a brief discussion of the building block it covers, followed by our study’s main findings for that component of the prison health system.

4.1. Organization and Governance of the Prison Health System

Organization and governance in a health system refers to the legal and policy frameworks, institutional arrangements, and organizational practices that determine how the health system’s priorities and objectives are set, and how the responsibilities and prerogatives of different stakeholders are established and enforced. Good governance involves setting specific goals and targets for the health system; determining which measures are most important to pursue if those goals are to be achieved; adopting a strategic plan of action; implementing it; monitoring and evaluating progress toward those goals and targets; and adjusting the plan or the goals and
in light of new evidence or arguments. Good governance also requires transparency and participation during all stages of the policy-making cycle just described, meaning that decisions at each stage must be made in consultation with, and with the participation of, all relevant stakeholders, including governmental entities, private sector partners, civil society, and the populations who stand to be affected. Transparency means that the reasons and rationales on which decisions are based must be publicly available. Responsibility and accountability for the health system’s organization and governance rests primarily on government officials: legislators, bureaucrats, and other governmental decisions-makers must publicly show that decision about the health are made with the participation of relevant stakeholders and after careful consideration of the best available evidence regarding the epidemiological, social, economic, cultural, and legal features of the local situation and of how different measures will help achieve the rights that impact on health.

Major changes to the organization and governance of the prison health system were first introduced in response to the Court’s injunctions in rulings T-153, T-606 and T-607 of 1998. In an effort to comply with these rulings, INPEC opened a public tendering process for EPSs to insure prisoners’ healthcare, but none came forward so INPEC had to continue acting as the guarantor of prisoners’ healthcare. However, between approximately 2001 and 2008, it began outsourcing the delivery of healthcare to private service-providing institutions (SPIs) contracted from the general health system.

The nature and scope of the contracts awarded to different SPIs varied substantially. For instance, one SPI might be awarded a contract for the provision of “low to medium complexity services to all female prisoners in the country”, whereas another might be contracted to provide only “extramural services to prisoners in Bogotá D.C.” (Defensoría Delegada para la Política Criminal y Penitenciaria, 2005). Such variability notwithstanding, virtually all of the healthcare-related contracts awarded by INPEC during this period had several key features in common. First, budgets were allocated prospectively to the SPIs, which had control over the resources
once they were disbursed. This meant that INPEC had limited capacity to monitor how resources were spent once they had been disbursed to the ISPs. In fact, funds were often disbursed to SPIs without an auditor or inspector having been designated (Contraloría General de la República, 2000).

Second, most of the contracts involved short periods of performance — typically between six and nine months (Defensoría Delegada para la Política Criminal y Penitenciaria, 2005). Renewing contracts thus became a considerable burden for INPEC, especially since public-procurement laws almost always required that this be done using a laborious public tendering process. INPEC struggled to keep up with this task, which led to frequent interruptions in the provision of healthcare in many prisons (Contraloría Delegada para el Sector Defensa, Justicia y Seguridad. Dirección de Estudios Sectoriales, n.d.; Contraloría General de la República, 2000; Defensoría Delegada para la Política Criminal y Penitenciaria, 2003, 2005; Procuraduría Delegada para la Prevención en Materia de Derechos Humanos y Asuntos Étnicos. Grupo de Asuntos Penitenciarios y Carcelarios, 2004). Irregularities in the procurement process were also common. For instance, in 2003 the Comptroller General found that four contracts involving sizable resource allocations had been awarded to proposals whose budgets, “appeared to stay within the required limits only because they contained arithmetic errors that deflated the projected expenses” (Contraloría General de la República, 2003, p. 124). It also found that INPEC often renewed contracts with the same SPIs without having first obtained reports on the completion of their previous assignment.

Lastly, the SPIs typically assumed little or no financial risk because their contracts typically included clauses specifying that their obligations to provide services were limited to the agreed upon period of performance, “or until the allotted funds are exhausted” (Defensoría Delegada para la Política Criminal y Penitenciaria, 2005, p. 36). Unfortunately, many SPIs indeed exhausted their budgets weeks or even months too early and INPEC often failed to renew such contracts in a timely manner, which led to further interruptions in the provision of
healthcare. As Libardo Ariza and Manuel Iturralde discuss elsewhere in this volume, these problems prompted further litigation, which led the Constitutional Court to reiterate on several occasions that an unconstitutional state of affairs continued to exist and to insist on comprehensive reform.

Such reform would be introduced in 2007 with the enactment of Law 1122, which contained a single clause regarding prisoners’ healthcare: namely, Article 14 paragraph m, which read, “The country’s prisoner population shall be enrolled in the General Social Security System for Health. The National Government shall determine the mechanisms needed to ensure this population receives its services” (Congreso de la República de Colombia, 2007, sec. 14m).

In other words, the law established that the responsibility for all aspects of prisoners’ healthcare should be transferred to the general health system. However, it did not specify how this might be accomplished nor what INPEC’s role should be going forward. The rest of the law dealt with various changes to the SGSSS (i.e. the general health system), none of which had a clear connection to the provision regarding prisoners’ healthcare. Moreover, neither the law itself nor the records of legislative proceedings contain any mention of the underlying rationale for the change to the prison health system nor about its foreseeable effects. In fact, congressional records show that this two-sentence provision was added to the law at the last minute, without documented justification or discussion, while the bill was in the final stage of legislative approval.

Implementing Article 14 paragraph m proved challenging. One policymaker who worked at the Ministry of Health at the time, whom we interviewed in 2013, described it as follows,

We were suddenly required by this law to solve a variety of problems in the prison health system using a set of policy instruments that had originally been designed to address a rather different set of issues specific to the general health system. The politics of implementation were also very difficult, since none of the EPS in the country was eager to insure this population — but we had to find a way to get them to do so because that’s just what enrolling the prisoner
population in the General Social Security System for Health means and that is what the law required.

It would take the National Government nearly two years to issue the first set of rules and regulations to implement this change (Ministerio del Interior y de Justicia, 2009). Nevertheless, the strategy that was set forth had several important flaws: First, it established that the prisoner population was to be enrolled in the subsidized regime of the SGSSS through a “publicly-owned EPS with nationwide operations” (Ministerio del Interior y de Justicia, 2009, sec. 2). In other words, responsibility for the management of prisoners' healthcare — along with the associated financial risk — was to be transferred from INPEC to a regular managed care organization from the general health system. However, only one EPS met the criteria quoted above: namely CAPRECOM, which unfortunately was already experiencing financially difficulties at the time and had a poor performance record compared to other managed care organizations in the subsidized regime (Grupo tutelas - Instituto Nacional Penitenciario y Carcelario, n.d.).

Second, the boundaries of INPEC’s and CAPRECOM’s respective purview and obligations were not clearly defined, which caused coordination problems and a dilution of accountability. For instance, access to extramural care was hampered by coordination problems between the two agencies; there were often disagreements about who was responsible for certain public health measures and for the upkeep of equipment and infrastructure at intramural healthcare facilities; administrative irregularities proliferated because effective audit mechanisms were not put in place; to name a few. Moreover, the new regulations left in place various carve-out arrangements for specific groups of patients, which added to the complexity of the system and made coordination and accountability even more difficult.

Lastly, it was established that financing for prisoners' healthcare would continue to come out of INPEC’s budget, but this problematic. By April of 2010 — less than a year after CAPRECOM began enrolling prisoners — its Director formally announced that expenses
stemming from this populations' healthcare was nearly twice the revenue that agency had received in exchange. He thus concluded that it was “not financially viable” for CAPRECOM to continue insuring this population (Tavera Méndez & E.P.S. Caprecom, 2010). The negotiations between INPEC and CAPRECOM to renew the terms of the agreement were fraught, however, by disagreements over the number of prisoners that CAPRECOM would be responsible for: whereas CAPRECOM claimed that it was providing healthcare to almost 73,000 prisoners, INPEC claimed that this figure was wrong and that the number of prisoners that CAPRECOM was responsible for did not exceed 52,000 (Contraloría General de la República, 2010).

The performance of the prison health system deteriorated after it was transferred to CAPRECOM, according to several regulatory agencies (Contraloría General de la República, 2010, 2014; Defensoría Delegada para la Política Criminal y Penitenciaria, 2010). Thus, as early as 2010, the government issued new regulations to try to correct the problems described in the previous paragraph. Additional guidelines were set forth to improve interagency coordination. The responsibility for financing prisoners’ healthcare was assigned to the social security fund and a clear mechanism was established for determining how many inmates should be insured by CAPRECOM at any given time (Presidencia de la República, 2010). Later, in 2012, the restrictions that prevented prisoners from being enrolled in any EPS other than CAPRECOM were eliminated (Presidencia de la República, 2012) and funding for prisoners’ healthcare was increased through adjustment to the capitation rate.

These efforts at improvement were largely unsuccessful. In 2012, riots erupted in several prisons, which INPEC attributed to the lack of access to adequate healthcare (Instituto Nacional Penitenciario y Carcelario, 2012a, 2012b). The agency temporarily resumed delivering healthcare services using its own personnel as part of an emergency response. This responsibility would soon be returned to CAPRECOM, however, since none of the other EPS in the country was willing to take its place as the primary health insurer of the prisoner population.
During those years, a variety of external forces were also acting on the prison health system, whose effects were mostly negative. On one hand, between 2007 and 2014, the country’s prisoner population nearly doubled in size — from 62,000 to 117,000 — without a proportional expansion of total prison capacity. This translated into a threefold increase in the rate of overcrowding (Figure 1), which in turn had negative effects on health in prisons and made healthcare delivery more challenging, as documented in numerous documents prepared by CAPRECOM, INPEC, the Ministry of Health, the Constitutional Court, and various other oversight agencies (Contraloría General de la República, 2010, 2011, 2013; Defensoría Delegada para la Política Criminal y Penitenciaria, 2010, 2011; Defensoría Delegada para la Política Criminal y Penitenciaria. Defensoría del Pueblo, 2016a; Tavera Méndez & E.P.S. Caprecom, 2010).

On the other hand, far-reaching reforms were introduced both to the general health system (Congreso de la República de Colombia, 2011, p. 143) and to the penitentiary system as a whole (Presidencia de la República, 2011). The penitentiary system was restructured in 2011 and a new agency, the Special Unit for Penitentiary and Carceral Services (SUPCS), was created to replace INPEC in the performance of all tasks other than those strictly related to custody and surveillance (Presidencia de la República, 2011). This meant that SUPCS would be responsible for the prison health system’s governance while CAPRECOM would continue to play the role of insurer and surrogate purchaser of prisoners’ healthcare. Meanwhile, INPEC’s responsibilities were reduced to providing ancillary support, such as providing transportation and custody for prisoners with referrals for extramural care.

The goal of this reform was to improve efficiency and transparency in the administration of the prison system. However, the addition of yet another actor (i.e. SUPCS) to the prison health system’s institutional arrangement further exacerbated the problems of coordination and accountability described earlier (Contraloría General de la República, 2014; Defensoría Delegada para la Política Criminal y Penitenciaria. Defensoría del Pueblo, 2016b; Observatorio
de Justicia Constitucional - Defensoría del Pueblo, 2012). Moreover, the ability of SUPCS to generate improvements was hampered from the outset, however, by a lack of stable leadership (the agency had four different General Directors within its first fifteen months, and three more over the next two years) and by insufficient human resources to handle the diversity of tasks assigned to it.

By May of 2013, the Minister of Justice and Law had declared a state of emergency within the penitentiary system citing problems caused by excessive overcrowding as well as deficiencies in the provision of healthcare (Ministerio de Justicia y del Derecho, 2013). This made additional funds available to UPEC and INPEC and allowed them to temporarily bypass CAPRECOM and directly contract third-party providers to deliver certain services in prisons. The declaration of a state of emergency also put pressure on Congress to craft new legislation aimed at creating a structural solution to the problems in the prison health system.

By January 2014, a bill introducing several major changes to the prison health system had been signed into law (Congreso de la República de Colombia, 2014). The new legislation established that the prison health system would once again be financed using general tax revenue instead of relying on the social security fund, and it created a National Prisoner Health Fund (NPHF) to replace CAPRECOM as the main insurer and surrogate purchaser of healthcare for prisoners. It also ordered the Ministry of Health (MOH) and the UPEC to jointly design a healthcare delivery model specific to prison settings.

The law stated that these changes should be implemented “gradually and progressively”, but it did not set forth a specific timeline. In the end, it would take the government fully 23 months after the new legislation had been enacted, until November 2015, to issue the guidelines and regulations for the creation of the creation of the NPHF and to publish the special healthcare delivery model (Presidencia de la República, 2015). CAPRECOM would thus continue to be responsible for healthcare in prisons through December of 2015. During this period, the Office of the Inspector General and that of the Ombudsman issued warnings to the
government about the “crisis in the prison system” and called for the government to once again declare a state of emergency within the penitentiary system (which went unheeded). Moreover, in 2015 the Constitutional Court handed down two separate rulings in which it reiterated that disarray of the prison health system, among other things, constituted an USoA (Corte Constitucional, 2013, 2015). That same year, INPEC’s custodial staff launched a general strike that lasted several months to protest the working conditions that resulted from the government’s failure to address the humanitarian crisis the prison system. Inmates in twenty-two prisons also launched hunger strikes to protest insalubrious living conditions and lack of healthcare and (Contraloría General de la República, 2016).

When the government finally implemented the policies consigned in Law 1709 of 2013, the changes were not introduced gradually and progressively. Just thirty-three days elapsed between the date the government issued the decree with the overarching guidance and regulations for the creation of the NFPH and the date CAPRECOM entered liquidation. The NPHF was not ready to start performing all of the functions assigned to it within such a short period of time, which lead to a near-total stoppage in the provision of healthcare in almost two thirds of the country’s prisons that lasted for over six months (Tiempo, 2015b, 2015a). This prompted the Ministry of Justice to declare a state of emergency in May of 2016, which was still in effect by the end of the study period.

4.2. Health information system

Health information is a cross-cutting health-system component. In the words of the WHO (2010, p. 44): “Sound and reliable information is the foundation of decision-making across all health system building blocks. It is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery and financing.” A health information system must perform three major functions: data generation and compilation, analysis and synthesis, and
communication and dissemination. This section presents our main findings with respect to how well the prison health information system performs these functions.

Accurate, up-to-date information about health and healthcare in the Colombian penitentiary system is all but nonexistent. We begin with two examples that illustrate the kinds of problems that affected even the most basic types of information, such as demographic data and death statistics. We then characterize various limitations in the way data is generated, analyzed, and communicated, that may explain the scarcity of high-quality data.

In 2014, the MoH’s Department of Health Insurance Benefits, Costs, and Tariffs carried out an analysis to update the risk adjusters used to determine the capitation rate that EPSs should be paid per prisoner (Ministerio de Salud y Protección Social, 2014). As part of this analysis, they obtained the monthly census for all prisons in the country from INPEC, which they used to calculate the size of and amount of turnover in the prisoner population between January and December of 2013. According to the analysis, a total of approximately 41,500 individuals entered the population during those twelve months, and roughly 44,000 exited; this implies the prisoner population shrank by around 2,500 individuals. However, the analysis also reports that the total number of prisoners in the country changed from roughly 133,000 in January to approximately 153,000 in December — but this implies that, instead of shrinking, the population grew by nearly 20,000 people. Furthermore, these figures differ from those reported by another branch within the MoH — namely, the Department of Epidemiology and Demography, which also used data provided by the Ministry of Justice and — and from the statistics that are published on INPEC’s official website (Dirección de epidemiología y demografía. Ministerio de Salud y Protección Social, 2013; “Instituto Nacional Penitenciario y Carcelario - INPEC,” n.d.).

Several government officials whom we interviewed for this study explained that these sorts of discrepancies arise because the prison system’s databases are not regularly updated by the prison staff-members and other ground-level functionaries in the criminal justice system who are tasked with entering the information about releases, admissions, and the daily census.
This claim is corroborated by a report published by the Ombudsperson for Human Rights in 2010, which concluded that fewer than half of all prisons generated reports on new admission and releases on a daily basis (Defensoría Delegada para la Política Criminal y Penitenciaria, 2010).

Our second example concerns the mortality data for the prisoner population: According to the official national coronial records, in 2015 there were 15 homicides in this population; however, in a response to a right-to-information request that we filed as part of this study, INPEC reported 81 homicides during the same period. Similarly, while the coronial records indicate that there had been 11 suicides, INPEC reported 20. Problems in the quality of mortality data are not limited to those related to deaths from violent causes: For example, all of the deaths from 2014 that appear in UPECS’s database — which was also obtained through a right-to-information request — are registered as having occurred before July, but such a pattern is highly implausible. Under-recording during the second half of the year is a more likely explanation. Furthermore, the database does not contain information on the age or sex of the deceased — and when a cause of death is listed (it was often omitted as well), it is not reported using a standardized classification system such as the ICD-10, but in terms of seemingly \textit{ad hoc} (and at times nonsensical) nosological descriptions, including “depression”, “P.O. inguinal herniorrhaphy”, and “thermal trauma due to direct exposure to open flame compromising 82\% of total body area, FIRE”. Meanwhile, death statistics for the prisoner population are entirely absent from the Ministry of Health’s databases.

Reliable data on morbidity, health services, medical supplies, health workforce, or financing are similarly scarce. The remainder of this section is devoted to analyzing various limitations in the way data is generated, analyzed, and communicated that contribute to this problem. Generally speaking, such data can be obtained from either primary sources (e.g. population health surveys, healthcare facility assessments, etc.) or administrative ones (e.g. clinical and administrative registries, public health surveillance systems, financial tracking
The Colombian prison health system has virtually no sources of primary data, and existing administrative data-sources are deficient to the point of being practically useless. We take up each in turn.

**Primary data-sources:** A representative health survey of the prisoner population has never been conducted, so all the existing information on health outcomes for this population comes from administrative data sources, which we discuss in the next paragraph. Healthcare facility assessments have been carried on multiple occasions since 1998 by the Inspector General, the Comptroller General, and the Ombudsman for Human Rights (Comité Internacional de la Cruz Roja & Ministerio de Justicia y del Derecho, 2014; Defensoría Delegada para la Política Criminal y Penitenciaria, 2003, 2005, 2010; Defensoría Delegada para la Política Criminal y Penitenciaria. Defensoría del Pueblo, 2016b; Observatorio de Justicia Constitucional - Defensoría del Pueblo, 2012). However, the goal of these assessments was to monitor compliance with regulatory and human-rights requirements, so they were not designed to generate the kind of data need to evaluate the health system’s performance. From the perspective of healthcare-delivery science, these assessments all suffered from serious methodological shortcomings, such as nonrandom sampling, inappropriate handling of missing data, and the use of non-standard data collection techniques. These limitations make their findings difficult to interpret and preclude drawing comparisons between the results of different assessments. As a result, these assessments provide only qualitative information about the overall function of healthcare delivery in the prison system, but they are not useful for measuring how its various inputs, outputs, and outcomes may have changed over time.

**Administrative data-sources:** There are several problems with existing administrative data-sources within the prison health system as a result of widespread deficiencies and substantial disparities in the availability, accessibility, and quality of health services in the prison system. Generally speaking, administrative data is generated through the routine provision of goods and services; therefore, any disparities in utilization of healthcare services between
different groups of prisoners could cause the resulting administrative data to contain biases. The magnitude such biases, if they are indeed present, will tend to be larger if only a small segment of the population accounts for most of the total healthcare utilization. Finally, problems with the quality of healthcare services can be a source of measurement error and of potential biases. These problems are all present in the Colombian prison health system.

First, only a small minority of inmates or have access to or utilize healthcare services (see section 4.6), so it is likely that diverse health needs in the population go unrecorded. To get a sense of this, consider the effect that the most recent declaration of a state of emergency had on the number of recorded cases of both communicable diseases like HIV and tuberculosis (TB), as well as noncommunicable ones like cancer and chronic renal failure (Table 1). Within a four-month period, 36 “massive health brigades” were carried out in many prisons around the country. On average, the number of detected cases of these diseases was 20% higher at the end of these four months, even while the total number of prisoners in the country decreased by 1% during that time. It is implausible that this reflects a real change in the incidence of these diseases; a more likely explanation is that it was an artifact of improved detection rates due as a result of greater healthcare utilization generated by the massive healthcare brigades.

Table 1.

<table>
<thead>
<tr>
<th></th>
<th>HIV</th>
<th>TB</th>
<th>Cancer</th>
<th>CRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>611 (50)</td>
<td>251 (21)</td>
<td>89 (7)</td>
<td>47 (4)</td>
</tr>
<tr>
<td>After</td>
<td>653 (54)</td>
<td>279 (23)</td>
<td>116 (10)</td>
<td>60 (5)</td>
</tr>
</tbody>
</table>

Number of detected cases (and rate per 10,000 inmates) of HIV, tuberculosis (TB), cancer, and chronic renal failure (CRF), before and after a state of emergency was declared and 135 massive health brigades were conducted

Second, it is a well-documented fact in Colombia that wealthy, politically-connected prisoners live in better conditions and have better access to healthcare compared to those with lower socioeconomic status or who belong to racial or ethnic minorities (Ariza, 2011). It is likely
that these disparities also correlate with differences in their respective health needs, which would introduce biases into the prison health system’s administrative datasets. Moreover, some disparities are the product of policies and practices that may only exist in some prisons in the country, which makes them difficult to anticipate.

For instance, during our fieldwork in one of the largest prisons in the country, we observed an explicit practice whereby only two individuals from each of the ten main cellblocks would be allowed to visit the prison emergency room per day, even though the total number of inmates in each pavilion ranged from 23 to 1126 inmates. This means that while some pavilions were allotted approximately one emergency room visit for every 12 individuals, others were allowed just one visit for every 563 detainees. Moreover, there were systematic differences both in the characteristics of the prisoners that were detained in each pavilion, and in the living conditions that they faced. For instance, while the overcrowding rate for the prison as a whole was approximately 180% (overcrowding rate = number of prisoners / prison capacity x 100), some pavilions had overcrowding rates that were close to 300%, such as those reserved for sex offenders and those for nonviolent first-time offenders. By contrast, the rate of overcrowding in some pavilions was below 100% (i.e. they were not being fully occupied), such as those reserved for foreigners and for “high-profile” inmates (the term in Spanish was internos de “alto perfil”, a euphemism for inmates who receive special treatment). In other words, the less affluent inmates were exposed to worse living conditions and had less access to emergency care. It is therefore likely that any estimates of the burden of disease in this prison that depend on data generated through the provision of emergency care will contain biases.

Lastly, the administrative records from the prison health system are plagued by errors and omissions that are introduced at the point of data generation, analysis, or reporting. For instance, several of the prison health workers that we interviewed mentioned that one of the consequences of the frequent personnel shortages (see section 4.4) is that healthcare providers sometimes became so pressed for time that they would skip recording information about their
patients’ clinical history or about what goods and services were provided, unless it was required for billing purposes.

Many of the internal reports and policy documents analyzed contained obvious errors that were probably introduced at the stage of data analysis or reporting. For instance, according to CAPRECOM’s 2011 official report on the epidemiological profile of the prisoner population, the 5th and 17th most frequent diagnoses among inmates seen by the intramural primary healthcare service at the correctional facility Bellavista, in Medellin — which had a population of more than 7,000 males and zero females — were vaginitis and diabetes during pregnancy, respectively (E.P.S. Caprecom, 2011).

### 4.3. Financing, resource allocation, and provider payment schemes

According to WHO (2010, p. 73), “health financing refers to the function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system… the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care.” Financing is thus a fundamental input to any health system. Furthermore, it is possible to describe a health system in terms of the flow of resources through the health system, which means that tracking this flow is an important element in a robust health-system monitoring and evaluation strategy.

The financing system of the Colombian prison health system changed for the first time in 2004, from a general-tax financed system in which yearly appropriations for prisoners’ healthcare were transferred to and administered by INPEC to a mixed system in which supplemental financing was provided to INPEC by the Social Security Fund through a system of capitated subsidies. The overall effect of this change is not clear, however, since the additional funding was calculated so as to defray a portion of the expected cost of a relatively narrow set
of services: namely, “extramural services and treatments for high-cost diseases, obstetric and gynecological care, trauma and orthopedic care, and pediatric care for children less than a year old” (Ministerio de Protección Social & Consejo Nacional de Seguridad Social en Salud, 2004). Additionally, inmates were only eligible for these subsidies after six months of incarceration, which further dampened the impact of this new policy. Moreover, there were often disagreements between the various stakeholders in this arrangement because the information needed to determine which inmates met this requirement was sometimes unavailable, as described in section 4.2.

Additional changes were introduced in 2010 with the implementation of Law 1122/’07, which specified that prisoners were to be enrolled in the subsidized regime of the General System for Social Security in Health. This meant that almost all of the financing for prisoners’ healthcare would now come from Social Security Fund, in the form of capitated payments made directly to CAPRECOM. Initially, the capitation rate for prisoners was roughly equal to that for non-prisoners in the subsidized regime, but it was approximately doubled in 2012 to reflect the additional insurance risk posed by prisoners.

Virtually all of these changes were reverted in 2016 with creation of the National Fund for Prisoners’ Health, which is currently responsible for organizing and insuring the provision of healthcare to the prisoner population. Its financing comes entirely from general tax revenue.

The only source of detailed financial information about the prison health system that is publicly available are the audit reports that have been released by the Comptroller General, which are limited to fiscal years 2010 and onwards (Contraloría General de la República, 2010, 2011, 2012, 2013, 2014, 2015, 2016). Three findings from these reports are especially noteworthy. First, between January 2011 and July 2014, a total of approximately $95 million USD were allocated to healthcare provision (keeping prices and the dollar to peso exchange rate constant at their 2013 levels); meanwhile, total expenditure on prisoners’ healthcare was
approximately $125 million US dollars (Table 1). In other words, expenditures exceeded revenue by as much as 30%. Most of these losses were absorbed by CAPRECOM.

Second, intramural primary medical and dental services accounted for the majority of total expenditure (approximately 51%), whereas extramural services — which includes all hospitalizations as well as many outpatient services — represented less than 35% of total spending. This contrasts sharply with spending patterns in the general health system, where hospital spending is typically greater than spending on primary care. We return to this point in section 4.6.

Turning to the last finding that we wish to highlight from the Comptroller General’s audit reports, between 2001 and 2011 the government allocated approximately $550 million USD to infrastructure projects that were meant to expand the total capacity of the penitentiary system by approximately 22,500 spaces (Consejo Nacional de Política Económica y Social & Departamento Nacional de Planeación, 2015). It was initially projected that they would cost up to $230 million USD and that they would be completed by 2004. However, in 2002 the projects were less than 25% complete and most of the budget had already been exhausted. Deadlines were extended and additional resources were allocated to these efforts in 2004, 2006, and 2009.

Although the primary rationale for these efforts had been to reduce prison overcrowding — which was below 110% when the projects were first conceived in 1995 — by the time the last infrastructure project was finished in 2011 the rate of overcrowding had risen to over 150%. The government nevertheless allocated another $400 million USD to new infrastructure projects in 2014, which are projected to be completed by 2018 (Contraloría General de la República, 2016, p. 36ff).

In other words, between 2002 and 2018, the government will have allocated nearly one billion dollars to infrastructure projects. This translates to roughly $60 million USD per year, on average, which is nearly twice as much as the average yearly expenditure on prisoners’
healthcare between 2011 and 2014. This contrast is noteworthy since virtually all commentators on the prison health system cite insufficient funding as a key driver of its shortcomings.

4.4. Health Workforce

A competent health workforce is a key input component of health systems, since the ability of a health system to meet its goals and targets depends largely on the knowledge, skills, motivation and deployment of the people responsible for orchestrating and delivering health services. WHO (2010, p. 24) defines the health workforce as, “all people engaged in actions whose primary intent is to enhance health.” This includes clinical staff (i.e. staff for general medicine, psychiatry, obstetrics and gynecology, other medical specialties, nursing, pharmacy, dentistry, psychology, and social work) as well as support staff (i.e. laboratory technician, pharmacy technician, radiology technician, administrative support personnel).

Quantitative data that could be used to measure the composition, density, or distribution of the health workforce in the prison system does not exist: an official registry of prison health workers has never been created, a health workforce survey has never been conducted, and potential sources of administrative data, such as audits, accounting data, or managerial records, either have not been consistently maintained or are not publicly accessible. For instance, most of the information from 2010-2015 appears to have been lost when CAPRECOM was liquidated.

The only sources of reliable information on this topic are reports from healthcare-facility assessments performed by various national and international oversight agencies during official inspections of the prison system. All currently operational prisons were inspected by at least one of these agencies since 1998, and several prisons (especially those with relatively large populations) were inspected by all of the agencies at different times.

As described in section 4.2, these assessments did not employ quantitative methods. Rather, they relied on qualitative methods that included desk reviews of official records and internal documents not publicly accessible, direct observation of prison conditions, and
structured or semi-structured interviews with inmates, health workers, guards, and the Warden at each prison. Several rulings handed down by the Constitutional Court during this period also contain evidence relevant to an analysis of the health workforce in prisons.

Taken as a whole, this body of evidence unambiguously shows that health-worker shortages have been a persistent problem in the prison health system throughout the past twenty years, despite the successive reforms described in section 4.1. This includes the period from 1998 to 2010, when INPEC began outsourcing the delivery of prisoners’ healthcare to service providers (IPS) from the general health system; the period the period between 2010 and 2016, when CAPRECOM was responsible for organizing the delivery of healthcare to prisoners (Comité Internacional de la Cruz Roja & Ministerio de Justicia y del Derecho, 2014, 2014; Contraloría General de la República, 2010, 2012, 2015, 2016); and that from 2016 to the time of this writing, after CAPRECOM was liquidated and replaced with the NFPH (Defensoría Delegada para la Política Criminal y Penitenciaria. Defensoría del Pueblo, 2016b, 2016a; Procuraduría General de la Nación, Presidencia de la República, & Defensoría del Pueblo, 2016).

Specifically, in 2003 the Ombudsperson for Human Rights evaluated the intramural healthcare facilities at 57 prisons (at the time, there were 186 operational prisons in the country) and found that approximately one in four did not have at least one general physician on staff during regular hours, one in three did not have at least one pharmacist on staff, and more than half did not have medical specialists available for consultations on a regular basis. The agency repeated the exercise in 2005, 2010, 2014 and 2016, and found similar results: significant health-worker shortages were present in most of the prisons that were inspected. Similarly, the Comptroller General carried out general audits of prison health system in 2008, 2010, 2012, 2014, and 2016, all of which involved desk-reviews of administrative data from all prisons in the country as well as follow-up visits to a handful of prisons. In each case, they found that only a small minority of prisons had maintained a full complement of health workers during most of the
year, and that most prisons had experienced worker shortages of more than one-half of their personnel allotment of health workers during three or more months.

Other entities have arrived at similar findings, including the Inspector General (Procuraduría Delegada para la Prevención en Materia de Derechos Humanos y Asuntos Étnicos. Grupo de Asuntos Penitenciarios y Carcelarios, 2004; Procuraduría General de la Nación et al., 2016), the UN High Commissioner for Human Rights, the International Committee of the Red Cross (Comité Internacional de la Cruz Roja & Ministerio de Justicia y del Derecho, 2014; “Crisis humanitaria en las cárceles de Colombia es insostenible | Comité Internacional de la Cruz Roja,” n.d.), and a Special Committee appointed by the Constitutional Court to monitor compliance with ruling T-762 of 2015 (Procuraduría General de la Nación et al., 2016). The report by this Special Committee for 2016 found a 25% overall shortage of health workers in the prison system. Moreover, it found that approximately one in six prisons did not have at least one general physician on staff at their intramural healthcare facilities during regular hours, and that the lack of sufficient personnel was seriously compromising the delivery of healthcare services to more than one half of the prison population in the country (Procuraduría General de la Nación et al., 2016, pp. 28–31).

4.5. Medicines and Supplies

Access to essential medical products and technologies is one of the immediate outputs of health systems. This health system component is closely intertwined with at least three other building blocks: good organization/governance and adequate financing (discussed in sections 4.1. and 4.3.) are necessary conditions to ensure equitable access to essential medical products and technologies, which in turn is a key determinant of the acceptability and quality of health services (discussed in section 4.6.) Our analysis focused on access to essential medicines in particular. According to WHO (Forte, n.d.): “Essential medicines are those that satisfy the priority health care needs of the population. Essential medicines are intended to be
available within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage, with assured quality, and at a price that individuals and the community can afford.”

Prisoners in Colombia have had extremely limited access to medicines — including essential ones — throughout the past twenty years. This is partly attributable to a lack of adequate access to healthcare services in general. Many inmates whom we interviewed reported having discontinued drug treatments when they were incarcerated because they had not been able to access a healthcare provider to renew their prescriptions in a timely manner. It is also partly due to problems in the supply of medicines in prisons. Frequent shortages of essential medicines at intramural healthcare facilities have been described in numerous reports since 1998.

We documented this problem during our fieldwork at one of Colombia’s largest prisons: On six different occasions between December 2013 and January 2016, we measured the availability at the intramural pharmacy of the ten drugs listed in Box 1. The list is a subset of the core list of medications which the WHO recommends including in all facility-based surveys of medicine availability (2010, Chapter 4).

Box 1.

<table>
<thead>
<tr>
<th>Cardiovascular disease</th>
<th>Mental health</th>
<th>Pain/inflammation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atenolol</td>
<td>Amitriptyline</td>
<td>Diclofenac</td>
</tr>
<tr>
<td>Captopril</td>
<td>Diazepam</td>
<td>Paracetamol</td>
</tr>
<tr>
<td>Simvastatin</td>
<td>Infectious disease</td>
<td>Ulcer</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Ciprofloxacin</td>
<td>Omeprazole</td>
</tr>
<tr>
<td>Glibenclamide</td>
<td>Amoxicillin</td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td>Ceftriaxone</td>
<td>Salbutamol</td>
</tr>
</tbody>
</table>

On all six occasions, more than one half of the medicines were not in stock at the intramural pharmacy, and on four occasions the two anti-inflammatory medicines were the only
medicines in stock. Moreover, on three occasions, the pharmacist reported that they had been out of stock of the other medicines for over three months. (On the other three occasions, we were unable to obtain information about the shortages’ duration because pharmacist had quit and none of the other health workers knew). Other agencies have reported similar drug shortages at other prisons.

There is less information available about the accessibility of medicines that prisons pharmacies are not required to keep in stock. However, in 2012 the Ombudsperson for Human Rights performed an analysis of tutelas (judicial protection writs) filed by prisoners and found that the most frequent types of cases were those involving requests for medications that had been prescribed by a physician and which were included in the benefits package covered by the subsidized regime, but which nevertheless had not been provided to the inmate.

Finally, the transition after the NFPH replaced CAPRECOM in 2016 appears to have had a negative effect on the accessibility of high-cost medications, which had previously been the objects of carve-out arrangements. Both the Comptroller General and the Ombudsperson for Human Rights have shown that many inmates who had been taking medications on a regular basis for chronic conditions — including nearly two hundred inmates living with HIV— experienced interruptions in their treatments lasting up to six months. They attributed these issues to problems in how the transition from CAPRECOM to the NFPH was handled.

4.6. Health Service Delivery

Ensuring availability of health services that are of good quality standard and securing access to them are key functions of a health system. Health service delivery is an immediate output of the inputs into the health system, such as financing and the health workforce. A key element of the right to health is the requirement that health facilities and services be available, accessible, acceptable, and of good quality (AAAQ). This study uses the definitions of these criteria adopted by the Committee on Economic, Social, and Cultural Rights (CESCR) in its
General Comment No. 14 (CESCR, 2000): Availability refers to the existence of sufficient quantities of functioning public health and healthcare facilities, goods and services, as well as programmes, including the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs. Accessibility refers to the ability of all persons, and especially of the most vulnerable or marginalized people, to access appropriate services to meet their needs in a timely manner, without undue legal, physical, economic, or informational barriers, and without discrimination on any of the internationally prohibited grounds, such as race, color, sex, language, religion, political views, etc. Acceptability is the extent to which goods and services are respectful of medical ethics of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. Quality is the extent to which goods and services are scientifically and medically appropriate and compliant with professional standards of care.

Improvements along the dimensions of AAAQ should translate to increased utilization of health services among health system’s beneficiary population, which is a necessary condition for progress towards important intermediate outcomes, such as improvements in health service coverage. (In the context of health service delivery, WHO (2010, p. 16) defines coverage as “coverage the proportion of people requiring a specific service or intervention that actually receive it.”). In turn, improvements in the level and distribution of health service utilization and coverage should translate into improvements in the level and distribution of health among the population.

There is no information available on the amounts or types of healthcare services that were delivered to the prisoner population prior to 2010, that is, before CAPRECOM started
managing the prison health system. Unfortunately, the information that is from 2010 onwards also has important limitations. For instance, Table 2 summarizes the figures reported by the Ministry of Health and the Comptroller General regarding healthcare utilization among the prisoner population during 2012 and 2013. Both agencies used the same administrative datasets. In addition to the discrepancies between the figures reported by the two agencies, the report by the Comptroller General also states, “that the number of claims filed by CAPRECOM is greater than the number of services that were actually delivered” (Contraloría General de la República, 2014). These problems make the results of these analyses difficult to interpret.

Table 2.

<table>
<thead>
<tr>
<th></th>
<th>Individuals seen</th>
<th>Services delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Ministry of Health*</td>
<td>3,754</td>
<td>79,427</td>
</tr>
<tr>
<td>Comptroller Gen.</td>
<td>40,554</td>
<td>116,490</td>
</tr>
</tbody>
</table>

Individuals seen and services delivered in Colombia’s prisons in 2012 and 2013, by source

Nevertheless, the available data supports the following view. First, it appears that the amount of healthcare delivered to prisoners increased substantially between 2012 and 2013, although a precise magnitude cannot be inferred from the available data. This may be related to the additional funding that would have resulted from the adjustment to the capitation rate that went into effect in 2012.

Second, both agencies agreed that the majority of healthcare services delivered to prisoners between 2010 and 2013 were for intramural primary medical and dental care (such as treatments for gastritis, backpain, headaches, gingivitis, and tooth capping). Each of these accounted for approximately 20-30% of all services delivered to prisoners. Services that were object of carveout arrangements with specialty managed-care organizations — such as those for HIV and for chronic renal failure — occupied second place in the ranking of the most
frequently-provided types of services, accounting for roughly 10-20% of the services provided. The remainder were medium and high-complexity services that were included in the array of benefits covered by the subsidized regime that were delivered extramurally.

This pattern of utilization differs substantially from that observed in the general health system, where medium and high complexity services account for the largest share of spending (Ministerio de Salud y Protección Social, 2014). This difference is likely explained by several factors. On the supply side, problems such as labor shortages or interagency coordination failures have a greater impact on the accessibility of services that have to be provided extramurally and which require more permanent, functional infrastructure, relative to services that can be provided intramurally by non-specialized health workers and those that can be delivered through massive, one-time “healthcare brigades”. On the demand side, most prisoners in Colombia are males younger than 35 years old, a group that generally need more primary care relative to medium- and high-complexity services.

Given available data, it is impossible to know how much can be attributed to any given factor. However, our opinion in light of all the primary and secondary information reviewed is that the supply-side factors played an important role in determining the pattern. This is concerning, since it means that many important health needs of the prisoner population are not being adequately met due to supply-side barriers to access.

The results from our survey among prisoners at a large, medium security prison in Bogotá also support this view. Nominal health insurance coverage among inmates in this prison appears to be similar compared to the nonincarcerated population in Bogotá. Approximately 85% (79-91%) of inmates in reported having some form of health insurance, 8% (95% CI: 4-12%) say they are uninsured, and 7% (95% CI:3-12%) does not know whether or not they have health insurance. By comparison, 93% of nonincarcerated survey respondents in Bogotá report having health insurance, 6% say they are uninsured, and 1% does not know (measures of dispersion were not reported by the authors of the survey among non-prisoners). However, this
coverage is less effective for prisoners compared to non-prisoners. For instance, prisoners appear to have greater difficulty accessing healthcare services when they need it: nearly one in four prisoners in our survey reported having had health problems in the last thirty days, of whom only 37% (95% CI: 20-54%) were able to access medical care. By contrast, fewer than one in ten nonincarcerated survey respondents in Bogotá said they recently had health problems and 67% were able to access medical care. Moreover, prison healthcare services scored lower on the only indicator of quality that we measured in survey: only 57% (95% CI: 36-79%) of prisoners in our study who had been diagnosed with hypertension or diabetes and who had been seen by a healthcare provider while in prison had had their cholesterol checked the last time they were seen. By contrast 85% of nonincarcerated survey respondents with hypertension or diabetes had gotten this test the last time they saw their healthcare provider.

Finally, when asked why they had been unable to obtain medical care when they thought they needed it, half of the prisoners in our study cited problems with the availability, accessibility, acceptability or quality (AAAQ) of healthcare services (e.g. “it’s impossible to get an appointment”, or “I went to the ER but the wait was so long I eventually gave up and left” or “the quality of care is so poor that trying to get medical care seems pointless”); none cited personal reasons (e.g. “I just never got around to it” or “I don’t like going to the doctor”). By contrast, one in three nonincarcerated respondents cited AAAQ-related problems, and nearly a half cited personal reasons (Ojeda, Ordóñez, & Ochoa, 2011).

4.7. Population Health

The ultimate goal of the prison health system is to help realize prisoners’ right to the highest attainable standard of health. Therefore, evaluating whether any given reforms to some or all of the six health-system building blocks translated into improvements in the system’s performance involves measuring the impact of those changes on the level and distribution of health among the prisoner population. Periodic population health surveys are an important tool
for measuring changes in population health over time, and thus for evaluating the impact of
efforts to strengthen health systems. Additionally, survey-based measures of population
health are also useful for evaluating other core health system functions. For instance, survey-
based estimates of the frequency of certain disease are an appropriate benchmark of the
accuracy of other sources of information such as administrative records or public health
surveillance systems. Information obtained from population health surveys is also necessary to
measure certain indicators of intermediate outcomes. For instance, the coverage of HIV care is
measured by dividing the number HIV-positive individuals who received appropriate care by the
estimated total number of people living with HIV, and the latter is best estimated using survey-
based methods.

A comprehensive, nationally representative health survey of the Colombian prisoner
population has never been conducted. To fill this data gap, we designed such a survey study,
obtained a promise of funding from the Colombian Ministry of Health (MoH), and conducted an
initial pilot study in an all-male, medium-security prison located in Bogotá between December of
2013 and November of 2014. Unfortunately, the MoH reneged on its promise of funding soon
after the start of data-collection for the pilot, which we were able to complete thanks to the
support provided by the Universidad de los Andes. However, the MoH’s failure to follow through
on its promise prevent the survey from progressing beyond the pilot stage. Nevertheless, the
pilot study is nevertheless the first of its kind in Colombia and it yielded valuable findings, which
we shall present in this section.

The pilot health survey relied on a probability sample of inmates \( n = 148 \) from an all-
males, medium-security prison located in Bogotá D.C. that had an average prisoner population of
>4,500. The sampling design and data analysis methods are described in detail in Appendix 1.
Data was collected by a team of six researchers using a structured, interviewer-administered,
paper-based questionnaires with question adapted from the 12 item version of the WHO
Disability Assessment Schedule 2 (WHODAS-12), the Patient Health Questionnaire 9-item
scale (PHQ-9) (Kroenke, Spitzer, & Williams, 2001), the Generalized Anxiety Disorder 7-item scale (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006), the Post-Traumatic Stress Disorder 7-item scale (PTSD-S) (Cameron & Gusman, 2003), the UNODC’s HIV in Places of Detention Toolkit (UNODC, 2008), the 2007 National Health Survey (Ministerio de Protección Social, 2007), and the 2010 National Demographic (Ojeda et al., 2011).

Table 3 summarizes the main findings from the health survey that we conducted between December of 2013 and November of 2014 in a large, medium-security prison located in Bogotá. For reference, the second column summarizes the results of nationally-representative household surveys among non-prisoners in Colombia that included the same survey items as those that we used in our survey among prisoners. Whenever possible given the information available from these general-population surveys, we have included the results specific to the subpopulation consisting of nonincarcerated adult males in Bogotá, since this is arguably the most appropriate reference group for our survey’s study population.

Compared to non-incarcerated individuals, prisoners in our survey scored worse on all the measures of health that we investigated. Consider the difference between the two groups in the prevalence of self-reported disability, as measured using the WHO Disability Assessment Schedule 2.0 12-item version (setting 15.8 as the cutoff score): whereas 9% (95% CI: 7-11%) of individuals between the age of 18 and 45 in Bogotá are estimated to have some form of physical or mental disability, the estimated prevalence among prisoners in our survey was 23% (95% CI: 16-31%). Similarly, when asked, “Overall, how would you rate your health in general?” — a measure that is considered a reliable predictor of mortality in populations — fewer than 10% (95% CI: 5-15%) of prisoners in our study chose the best rating (“excellent”) compared to 23% of nonincarcerated respondents in Bogotá (measures of dispersion were not reported for this variable by the authors of the survey of non-prisoners). The results for domain-specific measures of health were consistent with those for the global self-assessment: relative to non-prisoners, a higher the proportion of prisoners reported having been told by a health provider, at
<table>
<thead>
<tr>
<th>Data sources</th>
<th>GENERAL POPULATION</th>
<th>PRISONER POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Survey among inmates in a Bogotá prison</td>
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<table>
<thead>
<tr>
<th>POPULATION HEALTH</th>
<th>Prevalence (95% CI)</th>
<th>Prev. (95% CI)</th>
<th>Prev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability: WHO-DAS 2.0 12-tiem score &gt;75th percentile (ages 18-45)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>8% (7-9)</td>
<td></td>
<td>24% (95% CI)</td>
</tr>
<tr>
<td>Bogota</td>
<td>9% (7-11)</td>
<td></td>
<td>24% (16-31)</td>
</tr>
<tr>
<td>Self-Rated Global Health: &quot;Poor or &quot;Very Poor&quot; (ages 18-45)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>13%</td>
<td>NA</td>
<td>23% (16-30)</td>
</tr>
<tr>
<td>Bogota</td>
<td>8%</td>
<td>NA</td>
<td>23% (16-30)</td>
</tr>
<tr>
<td>HIV: self-reported diagnosis, lifetime (ages 18-45)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td></td>
<td>(0.3-0.5)</td>
<td>0.2%</td>
</tr>
<tr>
<td>Bogota</td>
<td>NA</td>
<td>2.8%</td>
<td>0.4%</td>
</tr>
<tr>
<td>STD: self-reported symptoms of diagnosis, previous 12 months (all ages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>1.4%</td>
<td>NA</td>
<td>10% (5-15)</td>
</tr>
<tr>
<td>Bogota</td>
<td>0.9%</td>
<td>NA</td>
<td>10% (5-15)</td>
</tr>
<tr>
<td>Diabetes: self-reported diagnosis, lifetime (all ages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>4% (3-5)</td>
<td></td>
<td>7% (3-11)</td>
</tr>
<tr>
<td>Bogota</td>
<td>4% (3-5)</td>
<td></td>
<td>7% (3-11)</td>
</tr>
<tr>
<td>Hypertension: self-reported diagnosis, lifetime (all ages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>9% (8-10)</td>
<td></td>
<td>3.5%</td>
</tr>
<tr>
<td>Bogota</td>
<td>8% (6-10)</td>
<td></td>
<td>3.5%</td>
</tr>
<tr>
<td>COPD: self-reported diagnosis, lifetime (all ages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>0.8%</td>
<td>NA</td>
<td>0.1%</td>
</tr>
<tr>
<td>Bogota</td>
<td>NA</td>
<td>1.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Screened positive for one or more mental disorder: (ages 15-49)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National</td>
<td>8% (7-9)</td>
<td></td>
<td>48% (39-57)</td>
</tr>
<tr>
<td>Bogota</td>
<td>NA</td>
<td></td>
<td>48% (39-57)</td>
</tr>
<tr>
<td>HEALTHCARE SERVICES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Has health insurance: self-reported (all ages)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National                           94% (93-96)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bogota                             93% (90-97)</td>
<td></td>
<td></td>
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</tbody>
</table>

| Was not able to get healthcare, attributes it to lack of availability or accessibility |
| National                           38% (37-40)                                      |
| Bogota                             32% (28-36)                                      |

| Had health problem and was able to get healthcare: self-reported                   |
| National                           65% (62-68)                                      |
| Bogota                             67% (60-74)                                      |

| Had health problem: self-reported, previous 30 days (all ages)                    |
| National                           9% (7-11)                                        |
| Bogota                             9% (5-12)                                        |

| Has hypertension or diabetes and got cholesterol test during last healthcare appointment: self-reported |
| National                           85% NA                                          |
| Bogota                             57% (36-79)                                      |

Results from survey among inmates in a large medium-security prison located in Bogotá, D.C. compared to results from published surveys among general population and to estimates for prisoner population derived from administrative data sources.
some point in their life, that they had HIV, hypertension, diabetes, or chronic obstructive pulmonary disease, or report having experienced symptoms suggestive of a sexually transmitted disease within the past twelve months. However, only the difference in the prevalence of HIV was statistically significant.

The results for the mental-health screeners exhibited a similar pattern: Whereas estimated 12-month prevalence of some form of depression and of generalized anxiety disorder (GAD) among non-incarcerated adult males in Colombia are, respectively, below 2% (95% CI: 0.8-1.8%) and below 1% (95% CI: 0.1-0.5%), nearly one in four prisoners in our study (95% CI: 17-31%) screened positive for major depression and one in six screened positive for GAD, which we defined, respectively, as a score ≥ 15 on the PHQ-9 and a score ≥ 15 the GAD-7. (Scores ≥ 15 on the PHQ-9 and the GAD-7 have been shown to have high specificity (≥95%) for identifying major depression and GAD, respectively.)

It is worth highlighting that, compared to survey-based estimates, those obtained using administrative data alone appear to underestimate the burden of disease among prisoners. For instance, according to a Ministry of Health analysis of the National Registry of Self-Reported Disability dataset, in 2012 the prevalence of physical or mental disability among prisoners detained in the prison where we conducted our survey was < 2%, which is nearly ten times lower compared to the results from our survey. Similarly, for all of the health outcomes that we measured in our study for which administrative data was also available, the survey-based point estimates were consistently five to ten times higher compared to those based on administrative data.

We do not know how representative the results from our survey of inmates of a single prison in Bogotá are of the rest of the country’s prisoner population. Nevertheless, they are consistent with findings from other studies conducted in various prisons around the country. For example, in a prospective cohort study in which 1,305 inmates from four prisons located in Medellín and Bucaramanga were followed over 12 months, Rueda et. al. found that the
prevalence of HIV, as measured using rapid HIV tests of capillary blood samples, was approximately 2.1% (confidence intervals not reported by study authors). By contrast, according to the statistics published by the Ministry of Health on the basis of existing administrative datasets, the prevalence of HIV in those same prisons during the same time period was below 0.5%.

Another limitation of our survey is that we only measured a small number of health outcomes, and all of those relied entirely on self-report. Future research should encompass a more comprehensive set of measures, including some that are susceptible to objective measurement. Finally, our estimates are subject to large sampling error since our sample size was small; this precluded trying to identify potential disparities in health or healthcare between different subgroups of the prisoner population, such as those defined by age, sex, legal status (i.e. sentenced vs. awaiting trial), socioeconomic status, etc.

5. Discussion

The Colombian prison health system continues to be in disarray nearly 20 years after the Colombian Constitutional Court first declared the existence of an unconstitutional state of affairs on the grounds that the failure by the government to solve the problems of overcrowding, poor sanitation, and lack of adequate healthcare in the country’s prison system constituted a “systematic violations of the rights of prisoners over many decades” (M.P.: Eduardo Cifuentes, 1998, para. 52). Despite the many reforms attempted between 1998 and 2016, the availability, accessibility, and quality of healthcare in prisons have remained severely inadequate and inmates have continuously been denied basic determinants of health such as basic sanitation and living conditions. In turn, this has translated into pervasive and egregious inequities in the enjoyment of the right to health between prisoners and the general population.

Our findings suggest that the observed lack of progress towards better health and healthcare during the past two decades can largely be attributed to retrogressive criminal and penitentiary policies, poor governance of the prison health system and reform process, and
inadequate financing. We take up each in turn. Since the early 1990’s, a consensus has existed among both government officials and non-government commentators that overcrowding has been a major cause of the problems affecting prisoners’ health and the delivery of healthcare in prisons. Multiple stakeholders insisted occasions insisted that the correct response to overcrowding would be to rely on penalties that do not involve privation of liberty for all but the most serious crimes. (For a discussion of these alternatives, see entry in this volume about the penal and penitentiary system by Libardo Ariza and Manuel Iturralde). These stakeholders included the National Inspector General (2006) as well as the Ombudsperson for Human Rights (2000, 2004, 2009, 2011, 2015), the UN High Commissioner for Human Rights (2001), and the International Committee of the Red Cross (2013). Nevertheless, the approach in Colombia has been to imprison even first-time minor offenders, and the government doubled down on this approach in 2007 with visible consequences on the growth of the prisoner population and the degree of overcrowding in the prisons system (see Figure 1.) To reduce overcrowding, the government has allocated enormous amounts of money to expanding prison capacity, but the impact of these efforts on prison overcrowding has been almost negligible.

Turning to the organization and governance of the prison health system and reform process. Judicial pressure from a strong Constitutional Court was the key driver of the reforms, beginning with rulings T-153, T-606, and T-607 of 1998. The changes that were introduced between 1998 and 2007 basically involved outsourcing the delivery of health services to private providers contracted from the general health system and supplementing INPEC’s tax-financed health budget with partial per-capita subsidies with resources from the Social Security Fund. These measures were conceived and planned in a piecemeal and disarticulated manner without any documented deliberation about how they might work together to improve the performance of the prison health system, what were the anticipated costs of implementing these measures on a large scale and whether sufficient resources were available, whether there were any feasible alternatives that could be pursued instead and what their relative merits might be, or
how the foreseeable problems of outsourcing the delivery of health services to private providers without any experience operating in prison contexts. Specifically, no notice was paid to the alerts that were raised through official channels by the Inspector General as early as 2004 that these measures would likely aggravate the shortages in the health workforce, worsen the availability and quality of health services, and reduce accountability for the performance of the prison health system. A likely explanation for this is that INPEC did not have the legal authority to enact more comprehensive reform measures, yet it was nevertheless liable for contempt if did nothing in response to the Court’s injections. It is thus plausible that the decision to outsource health-service delivery was driven by a political calculus by INPEC about how to obey the letter of the Court’s rulings and avoid further responsibility, as opposed to being part of a concerted, government-wide effort to determine which measures would have the biggest impact on improving the prison health system’s performance and to ensure their effective implementation, although a proper history of the subject would be needed to substantiate this hypothesis.

The next major change came with the enactment of Law 1122 of 2007, which ordered the complete integration of the penitentiary and prison health systems. But as mentioned in section 4.1., this step was taken without any prior public deliberation about the foreseeable effects for the prison health system and without a plan for the implementation and evaluation of the reform. This was a glaring omission, since theory predicts that the institutional arrangements and governance mechanisms of the general health system were not well suited to ensure good health-system performance in the prison context. The general health system in Colombia relies on a managed-competition model in which the government is responsible for collecting and pooling funds to finance the health system, a mix of private and public insurers are responsible for playing the role of surrogate purchasers of healthcare on behalf of their enrollees using monies disbursed by the government through a system of capitated payments, and the delivery of health services is the responsibility of private providers that are either contracted or owned by the insurers. This model relies heavily on market accountability to achieve good health system
performance: insurers must compete with each other to attract enrollees, since the amount of revenue a given insurer receives from the government is a function of how many enrollees it has, and providers must in turn compete with each other for contracts with the insurers. Although the government has some governance and regulatory responsibilities, such as defining what are the specific entitlements that all insurers must guarantee for their enrollees and establishing minimum quality and accreditation standards that providers must meet, accountability for good performance is primarily achieved through the disciplining effects of market competition.

Theory predicts that such an arrangement can be expected to produce desirable results only there are multiple insurers and providers participating competing in the same market, and this prediction has shown correct in many small cities and rural communities in Colombia where a only a small number of insurers or providers operated. So it was foreseeable that this model would not be appropriate for the prison context, where the conditions for a competitive market did not exist. The reader may recall that the regulations that were initially put in place to implement Law 1122 initially barred insurers other than CAPREOM from enrolling prisoners, yet even after the restrictions were lifted, other insurers declined to enter the market because the capitation rate for prisoners was not adequately risk adjusted to compensate for the fact that the expected cost of prisoners’ healthcare is greater than that of non-prisoners. Furthermore, poor planning and lack of clarity about the respective duties and prerogatives of different actors led to coordination problems between INPEC, CAPRECOM, and later UPECS, which aggravated the challenges of delivering healthcare to prisoners.

Our findings show that transferring the responsibility for prisoners’ healthcare from the national prison authorities to the general health system, as WHO/Europe’s Health in Prisons Project recommends, does not necessarily guarantee better results. Perhaps this recommendation is more appropriate some European countries that have more resources available to spend on health tha Colombia, where the governance of the general health system
is more directly controlled by the government, and where insurers and providers are more effectively regulated instead of depending heavily on market competition to achieve good performance. In low and middle income countries whose general health system resembles that of Colombia, a different approach may be required.

Unfortunately, although we have identified several shortcomings in each of the different components of the prison health system in Colombia — both before and after reforms were introduced — the fact that there is no reliable data that could be used to attribute any given outcomes to any given shortcomings means that it is not possible to identify what are the “binding constraints” acting on the system. In other words, given existing data, it is not possible to identify which of the many shortcomings of the Colombian prison healthcare system may need to be addressed before progress can be achieved from solving other problems. The information that would result from a appropriately-designed, comprehensive population-health surveys and intramural healthcare-facility assessments would therefore be an invaluable resource at this point. Moreover, the primary research that we carried out as part of this study provides proof of concept that it is feasible to conduct ethical, survey-based research in the Colombian penitentiary system. An example of the sampling design and data collection methods for a comprehensive health survey of the prisoner population is presented in Annex 2. (This design was prepared in 2016 on the request of the Ministry of Justice, but the study was not funded so the research did not proceed beyond that presented here). Therefore, our opinion is that this is the first step that the Colombian government should take towards realizing prisoners’ rights to health and healthcare.
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Protección constitucional y derechos fundamentales de las personas privadas de la libertad.


1. Introduction

Should doctors be undivided advocates for their own patients? Should they have clinical autonomy to decide how to treat? Should they have the power to make the health system carry out their decisions? Reasonable resource scarcity means that we cannot answer “yes” to all three questions. Health is not the only value we care about, so there are limits to how much we are willing to devote to it. This means that no health system can afford to do everything technologically possible for everyone who might benefit. So, either doctors must play the role of steward of shared resources, or the health systems’ bureaucracy must play this role and restrict doctors’ clinical autonomy and authority as necessary to ensure they stay within just limits.

Medical professionalism has traditionally been thought to require a kind of partisanship that bars doctors from giving weight in their clinical decision-making to considerations other than about their own patients’ best interests (Abrams, 1986; Angell, 1993; Hiatt, 1975; Levinsky, 1984; Pellegrino, 2001, 2006; Relman, 1990; Sulmasy, 1992; Weinstein, 2001). In the words of Norman Lenvinsky (1984, p. 311): “Physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. In caring for an individual patient, the doctor must act solely as that patient’s advocate, against the apparent interests of society as a whole, if necessary.” On this view, stewardship and patient advocacy are radically incompatible with each other since stewardship requires one to give certain considerations (such as reasonable societal concerns to conserve resources and distribute them fairly) a status as reasons that the ethic of advocacy and its absolute focus on the patient allegedly rules out. So, as it has traditionally been conceived, medical professionalism bars doctors from playing the role of steward of shared resources.

A division of labor is often proposed to preserve doctors’ role as their patients devoted advocates by assigning the role of steward to administrators or policymakers. Stewards must
restrict doctors’ clinical autonomy and authority as necessary to ensure they stay within the limits required by justice. However, many doctors believe that these restrictions impinge on their ability to pursue their patients’ best interests, and thus necessarily pose a threat to what is valuable in medical professionalism.

It appears that we face a dilemma: justice requires stewardship, yet medical professionalism allegedly rules it out. Norman Daniels (Daniels, 2008, p. 233) has suggested that the right response to this dilemma is to make a direct claim of priority for justice: “it is justice that should be primary in designing social institutions, including professional roles and their norms.” This implies that we must rethink the view that doctors’ clinical-decision making must be guided exclusively by a concern for their own patients’ best interests. But people who believe that the traditional conception of medical professionalism captures the kind of doctor-patient relationships that we would ideally want might worry that revising it necessarily means losing some morally desirable features of medical professionalism and of the doctor-patient relationship; that we must instead settle for a less desirable version of medical professionalism.

My goal in this essay is to address this worry. My central thesis is that it is possible to articulate a conception of medical professionalism that is worth valuing, and in fact captures what we normally mean by professionalism, but whose requirements do not clash with those of justice in the way the traditional conception suggests.

If the traditional were true, it would mean that medical professionalism is incompatible with many limit-setting measures that are widely-used by health systems. For instance, certain payment arrangements that create financial incentives for providers to alter their practice patterns in cost-conscious ways — including various kinds of capitation arrangements or schemes that involve “withholding” a portion of providers’ income if they exceed pre-defined expenditure targets — place substantial insurance risk on doctors (Daniels & Sabin, 2008), in effect imposing substantial stewardship responsibilities on them.
A division of labor is often proposed to preserve doctors’ traditional role by assigning the role of steward to the health system’s bureaucracy (Agich, 1990; Hiatt, 1975; McGuire, 2011; Mechanic, 2000; Mirvis, 1993; Pearson, 2000; Reinertsen, 2003; Tanenbaum, 1993; Ubel & Arnold, 1995; Weinstein, 2001). The suggestion is that doctors should remain the patient advocate, and thus be exempted from taking account of considerations other than their own patients’ best interests in their clinical decision-making. Meanwhile, other actors such as administrators, policymakers, or engaged citizens, should be responsible for establishing priorities and setting limits in a way that is reasonable and fair to all sides. The stewards must restrict doctors’ clinical autonomy and authority as necessary to ensure they stay within the limits required by justice. Familiar limit-setting methods that impose such restrictions on doctors include utilization reviews, prior-authorization requirements, and prospective coverage decisions.

These limit-setting methods are often criticized, however, on the grounds that bureaucrats lack the knowledge or expertise needed to make such decisions; that the administrative costs generated by these limit-setting methods consume resources that could otherwise be used to meet people’s health needs; and that they make the system less responsive to individual differences which might warrant differential treatment (to name just a few of the concerns that have been raised). In the words of Arnold Relman, “setting out formal guidelines to cover all the clinical circumstances under which [each medical intervention] might or might not be worthwhile would be a complex task… With each procedure, the cost—benefit assessment depends so heavily on individual circumstances that it is almost impossible to devise medically sound rules applicable to all patients” (Relman, 1990, p. 912). Additionally, as mentioned earlier, many doctors believe they should resist any attempts to restrict their clinical autonomy or authority in order to preserve their ability to pursue their patients’ best interests, and thus what is valuable in medical professionalism.
This sets up the following dilemma: On the one hand, justice requires fair and prudent stewardship of finite, shared resources; this involves setting limits to what any given doctor can do for his or her own patients in light of reasonable concerns about other patients and about the system as a whole. On the other hand, however, medical professionalism allegedly requires doctors to act solely as the advocates of their own patients, unfettered by concerns about other patients or about the system as a whole, and to resist any attempt to restrict their clinical autonomy or authority. In short, justice requires stewardship, yet medical professionalism allegedly rules it out.

One way to respond to this apparent dilemma is to make a direct claim of priority for either justice or medical professionalism. In the next section, I shall briefly present the main arguments that have been advanced on each side of the debate, which I believe can be seen as settled by the arguments in favor of the view that justice is primary or provides the framework for professional ethics. I shall then argue that this account of the relation between justice and medical ethics is compatible with a kind of medical professionalism that captures the kind of professionalism and professional norms that we normally find appealing.

2. Justice and Medical Professional Ethics

Many commentators have suggested that we can derive the content and stringency of doctors’ professional obligations from an idealized conception of the medical profession and of the doctor-patient relationship (Kass, 1975; Pellegrino, 2001; Zuger & Miles, 1987). In the words of Edmund Pellegrino: “The phenomenon which characterize this… relationship form the basis for the moral obligations a physician assumes when he or she offers to heal, help, care for, or comfort a sick person” (Pellegrino, 2001, p. 562). The argument proceeds as follows: Being a member of a profession entails a commitment to a certain end, which in turn entails an obligation to perform certain actions necessary to attain that end. The end of medicine is the good of the patient, so medical professionals have an obligation to do everything in their power
to promote the patient’s good. Additionally, patients are generally in a vulnerable and dependent position due to their illness and to the asymmetry in power and knowledge that exists between patients and doctors. The ideal of a good doctor-patient relationship can therefore be understood as a fiduciary relationship characterized by trust and dependence, on the one side, and benevolence and responsibility, on the other (Buchanan, 1988). The individual entering the medical profession must consent to adopting this conception, and thus to accepting the obligation to act as the fiduciary agent of his or her patients, whom they may trust to always pursue their best interests. Some proponents of this account argue that this ideal of the doctor-patient relationship even “establishes the normative standard for assessing [the] healthcare system as well as changes in the system” (Emanuel & Dubler, 1995, p. 323).

This account errs, however, by ignoring that there are relevant interests other than those of the doctor and the patient. Yet many people have a stake in what a given doctor does for his or her patients. This is because doctors need the cooperation of many people to produce, deliver, and pay for the care their patients need (Daniels, 2008). Everyone engaged in this enterprise of providing and receiving care through a common health system can thus be understood as participating in a cooperative scheme to achieve the shared goal of meeting their diverse health needs under reasonable resource constraints. This point is true regardless of whether the health system is comprised by a private, public, or mixed institutional arrangement.

If the cooperative scheme that a health system embodies is to be is to be justifiable to all its stakeholders, then whatever is done for one person must be fair in the light of what is done for others similarly dependent on that cooperative scheme. And it must be reasonable, in the sense of being justified by an appeal to reasons that “fair-minded” people — that is, people who are disposed to finding mutually justifiable terms of cooperation — can agree are relevant to the common goal of meeting health needs fairly under reasonable resource limits (Daniels, 2008; Daniels & Sabin, 2008).
In sum, to be able to care for their patients, doctors depend on the existence of an institutional arrangement that is itself justifiable only to the extent that it ensures a just distribution of healthcare resources. So, the ethical norms governing the medical profession cannot require doctors to act in ways that would undermine the institutions required by justice. Justice thus acts as a constraint on, or provides the framework for, the design of major social institutions impacting health, including professional roles and their norms. Not the other way around.

Many people who agree with this argument conclude that we need to establish a division of labor like the one I described earlier. For instance, in a seminal article titled, “Protecting the Medical Commons: Who Is Responsible?”, Howard Hiatt (Hiatt, 1975, p. 239), a former Dean of Harvard’s School of Public Health, suggested the following:

How should priorities be set in the United States? Who should set them? ... It is surely not fair to ask the physician or other medical-care provider to set them in the context of his or her own medical practice. A physician or other provider must do all that is permitted on behalf of his patient… The patient and the physician want no less, and society should settle for no less. For example, if society has set no ground rules for the use of kidney dialysis other than medical ones, and if in a physician’s judgment his 80-year-old patient’s overall condition warrants dialysis, everything must be done to see that he is so treated. On the other hand, the physician can, however reluctantly, accept society’s constraints regarding eligibility requirements for kidney dialysis, even if he does not consider them to be in the best interests of his patient.

This approach begs the question, however, by taking for granted the traditional conception of medical professionalism which sees doctors as being required to always do everything permitted for their patients. In other words, it begs the question by assuming that medical professionalism demands a kind of partisanship from doctors for their own patients that is incompatible with assigning major stewardship obligations to them. Some authors, such as Milton Weinstein, claim that this partisanship requirement is a feature of the fiduciary relationship between doctor and patient. Doctors cannot be required to abide by an ethic of stewardship in their clinical decision making, he claims, because “such an ethic would
compromise the fiduciary relationship between patient and physician. It would place the physician in a position of making trade-offs with faceless patients…. Physicians trained to do the best for individual patients would balk at this social agency role” (Weinstein, 2001, p. 271).

Contrary to this view, however, there are many situations in which we normally expect doctors to balance the interests of their own patients against those of other people. This is obvious, for instance, in emergency or critical care triage situations, where doctors may have to make trade-offs between the competing needs of multiple patients (Truog et al., 2006). There are also many situations where we expect doctors to show due regard for the interests of unidentified, or “faceless”, individuals, to whom they may have no immediate connection. For instance, it would be wrong if a doctor exaggerated the urgency of a patient’s medical condition, even if doing so would help that patient get the care he or she needs more quickly (this is a version of an example introduced by Norman Daniels and James Sabin (2008)). Similarly, it would be wrong if a doctor prescribed an antibiotic considered a “drug of last resort” in the absence of evidence of a drug-resistant infection, even if by doing so the doctor could achieve slightly better outcomes for his or her own patients, such as shorter recovery times or a lower likelihood of readmission.

These practices are wrong because they involve unjustifiable intrusions against some people, including violating their rights, taking advantage of them, or otherwise harming them without adequate justification. A doctor who exaggerated his patients’ needs would be helping them cut ahead of other patients who were waiting fairly for their turn, and whose needs may be more urgent. One who used antibiotics too liberally for the sake of obtaining relatively unimportant additional benefits for her own patients would be taking an unjustified risk of hastening the day when those drugs will no longer be useful at all, with all of its implications for future patients. Doctors who engaged in such practices would be exhibiting an objectionable lack of concern for the individuals who could be affected; they would be exhibiting an objectionable partisanship for their own patients.
Although there are legal and professional norms prohibiting such practices, we expect doctors to refrain from engaging in them out of a due regard for every person, as opposed to doing so from mere obedience to the norms that society has laid down. For instance, there would be something unnerving about a doctor who would be willing to steal a kidney for one of her patients were it not already forbidden by established legal or professional norms (this is a version of an example introduced by Thomas Scanlon (1998)). Such a disposition would be unnerving partly because of what it suggests about the doctor’s view of her patients, their rights, and their needs: namely, that she considers them to be important, but only because they happen to be her patients. It would suggest, in other words, that she fails to recognize her patients as individuals to whom respect and consideration is owed in virtue of being persons with intrinsic moral worth, not merely in virtue of being her patients.

A conception of medical professionalism that sanctioned such partisanship would convert doctors into potential adversaries of each other’s patients. Yet most of us would not want our doctors to be “hired guns,” willing to deceive, cheat, exploit or harm other people for our benefit. For one thing, this might undermine our trust in them, as Daniels has pointed out (Daniels, 2008, p. 236). We would probably also feel guilty or distressed at the thought of the mistreatment shown to others on one’s behalf. Another weighty reason (though perhaps a less obvious one) that we should not want doctors to engage in such behaviors is related to the importance as a source of good in our lives of living with others in ways that are justifiable to them (Scanlon, 1998). Most of us would not be able take the same enjoyment in our health, or in the opportunities that are open to us when we are healthy, if we knew that these goods had been obtained for us at the expense of someone else’s health or opportunity in ways that are unjust or otherwise wrong. (The fact that recipients of organ transplants often experience feelings of guilt towards the donor, even in the absence of any wrongdoing, shows that people are not immune to worries about the cost to others of the advantages they enjoy (Griva et al., 2002).) Instead, we want our doctors to constrain their behavior in ways that reflect a due
regard for those who stand to be affected because we understand that recognizing the claims of others as persons with moral standing — and thus refraining from behaving in ways that could not be justified to them — is crucial if we are to achieve a kind of relation with others, one of “mutual recognition” (Scanlon, 1998, p. 162), that is appealing and worth valuing in its own right.

I am not arguing here that a doctor is never justified in doing things for her patients out of a special regard for them as her patients. Nothing in what I have said denies that it may be crucial to a good doctor-patient relationship that the former sometimes be moved to do certain things for their patients by a special regard or affection, and not simply by the kind of impartial consideration that is owed to everyone. In other words, I need not deny that the fiduciary relationship between a doctor and a patient may be analogous to other kinds of special relationships, such as friendship and family ties. Whether or not this is correct is not something I can pursue here. But what the example of the doctor who would be willing to steal a kidney for her patients brings out is that the kind of doctor-patient relationship that is worth valuing requires doctors to recognize the moral claims of their patients qua persons, independent of their relationship as doctor and patient. Hence, it requires them to recognize the claims of other persons as well.

Neither am I claiming that no sane, rational person would ever want her doctor to do something wrong on her behalf. This is obviously not true; although living with others on terms that are justifiable to them is worth valuing, it is certainly not the only thing that we have reason to care about. Perhaps we would not be surprised, for instance, if the parent of a child who urgently needs mechanical ventilation felt tempted to ask his doctor to take the only available ventilator from the patient who is currently using it and give it to his child, even if it meant killing the other patient. My point is just that the parent would be forsaking an important good by unjustifiably killing a person to save his child, even if by acting wrongly in this way he would be gaining something that is more important to him in exchange.
This bears on the problem of medical ethics in the following way. Professional ethics can be understood a system of principles determining the responsibilities and prerogatives of those who undertake certain occupational roles, and which actions are required or forbidden to agents performing these roles. But as Scanlon (1998, p. 199) points out, principles are not rules that can be easily applied to settle specific questions about these matters without leaving room for the exercise of judgment: “Principles are general conclusions about the status of various kinds of reasons for action. So understood, principles may rule out some actions by ruling out the reasons on which they would be based, but they also leave wide room for interpretation and judgment.” Because principles constrain the reasons we may, or must, take into account, they can have important implications (both positive and negative) for our relations with others and for our view of ourselves. A principle instructing doctors to disregard how their actions on behalf of their patients might affect other people threatens to undermine any comfort or confidence we might otherwise have that the benefits conferred on us have been obtained in ways that are justifiable to others. It thus threatens to deprive us of the good of living in this kind of harmony with our fellows. Instead, our task is to articulate principles of medical professionalism that not only provide reasonable protections for our own rights and interests, but also support the kinds of relationships with others that we have reason to value by requiring doctors to act in ways that reflect a due regard for their rights and interests. As we shall see in the next section, however, doctors cannot live up to these requirements without institutional support.

3. Medical Ethics and the Support We Owe to Doctors

To take stock at this point, I have described Daniels’s argument that the shape of the doctor-patient relationship — and thus the duties, privileges, and powers of medical professionals — should depend on what kinds of institutions are needed to ensure a just distribution of medical resources. This is because doctors and their patients are dependent on an institutional arrangement that is itself justifiable only to the extent that it ensures a just
distribution of healthcare. Therefore, medical ethics cannot require doctors to act in ways that would undermine the institutions required by justice. In this sense, justice acts as constraints on the kinds of principles of medical professionalism that can be justified. I have argued that compatibility with the requirements of justice is already built into a conception of the doctor-patient relationship that is both familiar and worth valuing. We normally already expect doctors to recognize our moral claims as persons, and hence that they recognize the moral claims of other persons as well. This is not just a formal moral imperative, but an aspect of the positive value of a way of living with others that is appealing in its own right.

These two claims are answers to two distinct questions: The first claim is an answer to the question of whether a given institution, such as a particular system of professional responsibilities and prerogatives, is one that is permitted or required by justice. This is a question, as I understand it, of whether the institution can be justified to all those who are asked to accept it. My view can thus be traced to the contractarian tradition, which understands the idea that all people are fundamentally moral equals and are thus owed equal respect as meaning that we must recognize their moral claims and justify our institutions and how we live our lives in the light of those claims. On this view, determining whether an institution can be justified to all affected (and is therefore just) involves balancing the various interests of different stakeholders against each other; it involves an interpersonal balancing of interests (Scanlon, 2016).

The second claim is an answer to the question of whether and why a given person should regard the fact that an institution is in this sense just as sufficient reason to support it. Answering this latter question involves balancing the reasons one has to value living with others on terms that can be justified to them against the other reasons one may have, such as reasons of self-interest or ones arising from other kinds of values. This second kind of balancing is an intrapersonal one. In short, the first is an account of what makes an institution just or unjust, while the second is an account of why we should see just institutions as a source of good in our
lives. It is worth noting, however, that each person’s interests are already taken into account in the process of interpersonal balancing involved in settling whether an institution is just. In this sense, the process already gives each person’s interests as much weight as they can reasonably demand, consistent with showing due regard for the claims of others.

This bears on the question of the relation between justice and medical professionalism in the following way: In health systems operating under reasonable resource scarcity, doctors will inevitably find themselves in a framework of institutions that set limits, both direct and indirect, to how they may treat their patients. As mentioned above, if those institutions are just, then those who make decisions about these limits will be accountable for setting them in ways that show due regard for the interests of all stakeholders. Though limits inevitably create winners and losers, when they are set by just institutions, even the losers will have assurance that their own interests are taken seriously.

But in addition to being necessary if we are to have assurance that our own interests are reasonably and adequately protected, just limit-setting institutions are also necessary if we are to have assurance that this protection is achieved in ways that we can justify to each other. An assurance without which we may not be able to fully enjoy the benefits conferred on us by our doctors. These are the reasons that just institutions, and the limits they impose, are necessary to support the kind of medical professionalism that is worth valuing. To illustrate, let me return to Hiatt’s example of the 80-year-old patient who needs dialysis. The reader may recall his claim that, in the absence of ground rules establishing eligibility requirements for dialysis, the patient’s doctor should do everything possible to see that the patient receives that treatment. But if this is in fact what the doctor ought to do, it is not because doctors are exempted from having to consider other people’s interests when deciding what to do for their own patients. Rather, it is because in situations such as the one in the example, the doctor does not have the ability to evaluate what consequences his or her action could have for others, so he cannot have obligations to do so.
Doctors are generally not in a good position to evaluate how their decisions might affect the many people who have a stake in what they do. Nor do they have adequate means at their disposal either to elicit the kind of input from different stakeholders that is needed to vet the relevance of the reasons and rationales for their decisions, or to provide the kind of feedback to stakeholders that is required to achieve transparency. In fact, left to their own devices, doctors are often unable to identify the effects of their own decisions on their patients' outcomes. They also lack the means to ensure that similar cases are treated similarly. These are all reasons for exempting doctors from acting as stewards, but they are justice-based reasons.

Now we can better assess the objections I mentioned in the introduction to policies that seek to influence or impose constraints on how doctors practice, for instance, by requiring prior authorization for certain treatments or by creating financial incentives for doctors to practice in certain ways. Decisions that restrict access to treatments that are deemed insufficiently cost effective are often criticized on the grounds that the evidence regarding the cost-effectiveness on which the decisions were based lacks validity because the analyses rely on assumptions that do not obtain in the context where the cost-effectiveness estimates are being used. Concerns of this kind can be a sound reason to oppose a limit-setting decision. But this is not because cost-effectiveness is never a relevant consideration, nor is it because requiring doctors to practice in cost-worthy ways violates some morally-desirable features of the doctor-patient relationship. As Norman Daniels (Daniels, 2008, p. 128) has argued, “if people share in the goal of meeting the varied medical needs of a population covered by limited resources, as well as a commitment to justifying limitations by reference to reasons all can consider appropriate and relevant, then they would be interested in a reason that said a particular intervention had fallen below some defensible threshold of cost-effectiveness or relative cost-worthiness.” Yet, obviously, if limit-setting decisions are to be justified on grounds of cost-effectiveness, then the evidence on which they are based must be sound and the cost and effects are as claimed. If doctors have an obligation to practice in cost-worthy ways, then there must be corresponding social obligation to
ensure that determinations of cost-worthiness are based on sound evidence (Daniels, 2008; Daniels & Sabin, 2008).

Another worry that is often raised is that limit-setting measures that health systems typically use are not flexible enough in the face of individual differences. This worry highlights the importance of having adequate mechanisms for revising decisions in light of new evidence or arguments. When variation between individual cases in a given domain is known to be substantial and difficult to anticipate, perhaps it is reasonable to allow doctors to use their own judgment to decide whether the initial limit-setting decision is applicable to a given patient’s case. However, every approach to dealing with challenges such as that posed by individual variation will have some drawbacks. The flexibility needed to ensure that relevantly different cases are given appropriately different treatment may come at the expense of consistency in the way similar cases are treated, and vice-versa. How to make these trade-offs is itself a focus of reasonable disagreements, but the fact that no single approach is satisfactory in the eyes of all affected does not meant that we should not attempt to find a solution that reflects a reasonable balance between their different concerns.

4. Conclusion

Justice is typically seen as a source of restrictions on how we pursue our interests, not as a source of good in our lives. An example of this is the worry that revising the traditional view that doctors must always act solely out of concern for their own patients’ bests interests necessarily means that we must instead settle for some impoverished, less desirable version of medical professionalism. My suggestion is that if we look carefully at what is worth valuing in medical professionalism, we would see that the absence of institutions that can help us, and our doctors, act justly towards each other would make us worse off, not better.
5. References


