How do policymakers interpret and implement the principle of equivalence with regard to prison health? A qualitative study among key policymakers in England.

ABSTRACT

Background The principle of equivalence in prison health has been established for nearly four decades. It seeks to ensure that prisoners have access to the same level of healthcare as members of society at large, which is entrenched within the international legal framework and England's national health policies.

Aims This study examined how key policymakers interpret and implement the principle of equivalence in English prisons. It also identified opportunities and threats associated with the application of the principle.

Methods In total, 30 policymakers took part in this research. These participants engaged in policymaking activities and occupied positions of authority in the prison field.

Results Despite the policymakers' consensus on the importance of the equivalence principle, there was a varying degree of understanding regarding what constitutes "equivalence." Participants described how the security culture impedes prisoners' access to healthcare services. Additionally, the increasing size and complexity of the prison population, coupled with a diminishing level of resources, reduce the level of care being provided in prisons and thus compromise implementation of equivalence in English prisons.

Conclusions Inconsistent interpretation of equivalence, the prevailing security drive, increasing numbers and health complexities of prisoners, and fiscal austerity threaten the implementation of equivalence in English prisons. This research calls for new

guidance on how to interpret and implement equivalence, along with measures to educate prison governors and staff on the prison rehabilitation value, ensure greater investment in prison health, and consider alternatives to imprisonment to future-proof the principle of equivalence in the English prison system.

Keywords: equivalence, prisoners, ethics, health promotion, public health ethics.

INTRODUCTION

The establishment of equivalence as a guiding principle in prison health can be traced back nearly four decades.[1] According to this principle, prisoners should have access to the same level of care as members of society at large.[2] As advocated by Rawls,[3] disadvantaged populations should have either equal access to health care services, which are a primary commodity, or even greater access, in light of the health risks of the disadvantaged. Niveau[4] argues for equivalence from the perspective of morality: equivalence is a testament to how society responds to the needs of marginalised communities.

Equivalence is a right-based framework. It recognises prisons as a microcosm of society with links to the general community as the logical consequence of the high throughput of prisoners from and back to the community.[5] The United Nations (UN) introduced the principle in 1982 via Resolution 37/194,[1] and enshrined it in international law in Principle 9 of the UN Basic Principles for the Treatment of Prisoners: “prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”[6] Similarly, Articles 3 and 5 of the European Convention on Human Rights strengthen nations’ obligation, albeit indirectly, to preventing inhumane and degrading treatment, ensuring adequate medical treatment, and avoiding inappropriate detention of those with mental

disorders. These obligations each recognise the state's duty of care to protect prisoners' right to health, while ensuring rehabilitation is at the core of the prison agenda.

Domestically, the concept of equivalence in English prisons was first introduced in 1999 in the Joint Prison Service and National Health Service Executive working group report on the future organisation of prison health care.[7] The transfer of the responsibility for prison healthcare in England from the Prison Service to the National Health Services (NHS) via Primary Care Trusts in 2006 further enshrined the principle, ensuring the same health organisation would care for prisoners before, during, and after detention.[8] Academics, policymakers, and practitioners widely approved of the change in policy.[9]

Despite four decades in place as a guiding principle, 'equivalence' remains the subject of debate among ethicists. The tremendous number of soft laws and policies determining the state's obligations with respect to prisoner health lack clarity, leaving prison health stakeholders to decide how to interpret and implement equivalence.[10,11] Several studies have explicated the ambiguous nature of equivalence. Lines,[12] for instance, advocates looking at equivalence objectively, based on the need to tackle inherent health inequalities in prisons. In contrast, Forrester and colleagues[13] suggest that the principle should be viewed in terms of access to healthcare. Charles and Draper[14] believe that equivalence should be considered in terms of the outcome of care, and judged according to the success of embedding the principle in prisons. While these studies have collectively highlighted the need for a more sophisticated measure of standardisation and improvement in support of the principle of equivalence, the recommendations have yet to be incorporated into any formal guidelines concerning the equivalence principle.

English prisons currently face instability that threatens the application of equivalence. Along with the prevalence of physical and mental ailments in the prison population, the number of older prisoners continues to grow exponentially; currently, one in six prisoners is in this demographic category.[15] Overcrowding further impairs the efficacy of health interventions; in October 2017, the prison population numbered 86,327, which is just 1% below the full usable operational capacity.[16]

Additionally, the prevailing emphasis on security has impaired the implementation of equivalence.[8,11] Prison officers, as gatekeepers, favour bureaucracy within an authoritative environment where command and control are the primary concerns.[8] This perpetuates an inherent disconnect between prison governance and a healthcare ethos, inconsistent with the Ottawa Charter,[17] which proposes a supportive setting for health to flourish within the carceral environment.

Finally, the reduction in prison funding places equivalence in English prisons in a precarious position. Between 2009 and 2017, the UK government reduced prison funding by 13% and the number of prison staff by 30%.[18] As a result, prisoners spend less time outside their cells and suffer from delayed treatment, which may be associated with the 27% increase in the number of assault incidents per prisoner between 2015 and 2016.[19] Due to the instability in English prisons, it has been difficult to realise equivalence.

Despite the polarised understanding of, and the emerging threats to, the principle of equivalence, no previous research has tried to achieve an in-depth understanding of the implementation of equivalence from the perspective of prison decision-makers in England. The existing research on equivalence tends to focus on practitioners' views,[8] or on specific cohorts of users within prisons, such as ageing prisoners[11]

and prisoners with mental health needs.[20] Therefore, the research discussed here investigated how key policymakers interpret and implement the principle of equivalence in English prisons. Through this approach, the researchers identified opportunities and threats associated with the application of the principle.

METHODS

This paper is part of a broader qualitative study that explored the perspectives of policymakers. It examined the situatedness of legislation in implementing the Healthy Prisons Agenda in England.

Because many of the policymakers did not share the same understanding of the principle of equivalence, grounded theory, which builds theory from qualitative data, was used to construct the meaning of equivalence from policymakers' perspectives.[21] This methodology ensured that the findings were grounded in data from participants who had experience in prison policy-making; it also provides a way to examine how prison decision-makers understand the equivalence principle help to identify future threats to this principle. In total, 30 participants took part in this research. Their employers and departments included health, prison, voluntary organisations, probation and community rehabilitation companies, and regulatory entities. They were selected using the following four inclusion criteria: their specific perspective, the richness of their experience, their decision-making capacity, and geographical coverage. Participants were engaged in policy-making activities and held positions of authority in the prison field. While most of the participants worked at the national level, some worked at the operational (regional) level. These participants would be involved in crafting and implementing any policy imperatives regarding prison health and would have a direct view of the effects of any changes. A small number of participants had

retired from their substantive role within the prison field. Nevertheless, their inclusion was justified given that the maximum length of their retirement was two years and they were still active in the prison health field, albeit in different capacities.The participants were recruited using purposive, theoretical, and snowball methods.[22] Purposive sampling was used at the outset of the fieldwork by seeking policymakers who could provide an account of and context for the topic. The initial participants (n=14) were purposively selected from different key organisations pertinent to prison work. The initial contact was conducted via email and post using the Royal Mail Special Delivery service. The invitations were personalised, and the content of each letter emphasised that the recipient had experiences and insights that would be of value to the wider community. As theories emerged from the data obtained from the initial group of participants, theoretical sampling was deployed. We reached out to eight new participants who might have perspectives that could either further support or challenge our initial findings. Snowball sampling was also used; at the end of each interview, the participants were asked whether they could introduce the researchers to other decision-makers who might be able to contribute to the research findings. Eight participants were approached using the snowball method. Data were collected in both face-to-face and through telephone interviews. We interviewed 22 participants in person, and the rest by telephone. Given the inductive and interpretive nature of the research questions, semi-structured interviews were considered apposite for understanding the policymakers' views while adapting to the participants' responses. All interviews were audio recorded and transcribed verbatim. Interviews lasted between 21 and 65 minutes (average 37 minutes). The average length of interviews for each method differed slightly: 39 minutes for the face-to-face interviews and 32 minutes for telephone interviews. Written informed consent was obtained from all

participants. The University of the West of England Research Ethics Committee approved the study (approval number R1261).

The first researcher conducted the interviews and the second researcher audited the recordings and transcripts to increase accuracy and, when applicable, provided feedback to improve the first researcher's interview technique. The second researcher dip-sampled the recordings. No significant errors were noted, and therefore a simultaneous review of all the transcripts was not required, and the reliability of the coding was established. Each transcript was read four times prior to coding. This was to ensure that the researcher could become fully immersed in the content prior to analysis, assist data analysis, aid self-reflexivity as part of the research and demonstrate the trustworthiness of the study to ensure that the results are reported as accurately as possible. Data were imported into NVivo 11 for coding and retrieval. To ensure consistency with grounded theory, three stages of coding were performed: open coding, focused coding, and axial coding.[23] Transcripts were analysed until data saturation was achieved, which was reflected in the absence of new themes appearing in the interviews.[21] We achieved saturation in reviewing the 30 interviews by identifying the most divergent stories within the sample and looking for cases where the theory did not fit and for examples of contextual influences that the model did not address. This ensured that the results were reported in a transparent and accurate manner.

RESULTS

First, we describe the participants' consensus regarding the value of equivalence in English prisons. Next, we describe their various interpretations of what constitutes equivalence and how this correlates with participants' roles within the prison health

sector. As we describe, the prevailing security focus of the detention system, the increasing size and complexity of the prison population, and the reduction in prison funding as part of the austerity measures of the UK government exacerbate these discrepancies.

Shared understanding of the utility of equivalence

Despite the variation in the participants' backgrounds, they all demonstrated an understanding of the importance and utility of equivalence in realising the Healthy Prisons Agenda, albeit from different standpoints. Participants at the strategic level describe equivalence as a ceiling: "a kind of meter…a gold standard" (Participant 3, a Head of Service at a Prison Inspectorate). On the other hand, participants who actually deliver health services consider equivalence integral to the NHS's mission to deliver healthcare in prisons: "[I]t is part of the manifesto of the NHS…it is a mandate" (Participant 16, Assistant Commissioning Director of a National Health Organisation). Our participants stressed that prisons are a "holding place" and imprisonment is temporary. They believed there should be no discontinuity in prisoners' access to health services during their transitions to, and release from, imprisonment:

> [M]ost prisoners are imprisoned transitorily, so they should be dealing, generally speaking, with the same public services in prison with which they dealt before they were in prison and with whom they will have to deal again post-release. (Participant 18, former Chief Inspector of a Probation Inspectorate)

The view of equivalence as a value-laden principle is a central component of the participants' accounts. The core sentiment expressed was that equivalence

resonates with the ethics of justice and equality, and reinforces the intrinsic value of prisons as rehabilitative institutions and the prevailing notion of prisoners' right to health. We found a consensus among participants that prisons should be more than just an antiquated system of retribution. Accordingly, they viewed the equivalence principle as promoting the notion of solidarity by positioning prisoners within the broader community, and particularly in looking after members of the community who are often marginalised and excluded.

Diverse views of "equivalence"

While all participants agreed with the importance of equivalence, there was a wide range of opinion regarding what constitutes "equivalence." Some participants commented on a lack of guidance by prevailing authorities, noting that it breeds uncertainty and inconsistency in interpretation: "[P]eople pontificate for ages about what it's all about" (Participant 24, Project Lead for Prison Health Programme).

These different interpretations arose from the fact that equivalence can be defined in terms of three dimensions: need, due process, and end result. These different interpretations seemed to be associated with the level and status of the participant within the prison system. For strategically positioned participants, equivalence was inherently associated with the principle of basic need:

> Equivalence doesn't necessarily mean the same.…[I]t should be equivalence in terms of need. [It is the] minimum that the state must provide in prisons [that] may be higher and [in some cases]

> have to be higher than that in the community because prisoners are totally dependent and the principle of duty of care for a dependent population. (Participant 18)

In contrast, participants at a mid-level position in the prison system discussed the principle of equivalence from the perspective of accessibility:

> So prisoners [are] getting access to [healthcare]…not having to wait weeks to see a doctor, having all their needs met, being able to access specialist care quickly and easily…being able to get taken to hospital appointments and so on without delays and cancellations…not being handcuffed during treatment unless it's been justified on the base of risk assessment. (Participant 20, Head of Legal of a Prison Advocacy Organisation)

Those who are involved in delivering health services emphasised the importance of outcomes from the standpoint of the prisoners:

> There’s no difference between what we should be striving to deliver in prisons compared to what we’re striving to deliver in the community…[including] the best possible quality of service provision, best value for money, in a timely, efficient, and effective way for the benefit of prisoners. (Participant 28, Chief Executive of the Community Rehabilitation Company)

These narratives demonstrate that the various interpretations of the equivalence principle are unstable. They are often subject to negotiations between different actors at the different levels in the system. Within this narrative, while the lack of guidance is seen to be untenable, reducing the principle of equivalence to a precise formula would also be impractical. The participants would welcome new guidance regarding the framework of equivalence, if it were neither too simplistic nor too prescriptive:

> [N]ew guidance in equivalence will be very, very welcome, particularly around primary health services…but it should not be strictly black and white—that can sometimes cause difficulties. (Participant 22)

Participants evidenced further discrepancies regarding how to measure the success of the application of equivalence. They typically gave one of two contradictory responses. On one hand, those who operated at the strategic level suggested that equivalence has been successfully implemented in prison operations. To them, the concentration of health services in prisons rivals those in the community: “[W]e’re potentially seeing a flip where you get better service in prisons” (Participant 1, Head of Commissioning of a national health organisation).

On the other hand, participants who worked at a more operational level felt that such a view was an exaggeration. As a Prison Governor stated, “The principle of equivalence exists…whether or not we achieve it is a different kettle of fish...” (Participant 17). Participants’ feelings of anxiety and powerlessness were associated

with the possible futility of trying to provide services in prisons when similar services were not available in the community after release, which can exacerbate a prisoner's vulnerability in the long term.

> [W]e had to forcibly eject people from prison…[which resulted in them] going to live on the streets; they were going to struggle to see their doctor, they were going to struggle to get medication and they felt unsafe outside. I think that's a real indictment of where we're going as a society, when people feel they're safer in prison. (Participant 22, former Prison Governor)

Prison instability that threatens equivalence

Negative feelings about the state of society were juxtaposed with thoughts on the prevailing prison focus on security. First, the perception of prisons as a closed environment remains widespread across English prisons. Participants often described this view in terms of the prevailing security culture, which often trumps the notions of choice and access to health services by prisoners, which forms the basis of equivalence:

> If you decide [when] you wake up one morning you're not feeling well, you want to see your General Practitioner [GP], you ring your GP surgery and you go. Someone in prison may have to see whether there's a prison officer available to be able to take him to the GP practitioner in the prison. Access. Choice. Onward

> referral. Timeliness of interventions. Optimisation of services. That whole raft of things that intrinsically [gets disrupted] because of that security requirement. Your ability to use services in the same way as you would in the community is undermined or adversely affected. (Participant 9, Deputy Chief Inspector of a regulatory organisation)

Second, the exponential increase in the size and complexity of the prison population can reduce the level of care being delivered in prisons, thereby jettisoning the principle of equivalence. Prisons, according to participants, operate under an "open door policy," in that they accept new prisoners irrespective of the concomitant complexities of delivering health and social care. As one participant explained:

> [T]here's so much pressure in terms of volume of people coming through, and access to services…it affects our ability to deliver quality care to prisoners. (Participant 7, Health and Justice Lead at a National Health Organisation)

Third, while the turnover and complexities of the prison population are related to the institution's demand side, the strain on resources is associated with the supply side. Participant 29, a Chief Executive of a Voluntary Organisation, explained:

> I have to build in efficiencies year-on-year into all of my budgets, and that has implications on the way I deploy staff… [and] manage my teams.…More often than not, I'm redesigning existing roles and existing teams…changing roles or developing systems, or giving people more responsibilities. (Participant 29)

To those involved in direct care of prisoners, access to fewer resources leads to a reduction in the number of staff. This typically means that interventions cannot be delivered and appointments have to be cancelled.

DISCUSSION AND CONCLUSION

Discussion

Our research shows that, in practice, prison policymakers in England implement different interpretations of equivalence when they deliver the prison health agenda. From the outset, all of our participants appreciated the value of equivalence, as underpinned by the principles of justice, equality, morality and altruism.[3,4] The participants also articulated the advantages of the NHS being a conduit that looks after the health of prisoners and the rest of the nation.[5,9] However, despite this consensus, this research illuminates the challenges these policymakers faced in defining and implementing equivalence on a day-to-day basis,[10,11] despite the existing legal and policy structures surrounding this principle.[1, 6, 7]

Our study reveals greater insights into these variances. The inconsistent interpretations of what constitutes equivalence correlate with the level at which the participant operates within the prison system. In fact, the observed continuum of the definition of the equivalence principle mirrors the polarised academic definition of how equivalence should be defined and applied in the prison system.[12-14] Further, our research highlights the emphasis on health strategies in prisons to the exclusion of attention to the continuity of care after release, which is inconsistent with the view that equivalence applies to all stages of imprisonment.[9]

Additionally, our research provides new nuances to the position that the current instability in English prisons has compromised the implementation of equivalence at ground level. Participants felt that health is subservient to the need for security. This conflict is consistent with the existing literature which shows that prison officers prioritise security over health and wellbeing and that officers can “make or break” equivalence.[8,11] In this setting, access to health is a negotiated process between healthcare providers and security officials. This fragmented approach is inconsistent with the Ottawa Charter,[17] which seeks to establish a supportive environment. Thus, emphasising that the principle of equivalence can coexist with the requirement for security and public protection will support the longevity of the principle and its utility to enable prisons to promote health.

Participants also described the effects of the staggering increase in the number of prisoners in the system, and emerging cohorts of prisoners with complex health needs, including older prisoners with longstanding or chronic health conditions. Indeed, official data show the prison population is ageing and that England’s prisons are overcrowded.[15,16] Prisons are caretakers for those with health and social care needs whose needs might be better fulfilled outside of the carceral environment.

All of the participants recognised that prisons have been bearing the brunt of austerity. Our research provides a much-needed context for the existing data[18,19] on the effects of austerity on prisons: reduced staffing contributes to cancelled appointments and restricted access to health and wellbeing interventions. This, in turn, contributed to a 27% increase in the number of assaults per prisoner between 2015 and 2016.[19] Although the full impact of austerity is not yet apparent,[24] this finding clarifies the tension between aspirations to equivalence and the reality of institutional instability, which arises from scant resources.

Given the paucity of guidance to implement equivalence in practice, our participants suggested the need for new guidelines that clarify the notion of equivalence. Such guidance will ensure a more coordinated approach to equivalence, support policymakers in implementing the principle appropriately, reduce idiosyncratic disconnectedness within the prison system, and promote the longevity of equivalence as a health principle that is unique to the prison system. If prison gatekeepers can be persuaded that rehabilitation and security are not mutually exclusive, if more resources can be allocated constructively based on needs, and if imprisonment can be viewed as a last resort to lessen overcrowding, the prison health system will be able to focus on those who are at the greatest need within the penal environment.

Limitations

This study is the first qualitative investigation into the definition and implementation of the principle of equivalence in English prisons. Its unique contribution to the existing literature depends on a sample that consists of only 30 key decision-makers in the English prison field. This exclusivity discounts prisoners' views, a limitation future research should address.

Similarly, the findings herein have the greatest relevance to countries in which the national health ministry commissions prison healthcare, a small cohort of Western European countries, including France, Italy, Norway, Sweden, and Finland.[25] Future studies may benefit from investigating the application of equivalence in countries where the Justice or Interior ministries provide healthcare to prisoners, which would allow for transnational comparisons.

Conclusion

This study indicates that the interpretation of the principle of equivalence in prison health is unclear in practice, which stems from a lack of guidance at the international and national levels. Moreover, the prevailing focus on security, burgeoning population numbers, the health complications of the prison population, and austerity threaten equivalence as a principle.

Nearly four decades have passed since the inception of equivalence. New guidance on how to interpret and implement equivalence, without being too prescriptive or rigid, that caters to the evolving locus of the standard, will be timely. Measures to educate gatekeepers on the value of prison rehabilitation, to allocate more resources to prison health, and to use alternatives to imprisonment will promote the longevity of equivalence in the prison system. As we embrace the values of a progressive, rights-based, and civilised society, these concerted efforts would reflect our ongoing commitment to protecting and enhancing the health of this marginalised population.

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