

EDITORIAL

The model of *Institut Català de Salut* for Prison Healthcare

In October 2014 as a consequence of the implementation of the Presidential Decree of the *Generalitat de Catalunya* 300/2006 as of October 24th and the Order of the Department of Justice JUS/290/2014 as of September 29th, the Health Department of the *Generalitat de Catalunya* takes over the provision of healthcare for individuals deprived of their liberty and/or under detention of any type through the *Institut Català de la Salut* (ICS) (Catalonian Health Institute).

The ICS is the largest healthcare provider in Catalonia, since it manages 8 Hospitals and over 280 Primary Care Teams. It counts upon almost 39000 professionals and provides both specialized and primary healthcare to over 6 million citizens.

The model that the ICS has implemented for Prison Health is the same as that of the rest of Primary Healthcare.

This has been implemented by means of a Primary Healthcare Team in each prison alike their non-penitentiary homonymous with the appropriate specific adaptations (basically the management of the pharmacy, «hospitalization» in the infirmary, tender of Specialists within institutions— psychiatry, dentistry, trauma, etc. — and the obligations of the Healthcare Team with the Penitentiary and Judicial Institution).

Penitentiary Primary Health Care Teams (EAPP in Spanish) are structurally identical to the rest (they have a Director and Assistant Director) although not entirely as far as their composition is concerned (primary care physicians, nurses and nursing assistants but not administration staff, which still depends on the Department of Justice although it is functionally assigned to the Health Team).

All in all, EAPP are teams which count upon a high number of professionals regarding the ratio of assigned population due to the need of providing healthcare 24 hours a day 365 days a year and the specificity of the pharmacist supply management. I like to underline that EAPP are a hybrid structure between Primary Healthcare Teams, low-complexity hospitals, a socio-sanitary device and a mental health resource within an organization with the major objec-

tive of socially rehabilitating those hosted within and with which we must cooperate as part of our clinical responsibilities.

EAPP have been structurally and organizationally assigned to the corresponding territorial entities of the ICS also known as *Gerencias Territoriales* (territorial directorships) although there is a so called Prison Healthcare Program within the Corporate Centre of the ICS, in charge of cross-sectional corporate demarches in concert with the corresponding territorial entities. This program is structurally included in the Directorate of Primary Healthcare of the ICS.

Within territorial entities, EAPP are grouped together with non-penitentiary teams, in the geographically corresponding so called Primary Healthcare Service (*Servicio de Atención Primaria*, SAP), its Director being the immediate superior authority.

Practically all clinical, training and administration coordination activities (HHRR, purchases, etc) are implemented by means of the corresponding territorial SAP.

In fact, as in the rest of Primary Healthcare Teams, EAPP annually conclude an «agreement», known as Management Contract, which establishes the agreements reached regarding issues of healthcare production, professional development, quality and economics, whose results have to be accounted for by the end of the year and which, on the other hand, affects variable emoluments of professionals (variable productivity).

CRITICAL REVIEW OF THE MODEL

As in all models, we can find very positive aspects and others which are not so. I describe these for myself and probably other people could enhance this description with other aspects and even differ with my opinion.

In my view, the most positive aspects of the model are derived mainly from the belonging and participation of a specific healthcare organization, the ICS in this case. This is a key aspect since it entails access to strategic, organizational, management, training, tea-

ching and research elements which otherwise would not be available.

The overall positive framework can be specified, among others, through the following aspects:

- Team of professionals within a network with similar close objectives, goals and missions who share aspects regarding identity, organization management of economic and human resources, training and research.

- The existence of a specific «Management Contract» which establishes the relationship and specifies the results in terms of production, quality and economic management of the Team's activity, similar to the rest of surrounding teams, yet adapted to their own features and with their consequences on the variable economic conditions of professionals.

- ICS's participation allows for further specific training, research and professional development since it benefits from the offer of the aforementioned structure both at a territorial level and from a Corporative point of view.

- Possibilities are opened up for professionals since they can move by means of a general system of job provision, through all the organization (labor exchange, professional evaluation, provision tenders, service commissions, etc.).

- Since general rules regarding the management of human resources are applied, professionals have new advantages that they did not have before, such as the professional career or the individual and groupal incentive system.

- There are further participation possibilities both in work teams, clinical commissions, expert committees, etc and in representative and participation entities such as clinical boards and union movements.

- Proximity to management and support organs both for Direction Teams and the rest of professionals.

- Existence of accessible labor exchange and standard methods for a transparent management of leaves and substitutions.

- Existence of general frameworks for the development of organizational and clinical, quality and clinical safety management aspects within Teams with the corresponding territorial support.

- Close support for information management, clinical knowledge, teaching and research both specific and with external cooperation of other EAPs and Hospitals.

- Existence of information systems for institutional management: accessible and adaptable to the needs of each Team.

- Electronic medical record with a common structure and functionality yet with a specific structure and access according to strict patient confidentiality rules.

- Institutional support on legal issues of any kind.

- Hierarchic independence from the Direction of the Penitentiary Institution, lack of tasks other than those related with the provision of healthcare, yet with the necessary functional coordination to grant optimal overall functioning.

With regard to not-so-positive aspects, we can conclude that they derive from the local dissociation of dependencies (ICS, Justice) of Teams, the diverse territorial belonging within the ICS itself and the specificities of EAPP which differ from the rest of Primary Health care teams in the ICS. I want to believe that these issues are always a source of opportunity if conveniently identified and managed.

This can be specified, among others, through the following aspects:

- Potential lack of standardization of criteria, procedures and objectives between the EAPP and the Penitentiary Institution.

- Potential differences in the development, management and implementation between different EAPP due to their territorial assignment.

- EAPP are at risk of being considered marginal within their territorial authority due to their size and specificity.

- Loss of certain management autonomy for the benefit of the territorial functioning which is not always capable of identifying the specific needs of the population targeted and the specific Penitentiary Healthcare Team (pharmacy, knowledge, etc.).

EFFECT ON PATIENTS

Can this model affect patients assisted by Penitentiary Healthcare Teams? The answer is yes, and moreover, it does so in a positive way. Patients still receive top quality healthcare but with the new model they will have (in fact they already do) the possibilities that *Catsalut* creates for the population whose health is in charge of. We have to mention several community health programs, access to new provisions and new services for the identified needs (including Mental Health), an improved management of clinical information (common medical record) and the standardization of intra-and extra-penitentiary healthcare through the creation of the corresponding Individual Health Card. Patients are included in the

system therefore ensuring continuous care both upon admission and upon discharge. This aspect, relevant for those patients residing in Catalonia, can entail certain difficulties since it is not a common system with the rest of the Country for patients who come from or go back to other Autonomous Communities. This entails further efforts regarding external coordination, especially with regard to the information included in the medical record and the coverage of the care and pharmacy needs of patients.

THE INTEGRATION PROCESS

It is also fair to make an assessment of the process that the Department of Justice and the Health Department, through the ICS, have implemented to integrate Penitentiary Health in the ICS.

In my understanding this was a successful process in spite of evident difficulties and issues (labor, professional, management, information technology, etc.). So that this could happen, the following elements had to meet: a strong political will of both Departments together with sustained efforts based on mutual trust and shared tasks together with a negotiation process and union and professional participation where exquisite treatment to professionals— who also made efforts to enable the process— prevailed. The economic matters entailed by the transfer were also dealt with with loyalty, generosity and objectivity by all involved parties, which certainly contributed to overcome many difficulties. Under this there are proper names, which without specifically naming, I'd like to highlight now. Thanks to all of them the integration of Prison Healthcare in the ICS was possible, and can now be a model, with corresponding adaptations, for other Communities now that certain actions and declarations are speaking for this process which we still have not concluded despite the many years that national and autonomic legal and regulatory dispositions have established so.

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