

7-18-2012

The Future of Health Care? Lessons of a Simple Model

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STARS Citation

Potter, Roberto (2012). The future of health care? Lessons of a simple model. UCF Today, 2012-07-18. Retrieved from <https://today.ucf.edu/the-future-of-health-care-lessons-of-a-simple-model/>

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The Future of Health Care? Lessons of a Simple Model

By Roberto Hugh Potter
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Wednesday, July 18, 2012

Transforming health care is as much about social change and resistance as it is about individual health and party politics.

Imagine a place where you don't have to pay anything or maybe just \$5 for a visit to the medical clinic, where your prescribed medications cost you nothing, where there is no penalty for missing work or school to go to the clinic, and where every individual has an absolute right to access and receive "adequate, reactive" health care.

If you want a glimpse of one possible provision of universal health care in the United States, check out your local jail, state or federal prison.

Every person in a correctional facility has the constitutional right to a professional medical opinion about their health condition and a right to the care ordered by that professional without interference by non-medical administrators. Because of this constitutional guarantee, correctional facilities were excluded from the Affordable Care Act, which will become fully implemented by 2014.

In the "free world," about the only place anyone has a statutory right to that standard of health care is in an emergency room.

Correctional health has become big business, whether run by public agencies or the range of non- and for-profit health-care providers. Finding ways to reduce those costs has also become a concern for legislators and correctional officials. After all, this is a public cost funded by taxpayers, as is Medicaid, and taxpayers want their money spent wisely. Health care is not free.

So far, providing care has been mostly a shell game of cost-shifting by various levels of government using tax dollars. Now the need to find ways to reduce health costs begins in earnest. Perhaps prisons and jails can give us some good lessons.

Correctional systems have experimented with a variety of ways to reduce “unnecessary” utilization of medical services by prisoners, such as charging a co-pay for non-scheduled clinic visits. To many of us, a \$5 co-pay sounds better than our current co-pay. If you make less than \$1 an hour for prison work, that co-pay is considered by many to be a disincentive to seek necessary medical care, especially preventive care.

Many “prisoner-health advocates” object to a co-pay for non-scheduled sick calls. Note the “non-scheduled” part; the reality is that for regularly scheduled visits for such things as physicals or chronic-care conditions that already have been diagnosed, the prisoner does not pay for care.

One approach to managing health-care costs that is popular with many correctional systems and consultants is the “defined-benefits plan.”

Upon entry to the correctional system, an inmate or prisoner receives a booklet that details the standard medical services available to all prisoners. The cost of non-scheduled visits is detailed and an explanation of how those costs will be deducted from inmate accounts is provided, as well as the exemptions from having to pay.

Most of these service schedules follow the same guidelines in the health-insurance program many people have through employers.

In most facilities, access to health care begins with a “sick-call slip” provided to a triage nurse. The nurse determines whether the prisoner has an ailment that requires a visit to the clinic and makes arrangements with the correctional officers to allow the prisoner to attend the clinic.

A nurse, nurse practitioner or physician assistant sees the prisoner initially to determine whether the complainant needs to be seen by a physician.

If the answer is no, the prisoner patient is given whatever non-prescription treatment is needed and sent back to work or living quarters. If the answer is yes, an appointment is made with the physician at the next available opening.

Expect to see similar “gate-keeping” roles assigned to nurse practitioners, physician assistants and primary-care physicians in the near future, similar to what happens in Australia.

Through years of performing medical-services audits in Georgia prisons, visiting more county jails and state prisons than I ever wanted to – even as a criminal justice professional – I have discovered that how people perceive the quality and availability of medical care in prison is often colored by the care they had on the outside.

Those who had private health care in the free world tend to rate prison health care low. Inmates who had no health care in the free world, other than an emergency room, tend to rate prison health care much more highly. One wonders whether a similar dynamic will play out with a universal health system in the United States.

Regardless of where one sits on the issue of transforming the public-health system or the health-care delivery system in the United States, the reality is that it will cost money. Ideally and hypothetically, if we invest more money in prevention – including behavioral and commercial changes by individuals and profit-making companies – we will reduce the “downstream” costs of health care.

Even inside the jail or prison, some inmates with chronic diseases on special diets still stock up on canteen items that counteract the best efforts of health-care staff. So don’t think that New York Mayor Michael Bloomberg’s calls to limit high-calorie beverages won’t be followed by other items, and the list expanded.

Soon, everything I love will be immoral, illegal, or against the advice of the surgeon general.

Prison health care provides us with a glimpse into the mechanisms that can be utilized to transform public health and health-care delivery. Prisoner behavior in a highly controlled environment shows us the ways in which individuals can still resist the best health-care engineering efforts.

Transforming the health-care system will require a new level of social control in areas of behavior that extend beyond simply what is available at your local fast-food outlet.

In the end, we can learn a great deal by observing the health-promoting and health-defeating behaviors among prisoners – and we have a lot of those, unfortunately.

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