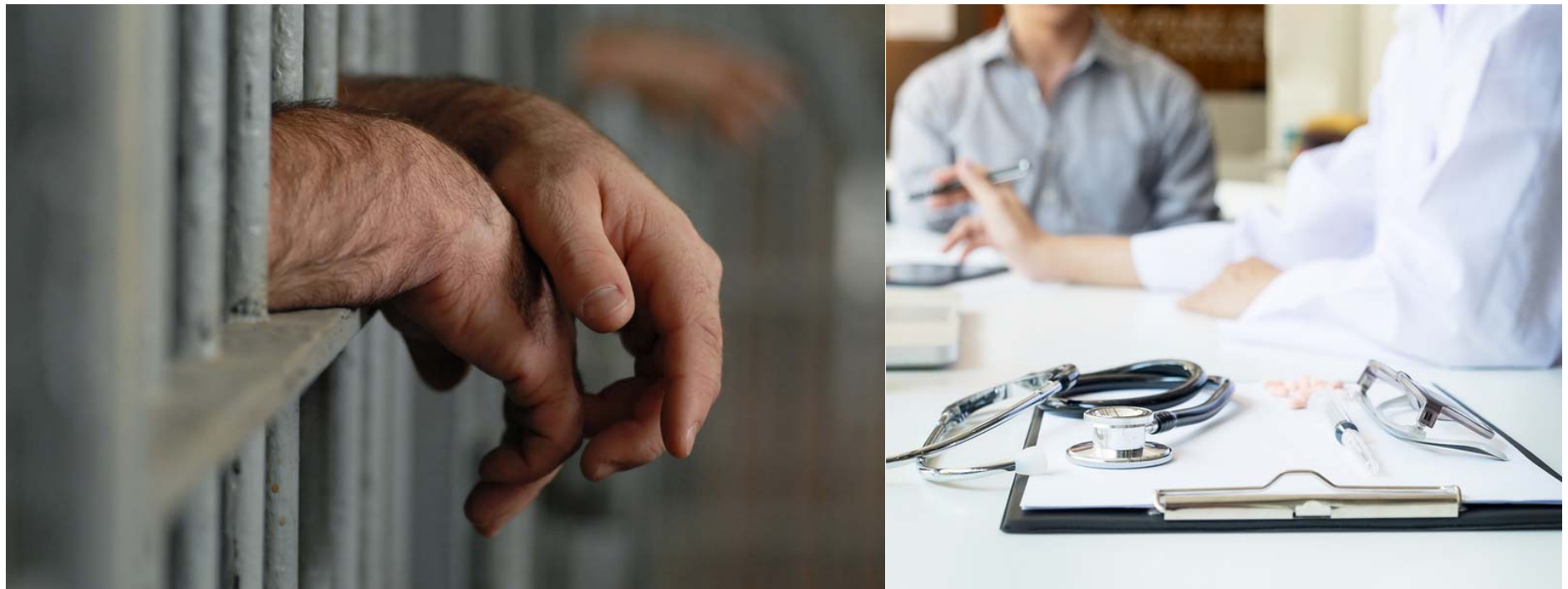


FUTURE ORGANIZATION OF HEALTH CARE IN BELGIAN PRISONS: FINAL STAKEHOLDER CONSULTATION



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- The external experts were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.
- Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.
- Finally, this report has been approved by common assent by the Executive Board.
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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
CMC	Centre Médical – Medisch Centrum
FPS	Federal Public Service
GP	General Practitioner
INAMI	Institut National d'Assurance Maladie-Invalidité
MD	Medical Doctor
PSD – SPS	PsychoSocial Dienst – Service PsychoSocial
RIZIV	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering



■ SCIENTIFIC REPORT

1 INTRODUCTION

Based on previous research in the earlier phases of the project, possible scenarios for the future organization of health care in Belgian prisons were developed. To gain insight in the feasibility and acceptability of those scenario's, stakeholders were consulted. Hereto, an online survey was held in which stakeholders could give their opinion.

The survey was send to a list of 450 persons; this list contained

- Representatives of the FPS Justice
- Representatives of the FPS Public Health
- All members of the steering committee 'Future Health Care Organization in Belgian prisons' (including representatives of the Ministry of Justice and the Ministry of Social Affairs and Public Health)
- All members of the central prison surveillance commission
- The chairmen and medical representatives from the local prison surveillance committees
- All members of the penitentiary health council
- Health care staff working in prisons (medical doctors, nurses, psychiatrists and dentists)
- Representatives of defederated entities, responsible for health care
- Representatives of RIZIV – INAMI
- Representatives of health care insurance companies
- Representatives of health care professional organizations/associations (medical specialists, GP, psychiatrists, nurses, dentists, psychologists, maisons médicales / wijkgezondheidscentra)
- Representatives of support organizations for prisoners and their relatives
- Representatives of labour unions



- (content and scientific) experts on prison health care, as identified during the project

The questionnaire was launched on a secured Limesurvey platform on 22nd March 2017 by sending an invitation e-mail to the 450 mail-addresses/persons; a reminder was send on 31st March 2017.

The website was open from 22nd March up to 2nd April midnight.

The questionnaire was anonymous, unless the respondents themselves entered their e-mail addresses.

2 RESULTS

The questionnaire was started by 344 persons of which 156 completed it fully.

From the 188 partially completed questionnaires, 158 did not go beyond the first question and were not used in any of the analyses; the remaining 30 partially completed questionnaires were only used as far as they contained qualitative remarks and used for the descriptive statistics.

Seventy two respondents chose the Dutch interface and 84 the French one. Almost all respondents provided additional comments in the free text boxes; these are discussed following each table.

One hundred and seven respondents filled out their e-mail address, from which some identifying characteristics could be derived. Based on this, we know that most of the above mentioned groups, with exception of the labour unions and associations of health care professionals, are represented in the respondents.

In all of the following tables, the denominator is 156 respondents.

In tables below the original phrasing in Dutch and French as used in the questionnaire, is presented to avoid losing language sensitive meaning by translating.

2.1 General organisation of health care in prisons

The questionnaire started with several statements about the basic principles for health care organization in prison. Respondents could (completely) agree or disagree with each of the statements or had the option 'no opinion'. Each of the statements is presented below with the quantitative percentages of agreement followed by the qualitative remarks respondents gave.

**Provision of health care inside or outside prison**

Statement A	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
A. Gezondheidszorg voor gevangenen gebeurt best zoveel mogelijk binnen de muren van de gevangenis en uitsluitend in geval van nood erbuiten. Les soins de santé pour les personnes détenues sont organisés de préférence le plus souvent possible au sein de la prison et sont organisés hors de la prison uniquement en cas d'urgence.	7	20	6	43	24
Total (%)	27		6		67

With regard to statement A, a majority (67%) agrees that health care should be given as much as possible within prison walls. Arguments given for this opinion related mostly to security issues; security can much better be guaranteed within prison walls and each extraction poses a danger. Moreover, extractions are difficult and costly to organize, because the needed security officers, that are not always available. According to the respondents it is much easier to bring health professionals inside prison than to take prisoners outside. Health care offer inside prison walls also enhance (speedy) accessibility to health care for prisoners. When health care is given inside prison, this is less stigmatizing compared to go outside with handcuffs and accompanied by two security officers. Finally, when care is given inside prison, it doesn't given burden to outside health care professionals and organizations. But proponents also remark that when healthcare is given inside prison, it should be given by health care professionals that are liaised

to the regular outside health care providers/organizations and are financed and controlled just like in the outside world.

On the other hand opponents comment that health care offer outside prison resembles more equivalent health care and it could also enhance reintegration in society for prisoners when released. Moreover, they point to the high budgets needed for an equivalent, comprehensive and up-to-date health care infrastructure within prisons and that much of the infrastructure cannot be used in a cost-efficient way. There is also a risk of lower quality of care inside prison compared to care given outside. Only basic health care can be given inside prison, but all more specialized care needs to be done outside. Also continuity of care could be enhanced when all health care could be given outside by regular health care professionals and organizations, especially if prisoners could go to the MD that treated them before.

**Health care is multidimensional**

Statement B	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
B. Uitgangspunt voor alle gezondheidszorg aan gevangenen, is dat gezondheid een multidimensioneel (fysiek, mentaal, sociaal) begrip is en dat aan noden op alle vlakken tegemoet gekomen dient te worden.					
La santé est un concept multidimensionnel, incluant des besoins physiques, mentaux et sociaux ; besoins qui doivent tous être satisfaits. Ceci doit constituer le point de départ des soins de santé des personnes détenues.	1	3	2.5	21	72
Total (%)	4		2.5		93

With regard to statement B, a large majority (93%) agrees that health is a multidimensional concept and that all types of health care needs of prisoners have to be assessed and treated. Opponents state that this is an ideal that is not attainable and not affordable. Also some respondents state that there is a danger of medicalisation of problems with such a point of view; another says that many problems of prisoners are out of scope for health care professionals and question if it is the task of health care to take care of social and mental problems. Moreover, they mention that prisoners not always want that all problems are addressed.

A proponent remarks that a multidimensional approach of health is essential, but can only be reached when there is also a meaningful activity program

organised in prison. Another states that e.g. a pharmacological treatment only of an addiction problem is useless without taking into account social and mental conditions.

Although many respondents agree, they remark that the current prison health care provision is far away from that multidimensional health care approach, due to a lack of time, a lack of human resources, a lack of financial means and a lack of coordination and communication between the several health care providers.

Finally, respondents state that the current division of competencies between federal and defederated entities hinders such a global approach.

**Public tender for the provision of health care services in prisons**

Statement C	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
C. Alle te leveren gezondheidszorgdiensten aan gevangenen worden openbaar aanbesteed door het Ministerie van Sociale Zaken en Volksgezondheid waarop reguliere zorgorganisaties/professionals uit de vrije samenleving kunnen intekenen. In de aanbesteding worden taken, uitkomstmaten, maximaal budget en betalingswijze gespecificeerd.					
Tous les soins de santé pour les personnes détenues sont sous-traités via un marché public à l'initiative du Ministère des affaires sociales et de la santé publique. Toute organisation de soins reconnue, tout professionnel de la santé habilité à exercer dans le système de santé belge peut postuler à ce marché public. Dans l'appel d'offre du marché public, les résultats attendus, le budget maximal et la modalité de rémunération des différents professionnels sont définis.	17	19	26	31	7
Total (%)	36		26		38

Concerning statement C, regarding outsourcing health care provision by a public tender, containing tasks, outcomes, budget and payment modality, we observe a lot of dispersion in the answers (36% disagree, 26% no opinion and 38% agree). Opponents are afraid that outsourcing by a public tender is too 'commercial'; they state that health and health care is not a market, but a public terrain/topic not suitable for such an approach. Why should health care to prisoners be subjected to a public tender while health care for persons in the external world is not? Some respondents state that they felt 'shocked' already with proposing the idea of outsourcing; health care should never be a commercial thing. Many opponents refer to bad experiences with outsourcing in the United States, but also to the recent Belgian experience with outsourcing the health care in the forensic psychiatric centres for mentally ill offenders, that in their opinion only led to very low quality of care. In case of outsourcing by public tender, all attention will be given to profitability and economic aspects and no longer to quality of services.

Another one fears that with outsourcing the link with the Justice will be lost, despite this remains essential.

Some respondents comment on '*the maximal budget*' that would be part of the public tender: they think that a maximum is not fair and would limit essential but costly treatments. Others question of such an approach is not conflicting with the right to free choice of health care professional and if there is not a risk of a monopoly. Finally, one wonders if there will be enough candidates to subscribe to the tender, since not many health care professionals and organizations are eager to take care of prisoners.

Proponents on the other hand think such an approach could enhance quality of care. However, they also see the danger of commercialization and state that such a public tender should only be open for not-for-profit organizations and they think close, continuous and independent inspection/monitoring is necessary. They stress that budget and payment must be attractive for health care professionals.



Implementation of e-health

Statement D	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
D. Er wordt zoveel mogelijk ingezet op diverse vormen van e-health (bijvoorbeeld video-consulteren, telemonitoring, online-programma's voor preventie of begeleiding enz.) om zo extracties naar buiten om medische redenen tot een minimum te beperken.					
Il faut investir le plus possible dans différentes formes de e-health (par ex. des consultations par vidéoconférence, du télémonitoring, des programmes en ligne pour la prévention ou l'accompagnement etc.) afin de limiter les extractions pour raisons médicales.	10	27.5	16	37	10
Total (%)	37.5				47

Concerning statement D on enforcing e-health possibilities in the prison context, 47% of the respondents are in favour of this, while 37.5% disagree.

Opponents mainly fear that e-health would endanger humanity and direct personal contact, what is seen as essential. Others doubt about who is responsible/accountable in case of e-health, especially since prisoners' lawyers are carefully watching if all health care provision is according to the laws.

Some respondents think that e-health might be a complement to traditional health care, but can never substitute it. For example, some see possibilities in e-health for prevention, counselling and support, but not for consultation. Some respondents have doubt about the effectivity of e-health and say that this still has to be demonstrated.

Others point that still much has to be done and much necessary logistics and infrastructure have to be developed before e-health could even have a chance and doubt if there is enough money available. Also some think that prisoners are not enough qualified/trained/educated to make use of e-health applications. Finally, some doubt if e-health applications are 'secure' enough to use within a prison context, in order to avoid unwanted communication between prisoners and the external world.

Proponents think that e-health can be a useful approach to enhance social contacts for prisoners. Others see a lot of opportunities in e-health to enhance collaboration and communication between health care professionals. Also time gain, less costs, less extractions, less security issues are mentioned as advantages of e-health. Since e-health applications can easily be tuned to different languages, some see many possibilities in the multicultural prison population.



Concentration of dangerous prisoners in some prisons

Statement E	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
E. Om veiligheidsrisico's te beperken, worden (vlucht)gevaarlijke gevangenen zoveel mogelijk geconcentreerd in één of slechts enkele gevangenissen, die voor specialistische zorg een contract hebben met een ziekenhuis in de buurt. Afin de limiter les risques liés à la sécurité, les personnes détenues dangereuses (ou avec un risque d'évasion) sont concentrées au maximum dans une ou plusieurs prisons, qui ont un contrat avec un hôpital voisin pour les soins spécialisés.	10	13.5	26	38	13
Total (%)	23.5		26		51

Statement E is on concentration of dangerous prisoners and prisoners with high flight risk in a single prison that has a contract with a nearby hospital for specialist somatic care. Half of the respondents agree that concentration is a valuable option while 24% disagree and 26% have no opinion.

Opponents say that specialised health care must be available in timely manner for all prisoners, wherever they are and whatever their degree of dangerousness. Also they think that concentration of dangerous prisoners creates an even more dangerous and problematic surrounding ("*poudrière*", "*ghetto*"). Concentration has also the risk of contamination, radicalisation and stigmatization and could compromise the re-entry in society. Also this would create a too high tension for the security staff. Some plea to locate prisoners as close as possible to their place of residence in order to maintain social contacts as much as possible and are against concentration of

prisoners based on a risk profile. Some respondents question how to assess and measure danger risk. Some are wondering if there would be a hospital that is willing to take care of that many very dangerous prisoners. Also in that hospital a separate secured wing would be needed. Better infrastructure and manpower in the current prison medical centres (CMC) could be a better solution for the dangerous prisoners, so they do not need to be extracted for health problems.

It is also questioned if there are that many very dangerous prisoners that concentration would be a viable option.

Proponents of concentration think that a close cooperation between a single prison and a single hospital in taking care of dangerous prisoners could enhance expertise in this field and could reduce security issues.



Comprehensive health assessment at prison entry

Statement F	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
F. Bij binnenkomst in de gevangenis wordt bij elke gevangene een integraal assessment uitgevoerd naar bestaande en mogelijke problemen op het vlak van lichamelijke gezondheid, psychische problemen, verslavingsproblematiek en maatschappelijk welzijn. Dit assessment wordt op een systematische manier met een gevalideerd instrument uitgevoerd en vormt de basis voor een individueel geïntegreerd zorgplan. A l'arrivée dans la prison, chaque personne détenue est soumise à un examen complet en vue de détecter d'éventuels problèmes de santé physique, de santé mentale, d'assuétudes et sociaux. Cet examen se fait systématiquement à l'aide d'instruments validés et sert de base à l'élaboration d'un plan de soins individuel et intégré.	2.5	10	6	37	44
Total (%)	12.5		6		81

Statement F concerns the comprehensive health assessment at prison entry as a base to create an individual care plan for each prisoner. A large majority (81%) supports this idea and only 12% disagree.

Many 'opponents' do in fact not disagree with the proposal, but they think it is not attainable due to lack of budget, lack of manpower, inadequate information to prisoners, suboptimal information from outside health care providers at entry or lack of a good validated assessment instrument. Also some others state that such entrance-assessment can never be obliged and consent of prisoner is always needed. Some question the need for an integral assessment (and the time involved), when prisoners stay only for a very short time. This would also frustrate health care professionals when they only can diagnose/detect problems and have no means or time to do something about them. Someone asks why would such an assessment been done in prisoners, while this is not the case in the outside world. Also the cost-effectiveness of screening for health problems is questioned. Finally, an opponent states that there is currently no well performing patient health record in which such an assessment could be recorded.

Proponents state that a comprehensive health assessment is a must to obtain an overview of problems and to assess necessary interventions and health care professionals. Moreover, they say that a comprehensive assessment is not only needed at entry, but should be done at regular intervals to evaluate the health condition and to work in prospective way. Other stress the importance of comprehensiveness of the assessment and that mental and social dimensions are very important to assess, since these influence physical dimensions. A well performed entry-assessment is a good base to initiate a comprehensive prevention and treatment approach and, for example, to start to resolve an addiction problem.

Side remarks given are that such an assessment should be done in a uniform way in all prisons and well recorded in automated medical file that can be assessed by the several health care providers, can be transferred from prison to prison and can liaise with external health care professionals. Also sufficient budget and human resources must be provided by the government before such assessments can be performed (currently not enough).



Someone suggested to do the entry-assessment in a stepped level wise manner; first initial screening on possible problematic areas and when necessary followed by a more profound assessment.

Continuity of care

Statement G	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
G. Gezondheidszorg in gevangenissen dient beschouwd te worden als een onderdeel van de totale gezondheidszorg, waarbij gestreefd wordt naar een zo goed mogelijke continuïteit en afstemming met de zorg voorafgaand aan de detentie en de zorg na detentie. Hiertoe dienen de verschillende zorgverleners elkaar optimaal van informatie te voorzien en moeten ze de adequate (ICT) infrastructuur ter beschikking hebben.	1	2.5	1	29	66
Les soins de santé en prison doivent être considérés comme faisant partie intégrante du parcours de soins des individus : il faut viser une continuité des soins optimale et aligner les soins fournis en prison sur ceux délivrés avant et après la détention. Pour cela, les différents professionnels de la santé doivent échanger des informations et avoir l'infrastructure informatique adéquate (ICT).					
Total (%)	3.5		1		95

Statement G about continuity of care receives support from 95% of the respondents and is seen as obvious, without questioning. One opponent states he does not want to give confidential patient information to a computer, another is against systematically sharing of information and another states that some problems are detention-specific and have not to be communicated to the outside world.

Side remarks given by proponents are that continuity of care is an ideal, and the current situation is far from that; also better communication from the FPS Justice is needed about release of prisoners before continuity of care can be attained. Moreover current automated medical file is not suitable to communicate with the outside world; much investments are needed. Finally, attention has to be paid to the patient confidentiality and patient consent when exchanging information.



Remuneration of health care professionals in prisons

Statement H	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
H. De honorering voor zorgverleners in de gevangenis wordt dusdanig geregeld dat die op zijn minst even aantrekkelijk is als de honorering buiten de gevangenis.					
La rémunération des professionnels de la santé en prison est au moins aussi avantageuse/attractive que celle hors de la prison.	8	10	12	20	51
Total (%)	18		12		71

Statement H concerns attractiveness of remuneration for health care professionals in prisons. Seventy-one percent of respondents agree that remuneration for prison work should at least be as attractive as the one in the outside world, while 12% have no opinion and 18% oppose to the statement. A closer look at the comments made by the opponents learns that they don't agree with '*at least as attractive*'; they find prison work deserves much better rewards than the outside work, because of the danger risk, the time involved to get in and out prison, the complexity of the work, etc. Moreover, they state that payment need to be made immediately and without delay. Better and timely remuneration are needed to keep the work

in prison attractive; it may never be the case that a health care professional can earn more money in the outside world than in prisons. Many complain about the current situation of remunerations and payments. So many of the 'opponents' are in fact proponents of the statement.

Also many proponents state that prison work should be rewarded better.

Remarkable is that some respondents state that current remunerations for prison work is better than in the outside world, while most other comments state the opposite.



Current health care budget

Statement I	Completely disagree	Disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
I. Om adequate somatische en mentale zorg te leveren, zijn de huidige budgettaire middelen voldoende. Les moyens actuels sont suffisants pour garantir une offre adéquate de soins somatiques et mentaux.	46	29	14	7	4
Total (%)	75		14		11

Statement I states that the current budget for prison health care is sufficient. Seventy-five percent of the respondents disagree, 14% have no opinion and 11% agree. Across the survey responses on several questions, it is a recurrent comment that current means in terms of budget, infrastructure, equipment, manpower etc. are absolutely insufficient to deliver all needed health care and to meet quality standards.

On the following question, respondents are asked to give their priority area for the future prison health care budget. "Personnel" is by far the most chosen priority, as can be seen in table below. Most of the respondents that chose another number one priority, put "Personnel" on the second rank.

Priorities for future budget

Toekomstige budgetten voor gezondheidszorg aan gevangenen moeten vooral besteed worden: Les budgets futurs en soins de santé pour les personnes détenues doivent principalement être accordés:	Preferences (%)
1. Gezondheidszorgpersoneel / Au personnel de santé	53
2. Preventie en gezondheidspromotie / A la prévention et à la promotion de la santé	14.5
3. Opleiding van alle personeel / A la formation de tout le personnel	11
4. Infrastructuur / A l'infrastructure	6.5
5. Ontwikkeling en uitrol van e-health / Au développement et à l'implantation de l'e-health	4
6. Innovaties in de gezondheidszorg / A l'innovation dans les soins de santé	1
7. Geen mening / Pas d'opinion	5



The adagio in the comments is *'without adequate sufficient well educated personnel, no other things are possible'*. Investment in personnel is a condition sine qua non. But many state that all areas are important to invest.

Priorities in the reorganization of prison health care

The question on what is most important aspect when reorganization prison health care, is answered with *"the health of the prisoner"* as priority by 84% of the respondents.

Wat is voor u het belangrijkste aspect bij de reorganisatie van de gezondheidszorg voor de gevangenen? Quel est l'aspect le plus important dans la réorganisation des soins de santé pour les personnes détenues?		Preferences (%)
1.	De gezondheid van de gevangene / La santé de la personne détenue	84
2.	De veiligheid voor personeel en maatschappij / La sécurité pour le personnel et la société	8
3.	De kosten voor de Staat / Les coûts pour l'Etat	4

2.2 Primary care

Preferred scenario

The scenario of preference for primary care, chosen by the most (68.5%) considers the installation of an interdisciplinary health care team that works on the base of a multidimensional assessment and an individual care plan. The respondents that preferred the continuation of the current organization, remark often that de facto they would prefer the interdisciplinary team but they think it is not attainable and would costs way too much. This remark is also made by many others that they fear that introduction of interdisciplinary team will increase costs very much.

Another frequently made remark was that is of utmost importance that the Ministry of Social Affairs and Public Health will take the accountability and responsibility for health care in prison

One psychiatrist states he does not want to work under the lead/coordination of a GP.



Scenarios for primary care services	Preferences (%)
1. In elke gevangenis wordt een interdisciplinair team geïnstalleerd, dat werkt vanuit een holistische en multidimensionele visie op gezondheid. Dit team start met een omvattende assessment, waarop een individueel passend integraal zorgplan wordt gemaakt. Het team bestaat uit huisartsen, (algemene en psychiatrisch) verpleegkundigen, psychologen, maatschappelijk werkers, psychiaters, kinesitherapeuten en tandartsen, die ingezet worden in hun specifieke domein. Het team werkt onder verantwoordelijkheid van een huisarts. Une équipe interdisciplinaire exerce dans chaque prison et travaille dans une perspective de santé holistique et multidimensionnelle. Cette équipe se base sur un examen d'admission intégré et élabore un plan de soins intégré et individuel. L'équipe est composée de médecins généralistes, d'infirmiers (responsables en soins généraux et/ou, spécialisés en santé mentale), de psychologues, d'assistants sociaux, de psychiatres, de kinésithérapeutes et de dentistes. L'équipe travaille sous la responsabilité du médecin généraliste.	68.5
2. De huidige organisatie van de eerstelijnszorg wordt voortgezet zoals het nu is, met lokale huisartsen die bepaalde dagen spreekuur hebben en in sommige gevangenissen worden ondersteund door verpleegkundigen. Maar in de toekomst vallen de uitvoerders onder de verantwoordelijkheid van het Ministerie van Sociale Zaken en Volksgezondheid. L'organisation actuelle des soins de première ligne, avec des médecins généralistes locaux qui font des consultations sur base d'un calendrier défini avec, parfois, l'assistance d'infirmiers est maintenue. Par contre, les professionnels seront placés sous la responsabilité du Ministère des Affaires Sociales et de Santé Publique.	31.5

All inclusive primary care

Statement 1 Primary care	Completely disagree	disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
PC1. Een interdisciplinair team onder leiding van de huisarts is verantwoordelijk voor assessment, screening, preventie, gezondheidspromotie, behandeling en opvolging van alle eerste lijnsgezondheidsproblemen in de gevangenis.					
Une équipe interdisciplinaire sous la responsabilité d'un médecin généraliste est responsable pour l'examen d'admission, le dépistage, la prévention, la promotion de la santé, le traitement et le suivi des problèmes de la santé de première ligne dans la prison.	2	5	6.5	49.5	37
Total (%)	7	6.5	86.5		



In line with the previous, 86% of the respondents agree with the PC1 statement stating that an interdisciplinary team coordinated by a GP takes care of prevention, assessment, screening, health promotion and treatment of all primary care problems. One opponent finds that a GP is not capable to coordinate care for mental health problems; this should be done by a psychiatrist; also other opponents doubt if a GP is the right person to be in the lead of the interdisciplinary team.

Side remarks made by proponents are: doubt about availability and willingness of GPs to work in prisons, the need for a close cooperation with the psycho-social service (PSD/SPS) of the prison who also perform an entrance-assessment, the need for a close cooperation with professionals (and defederated authorities) that are currently involved with prevention and health promotion, and doubt about the (financial) attainability. Also some remark that the interdisciplinary team has to know very well their own capability and the limits of it so they refer timely to more specialized health care professionals.

Management of emergency situations

Statement 2 Primary care	Completely disagree	disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
PC2. Bij acuut optredende (somatische of psychiatrische) problematiek, wordt (de wachtdienst van) het interdisciplinaire eerstelijns team opgeroepen, die de problematiek verder onderzoekt en adequate eerste hulp geeft en indien nodig zorgt voor verdere doorverwijzing/consultatie van meer gespecialiseerde zorgverleners (medisch specialist, psychiater, spoedgevallendienst, ...)	6.5	4.5	10	46	33
En cas de problème (somatique ou psychiatrique) aigu, (le service de garde de) l'équipe interdisciplinaire de première ligne est appelé. Celle-ci examine et traite le problème et/ou organise le transfert vers un professionnel / une consultation / un service de deuxième ligne (médecin spécialiste, psychiatre, urgences...).					
Total (%)	11		10		79

Regarding PC2-statement that the interdisciplinary primary care team is also in charge for (the assessment of) all emergency situations, 79% respondents agree on this. Comments made by both opponents and proponents that first of all a good remuneration system is needed for being

on call. Also in both groups there are doubts if the interdisciplinary team should be available on 24/7 base. Some suggest to use the regular GP-duty services or the 112-system to respond to emergency situations.



Payment modalities for primary care

Statements 3-4-5 Primary care	Completely disagree	disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
PC3. Vergoeding per prestatie is het meest aangewezen betalingssysteem voor diensten van de eerste lijns gezondheidszorg aan gevangenen.	20.5	27.5	31.5	15	5
Le financement à l'acte est le paiement le plus approprié pour les services de soins de santé de première ligne aux personnes détenues					
Total (%)	48		31.5		20
PC4. Vergoeding per indicatie/pathologie is het meest aangewezen betalingssysteem voor diensten van de eerste lijns gezondheidszorg aan gevangenen.	17	31.5	38	11	2.5
Le financement forfaitaire par pathologie est le paiement le plus approprié pour les services de soins de santé de première ligne aux personnes détenues.					
Total (%)	48.5		38		12.5
PC5. Vergoeding per patient is het meest aangewezen betalingssysteem voor diensten van de eerste lijns gezondheidszorg aan gevangenen.	8	16.5	45.5	21	9
Le financement forfaitaire par capitation est le paiement le plus approprié pour les services de soins de santé de première ligne aux personnes détenues.					
Total (%)	24.5		45.5		30



The statements PC3, PC4 and PC5 concern different payment modalities (fee for service, activity-based funding, capitation per prisoner/patient) for primary care services. Most remarkable finding is the large proportion (30-50%) of respondents that have no opinion on this issue, and that for each option there are relative outweighing proportions of proponents and opponents. Apparently, each option has pros and cons: payment in a fee for services could lead to escalation of costs and is incentive to do a lot of unnecessary things; there is much work that has no nomenclature and therefore difficult to pay in a fee for service system; a capitation-system has the risk for giving as less care as possible; activity-based funding has the risk that work will be done by lower-qualified / less costly personnel; activity-based funding and capitation-system do not take into account the large diversity between patients; a capitation system has been proven in the United Kingdom not to work; how will overhead duties be paid...are examples of such pros and cons. Many respondents are in a favour of mix of payment modalities: salary per hour + fee for services + disease-based payment + capitation, and they state that the most suitable payment system also depends on the type of health care provider (for example. fee for service is much more applicable to physicians than to nurses).

2.3 Secondary care

Preferred scenario

The scenario of preference for secondary somatic care, chosen by the most (44%) considers the option that each (cluster of nearby) prison has a contract with a single acute care hospital in the neighbourhood for taking care of all elective and urgent specialist somatic care. However, also one third of the respondents prefer the creation of a single central secured hospital to which all prisoners from over the country are transferred for elective procedures, and another 22.5% respondents choose for the creation of a complete hospital structure within the walls of a single central prison. So opinions diverge. In the comments several pro and cons for each option are mentioned; however the comments are not always congruent: e.g. some say that option 1 will lead to increased costs and others think that option 1 will lead to less cost. Common remarks are that option 1 has the advantage that healthcare for prisoners most resembles health care in the outside world and that prisoners could always count on up-to-date hospital infrastructure. Common concern across the respondents is the security issue that always occur when prisoners have to be extracted and should be kept to a minimum. One respondent remarks that very dangerous prisoners should stay in prison and that therefore a hospital infrastructure within prison walls is the most ideal. Another respondent state that it can never be cost-effective to create a single hospital infrastructure within prison walls for a population of only 11000 persons (much too small). But another states that creation of a single hospital, inside or outside prison, where all sick prisoners are transferred to give the opportunity for specialization in prison health care issue and would give a boost to expertise.



Scenarios for secondary care	Preferences (%)
1. Elke gevangenis (of een cluster van dichtbij elkaar gelegen gevangenissen) sluiten een contract af met 1 dichtbij gelegen ziekenhuis, waar gevangenen van die gevangenis(sen) naartoe worden gebracht voor alle spoedeisende en alle niet spoedeisende zorg. Chaque prison (ou un groupe de prisons situées dans la même zone géographique) est liée contractuellement avec un hôpital voisin, vers lequel les personnes détenues de la prison sont transférées pour tous les soins aigus et non-aigus. Les soins d'urgence sont gérés par ce même hôpital.	44
2. Er wordt 1 centraal gelegen (beveiligd) ziekenhuis gecontracteerd door het Ministerie van Sociale Zaken en Volksgezondheid, waar gevangenen uit het gehele land worden naar toegebracht voor alle niet spoedeisende specialistische somatische zorg. De zorg in dit ziekenhuis buiten de gevangenis wordt geleverd door en onder verantwoordelijkheid van het gecontracteerde ziekenhuis. Voor de spoedeisende zorg sluit elke gevangenis een contract met een nabij gelegen ziekenhuis. Un hôpital (sécurisé) central est sous contrat avec le Ministère des Affaires Sociales et de la Santé publique; toutes les personnes détenues du pays sont transférées vers cet hôpital pour tous les soins non-aigus, somatiques et spécialisés. Les soins dans cet hôpital - situé en dehors de la prison - sont fournis par et sous la responsabilité d'un hôpital contractant. Pour les soins d'urgence, chaque prison établit un contrat avec un hôpital voisin	33.5
3. Er wordt 1 centraal gelegen gevangenis uitgerust met een volledige ziekenhuisinfrastructuur, waar gevangenen uit het gehele land worden naar toegebracht voor alle niet spoedeisende specialistische somatische zorg. De zorg in dit ziekenhuis binnen de gevangenis wordt geleverd door en onder verantwoordelijkheid van een nabij gelegen ziekenhuis waarmee een contract wordt afgesloten. Voor de spoedeisende zorg sluit elke gevangenis een contract met een nabij gelegen ziekenhuis. Une prison centrale est équipée d'une infrastructure hospitalière complète; toutes les personnes détenues du pays sont transférées vers cette prison pour tous les soins non-aigus, somatiques et spécialisés. Les soins dans cet hôpital situé à l'intérieur de la prison sont fournis par et sous la responsabilité d'un hôpital (voisin) contractant. Pour les soins d'urgence, chaque prison établit un contrat avec un hôpital voisin.	22.5



Payment modalities in secondary care

Also for secondary care we ask opinions on preferred payment modalities. Just like for primary care 30-50% of the respondents have no opinion and the others diverge. Also here pro and cons for each option are mentioned and there is no clear ideal option. The same pro and cons as for primary care are mentioned for secondary care (and many respondents refer to the comments they made earlier regarding primary care). And also here many respondents favour a mix of payment modalities.

Statements on payment modalities for secondary care	Completely disagree	disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
Vergoeding per prestatie is het meest aangewezen betalingssysteem voor diensten van de tweede lijns somatische gezondheidszorg aan gevangenen.	11	17.5	35	29.5	7
Le financement à l'acte est le paiement le plus approprié pour les services dans les soins de santé somatique de deuxième ligne aux personnes détenues.					
Total (%)	28.5		35		36.5
Vergoeding per indicatie/pathologie is het meest aangewezen betalingssysteem voor diensten van de tweede lijns somatische gezondheidszorg aan gevangenen.	13	23	40	21	3
Le financement forfaitaire par pathologie est le paiement le plus approprié pour les services dans les soins de santé somatique de deuxième ligne aux personnes détenues.					
Total (%)	36		40		24
Vergoeding per patiënt is het meest aangewezen betalingssysteem voor diensten van de tweede lijns somatische gezondheidszorg aan gevangenen.	11	21	52	15	1
Le financement forfaitaire par capitation est le paiement le plus approprié pour les services dans les soins de santé somatique de deuxième ligne aux personnes détenues.					
Total (%)	32		52		16



2.4 Mental health care

Less severe mental health problems

This part of the questionnaire starts with a statement regarding less severe mental problems being part of primary care. A large majority (89%) agree with this statement.

Opponents state there is not enough manpower and not enough knowledge in primary care to take care of all less severe mental problems; one says that there is no such thing as less severe mental health problems, all mental health problems in prisoners deserve specialist approach.

Also proponents say that for taking care of less severe mental problems, adequate training and knowledge is required, and that at least there must always a psychiatrist available that can be consulted.

Statement mental health care	Completely disagree	disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
Minder ernstige mentale problemen zijn een integraal onderdeel van de eerstelijns zorg binnen de gevangenis. Het interdisciplinaire eerstelijns team is verantwoordelijk voor assessment, screening, preventie en begeleiding bij minder ernstige mentale gezondheidsproblemen, waar nodig ondersteund door meer specialistische zorgverleners.	3	5	2.5	52	37
Les problèmes de santé mentale les moins sévères sont pris en charge comme partie intégrante des soins de première ligne dans les prisons. L'équipe interdisciplinaire de première ligne est responsable pour l'examen, le dépistage, la prévention et l'accompagnement en cas de problèmes de santé mentale non sévères, si nécessaire avec le soutien de professionnels spécialisés.					
Total (%)	8		2.5		89



Preferred scenario

The scenario of preference for mental health care considers whether or not to concentrate prisoners with severe mental problems on special wings or even on special prisons. Most (71%) of the respondents are in favour of some form of concentration, since this would facilitate appropriate care and makes it more easy to hire security staff that has feeling with psychiatric behaviour of prisoners. Some think that concentration is certainly a good option for all addiction-related treatments.

Also concentration can offer a kind of protection for vulnerable prisoners. Opponents state that concentration is an impediment for social contacts and makes visits of relatives more difficult; others warn that concentration may stigmatize prisoners. Some question if prisoners with severe mental health problems should remain in prison; psychiatric hospitals might be a better place.

Scenarios for mental health care	Preferences (%)
1. Gevangenen met ernstige mentale gezondheidsproblemen worden zoveel mogelijk geconcentreerd op speciale afdelingen binnen een gevangenis, dan wel geconcentreerd binnen enkele specialistische gevangenissen, zodat een passend:e zorginfrastructuur geboden kan worden. De behandeling/begeleiding gebeurt door gespecialiseerde psychiatrische equipes, gestationeerd binnen de gevangenis en gelieerd aan een extern psychiatrisch ziekenhuis of een centrum voor ambulante geestelijke gezondheidszorg. Les personnes détenues avec des problèmes de santé mentale sévères sont concentrées au maximum dans des sections spéciales au sein de la prison OU concentrées dans quelques prisons spécialisées, afin de pouvoir fournir une infrastructure appropriée. Le traitement/l'accompagnement est fait par des équipes psychiatriques spécialisées dans les prisons ; ces équipes sont liées à un hôpital psychiatrique externe ou à un service de santé mentale.	71
2. Gevangenen met ernstige mentale gezondheidsproblemen blijven verspreid over de gevangenissen en behandeld door gespecialiseerde psychiatrische zorgverleners van buiten. Les personnes détenues avec des problèmes de santé mentale sévères sont réparties entre les différentes prisons et sont traitées par des professionnels spécialisés en psychiatrie, venant de l'extérieur de la prison.	28

Payment modalities for mental health care

With regard to preferred payment modalities for prison mental health care, we see the same picture as for primary and secondary care with almost half of respondents that have no opinion and for those that gave an opinion a lot

of divergence is observed. According to the comments each payment modality has pros and cons as were already listed for primary and secondary care. And again some respondents propose a mix of modalities.



Statements on payment modalities for mental health care	Completely disagree	disagree	No opinion	Agree	Completely agree
	%	%	%	%	%
Vergoeding per prestatie is het meest aangewezen betalingssysteem voor specialistische psychiatrische zorg aan gevangenen.	16	25	40	18	1
Le financement à l'acte est le système de paiement le plus approprié pour les soins psychiatriques spécialisés aux personnes détenues.					
Total (%)	41		40		19
Vergoeding per indicatie/pathologie is het meest aangewezen betalingssysteem voor specialistische psychiatrische zorg aan gevangenen.	11.5	27	45.5	14	2
Le financement forfaitaire par pathologie est le système de paiement le plus approprié pour les soins psychiatriques spécialisés aux personnes détenues.					
Total (%)	38.5		45.5		16
Vergoeding per patiënt is het meest aangewezen betalingssysteem voor specialistische psychiatrische zorg aan gevangenen.	7	15.5	50.5	21	6
Le financement forfaitaire par capitation est le système de paiement le plus approprié pour les soins psychiatriques spécialisés aux personnes détenues.					
Total (%)	22.5		50.5		27



2.5 Dental care

Regarding dental care we ask if every prison needs a full equipped dental offices or if small prison could also be visited by a mobile dental van.

Fifty-six percent of the respondents prefer the fixed full-equipped structure for large prisons in combination with the mobile dental van for small prisons.

However, whatever preference that is made, many respondents stress that dental problems are immense in the prison population and deserve much more attention, but it is difficult to find enough dentist to work in the prison context.

Scenarios for dental care	Preferences (%)
1. Uitsluitend in grote gevangenissen wordt een volledig uitgerust tandartskabinet geïnstalleerd. In kleine gevangenissen komt een mobiele tandartsunit wekelijks langs. Dans les grandes prisons uniquement, un cabinet dentaire complètement équipé est installé. Dans les petites prisons, une équipe dentaire mobile passe chaque semaine.	56
2. In elke gevangenis wordt een volledig uitgerust tandartskabinet geïnstalleerd Dans chaque prison, un cabinet dentaire complètement équipé est installé.	43

2.6 Additional remarks made by respondents

- There is need for more physiotherapist, nurses, dentists and psychologists.
- The prescription of psychopharmaceutics could be diminished by providing meaningful day activity program and prison work.
- The current program for patient health records, Epicure, is not performant and not user-friendly.
- There is also a need for palliative care in prisons.
- The current health care provision in prison is inadequate and insufficient, much more money has to be invested.
- There is need for more and easy accessible substitution therapy for drug-addicted prisoners.
- There is need to downsize prisons, smaller prisons are needed.
- There is a need for a better (central) quality control and monitoring system for prison health care.
- Nurse triage could be a way to decrease GP-workload and to direct prisoners to the most appropriate health care professional.



- There is a need for a kind of central commission that can easily be consulted in case of severe pathologies or complex situations.
- Also prisoners must have a right for free choice of health care professional or must at least be able to obtain a free second opinion.
- There is a need for central coordination by the Ministry of Social Affairs and Public Health for health care provision in the local prisons
- There is need cultural-sensitive care adapted to the diversity of cultures and languages of prisoners.

3 CONCLUSION

Based on the online stakeholder consultation, we conclude that following general principles for future health care have support from the field:

- health care should be given as much as possible within prison walls
- health is a multidimensional concept and that all types of health care needs of prisoners have to be assessed and treated
- every prisoner should receive a comprehensive health assessment at prison entry as a base to create an individual care plan for each prisoner
- continuity of care is seen as obvious, without questioning
- remuneration for prison work should at least be as attractive as the one in the outside world

Divergences are observed on the following aspects:

- outsourcing health care provision by a public tender, containing tasks, outcomes, budget and payment modality
- enforcing e-health possibilities in the prison context: 47% of the respondents are in favour of this, while 37.5% disagree
- concentration of dangerous prisoners and prisoners with high flight risk in a single prison that has a contract with a nearby hospital for specialist somatic care: half of the respondents agree that concentration is a valuable option while 24% disagree and 26% have no opinion.

There is a general agreement that the current budget for prison health care is insufficient.



3.1 Primary care

The scenario of preference for primary care, chosen by 68.5% of the respondents, considers the installation of an interdisciplinary health care team that works on the base of a multidimensional assessment and an individual care plan. In line with the previous, a large majority (86%) of the respondents agree with the statement stating that an interdisciplinary team coordinated by a GP takes care of prevention, assessment, screening, health promotion and treatment of all primary care problems. Regarding the statement that the interdisciplinary primary care team is also in charge for (the assessment of) all emergency situations, 79% respondents agree on this.

3.2 Secondary care

The scenario of preference for secondary care, chosen by the most (44%) considers the option that each (cluster of nearby) prison has a contract with a single acute care hospital in the neighbourhood for taking care of all elective and urgent specialist somatic care. However, also one third of the respondents prefer the creation of a single central secured hospital to which all prisoners from over the country are transferred for elective procedures, and another 22.5% respondents choose for the creation of complete hospital structure within the walls of a single central prison. So opinions diverge.

3.3 Mental health care

This part of the questionnaire started with a statement regarding less severe mental problems being part of primary care. A large majority (89%) agree with this statement. The scenario of preference for mental health care, considered whether or not to concentrate prisoners with severe mental problems on special wings or even on special prisons. Most (71%) of the respondents are in favour of some form of concentration, since this would facilitate appropriate care and makes it more easy to hire security staff that has feeling with psychiatric behaviour of prisoners.

3.4 Dental care

Regarding dental care we ask if every prison needs a full equipped dental offices or if small prison could also be visited by a mobile dental van. Fifty-six percent of respondent prefer the fixed full-equipped structure for large prisons in combination with the mobile dental van for small prisons.

3.5 Payment modalities

Many have no opinion; others show divergent opinions. No single modality appear to be the most appropriate or favourite one; many respondents suggest a mix of payment modalities.