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How Prisons are Exacerbating Health Inequalities — Especially for Aging Prisoners

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U.S. incarceration rates have dramatically increased since the introduction of "get tough" laws in the 1970s, including mandatory minimum sentences and increased use of life without parole. Many of the two million men and women currently in jails and prisons are serving extraordinarily long sentences. As correctional priorities shift away from promoting prisoner rehabilitation toward warehousing long-timers, prisons have become overcrowded, under-staffed, and under-resourced.

The population of state prisons is also aging. Between 2000 and 2016, the share of inmates 55 and older jumped from 3 to 11 percent of all prisoners. This trend increases the burden on taxpayers and exacerbates systemic health inequalities. Because elderly prisoners generally need more medical services, they cost two to three times as much to incarcerate as their younger peers. Correctional facilities not constructed to serve an aging population are forced to streamline health care delivery. However, the rising health concerns – and costs – of older prisoners are not exclusively a consequence of their chronological age. Research shows that incarceration itself increases risks for a host of deleterious health outcomes, including infectious disease, chronic illness, depression, anxiety, and premature physiological aging and mortality. What is more, because prison sentences are disproportionately doled out to the poor and people of color, prisons are exacerbating health disparities in the United States. These consequences are then often dumped on communities after prisoners finish lengthy terms.

How Social and Economic Inequalities Impact Prison Healthcare

In my research on the issue, I interviewed 279 incarcerated older men age 50 to 78 years. On average, the interviewees suffered from 3.6 chronic health conditions and reported taking an average of four medications each. My research identifies barriers to quality health care in the prison system – including high costs, medication delays, inadequate specialty care, delayed diagnoses, and health care providers who stigmatize prisoners because of their crimes.

I also learned about privileges for prisoners with greater social and economic means. At least two factors are related to which incarcerated men can best manage their own health. Skills and health-related knowledge render some better able to advocate for themselves, take up healthy behaviors, and ensure adequate treatment. Second, men who were better equipped to get their medical needs met tended to have extra resources. For example, some men in the sample relied on the prison commissary to substitute healthier diet options such as fish and nuts for unhealthy prison meals. Such men were thereby more capable of managing chronic diseases such as diabetes. However, only those who both knew that such options would enhance their health and had the means to pay the extra costs could protect their health in this manner.

Another issue contributing to health inequalities in the prison system is that correctional facilities increasingly require prisoners make co-payments for medications and appointments. Yet, overcrowding and limited prison resources mean that not all prisoners have access to employment opportunities during incarceration. Just over two-fifths of my respondents were unemployed, and even those with jobs earned only an average of 19 cents per hour – meaning they must work 27 hours to afford one five-dollar co-payment. What is more, not all prisoners have family or friends who they can rely on to deposit money into their accounts. As a result, health care opportunities are stratified based on prisoners' abilities to afford: medical co-payments, healthy food items, dietary supplements, vitamins, and prescribed medications.

Men also reported varying success in efforts to communicate problems to medical staff. Some disclosed that they were sent to punitive solitary confinement after attempting to advocate for their health-related needs. Others reported they had to file multiple grievances or hire attorneys before receiving needed medical care.

Only those able to discern how to communicate effectively with medical staff and resourced with access to supportive family, friends, or attorneys are likely to receive the care they need.

Consequences for Prisons – and Implications for Policymakers

Although prison health care is "available" to all inmates, not everyone has access to the same health management opportunities. As prison populations grow older, it will become increasingly difficult to meet their health care and other basic needs. Approximately 600,000 men and women are released from prisons annually – any health-related burdens acquired or aggravated during imprisonment also carry major public health implications. Prisons and policymakers can, however, take steps to lessen negative outcomes:

- ***Offer additional dietary options***, particularly for older prisoners and those with chronic health conditions. Men in this study described being "starched to death," forced to eat diets rich in potatoes, corn, noodles, pasta, and rice. More thoughtful dietary options can not only improve inmate health but also reduce health care costs in the long run.
- ***Provide a fair and transparent grievance process.*** Wardens can hire prisoner volunteers to assist inmates who have difficulties, and have grievances reviewed by external committees.
- ***Eliminate medical co-payments and increase voluntary job opportunities***, so that privileged prisoners do not reap health advantages over those without privileged statuses.
- ***Partner with researchers to support additional studies*** – especially to understand the perspectives and experiences of correctional medical providers and female prisoners.

Prisons and policymakers must invest in research and new solutions. Unless state legislatures and prison administrators recognize and address the health needs of changing prison populations , the health of prisoners will continue to deteriorate, inequalities will worsen, and prisons, the incarcerated, and taxpayers will bear the added costs.

Read more in Meghan A. Novisky, "Avoiding the Runaround: The Link between Cultural Health Capital and Health Management among Older Prisoners" *Criminology* (2018).