

HEALTH REMANDED TO CUSTODY

The Future of the Prison Health Care System in Israel



HUMAN RIGHTS
ISRAEL

PHYSICIANS FOR
HUMAN RIGHTS

דוכאים אטבא
לזכיוח אדם לחقوق الإنسآن

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Executive Summary

Morbidity among prison inmates (prisoners and detainees) is significantly higher than in the general population. The higher incidence of illness is usually explained as a result of the inmates' background prior to arrest in conjunction with the living conditions and quality of medical care in prison. Many inmates belong to socio-economically disadvantaged groups characterized by unhealthy lifestyles and a high rate of drug and alcohol abuse. In addition, living conditions in prison, which include overcrowding, a lack of physical space and restrictions imposed on the inmates' daily routine, result in a sedentary lifestyle, heightened stress, poor nutrition and smoking.

Inmates' health care is provided by the health care system of the Israel Prison Service (IPS), which operates independently of the Israeli public health system and the Ministry of Health and is not subject to effective external control and oversight. Consequently, the services provided to inmates are of poor quality and fail to meet the professional and ethical standards of the community health care system. Not only is the continued existence of a separate - and inferior - health care system for inmates morally wrong and not only does it violate the principle of equality, it is not cost-effective, as it will likely overburden the public health system which, once inmates are released from prison and rejoin society, will have to treat patients who did not receive optimal care.

Findings

Inferior Health Care

Several dozen medical files of inmates with chronic diseases underwent professional review by family medicine specialists who are Physicians for Human Rights–Israel (PHRI) volunteers. Their review indicates that the health care provided by the IPS is substandard, below the quality of care provided by the HMOs in Israel (not for profit national health plans, in Hebrew: kupot cholim). In almost half of the files examined, the patient's health was put in jeopardy by inadequate treatment or the denial of essential treatment.

Similarly, inmates' waiting times for treatment and tests at external medical facilities are unusually long as compared with the public health system in Israel. The long waiting times are the result of administrative failings in the IPS health care system. Moreover, when specialists send inmates for tests or treatments, the IPS often does not implement their medical recommendations and does so without providing any professional rationale.

The professional level of the IPS medical staff – responsible for both routine and emergency care – is significantly lower than that of the medical staff in the public health system. Unlike the HMOs, where about half of the practitioners in family medicine settings are specialists, the IPS employs no specialists in the prison clinics. Moreover, IPS medical services rely mainly on EMTs (emergency medical technicians, hereafter: medics), whose professional training is rudimentary and unsuitable for the extensive responsibilities they are given in prison.

Professional and Administrative Failings of the IPS Health Care System

The IPS health care system operates without a clear work plan and without conducting any professional assessment of the needs of the prison population. The system is completely unequipped to deal with issues such as the aging inmate population or the increase in the number of inmates with chronic diseases. Meanwhile, inconsistent IPS data make it impossible to estimate the extent of these trends. As far back as 2014, the IPS stated that it had begun drafting a long-term, multi-year work plan for the health care system. Nevertheless, at the time of writing this report, formulation of the plan has yet to be completed.

The IPS health care system is understaffed, a shortage that is expected to grow more acute in the next few years. It already proves very difficult to recruit physicians to fill job vacancies in the health care system, and many doctors employed by the IPS are nearing retirement age.

The budget of the health care system as officially reported by the IPS is significantly smaller than the actual budget. The mean outlay for medical services per inmate is significantly higher than what the HMOs spend on patients with similar characteristics. The fact that medical services are provided by the IPS makes them more costly, resulting in economic inefficiency.

No Medical Control and Oversight

Based on a dubious interpretation of the National Health Insurance Law, the Ministry of Health states that it does not have the authority to determine medical policies in prison, and thereby eschews any duty to monitor or oversee the IPS health care system. The Ministry of Health's Ombudsman, whose mandate includes processing inmate complaints, is not seen by inmates as relevant, and he therefore receives only a handful of inmate

complaints a year. Even when complaints are lodged, in most cases the Ombudsman does little more than take the IPS position at face value and conducts no independent review. Consequently, its absence of medical expertise notwithstanding, the Ministry of Public Security – which oversees the IPS – has become the body in charge of both setting and overseeing prison health care.

Over the years, several commissions of inquiry have been charged with reviewing the quality of medical services provided to inmates, yet the overwhelming majority of their recommendations has never been implemented. For example, out of 11 recommendations made by the 2002 Avi Israeli Commission on quality of medical services only one – regarding the computerization of medical records – has been fully implemented. Another recommendation – bringing specialist doctors to prisons – was only partly implemented, and even that partial implementation was achieved only after a High Court petition. As for the commission's review of issues related to prison conditions and their effect on inmates' health, some progress has been made, but only thanks to public advocacy and legal campaigns by human rights organizations.

Conclusions and Recommendations

- **Integrate the prison health system into the public health system.** The medical services currently provided to inmates are of poor quality and low availability, in breach of the state's duty to provide equitable care. PHRI believes the only real solution is reassigning responsibility for the health care services provided to inmates from the correctional authorities to the state health system, i.e., to the Ministry of Health and the HMOs. Based on the experience of other countries, transferring prison medical services to the responsibility of the Ministry of Health is expected to facilitate the recruitment of high-quality medical staff, raise the professional level of services offered, mitigate the problem of prison doctors' dual loyalty and make the system more cost-effective.
- **Establish an effective and professional mechanism for medical control and oversight of the IPS health care system.** The findings of this report suggest the urgent need to involve a professional medical body in formulating medical policy in correctional facilities and in controlling and overseeing implementation of the policy.
- **Increase the involvement of the medical community in prison medicine.** The Israel Medical Association (IMA) has stated on several occasions in recent years that medical services for inmates must be removed from IPS responsibility. This position should be adopted by other civilian medical associations as well. International experience has shown that active involvement by medical organizations was instrumental in promoting reforms and improving medical services for inmates.



Introduction

The present report is a preliminary attempt to offer a comprehensive overview of the problems and flaws afflicting the Israel Prison Service (IPS) health care system, to analyze their underlying causes and offer possible solutions. While the report describes the current problems in the IPS system, it also relies on twenty years of experience and knowledge that Physicians for Human Rights-Israel (PHRI) has gained since it became involved in promoting the rights of prison inmates – both convicted individuals and detainees – in correctional facilities in Israel.

In the late 1990s, PHRI began receiving disturbing testimonies from prison inmates who had been held in the IPS Medical Center. The testimonies prompted PHRI to petition the High Court of Justice (HCJ) in 2002, seeking the closure of the IPS Medical Center.¹ Following this petition, the Ministry of Health formed a commission – the Avi Israeli Commission – tasking it with examining the medical services provided to prison inmates. The commission recommended extensive reform. In the years since, PHRI has handled over 3,400 complaints from prison inmates regarding poor medical care and living conditions.² In addition to handling these complaints, PHRI – sometimes working jointly with other organizations – led various campaigns to promote inmates' rights, including the right of every inmate to a bed;³ inmates' right to a non-smoking cell;⁴ the right to humane conditions in transports to courts and hospitals;⁵ and the right to decent conditions and

¹ HCJ 3274/02 *Physicians for Human Rights-Israel v. Minister of Public Security*.

² From February 2003 – when PHRI began systematically recording complaints it received from prison inmates – through December 2018, PHRI was contacted by 3,463 inmates. Please note: Throughout this paper, the term inmates or prison inmates is used to denote all individuals in IPS custody, including both prisoners and detainees.

³ HCJ 4634/04 *PHRI v. Minister of Public Security*.

⁴ HCJ 1482/08 *Adalah – Legal Center for Arab Minority Rights in Israel v. Israel Prison Service [IPS]*.

⁵ HCJ 9513/10 *PHRI v. IPS*.

treatment for disabled prison inmates.⁶ We also fought against the severe overcrowding in prisons;⁷ against the IPS policy of placing suicidal inmates in restraints for extended periods of time;⁸ and against the extensive use of solitary confinement by the IPS.⁹

PHRI's decision to publish the present report at this time was driven by a sense that there has been a worrisome deterioration over the past two years in the functioning of the IPS health care system and the quality of care provided to inmates. Others have also gained a similar impression of the system. In a recent Knesset committee session that debated transferring the military's medical services to the civilian HMOs (not for profit national health plans, in Hebrew: *kupot cholim*), Director General of the Ministry of Health Moshe Bar Siman Tov said: "The IPS is in a major crisis in terms of providing services."¹⁰

Any examination of the crisis in prison health care must also bear in mind the shift (or at least the declared shift) in the overall attitude of Israeli authorities regarding the rights of prison inmates. This trend began when the government decided to adopt the recommendations made by the commission headed by former Supreme Court Justice Dalia Dorner regarding cutting back on custodial penalties and stepping up efforts geared at inmates' rehabilitation and re-integration into society.¹¹ The shift continued with the precedent-setting H CJ ruling that requires the state to supply funds to ensure adequate living space for inmates.¹² Yet while many features of the prison system have been undergoing significant reform, prison health care has not.

The first part of this report offers a general overview of prison inmates' right to health, as well as a detailed portrait of the medical profile of prison inmates in Israel and a description of the structure, staff and services of the IPS health care system. Part I also presents the legal framework under which the IPS health care system operates and describes the mechanisms meant to monitor and oversee it. Finally, this section also provides an analysis of the conclusions of the various commissions of inquiry tasked with examining the IPS health care system over the years and the extent to which the commissions' recommendations have been implemented.

The second part of this report identifies the main failings of the IPS health care system that PHRI has encountered over the years. The failings have to do with the availability and accessibility of health care; with ensuring that it is uninterrupted and of a high standard; and with the effect that extraneous, non-medical considerations – particularly economic and administrative considerations – have on providing health care services in prison. Part II is based both on inmates' testimonies and chiefly on the information in their medical records, which PHRI received from the IPS itself. This section uses case studies to provide details of the system's various problems. Based on a systematic analysis of the medical records of dozens of inmates with chronic diseases, which was carried out by family physicians who are PHRI volunteers, Part II reports on the quality of the medical services patients received.

The last section of this report reviews prevailing trends elsewhere in the world with regard to the issue of shifting the responsibility for inmates' health care from prison authorities to the health care system in the community. We conclude by recommending steps

⁶ HCJ 1892/14 *Association for Civil Rights in Israel [ACRI] v. Minister of Public Security*. The petition was filed jointly by ACRI, Academic Center of Law and Business, and PHRI.

⁷ HCJ 9513/10 PHRI v. IPS.

⁸ HCJ 7492/11 PHRI v. IPS.

⁹ *The Sounds of Silence: Isolation and Solitary Confinement of Palestinians in Israeli Detention*, PHRI, 2008.

¹⁰ IDF Human Resources Subcommittee, Transcript No. 39, September 5, 2018.

¹¹ Cabinet Resolution No. 1840 re: "Improving the Punitive Policy and the Rehabilitation of Prisoners in Israel," August 11, 2016.

¹² See footnote 7 above.

that would lead to the ultimate implementation of this type of move in Israel in the long run, as well as interim measures to improve the IPS health care system right away.

We hope this paper will serve to persuade the relevant authorities, particularly the Ministry of Public Security and the Ministry of Health, that the IPS health care system is in crisis and that a major, comprehensive transformation must be effected in order to ensure the rights of prison inmates.

Part I:

Inmates' Right to Health
and the IPS Health Care System:
Background, Description & Oversight



Background: Prison Inmates in Israel:

In June 2018, there were some 16,000 inmates (detainees and prisoners) in IPS facilities.¹³ This total included about 10,000 who were being held on criminal charges, about 5,500 Palestinian inmates who Israeli authorities define as "security prisoners," and several hundred migrant workers and asylum seekers in custody for undocumented residency (being in Israel without a permit). The prison population is virtually all male, with fewer than 250 women inmates.

A. Medical Profile

Whereas the prison population was once generally believed to be predominantly young, in recent years, Israel and other countries have seen an increase in the percentage of older prisoners. In 2010, about 40% of criminal prisoners were no older than 35, and some 8% (598) were 55 and over, falling under the designation "elderly" (also referred to as "older").¹⁴ In 2012, there were 838 elderly inmates. According to the IPS, these figures represent a 191% increase in the number of older inmates from 2002 to 2011.¹⁵ This trend is the result of a combination of the general aging of the population, including the prison population, and changes in punitive policy. It is a process that poses a new and particularly complex challenge for health care systems in prisons worldwide.

Studies elsewhere in the world suggest that multiple factors – including the prior lifestyle of most inmates, prison conditions (including overcrowding, active and

¹³ Based on data the IPS conveyed to B'Tselem (an Israeli NGO) on August 2, 2018, under a Freedom of Information Request.

¹⁴ "Criminal Convicts Who Are Israeli Citizens – 2010 Data," Prisoner Rehabilitation Authority.

¹⁵ "Elderly Prisoners: Inclusion or Separation," IPS Research Unit, 2012.

passive smoking), little physical activity, poor nutrition, and sub-optimal health care – result in inmates' state of health being comparable to that of non-inmates who are ten or more years their senior.¹⁶ A study in England found that 85% of older inmates had at least one chronic illness, which is a high proportion compared to both young inmates and to older adults in the general population. Moreover, older inmates were found to be more vulnerable to infectious diseases, which are more prevalent in prisons, and at heightened risk for age-related medical problems such as falls and fractures, cognitive impairment and failing eyesight and hearing.¹⁷

Yet heightened morbidity is also characteristic of younger inmates. Many come from a poor background and had unhealthy lifestyles, including smoking and drug and alcohol abuse. A US study found a higher rate of diabetes, hypertension and infectious diseases such as HIV and hepatitis C among inmates than in the general population.¹⁸ No comparable Israeli survey on prisoner health has been conducted, but various data published by IPS over the years also suggest a similarly complex medical profile. In 2013, over 1,200 inmates with a chronic disease were in IPS facilities, a 90% increase compared to 2008. According to recent data we received from the IPS, the figures for January 2019 show there were about 6,000 inmates who had been diagnosed with some kind of chronic disease.¹⁹ Nearly 75% of criminal prisoners required psychiatric evaluation or treatment, as compared with 1%-2% in the general population,²⁰ and some 600 inmates (nearly 4%) had been diagnosed with schizophrenia, as compared with 1-1.5% in the general population.²¹ In addition, according to IPS figures, about two-thirds of criminal prisoners have a history of alcohol addiction, and about half have a history of other substance addiction.²²

These figures are not fully applicable to Palestinian inmates, who constitute about a third of the prison population in Israel. While many patterns of morbidity among criminal inmates (i.e., inmates incarcerated on criminal charges) in Israel are consistent with data from elsewhere in the Western world, Palestinian inmates come from a different background so their medical profile is different due to a different and distinctive set of circumstances. Certain features prevalent among criminal inmates – such as alcohol and drug abuse and their resultant morbidity, such as infectious diseases – are rare among Palestinian inmates. Moreover, with regard to Palestinian inmates, PHRI's years of experience in handling inmate complaints has found a much higher frequency of gunshot wounds and physical injuries sustained during arrest and interrogation.

B. Inmates' Right to Health: Limitations Imposed and Bodies Responsible for Ensuring the Right

In 1994, Israel enacted its National Health Insurance Law, which codified the right of all Israeli residents to health services. The first article of the law states that National Health Insurance will be founded on the principles of justice, equality and mutual assistance. Article 3(a) defines who is entitled to health services: "Every resident is entitled to health services under this law, unless entitled to such services under other legislation."

¹⁶ Stephen Ginn, "Elderly prisoners," *BMJ* 2012, p. 345.

¹⁷ R. Bedard et al., "Ageing prisoners: An introduction to geriatric health-care challenges in correctional facilities," *International Review of the Red Cross* (2016), 98 (3), pp. 917-939.

¹⁸ Andrew P. Wilper et al., "The Health and Health Care of US Prisoners: Results of a Nationwide Survey," *American Journal of Public Health* 99, no. 4 (April 1, 2009), pp. 666-672.

¹⁹ Data obtained from the IPS by PHRI on January 1, 2019, under a Freedom of Information Request.

²⁰ "The IPS Health Care System," State Comptroller Annual Report, 2015.

²¹ 2017 Summary Report, Prisoner Rehabilitation Authority, p. 92.

²² Data provided by the IPS in a hearing of the Knesset's State Control Committee, Transcript No. 82, January 8, 2014.

According to the interpretation by the IPS and the Ministry of Health, the 1971 Prisons Ordinance [New Version] constitutes "other legislation" which regulates inmates' rights to health services, thereby excluding them from the provisions of the National Health Insurance Law.²³ The ordinance does refer to the issue briefly. Article 11B(c)(1) states: "A prisoner shall be entitled... [to] the medical care necessary to maintain his health, and to appropriate monitoring conditions as stipulated by an IPS physician."

Nevertheless, as its name suggests, the Prisons Ordinance is not a regulation whose focus is the right to health or medical care. In fact, apart from codifying the right of inmates to medical care, the ordinance makes no other reference to any other health-related issues, apart from administrative matters, such as that a physician must examine inmates upon their arrival in prison and prior to their release, or the procedure for transferring inmates to a hospital and preventing their escape en route.²⁴ Just how little attention is given to health issues in the ordinance is particularly glaring when compared with the National Health Insurance Law, which regulates many key issues such as the mandated benefit package of medical services (known as "the health basket") and extensions to the package; services not included in the package; the right to appeal HMO decisions; and the Ministry of Health's mechanisms of control and oversight, including the authority to impose sanctions on HMOs. Given this discrepancy, an interpretation that views the Prison Ordinance as a legislative alternative to the National Health Insurance Law seems unreasonable and leaves many fundamental issues unaddressed and unregulated.

The extent of medical services provided to inmates and the way they are provided are determined in internal IPS procedures. Whereas the National Health Insurance Law and the details of the services provided under it are made available to the public, only some of the procedures of the IPS health care system and the services to which inmates are entitled are made public, and most inmates remain ignorant of them. In 2018, PHRI called on the IPS to publish the procedures and regulations of its health care system. The impetus for PHRI's demand was finding that only a handful of procedures were posted on the IPS website, and that the procedures that were posted did not address most of the matters handled by the prison health care system. In response to PHRI's demand, the IPS explained that as they were transitioning to a new website, they had decided to review and reassess all procedures. Consequently, they are not publicly available. Further to a complaint PHRI filed with the Freedom of Information Commissioner at the Ministry of Justice, the IPS made public some 40 more procedures that address the health care system's operations. That said, the IPS has yet to publish either the procedures setting out the package of services it undertakes to provide to the inmates or the criteria for approving treatments not included in the package. The fact that IPS procedures are not transparent and that inmates' right to health services is in fact governed by internal procedures leaves the IPS with extensive latitude and discretion, including the option of denying treatment to inmates on the grounds that it is not mandated by the procedures.

The main procedure regulating medical treatment in prison is Civil Service Commission Directive No. 04.44.00: Medical Treatment of Prisoners. Article 1 of the directive defines the entitlement of inmates to treatment and the considerations guiding the decision on paying for treatment:

"An inmate will be entitled to the basic medical services package the Clalit HMO provides its insured, to be provided in Israel, be of reasonable quality and provided within a reasonable time, all subject to medical judgment and as long as they are within the funding resources available to the IPS."

²³ Letter from IPS Deputy Legal Adviser Adv. Nava Maimon to PHRI, dated October 23, 2001.

²⁴ An exception to this rule is the 2015 addition to the ordinance with regard to the force-feeding of hunger strikers.

On the face of it, this article is identical to Article 3(d) of the National Health Insurance Law, which stipulates that treatments included in the medical benefits package will be provided subject to medical judgment and as long as they keep within the funding resources of the HMOs. Unlike the IPS procedures, however, the law states in Article 3(c) that "the HMO is responsible for providing its registered members with all the health services to which they are entitled under this law [...]."

In other words, the HMO must provide any treatment included in the medical benefits package and cannot refuse to pay for the treatment on the pretext that its budget cannot cover it.²⁵ It is a crucial difference, as the IPS often cites an insufficient budget to explain why it denies inmates certain treatments.

It is worth noting that the current wording of Article 1 of the Commission Directive, which deviates from the principles laid down in the National Health Insurance Law, is not the original wording. It was revised by the IPS in 2006, when the IPS refused to pay for an inmate's kidney transplant. Prior to this revision, the directive had stated that treatment be provided according to the services that Clalit (HMO) provides to all of its insured, without any caveats. On the basis of this wording, PHRI contacted the IPS on behalf of an inmate by the name of Ahmad Tamimi, demanding that he be referred for a kidney transplant. This demand was based on the inmate's medical need, on the availability of a kidney donor from his family, and on the fact that the procedure is covered under the medical benefits package. When the IPS refused to pay for the treatment, PHRI petitioned the Tel Aviv-Jaffa District Court on Tamimi's behalf, and the directive was reworded shortly thereafter. In October 2007, the court ruled that the IPS must pay for the treatment. The court further added that from the time an individual is incarcerated and placed in state custody, the state is duty-bound to provide him/her with medical care of a standard equivalent to that of the civilian, community health care system.²⁶

The court ruling notwithstanding, over the years the IPS has continued in its attempts to withhold treatments listed in the medical benefits package – particularly costly ones – citing lack of funds as pretext. In 2016, for example, the IPS refused to provide a criminal inmate diagnosed with advanced hepatitis C the treatment his doctors recommended (see below, p. 68, for more on hepatitis C). As in the ruling in Tamimi's case, here too the court ruled that the IPS was required to provide the treatment that was in the medical benefits package, and could not deny it on the pretext of lack of financial resources.²⁷

C. The Right to a Second Opinion

Due to their incarceration, inmates are denied the right free people have to choose their own physicians. They cannot just go to a medical appointment whenever they so choose, or even make a phone call to the hospital to schedule one, nor can they choose to go to a different physician if they have doubts as to the medical opinion they received. In theory, the 1996 Patient Rights Law guarantees the right to a second opinion, including for inmates. Article 7 of the law states that a patient has the right to obtain a second opinion, and that the facility treating the patient must help him get it. Article 27 specifically states that the law's provisions apply also to the IPS and that the IPS Chief Medical Officer must establish procedures enabling inmates to exercise their right to a second opinion.

²⁵ See also the interpretation of this article given by the National Health Insurance Law Ombudsman: "If the HMO claims that the funding sources available to it are insufficient, such claims need to be directed at the state, as required by Article 3(b). Budgetary disagreements may not be conducted at the expense of the patients, and it is unlawful to refuse to provide a service included in the health benefit package." Ombudsman Report for 1998-1999, p. 44.

²⁶ Prisoner Petition Appeal 2808/05, *Tamimi v. Director of Medical Department*.

²⁷ Prisoner Petition 28629-08-15, *Rosalio v. IPS*.

That said, the IPS procedure on doctor visits by private physicians states that the inmate must pay for the visit, and that the relevant medical and security permits must be obtained from the IPS prior to the visit.²⁸ It has been PHRI's experience that obtaining approval is a process that can take weeks. Moreover, figures PHRI received from the IPS further to a freedom of information request indicate that the expense and bureaucratic obstacles involved in obtaining a second opinion render that right purely theoretical. For example, the entire Northern District of the IPS saw just one visit by a private physician in the last three months of 2016.²⁹ As a result, inmates are almost virtually dependent on the prison doctor and the prison clinic staff. This dependence makes it even more crucial that medical care is provided to inmates transparently and according to clear standards, and that it be subject to appropriate control and oversight.

D. Budgeting the Health Care System, Per Capita Expenses

An analysis of the budget of the IPS health care system was conducted by the accounting firm Wulkan Strolovitch & Co. at PHRI's request. The following section was written on the basis of the economic opinion they gave. It offers an overview of the budget review they carried out and their findings. See Appendix 1 below for their full report.

1. According to IPS figures, in 2017 the IPS health care system's expenses came to a total of 96 million Israeli shekels (NIS), excluding payroll costs. These were estimated at NIS 69 million, **bringing the total expenses to NIS 165 million.**
2. In June 2018, there were 15,943 inmates whose medical services were provided by the IPS. Hence, the cost per inmate was NIS 10,360.
3. In 2017, the mean expense of the HMOs per insured individual was NIS 5,561.30. However, adjusting for age and gender ratios among the prison population, the standardized cost comes to NIS 4,362 per capita.
4. According to the capitation formula, due to different rates of utilizing services, older populations are weighted higher than younger ones.
5. After standardization of expenses per inmate under IPS responsibility, the expense per inmate comes to NIS 7,996. The difference between this figure and the actual outlay probably represents some of the greater morbidity among IPS inmates when compared with the general population; the difference between the figures is about 29.6%. We think the percentage of excess morbidity is even higher, but as a conservative estimate, we will assume it is also 29.6%.
6. Therefore, *the standardized expenditure for the relevant population served by the HMOs would have been NIS 5,651 per patient* ($1.296 \times 4,362$).
7. The HMOs are much larger than the IPS, and they insure and provide health care to a far larger population. The premise assumed is that the HMOs have a much greater buying power than the IPS and that their overheads per insured are lower than IPS overheads per inmate.
8. For the purpose of estimating buying power, we posit that if the IPS had the buying power of the HMOs, the cost of each itemized expense would have been reduced by 15–20%; we also assume that the overhead burden per inmate increases the expense by a rate of 5% of the total expense. Hence, the expense per inmate after deducting the excess burden would be NIS 8,447.

²⁸ IPS Procedure 044600.

²⁹ Letter from IPS Management and Registration Officer Adv. Michael Avitan to PHRI, dated February 26, 2017. The IPS response provided only data on the Northern District for the last quarter of 2016. Please note that according to IPS figures, in addition to the physician's visit, four visits by private dentists were approved during the same period for Palestinian inmates. Many visits by private dentists to Palestinian inmates are coordinated and financed by the Palestinian Authority.

³⁰ Summary Report on HMO Activities in 2017, Ministry of Health.

9. In other words, the per capita outlay by the IPS is higher - some 49% higher - than what the HMOs would have spent for individuals with the same age and gender profile.

The Budgetary Implications of the Calculated Difference

10. In budgetary terms, the calculated difference indicates that if responsibility for medical services for IPS inmates were handed over to the HMOs, the same service for this population would be obtained for approximately NIS 75 million less than current IPS spending.
11. Even factoring in the HMOs' greater purchasing power vis-à-vis the IPS as well as the higher overhead costs burdened per inmate, there is still a difference in outlay, with the IPS spending approximately NIS 45 million more than the HMOs would have spent.

Standardized expense for the general population	IPS outlay per inmate	Expense per inmate after equating purchasing power and overhead burden	Standardized expense per capita for relevant age bracket	Standardized expense per inmate by age and gender distribution	Expense per inmate if services were provided by the HMOs, including supplement for excess morbidity
Amount in NIS					
5,651	10,360	8,447	4,362	7,996	5,651



The IPS Health Care System

From 2005 to 2007, detention facilities that had been the responsibility of the police or the military were transferred to the IPS's responsibility. Ever since the completion of that move, the IPS has been responsible for all detention and incarceration facilities in Israel and now runs thirty on-site medical clinics. Due to the nature of the facilities, the clinics provide medical services around the clock. The clinic physician, however, is on-site only during regular office hours, from the morning until the afternoon. At all other times, the clinics are staffed only by EMTs (emergency medical technicians, hereafter: medics). Medics constitute a key element of the prison health care system, not only because they serve as the senior medical authority when there is no physician on-site, but also because of their additional roles, such as dispensing prescribed medication, examining patients and managing the medical records.

In addition to primary medical care, the IPS also provides inmates with specialist medical services, including care by mental health specialists, and hospitalization facilities. Nevertheless, the fact that the IPS health care system is entirely separate from the general, community health care system in Israel leads to a host of problems that affect the quality and availability of medical services across the board, including the staff's level of medical training, access to more expert consultation and advanced treatment, and the supply of medications. As a result of these problems, which are reviewed in detail below, in practice, the professional standards of the IPS health care are substantially inferior to those provided in the community.

A. Emergencies

Prison clinics provide only primary medical care. In case of a medical emergency, or when further tests or treatments are required, such as medical imaging or surgery, inmates are referred to nearby hospitals. In an emergency, senior medical authority then on-site – the clinic physician during working hours or a medic at all other times – must assess how urgent the situation is and then decide whether or not the patient needs to be taken to a hospital, or whether emergency medical service providers should be summoned. As a rule, referring inmates to a hospital involves difficulties for the IPS since it means assigning prison guards to escort and guard them for the duration of the hospital treatment. It also involves difficulties for the inmates themselves, since travel to the hospital is usually via an IPS shuttle (known as "posta") that does not drive directly to the hospital from the prison. Instead, the journey often lasts hours under difficult conditions. In addition, inmates are usually kept in restraints throughout their hospitalization.³¹

B. The IPS Medical Center

The IPS Medical Center (IPSMC) is located in Ayalon Prison in the city of Ramla. The IPSMC fulfills two functions. First of all, it serves as a prison setting for patients whose medical conditions entail follow-up and supervision that cannot be provided in prison clinics (e.g., after surgery, chronic illness or in need of long-term or nursing care). Second, it serves as a specialized medicine hub. Patients from the various prisons are referred there for more expert consultation and diagnosis. Also on the premises are an X-ray clinic, a dialysis clinic and a state-wide lab for processing blood and urine tests. According to IPS figures, there are 115 hospital beds in the IPSMC. It also employs several dozen inmates as nurse assistants and cleaning staff.

Over the years, PHRI has twice petitioned the HCJ regarding the IPSMC. The first petition (hereafter, HCJ IPSMC) was filed in 2002³² after IPHRI had received many complaints from inmates regarding poor medical care, unacceptable comportment by the medical staff, neglect by the inmates employed as auxiliary staff, and harsh conditions.³³ The petition's main argument was that the IPS was operating the IPSMC as a "pseudo-hospital," yet doing so without meeting the relevant requirements of supervision and oversight by the Ministry of Health or of appropriate staffing. Further to the petition, the HCJ ordered that a commission be appointed to examine the medical services provided to inmates. The appointed commission, headed by Prof. Avi Israeli, stated that the IPSMC should not be considered a hospital because most of its patients did not require hospitalization, instead needing close medical supervision that could not be provided in the ordinary prison setting. (For a detailed review of the Avi Israeli Commission and its recommendations, see below, p. 45.)

In the years after the commission completed its report, the IPSMC had in its care inmates who fit the Ministry of Health's definition of patients in need of nursing or long-term

³¹ Placing restraints on prison inmates while they are in a hospital receiving medical treatment is degrading and violates their right to dignity. Moreover, it creates an inappropriate situation that violates physician-patient trust and could, in some circumstances, even affect the inmate's health because it restricts movement. Given these considerations, the Ministry of Health and the Israeli Medical Association have decided that the default situation is for prison inmates to be treated without restraints. Despite the position of medical authorities, however, the IPS usually places restraints on inmates for the duration of their hospital stay. In 2008, after PHRI fought for it for years, the IPS set out procedures governing the placing of restraints on prison inmates while in hospital. The procedures stated that the default is that inmates not be placed in restraints during their hospital stay and that the IPS would have to apply discretion prior to using restraints on inmates, taking their health status into account. Nevertheless, PHRI constantly receives testimonies from inmates and hospital physicians that indicate that despite said procedures, the IPS applies no discretion, and the using restraints is the default. For more on placing restraints on prison inmates in hospitals, see *Medicine in Handcuffs: Restraining Prisoners and Detainees Undergoing Medical Treatment and Hospitalization*, PHRI, June 2003.

³² HCJ 3274/02, PHRI v. *Minister of Public Security*.

³³ *These Worldly Bars: Maltreatment and Neglect at the Israel Prison Service Medical Center* PHRI, 2002.

care, e.g., being incontinent or confined to a wheelchair. PHRI received repeated reports of these patients suffering severe neglect, including some patients who developed pressure ulcers (bedsores) and infections due to inadequate treatment that was the result of a shortage in long-term-care personnel. As a result of these complaints, PHRI filed another H CJ petition against the IPSMC in 2010. We argued that the IPSMC was acting as a hospital setting for inmates in need of nursing or long-term care, despite not meeting the Ministry of Health's requirements for a nursing facility in terms of either personnel or living conditions. We added that PHRI volunteer physicians who had visited the IPSMC reported inadequate medical monitoring of these patients. In its response to our petition, the IPS once again argued that had these patients not been living in prison, they would not have been in a hospital, instead receiving long-term care at home.³⁴

The argument made by the IPS – like the view stated by the Israeli Commission – ignores the fact that even if these patients do not meet the standard criteria for hospitalization, their situation is completely different from that of similar patients living in the community. Inmates cannot rely on the help of relatives nor can they hire caregivers. Furthermore, they require special facilities such as wheelchair-accessible toilets, showers and recreation yards. A specially adapted prison could offer such an environment, thereby obviating the need for hospitalization, but these facilities most certainly do not exist in ordinary prisons. This leads to the problematic situation wherein the IPS confines these patients to the IPSMC, apparently in a hospital setting, but at the same time is not obliged to meet the expected standards of long-term care. Obviously, individuals who are in their own home have no need, nor any legal grounds, to stipulate guidelines regarding their living conditions or the nature of the care and nursing they require. However, when patients are incarcerated in a government facility, where they have no control over living conditions or the medical treatment provided, it is simply unacceptable for the system to operate without clear professional guidelines.

A final note: the H CJ did not dismiss PHRI's arguments, but ruled that they needed to be adjudicated as individual petitions by the inmates whose rights had been violated, not as a universal petition.

C. Specialist Clinics

As of 2005, following the H CJ IPSMC petition, the IPS has been paying for specialist consultations. The specialists come from the nearby Assaf Harofeh Hospital and provide medical consultations in urology, orthopedics, ENT (ear, nose and throat), general surgery, cardiology, nephrology, dermatology, ophthalmology and gastroenterology.³⁵

This model of specialist clinics within detention facilities was expanded in 2012 to 2013 to the Northern District as well, where they are provided at Zalmon Prison by Ziv Hospital; and in 2014 to the Southern District, where they are provided at Eshel Prison, mainly by physicians from Barzilai Hospital. Since October 2018, another clinic has been operating in HaSharon Prison, with services provided by Laniado Hospital.³⁶ In addition to primary and specialist medicine, the IPS has dental clinics in all its prisons, providing inmates with dental care, with the exception of crowns and implants.³⁷

³⁴ See footnote 6 above and further developments under H CJ 8388/11.

³⁵ See footnote 20 above, pp. 409, 415.

³⁶ See footnote 19 above.

³⁷ IPS Procedure No. 03-1001: Dental Care for Prisoners.

D. Mental Health Services

The IPS also provides mental health services, including psychiatric evaluations, routine follow-ups and, in certain cases, hospitalization. The services are provided by the Mental Health Center (MHC) in Ayalon Prison. The MHC is affiliated with Beer Yaakov Mental Health Center. It has both a secure ward and an open unit, whose doctors are also responsible for providing therapeutic drugs on an outpatient basis in the detention facilities. In 2010, the IPS began employing psychiatrists directly instead of through the MHC, and they are subject to the authority of the IPS health care system rather than being part of the Ministry of Health. The IPS has explained that hiring them was necessary because the MHC cannot meet the increased demand for mental health services that followed the IPS becoming the exclusive correctional authority in Israel. According to the MHC, the change in the IPS's status which led to a substantially increased demand for mental health services was not accompanied by an increased budget or more positions for mental health workers at MHC. In a 2015 report on the IPS health care system, the State Comptroller wrote that, for years, the Ministry of Health and the IPS have failed to agree on an appropriate division of labor or on a clear estimate of the number of mental health workers needed.³⁸

³⁸ See footnote 20 above, pp. 422-425.



IPS Medical Staff

According to IPS figures, the IPS health care system had 41 GPs on its payroll in 2014. It also employed two physicians in the role of District Doctors. In addition, there were nine nurses in various positions, and about 200 medics, some of whom served in the capacity of clinic directors.³⁹

Over the years, various commissions tasked with reviewing the medical services provided to inmates have devoted much attention to the issue of IPS medical staff and their training. However, despite the commissions' recommendations, the staff remains underqualified in terms of the medical training necessary for treating the inmate population.

A. IPS Physicians

As mentioned above, the IPS employs more than forty physicians in the IPSMC and the prison clinics. Most of them are general practitioners who are not certified in any medical specialty. This is very different from the situation in the HMOs. There, despite the shortage of family medicine specialists, more than half of the physicians who act as GPs – essentially the same function of the prison doctor – hold a specialty in one field or another. According to Ministry of Health figures, 32% of doctors serving as GPs in HMOs are board certified in family medicine, and another 12% are board certified internists.⁴⁰

³⁹ IPS response to a Freedom of Information Request by PHRI, June 22, 2014.

⁴⁰ "Medicine in the Community: Physicians Employed in Family Medicine in Israel," Ministry of Health, 2015.

A.1 Professional Training and Specialization

As far back as 2002, the Avi Israeli Commission saw the need for improving the professional qualification of IPS physicians, as they are not specialists. The commission recommended a series of long-term initiatives, including creating various training programs, employing specialists in the IPSMC and employing senior doctors as case managers and consultants:

"The Commission is aware that the IPS has made an effort to hire physicians, but to no avail. However, since most of the physicians are not specialists, and the question arises as to what kind of specialty the prison clinics need, the Commission recommends creating a dedicated training program for physicians, in addition to the workshops provided by the IPS. This program could include continuing education, such as certification in family medicine, internal medicine, etc., one-month rotations in hospital wards or accredited clinics for practical experience in the community, once every two years, for example [...]. The Commission recommends ensuring that at least the IPSMC physicians are specialists and preferably in a variety of specialties, such as internal medicine, family medicine, orthopedics and surgery. It is highly desirable for the Chief of the IPSMC to have both managerial skills and specialization in one of the relevant medical fields [...]. It is also recommended to consider the possibility of including, where appropriate, a case manager – a specialist in family or internal medicine – who is a senior physician and will manage the treatment as the leading consultant.⁴¹"

Similar conclusions were reached in an external consulting report commissioned by the IPS:

"The level of the physicians in the clinics appears to be low, due to lack of training programs and specialization programs. In the report submitted to the IPS, the adviser recommended drafting a multi-year program for a unique training track for the clinic physicians that would include specialization in family medicine with an emphasis on 'prison medicine.'⁴²"

To the best of our knowledge, no dedicated training programs have yet been created for IPS physicians⁴³, and no successful moves have been initiated to recruit specialists to the various prison clinics, particularly the IPSMC. It should be noted that in 2011 to 2014, the IPS did employ two family medicine specialists as "knowledge supporters." To the best of our knowledge, no physicians with such training are currently employed by the IPS.

In addition to the matter of professional training for prison physicians, the IPS finds it difficult to get any physicians willing to work for it. This difficulty will likely be exacerbated in the next few years, since many of the IPS physicians are nearing retirement age. According to IPS figures for 2014, six GP positions were not staffed, despite the availability of job openings; and of the 41 GPs then employed by the IPS, 24 were at least 50 years old.

⁴¹ Report of the Commission for Examining Medical Services for Prisoners, December 2002, pp. 12-13.

⁴² See footnote 20 above, p. 408. This information relies on what the State Comptroller wrote about the report, because all of PHRI's attempts to obtain a copy of the report have proved futile: in 2017 PHRI made a Freedom of Information Request to the IPS to obtain the report along with other, internal reports on medical services in the IPS. The IPS denied the request, claiming that these were internal discussions to which the Freedom of Information Law did not apply. In response to a Freedom of Information petition by PHRI to obtain the report (Administrative Appeal 27933-07-18, PHRI v. IPS), the IPS stated that it had "failed to locate them."

⁴³ In a 2008 letter to provide an update on the implementation of the Israeli Commission recommendations, the IPS stated that it had contacted the Ministry of Health and the HMOs "in order to find an additional training program, but no such programs are available." Letter from Adv. Nava Maimon to PHRI, dated February 20, 2008. In July 2018, the IPS issued a call for proposals to hospitals and HMOs for contracting to train specialist physicians with IPS funding, on condition that they work in the IPS after completing their residency. Call for Proposals No. 151/2018 - Physician Specialization in Medical Institutions, Funded by the IPS.

A.2 The Ethical Conflict: Dual Loyalty

As prison doctors are directly employed by the IPS and subject to its authority, they are confronted with a variety of situations that place their loyalties in conflict: to their patients, on the one hand, and the IPS on the other. They are forced to face serious ethical dilemmas, often resulting in the violation of patients' rights and detrimentally affecting treatment. This conflict is part of everyday life in prison, played out in different encounters between inmates and the health care system. For example, physicians are required to choose between their professional opinion that an inmate should be taken to the hospital and staff constraints because of the need to assign guards to escort the inmate. In other cases, a physician might recommend a certain treatment, but the IPS would rather not provide it because of budget concerns. There are even more extreme situations, with the patient's best interests coming into conflict with security considerations, e.g. in the case of detainees undergoing interrogation.

In professional scholarship, this conflict is known as "dual loyalty" and it may also be found in the community health care system, whenever the best interests of the patient clash with various organizational and financial considerations. That said, the conflict is believed to be much greater in prisons, due to their hierarchic and centralist organization and due to the inherent conflict between the inmate and the prison authorities⁴⁴. This situation can lead the inmates to distrust the medical staff, as they are seen as part of "the system."

Both international and local medical ethics organizations have written regulations and guidelines setting out the obligations of physicians employed in detention facilities. These stipulate that physicians and other medical staff must not use their knowledge for any purpose other than to evaluate, protect and improve their patients' health.⁴⁵ Moreover, the guidelines of the World Medical Association (WMA), also adopted by the Israel Medical Association (IMA), state: "A physician shall exercise his professional independence in deciding upon the appropriate medical care for a detainee or inmate for whom he is medically responsible, stemming from his responsibility to the individual's physical and mental wellbeing."⁴⁶

Nevertheless, in practice, it is clearly evident that the inherent conflict of loyalties in the prison health care system impinges on inmates' rights and leads to violating the ethical duties of prison physicians. The issue of dual loyalty was central to the IMA's position in HCJ IPSMC, where it expressed its support for transferring responsibility for the IPS health care system to the Ministry of Health:

"Given the position of the inmate in need of medical care, the issue of his informed consent to medical care – as required under Section D of the Patient Rights Law, including making a voluntary and independent choice regarding medical care – is problematic. The decision as to providing the medical care, transferring the patient for treatment outside the detention facility itself, and/or determining the surgical procedure, naturally involves considerations that are extraneous to medicine – budgetary and security considerations that are part of the ordinary decision making process [...]. It is the opinion of the IMA that the physicians of the IPS health care system should be subject to the authority of the Ministry of Health rather than to the IPS [...]. Transferring authority [over the doctors] as above-stated will preclude any possible concerns over a conflict of interests and dual loyalty, and will ensure independent and appropriate treatment."⁴⁷

⁴⁴ J. Pont, H. Stöver and H. Wolff, "Dual loyalty in prison health care," *American Journal of Public Health*, (2012), vol. 102(3), pp. 475-80.

⁴⁵ E.g., "Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," which was adopted by the UN General Assembly in 1982.

⁴⁶ "Prohibition of Physician Participation in Interrogations and Torture," 2007, IMA position paper on the ratification of the WMA's Declaration of Tokyo .

<https://www.ima.org.il/eng/ViewContent.aspx?CategoryId=4529>

⁴⁷ See footnote 32 above.

B. IPS Medics

The IPS employs about 170 medics, some of them in the capacity of clinic directors or assistant clinic directors. The medics serve in multiple functions and have extensive responsibilities in the IPS health care system. First, they serve as the senior after-hours medical authority in prison, beginning in the afternoon, once there is no longer any doctor on-site. Second, they visit the prison blocs regularly to dispense medication, attend the roll calls held several times a day, and help the prison doctor by performing various exams in the clinic, such as taking patients' blood pressure and measuring blood sugar levels. In addition, medics are the first responders to reports by inmates or prison officials of inmates' medical problems. They are also responsible for registering patients in the prison clinic and for the preliminary screening and prioritization of complaints, as inmates cannot usually simply show up at the clinic. The clinic director, responsible for managing the clinic and its team of medics, usually himself a medic by training, is charged with following up on the prison doctor's recommendations, referring inmates for tests and treatments outside the prison, and managing the stock of medicines.

Medics' regular assignments, including the treatment of chronic illnesses, which are particularly common among inmates, mean that their work is very similar to that performed by nurses in the community health system. However, their responsibility in an emergency, or when there is no doctor on-site – particularly given the difficulty involved in a speedy medical evacuation – is more comparable to that of a paramedic. Yet medics have only extremely basic training, and it does not prepare them for dealing with this sort of task. Medics usually undergo only a few weeks of training, three months at the most. In contrast, paramedics, who specialize in providing emergency medical response, receive certification after a course of studies that lasts more than a year, or else hold an academic degree in emergency medicine received after a three-year study program. Ministry of Health regulations clearly indicate there is a vast difference between the powers paramedics have in an emergency – such as providing medication and performing intubation or defibrillation – and the powers a medic has, which are limited to giving aspirin to a patient complaining of cardiovascular chest pain. Needless to say, nurses receive even more thorough training, which includes certification based on at least two to four years of studies and/or academic studies for an undergraduate, graduate or even doctoral degree. The powers given to nurses reflect their extensive training.⁴⁸

This issue had already been discussed in the 2002 Israeli Commission Report:

"It is the Commission's impression that the medics' knowledge is reasonable and that their performance is adequate. Nevertheless, in order to raise standards and make further improvements, it is important to raise the level of education and knowledge through further training and studies. The Commission believes that, ideally, all prison medical staff positions be filled by registered nurses. Nevertheless, under the current conditions of a nationwide shortage in the nursing professions, and given the special and difficult nature of the work in the IPS, the Commission realizes that this is a long-term goal [...]. The Commission also recommends encouraging some of the medics (for example, the clinic directors) to take advanced professional courses, and even a paramedics' course.⁴⁹"

In 2015, the Berlowitz Commission made similar recommendations in its report (for more on the Berlowitz Commission, see p. 51 below). As Commission Chair Dr. Yitzhak Berlowitz

⁴⁸ Physician Regulations (Qualification for Performing Unusual Activities), 2001. See also the extensive list the powers granted to registered nurses' in the Ministry of Health's Nursing Administration Circular No. 143/18 of May 2018.

⁴⁹ See footnote 42 above.

said at the Knesset Special Committee for Public Petitions, at a session discussing implementation of the report's recommendations:

"Because there is no doctor at night, sometimes the decision in the case of a prisoner with a medical problem – and until it reaches the situation where an ambulance has to be called – is delayed because of hierarchy issues within the IPS [...] because often whoever is on hand in the evening is not always sufficiently qualified to make that medical decision. Sometimes [...] this takes quite some time, sometimes a lot of time, and this can become life-threatening by the time the ambulance arrives [...] We do think there should be 24-hour coverage, not necessarily by a physician but by a paramedic or a nurse, someone who is able to provide a response also at night and in the early morning hours as part of [...] ensuring the IPS is well-prepared.⁵⁰"

It should be noted that in some of the correctional facilities, a physician is present at night as part of the medical services purchased by the IPS from a private company. However, this is true only of some of the facilities, and only for part of the night.⁵¹

C. Prison Clinic Directors

The clinic directors, medics by training, are in charge of the other medics on the staff. They are also responsible for the stock and inventory of medications, and for scheduling appointments for tests and treatments at medical clinics and hospitals outside the IPS.

The 2015 State Comptroller Report recommended expanding the training provided to IPS clinic directors:

"[...] as of late 2014, clinic directors were not required to undergo, nor do they undergo, any training or continuing education related to administration in general, and the administration of clinics in particular. This is the case even though the role of clinic director requires skills and expertise related to the nature of the work and the responsibilities derived from the job description, and notwithstanding the recommendation of the reform team. The State Comptroller's Office hereby advises the IPS that such training could impart to the administrators extensive knowledge and tools that would enable them to handle the tasks required by this complex role.⁵²"

A freedom-of-information request that PHRI submitted to the IPS in October 2017 sought to learn whether clinic directors receive any training or continuous education prior to their appointment, and what training had been provided over the past five years. The IPS referred us to the syllabus of a five-day course provided by Magen David Adom (the Israeli counterpart of the Red Cross) that covers issues such as dressing wounds, taking medical readings, etc. The course does not cover any issues related to medical administration.⁵³

As detailed below, the lack of appropriate training for clinic directors results in numerous administrative and logistical failings in areas within their purview, such as delays in scheduling appointments, not following up on the implementation of specialists' recommendations, and poor management of the drug inventory, leading to shortages and irregular dispensation of prescribed medications.

⁵⁰ Meeting of the Knesset Special Committee for Public Petitions, Transcript No. 28, December 23, 2015.

⁵¹ A tender issued by the IPS lists the Zalmom/Hermon, Tel Aviv (Abu Kabir), Hadarim and Beersheba detention facilities as requiring medical services from 7 PM to midnight. In facilities where Israel Security Agency (ISA, known by the Hebrew acronym *Shabak*) interrogations are held – Shikma, Kishon, Jerusalem (at the Russian Compound) and Petah Tikva – the tender states that medical services are required also at night.

⁵² See footnote 20 above, p. 403.

⁵³ Letter from IPS Freedom of Information Officer Adv. Einat Karpel to PHRI, dated April 25, 2018.



Control and Oversight of the Health Care System

As discussed above, according to the interpretation of the IPS and Ministry of Health, the National Health Insurance Law does not apply to inmates. Consequently, the Ministry of Health is completely uninvolved in determining health policy in prisons,⁵⁴ and does not have regulatory authority or control mechanisms such as those the law makes available to it vis-à-vis the HMOs. Moreover, the Ministry of Health does not even control or oversee the regular activities of the IPS health care system in the prison clinics.⁵⁵ This is the case because according to the Public Health Ordinance of 1940 (pre-statehood) and its attendant regulations, prison clinics do not perform medical processes that require licensing or supervision by the Ministry of Health. Furthermore, as a result of excluding the IPS health care system from the National Health Insurance Law, it was not made part of the national program for community health care quality standards that the Ministry of Health has been running since 2013.⁵⁶ The program measures and evaluates the quality of care provided by HMOs based on a list of indicators determined jointly with the HMOs, and the findings are made public in order to raise awareness and improve public service.

A. The Medical Professions Ombudsman at the Ministry of Health

The only mechanism for professional medical oversight of the IPS health care system is that of the Medical Professions Ombudsman (also known as the Public Complaints Officer for Medical

⁵⁴ Letter from Prof. Itamar Grotto, then Head of Public Health Services (today, Deputy Director General) in the Ministry of Health to PHRI, dated September 19, 2016: "According to Israeli law, the Ministry of Health does not make the policy regarding medical treatment of prisoners."

⁵⁵ Letter from Dr. Yitzhak Berlowitz, Deputy Director General of the Ministry of Health, to PHRI, dated February 24, 2002: "The Ministry of Health has no oversight authority in IPS facilities."

⁵⁶ The program is administered subject to regulations made by the Minister of Health by virtue of the powers vested in him under the National Health Insurance Law (Quality Standards and Providing Information), 2012 - Regulations.

Professions). As will be explained below, even this mechanism for medical oversight is virtually theoretical. In practice, it is an obscure function virtually unknown to the prison population. The office is capable of processing only a very few complaints, and its modes of operation are suited neither to the nature of the complaints nor to the unique situation of inmates.

According to Ministry of Health figures provided in response to a freedom-of-information request by PHRI, from December 2016 to July 2018, the Ombudsman received only 24 complaints. It is important to note that during that same time period, PHRI filed 18 complaints on behalf of inmates, so that in fact the Ombudsman received only six complaints directly from inmates. Of the 24 complaints received, the Ombudsman completed the examination of ten cases. Of those ten, no irregularity was found in four. In three others, the complaints were forwarded to the Ministry of Health's Medical Administration. In one case, the Ombudsman found no cause to intervene as the inmate had already been released from prison, and in another the information requested by the inmate was provided to him. Only in one case was the complaint found justified and meriting further handling by the Ombudsman himself.⁵⁷ The other complaints are still pending, awaiting the Ombudsman's decision.

In 2018, PHRI received two responses from the Ombudsman regarding complaints we had submitted on behalf of inmates. In January, PHRI filed a complaint on behalf of a criminal inmate who had been waiting to be examined by an orthopedist for four months, ever since he had slipped in his cell and injured his lower back. The injury affected his sleep and made ordinary daily functioning difficult. We applied to the Ombudsman after several complaints to the IPS Chief Medical Officer had been ignored. In late March – three months after filing our complaint with the Ombudsman – he responded, saying that the inmate's medical records had been reviewed and that "a four-month delay in an orthopedic checkup following a back injury and lower-back pain is unreasonable. We therefore find the complaint justified. [...] The inmate has since been examined by an orthopedist and we wish him the best of health."

In late May 2018, PHRI contacted both the IPS Chief Medical Officer and the Ombudsman with regard to an HIV-positive detainee who had not been receiving his medication regularly. In early October, more than four months after the complaint was lodged, the Ombudsman finally replied, assuring us that the IPS Medical Branch had informed him that "from the day the inmate first arrived at Saharonim Prison, he has been receiving his medications every day without any problems."⁵⁸

These cases and others, as well as the data provided above, show that the Ombudsman is unable to deal effectively with inmate complaints. This is the case because:

1. Most inmates are completely unaware there is an Ombudsman, and therefore only few address complaints to him.
2. Most health-related complaints by inmates require an immediate response. A response from the Ombudsman, however, takes several months, even in straightforward cases.
3. At least in some cases, the Ombudsman relies on input from the IPS and does not conduct any independent investigation, such as reviewing prison clinic records.
4. Even when the Ombudsman has found fault with IPS conduct, the matter was not examined or reviewed as a potentially systemic issue. Instead, the handling of the case went no further because the specific problem had been solved or was no longer relevant.

⁵⁷ Letter from Public Information Officer at the Ministry of Health Adv. Anat Iluz to PHRI, dated September 17, 2018.

⁵⁸ These examples and figures are not new. In 2008, PHRI conducted a similar analysis of complaints addressed to the Ombudsman at the Ministry of Health. We examined 59 complaints forwarded by PHRI on behalf of inmates. In only 17 of the cases did the Ombudsman respond, and the waiting time for response was at least six months. In 15 of the 17 cases, the Ombudsman's response relied on IPS input, and did not involve any independent investigation. See *Oversight and Transparency in the Israeli Penal System*, PHRI, July 2008, pp. 13-16.

In addition, the Ombudsman is primarily responsible for examining complaints of malpractice, regarding which the Ombudsman may appoint a medical commission of inquiry. Such commissions are usually appointed following unusual and particularly serious incidents resulting in severe disability or death; based on the commission's findings, the Ombudsman submits his recommendation to public attorneys at the Ministry of Health for the purpose of undertaking disciplinary procedures.⁵⁹ Apart from this type of incident, many of the complaints address administrative rather than clinical issues, such as delays in performing tests and operations, erratic supply of medications, etc. Moreover, while the Ombudsman usually focuses on incidents that are already over, examining whether the medical staff had acted appropriately, most inmate complaints involve matters that are still underway.

The Ombudsman was designated as the go-to address for inmates' health-related complaints further to the 2002 HCJ IPSMC, ostensibly in order to apply the recommendations of the Avi Israeli Commission. The commission identified the need for greater professional oversight of the IPS health care system. It therefore recommended creating two new functions within the organizational hierarchy of the Ministry of Public Security – the body responsible for the IPS – which would also include senior and experienced medical experts with professional ties to the Ministry of Health. The medical oversight unit recommended by the commission would have a physician and a nurse who would conduct periodic inspections, including unannounced spot checks in detention facilities, to examine the facility, the medical records and some of the patients. It was also suggested that this unit would be sent reports from the IPS according to guidelines it set out, and follow up to ensure that any problems found in the inspections are rectified. In addition to this unit, the commission recommended appointing an officer in the Ministry of Public Security to handle inmate complaints regarding medical issues. The Inmate Complaints Ombudsman would be a senior physician whose appointment would be approved by both the Minister of Public Security and the Minister of Health.

The commission defined the role of the Inmate Complaints Ombudsman as follows:

"An ombudsman is needed when prisoners cannot exercise their rights for some reason. Therefore, complaints usually require immediate attention. Handling the complaint will involve fact checking, making findings and stating what needs to be rectified and why. In examining the individual complaint, the Ombudsman will focus on safeguarding that particular prisoner and ensuring he receives proper medical care. In every inquiry, attention will also be devoted to the medical service provided to prisoners in general, so that systemic issues in medical services to inmates can also be identified. In his inquiries, the Ombudsman will be assisted by the oversight staff of the Ministry of Public Security. [...] The function of the Ombudsman must be made generally known [...]. Given the courts' frequent attention to prison medical services, the commission suggests that the court petitions and their outcomes be brought to the knowledge of the Inmate Complaints Ombudsman in order to identify trends and recurrent problems [...]. The Ombudsman will issue an annual report about the complaints and findings and will monitor the implementation of recommendations."⁶⁰

In the HCJ proceedings, the state addressed the commission's recommendations by listing the apparatuses that offer external oversight of the IPS health care system, including the option of applying to the Ministry of Health's Ombudsman.⁶¹ PHRI found the state's position incompatible with the commission's recommendations, given that

⁵⁹ "The Handling of Medical Malpractice in Israel by the Ministry of Health," Knesset Research and Information Center, June 2017.

⁶⁰ See footnote 41 above, pp. 10–11.

⁶¹ State Attorney's Office response in HCJ IPSMC, May 19, 2003.

the Ombudsman does not serve as an independent body for examining complaints, relying almost exclusively on information provided by the IPS. Moreover, and as we have shown, the Ombudsman is not a viable option, being neither available nor accessible to handle inmate complaints in a timely manner.⁶²

PHRI's position was supported by the IMA, which joined the petition as *amicus curiae*. The IMA wrote:

"The IPS must be subject to the Ministry of Health's oversight mechanisms. Accordingly, the IMA believes that the relevant branch of the Ministry of Health must be appointed as a permanent external comptroller of the system, as is the case in all other medical institutions or bodies in the State of Israel [...]. The Ombudsman at the Ministry of Health cannot serve as an adequate oversight mechanism for protecting the rights of prisoner-patients. The IMA believes that, to that end, an entity able to deal with and resolve the thorny dilemmas that regularly arise in the daily care of patients in custody needs to be established. As long as the Ombudsman does no more than respond to specific patient complaints most of which, if not all, relate to medical malpractice, then there is a need for an external control body able to safeguard the rights of patient-prisoners in general [...]. The Israeli Commission appears to have reached the same conclusion. Its report recommends the establishment of new oversight functions, and does not make a recommendation to expand the powers of the extant functions.⁶³ "

Yet despite both the IMA's clear position and the state's own statement to the HCJ that "the Israeli Report presents a desirable model,"⁶⁴ the commission's recommendations were distorted and watered down beyond recognition, resulting in an immense disparity between them and actual practice. PHRI believes that not only is the office of the Ombudsman at the Ministry of Health inadequate in terms of meeting inmates' needs, but that the function serves the IPS as a fig leaf, covering up the fact that in practice there is no viable mechanism of independent medical oversight in place.

B. Inmate Complaints Officer at the Ministry of Public Security

The oversight mechanism of the Public Security Ministry includes a Prisoner Complaints Officer (PCO). Officially, inmates may contact the PCO either by phone (an option unavailable to Palestinian security inmates) or in writing, via a dedicated complaint box that is supposed to be accessible to them. This avenue, however, cannot serve as an adequate oversight mechanism for two main reasons. First, the PCO is not a medical expert and is therefore unable to examine health-related complaints. Second, the PCO is just one person, obviously unable to handle the complaints of thousands of inmates from detention facilities across the country, regarding all issues. In addition, the 1992 Internal Audit Law, which stipulates that internal auditors must operate under the direct supervision of the minister or the director general of the ministry, does not set out a clear mechanism for the PCO's handling of complaints, nor does it invest him with the necessary powers or status.

In 2008, PHRI attempted to examine the PCO's performance by forwarding to his office copies of dozens of complaints previously sent to the IPS Chief Medical Officer. It did not take long for the PCO to inform us that he is unable to respond to all complaints, although he would make sure they are examined and handled by the Chief Medical Officer.⁶⁵

⁶² PHRI's response in HCJ IPSMC, July 20, 2004.

⁶³ IMA's response in HCJ IPSMC, February 24, 2004.

⁶⁴ HCJ IPSMC ruling, given December 22, 2004.

⁶⁵ See footnote 58 above, p. 11.

C. The Ombudsman at the State Comptroller's Office

Inmates may also turn to the Ombudsman at the State Comptroller's office, operating on the basis of the 1958 State Comptroller's Law (see p. 52 for more on the State Comptroller's oversight of the IPS health care system in his periodic reports). In practice, the State Comptroller's investigative procedure is subject to considerations of the office's annual work plan and its key issues. Furthermore, the State Comptroller's Office is not set up to handle inmate complaints, let alone health-related ones, nor do its representatives visit detention facilities regularly to collect inmate testimonies or review medical records.

Even the Knesset acknowledged that these oversight mechanisms are incapable of properly addressing inmate complaints, and recognized the need for pertinent legislation. A bill on creating a dedicated Inmate Complaints Ombudsman, submitted in 2009 by then Chair of the Knesset Internal Affairs Committee, the late MK David Azoulay, read as follows:

"External auditing of what goes on behind bars in the State of Israel is currently inadequate. Whereas there are several bodies – in addition to the existing internal functions in the IPS – to which inmates may apply, there is no body that combines all the necessary elements for effective and thorough handling of inmate complaints and for appropriate oversight of prison conditions: independence and autonomy, sufficient powers, the capacity to conduct in-depth fact-checking, adequate staff, expertise in the relevant fields, the ability to initiate probes into overarching issues that violate inmate rights, and so forth.⁶⁶"

D. Legal Petitions by Inmates

Legal petitions are often touted by the IPS as a major oversight mechanism available to inmates. Data from the court system do show that inmates use this avenue extensively, filing some 5,000 petitions a year on various issues related to their prison conditions, including health care. A study researched the rulings on hundreds of inmate petitions and found that, while technically the courts have tended to reject most petitions, in fact, about half are rejected, or proceedings dismissed, after the underlying problem had been resolved or an alternative remedy provided.⁶⁷ These figures not only provide evidence of violations of inmate rights that would not have been remedied without the legal petition, they also show that the very presence of an external oversight mechanism such as the courts often leads the IPS to undertake a renewed review of the case and find a solution.

Nevertheless, and although inmate petitions have proven somewhat effective in promoting inmate rights, they are no substitute for a permanent, dedicated oversight mechanism. For one thing, many of the inmates who contact PHRI report that they would rather not file a court petition, as doing so would brand them "problematic inmates," leading to harassment by the IPS. Second, the problems inmates encounter are often administrative, such as erratic supply of medicines or difficulty scheduling an appointment with the prison doctor. Such cases are more appropriately dealt with through a complaint mechanism. They do not merit legal remedy and therefore cannot be resolved by the courts. Third, a legal battle between the state and an inmate under its complete control is an essentially unequal situation, characterized by an inherent imbalance in power, resources and information. In about half the cases, inmate petitioners are not represented by legal counsel, whereas the IPS is represented by lawyers who specialize in inmate petitions.⁶⁸

⁶⁶ The bill was voted down on May 1, 2013. See Bill: Inmate Complaints Ombudsman and Oversight of Detention Facilities, 2013.

⁶⁷ Maya Rosenfeld, "Prisoner Petitions - Assessing the Effectiveness of the Legal Process," MA Thesis, Bar-Ilan University, 2016.

⁶⁸ *Ibid.*

In practice, many other factors limit the ability of inmates to seek legal remedy in the first place. Such factors include belonging to socio-economically disadvantaged minorities; language issues and barriers – Hebrew is not the mother tongue of many inmates, and learning disabilities and poor literacy are disproportionately high; a high rate of drug addiction and psychiatric problems; unfamiliarity with the law, compounded by limited access to IPS procedures and legal databases. Finally, like other government agencies, the IPS has the benefit of the presumption of administrative regularity, i.e., that its actions are considered legal unless proven otherwise.

This power imbalance becomes even more pronounced in health-related petitions, for two reasons. First, inmates usually do not have access to all their medical records. Test results and hospitalization records are usually handed over to the guard escorting the inmate, rather than to the patient. In addition, inmates do not know whether medical recommendations they received are indeed being followed up. For example, they do not know whether appointments have been scheduled for tests to which they have been referred, and if so, for when. These lacunae make it difficult for the inmates to substantiate their claims and present the facts to the courts (or any other authorities). Second, the discussion of medical issues usually relies on medical opinions. Yet, whereas the IPS can always provide an opinion by its own doctors, inmates' access to independent medical opinions is highly restricted and can rarely be obtained. Therefore, the court almost always relies on the opinions of IPS doctors and prison clinic staff.

It should be noted that cases handled by PHRI suggest that the statements by IPS medical authorities submitted to the courts are not necessarily entirely accurate, often omitting significant information or reporting it out of context. For example, A., a criminal inmate, sought PHRI's help in receiving treatment for severe, chronic back pain:

A. (49) had been suffering from backaches for years. In October 2015, the prison doctor referred him to a pain clinic. Yet only in February 2017 was he seen at a pain clinic. The clinic referred him for a CT scan, and he was told to return to the clinic with the test results for a follow-up appointment they scheduled for July. Time went by, but despite repeated requests to the IPS by both A. and PHRI, he was not taken for a CT scan and therefore also missed his July appointment at the pain clinic. A.'s medical record shows that it was not until June that the prison clinic made an appointment for the test, scheduling it for August. A. had the CT scan in August, but no new appointment was scheduled for the pain clinic. He therefore petitioned the court with PHRI's help. The IPS response to the petition in September stated that, according to the prison clinic, an appointment at the pain clinic had been scheduled for the patient for May 2018. The IPS added that appointments are made subject to availability at the hospital, constraints which have nothing to do with the IPS. The IPS response made no mention of the original appointment in July that A. had missed due to the IPS's delay in arranging for his CT scan.

PHRI checked with the hospital and found that, contrary to the IPS's claim, because A.'s details had already been entered into the hospital system, he could get an appointment to be seen within a month. The hospital also said that they had absolutely no record of the appointment supposedly scheduled for May. In response, the IPS representative said that the prison clinic had managed to push back the appointment to February 2018 and that this was the earliest date offered by the hospital. Once again, PHRI checked this with the hospital, and once again we were told that a much earlier appointment – in December – could be had. At PHRI's

request, the court ordered the IPS to let A. go to the pain clinic to the December appointment offered by the hospital.

Had A. not had legal counsel, and had he not had the benefit of PHRI's aid in crosschecking the information provided by the IPS, he would have been unable to counter official statements that were, at best, inaccurate and misleading.⁶⁹

⁶⁹ This is not the only case in which the IPS health care system gave the courts inaccurate or misleading answers. In the Rosalio case discussed above (see footnote 27 above), an inmate who was a hepatitis C carrier and had advanced cirrhosis (a disease that could lead to liver dysfunction and cancer) petitioned the Center District Court to require the IPS to provide him with the necessary medication. The state's response, relying on the opinion of prison doctors, argued that the petitioner was not in a life-threatening situation so that providing the treatment was not urgent. The court rejected this argument, stating that "would that it had not been made at all."

In another case, several years later, the District Court (Remand - *G. v. State of Israel* 2367-09-08) addressed the claims of an HIV-positive criminal detainee that he had not received his prescribed medications for a month: "The conclusion from the above is that a misrepresentation was brought before me, misleading me to believe that the respondent had been receiving the medicines prescribed for him by specialists. This misrepresentation was not made due to error or carelessness. It is my impression that it was made *knowingly*."



Commissions of Inquiry

Several commissions have been tasked with examining the medical care the IPS health care system provides to inmates. In addition to external commissions such as the Israeli Commission, several internal commissions have been appointed by the IPS and the Ministry of Public Security. They have also hired external experts to compile reports on various aspects of the IPS health care system. In addition, in 2015 the State Comptroller published a report devoted to the IPS health care system. The chapter below surveys these reports, explains how they were compiled, and discusses the IPS's implementation of their recommendations.

A. The Avi Israeli Commission

As mentioned above, the Minister of Health appointed the Israeli Commission in 2002 by order of High Court of Justice, following the HCJ IPSMC petition. The members of the commission were – in addition to Ministry of Health representatives – an IPS doctor, a doctor who was the head of a government hospital ward, and a PHRI volunteer who was the head of a cardiology clinic in a government hospital. The commission members visited detention facilities and spoke to IPS doctors and other prison officials. They also reviewed patient medical files selected at random and interviewed inmates at the prison clinics.

The commission concluded that, overall, inmates were receiving adequate and regular treatment. The commission did, however, highlight several failings in terms of access to care by specialists. First, they noted long waiting times to see a specialist. This is particularly problematic given that prison doctors are not specialists so that

expert consultations are required more often. Second, patients reported often forgoing appointments to specialists outside the prison because of the harsh conditions in the IPS shuttle and the long journey involved. Inmates also complained that it often takes very long for a medic to arrive after they ask for help, but the commission could not substantiate these claims since it had to schedule its visits in advance and did not make unannounced spot checks. The report also stated that "to the extent the commission was able to determine, IPS officials do not intervene in IPS doctors' professional medical actions."

A.1 Clinical Recommendations: Only One Was Fully Implemented

The commission's recommendations may be divided into two main spheres: medico-clinical and prison conditions affecting inmate health. In the first, the commission recommended the following: creating a medical oversight unit at the Ministry of Public Security; establishing the function of an Inmate Ombudsman; affiliating the IPSMC with a medical institute in the community; employing specialists in the IPSMC; having specialists come to the various detention facilities in order to avoid having to convey patients from remote facilities to the IPSMC; creating specialization tracks and continuing education programs for IPS doctors; appointing family and internal medicine specialists as chief physicians to supervise and advise prison doctors; employing nurses instead of medics and improving medics' professional training and knowledge; increasing the medical community's involvement in IPS medical services, including promoting studies of inmate medicine; and digitizing the prison medical records.

As related above, none of the commission's recommendations on medical oversight were implemented, nor were its recommendations regarding the training of IPS medical staff. In fact, out of ten recommendations in the medical area, only one – digitizing medical records – was fully implemented. Another recommendation – having specialists come to the prisons – was only partially implemented. The IPS contracted an agreement to bring specialists from Assaf Harofeh Hospital for consultation in the IPSMC, and subsequently began operating specialist clinics in its Northern and Southern Districts (in Zalmon-Hermon and Eshel Prisons, respectively). As noted earlier, since December 2018, the IPS has begun operating such a clinic also in HaSharon Prison. That said, in the Northern and Southern Districts the commission's recommendations were implemented only about a decade after they were issued.

Moreover, the specialist clinic at HaSharon Prison was only established following a court order. In 2012, two criminal inmates petitioned the district court, arguing that the IPS was not implementing the Israeli Commission's recommendation to provide specialist medical services in its various facilities. In response, the IPS argued that the commission's recommendations are not to be interpreted as a binding directive requiring physicians from all medical specialties to come to each and every facility. In the IPS's view, the fact that it was operating three district specialist clinics constituted sufficient implementation of the recommendation, subject to budgetary constraints. The court accepted the petitioners' demand in part, ruling in 2016 that another specialist clinic must be established, to serve the prisons in the vicinity of HaSharon Prison, thereby obviating the need to refer patients from those facilities (HaSharon, Hadarim, Ofer and Rimonim) to the IPSMC. The court emphasized that should the state not establish a specialist clinic there, it would be in violation of its obligation to implement the commission's recommendations.⁷⁰

It took more than two years until a specialist clinic was established in the HaSharon Prison compound. Furthermore, even were we to accept the IPS's position that the Israeli

⁷⁰ Prisoner Petition Appeal 5236-11-12 *Majadabeh v. IPS*.

Commission's recommendations do not oblige specialist physicians to be available in all prisons, the existing model of regional specialist clinics is still inadequate. For example, in remote prisons – such as Ketziot, Nafha and Saharonim – no specialists are available at all, and patients must undertake a long and arduous journey in order to reach the specialist clinic in Beersheba.

A.2 Recommendations regarding Health and Prison Conditions: Implementation Partial and Belated

In addition to clinical recommendations, the Israeli Commission also made several recommendations regarding living conditions in detention facilities and their effect on inmates' health. Below we offer a brief, but by no means exhaustive, discussion of this topic. Once again the commission's recommendations were only very partially implemented, and even that was only accomplished after lengthy legal proceedings initiated by PHRI and other human rights organizations.

The commission assumed that implementation of its recommendation that specialists visit the various prisons would reduce the need to convey inmates in the IPS transport vehicle, a journey which involves such discomfort that many inmates even forgo treatment. Consequently, the commission did not make specific recommendations regarding the transportation service. In practice, however, the recommendation to bring specialists to the detention facilities was implemented only in part, so that the need to drive inmates to clinics outside the prison was not significantly reduced. In the years since the commission published its recommendations, the extensive use the IPS makes of these shuttles, and the harsh conditions aboard the vehicles, have been the subject of two separate petitions to the HCJ (for more on this matter, see p. 61 below).

First, the commission referred to the overcrowding and otherwise inappropriate physical conditions in detention facilities: "Some of the prisons are overcrowded; in some cases there are not enough beds and the inmates use mattresses on the floor, with fifteen inmates in a room."⁷¹ Inmates' entitlement to a bed was resolved only following a petition to the HCJ by PHRI and the Association for Civil Rights in Israel, with the state undertaking to provide a bed for every inmate.⁷² Similarly, the authorities also failed to adequately handle overcrowding. Once again, some progress was achieved only thanks to an HCJ petition by human rights organizations. As a result of the petition, the court compelled the state to provide each inmate with at least 4.5 square meters of living space.⁷³

Second, the Israeli Commission observed that since many inmates smoke in their cells, even non-smokers are significantly exposed to second-hand smoke. The commission recommended raising inmates' awareness of the dangers of smoking and designating non-smoking cells. For several years after the recommendations were published, no progress was made in this matter. Then, in 2009, PHRI petitioned the HCJ jointly with the Israel Cancer Association to oblige the IPS to stipulate in its procedures that non-smoking cells be made available to non-smokers.⁷⁴ Following the petition, IPS procedures were revised so that inmates are theoretically entitled to a non-smoking cell. However, complaints to PHRI indicate that, in practice, this procedure is only partially implemented and that smoking is widespread in both cells and in public areas.

⁷¹ See footnote 41 above, p. 8.

⁷² See footnote 3 above.

⁷³ See footnote 8 above. The state did not meet the implementation deadline set by the court and stated its intention to take action to increase living spaces by building new detention facilities and by more frequently exercising the procedure of administrative release.

⁷⁴ See footnote 4 above.

The commission also voiced criticism of the practice of placing inmates in restraints en route to the hospital and for the duration of their treatment there. It recommended that restraints be used sparingly and proportionately. Once again, it took repeated appeals by PHRI to the Ministry of Health and the Ministry of Justice for the IPS to formulate procedures obliging its staff to exercise discretion before placing restraints on inmates in hospital.⁷⁵

A.3 Conclusions Requiring Re-assessment

In addition to recommendations – most of which have not been implemented as shown above – the Israeli Commission Report also cited two major conclusions: that the medical services provided to inmates were reasonable and satisfactory, and that the prison health care system should remain under IPS responsibility. With regard to the quality of health care in prison, the report stated that "the prisoners are mostly healthy men of working age [...]. In general, prisoners receive adequate treatment in prison and the treatment is provided reliably and consistently." Regardless of whether this statement was accurate at the time, it certainly does not reflect current reality. For the most part, the inmate population is unhealthy and, as will be elaborated below, medical services in prison are neither adequate nor provided regularly. As for reassigning responsibility for prison medical services, transferring it from the IPS to another body, the commission wrote as follows:

"Removing the health care system from the IPS involves complex problems related to the nature of working in this unique setting. Work there involves relatively long working hours under difficult conditions, with doctors sometimes required to return to the prison at night or on weekends and under special circumstances. Thus, even if medical services were to be made separate from the IPS, it stands to reason that there would not be much of a change in the population staffing the positions [...]. Every physician working in this setting would have to understand the IPS procedures, understand the special interests of the inmates and guards, address security and safety issues pertaining to the inmates and staff, etc. In conclusion, our concern is that even if separation is achieved, it will not be followed by any significant change. Disengagement raises the concern that a medical corps separate from the IPS would be weak and powerless."

In drawing its conclusions, the commission relied on the experience in England. In 1998, a professional commission recommended the transfer of medical services from the English Prison Service to the National Health Service (NHS). However, four years later, when the Israeli Commission was writing its recommendations, the reform in England had yet to be realized due to the difficulty of recruiting physicians prepared to work in prisons.

Nevertheless, PHRI believes the Israeli Commission reached an incorrect conclusion. As will be shown in Part II of this report, which discusses systemic failings of the IPS health care system, prison doctors have become accustomed to a reality wherein the medical standards of the Israeli health system are often compromised to accommodate various IPS constraints and interests. It stands to reason that if better-trained physicians with a higher professional standing are employed, they could more effectively look out for their patients' interests. In addition, as will be shown in Part III – which reviews models of prison health care services elsewhere in the world – since the Israeli Commission Report was published in 2002, considerable experience has been gained in several countries with regard to the hierarchical status of these systems in terms of chain of command issues. One example is England, where the reform has long since been successfully implemented. Other countries have also adopted similar reforms either partially or fully. It should be added

⁷⁵ See footnote 10 above. See also Jonathan Lis, "IPS to Allow Prisoners to Receive Medical Care without Handcuffs," *Haaretz*, December 16, 2008.

that the Israeli Commission did not consider its own stated position as the conclusive, final say on the issue of the medical services' hierarchy vis-à-vis the IPS. Instead, it recommended that the question "be reexamined, after the commission's recommendations are implemented and applied in practice for a while."

B. The Berlowitz Commission

The Berlowitz Commission was appointed by the Ministry of Public Security in 2015; it was chaired by Dr. Yitzhak Berlowitz, then Director of Wolfson Hospital. Its two main recommendations were to establish a body within the Health Ministry to provide medical supervision of IPS medical services and to improve IPS medical staff by employing paramedics instead of medics. However, as the Deputy Head of the Medicine Administration of the Ministry of Health stated, the necessary posts were not allocated nor were the recommendations implemented.⁷⁶ In addition, the commission found that the designated number of posts for IPS medical staff fell short of the actual needs of the system. To the best of PHRI's knowledge, no significant change has been made in this area either. It should be noted that the focus of the Berlowitz Commission was emergency medical response and the size of the IPS medical staff. It did not examine the overall quality of medical services, or the question of the hierarchical standing of the health care system.

C. State Comptroller Report

In 2015, State Comptroller Joseph Shapira published a special report on the IPS health care system. The report did not address the quality of medical treatment provided to inmates. Rather, the inquiry focused on organizational and administrative issues, such as failings in terms of the storage and supply of medicines; the lack of a plan for dealing with the aging inmate population; lack of training and continuing education for medical staff; and the fact that a laboratory director was not employed despite the availability of that position, resulting in the costly referral of many tests to an external laboratory. The report also provided an extensive review of the professional commissions of inquiry and the many external consultants who have analyzed the IPS health care system over the years, and stated that their recommendations have not been implemented:

"The need to examine the functioning of the IPS health care system, improve it and adapt it to the increased size of the inmate population as well as to changes in the makeup of this population was apparent as far back as 2002. In the decade that followed, significant changes took place; three commissions were appointed; a reform team created; and at least four external consultants were hired and submitted comprehensive reports on medical issues. All the commissions and consultants examined the health care system, sometimes exploring issues that had already undergone scrutiny. They all stated that changes must be made to the health care system and provided recommendations for implementing change. However, none of the recommendations have been developed into a comprehensive plan for health care reform or for taking real action to implement that reform."⁷⁷

In response to the report, the IPS and the Ministry of Public Security stated that a long-term, multi-year plan to upgrade the health care system had been drafted by the IPS over the course of 2014 and submitted to the Ministry of Public Security. They added that a comprehensive examination of the plan was underway at the Ministry of Public Security. In response to a freedom-of-information request submitted by PHRI in October 2017, in which we asked for all the reports mentioned in the State Comptroller's Report as well as

⁷⁶ See statement by Deputy Head of Medicine Administration in the Ministry of Health Dr. Idit Segal at the Knesset Knesset Special Committee for Public Petitions, July 31, 2016.

⁷⁷ See footnote 20 above, p. 395.

the long-term plan for upgrading the health care system, the IPS responded that it was under no obligation to make the reports public as these were "internal documents," nor was it under any obligation to make the multi-year plan public as it was still in process. In November 2018, four years after the IPS had informed the State Comptroller of the plan, the State Attorney's Office stated in response to a PHRI freedom-of-information petition that work on the plan was still underway, so that there was no obligation to publish it.⁷⁸

D. After a Decade and a Half of Recommendations, Has Anything Changed?

Since 2002, various commissions and bodies have examined the IPS health care system and recommended that it undergo significant reform. Yet of the host of recommendations regarding the quality of health care, only one was fully implemented and another was implemented in part. With regard to prison conditions that affect inmates' health, some progress has been made in recent years, but only thanks to a protracted fight by PHRI and other human rights organizations, including legal petitions. Many other issues have remained unaddressed. It should be borne in mind that some of the commissions and consultants who have examined the IPS health care system in recent years were appointed by the IPS or the Ministry of Public Security via an internal procedure, and their recommendations have never been made public on the grounds of being internal discussions, or that the documents had been lost.⁷⁹ Regardless, it seems that these commissions have not effected any significant changes on the ground either. Today, more than a decade and a half after the Israeli Commission Report was published, the IPS continues to assert that it is in the process of preparing a multi-year plan for upgrading its health care system, a process that has already been underway for over four years.

⁷⁸ See footnote 42 above.

⁷⁹ See footnote 42 above.

Part II

The Functioning of the IPS
Health Care System -
Questionable in Theory,
Poorer in Practice



Failings in the Medical Care Provided to Inmates

This part of the report examines how the conditions in which the IPS health care system operates, as described in Part I, affect inmates' daily lives and the medical treatment they receive. In the following pages, we discuss a series of systemic problems and illustrate them through cases PHRI has handled over the years. Please note that in all examples, we will present information based not only on the complaints of the patient himself, but also on medical records obtained from the IPS and hospitals. We will also present the findings of a PHRI review of medical records we conducted to obtain a professional appraisal of the quality of medical care in the IPS. The review itself was carried out by nearly two dozen PHRI volunteer doctors, all specialists in family medicine, who carefully read inmate medical records we received from the IPS.

A. Waiting Times

The issue of inmates' long waiting times for specialists and tests was raised as early as the 2002 Israeli Commission Report. Over the years, PHRI has repeatedly raised the matter with the IPS and the Ministry of Health, but we have not received any practical, pertinent response. For example, in 2009, the Ministry of Health's Ombudsman wrote in response to a general inquiry by PHRI: "I find the facts you have presented to be correct and that despite efforts by [IPS Chief Medical Officer] Dr. Adler and the medical staff, the response time for medical exams and consultations is longer than desirable."⁸⁰ Nor was the problem denied by the IPS itself. In a 2010 interview for the IPS magazine, IPS Chief Medical Officer Dr. Dini Orkin said that waiting times for medical appointments in the IPS were between seven and twenty (!) times longer than in the community health system.

⁸⁰ Letter from Prof. Chaim Hershko, Medical Professions Ombudsman at the Ministry of Health, to PHRI, dated August 23, 2009.

Z. (39, a criminal inmate) was referred for a colonoscopy in November 2017. It had to be completed before he could start taking medication for his hepatitis C. His illness was in an advanced, dangerous stage, prompting his doctors at Beilinson Hospital to recommend that he start treatment as soon as possible. Z. waited for the IPS to schedule the colonoscopy, but as time wore on and no appointment was forthcoming, he petitioned the district court with PHRI's help. In the February 2018 hearing, the IPS said that a colonoscopy had been scheduled for Z. for June. PHRI then contacted several hospitals and found that appointments could be had in a matter of weeks. After PHRI interceded, Z. was able to undergo the urgent examination in early March, during a special IPS-approved furlough.

This case, like many others, demonstrates not only that inmates' waiting times far exceed those in the public system, but also that the IPS's argument that delays are due to hospital scheduling has no basis in fact. Our review of these cases raises concerns that extraneous, non-medical considerations, such as the availability of a guarded escort, are taken into account when the IPS schedules appointments. It also seems that even in cases considered medically urgent, IPS clinic directors do not necessarily check if earlier appointments are available elsewhere.

B. Canceling Appointments for Non-Medical Reasons

In addition to delays in arranging for examinations and treatments, even after the IPS has scheduled an appointment, the inmate often misses it due to various faults on the part of the IPS, and must wait for the appointment to be rescheduled. Complaints to PHRI by inmates, as well as documentation available in some of the medical records we received from the IPS, suggest that the IPS often cancels appointments that had been scheduled long in advance because guards are unavailable to accompany the patient, or simply because the guards showed up late.

D. (49, a criminal inmate) has heart disease. In May 2017 he was referred by a cardiologist for an urgent stress test due to chest pains that had begun a month earlier. He went for the stress test in June. However, it was terminated before completion due to concerns over blood and oxygen supply to his heart, and he was rushed to the emergency room. Once cardiac arrest was ruled out, D. was discharged with a medical recommendation to undergo extensive outpatient examinations, including a Holter monitor test, cardiac mapping and a second stress test. Whereas the Holter test was done shortly after being given the recommendation, the second stress test was not done until almost nine months later, in March 2019. Again the test had to be cut short. Due to the poor test results, D. was referred for an angioplasty. The procedure found severe narrowing in two arteries, and he was therefore sent for emergency bypass surgery. Even after the surgery, there were delays with D.'s medical follow-up and treatment. Further to the operation, D. was sent for cardiac mapping and a cardiac rehabilitation institute. In May 2018, he was supposed to undergo the cardiac mapping. However, the guards assigned to accompany him came late, making him so late for his appointment that he could not be seen. It should be noted that the reason for canceling the examination is documented in D.'s medical file as sent by the IPS. In response to PHRI's complaint on D.'s behalf in July 2018, to the effect that he was not being referred for follow-up and rehabilitation as recommended by his physicians, the IPS informed us that he was scheduled for cardiac mapping in December 2018, a full seven months after the original appointment that was cancelled because the guards did not come on time.

Similarly, in A.'s case mentioned above, after the court had required the IPS to schedule an appointment for him at the pain clinic in December 2017, the physicians who examined him recommended that he return to the clinic in March 2018 for a spinal injection to alleviate his severe pain. A. was not taken to the clinic at the appointed time, however, and PHRI's inquiry with the hospital found that the IPS did not even bother to cancel the appointment, but simply did not get the patient there on time. Later, the appointment was rescheduled for May. Yet even then, the treatment was not provided, as he did not have current blood test results, tests that the hospital had asked the IPS to carry out. Eventually, A. received the treatment only in August 2018, and only after another PHRI petition to the court.

C. Non-Implementation of Specialist Recommendations

In addition to the various delays, tests and treatment are often compromised because recommendations by specialists are not implemented. In some cases the recommendations are only partly implemented, rendering medical follow-up less effective, or even completely ineffective, because essential information is missing. Our review of medical records obtained from the IPS and conversations with physicians in various hospitals show that the doctors are often frustrated because their recommendations are repeatedly disregarded, thereby harming inmates' health.

M., a 29-year-old Palestinian inmate, had been suffering from recurrent eye infections. In January 2017, he was examined at the ophthalmology clinic at Barzilai Hospital and given several recommendations to carry out: treatment with steroids, with dosage to be gradually decreased; blood tests for genetic disorders; and a follow-up visit to the clinic within a month. It was also recommended that M. consult with a rheumatologist to check for Behçet's disease, a rare autoimmune syndrome often involving arthritis and chronic eye infections that can cause blindness. In August 2017, M. was examined by a rheumatologist, who did in fact give a diagnosis of Behçet's disease. The rheumatologist noted that he had not received the results of the genetic tests, and recommended a follow-up appointment two months later. In October, M. returned to the rheumatologist, but the test results were still unavailable. The rheumatologist wrote that "the patient requires an urgent examination by an ophthalmologist, and a decision regarding the necessary treatment. Still only on steroids." Since he was already at the hospital, M. was immediately referred to the ophthalmology clinic. The ophthalmologist wrote: "Missed follow-up. Has been on prednisone 5mg [a steroid] in varying dosages for the past 10 months!!" M. was kept on inappropriate medication for ten months without a medical follow-up, despite the recommendations of both the ophthalmology and rheumatology clinics.

K. (78, a criminal inmate) has several chronic diseases, including diabetes that is treated with an insulin pump. Time and time again, his follow-up appointments with a diabetes specialist at Assaf Harofeh Hospital were at far greater intervals than recommended by the specialist and he came without vital test results. The summary of his June 2017 appointment read: "Did not show up to a scheduled appointment [...] labs - no A1C [glycated hemoglobin blood test], no lab results attached [...] diabetes that is more or less reasonable according to the sugar chart. It's difficult to say anything more than that without the A1C. Why is it missing??? Recommendations - follow-up in 3 months - not 6 months, three = 3!!!" The physician also provided a list of the lab test results that K. needed to bring to the next appointment. Despite the specialist's explicit instructions, the IPS clinic's medical record shows that only

in late October were arrangements made for the next appointment, which took place in January 2018, more than six months after the previous one. This time, K. arrived with the results of his A1C, but without the results of most of the other lab tests. The doctor's summary stated: "According to the nurse the pump is outdated and must be replaced. I had previously been told it had been replaced several months ago. Today he [the patient] told me that only a screw had been replaced [...]. A diabetes test panel includes – as a global standard – A1C, lipid profile, full liver and renal functions, salts, blood count. Please send him with these tests, all of them, and reasonably current."

D. Bureaucratic Delays

Bureaucratic and technical issues are other factors that detrimentally affect the quality and continuity of health care the IPS provides inmates. The IPS fails to communicate essential medical information to the hospital and to document hospital reports, leading to delays in tests and treatment.

G. (70, a criminal inmate) had been suffering from hearing and breathing difficulties for years. In early 2017, he was examined by an ear, nose, and throat doctor who recommended a CT scan of his sinuses to decide if treatment is necessary. G. had the CT in April but received the results only eight months later, in December. His medical records, as obtained from the IPS, show that he checked with the prison clinic four times during that period to find out why the results had not yet been received. In July, the prison doctor wrote: "The inmate came to inquire about the results of a CT head scan. He was referred to the assistant clinic director because I haven't yet received the scan results." In September, the same doctor wrote in G.'s appointment summary: "Says a CT was performed in March, still no results." In November, PHRI wrote to the IPS Chief Medical Officer on G.'s behalf, and the results were obtained shortly afterwards.

Before he was sent to prison, A. (30, a criminal inmate) had been involved in a serious traffic accident and was hospitalized for a long time. In August 2017, he was examined by an IPS neurologist, who recommended a brain MRI because A. was complaining of headaches and memory problems. He had the MRI at Sheba-Tel HaShomer Hospital in November. However, A.'s referral documents provided no details of his medical background or the reason for the referral, nor were the results of previous tests attached for comparison. Therefore, since they were missing significant information, the hospital doctors decided not to provide an interpretation of the scan. PHRI's inquiry with the hospital showed that even after the doctors contacted the IPS for the missing information, it was not sent to them. When PHRI wrote directly to the IPS Chief Medical Officer, asking for the information, there was no response. Eventually, in January 2018, after further requests by the hospital, the radiologist provided the MRI results to the IPS, but stated that the interpretation was carried out "without any clinical [data] or [other] tests for comparison."

E. Inmates Refusing Treatment due to Transportation Conditions

Another significant obstacle to obtaining medical treatment outside the prison is the trip itself, which is often very unpleasant and even painful, particularly for inmates with medical problems. Inmates often forgo appointments because of the unbearable conditions in the transport vehicle, the duration of the journey or having to wait in transition

cells. The IPS transport vehicles are not insulated, so it is freezing cold in winter and stifling in the summer. They are overcrowded and there are severe restrictions on access to bathrooms. In addition, food and medicine are not supplied regularly during the trip. According to inmate testimonies, traveling for medical treatment outside the prison often involves leaving in the middle of the night, but reaching the destination more than ten (!) hours later. The vehicle makes stops at various detention facilities along the way, and the patients have to wait for hours for other inmates to join them. Sometimes inmates have to spend one or more nights in "transition blocs," special wings in some of the correctional facilities designated for non-resident inmates en route to court or to the hospital. According to multiple testimonies, conditions in these wings are particularly bad, including overcrowding and poor sanitation.

As mentioned above, this issue had already been addressed by the Israeli Commission. However, despite the commission's recommendations, sick inmates still have to endure long, exhausting journeys to get to examinations and treatments. In 2008, PHRI and Adalah petitioned the HCJ to require the IPS to improve transportation conditions. The petition was dismissed in 2010 after the state announced it had already adopted several measures and planned to adopt several more in order to improve conditions, including increasing the number of guards in the escort and the number of vehicles.⁸¹ Nevertheless, a 2017 report by the Public Defense Office at the Ministry of Justice showed that the rights of inmates transported in IPS vehicles were still being violated.⁸² That same year, another HCJ petition in this matter was filed by four inmates. PHRI, together with Adalah and the Public Commission against Torture in Israel, joined the proceedings as amici curiae, in order – among other things – to present inmate testimonies we have received.⁸³ The testimonies show that a decade after the original petition by the NGOs' petition, the IPS transportation service still severely violates the rights of inmates, and particularly of inmates who are patients, some of whom would rather forgo treatments and examinations rather than take the dreaded *posta*, or IPS transport, despite IPS promises to shorten its routes.

I. is a 45-year-old Palestinian inmate represented by PHRI in a petition against the IPS. For many years, I. has had various health issues, including incontinence. According to his medical records obtained from the IPS, I. required many tests and a hernia operation. Nevertheless, he repeatedly refused to go out for tests, arguing that travel in the *posta* takes hours, during which time he suffers dizziness and loss of consciousness due to his medical problems. Moreover, his urinary and bowel incontinence, together with being unable to change and maintain his personal hygiene during the trip, cause him shame and mortification vis-à-vis the other passengers. I. testified that after PHRI inquired with the IPS on his behalf, he was told that he would be able to go out for tests via a transport that takes his situation into account. In fact, however, he was once again taken on the *posta*, after which he refused to go again.

F. Continuity of Treatment: What Happens When a Patient Arrives at the IPS?

The quality of medical treatment provided to inmates is compromised also by the way the IPS acts (or fails to act) to obtain information about the inmates' medical history prior to their incarceration. According to IPS procedures, when an inmate is detained and found to have a prior medical issue, the prison doctor must apply discretion to determine

⁸¹ See footnote 5, above.

⁸² *Public Defense Report: Imprisonment and Detention Conditions in the Prison Service Correctional Facilities in 2016* (published June 2017).

⁸³ HCJ 3354/17, *Awawi v. IPS*.

whether relevant medical information should be obtained from the medical institutions that had treated the patient. If the prison doctor believes the information is important, he must offer the inmate the option to sign a waiver of medical confidentiality to the IPS, enabling the doctor to obtain the information. In practice, as evidenced by complaints received by PHRI, patients must often obtain the information through relatives and friends outside the prison. When inmates have nobody outside the prison they can turn to, their treatment is delayed and compromised.

J. (60) is a criminal inmate. Prior to his arrest in November 2016 he underwent a neurological evaluation: an examination by a neurologist and a CT scan. The resulting diagnosis was chronic migraines and he was prescribed medication accordingly. When he was imprisoned, J. told the IPS doctors that he had undergone tests and was therefore on medication. The doctors insisted that he obtain his medical records himself. Since J. was unable to provide his records to the IPS, he did not receive the treatment he needed. His medical record states that in January 2018 – over a year after his arrest – the prison doctor unsuccessfully tried to look up J.'s information in the HMOs' computerized database. Instead of contacting J.'s HMO directly for the medical information, the doctor referred him for another neurological exam. Only after PHRI contacted the IPS in June 2018, did the IPS take action to obtain the essential medical information.

T. (54), an asylum seeker from Eritrea arrested in early 2018, was badly tortured on his way to Israel. His case is currently under review by the Ministry of Justice Commission for Recognizing Human Trafficking Victims. Prior to his arrest, T. was being treated by a psychiatrist in the Ministry of Health's Refugee Clinic and was on medication. After his arrest, T. told the prison clinic staff that he was receiving psychiatric treatment. However, since he had no corroborating documents, he was not given the medication he needed for nearly a month. In late February, PHRI contacted the IPS and provided the necessary medical records. The very next day T. was examined by an IPS psychiatrist and began getting his medicines.

These cases demonstrate that the IPS holds the patients responsible for obtaining their medical information, instead of the IPS acting to obtain their medical history from the community medical services. In the absence of the relevant medical information, inmates often fail to receive the treatment they need, or find themselves repeating medical tests for problems for which they already have a known diagnosis and treatment.

G. Treatment of Infectious Diseases

As noted above, the incidence of infectious diseases such as HIV/AIDS and hepatitis C is significantly higher among inmates than in the general population, usually due to a history of drug abuse. Nevertheless, the IPS has yet to formulate a program for detecting and treating carriers. Consequently, many inmates remain undiagnosed, exposing them to the risks involved if the disease progresses and placing others at risk of inadvertently contracting the virus. In addition to failing to screen inmates properly, the IPS also fails when it comes to treating diagnosed carriers. Whereas HIV-positive inmates receive medication, albeit not always regularly and continuously, in the case of hepatitis C, the IPS makes an effort to evade providing the necessary medication due to the expense involved. It is important to bear in mind that that both illnesses can prove ultimately fatal.

G.1 HIV/AIDS

According to IPS data shared with PHRI in January 2019, there are 50 HIV-positive inmates in Israel. They are under the medical supervision of infectious disease specialists who provide in-person consultation at the prisons. According to IPS representatives, HIV-treatment drugs are one of the biggest expenses of the health care system's medication budget.⁸⁴

The guidelines for the follow-up and treatment of patients with HIV and AIDS are set out in an internal IPS directive regarding screening for carriers, and providing treatment and follow-up. It also sets out the necessary measures to keep other inmates or the prison staff from becoming infected.⁸⁵ The introduction to the directive states that "the inmate population has been defined as a risk group due to the high rate of intravenous drug users and the risk of unprotected sex. In addition, HIV is considered endemic in the countries of origin of some of the population in IPS custody."⁸⁶

The IPS used to have every inmate undergo an HIV screening test upon arrival in prison, but this procedure has been revised. Now when an inmate enters the prison system, the procedure calls for making a risk estimate. That estimate is then used to decide whether or not to administer an HIV test, notwithstanding the working assumption that all inmates belong to a risk group. The IPS risk estimate questionnaire asks about intravenous drug abuse history, blood transfusions before 1987, homosexual intercourse, or sexual intercourse with a female prostitute. Despite the reference in the introduction to the procedure regarding inmates from countries where HIV is endemic, the questionnaire makes no reference to that matter.⁸⁷

The "risk estimate" policy is problematic, not only because the questionnaire is partial and inadequate, but also because the inmate does not always know how to respond correctly, or does not wish to share certain information with the prison clinic. In addition, this approach tends to reinforce prejudices and stigmas regarding inmates from certain population groups. Therefore, various health organizations worldwide have recommended a policy of universal testing in prisons.⁸⁸

G.1.a Failure to screen for HIV-positive inmates

P. (49), an asylum seeker from Ethiopia, had been placed in detention in Saharonim in 2015. According to his medical record obtained from the IPS, he went to the prison clinic in November 2017 because of numbness and paralysis of the right side of his face. The medic who examined him wrote that P. was suffering from facial asymmetry, difficulty swallowing, severe headaches and hypertension. After a phone consultation with the prison doctor, it was decided to rush P. to the emergency room at Soroka Hospital. The summary of his hospital examination stated that P. was suffering from confusion, disorientation and communication difficulties, and that a CT scan showed several lesions on his brain. It was found that P. was HIV-positive and that the virus, which had gone undetected in the detention facility, had weakened his immune system. The cause of P.'s neurological symptoms was identified as the *Toxoplasma gondii* parasite, usually found in undercooked meat or food that had come in contact with animal feces. The parasite mainly infects individuals with weak immune systems. P. was released from detention in December 2017, during his hospitalization.

⁸⁴ See testimony by the IPS Medicine Division in a hearing of the Knesset Special Committee on Drug and Alcohol Abuse, July 25, 2017, p. 16.

⁸⁵ "IPS Preparedness and Policy on Treating HIV-Positive Individuals and AIDS Patients," Procedure No. 05-2001.

⁸⁶ *Ibid.*, Art. 1.5.

⁸⁷ *Ibid.*, Appendix 1.

⁸⁸ See, e.g., "Public Health Guidance on Active Case Finding of Communicable Diseases in Prison Settings," European Centre for Disease Prevention and Control, 2018, p. 12.

G.1.b Faulty treatment of inmates diagnosed as carriers

The flawed process of detecting and diagnosing HIV-positive inmates is only part of the problem. Another major failing has to do with ensuring the regular and uninterrupted supply of medications to inmates who have been diagnosed as HIV-positive, and providing the necessary follow-up tests. One of the most common complaints HIV-positive inmates report to PHRI is that the prison clinic sometimes runs out of their medicines, and then days or even weeks go by without them getting treatment. The same thing happens to new inmates who did not happen to have their medicines on their person when they were arrested, and whose medication is not ordinarily stocked by the prison clinic. It is important to note that taking HIV drugs irregularly can lead to drug resilience and to deterioration in the patient's condition.⁸⁹ In addition, in some cases, the IPS fails to provide regular follow-up or does not carry out the necessary blood tests to monitor the effectiveness of treatment according to the schedule typically followed in Israeli community health care.

S. (39, a criminal inmate) is HIV-positive and has been in custody since August 2017. Since that time, he has not been given his medications regularly. His medical record shows recurrent medication shortages in the prison clinic. S.'s record shows that the clinic ran out of his medications shortly after his arrest, and that from September 4 to October 16 he did not receive any. Then, from May 1 to May 14, 2018, he again got no medication, and once again from July 7 to July 25. In addition, the IPS did not send S. for regular follow-up exams with an expert on communicable diseases. We asked Prof. Zvi Bentwich, an international HIV/AIDS expert and PHRI volunteer, to write up an opinion of S.'s treatment. He stated:

"This case represents a severe failure in treating an AIDS carrying patient. It can be life-threatening and raises tough questions that call into doubt the Prison Service's ability to provide the necessary medical treatment to such patients. To the best of my assessment, a detention facility of this kind is not the desirable setting for this individual, and he must be moved to a different setting that can offer him proper care."

G.2 Hepatitis C⁹⁰

Hepatitis C (type-C viral hepatitis) is an infectious disease usually communicated through exposure to blood. It affects the liver, and can lead to life-threatening conditions such as cirrhosis and liver cancer. Carriers of hepatitis C can remain asymptomatic for years. International studies show that the incidence of the disease among inmates ranges from 15%⁹¹ to 30%.⁹² In contrast, the incidence in the general Israeli population is estimated at 1-2%. These figures, attributed to the inmates' history of drug abuse, have led many researchers and health care organizations to consider inmates a high-risk population, a definition that requires proactive steps to detect the virus.⁹³

Despite there being a medical consensus regarding the designation of inmates as a population at heightened risk for hepatitis C, the IPS refuses to adopt a policy of universal screening tests. This approach only adds to the risk that carriers, who are unaware of their disease, will be detected only in advanced stages when severe symptoms

⁸⁹ Dr. Itzhak/Itzik Levy, "What's New in Treating HIV?," *Infectious Diseases*, 2009, 32-35.

⁹⁰ This chapter provides a brief review of the treatment of HIV-positive individuals in the IPS. For more on this issue, see "IPS Failures in Diagnosis and Treatment of Inmates with Hepatitis," PHRI, July 2018.

⁹¹ Bob Bielen, Samya R. Stumo, Rachel Halford, Klara Werling, Tatjana Reic, Heino Stover, Geert Robaey and Jeffrey V. Lazarus, "Harm reduction and viral hepatitis C in European prisons: A cross-sectional survey of 25 countries," *Harm Reduction Journal*, 15, 25 (2018).

⁹² Sarah Larney, Hannah Kopinski, Curt G. Beckwith, Nickolas D. Zaller, Don Des Jarlais, Holly Hagan, Josiah D. Rich, Brenda J. van den Bergh and Louisa Degenhardt, "Incidence and prevalence of hepatitis C, in prisons and other closed settings: Results of a systematic review and meta-analysis," *Hepatology*, 58(4), 1215 (2013).

⁹³ See, e.g. "Public Health Guidance on Active Case Finding of Communicable Diseases in Prison Settings," footnote 88 above.

begin to appear. Nor is this approach cost effective, since the cost of treating patients in advanced stages and the resulting burden to the public health care system are both much higher than the investment in early detection.⁹⁴ Moreover, not screening for carriers heightens the risk for infecting other inmates (for example by sharing razors) or visitors (for example, in conjugal visits).⁹⁵

PHRI called upon the IPS several times to adopt a hepatitis c screening policy, but was denied, on the grounds that the Ministry of Health had not issued directives obliging it to. Meanwhile, the Ministry of Health claims it does not have the authority to dictate prison policies. In October 2018, PHRI filed a petition with the HCJ against the IPS and the Minister of Health, demanding that they carry out these essential screening tests.⁹⁶ At the time of this writing, the petition is still pending.

IPS reluctance to test for hepatitis C has very good economic reasons. The drug therapy for the disease, which is covered by the medical benefits package, is very expensive and can run as high as NIS 200,000 a patient. Over the past two years, PHRI has handled several cases in which the IPS unreasonably delayed essential tests to determine how far along the disease was and similarly delayed initiating treatment – probably in order to postpone paying for the costly therapy. According to data provided by the IPS to the Knesset Research Department in August 2018, there were 450 inmates known to be hepatitis C carriers, but only 172 were on medication for it.⁹⁷ Presenting the numbers this way is misleading, however, since we know that 143 of those same carriers had been getting drug therapy from 2009 to 2015, before the new and expensive medicine was approved for use. In 2017 and the first eight months of 2018, only 18 inmates were treated with the new medicine. These figures show that many inmates diagnosed as carriers are not treated. Moreover, the low number of detected carriers raises concern of under-diagnosis.

H. Chronic Diseases: A Medical File Review Study

In this chapter, we analyze the medical treatment given to inmates with chronic diseases, as a test case demonstrating issues with the medical treatment provided to inmates in general. The analysis is based on a systematic review of dozens of medical records of inmates who have contacted PHRI for help on issues related to their medical condition. The records were reviewed by family medicine specialists who are PHRI volunteers.

Due to substantial discrepancies between various IPS reports, the actual number of inmates with chronic diseases is unclear. In 2008, the IPS estimated it at 600, and in 2013 at 1,200. According to data provided to PHRI in 2019, the IPS now estimates the number of inmates with chronic diseases at 6,000. It stands to reason that the great difference between the estimates is not due to a natural increase, suggesting that the way chronic patients are defined and counted by the IPS is inconsistent and inadequate.

The fact that the IPS operates without a set work plan and without a reliable assessment of the medical needs of the population under its responsibility combines with other factors to result in sub-standard treatment for inmates with chronic diseases. As the following review of medical files demonstrates, the various failures of the IPS health

⁹⁴ Prof. Ziv Ben Ari, Head of the Center for Liver Diseases at Sheba-Tel HaShomer Hospital in a talk delivered at a hearing of the Knesset Special Commission on Drug and Alcohol Abuse, July 28, 2015.

⁹⁵ On September 16, 2018, a former criminal prison inmate who had been released several weeks earlier said on IDF Radio that he had undergone a hepatitis C test while in prison and was diagnosed as a carrier. The results were not entered into his electronic medical record, and he was not told about them. Only about two years later, the test result form was found by accident by the prison clinic, and he was informed of his carrier status. According to his statement, during that period his wife became infected due to their having unprotected sex during conjugal visits.

⁹⁶ HCJ 7236, *PHRI v. IPS*.

⁹⁷ Roni Blank, "Dealing with Hepatitis C in Israel from 2014-2018," Knesset Research Center, October 14, 2018.

care system which were described earlier in the report are patently obvious in the treatment chronic patients receive.

H.1 The Medical File Review Process

The analysis below is based on a review of the medical files of 32 inmates with chronic diseases who had turned to the PHRI for help with medical-related complaints. The records were sent to us by the IPS per our request when we were handling these complaints. Several criteria guided the selection of the files for review: (1) inmates diagnosed as having at least one of the following chronic diseases: hypertension, asthma, ischemic cardiac disease, or diabetes; (2) files obtained from 2016 to 2018; (3) files containing at least one year of medical records.

Thirty-eight files met these criteria, but six were eventually not included: one because it was over 1,000 pages long; another because it was received from the IPS without the results of many of the tests it mentions; and four that had been sent to physicians for review, but their review had not been completed in time for publication.

The files were sent to 23 family medicine specialists who volunteer for PHRI and work in the various HMOs. Some reviewed more than one file. The doctors also received a multiple-choice questionnaire regarding the medical treatment's compliance with the standards of family medicine in community medicine. The doctors were also asked to express their overall impression of the quality of prison treatment and indicate whether, according to the data available to them, there were times when inmates did not receive essential treatment or received it after much delay, and whether a patient suffered harm or was placed at risk by the level of treatment provided.

H.2 Results

Medical information

One of the issues we wanted to investigate was whether the certain basic information was recorded in the medical files. An examination of the files shows that despite the digitization of IPS medical records, essential medical information is still not collected and documented with due diligence.

- Four files made absolutely no reference to whether the patient has any drug allergies.
- Nine files had no record of the patient's height, and eight had no record of the patient's weight.
- Only seven of the 32 files reviewed noted the patient's family medical history.
- Thirteen files did not state whether the patient was a smoker.
- **Even though 14 of the patients whose files were reviewed were at least 50 years old, only six were tested for colorectal cancer, as required by the Ministry of Health.⁹⁸**

That said, all files reviewed recorded the results of at least one blood pressure test. Nevertheless, as suggested by the data above, overall analysis of the files reveals a failure to document basic medical information about the patients. For example, it is possible that the number of inmates referred for colorectal cancer screening should have been higher, since Ministry of Health guidelines recommend testing any person above 40 with a first-degree relative who had colorectal cancer. However, since most of the files make no mention of the patient's family history, the exact number of patients who should have undergone screening cannot be determined.

⁹⁸ Ministry of Health Director General Circular No. 8/11, February 16, 2011, on "Prevention and Early Detection of Malignant Diseases."

Moreover, in almost half the files (14), the medical records were faulty or missing information, for example, providing insufficient documentation of patient complaints and prison clinic examinations, or results of tests noted as having been done not being registered in the file as sent by the IPS to PHRI.

Diabetes

Eight files of inmates diagnosed with diabetes were reviewed. The reviewers were asked to indicate whether the annual tests considered part of standard medical procedure in monitoring diabetic patients were carried out as required (or at least were carried out once a year most years).

- In seven of the eight cases, both LDL cholesterol and glycated hemoglobin blood (A1C) were tested regularly.
- In only five cases were there routine ophthalmological checkups. Diabetics are usually referred to an ophthalmologist once a year due to the vascular damage diabetes causes, particularly to the blood vessels in the eyes.
- Only in one case were a patient's feet examined regularly. This examination is considered standard practice in the case of diabetics, due to the heightened risk of lesions that fail to heal and may lead to amputation.
- **In a full half of the cases - four out of eight - the reviewers noted that abnormal test results were not addressed according to standard procedure.**

In his overall assessment, one of the reviewing doctors described his impressions of the treatment of a diabetic patient whose file he had reviewed:

"Diabetes - no comprehensive medical attention. Patient [glucose levels] not balanced throughout the prison term. A single examination by an endocrinologist and partial implementation of his recommendations. Poor overall [...] Suffers from neuropathy [neural damage caused by diabetes]."⁹⁹

Heart disease

Eight of the inmates whose files were reviewed had been diagnosed with ischemic heart disease, a condition of reduced blood supply to the heart muscle, affecting its functioning. The doctors were asked to indicate whether these patients were provided preventive drug therapy in accordance with standard procedure, whether their condition was regularly monitored, and whether abnormal test results were properly addressed.

- All eight patients were regularly treated with statins (to lower cholesterol and prevent vascular damage), and six of them were regularly treated with blood thinners to prevent blood clots.
- In only one case was LDL cholesterol level not regularly monitored.
- **In two of the eight cases, the reviewers wrote that medical treatment did not follow standard practice.**

In her overall evaluation of one of these two cases - a criminal inmate who had undergone bypass surgery in 2014 - the doctor who reviewed the file noted:

"Patient after CABG [coronary artery bypass grafting] and heart valve surgery without regular cardiologic follow-ups as required. According to the records, he was examined by a cardiologist for the first time after the bypass surgery in 2016, after having complained of chest pains for several months. Irregular follow-up of a patient after CABG and heart valve surgery puts his life at risk. He needs to undergo periodic echocardiograms and evaluation by a cardiologist [...]. It took almost a year from the time he first complained

⁹⁹ All explanations of medical terms in brackets have been added by the author of this report, and are not part of the original quote.

of chest pain until he had the CABG operation, which was ultimately defined as urgent, despite a known ischemic background."

Hypertension

As mentioned earlier, all the reviewed files had recorded the results of at least one blood pressure test. In 23 of the 32 files, there is either a diagnosis of hypertension, or there is a record of abnormally high blood pressure values continuing over a long period of time.

In six of the 23 cases with a stated diagnosis of hypertension or which provided consistent documentation of high blood pressure, the reviewers indicated that the treatment given for hypertension did not comply with standard practice.

In her overall evaluation of one of the files, the reviewing doctor wrote:

"He was not referred for testing to find out whether there is damage to target organs – eyes and kidneys (should be performed once a year). Although treated with ACE [a class of hypertension medicines that can cause increase potassium levels in the blood, which when excessive can damage cardiac functions], there is no blood test for potassium in the file. Treating hypertension with Fusid as a second medication is no longer accepted practice."

Another reviewer wrote as follows with regard to different file:

"In November 2015, high blood pressure (150/100) was measured. Subsequently, high values were recorded for an entire year, but he was not treated and no tests were done to find the cause of the hypertension – completely unacceptable!!!"

Asthma

In ten of the files, the patients were diagnosed with asthma. The reviewing doctors were asked to indicate whether the patient was receiving any additional treatment apart from Ventolin. We used this indicator to determine whether patients were receiving prophylactic treatment, which is currently standard practice for non-mild asthma. **In five of the ten cases reviewed, the patients received no treatment other than Ventolin.**

In her overall evaluation of one of the cases, the reviewing doctor wrote:

"Has asthma. No report of smoking. In addition, treated with Ventolin – taken daily – according to the doctor, without inhaled steroids as preventive treatment. This suggests the asthma is not under control. There is great importance for preventive treatment. All studies have shown that using Ventolin alone without preventive steroid treatment increases mortality among asthma patients. It should be noted that the inmate has never been seen by a pulmonologist."

Another doctor wrote the following in reference to a different case:

"He has been getting a medicine called Theotrim for his asthma. This medicine needs to be monitored for blood levels. Only in 2014 was the level in the blood checked. It was found to be low once, so they repeated the test later on, but since then the level was not checked again. This medicine can be dangerous and cause life-threatening arrhythmia when blood level is too high. Moreover, this medicine is hardly ever used for treating asthma anymore because there are better medicines available that involve less danger to the patient. It has also been proven that this medicine does not affect the long-term prognosis, so that there is no reason to continue using it."

Endangering patients and denying treatment

In addition to addressing specific aspects of the treatment of the chronic illnesses discussed above, the doctors who reviewed the files were asked to provide an overall assessment of the quality of health care in prison and of situations where essential treatment was denied or dangerous conditions inadequately treated. **In 15 of the 32 cases reviewed, the reviewers wrote that essential treatment was denied or that the patient was in danger due to inadequate treatment or inappropriate response to his condition.**

Although these are two different types of failings – inadequate or inappropriate treatment versus denying treatment on the basis of non-medical considerations – both can lead to a similar outcome: endangering patients' health or even their lives.

For example, with regard to three separate files, the doctors noted that the medical records documented repeated complaints of chest pain, and in some cases also of difficulty breathing, but the complaints were not appropriately addressed or followed up.

In another case, the doctor found a record of over a year of repeated blood tests with results showing high sodium, a condition that could adversely affect muscle and nerve functioning. Nevertheless, the patient was not referred for further examinations. In another case, the doctor noted that the inmate tested positive for fecal occult blood:

"The file states that he should be referred for a colonoscopy, but I haven't seen any indication that he underwent the exam.¹⁰⁰ The fecal occult blood test is a screening test, and when the result is positive, it must be followed up by a colonoscopy, given that it might indicate cancer in the digestive system."

In yet another case, a doctor who reviewed the file of an inmate diagnosed with uveitis (an inflammatory eye disease that may lead to blindness) noted that in addition to the patient not being sent for routine checkups at an ophthalmologic clinic and the fact that a referral was made only after the inflammation had become active, the recommended tests were not performed, possibly because of their expense.

Waiting Times

As described above, inmates' waiting times for medical treatments and examinations are substantially longer than in the Israeli public health care system. This problem is also reflected in the files reviewed by PHRI doctors: **in ten of the 32 files reviewed, the doctors found unreasonable waiting times for at least one treatment or examination.** For example, an eleven-month wait for a gastroenterologist or an eight-month wait for a colonoscopy. This wait comes on top of an often very long and even unreasonably long time that elapses from the time of an inmate's complaint until he is referred to the clinic. One of the reviewers summarized the situation as follows:

"What is clearly evident is that it takes a long time from the complaint to the diagnostic examinations. And once there is a diagnosis, it takes a long time to see a specialist and then to have the recommendations implemented."

Medication

Another issue that came up in the medical file review is prescriptions for medicines that are either inappropriate or are no longer used for the diagnosed condition. **In 11 of the**

¹⁰⁰ The record ends a year after the recommendation to perform the examination. During that period, there is no evidence that the examination was ever performed or that an appointment was ever made.

32 files reviewed, the doctors indicated that the drug therapy provided did not comply with the standard in the Israeli health care system.

This problem involved both treatments that were once standard practice but have been abandoned (e.g., the asthma example above) and overmedication, which could result in needless side effects and other damage. In one case, the doctor reviewing the file noted:

"With regard to blood pressure – he received treatment that is no longer recommended for rapid lowering of blood pressure (Isoket) prior to starting the permanent treatment. Once the permanent treatment began, blood pressure was measured and followed-up regularly. Overmedication – he continues to be treated with aspirin, a treatment begun due to chest pains, even after a heart condition was ruled out."

With regard to another case, the doctor wrote:

"In some of the visits, non-standard treatments were given, such as: treating an irritation in the groin (several times) with Betacorten [an aggressive steroid treatment that is not prescribed for this diagnosis]; Dexacort for conjunctivitis (without an examination by an ophthalmologist); Augmentin for pharyngitis [...]; Voltaren to treat a backache in an asthmatic and dyspeptic patient [Voltaren treatment can cause severe side effects in patients with asthma and stomach conditions] [...]; Bondormin [pills for sleep disorders, known to be addictive] upon first complaint of sleep disorders (subsequently prescribed on a permanent basis) [...]; adding Norlip to Lipitor for high LDL [a combination which heightens the risk of side effects]."

H.3 Conclusions: Substantial Systemic Failures in the Treatment of Inmates with Chronic Diseases

Before presenting the conclusions, there is one qualification: they are limited due to the small sample and the unique characteristics of the population surveyed (inmates who contacted PHRI regarding a medical complaint improperly addressed by the IPS). It should further be noted that in some of the cases reviewed – as indicated in the data presented above – the doctors felt that the treatment and follow up were adequate and met the professional standards of the Israeli public health care system.

That said, only a handful of cases were found to have been handled without any substantial flaws in treatment and follow-up. Furthermore, the overall picture that emerges is of several systemic problems that were observed in most of the cases, such as incomplete medical information, incomplete record of test results, no regular follow-up or vital examinations for patients at risk, and prescribing inappropriate medications.

These issues suggest that despite the continued increase in the number of inmates with chronic diseases, the IPS is ill-equipped to deal with them, in terms both of its medical staff's training and the ability of the IPS health care system to meet the standard norms of care in the Israeli health care system for systematic and regular treatment and follow-up. One of the doctors summarized it well in his overall evaluation of the file he reviewed:

"Treatment is episodic without seeing the patient as a whole. At every visit, the doctor only treats the problem presented in that visit, without addressing the other problems or considering that they might be related. There is no preventive medicine; some of the tests are done after extensive delay; there is no process of formulating a plan for examination and treatment."

Part III

Medical Services for Inmates: Global Trends



Health Care Systems for Inmates around the World

In 2002, when the Avi Israeli Commission addressed the question of transferring responsibility for inmates' medical care from the IPS to the community health care system, it stated that this issue had come up in other countries as well, including England, and that these countries had had trouble implementing this kind of reform due to difficulty recruiting doctors willing to work in correctional facilities. In the years since the Israeli Commission submitted its recommendations, international trends in prison medicine have undergone changes. The reform in England was successfully completed. Its success, together with encouraging reports from other countries that had completed similar reforms even earlier – for example, France and Norway – led to growing calls in support of reassigning responsibility for prison medical services to the community health care system.

This part of the report describes the growing trend in Western countries to transfer responsibility for medical services in prisons to civil authorities. This idea is supported by both medical and correctional experts, world health organizations and various UN and EU agencies. Below, we present the views of the various bodies, focusing particularly on the reforms completed successfully in France in 1994 and in England in 2006. We have chosen to focus on France and England because of the relative wealth of information available about them and the relatively long time that has gone by since the reforms were implemented, enabling us to make an informed analysis of the change. We will also briefly describe comparable reforms in other countries that have either already been carried out or are underway.

In the 1990s, various international organizations began calling to integrate prison medical services into civil health systems, or at least to strengthen the ties between the two systems.¹⁰¹ Proponents of this approach held that this move would improve the quality of health services and maintain treatment continuity between the community and prison, as well as mitigate the ethical conflicts faced by doctors working in correctional facilities. As time went by, close coordination between the systems was no longer seen as a satisfactory solution in certain countries and regions, leading them to gradually integrate prison medical services into the public health system. Examples include France (1994), Norway (1998), New South Wales (Australia) (1997) and England (2000–2006).

In 2004, senior prison and health care officials from these four places participated in a conference to discuss their reforms.¹⁰² The conference report stated that all four states felt that the move had improved the quality of inmate care, the assessment of inmate needs, the ability to recruit quality medical staff, and ties with the public system. Successful reform in these states led to the model being adopted in other countries as well. In addition, whereas recommendations by various international organizations once used to suggest a range of possible actions, from "closer ties" with the public health system to full integration, we now see greater support for the latter option. For example, a document published by the Council of Europe and the World Health Organization in 2014 stated that in countries where reform had been completed, there was significant evidence for improvement in health status not only among inmates, but also in other groups in society.¹⁰³ The document also states that making prison health services subordinate to the public health system is the most effective way to guarantee the professional independence and ethical conduct of prison medical staff.

In addition to these four cases, prison medical services were transferred to the community health system in at least six other places, namely: Finland, Sweden, Italy, Scotland, Catalonia and Nova Scotia.

In the province of Nova Scotia, **Canada**, prison medical services have been a part of the public health system since 2003. According to local senior health officials, the move has clearly had a positive impact, as is evidenced in the improved ability to recruit quality staff and better respond to common illnesses among inmates, such as infectious diseases. Since 2010, this model has also been adopted in the province of **Alberta**.¹⁰⁴

Italy began incorporating prison health services in its general health system in 2008, a process it completed in 2015. The clinics in the various detention facilities are now operated by district health services subject to state guidelines and professional supervision. The system is characterized by high availability of primary care (both physicians and nurses). Since the reform was completed, the system has been operating in accordance with guidelines that place an emphasis on detection and diagnosis: every detainee is examined by a doctor within 24 hours of entering the facility, and is offered the option of being tested for HIV and hepatitis.¹⁰⁵ Yet notwithstanding the benefits

¹⁰¹ See for example the Council of Europe's Recommendation No. R (98) 7 Concerning the Ethical and Organisational Aspects of Health Care in Prison (Apr. 8, 1998): "The role of the ministry responsible for health should be strengthened in the domain of quality assessment of hygiene, health care and organisation of health services in custody, in accordance with national legislation. A clear division of responsibilities and authority should be established between the ministry responsible for health or other competent ministries, which should co-operate in implementing an integrated health policy in prison." See also the 2003 Moscow Declaration on Prison Health as Part of Public Health by the World Health Organization (WHO): "Member governments are recommended to develop close working links between the Ministry of Health and the ministry responsible for the penitentiary system so as to ensure high standards of treatment for detainees, protection for personnel, joint training of professionals in modern standards of disease control, high levels of professionalism amongst penitentiary medical personnel, continuity of treatment between the penitentiary and outside society, and unification of statistics."

¹⁰² *Prison Health and Public Health: The Integration of Prison Health Services. Report from a conference organised by the Department of Health and the International Centre for Prison Studies*, London, April 2, 2004.
http://www.prisonstudies.org/sites/default/files/resources/downloads/prison_health_4.pdf

¹⁰³ World Health Organization, Regional Office for Europe-Council of Europe: Strasbourg Conclusions on Prisons and Health, 2014.
<https://rm.coe.int/strasbourg-conclusions-on-prisons-and-health-final-draft-20-june-2014/168075f56c>

¹⁰⁴ PC Webster, "Integrating prison health care into public health care: The global view," *CMAJ*, (2013), 185(7):E283.

¹⁰⁵ "Report to the Italian Government on the Visit to Italy Carried out by the European Commission for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 8 to 21 April 2016," pp. 35-41.

of the reform, Italian human rights organizations report that inmates still find it difficult to access consulting services outside the prison due to, among other reasons, a lack of guards to escort them.¹⁰⁶

In **Spain**, medical services for inmates started being integrated into the public health system in Catalonia since the end of 2014. This move has been perceived as offering many advantages, including the ability to use protocols and indicators from the civil health system in prison clinics and greater access by prison medical teams to medical research and training.¹⁰⁷ Health service integration is also seen as potentially improving the ability to maintain treatment continuity by ensuring access to medical information and by through the newly created role of contact nurse, who is assigned to help patients about to be released to arrange for continued medical treatment in the community.¹⁰⁸

In **Scotland**, a 2007 report by the parliamentary Prison Healthcare Advisory Board recommended that prison health services be integrated into the national health services.¹⁰⁹ The advisory board, whose conclusions were also influenced by the process already underway in England, felt that the transfer of services was essential in order to close the gap in treatment quality between prisons and the community, to expand the variety of services available to the inmate population, and ensure treatment continuity. Furthermore, the delivery of services by the prison authorities was seen as impracticable in the long term because of the difficulty of recruiting quality staff able to meet the complex needs of the inmate population. The reform was launched in late 2011, and opinions still differ as to its success.¹¹⁰ Detractors argue that although there are not yet enough data to determine whether the reform has succeeded, there is clearly a significant difference between the high expectations and the slow and limited change so far. This is attributed to the heavy workload of the medical staff, and to the fact that no additional funds have been allocated to the reform, contrary to the recommendations of the 2007 advisory board. Nevertheless, several positive trends have also been identified: improved access to prison services in various areas (for both inmates and guards) and moderate improvement in access to primary medicine.

France had integrated the prison medical services into the civil health system as far back as 1994.¹¹¹ The way the French system is organized, the district hospitals are responsible for prison health services and they operate the prison clinics located in their district. These clinics are staffed by doctors and nurses who provide primary medical services. They are hospital employees, even though they work in the detention facilities. Each hospital has a physician responsible for these services and for the liaison between prison clinics and the hospital. In addition to the primary medical services, various specialists come to the prisons. In addition, many prisons use telemedicine (remote medical services), including digital imaging instruments. Finally, the district hospitals have created dedicated units for inmates in order to make it easier for both prison authorities and the hospitals themselves to handle the transfer of inmates for treatment.

The integration process in France considerably improved medical services, not least thanks to significant increases in the number of medical staff in prisons. From 1997

¹⁰⁶ "Prison conditions in Italy," European Prison Observatory, Rome: 2013, p. 30.

¹⁰⁷ R. Morral-Parente, "Chronicity and primary care: the role of prison health," *Revista Española de Sanidad Penitenciaria*, (2015) 17(2), pp. 61-64. <https://dx.doi.org/10.4321/S1575-06202015000200005>

¹⁰⁸ "Improving Prison Conditions by Strengthening Infectious Disease Monitoring." The Observatory of the Penal System and Human Rights (University of Barcelona). Barcelona 2015, p. 16. http://www.ub.edu/ospdh/sites/default/files/documents/improving_prison_conditions_by_strengthening_catalonia_partner_reports_-_hri_prison_project_cb.pdf

¹⁰⁹ Prison Healthcare Advisory Board (2007), "Potential Transfer of Enhanced Primary health care Services to the NHS: Report to Cabinet Secretaries for Health and Wellbeing, and Justice." Volume 1 of 2.

¹¹⁰ Royal College of Nursing, "Five years on: Royal College of Nursing Scotland review of the transfer of prison health care from the Scottish Prison Service to NHS Scotland," November 2016.

¹¹¹ Evaluation du plan d'actions stratégiques 2010-2014 relatif à la politique de santé des personnes placées sous main de justice - Novembre 2015.

to 2013 their numbers doubled to over 2,600 physicians and nurses, at a time when the inmate population grew by only 25%. It should be noted, however, that despite the high medical staff to inmate ratio (in most facilities, 300–500 inmates per doctor), in some of the medical specialties and some areas recruitment is still an issue. Furthermore, despite the dedicated areas set aside for inmates in the hospitals, it is still difficult to refer inmates for tests outside the prison. Sometimes the reason is the distance from the prison to the hospital. In addition, there are problems coordinating between the hospitals and prison officials in charge of providing an escort to the patients.

In England, a highly critical review published by the Chief Inspector of Prisons in 1996 led to the decision to transfer medical services to the responsibility of the National Health Service (NHS). The reform was gradual. First, in 2000, the NHS took over responsibility for establishing standards and developing policy. Later, additional powers – such as control over the budget control – were transferred, until the reform was ultimately completed in 2006.¹¹² Today, most of the doctors providing medical services in detention facilities work part-time in the community. When necessary, specialists come to the prisons, or inmates are referred for treatment outside prison. In addition, detention facilities employ registered nurses who play a major role in providing care, bearing responsibility for medical follow-up and primary care.

The transfer of medical services to the NHS led to a series of significant changes. For example, most areas of care are currently regulated by protocols and guidelines developed by the National Institute for Health and Care Excellence (NICE), the government agency in charge of standardization.¹¹³ Periodic inspections and evaluations of detention facilities, including unannounced inspections, are also conducted by the Inspectorate of Prisons, which has broad oversight authorities, together with the Care Quality Commission and the government agency responsible for control and oversight of the health system in the community.¹¹⁴

As part of the system's control and oversight mechanisms, English detention facilities implement a quality indicator program that was developed by the Department of Health and Social Care to assess prison medical services in a variety of areas, including treatment safety, treatment of infectious diseases, and the treatment provided to particular populations such as the elderly, the disabled and minors. The indicator program suggests there has been a significant improvement in the quality of care.¹¹⁵

A report published in 2016 by Public Health England to evaluate the reform a decade after its completion considered the move a clear success.¹¹⁶ According to the report, in addition to applying civil control and oversight mechanisms, the reform improved the quality of prison medical services in other ways. For example, it led to a substantial improvement in the quality of the medical staff thanks to the employment of doctors and nurses with education and training recognized by national medical institutes such as the Royal College of Nursing. These institutes also provide opportunities for further education, thereby ensuring ties between prison medical staff and the community system. In addition, the reform led to a focus on preventive medicine with an emphasis on detecting diseases such as HIV and hepatitis B and C in all prisons. Finally, it should be noted that the conclusions of the English health authorities regarding the improvement in medical services in prison are supported by the medical community.¹¹⁷

¹¹² P. Hayton and J. Boyington, "Prisons and health reforms in England and Wales," *American Journal of Public Health*, (2006) 96(10), pp. 1730–1733.

¹¹³ National Institute for Health and Care Excellence, <https://www.nice.org.uk/guidance/settings/prisons-and-other-secure-settings#panel-pathways>.

¹¹⁴ <https://www.cqc.org.uk/guidance-providers/criminal-justice-system/health-care-criminal-justice-system>

¹¹⁵ Prison Health Performance and Quality Indicators Annual Report 2011, Department of Health and Social Care, UK, 2012. <https://www.gov.uk/government/publications/prison-health-performance-and-quality-indicator-report-and-guidance>

¹¹⁶ "Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure and detained settings to inform future health interventions and prioritization in England." Public Health England, 2016.

¹¹⁷ See for example the article by Richard Smith, former editor of *The British Medical Journal*, "Is prison health better now it's an NHS responsibility?" *The BMJ Opinion*, 2016. <https://blogs.bmj.com/bmj/2016/03/01/richard-smith-is-prison-health-better-now-its-an-nhs-responsibility/>



Summary and Conclusions

In the years since the Israeli Commission Report was published, there have been significant material changes that have shaped the challenges now faced by the IPS health care system. For one thing, the IPS became the national correctional agency, leading to a substantial increase in the number of inmates it is responsible for. Second, as elsewhere around the world, the inmate population in Israel is growing older and sicker. Despite the growing challenges and difficulties faced by the system, the IPS has implemented almost none of the commission's recommendations, and the only areas where progress has been achieved are the digitization of medical records and the introduction of visiting specialists to provide on-site consultation in prisons.

Consequently, compared to the already problematic starting point where the health care system was some fifteen years ago, the situation has gone from bad to worse. As shown in Part II, the medical services provided to inmates do not meet the standards of the Israeli health care system. Despite the establishment of specialist clinics in some facilities, inmates' waiting times for examinations and treatments are still extremely long compared to the general population. In addition, despite the recommendations of the Israeli Commission with regard to raising the professional training level of the medical staff in correctional facilities, the quality of medical care in prison clinics is still significantly lower than the standard in HMOs. Unless significant change is put into effect, this situation is expected to further deteriorate due to the ageing of the prison population and the IPS's difficulty to recruit new physicians to replace prison doctors who are approaching retirement age.

Contrary to the recommendations made by the Israeli Commission – and the Berlowitz Commission that followed it – the IPS health care system is not subject to medical review and oversight. The only medical oversight mechanism currently in place – the Ombudsman at the Ministry of Health – is ineffective. It serves the IPS as a fig leaf that obscures that, in practice, the system operates with no real professional supervision. The lack of control and oversight mechanisms affects not only the quality of care, but also the system's existing tendency to operate arbitrarily and to make medical decisions on the basis of non-medical considerations.

Responsibility for the crisis in the prison health care system does not lie with the IPS alone. For years, the Ministry of Public Security, which is in charge of the IPS, has enabled the IPS to keep from implementing the recommendations made by the commissions of inquiry and consultants hired to examine the functioning of the health care system. For example, since 2014 the IPS has been claiming to be working with the Ministry of Public Security to formulate a multi-year program for upgrading the health care system. This program has yet to be completed, let alone implemented. It therefore seems clear that the Ministry of Public Security has failed to regulate and oversee the health services provided to inmates, be it because of the ministry's own priorities or due to a lack of tools and professional knowledge.

Another agency largely responsible for the crisis in the IPS is the Ministry of Health. Its conduct over the years suggests that it considers itself exempt from any involvement or responsibility for prison health care. The ministry has adopted a dubious interpretation of the National Health Insurance Law, reading it as excluding inmates, and has chosen not to exercise its authorities under this law with regard to the inmate population. The Ministry of Health has also eschewed all responsibility for shaping health care policy in prisons and for control and oversight of the prison health care system's normal operations. Quite apart from the severe violation of inmate rights it entails, the Ministry of Health's policy of virtually ignoring inmates' health care will likely result in harm to the public health care system when those inmates eventually return to society as patients who have received inadequate treatment.

Given the poor condition of the IPS health care system as described in this report, and given that the relevant government authorities eschew responsibility for it, which practically constitutes neglect of inmates' health in Israel, PHRI recommends that measures be taken immediately on three separate levels, as detailed below.

A. Long-Term Solution: Legislation and Regulation

- **Integrating the prison health system into the public health care system.** The medical services currently provided to inmates are of low quality and availability, in breach of the state's duty to provide equitable care. PHRI believes the only real solution is reassigning responsibility for the health care services provided to inmates from the correctional authorities to the state health system, i.e., the Ministry of Health and the HMOs. Based on the experience gained in various countries, transferring prison medical services to the responsibility of the Ministry of Health is expected to facilitate the recruitment of high-quality medical staff, raise the services' professional level and mitigate the problem of prison doctors' dual loyalty.
- **Establishing an effective and professional mechanism for medical control and oversight of the IPS health care system.** The findings of this report suggest the urgent need for involving a professional medical body in formulating medical policy

in correctional facilities and in controlling and overseeing implementation of the policy. Even were we to accept the problematic interpretation that excludes inmates from the provisions of the National Health Insurance Law, given the disparity and the needs on the ground, the Ministry of Health must act to apply these provisions to the correctional health care system, under its authority as stipulated in Article 56 of the law. Alternatively, the Ministry of Health and Knesset committees must promote a legislative process to ensure that the Ministry of Health has the capacity to act as the regulator of prison medical services, for example, by approving the bill for establishing the Office of Inmate Ombudsman.

B. Interim Measures: Upgrading the Prison Health Care System

As the experience of other countries has shown, the process of integrating prison medical services into the community health system is gradual, and completing it may take years. Therefore, several steps must be taken in the meantime to improve available services:

- The Ministry of Health and the IPS must formulate **plans for training IPS medical staff**, including offering periods of training in community medical institutions. In addition, a plan must be made to **recruit additional medical staff** to the IPS, including through offering incentives such as ensuring an internship for doctors undertaking to work in the IPS, as well as an incentive program for nurses and paramedics.
- The IPS must publish **comprehensive and systematic data on the medical condition of the inmate population** and enable professional study and assessment of its needs and of the available services. The Ministry of Health and the IPS must **apply the national plan for quality indicators of community health care** also to the IPS health care system.

C. Fueling Change: Support and Involvement by the Medical Community

In addition to our demands and recommendations targeting the various authorities, PHRI is also turning to the Israeli medical community, calling upon it to become more involved in prison health care. IMA's consistent position in support of removing health care from the responsibility of the IPS is extremely important. International experience has shown that active involvement by the medical community proved decisive both in promoting the decision to integrate prison health services into the public system and in ensuring that the endeavor is successful.¹¹⁸ In both England and Australia, the local medical associations promoted the move through campaigns and continuous debate. In France, a report published by the public health services was pivotal to the success of the process. Moreover, greater involvement by the IMA and Israeli scientific associations will contribute to raising the medical community's awareness of the unique problems that affect inmates and will help improve the medical service provided to them even under the present conditions.

¹¹⁸ See footnote 96 above.

Appendix

Appendix 1

Economic Analysis of the Budgeting of the IPS Health Care System and Health Care Costs per Prisoner

The following analysis of the IPS health care system's budget was conducted by the firm of Wulkan Strolovitch & Co. CPA further to a request by PHRI.

Objectives

Examination of the following issues:

- The overall budget of the IPS health care system
- Medical expenditure per prisoner
- Comparison between the standardized expenditure per prisoner by the IPS and the expenditure per HMO client

Method and Scope

A. In order to understand the field, existing problems and avenues of improvement,

1. Budgeting data of the IPS health care system have been examined
2. Expenditure data of Israeli HMOs have been reviewed
3. The standardized expense per client has been calculated in accordance with the relevant age groups of Israeli prisoners

B. The following documents have been reviewed:

1. Various IPS publications and guidelines.
2. Various Ministry of Health publications and reports.
3. Various statistical reports on the Israeli health system and demographics.
4. IPS data obtained under the Freedom of Information Law.
5. Additional government documents.

Period

Analysis was conducted during the month of February 2019.

Background

1. General

- 1.1. The medical treatment of prisoners in Israel is provided by and under the responsibility of the IPS, subject to the IPS Commission's Directive No. 04.44.00 on the Medical Treatment of Prisoners (hereafter, "the Directive"), which stipulates the scope and entitlement of the prisoner to medical treatment during his prison term.
- 1.2. Accordingly, we wish to examine the scope of services provided in this framework to prisoners, according to data on the cost of medical services provided directly by the IPS.
- 1.3. Officially, Israeli prisoners are entitled to appropriate and comprehensive medical services, equivalent to the services provided within the state health benefit package and sometimes even exceeding them.
- 1.4. As a guiding premise, given the incarceration conditions and the social and general condition of the prisoner population and their morbidity levels, the need for medical services is often even higher than in the general population.

2. Summary of Findings

- 2.1. After factoring in all the figures available to us, the facts available to us as well as the conversion of the data to enable a valid comparison between the IPS's expenditures on medical services per prisoner and those of the HMOs per client, **it can be seen that despite the relative dearth of medical services that the IPS provides, the outlay by the IPS per prisoner is not negligible and is significantly higher than it could have been had those prisoners been receiving the service from the HMOs. This difference comes to another NIS 75 million when provided through the IPS medical system versus by the HMOs, with no added benefit in the services provided.**
- 2.2. The additional expenditure by the IPS means that were the exact same budget given to the HMOs for the purpose of providing medical services to prisoners, they would be able to provide far more extensive medical services than those supplied by the IPS.

The Health Care System's Budget and Expenditure per Prisoner

3. The IPS Health Care System's Budget

- 3.1. According to IPS data, in 2017 the health care system's expenditure on prisoners (i.e., excluding the cost of health services for IPS staff) totaled NIS 96 million, or a slight increase compared to 2016 (NIS 93 million).¹¹⁹
- 3.2. This total does not include payroll costs for those directly employed by the health care system – a cost we have therefore estimated according to the data available to us.
- 3.3. According to the calculation presented below, the payroll costs for health care system employees are estimated at NIS 69.5 million,¹²⁰ as detailed below:

¹¹⁹ Data obtained by a Freedom of Information Request, received from the IPS on April 25, 2018.

¹²⁰ Net of the payroll costs of dentists and narcologists employed by the IPS.

Table 1: Calculation of Payroll Costs in the IPS Medical System

Profession	No. of Employees	Mean Monthly Payroll Cost (NIS)	Total Annual Cost (NIS)
Physician	44	48,000	25,344,000
Nurse	10	20,051	2,406,120
Pharmacist	2	30,269	726,456
X-ray operator	1	30,867	379,404
Paramedical staff	220	15,372	40,582,080
TOTAL			69,429,060

- 3.4. The numbers of professionals in the above table have been reported by the IPS in response to a freedom-of-information request from June 22, 2014. The mean payroll costs used in the calculation are borrowed from sources and publications by the Ministry of Finance on payroll expenses in the public service, in security agencies and in the IPS for 2016. The payroll costs of the paramedical staff are unknown and were not obtained through the freedom-of-information request. Therefore, they have been estimated according to the mean costs for administrative IPS employees, based on said publications.
- 3.5. Accordingly, the total expenditure of the IPS health care system was NIS 165 million.

4. Total Expenditure per Prisoner

- 4.1. According to IPS data,¹²¹ the number of prisoners receiving medical service from the IPS in June 2018 was 15,943, of whom 98.6% were men. Therefore, the expenditure per prisoner would appear to be NIS 10,360. In order to compare the expense per prisoner to the HMOs' expense per client, however, we need to estimate the standardized expense, calculated according to the prisoners' age mix.
- 4.2. The mean expense per client in the HMOs in 2017 was NIS 5,561.¹²² Please note, however, that this figure takes into account the entire population, including children, and that its age mix and gender distribution is different from that of the prisoner population. Naturally, this fact affects the standardized cost and does not allow for accurate comparison.
- 4.3. The capitation formula according to which the resources of the state medical benefits package are divided among the HMOs assigns a different weight to each insured individual according to age, gender and place of residence. The weight assigned to each age and gender group is calculated according to the consumption of medical services by the clients and, in fact, reflects the HMOs' expected expense for each client in a particular group.
- 4.4. We therefore calculate and compare the mean cost per HMO client according to the distribution of prisoners served by the IPS, considering their age and gender distribution. The variable of residence was considered identical to the existing distribution in the general population, and was actually redundant.
- 4.5. The prisoners' age distribution was calculated according to the age

¹²¹ Data provided by the IPS to B'Tselem on a monthly basis.

¹²² Summary Report on HMO Operations in 2017, Ministry of Health.

distribution of criminal prisoners in 2010 and as reported by the Prisoner Rehabilitation Authority in "Convicted Criminal Prisoners Who Are Israeli Citizens, 2010," as follows:

Table 2: Distribution of IPS Prisoners in 2010 and Calculated Distribution for 2018

Age Group	Distribution of Criminal Prisoners, 2010	Age Group Weight	Distribution of Criminal Prisoners, 2018
14-18	56	0.76%	121
18-25	1,338	18.10%	2,885
25-35	2,391	32.34%	5,156
35-45	1,772	23.97%	3,821
45-55	1,238	16.75%	2,670
55 & older	598	8.09%	1,290
TOTAL	7,393	100%	15,943

4.6. We will now calculate the capitation weight for each age group as well as the weighted expense per prisoner according to the capitation weights and age and gender distribution, as well as the weighted expense per HMO client according to the relevant age and gender groups and their distribution in the general population and the prisoner population. Accordingly, the standardized expense per HMO client and prisoner is as follows:

Table 3: Calculation of Factored Expenses for Each of the Populations on Its Own

Age Group	Capitation Weight	Age Group Distribution in the General Population	Standardized Cost per Client in the General Population	Age Group Distribution in the Prisoner Population	Standardized Expense per Prisoner	Total Weighted Expense per Client by General Population Distribution	Total Weighted Expense per Client by Prisoner Population	Total Weighted Expense per Prisoner by Weight in the Prisoner Population
14-18	0.38	0.63%	2,138	0.76%	3,919	13	16	30
18-25	0.38	15.02%	2,138	18.10%	3,919	321	387	709
25-35	0.44	15.67%	2,503	32.34%	4,588	392	809	1,484
35-45	0.59	14.35%	3,339	23.97%	6,122	479	800	1,467
45-55	1.00	11.79%	5,643	16.75%	10,345	665	945	1,732
55 & older	3.07	23.90%	17,357	8.09%	31,821	4,148	1,404	2,574
TOTAL/Weighted		100%	5,651	100%	10,360	6,019	4,362	7,996

Explanations for the above table (all calculations relevant to this table are attached in Appendix A below):

- The capitation weight was calculated according to the HMOs' data for June 2018, as included in the monthly national report on HMO membership. This datum was weighted according to the capitation weight of the relevant age group and the population distribution in terms of gender and place of residence.
 - The 14-18 and 18-25 age groups, which overlap in terms of capitation and HMO membership, were weighted according to the weight of each group in the prisoner population, so as not to create a difference in the results of this calculation.
 - The distribution of the general population is based, as mentioned, on the National Insurance Institute's monthly HMO membership report for June 2018.
 - The distribution of the prisoners' age and gender is as calculated above and according to the number of prisoners in June 2018.
 - Standardized expense per client and prisoner was calculated as the mean expense per client/prisoner multiplied by the capitation weight for the relevant age group.
 - The total expense was calculated based on the expense datum according to capitation weight multiplied by the distribution of the relevant population.
- 4.7. The calculation of the standardized expense, as mentioned above, is based on the mean expense multiplied by the capitation weight according to age group distribution. In other words, every patient is assigned to a certain age group that is given a weight calculated according to the consumption data of the relevant age and gender groups in the general population.
- 4.8. The above table shows that if the general population were made up only of the population groups that correspond to the prisoner group (i.e., no children), then the mean outlay for the HMO would have been slightly higher, reaching NIS 6,019 per client.
- 4.9. **If the population distribution corresponded to the prisoner distribution - in other words, if the HMOs provided services to this group indistinguishably from the general population - then the mean expenditure would be NIS 4,362 per prisoner.**
- 4.10. This is the figure owing to the low mass of older prisoners in the IPS relative to the weight of older clients in the general population (the size of the elderly population).
- 4.11. It is likely that the expenditure under the HMOs is even lower. Due to a lack of data on the distribution of prisoners 55 years old and over, the age groups of 55 and above were consolidated and the capitation weight was calculated according to the distribution in the general population. It is highly likely that the distribution among IPS prisoners tends toward the lower age groups and has fewer prisoners in the 75 and over and 85 and over groups when compared with the general population (and in the table above, this group would have been given a weight lower than 3.07).
- 4.12. **The results of the comparison in Table 3 above show that the mean standardized expenditure of the HMOs per client in those age groups is NIS 4,362. In contrast, the actual expenditure per prisoner made by the IPS is NIS 10,360.**
- 4.13. **This difference results in an excess expenditure by the IPS, without**

providing any additional service, amounting to a total difference of NIS 96 million.

- 4.14. As mentioned in the introduction, although the figure for mean expenditure by the HMOs also factors in morbidity figures, we know that the prisoner population is characterized by a morbidity rate higher than in the general population.
- 4.15. Had we given each IPS prisoner a capitation weight corresponding to that of the general population and not factored in the higher morbidity rate then, as can be seen from the table above, the expenditure would have been NIS 7,996 per prisoner.
- 4.16. The fact that, in practice, the IPS spends NIS 10,360 per prisoner indicates the difference in morbidity between the general population and the IPS population. That is, had the morbidity rates of IPS prisoners matched those of the general population, we would have expected the actual expense to be equal to the standardized expenditure of NIS 7,996.
- 4.17. **This is a difference of 29.6%, a rate which may still be low in view of the actual differences in morbidity.**
- 4.18. This means that without excess morbidity, the expenditure by the IPS is approximately NIS 58 million higher (the difference between a mean expenditure of NIS 4,362 per prisoner and the expenditure of NIS 7,996 per prisoner).

5. Morbidity

- 5.1. In addition to the above and to the lower expenditure per prisoner compared to the standardized expenditure per client in the general population, note that the morbidity rates among IPS prisoners are higher than in the general population. This is due mainly to the higher exposure to infectious diseases, the fact that about two-thirds of criminal prisoners have a history of alcohol or drug abuse, and due to a lifestyle that does not promote health.
- 5.2. This suggests that among the prisoner population there are fewer "balancing factors," that is, fewer clients/prisoners who do not consume medical services or consume little of those services and thus balance the expense for those clients/prisoners who require intensive treatment, above the mean, and therefore require relatively higher expenditure. This in turn suggests that the IPS's health care expenses per prisoner should be much higher than those of the HMOs per client.
- 5.3. In section 4.16 above, we showed a 29.6% difference in morbidity between the IPS population and the general population, as indicated by the actual expenditure per prisoners. We estimate that this gap is actually much greater and may be estimated as 30-35% more services consumed due to a higher morbidity than the general population, given the facts presented in section 5.1 above. In order to calculate the difference, and as an estimate, we will consider the difference in morbidity to be a calculated rate of 29.6%.
- 5.4. **Therefore, had the characteristics of the general population been similar to those of the IPS population, the standardized expense for the relevant population would have been NIS 5,651 per patient ($1.296 \times \text{NIS } 4,362$).**
- 5.5. **This difference results in excess expenditure by the IPS, without providing any additional service, amounting to a total difference of NIS 75 million.**

6. The HMOs' Purchasing Power

- 6.1. The HMOs are much larger organizations than the IPS and they insure and provide health services for a much larger population. This fact, as well as the HMOs' professionalization and focus on medical services lead to the inevitable assumption that they have much stronger purchasing power than the IPS, as well as lower overheads per client than the IPS has per prisoner.
- 6.2. For the purpose of estimating purchasing power, we will assume that had the IPS had the HMOs' purchasing power, every expense listed would have been 15–20% lower, depending on the specific item.

We put forward that the discount rate per each item will be as follows:

Table 4: Calculated Cost per Prisoner, Taking Purchasing Power into Account

Item	Total Cost	Expenditure Weight	Cost per Prisoner	Estimated Discount for Purchasing Power	Cost per Prisoner after Discount
Hospitalization	34,033,177.98	0.21	2,134.68	18.5%	1,801
Medicines & Supplies	29,702,013.88	0.18	1,863.01	20%	1,553
Physicians (Not IPS Employees)	24,690,595.31	0.15	1,548.68	15%	1,347
Other	7,315,675.07	0.04	458.86	20%	382
Calculated Pay	69,429,060.00	0.42	4,354.83	15%	3,787
	165,170,522		10,360		8,870

- *Hospitalization*: The mean discount for HMOs according to the capitation rule is 18.5%. In practice, there are additional discounts for volume, which sometimes make the discount rate even higher. To the best of our knowledge, the IPS with its much weaker purchasing power cannot get these discounts and operates according to the Ministry of Health's official rates.
 - *Medicines & Supplies*: In this case, too, the expenditure of HMOs is much higher than that of the IPS; accordingly, their bargaining power is much greater, hence their greater discounts from the pharmaceutical companies.
 - *Physicians (Not IPS Employees)*: In this case, too, the discount is based on quantities, but the expense for the IPS may be even higher due to the need to transport the physician to the detention facility rather than have him provide service in his clinic. Even when a prisoner goes to the doctor's clinic, the number of patients does not provide the IPS with the bargaining power the HMOs have vis-à-vis external doctors.
 - *Other*: Mainly overheads, additional services and attendant costs, burdened on a smaller number of patients.
 - *Calculated Pay*: In the case of health professions, without the paramedical staff (about 42% of the expense), the IPS must offer a higher salary to the same employees in order to recruit them to work in this framework and with this population.
- 6.3. According to the calculation shown above, even could the IPS demonstrate a purchasing power equivalent to that of the HMOs and even could it secure the same price for each service, its expenditure would be higher, reaching a total of NIS 8,870 per prisoner, even though the service being provided

- and purchased by the IPS is ostensibly exactly the same.
- 6.4. The expenses presented for a prisoner under the IPS health care system as well as for an HMO client both incorporate a partial gross-up of the overheads. Nevertheless, we will present a calculation and another criterion which assume that the expense burden rate per prisoner is higher than that imposed on the HMO client (an advantage resulting from size).
- 6.5. Therefore, we will reduce the sum of the IPS expenditure per prisoner due to additional excess overhead by another 5%. We can therefore conclude that the expense per prisoner after reducing the excess burden would be NIS 8,447.
- 6.6. In other words, there is a sizeable difference between IPS expenditure and how much the HMOs would have spent per client, coming to another NIS 2,796 (=8,447-5,651) per prisoner, with this difference equivalent to some NIS 45 million of excess expenditure by the IPS, without the IPS providing any additional services, and even after deducting the HMOs' superior purchasing power.

7. Budgetary Implication of the Calculated Difference

- 7.1. Should responsibility for medical services for prisoners in Israel be transferred to the HMOs, the HMOs would spend NIS 5,651 per prisoner. In other words, due to the IPS providing health care services for prisoners, there is an excess expenditure of about NIS 75 million above what the HMOs would spend for providing the same services.

	Cost per Patient (NIS)	Number of Patients	Total Cost (NIS)
HMO Cost	5,651	15,943	90,093,893
Current Budget under IPS	10,360	15,943	165,170,522
Excess Expenditure			-75,076,629

This sum incorporates a "standardization" of the expenditure in accordance with population distribution among the IPS prisoners and taking into account an excess morbidity that is 29.6% among IPS prisoners than in the general population.

- 7.2. Even if we take into account the HMOs' purchasing power as compared with that of the IPS as well as the higher overheads burdened on each prisoner, there is still a difference in expense, with the IPS spending about NIS 45 million more than the HMOs would spend.

	Cost per Patient (NIS)	Number of Patients	Total Cost (NIS)
HMO Cost	5,651	15,943	90,093,893
Current Budget under IPS	8,447	15,943	134,677,366
Excess Expenditure			-44,583,473

This sum incorporates the deduction of expenses per prisoner under IPS health care for the additional discounts for medical services that the HMOs would get on account of their purchasing power (see section 6.2 above), as well as a further deduction of 5% of the overhead burdened on the prisoner.

In conclusion, the implication of the additional expenditure by the IPS is that if the identical budget would be given to the HMOs for the purpose of providing health care services to prisoners, the HMOs could - with the very same budget - provide substantially more extensive services than those provided by the IPS.

Appendix A

1. Distribution of insured, according to the National Insurance Institute report for June 2018

Male residents of non-remote areas, by age & HMO

Age Group	Total
TOTAL	3,606,484
1 & under	82,040
1-5	319,142
5-15	692,282
15-25	483,569
25-35	495,502
35-45	451,817
45-55	367,364
55-65	308,424
65-75	246,428
75-85	115,964
Over 85	43,952

Female residents of non-remote areas, by age & HMO

Age Group	Total
TOTAL	3,739,541
1 & under	78,282
1-5	302,016
5-15	659,481
15-25	495,498
25-35	500,629
35-45	466,781
45-55	383,397
55-65	339,638
65-75	284,104
75-85	154,316
Over 85	75,399

male residents of remote areas, by age & HMO

Age Group	Total
TOTAL	632,407
1 & under	13,783
1-5	52,173
5-15	123,664
15-25	97,497
25-35	91,082
35-45	79,145
45-55	67,437
55-65	53,186
65-75	34,682
75-85	15,221
Over 85	4,537

Female residents of remote areas, by age & HMO

Age Group	Total
TOTAL	635,834
1 & under	12,556
1-5	49,063
5-15	117,326
15-25	99,188
25-35	90,059
35-45	80,399
45-55	67,726
55-65	55,337
65-75	37,399
75-85	19,351
Over 85	7,430

2. Capitation weights, June 1, 2018

Age	Residents of Non-Remote Areas		Residents of Remote Areas	
	Female	Male	Female	Male
1 & under	1.4	1.85	1.44	1.9
1-5	0.75	0.94	0.8	0.99
5-15	0.39	0.42	0.43	0.46
15-25	0.44	0.37	0.48	0.41
25-35	0.74	0.43	0.78	0.48
35-45	0.79	0.58	0.83	0.63
45-55	1.14	0.99	1.18	1.03
55-65	1.69	1.78	1.73	1.83
65-75	2.6	3.1	2.64	3.14
75-85	3.35	4.07	3.4	4.12
Over 85	3.47	4.17	3.52	4.21

3. Standardized Number of Insured Individuals, June 1, 2018

Age	Residents of Non-Remote Areas		Residents of Remote Areas		TOTAL
	Female	Male	Female	Male	
1 & under	109,595	151,774	18,081	26,188	305,637
1-5	226,512	299,993	39,250	51,651	617,407
5-15	257,198	290,758	50,450	56,885	655,292
15-25	218,019	178,921	47,610	39,974	484,524
25-35	370,465	213,066	70,246	43,719	697,497
35-45	368,757	262,054	66,731	49,861	747,403
45-55	437,073	363,690	79,917	69,460	950,140
55-65	573,988	548,995	95,733	97,330	1,316,046
65-75	738,670	763,927	98,733	108,901	1,710,232
75-85	516,959	471,973	65,793	62,711	1,117,436
Over 85	261,635	183,280	26,154	19,101	490,169

4. Calculation of Mean Weight for Each Age & Gender Group, according to the Groups Reported by the IPS, June 1, 2018

Residents of Non-Remote Areas		Residents of Remote Areas		Weighted
Female	Male	Female	Male	
0.02	1.56	0.00	0.28	1.85
0.01	0.79	0.00	0.14	0.94
0.00	0.35	0.00	0.07	0.43
0.01	0.30	0.00	0.07	0.38
0.01	0.35	0.00	0.08	0.44
0.01	0.48	0.00	0.10	0.59
0.01	0.82	0.00	0.16	1.00
0.02	1.49	0.00	0.27	1.79
0.03	2.67	0.00	0.39	3.10
0.04	3.54	0.01	0.48	4.07
0.04	3.72	0.00	0.39	4.16

5. Calculation of Mean Weight for the Consolidated Age Group of 55 & Above

Total No. of Insured	Weight in the Population	Mean Weight
4,633,883	28.40%	3.07
	36.91%	
	24.11%	
	10.58%	

6. Distribution of Relevant Age Groups in the General Population

Age	June 2018	Weight	
14-18	19,464	0.3%	4%
18-25	465,059	6.2%	96%
25-35	697,497	9.3%	
35-45	747,403	9.9%	
45-55	950,140	12.6%	
55 & older	4,633,883	61.7%	
TOTAL	7,513,447	100%	

7. Gender Distribution of IPS Prisoners

Men	Women	TOTAL
98.6%	1.4%	100.0%

Appendix 2

Responses to the Report

The present report was sent to the IPS, the Ministry of Public Security, the Ministry of Health and the Israeli Medical Association for their response.

As of October 24, 2019 the Ministry of Public Security had not sent its response.

The other responses are provided below (translated by PHRI).

Response by the Israeli Medical Association (IMA):

Received by e-mail:

From: Seya Ashuri <seya@ima.org.il>

Sent: Tuesday, June 4, 2019 8:44 AM

To: Anat Litvin <anat@phr.org.il>

Subject: Response from the IMA regarding the Physicians for Human Rights report on the inmate health care system

Anat Litvin

Prisoners & Detainees Department

Physicians for Human Rights

We carefully read the draft you sent us of the report on the inmate health-care system.

As you wrote in the report, the IMA has always held, and continues to hold, that prisoners deserve the same level of medical care as any other person living in the country.

The IMA maintains that medical treatment must be provided by physicians. Paramedical professions and equipment can assist with medical treatment and be a part of the team providing treatment, but they cannot replace the physician. A situation in which nurses and medics provide medical treatment instead of physicians is, therefore, clearly unacceptable.

In addition, the IMA believes that medical specialization should be encouraged, although we do realize that even in the community setting not all attending physicians are necessarily specialists, and that the experience they gain over years of practice qualifies them to provide a satisfactory medical response.

The IMA also reiterates its view that it is extremely important that responsibility for the health care system be reassigned from the IPS to the Ministry of Health. While we have absolute faith in the medical staff that works in the IPS we feel that the present situation places them in impossible predicaments and that the move from being subject to the authority of the IPS to that of the Ministry of Health will benefit the medical care providers and increase patients' trust in the medical care.

We would like to add that a potential state of dual loyalty is practically inherent to this structure and imposes on the physicians complex ethical problems.

We congratulate you on the preparation of this report and, like you, we hope to see the implementation of the recommendations already made in past state reports.

Sincerely yours,

Att. Lea Wapner

Secretary General, IMA

Response by the IPS

Office of the Chief Medical Officer
Date: 22 August 2019
Commission: 4, Medical Unit: Outgoing Mail
Reference 59078519
Physicians for Human Rights

Office of IPS Commissioner
Director of Prisoner Division
Legal Adviser
Spokesperson

Re: Health Remanded to Custody – The Future of the Prison Health Care System in Israel

(Received from you: Document by Physicians for Human Rights, dated 28 March 2019)

We carefully read the draft of your document which was sent to us on 28 March 2019. The claims raised in the document are not based on official figures or inspections carried out in IPS facilities. Therefore, we find the said document to be biased and not an accurate reflection of reality.

It should be noted that several months ago, an application for leave to appeal that PHRI filed with the Supreme Court with regard to the state of medicine in the IPS was denied. Apart from that, we feel that no further comment is called for.

Sincerely yours,
Dr. Liav Goldstein
Chief Medical Officer, IPS
(signed)

Response by the Ministry of Health

23 Tishrei 5780
October 22, 2019
Ref.: 553420219
(When replying, please cite our reference no.)

Ms. Anat Litvin
Prisoners & Detainees Department
Physicians for Human Rights

Re: Inmate health care

Your letter of September 22, 2019

As many officials have replied often before, we have neither the authority nor the means to intervene in the inmate health care system.

We therefore respond with the simple truth: we have nothing to add to the PHRI report, nor to contribute to promoting its contents.

Sincerely yours,

Prof. Itamar Grotto
Associate Director General

Associate Director General
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