Original Article

Facing the challenges of an increasingly ageing prison population in Switzerland: In search of ethically acceptable solutions

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Abstract German and French abstracts see p. 139

Prisons in Switzerland are facing challenges associated with growing numbers of ageing prisoners. This paper explores two health care related concerns linked to this changing demographic pattern and evaluates them using the principle of equivalence of care. The principle stipulates that health care received by prisoners and non prisoners should be equivalent. Its implication for prison health care is analysed focusing on the declining abilities of older prisoners within the unsuitable physical environment of the prison. The equivalence principle is also used to address questions about adequate access to health care for older prisoners at the end of life. Health care services such as palliative or hospice care are explored along with other alternative solutions such as compassionate release. Finally, ethically acceptable solutions to prison medicine that adequately respond to the needs of ageing and dying prisoners are discussed with an emphasis on duties of health care providers and other stakeholders.

Keywords: ageing prisoner, principle of equivalence, housing, end-of-life care, compassionate release

Introduction

In both the community and in prisons[1], the ageing population raises novel issues. Today, there are more old people than at any other point in history. This is due to several factors including decreasing fertility rates, better public health measures, and improvements made in the field of medicine [1]. The growing older adult population impacts all facets of our lives, be it social, economic or political [2]. For instance, greater numbers of older persons are additional strains on the already burdened health care systems of many nations. Anderson and Hussey reported that industrialised countries spent between one-third and one-half of their total health care expenditure on older patients [1].

The ageing of our society is mirrored in prison institutions, where prisoners over the age of 50 years are considered «old»[2] [3, 4]. In the general population, «older adult» usually refers to citizens who are 60 years and older. The lower age limit used to categorise older prisoners is due to the their accelerated ageing: prisoners aged around 50 years suffer from similar health conditions as 60 year olds in the general population [5, 6]. In Western countries, the number of ageing prisoners is rising [7, 8]. In Switzerland for instance, prisons recorded a total of 8206 prison admissions in 2010. Of these, 8.5% were above the age of 50 years representing 700 older prisoners [9]. The proportion of older prisoners is relatively small considering that 17.2% of the general population in Switzerland are over 65 years [10]. However, the ageing prison population is expected to grow dramatically in the future due to trends toward longer sentences and more older adults entering the prison system [8, 11]. There are signs that more prisoners will grow old and many will even die in prison.

In Switzerland, all 26 cantons have their own judicial authority and health-related laws. The autonomy enjoyed by each canton leads to diverse prison systems and different prison health services. As of 2011, there are 113 institutions that incarcerate individuals in Switzerland. The total capacity of these institutions is 6660 places and as per the latest data, 6065 people are currently imprisoned [12].

According to recommendations from the United Nations and the Council of Europe[3], the quality of health care available to prisoners should be equivalent to that of any other person living in the community, as outlined by the principle of equivalence of care [13–19]. In this article, we address two health care related challenges faced by older prisoners and examine ethically acceptable solutions using the equivalence principle framework. We begin first by presenting the principle of equivalence of care, followed by an evaluation of the prison environment and its impact on the weakening physical health of older prisoners. We then analyse end-of-life care of dying older prisoners and conclude with a discussion of ethically satisfactory solutions, with a particular emphasis on the role of health care personnel working in prison and their obligations towards elderly prisoners.

1 The term «prison» is used to include all types of detention facilities. By «prisoners» we mean persons detained in any of these facilities.

2 In this article we use older, old, ageing and elderly as synonyms.

3 These recommendations from the UN or the Council of Europe are usually called «soft» law because they do not have binding character such as ratified conventions or treaties. They are nevertheless important regulatory documents to which the CPT or decisions of the ECHR refers to.

Equivalence of care – what does this mean in prison?

The principle of equivalence[4] was first mentioned in the *Principles of Medical Ethics* in 1982 [18] and is also noted in various legal recommendations and guidelines. Abiding to the guidelines of this principle is predominantly a European[5] phenomenon [20, 21] because it incorporates a unique human rights framework with enforcement mechanisms through the European Court of Human Rights and the European Committee for the Prevention of Torture (CPT). The Swiss Academy of Medical Sciences (SAMS) refers to the principle and reports that imprisoned persons are entitled to receive equivalent medical treatment to that obtained by any individual in the general population. This entitlement for prisoners means not only access to preventive, diagnostic, therapeutic and nursing care, but also the right to self-determination, information and confidentiality [22].

Although the SAMS guideline was issued 10 years ago, its implementation remains a challenge in Switzerland and in other countries. Prisons are fundamentally different from the community since they are an enclosed environment with distinctive rules [23, 24]. Ageing prisoners have unique health needs that must be specifically addressed to ensure that they obtain adequate health care access and appropriate treatment. Free choice of physicians is not guaranteed in prisons indicating that prisoners are treated only by general practitioners or physicians working within the prison system. Visits to geriatricians or a second opinion, though recommended in international soft law [17], represent an extra burden for prisoners and rarely occur. Birmingham and colleagues highlight the difficult situation that physicians face when seeking to offer equivalent medical attention to patients in a climate of cost restraints and lack of certain treatment options [24]. Equivalent provision of health care is further complicated by the prison organisational and security aspects that directly impact provision of health care [25].

The difficulties associated with ensuring equivalent provision of care in the prison setting is compounded by the inconsistent interpretation of what the principle of equivalence exactly means? The ambiguity associated with its meaning seemingly makes the implementation of the principle difficult. A clarification of the principle within the framework of health care for prisoners in general and ageing prisoners in particular is urgently needed. The essential question being: which characteristics must be fulfilled for a health care treatment to be considered equivalent for a person in prison?

A mechanism to conceptualise the intention of the principle of equivalence may be to not concentrate on «how» this principle should be interpreted in the prison context but «why» should we provide equivalent care to prisoners and «where» does this idea come from? Some people are opposed to the view that prisoners should receive this level of care as they might feel that prisoners must be punished and are therefore less deserving. Hence, establishing an ethical basis for the principle of equivalence is important and might also forward its application. The most important concept underlying the principle of equivalence is the abstention from inhuman and degrading treatment [26] which is ultimately based on respect for human dignity. However, the principle of human dignity has often been criticised as being a vague [28–30] and even a meaningless concept [31]. In a Kantian sense [32, 33], it is our shared humanity that justifies the equivalent provision of health care for prisoners. Pointless suffering and an early death are not acceptable under these premises, if we are able to prevent them [34, 35]. Health is a right deriving from human dignity itself and not from any kind of authority.

Indeed, the principle of equivalence raises questions concerning the goals and justifications of incarceration. Is retribution achieved with prisoners' loss of freedom? Or should retribution also impact the provision of health care? Within the framework of inalienable human rights enshrined in international human rights law, punishment will not include lower standards of health care than outside prisons. As access to health care varies in different countries, it has to be considered first, that with the loss of freedom, the state renders a detainee unable to provide for his basic needs and thus has the responsibility to fulfil them, including health care [30, 34]. However, another questions is, which level of care should be made available to prisoners, as discussions may arise, when we talk about scarce resources like organs for example [36]. There, the issue of just desserts becomes relevant [34] and could be resolved if we accept that the punishment is the loss of freedom. Other than that, detainees are equal members of our society and must not suffer additional retribution [34]. Finally, we should ask ourselves, what kind of society we want to be a part of and how the denial of equivalent health care to prisoners would affect it.

Last but not least, if we accept that human dignity is inherent to all human beings, on a collective level, theories of justice, like for example Rawls «veil of ignorance» [37] suggests that it would be fair to allow

4 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 (PME), 1982, Principle 1: «Health personnel, particularly physicians, charged with the medical care of prisoners and detainees, have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.»

5 The *Australian* medical association also stresses «equal duties» («The duty of medical practitioners to treat all patients professionally with respect for their human dignity and privacy applies equally to the care of those detained in prison»: http://ama.com.au/node/503), whereas the US does not use the principle of equivalence, but a standard called «cruel and unusual punishment» (20, 21).

prisoners to have the same level of care as everyone else [34]. Ethical principles such as equality and social justice are even used to support the provision of health care as a human right, but this is still quite controversial [38].

Although the principle of equivalence is grounded in ethical values like justice and equity, the concept is still vague and continues to be interpreted in various ways. For the sake of consistency, we use the equivalence of care for prisoners to mean the following: same quality and standard along with same outcomes for persons living in or outside prison. To elaborate, the principle of equivalence of care in prisons must be achieved in two steps. First, health care in prison should be of the same quality and standard like outside prison, i.e., the same preventive measures should be offered and the same treatments should be made available. But this is not enough in the case of imprisoned people and thus attention has to be paid to the results of the health care interventions. Charles and Harper stated that by achieving and measuring the equivalence of outcomes, the true spirit of the principle of equivalence is met [39].

Thus, it is not enough to just offer an older prisoner same treatments as that provided to an older person in the general population, because the older prisoners may need more or different interventions due accelerated ageing in prison. Treatments should therefore be administered according to need and not to provide equal services to individuals of the same age group.

Finally, equivalence of care for prisoners is a concept which is very difficult to implement in practice [14, 40] and physicians working in prison have to be aware of that. For the future and to ease this process, an assessment of health care treatments in prison is needed to be able to measure the outcomes, compare them with the general population and introduce a certain standard that would clarify the equivalent treatment for prisoners.

To ensure equivalence of care in prison, two major obstacles must be overcome: independence of prison health care and specifically trained prison health care personnel. The Council of Europe [17] and the CPT [27] have specified that prison health care personnel must be independent from the prison administration and judicial authorities. Unfortunately, only a few countries have implemented this recommendation. For instance, in Germany, the Ministry of Justice and not the Ministry of Health is responsible for prisoner's health care. If prison health care and public health authorities are distinct, necessary cooperation cannot be assured [41]. Such «parallel system» functioning has been criticised [42] since it is riddled with inherent problems. In order to realise true independence of prison health professionals from correctional and judicial authorities, countries such as France, Norway, and some cantons in Switzerland shifted this responsibility of prisoners' health to the Ministry of Health [42].

If health care is placed under the authority of prison administrations instead of health departments, a number of additional local factors may further impede equivalent care for prisoners. These include professional isolation of prison physicians, especially in remote rural prisons, potential lack of specialised and continued education and training, and the possibility that prison administrations interfere with medical decision making [41].

To address health care needs of ageing prisoners in an equivalent way, health care providers need to have special medical knowledge, realisable through regular geriatric training for prison physicians. In addition, to satisfy the principle of equivalence, cantons should ensure that prisoners have access to geriatricians and other specialists [43].

Accommodation of older prisoners

Adaptation to the prison environment for ageing prisoners is a challenge in itself. Elderly prisoners face particular difficulties in this respect. Appropriate physical surroundings are necessary as they impact the physical health and well-being of an older person [44]. Current prison settings and architecture were originally built to suit younger and able-bodied individuals, who continue to constitute the largest portion of the prison population [45, 46]. Almost everything from prison clothing to daily prison schedule is primarily designed with younger adults in mind and thus can be an impediment to older prisoners. Moreover, long corridors without places to rest, lacking handrails, stairs, noisy and crowded places make moving around the prison difficult. Thus, incarceration itself becomes an additional burden for the increasing number of ageing prisoners, who on a daily basis must confront the prison environment.

Equivalent treatment for all prisoners would imply that changes must be made to prison architecture so that it is «age friendly». The goal of these changes is to ensure that the prison's physical environment supports and even compensates for the declining competencies of its ageing members [44]. Prisons might need to be redesigned to reduce walking distances between a prisoner's cell to dining, recreational, and health care areas; include handrails in corridors to provide support while walking; and built-in elevators so that older prisoners could avoid using stairs. In addition, specially adapted furniture like higher beds and chairs should be incorporated to reduce accidental falls and injuries.

Another solution could be to construct new prison facilities suited for older prisoners. In such cases, the location of these prisons is of particular importance. Specialised health care facilities need to be available in the immediate vicinity and be accessible to older inmates. Close proximity to specialised facilities would imply that new correctional facilities must be built either in or near an urban area [45].

However, within the correctional institutions, stakeholders do not agree on whether older prisoners should be grouped together in special housing areas or whether it is best to continue mixed accommodation with younger prisoners [46, 47]. The arguments in favour of separation revolve around the provision of adequate and specialised health care for older prisoners and protection from possible violence. Examples of specialised health care could include on-site dialysis, counselling on death and dying as well as palliative and hospice services [47]. On the other hand, mixed housing conditions are said to have beneficial effects on younger as well as older inmates. Younger prisoners are calmer in the presence of older inmates and may profit from the elderly prisoners' assistance in administrative work. Such coresidence allows older prisoners to build social networks consisting of both older and younger inmates. Furthermore, it is argued that segregation of prisoners by age might exclude ageing inmates from other prison services available to the general prison population [46, 48].

Finally, older prisoners do not have the choice that their peers outside the prison have between selecting to stay where they are, thus «age in place» [44] (i.e., in prison), or choosing to move to a nursing home, a retirement home or an assisted living facility. Although older prisoners' wish to stay in their familiar environment might be similar to their peers' in the general population, the realisation of these wishes could be problematic. This is particularly the case when older prisoners have served many decades of a sentence and have aged in prison. Since these prisoners have lived most of their life in the correctional system, they may have come to consider it as their home. In such circumstances, they are likely to face great difficulties at the time of release. A proper process is needed that guides them gradually through this change. Conversely, an older person, who is a first-time offender, might not be able to adjust to the new and restrictive prison environment. Therefore, to avoid additional burden on ageing prisoners, it is necessary to create a system that is not only conducive to their health, but also receptive to new and flexible options. Older prisoners are not a homogenous group, their heterogeneity demands readiness to evaluate and evolve according to their individualised needs [11, 45]. However, costs for «age-friendly» environments, and qualitatively and quantitatively different health care needs of elderly prisoners must be adequately considered.

End-of-life care and death in prison

With increasing numbers of older prisoners and many of them living to an advanced old age, the prison system faces challenges associated with end-of-life care and deaths of its ageing members [49, 50]. As discussed above, the prison environment is at present poorly adapted to the needs of its older population with deteriorating physical health. This exacerbates problems associated not only with ageing prisoners' regular activities of daily living but also interferes with ethically appropriate end-of-life care.

In Switzerland, correctional institutions are not equipped with hospice or palliative facilities to respond to the needs of dying prisoners. Such services are available in a few correctional facilities in the US [51–53]. Studies evaluating prison palliative and hospice care have so far revealed their positive results [54, 55]. Older dying prisoners, who benefit from these support programs, and younger prisoners, who volunteer as hospice service providers, reported positive outcomes [52, 54]. Although it is practical and cost-effective that younger prisoners and prison guards provide informal help to ageing and dying prisoners, this nevertheless means that prisoners do not have access to trained personnel that would be available in similar settings outside prisons [43].

Within the framework of the principle of equivalence [14, 40], equivalent care must also be available to dying prisoners. Appropriate end-of-life care should incorporate not only help with activities of daily living, but also offer opportunities to bridge ties with family members, and psychological and spiritual counselling that would prepare dying prisoners to face their imminent death. Prison health services would need to adapt and revamp their health care structures by training their personnel in end-of-life care, hiring physicians mainly trained in prison and geriatric medicine, and ensuring that necessary tools are available to cater to the needs of severely ill and dying prisoners [43, 55].

The lack of suitable in-prison end-of-life care even in highly developed countries, where older inmates are dying within the system, has intensified the debate surrounding compassionate release [50, 56, 57]. This is a program designed to let terminally ill prisoners live the last days of their lives as free individuals. If prisoners still have ties to their families, this humanitarian measure allows them to spend their last days with family members. Unfortunately, in many countries it is a very seldom used program as the specified criteria are stringent and the process is arduous [49, 56]. In the US, one of the requirements for compassionate release is that the prisoner must be diagnosed with an incurable illness whose prognosis is predictably terminal. This prerequisite disqualifies many older prisoners who suffer from non life threatening diseases such as Alzheimer's and other dementias. Although these neurological conditions generally render older prisoners mentally and physically unable to harm another person or seek retribution when freed and permitted to live in the community, compassionate release is, in most cases, not permitted for this group of patients.

Compassionate release in case of fatal disease is strongly based on human dignity and the obligation to abstain from inhuman and degrading treatment. In the

case of incapacitating diseases (e.g., dementia) it might also involve questions surrounding two other elements, namely the concept of personal identity and the justifications for punishment. Considering a Lockean view of the person defined using criteria such as consciousness, rationality and purposive agency [58, 59], compassionate release for older prisoners suffering from dementia would be the most acceptable solution, as this person is arguably not the same person who committed the crime decades ago. Gordijn explains it as follows: «[…] corresponding to Locke's definition of personal identity, when a man is no longer conscious of a certain past action, he is not the same person as the one who committed the action, although he has remained the same man» [59]. The Lockean view of the person could be extended so far as to state that an individual with dementia is not a person anymore, as they lack those features that define a person and thus no longer retain the same rights and responsibilities as one [58, 60]. Moreover, the four classic justifications for imprisonment, namely retribution, deterrence, incapacitation and rehabilitation [61] that presuppose a rational and self-conscious person, could no longer be fulfilled. In the legal context also, individual accountability is based on similar considerations about the person. Other concepts of personal identity that claim to be stable over time, such as the situated-embodied-agent (SEA)-model was described by Hughes [60]. This model views the person within a historical and cultural context and could be interpreted as being more problematic as the personal identity of the perpetrator and the demented person is the same. However, the loss of certain capacities would eliminate the justifications for punishment as they require rationality, temporality and accountability. It is therefore important to ask, if the perpetrator's mere embodiment of the person is sufficient to justify continued punishment for the purpose of retribution or whether declining mental capacities and their consequent loss of personhood should also be taken into account. To comply with the principle of equivalence in Switzerland and other countries, greater support services are needed. The question remains who should be responsible for ensuring and securing adequate medical and supportive care for older dying prisoners and how these services should be implemented. Furthermore, when compassionate release is obtained, steps must be put in place to ascertain that these prisoners are properly cared for either by the family or by a state agency.

Discussion

Ethics in prison medicine is particular, in that the problem is not only interpreting what is ethically adequate, but how to act ethically in an environment that is not conducive to applying international ethical and legal requirements. Taking prison environment and details of medical care for older prisoners into consideration, prison health care personnel should seek support from public health authorities, cantonal health departments as well as from university and public health institutions to find individual solutions to each ageing prisoner's environmental needs as well as general solutions to questions related to prison architecture and planning. Ethical and social responsibility in prison medicine implies not only engagement for the benefit of individual patients but also encouraging authorities to participate in the search for adequate and timely solutions.

Given cantonal specificities, ethically acceptable outcomes may vary to achieve the common goal of equivalence of care. This implies that there is more than one outcome and therefore different solutions may be valid on the circumstances. An ethically unsatisfactory solution arises if an immediate sufficient option does not exist, but a less optimal «better than nothing» alternative is available. This is the case where prison authorities engage younger prisoners to help with daily care needs of those who are older. This arrangement is certainly one that is better than none, but health professionals know the dangers of such arrangements since most of them have treated patients for physical or psychological abuse and exploitation by other inmates. Hence, the ethical duty of health professionals in these cases is to insist that such «solutions» are not in line with the principle of equivalence and that changes are very much needed and necessary. Health professionals may have, in many cases, significant authority to propose and implement ethically suitable solutions if they adamantly insist on refusing to comply with false «better than nothing» compromises.

Concerning ethical care for dying prisoners, health care professionals have obligations to inform authorities, with patients' consent, about medical prognosis as well as, if appropriate, medical arguments concerning diminished dangerousness. Indeed, the Council of Europe highlights that detainees should not die in prison but be granted humanitarian release. Truly equivalent end-of-life care might only be best obtained outside prisons. Providing compassionate release is probably the less costly and more humane alternative.

As summarised above, a number of ethically acceptable solutions exist to implement equivalent health care for elderly prisoners [24, 47, 55, 56]. Not all of them will result in increased costs to the prison system. For example, compassionate release of non dangerous prisoners or transfer to palliative care structures is an ethical and a more cost-effective measure than continuing to detain dying prisoners in very expensive acute care facilities.

The first ethical duty of prison health care providers is to describe problems adequately. Prison health professionals are best placed to collect data that are necessary to help cantonal and federal stakeholders to make evidence-based decisions. Since physicians working in prisons lack necessary training in data collection and

research, Swiss medical schools and public health institutions should support scientifically sound data collection in prison. Previous efforts in this matter include research projects financed by the Swiss Health Department on smoking in prison [62] as well as a study on death in custody financed by the Swiss Network for International Studies [63].
The duty to describe implies informing cantonal health departments about current problems. This is also a responsibility of Swiss physician associations, as they must identify gaps in services and approach relevant officials. They have the obligation to make cantons aware of deficiencies in systems where prison health care personnel are employed by prison administrations or the justice system, instead of departments of health. This could even go as far as the one put forth by the British Medical Association [64, 65], where they stress «cooperation between medical bodies, non-governmental organisations and others who recognise that political and social reform is the best medicine and […] support systems for prison doctors» [66].

Conclusion

The steady increase of ageing prisoners requires active search for ethically acceptable solutions, in line with the principle of equivalence of care. One of the ethical and practical challenges is the identification of solutions that might vary from canton to canton but that pursue the same goal. Indeed, health care personnel in prisons have an ethical duty to provide time and resources to not only search for ad hoc solutions for their ageing patients, but also to stimulate a broader discussion and to collect needed data that will support ethically and scientifically sound evidence-based decision making.

Conflict of interest: None to declare

Zusammenfassung

Herausforderungen einer zunehmend alternden Gefängnisbevölkerung in der Schweiz

Gefängnisse in der Schweiz sind derzeit mit Herausforderungen konfrontiert, die im Zusammenhang mit der steigenden Anzahl von älteren Gefangenen stehen. Dieser Artikel beschäftigt sich mit zwei Aspekten der Gesundheitsversorgung im Rahmen der demographischen Veränderungen und evaluiert sie mit Hilfe des Äquivalenzprinzips. Das Prinzip besagt, dass die Gesundheitsversorgung, die Gefängnisinsassen erhalten, der von Nichtgefangenen entsprechen sollte. Die Folgen für die medizinische Versorgung im Gefängnis werden analysiert, indem ein besonderer Fokus auf die abnehmenden Fähigkeiten von älteren Gefangenen gelegt wird, die in einer für sie unpassenden Gefängnisumgebung leben müssen. Das Äquivalenzprinzip wird ebenfalls genutzt, um Fragen in Bezug auf den Zugang zu adäquater Pflege am Lebensende zu beleuchten. Gesundheitsangebote wie Palliativ- oder Hospizpflege werden als mögliche Lösungen ebenso diskutiert wie Alternativen in Form von vorzeitigen Entlassungen für schwerkranke Gefangene. Abschliessend werden ethisch vertretbare Lösungen für die Gefängnismedizin diskutiert, die den Bedürfnissen von älteren und sterbenden Gefangenen entsprechen. Dabei wird vor allem auf die Aufgaben von Gesundheitspersonal und anderen Entscheidungsträgern eingegangen.

Résumé

Les défis liés au vieillissement de la population carcérale en Suisse

Aujourd'hui, les prisons en Suisse sont confrontées à des difficultés nouvelles liées au nombre croissant de prisonniers âgés. Cet article s'intéresse à deux aspects particuliers des soins médicaux en liaison avec ces évolutions démographiques et les analyse à travers le principe d'équivalence. Conformément à ce principe, les soins de santé prodigués aux détenus doivent être les mêmes que ceux prodigués aux individus à l'extérieur des prisons. Les implications de ce principe pour le traitement médical en prison sont analysées, une attention particulière étant portée sur les capacités déclinantes des détenus les plus âgés contraints de vivre dans un cadre pénitentiaire inadapté à leurs besoins. Le principe d'équivalence est aussi utilisé pour aborder les questions de l'accès aux soins appropriés en fin de vie. Les alternatives possibles comme les soins palliatifs ou l'hospice sont discutées, de même que sont discutées d'autres possibilités comme la libération anticipée pour les détenus très malades. En conclusion sont proposées des solutions pour des soins de santé en prison éthiquement acceptables et qui répondent aux besoins des détenus âgés et en fin de vie. Les fonctions et le rôle du personnel médical et des autres intervenants en ce domaine sont plus particulièrement abordées ici.

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