WAJA
WA JUSTICE ASSOCIATION

Medicare Access in WA Prisons

A proposal for change

Medicare Access in WA Prisons

To: Craig Cumming and Damien Linnane

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1. Acknowledgements

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Aboriginal and Torres Strait Islander people should be aware that this Report contains the names of deceased persons.

2. Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
Casuarina	Casuarina Prison
COAG	Council of Australian Governments
DAAV	Direct-acting anti-virals
GP	General practitioner
Guiding Principles	*Corrective Services Administrators' Council, Guiding Principles for Corrections in Australia* (Report, February 2018)
HIA	*Health Insurance Act 1973* (Cth)
HIV	Human immunodeficiency viruses
HSDs	Highly-specialised drugs
ICESCR	International Covenant on Economic, Social and Cultural Rights
JHFMHN	Justice Health & Forensic Mental Health Network
Mandela Rules	United Nations Standard Minimum Rules for the Treatment of Prisoners
MBS	Medicare Benefits Scheme
Medicare benefit	A Medicare benefit under Part II of the *Health Insurance Act 1973* (Cth)
Medicare exclusion	The exclusion of prisoners from accessing Medicare benefits in accordance with section 19(2) of the *Health Insurance Act 1973* (Cth)
Medicare inclusion	The inclusion of prisoners from accessing Medicare benefits, as an exemption from section 19(2) of the *Health Insurance Act 1973* (Cth)
Minister	The Commonwealth Minister for Health
NHA	*National Health Act 1953* (Cth)
NSW	New South Wales
OICS	Office of the Inspector of Custodial Services (WA)
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association of Australia
PTSD	Post-traumatic stress disorder

RACGP	Royal Australian College of General Practitioners
Report	This report – *Medicare Access in WA Prisons*
State	A state or internal territory of Australia
STIs	Sexually transmitted infections
WA	Western Australia / Western Australian

3. Findings & Recommendations

Summary of Findings
Overall Findings
Overall Finding 1: The Commonwealth Minister for Health (the **Minister**) does not exercise their discretion to exempt prisoners from the Medicare exclusion. Prisoners are not eligible to access Medicare by virtue of s19(2) of the *Health Insurance Act 1973* (Cth) (***HIA***), which relevantly provides that Medicare benefits are not payable in respect of healthcare services provided by or on behalf of a State or statutory authority (or under an arrangement with a State or statutory authority), which includes prisons. However, the Minister has the power to make services that are generally ineligible under s19(2) of the *HIA*, eligible. The Minister has a broad discretion, meaning this power could be exercised in cases where the Medicare exclusion causes disadvantage. Despite this, the Minister does not, and has not, exercised this discretion in relation to prison healthcare.
Overall Finding 2: Community equivalent standards of healthcare are not met by prisons. State-led prison healthcare services are required to provide a community equivalent standard of healthcare but are generally not meeting this standard. Access to treatment and treatment options are of a lower standard relative to the community, despite the health needs of prisoners, as a cohort, generally being more substantial. This leads to poorer health outcomes for prisoners compared with the general population.
Overall Finding 3: Prisoners have greater health issues than the general population. Relative to the general population, Australian prisoners have higher rates of • mental health conditions; • chronic disease; • communicable disease; • acquired brain injury; • tobacco smoking; • high-risk alcohol consumption; and • recent illicit drug use, including intravenous drug use.

Overall Finding 4: Poor health outcomes contribute to deaths in custody. Multiple coronial inquests into the deaths of people in prisons demonstrate the need for improved access to healthcare in prison.
Overall Finding 5: Aboriginal and Torres Strait Islander people are disproportionately impacted by inadequate prison healthcare services. Prison healthcare services are ineffective in meeting the health needs of Aboriginal and Torres Strait Islander people. A lack of accessible and culturally safe care creates barriers to achieving better health outcomes.
Overall Finding 6: There are insufficient mechanisms to monitor drug dispensing in prisons. There is a lack of transparency and monitoring within prisons in relation to drug dispensing. Drugs may not be used for the purposes they were designed for and may not be reported when dispensed.
Overall Finding 7: Prison data is limited in availability. There is a dearth of publicly available data regarding prisons. This is a significant and perennial obstacle to researching, developing and advocating for prison reform proposals, including in relation to prison healthcare.
Specific Findings
Specific Finding 1: Medicare inclusion would likely expand treatment options for prisoners. Medicare inclusion can help address the complex health needs of Australian prisoners by improving treatment options. Medicare inclusion would also likely help prevent deaths in custody and improve the provision of mental healthcare in prisons.
Specific Finding 2: Medicare inclusion would likely improve continuity of care post-release from prison. Medicare inclusion may improve continuity of care upon release from prison, by supporting integrated care, communication and planning between prison and community healthcare services.
Specific Finding 3: Medicare inclusion would likely contribute to reduced rates of recidivism in WA. By improving the quality of prison healthcare, Medicare inclusion would likely contribute to reducing recidivism, since improving the health of people in prison has been shown to reduce recidivism rates.

Specific Finding 4: Medicare inclusion would likely lower health and non-health related costs for society.

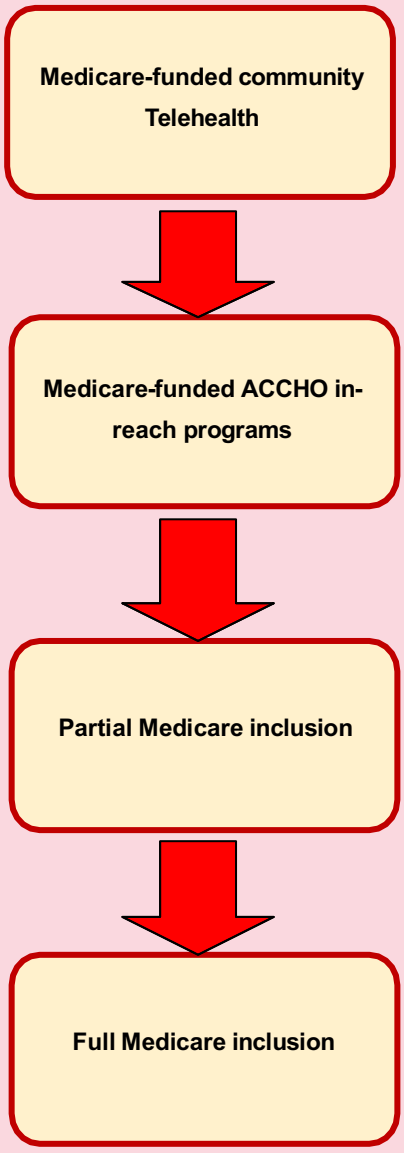
Medicare inclusion would likely reduce certain financial costs. For example:

- Early healthcare interventions funded by Medicare could prevent simple healthcare needs of prisoners from developing into more complex and costly conditions later in life.
- By reducing recidivism (see Specific Finding 3), the costs and impact of crime and subsequent response to crime (including police investigations, court hearings, imprisonment, etc.) would reduce.

Recommendations – A Proposed Model for Policy Reform

Recommendation 1: The Commonwealth Government should consider providing Medicare access in prisons.

To implement this policy, the Government may consider the following four-tiered approach:



Give prisoners access to Medicare-funded community Telehealth services. This would give prisoners access to external practitioners, sidestepping the funding and staffing issues that present a major obstacle to adequate healthcare provision in prisons. It could also improve continuity of care, as prisoners can maintain a relationship with these practitioners upon release.

Give Medicare funding to ACCHO in-reach programs. Aboriginal and Torres Strait Islander people are vastly overrepresented in WA prisons. ACCHOS could provide accessible and efficacious culturally sensitive care to Aboriginal and Torres Strait Islander people in prison. However, more consultation with ACCHOs is required to confidently recommend this option.

Give prisoners access to a limited number of Medicare items. Specific Medicare items – such as the Aboriginal and Torres Strait Islander Peoples Health Assessment and review (Items 715 and 10987) and the mental health treatment plan (Item 2715) – present relatively low-cost inclusions that would likely have material benefits for targeted health needs experienced by the prison population.

Give prisoners access to all Medicare items. Access to the full range of funding available in the community best meets Australia's international obligations regarding the principle of equivalence. Full inclusion would allow Medicare funding in prisons to adapt to changes in the prison community health profile.

Recommendation 2: The Commonwealth Government should lead a cost-benefit analysis, in consultation with state/territory governments, to ascertain the cost-saving potential of Medicare inclusion in prisons.

In conducting this analysis, the Commonwealth Government should explore the different models of Medicare inclusion (described in Recommendation 1) and compare the effect and feasibility of implementing each model in prisons. The Commonwealth Government should also consult with states and territories for any relevant data not currently in its possession to inform its analysis.

4. Executive Summary

The Western Australian (**WA**) prison population has greater health needs and poorer access to healthcare relative to the general population. This largely mirrors all Australian jurisdictions. Accordingly, the opportunity is being missed to address the health needs of this marginalised and disadvantaged group of people. There is broad consensus that prison provides a unique opportunity for screening and medical intervention to improve health outcomes for some of the most at-risk people in our community. This has implications that extend beyond the prison environment. Prison health is public health. It is in the interests of the wider community for people in prison to have their health improved prior to release. Improving the health of prisoners is crucial for reducing overall health costs, achieving relevant *Closing the Gap* targets, and supporting effective social re-integration upon release. This is particularly important for lowering recidivism rates and the costs of the justice and correctional systems.

The primary driver of prisoners' adverse health outcomes is a lack of adequate treatment options in prisons. This is largely attributed to the exclusion of Medicare from prisons. The authors of this Report propose Medicare inclusion as a means for expanding treatment options for people in prison. This position has been taken following an in-depth examination of this issue through expert consultations and a thorough analysis of prison health literature.

The Report has been structured into two components, further divided into five sections. Firstly, the Report analyses the contextual background concerning the issue of Medicare exclusion in prisons, comprising **three sections**:

I. background to prison healthcare in Australia;
II. the impact of staff shortages on the provision of healthcare services in WA prisons; and
III. the current unmet health needs impacting the WA prison population in relation to:

    a) communicable diseases;

b) mental health; and
c) deaths in and following custody.

The second component examines why Medicare access is an attractive means of addressing poor prison health outcomes and how Medicare inclusion could be implemented in WA prisons. This component is comprised of **two sections**:

I. the current unused options that may be implemented by the Commonwealth Government to address the health issues of people in prison, including:

   a) permitting Medicare-funded services to be provided in prisons, including potential benefits and arguments against its introduction in prisons;
   b) the option of introducing Medicare-funded services provided by Aboriginal Community Controlled Health Organisations (**ACCHOs**) in prisons; and
   c) the option of introducing Medicare-funded telehealth in prisons; and

II. this Report's recommendations for prison healthcare reform in WA, which comprise a sliding scale for policy reform from:

   a) Medicare-funded telehealth in prisons; to
   b) Medicare-funded telehealth and ACCHO services in prisons; to
   c) partial Medicare access in prisons; to
   d) full Medicare access in prisons,

   and a recommendation that the Commonwealth Government lead a cost-benefit analysis regarding the cost-saving potential of Medicare-funded services being made available for people in prison.

5. Background

5.1 The Australian Prison Population

Between 2012 and 2022, the Australian prison population increased from 29,380 to 40,591 people, according to a 2023 report published by the Australian Bureau of Statistics (**ABS**).[1] Of the 40,591 prisoners recorded in 2022, 92.6% of prisoners (37,605) were male and 60.2% of prisoners (24,416) had previously been incarcerated.[2] Prisoners aged 20 to 39 accounted for 61.6% of the overall prison population (24,979) in 2022.[3]

The WA prison population currently comprises 6,276 prisoners, accounting for approximately 15% of the total Australian prison population.[4] WA has the second highest imprisonment rate in Australia at 302.8 per 100 000 adults.[5] The report by the ABS also recorded that, in 2022, Aboriginal and Torres Strait Islander people constituted 40.2% of the WA prison population and 31.8% of the total Australian prison population.[6]

5.2 The Health of the Australian Prison Population

A 2022 report published by the Australian Institute of Health and Welfare (**AIHW**) found that prison populations often have higher healthcare needs relative to the general population due to many prisoners coming from disadvantaged backgrounds.[7] Such individuals also have more exposure to risks factors, such as drug and alcohol consumption, unhealthy lifestyles and living conditions that can cause health issues.[8]

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[1] Australian Bureau of Statistics, *Prisoners in Australia, 2022* (Catalogue No 4517.0, 24 February 2023).
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Australian Bureau of Statistics, *Corrective Services, Australia, June Quarter 2023* (Catalogue No 4512.0, 21 September 2023).
[6] Australian Bureau of Statistics (n 1).
[7] Australian Institute of Health and Welfare, *The health of people in Australia's prisons* (Report, 2022) 1.
[8] Ibid 85.

The AIHW report indicates that prisoner health needs are often quite complex in nature, with many prisoners having chronic illnesses or mental health conditions.[9] Sexually transmissible, blood-borne and other communicable diseases are also more prevalent in prison populations.[10] Additionally, poor continuity of care (i.e. the ability of a health system to provide uninterrupted care across programs, medical practitioners, and levels of treatment over the lifetime of a patient) is a key factor contributing to the rapid reversal of health gains made during incarceration.[11]

5.3 Community Equivalent Standard of Healthcare

Australian prison health services have agreed to provide a standard of healthcare equivalent to that in the community.[12] This equivalent standard requires the provision of equivalent services to what people living in the community receive, including services funded by Medicare. This is known as the 'principle of equivalence.' The principle of equivalence is outlined in the *Guiding Principles for Corrections in Australia* (**Guiding Principles**).[13] State governments, including the WA Government, have adopted the principle of equivalence and have effectively agreed to meet this standard.[14] However, available evidence shows that WA prisons are not currently achieving this standard.[15]

Australia has committed to several international frameworks that support the principle of eqivalence, including:

- Rule 24(1) of the United Nations Standard Minimum Rules for the Treatment of Prisoners (**Mandela Rules**); and

[9] Ibid 25.
[10] Ibid 30.
[11] Ibid 129.
[12] Corrective Services Administrators' Council, *Guiding Principles for Corrections in Australia* (Report, February 2018) 1, 20.
[13] Ibid 7.
[14] Government of Western Australia, *Health care: Corrective Services* (Web Page, 1 April 2022) <https://www.wa.gov.au/organisation/department-of-justice/corrective-services/health-care-corrective-services>.
[15] Plueckhahn et al, 'Are Some More Equal than Others? Challenging the Basis for Prisoners' Exclusion from Medicare' (2015) 203 *Medical Journal Australia* 359.

- Article 12 of the International Covenant on Economic, Social and Cultural Rights (**ICESCR**).[16]

These frameworks inform the Guiding Principles. The Mandela Rules are the central document that informed the development of the Guiding Principles, which were last updated in 2018.[17] The Guiding Principles state a commitment to the development of law to "reflect best practice".[18] This includes the equivalent standard of healthcare, as previously discussed.[19] Australian prisons will be non-compliant with the ICESCR if they do not provide the "highest attainable standard of physical and mental health" as stipulated in the Guiding Principles.[20] However, while the principle of equivalence has been adopted at a policy level, these international commitments have not been codified into domestic legislation, so may be more accurately regarded as 'moral' or 'aspirational' rather than legally binding in nature.

> *Prisoners should enjoy the same standards of healthcare that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status*.
> - Rule 24(1) of The Nelson Mandela Rules

[16] Craig Cumming et al, 'In Sickness and in Prison: The Case for Removing the Medicare Exclusion for Australian Prisoners' (2018) 26(1) *Journal of Law and Medicine* 140, 143.
[17] Anita Mackay, 'The relevance of the United Nations Mandela Rules for Australian prisons' (2017) 42(4) *Alternative Law Journal* 279, 280.
[18] Ibid.
[19] Ibid.
[20] Cumming et al (n 16) 143.

5.4 Medicare

The World Health Organisation defines universal healthcare as "people having full access to… health services without financial hardship".[21] Medicare is the umbrella term for the national health insurance scheme of Australia and is governed by the *HIA* and the *Human Services (Medicare) Act 1973* (Cth).[22] Universal healthcare was first introduced in Australia through Medibank in 1975, which was later replaced by Medicare in 1984.[23] Today, Medicare's main purpose is to assist Australian citizens, permanent residents and some temporary residents with the costs of healthcare by offering subsidies and rebates for a range of healthcare services. These services include consultations with medical professionals, tests and examinations required for a diagnosis or treatment, eye tests, some surgical procedures, specified dental items, and consultations with psychologists and certain allied health services.[24] Medicare consists of the Medicare Benefits Scheme (**MBS**) and the Pharmaceutical Benefits Scheme (**PBS**).

Both the PBS and the MBS are governed by the *HIA*. The PBS was established under the *National Health Act 1953* (Cth) (the ***NHA***) to assist patients with the cost of medication. It achieves this by offering a subsidised cost for approved medications listed in the Schedule of Pharmaceutical Benefits. In 2014, the PBS accounted for 21% of the funds provided by the Commonwealth Department of Health, while the MBS made up 47% of the administered funds.[25]

Australia's complex healthcare system has undergone multiple changes since the nation committed to providing universal healthcare. An overview of these changes is outlined on the following page:

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[21] World Health Organisation, *Universal health coverage* (Web Page) <https://www.who.int/health-topics/universal-health-coverage#tab=tab_1>.
[22] Amanda Biggs, 'Medicare: A Quick Guide' (Research Paper, Parliamentary Library, Parliament of Australia, 12 July 2016).
[23] Damien Linnane, Donna McNamara and Lisa Toohey, 'Ensuring universal access: The case for Medicare in prison' (2023) 48(2) *Alternative Law Journal* 102.
[24] Amanda Biggs (n 22).
[25] Department of Health, 'An MBS for the 21st Century: Recommendations, Learnings and Ideas for the Future' (Report, December 2020) 24.

Year	Health Reforms
1973	The *HIA* was passed.
1975	The Whitlam Labor Government introduced the Medibank health insurance scheme.
1976	The Medibank Review Committee was established and section 19(2) of the *HIA* was introduced based on the committee's recommendations. The effect of this legislative amendment was to prevent people in prison from accessing Medicare while incarcerated.[26]
1981	The Medibank insurance scheme was abolished.
1984	On 1 February 1984, Medicare came into effect under the *Health Legislation Amendment Act 1983* (Cth) and related legislation.
2006	The COAG Section 19(2) Exemptions Initiative was introduced. This initiative allows states and the Northern Territory to bulk bill primary care services in rural and remote areas.[27]

5.5 Medicare Exclusion under the *HIA*

Section 19(2) of the *HIA* limits Medicare eligibility. It states:[28]

> *Unless the Minister otherwise directs, a medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:*
>
> *(a) the Commonwealth;*
>
> *(b) a State;*
>
> *(c) a local governing body; or*
>
> *(d) an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.*

[26] Anne-marie Boxall and James Gillespie. *Making Medicare: The Politics of Universal Health Care in Australia* (UNSW Press, 2013) 1, 102.

[27] Department of Health and Aged Care, *COAG Section 19(2) Exemptions Initiative* (Web Page, 1 June 2023) <https://www.health.gov.au/our-work/coag-section-192-exemptions-initiative>. This initiative is expanded upon at section **Error! Reference source not found.**.

[28] *Health Insurance Act 1973* (Cth) s 19(2).

Accordingly, Medicare funding is not available for services provided by any State-funded entity unless the Minister grants an exemption. Currently, people in Australian prisons do not have access to Medicare-funded health services. Instead, health services for people in prison are funded almost exclusively by State Governments. The purpose of this legislative provision is to prevent the combined funding of health services by both the Commonwealth Government as well as State Governments.[29]

5.6 Exceptions to Medicare Exclusion

The Minister has the power to grant exemptions to the Medicare exclusion under section 19(2) of the *HIA*, which has been used to prevent the arbitrary application of the exclusion and to avoid disadvantaging individuals.[30]

To date, no exemption has been granted in respect of health services provided in prison, meaning neither the PBS nor the MBS is accessible to people in prison.

Exemptions previously granted by the Minister include:

1. the COAG Section 19(2) Exemptions Initiative exemption to include rural and remote health services;
2. the exemption to include some ACCHOs; and
3. the exemption to include medications listed under s 100 of the *NHA*, referred to as the Highly Specialised Drugs Program.

The first two of these exemptions are set out in more detail below.

5.6.1 Rural and Remote Health Services Exemption

As part of the COAG Section 19(2) Exemptions Initiative, in 2006, the Minister granted an exemption concerning the provision of health services to address the inequities experienced by rural and remote Australians, resulting from the limited healthcare

[29] Cumming et al (n 16) 140.
[30] See eg, Department of Health (Cth), *Evaluation of the COAG section 19(2) Exemptions Initiative: Improving Access to Primary Care in Rural and Remote Areas* (Final Report, 14 October 2021) 2.

resources available in these areas. In assessing the need for an exemption, governments found that rural Australians were disadvantaged by the exclusion under s 19(2) of the *HIA*, and that without Medicare access equivalent standards of healthcare would not be achieved.[31] An analogy can be drawn between this example and prisons. Specifically, existing literature shows that the prison environment also presents similar challenges that make equivalent healthcare difficult to provide and that people in prisons are also similarly disadvantaged as a result.[32]

5.6.2 ACCHOs

There have been some exemptions granted to Aboriginal and Torres Strait Islander-specific health services, such as ACCHOs providing midwives and nurse practitioner services.[33] The exemptions were granted in response to disproportionately higher rates of adverse health outcomes, such as child mortality, in Aboriginal and Torres Strait Islander communities. The exemptions sought to provide additional resources to these organisations, which were struggling to provide services due to the high demand.[34] Another exemption, granted to the Inala Indigenous Health Service, was aimed at assisting with staffing issues.[35]

[31] Cumming et al (n 16) 140.
[32] Ibid 157.
[33] Ibid 148.
[34] Ibid 147.
[35] Ibid.

6. The Impact of Staff Shortages on Prison Healthcare in WA

WA prisons often fail to meet the health needs of people in prison.[36] This is largely due to staffing shortages of available medical practitioners in prisons. In 2022, an OICS inspection of Casuarina Prison (**Casuarina**) revealed that seven of the 29 nurse positions (24%) at the facility were vacant.[37] This was due to high turnover, arising from the scarce job entitlements and incentives prison health staff receive relative to those at the WA Department of Health.[38] Staff retention and recruitment issues were even more acute for Casuarina's mental health team.[39] The OICS noted that the team's manager was acting in another capacity due to unfilled team positions.[40] This resulted in another clinician acting in the managerial role, without that clinician's previous position being filled.[41] A notable consequence of these issues is long waiting times to access needed treatments. At Casuarina, prisoners may have to wait for two or three months to see a medical officer after requesting an appointment.[42]

Similar examples of staff shortages are evident from the OICS's 2022 inspection of Broome Regional Prison.[43] There, the OICS reported that the on-site mental health specialist was not only providing services to prisoners at Broome Regional Prison, but also providing remote support to Roebourne Regional Prison and Greenough Regional Prison due to a lack of services at those prisons.[44] Similarly, during its 2021 inspection of Albany Regional Prison, the OICS observed that mental health and counselling

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[36] See, eg, Office of the Inspector of Custodial Services, *2020 inspection of Malaleuca Women's Prison* (October 2021), vii, chapter 5; Office of the Inspector of Custodial Services, *Annual Report 2022-2023* (November 2023), 25; Office of the Inspector of Custodial Services, *Directed Review into the Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody* (March 2023) 7-18, 47; Office of the Inspector of Custodial Services, *Annual Report 2021-2022* (November 2022), 22-23, 34; Office of the Inspector of Custodial Services, *Prisoner access to dental care in Western Australia* (October 2021). The vast majority of consultees expressed this view.

[37] Office of the Inspector of Custodial Services, *2022 Inspection of Casuarina Prison* (7 November 2023) 1, 34.

[38] Ibid.

[39] Ibid 37.

[40] Ibid.

[41] Ibid.

[42] Ibid 35.

[43] Office of the Inspector of Custodial Services, *2022 Inspection of Broome Regional Prison* (Report No 149, June 2023) 1.

[44] Ibid 35.

services at that prison were significantly understaffed.[45] These examples demonstrate that staff shortages in WA prisons are a systemic issue that impedes prisons' abilities to effectively address the health needs of people in prison.

7. The Current Unmet Health Needs Among People in Australian Prisons

Compared to the general population, people in prison are disproportionately affected by health conditions, including mental illness and communicable diseases.[46] This contributes to disproportionately high mortality rates among people cycling through the prison system.[47] This section of the Report analyses the most prevalent health conditions affecting people in prison and how the currently available treatments and services do not adequately address their needs.

7.1 Discrepancies Between the Health Needs of the Prison Relative to General Population[48]

Illnesses	Population			
	Prison		General	
	2018	2022	2018	2022
Mental Health				
Mental Health disorder	**40%**	**51%**	20.1%	21%
Drug and Alcohol disorder	**65%**	**73%**	16%	17%
Communicable Diseases				
Hepatitis C	**22%**	8.1%	-	-
Human Immunodeficiency Virus (**HIV**)	**0-2%**	-	0.1%	-

[45] Office of the Inspector of Custodial Services, *2021 Inspection of Albany Regional Prison* (Report No 138, November 2021) 1, 30.
[46] Australian Institute of Health and Welfare (n 7) 1.
[47] Ibid.
[48] Ibid 44.

7.2 Mental Health

7.2.1 Proportion of the Prison Population Affected by Mental Health Conditions

A person's mental health is integral to their functioning and can influence their rehabilitation and reintegration post-imprisonment, which not only affects the individual but their family and the wider community.[49] Relevant mental health conditions include post-traumatic stress disorder (**PTSD**), depression, anxiety, psychotic disorders and alcohol and drug disorders.[50]

As noted by WA Coroner, Philip Urquhart, in his 2023 findings in relation to the death in custody of Mr Blanket, an Aboriginal and Torres Strait Islander man, (**Blanket Inquest**), it is "undeniably true that there are a disproportionate number of prisoners with mental health issues compared to the general community".[51] Coroner Urquhart cited the following statistics from 2015 and 2018, noting that he "would expect these statistics [to] be very similar today"[52]

- two in five prisoners fulfilled the criteria of a diagnosis of mood disorder, anxiety disorder, PTSD and/or eating disorder;
- 24% of prisoners had attempted suicide sometime in their lives;
- 13% of prisoners had a lifetime diagnosis of a psychotic disorder such as schizophrenia, schizoaffective disorder, or organic psychotic disorder;
- 18% of prisoners had previously been inpatients in a psychiatric unit;
- 22% of prisoners have high or very high levels of psychological distress; and
- 10% of prisoners reported their mental health had deteriorated during their time in prison.

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[49] Manwell et al, 'What is mental health? Evidence towards a new definition from a mixed methods multidisciplinary international survey' (2015) 5(6) *BMJ Open* 1, 8.
[50] Ibid 9.
[51] Coroner's Court of Western Australia, Coroner Philip Urquhart, *Inquest into the Death of Jomen Blanket* [2023] WACOR 6 (**Blanket Inquest**). Available at: <https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death _of_jomen_blanket.aspx>.
[52] Blanket Inquest (n 51) [312] – [313].

Similarly, the 2018 National Prisoner Health Data Collection, a survey on prisoner health conducted by the AIHW, found that the prison population had high rates of mental health conditions and substance abuse, with at least 40% of new prisoners reporting a previous diagnosis of a disorder and 21% reporting that they had previously attempted self-harm.[53] Prisoners with severe mental health conditions are more likely to have alcohol and drug disorders and poorer health outcomes post-imprisonment.[54] The 2018 survey found that people entering prison were twice as likely to experience psychological distress compared with the general population.[55] The survey found that 39% of prison discharges reported that their mental health improved while in prison.[56] However, the survey also found that this changed post-release due to external pressures, such as family and other relationships in the community, alcohol and drugs, physical and mental health issues and inter-relationships in prison.[57] These latter two statistics highlight the importance of continuity of care in achieving positive long-term health outcomes for people in prison.

7.2.2 Treatment for Mental Health Conditions in Prisons

The current mental health treatments available in prisons do not adequately meet the needs of prisoners and do not meet the standard of community equivalent healthcare.[58] For instance, although some mental health conditions are often treated using psychotropic medications, such as antidepressants, anti-anxiety medication, antipsychotics, sedatives and hypnotics,[59] people in prison are prescribed psychotropic medication at higher rates than the general community.[60] The 2018 National Prisoner Health Data Collection found that the most regularly dispensed medications were antidepressants, constituting 67% of all mental health medication

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[53] Australian Institute of Health and Welfare, *The health of Australia's prisoners 2018* (Report, 30 May 2019) vi.
[54] Ibid.
[55] Ibid 35.
[56] Ibid 33.
[57] Ibid 157.
[58] See eg, Office of the Inspector of Custodial Services, *2022 Inspection of Karnet Prison Farm* (Report No 151, August 2023) vi.
[59] Ibid.
[60] Ibid 27.

dispensed.[61] Antipsychotics were the second most prescribed medications.[62] The survey also observed that some of the prescription medications dispensed were being prescribed 'off label' (i.e. not for the health condition they were originally approved for).[63] One key reason for the much higher rates of prescribing in prison compared to the community is a shortage of sufficient health professionals working in prisons to meet the substantial mental health treatment needs of those incarcerated.[64] The result of this is high rates of medication prescribing that may manage these conditions in the short term, but do not actually address the underlying causes.[65] Non-drug therapy, though lacking in availability in prisons, is often a key treatment modality for addressing these conditions in the longer term.[66]

7.3 Communicable Diseases

Diseases are deemed 'communicable' or 'infectious' if they can be transmitted from one person to another. The enclosed nature of the prison environment provides an ideal setting for the spread of communicable diseases. The availability of antibiotics and immunisation programs means that communicable diseases are not as prevalent within the general community. By contrast, the AIHW has found that the absence of these programs in prisons results in blood-borne viruses and certain sexually transmitted infections (**STIs**) widely affecting the Australian prison population.[67] The high prevalence of these conditions in prisons is often exacerbated by high-risk behaviours that create opportunities for infection and the spread of diseases, such as needle sharing, intravenous drug use, tattooing and unsafe sexual practices.[68]

Communicable diseases can develop into chronic issues that require constant management. To manage diseases, adequate access to medical practitioners for

[61] Australian Institute of Health and Welfare (n 53) 41.
[62] Ibid.
[63] Ibid.
[64] Davidson et al, 'Mapping the prison mental health service workforce in Australia' (2020) 28(4) *Australasian Psychiatry* 442.
[65] Ibid 446.
[66] Ibid.
[67] Ibid 51.
[68] Ibid 92.

diagnosis and treatment is required. Access to prescribed medications, such as anti-retroviral therapy used for treating HIV infections, is also needed.

Given that many prisoners may under-utilise healthcare before entering prison, prison provides an opportunity to address these illnesses. Providing suitable access to healthcare during incarceration can lower the risks of these conditions being spread to the wider community and improve continuity of care after release.[69] The particular need for treatment for communicable diseases among people in prison has been acknowledged by policymakers, leading to highly specialised drugs (**HSDs**) being made available in prisons through the PBS under s 100 of the *NHA*.[70] This provides access to specialised medications for the management of chronic illnesses, such as hepatitis C.[71] However, the lack of Medicare access more broadly can result in interruptions to continuity of care as people move through prison.[72] Additionally, restricting routine access to s 100 medications prevents access to other non-HSD medications, even if those medications also treat conditions that are prevalent among the prison population.[73]

7.3.1 STIs

The 2018 report on the health of Australia's prisoners by the AIHW found that the most prevalent STIs affecting the prison population were chlamydia, gonorrhoea, and syphilis.[74] In 2019, the National Notifiable Diseases Surveillance System of the Commonwealth Department of Health found that the incidence of these diseases had increased.[75] Chlamydia is more prevalent amongst female than male prisoners, and the likelihood of testing positive is 10 times more likely for prison entrants than for the

[69] Ibid 4.
[70] Department of Health and Aged Care, *Section 100 – Highly Specialised Drugs Program* (Web Page, 5 April 2023) <https://www.pbs.gov.au/info/browse/section-100/s100-highly-specialised-drugs>.
[71] Australian Institute of Health and Welfare, *Prison health services in Australia 2012* (Bulletin, August 2014) 1, 19.
[72] Butler et al, 'Multimorbidity and quality of primary care after release from prison: a prospective data-linkage cohort study' (2022) 22(876) *BMC Health Services Research* 1, 2.
[73] Department of Health, *PBS Pharmaceuticals in Hospitals Review* (Report, December 2017) 1, 8.
[74] Australian Institute of Health and Welfare (n 53) 49.
[75] Bree Gardoll, Luella White and Tony Butler, 'HIV policies in Australian prisons: a structured review assessing compliance with international guidelines' (2023) 41 *PlumX Metrics* 1.

general population.[76] For other STIs, such as gonorrhoea, prison entrants are approximately 15 times more likely than the wider population to test positive.[77] Accordingly, the evidence shows that people in prison are disproportionately impacted by STIs and that some infection rates are rising. This indicates a need for greater STI treatment in prisons.

7.3.2 Blood-borne Viruses

7.3.2.1 Hepatitis C

The most prevalent blood-borne viruses in Australian prisons are hepatitis C and HIV.[78] Hepatitis C infection can have long-term impacts on the body, including liver inflammation and complications, such as chronic liver disease or cancer.[79] In 2018, hepatitis C was the most prevalent blood-borne disease in Australia, with one infected person per 2,250 people.[80] Compared to the general population, hepatitis C is multiple times more prevalent among people entering prison, with more than one in five testing positive.[81] This positions prisons as a unique opportunity to diagnose and treat this hepatitis C in people entering prisons.

The approach to treating hepatitis C among people in prison has changed in recent years, largely influenced by the Commonwealth Department of Health's aim to eliminate hepatitis C in Australia by 2030. In 2016, the Commonwealth Government began to subsidise direct-acting anti-virals (**DAAV**) and removed some restrictions on eligibility, allowing prisoners to have access to these medications. DAAV treatments are favoured as they are shorter in course duration, have fewer side-effects and are

[76] Department of Health and Aged Care, Chlamydia (Web Page, 29 May 2019) <https://www.health.gov.au/resources/pregnancy-care-guidelines/part-g-targeted-maternal-health-tests/chlamydia>.
[77] Ibid.
[78] Ibid.
[79] Ibid.
[80] Australian Institute of Health and Welfare (n 53) 158.
[81] Ibid 49.

more effective than interferon-based treatments.[82] Since this change, there has been an improvement in the treatment of hepatitis C in prisons, with rates of uptake for hepatitis C treatment increasing by 620% from 4 courses of treatment per 1,000 people in 2012 to 50 courses per 1,000 people in 2017.[83] This case study demonstrates the significant improvements in health outcomes that can potentially be achieved when highly-demanded health services and treatments are made available to people in prison.

Despite this improvement, gaps in policy relating to a national correctional hepatitis C strategy have been identified. This includes treatment interruptions when prisoners are released before they have completed their DAAV treatment, negatively impacting continuity of care.[84] The National Prisons Hepatitis Network has released a consensus statement on the management of hepatitis C in prisons to address these gaps,[85] making several recommendations to address existing issues within the system that may hinder the long-term effectiveness of such treatment.[86] Their recommendations include that prisoners should be linked to community-based primary healthcare and provided with their full course of prescribed medication (under regulation 49 of the *National Health (Pharmaceutical Benefits) Regulations* 2017 (Cth)) as a way of improving continuity of care post-release from prison.[87] Another issue impeding continuity of care is the availability of prisoners' medical records when moving between prisons or released from prison. The National Prisons Hepatitis Network recommends the introduction of a jurisdiction-wide electronic medical records system to address this issue.[88] Despite these issues, the increased access to the PBS-subsidised medications has improved health outcomes in relation to hepatitis C.[89] Further access to other Medicare-funded health services could help address the additional problems

[82] David Kaplan et al, 'Cost-effectiveness of direct-acting antivirals for chronic hepatitis C virus in the United States from a payer perspective' (2022) 28(10) *Journal of Managed Care – Specialty Pharmacy* 1138, 1140.
[83] Ibid 54.
[84] Ibid 234.
[85] Winter et al, 'Consensus recommendations on the management of hepatitis C in Australia's prisons' (2023) 218(5) *The Medical Journal of Australia* 231.
[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] Department of Health, *Fifth National Hepatitis C Strategy* (Report, 2018) 8.

identified by the National Prisons Hepatitis Network affecting the health outcomes of people who move through prison.

7.3.2.2 HIV

In 2015, Hepatitis Australia found that around 25,513 people in Australia had HIV.[90] In the Australian prison population, prevalence rates are estimated to be 0.6%.[91] This is four times higher than the general population rate of 0.14%.[92] Research on HIV policies in Australian prisons has found that, although statistics show that HIV rates are low in comparison to other countries, factors including gaps in HIV screening, stigma and disclosure obstacles may have resulted in under-reporting.[93] Accordingly, this issue should be treated with caution. Since 2009, national surveillance reporting has ceased and there has been no standardisation regarding HIV screening, treatment, or prevention programmes. HIV screening is covered through the MBS under items 69408 and 69396, and people who are not eligible for Medicare (including prisoners) must claim testing costs through private health insurance.[94] The lack of Medicare inclusion in prisons is therefore hindering efforts to diagnose and treat HIV.

7.4 Gaps in Healthcare Leading to Deaths in Custody

Coronial inquest findings often highlight sub-par prison healthcare as a contributing factor to deaths in custody. The following case studies demonstrate that this is a serious issue which has had fatal consequences for people in Australian prisons. They also show that improved prison healthcare will have a material positive effect on preventing deaths in custody.

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[90] McGregor et al, 'HIV, viral hepatitis and sexually transmissible infections in Australia' (Annual Surveillance Report, 2015) 11.
[91] Ibid.
[92] Ibid.
[93] Ibid 14.
[94] Department of Health and Aged Care, *MBS Online* (Web Page) <https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=69396>.

7.4.1 Mr Blanket

Findings made in the Blanket Inquest[95] underscore the need to improve the quality and resourcing of mental healthcare in WA prisons. Mr Blanket was a 30-year-old Aboriginal man who took his own life in 2019 in the privately-run Acacia Prison. After entering prison, Mr Blanket began self-harming and experiencing suspected psychotic episodes. Although Mr Blanket received mental healthcare in Acacia Prison, he ultimately took his own life while waiting to be transferred to a 'safe cell'.

At the time, Acacia Prison's consultant psychiatrist only attended the prison two days a week, despite the prison having the capacity to house 1,525 prisoners[96] and despite the relatively high incidence of mental health disorders amongst the prison population.[97] Coroner Philip Urquhart stated that "[w]ell-funded and properly resourced treatment and care of a prisoner's mental health should be recognised as an essential part of a prisoner's rehabilitation".[98] The coroner also found that, without changes to "improve the capability of prison mental health services to provide effective care and treatment to prisoners with mental health conditions... more families like Mr Blanket's will bear the heartbreaking loss of a loved one to suicide in prison. The community will also ultimately bear the cost of released prisoners who have not had effective treatment in prison for their mental health issues because of resourcing issues".[99] These findings demonstrate that a lack of quality mental healthcare in WA prisons is directly contributing to both deaths in custody and recidivist offending.

[95] Blanket Inquest (n 51). Available at: <https://www.coronerscourt.wa.gov.au/I/inquest_into_the_death_of_jomen_blanket.aspx>.
[96] Ibid [131].
[97] Ibid.
[98] Ibid [316].
[99] Ibid [140].

7.4.2 Mr Danny Whitton

In 2021, a coronial inquest into the death of Danny Whitton, a 25-year-old Wonnarua man, found that his death was attributed to multiple organ failure caused by acute paracetamol poisoning.[100] The coroner's findings heavily criticised the prison's "overall suboptimal care" that led to Mr Whitton spending two days in the prison's clinic, where his condition deteriorated.[101] Shortly afterwards, Mr Whitton was airlifted to Sydney, where he died in pain.[102]

7.5 Post-Release Deaths

The transition between prison and living in the community is often a difficult one, where health and wellbeing are at heightened risk, which can lead to poor health outcomes (including hospitalisation and death). People recently released from prison are at a higher risk of illness and death than the general population.[103] A study conducted in Queensland over two years found that ex-prisoners visit a general practitioner (**GP**) at twice the rate of the general population.[104] Released prisoners also have substantially higher hospital admission rates.[105] One in five adults released from WA prisons between 2000 and 2002 were hospitalised within one year of release,[106] meaning released prisoners were 1.7 times more likely to be hospitalised than the general adult population of roughly the same age.[107] Another study showed that in Aboriginal and Torres Strait Islander released prisoners, rates of hospitalisation are over three times

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[100] Coroners Court of NSW, *Inquest into the death of Danny Keith Whitton* (State Inquiry, November 2021) 4.
[101] Ibid 8.
[102] Ibid 10.
[103] Australian Institute of Health and Welfare (n 53) 158; Jakov Zlodre and Seena Fazel, 'All-cause and external mortality in released prisoners: systematic review and meta-analysis' (2012) 102(12) *American Journal of Public Health* 67, 67-75.
[104] Megan Carroll et al, 'High rates of general practice attendance by former prisoners: a prospective cohort study' (2017) 207(2) *Medical Journal of Australia* 75, 77.
[105] Michael Hobbs et al, 'Mortality and morbidity in prisoners after release from prison in Western Australia 1995-2003' (2006) 320(1) *Australian Institute of Criminology: Trends and Issues in Crime and Criminal Justice* 1, 1-6.
[106] Janine Alan et al, 'Inpatient hospital use in the first year after release from prison: a Western Australian population-based record linkage study' (2011) 35(3) *Australian and New Zealand Journal of Public Health* 264, 266.
[107] Ibid 268.

greater than in the general population after adjustment for age.[108] The estimated annual number of deaths among recently released prisoners in Australia is considerably greater than the annual number of deaths in custody, "highlighting the extreme vulnerability of this population on return to the community".[109] It is estimated that between 449 and 472 of the total people released from Australian prisons in 2007–08 died within 1 year of release.[110] These statistics and findings demonstrate the importance of continuity of care and the general need for improved healthcare amongst the prison population.

[108] Michael Hobbs et al (n 105).
[109] Stuart A. Kinner et al, 'Counting the cost: estimating the number of deaths among recently released prisoners in Australia' (2011) 195(2) *The Medical Journal of Australia* 64, 64.
[110] Ibid 64-5.

8. Medicare: An Under-used Option

Currently, section 19(2) of the *HIA* operates to deny prisoners access to Medicare benefits, except in respect of the very limited exemptions discussed above. This Medicare exclusion likely exacerbates the poor health outcomes associated with the inadequate healthcare presently available in Australian prisons.

Expanding access to Medicare in WA prisons has the potential for significant benefits. **Six key arguments** in favour of this change in policy are:

1. Improving treatment options to address the complex health needs of Australian prisoners, potentially leading to physical and mental health improvements.
2. Reducing the risk of deaths in custody that occur due to preventable medical conditions and / or inadequate prison healthcare services.
3. Improving continuity of care upon release from prison, to reduce the risk of poor health outcomes (including hospitalisation and death) among people leaving prison.
4. Creating better outcomes for Aboriginal and Torres Strait Islander people in prison by providing funding for more culturally appropriate healthcare.
5. Reducing recidivism, as poor mental and physical health is a contributing factor to reoffending.
6. Reducing costs across government and society.

8.1 Arguments in Favour of Medicare Inclusion in WA Prisons

8.1.1 Improved Treatment Options

The inclusion of Medicare-funded services in prisons would improve treatment options and help to address the complex health needs of people in prison. Inadequate prison healthcare resourcing leads to missed opportunities for essential physical and mental health treatments. Under-resourcing is a particularly prominent issue in WA: the OICS

has reported that annual funding for WA prison health per prisoner is between 17% to 40% lower than the other Australian states.[111]

In the 2022 coroner's report into the death of Kevin Francis Bugmy in New South Wales (**NSW**), evidence given by a doctor described access to Medicare as "the elephant in the room" when speaking about the provision of holistic care, stating that if prisoners had access to Medicare, "a lot more services would be available, and more collaboration would be possible".[112] The potential for a greater variety of services attributed to Medicare inclusion was also noted in the 2023 findings of the coronial inquest into the death of Edgar Hugh Sandow in a Queensland prison.[113] In a written statement to the court, a doctor noted that, due to Medicare exclusion, "choices of treatment [in prisons] can be limited due to budget constraints".[114] These budget considerations apply to the provision of services that are subsidised by Medicare in the community, such as GP services, physiotherapy and occupational therapy.[115]

One example of how Medicare inclusion could improve treatment options for prisoners is through subsidising the provision of psychological and mental health services. In the community, psychological services have been available with Medicare rebates for up to 10 individual and 10 group allied mental health services each year.[116] Despite the disproportionately high prevalence of mental illness among people in prison,[117] prison mental healthcare services are usually "limited to those with the most severe need and with limited options for ongoing counselling".[118] A study conducted in 2020 determined

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[111] Office of the Inspector of Custodial Services, *Western Australia's Prison Capacity* (Report, December 2016) 10.
[112] Coroners Court of NSW, Inquest into the death of Kevin Francis Bugmy (July 2022) 36 [143] (**Bugmy Inquest**).
[113] Coroners Court of Queensland, Inquest into the death of Edgar Hugh Sandow (aka Conlon) (July 2023) 4 [25] (**Sandow Inquest**).
[114] Ibid.
[115] Ibid.
[116] Stuart Kinner and Tony Butler, *Public Health Association of Australia: Prisoner Health Background Paper* (Justice Health Special Interest Group, October 2017) 8; Department of Health, 'Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative', *Fact Sheet for Allied Health Professionals* (Fact Sheet, September 2020) [1]. <https://www.health.gov.au/sites/default/files/documents/2020/09/better-access-fact-sheet-professionals-better-access-fact-sheet-professionals.pdf>.
[117] Australian Institute of Health and Welfare (n 7) 2.
[118] Plueckhahn et al (n 15) 359-61.

that 11 full-time specialist mental health workers would be required for every 550 prisoners in Australian prisons to mirror the level of care available to the public.[119] Of the Australian States, only the Australian Capital Territory satisfies this minimum requirement, with WA reporting only enough funding to cover 2.29 full-time positions for every 550 prisoners.[120] This same study recommended ending the exclusion of people in Australian prisons from Medicare-subsidised mental health services as a "partial solution to the inevitable funding challenges".[121]

8.1.2 Addressing Deaths in Custody

Medicare inclusion could help reduce the risk of deaths in custody, which is partly rooted in untreated / undertreated medical issues and mental health challenges. A quantitative analysis of deaths in custody in Australia between 1991-2016 revealed that the most common primary cause of death was a "medical condition" (44% of the sample), followed by suicide (26%).[122] Deaths that occurred in the Northern Territory and WA were more likely to result from medical conditions than other States.[123] Data collected from 505 reports revealed that in 34 cases, the coroner specifically found that the person did not receive appropriate medical care in the circumstances.[124]

Several coronial inquests into deaths in custody have specifically noted or recommended that prisoners be given access to Medicare. Queensland State Coroner, Terry Ryan, noted in his findings in relation to the death of Edgar Hugh Sandow that "the exclusion of prisoners from Medicare limits the services Queensland Health can provide".[125] In her 2022 report on the death of Kevin Bugmy, NSW Deputy State Coroner, Harriet Grahame, recommended that the Justice Health and Forensic Mental Health Network (**JHFMHN**) ought to "continue its work advocating for a trial

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[119] Fiona Davidson et al, 'Mapping the prison mental health service workforce in Australia' (2020) 28(4) *Australas Psychiatry* 442, 446.
[120] Ibid.
[121] Ibid 444-5.
[122] Tamara Walsh and Angelene Counter, 'Deaths in custody in Australia: a quantitative analysis of coroners' reports' (2019) 31(2) *Current Issues in Criminal Justice* 143, 154.
[123] Ibid 155.
[124] Ibid 154.
[125] Sandow Inquest (n 113) 9 [57].

concerning Medicare for Aboriginal inmates".[126] Two weeks later, the coronial inquest into Douglas Mootijah Shillingworth's death in custody in NSW found that his death from an ear infection was preventable, and that there had been a fatal failure to identify and treat his ear infection in custody.[127] The NSW Deputy State Coroner, Joan Baptie, recommended a trial of Medicare for Aboriginal and Torres Strait Islander prisoners to improve the primary healthcare offered.[128]

These recommendations are not a recent trend. In an Ombudsman report on the investigation into deaths in prisons from 1991-1999, the Parliamentary Commissioner for Administrative Investigations, Murray Allen, called the lack of Medicare coverage a "concern" and a "major impediment to the provision of health service to prisoners".[129] He recommended that the issue should be referred to appropriate State and Commonwealth authorities for a comprehensive review and investigation.[130]

8.1.3 Improving Continuity of Care

Currently, continuity of healthcare between prison and community health services is regarded as "suboptimal and challenging".[131] Medicare inclusion may help to improve the continuity of care upon release by enabling throughcare (healthcare and support commencing pre-release and continuing uninterrupted after re-entry into the community). This is vital for ensuring the health and ongoing treatment of prisoners is not disrupted as they re-enter the community, which in turn will likely lead to better public health outcomes and fewer post-release deaths.

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[126] Bugmy Inquest (n 112) [215].
[127] Coroners Court of NSW, Inquest into the death of Mootijah Douglas Andrew Shillingsworth (July 2022) 50 [176]-[177].
[128] Ibid 49 [174].
[129] Ombudsman Western Australia, *31st Annual Report of the Parliamentary Commissioner for Administrative Investigations* (Report, 2002) 33.
[130] Parliamentary Commissioner for Administrative Investigations Murray Allen, *Report on an investigation into deaths in prisons* (Ombudsman WA, 15 December 2000) 116-17.
[131] Bastian Seidel, Peter O'Mara and Penelope Abbott, 'Aboriginal and Torres Strait Islander Health: Letter to the Minister for Health and the Minister for Indigenous Health' (Royal Australian College of General Practitioners, 10 August 2017) 1, 3.

The Public Health Association of Australia (**PHAA**) has stated that "continuity of care from prison to the community is important given the complex health needs of prisoners".[132] As previously noted in this Report, the transition between prison and living in the community presents an increased risk of poor health outcomes, including increased rates of hospitalisation and death.[133] Accordingly, it is important to ensure prisoners receive adequate healthcare post-release. For that to occur, it is essential that the transition from prison healthcare to the community is as smooth and undisrupted as possible. Achieving continuity of care is difficult, in part due to the separate funding streams for prison and community-based health services.[134] A lack of continuity of care produces inefficiencies and missed opportunities to both maintain any health gains achieved during incarceration and produce positive long-term health outcomes.[135]

A key issue regarding continuity of care is the immediate disruption to incarcerated individuals' healthcare treatment. In 2020, there were 55,766 cancelled appointments in NSW public prisons, 41% of which were cancelled due to individuals being unavailable, for reasons that included being recently released from prison, or being recently transferred to another prison.[136] In 2018, data collected by the AIHW found that approximately 36% of people discharged from prison either did not have, or did not know whether they had, a valid Medicare card on their first day of release.[137] Studies demonstrate that interrupted healthcare often compounds adverse health outcomes for ex-prisoners.[138]

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[132] Kinner and Butler (n 109) 4.
[133] Hobbs et al (n 105).
[134] Cumming et al (n 16) 156.
[135] Josiah D. Rich et al, 'How HealthCare Reform Can Transform The Health Of Criminal Justice–Involved Individuals' (2014) 33(3) *Health Aff (Millwood)* 462, 462-70; Penelope Abbott et al, 'Supporting continuity of care between prison and the community for women in prison: a medical record review' (2017) 41(3) *Aust Health Rev* 268, 268-76.
[136] Justice Health and Forensic Mental Health Network, *People in NSW Public Prisons: 2020 Health Status and Service Utilisation Report* (Report, November 2022) 1, 77.
[137] Productivity Commission, *Australia's prison dilemma* (Research Paper, October 2021) 45; Australian Institute of Health and Welfare (n 53).
[138] Young et al, 'Early primary care physician contact and health service utilisation in a large sample of recently released ex-prisoners in Australia: prospective cohort study' (2015) 5(6) *BMJ Open* 1, 2.

Poor communication between stakeholders is another issue contributing to a lack of continuity between healthcare inside and outside prisons. In a 2015 study conducted with 30 Aboriginal and Torres Strait Islander people released from prison, participants expressed concerns about inadequate communication between healthcare providers inside correctional facilities and those in the community before a prisoner's release.[139] In the same study, many participants with chronic conditions were found to be released without a discharge summary or plans, or without being connected to community primary healthcare services.[140] The study found that discharge planning and communication was variable and hampered, in part, by lack of access to Medicare.[141]

Effective access to healthcare outside of prison can be facilitated by providing appropriate healthcare to people in custody and by properly planning healthcare provision for after their release.[142] To achieve this, there is a pressing need to prioritise the establishment of continuous healthcare connections between prison and community health services. Adequate continuity of care is more likely to occur if the same organisation has responsibility both inside and outside the prison walls.[143] The PHAA supports this view, stating that "integrating prison health services into community health services is likely to support continuity of care".[144] The Royal Australian College of General Practitioners (**RACGP**) has also maintained that access to Medicare items in prison would enhance the ability of prison health services and community GPs to "provide integrated care, increase the confidence of people leaving prison that they can access primary care for ongoing management of health needs and enhance the ability of GPs to give prisoners follow up care after release".[145] Medicare funding could facilitate multi-disciplinary case conferencing and pre-release planning processes prior to release from prison, making it easier for prisoners to adhere to their treatment plans after release from prison.[146]

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[139] Jane E. Lloyd et al, 'The role of primary healthcare services to better meet the needs of Aboriginal Australians transitioning from prison to the community,' (2015) 16(86) *BMC Family Practice* 1, 1-10.
[140] Ibid 8.
[141] Ibid 5.
[142] Ibid 10.
[143] International Centre for Prison Studies, *Prison Health and Public Health: The integration of Prison Health Services* (Conference Paper, 2 April 2004) 1, 24.
[144] Kinner and Butler (n 109) 4.
[145] Seidel, O'Mara and Abbott (n 131) 3.
[146] Ibid 2-3.

8.1.4 Addressing Aboriginal and Torres Strait Islander Health Needs

Due to the overrepresentation of Aboriginal and Torres Strait Islander people within WA prisons, the prison healthcare service is the second largest provider of Aboriginal healthcare in the State.[147] For this reason, the success of prison healthcare plays a vital role in achieving several *Closing the Gap* targets.[148] However, the Medicare exclusion often poses a significant barrier for ACCHOs to provide culturally safe medical services, as they cannot claim expenses from Medicare, instead relying on variable state-based funding.[149]

The RACGP has argued that access to certain Medicare items will result in "increased capacity and funding for the provision of high quality, culturally appropriate care for Aboriginal and Torres Strait Islander people in prison".[150] This includes providing access to the Aboriginal and Torres Strait Islander Peoples Health Assessment and follow up services (MBS Items 715 and 10987), for which no culturally appropriate equivalent service currently exists in WA prisons.[151] The NSW Inspector of Custodial Services has also previously recommended a Medicare inclusion for Aboriginal and Torres Strait Islander people in prison, with a particular focus on the Aboriginal and Torres Strait Islander Peoples Health Assessment, as well as multidisciplinary care, team care, and GP management plans (MBS Items 721, 723 and 732), especially for those with chronic conditions.[152] Exempting people in prison from the Medicare exclusion in s 19(2) of the *HIA* would give prisoners access to these (and other) Medicare items. This would help to address the need for culturally appropriate care for incarcerated Aboriginal and Torres Strait Islander people.

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[147] Office of the Inspector of Custodial Services, *Thematic Review of Offender Health Services* (Report No 35, June 2006) 1, 3.
[148] Inspector of Custodial Services (NSW), *Health services in NSW correctional facilities* (Report, March 2021).
[149] Australian Indigenous Doctors' Association, *Incarceration: the disproportionate impacts facing Aboriginal and Torres Strait Islander people* (Report, September 2022) 1, 13.
[150] Seidel, O'Mara and Abbott (n 131) 4.
[151] Kinner and Butler (n 109) 8.
[152] Inspector of Custodial Services (NSW) (n 148).

8.1.5 Reducing Recidivism

Recidivism is a key challenge for the criminal justice system, with about 45% of people released from prison being re-imprisoned within two years post-release.[153] Evidence shows that poor physical and mental health is a strong predictor of recidivism.[154] A thorough long-term report conducted in the United States examined how physical and mental health conditions shape criminal behaviour after release from prison.[155] People released from prison with insufficiently treated physical health issues were more likely to violate their parole and be re-incarcerated. Over 50% of female ex-prisoners with physical health conditions had reoffended in the first eight to ten months after prison, compared to 38% of women without physical health conditions.[156] Both men and women with mental health conditions reported more post-release criminal behaviour than their counterparts without mental health conditions.[157] A study examining the health service utilisation by people recently released from prison in Australia also found that the "synergistic effect of multiple, concurrent health conditions may increase recidivism".[158]

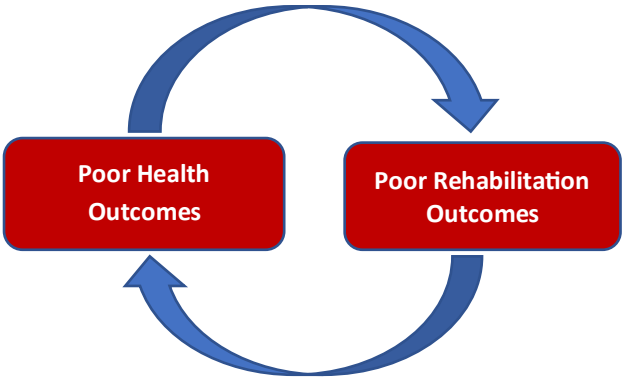

Figure: *The symbiotic relationship between poor health outcomes and correspondingly detrimental rehabilitation results for prisoners after release.*

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[153] Productivity Commission (n 137) 43.
[154] Stuart A. Kinner et al, 'Prisoner and ex-prisoner health: Improving access to primary care' (2012) 41(7) *Australian Family Physician* 535, 536; Qinglu Cheng et al, 'Cost–utility analysis of low-intensity case management to increase contact with health services among ex-prisoners in Australia' (2018) 8(8) *BMJ Open* 1, 2.
[155] Kamala Mallik-Kane and Christy A. Visher, 'Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration' (Urban Institute Justice Policy Centre, February 2008) 1.
[156] Ibid 29.
[157] Ibid 42-3.
[158] Young et al (n 138) 2.

An OICS report into recidivism rates and the impact of treatment programs suggested that improved mental health contributes to a reduced likelihood of a person returning to prison, and that this can be achieved by better support or assistance in prison or support and assistance upon release.[159] While more research is required in this space, current evidence suggests that improved healthcare and better-funded services in prison are a factor in reducing recidivism, as noted in a 2021 report published by the Australian Productivity Commission.[160] Research into the post-release experiences of prisoners in Queensland also found that there is scope to expand and enhance treatment in prisons.[161] This study stated that, at present, the heathcare services for people in Australian prisons are "fragmented, often under-funded and usually based on limited evidence".[162] Accordingly, Medicare inclusion could help with the funding of services to better meet prisoner healthcare needs and thereby reduce recidivism rates.

8.1.6 Reducing Costs

Medicare inclusion is likely to lead to improvements in health outcomes for people leaving prison, which would result in cost-savings for the public health and justice systems. In 2019–20, State Governments spent $5.2 billion on prisons, equating to more than $330 per prisoner per day.[163] This represents approximately 1.6% of total government expenditure.[164] Estimates show that recidivism accounts for more than half of these costs: approximately $3.1 billion nationally.[165] In 2013–14, $615 million was spent keeping WA prisoners in custody. Health services comprised around 5% (almost $31 million) of the total costs for WA's public prisons.[166]

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[159] Office of the Inspector of Custodial Services, *Recidivism rates and the impact of treatment programs* (Report, September 2014) v.
[160] Linnane, McNamara and Toohey (n 23) 106; Productivity Commission (n 137) 89.
[161] Stuart A. Kinner, 'The post-release experience of prisoners in Queensland' (2006) 325(1) *Australian Institute of Criminology: Trends and Issues in Crime and Criminal Justice* 1, 5.
[162] Ibid.
[163] Productivity Commission (n 137) 7.
[164] Ibid 47.
[165] Ibid 63.
[166] Economic Regulation Authority, *Inquiry into the Efficiency and Performance of Western Australian Prisons: Overview* (Fact Sheet, 2015) 2 <https://www.erawa.com.au/cproot/13941/2/Fact%20Sheet%20-%20Final%20Report%20-%20Prisons%20Inquiry.PDF>.

Healthcare costs do not cease upon a person being released from prison. It is important to remember that prisoner health is public health. The Australian Medical Association has emphasised that prisoner health must be considered in a context where it is understood that "public health imperatives can only be fully achieved if prisoner-patients are understood to be integral to state-wide health service needs".[167] The World Health Organisation has noted that "sooner or later most prisoners will return to the community, carrying back with them new diseases and untreated conditions that may pose a threat to community health and add to the burden of disease in the community".[168] Indeed, people recently released from prison place a great burden on the public health sector. In WA, a two-year study showed that one in five adults released from prisons were hospitalised within 12 months; this translated to 12,074 inpatient bed days at a direct cost of $10.4 million.[169]

While the inclusion of Medicare in prisons would require a modest increase by the Commonwealth Government in its healthcare budget, it is likely to be cost-effective in the long-term. The RACGP has stated that the complex needs of people in prison (especially Aboriginal and Torres Strait Islander people) can be met with the assistance of GPs, nurses and Aboriginal health workers, "but require support within the Medicare schedule to do so… potentially saving costs in the long run through decreased recidivism and hospitalisation".[170] While limited, the available evidence suggests that the costs to Medicare would both be relatively minimal and highly cost effective.[171] A 2015 study estimated that giving every Aboriginal and Torres Strait Islander prisoner in Australia a health assessment in any one year would cost less than 0.01% of the annual Medicare budget.[172] In Australia, intervention strategies for people with mental illness and cognitive impairment are known to be cost effective, and it is believed that screening prisoners for mental health issues would also give "extraordinary cost benefits to the community".[173]

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[167] Office of the Inspector of Custodial Services (n 147) 3.
[168] Linnane, McNamara and Toohey (n 23) 106.
[169] Janine Alan et al (n 106) 266.
[170] Seidel, O'Mara and Abbott (n 131) 3.
[171] Linnane, McNamara and Toohey (n 23) 106.
[172] Community Justice Coalition, *Medicare access for prisoners* (Report, 24 October 2022) 58; Plueckhahn et al (n 15) 359-61.
[173] Linnane, McNamara and Toohey (n 23) 106.

The OICS has previously suggested that any increase in prison health service budgets would be an investment towards reducing future health costs that people released from prison would incur on returning to the community, as they would likely have fewer untreated health conditions after release from prison.[174] This would help reduce the strain on community health services. Furthermore, as improved mental and physical health is known to reduce reoffending, this would likely contribute to reducing the currently high costs of reincarceration. A report by the OICS revealed that for every ten people released from WA prisons who do not return to prison for just one year, the projected saving in direct costs alone is over $1 million.[175] If these ten people never return to prison, "the savings are multiplied many times".[176] While the limited evidence cited here is informative, to fully understand the costs versus the likely benefits of making Medicare-funded services available in prisons, a thorough, wide-ranging cost-benefit analysis is warranted. The Commonwealth Government is best placed to lead such analysis as Medicare policy is a Commonwealth responsibility. The Commonwealth Government should, however, consult with the state and territory governmentsduring this process, as these governments are responsible for providing health services in prisons. Accordingly, they are critical stakeholders and also possess much of the relevant prison health service data needed to complete this analysis.

8.2 Potential Arguments Against Medicare Inclusion

While there is potential for positive change that would flow from implementing Medicare in prison, there are also likely to be some challenges which must be addressed.

First, there would be an initial increase in direct financial costs as Medicare funding is implemented in prisons. There would likely need to be investment in additional infrastructure in prisons, such as facilities to accommodate a greater number of

[174] Cumming et al (n 16) 20.
[175] Office of the Inspector of Custodial Services (n 159) i.
[176] Ibid.

healthcare professionals, or appropriate infrastructure for the implementation of other Medicare-funded services (for example, technology for Telehealth services).[177]

Secondly, there was a notable concern identified through the Project Team's consultations that full Medicare inclusion in prisons could lead State Governments to reduce their prison healthcare budgets, which would offset any benefits derived from Medicare inclusion and not deliver improvement on the status quo.

Thirdly, the Project Team's consultations highlighted potential concerns regarding logistical and security challenges that may arise due to Medicare inclusion. For instance, the number of healthcare practitioners providing services within prisons would likely increase, all of whom would require additional training to understand the unique challenges of providing healthcare in prisons. This includes a greater risk of diversion of some prescription medications by these new personnel.[178] Another challenge is that Medicare inclusion could cause fragmentation of care between Department of Justice-funded prison healthcare staff and Medicare-funded practitioners. Fragmentation of care occurs when there is a disconnect between services provided for a patient by different healthcare professionals. It may occur, for example, due to the siloing of medical notes or other information, mismatched funding streams, or a diffusion of responsibilities[179] causing a lack of communication and cooperation between practitioners. Fragmentation of care can cause adverse health outcomes for patients as important health conditions may be overlooked, or different medications may be prescribed without coordination. It is also more costly overall for healthcare providers.[180] Finally, as previously noted, additional workspaces would be required in prison medical centres to accommodate the increased number of healthcare providers in prisons.

[177] Community Justice Coalition (n 172) 61.
[178] WAJA Consultation with a health service professional (Anonymised).
[179] Pim Valentijn, 'Fragmentation of care: its causes and what we can do about it', *Essenburgh* (Web Page) <https://www.essenburgh.com/en/blog/fragmented-care-the-causes-and-what-we-can-do-about-it>.
[180] Ibid.

8.3 Responding to the Arguments against Medicare

Arguments against Medicare inclusion have little to do with Medicare as a funding mechanism and pertain more to do with the practicalities of how this mechanism would be incorporated into prison healthcare. The authors of this Report contend that, with good governance and clinical practice, there is no reason why Medicare-funded services would not be a beneficial addition to the health services currently provided in prisons.

First, any additional expenditure on infrastructure to support Medicare-funded services should be rightly seen as an investment into healthcare. As one health professional the Project Team consulted stated: "Money spent in prisons is always good value regardless of who spends it. You're likely to save money in the long term".[181] State Governments would undeniably need to invest in infrastructure (such as more rooms in prison medical centres) to facilitate changes in service delivery in prisons if Medicare funding was made available. However, the likely long-term benefits of these initial investments in the form of improved health outcomes, reduced recidivism, and a reduction in the use of hospitals after release from prison would likely deliver substantial savings in the long-term.

Secondly, concerns regarding reduced State Government investment into prisoner healthcare are understandable given that investing resources to assist people in prison is traditionally not seen as a political 'vote winner'. However, these are not problems inherent to the introduction of Medicare funding. Disinvestment could be avoided by good governance and accountability mechanisms and is not a necessary consequence of Medicare inclusion. Indeed, there is precedent for health providers receiving dual funding (i.e. from both Medicare and State Governments). ACCHOs have historically received both State and Commonwealth funding through agreements approved by the National Cabinet (and previously the COAG). An agreement between State and Commonwealth Governments could be reached in relation to Medicare inclusion, similar to the COAG Section 19(2) Exemptions Initiative. Such an agremeent

[181] WAJA Consultation with a health service professional (Anonymised).

could include a commitments by States to maintain prison health funding at a certain level, so that Medicare funding can provide actual improvements in access to healthcare services rather than simply a substitution of funding sources. Additionally, the current stream of funding for WA prison healthcare is woefully inadequate. It could be said that a state of disinvestment into prison healthcare already exists. Accordingly, the potential of an additional funding mechanism such as Medicare remains a logical policy option.

Finally, logistical and structural obstacles, such as fragmentation of care, do pose a real challenge for the implementation of Medicare in prisons, especially in cases of Medicare-funded in-reach programs. However, this is not an insurmountable challenge. It would require changes in practice and greater integration and communication between the prison and community healthcare practitioners, especially in the form of improved transfer of medical notes and prison-specific training. It would also require training in the nuances of prison healthcare for clinicians to develop good practice regarding when it is appropriate to utilise different Medicare items. Provided clinical practice and training is adequate, there should not be significant issues in utilising Medicare funding in prisons.

Overall, the available evidence suggests that making Medicare-funded services available in prisons would improve the healthcare provided to prisoners and likely lead to long-term cost savings. Medicare inclusion would certainly require challenges to be navigated. However, all of these challenges could be overcome by a prison healthcare system that prioritises good governance, clinical practice, and integration with community healthcare systems.

8.4 Improving Aboriginal and Torres Strait Islander Health in Prisons through Medicare Inclusion

8.4.1 Medicare Inclusion for ACCHOs

The Project Team acknowledges that this policy option remains subject to further consultation with ACCHOs to assess their capacity to provide additional in-reach

services. However, in principle, the increased engagement of ACCHOs in prisons has the potential to improve the health outcomes of Aboriginal and Torrres Strait Islander people in prisons. ACCHOs are Aboriginal-led health services that have been developed to address the gaps in healthcare service delivery for Aboriginal and Torres Strait Islander people. The health service delivery frameworks of ACCHOs are underpinned by a commitment to culturally appropriate and effective treatment and management of the complex health needs of Aboriginal and Torres Strait Islander people for long-term improvement of overall health outcomes.[182] The frameworks are centred around holistic care and principles of self-determination and community participation, whereas a lack of resourcing and cultural competency hinders the prioritisation of these frameworks in current prison healthcare systems.[183]

ACCHOs can provide general health services and specific health services to Aboriginal and Torres Strait Islander people in the community. The Australian Health Review in 2017 reported that ACCHOs provide health services that are more effective that mainstream services at improving health outcomes for Aboriginal and Torres Strait Islander people.[184] Aboriginal and Torres Strait Islander people access services provided by ACCHOs 23% more than mainstream services.[185] ACCHOs currently provide some in-reach services in select prisons, with the funding for these services coming largely from State Governments or government organisations. For example, the ACT 2022/2023 Budget reported that Winnunga Nimmityjah Aboriginal Health & Community Services would receive funding for the Alexander Maconochie Centre Clinic,[186] which provides a range of health services to Aboriginal and Torres Strait Islander prisoners.[187]

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[182] National Aboriginal Community Controlled Health Organisation, *ACCHOs* (Web Page, 2022) <https://www.naccho.org.au/acchos/#:~:text=What%20is%20an%20ACCHO%3F,locally%20elected%20Board%20of%20Management>.
[183] Ibid.
[184] Campbell et al, 'Contribution of Aboriginal Community-Controlled Health Services to improving Aboriginal health: an evidence review' (2017) 42(2) *Australian Health Review* 218.
[185] National Aboriginal Community Controlled Health Organisation, *Aboriginal Community Controlled Health Organisations are more than just another health service – they put Aboriginal health in Aboriginal hands* (Web Page) <https://www.naccho.org.au/app/uploads/2021/09/Key-facts-1-why-ACCHS-are-needed-FINAL.pdf>.
[186] ACT Health Directorate, *2022-2023 Budget Statements* (Report, 2022) 16.
[187] AMC Clinic, *Winnunga* (Web page) <https://winnunga.org.au/services/clinical-services/amc-clinic/>.

Existing prison in-reach services currently provided by ACCHOs prioritise rehabilitation with a focus on achieving long-term outcomes.[188] This is achieved by Aboriginal and Torres Strait Islander communities playing a significant role in developing and operating these in-reach services.[189] The programs take a holistic approach to healthcare that extends beyond health services given to Aboriginal and Torres Strait Islander people in prisons, including family and friends support services to visitors, and reintegration services beyond leaving prison that are provided by the same organisation. Particularly in regional and remote areas, the ability to access health services through the same organisation upon reintegration into the community is beneficial. These in-reach services help enable such continuity of care.

However, limited funding and restricted access to people in prison curtails the success of these in-reach programs, as evidenced by a study of the Winnunga Nimmityjah Aboriginal Health & Community Services provided at Alexander Maconochie Centre Health and Wellbeing Service[190] and a broader study of multiple ACCHOs.[191] Nonetheless, the ability to claim Medicare funding for in-reach services provided by ACCHOs may support such services, improving treatment for Aboriginal and Torres Strait Islander people in prisons and enhancing continuity of care post-release.[192] Supporting these in-reach services has would likely help address the staffing shortages in WA prisons, specifically in the context of mental healthcare and drug and alcohol treatment. This may enable meaningful long-term improvements in health outcomes for Aboriginal and Torres Strait Islander people in prison.

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[188] WAJA Consultation with an ACCHO (Anonymised).
[189] Ibid.
[190] Lachlan Arthur et al, 'Evaluating Patient Experience at a Novel Health Service for Aboriginal and Torres Strait Islander Prisoners: A Pilot Study' (2022) 3(1) *Journal of the Australian Indigenous* 1, 2.
[191] Simon Pettit et al,' 'Holistic primary healthcare for Aboriginal and Torres Strait Islander prisoners: exploring the role of Aboriginal Community Controlled Health Organisations' (2019) 43(6) *Australian and New Zealand Journal of Public Health* 538.
[192] Inspector of Custodial Services (NSW) (n 148) 83.

8.4.2 Medicare Access for Aboriginal and Torres Strait Islander People in Prison

Access to Medicare funding targeted to improve the health of Aboriginal and Torres Strait Islander people in prison should be considered, especially since WA prisons currently fail to provide a community equivalent standard of healthcare. This is particularly important given that Aboriginal and Torres Strait Islander people upon release disproportionately decrease contact with primary care physicians, suggesting that they experience increased barriers to care in the community compared to non-Indigenous people leaving prison.[193] Improving the range and access to treatment options for Aboriginal and Torres Strait Islander people in prisons will also likely have an impact on *Closing the Gap* targets regarding health and recidivism. Items that should be considered include the Aboriginal and Torres Strait Islander Peoples Health Assessment (MBS Item 715), chronic care planning and review by a GP or primary care team (MBS Items 721, 723 and 732) and possibly other follow up health services for Aboriginal and Torres Islander people who have had a health assessment.

Organisation	Prisons	Services currently provided in prisons
Winnunga Nimmityjah Aboriginal Health & Community Services (ACT)	• Bimbri Youth Justice Centre • Alexander Maconochie Centre	Alexander Maconochie Centre Clinic • Health checks and GP consultations • Mental healthcare plans • Chronic healthcare plans • Nursing assessments and procedures • Social and emotional wellbeing services • Diagnostic investigations • Medication management • Referrals to specialists and allied health • Men's and Women's health • Drug and alcohol rehabilitation counselling

[193] Young et al (n 138) 3.

Danila Dilba Health Service (NT)	• Don Dale Youth Detention Centre	• Primary healthcare services • Drug and alcohol rehabilitation services • Social and emotional wellbeing services • Youth support services

8.5 Community Telehealth

Telehealth is the delivery of health services using information and communication technologies.[194] It also encompasses patient and professional education and administration. Telehealth is a service already funded by Medicare.[195] Currently, Telehealth services are run in WA prisons by the Department of Justice (Corrective Services division), and elsewhere in Australia through telehealth services run by prison healthcare providers, such as by JHFMHN in NSW.[196] Enabling community practitioners to provide Medicare-funded telehealth services in prisons is another option that may address staff shortages and correspondingly long waiting times in prisons.[197]

[194] Department of Health and Aged Care, Telehealth (Web Page, 13 April 2022) <https://www.health.gov.au/topics/health-technologies-and-digital-health/about/telehealth>.
[195] Ibid.
[196] Community Justice Coalition (n 172) 14.
[197] Ibid 20.

9. Recommendations for Policy Change

9.1 Sliding Scale

Through consultations with various academics, medical practitioners and government departments, the Project Team found an overwhelming recognition of the need for greater funding within prison healthcare. However, there were differing views as to the degree to which Medicare inclusion was a viable solution and the ways in which it should be utilised to bring about improvements.

This section recommends four potential models of incorporating Medicare funding within prisons and seeks to highlight the strengths of each. These models of Medicare inclusion are not mutually exclusive, but rather build upon each other in terms of their ambition and scope, giving policymakers multiple reform options to consider and potentially implement incrementally as appropriate. That is, for example, a full Medicare inclusion model encompasses the other models below it on the sliding scale. The partial Medicare inclusion model encompasses the two models below it on the sliding scale in relation to the limited MBS items it would provide.

9.1.1 Full Medicare Inclusion

There are several reasons why a full Medicare inclusion model should be considered. The benefits of granting prisoners access to funding for the full range of MBS and PBS items with a full Medicare model include:

- closest alignment with Australia's relevant international obligations and domestic commitments to the principle of equivalence; and
- being best placed to adapt to changes in the community health profile and advances in clinical research.

First, a full Medicare inclusion model best fits Australia's international obligations and domestic commitments in relation to prison healthcare. Rule 24 of the Mandela Rules, which Australia has endorsed,[198] provides that:

> *(1) The provision of healthcare for prisoners is a State responsibility. Prisoners should enjoy the same standards of healthcare that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*
>
> *(2) Health-care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care...*

The evidence presented in this Report suggests that WA prison health services currently provide a lower standard of healthcare compared to healthcare provided in the community. Access to the same healthcare funding mechanisms in prison as those available for community health services would assist prisons to improve the standard of healthcare provided, consistent with the principle of equivalence. This would likely lead to improvements in a range of much-needed health services provided in prisons, as well as improvements in continuity of care.

Secondly, people in prison should have the benefit of the same evidence-based changes in healthcare practices as the rest of the community. Medicare items are periodically reviewed and amended, informed by the latest health data and scientific evidence, which inform best practice, and indicate current community health needs. As members of the community, people in prison should be entitled to receive the full range of healthcare that is also informed by the latest evidence, rather than a more limited range of treatment options.

[198] Australian Medical Association, *Healthcare in Custodial Settings* (Position Statement, 2023) 5.

9.1.2 Partial Medicare Inclusion

A partial Medicare inclusion model involves a limited inclusion of specific MBS items, such as the Aboriginal and Torres Strait Islander Peoples Health Assessment and review (Items 715 and 10987), chronic care planning and review (Items 721, 723 and 732), and the mental health treatment plan (Item 2715).[199] These are relatively low-cost items that can help to prevent poor health outcomes post-release. They also target two areas of urgent need within the prison population; thus, their inclusion is likely to benefit a large proportion of people in prison.

Proponents of this model include various academics, epidemiologists, and medical practitioners who support it in lieu of a full Medicare inclusion model, primarily as it is viewed as more politically palatable and achievable given the perennial challenges with prison health policy reform.

Indeed, there are three key reasons why a partial Medicare inclusion model should be considered. The first reason is the perception that there is a lack of political will to improve conditions for people in prisons, meaning that an ambitious full Medicare inclusion model is likely to be outright rejected. Summed up in one consultation as a "go for everything and get nothing" option,[200] the general consensus is that full Medicare inclusion is less likely to be implemented than partial Medicare inclusion. Arguably, it is pragmatic to pursue, at least in the first instance, smaller scale reform targeted to have a relatively larger impact on the most vulnerable people in prison.

The second argument for partial Medicare inclusion is that it could act as a trial for generating evidence that may support greater Medicare inclusion and other reforms.[201] Partial Medicare inclusion is seen as a possible first step in improving healthcare access for people in prison and presents an opportunity to investigate the impact of this change in policy on health outcomes. This evidence could then inform further policy reform in this space (including possibly moving towards full Medicare inclusion).

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[199] Inspector of Custodial Services (NSW) (n 148).
[200] WAJA Consultation with a health service professional (Anonymised).
[201] WAJA Consultation with an epidemiologist (Anonymised).

Thirdly, partial Medicare inclusion is promoted as a cost-efficient solution. This reasoning links to broader concerns regarding potential disinvestment of prison healthcare funding by State Governments if full Medicare inclusion were implemented. This view favours a partial Medicare inclusion model, providing a limited number of very effective services which can improve the health of people in prisons, without increasing funding sufficiently to prompt States to reduce their spending. Through selecting MBS items aimed at addressing the most prevalent health problems in the prisoner population, such as chronic health conditions, mental health conditions and the complex health needs of Aboriginal and Torres Strait Islander people, a partial Medicare inclusion model may result in measurable improvements in health outcomes, with a lower risk of disinvestment. The Project Team considers that the potential for these limited changes to achieve significant improvements in health outcomes justify their subsidisation in prisons through Medicare.

9.1.3 Medicare-Funded ACCHOS In-Reach Programs

The in-reach services provided by ACHHOs in prison are either funded by the Commonwealth Government or through a contract with the relevant State's Department of Justice. While this funding is important, it remains insufficient to support the programs on a long-term basis. While subject to further consultation with ACCHOs, this Report preliminarily proposes that the MBS-funded items available to ACHHOs in the community should also be available to ACCHOs to provide services in prisons.[202] The Project Team considers that this could help:

- encourage long-term retention of ACCHOs' in-reach services;
- build rapport between ACCHOs and Aboriginal and Torres Strait Islander patients (via increased frequency and consistency of service provision); and
- improve continuity of care in relation to Aboriginal and Torres Strait Islander people moving through prison.

[202] Ibid 84.

9.1.4 Medicare-Funded Access to Community Telehealth

Access to Medicare-funded community telehealth could help alleviate several problems identified in this Report. The first of these problems is poor staff recruitment and retention and the resulting long wait-times for access to prison healthcare services. In NSW, JHFMHN has implemented a centralised GP and specialist telehealth service. During 2018–19, despite a 335% increase in the number of patients seen by GPs, there was a 20% reduction in waiting times.[203] The NSW Inspector of Custodial Services attributes this to the investment in telehealth technology.[204] They also highlight telehealth's ability to improve access to specialist care, such as occupational therapy and physiotherapy, two services currently funded by Medicare.[205]

Telehealth also presents an opportunity for long-term cost savings. There would most likely be initial short-term costs associated with investment into adequate infrastructure to facilitate large-scale telehealth access to people in prisons. However, these short-term costs would be offset over time by savings from reduced supervised day-trips and transfers to external service providers. One study found that in Queensland, which already has infrastructure in place, the use of telehealth would result in cost savings of up to $969,731 per annum depending on the level of utilisation.[206] Telehealth could increase the services available in prisons and help to manage some health problems, to ensure that other resources could be directed towards health conditions that are *not* manageable by telehealth.

Additionally, telehealth allows prisoners to choose their own healthcare professionals;[207] this is not typically the case in prisons. For patients who enter prison while being treated for existing health conditions, this could allow them to retain the same healthcare provider in the prison and the community. The Project Team consider

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[203] Ibid.
[204] Ibid.
[205] Ibid.
[206] Esther Jie Tian, 'The impacts of and outcomes from telehealth delivered in prisons: A systematic review' (2021) 16(5) *PLoS One* 1, 22.
[207] Department of Health and Aged Care (n 194).

this to be important for developing relationships of trust and cooperation that can last beyond the individual's prison sentence, potentially facilitating continuity of care for people moving through prison. The ability for people in prison to select their own healthcare professionals may also give those people a greater sense of autonomy over, and dignity in relation to, their health, which is likely to lead to improved health outcomes.

9.2 Cost–Benefit Analysis

There is currently limited evidence to inform policy decisions in relation to prison health because data concerning people in prison and prison conditions is difficult to acquire. This presents a problem in assessing and analysing the potential benefits and drawbacks of proposed policy reforms, such as Medicare inclusion. The Project Team considers the foundation of good policymaking to be high-quality data, which underpins the production of empirical evidence on which to base policies. Where data are not collected or are made inaccessible to researchers and the general public, it is easier for decision-makers to obfuscate and dismiss valid policy proposals based on publicly-available empirical evidence and lived experience.

Understanding and weighing the possible short-term costs of the policy options set out in this Report against their potential medium and long-term cost savings and other benefits would help all stakeholders assess the merits of each option. We recommend a cost-benefit analysis be undertaken by the Commonwealth Government in consultation with the state and territory governments, regarding the cost-saving potential of Medicare-funded services being made available for people in prison. The cost-benefit analysis should take a societal perspective and consider the impact on all stakeholders,[208] including the costs and potential savings to the criminal justice system, health system, Department of Communities, and other stakeholders that may be impacted by Medicare-subsidised healthcare in prisons. As reflected in the quote below, such analysis would allow decision-makers to adequately consider the potential net social benefit of Medicare inclusion.

[208] Department of the Prime Minister and Cabinet Office of Impact Analysis, *Cost Benefit Analysis* (Guidance Notice, July 2023) 10.

> *"High quality cost-benefit assessments developed using a consistent framework allow governments to consider which spending options offer the best return to the community".*[209]
> - Australian Productivity Commission

Accordingly, a cost-benefit analysis should consider the short-term costs of enabling Medicare-funded services to be provided in prisons: the investments in infrastructure needed to facilitate Medicare-funded service provision, training for healthcare professionals, costs of restructuring medical records systems, and other costs associated with the de-fragmentation of care. It should also consider the ongoing costs of providing Medicare-funded services within prisons. These should be weighed against the potential medium and long-term benefits across all relevant sectors.

[209] Productivity Commission (n 137) 7.

10. Conclusion

Currently, prison health services do not adequately meet the treatment needs of people in prison. This results in poor outcomes for individuals and the broader community. People who go to prison are a vulnerable population and are disproportionally affected by adverse health conditions, such as mental illness and communicable diseases. Despite the disproportionately high health needs of people in prison, the level of access to healthcare they receive is not of an equivalent standard to that provided in the community. This is largely due to inadequate funding and staffing within prisons.

Medicare is an under-utilised existing mechanism that could serve to improve access to healthcare services in prison. Medicare inclusion for prisoners could have several benefits including improvements in treatment options, reductions in deaths in custody, improved continuity of care, improved culturally safe healthcare options for Aboriginal and Torres Strait Islander people, and reduced recidivism. All of this may be achieved while also reducing overall net costs to the taxpayer, at least in the medium to long-term.

This Report has proposed several policy reform options in this area which could be trialled to generate much-needed evidence. These proposed reform options, formulated through consultations with various academics, government departments, and medical practitioners, are a full Medicare inclusion model, a partial Medicare inclusion model, Medicare-funded ACCHO in-reach programs,[210] and access to Medicare-funded community telehealth services. These different policy options have been presented as a sliding scale of reform to emphasise that they are not mutually exclusive and may instead be progressively implemented. Each stage of implementation could provide valuable data and evidence to inform future reform.

Additionally, a robust cost-benefit analysis of Medicare inclusion in prisons would provide crucial data and evidence to policymakers and, if publicly released, the general

[210] Noting that more consultation would be required before progressing this proposal.

public. Such analysis would greatly enhance the ability of decision-makers to properly assessthe potential feasibility and impacts of Medicare inclusion.

This Report acknowledges that Medicare inclusion is not a panacea, despite its potential to deliver significant benefits for people in prison and the community at large. Nonetheless, it is one available mechanism to address the current significant issues faced by people in WA's criminal justice system. Policymakers have a unique opportunity to drive change in this space at a time when improvements are desperately needed. Achieving meaningful change is vital not only for those directly involved in the criminal justice system, but also for the betterment of our society.

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