A CRUEL AND UNUSUAL PUNISHMENT: AN OVERVIEW OF PRIVATE HEALTHCARE IN U.S. JAILS AND PRISONS

BY: MAKAYLA MARAGANIS*

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* Makayla Maraganis graduated from Willamette University College of Law in May of 2022. She received a bachelor's degree in Criminology and Criminal Justice from Northern Arizona University in December of 2018 and has focused most of her academic and professional career studying and working in the criminal justice system.

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I. INTRODUCTION

This article discusses private healthcare in correctional facilities in three sections. The first section explores the problem of private healthcare in jails and prisons which includes: the affect of the rise of the prison population on healthcare in correctional facilities, the scholarly work in the area and how this paper adds to the conversation, how privatized healthcare creates and exacerbates the issues of healthcare in jails and prisons, the private companies who provide healthcare in jails and prisons, COVID-19's exacerbation of the problem; the constitutional and human rights issues.

The second section discusses the solutions to the substandard healthcare provided by private companies in jails in prisons. These solutions include reducing prison overcrowding through both long-term and short-term practices, changing the punitive damages model to better deter private healthcare providers, increasing state and federal legislation and regulation in correctional healthcare, and finally, a discussion of the importance of implementing all three of these methods to create the best chance at major change of healthcare in jails and prisons.

The third section is a conclusion of the problems and path to reform.

II: THE PROBLEM

A. The Rise of Mass Incarceration and its Effect on Healthcare in Prisons and Jails.

The Thirteenth Amendment of the United States Constitution may have outlawed private forms of slavery, but the United States continues to devise new ways to uphold the racist and classist hierarchies on which slavery and this country were founded.[1] One of the most common ways the government upholds the history of slavery is through mass incarceration. The Thirteenth Amendment reads: "Neither slavery nor involuntary servitude, *except as a punishment for crime*

[1] Kica Matos & Jamila Hodge, *The Chains of Slavery Still Exist in Mass Incarceration*, VERA INSTITUTE OF JUSTICE (June 17, 2021), https://www.vera.org/blog/the-chains-of-slavery-still-exist-in-mass-incarceration.

whereof the party shall have been duly convicted, shall exist within the United States."[2]

As of 2020, there are roughly 2.12 million people incarcerated in the United States, at a rate of 639 prisoners per 100,000 of the national population.[3] Not only does the United States have the largest prison population in the world, but it also has the highest incarceration rate in the world.[4] How did this happen?

The United States prison population began to grow in the 1970s.[5] President Richard Nixon started this rhetoric with a tough on crime policy and the War on Drugs.[6] He drastically increased the size and presence of federal drug control agents and pushed through measures such as no-knock warrants and mandatory sentencing laws.[7] During Ronald Reagan's presidency, the prison population exploded,[8] largely due to his expansion of the drug war.[9] When Reagan started his presidency in 1980, the total prison population was 329,000 and when he left office after two terms, the prison population was 627,000.[10] The number of people incarcerated for nonviolent drug offenses increased from 50,000 in 1980 to 400,000 in 1997.[11] Incarceration grew at both state and federal levels and was spurred in part by laws such as the 1994 Crime Bill.[12] Other factors that led to the mass incarceration problem include: (1) unreasonably high bail, (2) three-strikes laws, (3) "truth" in sentencing laws, (4) harsh punishment for non-violent crimes resulting in increased plea bargaining, (5) strict parole and

probation rules, (6) lack of mental health services, (7) longer sentences and more life sentences, and (8) private prisons and profit motive.[13]

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[2] U.S. CONST. amend. XIII, § 1. (emphasis added).
[3] *Incarceration Rates in Selected Countries*, STATISTA (June 2, 2021), https://www.statista.com/statistics/262962/countries-with-the-most-prisoners-per-100-000-inhabitants/.
[4] *Id.*
[5] James Cullen, *The History of Mass Incarceration*, BRENNAN CENTER FOR JUSTICE (July 20, 2018), https://www.brennancenter.org/our-work/analysis-opinion/history-mass-incarceration.
[6] *Id.*
[7] *A History of the Drug War*, DRUG POLICY ALLIANCE, https://drugpolicy.org/issues/brief-history-drug-war.
[8] Cullen, *supra* note 5.
[9] *A History of the Drug War*, *supra* note 7.
[10] Cullen, *supra* note 5.
[11] *A History of the Drug War*, *supra* note 7.
[12] Cullen, *supra* note 5.
[13] *Mass Incarceration and Mass Punishment*, FAIR FIGHT INITIATIVE, https://www.fairfightinitiative.org/the-history-causes-and-facts-on-mass-incarceration/.

The growth of the prison population put pressure on healthcare providers.[14] States spend around eight billion dollars annually on prison healthcare.[15] In an effort to cut costs, more prisons are outsourcing healthcare to for-profit companies.[16] While private healthcare providers aim to reduce costs and argue that prisoners are receiving adequate healthcare,[17] opponents claim that the industry takes advantage of the public's dislike toward inmates to provide subpar care, all while making a profit.[18] According to a Reuters data analysis, "[H]ealthcare overseen by private companies incur higher death rates on average than those with care handled by government agencies."[19] In addition to higher death rates, very few state and federal inmates with persistent medical problems have received medical examinations since incarceration.[20] Furthermore, inmates in both jail and prison are more likely to have chronic conditions and infectious diseases than persons in the general population.[21]

B. The Literature on Private Healthcare in Prisons.

There is a vast amount of literature that grapples with the issue of correctional healthcare. This section will examine four scholarly works that address topics analogous to the topics discussed in this paper, while also discussing how this paper adds to the conversation around prison healthcare.

In his discussion of health care in prisons, Holger Sonntag focuses on state regulation and litigation of healthcare in prisons.[22] In his

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[14] Alexandra Casendino, *Convicts without Care: How the Privatization of Healthcare in the U.S. Prison System Fails to Protect Inmates' Health*, BERKELEY POLITICAL REVIEW (Jan. 28, 2017), https://bpr.berkeley.edu/2017/01/28/convicts-without-care-how-the-privatization-of-healthcare-in-the-u-s-prison-system-fails-to-protect-inmates-health/.
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *See* Richard Siever, *HMO's Behind Bars: Constitutional Implications of Managed Health Care in the Prison Systems*, 58 VAND. L. REV., 1365, 1378-79 (2005); *See also* Doug Jones, *A Cruel and Unusual System: The Inherent Problems of The Practice of Outsourcing Health Care of Prisons and Jails*, 27 UCLA Chicana/o-Latina/o L. Rev., 179, 182 (2008).
[19] Jason Szep et al., *U.S. Jails are Outsourcing Medical Care — And the Death Toll is Rising*, REUTERS (Oct. 26, 2020), https://www.reuters.com/investigates/special-report/usa-jails-privatization/.
[20] Andre Wipler et al., *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. OF PUB. HEALTH 666, 669 (2009).
[21] Laura Maruschak et al., *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12*, BUREAU OF JUST. STAT. 1 (Feb. 2015).
[22] Holger Sontag, *Medicine Behind Bars: Regulating and Litigating Prison Healthcare Under State Law Forty Years After Estelle v. Gamble*, 68 CASE W. RSRV 603 (2017).

solutions section, he discusses state prison litigation reform in the context of access to courts.[23] He also talks about removing financial incentives of MCOs at a state level.[24] This paper also briefly discusses litigation reform in the solution section. However, it focuses on reforming the punitive damages system to punish healthcare providers in a way that disincentivizes these companies from their cost-cutting model by making it unprofitable. Both Sonntag's article and this paper examine European healthcare. While Sonntag focuses on the high cost of these healthcare systems and how other social programs are used in addition to healthcare programs in European countries,[25] this paper focuses on using a rehabilitative model in Norway's prisons to reduce recidivism in the U.S.

In her article, Laura Appleman generally discusses privatization in jails and prisons, while also discussing private healthcare in correctional facilities.[26] In her discussion on privatized healthcare in prison, Appleman talks about the poor quality of care and how there is a lack of transparency and accountability on the part of the healthcare providers.[27] Appleman examines the role of community in gaining legitimacy.[28] Specifically, Appleman talks how privatized corrections can obtain more legitimacy in the eyes of the public by including more community involvement in its regulation.[29] This paper also discusses legitimacy and community involvement in prison regulation, but in a different context. First, to create more effective investments in public safety to reduce violent crime rates and ultimately reduce the prison population, creating legitimacy of the police in the eyes of the public is a necessary step. Furthermore, this paper talks about community-based interventions to reduce violent crime rates and community member involvement in the regulation and oversight of private healthcare in prisons. While both Appleman's article and this paper discuss community oversight panels for prisons, this paper focuses on community involvement in a federally-created panel.

Brittany Bondurant's article on private healthcare in prisons focuses on the effect of privatization on prisoner's rights under the Eighth Amendment, discusses the privately contracted companies who

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[23] *Id*. at 646.
[24] *Id*. at 647.
[25] Sontag, *supra* note 22 at 648.
[26] Laura Appleman, *Cashing in on Convicts: Privatization, Punishment, and the People*, 2018 UTAH L. REV. 579 (2018).
[27] *Id*. at 597.
[28] *Id*. at 629.
[29] *Id*.

provide healthcare in prisons, and proposes improvements in court oversight.[30] In her solutions, to achieve healthcare in prisons that meets the constitutional standard, Bondurant proposes heavy state and federal regulations through detailed contracts and state constitutions and through the court system by addressing the constitutional issue on a case-by-case basis.[31] This paper also discusses creating more state and federal regulations, but it focuses on changing state punitive damages models to abolish private healthcare in the long-run and incentivize states to switch to publicly operated healthcare systems in prisons in the short-term. This paper also proposes a federal oversight panel.

In an article that explores both private and public healthcare in prisons, Micaela Gelman discusses why privatized healthcare fails, barriers to improving correctional healthcare, and the pros and cons of publicly run healthcare.[32] In her solutions, Gelman's main point is that governments should look to alternatives to private companies such as using "public-driven" models as an important first step in providing quality care in prisons.[33] This paper also discusses adopting a publicly run model in correctional facilities, but notes that this step cannot be the first step in moving away from private healthcare in prisons. The first step toward abolition must be to incentivize states to move toward public health care and later completely abolish private healthcare in prisons once states have established public health models.

C. Privatized Healthcare in Prisons and Jails: Providing Substandard Care Which Creates and Exacerbates Problems

1. Mental Illness and Addiction.

Mental illness in jails and prisons is a prevalent issue exacerbated by the presence of private healthcare companies in correctional facilities. The prevalence of mental illness in United States jails and prisons is now so high that they are commonly called "the new asylums."[34] As of 2016, 14.5% of men and 31% of women in jails have

[30] Brittany Bondurant, *The Privatization of Prisons and Prisoner Healthcare: Addressing the Extent of Prisoners' Right to Healthcare*, 39 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 407, 408 (2013).

[31] *Id*. at 426.

[32] Micaela Gelman, *Mismanaged Care: Exploring the Costs and Benefits of Private vs. Public Healthcare in Correctional Facilities*, 95 N.Y.U. L. REV. 1386, 1386-87 (2020).

[33] *Id*. at 1434.

[34] *Serious Mental Illness (SMI) Prevalence in Jails and Prisons*, TREATMENT ADVOCACY CENTER (Sep. 2016), https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf.

serious mental health issues compared to 3.2% of men and 4.9% of women in the general population.[35] 20% of the inmates in jails and 15% of the inmates in prison are projected to have a serious mental illness.[36] Mental illness and addiction are closely connected with incarcerated individuals. In a study by the Department of Justice, among those with mental health problems, there were high rates of substance abuse disorders (76% of jail inmates, 74% of state prison inmates, and 64% of federal prison inmates).[37]

While there is data to show that incarcerated individuals tend to have greater access to psychiatric care than they did before incarceration, the conditions in jails and prisons and the care provided to incarcerated people with mental health issues exacerbates the problem.[38]

For example, In May 2018, in Canton, Mississippi, Harvey Hill was arrested for trespass after experiencing a mental health episode.[39] This arrest turned into a death sentence.[40] While in jail, his mental state worsened, and in a fit of rage he struck a guard with a lunch tray.[41] Three guards then tackled Mr. Hill, pepper-sprayed him, kicked him repeatedly in the head, and after handcuffing him, slammed him into a concrete wall.[42] After the guards led Mr. Hill away, they took him to a shower where they continued beating him.[43] He was then brought to the infirmary where he was assessed by a nurse and sent to an isolation cell where a guard left him on the concrete floor.[44] No one checked on Mr. Hill for forty-six minutes but when they did, he did not have a pulse.[45] He was dead within hours.[46] Even though Mississippi law dictates that a doctor or higher credentialed nurse needs to be the one to make medical interventions, this was ignored by the jail staff.[47]

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[35] *The Human Toll of Jail*, VERA INSTITUTE OF JUSTICE (Feb. 2016), https://storage.googleapis.com/vera-web-assets/downloads/Publications/human-toll-of-jail-fact-sheet/legacy_downloads/human-toll-of-jail-factsheet.pdf.
[36] *Id*.
[37] Doris James & Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. DEPARTMENT OF JUSTICE: BUREAU OF JUSTICE STATISTICS (Dec. 14, 2006), https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf.
[38] Wipler et al., *supra* note 20 at 666, 669.
[39] Peter Eisler et al., *Dying Inside: The Hidden Crisis in American Jails*, REUTERS (Oct. 16, 2020), https://www.reuters.com/investigates/special-report/usa-jails-deaths/.
[40] *Id*.
[41] *Id*.
[42] *Id*.
[43] *Id*.
[44] *Id*.
[45] *Id*.
[46] *Id*.
[47] *Id*.

In *Braggs v. Dunn*, the court found that the Alabama Department of Correction's quality of mental-health care was "horrendously inadequate."[48] The court further found that "persistent and severe shortages of mental-health staff and correctional staff, combined with chronic and significant overcrowding," exacerbate the listed factors that contributed to inadequate mental-health care.[49]

In *Gray v. County of Riverside*, plaintiffs who were current and former inmates of the Riverside jails, filed a class action suit based on the Eighth Amendment for the "systematic inadequacies" in the medical and mental health care provided by the county.[50]

2. Chronic Conditions.

Jail and prison inmates have chronic conditions that go untreated, ignored, or receive subpar care. Incarcerated and formerly incarcerated individuals are at an elevated risk for chronic health conditions such as infectious diseases, cardiovascular disease, weight gain, hypertension, and cancer.[51] 89% of deaths in state prisons are due to chronic health conditions.[52] In 2014, a study was conducted on the perspective of prisoners with chronic health conditions.[53] One of the main themes was the lack of compassionate care demonstrated toward the chronically ill and dying prisoners.[54] Another study conducted by the Clumbia Mailman School of Public Health found that increases in county jail incarceration rates in over 1,000 counties in the U.S. between 1987-2017 were correlated to increased deaths from chronic conditions such as emphysema and chronic obstructive pulmonary disease.[55] To show how private healthcare companies exacerbate the problem, examples will be provided.

Walter Jordan was housed in the Arizona Department of Corrections (ADOC) in 2017 when he died due to subpar medical

[48] Braggs v. Dunn, 257 F Supp 3d 1171, 1267 (MD Ala 2017).
[49] *Id*. at 1268.
[50] Gray v. Cnty. of Riverside, No. EDCV 13-00444-VAP, 2014 WL 5304915, at *3 (CD Cal. Sep. 2, 2014).
[51] Michael Massoglia & Brianna Remster, *Linkages Vetween Incarceration and Health*, 134 PUB. HEALTH REP. 8S, 9S (2019).
[52] Susan Loeb et al., *Who Wants to Die in Here? Perspectives of Prisoners with Chronic Conditions*, 16 J. OF HOSPICE AND PALLIATIVE NURSING 173, 173 (2014).
[53] *Id*.
[54] *Id*. at 178.
[55] Sandhya Kajeepeta et at., *Association Between County Jail Incarceration and Cause-Specific County Mortality in the US, 1987-2017: A Retrospective, Longitudinal Study*, 6 LANCET PUB. HEALTH e240, e240 (2021) http://doi.org/10.1016/S2468-2667(20)30283-8.

care.[56] Mr. Jordan died of an invasive squamous skin cell cancer that ate through his skull and ultimately invaded his brain.[57] "According to Dr. Todd Wilcox, a physician who reviewed Jordan's case, the sixty-seven-year-old might have survived if he had received competent treatment by the [ADOC] and its private, for-profit health care contractor, Corizon Health."[58] Nine days before Mr. Jordan died, he wrote a handwritten message to the Federal Court in Phoenix notifying it of his impending death.[59] In the letter, he said that "ADOC and Corizon delayed treating [his] cancer…."[60]

In 2010, Don Lippert sent a handwritten complaint to an Illinois court alleging that he was being denied his twice-daily insulin dose.[61] The court found there was significant lack of care that resulted in the deaths of several inmates.[62]

3. COVID-19

A modern-day discussion on health care in any form, but especially in the correctional health care context, cannot gloss over the impact of COVID-19. COVID-19 hit jails and prisons hard. As of April 16, 2021, more than 661,000 incarcerated persons and correctional staff were infected with COVID-19 and at least 2,990 people have died.[63] Incarcerated people are five times more likely to be infected by COVID-19 than the general population and the reported death rate of inmates is also higher than that of the general population (thirty-nine per 100,000 inmates versus twenty-nine per 100,000 people in the general population.)[64] COVID-19 has exposed the major problems of

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[56] David Fathi, *How Poor Health Care Turned Walter Jordan's Prison Sentence into a Death Sentence*, ACLU (Jan. 11, 2018), https://www.aclu.org/blog/prisoners-rights/medical-and-mental-health-care/how-poor-health-care-turned-walter-jordans.
[57] Fathi, *supra* note 5.
[58] *Id*.
[59] *Id*.
[60] *Id*.
[61] Dylan Walsh, *Does Bad Health Care Constitute Cruel and Unusual Punishment?*, THE ATLANTIC (June 17, 2017), https://www.theatlantic.com/politics/archive/2017/06/illinois-prisons-health-care/530400/.
[62] *Id*.
[63] *Covid-19's Impact on People in Prison*, EQUAL JUSTICE INITIATIVE, https://eji.org/news/covid-19s-impact-on-people-in-prison/, (Apr. 16, 2021). [It is noted that the number of infections and deaths as of April is probably higher because jails and prisons are conducting limited tests on incarcerated people and many facilities will not test people who die after showing symptoms of COVID-19].
[64] *Id*.

healthcare in correctional facilities that need to be addressed (overcrowding, vulnerable populations, violence and abuse, etc.).[65]

a. COVID-19-Related Lawsuits

Many lawsuits have followed the disastrous effects of COVID-19 in prisons. In April of 2020, the Oregon Justice Resource Center (OJRC) filed a class action lawsuit to order the Oregon Department of Corrections to protect adults in custody from COVID-19 (*Maney v. Brown*).[66] The federal court denied this request.[67] In January of 2021, OJRC asked the court to offer the highest priority COVID -19 vaccines to adults in custody.[68] This motion was granted.[69] The case is currently awaiting class certification.[70]

In April of 2020, several civil rights groups filed a class action suit accusing Arkansas of not taking adequate steps to prevent the spread of coronavirus in its prisons after 38% of all COVID-19 cases in Arkansas were reported in prisons.[71] The lawsuit further claimed lack of sanitizer and cleaning products and sought the release of inmates who were at a high risk of contracting COVID-19.[72]

The ACLU filed a class action suit in April of 2020 calling for the release of inmates in Connecticut correctional facilities who were at the highest risk for severe illness or death from COVID-19.[73]

In February of 2021, a class action lawsuit was filed in Maryland alleging that there was an uncontrolled outbreak of COVID-19 at the Chesapeake Detention Facility.[74] Among the many reasons for the

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[65] *Covid-19's Impact on People in Prison*, *supra* note 63.
[66] *Covid-19 Class Action Lawsuit*, OREGON JUSTICE RESOURCE CENTER (Nov. 2021), https://ojrc.info/covid-19-lawsuit; *See also* Plaintiffs' Motion to Certify Damages and Wrongful Death Classes and Alternative Motion to Certify Issue Class, Maney v. Brown, No. 6:20-cv-00570-SB (D. Or. *filed* Apr. 2020). (Correctional Health Partners is the private company who provides healthcare in Oregon Prisons, but was not a party to the suit).
[67] *Covid-19 Class Action Lawsuit*, *supra* note 66.
[68] *Id*.
[69] *Id*.
[70] *Id*.
[71] *See* Carolyn Casey, *Dozens of Prisons Now Face COVID-19-Related Civil Rights Lawsuits*, EXPERT INSTITUTE (Aug. 9, 2021), https://www.expertinstitute.com/resources/insights/dozens-of-prisons-now-face-covid-19-related-civil-rights-lawsuits/ (Aug. 9, 2021); *see also* Andrew DeMillo, *Lawsuit Filed Over Coronavirus Outbreak at Arkansas Prison*, ASSOCIATED PRESS NEWS (Apr. 21, 2021), https://apnews.com/article/a4c42840e6e742ae72011a8684cc4798.
[72] DeMillo, *supra* note 71.
[73] Casey, *supra* note 71.
[74] David Reutter, *Class Action Lawsuit Over COVID at Chesapeake, MD Jail Reaches Settlement*, PRISON LEGAL NEWS (June 1, 2021),

outbreak were overcrowding (it is a facility designed for 192 single-person cells that are used as two-person cells) and lack of implementation of CDC COVID-19 protocols (it failed to implement the use of face masks, social distancing, or sufficient cleaning supplies).[75] A settlement was reached in June of 2021 which included implementing CDC COVID-19 protocols and other protocols designed to protect the inmates.[76]

There are countless lawsuits popping up nationwide in response to the detrimental effect of COVID-19 in jails in prisons. These suits mirror the other themes in private correctional healthcare as discussed previously (overcrowding, ignoring medical needs of prisoners, and failure to implement protocols that meet a standard of care).

b. Criminal Justice Responses or the Lack Thereof to COVID-19.

While the beginning of the pandemic exposed another fold of the gross inadequacies that inmates are subjected to when it comes to healthcare in correctional facilities, there have been some significant policy changes. While on a nationwide scale lawmakers failed to reduce jail and prison populations enough to stop the spread of COVID-19, some individual state and local policies recognized the urgency of the situation.[77]

Since the pandemic started, there have been moderate drops in prison populations which was a result of a decrease in admissions not an increase in releases.[78] As of December 2020, state prisons were still at a 90% capacity or higher.[79] However, state officials in many states have taken steps to reduce their prison populations during the pandemic.[80] Some examples include: (1) the New Jersey Legislature passed a bill allowing "people with less than a year left on their sentence to be released up to eight months early"; (2) in response to "an NAACP lawsuit challenging prison conditions in North Carolina during [the] COVID-19 [pandemic]," the North Carolina governor committed to release 3,500 people in state custody; (3) Oklahoma's

https://www.prisonlegalnews.org/news/2021/jun/1/class-action-lawsuit-over-covid-chesapeake-md-jail-reaches-settlement/.

[75] *Id.*

[76] *Id.*

[77] *The Most Significant Criminal Justice Policy Changes from the Covid-19 Pandemic*, PRISON POLICY INITIATIVE (Nov. 4, 2021), https://www.prisonpolicy.org/virus/virusresponse.html.

[78] *Id.*

[79] *Id.*

[80] *Id.*

governor "commuted the sentences of over 450 people;" (4) Oregon's governor began releasing some people who were medically vulnerable, not serving a sentence for a violent crime, and had served at least 50% of their sentence, and (5) in Illinois, the governor eased the restrictions on early releases of prisoners for good behavior.[81] There were also policy changes in many states' correctional departments and various court orders aimed at reducing correctional facility populations.[82]

Vaccine availability and uptake is another issue face in correctional facilitates. Even with the extreme number of cases and high death rates, only ten states ranked incarcerated people in phase one of vaccine distribution.[83] Eight states did not list inmates in vaccine phases at all.[84] According to the Prison Policy Initiative, as of May 2021 only 50% of people in prisons had received at least one dose of the COVID-19 vaccine, and as of July of 2021, "fifteen states still vaccinated less than 60% of their inmates."

Inmates in most states are expected to pay copays for medical care, which are drastically more expensive than the hourly wage they make.[85] This discourages medical treatment and exacerbates the COVID-19 pandemic in prisons.[86] Five states that normally require copays have suspended all copays for incarcerated people in response to the COVID-19 pandemic.[87] Fifteen states that typically require copays have suspended all copays for respiratory, flu-related, or COVID-19 symptoms.[88] Nevada is the only state that has not made any changes in their copay policies during the pandemic.[89]

While overall, the national response in jails and prisons has done very little to combat COVID-19 as it has been ravaging correctional facilities, some states have made minor changes and others have made major changes in policy to reduce the spread of and deaths from COVID-19.

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[81] *Id*.
[82] *Id*.
[83] *Id*.
[84] *The Most Significant Criminal Justice Policy Changes from the Covid-19 Pandemic*, *supra* note 77.
[85] *Id*.
[86] *Id*.
[87] *Id*.
[88] *Id*.
[89] *Id*.

4. Ignoring Inmates' Cries for Help: Avoidable Injuries and Deaths.

Not only does the private healthcare industry exacerbate mental-health, chronic health, and COVID-19-related issues, inmates' complaints and cries for medical care are often ignored. Several examples will be provided to highlight the avoidable injuries and deaths caused by ignoring the needs of inmates.

In 2005, after an injury to his back, Francis Brauner was left mostly unattended in a bed at Angola Prison, where he developed sores that became so infected that they almost killed him.[90]

In 2013, Rashod McNulty was accused by a nurse in a New York Jail of faking chest pain.[91] He went into cardiac arrest and died hours later in what a state report concluded was a potentially preventable death.[92]

In 2016, Henry Stewart was housed in a jail in Virginia.[93] He complained of blackouts, abdominal pain, and the inability to keep food down.[94] After seeking medical assistance for almost a month, he died from a perforated ulcer.[95]

In April of 2017, Denny Lovern was housed a Colorado jail.[96] When admitted, he made the staff aware of his serious heart condition and the medication he was taking to prevent heart attacks.[97] During his first few days he was not given his medication because it was out of stock.[98] He then started complaining of acid reflux and asked to speak with a doctor.[99] This request was ignored.[100] The next day he asked to see a doctor once again for chest pain.[101] Instead of calling a doctor, the nurse gave him an antacid and admitted him into the medical ward for the night.[102] The next day he was finally given his first dose of heart

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[90] Amanda Aronczyk & Katie Quandt, *Angola Prison Lawsuit Poses Question: What Kind Of Medical Care Do Inmates Deserve*, NPR (Mar. 10, 2018), https://www.npr.org/sections/health-shots/2018/03/10/591624904/angola-prison-lawsuit-poses-question-what-kind-of-medical-care-do-inmates-deserv.
[91] Blake Ellis & Melanie Hicken, *CNN Investigation Exposes Preventable Deaths and Dangerous Care That Government Agencies Have Failed to Stop*, CNN (June 25, 2019), https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs/.
[92] *Id.*
[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] Ellis & Hicken, *supra* note 91.

medication, but still a doctor did not come to see him.[103] The next day, about five days after being admitted to the jail, he was found dead in a pool of his own blood and vomit, which is also how another inmate died at the same jail in 2014.[104]

In 2017, Marques Davis was housed in the Hutchinson Correctional Facility in Kansas.[105] He complained for months to Corizon staff about numbness and weakness in his legs but was ignored.[106] He then told Corizon staff that it felt like something was eating his brain, but the staff believed he was faking his illness.[107] A fungal growth progressed in his brain causing blurry vision, slurred speech, and extreme impairments in his cognitive function.[108] In April of 2017, Mr. Davis suffered a heart attack and was brought to a hospital.[109] The next day he was declared brain dead.[110]

In January of 2020, Jennifer McLaren was arrested for a probation violation in Oregon.[111] She complained of rib pain shortly after being booked and eventually asked to be taken to a hospital, but she never was.[112] She was found unconscious in her jail cell and eventually died at the jail.[113]

Companies who provide healthcare in prisons use an HMO model with an emphasis on cutting costs, and prisoners have no other options to maintain medical treatment except through the company the jail or prison they are housed in has contracted with.[114] The examples provided are just a few of the many that demonstrate the inadequacy of

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[103] *Id*.
[104] *Id*.
[105] Matthew Clarke, *Neither Fines Nor Lawsuits Deter Corizon From Delivering Substandard Health Care*, PRISON LEGAL NEWS (Mar. 3 2020), https://www.prisonlegalnews.org/news/2020/mar/3/neither-fines-nor-lawsuits-deter-corizon-delivering-substandard-health-care/.
[106] *Id*.
[107] *Id*.
[108] *Id*.
[109] Clarke, *supra* note 105.
[110] *Id*.
[111] Maxine Bernstein, *Subpar Medical Care, Lack of Suicide Precautions Led to Many of the 10 Deaths in Oregon Jails in 2020, Report Finds*, THE OREGONIAN (Feb. 8, 2021), https://www.oregonlive.com/crime/2021/02/subpar-medical-care-lack-of-suicide-precautions-led-to-many-of-the-10-deaths-in-or-jails-in-2020-report-finds.html.
[112] *Id*.
[113] *Id*.
[114] Greg Dober, *Corizon Needs a Checkup: Problems with Privatized Correctional Healthcare*, PRISON LEGAL NEWS (Mar. 15, 2014), https://www.prisonlegalnews.org/news/2014/mar/15/corizon-needs-a-checkup-problems-with-privatized-correctional-healthcare/.

and subpar medical care provided by outsourced privatized healthcare companies that have led to the mistreatment and death of inmates.

D. Introducing Managed Healthcare Providers in Jails and Prisons.

Managed care is a healthcare system that is organized to manage costs, utilization, and quality.[115] States contract with MCOs to deliver Medicaid and other health services to inmates at a reduced cost.[116] For-profit MCOs are the most commonly-used MCOs.[117] Most contracts between MCOs and correctional facilities operate on a fixed per-patient or per-incident fee and the MCO assumes the financial risk if the costs exceed the contractual amount.[118] Since inmates do not have a choice in the healthcare they receive, low quality care focused on keeping costs down is usually the result because there is not the traditional consumer demand for quality care.[119]

1. Corizon Health

As of 2018, Corizon was the largest for-profit provider of healthcare in U.S. prisons.[120] It had contracts with 534 correctional facilities in twenty-seven states,[121] meaning that it was the healthcare provider for 15% of the nation's prisoners.[122] Corizon has major inadequate staffing and understaffing issues and continues to provide substandard healthcare even after being sued for malpractice 660 times in five years and being subject to millions of dollars in fines and penalties.[123] Corizon continues to write off liquidated damages and other penalties as a cost of doing business rather than using it as a catalyst to provide adequate healthcare to persons who are incarcerated.[124] Since Corizon is privately held, there is very little

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[115] *Managed Care*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/managed-care/index.html (last visited June 12, 2022).
[116] *Id.*
[117] Ira Robbins, *Managed Health Care in Prisons as a Cruel and Unusual Punishment*, 90 J. OF CRIM. L. & CRIMINOLOGY, 195, 199 (1999).
[118] *Id.*
[119] *See* Farmer v. Brennan, 511 U.S. 825, 832 (1994); *see also* Robbins, *supra* note 199.
[120] Clarke, *supra* note 105.
[121] *Id.*
[122] Clarke, *supra* note 105.
[123] *Id.*
[124] *Id.*

transparency regarding its internal operations and financial information.[125]

2. Wellpath

As of 2019, Wellpath is the largest for-profit provider of healthcare to correctional facilities.[126] It has contracts with more than 500 facilities in thirty-four different states.[127]

[I]nternal documents, emails, medical records, autopsy reports, audits, interviews with more than 50 current and former employees, and scathing correspondence from government clients show that amid a focus on 'cost containment' and massive corporate growth, the company has provided substandard care that has led to deaths and other serious outcomes that could have been avoided.[128]

The major themes of the standard of care provided by Wellpath across the country are: (1) inexperienced workers with minimal training are being staffed in these understaffed facilities, and (2) doctors and nurses are failing to diagnose and monitor chronic diseases and life-threatening conditions.[129] Even though the number of lawsuits against the company continue to grow, and the standard of care declines, the company has only grown larger by maintaining contracts and obtaining new ones.[130]

Why are we – as in we as individuals and we as constituents of our government – okay with companies who are responsible for killing thousands of people continuing to provide healthcare to prisoners across America? Why does our compassion for quality healthcare stop at the prison gates?

E. Constitutional Issues

The Eighth Amendment of the United States Constitution says that "cruel and unusual punishment shall not be inflicted."[131] In *Estelle v. Gamble*, the Supreme Court of the United States articulated the right of prisoners to receive adequate medical treatment.[132] The Court said

[125] Dober, *supra* note 114.
[126] Ellis & Hicken, *supra* note 91.
[127] *Id*.
[128] *Id*.
[129] Ellis & Hicken, *supra* note 91.
[130] *Id*.
[131] U.S. CONST. amend. VIII.
[132] Estelle v. Gamble, 429 U.S. 97 (1976).

that deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment under the Eighth Amendment.[133] This standard applies whether the indifference is manifested by prison doctors in response to a prisoner's needs or by a prison guard who intentionally delays or denies access to medical treatment or intentionally interferes with the treatment once it is prescribed.[134] Negligence by a physician however, is not a valid Eighth Amendment claim.[135]

Although the United States Supreme Court articulated a clear standard of healthcare that it expects prisoners to receive, its holding in *Estelle v. Gamble* continues to be ignored by correctional facilities and their private healthcare providers. This calls into question the effectiveness of the court system to address the inadequacies of healthcare in prisons. The following class actions demonstrate a pattern of behavior by state governments and their outsourced healthcare providers in ignoring constitutional standards that were created in *Estelle v. Gamble*.

In *Braggs v. Dunn*, as previously discussed, the court found violations of the Eighth Amendment due to the Alabama Department of Correction's "horrendously inadequate" mental health care.[136]

In 2009, the Arizona Legislature passed a bill that required Arizona by statute to privatize healthcare in prisons.[137] In July of 2012, the Arizona Department of Corrections (ADOC) awarded a contract to Wexford Health despite its history of failing to provide proper healthcare and receiving fines in other jurisdictions.[138] In August of 2012, 103 people incarcerated in ADOC prisons were exposed to Hepatitis C through a nurse's negligence.[139] In a class action, prisoners sued the director of the ADOC for violation of constitutional healthcare requirements.[140] In October of 2014, the parties settled and ADOC agreed to several changes including 103 specified healthcare measures.[141] In the interim, the contract with Wexford was severed and

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[133] *Id*. at 104.
[134] *Id*. at 104-105.
[135] *Id*. at 106.
[136] Braggs v. Dunn, 257 F.Supp. 3d. 1171, 1267 (M.D. Ala. 2017).
[137] ARIZ. REV. STAT. ANN. § 36-2903 (2009); Molly Rothschild, *Cruel and Unusual Prison Healthcare: A Look into the Arizona Class Action Litigation of Parsons v. Ryan and the Systemic Deficiencies of Private Healthcare Services in Prison*, 61 ARIZ. L. REV., 945, 954 (2019).
[138] Rothschild, *supra* note 137, at 955.
[139] *Id*.
[140] Parsons v. Ryan, 289 F.R.D. 513 (D Ariz. 2013).
[141] Rothschild, *supra* note 137 at 960-61.

awarded to Corizon Health.[142] In October of 2015 a notice of substantial noncompliance was provided to ADOC and in April of 2016, plaintiffs filed a motion to enforce the court's stipulation.[143] In June of 2018, ADOC was held in contempt based on internal monitoring and issues with privatized healthcare.[144] The court was also concerned with the fact that ADOC was financially incentivizing Corizon to comply with court orders on compliance thresholds even though it was already contractually mandated to comply.[145] The Defendants were ordered to pay out over 1.4 million dollars.[146]

In *Gray v. County of Riverside*, a class action lawsuit was filed alleging Eighth Amendment violations in Riverside jails.[147] In November of 2015, the county agreed to settle.[148] The settlement included: (1) "comprehensive reform of the process for providing medical and mental health treatment," and (2) 1.25 million dollars in attorney's fees.[149]

In 2010, a complaint was filed in Illinois by a diabetic inmate at the Stateville Correctional Center claiming that he was being denied his twice daily insulin dose.[150] The case turned into a class action lawsuit alleging, among several things, violations of the Eighth Amendment.[151] In an audit conducted against Wexford Health Services, the provider of healthcare, it found that 60% of inmate deaths from nonviolent causes were due to significant lapses in care.[152]

In 2016, an initial class action settlement took place between a class of incarcerated people, the Florida Department of Corrections (FCOD), and its former medical provider Corizon.[153] The original complaint alleged that the defendants failed to provide hernia surgeries

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[142] *Id*. at 955.
[143] *Id*. at 962.
[144] *Id*.
[145] *Id*. at 963.
[146] *Id*. at 964.
[147] Gray v. Cnty. of Riverside, No. EDCV 13-00444-VAP, 2014 WL 5304915, at *3 (CD Cal. Sep. 2, 2014).
[148] Matthew Clarke, *California County Settles Class-action Lawsuit Over Jail Medical and Mental Health Care*, PRISON LEGAL NEWS (Jan. 10, 2017), https://www.prisonlegalnews.org/news/2017/jan/10/california-county-settles-class-action-lawsuit-over-jail-medical-and-mental-health-care/.
[149] *Id*.
[150] Walsh, *supra* note 48.
[151] Lippert v. Baldwin, No. 10 C 4603, 2017 WL 1545672 (N.D. Ill. Apr. 28, 2017).
[152] Walsh, *supra* note 48.
[153] *Judge Preliminarily Approves Settlement with Fla. Dept. of Corrections and Corizon Over Failure to Provide Hernia Surgeries*, FLORIDA JUSTICE INSTITUTE (Sep. 20, 2016), https://www.floridajusticeinstitute.org/homepage-featured/fji-files-class-action-lawsuit-against-fla-dept-of-corrections-and-corizon-for-not-providing-hernia-surgeries/.

that resulted in thousands of prisoners left in extreme pain with risk of serious complications and unable to engage in normal activities.[154]

For years after the Francis Brauner incident (discussed previously), complaints regarding medical care at the Angola Prison in Louisiana have increased.[155] In 2015, a suit was filed accusing Angola Prison of causing needless pain and suffering.[156]

The repeated instances of Eighth Amendment claims around inmate healthcare standards seems to demonstrate that holding in *Estelle v. Gamble* is continually ignored by correctional facilities that have outsourced private healthcare in the name of cutting costs. This is, in no way, the only area that state governments choose to ignore constitutional rights, however, it seems to get little public attention or outcry because it affects a population of undesirable people.

F. Human Rights Issues

1. History and Background of the United Nation's Rules Regarding the Care of Prisoners.

Standards for healthcare in prisons are not only a constitutional issue, but also a human rights issue. Nelson Mandela once said: "It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones."[157] In 2015, the U.N. General Assembly adopted a revised set of rules for the *minimum standards* for the treatment of prisoners known as the Nelson Mandela Rules.[158] These are the universally accepted minimum standards for the treatment of prisoners.[159] The new version of the rules emphasize that healthcare for prisoners is a State responsibility, that prisoners should enjoy the same level of healthcare that is necessary to the community at large, and that prisoners should have "access to necessary health-care services free of charge without discrimination on the grounds of their legal status."[160] The resolution also includes details on expectations of doctors and medical providers, prompt medical access, and evaluations upon

[154] *Id.*
[155] Aronczyk & Quandt, *supra* note 90.
[156] *See* Lewis v. Cain, 324 F.R.D. 159 (MD La. 2018); *see also* Aronczyk, *supra* note 90.
[157] *Nelson Mandela Rules*, UNITED NATIONS, https://www.un.org/en/events/mandeladay/mandela_rules.shtml.
[158] *Id.* (emphasis added).
[159] *Id.*
[160] G.A. Res. 70/175, U.N. Doc. A/70/490, at 12 (Dec. 17, 2015).

admission.[161] Furthermore, every example of the horrendous treatment of inmates in U.S. jails and prisons and every example of class actions due to the dreadful treatment of inmates that was previously provided, violates the basic human rights of prisoners laid out in the Nelson Mandela Rules.[162] Not only is the subpar level of healthcare provided to prisoners in the United States a constitutional issue, but it is also very clearly a human rights issue.

2. Delineating the Prison Healthcare System in the United States as a Human Rights Crisis: Whether this will be effective in spurring change?

In short, probably not. The United Nations Human Rights Council is responsible for both the protection and promotion of human rights as well as addressing situations on human rights issues and violations.[163] In 2018 the U.S. left the United Nation's Human Rights Council,[164] but was elected back to the Council in October of 2021.[165] The U.S., especially in recent years, has received criticism for its human rights record.[166] Despite the vast amount of human rights issues that the

[161] G.A. Res. 70/175, *supra* at 12-15.
[162] G.A. Res. 70/175, *supra* at 12. [Rule 24(1) of the Nelson Mandela Rules says, in relevant part, that, "[p]risoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services…"; Rule 24(2) of the Nelson Mandela Rules state that "[h]ealth-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care; Rule 25 of the Nelson Mandela rules reads: "[h]ealth-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence and shall encompass sufficient *expertise in psychology and psychiatry*." (emphasis added); and Rule 27 of the Nelson Mandela Rules states "[a]ll prisons shall ensure prompt access to medical attention in urgent cases."]
[163] United Nations Human Rights Council, https://www.ohchr.org/en/hrbodies/hrc/pages/aboutcouncil.aspx.
[164] Colin Dwyer, *U.S. Announces Its Withdrawal From U.N. Human Rights Council*, NPR (June 19, 2018).
[165] Carlie Porterfield, *U.S. To Rejoin U.N. Human Rights Council After Trump-Era Exit*, FORBES (Oct. 14, 2021), https://www.forbes.com/sites/carlieporterfield/2021/10/14/us-to-rejoin-un-human-rights-council-after-trump-era-exit/?sh=6023a68e1f32.
[166] This is evidenced by the Human Rights Watch 2020 World Report on high incarceration rates, unfairness in the criminal legal system, racial disparities in prison populations, the existence of the death penalty, the bail system, the treatment of children in the criminal and juvenile justice system, poverty and inequality, rights of non-citizens, environmental rights, gender rights, sexual orientation and gender identity, surveillance and data protection, freedom of expression, national security, and foreign policy. *See United States Events 2019*, Human Rights Watch: World Report 2020, https://www.hrw.org/world-report/2020/country-chapters/united-states. Much of the international criticism is directed toward systemic racism [*See* Marina Riera, *UN Condemns Systemic Racism, Police Violence: Unanimous Resolution Brings Scrutiny to Global Violations*, HUMAN RIGHTS WATCH (July 20, 2020),

United States is under scrutiny for in the international community, including treatment of prisoners, and despite the fact among the U.S. population, 91% of Americans support criminal justice reform, 71% think it is important to reduce prison populations, and 71% of Americans believe that incarceration is counterproductive for public safety,[167] recent attempts at reform to combat human rights issues have been ineffective.[168] So even if the U.N. added the inhumane private healthcare system in U.S. prisons to its long list of human rights issues to watch out for in the United States, it seems that it may not make a major difference. This is because (1) the U.S. already has a long list of extremely concerning human rights issues to address, and (2) while criminal justice reform measures are cropping up due to more recent attention on the system, they have failed to completely address these human rights issues.

III. PATH TO REFORM

A. Reducing Prison Overcrowding: Expediting the End of Mass Incarceration.

Mass incarceration and prison overcrowding spurred the national movement toward private healthcare systems in U.S. prisons.[169] A major step in fixing the issue of inadequate healthcare in U.S. prisons and jails is to reduce overcrowding. While the U.S. prison population

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https://www.hrw.org/news/2020/07/20/un-condemns-systemic-racism-police-violence-0], weak labor protections [*See* Fergal O'Brien, *U.S. Ranked Worst for Workers' Rights Among Major Economies*, BLOOMBERG (June 18, 2020) https://www.bloomberg.com/news/articles/2020-06-18/u-s-ranked-worst-for-workers-rights-among-major-economies], criminalization of homelessness and poverty [*See* National Law Center on Homelessness & Poverty, *Cruel, Inhuman and Degrading: Homelessness in the United States under International Covenant on Civil and Political Rights* (2013)], police brutality [*See UN Condemns U.S. Police Brutality, Calls For 'Stand Your Ground' Review*, REUTERS (Sep. 1, 2014), https://www.huffpost.com/entry/un-police-brutality-stand-your-ground_n_5740734], police corruption [*See UN Experts Urge US to Address Legacies of the Past, Police Impunity and 'Crisis of Racial Injustice'*, United Nations (Jan. 29, 2016), https://news.un.org/en/story/2016/01/521182-un-experts-urge-us-address-legacies-past-police-impunity-and-crisis-racial], for-profit incarceration, mistreatment of prisoners, abuse of immigrants, for-profit healthcare [*See* Anne Case & Angus Deaton, *Deaths of Despair and the Future of Capitalism* 9 (2020)], and many other things.

[167] *91 Percent of Americans Support Criminal Justice Reform, ACLU Polling Finds*, ACLU (Nov. 16, 2017), https://www.aclu.org/press-releases/91-percent-americans-support-criminal-justice-reform-aclu-polling-finds.

[168] *United States at a Glance*, HRMI Rights Tracker, https://rightstracker.org/en/country/USA?as=HI.

[169] Alexandra Casendino, *supra* note 14.

has declined over the last decade – after having a 700% growth from 1972 to 2009 and since then, a 1% annual decrease – if states and the federal government decrease incarceration at this rate, it is projected that it will take seventy-two years to cut the prison population in half.[170] In order to speed up decarceration and thereby give inmates a better chance at receiving healthcare that meets their needs, policies, both in the long-term and short-term, should aim at sentencing reforms for violent crimes and focus on moving away from a carcel method of incarceration to a rehabilitative method.

1. Intensifying Sentencing Reforms for Violent Crimes.

Between 2007 and 2016, reforms in drug policy helped to reduce the number of people imprisoned for a drug offense by 26%.[171] Between 2007 and 2016, reforms have reduced the number of people imprisoned for property crimes by 14%.[172] The number of people who are incarcerated for violent offenses has only decreased by 2% between 2009 and 2016.[173] Increasing reforms for non-violent crimes is important and seems to be leading the way in decarceration, but increasing reform for violent offenses is crucial in reducing the prison population at a faster rate.

There seems to be a general reluctance for lawmakers to scale back excessive sentences for persons who commit violent crimes. However, this reluctance is at odds with evidence.[174] Policies and laws implemented to reduce the amount of people in prison for violent crime will show results in the short-term. First, long sentences that incapacitate older people are unnecessary because older people pose little threat to public safety.[175] Long sentences also produce little deterrence effect since the number of arrests has not substantially changed due to these sentences.[176] Finally, long sentences “detract from more effective investments in public safety.”[177]

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[170] Nazgol Ghandnoosh, *U.S. Prison Population Trends: Massive Buildup and Modest Decline* 1 (2019).
[171] *Id*. at 3.
[172] *Id*.
[173] *Id*.
[174] Nazgol Ghandnoosh, *supra* note 170 at 3.
[175] *Id*.
[176] *Id*.
[177] *Id*.

a. Older Adults are Less Likely to Reoffend, so we Should Release Them at Higher Rates.

The number of adults over the age of fifty-five in U.S. state prisons grew from 3%-10% of the total prison population between 1993 and 2013.[178] As of December 31, 2019, adults between the ages of fifty-five to fifty-nine made up 6.3% of state and federal prison populations, adults ages sixty to sixty-four made up 3.6%, and adults sixty-five and older made up 3.2% (totaling 13.2% of the prison population in state and federal correctional facilities).[179] The large amount of baby boomer population in prisons exacerbates the prison healthcare issue because they experience chronic illnesses and disabilities at a higher rate than people chronologically much older.[180] Furthermore, the medical needs of aging people generally, who are incarcerated, aggravates the prison healthcare issue.[181]

A vast body of research shows that as an offender's age increases, the chances of committing crime or reoffending reduces substantially.[182] Some reasons and theories for this lower likelihood of reoffending include: (1) health costs associated with crime and deviance, (2) the influence of social bonds interacts with age (e.g. marriage, work, military service), and (3) fear of doing more time in prison becomes more critical with age.[183] Regarding the influence of social bonds, there are specific turning points and major life experiences that as someone ages, act to strengthen their social bonds.[184] This, in turn, makes someone less likely to reoffend.[185]

The ageing population makes up almost 15% of the prison population and need medical care at higher rates than other age groups. This exacerbates the already strained and subpar private healthcare system in U.S. prisons. Since people are less likely to reoffend as they age, sentencing reform policies should aim to reduce the number of adults over the age of fifty-five who are in prison, even if they are incarcerated for violent offenses. This would be a first major step in

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[178] Zachary Psick et al., *Prison Boomers: Policy Implications of Aging Prison Populations*, 13 INT'L J. OF PRISONER HEALTH 57 (2017).
[179] Ann Carson, *Prisoners in 2019*, BUREAU OF JUSTICE STATISTICS 1, 15 (2020).
[180] Psick et al., *supra* note 178.
[181] *Id*.
[182] *See* Psick et al., *supra* note 178; *see also* John Laub & Robert Sampson, *Shared Beginnings, Divergent Lives: Delinquent Boys to Age 70*, 105 (2009).
[183] John Laub & Robert Sampson, *supra* note 182 at 39.
[184] *Id*. at 39-40.
[185] *Id*. at 40.

reducing prison overcrowding and thereby reducing the strain on prison healthcare systems.

b. Deterrence: Moving Away from Harsh Sentences.

Although it is a common belief that long sentences for violent crimes have a deterrent effect, research shows that harsher sentences do not effectively prevent new people from committing violent crimes, nor do harsher sentences prevent recidivism.[186] In the context of specific deterrence, (1) there is data to support that short sentences may act as a deterrent whereas long sentences do not, and (2) prisons may exacerbate recidivism because it can be a place to learn to commit new crimes.[187] In the general deterrence context, research indicates that certainty rather than severity can impact deterrence.[188] Severity is the length of a sentence and certainty refers to the likelihood of being caught and punished for a sentence.[189] Instead of focusing on harsh sentences for those who commit violent crimes, resources would be better used by ensuring effective policing because the fear of being punished does not deter people from committing violent crime, but the certainty of being caught does.[190]

c. More Effective Investments in Public Safety.

Effective policing is not the only effectual public safety measure that reduces violent crime. In May of 2021, the U.S. Department of Justice issued a memorandum for a comprehensive strategy for reducing violent crime.[191] The memorandum focuses on three public safety investments: (1) fostering trust and having legitimacy in the communities they serve, (2) investment in community-based prevention and intervention programs, and (3) setting strategic enforcement priorities.[192]

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[186] Alexi Jones, *Reforms without Results: Why States Should Stop Excluding Violent Offenses from Criminal Justice Reforms*, PRISON POLICY INITIATIVE (Apr. 2020), https://www.prisonpolicy.org/reports/violence.html.
[187] Five Things About Deterrence 2, NATIONAL INSTITUTE OF JUSTICE, (2016).
[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] Memorandum from the Deputy Attorney General on Comprehensive Strategy for Reducing Violent Crime, U.S. Department of Justice, (May 26, 2021).
[192] *Id.*

Despite declining crime rates, tensions between law enforcement and the communities they serve frustrates the cooperative nature needed to improve public safety.[193] In a study done by the National Academy of Sciences, the findings indicate that even one positive contact with a law enforcement officer can improve public attitudes toward police.[194] This improvement in public attitudes toward police includes legitimacy and willingness to cooperate.[195] Furthermore, the study indicates that generally, positive non-enforcement contacts with police increase attitudes toward police and police departments would benefit from implementing strategies that promote positive police-citizen contact.[196]

Research shows that community-based interventions have been successful.[197] For example, the city of Richmond, California established an Office of Neighborhood Safety (ONS) in 2007 to prevent gun violence and strengthen community well-being. Since its implementation, homicide rates have dropped significantly (from forty-five homicides per 100,000 residents to less than ten homicides per 100,000 residents).[198] Systems such as ONS can act as a violence interruption tool by connecting community members with high-risk individuals based on their similar backgrounds and experiences.[199] ONS also uses transformative mentoring where credible mentors provide intensive one-on-one mentoring to high-risk individuals.[200] ONS further provides for job readiness programs and helps to bridge the trust gap between communities and law enforcement and elected leaders.[201] Community-based interventions such as ONS provide solutions to and prevention of violence in communities. Community-based interventions, as seen in Oakland, can create a decrease in crime in a short period of time. Communities, such as Richmond, California, that implement these community-based interventions have success in reducing violence. If more communities invested in ONS or a similar

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[193] Kyle Peyton et al., *A Field Experiment on Community Policing and Police Legitimacy*, 116 PROCEEDINGS ON THE NAT'L ACAD. OF SCIENCES 19894, 19894 (2019).
[194] *Id*.
[195] *Id*.
[196] *Id*.
[197] Betsy Pearl, *Beyond Policing: Investing in Offices of Neighborhood Safety*, THE CENTER FOR AMERICAN PROGRESS (Oct. 15, 2020), https://www.americanprogress.org/article/beyond-policing-investing-offices-neighborhood-safety/.
[198] *See Id.*; *see also 2017 Crime in the United States*, FBI: UNIFORM CRIME REPORT, https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/tables/table-1.
[199] Pearl, *supra* note 197.
[200] *Id*.
[201] *Id*.

system, nationally, the U.S. could see major drops in violent crime rates.

In summary, one step in combatting the mass incarceration issue that leads to deplorable standards of healthcare in prisons is to reduce the harsh sentences for violent crimes. To do this: (1) both at the federal and state level, lawmakers should focus on keeping the elderly population to a minimum in prisons, (2) research-proven methods of deterrence should be implemented (e.g. shorter sentences and effective policing that focuses on certainty rather than sentences that focus on severity), and (3) fostering a positive relationship between police and citizens while implementing community-based programs to prevent violence can act as a solution to violence in some situations. The first two solutions can be implemented in the short-term and will show results more quickly than the third. While implementing community-based programs can also be implemented in the short-term, creating a positive relationship between communities and those who police them, is a goal that will likely take a long time to achieve.

2. Movement Toward Rehabilitative Methods of Punishment and Away from Carceral Methods of Punishment.

The current approach to punishing offenders is clearly not working; it is both costly and has not resulted in a crime-reduced society. So maybe it is time to reevaluate our methods.[202] The U.S. currently has one of the highest recidivism rates in the world: more than 75% of prisoners are rearrested within five years.[203] Rehabilitative methods can be used to reduce recidivism and decrease the number of incarcerated persons in the U.S. The United States used to employ some rehabilitative methods. After an influential report was published by Robert Martinson stating that "nothing works," policy around incarceration began focusing on punishment and incapacitation over rehabilitation.[204] However, research indicates that rehabilitative programs reduce recidivism if they are targeted to the specific

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[202] Gordan Dahl & Magne Mogstad, *The Benefits of Rehabilitative Incarceration*, THE NATIONAL BUREAU OF ECONOMIC RESEARCH (Mar. 2020), https://www.nber.org/reporter/2020number1/benefits-rehabilitative-incarceration#1.
[203] Liz Benecchi, *Recidivism Imprisons America's Progress*, HARVARD POLITICAL REVIEW (Aug. 8, 2021), https://harvardpolitics.com/recidivism-american-progress/.
[204] *See* Benecchi *supra* note 203; *See also* Robert Martinson, *What Works? – Questions and Answers About Prison Reform*, PUBLIC INTEREST (1974).

offenders and use proven methods.[205] Prisoners who participate in educational programs while incarcerated are 43% less likely to be reincarcerated than those who do not.[206] Prisoners who partake in vocational training are 24% less likely to end up back in prison.[207] People who receive drug treatment while incarcerated are less likely to relapse.[208]

Norway's incarceration method is an example of how incarceration based on a rehabilitative method can reduce recidivism.[209] In a study done by the Bureau of Economic Research on Norway's prisons, imprisonment discourages further criminal behavior.[210] Incarceration lowers recidivism rates within five years by 27%.[211] The study also found that crime reduction is driven by those who were not employed before incarceration.[212] Imprisonment causes a 34% increase in participation in job training and within five years, the employment rate rises by 40%.[213] The study concludes that a European-style incarceration system that focuses on rehabilitation with higher costs but shorter sentences would have a major cost saving effect in the U.S.[214] When time spent in prison is focused on rehabilitation, the outcomes for imprisoned individuals are more positive.[215] Creating a rehabilitative-focused incarceration system in the United States that concentrates on the specific offender and is based on research-proven methods would likely reduce recidivism rates. If recidivism rates in the United States are reduced, then the overall prison population would

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[205] Joan Petersilia, *Beyond the Prison Bubble*, NATIONAL INSTITUTE OF JUSTICE (Nov. 2, 2011), https://nij.ojp.gov/topics/articles/beyond-prison-bubble

[206] Benecchi, *supra* note 203.

[207] *Id*. (It is important to note that whether the ex-prisoner is paid a fair and equitable wage is an important factor in recidivism based on vocational training).

[208] Petersilia, *supra* note 205.

[209] Dahl & Magne, *supra* note 202. (The study notes and address that Norway has some key differences when compared to the United States: (1) the average time spend in prison in Norway is six months and the average time spent in prison in the U.S. is three years; (2) Norway places its low level offenders in "open prisons" with more freedoms and responsibilities than low-level offenders in U.S. prisons; (3) there is more separation between minor and hard offenders in Norway's prisons than in U.S. prisons; (4) there is no overcrowding in Norway's prisons which allows for better personal safety; (5) Norway's prisons offer better education, drug-treatment, and vocational training programs than the U.S. does; (6) Norway places an emphasis on reintegration; and (7) characteristics, including demographics, are more similar in Norway.)

[210] *Id*.

[211] *Id*.

[212] *Id*.

[213] *Id*.

[214] Dahl & Magne, *supra* note 202.

[215] *Id*.

decline, and a decline in mass incarceration would help improve medical care in prisons.

B. Adjusting the Punishments of Healthcare Companies When They Provide Inadequate Healthcare to Disincentivize the "Cost-of-Doing-Business" Mindset.

As discussed previously, companies such as Corizon and Well-Path have not been deterred from providing inadequate healthcare in prisons through lawsuits, punitive damages, or court orders. One of the goals of punitive damages is to act as a specific and general deterrent.[216] However, the current punitive damages system is flawed,[217] and it needs to take a different approach to be effective. Many jurisdictions use the defendant's wealth as a benchmark for punitive damages, but research shows that this may not be the best method.[218] For torts that have non-economic motivations (e.g. assault), consideration of a defendant's wealth serves a reasonable purpose because it is "necessary to monetarize the satisfaction derived from the misconduct."[219] However, when a tort has economic motives, they way to achieve optimal deterrence is not by measuring the defendant's wealth, but the economic circumstances of the transaction.[220]

The removal of the prospect of profit, the motive of companies large or small, will have a greater deterrent effect than substantial punitive damage awards based on the company's wealth.[221] "The level of penalty necessary to induce these businesses to stop ignoring [basic standards of healthcare] is the amount that makes it unprofitable to reap whatever benefits attach to" the cost-reducing mindset.[222] In order to make deterrence against private healthcare companies in prisons effective, state legislatures should adjust the calculation of punitive damages. This calculation needs to focus on making cost-reducing

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[216] James Boyd & Daniel Ingberman, *Do Punitive Damages Promote Deterrence*, 19 INT'L REV. OF L. & ECON. 47, 47 (1999).
[217] *Id*.
[218] Andrew Frey, *Corporate Finances: Punitive Damages' 800-Pound Gorilla*, PUNITIVE DAMAGES THEORY (Oct. 14, 2014), https://www.punitivedamagesblog.com/2014/10/corporate-finances-punitive-damages-800-pound-gorilla/.
[219] *Id*.
[220] Frey, *supra* note 218. (These economic circumstances include the loss the victim suffered, the gain the defendant expected to reap, and the penalty necessary "to alter the economic calculus of the defendant and others similarly situated so that such conduct is seen as unprofitable and therefore not repeated.")
[221] Frey, supra note 218.
[222] *Id*.

healthcare practices unprofitable to these companies. More research needs to be conducted to determine what this calculation would look like for private healthcare companies.

C. Increasing Federal and State Legislation and Regulation of Prison Healthcare.

1. Incentivizing States to use a Public Health Approach in Jails and Prisons & Eventually Abolishing Private Healthcare.

Private healthcare in prisons is clearly not working. To move toward a publicly run healthcare system in correctional facilities that focuses on community-based public health, the federal government should implement a two-step process. First, the federal government should create incentives for states to switch to a public health system that is based on a community health model. This will be a short-term goal of federal regulation. In the long-term, after many states have set up working community-based public health models, the federal government should abolish the use of private healthcare in jails and prisons.

Creating a community-based public health model will not only increase the quality of healthcare inmates receive but will also benefit society overall. Around 600,000 inmates are released annually from federal and state prisons.[223] Since the vast majority of inmates are eventually released from prison (over 95%),[224] the subpar care that inmates receive in prison has become a public health issue.[225] The health issues of inmates are much worse than the general population, but are seen as disjointed from the general population.[226] While the health-related issues of incarcerated persons may be seen as a non-pressing issue to persons in the general population, inmates can have a direct impact on healthcare to the general population.

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[223] *See* Nathan James, OFFENDER REENTRY: CORRECTIONAL STATISTICS, REINTEGRATION INTO THE COMMUNITY, AND RECIDIVISM 1 (2015); *see also Reentry Trends in the United States*, BUREAU OF JUSTICE STATISTICS (2012), https://bjs.ojp.gov/topics/recidivism-and-reentry.

[224] James, *supra* note 223, at 1.

[225] Wipler et al., *supra* note 20, at 669.

[226] Alexandria Macmadu & Josiah Rich, *Correctional Health is Community Health*, ISSUES IN SCIENCE AND TECHNOLOGY (2015), https://issues.org/correctional-health-care-community-health-prisons-jails/. (More than half of state prison inmates and 90% of jail detainees suffer from substance use disorders; incarcerated individuals are nine to ten times more likely to have Hepatitis C than the general population; chronic health and mental health conditions affect prisoner populations far more than the general population).

First, a community-based healthcare system would positively impact recidivism rates. Access to healthcare in and out of prison reduces the need to commit crime and prevents recidivism rates that are related to uncontrolled health issues such as substance abuse and mental health issues.[227] For example, after Michigan implanted a program that links newly released prisoners to a medical home that gives them access to medications, primary care, specialty care, and their medical records, there was reduced recidivism.[228]

Second, the link between community-based healthcare and reduced recidivism will likely create savings for states,[229] which was a major factor in outsourcing healthcare in the first place. In 2014, Medicaid criteria was expanded for inmates under the Affordable Care Act (ACA).[230] This further promoted inmate health because it provides a smooth transition of healthcare once released.[231]

There is already a system in place for community health to be implemented into the prison healthcare system regardless of whether the healthcare provider is state-run or an MCO. However, because private healthcare providers in prisons are providing subpar healthcare, the system should be further reformed to first incentivize correctional facilities to terminate or to not renew contracts with MCOs and instead use a public health model and second, eventually require abolition of private healthcare in prisons. The former of the two options is more likely to be implemented in the short-term through cost-saving methods that still provide adequate healthcare, while abolition of the private healthcare system in prisons is a long-term goal.

2. The Creation of a Federal Oversight Prison Healthcare Panel: Tackling the Failings of Courts and Self-Regulation of Correctional Facilities.

The creation of a Federal Oversight Prison Healthcare Panel (hereafter "The Panel") that operates in each state would tackle the issue created by court-based oversight. As previously discussed,

[227] Nan Myers, *Managed Medicaid Braces for Influx of Ex-Inmates*, MANAGED CARE (Nov. 2014), https://www.managedcaremag.com/archives/2014/11/managed-medicaid-braces-influx-ex-inmates.
[228] *Id.*
[229] Sontag, *supra* note 22, at 611.
[230] *How and When Medicaid Covers People Under Correctional Supervision: New Federal Guidelines Clarify and Cevise Long-Standing Policies*, PEW CHARITABLE TRUSTS (Aug. 2, 2016), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision.
[231] *Id.*

countless lawsuits have cropped up over the years claiming Eighth Amendment violations under *Estelle v. Gamble*.[232] Courts have imposed orders and penalties but the problem of substandard healthcare in prisons persists. Furthermore, reports made from inside prisons and jails are often ignored since correctional departments are usually responsible for their own oversight of healthcare.[233] Prison healthcare quality monitoring tends to vary by state,[234] and federal oversight over inmate healthcare is poor.[235] The Panel could nearly eliminate the issue of a lack of federal oversight in correctional facilities if implemented correctly.

Criminal justice panels, commissions, and oversight boards are not new to the United States.[236] The National Commission on Correctional Health Care (NCCHC) is a non-profit that was created to establish, in part, an improvement in healthcare quality in jails and prisons.[237] While the NCCHC has tackled many issues surrounding healthcare is correctional facilities, the creation of federal oversight dedicated to the issue of prison healthcare is necessary to provide more investigation, regulation, and oversight of the prison system as well as a more diverse panel of people to carry out its duties would be more effective.

The Panel should be responsible for creating regulations that state and federal prisons need to abide by, taking complaints regarding

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[232] *See* Braggs v. Dunn, 257 F.Supp at 1267; *see also* Rothschild, *supra* note 137 at 954; *Parsons v. Ryan*, 289 F.R.D. 513 (D Ariz. 2013).; Gray v. Cnty. of Riverside, No. EDCV 13-00444-VAP, 2014 WL 5304915 (CD Cal. Sep. 2, 2014).; Clarke, *supra* note 148; Walsh, *supra* note 48 Lippert v. Baldwin, No. 10 C 4603, 2017 WL 1545672 (N.D. Ill. Apr. 28, 2017).; *Judge Preliminarily Approves Settlement with Fla. Dept. of Corrections and Corizon Over Failure to Provide Hernia Surgeries*, *supra* note 153; *see also* Aronczyk & Quandt, *supra* note 90.; *See* Lewis v. Cain, 324 F.R.D. 159 (MD La. 2018).

[233] Ellis & Hicken, *supra* note 51. (Nurse Kelly Brumley worked in a Memphis prison. In September of 2014, she was made aware of another nurse at the prison who was so overwhelmed with inmate requests that she stuffed them into a shredder box. She reported both this incident and a prior incident of a third nurse who had not examined patients when they asked to be seen. The correctional facility never followed up, investigated, or spoke about the incidents again. For the next year, Kelly continued to report problems to her supervisors and was eventually fired for a "vague attendance issue.")

[234] Matt McKillop, *Prison Health Care Quality Monitoring Systems Vary by State: How Jurisdictions Can Select The Best Way to Measure Performance*, PEW TRUSTS (May 18, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/05/18/prison-health-care-quality-monitoring-systems-vary-by-state.

[235] Kevin Fiscella et al., *The Inmate Exception and Reform of Correctional Health Care*, 107 AM. J. OF PUB. HEALTH 384, 384 (2017).

[236] *See, e.g.,* The U.S. Sentencing Commission (*About the Commission*, The United States Sentencing Commission, https://www.ussc.gov/.); *See also* the National Commission on Correctional Healthcare (*About Us*, the National Commission on Correctional Healthcare, https://www.ncchc.org/about).

[237] *Id*.

standards of care in correctional facilities, investigating and reviewing facilities suspected of violating the federal regulations, and enforcing the rules and regulations it creates. The Panel should also operate at a state-level, meaning that the panel exists as a federal agency but has a division in each state to provide better oversight and create the best practices tailored for that individual state's needs. Furthermore, unlike the NCCHC,[238] the Panel should be comprised of more than just people in the healthcare industry to tackle the issue. To promote the best policies, comprising the Panel of members of the healthcare field is necessary. The Panel should also include criminal justice scholars, members of individual communities, formerly incarcerated persons, people who have suffered from substance abuse, people from communities of color, and people who have worked in correctional facilities.

The Panel could positively impact the court-based regulation system of court orders directing correctional facilities to implement certain practices to meet the *Estelle v. Gamble* standard. The Panel could instead implement these regulations proactively, investigate any facilities that are not following the regulations, and take complaints from correctional staff that would otherwise be overlooked by correctional departments. The Panel, in order to be effective, should also be given enforcement power. While this section gives a brief overview on the goals of a federal oversight panel, evidenced-based practices need to be used in the implementation of this panel.

D. Implementing the Proposed Solutions Together to Have the Greatest Positive Effect on the Healthcare System in Prisons.

Methods of decarceration, both short-term and long-term, need to be implemented to solve the issue of mass incarceration which is a direct cause of the poor healthcare standards in prisons. But these methods, by themselves, are not enough to solve the problem of MCOs in prisons. In combination with the decarceration methods described previously, federal and state lawmakers need to get involved. Policymakers, at a state level, should address the fact that lawsuits and the current system of punitive damages are not enough to stop healthcare companies from providing inadequate care to inmates. A new approach to punitive damages that disincentivizes these companies is the first step in legislation that must be addressed. Federal lawmakers

[238] *NCCHC Committee Members*, THE NATIONAL COMMISSION ON CORRECTIONAL HEALTHCARE, https://www.ncchc.org/leadership.

also need to incentivize states through changes in Medicaid to move away from private healthcare providers to a public health approach. This would be the ideal short-term approach to reducing the number of jails and prisons who use MCOs. In the long-term, the federal government needs to aim its efforts at abolishing the use of for-profit companies that provide healthcare in prisons. Finally, Congress needs to create a Federal Oversight Prison Healthcare Panel in addition to the other federal changes. The Panel could have a positive impact on healthcare in prisons by providing desperately needed oversight, whether the facilities are under a MCO or public healthcare model.

IV. CONCLUSION

Private healthcare companies are responsible for inadequate medical care of prisoners in the United States. This results in deaths, serious injuries, and worsened physical and mental conditions of inmates. The existing problems in prison healthcare are further exacerbated by the cost-cutting methods employed by MCOs. The quality of medical care provided by private companies does not meet constitutional standards and fails to meet the floor for basic human rights standards of prisoners. Mass incarceration makes prison healthcare extremely expensive. Therefore, to combat the costs of healthcare and the lack of quality healthcare in prisons, major reforms, both long-term and short-term, need to take place to reduce prison populations in the United States. A major overhaul of the punitive damages model that would disincentivize MCOs from providing inadequate healthcare needs to take place. Additionally, there needs to be more federal and state-level regulations and oversight. Finally, these three areas of solutions need to be implemented together to have the greatest impact on the healthcare system in prisons.