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## The Perils of Privatization: Exploring the Side Effects of Privatized Correctional Health Care in Favor of a Public Delivery Model

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# The Perils of Privatization: Exploring the Side Effects of Privatized Correctional Health Care in Favor of a Public Delivery Model

Peyton Holahan\*

## *Abstract*

*On July 16, 2020, Judge Roslyn Silver of the U.S. District Court for the District of Arizona set a trial between Arizona's Department of Corrections and a class of Arizona's prisoners alleging grossly inadequate health care in the state's prison system. Arizona, like more than half of the states in the U.S., has outsourced prison health care to private correctional healthcare providers. While correctional healthcare providers win states over with promises of cost-effective care and limited liability, ever since the emergence of the correctional healthcare industry in the 1970s, problems with privatized health care in jails and prisons have persisted, creating legal and ethical concerns about the role of for-profit providers in public correctional institutions. This Note examines the rise of the correctional healthcare industry and brings awareness to the inherent flaws of the private delivery model. This Note also provides a case study of New York City's successful departure from privatized correctional health care to illustrate the benefits, capabilities, and policy-driven goals of a public delivery system led by invested stakeholders. This Note then concludes with an argument supporting the deprivatization of correctional health care in favor of public alternatives and hybrid models. This Note contends that only states and public interest partners can ensure*

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\* J.D. Candidate, May 2023, Washington and Lee University School of Law. I would like to thank my faculty advisor Professor Weiss, and my Note Editor Hayden Driscoll for assisting me throughout the Note writing process. I would also like to thank my family and friends who offered me immense support throughout my law school experience and for whom I am forever grateful.

*adequate oversight and delivery of correctional health care that meets constitutionally acceptable levels. States, and states alone, should take responsibility and accountability for the health, safety, and well-being of their incarcerated populations.*

*Table of Contents*

I. Introduction..... 332

II. Background..... 338

    A. Historical Origins of Health Care in U.S. Jails and Prisons  
        .....339

    B. Beginning in the Twentieth Century, States Began to  
        Outsource Correctional Health Care to Private Providers to  
        Reduce Costs and Limit Risks ..... 341

    C. Issues with Incarceration in the United States Worsen the  
        Quality and Quantity of Correctional Health Care ..... 347

    D. U.S. Jails and Prisons Are Experiencing a Public Health  
        Crisis .....350

    E. The COVID-19 Pandemic Depicts the Most Recent  
        Correctional Health Care Crisis and How Jails and Prisons  
        Failed to Adequately Respond ..... 351

III. Legal and Procedural Challenges Reduce Incarcerated  
Individuals' Chance of Success in the Courtroom ..... 353

    A. The Eighth Amendment..... 354

    B. Plaintiffs Must Prove Liability Under a Deliberate  
        Indifference Standard..... 355

    C. The Prisoner Litigation Reform Act (PLRA) Creates  
        Additional Barriers for Incarcerated Litigants ..... 358

IV. Privatized Correctional Health Care Makes Correctional  
Systems Worse, Not Better..... 362

    A. Privatized Correctional Health Care Diminishes  
        Transparency and Accountability in Correctional Institutions  
        .....363

    B. Private Providers Engage in Suspect Hiring and Staffing  
        Practices..... 365

- C. Profit Motives Drive the Correctional Health Care Industry .....367
- D. Absence of Uniform Standards in the Correctional Health Care Industry Furthers the Need for Greater Public Oversight .....369
  
- V. What a Public Approach to Correctional Health Care Looks Like in Practice: A Case Study of New York City’s Decision to Deprivatize..... 371
  - A. New York City Ends Its Contract with Private Provider Corizon ..... 372
  - B. New York Transitions to a Public Delivery Model for Correctional Health Care in Partnership with the City’s Hospital System ..... 374
  - C. Accomplishments of New York’s Partnership with Health + Hospitals to Date..... 376
  
- VI. Recommendations for Moving Away from Privatized Care. 378
  - A. The Benefits of Non-Privatized Care: Accountability, Oversight, and Institutional Trust ..... 380
  - B. Alternative Approaches to Privatized Correctional Health Care .....381
  
- VII. Conclusion ..... 385

“Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care.”

— Justice Anthony Kennedy

### I. Introduction

“The present situation must end.”<sup>1</sup> These were the terse words of Judge Roslyn Silver of the U.S. District Court for the District of Arizona. On July 16, 2021, she sent shockwaves to Arizona’s Department of Corrections and the Department’s current healthcare contractor, Centurion.<sup>2</sup> She concluded that the Department of Corrections, one of the defendants in the case, had grossly failed to comply with a court-mandated settlement agreement and would face the consequences of its actions in a public trial.<sup>3</sup> By setting a trial date for November of 2021, Judge Silver put an end to a six-year long class action settlement agreement, otherwise known as the “Stipulation,” between a class of Arizona prisoners and the Arizona Department of Corrections.<sup>4</sup> The settlement agreement, entered into by the state in 2014, required the Department to resolve its years long pattern of failing to provide adequate medical care to the state’s prisoners.<sup>5</sup>

In a 37–page order, Judge Silver detailed the Department’s six-year-long history of noncompliance with the 2014 agreement’s

1. Ct. Order Vacating Settlement at 1, *Jensen v. Pratt*, No. CV-12-00601-PHX-ROS (D. Ariz. July 16, 2021) [hereinafter Ct. Order].

2. *Id.*

3. *See id.* at 37 (“[T]he parties must . . . [be] ready for trial no later than November 1, 2021. Defendants must provide constitutionally adequate health care in the interim.”); *see also* Beth Schwartzapfel and Jimmy Jenkins, *Arizona Privatized Prison Health Care to Save Money. But at What Cost?*, THE MARSHALL PROJECT (Oct. 31, 2021, 10:00 AM) (“Judge Silver rescinded the settlement agreement and set the case for trial, writing in a scathing order that she could no longer trust the state was making a good-faith effort to meet the terms of the settlement.”) [perma.cc/4XLD-E2MC].

4. Ct. Order, *supra* note 1, at 2.

5. *See* Robert Anglen, *Federal Judge Blasts Arizona Prison System Over Inmate Health Care, Orders Trial*, AZ CENTRAL (July 19, 2021, 4:12 PM) (explaining that the settlement agreement required the Department of Corrections to maintain an 85% compliance rate with specific performance measures and if compliance was met and maintained, the monitoring and lawsuit would end) [perma.cc/VNC6-NJ9M].

compulsory performance measures requiring constitutional levels of health care in Arizona's ten prison complexes.<sup>6</sup> The Stipulation established benchmarks and obligations that the Department of Corrections was required to meet, but consistently failed to, despite severe court-ordered sanctions and fines.<sup>7</sup> Judge Silver stated

[N]either plaintiffs nor the Court expected that six years after the Stipulation, the Court would be faced with having to sanction Defendants for at least 229 instances of noncompliance regarding health care performance measures, assessing Defendants' refusal to comply with clear Court orders regarding monitoring requirements, and beginning anew with maximum custody and mental health monitoring.<sup>8</sup>

In the order, Judge Silver emphasized that the Director of the Department of Corrections, and not the state's private health care provider, was "legally responsible in Arizona for the provision of health care."<sup>9</sup>

Arizona's correctional healthcare system, however, is ultimately in the hands of private contractors who oversee and administer health care to prisoners in all the state's prisons.<sup>10</sup>

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6. See Ct. Order, *supra* note 1, at 1 ("Defendants have in the past six years proffered erroneous and unreliable excuses for non-performance, asserted baseless legal arguments, and in essence resisted complying with the obligations they contractually knowingly and voluntarily assumed.").

7. See *id.* at 2 (explaining that the Stipulation contained health care provisions that would be assessed against specific performance measures on a monthly basis at each of the ten prison complexes); see also *id.* at 17 ("Defendants have been found in civil contempt twice during the monitoring phase of this action. The first sanction was \$1.445 million and the second was \$1.10 million. Neither sanction coerced or even motivated complete compliance.").

8. *Id.* at 34.

9. See *id.* at 25 (citing ARIZ. REV. STAT. § 31-201.01 (D)); see also *West v. Atkins*, 487 U.S. 42, 56 (1988) ("Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights.").

10. See *Groundbreaking Trial Challenging Arizona Prisons' Inhumane and Unconstitutional Failures Set to Begin*, ACLU ARIZ. (Nov. 1, 2021) (noting that Arizona's taxpayers pay hundreds of millions of dollars each year to a private, for-

While Arizona is ultimately responsible for the care of its prisoners, Arizona, like most states, has outsourced correctional health care to private, for-profit providers.<sup>11</sup> Arizona began outsourcing its prison health care in 2012.<sup>12</sup> Over the past decade, the state has employed three major contractors: Wexford Health, Corizon, and Centurion.<sup>13</sup> Though outsourcing prison health care was initially supported by Arizona's state legislature in 2011 in the belief that it would save the state a significant amount of money, privatization ended up costing the state more than when the state, itself, oversaw correctional health care.<sup>14</sup> Despite the state legislature's willingness to pay more for privatization of correctional health services, Arizona's prison healthcare system has fared worse under privatization. Understaffing, inadequate provision of mental health services, and untimely referrals of patient inmates to medical specialists are just a few of the plethora of problems resulting from the state's decision to privatize care.<sup>15</sup>

While litigation against private correctional health care providers is not a recent phenomenon, the litigation in Arizona presents a unique and cautionary case. This is because it is rare

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profit contractor that administers healthcare to more than 27,000 people in the state's ten prisons) [perma.cc/37GF-YTXK].

11. See Schwartzapfel & Jenkins, *supra* note 3 (noting that Arizona is one of around two dozen states that use a private contractor to provide medical care to incarcerated populations).

12. *Id.*

13. See *id.* (noting that allegations of inadequate care and severe understaffing have been alleged against all three companies).

14. See *id.*

An earlier version of the bill required that privatization save the state money, but when no company could do that, [Arizona state Rep. John Kavanaugh] removed the requirement. The legislature pressed ahead with privatization, and the lowest bidder, Wexford, got the initial contract, which cost the state about \$116 million a year, about \$5 million more than the state spent the previous year.

15. See *id.* (stating that between 2012 and 2019, the medical staff in Arizona's prisons decreased by 11% despite the prison population remaining relatively the same); see also Anglen, *supra* note 5 (describing the consequences of privatization in Arizona, including failures by the state and private providers to prevent deaths and "untold suffering by inmates unable to obtain medical treatment").

for a case about substandard correctional health care to go to trial.<sup>16</sup> States and correctional healthcare providers prefer to settle major lawsuits outside of the courtroom to avoid negative press and public disclosure of misconduct.<sup>17</sup> While correctional health care, privatized or not, is not synonymous with high quality health care, outsourcing correctional health care to private companies with profit motives creates conflicts of interest in public correctional systems.<sup>18</sup> By rescinding the state's settlement agreement and setting the case for trial, Judge Silver clearly stated that she could no longer trust that Arizona's Department of Corrections was making a good-faith effort to comply with the terms and obligations of the agreement to provide constitutionally acceptable levels of health care to the state's prison population.<sup>19</sup>

The litigation in Arizona over the state's prison health care system has outlasted lawyers, Department of Corrections officials, the original judge on the case, and the original plaintiff.<sup>20</sup> In an interview with the original plaintiff in the case, Victor Parsons, he voiced his belief that "even though people forgo their freedoms

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16. See Schwartzapfel & Jenkins, *supra* note 3 (stating that "a trial is rare, as most states settle to avoid this kind of exhaustive public scrutiny").

17. See Micaela Gelman, *Mismanaged Care: Exploring the Costs and Benefits of Private vs. Public Healthcare in Correctional Facilities*, 95 N.Y.U. L. REV. 1386, 1410 (2020) ("Settlement means companies face few repercussions, and the details of those cases that do resolve in payout may remain hidden from the public."); see also Schwartzapfel and Jenkins, *supra* note 3 (noting that at least forty-seven states have been the target of major lawsuits about correctional health care).

18. See Schwartzapfel & Jenkins, *supra* note 3 (explaining that because correctional healthcare companies have profit motives, there is a stronger likelihood that they will cut corners to save money and increase profit margins).

19. See Ct. Order, *supra* note 1, at 34

The history of Defendants' conduct establishes a lack of good faith and fair dealing. The record establishes Defendants, who were represented by competent counsel, understood the terms of the Stipulation and chose to knowingly and voluntarily enter into it. Defendants' post-Stipulation behavior has involved chronic failures to perform health care performance measures, falsifying records in connection with health care performance measures, and refusing to correct obvious errors . . . .

20. See Schwartzapfel & Jenkins, *supra* note 3 (stating that "the lawsuit has outlasted lawyers, Department of Corrections directors, the original judge, and even the original plaintiff in the case, known as Parsons v. Ryan").



when they come to prison, they shouldn't have to forgo their lives."<sup>21</sup> In other words, Parsons makes the point that even though incarceration limits the rights of individuals, these individuals still have an expectation and right to basic living conditions while incarcerated, which includes adequate health care. However, the privatization of correctional health care in the United States has created more harms than goods. This Note addresses the perils of privatized correctional health care and argues for the return of correctional health care to the states and public agencies that can adequately oversee and provide health services to incarcerated populations.

This Note proceeds as follows. In the following section, Part II provides a brief overview of the origins of health care in American jails and prisons and the rise of the correctional healthcare industry.<sup>22</sup> Part II also provides some background on the state of incarceration today and the statistically significant health issues affecting imprisoned and jailed populations. With millions of people behind bars each year suffering from wide ranges of health issues, that Part will shine light on why adequate correctional health care is essential for the betterment of both incarcerated and nonincarcerated populations. Lastly, that Part will address the most recent major public health crisis in jails and prisons caused by the COVID-19 pandemic. The inability of jails and prisons to contain the spread of the virus further illustrated the grave inadequacies of correctional health care and further demonstrated why the current infrastructure in jails and prisons is not effective in creating safer and healthier conditions for incarcerated populations.

Part III provides an overview of the legal standards and procedural challenges that incarcerated individuals must surmount to allege unconstitutional levels of care in jails and prisons.<sup>23</sup> That Part breaks down the Eighth Amendment deliberate indifference standard as well as the detrimental effects of the Prisoner Litigation Reform Act (PLRA).

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21. *Id.*

22. *See infra* Part II.

23. *See infra* Part III.

Part IV discusses the major problems with privatization.<sup>24</sup> That Part examines the lack of transparency and accountability in the private correctional health care sector. Part IV also discusses the suspect hiring and business practices of correctional health care providers that are primarily aimed at reducing costs and maximizing profits to appease corporate shareholders. That Part explains why privatization is not an effective approach to correctional health care because it leaves injured, incarcerated individuals with little to no recourse in seeking legal remedies or higher quality care.

Part V of this Note is a case study of New York City's public approach to correctional health care.<sup>25</sup> In 2015, the City of New York decided to renege its contract with its private provider. Rather than find another private provider that would deliver care to its incarcerated population, the city formed a partnership with the city's public hospital system for the delivery of correctional health care.<sup>26</sup> By looking to New York as a concrete example of what public correctional health care looks like in practice, that Part will discuss the reasoning behind the city's decision to deprivatize and highlight the accomplishments of the city's public partnership to date.

Finally, Part VI of this Note supports and ultimately recommends deprivatization of correctional health care in jails and prisons.<sup>27</sup> Part VI summarizes the advantages of deprivatizing correctional health care and recommends alternative approaches to privatization whereby states, public hospitals, and/or nonprofit organizations oversee health care administration in jails and prisons. This Note ultimately argues that when correctional health care is overseen and provided by states and public stakeholders, states become directly accountable to the people they confine. States are more likely to deliver constitutionally acceptable levels

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24. See *infra* Part IV.

25. See *infra* Part V.

26. See *Health and Hospitals Corporation to Run City Correctional Health Service*, NYC.GOV (June 10, 2015) (describing the city's decision to end its private correctional healthcare contract) [perma.cc/N4W4-WUWL].

27. See *infra* Part VI.

of care and are more likely to be invested in the people, processes, and outcomes involved in correctional healthcare systems.

## *II. Background*

Correctional facilities in the United States, up until recent times, provided incarcerated individuals with virtually no health care.<sup>28</sup> However, in the 1970s and 1980s, courts allowed for an explosion of civil rights lawsuits which, for the first time, required jails and prisons to administer health care to incarcerated populations.<sup>29</sup> With a constitutional obligation to provide care yet a desire to limit costs and legal risks, states, starting in the 1980s, increasingly turned to third-party health care contractors to take over correctional health care in their jails and prisons.<sup>30</sup>

This Part will provide a brief history of correctional health care in the United States and explain why states began to outsource health care to third party providers rather than oversee the provision of health services to incarcerated populations, themselves. Then, to give more context to the vital role that health care plays in America's jails and prison systems, this Part will conclude with a brief overview of the state of incarceration today, the common health issues that afflict incarcerated populations, and the lasting impact that the COVID-19 pandemic had on carceral systems; together, these realities of incarceration not only highlight the ongoing public health crises in our nation's jails and prisons but further reinforce the need for better health care infrastructure in jails and prisons, which can only be provided for by states and public actors.

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28. See Douglas C. McDonald, *Medical Care in Prisons*, 26 CRIME & JUST. 427, 427 (1999) (“[P]rior to the late 1960s, prisoners’ health care was substandard at best, relative to the quality of care available in the larger society, and appallingly negligent and even brutal at worst.”).

29. See *id.* at 428 (noting that a string of federal court decisions established standards for correctional healthcare).

30. See *id.* at 470 (explaining that states began to outsource correctional health care in the 1980s to control costs and shift risks to private contractors).

*A. Historical Origins of Health Care in U.S. Jails and Prisons*

Before the 1970s, jails and prisons were responsible for providing medical services to their incarcerated populations.<sup>31</sup> Prior to judicial intervention in the late Twentieth Century, correctional health care “operated without . . .” standards of decency<sup>32</sup> and was frequently delivered by unqualified providers, resulting in negligence and poor quality” care.<sup>33</sup> For a long time, the federal government refrained from interfering with states’ operation of correctional health care, leaving state and local officials to make subjective decisions about prisoners’ medical needs without defined standards or limits.<sup>34</sup>

According to Reuters, “[u]ntil the 1970s, jail healthcare was minimal. Most lockups offered more than first aid, a 1972 American Medical Association survey found.”<sup>35</sup> Jails and prisons hired medical staff who practiced with restricted medical licenses or no licenses at all, and corrections officers often refused to defer to the medical opinions of health care workers in correctional settings.<sup>36</sup> Because incarcerated individuals were physically suffering under the supervision of unqualified health care workers who provided defective medical treatment, or no treatment at all,

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31. See Gelman, *supra* note 17, at 1392 (noting that correctional institutions employed their own medical staff, including doctors and nurses, to administer medical services to incarcerated individuals).

32. See *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (stating that punishments must be compatible with “the evolving standards of decency that mark the progress of a maturing society” to not violate the Eighth Amendment).

33. *Prison Health Care: Costs and Quality*, PEW CHARITABLE TRUSTS 1, 4 (2017).

34. See Gelman, *supra* note 17, at 1393 (“Before a series of federal cases in 1963, courts largely refused to interfere with states’ operation of their prisons.”).

35. Jason Szep, Ned Parker, Linda So et al., *U.S. Jails Are Outsourcing Medical Care — And the Death Toll Is Rising*, REUTERS (Oct. 26, 2020, 11:00 AM) [perma.cc/M6FU-F63N].

36. See Gelman, *supra* note 17, at 1393 (emphasizing that correctional healthcare staff largely lacked professional autonomy because they were often required to report to the corrections department rather than an independent medical board); see also McDonald, *supra* note 28, at 428 (“Health care was often delivered, if at all, by persons having little or no medical training—sometimes, even other prisoners or by small numbers of qualified physicians overwhelmed by huge caseload.”).

incarcerated individuals started filing lawsuits alleging unconstitutional medical care in jails and prisons across the United States.<sup>37</sup>

In 1976, the Supreme Court ruled in the landmark case *Estelle v. Gamble*<sup>38</sup> that “deliberate indifference to [the] serious medical needs of prisoners” was a violation of a prisoner’s Eighth Amendment constitutional right to be free from cruel and unusual punishment.<sup>39</sup> The *Estelle* decision constitutionally required jails and prisons to provide health care to their incarcerated populations.<sup>40</sup> Following the *Estelle* decision, litigation surrounding correctional health care proceeded to skyrocket in the 1980s and 1990s, with growing numbers of incarcerated plaintiffs alleging Eighth Amendment violations because of inadequate medical treatment.<sup>41</sup>

Lower federal courts expanded upon the *Estelle* standard by providing greater clarity and explanation as to what is required of state correctional institutions in the provision of health services.<sup>42</sup> One court stated that adequate correctional health care consists of “services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards.”<sup>43</sup> Another federal court added that “[t]he state must provide . . . a level of health services reasonably designed to meet

37. See McDonald, *supra* note 28, at 434 (“Presented with cases alleging appallingly unhygienic conditions and inadequate health care services in prisons and jails, the federal courts began in the late 1960s to accept cases and to rule in favor of prisoners’ claims.”).

38. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (holding that “deliberate indifference” to an incarcerated individual’s medical needs amounts to “unnecessary and wanton infliction of pain” in violation the Eighth Amendment).

39. *Id.* at 103.

40. *Id.*

41. See Szep et al., *supra* note 35 (noting that following the *Estelle* decision, the number of lawsuits filed by incarcerated individuals increased in the 1980s); see also *Prison Health Care: Costs and Quality*, *supra* note 33, at 4 (stating that “[b]y January 1996, only three states had never been involved in major litigation challenging conditions in their prisons”).

42. See *Prison Health Care: Costs and Quality*, *supra* note 33, at 4 (“A series of federal court decisions established a legal basis under which state correctional authorities are constitutionally obligated by the Eighth Amendment to provide prisoners with “reasonably adequate” health care.”).

43. *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987).

routine and emergency medical, dental, and psychological or psychiatric care.”<sup>44</sup>

While federal courts since *Estelle* have “established principles [for medical services] with specific examples, from which standards can be deduced,” not all court decisions apply equally to all subgroups of incarcerated populations.<sup>45</sup> Therefore, the judicial standards for correctional health care remain fairly ambiguous as lower federal court decisions are not binding in every state and jurisdiction.<sup>46</sup> With ambiguous criteria for what constitutes constitutional levels of care, increasing costs, and a growing incarcerated population, states began to look elsewhere for assistance in overseeing and providing the one area of incarceration they deemed to not be within their purview.

*B. Beginning in the Twentieth Century, States Began to Outsource Correctional Health Care to Private Providers to Reduce Costs and Limit Risks*

The end of the Twentieth Century presented new challenges for jail and prison officials.<sup>47</sup> State correctional systems were constitutionally required to comply with ongoing federal court decisions outlining standards for medical care at a time when the incarcerated population was also changing.<sup>48</sup> In the 1970s, a rise in political conservatism and its consequential effects on sentencing policy directly affected the United States’ criminal

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44. *Tillery v. Owens*, 719 F.Supp. 1256, 1301 (W.D. Pa. 1989), *aff’d*, 907 F.2d 418 (3d Cir. 1990).

45. *See McDonald*, *supra* note 28, at 437 (“[N]ot all court decisions apply equally to all categories of inmates.”).

46. *See id.* (noting that correctional healthcare administrators often look to professional standards for guidance regarding the amount and kinds of care to provide incarcerated populations in addition to judicial precedent).

47. *See Gelman*, *supra* note 17, at 1394 (noting that some of these challenges included “the apparent failure of the direct service model, the growing correctional population, and correctional facilities’ newfound responsibility to provide adequate medical care”).

48. *See James Cullen*, *The History of Mass Incarceration*, BRENNAN CTR. FOR JUST. (July 20, 2018) (“The prison population began to grow in the 1970s, when politicians from both parties used fear and thinly veiled racial rhetoric to push increasingly punitive policies.”) [perma.cc/3WJH-NJK7].

justice system.<sup>49</sup> Under the Reagan administration, policies favoring tougher sentencing laws and the general privatization of correctional institutions led to a direct increase in prison and jail populations across the country.<sup>50</sup>

Beginning in the 1980s, in direct response to *Estelle* and increasing prison populations, correctional institutions throughout the United States sought out alternative methods for providing medical care to incarcerated populations.<sup>51</sup> The national war on drugs and closing of mental hospitals contributed to prison and jail populations that were suffering with more serious health conditions, which required more robust correctional health care systems.<sup>52</sup> Rather than continue administering health care directly in correctional facilities, states increasingly turned to for-profit companies in the emerging “correctional health care industry.”<sup>53</sup> Private health care contractors promised to deliver better care to incarcerated individuals in jails and prisons at lower costs to state governments.<sup>54</sup> Prisons and jails viewed privatization as an

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49. See *id.* (noting the impact that President Nixon’s declared “war on drugs” and “tough on crime” speeches had on criminal justice policies and institutions).

50. See *id.* (stating that the prison population “exploded” under the Reagan administration with increasing rates of incarceration hitting communities of color the hardest); see also Gelman, *supra* note 17, at 1395 (describing the neoliberal policies espoused by Reagan’s administration that supported government deregulation and increased privatization of public services).

51. See Gelman, *supra* note 17, at 1395 (noting that “[a]s the prison population continued to rise and began aging, administering healthcare became even more expensive for states and concerns over the quality of existing healthcare regimes grew”); see also Brittany Bondurant, *The Privatization of Prisons and Prisoner Healthcare: Addressing the Extent of Prisoners’ Right to Healthcare*, 39 NEW ENG. J. CRIM. & CIV. CONFINEMENT 407, 416 (2013) (explaining that after the *Estelle* decision, both prison populations and the cost of healthcare skyrocketed, forcing correctional systems to seek out alternative methods for delivering care).

52. See *Prison Health Care: Costs and Quality*, *supra* note 33, at 3 (“[C]orrectional facilities increasingly became a setting in which individuals with serious health conditions . . . were diagnosed and treated. This was largely driven by the dual forces of the national war on drugs . . . and the closing of mental hospitals as part of deinstitutionalization efforts.”).

53. See Szep et al., *supra* note 35 (describing the emergence of the “correctional healthcare industry” in the 1980s).

54. See Gelman, *supra* note 17, at 1388–89 (“With prison populations increasing exponentially and federal courts imposing new legal standards for correctional healthcare, corrections departments turned to private providers for

opportunity to remedy their deficient systems.<sup>55</sup> They believed that private sector healthcare companies would “take the legal risk off localities’ shoulders, offering in one company’s words, safe and defensible care.”<sup>56</sup>

The private correctional healthcare industry continued to grow and expand throughout the 1990s and 2000s.<sup>57</sup> Today, it is estimated that more than 60% of jails have outsourced their health care to private corporations.<sup>58</sup> In a survey of U.S. jails conducted by *Reuters*, they reported that in 2010, nearly half of the jails they surveyed had outsourced their health care to private providers, and by 2018, this number rose to 62%.<sup>59</sup> Similarly, more than half of the states outsource at least some of their prison health care to private contractors.<sup>60</sup> This sector is also extremely profitable.<sup>61</sup> According to Steve Coll from *The New Yorker*, “[c]ompanies that contract to provide health care to the incarcerated are tapping into an enormous business opportunity—annual spending now exceeds ten billion dollars—and they are obligated to their owners to seek profit.”<sup>62</sup>

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a more cost-efficient and effective method of providing healthcare services to their incarcerated populations.”).

55. *Id.*

56. See Marsha McLeod, *The Private Option*, THE ATL. (Sept. 12, 2019) (noting that private firms help to reduce states’ liability for inadequate correctional healthcare) (internal quotations omitted) [perma.cc/V8QZ-JXC2].

57. See Szep et al., *supra* note 35 (stating that “[t]he industry expanded through the 1990s and early 2000s as a push to deinstitutionalize the mentally ill spurred the closure of mental health hospitals”).

58. See *id.* (reporting that “more than 60% of America’s jails now hire private companies to deliver inmates’ medical care”).

59. *Id.*

60. See Steve Coll, *The Jail Health-Care Crisis*, THE NEW YORKER (Feb. 25, 2019) (“According to a 2018 study from the Pew Charitable Trusts, more than half the states hire private companies to provide at least some of their prison health care.”) [perma.cc/5Y7V-4WUM].

61. See Beth Healy and Christine Willmsen, *Pain and Profits: Sheriffs Hand Off Inmate Care to Private Health Companies*, WBUR (Mar. 24, 2020) (characterizing correctional healthcare as a multi-billion-dollar industry) [perma.cc/G4SN-EWEZ].

62. Coll, *supra* note 60.



In essence, “contracting out” has become the norm.<sup>63</sup> While there are currently no comprehensive statistics about the prevalence of private providers in jails, recent reports and surveys suggest that the trend towards privatization of health care services in both jails and prisons is not slowing down.<sup>64</sup> In interviews with correctional administrators and law enforcement officers about correctional health care, *Reuters* journalists received positive feedback from state correctional officials who decided to privatize their healthcare systems.<sup>65</sup> A county commissioner told *Reuters*, “[i]t makes sense to have someone whose specialty is to come in and take care of inmates.”<sup>66</sup> A police captain analogized privatization to “a package deal” where “everything is done for you.”<sup>67</sup>

However, unlike the non-incarcerated population’s ability to choose from hundreds of healthcare providers, “prisoners do not have a choice in the healthcare they receive.”<sup>68</sup> Therefore, the care they do or do not receive is out of their control.<sup>69</sup> On top of this, only a handful of companies dominate the correctional healthcare

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63. See Gelman, *supra* note 17, at 1394 (“Contracting out” services to outside provider became popular because it allegedly drove down costs, improved care, increased provider autonomy, and transferred risk from governments to contracting private entities.”).

64. See Coll, *supra* note 60 (noting that there are currently no comprehensive studies or data about the prevalence of private contractors in jails, but one estimate suggests that 70% of jails have outsourced medical services); see also Gelman, *supra* note 17, at 1389 (“With states and municipalities extending . . . contracts and negotiating new ones, [privatization] is not fading anytime soon.”).

65. See Szep et al., *supra* note 35 (noting that some correctional officials appear to be pleased with outsourcing correctional care to private providers, “embrac[ing] the chance to shed the headaches of managing their own medical operations”).

66. See *id.* (quoting Chatham County Commissioner Helen Stone of Georgia).

67. See *id.* (quoting Captain Jessica Pete of the St. Louis County Jail in Duluth, Minnesota).

68. See Bondurant, *supra* note 51, at 417 (noting that prisoners lack health care options).

69. See Coll, *supra* note 60 (explaining that “a distinct feature of correctional health care is that, if incarcerated people believe that their health—or their life—is in jeopardy, they can’t just drive themselves to an emergency room”).

industry.<sup>70</sup> To date, this small but powerful and profitable handful of companies includes Corizon, Centurion, Wellpath, and Armor Correctional Health Services, among others.<sup>71</sup> Thus, with only a few providers for states to choose from, the correctional healthcare market lacks competition, which is necessary for incentivizing higher quality services.<sup>72</sup>

Despite the lack of competition in the for-profit correctional healthcare market, states have become “dependent on these companies.”<sup>73</sup> They bounce from provider to provider despite the lawsuits and allegations made against these companies for inadequate care.<sup>74</sup> However, states appear to be more interested in the alleged money and resources they are saving from outsourcing correctional health care to private providers.<sup>75</sup> “[A]s long as the companies promise low costs, the governments tend to be satisfied.”<sup>76</sup> The absence of competition in the correctional healthcare industry, mixed with states’ relative indifference to the quality of care provided, allows providers to operate largely unchecked.<sup>77</sup>

Many states choose to privatize correctional health care in the belief that outsourcing care to healthcare professionals will

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70. See Gelman, *supra* note 17, at 1389–90 (stating that “[o]nly a few major players dominate the market, and governments are incentivized to stick with their providers, or contract with another private provider, even when quality is low”).

71. See Szep et al., *supra* note 35 (stating that Wellpath, Corizon, NaphCare, PrimeCare Medical, and Armor Correctional Health Services are the major providers in the correctional healthcare industry).

72. See Gelman, *supra* note 17, at 1399 (arguing that the correctional healthcare market suffers from “market failure” because critical elements of competition are not present to incentivize high-quality goods and services).

73. See *id.* (noting that states have “few legal and financial incentives” to stray from privatized care).

74. See *id.* at 1398 (stating that “[e]ven when there are successful lawsuits or large settlements against one provider, governments may choose another provider rather than exit the private provider market” because of the low costs promised by another provider in the market).

75. *Id.* at 1399.

76. *Id.*

77. See Coll, *supra* note 60 (emphasizing that “[m]arket forces don’t operate in the prison context for the reason that prisoners have absolutely no consumer choice”).

heighten the quality of medical services in jails and prisons and reduce litigation.<sup>78</sup> States believe they derive benefit from years-long contracts with private correctional healthcare providers that may transfer liability to the providers, thus insulating states from legal accountability for any claims of deficient care.<sup>79</sup> Despite the perceived benefit of insulation from lawsuits alleging deficient care, states are not receiving the services they bargained for.<sup>80</sup> Lawsuits, complaints, and deaths related to the substandard practices of private correctional healthcare companies have not ceased.<sup>81</sup> Thousands of lawsuits have been filed and continue to be filed against correctional healthcare companies for failing to provide adequate, constitutionally acceptable levels of care.<sup>82</sup> The problem is not going away. Even if states are reluctant to improve conditions within correctional institutions, they need to at least acknowledge that problems with privatized health care impact not only incarcerated populations but the greater communities that most incarcerated individuals return to upon release.<sup>83</sup>

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78. See Jeff Mellow & Robert Greifinger, *Successful Reentry: The Perspective of Private Correctional Health Care Providers*, 84 J. URB. HEALTH 85, 87 (2006) (explaining that states often outsource care because providers oversee and provide “staffing, pharmaceuticals, and outside specialty and hospital care”).

79. See Beth Kutscher, *Rumble Over Jailhouse Healthcare*, MOD. HEALTHCARE (Aug. 31, 2013, 1:00 AM) (“Outsourcing is viewed as a risk-management strategy, where the vendor assumes most of the liability when there are adverse medical outcomes.”) [perma.cc/QTQ8-29RN]; see also Gelman, *supra* note 17, at 1400–01 (noting that “insulation provisions” in contracts between states and providers often insulate state and local governments from legal liability and settlement payouts through indemnification).

80. See Coll, *supra* note 60 (“[F]or-profit companies, which were promoted as a solution, have instead become an integral part of a troubled system.”).

81. See Szep et al., *supra* note 35 (stating that between 2009 and 2018, 54 inmates died in Oklahoma County Jail “under Armor’s medical and mental health care”); see also McLeod, *supra* note 56 (noting that Wellpath’s predecessor, Correct Care Solutions, was sued 1,395 times over the span of a decade).

82. See Healy & Willmsen, *supra* note 61 (noting that between 2015 and 2020, around 1,200 lawsuits were filed against provider, Wellpath, in federal courts); see also Coll, *supra* note 60 (stating that Wellpath and Corizon were sued around 1,500 times over a five-year period based on federal and state court records).

83. See Gelman, *supra* note 17, at 1427 (stating that over 95% of incarcerated individuals are released back into their communities); see also *infra* Part IV (describing problems resulting from the privatization of correctional health care).

*C. Issues with Incarceration in the United States Worsen the Quality and Quantity of Correctional Health Care*

As states continue to incarcerate high numbers of individuals, the level of care afforded to these individuals should be commensurate. Incarceration rates in the last few years have decreased slightly, partly because of jails' and prisons' responses to the COVID-19 pandemic.<sup>84</sup> However, the number of people behind bars in the United States remains extraordinarily high.<sup>85</sup> Harsh sentencing policies, mass incarceration, and racial and socioeconomic inequities have all contributed to a criminal justice system in our country that is ripe with systemic injustices and issues of overcrowding.<sup>86</sup> While the pandemic has led to sustained overall reductions in prison and jail populations based on data collected from the Vera Institute of Justice, states and the federal government are failing to propose and implement substantive reforms directed at permanently reducing criminalization and incarceration rates.<sup>87</sup> Furthermore, high incarceration rates

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84. See Weihua Li, David Eads, & Jamiles Lartey, *There Are Fewer People Behind Bars Now Than 10 Years Ago. Will It Last?*, THE MARSHALL PROJECT (Sept. 27, 2021, 1:00 PM) (noting that based off numbers from the 2020 Decennial Census, there was “a 13% drop in the total number of incarcerated people . . . compared with the 2010 Census”) [perma.cc/CJD9-SZTJ].

85. See JACOB KANG-BROWN ET AL., PEOPLE IN JAIL AND PRISON IN SPRING 2021, 3 (2021) (noting that there is still close to two million incarcerated people even with the declines in incarceration resulting from the pandemic).

86. See *Criminal Justice Facts*, THE SENT'G PROJECT (stating that “[c]hanges in sentencing law and policy, not changes in crime rates” explain the 500% increase in incarceration over the last forty years) [perma.cc/6YDB-CTJP]; see Ashley Nellis, *The Color of Justice: Racial and Ethnic Disparity in State Prisons*, THE SENT'G PROJECT (Oct. 13, 2021) (noting that “Black Americans are incarcerated in state prisons at nearly 5 times the rate of white Americans”) [perma.cc/8ZFC-MFLH]; see *Criminal Justice Reform*, EQUAL JUST. INITIATIVE (stating that ““tough on crime” policies that led to mass incarceration are rooted in the belief that Black and brown people are inherently guilty and dangerous—and that belief still drives excessive sentencing policies today”) [perma.cc/4SQ2-7DVV].

87. See KANG-BROWN ET AL., *supra* note 85, at 8 (stating that “[a]t minimum, states should be looking to close prisons and reduce budgets to match the much lower prison populations” while noting that “[a]t the federal level, neither the Biden administration nor Congress has taken action that reflects a commitment toward sustained decarceration”); see also Katie Park, Keri Blakinger, & Claudia Lauer, *A Half-Million People Got COVID-19 in Prison. Are Officials Ready for the*

directly affect and constrain the provision of healthcare services in prisons and jails. Problems with incarceration are not mutually exclusive and require reform on many levels.

There are currently over 3,000 jails and over 1,800 state prisons in the United States.<sup>88</sup> Local jails are overseen by counties or sheriff's offices while prisons are usually overseen by state and federal agencies.<sup>89</sup> Jails and prisons mostly differ in the types of individuals they confine and the length of time with which these individuals remain incarcerated.<sup>90</sup> The temporal differences in length of stay also distinguish the quantity and quality of services provided by private correctional healthcare providers in jails and prisons.<sup>91</sup> For example, the former CEO of correctional health care provider Corizon likened the provider's services in jails to that of an emergency room.<sup>92</sup> Because the average stay of detainees in jails is usually between 20 and 30 days, health services in jails tend to be limited.<sup>93</sup> However, in prisons, health care tends to be a little

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*Next Pandemic?*, THE MARSHALL PROJECT (June 30, 2021, 6:00 AM) ("While many jails emptied out during the pandemic and prison populations declined, the criminal justice system has not fundamentally changed.") [perma.cc/QV4X-YTRP].

88. Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2020*, PRISON POL'Y INITIATIVE (March 24, 2020) [perma.cc/5HSZ-VE28].

89. See Alexandra Gates, Samantha Artiga, and Robin Rudowitz, *Health Coverage and Care for the Adult Criminal Justice-Involved Population*, KFF (Sept. 5, 2014) (stating that "[p]risons are overseen by the federal government and states, while jails typically are governed by the local city or county") [perma.cc/M8MB-EYDW].

90. See *id.* (explaining that "prisons . . . typically house longer-term felons or inmates serving a sentence of more than one year, and jails . . . house individuals awaiting trial or sentencing and those convicted of misdemeanors and serving shorter terms that are typically less than one year"); see also Nina Goepfert, *Beyond Deliberate Indifference: Improving Jail Health Care with False Claims Acts*, 25 VA J. SOC. POL'Y & L. 123, 130 (2018) (noting that jail populations are "meaningfully distinct" from prison populations in that "jail populations are highly transient whereas prison populations are not").

91. See Kutscher, *supra* note 79 (describing the differences in correctional health care in jails and prisons).

92. See *id.* (explaining that Corizon compares its business model to "free world" healthcare providers based on the company's varying services in jails and prisons).

93. *Id.*; see also Coll, *supra* note 60 (noting that "[m]any jails are in rural or poor counties, where administrators complain that they have neither the

more robust and comprehensive.<sup>94</sup> Because most prisoners are incarcerated for at least a year, prison healthcare systems tend to offer more long-term care options, especially for their sick and aging populations or prisoners with histories of addiction.<sup>95</sup>

In 2020, it was estimated that jails held an average of 746,000 people each day, 65% of whom were being held while awaiting trial.<sup>96</sup> In total, more than 10 million people were in and out of the jail system in 2020.<sup>97</sup> The prison population in the United States is also high, with around 600,000 people entering prisons each year.<sup>98</sup> On any given day, state prisons in the United States house more than one million people.<sup>99</sup>

With the highest incarceration rate in the world, the United States is witnessing the harsh effects of mass incarceration and inequitable sentencing policies.<sup>100</sup> Simply but not so simply put, “[m]ass incarceration refers to the reality that the United States criminalizes and incarcerates more of its own people than any other country in the history of the world and inflicts that enormous harm primarily on the most vulnerable among us: poor people of

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resources nor the expertise to hire, train, and supervise doctors and nurses in the particular demands that their facilities require”).

94. See Kutscher, *supra* note 79 (stating that in prisons, Corizon provides a wider range of services including initial health assessments, sick care, and discharge planning).

95. See DANIELLE KAEBLE, *TIME SERVED IN STATE PRISON*, 2016, 1 (2018) (reporting that the average time served by state prisoners in 2016 was 2.6 years and the median time served was 1.3 years) [perma.cc/5R5S-NTKK]; see also Coll, *supra* note 60 (describing the chronic diseases and conditions related to aging and addiction that are prevalent in prison populations).

96. Sawyer & Wagner, *supra* note 88; see also McLeod, *supra* note 56 (characterizing the jail system in the United States as “big and fragmented, and . . . not much of a system at all”).

97. See Sawyer & Wagner, *supra* note 88 (explaining that “[j]ail churn is particularly high because most people in jails have not been convicted”).

98. *Id.*

99. See *Prison Health Care: Costs and Quality*, *supra* note 33, at 1 (“On a typical day, state prisons house more than a million people, . . .”).

100. See *Highest to Lowest – Prison Population Rate*, WORLD PRISON BRIEF (noting that the U.S. ranks first in prison population rates) [perma.cc/CD6Y-3QPR]; see also *Highest to Lowest – Prison Population Total*, WORLD PRISON BRIEF (observing that the U.S. ranks first in prison population rate) [perma.cc/L5P7-PGS2].

color.”<sup>101</sup> Black Americans are incarcerated at five times the rate of white Americans<sup>102</sup> and even though the rate of violent crime has dropped significantly since 1991, the number of incarcerated individuals has risen by fifty percent since then.<sup>103</sup> As states continue to incarcerate millions of people each year, many of whom have pre-existing conditions or conditions that develop as a result of confinement, correctional healthcare systems inevitably feel the brunt of high incarceration rates and must perform an even more essential role in serving all the health needs of incarcerated populations.<sup>104</sup>

#### *D. U.S. Jails and Prisons Are Experiencing a Public Health Crisis*

Incarcerated populations are inherently unhealthy and are more prone to the worsening or development of health conditions in comparison to the general population. “This [incarcerated] population tends to suffer in greater numbers from infectious disease, mental health problems, and substance use and addiction.”<sup>105</sup> According to the federal Bureau of Justice Statistics, between 2011 and 2012, fifty percent of state and federal prisoners and incarcerated individuals in jails reported ever having a chronic condition.<sup>106</sup> Forty percent reported having chronic medical conditions while incarcerated.<sup>107</sup> Infectious diseases are also

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101. *What We Mean by “Mass Incarceration,”* INST. TO END MASS INCARCERATION [perma.cc/YB9B-9W4D].

102. *Criminal Justice Fact Sheet*, NAACP (internal quotations omitted) [perma.cc/7ADY-JKB9].

103. *Id.*

104. Exec. Order No. 14006, 86 Fed. Reg. 7483 (Jan. 29, 2021).

105. *Incarceration and Health: A Family Medicine Perspective*, AAFP (2021) [perma.cc/EEB4-559M].

106. LAURA M. MARUSCHAK, MARCUS BERZOFSKY, & JENNIFER UNANGST, *MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES 2011-12, 2* (2016) (describing chronic medical conditions as those that “involve persistent health problems that have long-lasting effects”).

107. *See id.* at 1 (noting that some chronic conditions include “cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and cirrhosis of the liver”).

prevalent among confined populations.<sup>108</sup> In the same report, 21% of prisoners and 14% of incarcerated persons in jails reported having an infectious disease, of which the most common were sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), hepatitis B and C, and tuberculosis.<sup>109</sup>

Mental health issues in prisons and jails are also widespread as 64% of incarcerated individuals in jails and 54% of individuals in state prisons report mental health concerns.<sup>110</sup> Conditions of confinement exacerbate pre-existing mental health disorders or mental illness.<sup>111</sup> In addition to the high prevalence of physical and mental health conditions among incarcerated populations, prison populations are aging.<sup>112</sup> <sup>113</sup>

*E. The COVID-19 Pandemic Depicts the Most Recent Correctional Health Care Crisis and How Jails and Prisons Failed to Adequately Respond*

Prior illnesses and chronic conditions are not the only health issues facing incarcerated populations. Individuals in jails and prisons can be afflicted with serious physical and mental health

108. *See id.* (reporting that “[b]oth prisoners and jail inmates were more likely than the general population to report ever having a chronic condition or infectious disease”).

109. *Id.*

110. Amy Morin, *The Mental Health Effects of Being in Prison*, VERYWELL MIND (April 21, 2021) [perma.cc/9F3J-EQ2S].

111. *See id.* (explaining that pre-existing conditions may worsen in prisons or jails, including depressive disorders, anxiety disorders, and PTSD among other mental illnesses and conditions).

112. *See* Emily Widra, *Since You Asked: How Many People Aged 55 or Older Are in Prison*, PRISON POLY INITIATIVE (May 11, 2020) (illustrating that, on average, more than 10% of prisoners in state prisons are over the age of 55 which is significant because incarceration, itself, shortens life expectancy and quickens physiological aging) [perma.cc/2CSD-84HB].

113. *See* Julia Acker et al., *Mass Incarceration Threatens Health Equity in America*, RWJF (Dec. 1, 2018) (“Mass incarceration’s effects on health last far beyond the period of imprisonment. It impacts social, educational, and economic opportunities; increases the prevalence of chronic health conditions; and decreases life expectancy . . . .”) [perma.cc/AJ9A-86HT].



conditions while incarcerated.<sup>114</sup> In recent years, there is no greater example of this than the rampant spread of the Coronavirus, or COVID-19, in prisons and jails across the United States. In the height of the pandemic, incarcerated individuals were five times more likely than the public to test positive for Coronavirus.<sup>115</sup> By April 16, 2021, more than 661,000 people in jails and prisons had been infected with COVID, of which 2,990 incarcerated individuals and correctional officers died as a result.<sup>116</sup> The failure to contain the spread of the virus in jails and prisons was largely due to institutional factors of overcrowding, understaffing, and substandard medical care.<sup>117</sup> In many ways, the COVID-19 pandemic shined a spotlight on the ongoing public health crisis in jails and prisons, which is partially attributable to ineffective correctional health care systems. The inability of jails and prisons to contain the spread of the virus illustrated the lacking infrastructure in jails and prisons needed to combat potential outbreaks and to improve general health and safety

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114. See *Health and Incarceration: A Workshop Summary*, NAT'L RSCH. COUNCIL (Aug. 8, 2013) (noting that poor nutrition, smoking, inadequate ventilation, overcrowding and stress can lead to adverse effects on individuals' physical health in prison environments) [perma.cc/XJG6-4G7V]; see also Katie Rose Quandt and Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health*, PRISON POL'Y INITIATIVE (May 13, 2021) (stating that incarceration often perpetuates mental health problems in jails and prisons "by creating and worsening symptoms of mental illness" and mental disorders) [perma.cc/9S9C-VC9G].

115. Meghan Peterson & Lauren Brinkley-Rubinstein, *Incarceration Is a Health Threat. Why Isn't It Monitored Like One?*, HEALTH AFFAIRS (Oct. 19, 2021) ("In the past year, people who were incarcerated were about five times more likely than the general population to test positive for COVID-19.") [perma.cc/U48T-RLMG].

116. *Covid-19's Impact on People in Prison*, EQUAL JUST. INITIATIVE (Apr. 16, 2021) [perma.cc/ZYF9-4AH4].

117. See Park et al., *supra* note 87 ("With crowded conditions, notoriously substandard medical care and constantly shifting populations, prisons were ill-equipped to handle the highly contagious virus."); see also Bill Chappell, *Crowded U.S. Jails Drove Millions of COVID-19 Cases, A New Study Says*, NPR (Sept. 2, 2021) (characterizing U.S. jails and prisons as "infectious disease incubators") [perma.cc/P343-QQKN].

conditions among correctional populations.<sup>118</sup> As most recently demonstrated by the COVID-19 pandemic and problems created by mass incarceration, the United States is experiencing a public health crisis within its criminal justice system that will continue to worsen if not managed by states and the correctional institutions directly under their control.<sup>119</sup>

### *III. Legal and Procedural Challenges Reduce Incarcerated Individuals' Chance of Success in the Courtroom*

Litigation is one of the few, if not only, avenues that incarcerated individuals can pursue to seek redress for injuries caused by the delivery of grossly inadequate correctional health care, or no care at all.<sup>120</sup> While filing a lawsuit is often the most accessible option for incarcerated individuals, they nonetheless face legal, procedural, and institutional obstacles that make it extremely difficult for them to succeed on the merits of their claim.<sup>121</sup> For example, even when incarcerated plaintiffs have valid claims against correctional healthcare providers, they are often incentivized to settle with the provider to avoid the risks and burdens that accompany litigation and trial.<sup>122</sup>

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118. See Chappell, *supra* note 117 (noting that crowded conditions and poor healthcare systems contributed to the spread of Coronavirus in correctional facilities).

119. *Id.*; see also Julia Acker et al., *Mass Incarceration Threatens Health Equity in America*, RWJF (Dec. 1, 2018) (“Mass incarceration’s effects on health last far beyond the period of imprisonment. It impacts social, educational, and economic opportunities; increases the prevalence of chronic health conditions; and decreases life expectancy . . . .”) [perma.cc/AJ9A-86HT].

120. See McLeod, *supra* note 56 (stating that “for many inmates, the only means of recourse—after filing a grievance slip—is to sue”).

121. See Gelman, *supra* note 17, at 1409 (“Whenever an inmate-patient wishes to sue a medical provider, whether a government entity or a private company, the prospective plaintiff must first overcome judicially and legislatively imposed obstacles.”).

122. See Coll, *supra* note 60 (reporting that a significant number of lawsuits filed against Corizon and Wellpath ended in settlement agreements with confidentiality provisions); see also Gelman, *supra* note 17, at 1410 (describing a case in which a victim’s family agreed to settle a wrongful death claim with Corizon for \$8.3 million rather than endure a public trial).

This Part will provide an overview of some of the common legal and procedural hurdles that incarcerated plaintiffs encounter in correctional healthcare litigation starting with a discussion of Eighth Amendment jurisprudence and its corresponding deliberate indifference standard. This Part will conclude with a summary of the harsh effects of the Prisoner Litigation Reform Act (PLRA) and the additional barriers it creates for incarcerated individuals trying to assert claims of inadequate and unconstitutional medical care.

### *A. The Eighth Amendment*

The Eighth Amendment of the United States Constitution prohibits the imposition of cruel and unusual punishments.<sup>123</sup> The Eighth Amendment is often the source of most prisoner litigation because “[p]risoners incarcerated after conviction/sentence make claims under this provision to challenge many aspects of their experience during incarceration: inadequate medical care, . . . , inadequate nutrition, unsanitary environmental conditions, and many more.”<sup>124</sup> Therefore, most claims alleging violations of the Eighth Amendment are considered “conditions of confinement” claims.<sup>125</sup>

Incarcerated individuals raising Eighth Amendment claims for violations of inadequate medical care will bring those claims under 42 U.S.C. § 1983, a civil rights statute.<sup>126</sup> Section 1983 creates a cause of action against any person who acted “under color of any statute, ordinance, regulation, . . . , of any State” during the alleged violation of a plaintiff’s federal constitutional or statutory

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123. See U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”); see also Bryan A. Stevenson & John F. Stinneford, *Common Interpretation: The Eighth Amendment*, NAT’L CONST. CTR. (explaining that “[t]his amendment prohibits the federal government from imposing unduly harsh penalties on criminal defendants . . . .”) [perma.cc/E4PM-NFFH].

124. MARGO SCHLANGER, ET AL., *INCARCERATION AND THE LAW* 57 (10th ed. 2020).

125. See *id.* (explaining that “conditions of confinement” claims usually fall into two buckets: use of force cases and non-force claims).

126. 42 U.S.C. § 1983.

right.<sup>127</sup> In other words, through a § 1983 claim, incarcerated litigants can sue persons acting “under color of state law” for alleged violations of their Eighth Amendment rights.<sup>128</sup>

In 1988, the Supreme Court extended § 1983’s application to private healthcare contractors in *West v. Atkins*.<sup>129</sup> In *West*, the Court held that private doctors providing medical services in state correctional facilities act “under the color of state law,” which opens them to liability under § 1983.<sup>130</sup> The Court emphasized that “[i]t is the physician’s function within the state system . . . that determines whether his actions can fairly be attributed to the State.”<sup>131</sup> When private medical professionals carry out the obligatory functions of the state, they become state actors for purposes of § 1983 and thus are potentially liable for constitutional violations.<sup>132</sup>

#### *B. Plaintiffs Must Prove Liability Under a Deliberate Indifference Standard*

Eighth Amendment “conditions of confinement” claims that are unrelated to use of force, like those alleging inadequate health care, are litigated under a “deliberate indifference” standard.<sup>133</sup> In *Estelle v. Gamble*, the Supreme Court held that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ proscribed by the [8th] Amendment.”<sup>134</sup> In other words, the Court held that a corrections officer’s deliberate indifference to the serious medical needs of an

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127. *Id.*

128. *Id.*

129. *See West v. Atkins*, 487 U.S. 42 (1988) (holding that a private doctor who contracts with a state prison to provide medical care to incarcerated individuals acts “under color of state law” to fall within the meaning of § 1983).

130. *Id.* at 55–58.

131. *Id.* at 55.

132. *Id.*

133. *See SCHLANGER, ET AL.*, *supra* note 124, at 58–59 (stating that “[n]on-force Eighth Amendment claims are currently governed by a “deliberate indifference” standard”).

134. *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

incarcerated individual amounts to a violation of his Eighth Amendment right to be free from cruel and unusual punishment.<sup>135</sup> The *Estelle* opinion set out a two-pronged test for incarcerated plaintiffs alleging claims of inadequate health care.<sup>136</sup> Plaintiffs were required to show: 1) an objectively serious medical problem or need and; 2) that actions or omissions of a correctional employee in addressing that need were sufficiently harmful to rise to the level of deliberate indifference.<sup>137</sup>

In 1994, in the case *Farmer v. Brennan*,<sup>138</sup> the Supreme Court added another layer to *Estelle*'s deliberate indifference standard. The Court added a subjective component to *Estelle*'s seemingly objective test.<sup>139</sup> In *Farmer*, the Court held that incarcerated individuals, in addition to proving an objectively serious medical need, must also show that a prison or jail official knew of, and disregarded, "an excessive risk to [their] health or safety."<sup>140</sup> The deliberate indifference analysis thus turns on correctional officers' knowledge at the time of the alleged mistreatment.<sup>141</sup> In sum, to satisfy the modern-day deliberate indifference test, a plaintiff must show that a correctional officer knew about the incarcerated individual's substantial risk of serious harm *and* failed to take subsequent action with that knowledge.<sup>142</sup>

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135. *Id.*

136. *Id.* at 104.

137. *Id.*

138. *See* *Farmer v. Brennan*, 511 U.S. 825, 847 (1994) (holding that a prison official may only be liable for an Eighth Amendment violation of inadequate health care "if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it").

139. *See id.* at 837 (declaring that "[a] [subjective] approach comports best with the text of the [Eighth] Amendment as our cases have interpreted it").

140. *See id.* ("[T]he official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.").

141. *Id.*

142. *See* SCHLANGER, ET AL., *supra* note 124, at 134 ("The defendant official must subjectively know of the potential harm—it is not enough that she should appreciate the potential for harm, that a reasonable person would appreciate that potential, or that the risk is obvious.").

By stating that “the Eighth Amendment does not outlaw cruel and unusual conditions,”<sup>143</sup> only cruel and unusual punishments, the *Farmer* Court emphasized that jails and prisons, as penal facilities, will not be liable for constitutional violations for failing to offer comfortable living accommodations. To distinguish between ‘conditions’ and ‘punishments’, the Court found that a subjective component of the deliberate indifference analysis was necessary.<sup>144</sup> Only the conscious disregard of prisoners’ medical needs would rise to the level of an Eighth Amendment violation.<sup>145</sup> In the *Farmer* opinion, Justice Souter noted “[a]n official’s failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.”<sup>146</sup> In other words, correctional officers who fail to perceive or acknowledge a prisoner’s significant medical need, even if they should have, do not violate the prisoner’s Eighth Amendment rights.<sup>147</sup>

By adding a subjective component to the deliberate indifference test, the *Farmer* Court proceeded to raise the bar for claims against corrections officers and private contractors for Eighth Amendment violations, largely to the detriment of incarcerated plaintiffs.<sup>148</sup> Under *Farmer* and *Estelle*, medical and correctional staff negligence is not enough to win a constitutional claim, “no matter how often or repeatedly they were negligent.”<sup>149</sup> The bar is set extremely high for proving Eighth Amendment liability. Further yet, incarcerated plaintiffs often lack, and are usually barred from, the evidence necessary to sufficiently prove

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143. *Farmer*, 511 U.S. at 837 (internal quotations omitted).

144. *See id.* (“[T]he official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.”).

145. *Id.*

146. *Id.* at 838

147. *Id.*

148. *See infra* Part IV.A (finding that in addition to the high bar for liability, lack of access to evidence makes proving claims of constitutional violations extremely difficult).

149. *See A Jailhouse Lawyer’s Manual*, in COLUM. HUM. RTS. L. REV. 717 (12th ed. 2020) (“You cannot win a federal constitutional claim of deliberate indifference by alleging only that prison medical staff acted negligently, no matter how often or repeatedly they were negligent.”).

their claims under an Eighth Amendment deliberate indifference standard.<sup>150</sup>

*C. The Prisoner Litigation Reform Act (PLRA) Creates Additional Barriers for Incarcerated Litigants*

Even if an incarcerated individual challenging substandard health care can satisfy the requirements of the Eighth Amendment deliberate indifference standard through a § 1983 claim, the effects of the Prisoner Litigation Reform Act may still bar litigation. In 1996, Congress passed the Prisoner Litigation Reform Act (PLRA), which was signed into law by President Bill Clinton.<sup>151</sup> Supporters of the PLRA believed that too many incarcerated individuals were filing frivolous lawsuits against the government and that drastic reform was needed to prevent meritless prisoner litigation.<sup>152</sup> Since its enactment, the PLRA has had the adverse effect of making it significantly harder for incarcerated individuals to file lawsuits in federal court.<sup>153</sup> Imposing additional procedural requirements and penalties on prisoners and detainees, the PLRA creates additional barriers for the plethora of incarcerated individuals who “face harsh, discriminatory, and unlawful conditions of confinement —

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150. See Healy & Willmsen, *supra* note 61 (noting that legal complaints against correctional healthcare companies are “often dismissed by judges for lack of evidence”); see also *infra* Part IV.A (describing private correctional healthcare companies’ nondisclosure policies that make it extremely difficult for incarcerated litigants to access evidence to support their claims).

151. 42 U.S.C. § 1997e.

152. See Andrea Fenster & Margo Schlanger, *Slamming the Courthouse Door: 25 Years of Evidence for Repealing the Prison Litigation Reform Act*, PRISON POL’Y INITIATIVE (April 26, 2021) (“When the PLRA was being debated, lawmakers who supported it claimed that too many people behind bars were filing frivolous cases against the government.”) [perma.cc/CPN2-7TXZ].

153. See *id.* (stating that the PLRA “makes it much harder for incarcerated people to file and win federal civil rights lawsuits”); see also Gelman, *supra* note 17, at 1413 (“In 2009, Human Rights Watch reported that the number of lawsuits brought by prisoners per thousand prisoners has decreased by sixty percent since the [PLRA’s] passing.”).

and when mistreated, . . . have little recourse outside the courts.”<sup>154</sup>

The strict procedural requirements of the PLRA have prevented many incarcerated individuals from litigating potentially successful civil rights claims in federal court.<sup>155</sup> The most severe components of the PLRA are the ‘exhaustion rule,’ requirements for filing fees, and the three strikes provision.<sup>156</sup> Each of these will be briefly discussed.

First, under the PLRA’s ‘exhaustion rule,’ incarcerated individuals are required to exhaust all administrative remedies prior to filing a lawsuit against the government.<sup>157</sup> The ‘exhaustion rule’ requires prisoners and detainees to try to resolve their complaints and appeals through the prison’s or jail’s internal grievance process before pursuing a case in federal court.<sup>158</sup>

The second major provision of the PLRA is the fee-filing requirement, which requires all prisoners to pay court filing fees in full.<sup>159</sup> Even if incarcerated litigants proceed *in forma pauperis* (IFP),<sup>160</sup> they must pay the full filing fee, which most courts allow

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154. See Fenster & Schlanger, *supra* note 152 (describing conditions of confinement that are the source of substantial prisoner litigation).

155. See *id.* (asserting that “the legislation has created a double standard that limits incarcerated people’s access to the courts at all stages” because it “requires courts to dismiss civil rights cases from incarcerated people for minor technical reasons before even reaching the case merits”).

156. See *Know Your Rights: The Prisoner Litigation Reform Act*, ACLU, 1–3 (describing the important provisions of the PLRA).

157. See *id.* at 1 (stating that incarcerated individuals must first try to “resolve [their] complaint through the prison’s grievance procedure”).

158. *Id.*; see also Fenster & Schlanger, *supra* note 152 (“The PLRA makes many lawsuits non-starters by requiring cases to be dismissed if plaintiffs have failed to “exhaust” all of the prison or jail’s internal administrative grievance processes before taking their case to court.”).

159. See *Know Your Rights*, *supra* note 156, at 2; see also *A Jailhouse Lawyer’s Manual*, *supra* note 149, at 340 (stating that “[t]he PLRA requires all prisoners, including poor or needy prisoners . . . , to pay all of their court filing fees”).

160. See 28 U.S.C. § 1915(a)(1) (granting United States courts the authority to commence civil or criminal actions or proceedings without prepayment of fees upon a litigant’s showing of financial inability to pay such fees).



to be made in installments.<sup>161</sup> Despite poor or needy prisoners' lack of financial resources and potential IFP status, there is no exception to the fee requirement.<sup>162</sup>

Lastly, incarcerated litigants must be wary of the PLRA's "three strikes" provision.<sup>163</sup> If an incarcerated plaintiff files a lawsuit or appeal that is dismissed on the grounds that it is "frivolous, malicious, or fails to state a claim upon which relief may be granted," that lawsuit will be deemed a 'strike.'<sup>164</sup> If a prisoner or detainee gets three "strikes," he or she is precluded from filing another lawsuit *in forma pauperis* and cannot file again unless he or she pays the entire court filing fee up-front.<sup>165</sup> The only exception to the three strikes provision is for incarcerated litigants filing lawsuits alleging imminent danger of serious physical injury.<sup>166</sup> If an incarcerated plaintiff can show that a serious injury is imminent, the court will allow the plaintiff to file *in forma pauperis*.<sup>167</sup> In sum, the three strikes provision raises the bar for complaints filed by incarcerated plaintiffs.<sup>168</sup> Plaintiffs must "describe a specific violation of law" to prevent their claims from

161. See *A Jailhouse Lawyer's Manual*, *supra* note 149, at 339 ("Under the PLRA, even if you proceed *in forma pauperis*, you have to pay the full \$350 filing fee . . . in installments.").

162. See *id.* at 341 (noting that there are no exceptions to the fee requirement because courts do not allow a delay of payment until after release).

163. See 28 U.S.C. § 1915(g) (describing the penalties of the three strikes provision of the PLRA).

164. See *id.* (quoting 28 U.S.C. § 1915(g)); but see *A Jailhouse Lawyer's Manual*, *supra* note 149, at 347 (stating that a case dismissed on grounds other than frivolousness, maliciousness, or failure to state a claim is not counted as a "strike" for purposes of 28 U.S.C. § 1915(g)).

165. See *A Jailhouse Lawyer's Manual*, *supra* note 149, at 345 (asserting that if a litigant has "three complaints or appeals dismissed as wasteful, intended to hurt, or that fail to state a legitimate legal basis," he or she "cannot file a new complaint or appeal *in forma pauperis*"); see also *Know Your Rights*, *supra* note 156, at 3 (explaining that after a claimant has three strikes, he or she "cannot file another lawsuit *in forma pauperis*" and thus can only continue to file suit by paying the entire court filing fee up-front).

166. See 28 U.S.C. § 1915(g) (stating the physical injury exception).

167. *Id.*; see also *A Jailhouse Lawyer's Manual*, *supra* note 149, at 345 (noting that claimants who provide sufficient showing of a serious imminent physical injury can overcome the three strikes bar).

168. See *A Jailhouse Lawyer's Manual*, *supra* note 149, at 346 (emphasizing the particularity with which incarcerated individuals must support their claims).

getting dismissed with a ‘strike’ because each strike becomes one closer to potentially irreversible consequences.<sup>169</sup>

In the two decades following the PLRA’s enactment, the number of civil rights cases filed by prisoners and incarcerated individuals decreased substantially, primarily due to the Act’s heightened requirements and provisions for prisoner litigation.<sup>170</sup> In the context of correctional health care, the PLRA’s requirements also apply to claims made against private correctional health care providers.<sup>171</sup> While prison and jail populations have increased since the late 1990s, the drastic decrease in prisoner litigation suggests that the PLRA, though passed with the purpose of filtering out meritless lawsuits, has “tilted the playing field against prisoners across the board.”<sup>172</sup> While incarcerated litigants are free to file their constitutional claims in state courts, many states have adopted their own PLRAs similar to the federal statute, thus making litigation difficult and burdensome in both the state and federal systems.<sup>173</sup>

Incarcerated individuals who have viable Eighth Amendment claims for inadequate health care may be disincentivized to pursue litigation because of the various legal and procedural challenges just mentioned. With high bars imposed by the deliberate indifference standard and the filing requirements of the PLRA, incarcerated litigants are often deterred from pursuing civil rights claims because of procedural hurdles, lack of evidentiary proof, and

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169. *Id.*

170. *See* Goepfert, *supra* note 90, at 142 (“While the U.S. prison population increased more than forty percent between 1995 and 2014, prison litigation decreased by more than fifty percent.”).

171. *See* Gelman, *supra* note 17, at 1414 (“While the statute gives no definition outlining who may *be sued* under the PLRA, it is “well established” judicial practice “that the PLRA applies to prison contractors,” including private healthcare companies.”).

172. *See id.* at 1413 (internal citations omitted); *see also* Goepfert, *supra* note 90, at 143 (“[D]ata suggests that after the PLRA was enacted, prisoner plaintiffs lost more cases pretrial, arrived at fewer settlements, and went to trial less often.”).

173. *See* Gelman, *supra* note 17, at 1413–14 (noting that both state and federal statutes add burdens and restrictions to litigation that only applies to incarcerated individuals).

the high costs of litigation.<sup>174</sup> Therefore, incarcerated plaintiffs with severe cases of deficient care are often driven to settle with correctional healthcare providers.<sup>175</sup> Correctional healthcare providers get the upper hand in settlement agreements because they get to escape a public trial and are not required to disclose the egregious misconduct that led to the settlement agreement in the first place.<sup>176</sup> Because correctional healthcare providers' settlement and nondisclosure agreements distance them from the courtroom, incarcerated individuals alleging unconstitutional care through traditional litigation struggle to achieve legal wins in this arena.<sup>177</sup>

#### *IV. Privatized Correctional Health Care Makes Correctional Systems Worse, Not Better*

While some contend that privatized health care benefits correctional institutions and incarcerated populations, problems associated with privatization have come to the forefront after decades of incessant failures in jails and prisons that have outsourced health care to for-profit companies.<sup>178</sup> Privatization has

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174. *See id.* at 1410 (stating that even when a plaintiff has a potentially viable claim against a private provider, he or she may be disincentivized to go to trial).

175. *See* Healy & Willmsen, *supra* note 61 (reporting that Wellpath settled with one victim's family for \$525,000 after the victim died from a bleeding stomach ulcer in a Virginia jail and NaphCare similarly settled with a victim's family for \$500,000 after the victim had a seizure and died while restrained in an Ohio jail).

176. *See id.* (stating that correctional companies often advertise that they never lose legal cases when the reality is that they settle lawsuits totaling millions of dollars behind closed doors).

177. *Id.*

178. *See* Mellow & Greifinger, *supra* note 78, at 87 ("Some governments argue that the advantages include better inmate health care, a more effective way to budget for rising health care costs, and the belief that the [private correctional health care provider] expertise will prevent health related lawsuits."); *see also* Lauren Galik & Leonard Gilroy, *Public-Private Partnerships in Correctional Healthcare*, REASON FOUND. 4 (2014) ("There are several potential advantages to forming [public-private partnerships] in correctional health care, which include cost savings, improved performance and quality of services inmates receive, incentivizing innovation in care, and transferring risk of litigation away from the state."); *but see* Ned Oliver, *Virginia Moves to Immediately Sever Ties with Prison Health Care Contractor. 'The Relationship Has Degraded Significantly.'*, VA.

not contributed to higher quality health care, is not an efficient means of government resources and spending, and does not ensure adequate oversight over the conduct of private employees in public facilities.<sup>179</sup> Increasing concerns with privatization have been exacerbated by recent reports that mortality rates are higher in jails that contract with private correctional healthcare providers than in jails that deliver incarcerated individuals' health care under a public delivery model.<sup>180</sup>

This Part will provide an overview of the major problems with private correctional health care. While this Note does not address all the troubling aspects of privatized care in jails and prisons, Part IV will highlight and discuss the most glaring problems with privatization including the lack of transparency in privatized systems, systemic staffing and quality issues, and the suspect nature of a profit-driven industry.

*A. Privatized Correctional Health Care Diminishes Transparency and Accountability in Correctional Institutions*

In jails and prisons that have outsourced correctional health care, private actors oversee all healthcare functions and services with limited government oversight and public accountability.<sup>181</sup> This is largely because private companies, including the private correctional healthcare industry, are not required to publicly

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MERCURY (Oct. 13, 2021, 3:01 PM) (noting that in 2021, Virginia ended its \$90 million annual contract with Armor Correctional Health because “lack of communication and activities of the vendor significantly jeopardize[d] the ability of the [Department of Corrections] to ensure constitutionally adequate medical care [was] being provided as contractually required . . .”) [perma.cc/C3LU-8JZA].

179. See Oliver, *supra* note 178 (describing the reasons why Virginia cancelled its contract with Armor before its termination date because of findings of egregious misconduct and lack of oversight).

180. See Szep et al., *supra* note 35 (“A Reuters review of deaths in more than 500 jails found that, from 2016 to 2018, those relying on one of the five leading jail healthcare contractors had higher death rates than facilities where medical services are run by government agencies.”).

181. See McLeod, *supra* note 56 (noting that there are no inspection programs or national agencies charged with ensuring adequate delivery and quality of correctional health care); see also Healy & Willmsen, *supra* note 6161 (describing the correctional health care industry as one marked by “little public scrutiny”).

disclose information about their policies, practices, or lawsuits.<sup>182</sup> As nongovernmental entities, private healthcare contractors are not subject to states' freedom of information laws that require disclosure of government and public agency records.<sup>183</sup> Modeled after the federal Freedom of Information Act,<sup>184</sup> all fifty states have passed their own freedom of information laws that require the release of state and local government records.<sup>185</sup> These open records laws are geared towards increasing accountability and transparency in public systems.<sup>186</sup>

However, because private healthcare providers are not subject to state freedom of information laws, they are under no obligation to release records that may expose patterns of misconduct or be of evidentiary value to incarcerated individuals asserting Eighth Amendment violations.<sup>187</sup> Without access to company records, incarcerated plaintiffs usually fail to meet their evidentiary burdens in holding private healthcare companies liable under 42 U.S.C. § 1983.<sup>188</sup> While the lawsuits filed against correctional providers are a matter of public record, the companies, themselves,

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182. See Gelman, *supra* note 17, at 1429 (observing that while public agencies have obligations to the public that require them to disclose records like budget documents, the activities of private companies can remain under secret such as settlement agreements).

183. See *id.* at 1429 (“Public agencies, . . . have certain disclosure requirements that allow for more stringent oversight by the public.”).

184. 5 U.S.C. § 552; see also *FOIA/PA Overviews, Exemptions, and Terms*, FBI (2021) (explaining that the FOIA “generally provides that any person has a right—enforceable in court—of access to federal agency records” subject to certain exceptions) [perma.cc/QF3P-E9QX].

185. See *A Jailhouse Lawyer’s Manual*, *supra* note 149, at 83 (noting that “[o]nly state freedom of information laws grant access to state and local government records”).

186. See Gelman, *supra* note 17, at 1431 (“Such disclosures, whether voluntary or court-ordered, can expose deficiencies in service and lead to much-needed improvements.”); see also *id.* at 1430 (“[W]hen government agencies refuse to comply with disclosure requirements, public oversight puts pressure on the government to either comply or change their policies.”).

187. See *id.* at 1429 (stating that without access to necessary records, an incarcerated plaintiff may struggle to pursue a claim against a provider).

188. See *id.* (“[C]onclusory allegations that the organization acted according to a policy are insufficient; instead, potential plaintiffs must have some evidence of such a policy.”).

do not have to reveal their litigation history or corporate records.<sup>189</sup> They often justify nondisclosure by labelling the information as trade secrets.<sup>190</sup> In New Mexico, for example, Corizon pushed back on court-mandated rulings requiring disclosure of the company's past settlement agreements.<sup>191</sup> The company maintained its position "that [they] are not subject to" the state's public records laws and thus are under no obligation to produce those records to the public.<sup>192</sup> Because private healthcare providers are essentially immune from having to disclose corporate policies and records, incarcerated plaintiffs and the public lack vital information to hold these companies accountable.<sup>193</sup>

### *B. Private Providers Engage in Suspect Hiring and Staffing Practices*

While correctional healthcare providers keep the public in the dark regarding their official policies, these companies have come under fire because of their suspect hiring practices.<sup>194</sup> To cut costs where possible, correctional healthcare companies make strategic

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189. See McLeod, *supra* note 56 (stating that one major provider highlighted in a contract proposal that the company's litigation history was a trade secret).

190. See *id.* (commenting that private providers like Wellpath consider "basic information including health-care policies, training protocols, and its client list, to be trade secrets").

191. See Phaedra Haywood, *Ex-Prison Health Contractor Won't Release Records Despite Court Rulings*, SANTA FE NEW MEXICAN (Mar. 1, 2021) (explaining that Corizon, which held a \$37.5 million contract in the state, refused to comply with court rulings requiring the company to disclose former settlements made with incarcerated individuals who sued over poor care) [[perma.cc/V4DV-VPF3](https://perma.cc/V4DV-VPF3)].

192. See *id.* (noting that Corizon maintains that it is not subject to the state's public records law, the Inspection of Public Records Act, and will seek further court review).

193. See Healy & Willmsen, *supra* note 61 ("Unlike elected sheriffs, contractors such as Wellpath aren't subject to public records laws. Most have used that as a reason, along with privacy concerns, to keep records secret, making it difficult for families to hold them accountable. Often, the only way to do so is to sue.").

194. See Schwartzapfel & Jenkins, *supra* note 3 (identifying that over a six-year period, "Corizon paid [Arizona] more than \$3 million in fines for failing to hire enough doctors and nurses" in the state's prisons).

decisions about the number and caliber of people they hire. Because these companies are independent private contractors, they are not constrained by civil service regulations or salary scales that highly regulate public employment.<sup>195</sup> Therefore, to reduce costs, these companies often understaff workers in prisons and jails and hire unqualified employees.<sup>196</sup>

Healthcare providers that have failed to comply with staffing requirements have been fined severely by states and have been reprimanded by courts.<sup>197</sup> Several correctional healthcare companies including Corizon, Centurion, and NaphCare were fined millions of dollars by states and counties for failing to meet their contractual staffing obligations.<sup>198</sup> Providers have also been criticized for hiring workers who lack the requisite degree of skill and training needed for many healthcare positions.<sup>199</sup> For example, investigations of Corizon's hiring practices revealed that the company was largely staffing licensed vocational nurses (LVNs) in positions that should have been filled by registered nurses (RNs).<sup>200</sup> The company was thus allowing LVNs to perform jobs

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195. See Mellow & Greifinger, *supra* note 78, at 87 (explaining that it is easier for local and state governments to hire and retain physicians and healthcare professionals when they are not restricted by public service regulations and pay scales).

196. See *infra* Part V (discussing the poor hiring practices and deaths of incarcerated individuals that led New York to cancel its contract with Corizon).

197. See *supra* Part I (describing Arizona's history of failures to provide adequate care to prisoners and the severe sanctions imposed on the state and providers for failing to comply with compulsory performance measures).

198. See Gelman, *supra* note 17, at 1416–17 (noting that Corizon was fined \$1 million in for understaffing its facilities in New Mexico between 2007 and 2011 and even when New Mexico switched to a different private provider, Centurion, the state continued to fine Centurion \$2.1 million for staffing shortages between 2016 and 2018); see also Healy & Willmsen, *supra* note 61 (explaining that the sheriff's department in Suffolk County, Massachusetts fined NaphCare \$2.4 million in penalty fees for understaffing).

199. See Michael Winerip & Michael Schwirtz, *New York City to End Contract With Rikers Health Care Provider*, N.Y. TIMES (June 10, 2015) (discussing Corizon's troubling hiring practices in New York City jails in which the company failed to conduct thorough background checks on several employees) [perma.cc/UDF4-VHVV].

200. See Gelman, *supra* note 17, at 1414 (noting that Corizon had been staffing licensed vocational nurses instead of registered nurses in its jails primarily to cut costs).

that they were neither qualified nor trained to perform since the educational and licensing requirements for LVNs are considerably less than the licensing requirements for RNs.<sup>201</sup>

Corizon's inexcusable hiring practices contributed to the tragic death of an incarcerated individual, Martin Harrison, in a California jail in 2010.<sup>202</sup> Upon incarceration, Harrison told one of Corizon's nurses that he was suffering from severe alcohol withdrawal.<sup>203</sup> The nurse, a licensed vocational nurse, disregarded his requests for medical attention and failed to treat him.<sup>204</sup> Harrison died a few days later at the hands of deputies who tasered him while he was hallucinating.<sup>205</sup> After his death, Harrison's family filed a civil rights lawsuit and after one week into trial, the county and Corizon reached a deal with Harrison's family.<sup>206</sup> The parties agreed to settle the case for \$8.3 million, "the largest wrongful death settlement in a civil rights case in [California's] state history."<sup>207</sup>

### *C. Profit Motives Drive the Correctional Health Care Industry*

The correctional healthcare industry is largely driven by profit motives.<sup>208</sup> "These companies are inherently motivated to make money. That's why they're in the business."<sup>209</sup> While private companies contract with state and local governments to provide

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201. See *id.* at 1415 (explaining that the responsibilities of LVNs include transcribing and distributing medications whereas RNs typically supervise LVNs and provide direct care).

202. Henry K. Lee, *\$8.3 Million Settlement in Death of Alameda County Inmate*, SFGATE (Feb. 10, 2015, 4:12 PM) [perma.cc/8V42-P34F].

203. See *id.* (stating that Harrison had been arrested for jaywalking and a warrant for failure to appear in a DUI case).

204. *Id.*

205. *Id.*

206. *Id.*

207. See *id.* (explaining that the county and Corizon would split the costs of the payout).

208. See Coll, *supra* note 60 (stating that annual spending on correctional healthcare exceeds ten billion dollars).

209. See Healy & Willmsen, *supra* note 61 (quoting Andrew Harris, professor of criminology and justice studies at the University of Massachusetts, Lowell).



correctional health services, the directors of these companies owe fiduciary duties to their shareholders, not their patients.<sup>210</sup> Therefore, beyond providing healthcare services to individuals in jails and prisons, these for-profit companies want to make the most money possible to appease their shareholders and investors.<sup>211</sup>

Currently, the largest and most profitable correctional healthcare company is Wellpath.<sup>212</sup> It is estimated that Wellpath serves about 10% of the nation's counties, overseeing nearly 300,000 patients in 36 states on a daily basis.<sup>213</sup> The company's total annual revenue is estimated to be around \$1.6 billion.<sup>214</sup> As a multibillion dollar industry that is continuing to grow and expand, correctional health care attracts investors and shareholders who want to benefit from these companies' expansions and earnings.<sup>215</sup> However, cutting costs to maximize profits often leads to negative outcomes for incarcerated patients.<sup>216</sup> By intentionally understaffing facilities, refusing to send patients to the hospital, and hiring unqualified workers to deliver care, private correctional healthcare providers are reducing costs while simultaneously putting patients' lives at risk, all in the name of money.<sup>217</sup>

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210. See McLeod, *supra* note 56 (“They forget the private company doesn’t have fiduciary responsibility to the sheriff—they have a fiduciary responsibility to their shareholders.”).

211. See *id.* (clarifying that according to Moody’s Investors Service, “jails are an attractive sector” for correctional healthcare companies because they involve higher margins).

212. See *id.* (explaining that Wellpath was founded by H.I.G. Capital, “a private-equity firm with more than \$34 billion in equity capital under management”).

213. *Id.*

214. Healy & Willmsen, *supra* note 61.

215. See *id.* (describing investors who view “prison medicine as ripe for cost savings and potential investment payoffs”).

216. See *id.* (explaining that because profits derive from spending less than what is contracted for, correctional health care companies are not incentivized to increase the amount of care or quality of services provided).

217. See *id.* (“A WBUR investigation found inmates in county jails suffering, and sometimes dying, under the care of companies with contracts that provide incentives to curb costs and hospital trips.”).

*D. Absence of Uniform Standards in the Correctional Health Care Industry Furthers the Need for Greater Public Oversight*

In addition to problematic hiring practices and profit motives, the correctional healthcare industry has relatively no benchmarks or standards through which healthcare services and quality levels may be assessed.<sup>218</sup> However, a non-profit organization, the National Commission on Correctional Healthcare (NCCHC), claims to establish healthcare standards for prisons and jails in the United States.<sup>219</sup> NCCHC was founded in response to the lack of national standards for health services in correctional facilities.<sup>220</sup> The organization publishes recommendations, known as *Standards*, to help guide correctional health systems in the management and administration of healthcare services.<sup>221</sup> NCCHC also oversees a voluntary accreditation program based on its *Standards* to determine whether correctional facilities meet certain criteria in the provision of health services.<sup>222</sup>

While NCCHC's mission is to standardize minimum levels of care in correctional institutions, the organization's standards have

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218. See Blake Ellis & Melanie Hicken, 'Please Help Me Before It's Too Late', CNN (June 25, 2019) ("What adequate care actually means . . . has been left open for interpretation. No federal regulations set specific and detailed standards for health care provided to inmates in state and local prisons and jails.") [perma.cc/3EPG-6HLLG]; see also Schwarztapfel & Jenkins, *supra* note 3 (explaining that unlike hospitals and medical settings that are subject to Medicare's strict quality standards, prison and jail health care are not regulated by any similar accreditation processes or data transparency).

219. See *About Us*, NCCHC (2022) (stating that NCCHC "establishes standards for health services in correctional facilities" and "operates a voluntary accreditation program for institutions that meet those standards") [perma.cc/5MAV-MYAJ].

220. See *id.* (noting the nonprofit's origins date to the early 1970s "when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards").

221. See *id.* ("Written in separate volumes for prisons, jails and juvenile confinement facilities, . . . the *Standards* cover the areas of care and treatment, health records, administration, personnel and medical-legal issues.").

222. See *id.* (stating that the organization conducts an external peer review process to process to determine whether jails and prisons meet the organization's *Standards* for accreditation).

little, if any, legal impact.<sup>223</sup> Their proposals are mere recommendations and their accreditation process is only conducted on a voluntary basis.<sup>224</sup> The organization’s website maintains: “[w]hen a correctional facility achieves NCCHC accreditation, the message is clear: Its leaders are committed to providing a nationally accepted standard of care in health services delivery.”<sup>225</sup> However, while the organization’s motives and mission are admirable, the organization does not release any information about the facilities that it accredits.<sup>226</sup> There is also no other public database that discloses the means through which jails and prisons provide health care to their incarcerated populations.<sup>227</sup>

While states and correctional institutions can seek accreditation, most states do not require or conduct inspections of jails and prisons.<sup>228</sup> Additionally, no national agency is charged with ensuring that health care in correctional facilities meets certain quality standards.<sup>229</sup> Therefore, the most effective form of

223. See McDonald, *supra* note 28, at 438 (noting that “there remains considerable ambiguity regarding how much and what kinds of care prisoners should and should not be given”).

224. See *Jails and Prisons*, NCCHC (2022) (clarifying that while the *Standards* claim to “lay the foundation for constitutionally acceptable health services systems,” such recommendations are not made freely available to the public and must be purchased in volumes via the organization’s website) [perma.cc/CHD2-KG26].

225. See *Benefits of NCCHC Accreditation*, NCCHC (2022) (claiming that “[a]ccreditation signals a constitutionally acceptable level of care for a facility’s inmates”) [perma.cc/87HB-5PN2].

226. See *Accreditation FAQs*, NCCHC (2022) (“By policy, NCCHC does not release . . . lists [of all correctional facilities accredited by NCCHC], nor can it respond to inquiries as to whether a given facility is accredited.”)[perma.cc/4RGW-6GQM]; see also Kutscher, *supra* note 79 (stating that a spokeswoman for the commission declined to provide any information or statistics on the number of facilities the organization accredits).

227. See McLeod, *supra* note 56 (explaining that there is no federal database that records how jails and prisons provide health care whether publicly or through a private correctional healthcare).

228. See *id.* (noting that “[b]ecause there are no mandatory national standards, . . . administrators can decide what care they think is good enough to meet the Supreme Court’s standards”).

229. See *id.* (acknowledging that the U.S. Department of Justice has the power to investigate potential civil rights violations of incarcerated individuals but rarely exercises this power).

oversight is usually through litigation and constitutional challenges of inadequate care.<sup>230</sup> However, as discussed earlier in this Note, legal battles against private providers become much more difficult when incarcerated plaintiffs are unable to access records and evidence of wrongdoing.<sup>231</sup> If incarcerated individuals are consistently barred from accessing the resources necessary to sue and hold these companies accountable through litigation or public dissemination of misconduct, they will also continue to lack the power needed to drive systemic change for better correctional health care.

*V. What a Public Approach to Correctional Health Care Looks Like in Practice: A Case Study of New York City's Decision to Deprivatize*

In June of 2015, Bill de Blasio, then Mayor of New York City, announced that the city's contract with private provider, Corizon, for correctional health services would not be renewed.<sup>232</sup> As part of his administration's efforts to reform the city's criminal justice system and provide higher quality care to the city's incarcerated population, de Blasio announced that correctional health services in the city's jails would be turned over to NYC Health + Hospitals Corporation (HHC).<sup>233</sup> As the premier public health system

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230. See *id.* (quoting Carolyn Sufrin) (“The only de facto oversight system we have is litigation.”); *but see* Coll, *supra* note 60 (stating that litigation is not always the best way to improve public policy because “correctional health care is more than an arena that requires legal accountability when failures occur”).

231. See *supra* Part IV.A (discussing companies' nondisclosure policies).

232. See *Health and Hospitals Corporation To Run City Correctional Health Service*, *supra* note 26 (explaining the city's decision to not renew the contract with Corizon after “an extensive review by an interagency team . . . explore[d] new strategies for organizing and delivering health care in the New York City jail system.”).

233. See *Correctional Health Services Progress Report*, NYC HEALTH + HOSPITALS, 1 (2016) (describing “the de Blasio administration's commitment to reform the city's correctional system”); see also Maura Ewing, *Why New York Dropped Corizon*, MARSHALL PROJECT (June 11, 2015, 10:07 AM) (quoting Mayor de Blasio) (“We have an essential responsibility to provide every individual in our City's care with high-quality health services – and our inmates are no different. This transfer to HHC will give our administration direct control and oversight of our inmates' health services . . . .”) [perma.cc/VE4R-8RAJ].

overseeing all of New York City’s public hospitals, NYC Health + Hospitals was chosen to become the direct provider of health care in the city’s jails beginning in 2016.<sup>234</sup> De Blasio’s decision to terminate the city’s 15-year contract with Corizon marked an abrupt end to the outsourcing of public services to the private, for-profit corporation that had failed to meet the city’s expectations and desired results for correctional health care.<sup>235</sup> This Part will summarize New York City’s transition to public correctional health care, providing a concrete example of the benefits and innovations of a public delivery system.

This Part will highlight the influence, resources, and vital connections that mission-driven stakeholders, like the ones in New York, possess. As successfully evidenced by New York City’s partnership with public hospitals for the provision of correctional health services, this Part suggests that invested public agencies are more likely to acknowledge the inherent flaws of a privatized correctional health care system and favor a public delivery model that better serves the interests of the city, incarcerated populations, and criminal justice systems at large.

#### *A. New York City Ends Its Contract with Private Provider Corizon*

Before providing an overview of the positive impact that New York City’s public approach to correctional health care has had in improving delivery, quality, and oversight of care in the city’s jails,

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234. See *About NYC Health + Hospitals*, NYC HEALTH + HOSPITALS (“NYC Health + Hospitals is the largest public health care system in the United States. [They] provide essential inpatient, outpatient, and home-based services to more than one million New Yorkers every year in more than 70 locations across the city’s five boroughs.”) [perma.cc/F2QR-GT6P]; see also *Correctional Health Services*, NYC HEALTH + HOSPITALS (“In 2016, as a new division of NYC Health + Hospitals, Correctional Health Services became the direct provider of health care in the city’s jails. Since the transition, Correctional Health Services has leveraged the resources of the nation’s largest municipal public health care system . . . .”) [perma.cc/A39E-WNWM].

235. See Winerip & Schwirtz, *supra* note 199 (“The decision ends the company’s troubled 15-year history at the city’s jails . . . .”); see also Ewing, *supra* note 233 (explaining that problems of “poor oversight, disciplinary problems and neglect” along with “de Blasio’s conviction that basic public services should not be entrusted to for-profit contractors” played a role in the decision).

it is important to first address why Corizon lost its contract with the city and why the city ultimately stepped away from privatized health care altogether.

New York City's Department of Investigation conducted a thorough investigation of Corizon's conduct within the city's Rikers Island jail complex.<sup>236</sup> The Department reported that the company failed to conduct background checks on many of its employees and hired workers with disciplinary issues and criminal convictions.<sup>237</sup> New York state investigators also accused Corizon of medical negligence which played a role in the deaths of up to twelve incarcerated individuals at Rikers Island.<sup>238</sup> The report's shocking findings, along with the Mayor's increasing lack of trust in privatized services, led New York City administrators to pursue a public partnership with Health + Hospitals. They hoped to "leverage[e] the resources of the nation's largest municipal public health care system and chang[e] the culture of service to individuals in the custody of the city."<sup>239</sup>

While the Department of Investigation's report largely influenced the city's decision to end its contract with Corizon, New York City was not the only city or locality to do so based on findings of Corizon's subpar and suspect practices.<sup>240</sup> Between 2012 and 2016, Corizon "saw contracts terminated in Tennessee, Pennsylvania, Maine, Maryland, Minnesota and New Mexico."<sup>241</sup> Several other states and counties in the last few years also ended

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236. Winerip & Schwirtz, *supra* note 199.

237. *See id.* ("City investigators found that for 89 of 185 personnel files of health care workers they reviewed, there was "no evidence that Corizon conducted a candidate background investigation of any kind." The report said the result was hiring people with serious criminal convictions.").

238. *See id.* ("In one case that the State Commission of Correction found to 'shock the conscience,' an inmate was left dying, untreated for six days while uniformed officers, doctors, mental health clinicians and nurses made 57 visits to his cell without assisting him.").

239. *See Correctional Health Services, supra* note 234.

240. *See* Winerip & Schwirtz, *supra* note 199 (noting that Corizon faces "increasing scrutiny about its practices by prison officials, journalists and the courts" with numerous lawsuits filed against the company, many of which are filed by *pro se* incarcerated individuals).

241. *Id.*

their contracts with the provider for correctional health services.<sup>242</sup> Coming to relatively the same conclusions as the city investigators in New York, these states and municipalities fined or ended their contracts with Corizon because of the company's blatant noncompliance with contract benchmarks that require the provision of adequate and timely care to incarcerated individuals under the supervision of qualified staff.<sup>243</sup> While the company claims to provide "high quality healthcare . . . that will improve the health and safety of [their] patients,"<sup>244</sup> the number of contracts lost by Corizon, the number of lawsuits filed against the provider, and the number of settlement agreements paid out by the company imply that they are not holding true to their own promise of high standards.<sup>245</sup>

*B. New York Transitions to a Public Delivery Model for  
Correctional Health Care in Partnership with the City's Hospital  
System*

In moving away from the for-profit sector, Correctional Health Services (CHS) was created as a division of New York City's extensive public health system.<sup>246</sup> In 2015, the program was given

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242. See Rudi Keller, *Trial Set to Begin in Dispute Over \$1.4 Billion Missouri Prison Health Care Contract*, MO. INDEP. (Nov. 3, 2021, 5:50 AM) (explaining that Michigan, Missouri, and Kansas chose not to renew their contracts with Corizon) [perma.cc/RR5M-LEC3]; see also Szep et al., *supra* note 35 (stating that the company lost major contracts with Alameda County, California, Indiana, and Arizona).

243. See Will Tucker, *Profits vs. Prisoners: How the Largest U.S. Prison Health Care Provider Puts Lives in Danger*, S. POVERTY L. CTR. (Oct. 27, 2016) (describing a timeline of Corizon's controversies in several states and cities between June 2011 and June 2016) [perma.cc/59YM-86S4].

244. See *Home*, CORIZON HEALTH (2021) (outlining the company's mission) [perma.cc/D85V-TQ6W].

245. See David Royse, *Medical Battle Behind Bars: Big Prison Healthcare Firm Corizon Struggles to Win Contracts*, MOD. HEALTHCARE (Apr. 11, 2015, 1:00 AM) (explaining that the company has had more than 1,300 lawsuits over a five-year period because of "numerous allegations of quality problems") [perma.cc/88D7-W8EB].

246. See *Correctional Health Services*, *supra* note 234; see also *Healthcare in New York Correctional Facilities*, NYC HEALTH + HOSPITALS, 2 (2017) ("By October 2016, CHS successfully became the sole and direct provider of health care

a \$235 million annual budget, which grew to \$258 million in fiscal year 2022.<sup>247</sup> CHS would be comprised of 1,500 employees who would oversee the care of almost 10,000 people in the city's twelve jails.<sup>248</sup> Rather than choose another private vendor to take over the city's contract, New York City officials believed that a public approach to correctional health care would "streamline care before, during, and after incarceration" while also bridging the gaps between health services in the city's jails and the communities that most incarcerated individuals would return to.<sup>249</sup> NYC Health + Hospitals stated that its mission as the city's new correctional health care provider was "to achieve two main goals for incarcerated persons: (1) [to] increase the quality of and access to care while reducing the challenges to and demands on correction security staff; and (2) [to] improve continuity of care during and after incarceration."<sup>250</sup>

With the direct support of the city's officials and New York City's public hospital system, CHS is now a comprehensive system of care that provides "medical and mental health care, substance use treatment, dental care, social work services, discharge planning and re-entry services 24-hours a day, 7-days a week."<sup>251</sup> CHS's approach to correctional healthcare in New York City's jails

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– a service with 1,500 employees and 24/7 operations caring for almost 10,000 people daily in twelve jails citywide – with no lapses in coverage and no disruptions in patient care.”).

247. See *Oversight Hearing: Evaluating Recent Changes in Healthcare in New York City Correctional Facilities*, NYC HEALTH + HOSPITALS (May 26, 2016) (noting that \$235 million was allotted for the program in 2015) [perma.cc/9UE8-VYJH]; see also *March 22, 2021: Fiscal Year 2022 Preliminary Budget Hearing*, NYC HEALTH + HOSPITALS, 1 (2021) (explaining that the City's operating budget for fiscal year 2022 "totals \$285M . . . with a total headcount of 1,736 full-time staff").

248. See *id.* (describing program logistics).

249. See Ewing, *supra* note 233 (quoting Dr. Robert Cohen) ("The better integrated prisoner medical care is with community medical care, the better it's going to be. HHC comes at it from a healthcare perspective, and not from a corrections perspective.”).

250. *Correctional Health Services Progress Report*, *supra* note 233, at 1.

251. See *Healthcare in New York Correctional Facilities*, *supra* note 246, at 1 (stating that CHS's facilities "include at least one clinic in each jail in addition to two infirmaries, an urgicare clinic, a communicable disease unit, separate facilities for females and for youth, and a nursery”).



combines public health initiatives with efforts at criminal justice reform to decrease the city's incarcerated population while simultaneously increasing their access to necessary health services in both jail and community settings.<sup>252</sup> Speaking on behalf of CHS, Dr. Yang, Senior Vice President for Correctional Health Services, stated in 2017

[L]everaging our relationship with the larger system has resulted in the improved ability to recruit and retain talented professionals, enhanced information sharing, greater efficiencies and cost savings in the purchase of supplies and equipment. We undertook a concerted effort to reduce our reliance on private contractors. We have replaced specialty contracts, such as ob-gyn services, with staff specialists and or specialty services at Health + Hospitals facilities. Through these and other efficiencies CHS has reduced its reliance on private contracts by 80%, generating approximately 2 million in annual savings.<sup>253</sup>

*C. Accomplishments of New York's Partnership with Health + Hospitals to Date*

By transitioning to public delivery of correctional health care, New York officials hoped that public provision of care would bring about three key benefits: "continuity of care," "integration of physical and behavioral health services," and "direct, public accountability."<sup>254</sup> The city's goals were to streamline care in and

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252. *See id.*

CHS is an essential partner in New York City's criminal justice reform efforts as we help to create new avenues for diversion, reduce recidivism and decrease the overall jail population. We strive to be a smart, nimble multidisciplinary team of 1,500 professionals committed to human rights, social justice and accessible quality health services for people while they are in the City's custody and as they return to their communities.

253. *Id.* at 3.

254. *Health and Hospitals Corporation to Run City Correctional Health Service*, *supra* note 26.

out of the city's jails while holding HHC accountable as a "public entity" that is "held to higher standards of care by the Mayor, its Board, and the City of New York."<sup>255</sup> Unlike private providers, HHC owes duties to its patients and government partners, not corporate directors or shareholders.

In 2020, the city marked its fifth year of public correctional healthcare which was also the culmination of the city's five-year "CHS 2020" plan, an established set of goals from 2015 "designed to improve the quality of and access to care."<sup>256</sup> In its five years of operation, CHS claims to have not only met, but exceeded their goals, citing many of them in a report to the New York City Council Committee on Hospitals.<sup>257</sup> On top of meeting challenges presented by the COVID-19 pandemic, CHS "drove improvements in patient care while bolstering the City's commitment to creating a better criminal justice system."<sup>258</sup> Some of CHS's accomplishments included expanding their innovative mental health programs and enhancing pre-arraignment screening services "to identify patients with priority health issues."<sup>259</sup> They also established reentry support services to encourage patients' "successful transition into the community" and focused substantially on providing services to incarcerated individuals with substance abuse disorders.<sup>260</sup> CHS also used its government connections and developing relationships with incarcerated patients to support non-clinical programs, such as those directed at helping individuals register to vote and apply for Medicaid while incarcerated.<sup>261</sup>

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255. *Id.*

256. *See March 22, 2021: Fiscal Year 2022 Preliminary Budget Hearing, supra* note 247, at 1.

257. *See id.* ("We are proud to announce that we not only met but exceeded our goals. Achieving these CHS 2020 goals . . . drove improvements in patient care while bolstering the City's commitment to creating a better criminal justice system.")

258. *Id.*

259. *See id.* (describing CHS' innovative efforts and improvements in care since 2015).

260. *Id.* at 2.

261. *See id.* at 2 ("In addition to the expansion and enhancement of clinical services, 2020 brought increased civic engagement to the jails. CHS leveraged its relationship with its patients to help patients complete the census; register to vote; . . ."); *see also id.* at 4 (noting that CHS "partnered with DOC to help

In partnership with the city’s public hospital system, jail health care in New York City has improved considerably.<sup>262</sup> However, as noted by Dr. Bedard, the senior director of the Geriatrics and Complex Care Service at Correctional Health Services, “[c]orrectional health alone can’t mitigate all of the harms of incarceration . . .”. In New York City jails, for example, employees and detainees have increasing concerns about their safety and security as violence and dangerousness in the city’s jails has escalated in the last few years.<sup>263</sup> Therefore, adequate correctional health care can neither address nor remedy all the deep-seated problems within correctional systems. However, as evidenced by New York’s transition to public delivery of care, by placing trust, accountability, and oversight back into public governance, both broader public health goals and criminal justice reforms can be established and achieved. Further yet, improving conditions within confinement directly benefits the health, safety, and well-being of non-incarcerated populations as well.<sup>264</sup>

#### VI. Recommendations for Moving Away from Privatized Care

According to *Pew Charitable Trusts*, “[o]perating high-performing prison health care systems that meet constitutional

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patients apply for the Coronavirus Relief and Economic Security (CARES) Act payments” and “[i]n 2020, CHS also held its first-ever book drive”); *see also id.* at 2 (explaining that reentry support services also include helping inmate-patients complete Medicaid applications and informing them of post-release services).

262. *See* Ted Alcorn, *On Rikers Island, a Doctor Who Tends to the Oldest and Sickest*, N.Y. TIMES (Nov. 12, 2021) (quoting Dr. Rachael Bedard) (“In 2019, New York City had three in-custody deaths. This was the lowest in-custody mortality rate for any jail system in the country, and the lowest in New York City’s history.”) [perma.cc/FAY2-262H].

263. *See id.* (“Jails are incredibly dangerous places where you are concentrating folks who are in crisis. And harm reduction can only go so far if the . . . dangerousness escalates.”); *see also* Jonah E. Bromwich & Jan Ransom, *An ‘Absolute Emergency’ at Rikers Island as Violence Increases* (Nov. 8, 2021), N.Y. TIMES (noting that severe staffing shortages and deterioration of security protocols have contributed to an atmosphere marked by high levels of fear and increasing violence in New York’s jails) [perma.cc/XU2F-E2CD].

264. *See* Christy Visher and John Eason, *A Better Path Forward for Criminal Justice: Changing Prisons to Help People Change*, BROOKINGS (April 2021) (“Prison culture and environment are essential to community public health and safety.”) [perma.cc/SNQ5-DX5T].

obligations and make the most of opportunities to improve public health and public safety is in every state's interest."<sup>265</sup> However, outsourcing prison and jail health care to private providers has not improved public health or public safety. Despite exorbitant spending on correctional health care, states that have privatized care are not only failing to address the public health crises in their jails and prisons but are failing to protect the constitutional rights of their incarcerated populations.<sup>266</sup>

States and local governments must make conscious decisions about whether outsourcing correctional health care to private companies is in the state or locality's best interest. States that privatize care risk judicial intervention and condemnation for failure to provide constitutional levels of care, as demonstrated by the litigation in Arizona.<sup>267</sup> States that opt for public delivery models, however, can divert funding and resources to increase governance and oversight of correctional health care. This was the successful approach taken by officials in New York City.<sup>268</sup> Through discussion of the advantages of non-privatized care and alternative approaches to privatization, this Part urges states to deprivatize correctional health care in favor of public delivery models driven by invested stakeholders and qualified providers. While it is beyond the scope of this Note to fully address the lack of federal oversight and lack of uniform standards for correctional health care mentioned earlier in this Note,<sup>269</sup> policymakers and legislators should also support and fight for the creation of state and federal agencies whose sole job is to establish universal benchmarks for correctional health care systems and actually oversee that such benchmarks are being met by jails and prisons throughout the United States.

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265. *Prison Health Care: Costs and Quality*, *supra* note 33, at 6.

266. *See id.* at 3 (“[S]tates spent \$8.1 billion on prison health care in fiscal 2015—probably about a fifth of overall prison expenditures.”).

267. *See* Part I (describing litigation in Arizona about inadequate healthcare in the state's prisons).

268. *See* Gelman, *supra* note 17, at 1433 (“To improve care, governments and corrections departments must seriously consider whether contracting with private healthcare companies is the best way to provide prisoner healthcare.”).

269. *See* Part IV.D (describing the absence of uniform standards for correctional health care systems).

*A. The Benefits of Non-Privatized Care: Accountability, Oversight, and Institutional Trust*

Correctional healthcare is not good healthcare.<sup>270</sup> Regardless of whether the care is provided by the state or a third-party provider, health care in jails and prisons is limited.<sup>271</sup> However, states, alone, possess the resources and political will needed to improve correctional health care and achieve far-reaching policy goals. When correctional health care is delivered through public agencies, states take full responsibility over the well-being of their citizens.<sup>272</sup> They become directly accountable to the individuals they confine and subject to criticism and litigation upon failure to provide adequate care.

Public control over correctional health care furthers accountability, oversight, and trust in correctional systems.<sup>273</sup> Michele Deitch, in her article *Special Populations and the Importance of Prison Oversight*, states that “[i]n the correctional context, systems of accountability are . . . critical because the stakes are so much higher and because we are dealing with closed institutions with total control over human beings.”<sup>274</sup> Deitch goes on to emphasize the particular need for effective oversight of correctional health care because an incarcerated individual has no other alternative for care if his request for medical attention is wrongfully denied.<sup>275</sup> Public systems can provide this level of

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270. See Schwartzapfel & Jenkins, *supra* note 3 (noting that prison healthcare systems, privatized or not, rarely get high marks for quality care).

271. See *id.* (explaining for example that in Arizona “[t]he number of medical staff decreased by 11% from 2012 to 2019, despite Arizona’s prison population remaining relatively flat, leaving prisons with hundreds of fewer providers than they needed . . .”).

272. See Michele Deitch, *Special Populations and the Importance of Prison Oversight*, 37 AM. J. CRIM. L. 291, 294 (“Every public agency must have effective systems of accountability.”).

273. See Schwartzapfel & Jenkins, *supra* note 3 (“The state’s oversight of care, high and measurable quality standards, and efficient use of resources all matter . . .”).

274. Deitch, *supra* note 272, at 294.

275. See *id.* at 301 (“The numbers of grievances and lawsuits filed by prisoners about inadequate medical care—not to mention the billions of dollars spent on correctional health care annually—speak volumes about the need for effective oversight of this service.”).

oversight and external scrutiny. While publicly delivered health care is not guaranteed to be leaps and bounds better than privatized correctional health care, “public models . . . allow for the increased oversight necessary to pressure governments into improving care.”<sup>276</sup>

To that end, New York City is a living model of successful public oversight. Dr. Yang of Correctional Health Services in New York publicly stated that the program is “morally and ethically obligated” to improving the care of patients in the city’s jails so that when they leave, they hopefully do not return.<sup>277</sup> The goals of Correctional Health Services in New York, to “create and support new avenues for diversion, reduce recidivism and decrease the overall jail population,”<sup>278</sup> would not be possible without the support of the City and its agency partners. It is unlikely that such goals would be the same in a privatized system. Public governance and oversight can improve the quality and quantity of health care in correctional institutions while also being an effective mechanism for achieving other policy goals.

### *B. Alternative Approaches to Privatized Correctional Health Care*

There are several public and nonprofit alternatives to private correctional health care. While the New York City case study is representative of a public delivery model, other states deliver care in collaborative and efficient ways. It is beyond the scope of this Note to fully address and discuss all the possible approaches to correctional health care. Rather, this section discusses a few of the public delivery approaches currently at work. This section highlights the unique position states are in to take accountability for the well-being of their incarcerated populations and to remedy defective correctional health care systems. Deprivatizing correctional health care is not a simple task, and some states may not possess the infrastructure to solely deliver correctional health

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276. Gelman, *supra* note 17, at 1434.

277. *Healthcare in New York Correctional Facilities*, *supra* note 246, at 6.

278. *Id.*

care on their own.<sup>279</sup> However, states can look to one another for guidance and implement changes geared at either partial or full deprivatization. Even partial deprivatization of correctional health care can lead to increasing oversight and public accountability.

Public university systems, nonprofits, and public agencies can all be stakeholders and partial or full providers of correctional health care. Since the 1980s, four states – Texas, Georgia, New Jersey, and Connecticut – have outsourced some or all of their correctional health care to state university systems.<sup>280</sup> In New Jersey, for example, the state contracts with Rutgers University to provide correctional health care.<sup>281</sup>

In Texas, the correctional healthcare system is a collaboration between the state’s prison system, the Texas Department of Criminal Justice (TDCJ), and two of the state’s leading health sciences centers – Texas Tech University Health Sciences Center and the University of Texas Medical Branch at Galveston.<sup>282</sup> Together, these organizations make up the Correctional Managed Health Care Committee (CMHCC) whose mission is to “to develop a statewide managed health care plan that provides TDCJ offenders with timely access to quality health care while also controlling costs.”<sup>283</sup> CMHCC believes their partnership creates “win-win” scenarios for all partners involved because each partner’s ‘specialty’ and long-term policy goals benefits the others.<sup>284</sup> This is clearly stated on the Texas Department of Criminal Justice’s website, which says “[t]he criminal justice agency is seeking quality, cost-effective health services. The

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279. See McLeod, *supra* note 56 (stating that “[s]ome counties are beginning to question the move to go private, only to find it’s not so easy to go back” because of “a few big hurdles” that prevent deprivatization including a lot of up-front investment in infrastructure and medical systems that are extremely costly).

280. Coll, *supra* note 60.

281. See *University Correctional Health Care*, RUTGERS, (explaining that the partnership program between the Rutgers and the state was established in 2005 through “inter-State agency agreements”) [perma.cc/JZF5-9G55].

282. See *Texas Correctional Managed Health Care Committee*, TEX. DEPT. OF CRIM. JUST. (stating that “the primary purpose of the . . . partnership is to ensure that [Texas Department of Criminal Justice] offenders have access to quality health care while managing costs”) [perma.cc/575V-P6FH].

283. *Id.*

284. *Id.*

universities are seeking teaching and placement opportunities as well as financial support. The participating hospitals are seeking financial stability.”<sup>285</sup> More states and counties can look to Texas’ model as an example of how state university and medical systems can work in conjunction with the state’s criminal justice system. Similar partnerships can promote accountability and integration within criminal justice, public health, and correctional health care systems.

Another alternative to public delivery of correctional health care is through a federal agency like the U.S. Public Health Service Commissioned Corps. The Commissioned Corps is “a uniformed medical civil service of more than six thousand physicians, public-health specialists, and other professionals.”<sup>286</sup> One of the responsibilities of the Commissioned Corps is to oversee and manage medical and mental health programs for federal prisoners.<sup>287</sup> States could potentially form partnerships with agencies like this one to deliver care that is still under the government’s purview and driven by public interest.

There are also nonprofit organizations like Community Oriented Correctional Health Services (COCHS) that “work to bridge the gap between correctional community providers.”<sup>288</sup> Similar to New York City’s model that prioritizes continuity of care, COCHS works to streamline health care in and out of jails and prisons through advocacy and support services.<sup>289</sup> COCHS provides technical assistance for health information technology to more easily transmit health information between local correctional

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285. *Id.*

286. *See* Coll, *supra* note 60 (noting some alternative approaches to privatized care).

287. *See id.* (suggesting that states can look to the Commissioned Corps’ success in delivering healthcare to federal prisoners for ideas on how to publicly deliver care to states’ incarcerated populations).

288. *See COCHS’ Mission*, COCHS (“COCHS’ major emphasis has been to re-frame jail healthcare not as a place separate from the rest of the community but as another healthcare delivery site within the community.”) [[perma.cc/HA3D-8PGR](http://perma.cc/HA3D-8PGR)].

289. *See id.* (“Even though jails are not considered healthcare delivery sites, considerable resources are dedicated to medical care in these settings, including intake assessments, sick call, chronic medical and mental health care, emergency responses.”).



facilities and surrounding communities.<sup>290</sup> They also support legislation at the federal and state level. COCHS advocates that the Social Security program of Medicaid can play an important role “in addressing the underlying challenges faced by justice involved individuals.”<sup>291</sup> Nonprofits, like COCHS, are driven by a mission to improve the health conditions of incarcerated populations while also supporting greater public policy goals.<sup>292</sup> States and counties can look to form partnerships with nonprofit organizations in their areas that serve similar interests and that would improve both the correctional health care setting and the communities that incarcerated individuals will eventually return to.

Stakeholders, like nonprofits and university systems, can improve correctional healthcare systems through their resources, expertise, and collaborative approaches to public health and criminal justice reform. Public officials and legislators can also support and recommend state and federal legislation directed at releasing extremely ill incarcerated populations and providing smoother transitions of care into the community upon release.<sup>293</sup> States no longer have the luxury of looking away from the severe consequences of constitutionally deficient care in jails and prisons. Research, litigation, and negative health outcomes continue to highlight the perils of privatization.<sup>294</sup> States must take action to

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290. See *Jail Healthcare*, COCHS (“COCHS provides technical assistance to assist communities in finding ways to improve healthcare in local correctional facilities as well as providing expertise on health information technology to create connectivity and data sharing.”) [perma.cc/HA3D-8PGR].

291. See *Medicaid*, COCHS (summarizing the organization’s vocal position on improving the health of incarcerated populations through Medicaid funding) [perma.cc/DPR2-MT5Z].

292. See *COCHS’ Mission*, *supra* note 288 (“COCHS has also been the leader in identifying policies at the federal, state, and local levels that help local jurisdictions address the healthcare needs of their community members who are temporarily displaced within correctional institutions.”).

293. See, e.g., Brie A. Williams et al., *For Seriously Ill Prisoners, Consider Evidence-Based Compassionate Release Policies*, HEALTH AFFAIRS (Feb. 6, 2017) (“There are powerful moral arguments for releasing some prisoners of very advanced age or with serious life-limiting illness. But compassionate release also makes sense from an economic and a public safety perspective.”) [perma.cc/ZWQ2-RU5W].

294. See generally Szep et al., *supra* note 35.

overcome the stagnation and pitfalls of privatized correctional health care.

### *VII. Conclusion*

The litigation in Arizona, discussed in the Introduction of this Note, is a cautionary tale to states and localities that continue to rely on privatized correctional health care.<sup>295</sup> Privatization is neither a sustainable nor a successful system. While trials over correctional health care are rare, Judge Silver's order forcing the Arizona Department of Corrections to go to trial to publicly defend their consistent contractual failures and suspect practices is hopefully indicative of stronger judicial intervention in this arena. More judges, courts, and public officials need to scrutinize and condemn providers that consistently fail to comply with contractual obligations, risking the lives of incarcerated patients who are wholly reliant on the provider's care and decisions.

States, more importantly, need to end the cycle of deficient care within their correctional systems. They need to recognize that public delivery models offer what privatized systems cannot: oversight, accountability, and innovation. In Arizona, a correctional health care expert appointed by Judge Silver concluded "[p]rivatization has not served, and will continue to not serve, [Arizona Department of Corrections] well."<sup>296</sup> This holds true for other states that rely on privatized health care in jails and prisons. Incarcerated populations are inherently unhealthy and likely to return to their communities upon release. Ensuring that these individuals receive the care they need and deserve is in every state's best interest, but outsourcing public services to private, for-profit companies is not.

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295. See Part I (describing the Arizona Department of Correction's yearslong pattern of outsourcing care to providers who continue to provide grossly inadequate services).

296. Schwartzapfel & Jenkins, *supra* note 3.

*Update on Arizona Litigation:*

*This Note was written between September 2021 and February 2022. On June 30, 2022, Judge Roslyn Silver of the U.S. District Court for the District of Arizona ruled that the Arizona Department of Corrections violated the constitutional rights of incarcerated individuals in Arizona’s prisons.<sup>297</sup> She held that the Department of Corrections consistently failed to provide minimally adequate medical and mental health care to the state’s prisoners.<sup>298</sup> Characterizing the state’s correctional healthcare system as “grossly inadequate,” Judge Silver stated that “Defendants’ years of inaction . . . establish Defendants are acting with deliberate indifference to the substantial risk of serious harm posed by the lack of adequate medical and mental health care affecting all prisoners.”<sup>299</sup> The monumental decision in *Jensen v. Shinn* is hopefully indicative of a shifting tide towards greater public scrutiny and judicial oversight of systemically inadequate and non-functioning correctional healthcare systems overrun by for-profit private providers. In the first paragraph of the June 30 opinion, Judge Silver stated that “the health care and conditions of confinement must reflect basic common decency and a recognition of the dignity the government must accord all human beings.”<sup>300</sup> Incarcerated individuals have a constitutional right to health care; states and localities must take it upon themselves to provide care that meets at least constitutionally acceptable levels.*

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297. See Corene Kendrick and Maria Morris, *Federal Judge Finds Arizona’s Prison Health Care Is “Plainly Grossly Inadequate” and Unconstitutional*, ACLU (July 8, 2022) (“[A]fter almost a decade of broken promises by Arizona state prison officials, U.S. District Judge Roslyn O. Silver ruled on June 30 that the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) systematically violates the constitutional rights of people incarcerated in the state’s prisons.”)[[perma.cc/PU32-NSJG](https://perma.cc/PU32-NSJG)].

298. See *Jensen v. Shinn*, No. CV-12-00601-PHX-ROS, 2022 WL 2911496, at \*1 (D. ARIZ. June 30, 2022) (Defendants have failed to provide, and continue to refuse to provide, a constitutionally adequate medical care and mental health care system for all prisoners.”).

299. *Id.*

300. *Id.*