

JOHN V. JACOBI*

Abstract

Prison and jail populations are at record highs after twenty years of increasingly tougher sentencing laws. Simultaneously, government revenues are strained as a result of anti-tax sentiments. The result is too often inadequate and dangerous prison health care. The problem is very large, but not very new. American prisoners in all eras have suffered unhealthy conditions. Prison reformers from the founding of the Republic have argued for conditions reform on humanitarian grounds, and on the grounds that rehabilitation suffers when conditions are inhumane. Those arguments have not achieved significant improvements. More recently, the civil rights revolution of the 1960s and 1970s fostered a flowering of prison litigation based on the prisoners' own rights. After a brief period of expansion, the Court's and legislatures' anti-prisoner reactions have rendered prison litigation difficult to pursue and prisoners' rights difficult to vindicate.

This paper argues for a new vision of prison health reform. It argues that reform arguments should couple humanitarian impulses with pragmatic concerns. Almost all prisoners are eventually released. Poor prison health care is increasingly creating public health risks to the general population, and in particular to the communities to which prisoners return. Failure to treat chronic conditions and mental illness creates strains on community health providers and families, and causes recidivism. Failure to properly treat communicable diseases such as tuberculosis, HIV disease, hepatitis C, and syphilis harms the public more directly by exposing them to infection. The danger of the infection can be enhanced by poor prison care, as inconsistent treatment can produce treatment resistant microbes, allowing extremely deadly tuberculosis and HIV microbes to spread on prisoners' release. Prison health reform is therefore a selfless and a selfish act, as it protects the health of both prisoners and society more broadly. The paper finally sketches out some legal theories that may be brought to bear in forcing reform of prison health services.

* Professor of Law and Associate Director of the Health Law & Policy Program, Seton Hall Law School, jacobijo@shu.edu. Thanks to Tara Swenson for excellent research assistance. Contact at: jacobijo@shu.edu.

We don't care enough about prisoners' welfare. We should care deeply because, as two prominent commentators on the history of prisons have said, "Prisoners are ourselves writ large or small. And, as such, they should not be subjected to suffering exceeding fair expiation for the crimes for which they have been convicted."¹ Well over two million persons are imprisoned in America today. We imprison a higher percentage of our population than any other country. Those we imprison are disproportionately poor, of color, uneducated, and sick. They have chronic conditions, mental illnesses, sexually transmitted diseases and other infectious diseases. They usually receive inadequate health care – and sometimes shockingly poor care. It has always been so. Prison reformers have argued for decent prison care based on humanitarian principles since the founding of the Republic, and, notwithstanding some notable achievements, have failed to achieve decent conditions. In the last fifty years, reformers shifted to individual rights arguments based on prisoners' constitutional rights. Substantial progress in the early years of that era has given way to reaction from courts and legislatures, throwing this strategy of prison reform into doubt.

This article seeks to identify a third vision of prison reform to supplement the historic humanitarian and more recent individual rights efforts. This third vision of prison reform argues for decent prison health care on the basis of equal parts selfless and selfish motivations. Reform failures of the past notwithstanding, Americans retain some fellow feeling for prisoners. The power of this fellow feeling should not be overstated, as such feelings have proven too diffuse in the past to permit reform traction. The selfish motive for prison health reform therefore takes on great importance. The selfish motive springs from public health effects – the harm to communities that flows from mismanagement of prison health care. The harm that flows from mismanagement of chronic conditions and mental illness comprises severe strain on community health facilities, harm to the communities flowing from the inability of sick ex-prisoners to reintegrate into society, and the costs of recidivism when failure to reintegrate contributes to ex-prisoners' return to crime.

The harm that flows from mismanagement of sexually transmitted diseases and other infectious diseases is more direct. Almost all of the two million prisoners now in prisons and jails will return to their communities one day. If, due to poor prison health care, they return with uncontrolled syphilis, tuberculosis, HIV disease, and other infectious conditions, they will infect those around them. In these circumstances, prisons and jails serve as "epidemiological pumps,"² amplifying infectious conditions, perhaps even

¹ Norvall Morris and David Rothman, *Introduction*, in *THE OXFORD HISTORY OF THE PRISON: THE PRACTICE OF PUNISHMENT IN WESTERN SOCIETY XIII* (Norvall Morris and David J. Rothman, eds. 1998), at xiii.

² See *infra* text at notes 223-225.

transforming them into treatment-resistant strains, and then sending them out into society for distribution. It is in the interest of all in society to prevent the population health effects that demonstrably flow from mistreatment of the health conditions of prisoners.

The following pages describe the sorry state of health care services for an enormous prison and jail population, the serious harm poor health care works on the prisoners and the communities to which they return upon release, and the steps that should be taken to protect them and the communities they will reenter. Part I discusses the demographics and health status of the American prison population, and the health services provided them while imprisoned, with particular attention to communicable diseases, chronic illness, and mental illness. It grounds this discussion in modern-day realities in which one of every one hundred Americans is behind bars on any particular day. Part II describes the ebb and flow of prison conditions and health care reforms, focusing on the humanitarian movements of the 19th Century and the prisoners' rights movement of the mid-20th Century. Part III describes what may be a catalyst of a third wave of reform: the reentry movement, which seeks changes in the treatment of prisoners in order to facilitate their successful return as healthy, productive members of their community. This Part relates the third wave of prison health reform to the two that came before it, and describes the steps that should be taken to protect the community from harm. Public health measures have gained increasing public and political support in recent years, and public health is an increasingly common lens through which public policy concerns are viewed. Public health principles permit the focus of prison reform efforts to shift from the politically unpopular issue of prisoners' health to the more politically compelling issue of community health. This argument posits a marriage of convenience between the humanitarian or individual rights *obligation* to provide decent health care for prisoners' sake, and the public health *opportunity* to improve prison health care for the sake of the society to which most prisoners will return one day.

I. Prisons today: many sick, poorly treated prisoners.

America has been on a twenty-year spree of prison building, and has filled its old and new prisons and jails with unprecedented numbers of prisoners. Prisoners are disproportionately people of color, poorly educated, and sick. This Part sets out the current state of American imprisonment, with particular focus on the health status and health treatment of those behind bars.

A. Who is imprisoned?

Prison and jail populations increased more than four-fold from 1980 to 2003, from about 500,000 in 1980 to over 2,000,000 in 2003.³ The rate of incarceration in the United States grew to 726 persons per 100,000 by 2004, far outstripping the imprisonment rates in every other country in the world for which such statistics are maintained.⁴ In comparison, the rate of the second most prolific jailer, The Russian Federation, is 550 per 100,000, while Israel's is 209, Iran's is 191, Australia's is 117, Canada's is 116, Germany's is 96, Ireland's is 85, and Norway's is 65.⁵ The American increase in the rate of imprisonment far exceeds the rate of increase in the general population, and follows a fifty-year period of relatively stable rates of incarceration.⁶

The majority of those in prisons and jails are black or Hispanic. In federal and state prisons, the racial composition in 2003 was 35 percent white, 44.1 percent black, 19 percent Hispanic, and 1.9 percent other.⁷ In local jails, the composition was similar: 36 percent white, 40.1 percent black, 18.5 percent Hispanic, and 5.4 percent other.⁸ The impact of the growth of imprisonment has been most severe on black men.⁹ Almost three in ten black males (28.5 percent) will be incarcerated at some point in their lives. The figure for Hispanic men is three in twenty (16 percent), while that for white men is fewer than one in twenty-five (4.4 percent).¹⁰ The rate of incarceration for young black men is staggering. For example, in New York State in 1994, fully one in

³ U.S. Dep't. of Justice, Bureau of Justice Statistics, Key Facts at a Glance: Correctional populations: Number of persons under correctional supervision, (2004) available at <http://www.ojp.usdoj.gov/bjs/glance/tables/corr2tab.htm>.

⁴ See The Sentencing Project, *New Incarceration Figures: Growth in Population Continues* at 5 (May 2005) available at <http://www.sentencingproject.org/pdfs/1044.pdf>.

⁵ See International Centre for Prison Studies, *Entire World-Prison Population Rates per 100,000 of the national population* (March 23, 2005) available at <http://www.prisonstudies.org/>. The International Centre for Prison Studies is in the School of Law, King's College, University of London, and it has maintained a regularly updated compilation of incarceration rates since 2000. *Id.*

⁶ See MARC MAUER, RACE TO INCARCERATE 17 (1999).

⁷ Paige M. Harrison and Allen J. Beck, *Prisoners in 2003*, at 9 (U.S. Dep't. of Justice, Bureau of Justice Statistics, November 2004) available at <http://www.ojp.usdoj.gov/bjs/abstract/p03.htm>.

⁸ Doris J. James, *Profile of Jail Inmates, 2002*, at 2 (U.S. Dep't. of Justice, Bureau of Justice Statistics, July 2004, Revised October 12, 2004) available at <http://www.ojp.usdoj.gov/bjs/abstract/pji02.htm>.

⁹ See MAUER, *supra* note 6 at 124-25.

¹⁰ See Thomas P. Bonczar and Allen J. Beck, *Lifetime Likelihood of Going to State or Federal Prison* at 1 (March 1997) available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/lgsfp.pdf>.

four black men between the ages of 20 and 29 were in prison or jail, or on probation or parole.¹¹

Prisoners are remarkably less educated than the general population. Almost 75 percent of state prison inmates and almost 69 percent of those in local jails did not complete high school, compared with 18.4 percent of the general population.¹² Fifty two percent of black men born between 1965 and 1969 who did not graduate from high school had prison records by 1999 – that is, by the time they were thirty four years old.¹³ Not surprisingly -- given the correlations among education, race, and poverty -- prisoners are also predominantly poor. Of the large number of prisoners without a high school diploma, almost two-thirds had earned less than \$1,000 in the month before their arrest.¹⁴ America's prison population, then, is enormous and growing, and is disproportionately composed of poor, ill-educated men of color.

B. Health status of prisoners.

Two million prisoners do not reflect a cross-section of America; they are poorer, less well-educated, and much more likely to be of color. In addition, however, they are sicker:

The prevalence of chronic illness, communicable diseases, and severe mental disorders among people in jail and prison is far greater than among other people of comparable ages. Significant illnesses afflicting corrections populations include coronary artery disease, hypertension, diabetes, asthma, chronic lung disease, HIV infection, hepatitis B and C, other sexually transmitted diseases, tuberculosis, chronic renal failure, physical disabilities, and many types of cancer.¹⁵

¹¹ SCOTT CHRISTIANSON, WITH LIBERTY FOR SOME 281 (1998).

¹² Carol Wolf Harlow, *Education and Correctional Populations*, at 2-3 (U.S. Dep't. of Justice, Bureau of Justice Statistics, January 2003, Revised April 14, 2003) available at <http://www.ojp.usdoj.gov/bjs/abstract/ecp.htm>. The state prison and general population figures are from 1997, and the jail figures are from 1996.

¹³ Bruce Western, Vincent Shiraldi, and Jason Ziedenberg, *Education & Incarceration* at 7 (Justice Policy Institute, August 28, 2003), available at http://www.soros.org/initiatives/justice/articles_publications/publications/education_incarceration_20030828/EducationIncarceration1.pdf.

¹⁴ See Harlow, *supra* note 12 at 10. See also MAUER, *supra* note 6 at 162-63.

¹⁵ RE-ENTRY POLICY COUNCIL, REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 157 (2005) (footnotes omitted) (hereafter, "REPORT OF THE RE-ENTRY POLICY COUNCIL"). (The Re-Entry Council was formed by the Council of State Governments and was funded by the United States Departments of Justice, Labor, and Health and Human Services. Project partners included the American Probation and Parole Association, the Association of State Correctional Administrators, and the National Center for State Courts.). See Theodore M. Hammett, Cheryl Roberts, and Sofia Kennedy, *Health-Related Issues in Prisoner Reentry*, 47:3 CRIME & DELINQUENCY 390, 390 (2001) ("Prison and jail inmates represent an extremely large population that is disproportionately burdened with problems of physical and mental illness and substance abuse.").

They are sicker going in, and they are also sicker when they are released.¹⁶

Four categories of prisoners' conditions are worthy of particular attention: communicable diseases such as HIV disease and tuberculosis ("TB"); sexually transmitted diseases ("STDs") such as syphilis and chlamydia; chronic conditions such as asthma and diabetes; and serious mental illness such as schizophrenia and bipolar disorder.¹⁷

1. Communicable diseases.

Communicable diseases are spread from person to person, easily (as with TB, transmissible by air) or with more difficulty (as with hepatitis, transmissible with direct contact between persons' bodily fluids).¹⁸ The rate of infection with communicable diseases among prisoners is startlingly high. They are disproportionately infected when they arrive in prison. Compared to the general population, it has been estimated that "rates of human immunodeficiency virus (HIV) infection . . . are 8 to 10 times higher, rates of hepatitis C are 9 [to] 10 times higher, and rates of tuberculosis are 4 [to] 7 times higher."¹⁹

Prisoners are disproportionately infected when they are released from incarceration. Large though the prisoner population is in the United States, it is still a small percentage of the overall population. Released prisoners, however, are greatly over-represented in the population infected with communicable diseases. Released prisoners in 1996 accounted for 35 percent of all people in the United States with tuberculosis, 29 percent of those with hepatitis C, 12 percent of those with hepatitis B, and 13 percent of those with HIV infection.²⁰

2. Sexually transmitted diseases.

Sexually transmitted diseases (STDs) are a subset of communicable diseases (that is, they are transmissible from person to person) that are also over-represented in prisons and jails. Approximately 2.6 to 4.3 percent of prisoners are infected with syphilis, 2.4 percent with chlamydia, and 1 percent with gonorrhea.²¹ The incidence of STDs in jails, in particular, is very high. Studies of women in jails in the United States have found that "35% of the women had syphilis, 27% had chlamydia, and 8% had gonorrhea."²² A study of syphilis in New York City jails found that women with multiple incarcerations had an incidence of syphilis infection that exceeded the rate of

¹⁶ See NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, *THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS, VOLUME 1, 17-19* (March 2002) (hereafter, "NCCHC REPORT TO CONGRESS").

¹⁷ The National Commission on Correctional Health Care uses these categories to discuss prisoners' health status. See NCCHC REPORT TO CONGRESS, *supra* note 16 at 15.

¹⁸ See TABER'S CYCLOPEDIA OF MEDICAL DICTIONARY 362-65 (15th Ed. 1985).

¹⁹ Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health*, 78:2 J. URBAN HEALTH 214, 217 (2001) (footnotes omitted).

²⁰ NCCHC REPORT TO CONGRESS, *supra* note 16 at 19. See Freudenberg, *supra* note 19 at 218 (30 to 40 percent of prisoners are infected with hepatitis C; rates of infection with other communicable diseases also high).

²¹ NCCHC REPORT TO CONGRESS, *supra* note 19 at 18.

²² Freudenberg, *supra* note 19 at 218 (footnotes omitted).

women in the general New York City population “by more than a thousand-fold.”²³ A 1999 study of early syphilis in Chicago found that “almost one third of all incident cases. . . were diagnosed at Cook County Jail.”²⁴

3. Chronic illness.

A large number of prisoners have serious chronic illnesses. The rate in United States prisons and jails in 1995 of asthma was 8.5 percent; diabetes, 4.8 percent; and hypertension, 18.3 percent.²⁵ The rate for asthma was higher than that of the general population.²⁶ The rates for diabetes and hypertension were lower than the general population.²⁷ The relative youth of the prison population, however, coupled with the fact that both diabetes and hypertension are more likely to arise in older persons, suggests that prison populations are disproportionately affected by these conditions as well.²⁸

4. Mental illness.

America’s prisons and jails have, with the sharp reduction in the census in mental hospitals, become the “new asylums.” The simultaneous surge in imprisonment of people with mental illness and decrease in institutionalization in mental hospitals has been referred to as “transinstitutionalization.” Transinstitutionalization has been attributed to the failure of the community mental health system to provide services to those cleared from psychiatric hospitals in the process of deinstitutionalization, and to changes in criminal sentencing processes that increased penalties for “quality of life” and drug offenses while reducing the exculpatory or sentence-reducing effects of mental illness.²⁹ “The nation’s largest mental health facilities are now found in urban jails in Los Angeles, New York, Chicago, and other big cities.”³⁰

About 16 percent of people in state prisons and jails have a mental illness.³¹ About seven hundred thousand people with mental illness are placed in American jails each year,³² about three-quarters of whom also have substance abuse disorders.³³ The incidence of mental illness, particularly

²³ *Id.* (footnote omitted).

²⁴ Hammett, Roberts, & Kennedy, *supra* note 15 at 391 (reference omitted).

²⁵ NCCHC REPORT TO CONGRESS, *supra* note 16 at 21.

²⁶ *Id.* See Hammett, Roberts & Kennedy, *supra* note 15 at 390.

²⁷ NCCHC REPORT TO CONGRESS, *supra* note 16 at 21. *But see* Freudenberg, *supra* note 19 at 221 (citing “anecdotal reports, commentaries, and facility case histories” for the proposition that rates of diabetes and hypertension, as well as seizure disorder were above the rates in the general population).

²⁸ See NCCHC REPORT TO CONGRESS, *supra* note 16 at 21; Hammett, Roberts & Kennedy, *supra* note 15 at 390-91.

²⁹ See TERRY KUPERS, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT xv-xvi (1999); T. Howard Stone, *Therapeutic Implications of Incarceration For Persons With Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 291 (1997).

³⁰ Freudenberg, *supra* note 19 at 220.

³¹ Freudenberg, *supra* note 19 at 220, *citing* Paula M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, at 1 (U.S. Dep’t. of Justice, Bureau of Justice Statistics July 1999) available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf>.

³² Freudenberg, *supra* note 19 at 220.

³³ See COUNCIL ON STATE GOVERNMENTS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT 4 (2002) available at www.consensusproject.org (hereafter, “CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT”). The Consensus Project was coordinated by the Council on State Governments with

major mental illness, is substantially higher in prisons and jails than in the free world.³⁴ The incidence of schizophrenia in state prisons is three to five times higher than in the general population,³⁵ and two to three times higher in jails than in the general population.³⁶ These data on the prevalence of mental illness among prisoners are contested in their specifics; the lack of information available to researchers hampers precise assessments.³⁷ It is, however, clear that “severe mental disorders among prison and jail inmates are a significant, complex, and intractable health problem that has defied both explanation and resolution.”³⁸

C. The status of prison health services.

Prison conditions in America have been dismal since the founding of the Republic. Oppressive, brutal conditions predominated with reformist zeal for improving the conditions leading to brief periods of improvement.³⁹ Overcrowded, brutal prisons are of course unhealthy, and prison reformers of course attempted to ameliorate those conditions.⁴⁰ With the rise in the 20th Century of curative medicine, access to or denial of decent health services became a significant issue in prison reform. It is clear that prison health care was shockingly bad during much of the 20th Century, as vital, life-saving care was delayed, denied, or provided by untrained fellow prisoners.⁴¹ The quality of health care services in modern prisons varies from prison to prison, and state to state. Reform efforts, including prisoners’ rights litigation, have increased funding and oversight in some prison systems. For example, the Re-Entry Council’s recent report, drawing on a variety of federal and state sources and federal corrections sources, recently asserted that the “quality and availability of medical services for the prisoner population has been enhanced by multiple federal judicial decisions and by initiatives of a host of professional organizations.”⁴² It is possible, however, to exaggerate the improvements.

Too often prison care is abysmal and dehumanizing. This is true even in the state highlighted as an example of improvement in the Re-Entry Council’s Report: California.⁴³ Shortly after the Re-Entry Council issued its report, a federal judge blasted California’s prison health care, issuing an Order

the assistance of, among others, The Bazelon Center for Mental Health Law, The Association of State Correctional Administrators, and the Association of State Mental Health Program Directors. *Id.* at iii.

³⁴ See NCCHC REPORT TO CONGRESS, *supra* note 16 at 24.

³⁵ *Id.*

³⁶ *Id.*

³⁷ See Stone, *supra* note 29 at 287; NCCHC REPORT TO CONGRESS, *supra* note 16 at 22-26.

³⁸ See Stone, *supra* note 29 at 287.

³⁹ See *infra* Part IIA and B.

⁴⁰ See *infra* text at notes 92-97.

⁴¹ See *infra* text at notes 102-105.

⁴² See REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 157.

⁴³ *Id.* (“California alone spent nearly one billion dollars (about one-sixth of its total corrections budget) on health services for its 160,000 inmates in the 2002-03 fiscal year, nearly doubling its correctional health care costs from 1999.”) (footnote omitted).

to Show Cause why management of health services in the California Department of Corrections should not be taken away from the State and assigned to a court-appointed receiver.⁴⁴ The text of the order relates a hair-raising account of a “totally broken system”⁴⁵ The court found that,

[e]ven the most simple and basic elements of a minimally adequate medical system were lacking.”⁴⁶ In one of the California prisons toured by the Judge, “the main medical examining room lacked any means of sanitation – there was no sink and no alcohol gel – where roughly one hundred per day undergo medical screening, and the Court observed that the dentist neither washed his hands nor changed his gloves after treating patients into whose mouths he had placed his hands.”⁴⁷

Expert reports on this prison noted referral slips for health care unattended for over one month,⁴⁸ and dirty, dangerous, and antiquated facilities, unchanged by prior court orders due to the indifference of corrections officials.⁴⁹ Remarkably, the Department of Corrections apparently did not either disagree with the facts or object to the proposal to divest it of its authority to manage prison health, and officials acknowledged that they were “unable to correct the problems on their own, and that unconstitutional conditions will remain until an outside agency is hired to take over.”⁵⁰

Plata does not stand alone. A 1999 decision⁵¹ decried the fact that, after 27 years of litigation, the Texas Department of corrections continued to provide care through inadequately trained personnel,⁵² failed to treat or even properly isolate, prisoners with infectious tuberculosis,⁵³ and denied psychiatric care to prisoners clearly in crisis.⁵⁴ Similarly, a 1998 decision reviewed a two-decade history of noncompliance with an order on medical care within the Puerto Rican prison system⁵⁵ found deteriorating conditions in which prisoners were denied emergency treatment, medications, prescribed medically necessary care, and essential psychiatric services, leading to prisoner

⁴⁴ *Plata v. Schwarzenegger*, Civ. No. C01-1351 THE, Order to Show Cause Re: Civil Contempt and Appointment of Interim Receiver (May 10, 2005) at 2, available at [http://www.cand.uscourts.gov/cand/judges.nsf/0/43baa340b75c167288256ffd007bb1d5/\\$FILE/Plata%200SC.pdf](http://www.cand.uscourts.gov/cand/judges.nsf/0/43baa340b75c167288256ffd007bb1d5/$FILE/Plata%200SC.pdf).

⁴⁵ *Id.* at 4 (quoting with approval report of a court-appointed expert).

⁴⁶ *Id.* at 4.

⁴⁷ *Id.*

⁴⁸ The comment of the nursed assigned to this area of the prison was, “Some of these guys are either dead or better, one of the two.” *Id.* at 6.

⁴⁹ *Id.* at 5-6.

⁵⁰ *Id.* at 8.

⁵¹ *Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Tex. 1999). The court also found that

⁵² *Id.* at 897-98.

⁵³ *Id.* at 897.

⁵⁴ *Id.* at 904.

⁵⁵ *Felilciano v. Gonzalez*, 13 F. Supp. 2d 151, 158-59 (D.P.R. 1998).

deaths and “actual pain and suffering with no conceivable penological purpose.
...”⁵⁶

The record in these cases documents the broad failure of major prison systems to provide decent care. In the treatment areas most responsive to the actual condition of prisoners -- chronic disease, sexually transmitted disease, communicable disease, and behavioral health⁵⁷ -- there is particular evidence that prisons are simply not providing adequate care. Many prison systems have no protocols for the treatment of such common chronic conditions as asthma, hypertension, and diabetes, and those that do often have protocols that are incomplete or out of date.⁵⁸ “Very few correctional systems routinely screen inmates for syphilis,”⁵⁹ and therefore are able to provide treatment for only those prisoners with obvious symptoms. A significant number of prisons and jails “do not adhere to CDC standards with regard to screening for and treating TB,” leading some to fail to implement mandatory TB screening, and some to fail to follow proper infection control procedures to protect other prisoners and staff.⁶⁰ HIV care in many facilities is inadequate; prevention programs are often nonexistent, and testing is not widely provided.⁶¹ In some facilities, antiretroviral drugs for the treatment of HIV are provided inconsistently, leading to the development of treatment resistant strains of the virus.⁶² A recent survey of mental health care provided in prisons and jails resulted in a damning report, documenting poor intake screening of prisoners for mental health needs;⁶³ lack of timely access to qualified mental health staff, in part due to the hostility of custody staff, and the over-attribution of symptomatic behavior to “malingering”;⁶⁴ the inappropriate treatment of prisoners with serious psychiatric illnesses solely with drugs, which can render a prisoner docile, but do not advance the prisoner to wellness and recovery;⁶⁵ and a dearth of appropriate facilities for crisis care.⁶⁶

⁵⁶ *Id.* at 179-82.

⁵⁷ *See supra*, Part I(B).

⁵⁸ *See* NCCHC REPORT TO CONGRESS, *supra* note 16 at 30. *See also* Ruiz v. Johnson, 37 F. Supp. 2d 855, 899 (S.D. Tex. 1999) (documenting poor diabetes care); Madrid v. Gomez, 889 F. Supp. 1146, 1210-11 (N.D. Cal. 1995) (no established protocols for diabetes or hypertension).

⁵⁹ *See* NCCHC REPORT TO CONGRESS, *supra* note 16 at 29. *See also* Madrid v. Gomez, 889 F. Supp. 1146, 1205 (N.D. Cal. 1995) (no testing for syphilis).

⁶⁰ *See* NCCHC REPORT TO CONGRESS, *supra* note 16 at 31. *See also* Ruiz v. Johnson, 17 F. Supp. 2d 855, 897 (S.D. Tex. 1999) (finding that HIV-infected prisoners were exposed to infections TB patients, and documenting “significant, even deadly, inadequacies in the level of care provided to ill inmates.”); Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 174 (D.P.R. 1998) (lack of proper isolation facilities for TB); Madrid v. Gomez, 889 F. Supp. 1146, 1205 (N.D. Cal. 1995) (finding “slipshod” TB testing and follow-up care; of those testing positive for TB, over one-half were never treated).

⁶¹ *See* NCCHC REPORT TO CONGRESS, *supra* note 16 at 29. *See also* Madrid v. Gomez, 889 F. Supp. 1146, 1205 (N.D. Cal. 1995) (no education or outreach for HIV; no encouragement of voluntary testing).

⁶² *See* Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 181 (D.P.R. 1998). *See also infra* Part IIIC(2) (describing effect of inconsistent administration of HIV drugs).

⁶³ HUMAN RIGHTS WATCH, ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 101 (2003).

⁶⁴ *Id.* at 103-09.

⁶⁵ *Id.* at 109-27.

⁶⁶ *Id.* at 128-30; KUPERS, *supra* note 29 at 75-76.

American prisons and jails are overcrowded with prisoners in poor health frequently receiving inadequate health care. The following section will trace the course of the development of prison reform in America from their beginnings in the 18th Century, through waves of brutal unhealthy conditions overcoming periods of reform in the 19th and 20th Centuries, to the present, with over 2 million men and women, many in poor health, imprisoned in overcrowded facilities with woefully inadequate health care services.

II. Decent treatment: reconciling corrections' and prisoners' interests.

The preceding section described stark facts about American prisoners, focusing on the phenomenon of mass incarceration, the poor health of many prisoners, and the poor health care they receive. But who *are* prisoners? Are they the “other,” people apart from the law-abiding “us”?⁶⁷ Are they “disgusting objects of popular contempt”?⁶⁸ Are they erring members of a rational, contractarian society who must be subjected to clear, moderate laws just sufficiently punitive to deter?⁶⁹ Are they ignorant or faulty citizens who must be corrected and rehabilitated so as to become useful members of society?⁷⁰ Or are they citizens who have not been “stripped of constitutional protections” with the right to enforce their rights to equal and humane treatment subject only to the necessary limitations imposed by their imprisonment?⁷¹ It has been said that prisoners include “the best and the worst among us.”⁷² A normative principle that has animated much of the prison reform effort over the centuries is that prisoners, no matter their crime, remain fellow human beings, fellow citizens, and, for those religiously inclined, fellow children of God.

Prisoners are ourselves writ large or small. As such, they should not be subjected to suffering exceeding fair expiation for the crimes for which they have been convicted. Below that admittedly vague ceiling of

⁶⁷ See JEREMY TRAVIS, *BUT THEY ALL COME BACK: FACING THE CHALLENGE OF PRISONER REENTRY* XXVI (2005) (describing the importance of the language used in the prison context, and noting the tendency of the terms used to characterize prisoners as “other” or different from “us”). I agree with Travis’s choice of language, and for many of the reasons he cites, *see id.* at xxv-xxvi, I tend toward the terms “prisoner” and “imprison” rather than “inmate” or “incarcerate.” Personal experience has taught me that many prisoners, subjected to harsh, violent, anti-therapeutic treatment, are offended by the falsely therapeutic ring (in today’s prisons) of the designation “inmate.”

⁶⁸ Note, Matthew W. Meskell, *The History of Prisons in the United States from 1777-1877*, 51 *STANFORD L. REV.* 839, 839 (1999) *quoting* HARRY ELMER BARNES, *THE EVOLUTION OF PENOLOGY IN PENNSYLVANIA* 64 (1968), in turn *quoting* Robert Vaux, describing Pennsylvania jails in 1776.

⁶⁹ See DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM* 59-61 (Revised edition 1990) (hereafter, “DISCOVERY OF THE ASYLUM”) (describing an Enlightenment sensibility, drawn largely from the writings of Cesare Beccaria. This contractarian view comprised in part a Revolutionary reaction to the harsh, brutal, and sometimes arbitrary British punishment systems.).

⁷⁰ *Id.* at 97-103 (describing early 19th Century prison philosophy).

⁷¹ *Wolff v. McDonnell*, 418 U.S. 539, 555-56 (1974).

⁷² *THE OXFORD HISTORY OF THE PRISON: THE PRACTICE OF PUNISHMENT IN WESTERN SOCIETY* XIII (Norvall Morris and David J. Rothman, eds. 1998) (hereafter, “OXFORD HISTORY OF THE PRISON”).

suffering, they are entitled to a reasonably safe, clean environment. They must be spared cruelty, *cruelty* being defined as violations of their bodily and psychological integrities beyond the legitimate necessities of their punishment.⁷³

This fundamental human principle sometimes gets lost in the pragmatic questions about how to achieve the deterrence, retribution, and exclusion goals of criminal punishment; indeed, the central argument of this Article is pragmatic, in that it argues that “they all come home again”⁷⁴ – prisoners return to society, and we harm society when the conditions of their imprisonment predictably render released prisoners a health hazard to their communities.⁷⁵

Many people – perhaps a majority – more or less agree with this fellow-feeling argument to some degree; most, of course, also believe that prisoners, by dint of their crimes, have forfeit to a greater or lesser degree claims to comfort or compassion. Society’s view of prisoners is heterogeneous, and has changed over time. Social disputes and ambivalence over prisoners, and the changes in the debate over time, can be illustrated by the contentions over the physical treatment of prisoners, including the provision of health treatment. Decent prison treatment, including health care, is costly. As prisoners are out of view and frequently outside the public consciousness,⁷⁶ the default position of governments funding prisons is likely to tend toward less, and less humane, treatment.

History bears this out. The course of the development of the American prison has been marked by disputes over the treatment to which prisoners are exposed. Advocates resisting what they regard to be inadequate treatment have urged improvement on various grounds. The early 19th to the mid 20th Century saw a form of other-regarding argument. During that period, advocates rooted their arguments in humanitarian or religious terms, and expressed concern for prisoners as fellow human beings, deserving humane care.⁷⁷ The next period, beginning in the mid 20th Century and arguably extending to the present, saw emphasis on the individual rights of prisoners. During that period, advocates argued that prisoners could vindicate their constitutional and statutory rights through litigation notwithstanding their imprisonment.⁷⁸ Both of these approaches achieved some progress, but ultimately failed to reach their goals, as the arguments could not overcome

⁷³ *Id.* The quote is from the introduction to *THE OXFORD HISTORY OF THE PRISON*, which is the work of its editors, Norval Morris and David J. Rothman.

⁷⁴ See generally TRAVIS, *supra* note 67.

⁷⁵ See *infra* Part IIC.

⁷⁶ See Scott Christianson, *With Liberty For Some: 500 Years of Imprisonment in America* xv (1998) (“Prisons are repositories of failure that remind us of problems which would prove unsettling if put in open view. So we hide them in remote places and keep them guarded and inaccessible to outsiders. Few of us want to face what seems so messy, so troubling, so well concealed.”).

⁷⁷ See *infra* Part II(A).

⁷⁸ See *infra* Part II(B).

social concerns over cost and disinterest in the well-being of prisoners. Finally, in a shift introduced in this Part and more fully described in the following, advocates have advanced arguments based on the interests of communities to which prisoners return after release. Advocates advancing this perspective argue that people in the free world should embrace adequate health care for prisoners because inadequate prison health care subjects the community to serious public health threats. Even if people care nothing for prisoners themselves, the argument goes, they should care about themselves, and therefore support good prison health care.⁷⁹

A. Other-regarding approach: empathy and rehabilitation.

“Imbalance and inflexibility” characterized responses to crime in the American colonial period.⁸⁰ Adhering to British models, some crimes resulted in a fine, or “banishment” – the requirement that an offender merely move on to the next town.⁸¹ Other crimes, or crimes committed by recidivists, were dealt with brutally, by whippings and execution.⁸² Prisons and jails were not used for punishment, but only as holding facilities for those awaiting trial.⁸³ Post-revolutionary states turned away from the British model, embracing instead Enlightenment principles of rationality and self-direction.⁸⁴ Part of this reaction was expressed as repugnance for the broad use of corporal and capital punishment, and the consequent refusal of colonial juries to convict when brutal punishments seemed disproportionate to the crimes.⁸⁵ Alternative forms of punishment were necessary; imprisonment filled the void.⁸⁶

Imprisonment as punishment, then, was a humanitarian reform in post-revolutionary America, as “[i]ncarceration seemed more humane than hanging and less brutal than whipping.”⁸⁷ Early in the nation’s history, it was anticipated that the substitution of imprisonment as a relatively humane punishment for more brutal forms would reduce crime rates. The end of jury nullification would lead to more certain consequences for criminal acts, and all Americans, embodying the Enlightenment ideal of the clear-eyed rationalist, would choose to obey the law.⁸⁸ The faith that sentencing reform and a shift from brutal to more benign incarcerative punishments would lead to reductions in crime rates made it natural that the actual management of the prisons was ignored. If the very fact of imprisonment as a certain punishment would deter

⁷⁹ See *infra* Part II(C).

⁸⁰ DISCOVERY OF THE ASYLUM, *supra* note 69 at 51.

⁸¹ *Id.* at 48-50.

⁸² See *id.* at 48-51; David J. Rothman, *Perfecting the Prison: United States, 1789-1865* in OXFORD HISTORY OF THE PRISON, *supra* note 72 at 101; Meskill, *supra* note 68 at 841.

⁸³ DISCOVERY OF THE ASYLUM, *supra* note 69 at 48.

⁸⁴ Rothman, *supra*, note 82 at 102-03; Meskill, *supra* note 68 at 843.

⁸⁵ DISCOVERY OF THE ASYLUM, *supra* note 69 at 59-60.

⁸⁶ *Id.* at 61.

⁸⁷ *Id.* at 62.

⁸⁸ *Id.* at 61-62; Meskill, *supra* note 68 at 844-49; MICHAEL SHERMAN AND GORDON HAWKINS, IMPRISONMENT IN AMERICA 82-83 (1981).

crime, prison populations would surely be low and prison management unimportant.⁸⁹ The first crisis in the American experiment with imprisonment as punishment arose when the rational deterrence effect did not materialize: crime rates did not decline, and prisons were poorly run, overcrowded, and subject to riots.⁹⁰ Attention, therefore, shifted from sentencing reform to prison management,⁹¹ and the two hundred year process of American prison reform began.

The rhythm of prison reform between 1820 and the mid-twentieth century comprised repeated patterns of rising concern for the brutality of prison conditions, resulting in reforms springing from humanitarian and reformative impulses, and a failure of those reforms due to lack of funding and public indifference toward the welfare of prisoners. The first reforms in the 1820s reacted to both the brutality of conditions and prisons' failure to reduce crime, and reinvented prisons as "penitentiaries."⁹² Prisons were chaotic and violent; penitentiaries, originating in Pennsylvania and New York, sought through silence and contemplation to correct the prisoner by separating him from his corrupt environment and "[t]eaching him the habits of order and regularity."⁹³ Reformers focused on prisoners' spirit and soul, making up for familial and social failings through the imposition of a stern but wholesome setting.⁹⁴

They failed. The penitentiaries, like the jails and prisons they were meant to replace, were by the 1850s "characterized by overcrowding, brutality, and disorder."⁹⁵ By the post-Civil War period, the goal of rehabilitation was abandoned, and penitentiaries were merely warehouses for too many prisoners in extremely harsh conditions.⁹⁶ The failure of this wave of reform can be traced to social indifference to the conditions of prisoners – many of whom were new immigrants – and the consequent refusal to pay the costs of decent prison care.⁹⁷

Another wave of reforms followed the 1867 report of Cobb Wines and Theodore Dwight on prison conditions.⁹⁸ Wines and Dwight reported widespread overcrowding and brutal treatment.⁹⁹ Their report spawned the "reformatory" movement, which again urged humane treatment, emphasized the education of prisoners, and relied on a shift to indeterminate sentencing as

⁸⁹ See Rothman, *supra* note 82 at 103; DISCOVERY OF THE ASYLUM, *supra* note 69 at 62.

⁹⁰ See Rothman, *supra* note 82 at 103-04; DISCOVERY OF THE ASYLUM, *supra* note 69 at 62.

⁹¹ DISCOVERY OF THE ASYLUM, *supra* note 69 at 62.

⁹² *Id.* at 79.

⁹³ *Id.* at 83. See DWIGHT JARVIS, INSTITUTIONAL TREATMENT OF OFFENDERS 25-29 (1978) (describing Pennsylvania and New York (Auburn) plans).

⁹⁴ DISCOVERY OF THE ASYLUM, *supra* note 69 at 72-75.

⁹⁵ Rothman, *supra* note 82 at 112. See SHERMAN & HAWKINS, *supra* note 88 at 89 (Jacksonian reforms failed, brutality dominated prisons).

⁹⁶ *Id.* at 112-13; DISCOVERY OF THE ASYLUM, *supra* note 69 at 240-42.

⁹⁷ Edgardo Rotman, *The Failure of Reform: United States, 1865-1965* in OXFORD HISTORY OF THE PRISON, *supra* note 72, 151, 152-53; Meskill, *supra* note 68 at 860-61; DISCOVERY OF THE ASYLUM, *supra* note 69 at 253-54.

⁹⁸ Rotman, *supra* note 97 at 154.

⁹⁹ *Id.*

a means to encourage prisoners to participate in their own reformation.¹⁰⁰ These reforms also failed in the face of brutal and corrupt prison management in which low budgets and public indifference lead to “chaotic prison atmospheres” rife with “arbitrary punishment and persistent overcrowding.”¹⁰¹

In the early 20th Century, Progressive reformers decried unsanitary, overcrowded, and vermin-ridden prison conditions.¹⁰² The Progressives sought to “cure” criminals rather than punish them, using the new disciplines of psychiatry and social work.¹⁰³ They hoped that according prisoners dignity and providing a level of self-direction within prisons would ease prisoners’ reintegration into society upon release.¹⁰⁴ Although Progressive reforms improved some aspects of prison treatment, the indifference of prison management and society at large toward prisoners’ welfare and the lack of financial support for humane conditions doomed the effort.¹⁰⁵ Riots over inadequate medical care, unsanitary conditions, and overcrowding in the 1950s suggested that prison reform efforts had come full circle, leaving prisoners in conditions similar to those they experienced in the early 19th Century. The calls for humane treatment by small numbers of dedicated reformers repeatedly failed to arouse empathetic reactions, and prisons remained unhealthy, overcrowded, and brutal environments.

B. Individual rights: respecting prisoners’ civil rights claims.

The first 150 years of prison reform, premised on reformers empathy and calls for humanitarian treatment, failed to achieve decent conditions, leaving prisons in the mid-20th Century where they had been at the opening of the 19th: unhealthy and overcrowded. The mid-20th Century, however, saw a shift in orientation, or at least tactics. Rather than rely on appeals to fellow-feeling, prison reform advocates argued that the prisoners themselves were invested with individual rights rooted in the Constitution that empowered them to seek remedies for oppressive prison conditions in their own name and by their own right. The strength of this strategy was that it did not rely on the kindness or sympathy of strangers, but rather placed in the hands of prisoners themselves the tools to achieve – or at least seek – decent conditions.

The contrast should not be overstated, however. First, while prisoners often proceed *pro se*, they benefit from the assistance and representation of dedicated and talented lawyers, epitomized by Al Bronstein of the ACLU Prison Project¹⁰⁶ and John Boston of the Prisoners’ Rights Project of the Legal

¹⁰⁰ *Id.* at 155-56; TRAVIS, *supra* note 67 at 10-11; SHERMAN & HAWKINS, *supra* note 88 at 91.

¹⁰¹ Rotman, *supra* note 97 at 156.

¹⁰² *Id.* at 157-58.

¹⁰³ *Id.* at 158-59.

¹⁰⁴ *Id.* at 160.

¹⁰⁵ *Id.* at 168-69.

¹⁰⁶ See Malcolm M. Feeley and Van Swearingen, *The Prison Conditions Cases and the Bureaucratization of American Corrections: Influences, Impacts and Implications*, 24 PACE L. REV. 433, 453 (2003) (recognizing Alvin Bronstein as a leader in prison litigation).

Aid Society of the City of New York.¹⁰⁷ Second, prison reform litigation does not occur in isolation, and the positive effects associated with it are attributable in part to the humanitarian responses of some executive and legislative government officials and members of the public acting in response to issues raised in litigation.¹⁰⁸ The focus shifted, however, from outsiders' other-regarding efforts to prisoners' individual rights claims when prison reform embraced the civil rights movement. Evaluation of the efficacy of the individual rights vision of prison reform is more problematic than that of the humanitarian vision in part because it is closer in time – indeed, it is still a powerful theme in civil rights law.

Until the 1960s, federal courts adhered to a “hands off” policy toward prisons.¹⁰⁹ The decades of the 1960s and 1970s saw dramatic recognition of prisoners' constitutional rights and of the power to vindicate those rights in federal courts. In 1964, the Court allowed a § 1983 cause of action¹¹⁰ by a group of Muslim prisoners against prison officials for violations of their right to religious exercise.¹¹¹ First amendment protections were soon extended to prisoners observing less conventional religions,¹¹² and to prisoners seeking uncensored access to mail,¹¹³ and due process protections were recognized in disciplinary hearings.¹¹⁴

Prisoners challenged prison health care under the Eighth and Fourteenth Amendments during this period. In a case filed in 1972 by Oklahoma prisoners challenging, *inter alia*, the adequacy of medical care, the court found that the prison “was and is incapable of providing, has failed to provide, and continues to fail to provide adequate medical care for the inmates.”¹¹⁵ The prison provided medical care through unlicensed physicians and through untrained prisoners acting as health professionals, and had no qualified mental health professionals on staff to treat mentally ill prisoners, who were treated only with sedatives.¹¹⁶ In a 1972 decision on the medical care available in the Alabama prison system, the court found that the care “could justly be called barbarous and shocking to the conscience.”¹¹⁷ Medical personnel (even unlicensed staff) was in such short supply that even

¹⁰⁷ See *Testimony of John Boston* to the Commission on Safety and Abuse in America's Prisons, April 20, 2005, available at http://www.prisoncommission.org/statements/boston_john.pdf (describing long course of litigation on behalf of prisoners' rights to safe conditions).

¹⁰⁸ See Susan P. Sturm, *The Legacy and Future of Corrections Litigation*, 142 U. PENN. L. REV. 639, 656, 57 (1993) (noting the interplay between courts and broader social forces in advancing prison reform goals).

¹⁰⁹ See JOHN A. FLITTER, *PRISONERS' RIGHTS: THE SUPREME COURT AND EVOLVING STANDARDS OF DECENCY* 64 (2001).

¹¹⁰ 42 U.S.C. § 1983. See *Monroe v. Pape*, 365 U.S. 167, 179-80 (1961) (recognizing – revitalizing – the § 1983 cause of action for persons deprived of federal rights by those acting under color of state law).

¹¹¹ *Cooper v. Pate*, 378 U.S. 546 (1964).

¹¹² *Cruz v. Beto*, 405 U.S. 319 (1972).

¹¹³ *Procunier v. Martinez*, 416 U.S. 396 (1974).

¹¹⁴ *Wolff v. McDonnell*, 418 U.S. 39 (1974).

¹¹⁵ *Battle v. Anderson*, 376 F. Supp. 402, 415 (E.D. Okla. 1974).

¹¹⁶ *Id.* at 415-16.

¹¹⁷ *Newman v. Alabama*, 379 F. Supp. 278, 281 (D. Ala. 1972) (internal quotations and citations omitted).

emergency conditions often went untreated.¹¹⁸ The lack of treatment or treatment by untrained persons (including prisoners) lead to gruesome injuries and many deaths.¹¹⁹

The Supreme Court addressed the rights of prisoners to adequate health care in 1976 in *Estelle v. Gamble*.¹²⁰ The Court recognized a broad interpretation of the Eighth Amendment, finding that it prohibited “punishments which are incompatible with the evolving standards of decency that mark the progress of a maturing society.”¹²¹ It held that prison officials’ “deliberate indifference to serious medical needs of prisoners” violates the constitutional standard.¹²² The recognition of prisoners’ constitutional rights in cases such as *Cooper*, *Procunier*, and *Wolff* suggested a venue for reform arguments and a robust doctrinal foundation for the advocacy of decent treatment. *Estelle* in particular suggested that federal courts would address in a sustained way the issues humanitarian reform efforts had succeeded in bringing to the public debate only sporadically: the state’s responsibility to provide safe and healthy conditions for prisoners. Indeed, subsequent decisions demonstrate the partial fulfillment of that promise, as courts have occasionally reviewed closely prison conditions and ordered relief where medical¹²³ and mental health¹²⁴ care has been shown to violate the *Estelle* standard.

But the individual rights model of prison reform has been significantly restrained by the Court and Congress in the last 20 years. Perhaps most tellingly, *Turner v. Safley* signaled a shift in prison jurisprudence when it refused to apply the usual strict scrutiny standard to a prisoner’s First Amendment right to marry.¹²⁵ Instead, the Court permitted prisons to restrict prisoner’s right to marry so long as the restriction is “reasonably related to legitimate penological concerns.”¹²⁶ The Court also cut back on Eighth Amendment review by imposing increasingly difficult scienter requirements.¹²⁷ In addition, it found that prisoners’ procedural due process rights attached only if the deprivation at issue subjected the prisoner to

¹¹⁸ *Id.* at 282.

¹¹⁹ *Id.* at 283-85.

¹²⁰ *Estelle v. Gamble*, 429 U.S. 97 (1976).

¹²¹ *Id.* at 102 (internal quotations and citations omitted).

¹²² *Id.* at 104.

¹²³ See *Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Tex. 1999); *Plata v. Scharzenegger*, Civ. No. C01-1351 THE, Order to Show Cause Re: Civil Contempt and Appointment of Interim Receiver (May 10, 2005) available at [http://www.cand.uscourts.gov/cand/judges.nsf/0/43baa340b75c167288256ffd007bb1d5/\\$FILE/Plata%20SC.pdf](http://www.cand.uscourts.gov/cand/judges.nsf/0/43baa340b75c167288256ffd007bb1d5/$FILE/Plata%20SC.pdf).

¹²⁴ See *Coleman v. California*, 912 F. Supp. 1282 (E.D. Cal. 1995).

¹²⁵ *Turner v. Safley*, 482 U.S. 78, 89 (1987). The *Turner* standard of review applies to a broad range of constitutional claims that arise in prisons, see *Johnson v. California*, 125 S.Ct. 1141, 1148 (2005). It does not apply to 8th Amendment claims, where the Court continues to apply the *Estelle* deliberate indifference standard, see *Hope v. Peltzer*, 536 U.S. 730, 738 (2002). The Court recently held that strict scrutiny continues to apply to at least one species of claim in prisons: race discrimination. *Johnson v. California*, 125 S.Ct. 1141, 1148-50 (2005).

¹²⁶ *Id.*

¹²⁷ See *Wilson v. Seiter*, 501 U.S. 294, 296 (1991); *Helling v. McKinney*, 509 U.S. 25, 27 (1994).

“atypical and significant hardship.”¹²⁸ Foreshadowing Congressional action aimed at limiting prisoners’ access to courts and ability to sustain remedies, the Court narrowly construed prisoners’ rights to legal materials and other litigation assistance,¹²⁹ and broadly construed prisoners’ ability to break promises made in connection with consent decrees.¹³⁰

Congressional action has also significantly reduced the efficacy of prison litigation as a means of advancing prison reform. The Prison Litigation Reform Act (“PLRA”)¹³¹ created a series of procedural barriers “designed to discourage the initiation of litigation by a certain class of individuals – prisoners – that is otherwise motivated to bring frivolous complaints as a means of gaining a short sabbatical in the nearest Federal courthouse.”¹³² The barriers erected by the PLRA, of course, also make it more difficult for prisoners with meritorious claims to gain access to courts and obtain relief. For example, the PLRA eliminates fee waivers for indigent prisoners, and requires instead increased documentation of financial status and installment-plan payment of the full fees from whatever wages the prisoner earns.¹³³ In addition, the PLRA requires that prisoners exhaust all “available” remedies prior to filing a civil complaint.¹³⁴ The Court has giving this provision extremely broad meaning, reading “available” not as “effective”, but rather as any administrative proceeding provided by the prison, regardless of the effectiveness of the remedy, thereby requiring exhaustion of even absolutely futile administrative steps.¹³⁵ The PLRA also limits the effectiveness of remedies available to prisoners by sharply limiting their breadth,¹³⁶ and permitting consent decrees to be modified or terminated under certain conditions two years after their entry.¹³⁷ Money damages remedies and attorneys fees are also limited.¹³⁸

The development of a prisoners’ rights jurisprudence in the 1960s and 1970s was directed at the same goal embraced by 19th and early 20th Century reformers: safe and healthy conditions for prisoners. That avenue remains formally open, and prisoner litigation continues to be an important reform

¹²⁸ See *Sandin v. Conner*, 515 U.S. 472, 484 (1995). See also *FLITER*, *supra* note 109 at 177.

¹²⁹ See *Lewis v. Casey*, 518 U.S. 343, 359 (1996).

¹³⁰ See *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 383-84 (1992).

¹³¹ Prison Litigation Reform Act, Pub. L. No. 104-134 (codified in scattered sections of 11 U.S.C., 18 U.S.C., 28 U.S.C., and 42 U.S.C.).

¹³² *Doe v. Washington*, 150 F.3d 920, 924 (8th Cir. 1998). See Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555, 1633-34 (2003) (legislative history suggests that Congress wanted to limit only frivolous actions; despite the rhetoric accompanying the PLRS, it has limited both).

¹³³ 28 U.S.C. § 1915(a), 1915(b)(2).

¹³⁴ 42 U.S.C. § 1997e(a).

¹³⁵ See *Booth v. Churner*, 532 U.S. 731, 741 (2001). In addition, the Court has read broadly the application of the exhaustion requirement, which applies to actions “brought with respect to prison conditions”. 42 U.S.C. § 1997e(a). The Court interpreted this language to apply to any prisoner civil complaint, and not merely to those complaining of the condition of the prison. See *Porter v. Nussle*, 534 U.S. 516, 532 (2002).

¹³⁶ 18 U.S.C. § 3626(a) and (c).

¹³⁷ 18 U.S.C. § 3626(b).

¹³⁸ See 28 U.S.C. § 1346(b)(2) (forbidding the award of damages for “mental or emotional injury” without coincident physical injury); 42 U.S.C. § 1997e(d)(2) and (3) (limiting attorneys fees recovery to percentage of monetary recovery in underlying action, and limiting hourly fee amounts).

tool.¹³⁹ The Court in recent years has, however, narrowed the scope of victories won earlier, and the PLRA further restricts the ability of prisoners to pursue reform cases. The PLRA has sharply reduced the number of prisoner filings even while prison populations are exploding.¹⁴⁰ At the same time, prisoners are no more successful in the remaining cases than they were prior to the PLRA; to the contrary, their success rate remains dismal.¹⁴¹ That being said, prisoners' rights litigation continues to be valuable and necessary. Indeed, to the extent prison health conditions have improved in recent decades, most improvement has "resulted from litigation, judicial oversight, and consent decrees, not from a public desire to treat prisoners more humanely."¹⁴² Without abandoning the still-useful tool of individual litigation, it appears to be time to move to a new vision of prison reform.¹⁴³ The following section takes up that challenge.

C. Population health: protecting society from the effects of bad prison policy.

Impulses toward prison reform spring from the fellow feeling toward prisoners and the pragmatic desire to have our penological methods serve the purposes of punishment. As society's belief in rehabilitation or redemption faded, replaced by a focus on retribution and incapacitation,¹⁴⁴ there was little pragmatic reason for decent prison treatment, and reasons rooted in fellow feeling came to seem quaint.¹⁴⁵ Individual rights arguments can seem a bit sterile from this historical perspective; at least the Jacksonians sought to remake prisoners as useful citizens¹⁴⁶ and 20th Century progressives sought to cure them, to restore them as useful citizens.¹⁴⁷ Individual rights arguments for decent health care are based "only" on principle – there is nothing in it for law-abiding citizens.

The argument for prison reform is strongest, of course, when it is supported both by principle and pragmatism. Put another way, our fellow feeling for prisoners is somewhat grudging, and it forms a somewhat thin basis for what must be broad-based support for quite expensive reforms of an

¹³⁹ See Sturm, *supra* note 108 at 705-06.

¹⁴⁰ See Schlager, *supra* note 132 at 1634.

¹⁴¹ *Id.* at 1663-64.

¹⁴² TRAVIS, *supra* note 67 at 186.

¹⁴³ The frustration produced by the accumulation of restrictions on prisoners' health care claims was evident in *Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Tex. 1999). After detailing the deficiencies in the prison system's medical and psychiatric services, the court found that, "Simply stated, large numbers of inmates throughout the [Texas prison system] are not receiving adequate health care." *Id.* at 906. The court deplored that, under the Supreme Court's current reading of the Eighth Amendment, no violation could be found, *id.* at 907, and expressed hope the Court would modify the standard to require the provision of humane to prisoners. *Id.* As the following section suggests, it may be prudent to look elsewhere for progress on that front.

¹⁴⁴ See SHERMAN & HAWKINS, *supra* note 88 at 93-96.

¹⁴⁵ *Id.* at 92-93.

¹⁴⁶ See *supra* text at notes 92-97.

¹⁴⁷ See *supra* text at notes 102-105.

enormous prison system. The humanitarian basis for prison reform is noble and correct, but insufficiently persuasive to move the debate sufficiently to cause society to open its purse strings for the benefit of prisoners. It must be coupled with a pragmatic argument directed to the free population's self-interest. That pragmatic argument is supplied by describing the public health consequences of inadequate programs of prison care, and the salutary effects on public health of decent prison care: treat prisoners well and we all benefit by avoiding the personal health and financial consequences of sick prisoners released to the community at the end of their sentences.

The pragmatic argument for a new prison health reform movement is made in the following Part. I first sketch out the meaning of public health, as distinct from personal health.¹⁴⁸ I then describe the reentry movement, a growing social movement that is a force for reform and a vehicle for connecting population health with prison health care. The reentry movement begins with the observation that “virtually every person incarcerated in a jail in this country – and approximately 97 percent of those incarcerated in prisons – will eventually be released.”¹⁴⁹ It then chronicles the lack of preparation prison and jails provide released prisoners, and the effects such lack of preparation has, *inter alia*, on the communities to which they return.¹⁵⁰ Finally, I argue that it follows from public health principles and arguments of the reentry movement that a continuation of our current inadequate prison health programs will inevitably lead to the infection of the broader population with communicable diseases and sexually transmitted diseases, and saddle society with the costs of untreated mental illness and other chronic diseases.¹⁵¹

III. A third wave of reform: obligations to others and opportunities for ourselves.

We have an enormous prison population comprising sick and vulnerable men and women, consigned to prison health services that often fail to provide even basic life-sustaining care, and that comprehensively fail to address such critical health areas as communicable diseases, sexually transmitted diseases, mental illness, and chronic diseases. Prison reform movements have sought to ameliorate inhumanely harsh prison conditions, including inadequate medical care, almost since the time of American independence. These movements first focused on humanitarian principles, and more recently on individual rights principles. Humanitarian arguments largely failed to improve prison conditions because society, outside the small committed groups of reformers, was uninterested or unwilling to commit the resources needed to enact reforms.

¹⁴⁸ See generally Geoffrey Rose, Sick Individuals and Sick Populations, in DAN BEAUCHAMP AND BONNIE STEINBOCK, NEW ETHICS FOR THE PUBLIC'S HEALTH (1999) at 28 (contrasting personal and population perspectives on health).

¹⁴⁹ REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at xviii. See TRAVIS, *supra* note 67 at xvii (“Except for those few individuals who die in custody, every person we send to prison returns to live with us.”).

¹⁵⁰ See *infra* Part IIIB.

¹⁵¹ See *infra* Part IIIC.

Individual rights arguments after a period of success have faced growing resistance from Congress and the courts, and disinterest from broader society, as interests in punishment and incapacitation seem more salient than prisoners' arguments for decent health care.

Individual rights and humanitarian arguments, then, have failed to achieve remedies for substandard health care at least in part for failure to engage the self-interest of broader society. This Part will set out a vision of prison reform that seeks to unite the interests of prisoners with those of broader society. It links the personal health needs of prisoners with the broader social goals of population health. It first describes the discipline of public health, which is devoted to the goal of improving overall population health. It then describes a growing movement seeking the successful reentry of released prisoners into their communities. It then relates the goals and methods of the reentry movement to the goals of public health, and argues that the logic of sound reentry programs demands improvement in the personal health services provided to prisoners. There is common ground between prisoners and the broader population. A marriage of convenience is necessary and possible between the humanitarian or individual rights *obligation* to provide decent health care for prisoners' sake, and the public health *opportunity* to improve prison health care for the sake of the society to which most prisoners one day return.

A. The connection: population health.

The humanitarian and individual rights-based efforts to reform prison health were directed toward the treatments provided to prisoners – their personal medical care. The focus in medical care is the patient, “the individual person.”¹⁵² Public health's goal, on the other hand, is not advancing the goals of personal medical care, but of public health or population health, in which “the ‘patient’ is the whole community or population.”¹⁵³ The orientations of personal medical care and public health have been distinguished in the following terms:

Public health can be distinguished from health care in several critical respects. Public health focuses on: (1) the health and safety of populations rather than the health of individual patients; (2) prevention of injury and disease rather than treatment or care; (3) relationships between the government and the community rather than the physician and patient; and (4) population-based services grounded on scientific methodologies of public health (e.g., biostatistics and epidemiology) rather than personal medical services.¹⁵⁴

¹⁵² Dan E. Beauchamp and Bonnie Steinbock, *Population Perspective* in DAN E. BEAUCHAMP AND BONNIE STEINBOCK, *NEW ETHICS FOR THE PUBLIC'S HEALTH* 25, 25 (1999).

¹⁵³ *Id.*

¹⁵⁴ Lawrence O. Gostin, *Public Health Law: A Renaissance*, 30 *J. LAW, MEDICINE & ETHICS* 136, 136 (2002).

Public health, then, focuses on interventions and conditions affecting broad populations and not treatments provided to individuals. That focus can be conceived narrowly or broadly. A well-accepted broad definition of public health was articulated by the Institute of Medicine in 1988 as “what we, as a society, do collectively to assure the conditions for people to be healthy.”¹⁵⁵ Under this broad view, often called a “population perspective,”¹⁵⁶ public health practice uses a broad array of public policy tools – legislation, regulation, litigation, and public education, for example -- to improve society’s health status. In this broad view, public health policy should serve a communal cost-benefit analysis, applying social resources cost-effectively to achieve optimal social health outcomes. This broad view of public health is captured by the following description from two of its proponents:

Commonly we ask: Why did this person get sick at this time? Why did this person die of heart disease? But from a population perspective, we have a different purpose. We want to know why this population (or community) has a higher rate of disease than other societies, or why disease rates in a society are on the rise. Which conditions we identify as “the cause” depends in large measure on our purposes. For example, alcoholism has often been viewed as the result of an individual failure to control one’s drinking. Those who take a population perspective, however, are more likely to focus on the conditions in society that make excessive drinking likely, from the availability of alcohol to the social practices that encourage heavy or frequent use of alcohol.¹⁵⁷

The broad understanding of public health as population health has achieved wide currency.¹⁵⁸ A narrower view of public health is championed by Mark Rothstein, who, after surveying the trend toward broader visions of public health,¹⁵⁹ advocates for a narrow vision, limited to the actions taken by government public health agencies “pursuant to specific legal authority” to protect the public from health threats.¹⁶⁰ Rothstein argues that public health principles and powers should apply only when the health of the public is threatened, government has “unique powers and expertise” to respond to the

¹⁵⁵ INSTITUTE OF MEDICINE, *THE FUTURE OF PUBLIC HEALTH* 19 (1988).

¹⁵⁶ See Beachamp & Steinbock, *supra* note 152 at 25.

¹⁵⁷ *Id.* at 27.

¹⁵⁸ See e.g., Richard J. Bonnie and Bernard Guyer, *Injury as a Field of Public Health: Achievements and Controversies*, 30 J. LAW, MEDICINE & ETHICS 267, 267 (2002) (arguing that the “mission of public health has come to encompass the prevention and treatment of injury”); Richard A. Daynard, *Regulating Tobacco: The Need for a Public Health Judicial Decision-Making Canon*, 30 J. LAW, MEDICINE & ETHICS 281, 282 (2002) (arguing that public health principles should guide judges in tobacco litigation); Bebe J. Anderson and Lynne S. Wilcox, *Reproductive Health*, in *LAW IN PUBLIC HEALTH PRACTICE* (Richard Goodman *et al.* Eds. 2003) at 348 (applying public health principles to a wide variety of reproductive health concerns, including insurance coverage and government funding of services).

¹⁵⁹ Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J. LAW, MEDICINE & ETHICS 144, 144-46 (2002) (describing broad notions of public health that focus on human rights and population health)..

¹⁶⁰ *Id.* at 146.

threat, and government intervention is more efficient than the alternative responses.¹⁶¹

Attempts to set the proper scope of public health practice or policy can be described in political terms. The broad conception of public health policy that seeks to engage public and private resources in an egalitarian effort to improve the health of all members of society has historically been associated with European social democratic or American liberal thinkers.¹⁶² More recently, advances in social science have tended to squeeze the politics out of population health analysis, increasingly supporting apolitical judgments on the population health effects of public and private actions.¹⁶³ This perspective is disputed, of course. Some regard the broader definitions of public health as straying too far from the older, narrower view of public health's function of "containing epidemics, contagion, and nuisances," and as injecting "meddlesome" public action into areas best left to private choice and market conduct.¹⁶⁴

These definitions matter to some but not all of the aspects of my argument for a third wave of prison health reform. I focus below on the treatment in prisons and jails of four types of conditions: infectious diseases such as tuberculosis, hepatitis C, and HIV; sexually transmitted diseases such as syphilis and chlamydia; chronic diseases such as diabetes, asthma, and hypertension; and serious mental illness such as schizophrenia and bipolar disorder.¹⁶⁵ The first two categories – infectious diseases and sexually transmitted diseases – fit comfortably into even the narrowest of definitions of public health. As is described below, the failure of prisons to treat properly prisoners with infectious diseases or sexually transmitted diseases endangers not only the prisoner himself, but also fellow prisoners and staff and, for this is the heart of my argument, the broader community to which the prisoner returns when he is released from imprisonment. Poorly performing prison health services are failing in their obligations to treat these prisoners, but they are also missing the opportunity to address a public health threat to society, which bears the brunt when infected prisoners return home.¹⁶⁶ Poorly performing prisons can even make things dramatically worse, as when, through misdiagnosis, poor administration of medications, and interruptions in treatment they foster the creation of drug resistant strains of tuberculosis and HIV, in essence becoming factories for treatment resistant strains of deadly diseases that are then reintroduced to communities – typically communities underserved by medical providers.¹⁶⁷

¹⁶¹ *Id.*

¹⁶² See Daniel M. Fox, *Commentary, Populations and the Law: The Changing Scope of Health Policy*, 31 J. LAW, MEDICINE & ETHICS 607, 608 (2003).

¹⁶³ *Id.* at 609.

¹⁶⁴ See Richard A. Epstein, *In Defense of the "Old" Public Health: The Legal Framework for the Regulation of Public Health*, 69 BROOKLYN L. REV. 1421, 1423-26 (2004).

¹⁶⁵ See *infra* Part IIIC.

¹⁶⁶ See *infra* Part IIIC(1).

¹⁶⁷ See *infra* Part IIIC(2).

The remaining categories – chronic illness and mental illness – fit less well into the narrowest conceptualization of public health. When returning prisoners bring back to their communities poorly treated asthma or schizophrenia, they are not (at least not literally) bringing “epidemics, contagion, [or] nuisances.”¹⁶⁸ Rather, they are bringing with them conditions that will limit their ability to become productive participants in those communities’ lives, and their poorly treated conditions will place stress on people and health care systems, thereby threatening the community’s wellbeing.¹⁶⁹ The poor care provided in prisons for chronic conditions and mental illness does not literally lead to a spread of those conditions to others in the community. It does, however, frustrate the process of reintegration for released prisoners, fostering recidivism, unemployment, homelessness for the former prisoner, and economic and emotional strain on his family and community.¹⁷⁰ The opportunity lost when prisons fail to provide proper chronic care and mental health treatment is a failure of public health in the broader sense. The rejection of the public health label changes little; these failures in prison health care comprise foolish and inefficient actions missing clear opportunities to forestall disaster for prisoners, their families, and their communities.

B. The catalyst: the reentry movement.

America’s prison population explosion has a back-end consequence. “[N]early 650,000 people were released from prison in 2004, while over 7 million different people were released from jails across the U.S.”¹⁷¹ As these prisoners are released, and as they return to their communities, the attention of governments and private agencies has turned to their reintegration in to society.¹⁷² The concern for prisoner reentry is increasingly wide-spread; it is not an ideological movement, but rather a practical one engaging organizations broadly representative of public and private interests. Perhaps the most comprehensive study of the problems of prisoner reentry is the Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community published in 2005.¹⁷³ The reentry project that resulted in the Report was coordinated by the Council of State Governments, and included as project partners the American Probation and Parole Association, the

¹⁶⁸ Epstein, *supra* note 164 at 1423.

¹⁶⁹ See NCCHC REPORT TO CONGRESS, *supra* note 16 at 32-33.

¹⁷⁰ *Id.*

¹⁷¹ REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at xviii.

¹⁷² See generally, REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15;

TRAVIS, *supra* note 67; Anthony C. Thompson, *Navigating the Hidden Obstacles to Ex-Offender Reentry*, 45 B.C. L. REV. 255 (2004); JOAN PETERSILIA, *WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY* (2003); James P. Lynch and William J. Sabol, *Prisoner Reentry in Perspective* (Urban Institute, Justice Policy Center: Crime Policy Report, Vol. 3, September 2001) available at http://www.urban.org/pdfs/410213_reentry.pdf; United States General Accounting Office, *Prisoner Releases: Trends and Information on Reintegration Programs*, GAO-01-483 (June 2001).

¹⁷³ REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15.

Association of State Correctional Administrators, the National Center for State courts, and the Police Executive Research Forum.¹⁷⁴ Advisory groups were peopled by police chiefs, corrections personnel, state legislators, and state social service personnel, as well as representatives of non-profit organizations and public policy centers.¹⁷⁵ The process was clearly not merely an exercise in liberal law reform. Rather, it was evidence that the reentry movement comprises a bipartisan effort to grapple with the social problems raised by high rates of imprisonment and the consequent high rates of prisoner reentry. The goal of the reentry movement is to encourage public and private action that will “improv[e] the likelihood that a person will safely and successfully transition back to the community.”¹⁷⁶

With funding from the administrations of both Bill Clinton¹⁷⁷ and George W. Bush,¹⁷⁸ and participation by a wide range of public and private actors, the reentry movement is a substantial force in public policy development. The concerns addressed by the reentry process tend to be interlocking. One concern, for example, is public safety, and the problem of ex-prisoner recidivism.¹⁷⁹ The problems of recidivism, however, are caused “in part [by] an unavailability of economic and social supports.”¹⁸⁰ Employment problems are central to those seeking to ease reentry, as ex-prisoners return to depressed communities, without skills, and facing stigma and legal limitations on employment related to their history of convictions.¹⁸¹ The reentry process is also complicated by family issues. Parent-child and spousal relationships are strained by imprisonment, and the family left in the community is often impoverished by one parent’s imprisonment.¹⁸² An overarching issue is that of the “collateral consequences” of conviction – the often overlooked effects of conviction including ineligibility to vote, to live in public housing, to obtain a driver’s license, to qualify for public benefits, and

¹⁷⁴ *Id.* at xiv-xvii.

¹⁷⁵ *Id.* at ix-xiii.

¹⁷⁶ *Id.* at xx.

¹⁷⁷ See Thompson, *supra* note 172 at 260 (describing Clinton administration funding efforts).

¹⁷⁸ See U.S. Department of Justice, Office of Justice Programs, Learn About Reentry: Attorney General Ashcroft Announces Nationwide Effort To Reintegrate Offenders Back Into Communities, available at <http://www.ojp.usdoj.gov/reentry/ashcroftpr.html> (undated); U.S. Department of Labor, Employment and Training Administration, Announcement: Workforce Investment Act – Demonstration Grants; Solicitations for Grant Applications – Prisoner Re-Entry Initiative, 70 F.R. 16853 (April 1, 2005).

¹⁷⁹ See General Accounting Office, *supra* note 172 at 1 (“Although many [ex-prisoners] are successfully reintegrated into society, other ex-offenders are arrested for new crimes or violations of parole and are returned to prison.”); Lynch & Sabol, *supra* note 172 at 14 (returning prisoners pose “problems for public safety”); TRAVIS, *supra* note 67 at 94-98 (discussing re-arrest and recidivism concerns).

¹⁸⁰ Thompson, *supra* note 172 at 259.

¹⁸¹ TRAVIS, *supra* note 67 at 162-67 (describing employment difficulties of ex-prisoners); REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 294-95 (describing employers’ disinclination to hire ex-prisoners, and the difficulties caused by the ex-prisoners’ return to the poorest neighborhoods with the least access to jobs).

¹⁸² TRAVIS, *supra* note 67 at 123-27 (describing family problems caused by imprisonment); REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 323-29 (describing range of family problems arising in context of prisoner reentry).

to apply for some jobs.¹⁸³ These barriers frustrate reentry, as it is often “impossible for offenders to take certain steps generally considered crucial toward reintegration because of so-called collateral consequences, or collateral sanctions.”¹⁸⁴

The reentry movement urges decision makers to step back, reconsider the barriers prisoners face to reintegration, and begin to consider modifications to the policies and realities of conviction and imprisonment that would facilitate prisoner reentry without frustrating the punitive and incapacitating goals of imprisonment. Looming large in the reentry movement are health issues, primarily the health care to which prisoners transition upon release from imprisonment. As is described above, prisoners come to prisons and jails sicker than the background population,¹⁸⁵ and once imprisoned receive some health services, however flawed.¹⁸⁶ The reentry movement seeks to ensure health care continuity as prisoners return to their communities, a process of providing “discharge planning.”¹⁸⁷

Discharge planning focuses on connecting a released prisoner to community health care providers in order to minimize the possibility that untreated health concerns will frustrate community reintegration.¹⁸⁸ This process should include providing the prisoner with referrals, and making appointments with appropriate providers.¹⁸⁹ In practice, the former occurs more frequently than the latter.¹⁹⁰ Other services should include providing an interim supply of medications,¹⁹¹ providing the released prisoner with a full copy of his medical records,¹⁹² and facilitating poor prisoners’ obtaining or regaining eligibility for public benefits, including Medicaid.¹⁹³ Although much of the health focus of the reentry process is on the period just before and following prisoners’ release, it is inevitable that analysis of the discharge planning process leads back to the medical care provided during imprisonment; facilitating the continuity of appropriate care, after all, presupposes the provision of appropriate care in the prison or jail from which the prisoner is released,¹⁹⁴ an issue taken up below.¹⁹⁵

¹⁸³ See Christopher Mele and Teresa A. Miller, *Collateral Civil Penalties as Techniques of Social Policy* in CIVIL PENALTIES, SOCIAL CONSEQUENCES (Christopher Mele and Teresa A. Miller, eds., (2005) at 9-26; TRAVIS, *supra* note 67 at 253-59 (discussing collateral consequences).

¹⁸⁴ Norma Demleitner, *A Vicious Cycle: Resanctioning Offenders*, in MELE & MILLER, *supra* note 183 at 185-201 (discussing effects of collateral sanctions on child custody, driving, employment, voting, and housing opportunities).

¹⁸⁵ See *supra* Part IB.

¹⁸⁶ See *supra* Part IC.

¹⁸⁷ TRAVIS, *supra* note 67 at 327; REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 283.

¹⁸⁸ TRAVIS, *supra* note 67 at 327; REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 286-87.

¹⁸⁹ TRAVIS, *supra* note 67 at 327.

¹⁹⁰ See Theodore M. Hammett, Cheryl Roberts, and Sofia Kennedy, *Health Related Issues in Prisoner Reentry*, 47 CRIME & DELINQUENCY 390, 393 (2001).

¹⁹¹ REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 290.

¹⁹² See TRAVIS *supra* note 67 at 327.

¹⁹³ *Id.*; Hammett *et al.*, *supra* note 15 at 402.

¹⁹⁴ See TRAVIS, *supra* note 67 at 205 (describing the need for prisons to “embrace responsibility for health care of prisoners” if reentry goals are to be met); REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 158 (imprisonment should be seen as a “window of opportunity” for the provision of necessary health

This discharge planning process is primarily concerned with the health of the released prisoner, to facilitate his successful reintegration to the community. Discharge planning for “special needs” prisoners also raises public health concerns. Prisoners with TB and HIV, for example, may be on courses of medication requiring adherence to particularly rigorous administration schedules.¹⁹⁶ The management of these “special needs” prisoners is a particularly problematic aspect of prison health; while many prisons and jails provide referrals for services for released special needs prisoners, far fewer make appointments to connect them with services, and many seriously ill prisoners are lost to treatment,¹⁹⁷ although some model programs exist.¹⁹⁸

The reentry movement, then, is a broad-based, pragmatic, and bipartisan attempt to maximize the chances that released prisoners will successfully reintegrate into their communities. The health focus of the reentry movement is in the first instance on the community linkages necessary to permit released prisoners to succeed. Failures of treatment at reentry have effects on the community as well as the released prisoner. Unsuccessful reentry can burden families and communities when an ex-prisoner is unable to succeed as a parent, spouse, worker, or citizen. Failure to provide for health services to reentering prisoners renders their success more doubtful. More concretely, failure to provide health services to reentering prisoners with infectious and sexually transmitted diseases present the danger of transmission of illness to family members, neighbors, and others. It is clear, however, that thinking of health treatment for the first time at reentry is thinking about it too late. The movement, however, has application to the public health arguments for reform of prison health services. Preparing for proper community transition of health care services must begin with appropriate health services in prison, to prepare the prisoner for reentry, and to protect the community to which he returns from the consequences of medical neglect.

C. Obligations and opportunities: regard for others and protection of ourselves.

The reentry movement focuses on the health status of released prisoners and appropriate links to community health care in order to decrease the likelihood of recidivism and increase the likelihood of successful community reentry. Good reentry health planning necessitates attention to health care during imprisonment; reentry planning is frustrated by the failure of

care to facilitate reintegration) and 173 (providing appropriate mental health services in prisons is necessary to maximize successful reentry).

¹⁹⁵ See *infra* Part III C.

¹⁹⁶ See TRAVIS, *supra* note 67 at 327; Hammett *et al.*, *supra* note 15 at 398-400; REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 283-84.

¹⁹⁷ See Hammett *et al.*, *supra* note 15 at 392.

¹⁹⁸ See Josiah Rich *et al.*, *Successful Linkage of Medical Care and Community Services for HIV-Positive Offenders Being Released From Prison*, 78 J. URBAN HEALTH 279, 280-81 (2001) (describing Rhode Island program).

prisons to provide good health care services to prisoners. The reentry movement has drawn attention to the relationship between good prison health care and population health in two ways. First, poor prison health care can exacerbate chronic conditions such as asthma, hypertension, diabetes, schizophrenia, and bipolar disorder. Such failures threaten population health by straining the limited health services of the low-income communities to which prisoners frequently return,¹⁹⁹ and by lessening the rates of medical complications ex-prisoners experience.²⁰⁰ Second, poor prison health care can fail to cure or control communicable diseases, including tuberculosis, HIV, syphilis, and Chlamydia, permitting threats of infection to move with prisoners to their communities.²⁰¹

Frankly acknowledging that humanitarian impulses and individual rights jurisprudence have proven inadequate bases for the reform of prison health services, this section employs public health principles to suggest a third vision of prison reform. It first considers the population health effects of poor prison health care for prisoners' chronic conditions and mental illnesses, and argues that the broad vision of public health²⁰² supports arguments for prison health reform. Second, it considers the consequences of poor prison health care for prisoners' communicable and sexually transmitted diseases, and argues that even the narrow vision of public health²⁰³ supports arguments for prison health reform. Finally, it considers implementation issues: if there is to be a third vision of prison health reform, how will it effect change?

1. Population health and care for prisoners' chronic and mental illnesses.

Poor chronic and mental health care treatment of prisoners affect the health of the community to which prisoners return. Many prisoners suffer from chronic illnesses such as asthma, diabetes, and hypertension,²⁰⁴ and prisons are generally very bad at providing appropriate chronic care services.²⁰⁵ The failure to treat chronically ill prisoners properly can render them heightened risks for recidivism, as they will be less able to find work and otherwise fully reintegrate into their community.²⁰⁶ The failure to treat chronic conditions in prisons can burden the underfunded health care facilities in the poor communities to which most released prisoners return.²⁰⁷ In addition, however, the failure to take the opportunity to treat chronic conditions in prison increases the overall social costs of care for those conditions:

¹⁹⁹ See Lynch & Sabol, *supra* note 172 at 15-16 (describing geographic concentration of returning prisoners; TRAVIS, *supra* note 67 at 28-83 (describing concentration of returning prisoners and the impoverishment of the most likely communities of return).

²⁰⁰ See NCCHC REPORT TO CONGRESS, *supra* note 16 at 58

²⁰¹ See Hammett *et al.*, *supra* note 15 at 398-400 (describing public health effects of inadequate prison treatment of tuberculosis and HIV disease).

²⁰² See *supra* Part IIIC(1).

²⁰³ See *supra* Part IIIC(2).

²⁰⁴ See Freudenberg, *supra* note 19 at 221; NCCHC REPORT TO CONGRESS, *supra* note 16 at 21.

²⁰⁵ See NCCHC REPORT TO CONGRESS, *supra* note 16 at 30. See also Ruiz v. Johnson, 37 F. Supp. 2d 855, 899 (S.D. Tex. 1995) (documenting poor diabetes care).

²⁰⁶ See TRAVIS, *supra* note 67 at 185-86.

²⁰⁷ See Lynch & Sabol, *supra* note 172 at 15-16.

The inmate whose diabetes is poorly managed while incarcerated is more likely to use costly health care services, such as dialysis for kidney failure, limb amputation, or emergency room visits for glucose (sugar) control when released into the community. Untreated hypertension, the most common chronic illness among adults (and inmates), can eventually require expensive health care services because it is a major risk factor for coronary heart disease, kidney failure, stroke, and blood vessel disease.²⁰⁸

Many prisoners have not had appropriate treatment of these chronic conditions in the distressed communities from which they come.²⁰⁹ The imprisonment of chronically ill persons thus presents a public health opportunity to provide cost effective services that will both facilitate successful reentry and reduce community and overall health care costs.

Mental illness provides another example of a public health opportunity in prison health. People with mental illness are dramatically overrepresented in prisons and jails.²¹⁰ In addition, prisons may act as an amplifier, or “incubator.”²¹¹ Many people who have not exhibited symptoms of mental illness in the free world develop mental illness in prisons due to the stress, crowding, harsh conditions (including solitary confinement), and lack of privacy.²¹² As is true chronic illnesses generally, prisoners are likely to have experienced poor access to community mental health services prior to imprisonment.²¹³ Indeed, it is the lack of community services that causes many people with mental illness to find themselves in prisons and jails.²¹⁴ The mental health care provided in prisons and jails is inadequate to address the needs of this large population.²¹⁵

Two of the shortcomings of prison mental health are worthy of particular note in the public health context. First, many prisoners who do receive mental health treatment are treated predominantly or exclusively with medications, and receive little or no additional therapy such as behavioral therapy and psychosocial rehabilitation.²¹⁶ Such limited treatment may render a prisoner more docile by temporarily alleviating his symptoms, but it does not advance him toward wellness and recovery.²¹⁷ As a result, prisons have

²⁰⁸ NCCHC REPORT TO CONGRESS, *supra* note 16 at 20-21.

²⁰⁹ See TRAVIS, *supra* note 67 at 282-83 (prisoners come from communities of “concentrated disadvantage”); REPORT OF THE RE-ENTRY POLICY COUNCIL, *supra* note 15 at 160-61 (prisoners often have limited access to care in their home communities).

²¹⁰ See Freudenberg, *supra* note 19 at 220; NCCHC REPORT TO CONGRESS, *supra* note 16 at 24.

²¹¹ See HUMAN RIGHTS WATCH, *supra* note 63 at 3.

²¹² See KUPERS, *supra* note 29 at 44-58.

²¹³ See KUPERS, *supra* note 29 at 13; HUMAN RIGHTS WATCH, *supra* note 63 at 20-23.

²¹⁴ See Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO NORTHERN U. L. REV. 641, 655-56 (2003); Stone, *supra*, note 29 at 291.

²¹⁵ See NCCHC REPORT TO CONGRESS, *supra* note 16 at 31-32 (“Most prisons and jails do not conform to the nationally accepted health care guidelines for mental health screening and treatment.”); KUPERS, *supra* note 29 at 68-83 (describing inadequate mental health care in prisons and jails).

²¹⁶ See KUPERS, *supra* note 29 at 78-80; HUMAN RIGHTS WATCH, *supra* note 63 at 109-14.

²¹⁷ See HUMAN RIGHTS WATCH, *supra* note 63 at 109-11.

missed “an important opportunity to provide them with the cognitive and life skills enhancement that will increase the likelihood of successful reentry into society following release from prison.”²¹⁸ Second, many symptoms of severe mental illness are treated by prisons as signs of disrespect or willful misbehavior, and the symptomatic prisoners are therefore confined in punitive solitary confinement rather than referred for treatment.²¹⁹ Segregation in prisons is an extremely harsh punishment, and can mean lock-down in a solitary confinement cell for 23 or more hours per day for weeks or months at a time.²²⁰ As might be expected, such isolation can be devastating for prisoners with mental illness, causing unspeakably severe suffering.²²¹

Prisons’ treatment of chronic illness, then, fails to provide for the health care needs of a large number of prisoners. This failure obviously harms the prisoners during their imprisonment, and in addition reduces the probability of successful reentry. Proper mental health treatment, particularly lacking in prisons and jails, is particularly necessary to successful reentry and the promotion of public health:

Mental health treatment can help some people recover from their illness, and for many others it can alleviate its painful symptoms. It can enhance independent functioning and encourage the development of more effective internal controls. In the context of prisons, mental health services play an even broader role. By helping prisoners regain and improve coping skills, they promote safety and order within the prison community as well as offer the prospect of enhancing community safety when the offenders are ultimately released.²²²

Prisoners failing to provide appropriate chronic and mental health care, then, not only hurt reentry efforts, but in addition harm public health by releasing prisoners who have become more ill during imprisonment to communities already underserved by community health providers. This stark failure to seize the opportunity to address health care needs is tragically inefficient in terms of long-term social costs of care, and demonstrably harmful to the population health of the communities to which prisoners are released.

2. Public health and care for prisoners’ communicable diseases.

Prisons’ failures in chronic and mental health care constitute a failure of public policy, an impairment of reentry efforts, and a failure of the broader goals of public health policy. Prisons’ failures in treating communicable and sexually transmitted diseases stand on an entirely different footing. With respect to these transmissible diseases, prisons’ neglect and mismanagement of health care services is a public health disaster, no matter how narrowly one construes public health functions. To the extent they fail to screen for and

²¹⁸ *Id.* at 110.

²¹⁹ See KUPERS, *supra* note 29 at 80-82; HUMAN RIGHTS WATCH, *supra* note 63 at 59-69.

²²⁰ See HUMAN RIGHTS WATCH, *supra* note 63 at 145-46.

²²¹ *Id.* at 149-53.

²²² HUMAN RIGHTS WATCH, *supra* note 63 at 3.

properly treat transmissible diseases, prisons and jails act as “epidemiological pumps,” permitting the agents for tuberculosis, HIV disease, and other conditions to spread within prisons, perhaps mutate into treatment resistant forms, and then travel with released prisoners to infect the broader community.²²³ In connection, then, with transmissible diseases such as tuberculosis, HIV disease, syphilis, and chlamydia, we see the strong public health argument. Even if we care nothing for the prisoners themselves; even if we think that public health should concern itself with nothing but “containing epidemics, contagion, and nuisances;”²²⁴ even if we believe that the public health function is properly served only by government agencies responding to specific threats to public threats;²²⁵ even with these contingencies in mind, public health principles demand reform of prison health services to address their failure to control communicable disease threats.

Prisoners enter prisons and jails disproportionately infected with communicable diseases.²²⁶ Prisoners are four to ten times more likely than the average member of society to be infected with tuberculosis, HIV, and hepatitis C, and released prisoners account for about one-third of all cases of tuberculosis and hepatitis C.²²⁷ Prisons and jails often do a very poor job of identifying and treating communicable diseases.²²⁸ Few prisons and jails screen for syphilis;²²⁹ many do not conform to rudimentary infection control provisions for tuberculosis;²³⁰ and some fail to follow the therapeutically essential administration requirements for HIV medications.²³¹ These treatment failures, of course, cause harm the prisoners themselves; but their effect on public health is also very powerful.

Some public health steps omitted by prisons are inexpensive and would pay large population health dividends. For example, while HIV disease cannot be cured, the risk of transmission from a released prisoner to others can be reduced by providing harm-reduction training to prisoners.²³² Educational programs, often provided by community groups and peer counselors, can be

²²³ The term “epidemiological pump” was coined by Paul Farmer, a public health physician, member of the faculty of Harvard Medical School, and founder of the international aid organization Partners in Health, in describing Russian prisons in the late 1990s. During that time, about half of Russia’s substantial population of people infected with tuberculosis were prisoners, as were most of the people infected with strains of tuberculosis resistant to the main drug therapies for tuberculosis. See TRACY KIDDER, MOUNTAINS BEYOND MOUNTAINS: THE QUEST OF DR. PAUL FARMER, A MAN WHO WOULD CURE THE WORLD 231-32 (2003).

²²⁴ See Epstein, *supra* note 164 at 1423.

²²⁵ See Rothstein, *supra* note 159 at 146.

²²⁶ See *supra* Part IB.

²²⁷ Freudenberg, *supra* note 19 at 217-18; NCCHC REPORT TO CONGRESS, *supra* note 16 at 19.

²²⁸ See *supra* Part IC.

²²⁹ See NCCHC REPORT TO CONGRESS *supra* note 16 at 29. See also *Madrid v. Gomez*, 889 F. Supp. 1146, 1205 (N.D. Cal. 1995).

²³⁰ See NCCHC REPORT TO CONGRESS *supra* note 16 at 31.

²³¹ See *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 181 (D.P.R. 1998).

²³² See NCCHC REPORT TO CONGRESS *supra* note 16 at 41.

quite effective in obtaining compliance with harm-reduction measures.²³³ These educational programs are not cost-free,²³⁴ a barrier to implementation that might seem insurmountable in light of society's historic indifference to the health of prisoners. However, these programs are cost-effective if we take into account the benefit gained by avoiding transmission of HIV to community members after prisoners' release.²³⁵

Perhaps the most serious public health threat raised by prison health failures is the failure to take the opportunity of imprisonment to treat and cure prisoners infected with communicable diseases. A very high percentage of people infected with syphilis and chlamydia, for example, cycle through prisons and jails.²³⁶ The opportunity to address these health threats when those infected are literally a captive population, available for treatment if treatment is offered, should be seized to address the periodic emergence of epidemics in sexually transmitted diseases. The argument for providing adequate health care treatment of sexually transmitted diseases is now being made in the context of reentry planning;²³⁷ broadening this argument to drive home the population health connection will serve the community – and the prisoners.

Tuberculosis care in prisons raises different, but equally pressing public health concerns. The high rate of tuberculosis infection among prisoners, most of whom will be reentering their communities, presents concerns and opportunities. “To reduce TB rates among inmates and prevent transmission to the general population, effective TB prevention and control measures in jail systems are vital.”²³⁸ Studies have established that crowding and the high concentration of infected prisoners make jails “an important amplification point” in tuberculosis epidemics.²³⁹ Again, the transmission of tuberculosis to prisoners may be seen as a personal health problem for an unsympathetic cohort of patients, but the population health implications raise issues of greater salience to most Americans, as jails and prisons are increasingly identified as a principal source of tuberculosis infection in broader society.²⁴⁰ Decent health

²³³ See Freudenberg, *supra* note 19 at 225; REPORT OF THE REENTRY POLICY COUNCIL, *supra* note 15 at 161-62; Breena Varghese and Thomas A. Peterman, *Cost-Effectiveness of HIV Counseling and Testing in US Prisons*, 78 J. URBAN HEALTH 304, 309 (2001).

²³⁴ See Varghese & Peterman, *supra* note 233 at 307-308 (estimating harm-reduction programs' costs).

²³⁵ See *id.* at 309. See also TRAVIS, *supra* note 67 at 206 (describing preliminary positive results from harm-reduction counseling); REPORT OF THE REENTRY POLICY COUNCIL, *supra* note 15 at 160-62 (describing benefits from prisoner educational programs).

²³⁶ See Freudenberg, *supra* note 19 at 218 (about one-third of women in jails are infected with syphilis or Chlamydia; women with multiple imprisonments in New York city jails had an incidence of syphilis that exceed that of women in the general population “by more than a thousand-fold”); Hammett, Roberts, & Kennedy, *supra* note 15 at 390 (almost one-third of syphilis cases in Chicago were diagnosed at the Cook County Jail).

²³⁷ See Hammett, Roberts, & Kennedy, *supra* note 15 at 391.

²³⁸ Mark N. Lobato *et al.*, *Public Health and Correctional Collaboration in Tuberculosis Control*, 27 AM. J. PREV. MED. 112, 112 (2004).

²³⁹ See Freudenberg, *supra* note 19 at 218-19; Lobato *et al.*, *supra* note 238 at 112; Kimberly G. Dobbs, *et al.*, *Value of Mycobacterium tuberculosis Fingerprinting as a Tool in a Rural State Surveillance Program*, 120 CHEST 1877, 1879 (2001).

²⁴⁰ See Dobbs *et al.*, *supra* note 239 at 1879; Jessica R. MacNeil *et al.*, *Jails, a Neglected Opportunity for Tuberculosis Prevention*, 28 AM. J. PREV. MED. 225, 227 (2005).

care treatment in all prisons including the improved tuberculosis programs pioneered in, for example, New York State's prison system, would prevent infections and improve prisoners' health.²⁴¹ If health care to prisoners were embraced as a public health opportunity rather than as a grudging obligation, similar programs, suitably tailored to the much shorter lengths of imprisonment, could be provided jail prisoners as well.²⁴² In all correctional settings, and particularly in jails, the connection between improved health in prisons and jails and linkage to treatment in the community is a vital aspect of reentry planning.²⁴³

One of the most frightening consequences of inconsistent, discontinuous treatment of prisoners with communicable diseases is that mistreatment can lead to mutation of the infectious agent, rendering it resistant to some, or in the worst case all available treatments. Antimicrobial resistance has become a public health concern on a number of fronts.²⁴⁴ In the prison and jail context, the concern is that inappropriate treatment of tuberculosis and HIV leads to the production of treatment-resistant disease that can be broadly spread on prisoners' release. In the treatment of prisoners with both HIV disease and tuberculosis, failures to maintain adherence to fairly rigid treatment protocol can lead to disease resistance.²⁴⁵ Slipshod recordkeeping, inconsistent administration procedures, and frequent transfers of prisoners can cause the breakdown of treatment adherence. The short stays of jail prisoners lead to adherence problems almost as a matter of course. Without improvements in prisons' and jails' treatment of infected prisoners, and appropriate linkages with community providers able and willing to provide care to ex-prisoners, prisons and jails run the risk of becoming factories for the production of treatment-resistant strains of tuberculosis and HIV disease for export to the greater community.²⁴⁶

Poor prison health care and the lack of suitable reentry planning raise classic public health threats of transmission of deadly communicable diseases. The ramifications of these failures go beyond harm to prisoners, implicating the health of the community.

Seen this way, the failure of our nation's prison systems (and the legislatures that fund them) to come to grips with the reality and consequences of communicable diseases among prisoners is a gross display of social negligence. Disregarding the immediate and long-term impact of releasing prisoners into the community without appropriate screening and treatment procedures in place jeopardizes community

²⁴¹ See TRAVIS, *supra* note 67 at 200 (describing New York's system).

²⁴² See MacNeil *et al.*, *supra* note 240 at 227; Lobato *et al.*, *supra* note 238 at 112.

²⁴³ See TRAVIS, *supra* note 67 at 209-212 (describing post-release community programs providing care continuation for released prisoners with communicable diseases including tuberculosis).

²⁴⁴ See generally Joan Stephenson, *Researchers Describe Latest Strategies to Combat Antibiotic-Resistant Microbes*, 285 JAMA 2317 (2001); Robyn L. Goforth and Carol R. Goforth, *Appropriate Regulation of Antibiotics in Livestock Feed*, 28 B.C. ENVIRON. AFF. L. REV. 39 (2000).

²⁴⁵ See Hammett *et al.*, *supra* note 15 at 398.

²⁴⁶ See TRAVIS, *supra* note 67 at 207-09.

health and well-being. A more enlightened policy would implement a systematic, professional program of detection and treatment for communicable diseases in American prisons. Moreover, because the benefits of this policy would be shared by society at large, the taxpaying public would likely be willing to pay its price.²⁴⁷

The reform of prison health services, then, regardless of the dearth of humanitarian feelings for prisoners, is a public health imperative.

3. Implementation issues: from theory to action

The motivation for writing this article should be clear: it is immoral, an injustice, to imprison two million Americans and fail to provide them with minimally adequate health care services. And yet that is the state of the affairs for very many prisoners, and for very many prisons and jails. Poor treatment, including poor health treatment has been the norm rather than the exception during the history of American prisons.²⁴⁸ People objecting to the mistreatment of prisoners have tried two categories of arguments to achieve reforms. First, they tried humanitarian arguments, combining appeals to fellow-feeling for prisoners with pragmatic arguments that the cost of reform was justified by the return that would be achieved by restoring the offender to full and productive citizenship. These were political arguments, addressed to legislatures and executive agencies. These arguments largely failed to achieve any lasting improvements in prison conditions.²⁴⁹ Second, they tried arguments based on the individual constitutional rights of prisoners, appealing to judgments that the Bill of Rights guarantees prisoners a certain, basic modicum of dignity and health treatment. These were legal arguments, addressed to courts. These arguments continue to be made, and continue on occasion to succeed, particularly in extremely egregious cases.²⁵⁰ This avenue of prison reform is, however, hampered by restrictions imposed by courts and legislatures.²⁵¹ This article is motivated by a desire to fashion a third vision of prison reform, one that might succeed where the first two failed.

Is prison reform as public health a legal theory, one that can be addressed to courts with the realistic hope of achieving remedies? The answer to that question is largely for another day, and another article. Some preliminary lines of thought are possible, however. States protect the public health as a matter of their police power, a core power inherent in sovereignty, as to which they enjoy very broad discretion.²⁵² Are states liable in state tort law for negligently failing to protect public health? The immunity that states

²⁴⁷ *Id.* at 202.

²⁴⁸ See Part IIB and C, *supra*.

²⁴⁹ See *supra* Part IIA.

²⁵⁰ See e.g., Plata v. Schwarzenegger, Civ. No. C01-1351 THE, Order to Show Cause Re: Civil Contempt and Appointment of Interim Receiver (May 10, 2005) at 2, available at [http://www.cand.uscourts.gov/cand/judges.nsf/0/43baa340b75c167288256ffd007bb1d5/\\$FILE/Plata%200SC.pdf](http://www.cand.uscourts.gov/cand/judges.nsf/0/43baa340b75c167288256ffd007bb1d5/$FILE/Plata%200SC.pdf); Ruiz v. Johnson, 37 F. Supp. 2d 855 (S.D. Tex. 1999).

²⁵¹ See *supra* Part IIB.

²⁵² See Jacobson v. Massachusetts, 197 U.S. 11 (1905).

retain for discretionary judgments after limited waivers of sovereign immunity would suggest not.²⁵³

State actions that disparately affect poor communities and communities of color may be suspect under a variety of other theories premised on prohibitions against unequal treatment in environmental matters.²⁵⁴ Application of these environmental justice/environmental racism theories has the benefit of highlighting the injustice of saddling poor communities of color with the results of states' prison mismanagement,²⁵⁵ permitting the argument that states are obliged to remedy that disproportionate harm. It has the detriment of suggesting that prisoners, the most direct victims have become something akin to toxic waste by virtue of states' prison mismanagement. Suffice it to say, this argument must be pursued with care; it would be cruelly unjust for arguments against negligent prison health care to result in the further demonization of ex-prisoners.

Finally, the positive rights granted under state constitutions have some power. Large populations made up of the poor and people of color are disparately affected by a state's failure to protect. Positive state constitutional rights obviously reach situations where federal constitutional protections do not.²⁵⁶ These positive rights may be argued to extend to the community's right of protection from the state's mismanagement of prison health causing avoidable public health injuries to poor communities and communities of color.

But the argument at this point does not address these possible legal applications. Instead, it is "merely" a political argument, much like that made by reformers such as Cobb Wines and Theodore Dwight in 1867, when they argued that brutal conditions in prisons were both inhumane and contrary to social interests in reforming prisoners, permitting them to return with dignity to a useful role in society.²⁵⁷ Similarly, the political argument here is that poor prison health care is both inhumane and contrary to social interests in achieving prisoner reentry maximizing ex-prisoner integration and minimizing the public health threats to their communities. A broad recognition that prisoner reform is supported by this combination of humanitarian impulse and social self-interest may provide the balance of selfish and selfless interests necessary to advance the goal of decent health care for prisoners.

²⁵³ See *Watson by Hanson v. Metropolitan Transit Commission*, 553 N.W.2d 406, 412 (Minn. 1996) (describing protection from tort liability enjoyed by states in discretionary actions).

²⁵⁴ See generally Alice Kaswan, *Distributive Justice and the Environment*, 81 N. CAR. L. REV. 1031 (2003); Sheila Foster, *Justice from the Ground Up: Distributive Inequities, Grassroots Resistance, and the Transformative Politics of the Environmental Justice Movement*, 86 CAL. L. REV. 775 (1998); Note, Rachel D. Godsil, *Remedying Environmental Racism*, 90 MICH. L. REV. 394 (1991).

²⁵⁵ See TRAVIS, *supra* note 67 at 279-99.

²⁵⁶ See William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977); Helen Hershkoff, *Positive Rights and State Constitutions: The Limits of Federal Rationality Review*, 112 HARV. L. REV. 1131 (1999).

²⁵⁷ See Rotman, *supra* note 97 at 153-55.

Conclusion

Government acquires obligations when it locks up prisoners, even when it does so for good reason. And government acquires significant obligations when it decides to imprison over two million Americans. One of those obligations is that of providing decent treatment, including necessary medical care. That obligation has been based since the beginning of the Republic on humanitarian impulses and pragmatic goals of social enhancement. It has been based in the last fifty years on the constitutional rights of prisoners to imprisonment free from cruel and unusual treatment. It is an obligation that government has largely ignored, notwithstanding constant arguments by prison reformers.

Decent prison health treatment should be advanced pursuant to a third vision of prison reform, one based on a confluence of selfless and selfish interests. The selfless interest continues to be the normative commitment to humane treatment for prisoners. The selfish motive is based on the potentially devastating population health effects flowing from poor prison care. Almost all of the two million American incarcerated today will be released to their communities. Prisons' and jails' failure to provide adequate treatment to a wide variety of chronic conditions, mental illnesses, sexually transmitted diseases, and communicable diseases threaten those communities with physical and financial harm, with infection and illness. Public health arguments, drawn in part from the emerging reentry movement, have the potential to move society to pay the costs for decent prison health care out of clear self-interest, where it has been unwilling to do so as a matter of justice and morality.