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Prison Health Care

Introduction

Fyodor Dostoyevsky once said that "the degree of civilization in a society is revealed by entering its prisons." While this would seem to be a logical conclusion, it does not hold in this country. The United States is the only developed nation that has failed to provide universal health care to all of its citizens. Ironically, prisoners are the only persons in the United States guaranteed the right to medical care by the U.S. Constitution. Based on this, one would conclude that prisoner health care must be the best in the country however despite the fact that time and again this group has been the victim of great suffering and even death as a result of substandard medical treatment. The current trend towards privatization raises further questions as to its implications for prisoners' rights.

Within this paper, we will address the problem of health care in prison, starting with a brief history of health care in U.S. correctional facilities and the evolution of prisoners' rights to health care as exemplified through international treaties, voluntary standards, and court cases. Next, we will look at the factors responsible for the rising costs of prison health care and the subsequent push towards privatization as well as its implications for prisoners' rights. In addition, using Prison Health Services as an example, we will demonstrate why privatization is detrimental to prisoners' rights to medical care. Next, we will discuss specific populations within prisons that have special medical needs and the inadequate treatment currently being administered to them. Lastly,

we will conclude with prescriptive policies and suggestions for the future of prison health care in the United States.

General History of Medical Care in U.S. Prisons

There are many challenges in providing health care to prisoners. "Even the term 'prison medicine' borders on oxymoron: whereas prison is designed to alienate and punish, medicine exists to nurture and soothe. So where is the boundary between care and punishment? At what point do they meet?" (Hylton 2003). This observation highlights the central conflict present within the issue and one that goes to the very heart of the question, which renders this a problem of human rights. If all persons are endowed with certain inalienable rights that the state must protect and promote, what restrictions can be placed on the rights of individuals who break the social contract? Clearly the state has the right to confine individuals, restricting their liberty, but such restrictions do not negate other rights or entitlements such as proper shelter, food, and medical care.

Prior to the 1970s, health care in prisons was seen as a privilege rather than a right. Prisoners were at the mercy of their wardens who, not having any formal health care training, often relied on other inmates or unqualified personnel to perform medical procedures. "A U.S. Supreme Court decision in 1972 regarding Alabama's prisons found that prisoners without any formal medical training extracted teeth, dispensed drugs, operated x-ray equipment, and performed minor surgery" (McDonald 1999). In addition to this case, there were a number of others pending litigation that compounded with the 1971 Attica uprising, paved the way for the assertion of prisoners' rights to medical care through numerous standards, accreditation programs, and judicial interpretations.

Prisoners' Rights to Health Care

The most relevant international treaties that deal specifically with the health care rights of prisoners are the International Covenant on Civil and Political Rights (ICCPR), the Convention against torture, the U.N. Standard Minimum Rules for the Treatment of Prisoners, and the U.N. Basic Principles for the Treatment of Prisoners, though many others can be applied. There is an overall U.S. resistance to the international and U.N. human rights treaties that deal with the treatment of prisoners. The United States, which ratified the ICCPR in 1992, entered into force in 1976. Article 10 of the ICCPR states that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person" (ICCPR). Although the U.S. ratified the ICCPR, it has a reservation concerning Article 7; "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment" (ICCPR). The United States said that it is bound to this article "only to the extent that this 'means the cruel and unusual treatment or punishment prohibited by…the Constitution of the United States.' That is, it was not willing to prohibit conduct that was not already prohibited by US law" ("Not part of my sentence" 1999). The U.S. believes that since its constitution already prohibits "cruel and unusual punishment," it is bound only to the constitution concerning this article. In specific relation to incarcerated people, the ICCPR states that "…all persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person" (ICCPR). The same restriction that was placed . on the ICCPR by the U.S. was placed on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The International Covenant on Economic, Social and Cultural Rights, which the United States has not ratified, in Article 12 guarantees the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This article does not discriminate against incarcerated people. Rather, everyone has the right, regardless of their legal situation, to have their health care needs met in order to enjoy good health.

The U.N. Principles of Medical Ethics, adopted in December 1982, clearly states the responsibilities of health personnel to prisoners. Principle 1 of the U.N. Principles of Medical Ethics states that "health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained" (U.N. Principles of Medical Ethics). The findings presented on the living conditions that exacerbate infectious diseases, and the blatant medical neglect on the part of health officials and prison staff, proves that this article is especially violated.

The most relevant principle in the U.N. Basic Principles for the Treatment of Prisoners is principle 9, which states that "access to health services available in the country without discrimination on the grounds of their legal situation" (U.N. Basic Principles for the Treatment of Prisoners). This means that prisoners require the same quality of health care as members of the general community, and that prisoners' access to these services should not be hindered because of their legal position. The U.S. has ratified the U.N. Standard Minimum rules for the Treatment of Prisoners, although they have reservations. This document provides descriptions of the medical services that

prisons are required to provide. Among the requirements are that inmates who have special health care needs be transferred to general hospitals if necessary; and each institution must have one "qualified medical officer who should have some knowledge of psychiatry;" as well as a "dental officer" (U.N. Standard Minimum Rules for the Treatment of Prisoners). Additionally, the document emphasizes that every prisoner must have access to the services provided by these two officers.

The National Commission on Correctional Health Care (NCCHC) was established in the early 1980s by the American Medical Association. The NCCHC sets voluntary standards along with minimum requirements for prison health services in order to receive accreditation. There are 73 standards and each is classified as being either "essential" or "important". The "essential" standards are more directly related to the health of prisoners and the "critical components of a health care system (e.g., receiving screening, health assessment, quality assurance)", and prisons must comply with all of these standards in order to receive accreditation (NCCHC 2003). However, only 85% of the "important" standards must be adhered to (NCCHC 2003). Although the NCCHC provides a list of standards, the process of accreditation merely "consists of a self-survey and site visit which is only scheduled when [prison administrators] feel ready" (Robbins 1999). Surprisingly, even with the ease with which prisons can acquire accreditation, only 231 of the more than 1,400 prisons in the country have received accreditation by the NCCHC ("Ill-Equipped" 2003). It is important to note that all of these standards are only the minimum requirements that the NCCHC recommends for prisons to improve the quality of their health services and to receive accreditation. There are 9 general sections into which these standards fall. The highest number of standards fall into Section E-"Inmate

Care and Treatment" (NCCHC 2003). Each standard is specifically named, categorized, and given a number. Each standard is also explained through different subheadings: the standard itself; indicators of compliance to that standard, which describes how health authorities will make sure the standard is applied; a definition; a discussion, in which they state their intent; and finally, a section dedicated to recommendations. According to the 2003 NCCHC "Prison Health Standards," the 2 most important sections in meeting the standards are the "Compliance Indicators," and the statements of intent within the "Discussion" categories. The very first standard, P-A-01-"Access to care," was established out of the 1976 Supreme Court case, *Estelle v. Gamble*. It defined access to care as "in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered" (NCCHC 2003). This standard is the most basic; it intends to "ensure that inmates have access to care to meet their serious health needs and is the principle upon which all National Commission on Correctional Health Care standards are based" (NCCHC 2003). Among other standards that are related to categories discussed in this paper are the P-A-03 "Medical Autonomy" standard, which states that health care professionals, not prison staff, will be responsible for the health care decisions made for prisoners in need of medical attention (NCCHC 2003), and the P-B-01 "Infection Control Program" which provides guidelines that prisons are suggested to follow in implementing an infection control program.

In November of 1976, the U.S. Supreme Court handed down its landmark decision in the case of *Estelle v. Gamble* which not only found that the state had an obligation to provide medical care to prisoners, but further set a legal standard for prison health care in the United States. The plaintiff, J.W. Gamble, an inmate at the Texas

Department of Corrections, claimed he injured his back during a work assignment. He alleged that W.J. Estelle, the Director of the Department of Corrections, and numerous other individuals had violated his 8th Amendment rights as a result of inadequate treatment, thereby subjecting him to cruel and unusual punishment. The plaintiff asserted that the doctors could have pursued a number of options that would have provided him with a better diagnosis and treatment, including an X-ray of his back. Though this case set the standard for prisoner health care, the court did not decide in favor of the plaintiff. Rather, they stated that Mr. Gamble's case was, if anything, an issue of malpractice and did not constitute medical mistreatment under the 8th Amendment. Thus a failure to provide inadequate medical care alone does not constitute a violation of the 8th Amendment. More precisely, the court concluded that "deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain, proscribed by the 8th Amendment" (*Estelle v. Gamble*, 429 U.S. 97). Later in *Farmer v. Brennan*, the Court refined its definition of deliberate indifference to include 3 circumstances: (1) "the official knows of and disregards an excessive risk to inmate health or safety"; (2) "the official is aware of facts from which the inference could be drawn that a substantial risk of serious harm exists"; and (3) "the official draws the inference" (Robbins 1999). Thus, prisoners must demonstrate not only that the neglect of their medical conditions caused unnecessary pain, but also that the neglect was deliberately intentional, thereby placing the burden of proof unfairly on the plaintiff.

In deciding this case the court developed a two-pronged test known as the Estelle medical professional judgment standard or Estelle MPJ test.

> "This test, which is the current constitutional standard, holds that prisoners' 8th Amendment right to medical care is violated if: (1)

> prison officials manifest 'deliberate indifference' to prisoners' medical needs and (2) those medical needs are 'serious.' By its very terms, this test excludes negligence on the part of prison officials and 'deliberate indifference' to medical needs that fall short of being 'serious'" (Posner 1992).

The Estelle MPJ test places a heavy emphasis on the decisions of the physician or person administering medical treatment, since it is that person who determines the severity of the problem and treatment a prisoner will receive. Once the prisoner's condition has been defined as "serious," he or she is constitutionally entitled to the treatment prescribed by the doctor without any consideration to the costs. This is important to point out, as it demonstrates that treatment is to be based on a physician's best judgment with disregard to financial issues. "The Estelle MPJ test offers a definite and objective standard to determine the constitutional obligation. The state's obligation consists of exactly what the medical professional decides is the appropriate treatment, assuming this is based on professional judgment" (Posner 1992). The brilliance of this test is that it stets a standard yet provides flexibility, allowing the standard to evolve in tandem with society's standards of decency.

Rising Rates of Imprisonment & Costs

Recently the U.S. has witnessed a surge in incarceration rates mainly due to the U.S. "punitive anti-crime effort," which instituted three-strike laws and other forms of retributive justice. These have led to the longer imprisonment of massive numbers of criminals convicted of minor drug and property offenses. By focusing on this sector of crime, the government unknowingly imprisoned and in turn took responsibility for greater numbers of the mentally ill (Human Rights Watch 2003). "The costs of incarcerating individuals with severe psychiatric disorders are enormous. According to

recent estimates, it costs taxpayers $15 billion annually to treat individuals with psychiatric disorders in jails and prisons" (Kinsella 2004). Mentally ill prisoners are not the only group driving up costs; with longer incarceration periods, prisons now have larger populations of elderly inmates. "Currently, elderly inmates comprise 8.2% of the total prison population, more than double the elderly proportion from 1990" (Kinsella 2004). Elderly prisoners are far more expensive to care for than younger prisoners mainly due to their medical needs. Thus, not only has the system had to deal with greater numbers, it has also had to adjust to a larger proportion of cost-intensive individuals, namely the mentally ill and the elderly. "From 1998 to 2001, state corrections budgets grew an average of 8% annually, outpacing overall state budgets by 3.7%. During that same 3-year period, corrections health care costs grew by 10% annually and comprised 10% of all corrections expenditures" (Kinsella 2004). Attempting to offset rising costs, the federal and local governments have packed prisons beyond their capacity leading to further problems of overcrowding and increased risk of communicable diseases as a result.

What is to be done about this problem? Currently there is a push towards privatized services including medical care with private companies promising to provide these services with greater efficiency and at lower costs than the government can offer. Despite their claims, the great majority of evidence and statistics proves them false and further finds great faults with the private sector.

Privatization

The privatization of prisons is not a new phenomenon; privatization was popular in the post-Civil War South when it was necessary to find a new source of cheap labor to substitute for slaves. "These early attempts at privatization were abandoned, however, because of the harsh treatment to which the inmates were subjected by private entrepreneurs" (Dunham 1986). Despite its historical record, the concept of privatization was resurrected in the late 1970s and has since that time burgeoned into a $2 billion-a-year industry (Zielbauer 2005). In 2005, "40% of all inmate medical care in America was contracted to for-profit companies" and it is expected to increase even further (Zielbauer 2005). With the problems of rising costs and overcrowding in prisons plaguing government officials, privatization has once again become an attractive alternative.

There are multiple forms of prison privatization ranging from prisons completely built and paid for by private firms to public prisons which contract with private firms to provide services such as food and health care. For the purposes of this paper, privatization will refer to the latter form. While the former does exist, the latter is a much more popular form of privatization, allowing state and local governments to bounce from one provider to another every few years to find the lowest bidder.

There are many questions surrounding this issue; one of the most important is the question of liability. Is the government able to pass its obligations to a private company,, and if so, is it free of liability? Once again it was the courts and not laws or legislations that determined this issue. In *Ancata v. Prison Health Services*, the court found that, ". . . a county that contracts with a private firm to supply medical care to inmates 'remains liable for any constitutional deprivations caused by the policies or customs of the [firm]"

(Dunham 1986). Consequently, the privatization of prisons does not negate the government's responsibilities and obligations to the prisoners. Moreover it holds both the government and the private firm accountable.

The privatization of prisons is a hotly contested issue within the prison world. Proponents argue that it can provide adequate services more efficiently and cheaply-- firms claim 10-20% cheaper-- than the government (Cheung 2004). Generally these promises are enough to sign most prisons on without a thought for how these companies are able to cut their operational costs. However it is important to note that ". . . 65 to 70% of the costs of operating a prison goes to staff salaries, fringe benefits, and overtime" (Austin and Coventry 2001). This fact begs the question of how the private sector is able to provide adequate service at a cheaper rate. The answer to this question raises one of the main contentions of critics; "in an effort to lower costs, firms often compromise the quality of inmate care by reducing staffing levels and employing unqualified medical personnel" (Robbins 1999). This is a serious problem in terms of medical services in particular as it deals with human life and could result in litigation which costs the firm and government more than they would have saved had they hired qualified personnel.

Last winter The New York Times completed a year-long exposé of Prison Health Services, the Tennessee-based firm hired by the city of New York to provide health care for all its prisons and jails. The Times discovered that ". . . at least 14 doctors who have worked for Prison Health Services have state or federal disciplinary records, among them a psychiatrist forbidden to practice in New Jersey after state officials blamed him for a patient's fatal drug overdose" (Zielbauer 2005). Despite the numerous cases against the

company in New York and a 2001 commission recommendation that the city stop the company's operations in New York, in January of 2004, the city renewed its contract with Prison Health Services for another 3 years (Zielbauer 2005). If one accepts Adam Smith's classic interpretation of the market, one would assume that poor-performing companies like Prison Health Services would eventually be pushed out of the industry by better companies; however, as this example proves, this is not the case. The reason for this is twofold; first, there are only a few very large companies within this sector, thereby limiting competition and incentive; second, when the government puts out contracts to private firms, it generally chooses the lowest bidder, which may not necessarily provide the best standard of care.

Within the industry there are other glaring problems, most notably the conflicting interests of private firms to be both profitable and provide adequate treatment. Though *Estelle v. Gamble* established and *Ancata v. Prison Health Services* reiterated, ". . . prison health care providers may not place financial considerations ahead of the medical needs of prisoners," the way the contracts are devised almost certainly implies that financial considerations will be taken into account (Robbins 1999). Generally firms are paid a fixed per-capita rate and retain the difference between that rate and their expenditures; thus it is in the financial interest of the firms to spend as little as possible on each prisoner (Dunham 1986). There have been numerous stories and lawsuits to substantiate this claim, ranging from diabetic prisoners who say they were denied their insulin for days to a woman given Tylenol for chest pains, which would ultimately lead to her death a few days later as a result of a heart attack (Zielbauer 2005). "In an affidavit a Prison Health Services nurse admitted to having joked that, 'we save money because we skip the

ambulances and bring them right to the morgue"' (Robbins 1999). These are only two examples among hundreds of the way in which private firms have demonstrated a deliberate indifference to the medical needs of prisoners by putting profits above treatment. These examples are quite disturbing and illustrate the ways in which the conflicting interests of a private firm can be detrimental to the medical needs of the prisoner. What is more, in 2001 the Bureau of Justice Assistance concluded that the average saving from privatization was, on average, only 1%; thus not only do these companies fail to provide adequate care, they do so at the same expenditures as the state (Austin and Coventry 2001). Given this statistic and the tragic stories that have emerged from prison privatization, the government should seriously consider the implications of privatization.

Women

Since the 1980s, women have become the fastest growing prison population in the United States, compromised by a majority of minority women. Since 1981, the rate at which women are incarcerated has surpassed the incarceration rate of men (Belknap 1996). Most of these women are Blacks and Hispanics with histories of unemployment, lack of education, and poverty. "32% head broken homes, 53% come from broken homes and 41% report a history of sexual or physical abuse" (Ross and Lawrence 1998). For these reasons, women have experienced little to no "community-based" health care (Ross and Lawrence 1998), and there health issues are exacerbated in the prison setting: "the subpopulation of women offenders comes from the growing pool of poor and often victimized women in our urban centers who are quickly returned there. Their health problems and needs do not arise in prison; rather, the women bring their health care

problems to prison" (Ross and Lawrence 1998). Women already bring health problems to prison, and having them exacerbated in prison comes from the above-mentioned lack of community-based health care in impoverished areas around the U.S. At the state level, the percentage of Black female inmates is 48, 15 for Hispanics, and 29 for White women. At the federal level, 33% of female inmates are White, 35% are Black, and 32% are Hispanic (Hogben and Lawrence 2000).

The dramatic increase is mostly due to the war on drugs during the 1980s. After all, admissions into prison for drug-related offenses increase annually at incredible rates. Over 40% of women are in prison for non-violent drug offenses. After the enactment of policies that would crack down on drug offenses throughout the early 80s, the 90s would see the incarceration rate for women increase by 313%, consequently much greater than male incarceration rate at 182% (Weatherhead 2003). As of 2000, it is estimated that since 1980, the population of female prisoners has increased by 573% (Siefert and Pimlott 2001). According to Weatherhead, the punishments that both men and women receive for drug offenses are often as severe as the punishments given for violent crimes, and many inmates end up serving as long a sentence as they would for murder (Weatherhead 2003).

There is currently no national standard concerning the needs of pregnant prisoners (Siefert and Pimlott 2001). Approximately 18% of women in prison are pregnant (Weatherhead 2003). Eighty percent of women prisoners are mothers (Siefert and Pimlott 2001). Eighty thousand of the female inmates in the U.S. are mothers of children under the age of 18 (Allen 2000), and prior to incarceration, 85% had custody of their children (Siefert and Pimlott 2001). In most U.S. prisons, there is a lack of prenatal

examinations, preparation classes for childbirth, and counseling and emotional support for pregnant women. A disturbing fact that attributes to the high rate of depression and anxiety among pregnant female inmates is that, in over forty states, babies are taken away from their mothers immediately at birth (Weatherhead 2003). Due to the length of time that the mother is in prison, the conditions she lives in, and the inadequacy of prenatal health services, pregnant prisoners experience higher rates of miscarriages, pre-term labor, "fetal and neonatal death", and "intrauterine growth retardation" (Siefert and Pimlott 2001). Even though women are the fastest growing prison population, the response to their special health care needs has been poor, and prisons only offer inadequate, if any, reproductive services.

Inmates who are both drug-dependent and pregnant have even more specific needs that are also not addressed. Prior to incarceration, many of these women are also vulnerable to and have health problems such as HIV, TB and STDs. Their special needs are not met because "most correctional systems lack the specialized medical personnel and treatment protocols needed to safely detoxify addicted pregnant women" and because of the high availability of illicit drugs in prison (Siefert and Pimlott 2001). Although programs such as Alcoholics Anonymous and Narcotics Anonymous are offered by most prisons, the complexities that pregnant and drug dependent inmates bring are not sufficiently met by such programs.

According to a 2000 journal of women's health, only 20% of U.S. prisons screen entering inmates for Chlamydia infection, and 48% for syphilis (Hogben and Lawrence 2000). The very low percentage of prisons that perform initial screening for STDs is dangerous, because it is very important to know in what medical conditions inmates enter

the prison. Chlamydia rates, along with most other STD rates, are significantly higher in prisons than in the general population. The high prevalence of STDs in prisons "is influenced by social factors, for example, policies toward incarcerating sex workers" (Hogben and Lawrence 2000). Instead of helping these women by creating programs or rehabilitation centers that tend to their medical needs and help them find decent jobs, they are thrown into the prison system where they encounter the same conditions which forced them into being sex workers in the first place.

In the article "Cruel but not Unusual Punishment," Weatherhead provides an example of how the "deliberate indifference" standard was used in relation to pregnancy. A woman named Karen Allen was pregnant when she entered prison and she experienced extreme untreated pains and conditions, such as abdominal pains, to the point that she could not stand up. Weeks passed before she was even given an ultra sound, which found that there were many abnormalities that endangered Karen's life. According to the article, after the results of the ultra sound were given, Karen was never seen again by medical staff in prison (Weatherhead 2003).

Karen's case is not unusual. Most prisons fail to provide adequate gynecological services for women prisoners due to the fact that, although women are the fastest growing inmate population, they still constitute a minority. There are, however, some examples of successful programs for women that address their special needs. In 1989, officials from Santa Rita County, California, established a successful and elaborate OB/GYN unit for incarcerated women. The unit features prenatal services, initial screenings for STDs, TB, and HIV, as well as thorough pap smears.

Infectious Diseases

Among the guidelines stated in the P-B-01 "Infection Control Program" standard are that the prisons must ensure that "immunizations to prevent disease are provided when appropriate; infected patients receive medically indicated care" as well as assuring that "inmates who are released with communicable or infectious diseases are provided community referrals" (NCCHC 2003). As explained further in the paper, even these most basic suggested requirements are not followed by the majority of U.S. prisons. Prisons have actually become places where these diseases are more easily spread. "Prison conditions have led some authorities to the view that, 'prisons have now become the new tenements, overcrowded compounds, fertile and accommodating to disease'" (Koehler 1994). Additionally, the people entering prisons already come in with their health care inequalities; they are often from the sectors of the poor, the homeless, and those with little to no access to "preventive and primary healthcare" (Braithwaite 1998). So not only does the majority of the prison population carry with them the burden of healthcare inequalities upon entry, but those health problems are exacerbated once in prison; and the same lack of access experienced outside of prison is experienced within.

According to the National Institute on Drug Abuse, people who inject drugs with shared needles make up 1/3 of new HIV cases in the U.S. (Gentile 2005). "Correctional populations have the highest rates of HIV infection of any public institution" (Braithwaite 1998). The rates at which prisoners are infected with HIV and AIDS far exceed that of the general population. Because there is an emphasis on keeping drugs out of prisons, and because of the difficulty of prisoners having needles smuggled in for them, prisoners who are addicted to intravenous drugs are forced to resort to sharing needles.

In some prisons in the U.S., 20 % of inmates carry HIV, and rates of TB infection often far exceed the rates of infection seen in the society ("Prison health: threat or an opportunity"). The living conditions in prisons make it easy for tuberculosis to spread rapidly between inmates and also from inmates to prison staff. The living conditions in prisons that facilitate the spread of tuberculosis are overcrowding, the closeness of sleeping quarters, communal showers, and poor air circulation and ventilation systems. This aids in the spread of TB, because it is spread through the inhalation of germs via others' coughs and sneezes. Prisons have also failed to give prisoners initial medical screenings to detect for infections and diseases such as TB.

Another serious growing problem in U.S. prisons is the rate of hepatitis C infection. It is estimated that "somewhere between 20-40% of American prisoners are, at this very moment, infected with hepatitis C, and therefore quite contagious…most of them will eventually be released back into the general population, where the infection rate is, for now, only about 2 percent" (Hylton 2003). Association of State and Territorial Health Officials noted in a 2000 report that "an estimated 1.4 million HCV-infected persons pass through the correctional system each year" (Hylton 2003). The rate of infection increases rapidly in prison due to the high drug use and sharing of dirty needles. The number of prisoners with hepatitis C is high, and despite the fact that the cost of a hepatitis test is affordable, very few prisons offer them, and there has been no legislation from the federal government that requires them to provide these tests (Hylton 2003).

Needle-exchange programs (NEPs), which are an effective way of controlling the spread of HIV in prisons, have been met by fierce opposition, especially in the United States. Those who oppose NEPs say that these programs prove there has been a failure to

terminate drug use in prisons. In the 1980s, Europe began implementing needle exchange programs, and so far they have been effective. "These measures have decreased rates of drug use, syringe sharing, and HIV transmission. Needles have not been used as weapons, and there has been no recorded increase in drug use" (Davies 2004). On the other hand, the prisons that do not implement "harm-reduction strategies" such as NEPs have the highest and fastest growing HIV rate, such as the U.S., which, as mentioned earlier, has an HIV infection rate of 20% in some prisons (Davies 2004). Being that a large percentage of HIV is caused by intravenous drug use, incarceration would seem ineffective and counter productive for these non-violent drug crimes, especially since drugs are just as readily available in the prison setting, and because of this, prisoners are forced to share dirty needles. For this reason, a program where prisoners could receive clean syringes upon handing over used ones would greatly control the rate at which HIV is spread (as countries which have implemented these programs have proven), even though the first priority is not to completely eliminate drug use. Baltimore saw one of the first NEPs set up in 1994, and in the first few years of its establishment, HIV rates declined twelve percent (Nation's Health 2004/2005).

In 1993, the World Health Organization (WHO) gave guidelines for prison reform for controlling the spread of HIV. Distribution of condoms was one of the guidelines given, but similar to the exchange of clean needles and syringes, the distribution of condoms poses a moral dilemma for reluctant prison officials (Braithwaite 1998). If done right, and if the criminal justice system and health officials and correctional officials worked together, the prison setting could actually provide a vital opportunity to help the overall health crisis; because the health crisis experienced most intensely by the homeless and

drug users is exacerbated in the prison setting. Richard J. Koehler, the former Commissioner of the New York City Correction Department in the 1980s, makes recommendations for the criminal justice system to help end the health crisis by starting with prisons. As a start, he suggests that instead of having inmates charged with drug-related offenses, especially those who carry HIV, placed in prison; they should be placed in specialized facilities that treat substance abuse: "this would not endanger public safety, and it would permit medical providers to deal more aggressively with the substance abuse, TB, and HIV problems of inmates" (Koehler 1994). Alternative housing for "nonviolent drug abusers" such as these voluntary, confidential facilities also prove to be more cost effective (Koehler 1994). They also lessen the risk of spreading TB and other diseases that worsen the conditions of inmates with HIV, which in prison is made easy because of the crowded and poor ventilation. He also stresses the importance of providing education programs on safe sex and condom use, along with distribution of condoms due to evidence of the high incidences of unprotected sex that take place in prisons (Koehler 1994).

Due to the fact that so many people, especially women (40%), are incarcerated for non-violent drug crimes, more funding should go into residential programs, halfway houses, and rehabilitation and education programs, rather than imprisoning these people, where the health problems that they bring from injection and other drug use are made worse. A reduction in unnecessary incarceration would also control the high and rising rate of infectious diseases in prisons, because as mentioned before, many of these diseases are spread through overcrowding. So if 40% of the 138,000 women who are currently in prison were taken out of prison, the rate at which TB spreads would most

likely decrease dramatically. Another proposition is that the U.S. accepts and federally funds needle exchange programs in the communities and prisons, as Europe has done, as well as condom distribution in prisons.

Mentally Ill Prisoners

As noted in a recent article by Human Rights Watch, "jails and prisons have become, in effect, the country's front-line mental health providers" ("Ill-Equipped" 2003). Throughout the U.S., prisons and jails are witnessing a rapid increase in the number of mentally ill prisoners due to both the wide-spread deinstitutionalization of the mentally ill and the country's "punitive anti-crime effort" as mentioned earlier. Beginning in the 1960s, there was a major push to integrate the mentally ill back into society. While this was a well-intentioned policy it failed to provide the necessary funds to community facilities, leaving them unequipped to treat the bourgeoning population of mentally ill individuals. As a result, "thousands of mentally ill are left untreated and un-helped until they have deteriorated so greatly that they wind up arrested and prosecuted for crimes they might never have committed had they been able to access therapy, medication, and assisted living facilities in the community" ("Ill-Equipped" 2003). In addition, the government's decision to concentrate on minor offenses, particularly drug possession, has increased the likelihood that those imprisoned would be mentally ill since the Department of Health and Human Services estimates that ". . . 72% of mentally ill individuals entering the jail system have a drug-abuse or alcohol problem" ("Ill-Equipped" 2003).

Prisoners suffering from a mental illness require additional specialized treatment. Their right to this care was first established under the case of *Bowring v. Godwin.* In this case, the court found that there is no difference between physical and mental illnesses and

thus prisoners have a right to treatment for physical as well as psychological conditions (Posner 1992). Despite the court's decision in favor of mental health rights, the court also determined that financial factors could be used in determining treatment; this ruling conflicts with the courts earlier ruling in *Estelle v. Gamble,* but is consistent with the country's failure to provide mental health parity within the wider public as well. Thus while prisoners are entitled to mental health care, that care can be determined by costs. Most prisons lack the resources and personnel necessary to treat the massive number of prisoners suffering from some form of mental illness. The deficiency is clear from the start when many incoming prisoners are not screened for mental illness nor are their files transferred and read in a timely fashion (Zielbauer 2005). As a result, these people do not receive the necessary medications or counseling that they require. In addition, the correctional staff, who have the most contact with inmates, are not trained to recognize and handle prisoners suffering from mental illness. The lack of qualified personnel and comprehensive care for this growing population within correctional facilities has devastating effects on these individuals.

> Without the necessary care, mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, extreme and uncontrollable mood swings. They huddle silently in their cells, mumble incoherently, or yell incessantly. They refuse to obey orders or lash out without apparent provocation. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide ("Ill-Equipped" 2003).

The conditions which are described in this quote point to the indifferent and barbaric treatment to which these prisoners are subject to. Clearly there is a great need for mental health treatment within U.S. correctional facilities; however, as illustrated, these needs are currently not being met. In this country, mental illness has a huge social stigma

attached to it, which has weakened individuals' rights and access to care for both prisoners and non-prisoners. However, this problem is further exasperated in prisons which lack the means of identifying and treating these individuals leading to atrocious conditions and in severe cases the unnecessary loss of life.

Conclusion

Despite the current trend towards privatization of prison health care, we believe that the inherent tension between profit and adequate care is irreconcilable and therefore should be terminated. In taking away the obvious rights and freedoms that come with incarceration, the state has a duty to provide adequate care and treatment to these individuals. John Rawls' theory of "original position," states that men and women who know nothing about their place and privilege in society will naturally choose a basic minimum standard of conditions which guarantees their fundamental rights. We believe that this theory should be put into practice in order to begin to address the health care inequalities that exist. The prison system represents a microcosm of U.S. society and the problems created by the inequalities and inefficiencies of its health care system.

It is not only a matter of the rights of the prisoner, but in the interest of society as a whole to care for these individuals, as the majority of prisoners will eventually rejoin society and bring with them the communicable diseases that they either acquired or that were worsened in the prison setting. Therefore, the fight to prevent these communicable diseases should begin in the prison setting itself.

Clearly, voluntary standards and accreditation programs are not adequate in addressing the pandemic of medical neglect in prisons. Looking to the Europe Union as an example, the U.S. should adopt similar prison rules, which would set standards and

provide accountability for the duties of medical and correctional staff in providing adequate service to prisoners. Additionally, the state should institute independent commissions or evaluations which are made public, providing transparency and public scrutiny of the system. Lastly, there should be a system of formal complaints allowing prisoners to air their grievances without the costs and lengthy amount of time of the court system, though the court system should be used in cases of gross violations.

It is shameful that one of the richest countries in the world, with the resources to make possible an excellent system of health care, allows so many of its citizens to go without the basic minimum standards of care. Despite the fact that prisoners are the only group constitutionally guaranteed a minimum standard of health care, prison administrators and criminal justice administrators have failed miserably to seize this opportunity in addressing the health care needs of prisoners, and therefore the entire population. If there is only one group in the United States whose right to health care is guaranteed by the Constitution, yet their rates of infectious diseases go anywhere between 10 to 100 times greater than the general population; their psychiatric medicine discontinued; and few to no gynecological services provided; among all the other incidences of gross medical neglect, then that is enough to conclude that the health care system in the United States, especially in the microcosm of the prison harbors gross human rights violations that absolutely need to be addressed. There is no reason why a woman in labor should have to be chained to a bed while transported to a hospital, or why the no tolerance and Christian moral policies should prevent the implementation of programs, such as NEPs and condom distribution, which could, and have, saved so many people's lives.

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