The Report Committee for Rebecca Ann Larsen
Certifies that this is the approved version of the following report:

Privately Run Health Care in Prisons:
An Industry and Health Impacts Analysis

APPROVED BY
SUPERVISING COMMITTEE:

Supervisor: _____
David Warner

Co-Supervisor: _____
Michele Rountree

Privately Run Health Care in Prisons:
An Industry and Health Impacts Analysis

by

Rebecca Ann Larsen, BA

Report

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degrees of

Master of Public Affairs

and

Master of Science in Social Work

The University of Texas at Austin

August 2014

Dedication

This report is dedicated to those suffering in captivity in a racialized, unjust criminal justice system. May your stories be heard and may your humanity be acknowledged and honored.

Acknowledgements

I would like to thank Dr. David Warner and Dr. Michele Rountree for the time and effort they dedicated in helping me to refine this report. I would also like to thank 'John' from Arizona for sharing his story and Grassroots Leadership for their access to experts, stories, and information. Lastly, I would also like to thank Caitlin Dunklee for helping me develop and continually challenge my understanding of criminal justice and racial justice work through her impressive expertise and dear friendship.

Abstract

Privately Run Health Care in Prisons: An Industry and Health Impacts Analysis

Rebecca Ann Larsen, MPAFF;MSSW

The University of Texas at Austin, 2014

Supervisor: David Warner

Co-Supervisor: Michele Rountree

The following report is an assessment of the privatization of health care in U.S. prisons. It attempts to better understand the industry, the leading companies, and to determine whether they are providing adequate and constitutionally mandated levels of care. The report begins with an overview of prison health care, covering its history and its current state. It then examines the private correctional health care industry by looking at industry structure, market share, and leading companies. In an attempt to analyze the impact this industry has on people behind bars, several research approaches were utilized, including a literature review, a review of government reports and court documents, a review of case studies, a narrative report of one individual's experiences, and an assessment of mortality rates. Research findings suggest that the current privatization model incentivizes limiting services rather than improving oversight and access to care. Mortality rates were found to be the highest in privately run care facilities. Case study findings further suggest that

private correctional care is routinely inadequate and exposes prisoners to harm and risk of harm, including inhibited access to care, severe medical conditions, amputations, suicide, and death. The propensity of this harm compared to publically run care remains inconclusive. Increased independent oversight and population reduction over privatization are recommended.

Table of Contents

List of Figures

Chapter 1: Introducing Prison Health Care

The United States imprisons more people than any other country in the world, including China (Walmsley, 2013). Years of tough on crime policies, such as three strikes laws and mandatory minimums, led to a 667% increase in incarceration from 1972 to 2010 (Stevenson, 2011), and doubled the length of prison sentences (Caravelis, Chiricos & Bales, 2011). This mass incarceration disproportionately targets and harms communities of color (The Sentencing Project, 2013), while cumulatively costing states billions each year, with the largest portion of corrections budgets going to increasing health care costs (Schmitt, Warner, & Gupta, 2010). Advocacy groups, academic literature, and government reports have called for policy reforms to imprison fewer people as both a cost savings and humanitarian measure (Austin, et.al., 2013; Cole, 2011; Koppell & Burrus, 2012; Department of Justice, 2014). However, many states have responded by outsourcing their prison health care to private companies. Twenty-three states now have all of their prison health care outsourced to private providers, as do hundreds of jail municipalities (Arnquist, 2014a). This translates into the health and mental healthcare of hundreds of thousands of confined Americans, yet there is little data and academic research to conclude whether or not these companies are providing adequate and constitutionally mandated levels of care.

The aim of this report is to better understand private correctional health care.

Questions posed and pursued in this report are: What is private correctional health care?; Who are the leading companies?; What are the outcomes of outsourced care?; Does outsourced care improve upon public care?; Are there instances of unconstitutional treatment under outsourced care?; If so, what are the experiences of incarcerated persons and family members?; What is the propensity of ill-treatment experienced by incarcerated persons?; How can incarcerated persons be better protected? This report is developed with the contextual understanding that publically provided health care is regularly found to be flawed and negligent (Brooks, Pompi, & Nink, 2007; Wiler, et. al., 2009; Gibbins & Katzenbach, 2006; Bedard & Frech, 2009).

In an attempt to produce a publically accessible comprehensive look at this industry and the impact it has on incarcerated individuals and their families, several research approaches were utilized including a literature review, a review of government reports and court documents, a review of case studies, a narrative report of one individual's experiences, and an assessment of mortality rates.

Findings suggest that issues incarcerated people suffer from in publically run prison care are also found in privately outsourced care. Mortality rates were found to be higher in privately run care facilities and literature suggests that the current model incentivizes limiting services rather than improving oversight and access to quality care. Findings further conclude that private correctional care is routinely inadequate and exposes prisoners to harm and risk of harm, including inhibited access to care, severe

medical conditions, amputations, suicide, and death. However, the propensity of this harm compared to publically run care remains inconclusive.

HISTORY OF HEALTH CARE IN PRISON

Prior to federal court intervention in the 1970s, health care in American prisons was limited and often considered a privilege by prison staff (McDonald, 1999). Prison staff commonly withheld access to medical intervention as a disciplinary means (Bedard & Frech, 2009). Few physicians were hired within the prison setting, and those that were often had restricted licenses (McDonald, 1999). Not surprisingly, stories of extreme neglect, deaths, and riots to improve conditions were common.

In 1971, a now famous uprising in the Attica Correctional Facility in New York brought national attention to human rights abuses and inadequate health conditions in prisons (Parkin, 2002). A series of uprisings and subsequent lawsuits followed, including one on behalf of J.W. Gamble. Gamble was imprisoned in a Texas prison where he had a prison labor assignment of loading and unloading cotton bales from a truck. On November 8, 1973 a cotton bale fell on his back. He complained of back and chest pains for three months, and when he could not work because of the pain, was subjected to a disciplinary hearing and placed in solitary confinement. After being refused medical treatment multiple more times for what turned out to be an irregular heartbeat, and being punished for being unable to work, Gamble swore out in a pro se[1] handwritten note, initiating a lawsuit (Estelle v. Gamble, 1976).

1 Representing oneself rather than being represented by legal counsel.

In 1976, the U.S. Supreme court did not rule in favor of Gamble, but did establish that the "deliberate indifference to serious medical needs of prisoners" was "cruel and unusual punishment" and thus violated the Eighth Amendment (Estelle v. Gamble, 1976). It further established that an incarcerated person must rely on prison authorities to treat medical conditions, and has no way of meeting those needs if authorities fail to do so (Estelle v. Gamble, 1976). This landmark case and a multitude of subsequent federal court decisions, legally acknowledged health care in prison as a human right.

Though corrections institutions have made significant changes in how they approach the provision of health care to incarcerated persons, considerable barriers to adequate health and mental health care persist across states (Brooks, Pompi, & Nink, 2007). Regular scandals and academic findings indicate that health care remains deficient for many incarcerated persons (Wiler, et. al., 2009). One study found that when asked to think about someone they know in prison, 84% said they were concerned about the persons safety, and 76% of people said they were concerned for the persons health (Gibbins & Katzenbach, 2006). Measures to address barriers to care most frequently occur due to court orders, making medical care the most litigated issue involving prisons (Bedard & Frech, 2009).

CURRENT STATE OF INCARCERATION AND PRISON HEALTH CARE

The United States currently has the highest incarceration rate in the entire world (Conklin, Lincoln, & Wilson, 2002; NAACP, 2010). Over 2.2 million people are incarcerated at a given time (Bureau of Justice Statistics, 2013) with 1 in 35 adults under

correctional supervision (Glaze & Herberman, 2012). While the United States accounts for 5% of the world's population it holds 25% of the world's prisoners (NAACP, 2010; Kirchhoff, 2010).

The criminal justice system disproportionately impacts and targets people of color at each level of the system. Thirty percent of the U.S. population is comprised of people of color, yet 60% of people in prison are people of color (The Sentencing Project, 2013). Black men are eight times as likely as white men to be incarcerated (Western & Wildeman, 2009). Once convicted, black men receive longer sentences compared to white men (The Sentencing Project, 2013; The Sentencing Project, 2005; Spohn, 2011; U.S. Sentencing Commission, 2010). The U.S. Sentencing Commission (2010) reported the federal system gave African Americans sentences that were 10% longer than white Americans for the same crimes, further finding that mandatory minimums are applied disproportionately to African Americans.

Meanwhile, women are the fastest growing group of persons being imprisoned (Luong, 2013; Conklin, et al., 2002). As with the male prison population, women of color are disproportionately represented (The Sentencing Project, 2007). African American women are three times more likely than white women to be incarcerated, while Hispanic women are 69% more likely than white women to be incarcerated (The Sentencing Project, 2007).

The increased length of prison sentences largely attributed to mandatory minimums, three strikes laws, and life without parole sentences has also led to an

increase in aging incarcerated persons (Kirchhoff, 2010; Buck, 2008). The number of incarcerated persons age 65 and older grew by 67% between 2008 and 2012 (Policy Research Associates, 2012).

Research shows that incarcerated persons develop health issues at an earlier age than the general population (Kirchhoff, 2010) and experience higher rates of infectious and chronic diseases, substance abuse, mental illness and trauma (Justice and Health, 2013; Buck, 2008; Conklin, 2002). More than half of all people in prison and jail, including 56% in state prisons, 45% in federal prisons, and 64% in local jails, experience a mental health diagnoses (Buck, S. 2008). An increase in aging incarcerated persons has also resulted in significant increases in the development of chronic conditions and diseases associated with old age (Chiu, 2010). Furthermore, the stress of prison has been found to cause premature aging (Massoglia, Pare, Schnittker, & Gagnon, 2014).

As more people live behind bars for longer periods of times with complex health and mental health needs, states have turned to private correctional health care companies to meet health needs and alleviate strained budgets. The following chapter introduces the private correctional health care market and assesses the industry and leading companies.

Chapter 2: The Private Correctional Health Care Industry

With the highest incarceration rate in the world, a constitutional requirement to provide health care in prison, and disproportionate health and mental health issues experienced by, and often because of the prison setting, correctional health care has become one of the most expensive elements of state budgets. Prison health care expenditures can account for 20% of states' corrections budgets, making correctional health care a $10 billion industry (Arnquist, 2014a). Privatizing services in prisons, like privatization of other public services, is sought to increase efficiency and save money.

The terminology "private correctional health care" or "outsourced correctional/prison health care" as used throughout this report, refers to private companies being contracted with to provide health, mental health and dental treatment in prisons. The use of the term "private" is not to be confused with private prisons. Throughout the United States companies are contracted with to run entire prisons. Therefore, health care that is privately run may occur in public or private prison facilities.

Private correctional health care companies receive contracts facilitated through state Departments of Corrections to run health services in state prisons and through local municipalities to operate in state and local jails. State prisons confine the majority of incarcerated persons in the United States. Concurrently, contracts to run health and mental health care in state prisons are the largest source of profits for private providers (The State of Michigan, 2013; Arizona Dept. of Corrections, 2013; The State of Maryland, 2013; The State of Florida, 2012; The State of Kansas, 2013). Typically a

state's Department of Corrections will release a Request for Proposal (RFP) to run either the entire state prison system health care or for specific prison facilities. These RFPs are most commonly triggered by state legislatures passing legislation to privatize a system or series of facilities. Particularly in the face of ongoing state budget cuts, and more fiscally conservative legislatures, privatization of government services is looked to as an efficient, cost savings measure (Kim, 2012).

Due to the fact that these private companies are not publically traded, access to information is limited. They are not required to release 10Ks, financial reports, or respond to most public requests for information. Extensive attempts to obtain information were conducted including talking to industry analysis experts and prison health care experts, most of whom concluded little information is available. A recent industry analysis by consultant, Paula Arnquist (2014a; 2014b; 2014c), produced previously unreleased industry information. Though the work was conducted for agencies and not released for public consumption, Arnquist gave permission to utilize the research to craft a publically accessible understanding of who the companies are that provide health care to people behind bars.

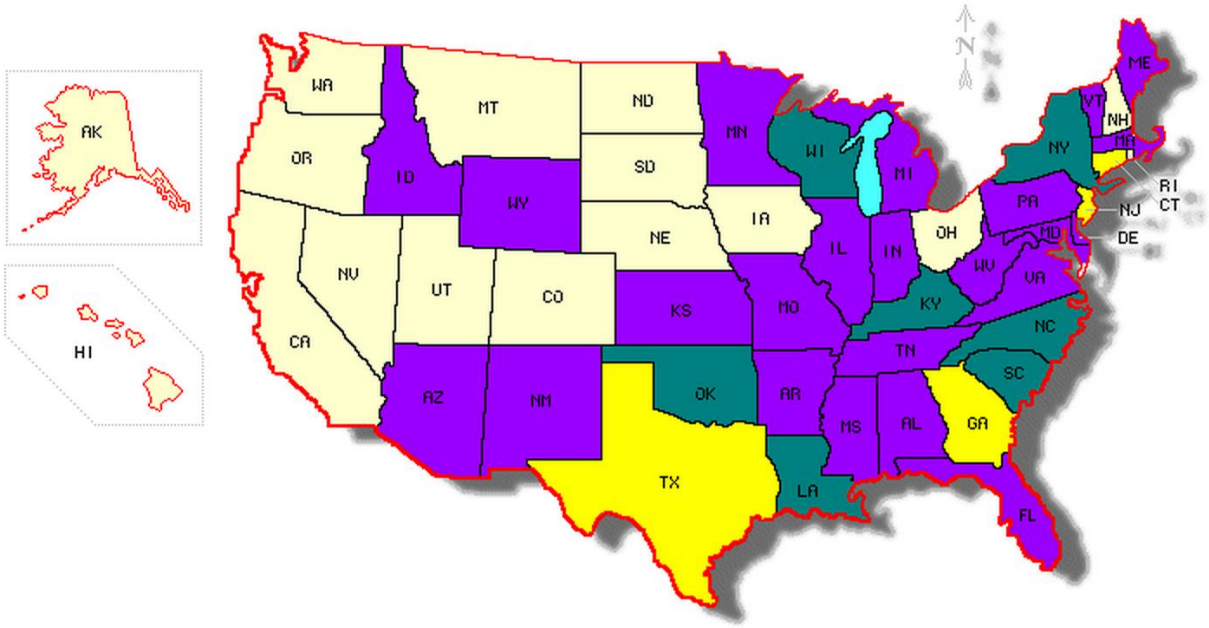
MARKET SHARE

In the 1990s, states began to consider the use of private companies for prison health care in order to save money (Montague, 2003). By 1997, 12 states had contracts with private companies to provide all of their prison health care (Montague, 2003). Today, one third of all correctional health care is now privately outsourced. As of January

2014, twenty three states in the United States have privatized correctional healthcare and seven are partially privatized [See Figure 1 below] (Arnquist, 2014b). There are also numerous counties impacted, as municipal jails are also contracting their health and mental care out to private organizations. These exact numbers have not yet been identified but as of 2012 one private company, Corizon, held contracts with 23 municipal jails (Arnquist, 2014a).

Figure 1: Correctional Health Care.

As of January 1, 2014, 22 states have privatized healthcare and 7 are partially privatized.



Purple States Are Privatized.
Green States are partially privatized.
Tan are public.
Yellow States are hybrid models, such as University-run.

Source: Adapted from Arnquist, P. 2014. "New frontiers for private prison corporation profits."

LEADING COMPANIES

Four private companies largely compete for the contracts – Corizon, Wexford, Correct Care Services, and Centurion (Arnquist, 2014a). Through a series of mergers and

acquisitions, two companies primarily monopolize this entire market – Corizon and Wexford (Arnquist, 2014a). Wexford and Corizon are not typical private medical service providers; meaning that they provide only prison based health care, promoting cheap, efficient care. (Corizon Health, 2014; Wexford Health, 2014).

Wexford

Wexford Health is a subsidiary of The Bantry Group and is also affiliated with the equity firm The Hawthorne Group (Wexford Health, 2009; Arnquist, 2014c). They reportedly hold contracts with 100 prisons and jails (Ortega, 2012a). Wexford is currently in charge of the health care of 90,000 incarcerated persons, and operating in 10 states (Arnquist, 2014c). The majority of their profits come from their contracts with state Department of Corrections, through which they operate health services in state prisons.

However, Wexford's business has declined over the past few years. Their profits diminished from $170 million in 2009 to $69 million in 2012 (Arnquist, 2014a). These changes in profit margins are largely attributed to losing 8 state contracts, often to Corizon. Of their remaining state contracts, Florida, Illinois, Pennsylvania, Maryland, Mississippi, and West Virginia are the largest.

Industry analysts expect to see Wexford shift to more county contracts, as they become less competitive compared to Corizon (Arnquist, 2014c). The loss of these key contracts can be attributed to both lawsuits and allegations of kickbacks. In 2008, Arizona Chief of Prisons, Donald Snyder, admitted to taking $30,000 in kickbacks from a Wexford lobbyist in order to "steer business their way" (Ortega, 2012a). Industry analysts

have further criticized the company for donating $87,000 to state governor and legislature races in Illinois – the location of their largest contract (Arnquist, 2014c). From 2008 to 2012, Wexford was also sued for malpractice 1,092 times (Christenson, 2013).

Corizon

Corizon Health is a subsidiary of Valitas Health Services, Inc with the backing from private equity firm Beeken Petty O'Keefe and Co (Moody's Investors Service, 2013; Arnquist, 2014a). In 2011, America Service Group/Prison Health Services was bought out by Valitas/Correctional Medical Services and rebranded as Corizon Health (Corizon Health, 2011). This merger solidified Corizon as the largest private correctional health care provider. As of November, 2013, Corizon was in charge of the health care of 319,000 incarcerated persons, operating in 31 states, and bringing in annual profits of $1 billion (Privco, 2013). Corizon's largest state contracts are in Alabama, Arizona, Florida (shared with Wexford), Idaho, Indiana, Kansas, Michigan, Missouri, New Mexico, Virignia, and Wyoming (Arnquist, 2014a).

Corizon reports employing 14,000 people, of whom 10,000 are Registered Nurses and 2,000 are physicans or "physician extenders" (Arnquist, 2014a). Corizon employees are largely not represented by unions. Of the 14,000 approximate employees, 160 at the Alameda County Jail in California are the only staff operating under a Collective Bargaining Agreement (Arnquist, 2014a).

In September 2013, Moody's conducted a series of downgrades for Corizon, change the company's financial rating from stable to negative (Moody's Investors

Service, 2013). Rational for the downgrade included the loss of recent state Department of Corrections contracts, customer concentration, and constrained credit. Corizon has been sued nearly 700 times in the last five years (Christensen, 2013). Half of these cases are still open. Approximately one-fourth of the cases that have closed were settled in a confidential settlement (Moody's Investors Service, 2013). These key companies' operation within only corrections settings, along with the quantity and content of lawsuits filed against them, has drawn criticism from advocacy groups and criminal justice beat journalists (Segura, 2013; Kutscher, 2013; Lava & Solon, 2013; Ortega, 2012b).

The next chapter reviews the existing literature on privately outsourced care in order to gain a better understanding of industry patterns and care.

Chapter 3: Literature Review

Despite the fact that private prison health care companies control one third of the multi-billion dollar correctional health care industry, a limited amount of academic literature exists on these companies and the care they provide. The speculated reason for this is two-fold – prisons are not transparent, having a history of hiding abuse and not reporting incidents (Deitch, 2012), and these companies are private and not publically traded. This shields them from many transparency measures (Arnquist, 2014c). The academic research, though limited, finds opportunities for cost savings, cost savings negatively impacting quality of care, understaffing issues, and quantitative and qualitative findings of inadequate care.

COST SAVINGS

Literature suggests that in the midst of budget concerns, outsourcing prison services to private companies can be an appealing option due to promises of cost savings (Wallace, 2012; Kinsella, 2004). A 2004 report from the Council for State Governments suggests that contracting with private prison health care companies can save a state 10%-20% on annual budgets (Kinsella, 2004). Illinois is pointed to as one such example. In 1991 the state outsourced their prison health care and is reported to now have one of the lowest per person costs in the country (Kinsella, 2004).

A report from Alabama calls privately contracted health care in prisons an "excellent solution" to governments' fiscal crises due to the ability to tailor a contract and reduce overall costs (Wallace, 2012). He further points out that privately contracted

companies can work on a fixed budget, where states can fix the amount of money and any overage costs are absorbed by the private prison health care company (Wallace, 2012).

However, other literature questions these cost savings. In Florida, an analysis by the Florida Center for Fiscal and Economic Policy (2010) found no evidence of cost savings, despite the fact that state law required 7% savings for contracted correctional health care. The analysis concluded that the required evidence of produced cost savings was not meaningful.

COST SAVINGS IMPACT ON QUALITY AND SAFETY

Hart, Schleifer and Vishny (1997) show with a formal model that financial efficiency cannot be the only consideration for health care in prisons. Their model shows that a government or private provider can invest in either improving quality or reducing costs, both of which have a parallel impact on the other. Therefore, as costs increase so does quality and the inverse. Their results show that private contractors have a stronger incentive than government employees to reducing costs and also to improving quality. However, their findings further show that the incentive to reduce costs in order to profit often outweighs considerations for the adverse impact on quality. Particularly related to prisons, the researchers conclude that the possibility for significant reductions in quality are likely (Hart, Schleifer & Vishny, 1997).

Easley (2011) explains, in an academic study on improving health in prisons, that the priorities of prison administration and staff are commonly order and security, and not

the provision of health care. Expense limitations are a common barrier to quality care, which are exacerbated by the profit motive of private companies. The result of these factors are inadequate diagnosis and insufficient care for acute and chronic issues (Easley, 2011).

In a 2013 academic article looking at prisoners' legal health rights, Bondurant explains that the most common form of managed care options outside of prison consist of for-profit organizations which continually work to balance costs with paying member's expectations of quality health care. However, in prison the prisoners do not have a choice in the care they receive, resulting in no push back from the consumer to maintain a level of quality. The result is typically low quality care that is exclusively focused on maintaining the lowest possible costs, which include high incentives to minimize expensive treatments such as emergency room care, specialist visits, and testing. Bondurant further discusses how the goal to outbid fellow private companies for contracts further drives cost cutting measures. Though prison care costs continue to rise as prison populations rise due to tough on crime policies, bids for health care get lower and lower. The result is a drop in the quality of medical care, particularly considering the lack of political power prisoners have within the prison system (Bondurant, 2013).

UNDERSTAFFING AND STAFF QUALIFICATIONS

Staffing issues in the form of understaffing and underqualified staff are also a concern cited (Robbins, 1999; Stern, 2012; Bondurant, 2013; Isaacs, 2013; Southern Poverty Law Center, 2014). Stern's master report (2012) expressed challenges faced by

psychiatric prescribers due to "significant understaffing." Psychotropic drugs cannot be safely prescribed without occasional in-person visits with the patient, because practitioners must insure that medications and dosages are working and there are no serious side effects. Yet psychiatrists were found to be writing open prescriptions without actually visiting with the patient (Stern, 2012).

In Arizona, the Department of Corrections was found to have a 34% shortage of full-time Corizon nurses, which was cited by a nurse as "with that lack of steady staff, there is absolutely no direction, absolutely no leadership. It creates a very hostile environment," (Isaacs, 2013). Wexford has also been fined numerous times for staff shortages, including a $12,500 fine by New Mexico's Department of Corrections in 2006; a $106,000 fine by Ohio's Correction Department in 2009; $50,000 by Chesapeake, Virginia (Isaacs, 2013).

A report from the South Poverty Law Center (2014) told a similar story in Alabama where they found only 15.2 doctors and 12.4 dentists for the entire locked up population. This translated into average patient caseloads of 1,648 for doctors and more than 2,000 for dentists (SPLC, 2014). The report concluded that there was understaffing, "There should be no doubt that this understaffing is a direct result of the ADOC's bid process for its medical services contract, a process that placed far greater emphasis on cost than any other factor (SPLC, 2014).

Companies were also found to be hiring medical professionals with questionable or non-existent credentials, including unlicensed doctors and nurses (Bondurant, 2013).

Beyond substandard licensures, Bondurant (2013) also found high staff turnover rates, which directly impact low quality of care.

FINDINGS OF INADEQUATE CARE

Privatization of prison health care is not always made on financial incentives alone. In some cases, courts ordered states to outsource their health care with the intention of improving upon the poor quality of care in publically run facilities (McDonald, 1999). A Council to State Governments report claims in support of that goal that private outsourcing supplies doctors and nurses who are working to meet high standards (Wallace, 2012). Other literature points to inadequate health care within privately contracted correctional health care companies (Isaacs, 2013; Robbins, 1999; Bedard & Frech, 2009; Tapia & Vaugh, 2010; Hart, Schleifer & Vishny, 1997; Southern Poverty Law Center, 2014).

A 2010 study out of Sam Houston University found that inadequate care is a recurring problem within privately outsourced care facilities, specifically among women who are pregnant. The study explores multiple lawsuits where women's constitutional rights are claimed to be violated when negligent care lead to or caused miscarriages (Tapia & Vaughn, 2010).

Only one study directly compares public versus private prison health care. The 2007 University of California study looked at mortality rates (as morbidity rates are not made available) from 1979 to 1990 and utilized a Poisson model to estimate the change in mortality associated with the percentage increase of medical prison personal under

private contract (Bedard & Frech, 2009). The research found that a 13% increase in percentage of medical personnel employed under contract increases mortality in the cases of death by suicide of illness by 1.3%. The researchers concluded that higher mortality rates were found when states contracted our prison healthcare services (Bedard & Frech, 2009). The report controlled for operational variables, such as only including facilities with the capacity to offer full medical care, and those facilities with a population over 100, but was not able to control for age or race due to data limitations.

An Arizona report that analyzed trends in correctional health care privatization and presented fourteen case studies concluded that given the long-standing problems with both Corizon and Wexford in the state that "privatization is not a solution to the serious deficiencies in medical care at the Arizona Department of Corrections" (Isaacs, 2013, p.11). The report further concluded that privatization has resulted in "more delays, less transparency, and little accountability" (Isaacs, 2013, p.11). An exploration of the results of a profit motive was also conducted with findings concluding that not only are these state contracts being bid on at increasingly low rates but that the companies then need to make a profit on top of that already low bid. The result is commonly "cutting corners, running staff vacancies, denying procedures, hospitalizations and medications" (Isaacs, 2013, p. 11).

A recent report released by the Southern Poverty Law Center (2014), which conducted a comprehensive analysis of conditions in Alabama's prisons, found inadequate medical staff leading to deadly delays, a system failure for mental health care,

and multiple human rights violations specifically of people with disabilities. Corizon, which operates the state's prison health and mental health care, was found to be grossly understaffed and complicit in delays and violations that lead to numerous deaths, avoidable amputations, and illegally obtained Do Not Resuscitate (DNR) orders (Southern Poverty Law Center, 2014).

LACK OF FREE MARKET

Bondurant (2013) suggests another element to private correctional health care is the lack of free market choice for states, often associated with the private sector. Because the field is monopolized by a few companies, it is common for states to contract with companies they previously fired for cause, particularly if the state is mandated to accept the lowest bidder (Bondurant, 2013).

The next chapter expands on the academic literature through an overview of government report and document findings on private correctional health care.

Chapter 4: Government Reports and Documents

In order to build on the information available from academic findings, publically released government reports and court documents on private correctional health care were acquired and reviewed. Google Scholar, Lexis Nexis, and the UT Library were utilized to access reports. Search terms included; private health care prisons, private correctional health care, Corizon, Wexford, and outsourced prison care. Findings include long waits to access medical attention, mixed results on audit measures, usage of expired medications, assessments of cruel and unusual punishment, and questionable cost savings.

The academic literature available on this topic suggests instances of cost savings over quality of care. In contrast, the Office of the State Monitor in Vermont authored a report in 2013 that found the state's contracted correctional health care lacked cost and performance monitoring by the State Department of Corrections. In the first three years of the contract, the state paid $4.2 million above the $49.1 million contract. The report found that the DOC has made substantial improvements in monitoring the contract, and further recommended steps to reduce risk in the implementation of health care delivery. (Office of the State Auditor Vermont, 2013).

In 2008, an independent monitor in Idaho released a third report on health care within the Department of Corrections. The report found poor supervision of medical personnel, inadequate staffing, long waits for people seeking care and inappropriate care. Lt. Gov. John Carney Jr. said he was especially disturbed by the problems with sick call.

In one sample reported, 12 out of 15 inmates calling for medical attention at the Vaughn Correctional Center in Smyrna were not examined in a timely fashion, if at all. And, the report said, the sick-call waiting list averaged 100 inmates at some facilities (Wilmington News Journal, July 31, 2008).

The Maine Legislature's Office of Program Evaluation and Government Accountability reviewed the Michigan Department of Corrections for more than a year and recommended a new provider of medical services for the state's privately run correctional facilities (Office of Program Evaluation, 2011). The report stated that the contracted corrections agency was at fault rather than the Department of Corrections, adding that the "deficiencies appear to be persistent, with clear implications for the adequacy and timeliness of services provided to prisoners" (Office of Program Evaluation, 2011).

In 2012, a special court ordered master's report delivered to a federal judge about conditions at the Idaho State Correctional Institution, where Corizon manages health services, found deficiencies that the report called "cruel and unusual." The report noted that during a 2010 annual audit of the Idaho Department of Corrections, Corizon failed 23 of the 33 audit categories. In 2011, after feedback and follow up from the 2010 results, Corizon failed 26 of the 33 audit categories (Stern, 2012). The findings reported by Dr. Stern, the lead physician conducting the study, included a patient who was not notified for seven months about a suspicious chest X-ray, delayed or no response to emergencies, the use of expired medication, and incomplete record keeping. Stern's research team

reported to find serious problems with the delivery of medical and mental health care in the facility, stating that many of the problems have resulted or risk resulting in "serious harm to inmates" (Stern, 2012). In Dr. Stern's own words:

> In multiple ways, these conditions violate the right of inmates at ISCI to be protected from cruel and unusual punishment. Since many of these problems are frequent, pervasive, long standing, and authorities are or should have been aware of them, it is my opinion that authorities are deliberately indifferent to the serious health care needs of their charges (Stern, 2012).

The report goes on to identify issues with triage treatment protocol, cursory evaluations, and lack of examination, all of which were concluded to greatly risk patient harm. On one occasion when a patient presented with the serious symptom of bleeding from the rectum, the patient was released without "further diagnosis, treatment, or plan for follow up." Stern also stated, "when nurses do appreciate that significant disease is present, care is not necessarily better or provided at all" (Stern, 2012).

In response to this controversial report, Corizon responded with a self-commissioned report by the National Commission on Correctional Health Care (NCCHC) to conduct an assessment of the same Idaho facility (2012). This report stated that the facility was in compliance of health services standards. They identified inconsistent quality of patient care, rating it to varying degrees of needing improvement, improving, or satisfactory (NCCHC, 2012).

In 2006 a Michigan judge ordered Correctional Medical Services (CMS, now Corizon) to provide adequate care, saying with the order, "the days of dead wood in the Department of Corrections are over, as are the days of CMS intentionally delaying referrals and care for craven profit motives." (Hadix v. Caruso, et al, 2006).

Ongoing Lawsuit: Parsons v. Ryan

Corizon and Wexford have been sued 2,000 times with state Department of Corrections also being sued thousands of times for negligent health care while contracting with private companies. One key lawsuit currently being pursued by the ACLU is the class action suit Parsons v. Ryan. Filed in 2012 on behalf of 33,000 incarcerated people in Arizona against the Arizona Department of Corrections, the suit charges that grossly inadequate medical, mental health, and dental care has and is placing those in prison in grave danger, and has led to preventable injury, amputation, disfigurement and premature death (Parsons v. Ryan, 2012). According to the lawsuit, critically ill people have begged prison officials for medical treatment, being told to "be patient," that "it's all in your head," or that they should "pray" to be cured. The suit names Wexford, which ran health, mental and dental care from July 2012 to March 2013 as perpetuating these egregious conditions along with Arizona Department of Corrections. Corizon has since taken over care operations in Arizona's prisons, and will be subpoenaed to testify on behalf of continued violations occurring since their take over.

The lawsuit does not seek monetary damages, but rather requests adequate health care, distribution of medications, and other basic health access improvement. The

lawsuit's class certification, which means judgment would apply to other, similarly situated people in prison, was challenged by Arizona, but the U.S. Ninth Circuit Court of Appeals unanimously ruled in June 2014 that the ACLU could move forward with the case (Parsons v. Ryan, 2014).

The next chapter aims to understand the impact the issues raised by academic and government sources have on individuals in prisons. This is attempted through a review of available case studies.

Chapter 5: Patterns from Case Studies

In an attempt to contextualize the academic and government report findings into an understanding of the lived experiences for those confined in prison, further research was conducted. For this section, case studies were compiled and reviewed. Where patterns emerged, stories were sorted into categories, with key examples reported on. Categories where patterns emerge include experiences of death, living in untreated pain, avoidable amputations, and exposure to and limited or no treatment for infectious diseases. Though each of these categories presents patterns of similar issues, the propensity of these experiences, particularly in comparison to publically provided care remain unknown. As a note, reports written and disseminated by unions were intentionally left out of this analysis. Though their sources and methodology are not necessarily in question, unions benefit from the dissemination of negative information concerning the privatization of public services.

DEATHS

As reflected in the Parsons v. Ryan lawsuit, summarized above, Corizon recently took over Arizona's correctional health care, which was previously run by Wexford. Within the first eight months of Corizon's operation, there were 50 deaths in Arizona prisons, including eight suicides, which is a significant increase from previous years (Isaacs, 2013). A Cure Notice sent to the Arizona Department of Corrections in September of 2013, reported that a man who was not given his psychiatric medications for 23 days was discovered hanging in his cell (Profiri, 2013).

The Southern Poverty Law Center's research uncovered numerous stories ending in the death of patients in Alabama prisons, including these incidents:

- In 2011, a man confined in an Alabama prison who was treated for prostate cancer five years prior began showing a significant rise in protein levels (the main indicator of prostate cancer). Despite frequently vomiting blood, he was not diagnosed until a year and a half later at which point the cancer had spread to his bones. He died in January 2014.
- In another Alabama prison a man who underwent abdominal surgery complained to medical staff that he was bleeding from his rectum. On the day he died, he had to ask for two new pairs of pants due to bleeding through his clothes, yet the medical staff only responded by giving him an antacid.
- In November 2012 at the St. Clair Correctional Facility, nurses called the off-site doctor when a dialysis patient complained of pain after his treatment. Though this a sign of serious complications, the doctor informed the nurses just give him some water, return the patient to his cell, and not call him again or send the patient to the hospital. The patient went back to the infirmary multiple more times that night, but was sent back to his cell each time. He died the next morning (SPLC, 2014).

In Illinois a man died an hour after a doctor instructed medical staff to send him immediately to the hospital. Records from the wrongful death and malpractice suit filed

in 2012 reported that a "Corizon nurse believed that the prisoner's episodes were 'staged'" (Isaacs, 2013).

In Kentucky in August 2011 a Corizon nurse and mental health specialist denied Anthony Dwayne Davis' request to go to the medical unit. The employees were reported to believe that the man was trying to manipulate the system. Nineteen hours later, Davis was found dead after being left alone in a cell for 17 hours (Lexington Herald Ledger, Aug. 2, 2011).

In Michigan, under the care of Correctional Medical Services, now merged as Corizon, 21-year-old Timothy Joe Souders who was diagnosed with a mental illness, died after spending four days locked in four-point restraints on a concrete slab bed in 100 degree heat in a Michigan prison. Michigan paid $3.25 million to settle the lawsuit. (Michigan Corrections, 2012).

Reported Quotes from Private Prison/Jail Medical Provider Staff in Situations that Lead to Deaths

- Former Florida Corizon nurse admitted in a court deposition concerning 2 deaths in 2 months that she had joked to staff, "We save money by skipping the ambulance and taking prisoners directly to the morgue" (Nelson v. Prison Health Servs., Inc, 1997).
- Nurse to Diane Nelson, 46, when she collapsed of a heart attack later dying, "stop the theatrics" (Nelson v. Prison Health Servs. Inc., 1997).

UNTREATED PAIN

There are also reports of incarcerated persons living in constant, untreated pain. Again in Alabama, a man who was treated for a gunshot wound eight years ago was told he would utilize a colostomy bag for six months and then undergo surgery to repair the damage of the wound. He has still not had the surgery and is in constant pain, often suffering from urinating blood and infections from the catheter. (SPLC, 2014).

Eleanor Grant's partner Thomas has been in prison since 1994. He has an enlarged prostate and a growth, is in constant pain, and all of his requests for medical care are being ignored, including being denied pain medication. In a call captured by the project Beyond Bars, he tells Eleanor that he is to the point of not being able to sit (Beyond Bars, 2013).

AMPUTATIONS

Stories of amputations occurring after treatment due to delays or denials also exist. In 2013 a man with diabetes had his toe amputated after a blister was untreated for six weeks, despite continual requests for medical care. He continued to not receive proper care after the procedure which lead to his surgical wound becoming infected and another toe being amputated (SPLC, 2014).

Staph infections also often go untreated, which can lead to serious complications and even death. One incarcerated person suffered from a staph infection on his leg which swelled. He was denied approval to receive intravenous antibiotics and refused treatment. When his leg turned black, emergency surgery resulted in a portion of his leg being removed (SPLC, 2014).

A man that developed a growth on his penis was denied treatment for two years. By the time doctors finally diagnosed the growth as cancerous, the organ had to be amputated and the cancer spread to the man's stomach (Ortega, 2011).

INFECTIOUS DISEASES

The spread of infectious disease has historically been a serious issue in prisons. The U.S. Supreme Court recognized numerous times that exposing incarcerated persons to infectious disease can violate the Eighth Amendment (SPLC, 2014). Despite this, Corizon has been reported to have no protocol for screening, controlling or treating Hepatitis C (Beyond Bars, 2013; Hylton, 2003), and Wexford has a record of exposures and issues with treatment, including not complying with requirements to report contagious disease exposures to state health authorities (Isaacs, 2013).

A 2012 report from Corizon revealed that 2,144 incarcerated persons were known to be infected with hepatitis C in Alabama, but only four of them were receiving treatment (SPLC, 2014). A man at Alabama's Holman Correctional facility who went without treatment for Heptatitis C recently died due to complications (SPLC, 2014).

On August 27, 2012 a Wexford nurse exposed 103 incarcerated people to hepatitis C by contaminating the insulin supply. Wexford did not alert state and local health officials, which it is required to do immediately, until 8 weeks later. (Harris, 2012).

In January 2014 a Corizon nurse infected 24 incarcerated people with Hepatitis B and C. The exposures occurred when a nurse disregarded proper injection protocol, said

Clarisse Tsang, the Department of Health Services hepatitis-prevention coordinator. Corizon did not make a statement about exposing patients and still refuses to answer more specific questions. This is the same facility that Wexford previously exposed with hepatitis (Arizona Department of Corrections, 2014).

In an internal memo by Correctional Medical Services, which has since become Corizon, a medical director stated, "as a matter of formal company policy, CMS discourages treatment for hepatitis" (Hylton, 2003). Journalist Wil Hylton wrote an expose on the matter, in which a nurse expressed, "It was absolutely appalling, to the point that I can't even tell you. You knew that as long as you worked there, you did not challenge any of it. But your disgust builds as the horrible cases build…. As far as I'm concerned, if you're sick and you get into one of these places, you might as well be signing your death certificate." (Segura, 2013).

A decade after Hylton's expose, CMS is now Corizon, and the same policy exists. Frankie Barton's son is sick with Hepatitis C and in prison. She says her son is told they have no protocol for treating Hepatitis C. She says his liver is being continually damaged, to the point where he will eventually develop cirrhosis of the liver and die (Beyond Bars, 2013).

This review of available case studies and stories suggests a pattern of barriers to health care and negligent care. Though propensity of these incidents is not captured by these narratives, a better understanding of the individual impact negligent care has on people behind bars is gained.

The next chapter further contextualizes these experiences through a detailed account of one man's experience under Corizon's care in an Arizona prison.

Chapter 6: Narrative from an Incarcerated Man's Son[2]

John's father is housed in an Arizona state prison, in his third year of a ten-year sentence. He was recently diagnosed with stage-4 prostate cancer and given months to live. The following highlights the experience John's father and family have had under Corizon's care. John's name is changed to protect his father and family's identity.

- John's father originally requested medical attention for his prostate on May 23, 2012. After nine more written requests, he was given a prostate exam on August 9, 2013 (15 months later) where it was determined that he had stage 4 prostate cancer.
- John's father's medical records show that on the date of his first request for prostate exam, his Prostate Specific Androgen (PSA) level was already elevated to 23.3 (normal levels usually range from 0 to 4 depending upon the person's age and weight). On August 9, 2013, when his cancer was confirmed, his PSA level had risen to 283.5.
- John's father submitted multiple requests medication and at one point prior to a medical exam, was "required to self-administer an enema in an empty shower stall because no medical staff was able or willing to assist him."
- John's father has catheter which does not get changed at required intervals, causing urinary infections.

2 This personal account is included at the permission of Grassroots Leadership.

- On April 16th 2014, John's father collapsed while shaving when his legs could no longer support his weight. He was transferred to the prison medical unit where Corizon communicated to John and his siblings that he would receive round-the-clock medical care. Within two weeks of arriving at the medical unit, he was transferred to St. Luke's hospital in Tempe where it was revealed that he suffered from coxxyx ulcers, more commonly referred to as bedsores, as well as similar ulcers on his ankles. These bed sores are caused due to a lack of being turned and being forced to remain in the same position for extended periods of time. Medical records note that he should have been turned every two hours.
- All requests for information made by John and his family have been ignored or directed back to Corizon who has not responded. When calling Corizon, a recorded message informs the listener that he or she should expect a response turn-around time of 48 hours. John says Corizon responds weeks for a response or does not receive a response.
- John and his family were given false information by Corizon personnel, upon his father's collapse on April 16th. After dozens of calls from John and his family, they were informed that his father was "up and moving around" and that while he was weak, he had "full use of his legs and that he was responding well to treatments." John confronted Corizon staff once they spoke to his father, and Corizon staff confirmed the information they had provided was false. A Corizon

representative, then suggested that John and his family visit my as his father did "not have much time left."

- John also claims that Corizon staff members regularly ridicule his father, due to the odor that emanates from his bedsores and unchanged adult pads. John's father shared with him that staff members have ridiculed him in front of others, explaining loudly that he smells bad and that they refuse to clean him or change his bandages because of this smell.
- One staffer reportedly told John's father that he should not be in the facility because they are "unprepared both medically and with inadequate numbers of staff available" to properly care for him.

John concludes "it is now too late to save my father's life," but aims to help "save the lives of countless other inmates."

This father's claimed barriers to access and delays in regular treatment illustrate further support and contextualize findings from academic literature, government reports, and other case studies. Though there is ample evidence to support that negligent care and abuse occurs under privatized correctional health care, it is still unknown how that compares to publically run care. The next chapter attempts to quantify information on prison health care to gain a better understanding of the treatment of incarcerated persons across the country.

Chapter 7: Mortality Rates

Academic research, government reports, court documents, case studies and individual stories suggest trends of inadequate health care provision in privately run prison health care. States have a responsibility of responding to these findings regardless of propensity. However, it is still unknown how these research findings compare to public care. Adequate data or research does not exist. Unfortunately, morbidity and health outcome data is not available on facility by facility or even state by state basis, nationwide. Therefore, mortality rates were assessed as one approach for attempting to quantify outcomes in prison health care and the potential differences in public vs. private care.

Data on mortality rates was obtained from the Bureau of Justice Statistics (BJS). Deaths due to violence were not included as they are reflective of safety in prisons, but not directly to the health care provider. The BJS data was then divided into categories based on whether the state's prison health care is public, private or a combination. In order to assess differences in public vs. private prison health care and mortality rates, only states that are entirely public or entirely private were included. Data from the Center for Disease Control was used to compare these rates to national mortality by overall population and by race.

National mortality rates reported by the Center for Disease Control in 2010 reveal a rate of 742 people per 100,000 [See Figure 2]. African Americans have higher mortality rates than that of white persons, with a mortality rate of 898 people per 100,000 [See

Figure 3]. However, mortality rates in prison are found to be significantly higher. Prison mortality rates reported by the Bureau of Justice Statistics in states with private health care on average are higher than those with public health care [See Figure 1 and 2]. The average prison mortality rate in privately run states is 6,870 per 100,000 people, while the average prison mortality rate in publically run states is 4,373 per 100,000 people. When considering the leading causes of death within state prisons, this trend continues, with prisons with private health care having higher rates of death from cancer, heart disease, HIV/AIDs, and liver disease [See Figure 4].

Figure 2: Mortality Rates in Prison vs. General Population

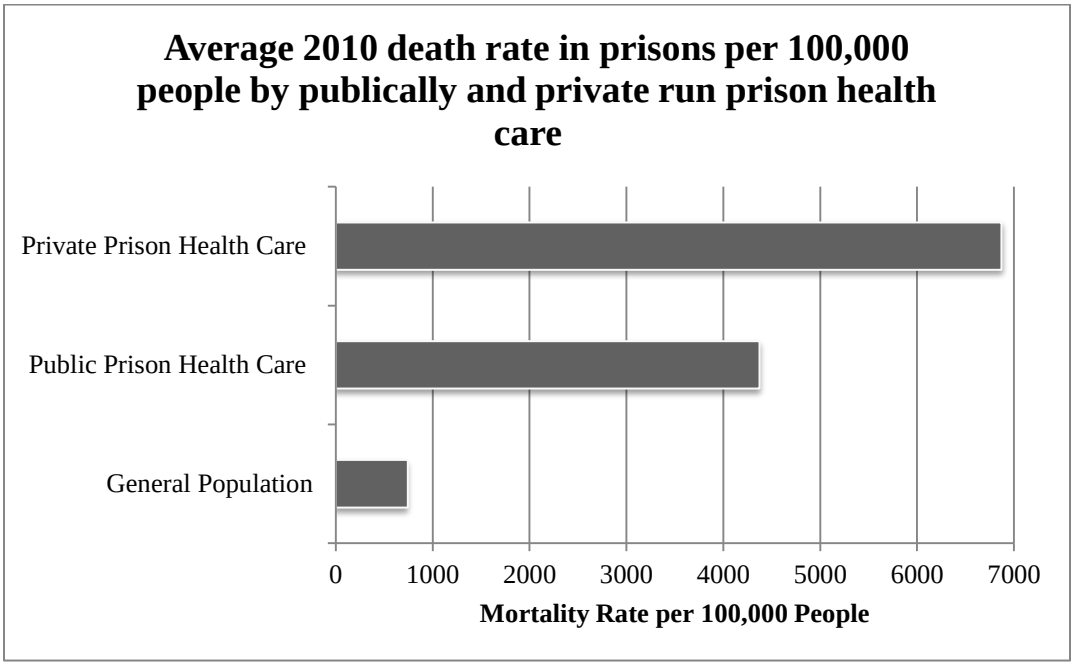


Figure 3: Mortality Rates in Prison vs. General Population by Race

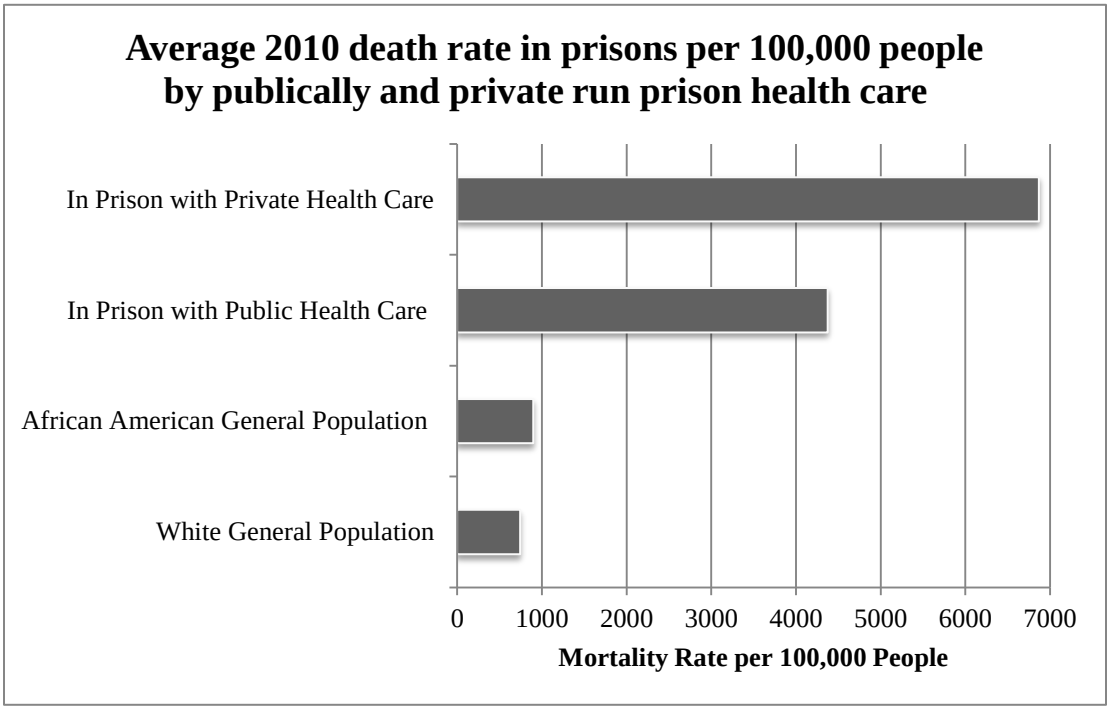
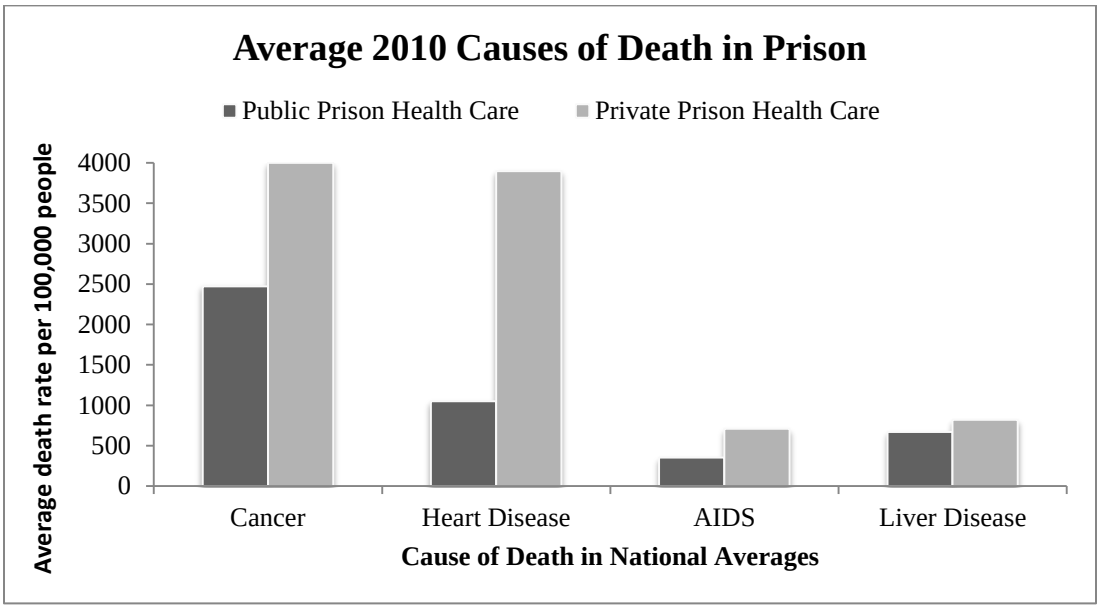


Figure 4: Average Mortality by Leading Causes of Death in Prison by Public and Private Health Care



Though these numbers appear compelling, extreme caution should be utilized in interpreting and drawing conclusions from this data, as they are not age adjusted. Unfortunately, the BJS only reports on raw numbers of deaths and causes of death, which introduces a major flaw into interpreting this data. In late 2014, the BJS will begin offering age adjusted mortality rates. What is known are age percentile breakdowns in both prisons and the general population. In 2010 the U.S. Census Bureau reports 9.9% of people between the age of 18-24; 26.6% between the ages of 25-44; 26.4% between the ages of 45-64; and 13% of the U.S. population over the age of 65 [See Figure 4]. In comparison, age percentile breakdowns in prison as reported by BJS for the same year show 13.4% between the ages of 18-24; 58.9% between the ages of 25-44; 25.7% between the ages of 45-65; and 1.7% of people in prison to be over the age of 65 [See Figure 4].

Figure 5: 2010 Population by Age in Prison vs. General Population

2010 Population Proportion in Prison vs. General Population by Age Categories		
Age	**In Prison**	**U.S. General Population**
18-24	13.40%	9.90%
25-44	58.90%	26.60%
25-29	*16.30%*	*NA*
30-34	*16.30%*	*NA*
35-39	*13.80%*	*NA*
40-44	*12.60%*	*NA*
45-64	25.70%	26.40%
65 +	1.70%	13.00%

Compiled from 2010 Bureau of Justice Statistics, *Prisoners in 2010* & 2010 U.S. Census Bureau, *Age and Sex Composition: 2010*.

It is clear that mortality rates are disproportionately higher in prison, and particularly prisons with private health care, even when considering the aging population. It is of interest that prisons hold higher proportions of people between the ages of 18-24 – 13.4% compared to 9.9% in the general population – an age group known to be the healthiest, and proportionately fewer aging adults over the age of 65 – 1.7% in prison compared to 13% in the general population – the age group known to be the least healthy. Of course, the general population age percentages also include those between the ages of 0-18, yet the differences remain significant.

However, without the ability to adjust for each age group with each cause of death, this data raises more questions than it answers. These mortality rates in their current form ask preliminary questions and require further research once age adjusted mortality rates become available. Furthermore, research shows that incarcerated persons develop health issues at an earlier age than the general population (Kirchhoff, 2010) and experience higher rates of infectious and chronic diseases, substance abuse, mental illness and trauma (Justice and Health, 2013; Buck, 2008; Conklin, 2002). Further research is needed to understand prison mortality rates in context with the high rates of health issues experienced by incarcerated persons. Particularly breaking down what portion of health issues are due to the prison setting and which may be due to social stressors prior to imprisonment.

The next and final chapter presents recommendations for improving health care in correctional facilities based on the findings of this report.

Chapter 8: Recommendations and Conclusion

Accessing safe health care in prison continues to be a serious issue for incarcerated persons in the United States. Research findings presented within this report suggest that incarcerated persons are vulnerable to poor health care treatment when the care is outsourced to private providers. The question of whether private care is better or worse than public care remains unanswered. However, this preliminary research reveals patterns of prisoner neglect and mistreatment. Though conclusions cannot be definitively drawn on the propensity of these experiences, states have a duty to respond to remedy any and all instances of unconstitutional treatment in prisons. Recommendations based on the above findings include further research, increased independent oversight, and employing population reduction policies.

CHANGES TO STATE CONTRACTS

Staffing Levels

The ratio of medical staff to patients in prisons under privatized care has been highlighted as dangerous throughout the research findings (Robbins, 1999; Stern, 2012; Bondurant, 2013). State contracts with private providers should include staffing level requirements to better ensure that incarcerated people are able to receive care in a timely manner. Furthermore, penalties for negligent understaffing levels should be treated more harshly, in light of the fact that fines in the past have not successfully addressed this

issue. However, in order to oversee staffing levels and other monitoring of quality of care measures, independent oversight should be incorporated into every state contract.

Low Bid Requirements

Some states require that Departments of Corrections contract out correctional health care with the lowest bidder or require certain percentages of savings from previous years (Arizona House of Representatives, 2009; Florida Center for Fiscal and Economic Policy, 2010). Due to the fact that this market is monopolized by a few companies, some states have been forced to contract with a company that they previously fired for cause (Bondurant, 2013). This practice affirms placing cost savings over protecting lives, and will likely continue to open up states to liability claims.

INDEPENDENT OVERSIGHT

Ultimately, state legislators are responsible for allowing and in some cases requiring states to privatize correctional health care. In the short term, states should hold these contractors to minimum health and safety protocols and disclosure methods. Even though the companies are private, they are providing public services, and should therefore be held to the same audit, oversight, and disclosure requirements.

Currently, many states oversee their own oversight through internal positions with the Department of Corrections. For example, in Maine, The Maine Department of Corrections Health Care Services Director is responsible for both administration and oversight of health care. Though not employed by Corizon, the company that runs prison

health care for the state, there is not a third party, independent oversight mechanism (Office of Program Evaluation & Government Accountability, 2011).

The need for independent oversight in prisons is reiterated throughout criminal justice literature (Deitch, 2012; Gibbins & Katzenbach, 2006). Only third party overseeing bodies can produce audits without conflicts of interest (Deitch, 2012). Routine, preventive monitoring by an independent body assists in providing accurate and unbiased information about the treatment of incarcerated persons (Deitch, 2012). It also serves in a preventive manner when someone is watching and taking notes of actions and lack thereof (Deitch, 2012).

However, states must chose to employ this best practice recommendation knowing that results will likely be findings of negligence that will then need to be addressed. As states are beginning to be targets for prison health care lawsuits (Parsons v. Ryan, 2012), and not only the companies contracted with, perhaps a willingness to improve conditions prior to lawsuits in order to avoid costly suits and settlements will result.

FIND ALTERNATIVES TO PRIVATIZATION IN ORDER TO REDUCE BUDGETS

Even with staffing level improvements, increased third party independent oversight, and improvements to contract requirements, incarcerated persons are unable to take their business elsewhere but are subjected to the care or lack of care provided by companies. If those companies make more money when providing fewer services, this places incentives to continue to provide the lowest level of care. Furthermore, when

states are required to save money on health care when contracting out, in order to be competitive, companies bid well below costs for providing quality care, and then must further make a profit on top of that bid.

With questionable records of saving states money, along with the pattern of problems with care under these corporations, privatization appears to not improve health care within prison facilities, but rather to further complicate issues inherent within prison services. Therefore, prison health care is recommended to be conducted with increased and unfettered oversight, coupled with population reduction policies.

Look to Population Reduction Over Privatization

In the long term, legislators should look to reduce costs and increase safety by reducing the overall prison population. Looking at sentencing reduction of incarcerated persons that were sentenced under three-strike laws and mandatory drug minimums would significantly reduce the financial burden states are experiencing in a humane manner (Austin, et.al., 2013; Cole, 2011; Koppell & Burrus, 2012; Department of Justice, 2014). Furthermore, future drug and sentencing policy reforms could prevent increasing the prison population (Koppell & Burrus, 2012). These sentencing reforms should be coupled with community health and mental health care measures to help reduce recidivism and the usage of the criminal justice system as a the most utilized mental health care provider. States have numerous population reduction policy options to reduce the burden of prison health care costs, and academic research and government reports

both support this approach (Austin, et.al., 2013; Cole, 2011; Koppell & Burrus, 2012; Department of Justice, 2014).

AREAS FOR FURTHER RESEARCH

Significantly more research should be conducted on the issue of privatized correctional health care. The fact that little research exists on the private prison health care industry, yet one-third of the market is privatized, is cause for concern for researchers and policymakers.

In late 2014, the Bureau of Justice Statistics will begin reporting on age adjusted mortality rates. This will allow researchers to expand upon this exploration of the private correctional health care industry, and further understand whether disproportionate mortality rates are correlated with age, social factors prior to prison, and/or the prison setting. Looking at various health measures rather than only mortality rates could quantitatively analyze this industry's impact beyond life and death, and assess health impacts.

As mentioned throughout this report, information on health care in prison, especially that run by private providers is incredibly difficult to obtain. When attempting to understand the national scope and impact of the industry, it is nearly impossible to find meaningful data and information. Experts across the country were consulted for this report, with conclusions being that the information in public form does not exist, but that these questions need to be asked and answered. Conditions in prisons are historically hidden from the public with incarcerated persons suffering in isolation. Regardless of

whether health care is publically or privately run, access to data and information on conditions need to made available to the public to provide an element of oversight.

CONCLUSION

Private correctional health care companies run one-third of health care in prisons across the country, with a few companies monopolizing the market. An answer to how privately run prison health care compares to publically run care remains largely unanswered. However, the various research explored through this report reveal a clear pattern of inadequate care that is resulting in the harm of people behind bars. The 8th Amendment of the Constitution holds states liable for the provision of safe medical care in prisons. In order to avoid constitutional violations, protect incarcerated persons from abuse and poor health outcomes, and reduce state budgets, states should implement short term reforms to improve current privatization contracts and ultimately seek out population reduction policies to incarcerate fewer individuals for shorter periods of time and save states money.

References

Arizona Department of Corrections (2014). Arizona Department of Corrections statement on Corizon plan to address medical protocol violation at Lewis prison [Press release]. Retrieved from http://www.azcorrections.gov/adc/news/2014/010914_Corizon_update.pdf

Arizona House of Representatives. (2009). House Bill 2010: Criminal justice; budget reconciliation. Retrieved from https://votesmart.org/static/billtext/27526.pdf

Arnquist, P. (2014a). Correctional Healthcare Industry and Profiles. *Cincinnatus Consulting.* Prepared for Treatment Industrial Complex Convening in Austin, TX 2014.

Arnquist, P. (2014b). New frontiers of private prison corporation profits. Prepared for Treatment Industrial Complex Convening in Austin, TX 2014.

Arnquist, P. (2014c). The Treatment Industrial Complex. *Cincinnatus Consulting.* Prepared in 2013 and updated in 2014 for the Langeloth Foundation.

Austin, J., Cadora, E., Clear, T.R., Dansky, K., Greene, J., & Gupta, V., et. al. (2013). Ending mass incarceration: Charting a new justice reinvestment. *National Criminal Justice Resource Service.* Retrieved from https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=264175

Bedard, K. & Frech, H.E. (2009). Prison health care: Is contracting out healthy? *Health Economics, 18*(11). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19142875

Beyond Bars. (2013). Prison profiteers – Corizon. *Brave New Films*. Retrieved from http://www.beyondbars.org/pp_corizon

Bondurant, B. (2013). The privatization of prisons and prisoner healthcare: Addressing the extent of prisoners' right to healthcare. *New England Journal on Criminal and Civil Confinement, 39*. Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/nejccc39&div=26&id=&page=

Brooks, C., Pompi, K.F., Nink, C.E. (2007). Correctional health care: Barriers, solutions and public policy. *Corrections Today, 69*(5). Retrieved from https://www.ncjrs.gov/App/publications/abstract.aspx?ID=242754

Buck, S. (2008). The impact of mental illness and addiction on the criminal justice system: National and Oklahoma perspectives. *ODMHSAS*. Southern Legislative Conference, 2008. Retrieved from https://www.slcatlanta.org/meetings/OKC_08/presentations/hsps/Steve_Buck.pdf

Bureau of Justice Statistics. (2013). Correctional populations in the United States, 2012. *U.S. Department of Justice*. Retrieved from http://www.bjs.gov/content/pub/pdf/cpus12.pdf

Caravelis, C., Chiricos, T. & Bales,W. (2011). Static and dynamic indicators of minority threat in sentencing outcomes: a multi-level analysis. *Journal of Quantitative Criminology, 27*, 405-425. DOI 10.1007/s10940-011-9130-1

Chiu, T. (2010). It's about time: Aging prisoners, increasing costs, and geriatric release.

VERA Institute of Justice. Center on Sentencing and Corrections. Retrieved from http://www.vera.org/sites/default/files/resources/downloads/Its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf

Christensen, D. (2013, October 2). Florida prison health care providers sued hundreds of times. *Miami Herald.* Retrieved from http://www.miamiherald.com/2013/10/02/3666091/florida-prison-healthcare-providers.html

Cole, D. (2011). Turning the corner on mass incarceration? *Ohio State Journal of Criminal Law, 9*. Retrieved from http://ssrn.com/abstract=1972284

Conklin, T., Lincoln, T., & Wilson, R. (2002). A public health manual for correctional health care. Massachusetts Public Health Association. Retrieved from http://www.mphaweb.org/documents/PHModelforCorrectionalHealth.pdf

Corizon Health. (2014). About Corizon: Who we are – history and today. Retrieved from http://www.corizonhealth.com/About-Corizon/Who-We-Are-History-and-Today

Corizon Health. (2011). Corizon news: Corizon launches from correctional healthcare merger. Retrieved from http://www.corizonhealth.com/Corizon-News/Corizon-Launches-From-Correctional-Healthcare-Merger1

Deitch, M. (2012). The need for independent prison oversight in a post-PLRA world. *Federal Sentencing Reporter, 24*(4), 236-244. DOI: 10.1525/fsr.2012.24.4.236.

Department of Justice. (2014). Justice Department urges U.S. Sentencing Commission to

make certain individuals incarcerated for drug offenses retroactively eligible for reduced sentences. Retrieved from http://www.justice.gov/opa/pr/2014/June/14-ag-619.html

Easley, C.E. (2011). Together we can make a difference: The case for transnational action for improved health in prisons. *Public Health, 125*(10), 675-679. DOI: 10.1016/j.puhe.2011.09.012

Estelle v. Gamble (1976). 429 U.S. 97. Retrieved from http://biotech.law.lsu.edu/cases/prisons/Estelle_v_Gamble.htm

Everett Hadix et al v. Patricia Caruso et al. (2006). 461 F. Supp. 2nd 574, 599. Retrieved from http://www.gpo.gov/fdsys/pkg/USCOURTS-ca6-07-02560

Florida Center for Fiscal and Economic Policy. (2010). Are Florida's private prisons keeping their promise? Lack of evidence to show they cost less and have better outcomes than public prisons. Retrieved from http://www.fcfep.org/attachments/20100409--Private%20Prisons

Gibbins, J.J. & Katzenbach, N.B. (2006). Confronting confinement: A report of the commission on safety and abuse in American's prisons. *Vera Institute of Justice*. Retrieved from http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf

Glaze, L.E. & Herberman, E.J. (2012). Correctional populations in the United States.

Bureau of Justice Statistics. Retrieved from http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4843

Harris, C. (2012, September 4). Prison nurse tied to hepatitis C exposure at Buckeye facility. *Arizona Central*. Retrieved from http://www.azcentral.com/news/articles/20120904arizona-inmates-exposed-hepatitis-c-diryt-needle.html

Hart, O., Shleifer, A., & Vishny, R. W. (1997). The proper scope of government: Theory and an application to prisons. *The Quarterly Journal of Economics*, *112*(4), 1127-1161. Retrieved from http://qje.oxfordjournals.org/content/112/4/1127.full.pdf

Hylton, W.S. (2009). Sick on the inside: Correctional HMOs and the coming prison plague. In T. Herival & P. Wright (Eds.) *Prison Profiteers: Who Makes Money from Mass Incarceration.* NewYork,NY: New Press.

Isaacs, C. (2013). Continuing problems with Arizona's correctional health care. *American Friends Service Committee – Arizona*. Retrieved from http://www.afsc.org/sites/afsc.civicactions.net/files/documents/DeathYardsFINAL.pdf

Justice and Health Connect (2013). Health disparities in the Criminal Justice System: Quick facts. Retrieved from http://www.jhconnect.org/wp-content/uploads/2013/09/health-disparities-final.pdf

Kim, Y. (2012). Local, state, and federal prison privatization. In B.E. Price & J.C. Morris

(Eds.) *Prison Privatization: The Many Facerts of a Controversal Industry, Volume 1*. Westport, CN: Praeger.

Kirchhoff, S.M. (2010). Economic impacts of prison growth. *Congressional Research Service*. Retrieved from http://www.fas.org/sgp/crs/misc/R41177.pdf

Koppell, D.B. & Burrus, T. (2012). Reducing the drug wars damage to government budgets. *Harvard Journal of Law and Public Policy, 543*. Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/hjlpp35&div=29&id=&page=

Kutscher, B. (August 2013). Rumble over jailhouse healthcare. *Modern Health Care*. Retrieved from http://www.modernhealthcare.com/article/20130831/MAGAZINE/308319891

Lava, J. & Solon, S. (2013, October 8). Meet the company making $1.4 billion a year off sick prisoners. *ACLU*. Retrieved from https://www.aclu.org/blog/prisoners-rights/meet-company-making-14-billion-year-sick-prisoners

Luong, J. (2013). An examination of the complexities or prison health care. *University of Washington Department of Anthropology*. Retrieved from http://www.doc.wa.gov/aboutdoc/measuresstatistics/docs/AnExaminationoftheComplexitiesofPrisonHealthCareJenniferLuongThesisUW8.2013.pdf

Massoglia, M., Pare, P.P., Schnittker, J., & Gagnon, A. (2014). The relationship between incarceration and premature adult mortality: Gender specific evidence. *Social Science Research, 46*, 142-154. DOI: 10.1016/j.ssresearch.2014.03.002

Montague, E. (2003). Prison health care: Healing a sick system through private competition. *Washington Policy Center*. Retrieved from http://www.washingtonpolicy.org/sites/default/files/PN2003-08.pdf

McDonald, D.C. (1999). Medical are in prisons. *Crime and Justice*, *26*. Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/cjrr26&div=13&id=&page=

Michigan Corrections Organization (2012). Pitfalls and Promises. The Real Risks to Residents and Taxpayers of Privatizing Prisons and Prison Services in Michigan http://www.mco-seiu.org/files/2012/02/MCO-Private-Prison-Report-v8.pdf

Moody's Investor Service. (2013). Moody's downgrades Valitas Health Services' (owner of Corizon) CFR to B3 from B2; Outlook negative. Retrieved from https://www.moodys.com/research/Moodys-downgrades-Valitas-Health-Services-owner-of-Corizon-CFR-to--PR_282492?WT.mc_id=NLTITLE_YYYYMMDD_PR_282492

National Alliance on Mental Health. (2009). The high cost of cutting mental health. Retrieved from http://www.nami.org/Template.cfm?Section=About_the_Issue&Template=/ContentManagement/ContentDisplay.cfm&ContentID=114145

National Association for the Advancement of Colored People (NAACP) (2010). Criminal Justice Fact Sheet. Retrieved from http://www.naacp.org/pages/criminal-justice-fact-sheet

National Commission on Correctional Health Care. (2012). A report on health services at the Idaho State Correctional Institution. Retrieved from http://www.idahoprisonhealthreport.com/assets/documents/NCCHCIdahoReport.pdf

Nelson v. Prison Health Servs., Inc. (1997). 991 F. Supp. 1452 (M.D. Fla. 1997). Retrieved from http://www.leagle.com/decision/19972443991FSupp1452_12267.xml/NELSON%20v.%20PRISON%20HEALTH%20SERVICES,%20INC.

Office of Program Evaluation & Government Accountability of the Maine State Legislature. (2011). Health care services in state correctional facilities: A report to the Government Oversight Committee. Retrieved from http://www.maine.gov/legis/opega/GOC/GOC_meetings/Current_handouts/11-15-11/MEDSERV%20Final%20Report%2011-10-11.pdf

Ortega, B. (2011, Dec 5). Prison inmates in Arizona crying foul over medical care. *The Arizona Republic.* Retrieved from http://www.azcentral.com/news/articles/2011/11/22/20111122arizona-prison-inmates-cry-foul-over-care.html

Ortega, B. (2012a, April 3). Arizona prisons' health care to be run by PA company. *The Arizona Republic*. Retrieved from http://www.azcentral.com/arizonarepublic/news/articles/2012/04/03/20120403arizona-prisons-health-care-run-by-penn-company.html

Ortega, B. (2012b, June 4). Arizona prisons can be deadly for sick. *The Arizona Republic.* Retrieved from http://www.azcentral.com/news/articles/2012/06/02/20120602arizona-prisons-can-deadly-sick.html?nclick_check=1

Parkin, J. (2002). Throwing away the key: The world's leading jailer. *International Socialist Review, 21*. Retrieved from http://isreview.org/issues/21/prisons.shtml

Parsons v. Ryan (2012). Ariz. Sup. Ct. R. 38(f). https://www.aclu.org/files/assets/gamez_v_ryan_final_complaint.pdf

Parsons v. Ryan. (2014). Court of Appeals 9th Circuit. https://www.aclu.org/sites/default/files/assets/parsons_9th_cir_opinion_6-5-14.pdf

Privco, LLC. (2013). Industry report: Corizon. Retrieved from http://www.privco.com/private-company/valitas-health-services-inc

Profiri, J. (September 2013). Written Cure Notification-Contract N. 120075DC. *Arizona Department of Corrections*.

Policy Research Associates. (2012). A new challenge for America's prisons: An exploding aging population. Retrieved from http://www.prainc.com/2012/06/

Rich, J.D., S. E. Wakeman, & S. L. Dickman. (2011). Medicine and the epidemic of incarceration in the United States. *The New England Journal of Medicine, 364*(22).

Robbins, I.P. (1999). Managed Health Care in Prisons as Cruel and Unusual

Punishment. *Journal of Criminal law and Criminology, 90* (1).

Schmitt, J., Warner, K., & Gupta, Sarika. (2010). The high budgetary cost of incarceration. Center for Economic and Policy Research.Retrieved from http://www.cepr.net/documents/publications/incarceration-2010-06.pdf

Segura, L. (2013, October 1st). With 2.3 Million People Incarcerated in the US, Prisons Are Big Business: Meet the corporations who are profiting off our prison system. *The Nation.* Retrieved from http://www.thenation.com/prison-profiteers#

Southern Poverty Law Center. (2014). Cruel confinement: Abuse, discrimination and death within Alabama's prisons. Retrieved from http://www.splcenter.org/get-informed/publications/Cruel-Confinement-Abuse-Discrimination-and-Death-Within-Alabamas-Prisons

Spohn, C. (2011). Race and sentencing: In search of fairness and justice. In Walker, S. Spohn & M. DeLone (Eds.), *The color of justice: Race, ethnicity, and crime in America* (pp. 231-281). Independence, KY: Cengage Learning.

Stern, M.F. (2012). Special Master Report to Idaho Department of Corrections. Case 1:81-cv-01165-BLW. Document 822. Retrieved from http://www.idahoprisonhealthreport.com/assets/documents/SternReport.pdf

Stevenson, B. (2011). Drug Policy, Criminal Justice and Mass Imprisonment. Global Commission on Drug Policies. http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Bryan_Stevenson.pdf

Tapia, N.D. & Vaughn, M.S. (2010). Legal Issues Regarding Medical Care for Pregnant

Inmates. *The Prison Journal, 90*(4). Retrieved from http://tpj.sagepub.com/content/90/4/417

The Sentencing Project. (2005). Racial Disparity in Sentencing: A Review of the Literature. Retrieved from http://www.sentencingproject.org/doc/publications/rd_sentencing_review.pdf

The Sentencing Project (2013). Report of The Sentencing Project to the United Nations Human Rights Committee regarding racial disparities in the United States Criminal Justice System. Retrieved from http://sentencingproject.org/doc/publications/rd_ICCPR%20Race%20and%20Justice%20Shadow%20Report.pdf.

The Sentencing Project. (2007). Women in the Criminal Justice System. Retrieved from http://www.sentencingproject.org/doc/publications/womenincj_total.pdf

Arizona Department of Corrections. (2013). Direct contract 130051DC. Retrieved from https://procure.az.gov/bso/external/purchaseorder/poSummary.sdo;jsessionid=F0C05B8E980C50B2C802EEE9357E7C55?docId=ADOC13-041943&releaseNbr=0&parentUrl=contract

The State of Florida (2013). Contract #C2758 Amendment #2. *Florida Department of Corrections*. Retrieved from http://www.dc.state.fl.us/business/contracts/C2758amd3.pdf

Kansas Department of Administration. (2013). Contract award: Service, comprehensive

health care. *Office of Facilities & Procurement Management*. Retrieved from http://www.da.ks.gov/purch/Contracts/Default.aspx?getfile=DA00TXS2013-10-04-13.12.04.006SOKID_00000000000000000000038617_0.00%5B1%5D.xml

The State of Maryland (2013). Second modification to the inmate medical health care and utilization services contract between the state of Maryland Department of Public Safety and Correctional Services and Wexford Health Sources, Inc. *Department of Budget and Management*. Retrieved from http://dbm.maryland.gov/contractors/contractlibrary/Documents/DPSCSInmateMedHlth/Q0012013-Contract-Mod-2.pdf

The State of Michigan. (2013). Form No. DTMB-3521. *Department of Technology, Management and Budget Procurement*. Retrieved from http://www.michigan.gov/documents/buymichiganfirst/0200162_321531_7.pdf

U.S. Government Printing Office. (1992). Eight Amendment: Further guarantees in criminal cases. *Federal Digital System*. Retrieved from http://www.gpo.gov/fdsys/pkg/GPO-CONAN-1992/pdf/GPO-CONAN-1992-10-9.pdf

U.S. Sentencing Commission (2010). Fact sheet: Racial fairness in the advisory guidelines system. *Office of the United States Court*. Retrieved from http://www.fd.org/docs/select-topics/sentencing-resources/bookerfix_factsheet_3.pdf?sfvrsn=6

Walmsley, R. (2013). World prison population list (tenth edition). *International Centre for Prison Studies*. Retrieved from http://www.prisonstudies.org/sites/prisonstudies.org/files/resources/downloads/wppl_10.pdf

Western, B. & Wildeman, C. (2009). The black family and mass incarceration. *The ANNALS of the American Academy of Political and Social Science*. *621*(1). DOI: 10.1177/0002716208324850.

Wexford Health. (2014). Innovative correctional health care. Retrieved from http://www.wexfordhealth.com/

MITN Purchasing Group. (2009). Wexford Health bidder history: RFP section II. *Oakland County Sheriff's Office*. Inmate Medical Services for the Oakland County Jail Facilities. Retrieved from http://www.mitn.info/xfer/PubTab_Docs/SDIR~113540/32-W%20Proposal%20PART%20THREE%20(FINAL).pdf